133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

s 9(2)(a)

By email: s 9(2)(a)
Ref: s 9(2)(a)

Dear s 9(2)(a)

Response to your request for official information

Thank you for your request for information under the Official Information Act 1982 (the Act) on 18 February 2020 for:

> *"We request all information regarding this review and the relationship between your organisation and the one subject to our complaints, Nga Hau E Wha."*

Your request was in response to an email from the Ministry of Health (the Ministry) dated 11 September 2019, that referred to *"an internal review of the named organisation including past and present membership, Terms of Reference, historical reports, correspondence and contract specifications"*. We have proceeded on the basis that your request for *"this review"* is a reference to the internal review set out in the Ministry's earlier email. The information you have requested regarding the review is attached as Appendix One. Some information has been withheld under section 9(2)(g)(i) of the Act, to maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to members of an organisation in the course of their duty.

Please note, that the Ministry does not have a direct contractual relationship with Nga Hau E Wha. Until 30 June 2019, the Ministry contracted with Mental Health Advocacy and Peer Support Trust for the management and coordination of quarterly meetings of Nga Hau E Wha to provide sector intelligence (contract 356272).

Information regarding the Ministry's relationship with Nga Hau E Wha prior to 26 June 2019 is publicly available at: https://fyi.org.nz/request/9896-all-information-regarding-contracts-and-funding-awarded-to-nga-hau-e-wha-supporting-applications-etc#incoming-38352. Therefore, this is refused under section 18(d) of the Act. There is no other information regarding the Ministry's relationship with Mental Health Advocacy and Peer Support Trust in relation to Nga Hau E Wha, after 26 June 2019.

On 9 July 2019, the Ministry entered into contract 363326 with Tu Kupenga Net Trust. This contract was for the management and coordination of quarterly meetings of Nga Hau E Wha to provide sector intelligence from 1 July 2019 to 30 June 2020. The following documents relating to the contract with Tu Kupenga Net Trust are attached as Appendix Two:

#	Date	Document
1	9 July 2019	Contract 363326/00
2	undated	Finance Report 1 July 2019 to 30 September 2019
3	undated	Report for 1 July 2019 to 30 September 2019
4	11 October 2019	Email from Victoria Roberts to Marie Farquhar
5	12 October 2019	Email from Victoria Roberts to Marie Farquhar
6	undated	Report for 1 October 2019 to 31 December 2019
7	undated	Finance Report 1 July 2019 to 31 December 2019

Please note that some information has been withheld under section 9(2)(a) of the Act, to protect the privacy of natural persons.

I trust that this information fulfils your request. Under section 28(3) of the Act you have the right to ask the Ombudsman to review any decisions made under this request.

Please note that this response, with your personal details removed, may be published on the Ministry website.

Yours sincerely

Robyn Shearer
Deputy Director-General
Mental Health and Addiction

Email from Katherine Raue, 10/09/2019 (noted: Te Enga Harris, Te Ringa Mangu Mihaka, Kuia and Kaumatua of Te Tii Marae – Waitangi

"WE REQUEST AN URGENT MEETING WITHOUT DELAY TO DISCUSS THE INFORMATION RECENTLY RELEASED BY THE MINISTRY REGARDING NGA HAU E WHA AND ASSOCIATED INDIVIDUALS, ONGOING FUNDING OF THIS FRAUDULENT AND NEBULOUS ORGANISATION AND DEMAND FOR AN URGENT INQUIRY INTO THESE MATTERS - THE INFORMATION CONFIRMS THAT THEY MADE FRAUDULENT MISREPRESENTATION ON FUNDING APPLICATIONS AND WE INSIST THAT THE MINISTRY MEET WITH US WITHOUT DELAY!"

Also: call(s) to MoH by Katherine Raue to Marie Farquhar on 10/09/19

BACKGROUND/TIMEFRAME

DATE	QUERIES ETC RAISED
01/072016-30/06/18	MHAPS contract holders
15/02/18	Letter from NHEW to Minister
05/06/18 H201804146	Vicki Blake re: Complaint from Katherine Raue: This complaint is referred to the Ministry of Health, it is urgent, and we would appreciate any assistance you are able to offer. We look forward to hearing from you, you can phone me on 021 04 818 93 if you like. We believe that the claims made in Ms Taurua's profile on the NHEW website is seriously misleading, deliberately deceptive and that the effect of this deceptive 'advertising' warrants intense scrutiny under the circumstances. Thank you for your attention to this matter.

s 9(2)(g)(i) [redacted]

01/07/18	MHAPS notified of non renewal of contracts	s 9(2)(g)(i)
26/09/18	MoH/NHEW	
22/11/19	MoH	
07/06/18 **H201804206**	Katherine Raue: OIA: We request all information regarding interaction between the MOH and its subsidiaries (DHBs, etc) and an organisation calling themselves "Nga Hau E Wha" or "NHEW". To avoid confusion with the large number of nebulous orgs using this name, we refer to the org using the website "http://scanmail.trustwave.com/?c=5305&d=neiY2-okNOy0Q-zQtbFcbYDztHiucUu2pa4HnfxWrg&u=http%3a%2f%2fnhew%2eorg%2enz". During previous discussions with Vicki Blake of the Ministry we made a formal complaint regarding one of the profiles on this website which infers that one of the representatives of this org has around 20 years experience as a "clinician", when it has been confirmed by the head of the org, Victoria Roberts, that the person is not and has never been a clinician. What is the definition of the term "clinician" as recognised by the Ministry, and in the context of the current legislation (such as the Mental Health Act and the Criminal Proceedings Mentally Impaired Persons Act) - which refers to, and grants considerable unbridled power, to "Responsible Clinicians", including the power to detain persons (such as Ashley Peacock, and myself) indefinitely and arbitrarily despite overwhelming and damning evidence that such action is unethical, unacceptable an d unjust? Vicki Blake indicated that Nga Hau E Wha is "not a legal entity" but that the Ministry have provided them with funding. What is the Ministry's policy on funding non legal entities? How much funding has been provided to this organisation through the Ministry, directly or indirectly through various DHBs, etc?	

	Vicki Blake stated that a letter had been sent to NHEW regarding the claims made in the profile on the website (at the link http://scanmail.trustwave.com/?c=5305&d=neiY2-okNOy0Q-zQtbFcbYDztHiucUu2pawBnv8HrA&u=http%3a%2f%2fnhew%2eorg%2enz%2ftuis-profile%2ehtml%29 that this person has 20 years experience "working in Mental Health . . . as a clinician and project manager" when these claims are clearly untrue and highly misleading. We request a copy of that letter and all other correspondence and other information regarding these matters. This request is URGENT because of the possible harm caused to vulnerable people on the basis of the untrue claims, and the allocation of available funding to such flawed initiatives. It is also URGENT because we have become aware of two letters to the Prime Minister which contain gross inaccuracies and false claims, these letters are from NHEW, and the actions of NHEW are preventing and hindering a number of people from making submissions to the current mental health inquiry.	s 9(2)(g)(i)
21/03/19 **H201901868**	Te Ringa Mangu Mihaka – OIA request re all info regarding funding, contracts, communications, applications for funding, contracts, provision of services and all other matters, made to the Ministry of Health or any of its subsidiaries including District Health Boards, to an organisation known as 'Nga Hau E Wha', including a copy of the contract number 356272/00 - Management and co-ordination of Nga Hau E Wha (NHEW), and all previous contracts with this organisation. I further request all information held by the Ministry of Health or any of its subsidiaries including District Health Boards regarding the Chairperson (or former Chairperson) Victoria Roberts, and others associated with NHEW including Jak Wild and Tui Taurua Peihopa - in particular any and all communication with Tui Taurua Peihopa or anyone from the organisation NHEW regarding the letter sent to her in about June last year regarding her misleading claim to being a "clinician".	
16/04/19 **H201902528**	Te Ringa Mangu Mihaka – OIA request re Tui Taurua claiming her employers at Tiaho Mai Middlemore called her 'clinician'	

s 9(2)(g)(i)

The objectives of these Services are to enable Nga Hau E Wha to:

- provide sector intelligence from the perspective of people with lived experience to the Ministry;
- be able to coordinate input into strategic documents and key pieces of work within the sector and those developed by the Ministry to provide a consumer perspective;
- provide input and comment on strategic service developments proposed by the Ministry to ensure responsiveness to the needs of those with lived experience;
- provide an overview of national issues or challenges identified by consumers that will also include peer support services;
- provide an overview of areas of best practice as identified by consumers;
- develop and maintain relationships with key stakeholders in the sector.

Output 1: Management and coordination of quarterly Nga Hau e Wha meetings and processes

1.1 You will provide secretarial services for the management and coordination of quarterly Nga Hau E Wha meetings and processes including:

- Agreeing dates, times and agenda for meetings with the Nga Hau E Wha members.
- Initiate and progress discussions with Nga Hau E Wha members to obtain business guidelines including clear and defined practices covering the following:

1. Terms of Reference including internal process for amendments;
2. Conflict of Interest Process;
3. Quarterly Meeting travel process;
4. Expenditure process including:
   a. Defined meeting attendance fees and process for payment;
   b. Agreed hours for Chair work outside of meeting attendance;

c. Additional fees process (outside of budget) including: conferences, koha, assets, training, travel and expenses outside of quarterly meetings.

- Funding and arranging suitable return flights for the representatives, accommodation, airport transfers, venue hire, catering and any other services required for the effective and efficient management of the quarterly Nga Hau E Wha meetings.

- Where possible quarterly meetings will be held at Ministry of Health, 133 Molesworth Street, Thorndon, Wellington. For venue booking co-ordination please contact Marie Farquhar, Senior Contract Advisor Marie_Farquhar@health.govt.nz at the earliest convenience.

1.2 You will ensure that the Nga Hau E Wha meetings include two representatives from each of the following areas:

- Northern Region
- Midland Region
- Central Region
- Southern Region

These regions are defined as the DHB regions.

Representatives from these regions will usually be mandated by the established consumer networks in those regions. In the absence of established network organisations, or in the event that those organisations do not mandate representatives to Nga Hau E Wha, then representatives from those regions shall be selected following the processes described in Nga Hau E Wha's Terms of Reference. Nga Hau E Wha are responsible for recruiting representatives to the group.

1.3 You will ensure that the agenda for meetings is structured to enable the existing NHEW representatives identified in clause 1.2 to learn about consumer networking activities in each other's regions and collaborate to strengthen their capacity for their experiences to be shared at local, regional and national levels. The agenda will also provide opportunities to discuss national issues, and link with other key strategic partners.

1.4 You will support and help develop the relationship between Nga Hau E Wha and Ministry officials, including quarterly meetings.

1.5 You will operate in a way that is consistent with and furthers the Terms of Reference of Nga Hau E Wha.

1.6 This Agreement concerns only the management and coordination of quarterly meetings of Nga Hau E Wha; any documents or communications produced by Nga Hau E Wha at (or as a result of) any meetings held to fulfil this contract are owned by Nga Hau E Wha. In instances where the Ministry considers that material produced by Nga Hau E Wha should be distributed to other stakeholders, the Ministry will seek the agreement of Nga Hau E Wha before doing so.

1.7 You will provide an overview of national issues or challenges in the Mental Health and Addiction sector as identified by people with experience in that sector.

1.8 You will provide an overview of areas of best practice in the Mental Health and Addiction sector as identified by people with experience in that sector.

Output 2: Quarterly reporting

2.1 You will provide quarterly reports in partnership with Nga Hau E Wha to the Ministry's Senior Contract Advisor on the outputs described in this specification. Please also refer: **Appendix 1 – TKNT Work and Reporting Plan**. Quarterly reports will include a record of the dates of meetings held in the preceding three months and names of attendees from each region.

2.3 As a minimum the three monthly reports will include the following information:

- an overview of the areas identified in clauses 1.1, 1.7,1.8 and 1.9
- consumer and/or sector feedback to the Ministry on the strategic direction of mental health and addictions including He Ara Oranga recommendations
- any other information you would like the Ministry to be aware of.

2.4 You will work closely with Nga Hau E Wha to agree on the process for the development of the six-monthly reports, and a final copy will be made available to Nga Hau E Wha for comment before being sent to the Ministry.

2.6 While you have responsibility for submitting the three-monthly reports, the Ministry expects that compiling the reports will be the collective responsibility of those people who attended each meeting of Nga Hau E Wha.

2.7 The three-monthly reports will be provided to the Ministry's Senior Contract Advisor, Mental Health Programmes, Mental Health & Addiction Directorate, Ministry of Health, PO Box 5013, Wellington or preferably email to:

2.7 The three-monthly reports will be provided to the Ministry's Senior Contract Advisor, Mental Health Programmes, Mental Health & Addiction Directorate, Ministry of Health, PO Box 5013, Wellington or preferably email to:

MentalHealth&AddictionsContracts@health.govt.nz with the subject line "Nga Hau E Wha Report" attention Marie Farquhar.

Period	Report due date
1 July 2019 – 30 September 2019	10 October 2019
1 October 2019 – 31 December 2019	10 January 2020
1 January 2020 – 31 March 2020	10 April 2020
1 April 2020 – 30 June 2020	10 July 2020

2.8 You will also provide a three-monthly expenditure report. This report will include:

- Travel: Airfares, Taxis etc;
- Accommodation;
- Venue hire, catering and other meeting costs;
- Administration allocation;
- Meeting Fees;
- Overheads – TKNT Fee

Funding

3.1 You will provide the Services under this Agreement up to the total amounts (GST exclusive) as noted in the following table:

For services supplied in the period:	On invoices received by us on or before:	Amount (excl GST)
1 July 2019 – 30 September 2019	On Signing after 1 July 2019	$15,000.00
1 October 2019 – 31 December 2019	31 August 2019	$15,000.00
1 January 2020 – 31 March 2020	30 November 2019	$15,000.00
1 April 2020 – 30 June 2020	28 February 2020	$15,000.00
	TOTAL CONTRACT VALUE 2019/2020 FY	**$60,000.00**

3.2 Payment of Funding is dependent on delivery of the Services in accordance with the requirements of this Service Specification, including receipt of satisfactory reports as specified in clause 2.1 of this Service Specification.

3.3 The Funding will be paid in equal quarterly instalments in advance. First quarterly payment will be on signing of this agreement after 1 July 2019.

Application of Funding

3.4 You agree to apply 100% of the Funding in accordance with this Agreement.

3.5 If, upon the expiry or termination of this Agreement, you have any surplus (including any interest accrued) funding, you will repay the surplus to us, or with our prior agreement, apply the surplus to further Nga Hau E Wha activity.

Provider #: 237725 Agreement #: 356272/00

MHAPS – Mental Health Advocacy and Peer Support

REPORT AND RECOMMENDATIONS RE: NGĀ HAU E WHĀ

Report prepared for Ministry of Health

on MHAPS exiting the Ngā Hau e Whā contract

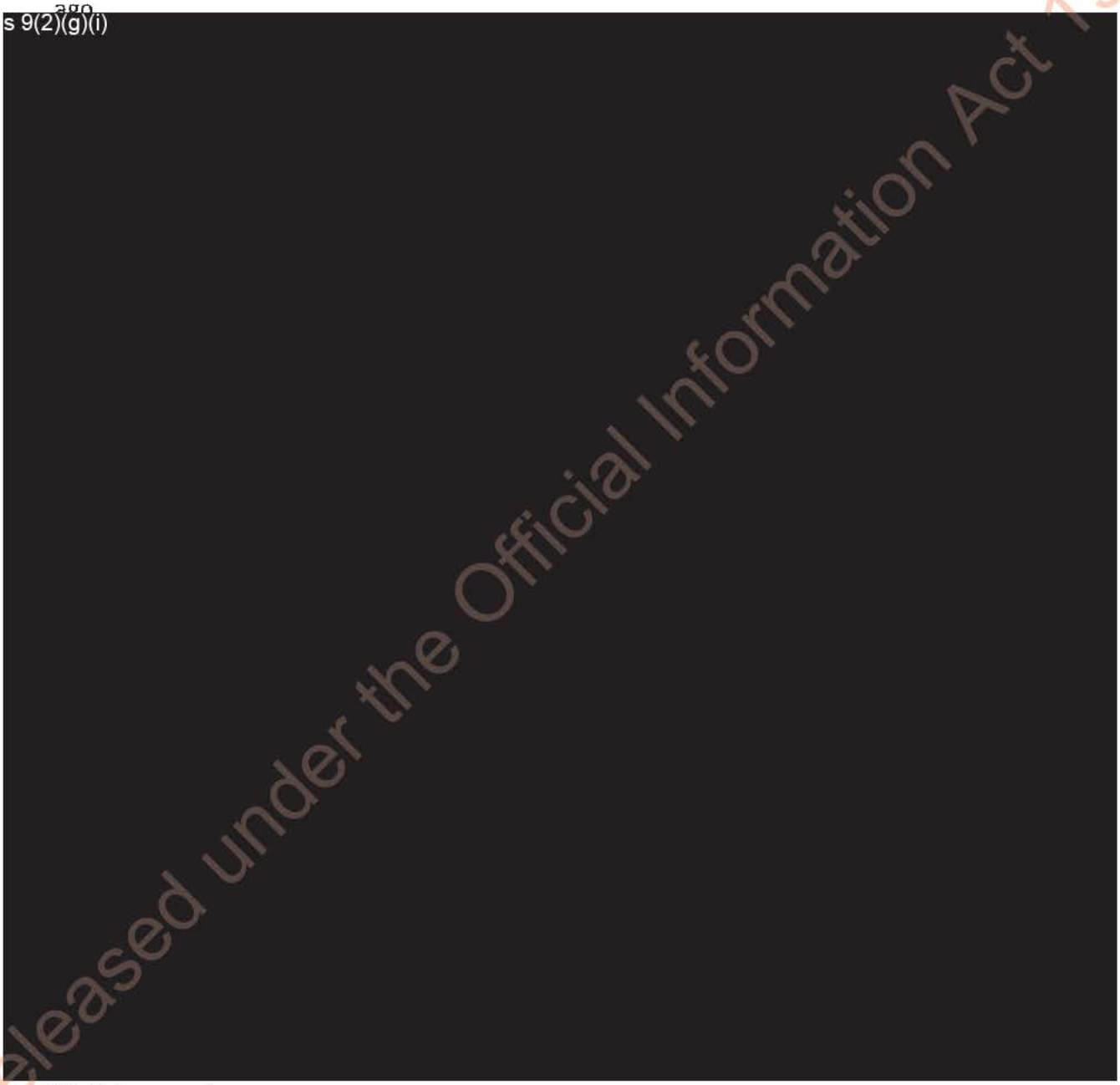
as of 30 June 2018

Executive summary

Ngā Hau e Whā, a regional representative group, has been funded by the Ministry of Health to meet quarterly since 2007. Members have consistently shared a collective passion for making a positive difference in the mental health and addictions sector, and have provided the Ministry with a useful mechanism to access consumer views and perspectives during this time.

However, the consumer network environment is very different now to what it was a decade ago.

s 9(2)(g)(i)



Background

Ngā Hau e Whā, a regional representative group, has been funded by the Ministry of Health to meet quarterly since 2007, at a time when each of the four regions (more or less) had an active consumer network. As with other representative-type groups drawn to a large extent from volunteers, the expertise and skills of the group's members have varied during that time, as has the group's overall focus and direction. However, members have consistently shared a collective passion for making a

positive difference in the mental health and addictions sector, and have provided the Ministry with a useful mechanism to access consumer views and perspectives during this time.

The group is rightly proud of its significant input over the years to initiatives such as the work done in New Zealand on implementing the UN Convention on the Rights of Persons with Disabilities, in conjunction with the Disabled Persons' Assembly and other DPOs. Likewise, Ngā Hau e Whā's involvement has helped to influence the monitoring of places of detention, including mental health seclusion, under the OPCAT protocol. The OPCAT monitoring of seclusion has been seen as particularly important to the consumer sector, in the wake of the New Zealand Mental Health Commission being disestablished in 2012.

It would be fair to say that many in consumer roles in the sector have noted the waxing and waning of the group's reach and transparency to flaxroots service users and networks over the years. A notable peak occurred some years ago when the chair's role was filled by a consumer advisor from the Midland region. For example, at that time the minutes from Ngā Hau e Whā were consistently circulated each quarter to regional consumer networks and via DHB consumer advisors, as well as to individual subscribers. This helped to keep regional groups informed about national initiatives and also of developments in other parts of the country, and to an extent kept the representatives of Ngā Hau e Whā clearly linked and accountable to a wide range of regional groups and networks.

Individuals on the group, and perhaps the longer-serving members in particular, continue to feel a strong sense of responsibility for making meaningful, systemic change in the mental health and addictions sector via Ngā Hau e Whā.

However, the consumer network environment is very different now to what it was a decade ago. In one or two places, consumer networks flourish, while much of the country no longer has this type of structure. In the last couple of years, when existing members have left the national group, the remaining members have started to nominate and select the replacements for some regions, rather than being able to draw on networks in each region to nominate and select their own representatives.

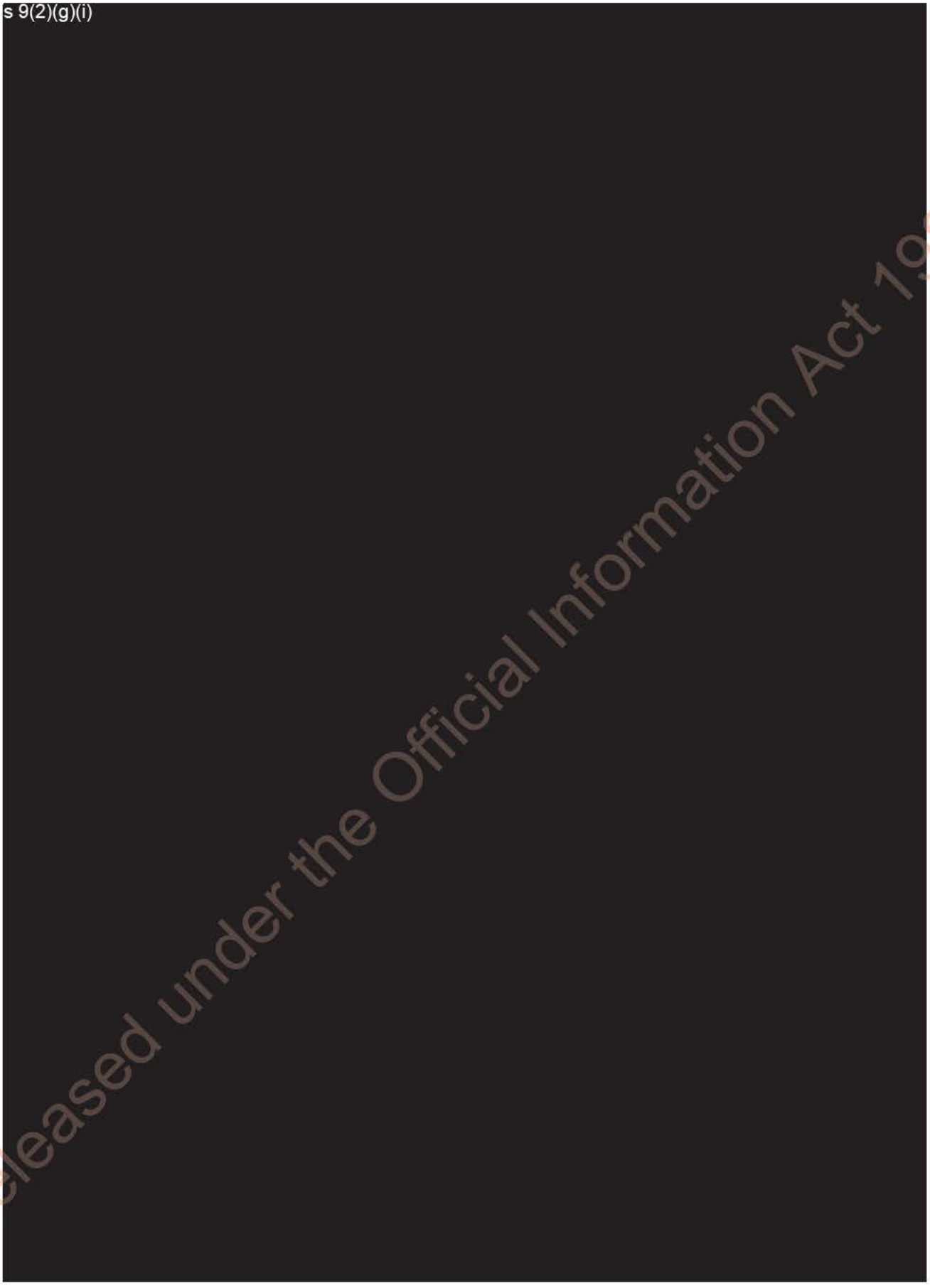
s 9(2)(g)(i)

[redacted]

s 9(2)(g)(i)

[redacted]

s 9(2)(g)(i)



s 9(2)(g)(i)

[redacted]

Report prepared by:

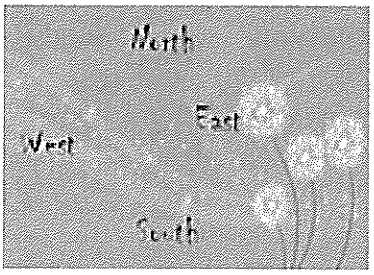
Fiona Clapham Howard

Te Kaihautū / Service Director, MHAPS

March 2019

MHAPS
Mental Health
Advocacy and Peer Support
Together on the road to wellbeing

APPENDIX 1: Assets held on behalf of Ngā Hau e Whā



Nga Hau E Wha

"Championing Many Voices"

ASSETS HELD ON BEHALF OF NGA HAU E WHA

WHĀINGA / PURPOSE

1.1 The following assets are provided to the chairperson of Nga Hau E Wha in order that the contractual responsibilities of the group are achieved through effective communication including with members and with the Ministry.

1.2 These assets are not for personal use.

? / OWNERSHIP

2.1 These assets are owned by the holder of the Ministry of Health contract.

2.2 The costs of repair, maintenance and payment plans will be met by the contract holder so long as this work has been agreed in principle before it is undertaken and on receipt of an invoice on completion.

HAEPAPA / RESPONSIBILITY

3.1 It is the responsibility of the Chairperson to keep these assets securely and safely.

3.2 They will not be replaced except under exceptional circumstances (e.g. burglary, catastrophic event such as an earthquake, fire, etc.)

3.3 Anti-virus software and Microsoft updates must be regularly maintained and acted upon if malware detected.

3.4 Following the election of a new Chairperson, the assets will be immediately handed over to them by the retiring Chairperson in their entirety complete with existing programmes, files, folders, and text messages.

? / ISSUES

4.1 The MOH contract holder must be contacted if there are any issues regarding these assets.

ASSET	DATE PURCHASED	PROVIDER	COST
SamsungGalaxy A7 phone	25.8.2017	Spark	$899.00
ASUS P2530UA-DM1273R 15.6 Notebook	4.9.2017	Solved.net.nz	$1437.50
Microsoft Office Professional Plus	22.8.2017	TECH Soup	$63.25

APPENDIX 2: Customised Service Specs

SERVICE SPECIFICATION

Management of Quarterly Meetings of Nga Hau E Wha to provide Sector Intelligence from consumers to the Ministry of Health

Background

Nga Hau E Wha consists of two representatives from each of the four regional consumer networks and was established to enable the networks to learn from each other in order to strengthen the consumer voice and improve consumer engagement and involvement locally, regionally and nationally.

Nga Hau E Wha also contributes to the following Mental Health Commission and Ministry of Health strategic policy documents:

- Blueprint II Improving mental health and wellbeing for all New Zealanders: How things need to be
- Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017

Services to be provided under this Agreement

The Ministry of Health (the Ministry) requires Mental Health Advocacy and Support ("you") to be responsible for the management and coordination of quarterly Nga Hau E Wha meetings and processes ("the Services").

The objectives of these Services are to enable Nga Hau E Wha to:

- provide sector intelligence from the perspective of people with lived experience to the Ministry
- be able to coordinate input into strategic documents and key pieces of work within the sector and those developed by the Ministry to provide a consumer perspective
- provide input and comment on strategic service developments proposed by the Ministry to ensure responsiveness to the needs of those with lived experience
- provide an overview of national issues or challenges identified by consumers that will also include peer support services
- provide an overview of areas of best practice as identified by consumers
- develop and maintain relationships with key stakeholders in the sector.

Output 1: Management and coordination of quarterly Nga Hau e Wha meetings and processes

1.1 You will provide secretarial services for the management and coordination of quarterly Nga Hau E Wha meetings and processes including:

- Agreeing dates, times and agenda for meetings with the Nga Hau E Wha members.
- Funding and arranging suitable return flights for the representatives, accommodation, airport transfers, venue hire, catering and any other services required for the effective and efficient management of the quarterly Nga Hau E Wha meetings

1.2 You will ensure that the Nga Hau E Wha meetings include two representatives from each of the following areas:

- Northern Region

- Midland Region
- Central Region
- Southern Region

These regions are defined as the DHB regions.

Representatives from these regions will usually be mandated by the established consumer networks in those regions. In the absence of established network organisations, or in the event that those organisations do not mandate representatives to Nga Hau E Wha, then representatives from those regions shall be selected following the processes described in Nga Hau E Wha's Terms of Reference. Nga Hau E Wha are responsible for recruiting representatives to the group.

1.3 You will ensure that the agenda for meetings is structured to enable the representatives identified in clause 1.2 to learn about consumer networking activities in each other's regions and collaborate to strengthen their capacity for their experiences to be shared at local, regional and national levels. The agenda will also provide opportunities to discuss national issues, and link with other key strategic partners.

1.4 From time to time you will invite officials from the Ministry of Health or other agencies to attend meetings with Nga Hau E Wha.

1.5 You will operate in a way that is consistent with and furthers the Terms of Reference of Nga Hau E Wha.

1.6 This Agreement concerns only the management and coordination of quarterly meetings of Nga Hau E Wha; any documents or communications produced by Nga Hau E Wha at (or as a result of) any meetings held to fulfil this contract are owned by Nga Hau E Wha. In instances where the Ministry considers that material produced by Nga Hau E Wha should be distributed to other stakeholders, the Ministry will seek the agreement of Nga Hau E Wha before doing so.

1.7 You will provide an overview of national issues or challenges in the Mental Health and Addiction sector as identified by people with experience in that sector.

1.8 You will provide an overview of areas of best practice in the Mental Health and Addiction sector as identified by people with experience in that sector.

1.9 You will provide an overview of changes or developments that Nga Hau E Wha believe have been generated out of Rising to the Challenge.

Output 2: Six monthly reporting

2.1 You will provide six-monthly reports in partnership with Nga Hau E Wha to the Ministry's Senior Contract Manager on the outputs described in this specification.

2.2 The six-monthly reports will include a record of the dates of meetings held in the preceding six months and names of attendees from each region.

2.3 As a minimum the six monthly reports will include the following information:

- an overview of the areas identified in clauses 1.7,1.8 and 1.9
- consumer sector feedback to the Ministry on the strategic direction of mental health and addictions

- any other information you would like the Ministry to be aware of

2.4 You will work closely with Nga Hau E Wha to agree on the process for the development of the six-monthly reports, and a final copy will be made available to Nga Hau E Wha for comment before being sent to the Ministry.

2.6 While you have responsibility for submitting the six-monthly reports, the Ministry expects that compiling the reports will be the collective responsibility of those people who attended each meeting of Nga Hau E Wha.

2.7 The six-monthly reports will be provided to the Ministry's Senior Contract Manager, Mental Health Programmes, Mental Health & Addiction Programmes, Service Commissioning, Ministry of Health, PO Box 5013, Wellington or preferably email to:

MentalHealth&AddictionsContracts@moh.govt.nz with the subject line "Nga Hau E Wha Report".

Period	Report due date
01 July 2016 to 31 December 2016	20 January 2017
01 January 2017 to 30 June 2017	20 July 2017

2.8 You will also provide a six-monthly expenditure report. This report will include expenditure as follows:

Expenditure Item	Budget	Actual
Travel – (airfares, taxis, etc)	$18,600	
Accommodation	$4,800	
Venue hire, catering and other meeting costs	$6,400	
Administration allocation	$3,880	
Meeting fees	$6,120	
Overheads (MHAPS Fee)	$8,000	
Total	**$48,000**	

Funding

3.1 For the period 1 July 2016 to 30 June 2017, you will provide the Services under this Agreement for up to a total amount of forty eight thousand dollars only ($48,000.00) per annum (GST exclusive) (the Funding).

3.2 Payment of Funding is dependent on delivery of the Services in accordance with the requirements of this Service Specification, including receipt of satisfactory reports as specified in clause 2.1of this Service Specification.

3.3 The Funding will be paid in equal monthly instalments in arrears.

Application of Funding

3.4 You agree to apply 100% of the Funding in accordance with this Agreement.

3.5 If, upon the expiry or termination of this Agreement, you have any surplus (including any interest accrued) Funding, you will repay the surplus to us, or with our prior agreement, apply the surplus to further Nga Hau E Wha activity.

605210 / 363326/00
Provider No. / Contract No.

Agreement

between

HER MAJESTY THE QUEEN IN RIGHT OF HER GOVERNMENT IN NEW ZEALAND (acting by and through the Ministry of Health)

MANATŪ HAUORA

Private Bag 92522
Wellesley Street
Auckland 1141
Ph: 09 580 9000
Fax: 09-580 9001

PO Box 1031
Waikato Mail Centre
Hamilton 3240
Ph: 07 858 7000
Fax: 07 858 7001

PO Box 5013
Lambton Quay
Wellington 6140
Ph: 04 496 2000
Fax: 04-496 2340

PO Box 3877
Christchurch
Ph: 03-974 2040
Fax: 03-372 1015

Private Bag 1942
Dunedin 9058
Ph: 03 474 8040
Fax: 03 474 8582

Contact: **Mental Health Senior Contract Advisor (Wellington)**

and

Te Kupenga Net Trust t/a Mental Health Advocacy and Peer Supports

Management and Coordination of quarterly meetings of Nga Hau E Wha to provide sector intelligence

PO Box 258
Gisborne

Contact: **Hine Moeke-Murray**

CONTENTS OF THIS AGREEMENT

A: SUMMARY

A1 Agreement to Purchase and Provide Services

A1.1 We agree to purchase and you agree to provide services on the terms and conditions set out in the Agreement.

A1.2 The Agreement means all documents included in Part 1 (this document, to be referred to as the Head Agreement), together with Parts 2 and 3 (the documents listed in the Agreement Summary below).

A1.3 The Agreement sets out the entire agreement and understanding between us and supersedes all prior oral or written agreements or arrangements relating to its subject matter.

A2 Duration of the Agreement, and Components of the Agreement

A2.1 Part 2 (the General Terms) will apply for the period specified in the Agreement Summary below, or until terminated in accordance with the Agreement, subject to any rights to review, extend, vary or terminate any of these documents in accordance with the terms of this Agreement.

A2.2 Each Service Schedule will apply for the period specified in Part 3, and shown in the Agreement Summary below, subject to any rights to review, extend, vary or terminate any of these documents in accordance with the terms of this Agreement.

A2.3 The Agreement will automatically terminate upon the expiry of all Service Schedules in Part 3. Notwithstanding any end date given in Part 2 (the General Terms) the terms and conditions of Part 2, including the right to terminate the Agreement of any part of the Agreement, Part 2 (the General Terms) will be deemed to continue as long as there is one or more active Service Schedule in Part 3.

A3 Relative Priorities of the Component Parts of the Agreement

A3.1 In the event of any conflict between the terms of the Provider Specific Terms and Conditions within Part 3 (Service Schedules) and any other part of the Agreement, the terms of the Provider Specific Terms and Conditions within Part 3 (Service Schedules) will have priority.

A3.2 In the event of any conflict between the terms of Part 2 (the General Terms) and Part 3 (the Service Schedules), the terms of the Service Schedules will have priority.

A3.3 In the event of any conflict between the terms of Section B (the Standard Conditions of Contract) and Section E (the Provider Type Terms and Conditions), the terms of Section E (the Provider Type Terms and Conditions) will have priority.

A4 Enforceability of the Agreement, and its Component Parts

A4.1 If any provision in any of the documents listed in the Agreement Summary below is lawfully held to be illegal, unenforceable or invalid, the determination will not affect the remainder of the relevant document or the Agreement, which will remain in force.

A4.2 If an entire document listed in the Agreement Summary below is lawfully held to be illegal, unenforceable or invalid, the determination will not affect any other documents listed in the summary or the Agreement, which will remain in force.

A4.3 If any provision in any of the documents or an entire document listed in the Agreement Summary below is held to be illegal, unenforceable or invalid, then we agree to take such steps or make such modifications to the provision or document as are necessary to ensure that it is made legal, enforceable or valid. This is in addition to and not in substitution of our rights to give notice of the terms and conditions on which we will make payments to you pursuant to section 51 of the Health and Disability Services Act 1993 or otherwise.

A4.4 The above provisions with respect to illegality, unenforceability or invalidity are not to affect any rights validly to terminate any of the documents in the above schedule or the Agreement as a whole in accordance with the terms of the Agreement or otherwise.

A5 Agreement Summary

A5.1 This section lists all documents included in The Agreement. The Agreement comes into effect from the commencement date identified in Part 1 below. This summary will be updated, by a contract variation, whenever there is a change to this list.

A6 Part 1 – The Head Agreement

Document	Commencement Date
This document	1 July 2019

A7 Part 2 – The General Terms

Document	Document Version No.	Commencement Date	End Date, if specified
Conditions of Contract	1.0	1 July 2019	30 June 2020
Provider Quality Specifications	1.0	1 July 2019	30 June 2020
Standard Information Specifications	1.0	1 July 2019	30 June 2020
Provider Type Terms and Conditions	1.0	1 July 2019	30 June 2020

A8 Part 3 - The Service Schedules

Service Schedule(s)	Reference/ Version No.	Commencement Date	End date
MHSD Mental Health - Service Development	1.0	1 July 2019	30 June 2020

A9 Signatures

Please confirm your acceptance of the Agreement by signing where indicated below.

For **HER MAJESTY THE QUEEN In Right Of Her Government In New Zealand** (acting by and through the Ministry of Health)

(signature)

Name: ROBYN STEARER.

Position: Deputy Director General

Date: 9 JULY 2019.

For **Te Kupenga Net Trust t/a Mental Health Advocacy and Peer Supports**:

(signature)

Name: Hine Maeke-Murray

Position: Manager

Date: 03/07/2019

PART 2: GENERAL TERMS

2. 01 This Part 2 contains all of the parts of the Head Contract, as listed in the Contract Agreement (Agreement Summary).

2. 02 Each of the documents in Part 2 (the Head Contract) form part of the Agreement between us, as defined in the Contract Agreement or in a subsequent Variation to the Contract Agreement, as applicable.

2. 03 Section B -the Standard Conditions of Contract set out the conditions on which our relationship with all our providers is based.

2. 04 Section C -the Provider Quality Specification (PQS) sets out the minimum quality of service required of all our providers. Where appropriate, the PQS also requires providers to meet the Health and Disability Services Standards 2008. The PQS applies to all Services provided under the Agreement. More detailed and service specific quality requirements are included in the Service Schedules.

2. 05 Section D -the Standard Information Specifications (SIS) sets out information management principles required of all our providers. The SIS applies to all Services provided under the Agreement. More detailed and service specific information requirements are included in the Service Schedules.

B: STANDARD CONDITIONS OF CONTRACT

INTRODUCTION

B1 Standard Conditions

B1.1 Any Agreement you enter into with us will be deemed to include the following Standard Conditions.

B1.2 If however any other terms in the Agreement directly conflict with these Standard Conditions, the other terms will have priority.

B1.3 There is a glossary at the back of these Standard Conditions setting out definitions, interpretations and terms used.

B2 Māori Health

An overarching aim of the health and disability sector is the improvement of Māori health outcomes and the reduction of Māori health inequalities. You must comply with any:

(a) Māori specific service requirements;

(b) Māori specific quality requirements; and

(c) Māori specific monitoring requirements

contained in any Service Schedules to this Agreement

B3 Relationship Principles

B3.1 The following values will guide us in all our dealings with each other under the Agreement:

Integrity – we will act towards each other honestly and in good faith.

Good communication – we will listen, talk and engage with each other openly and promptly including clear and timely written communication.

Enablement – we will seek to enable each other to meet our respective objectives and commitments to achieve positive outcomes for communities and consumers of health and disability services.

Trust and co-operation – we will work in a co-operative and constructive manner recognising each other's viewpoints and respecting each other's differences.

Accountability – we will each recognise the accountabilities that each of us have to our respective and mutual clients and stakeholders.

Innovation – we will encourage new approaches and creative solutions to achieve positive outcomes for communities and consumers of health and disability services.

Quality improvement – we will work co-operatively with each other to achieve quality health and disability services with positive outcomes for consumers.

B4 Reserved

SERVICE PROVISION

B5 Provision of Services

B5.1 You must provide the Services and conduct your practice or business:

In a prompt, efficient, professional and ethical manner, and

In accordance with all relevant published Strategies issued under the Act; and

In accordance with Our obligations, and

in accordance with all relevant Law; and

from the Commencement Date and then without interruption until the Agreement ends or is ended in accordance with the Agreement.

B5.2 Nothing in the Agreement gives you an exclusive right to provide the Services.

B6 Payments

B6.1 We will pay you in accordance with the terms of the Agreement.

We will pay you default interest on any payments due to you under the Agreement and in arrears for more than 14 days.

You must first have given us an invoice completed in the format required and we must have received it 14 working days before it is due.

"Default interest" means interest at the base rate of our bankers calculated from the due date for payment to the date of actual payment, plus the rate of 2 per cent per annum.

This clause does not apply to payments due to you in respect of which we have exercised our right of set off (see clause B6.2).

B6.2 In that case payments may be withheld from the date of non-compliance until such time compliance occurs.

B7 Cost and Volume Shifting

B7.1 You must not:

a) act in such a way that increases cost to another provider,

b) be party to any arrangement which results in our effectively having to pay more than once for the supply of the same Services or any component of them,

c) act in such a way that shifts volumes relating to Services being provided separately by you where such volumes have been specifically related to that Service.

B8 Responsibility for Others

B8.1 You will be responsible for all acts and omissions of your employees, agents and subcontractors even if they are done without your knowledge or approval.

B9 Other Arrangements

B9.1 You must not enter into any other contract or arrangement which might prejudice your ability to meet your obligations in the Agreement/

B9.2 You may (subject to your obligations in the Agreement), agree to provide Services for any other person.

B10 Subcontracting

B10.1 You may not subcontract any of the Services or part of them without our prior written consent which may not be unreasonably withheld.

B10.2 If we give consent you must comply with any reasonable conditions we impose as part of the consent.

B11 Transfer of your Rights and Obligations

B11.1 You must not transfer any part of your rights or obligations under the Agreement without our prior written consent.

QUALITY ASSURANCE

B12 Quality of Services

B12.1 You must comply with the quality requirements set out in the Agreement.

B13 Information and Reports

B13.1 You must comply with the information requirements set out in the Agreement.

B13.2 You must keep and preserve Records and protect the security of them and make them available to us in accordance with our reasonable instructions.

B13.3 You must take all due care to ensure that in the event of your ceasing to provide the Services, the Records are properly preserved and transferred to us.

B13.4 You must keep proper business records and promptly complete a balance sheet, statement of income and expenditure and cashflows in accordance with accepted accountancy principles at the end of each financial year.

B13.5 We may use any information concerning you:

a) for our own purposes; and

b) for any purposes required by any Minister of the Crown or any Governmental Body.

B13.6 You must report to us in accordance with our reasonable instructions.

B13.7 We may reasonably require you to send reports direct to any Minister of the Crown or any Governmental Body within a time reasonably fixed by us.

B14 Appointment of Auditors

B14.1 We may appoint people to Audit, on our behalf, in relation to any of the matters contained in the Agreement.

B14.2 We will give you prior written notice of the names of the people we have appointed.

B14.3 Both of us must agree to the people we have appointed. You may not refuse where any or all of those people are suitably qualified and have no demonstrable conflict of interest, but your refusal may be based on some other good reason.

B14.4 Those people may take copies of any parts of the Records.

B15 Access for Audit

B15.1 You and your sub-contractors must co-operate with us fully and allow us or our authorised agents, access to:

a) your premises,

b) all premises where your Records are kept,

c) service users and their families,

d) staff, sub-contractors or other personnel used by you in providing the Services,

For the purposes of and during the course of carrying out any Audit.

B15.2 We will ensure that our exercise of access under this clause B15will not unreasonably disrupt the provision of the Services to Service Users.

B15.3 Notice of Audit

a) we will give you prior notice of any Audit as agreed in any Audit protocols.

b) If we believe that delay will unnecessarily prejudice the interests of any person, we may give you notice of our intention to carry out an Audit within 24 hours.

B15.4 Times for Audit

a) Subject to Clause B15.3b an Audit may be carried out at any time during working hours and at any other reasonable times.

b) You must ensure that the people appointed by us to carry out the Audit have access, during the hours they are entitled to Audit.

B16 Audit Process

B16.1 Subject to clause B23, in carrying out any Audit we may:

a) Access confidential information about any Service User; and

b) Observe the provision or delivery of the Services; and

c) Interview or follow up Service Users and/or their families; and

d) Interview or follow up any staff, sub-contractors or other personnel used by you in providing the Services.

B17 Financial Audit

B17.1 Despite the other provisions in this section B12 (Quality Assurance) we may not inspect your accounting system or record of your costs of providing the Services.

a) We may, however, appoint as set out in the Agreement, an independent auditor to Audit;

i. The correctness of the information you give us; and

ii. Your calculations of the cost of supplying the Services; and

iii. Your financial position.

b) The auditor:

i. Must not disclose specific details of your financial position to us; but

ii. May advise us if he or she considers your financial position may prejudice your ability to carry out your obligations under the Agreement.

B17.2 We retain the right to Audit under this Section B12 (Quality Assurance) after the Agreement ends but only to the extent that it is relevant to the period during which the Agreement exists.

B18 Insurance

B18.1 You must immediately take out adequate comprehensive insurance throughout the term of the agreement covering your practice or business.

B18.2 You must make sure that all the insurance cover always remains in force for the term of the Agreement or so long thereafter as required for the purposes of the Agreement.

B19 Indemnity

B19.1 You must indemnify us against all claims, damages, penalties or losses (including costs) which we incur as the result of:

a) Your failing to comply with your obligations in the Agreement; or

b) Any act or omission by you or any person for whom you are responsible.

B20 Complaints

B20.1 You must comply with any standards for the Health sector relating to complaints

B20.2 If there is no such standard applicable to you, then you must implement a complaints procedure in accordance with the terms of the Agreement.

B21 Complaints Body

B21.1 You must at all reasonable times co-operate with any Complaints Body and comply with its reasonable requirements.

B21.2 We will advise a Complaints Body of any complaints we receive about you if we believe it is appropriate to do so.

B21.3 We will give you reasonable assistance when we can in respect of any complaints made to the Privacy Commissioner which involve both of us.

B22 Warranties

B22.1 You warrant to us that:

a) All material information given to us by you or on your behalf is correct; and

b) You are not aware of anything which might prevent you from carrying out your obligations under the Agreement.

B22.2

a) The above warranties will be deemed to be repeated on a daily basis from the date of the Agreement and,

b) You must advise us immediately if at any time either of the warranties is untrue.

B23 Limitation of our Rights

B23.1 Our rights and the rights of others to:

a) Access confidential information about any Service User; and

b) Observe the provisions or delivery of the Services; and

c) Interview or follow up Service Users and/or their families,

Must be either authorised by statute or by a code of practice under the Privacy Act 1993 covering health information held by health agencies or by the informed consent of each Service User concerned. The consents will normally be in writing.

DEALING WITH PROBLEMS

B24 Notification of Problems

B24.1 You must advise us promptly in writing:

a) Of any:

i. changes,

ii. problems,

iii. significant risks,

iv. significant issues,

which materially reduce or affect your ability to provide the Services, or are most likely to do so, including those relating to:

v. any premises used by you,

vi. any equipment you are using,

vii. your key personnel; or

b) if you materially fail to comply with any of your obligations in the Agreement; or

c) of any serious complaints or disputes which directly or indirectly relate to the provision of the Services; or

d) of any issues concerning the Services that might have high media or public interest.

B24.2 We must discuss with each other possible ways of remedying the matters notified. Our discussion or attempted discussions will not however limit any of our rights under the Agreement.

B24.3 You must have in place realistic and reasonable risk management processes and contingency plans to enable you to continue to provide the Services on the occurrence of any of the matters in this clause B24.

B25 Uncontrollable Events

B25.1

a) For the purposes of this Clause B25 an "uncontrollable event" is an event which is beyond the reasonable control of us ("the person claiming"), or an event as set out in Clause B29.4.

b) An uncontrollable event does not include:

i. any risks or event which the person claiming could have prevented or overcome by taking reasonable care including having in place a realistic and reasonable risk management process; or

ii. a lack of funds for any reason.

B25.2 The person claiming will not be in default under the terms of the Agreement if the default is caused by an uncontrollable event.

B25.3 The person claiming must:

a) promptly give written notice to the other specifying:

i. the cause and extent of that person's inability to perform any of the person's obligations; and

ii. the likely duration of the non-performance;

b) in the meantime take all reasonable steps to remedy or reduce the uncontrollable event.

B25.4 Neither of us is obliged to settle any strike, lock out or other industrial disturbance.

B25.5 Performance of any obligation affected by an uncontrollable event must be resumed as soon as reasonably possible after the uncontrollable event ends or its impact is reduced.

B25.6 If you are unable to provide the Services as the result of an uncontrollable event we may make alternative arrangements suitable to us for the supply of the Services during the period that you are unable to supply them after we consult with you.

B25.7 If either of us is unable to perform an obligation under the Agreement for 90 days because of an uncontrollable event, both of us must first Consult and decide to what extent if any the Agreement can be varied and to continue.

B25.8 If we cannot agree that the Agreement may continue, then either of us may cancel the Agreement after giving at least 14 days prior written notice.

B25.9 Clause B34.1 will apply to cancellation of the Agreement under this clause.

B26 We May Remedy Your Failure To Meet Your Obligations

B26.1 If you fail to carry out any of your obligations in the Agreement we may do so on your behalf at your expense and risk.

B26.2 We may do this without giving you notice where the circumstances reasonably require such action. Otherwise, we will give you 7 days notice in writing of our intention to act.

B26.3 All costs we incur in doing so, must be paid by you to us on demand or we may deduct them from moneys which we owe you.

B27 Public Statements, Issues and Advertising

B27.1

a) Neither of us may directly or indirectly criticise the other publicly, without first fully discussing the matters of concern with the other.

b) The discussion must be carried out in good faith and in a co-operative and constructive manner.

c) Nothing in this clause prevents you from discussing any matters of concern with your people being your staff, subcontractors, agents or advisors.

d) Nothing in this clause prevents you from discussing any matters of concern with our people being our staff, subcontractors, agents, advisers or persons to whom we are responsible.

e) If we are unable to resolve any differences then those differences may be referred by either of us to the Dispute Resolution process set out in clause B28.

B27.2 You may use our name or logo only with our prior written consent.

B27.3 The provisions of this clause B27 will remain in force after the Agreement ends.

B28 Dispute Resolution

B28.1 If either of us has any dispute with the other in connection with the Agreement, then:

a) Both of us will use our best endeavours to settle the dispute or difference by agreement between us. Both of us must always act in good faith and co-operate with each other to resolve any disputes, and

b) If the dispute or difference is not settled by agreement between us within 30 days, then, unless both of us agree otherwise:

i. full written particulars of the dispute must be promptly given to the other.

ii. The matter will be referred to mediation in accordance with the Health Sector Mediation and Arbitration Rules 1993 as amended or substituted from time to time. A copy of the Rules are available from the Ministry of Health.

c) neither of us will initiate any litigation during the dispute resolution process outlined in paragraph b) above, unless proceedings are necessary for preserving the party's rights.

d) both of us will continue to comply with all our obligations in the Agreement until the dispute is resolved by payments may be withheld to the extent that they are disputed.

B28.2 Clause B28.1 will not, however, apply to any dispute:

a) concerning any renegotiation of any part of the Agreement,

b) as to whether or not any person is an Eligible Person,

c) directly or indirectly arising from any matter which has been referred to a Complaints Body unless the Complaints Body directs the matter to be resolved in accordance with clause B28.1.

B29 Variations to the Agreement

B29.1 The Agreement may be varied by written agreement signed by both of us.

B29.2 Where the Agreement is for a term exceeding 1 year, we both agree that the Agreement shall be reviewed annually.

B29.3 Variation on requirement by Crown

a) We may require you to vary the Agreement by written notice to you to comply with any requirement imposed on us by the Crown.

b) We will give you as much notice of the requirement and details of the proposed change as possible, to the extent that we are able to do so.

c) Both of us must Consult and decide to what extent if any the Agreement can be varied and the continue on that basis.

d) If we cannot agree within 60 days, then either of us may cancel the Agreement after giving at least 30 days prior written notice.

e) You must continue to comply with your obligations under the existing Agreement until any variation of it takes effect.

B29.4 The Agreement will be varied in the event of a disaster, local or national epidemic, emergency or war in accordance with our requirements but this clause is subject to clause B25.

B30 Our Liability

B30.1 Except to the extent that we agree otherwise, we will not be liable to you for any claims, damages, penalties or losses (including costs) which you incur.

ENDING THE AGREEMENT

B31 Notice of Your Future Intentions

B31.1 Before the end of the Agreement you must give a minimum of 3 months notice if:

a) you do not wish to enter into a new agreement with us when the Agreement ends; or

b) you wish to enter into a new agreement with us when the Agreement ends but on materially different terms.

This clause does not mean we must enter into a contract with you when the Agreement ends.

B31.2 You must discuss with us your intentions before giving any notice under clause B31.1.

B31.3 We must give you a minimum of 3 months notice if we do not intend to renew the Agreement, except where Management of Change Protocols may apply.

B32 Your Default and our Right to End the Agreement

B32.1 We may end the Agreement immediately by written notice to you on the occurrence of any of the following events:

a) We have good reason to believe you are unable or will soon become unable to carry out all your material obligations under the Agreement.

i. We must, however, consult with you before ending the Agreement for this reason.

ii. If we believe the health or safety of any person or Population Serviced is at risk we may suspend your provision of the Services while we consult.

b) You have failed to carry out any of your obligations in the Agreement; and

i. the failure is material; and

ii. it cannot be remedied

c) if:

i. you are or adjudged bankrupt; or

ii. you are more than one person, if any of you are adjudged bankrupt; or

iii. you are a company and you are placed in receivership or liquidation.

d) You have failed to carry out any of your obligations in the Agreement and the failure can be remedied by you but you fail to do so within 30 days of your receiving written notice of the default from us.

e) After 30 days from your receiving the notice, so long as the obligation still has not been met, we may instead of ending the Agreement;

i. At any time vary or withdraw from coverage by this Agreement any of the Services in respect of which you have not met your obligation, either straight away or at any later date, and

ii. Cease payment for any of the services from the date of withdrawal.

f) You have the same right and must follow the same procedure if we have not met any obligation and you wish to vary or withdraw any of the Services.

g) Any dispute regarding the withdrawal or variation of any of the Services under this paragraph d) must be resolved under clause B28.

B32.2 Nothing in clause B32.1 affects any other rights we may have against you in law of in equity.

B33 Our Default and your Right to End the Agreement

B33.1 If we default on any payments which we are not entitled by the Agreement to withhold and we fail to remedy the default within 20 days of your giving us written notice of the default you may do any one of more of the following:

a) Cancel the agreement,

b) Seek specific performance of the Agreement,

c) Seek damages from us,

d) Seek penalty interest.

B34 Effect of Ending the Agreement

B34.1 Any cancellation of the Agreement will not affect:

a) the rights or obligations of either of us which have arisen before the Agreements ends; or

b) the operation of any clauses in the Agreement which are expressed or implied to have effect after it ends.

GENERAL

B35 Confidentiality

B35.1

a) Except to the extent that these Standard Conditions provide otherwise, neither of us may disclose any Confidential Information to any other person.

b) Both of us acknowledge that the Agreement, but not any Confidential Information, may be published publicly by us through any media including electronically via the Internet.

B35.2 Neither of us will disclose to any third party information which will identify any natural person (as defined in the Privacy Act 1993);

a) without that person's informed consent; or

b) unless authorised by statute, or by a Code of Practice under the Privacy Act 1993 covering Health Information held by Health Agencies.

B35.3. Clause B35.1 does not apply:

a) to terms or information which are or become generally available to the public except as the result of a breach of clause B35.1; or

b) to information which either party is required by law to supply to any person but only to the extent that the law required; or

c) to terms or information disclosed to the professional advisers of either of us or to those involved in a Service User's clinical or care management where disclosure is reasonably necessary for the management; or

to information which you are required by the Agreement to disclose or forward to any person.

B35.4 Nothing in clause B35.1 will prevent us from disclosing any terms or information in accordance with any Funding Agreement, or by direction or requirement from the Minister under the Act.

B35.5 Each of us will ensure all Confidential Information is kept secure and is subject to appropriate security and user authorisation procedures and audits.

B36 Governing Law

B36.1 The Agreement is governed by New Zealand law.

B37 Contracts (Privity) Act 1982

B37.1 No other third party may enforce any of the provisions in the Agreement.

B38 Waiver

B38.1 Any waiver by either of us must be in writing duly signed. Each waiver may be relied on for the specific purpose for which it is given.

B38.2 A failure of either one of us to exercise, or a delay by either one of us in exercising, any right given to it under the Agreement, does not mean that the right has been waived.

B39 Entire Agreement

B39.1 Each of us agree that the Agreement sets forth the entire agreement and understanding between both of us and supersedes all prior oral or written agreements or arrangements relating to its subject matter.

B40 Notices

B40.1 Any notice must be in writing and may be served personally or sent by security or registered mail or by facsimile transmission. All notices are to have endorsed on them the contract reference number given to the Agreement.

B40.2 Notices given:

a) personally are served upon delivery;

b) by post (other than airmail) are served three days after posting;

c) by airmail are served two days after posting;

d) by facsimile are served upon receipt of the correct answer back or receipt code.

B40.3 A notice may be given by an authorised officer, employee or agent of the party giving the notice.

B40.4 The address and facsimile number for each of us shall be as specified in the Agreement or such other address or number as is from time to time notified in writing to the other party.

B41 Relationship of Both of Us

B41.1 Nothing in the Agreement constitutes a partnership or joint venture between both of us or makes you an employee, agent or trustee of ourselves.

B42 Signing the Agreement

B42.1

a) You must satisfy us that the Agreement has been properly signed by you and is a valid and enforceable agreement before we have any obligations to you under the Agreement.

b) We may however waive all or part of this provision with or without conditions by us.

B42.2 If the condition in clause B42.1 is not satisfied or waived by the Commencement Date or any later date we may void the Agreement by written notice to you.

B43 Partial Invalidity

B43.1

a) If any provision in the Agreement is lawfully illegal, unenforceable or invalid, the determination will not affect the remainder of the Agreement which will remain in force.

b) This clause does not affect any right of cancellation we may have in the Agreement.

GLOSSARY

B44 Definitions

B44.1 In the Agreement Terms given a meaning in the Glossary have that meaning where the context permits.

B44.2 In the Agreement

a) "We", "us" and "our" means the Ministry of Health including its permitted consultants, subcontractors, agents, employees and assignees (as the context permits).

b) "You" and "your" means the Provider named in this contract, including its permitted subcontractors, agents, employees and assignees (as the context permits).

c) "Both of us", "each of us", "either of us" and "neither of us" refers to the parties.

B45 Interpretation

B45.1 In the Agreement:

a) A reference to a person includes any other entity or association recognised by law and the reverse:

b) Words referring to the singular include the plural and the reverse;

c) Any reference to any of the parties includes that party's executors, administrators or permitted assigns, or if a company, its successors or permitted assigns or both;

d) Everything expressed or implied in the Agreement which involves more than one person binds and benefits those people jointly and severally;

e) Clause headings are for reference purposes only;

f) A reference to a statute includes:

i. all regulations under that statute; and\

ii. all amendments to that statute; and

iii. any statute substituting for it which incorporates any of its provisions.

g) All periods of time or notice exclude the days on which they are given and include the days on which they expire:

h) Working Days – anything required by the Agreement to be done on a day which is not a Working Day may be done on the next Working Day.

B46 Glossary Terms

Expression	Meaning
Act	The New Zealand Public Health & Disability Act 2000
Agreement	The agreement or arrangement between both of us for the provision of any Services and each schedule to that agreement or arrangement and these Standard Conditions of Contract
Audit	Audit includes (without limitation) audit, inspection, evaluation or review of: a) quality, b) service delivery c) performance requirements, d) organisational quality standards, e) information standards and, f) organisational reporting requirements, g) compliance with any of your obligations in relation to the provision of the Services by you.
Commencement Date	The date the Agreement comes into effect
Complaints Body	Any organisation appointed: a) under the Agreement; or b) by both of us by mutual agreement; or c) by a Health Professional Authority; or d) by law to deal with complaints relating to the Services.
Confidential Information	Any information disclosed either before or during the course of the Agreement, by us to you or vice versa that is agreed by both of us as being confidential and which may not be disclosed (subject to any law to the contrary) but excluding the terms of the Agreement.
Consult	a) Each of us must fully state our proposals and views to the other and carefully consider each response to them. b) Each of us must act in good faith and not predetermine any matter. c) Each of us must give the other adequate opportunity to consult any other interested party. The obligation of either of us to Consult will be discharged if the other refuses or fails to Consult.
Crown	The meaning given in the Act.

Eligible Person	Any individual who: a) is in need of the Services; and b) meets the essential eligibility criteria and other criteria, terms and conditions which, in accordance with any direction given under Section 32 of the Act or continued by Section 112(1) of the Act, or any other direction from the Minister, or the Funding Agreement, must be satisfied before that individual may receive any Services purchased by us. c) The Ministry of Health will determine if any individual is an Eligible Person if there is any dispute. "Eligible People" has a corresponding meaning.
End Date	The date the Agreement ends or is ended in accordance with the Agreement.
Funding Agreement	The relevant Crown funding agreement within the meaning of Section 10 of the Act, entered into by us.
Governmental Body	Includes any entity lawfully formed by, or in accordance with any direction of, the Crown or any Minister or officer of the Crown.
GST	Goods and Services Tax under the Goods and Services Tax Act 1985.
Ministry of Health	Includes any of its legal successors.
Health Professional Authority	Any authority or body that is empowered under and by virtue of any enactment of law, or the rules of any body or organisation, to exercise disciplinary powers in respect of any person who is involved in the supply of Health or Disability Services, or both.
Law	Includes: a) Any legislation, decree, judgement, order or by law; and b) Any rule, protocol, code of ethics or practice or conduct and other ethical or other standards, guidelines and c) Requirements of any Health Professional Authority; and d) Any relevant standards of the New Zealand Standards Association; and e) Any future law.
Management of Change Protocols	Such protocols as may be agreed between us relating to the management of change.
Minister	The Minister of Health.
Ministry	The Ministry of Health (by whatever name known) and any other successor department of state and include the Minister of Health and the Director-General of Health and any of his her or their delegates.
Our Objectives	Include: a) The objectives listed in Section 22 of the Act, and b) The objectives specified in our statement of intent (as defined in the Act). c) To meet the directions and requirements notified to us under the Act from time to time.

Person	Includes a corporation, incorporated society or other body corporate, firm, government authority, partnership, trust, joint venture, association, state or agency of a state, department of Ministry of Government and a body or other organisation, in each case whether or not having a separate legal identity.
Population Served	Means communities or targeted populations, including Eligible People, for whom Services are or may be provided.
Records	Means without limitation: a) All relevant written and electronically stored material; and b) Includes all relevant records and information held by you and your employees, subcontractors, agents and advisers.
Services	Health Services, or disability services or both as specified in the Agreement.
Service Users	Users of any of the Services.
Standard Conditions	These Standard Conditions of Contract.
Working Day	Any day on which Registered Banks are open for business in New Zealand, relative to your principal place of business.

C: PROVIDER QUALITY SPECIFICATIONS

INTRODUCTION

C1 Relationship Principles

C1.1 The following values will guide us in all our dealings with each other under the Agreement:

a) Integrity -we will act towards each other honestly and in good faith.

b) good communication -we will listen, talk and engage with each other openly and promptly including clear and timely written communication.

c) enablement -we will seek to enable each other to meet our respective objectives and commitments to achieve positive outcomes for communities and consumers of health and disability services.

d) trust and co-operation -we will work in a co-operative and constructive manner recognising each other's viewpoints and respecting each other's differences.

e) accountability -we will each recognise the accountabilities that each of us have to our respective and mutual clients and stakeholder.

f) innovation -we will encourage new approaches and creative solutions to achieve positive outcomes for communities and consumers of health and disability services.

g) quality improvement – we will work co-operatively with each other to achieve quality health and disability services with positive outcomes for consumers.

C2 Quality of Service

C2.1 These Provider Quality Specifications define the quality of service which consumers and populations served under the terms of this contract will receive. Provider quality requirements will in final form be described in three key levels.

a) Health and Disability Services Standards 2008

b) Provider Quality Specifications (PQS)

c) Service Specific Quality Specifications (SSQS)

C3 Health and Disability Services Standards 2008

C3.1 The Health and Disability Services Standards 2008 have been developed to replace several pieces of previous consumer safety legislation. Compliance with them will become mandatory when the Health and Disability Services (Safety) Bill is passed and fully implemented. At that stage compliance with the Standards will replace compliance with the regulations and statutes that apply to hospital in-patient and residential care services. As the standards are implemented the Provider Quality Specifications will be revised to those Standards, and to eliminate repetition.

C4 Provider Quality Specifications (PQS)

C4.1 All providers are required to meet these Provider Quality Specifications (PQS). The PQS have been developed to ensure a common basis for quality among providers of similar services nationally. They focus on key processes and outcomes. The PQS apply to all services provided under the terms of this Contract.

C4.2 These PQS include:

a) specifications for all providers, (Sections C1 – C40 inclusive).

b) facility specifications only for providers who offer services to consumers within premises (C41 and C42).

C4.3 The PQS may be supplemented in contracts by Service Specific Quality Specifications (SSQS) or by specific quality requirements in the Service Specification.

C5 Auditing and Reporting

C5.1 We may, at any time, audit your service against the Health and Disability Services Standards 2008 (when implemented) or against a PQS or SSQS by asking you to demonstrate compliance with it. This is part of the Provider Quality Improvement Strategy, which may include regular, random and risk based auditing of services. The PQS and SSQS are not, at present, subject to regular reporting unless required elsewhere in the Agreement or as part of any specified Quality Improvement initiative. You are, however, invited to raise with us at any time any concerns you have about your ability to meet these PQS so corrective processes can be put in place. Please see also Clause C11, C12, C16, C17 and C18 of the Standard Conditions and the Schedule or Templates for Information Requirements.

PROVIDER QUALITY SPECIFICATIONS

C6 PQS Apply to All Services

C6.1 You will operate all services covered in this Agreement according to these PQS. You will implement these requirements in a manner that is appropriate for your Organisation, taking into account:

a) requirements of Government Māori Health Policy and Strategies,

b) identified needs of consumers, carers and families,

c) service goals and objectives,

d) parameters of activities,

e) management of risks,

f) any good practice guidelines endorsed by us and by the Ministry of Health,

g) professional standards and codes relevant to your service.

C7 Written Policy, Procedures, Programme, Protocol, Guideline, Information, System or Plan

C7.1 Where, to meet a H&DS Standard or an PQS or SSQS, you need to develop a written policy, procedure, programme, protocol, guideline, information, system or plan etc, you will:

a) Develop such a document,

b) Demonstrate systems for reviewing and updating all such documents regularly and as required by current performance or risks,

c) Demonstrate implementation, through documentation supported as requested through interviews with staff, consumers, and Māori,

d) Demonstrate that staff are adequately informed of the content and the intent of these written documents,

e) Provide us with a copy on request.

C8 All Staff Informed

C8.1 You will ensure that:

a) these PQS are attached to each and every service specification contracted by us and delivered by you,

b) employees and sub-contractors are aware of your and their responsibilities for these PQS and relevant Service Specifications as they relate to services provided

C9 Requirements for Māori

C9.1 Requirements for Māori are specified here and elsewhere in this Agreement.

C9.2 Your services will meet the diverse needs of Māori, and apply any strategy for Māori Health issued by the Minister.

C10 Māori Participation

C10.1 Māori participation will be integrated at all levels of strategic and service planning, development and implementation within your organisation at governance, management and service delivery levels.

This will include:

a) consultation with, and involvement of, Māori[1] in your strategic, operational and service processes,

b) development of a monitoring strategy in partnership with Māori that reviews and evaluates whether Māori needs are being met by your organisation, including:

i. removal of barriers to accessing your services;

ii. facilitation of the involvement of whanau and others;

iii. integration of Māori values and beliefs, and cultural practices;

[1] Reference to "Māori" includes the development of a relationship with local tangata whenua and if appropriate, regional tangata whenua, Māori staff, Māori providers, and Māori community organisations to achieve the required Māori input.

iv. availability of Māori staff to reflect the consumer population

v. existence, knowledge and use of referral protocols with Māori service providers in your locality.

c) Education and training of staff in Māori values and beliefs and cultural practices, and in the requirements of any Māori Health Strategy,

d) Support and development of a Māori workforce

QUALITY MANAGEMENT

You are required to develop, document, implement and evaluate a transparent system for managing and improving the quality of services to achieve the best outcomes for consumers.

C11 Quality Plan

C11.1 You will have a written, implemented and at least annually reviewed Quality Plan designed to improve outcomes for consumers. This plan may be integrated into your business plan. It will describe how you manage the risks associated with the provision of services. The plan will outline a clear quality strategy and will identify the organisational arrangements to implement it. The plan will be of a size and scope appropriate to the size of your service, and will at least include:

a) an explicit quality philosophy,

b) clear quality objectives,

c) commitment to meeting these and any other relevant Quality Specification and Standards, and guidelines for good practice as appropriate,

d) quality improvement systems,

e) written and implemented systems for monitoring and auditing compliance with your contractual requirements,

f) designated organisational and staff responsibilities,

g) processes for and evidence of consumer input into services and into development of the Quality Plan,

h) processes for sound financial management,

i) how you will address Māori issues including recognition of:

i. Māori participation with Strategic, Governance, Management and Service Delivery planning, implementation and review functions,

ii. Māori as a Government Health Gain priority area,

iii. The Pathways set out in any Māori Health Strategy issued by the Minister,

iv. Māori specific quality specifications,

v. Māori specific monitoring requirements,

vi. Māori service specific requirements.

C12 Employees Registration, Education and Training

C12.1 Employees will be, where relevant, registered with the appropriate statutory body, and will

hold a current statutory certificate.

C12.2 Employees will have access to continuing education to support maintenance of professional registration and enhancement of service delivery/clinical practice, and to ensure practice is safe and reflects knowledge of recent developments in service delivery.

C12.3 Your employment policies and practices will support professional career pathway development for Māori health workers; Māori service advisory positions; Māori change management positions, and the recruitment and retention of Māori employees at all levels of the organisation to reflect the consumer population.

C13 Training and Supervision of Assistants and Volunteers.

C13.1 Assistants, volunteers and other relevant support employees will receive training to enable them to provide services safely, and will work only under the supervision and direction of appropriately qualified staff.

C14 Supervision of Trainees.

C14.1 Trainees will be identified and will provide services only under the supervision and direction of appropriately qualified staff.

C15 Performance Management

C15.1 You will have in place a system of performance management for all employees.

C16 Clinical Audit

C16.1 You will have in place clinical audit/peer review processes that incorporate input from relevant health professionals from all services.

C17 Access

C17.1 All eligible people will have fair, reasonable and timely access to effective services within the terms of this agreement. You will define and apply criteria for providing services, including any priority or eligibility criteria agreed between us. You will manage access to services within available resources and according to those criteria. You will maintain records of people who receive services and those who do not, and the criteria by which these decisions are made.

C18 Service Information

C18.1 Potential and current consumers, and referrers, will have access to appropriately presented information in order for eligible people to access your services. This information may be in the form of a brochure and will include at least:

a) the services you offer,
b) the location of those services,
c) the hours the service is available,
d) how to access the service (e.g. whether a referral is required),
e) consumer rights and responsibilities including copy of H&DC Code of Rights, and

Complaints Procedure,

f) availability of cultural support,

g) after hours or emergency contact if necessary or appropriate,

h) any other important information in order for people to access your services.

This information will be presented in a manner appropriate to the communication needs of consumers and communities.

C19 Support for Māori

C19.1 You will facilitate support from whanau/hapu/iwi; kuia/kaumatua; rongoa practitioners; spiritual advisors; Māori staff and others as appropriate for Māori accessing your service.

ACCEPTABILITY

C20 Consumer Rights

C20.1 Each consumer will receive services in a manner that complies with the Health and Disability Commissioner Act 1994, and with all aspects of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (H&DC Code). This will include provision for the:

a) right to be treated with respect for person, privacy and culture,

b) freedom from discrimination, coercion, harassment, and exploitation,

c) right to dignity and independence,

d) right to services of an appropriate standard including legal, professional, ethical,

e) right to effective communication,

f) right to be fully informed,

g) right to make an informed choice and give informed consent,

h) right to support person present,

i) rights in respect of teaching or research,

j) right to complain,

You will make available and known to consumers and visitors to the service the Code of Health and Disability Services Consumers' Rights. You will ensure staff are familiar with and observe their obligations under this Code.

C21 Confidentiality

C21.1 You will disclose information about consumers to any third party only:

a) with the person's informed consent or,

b) in accordance with the Health Information Privacy Code,

c) to assist in effective service provision and achieving positive outcomes for the consumer.

C22 Cultural Values

C22.1 You will deliver services in a culturally appropriate and competent manner, ensuring that the integrity of each consumer's culture is acknowledged and respected. You will take account of the particular needs within the community served in order that there are no barriers to access or communication, and that your services are safe for all people. You will include significant local or service specific ethnic and other cultural groups in assessing satisfaction with services.

C22.2 You will incorporate Māori principles/tikanga into your organisation. These may be explained in the following ways:

Wairua	Spirit or spirituality	A recognition that the Māori view of spirituality is inextricably related to the wellbeing of the Māori consumer
Aroha	Compassionate love	The unconditional acceptance which is the heart of care and support
Turangawaewae	A place to stand	The place the person calls home, where their origins are. Must be identified for all Māori consumers
Whanaungatanga	The extended family	Which takes responsibility for its members and must be informed of where its member is
Tapu/Noa	Sacred/profane	The recognition of the cultural means of social control envisaged in tapu and noa including its implications for practices in working with Māori consumers
Mana	Authority, standing	Service must recognise the mana of Māori consumers
Manaaki	To care for and show respect to	Services show respect for Māori values; traditions and aspirations
Kawa	Protocol of the marae, land, iwi	Determines how things are done in various circumstances. Respect for kawa is very important. If the kawa is not known the tangata whenua should be consulted.

C23 Consumer Advocates

C23.1 You will inform consumers and staff, in a manner appropriate to their communication needs, of their right to have an advocate, including to support the resolution of any complaint. You will allow advocates reasonable access to facilities, consumers, employees and information to enable them to carry out their role as an advocate. You will know of and be able to facilitate access to a Māori advocate for consumers who require this service.

C24 Consumer/Family/Whanau and Referrer Input

C24.1 You will regularly offer consumers/families/whanau and referrers the opportunity to provide feedback as a means of improving the outcomes for consumers. When you obtain feedback from consumers by means of written surveys, you will comply with the Ministry of Health Guidelines for Consumer Surveys. Consumer input will be reflected in the maintenance and

improvement of quality of service, both for the individual consumer and across the service as a whole. You will actively seek feedback from Māori by appropriate methods to improve organisation responsiveness to Māori. When requested you will make available to us the results of such surveys.

C25 Community Involvement

C25.1 You will have in place and follow active processes for consulting with the local community in matters affecting them such as service location and building programmes.

C26 Complaints Procedure

C26.1 You will enable consumers/families/whanau and other people to make complaints through a written and implemented procedure for the identification and management of Complaints. This procedure will meet the H&DC Code requirements and will also ensure that:

a) the complaints procedure itself is made known to and easily understandable by consumers,

b) all parties have the right to be heard,

c) the person handling the complaint is impartial and acts fairly,

d) complaints are handled at the level appropriate to the complexity or gravity of the complaint,

e) any corrective action required following a complaint is undertaken,

f) it sets out the various complaints bodies to whom complaints may be made and the process for doing so. Consumers will further be advised of their right to direct their complaint to the H&D Commissioner and any other relevant complaints body, particularly in the event of non-resolution of a complaint,

g) complaints are handled sensitively with due consideration of cultural or other values,

h) Māori consumers and their whanau will have access to a Māori advocate to support them during the complaints process,

i) consumers who complain, or on whose behalf families/whanau complain, shall continue to receive services which meet all contractual requirements,

j) complaints are regularly monitored by the management of the service and trends identified in order to improve service delivery,

k) it is consistent with any complaints policy as we may notify from time to time.

C27 Personnel Identification

C27.1 Employees, volunteers, students or sub-contractors undertaking or observing service delivery will identify themselves to all consumers and family/whanau.

C28 Ethical Review

C28.1 If you conduct research and innovative procedures or treatments you will have written and implemented policies and procedures for seeking ethical review and advice from a Health and Disability Ethics Committee in accordance with the current "National Standard for Ethics Committees" (or any replacement publication). You will consult with and receive approval from Māori for any research or innovative procedures or treatments which will impact on Māori.

SAFETY AND EFFICIENCY

C29 General Safety Obligation

C29.1 You will protect consumers, visitors and staff from exposure to avoidable/preventable risk and harm.

C30 Risk Management

C30.1 You will have in place well developed processes for:

a) identifying key risks including risks to health and safety,

b) evaluating and prioritising those risks based on their severity, the effectiveness of any controls you have and the probability of occurrence,

c) dealing with those risks and where possible reducing them.

C31 Equipment Maintained

C31.1 You will ensure that equipment used is safe and maintained to comply with safety and use standards.

C32 Infection Control/Environmental and Hygiene Management

C32.1 You will safeguard consumers, staff and visitors from infection. You will have written, implemented and regularly reviewed environmental and hygiene management/infection control policies and procedures which minimise the likelihood of adverse health outcomes arising from infection for consumers, staff and visitors. These will meet any relevant profession-specific requirements and the requirements of the Standard Universal Precautions Guidelines. They will include definitions and will clearly outline the responsibilities of all employees, including immediate action, reporting, monitoring, corrective action, and staff training to meet these responsibilities.

C33 Security

C33.1 You will safeguard consumers, employees and visitors from intrusion and associated risks. You will have written, implemented and reviewed policies and practices relating to security to ensure that buildings, equipment and drugs are secure.

C34 Management Of Internal Emergencies and External Disasters

C34.1 You will have written, implemented and reviewed contingency management policies and procedures that minimise the adverse impact of internal emergencies and external or environmental disasters on your consumer, staff and visitors. The policies and procedures will include the processes for working with the organisations who have responsibility for co-ordinating internal and external (environmental) disaster services. These policies and procedures will be linked to your risk management processes.

C35 Incident and Accident Management

C35.1 You will safeguard consumers, staff and visitors from untoward risk arising from avoidable incidents, accidents and hazards. You will have written, implemented and reviewed incident,

accident and hazard management policies and procedures which assist in managing safety and risk. These will include definitions of incidents and accidents and will clearly outline the responsibilities of all employees, including:

a) taking immediate action,

b reporting, monitoring and corrective action to minimise incidents, accidents and hazards, and improve safety,

c) debriefing and staff support as necessary.

C36 Prevention of Abuse and/or Neglect

C36.1 You will safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment or neglect. You will have written, implemented and reviewed policy and procedures on preventing, detecting and removing abuse and/or neglect. These will include definitions of abuse and neglect and will clearly outline the responsibilities of all staff who suspect actual or potential abuse, including immediate action, reporting, monitoring and corrective action. You will ensure that relevant employees are able to participate in family, inter-agency or court proceedings to address specific cases of abuse and neglect. These procedures will also include reference to the Complaints Procedure.

EFFECTIVENESS

C37 Entry to Service

C37.1 You will manage consumer entry to your service in a timely, equitable and efficient manner, to meet assessed need.

C38 Plan of Care/Service Plan

C38.1 You will develop for each consumer a written, up to date plan of care/service plan and/or record of treatment which:

a) is based on assessment of his/her individual needs, including cultural needs,

b) includes consultation with the consumer, and,

c) where appropriate, and with the consent of the consumer, includes consultation with the consumer's family/whanau and/or caregivers,

d) contains detail appropriate to the impact of the service on the consumer,

e) facilitates the achievement of appropriate outcomes as defined with the consumer,

f) includes plans for discharge/transfer,

g) provides for referral to and co-ordination with other medical services and links with community, iwi, Māori and other services as necessary.

C39 Service Provision

C39.1 You will deliver to consumers services that meet their individual assessed needs, reflect current good practice, and are co-ordinated to minimise potentially harmful breaks in provision.

C40 Planning Discharge from the Service or Transfer between Services

C40.1 You will collaborate with other services to ensure consumers access all necessary services. When a consumer is transferred or discharged from your services and accesses other appropriate services they will do so without avoidable delay or interruption. You will have written, implemented and reviewed policies and procedures for planning discharge/exit/transfer from your services. These will facilitate appropriate outcomes as defined with the consumer. The policies and procedures will include:

a) defined employees' responsibilities for discharge planning,

b) incorporating discharge planning into the consumer's plan of care/service plan, where appropriate from or before admission,

c) full involvement of the consumer in planning discharge,

d) involvement of family/whanau, including advising them of discharge, as appropriate,

e) assessment and management of any risks associated with the discharge,

f) informing the consumer on their condition, possible future course of this, any risks, emergency contacts, and how to access future treatment, care or support services,

g) where appropriate involving the original referrer and the health professional having ongoing responsibility for the consumer in planning discharge and informing them of confirmed discharge arrangements,

h) a process for monitoring that discharge planning does take place, which includes assessment of the effectiveness of the discharge planning programme.

C41 Where Services are Declined

C41.1 You will have written and implemented policies and procedures to manage the immediate safety of the consumer for whom entry to the service is declined and, where necessary the safety of their immediate family/whanau and the wider community. These include:

C41.2

a) applying agreed criteria for providing services,

b) ensuring all diagnostic steps have been taken to identify serious problems which may require your service,

c) advising the consumer and/or their family/whanau of appropriate alternative services,

d) where appropriate advising the family/whanau or other current services that you have declined service,

e) recording that entry has been declined, giving reasons and other relevant information,

f) having in place processes for providing this information to us.

C42 Death/Tangihanga

C42.1 You will have written and implemented policies and procedures to follow in the event of a death including:

a) immediate action including first aid, calling appropriate emergency services,

b) appropriate and culturally sensitive procedures for notification of next of kin,

c) any necessary certification and documentation including notifying us or the Ministry of

Health if required in the Service Specifications,

d) appropriate and culturally competent arrangements, particularly to meet the special needs of Māori, are taken into account in the care of the deceased, until responsibility is accepted by the family or a duly authorised person.

C43 Health Education, Disease Prevention and Health Advice/Counselling

C43.1 You will incorporate within your services, where appropriate, an emphasis on health education, disease prevention and health advice/counselling, and support the goals of The Ministry of Health Strategy "Strengthening Public Health Action" June 1997 or subsequent publications.

FACILITIES

C44 Accessible

C44.1 You will support consumers in accessing your services by the physical design of your facilities. You will make specific provision for consumers with a mobility, sensory or communication disability available and known to consumer. You will make services available to deaf people through the provision of interpreters and devices to assist communication.

C45 Facilities, Maintained

C45.1 You will provide services from safe, well-designed, well-equipped, hygienic and well-maintained premises.

D: STANDARD INFORMATION SPECIFICATION

REPORTING REQUIREMENTS

D1 Information to be Reported to The MOH

D1.1 Unless stated otherwise in the Service Schedule, information to be provided to us is to be provided at three monthly intervals in accordance with the timetable below. Where the Agreement begins or ends part way through a quarter, the report will be for that part of the quarter which falls within the term of the Agreement.

Any delays will be notified to The Performance Reporting Team (see below for details).

D2 Reporting Requirement Timetable

Quarters for Reporting	Due Date
1 January to 31 March	20 April
1 April to 30 June	20 July
1 July to 30 September	20 October
1 October to 31 December	20 January

D3 Forwarding Your Completed Report

You shall forward your completed Performance Monitoring Returns to:

Email: performance_reporting@health.govt.nz

Or post to:

The Performance Reporting Team
Sector Operations
Ministry of Health
Private Bag 1942
Dunedin 9054

PART 3: SERVICE SCHEDULES

3.01 INTRODUCTION

3.01.1 This Part 3 contains each of the Service Schedules listed in the Head Agreement (Agreement Summary).

3.01.2 Each of the Service Schedules in Part 3 form part of the Agreement between us as defined in the Head Agreement or in a subsequent Variation to the Head Agreement, as applicable.

3.01.3 Each Service Schedule contains the Service Specifications and Provider Specific Terms and Conditions associated with the Service.

3.01.4 The Service Specification described the service, and set up quality and information reporting requirements additional to those specified in Part 2 (the General Terms). Note that nationally standard service descriptions may contain details (particularly Purchase Units and Reporting Requirements) which do not apply to all contracts.

3.01.5 The Provider Specific Terms and Conditions detail those elements of the Agreement that are unique to you. This will include payment terms, the term of the Service Schedule, and any details which differ from Part 2 (the General Terms) and/or standard Service Specification/s (including detailed clarification of any parts of the nationally standard service description which do not apply to your contract, and a full list of relevant purchase units, volumes, prices and reporting requirements).

CONTENTS OF EACH SERVICE SCHEDULE WITHIN PART 3

3.02 Service Specifications

3.02.1 Standard national specifications (note this may not be physically contained in the contract but will be made available for Providers in electronic and hardcopy editions for distribution within their organisations).

a) Additional specifications (if appropriate).

3.02.2 Provider Specific Terms and Conditions

a) Introduction
b) Details of all Volumes and Prices which apply to this Service Schedule
c) Reporting Requirements
d) Payment Details
e) Detail of Changes to standard documents

i. Summary of changes to the General Terms (if any)
ii. Summary of additional service specifications (if any)
iii. Summary of changes from standard service specification (if any)

E: PROVIDER SPECIFIC TERMS AND CONDITIONS

INTRODUCTION

E1 **Service Details**

E1.1 It is agreed that the following details apply to this Service Schedule.

Legal Entity Name	Te Kupenga Net Trust t/a Mental Health Advocacy and Peer Supports
Legal Entity Number	605210
Contract Number	363326 / 00
Contract Commencement Date	1 July 2019
Contract End Date	30 June 2020

E2 **Standard Documentation**

E2.1 It is agreed that the Service Schedule includes the standard documentation in Part 2 (the General Terms), and the standard service specifications included in this Service Schedule, as amended by any changes (if any) identified below.

E2.2 It is agreed that the services will be paid for in accordance with the details given in the Payment Details below.

E3 **Details of all Purchase Units which apply to this Service Schedule**

Purchase Unit (PU ID)	Total Price excl. GST	GST Rate (%)	Payment Type
MHSD Mental Health - service development	$60,000.00	15	CMS
Total price for the Service Schedule	**$60,000.00**		

PAYMENT DETAILS

E4 **Price**

E4.1 The price we will pay for the Service you provide is specified above. Note that all prices are exclusive of GST.

E5 **Invoicing**

E5.1 We will pay you on the dates set out in the Payment Schedule below for the services you provide in each invoice period so long as we receive a valid GST tax invoice from you. The invoice must meet all legal requirements and must contain the following information:

a. provider name (legal entity name)

b. provider number (legal entity number)

c. provider invoice number
d. contract number
e. purchase unit number or a description of the service being provided
f. date the invoice is due to be paid/date payment expected
g. dollar amount to be paid
h. period the service was provided
i. volume, if applicable
j. GST rate
k. GST number
l. full name of funder

E5.2 If we do not receive an invoice from you by the date specified in the payment schedule below, then we will pay you within 20 days after we receive the invoice.

E6 **Invoicing Address**

Send invoices to:

providerinvoices@health.govt.nz

or post to:

Provider Payments
Ministry of Health
Private Bag 1942
Dunedin 9054

E7 **Payment Schedule**

Payments will be made by us on these dates:	On invoices received by us on or before:	For services supplied in the period:	Amount (excl GST)
On signing after 1 July 2019	31 July 2019	1 July 2019 – 30 September 2019	$15,000.00
20 September 2019	31 August 2019	1 October 2019 – 31 December 2019	$15,000.00
20 December 2019	30 November 2019	1 January 2020 – 31 March 2020	$15,000.00
20 March 2020	29 February 2020	1 April 2020 to 30 June 2020	$15,000.00
Total			**$60,000.00**

E8 **Children's Act 2014**

According to section 15 of the Children's Act 2014[2], children's services cover the following:

- services provided to one or more children
- services to adults in respect of one or more children

NB At a future date, the scope of children's services can be expanded by regulations. Expansion may include services to adults which could significantly affect the well-being of children in that household.

[2] http://www.legislation.govt.nz/act/public/2014/0040/latest/DLM5501618.html

E8.1 Child Protection Policy

If you provide children's services as per section 15 of the Children's Act 2014 you will adopt a child protection policy as soon as practicable and review the policy within three years from the date of its adoption or most recent review. Thereafter, you will review the policy at least every three years. In accordance with the requirements set out in section 19(a) and (b) of the Children's Act 2014, your child protection policy must apply to the provision of children's services (as defined in section 15 of the Act), must be written and must contain provisions on the identification and reporting of child abuse and neglect in accordance with section 15 of the Oranga Tamariki Act 1989.

E8.2 Worker Safety Checks

If you have workers that provide children's services, the safety check requirements under the Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015 will need to be complied with.[3]

[3] http://www.legislation.govt.nz/regulation/public/2015/0106/latest/DLM6482241.html

F: SERVICE SPECIFICATION

MENTAL HEALTH AND ADDICTION SERVICES
TIER ONE SERVICE SPECIFICATION

Background

The full continuum of publicly funded mental health and addiction care includes health promotion, prevention, primary, secondary and tertiary services.

Mental Health and Addiction service specifications cover specialist mental health and addiction services targeted at those most severely affected by mental illness or addiction. However, it is recognised that a focus on early intervention and integration between specialist, primary and community services will lead to increased access for those who may be more at risk of developing mental health or addiction issues.

Primary mental health services provide a general primary care response to the needs of people of any age with mild or moderate illness. The national expectations are outlined in the primary health strategy and are excluded from this suite of service specifications.

This tier one service specification provides the overarching specification for all publicly funded specialist mental health and addiction services (the Service). The tier two and tier three service specifications are used with this service specification to provide additional service-specific detail. Refer to the accompanying glossary for definitions of terms used within the tier one, two and three service specifications.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 sets the direction for service delivery across the health sector over the next five years. The primary focus of Rising to the Challenge is to assist health services to collectively take action to achieve four overarching goals in the table below.

The ABCD overarching goals and desired results

Overarching goal		Results we wish to see
A	Actively using our current resources more effectively	Increased value for money
B	Building infrastructure for integration between primary and specialist services	Enhanced integration
C	Cementing and building on gains in resilience and recovery for: i. people with low-prevalence conditions and/or high needs (psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions) ii. a) Māori b) Pacific peoples, refugees, people with disabilities and other groups	Improved mental health and wellbeing, physical health and social inclusion Disparities in health outcomes addressed
D	Delivering increased access for: i. infants, children and youth ii. adults with high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms)	Expanded access and decreased waiting times in order to: • avert future adverse outcomes • improve outcomes
	iii. our growing older population	• support their positive contribution in the home and community of their choice

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017[1] seeks to improve outcomes for all people with mental health and addiction issues. It also seeks to improve the integration of and quality of services to reduce disparities. A key step in achieving these goals is through developing a culture of responsiveness where Service Users, families, whānau and significant others are actively supported and involved in treatment and recovery.

The refreshed New Zealand Health Strategy outlines the high level direction for New Zealand's health system to improve the health of people and communities. It has been developed to guide change in the system and has two parts, the Future Direction and the Roadmap of actions 2016. The strategy describes new ways of working so that all New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system (Ministry of Health 2016, p 13).

Social and economic inequalities are associated with poor health outcomes. Section four of the Mental Health and Addiction Service Development Plan has a focus on building on gains in resilience and recovery for Māori and Pacific peoples, refuges, people with disabilities and other groups. The expected result is consistent mental health and addiction outcomes for all.

It is unlikely that any single provider will deliver the full range of services, therefore all services in the mental health and addiction sector must work collaboratively and co-operatively to provide a well-integrated and seamless continuum of care. Effective, robust planning and partnerships within and across health service providers, other government-funded services and private sector service providers are critical in enabling better recovery outcomes for Service Users, their family, whānau and communities.

1. Service Definition

Specialist mental health and addiction services are delivered to those eligible people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. However, it is recognised that a focus on early intervention strategies will mean services may be delivered to people who are at greater risk of developing more severe mental illness or addiction.

To the extent that funding for specialist mental health and addiction services does not support coverage for all target populations, it is expected that District Health Boards (DHBs) will have criteria in place for prioritising the provision of services, to people with the highest level of need.

2. Service Objectives

These following objectives have been developed in collaboration with, and should apply to all specialist mental health and addiction services:

2.1 Services will be responsive

Responsive services adapt to meet the unique needs of specific population groups and individuals. This is achieved through being flexible around service delivery settings in both urban and rural areas and adaptable to the Service Users' individual circumstances and needs, including cultural and spiritual needs. Services should be age and gender appropriate.

Responsive services focus on recovery, reflect relevant cultural models of health and take into account the clinical and cultural needs of people affected by mental illness and addiction. Services working together will also ensure adequate referrals between mainstream services and those developed to meet the unique needs of specific population groups.

Service delivery should be flexible and responsive to the local situation, national direction and future innovation and evidence.

Where services have smoke-free policies, Service Users should be routinely offered advice on how to quit smoking and should have access to appropriate cessation supports, including nicotine replacement therapy (NRT) products.

[1] http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017

2.2 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. Actively involve tangata whenua in planning for mental health and addiction services.

2.2.1 Responsive to Māori

The overall aim of *Te Puāwaiwhero*, is whānau ora, that is Māori families achieving their maximum health and wellbeing. Kaupapa Māori services working together with Whānau Ora providers will support positive outcomes for those using infant and child services.

2.3 Responsive to Family and Whānau

Family and whānau are critical to successful recovery. Services will acknowledge the particular role the Service User plays in their family and whānau. This may include their role as parents or carers. For most Service Users, family and whānau plays a key role in the road to recovery. There are significant clinical, social and economic advantages to providing mental health and addiction services in a family inclusive way. Services need to listen to family and whānau and respond to their specific needs, including providing education on recovery and referral of family and whānau to appropriate support services.

2.4 Recovery Focused

Recovery is defined as the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential. Recovery is different for everyone; therefore there should be a range of service models and flexibility of services. For those with addiction problems, recovery is a process whereby Service Users are assisted to minimise harms and to maximise wellbeing. Recovery may or may not involve abstinence.

2.5 Foster Resilience

Resilience can be encouraged through a continuous process where individual and family whānau capacities are recognised along with protective factors in the community. Building upon and fostering these factors can help people counter life challenges such as mental illness and/or an addiction. Strength-based approaches help to promote engagement and build resilience.

2.6 Encourage Natural Supports

Supports may include family whānau, partners, friends, neighbours, colleagues or those from an identified group. Mental health and addiction workers will foster relationships with natural supports, as defined and chosen by the Service User, as supports play an important role in building resilience and recovery.

2.7 Promote Independence

Services should support individuals to live as independently as possible within the context of their treatment and support needs, and in an environment that is consistent with these goals.

2.8 Support Service Users to Make Informed Choices

All providers need to ensure information about services is available and easily accessible to Service Users and their family and whānau. Service Users should be informed of their choices and options for care.

2.9 Reduce Inequalities

A desired result of Rising to the Challenge is to see disparities in health outcomes addressed. Social and economic factors, such as income, poverty, employment, education and housing, have been cited as contributing significantly to mental health and addiction status. It is acknowledged that socioeconomically disadvantaged groups bear a disproportionate burden of risk for mental ill health. This highlights the importance of mental health and addiction services, to co-ordinate and co-operate with other government agencies, such as, housing, employment and education. Responsiveness to infants, children, adolescents and youth is critical to interrupt cycles of mental illness and addiction within families, whānau and communities.

2.10 Promote Seamless and Integrated Services

An overarching goal for Rising to the Challenge is building infrastructure for integration between primary and specialist services. Service Users may be receiving care/treatment for both addiction and mental health issues. Both types of services need to be provided in a seamless way. It is vital that 'any door is the right door' and the mental health and addiction sector must build capacity and capability to respond to co-existing disorders.

Mental health and addiction Service Users may also access other services. Services should work together to determine shared care arrangements that best meet the Service User's needs. It is important that those with a mental illness and/or addiction also have their physical health needs met.

Increasing recognition by the Justice system of the need for health interventions for offenders requires mental health and addiction services to interface well with the Justice system. This population is particularly high risk, with a high incidence of co-existing disorders.

2.11 Develop Organisational Governance

Organisational governance structures contribute to the stability and viability of organisations. A strong and active engaged board that is structured to provide fiscal oversight, has the skills and experience to work alongside other mental health and addiction organisations to deliver seamless, well-integrated services and meet the organisation's governance needs is promoted.

2.12 Develop Workforce

Workforce development needs to be part of the focus for every service. This development involves building the capacity and capability of the Service providers to work in partnership with the Service Users. Investment in the development of the mental health and addiction workforce is key to ensuring the delivery of effective services. Integrated care and treatment can be achieved through the establishment of a competent workforce appropriately trained to recognise and respond to mental health and addiction issues.

Let's get real: Real Skills for people working in Mental Health and Addiction (Ministry of Health 2008) is a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services.

Rising to the Challenge will deliver a national workforce development plan which considers:

- new ways of working
- new roles to complement existing staff groups
- future services, changing demography and future demand for services.

2.13 Value Lived Experience

People with a lived experience of mental illness and addiction offer a unique contribution to services. The important perspective of those with a lived experience should be utilised in the planning and implementation of services. Services should foster a culture that promotes Service Users participation and recovery. Real life examples of recovery can offer hope to Service Users. Service Users should be encouraged into a range of roles, both within consumer-led services and across the continuum of services.

The valuable perspective and experience of family and whānau supporting a loved one with a mental illness and / or addiction should also be seen as an asset within the mental health and addiction workforce.

3. Service Users

A Service User is an eligible person/people[2] deemed to receive or be receiving publicly funded specialist mental health and/or addiction services for those who are most severely affected by mental illness or addiction.

[2] Not all patients who are referred or present to the Service are eligible for publicly funded services. Refer to www.moh.govt.nz/eligibility for more eligibility information.

Specialist mental health and/or addiction services includes healthcare, health information, or support services resulting from direct contact with a healthcare provider where the healthcare results in use of resources associated with observation, assessment, diagnosis, consultation, rehabilitation or treatment. This includes ongoing support, education, training, or ensuring or monitoring compliance with relevant legislation.

4. Access

4.1 Entry and Exit Criteria

Referrals to the Service may be made from any source, including self-referral. Some speciality services have specific requirements before accepting a referral. In these circumstances, services need to have clear documented access criteria and protocols, and ensure these are communicated with family, whānau and others making contact with the Service.

On referral (including self-referral), the criteria for assessment is based on the person having a suspected, developing or identifiable mental illness, and/or an addiction problem.

Services may prioritise referrals based on:

- clinical assessment about need and the severity of the mental illness and/or addiction
- the likely impact the mental illness and / or addiction will have on the person's ability to participate in activities of daily living, work, education and community life, and their role as a family and whānau member
- relevant legal requirements including the Mental Health Compulsory Assessment and Treatment (CAT) Act 1992 and Alcoholism and Drug Addiction Act 1966
- the safety of the individual and/or of others such as family members
- patients may exit the Service by transfer, discharge from the Service or death
- the Child Health Strategy (1998), defines a child as being aged from before birth to 14 years, and further identifies that young people up to the age of 18 years should be given care within the most developmentally appropriate services, as young people have specific developmental needs which require that they are cared for in youth appropriate settings. It is also necessary to recognise that the transition to adult services must occur at the appropriate time
- on entry to the Service, the most appropriate course of action will be discussed in consultation with the Service User and their family and whanau. This will be based on needs, strengths, mental health and /or status and supports. Service Users must be informed of their choices and options for care in line with consent protocols.

4.2 Distance

Services will be delivered locally where possible. DHBs are also expected to have in place arrangements that ensure the people of their DHB area have access to regionally and nationally provided mental health and addiction services.

4.3 Timeliness of Services

When assistance is required under the Mental Health (CAT) Act 1992, 90% of people presenting should be assessed within four hours. DHBs with isolated rural communities will ensure that effective arrangements are in place.

If a person is assessed as needing hospital care under the Mental Health (CAT) Act 1992, 90% should be admitted to a hospital within six hours of being assessed by a doctor or health professional.

The DHB will ensure that crisis services to deal with a critical or urgent mental health and/ or addiction needs will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act) as follows:

- telephone or other remote assistance will be available at all times with minimal delay
- where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided within four hours; DHBs with isolated rural communities will ensure that effective arrangements are in place
- other services will be arranged when required, including acute inpatient admission and crisis respite.

People are seen and assessed as needing services will receive those services as soon as possible. For some services, there may be a wait before treatment can begin (eg, opioid substitution programmes.)

Note: until a person is assessed, it will not be known whether they fall under the Mental Health (CAT) Act 1992.

5. Service Components

5.1 Processes

Processes occur as part of a Service User pathway. Processes that include: health education, health promotion, engagement, assessment, diagnosis, treatment, rehabilitation, onward referral, family support, case management, liaison and consultation and ongoing support.

At all stages of this pathway, skilful engagement, consultation and, where appropriate joint care planning between services will be used to ensure the needs of the Service User are identified and responded to. Service Users and their family and whānau should be encouraged to participate in evaluation/review at each step. Appropriate risk management procedures should also be put in place for the safety of the Service Users, staff and others.

5.1.1 Assessment

Assessment will be appropriate and sufficiently comprehensive for the purpose of the particular service. It forms the basis of the recommended treatment, intervention or support and must be completed by staff with the required competency, knowledge and skills.

The assessment process will vary and take into account individual circumstances and, as well as the Service User, will include agreed family, whānau and support people where practicable. The assessment will take into consideration cultural needs. A full explanation of the process must be provided and reiterated to the Service User and those accompanying them.

The assessment will help develop an initial recovery plan, which will include treatment, intervention or support options, appropriate risk assessment/management and the plan for discharge. Recovery plans will be developed in a collaborative process with Service Users, their family and whānau and support networks and will address their broader physical, spiritual, social and psychological needs and aspirations. The recovery plan will be discussed with the Service User, and informed consent must be sought. There will be a process in place for reassessment. The assessment process should take into account identification of parental roles and responsibilities. Because the Service Users may be linked into several different services, all will contribute to the overall recovery plan.

5.1.2 Treatment, Intervention and Support

Treatment, intervention and/or support are the key focuses for the Service delivery. The models for treatment, intervention and/or support will vary, and are described in further detail in tier two and three specifications.

After the initial assessment, treatment, intervention and/or support options will be recommended specific to the Service Users' individual needs and circumstances. The recovery plan will be developed collaboratively with the Service User and, if appropriate, their family and whānau that will identify goals towards discharge and outline supports to assist the person to achieve those goals. It will include early warning signs, wellness maintenance, relapse prevention information and may include advance directives. Recovery plans will address the Service User's broader physical, spiritual, social and psychological needs and aspirations. Recovery plans will be kept current by regular review. Evidence-based, best practice education and information will be proactively provided to Service Users and their family and whānau. The Service User will give written informed consent for treatment, intervention and/or support and will receive a copy of their recovery plan.

More positive outcomes occur when people are able to easily access services, and when services show flexibility and encourage Service User participation within clearly communicated and coherent treatment programmes. Information should also be provided about the role of family and whānau and the supports available to them, and other social networks.

5.1.3 Review Process

This is the process of formally reviewing recovery plans, goals and outcomes both with the Service User and in a multi-disciplinary setting. Reviews must occur at a minimum of every six months but the

frequency will be determined by the Service User's individual circumstances, for example, their specific goals and the specific role of the service involved. In the addiction sector it is recommended that a review of progress is more frequent, occurring at a minimum of once every four months.

The review will include the Service User and with their consent, their family and whānau. Reviewed outcomes and new treatment goals will be reflected in ongoing recovery plans.

5.1.4 Discharge

Discharge is a planned process that is part of the recovery plan. It should begin from when the service is accessed.[3] Discharge planning must involve Service Users and, with their consent, be communicated to all relevant support people. It will include reassessment of risk, the relapse prevention plan and follow-up arrangements. Discharge planning may also include advance directives and will identify medication on discharge and education about this. The Service Users, family, whānau and other services and agencies involved should be informed of how to re-engage with the service if required.

A discharge summary will be given to the Service User and, where relevant, the general practitioner/primary care provider and support people.

5.2 Settings

The Service will be provided in the appropriate setting to provide the desired health outcomes. A consideration in determining the settings for the service should include (but not be limited to) issues such as cultural appropriateness, accessibility, gender, age and developmental stage, and the most effective and efficient use of resources. Services may be provided using hospital settings such as inpatient and day hospital, and outpatient settings such as those community based and mobile services. Some services may be electronic, such as e-therapies.

5.3 Support Services

The following support services, if required, are to be provided as an integral part of the Service.

- clinical support services such as: laboratory, pharmaceutical, pathology
- allied health support services such as: dietetic, physiotherapy, social work and counselling service
- ancillary services such as: sterile supplies, laundry and cleaning, occupational health, infection control
- interpreting services (including sign language)
- chaplaincy services
- corporate services such as: human resource department, legal, finance.

Additional support services if any are listed in the appropriate tier two and three service specifications.

5.4 Key Inputs

The key input for mental health and addiction services is the workforce and national electronically delivered programmes such as the National Depression Initiative [4] and Like Minds, Like Mine[5].

5.5 Pacific Health

Mental Health and Addiction Services for Pacific are underpinned by the Ministry of Health strategic document Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018. Pacific peoples share similar risk factors to Māori in terms of health and social inequalities. Te Rau Hinengaro. The New Zealand Mental Health Survey (Ministry of Health 2006) confirms that Pacific peoples experience mental illness at higher levels than the general population. Pacific people are also less likely to access treatment than the total New Zealand population. The service must take account of key strategic frameworks, principles and be relevant to Pacific health needs and identified concerns.

For regions that have significant Pacific populations, the service must link service delivery to the improvement of Pacific health outcomes. Health service providers should also ensure that their service provides a holistic approach to health and wellbeing, assessment and treatment for Pacific

[4] www.ndi.org.nz/index.php?q=content/welcome
[5] www.likeminds.org.nz/

peoples. This approach should include focusing on family, relationships, spiritual, physical, language, cultural, emotional and mental dimensions.

5.6 Health for other Ethnic Groups

Mental health and addiction services will be relevant and responsive to the diversity of cultures within local communities. Services will recognise resources, relationships and other protective factors in the community that will empower and promote wellbeing. Services will deliver culturally appropriate care, considering the individual ethnic, spiritual and cultural beliefs of those served.

Service planning, development and delivery will ensure that people are not discriminated against or disadvantaged. Mental health and addiction services will acknowledge that different cultures come with varying perspectives. Mental health and addiction services shall demonstrate effort to recruit staff from different cultures to reflect and match the cultural needs of people from Asian, migrant and refugee backgrounds in the community. Services will take steps to ensure that the mental health and addiction workforce is culturally competent and that qualified interpreters are available to provide maximum access for ethnic/cultural communities.

6. Service Linkages

Service linkages are requirements regarding linkages to other related services and provide a description of such links. The costs of such services are not included in the price of the Service, however, the costs of liaison and linkages with these services are included within the Service Purchase Unit price.

Service Provider	Nature of Linkage	Accountability
Other primary, secondary and tertiary services that the service refers Service Users to	Refer and access to skills, expertise and resources within other disciplines ie medical services, surgical services	Referral processes and protocols are in place include mechanisms for shared working where appropriate. Services assist the Service User to access the other services that are required
Supporting services not purchased within this service specification	Provide continuity of care and facilitate access to services that best meet the needs of the Service User	Knowledge of other services within a district maintained Relationship with other providers through stakeholder networks
Publicly funded disability or long term support services for the Service Users with co-existing disabilities/ conditions who meet other funding streams eligibility criteria such as: Needs assessment and service co-ordination (eg, NASC) Specific support services such as: home and community support; carer support and respite; residential services; supported independent living; habilitation/rehabilitation; other specialist support services, as appropriate Environmental support services (eg, long-term equipment, including specialist assessment services, home modifications) to assist with essential daily activities Information and advisory	• Referral and liaison • Consultation	• Effective local and regional linkages are in place to facilitate appropriate referrals • Service Users needing long-term support services: have: – timely access to individual needs assessment and service coordination services – receive appropriate services across the continuum of care and support to meet their individual needs, within available resources • Service Users needing environmental support services receive appropriate equipment and environmental modifications • Service Users have timely access to appropriately presented information and relevant advice

Service Provider	Nature of Linkage	Accountability
services (eg, on available services and how to access these)		
Local Māori health providers, Māori agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Māori	Local Kaupapa Māori services are strengthened by relationships, networks and cross agency working.
Local Pacific health providers, Pacific agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Pacific people.	Local Pacific services are strengthened by relationships, networks and cross agency working.
Other Government funded social services such as Education, Justice, Police, Social Development eg Work and Income and Child Youth and Family	Alignment of delivery of health services and delivery of other government funded social services to better meet the goals of government strategies and policies from health and related sectors (eg Social Development , Education, Justice, etc) Where children/young people are receiving services from other agencies, the service provider will participate in inter-sectoral collaboration and co-ordination initiatives such as 'Strengthening Families'.	Agreements and protocols regarding obligations of lead providers and collaborative working.
Consumer support groups	Share information with other providers about how to better meet the needs of Service Users.	Maintain communication with consumer groups. Support the consumer voice at planning and delivery of services.
Between DHB providers, non-governmental organisations and Primary Health Organisations	Share innovative ideas, solve problems and improve access to services Provide co-ordinated support to people affected by mental illness and/or addiction.	Document agreements in memorandum of understanding (MOU) and protocols.

There will be:

- clear arrangements/protocols/statements describing the accountabilities for access, entry, treatment, care management, exit processes, follow up and information sharing between linked providers.
- definitive statements on the boundaries between services and whether these are a matter of clinical judgement or prescribed by regulation/other mechanism.
- clear arrangements/protocols/statements describing how the provider will ensure treatment is delegated to the most appropriate person or agency, and which provider is primarily responsible for the care on each occasion.
- the requirement for providers to establish dispute resolution processes (depending on the linkage/relationship).

7. Exclusions

Mental illness or addictions often co-exist with other health or social service needs that impact on intervention outcomes. The presence of such needs shall not reduce a Service User's access to mental health and addiction services to which they would otherwise be eligible, but should be a signal

that collaboration with another agency or health provider and joint intervention planning/provision is likely to be required.

DHBs do not fund services for mental health and addiction when the service or support needs are solely orientated to:

- sexual abuse
- violence and anger
- intellectual disability (including post-head injury), with or without behavioural problems
- learning difficulties
- criminal activities (anti-social behaviours)
- conduct disorder
- parenting difficulties
- relationship issues
- nicotine addiction.

Where people are eligible for services funded under the Injury Prevention, Rehabilitation, and Compensation Act 2001, they are excluded from receiving these services through public funding under Vote: Health.

The following services are not funded mental health and addiction treatment services where they are the sole focus of the intervention. They may be funded through other health funding or, in some cases, by other agencies:

- relationship services
- sexual abuse counselling services
- any counselling interventions not related to mental health and addiction
- psychological testing for educational requirements
- preparation of court reports ordered by the Ministry of Justice, except for those under the Criminal Procedure (Mentally Impaired Persons) **Act** 2003
- preparation of court-ordered reports or parole board reports
- assessments under section 65 of the Land Transport Act 1998
- assessments and reports under section 333 of the Children, Young Persons, and Their Families Act 1989.

8. Quality Requirements

8.1 General

The Health and Disability Sector Standards (HDSS) applies to this Service. Where available, the Service should use accepted clinical guidelines and standards.

Refer to the Operational Policy Framework[6] for a comprehensive and updated list of standards and legislation that require provider compliance.

8.2 Monitoring Quality

It is important that at each stage of the pathway Service Users and their family and whānau are able to give feedback on the Service. Regular contract monitoring and auditing will occur and contribute to a continuous quality improvement cycle for all services.

When assessing the quality of the Service to the extent to which the Service has met the following priorities will be considered:

The process of service delivery should ensure:

- the Service User's needs are central
- Service User and wherever possible family / whānau participation
- recognition that many Service Users will have parental roles and this will impact on their needs and those of their children
- high-quality mental health and/or addiction care is supported
- compliance with the Health and Disability Services Standards[7]

[6] www.nsfl.health.govt.nz/accountability/operational-policy-framework-0

- Mental Health and Addiction key performance indicators and PRIMHD data are reported
- evidence-based best practice is followed.

8.3 Mental Health and Addiction Service specifications

When selecting the appropriate service specifications required for a Mental Health and/or Addiction service to be purchased, the following steps are to be taken:

- select tier one Mental Health and Addiction service specification
- consider the most appropriate service type and select one or more tier two service specifications
- consider the Service User needs to be met and the preferred service delivery mode
- select the tier three service specification that best meets these requirements.

(A minimum of three Mental Health and Addiction service specifications are required for each contract- a tier one, at least one tier two and a tier three service specification).

9. Purchase Unit Codes

9.1 The Mental Health Purchase Unit (PU) codes are published in the joint DHB Ministry Nationwide Service Framework Purchase Unit Data Dictionary on www.nsfl.health.govt.nz.

The following PU codes do not have specific nationwide mental health and addiction services service specifications, but may be included under this Tier One service specification.

PU Code	PU Description	PU Definition	Unit of Measure
MHFF	Mental Health - flexifund	Service to cover the costs for flexible funding for mental health services in addition to specific services with a unit of measure client, available bed day, occupied bed day or FTE.	Programme
MHFF0001	Individual Treatment bed (Mental Health & AOD)	Bed for a client of mental health and/or alcohol and other drugs (AOD) services, of any age, who requires individualised care	Occupied bed day
MHQU	Mental Health - quality and audit	Service to cover the costs for quality and auditing of mental health services	Programme
MHWF	Mental Health - workforce	Service to cover the costs for mental health workforce development.	Programme
MHSD	Mental Health - service development	Costs to cover service development projects.	Project

PU codes for mental health and addiction services are included at tier three service specification level and reflect the tier one and tier two service specification components.

Unit of measure	Definition
Occupied bed day	Total number of beds that are occupied each day over a designated period. For reporting purposes, count beds occupied as at 12 midnight of each day. Leave days, when the bed is not occupied at midnight are not counted. Counting formula is discharge date less admission date less leave days.
Programme	A set of related measures or activities that is purchased in a block arrangement and is uniquely agreed at a local level
Project	Agreed lump sum amount. Service purchased in a block arrangement

[7] Health and Disability Services Standards: www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards

9.2 Programme for the Integration of Mental Health Data

Mental Health and Addiction providers will provide the required data electronically to Ministry of Health Information Services via the Programme for the Integration of Mental Health Data (PRIMHD).

There will be participation in KPI Benchmarking project as this work is implemented in the sector. Refer to Mental Health Data Definitions and Descriptions document[8].

[8] www.nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-and-addiction-services

GLOSSARY FOR MENTAL HEALTH AND ADDICTION SERVICES SERVICE SPECIFICATIONS

The definitions in this glossary are consistent with the definitions used in other national documents.

Addiction
Addiction in the context of the mental health and addiction services relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance abuse, or problem gambling leading to significant impairment or distress.

Advocacy
Actively advancing or protecting the rights and interests of people with mental illness and/or addiction.

AOD
Alcohol and other drugs.

Assessment
A service provider's systematic and ongoing collection of information about a consumer to form an understanding of consumer needs.

Clinical Assessment
Forms the basis for developing a diagnosis and an individualized treatment and support plan with the Service User, their family, whanau and significant others.

Community Service
A service based within the community that maybe delivered in hospital outpatient and/or community settings.

Consultation
Obtaining opinions and views of people affected by potential or proposed changes or developments, in order to consider those views in the decision making process.

Culture
The beliefs, customs, practices, and social behaviour of a particular nation or people, a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong.

Family Inclusiveness
Families and whānau have a fundamental role in supporting recovery and wellness and their participation in service planning and delivery will be critical.

Harm Reduction
Harm reduction focuses on reducing harms associated with addiction, including health, social economic and other harms experienced by individuals, families, communities and society.

Lived Experience
The term refers to having experience of mental illness or addiction.

Natural Supports
Natural supports include family whānau, partners, friends, neighbours, colleagues or those from an identified group who help the Service User in his/her recovery.

PRIMHD
Programme for the Integration of Mental Health Data; a common code set for the health sector.

Protective Factors
Supports, strengths and activities that help build resilience.

Recovery
Recovery is defined as the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential. Recovery in the addiction sector includes a view of both abstinence and harm minimization perspectives that have evolved over time to represent the individual's view. There is a long and generally held view that in the addiction field recovery involves an expectation/ hope that people can and will recover from their addiction / unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the word's widest sense) providing help. Health and Social Services will need to expect recovery and work in a way that will support it and will build future resilience.

Relapse Prevention Plan
Relapse prevention plans identify early relapse warning signs of clients. The plan identifies what the client can do for themselves and what the service will do to support the client.

Ideally, each plan will be developed with involvement of clinicians, clients and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each client will know of (and ideally have a copy of) their plan.

Residential
The term residential has been replaced by the terms "housing" or "accommodation" dependant on the type of service.

Resilience
Personal and community strengths or skills that enable people to rebound from adversity, trauma, tragedy, loss or other factors, and go on with life with a sense of control, competence, and hope.

Service User
A person who uses specialist mental health or addiction services regardless of level of need. This term is often used interchangeably with consumer and/or tāngata whaiora

Strength based
A treatment approach, that focuses on and helps develop the Service User's strengths. This approach combines both provision of direct services and treatment, along with helping people define or priorities their needs, navigate the system and link into community resources.

Talking Therapies
Talking therapies involve people taking about their problems or issues with trained therapists. They encompass a wide range of psychological and behavioural therapies, including behavioural therapy, cognitive therapy and other types of counselling.

Whanāu
Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term in this document is not limited to traditional definitions, but recognises the wide diversity of families represented within Māori communities.

Whanāu Ora
Māori families achieving their maximum health and wellbeing, and provides an overarching principle for recovery and maintaining wellness.

SERVICE SPECIFICATION

Management of Quarterly Meetings of Nga Hau E Wha to provide Sector Intelligence from consumers to the Ministry of Health

Background

Nga Hau E Wha consists of two representatives from each of the four regional consumer networks and was established to enable the networks to learn from each other in order to strengthen the consumer voice and improve consumer engagement and involvement locally, regionally and nationally.

Nga Hau E Wha also contributes to mental health and addiction strategy, policy and priority projects as appropriate, including implementation of He Ara Oranga.

Services to be provided under this Agreement

The Ministry of Health (the Ministry) requires Te Kupenga Net Trust (TKNT) ("you") to be responsible for the management and coordination of quarterly Nga Hau E Wha meetings and processes ("the Services").

The objectives of these Services are to enable Nga Hau E Wha to:

- provide sector intelligence from the perspective of people with lived experience to the Ministry;
- be able to coordinate input into strategic documents and key pieces of work within the sector and those developed by the Ministry to provide a consumer perspective;
- provide input and comment on strategic service developments proposed by the Ministry to ensure responsiveness to the needs of those with lived experience;
- provide an overview of national issues or challenges identified by consumers that will also include peer support services;
- provide an overview of areas of best practice as identified by consumers;
- develop and maintain relationships with key stakeholders in the sector.

Output 1: Management and coordination of quarterly Nga Hau e Wha meetings and processes

1.1 You will provide secretarial services for the management and coordination of quarterly Nga Hau E Wha meetings and processes including:

- Agreeing dates, times and agenda for meetings with the Nga Hau E Wha members.
- Initiate and progress discussions with Nga Hau E Wha members to obtain business guidelines including clear and defined practices covering the following:

    1. Terms of Reference including internal process for amendments;
    2. Conflict of Interest Process;
    3. Quarterly Meeting travel process;
    4. Expenditure process including:
        a. Defined meeting attendance fees and process for payment;
        b. Agreed hours for Chair work outside of meeting attendance;

c. Additional fees process (outside of budget) including: conferences, koha, assets, training, travel and expenses outside of quarterly meetings.

- Funding and arranging suitable return flights for the representatives, accommodation, airport transfers, venue hire, catering and any other services required for the effective and efficient management of the quarterly Nga Hau E Wha meetings.

- Where possible quarterly meetings will be held at Ministry of Health, 133 Molesworth Street, Thorndon, Wellington. For venue booking co-ordination please contact Marie Farquhar, Senior Contract Advisor Marie_Farquhar@health.govt.nz at the earliest convenience.

1.2 You will ensure that the Nga Hau E Wha meetings include two representatives from each of the following areas:

- Northern Region
- Midland Region
- Central Region
- Southern Region

These regions are defined as the DHB regions.

Representatives from these regions will usually be mandated by the established consumer networks in those regions. In the absence of established network organisations, or in the event that those organisations do not mandate representatives to Nga Hau E Wha, then representatives from those regions shall be selected following the processes described in Nga Hau E Wha's Terms of Reference. Nga Hau E Wha are responsible for recruiting representatives to the group.

1.3 You will ensure that the agenda for meetings is structured to enable the existing NHEW representatives identified in clause 1.2 to learn about consumer networking activities in each other's regions and collaborate to strengthen their capacity for their experiences to be shared at local, regional and national levels. The agenda will also provide opportunities to discuss national issues, and link with other key strategic partners.

1.4 You will support and help develop the relationship between Nga Hau E Wha and Ministry officials, including quarterly meetings.

1.5 You will operate in a way that is consistent with and furthers the Terms of Reference of Nga Hau E Wha.

1.6 This Agreement concerns only the management and coordination of quarterly meetings of Nga Hau E Wha; any documents or communications produced by Nga Hau E Wha at (or as a result of) any meetings held to fulfil this contract are owned by Nga Hau E Wha. In instances where the Ministry considers that material produced by Nga Hau E Wha should be distributed to other stakeholders, the Ministry will seek the agreement of Nga Hau E Wha before doing so.

1.7 You will provide an overview of national issues or challenges in the Mental Health and Addiction sector as identified by people with experience in that sector.

1.8 You will provide an overview of areas of best practice in the Mental Health and Addiction sector as identified by people with experience in that sector.

Output 2: Quarterly reporting

2.1 You will provide quarterly reports in partnership with Nga Hau E Wha to the Ministry's Senior Contract Advisor on the outputs described in this specification. Please also refer: **Appendix 1 – TKNT Work and Reporting Plan**. Quarterly reports will include a record of the dates of meetings held in the preceding three months and names of attendees from each region.

2.3 As a minimum the three monthly reports will include the following information:

- an overview of the areas identified in clauses 1.1, 1.7,1.8 and 1.9
- consumer and/or sector feedback to the Ministry on the strategic direction of mental health and addictions including He Ara Oranga recommendations
- any other information you would like the Ministry to be aware of.

2.4 You will work closely with Nga Hau E Wha to agree on the process for the development of the six-monthly reports, and a final copy will be made available to Nga Hau E Wha for comment before being sent to the Ministry.

2.6 While you have responsibility for submitting the three-monthly reports, the Ministry expects that compiling the reports will be the collective responsibility of those people who attended each meeting of Nga Hau E Wha.

2.7 The three-monthly reports will be provided to the Ministry's Senior Contract Advisor, Mental Health Programmes, Mental Health & Addiction Directorate, Ministry of Health, PO Box 5013, Wellington or preferably email to:

MentalHealth&AddictionsContracts@health.govt.nz with the subject line "Nga Hau E Wha Report" attention Marie Farquhar.

Period	Report due date
1 July 2019 – 30 September 2019	10 October 2019
1 October 2019 – 31 December 2019	10 January 2020
1 January 2020 – 31 March 2020	10 April 2020
1 April 2020 – 30 June 2020	10 July 2020

2.8 You will also provide a three-monthly expenditure report. This report will include:

- Travel: Airfares, Taxis etc;
- Accommodation;
- Venue hire, catering and other meeting costs;
- Administration allocation;
- Meeting Fees;
- Overheads – TKNT Fee

Funding

3.1 You will provide the Services under this Agreement up to the total amounts (GST exclusive) as noted in the following table:

For services supplied in the period:	On invoices received by us on or before:	Amount (excl GST)
1 July 2019 – 30 September 2019	On Signing after 1 July 2019	$15,000.00
1 October 2019 – 31 December 2019	31 August 2019	$15,000.00
1 January 2020 – 31 March 2020	30 November 2019	$15,000.00
1 April 2020 – 30 June 2020	28 February 2020	$15,000.00
	TOTAL CONTRACT VALUE 2019/2020 FY	**$60,000.00**

3.2 Payment of Funding is dependent on delivery of the Services in accordance with the requirements of this Service Specification, including receipt of satisfactory reports as specified in clause 2.1 of this Service Specification.

3.3 The Funding will be paid in equal quarterly instalments in advance. First quarterly payment will be on signing of this agreement after 1 July 2019.

Application of Funding

3.4 You agree to apply 100% of the Funding in accordance with this Agreement.

3.5 If, upon the expiry or termination of this Agreement, you have any surplus (including any interest accrued) funding, you will repay the surplus to us, or with our prior agreement, apply the surplus to further Nga Hau E Wha activity.

Appendix 1

Te Kupenga Net Trust
Work and Reporting Plan

Provider Number: 480030 Contract Deliverables	**Contract Number:** TBC	**Work/Reporting period** 1 July 2019 – 30 September 2019
Support Nga Hau E Wha to build their own capacity and capability and continue to strengthen the consumer voice and improve consumer engagement and involvement locally, regionally and nationally.		
Establishment of effective relationship with Nga Hau E Wha and Business Guidelines development	**Development and initiation of Business Guidelines including:** • Clear and defined Terms of Reference (including process for amendments); • Conflict of Interest process; • Quarterly Meeting travel process; • Expenditure process including: ➢ Defined meeting attendance fees/process for payment ➢ Agreed hours for Chair work outside of meeting attendance ➢ Additional fees process (outside of budget) including: conferences, koha, assets, training, travel and expenses outside of quarterly meetings (➢ Confirmation of Quarterly Meeting dates, times and agenda for meetings with Nga Hau E Wha members.	
Quarterly meeting management	**Provision of Secretarial Services for Quarterly Meetings** • Funding and arranging suitable return flights for the representatives including: ➢ Accommodation ➢ Airport transfers ➢ Venue hire and catering *(MoH venues to be utilised where possible)* ➢ Any other services required to ensure efficient management of the meetings.	
Stakeholder Engagement/Liaison	**Relationship Management** • Provide support and development between the relationship between Nga Hau E Wha and Ministry officials.	
Reporting	**Refer Output 2: Three Monthly reporting**	

Provider Number: 480030 Contract Deliverables	**Contract Number:** TBC	**Work/Reporting period** 1 October 2019 – 31 December 2019
Ongoing support for Nga Hau E Wha to continue to strengthen the consumer voice and improve consumer engagement and involvement locally, regionally and nationally		
Quarterly meeting management	**Provision of Secretarial Services for Quarterly Meetings** • Funding and arranging suitable return flights for the representatives including: ➢ Accommodation ➢ Airport transfers ➢ Venue hire and catering ➢ Any other services required to ensure efficient management of the meetings.	
Stakeholder Engagement/Liaison	**Relationship Management** • Provide support and development between the relationship between Nga Hau E Wha and Ministry officials.	
Reporting	**Refer Output 2: Three Monthly reporting**	

Provider Number: 480030 Contract Deliverables	**Contract Number:** TBC	**Work/Reporting period** 1 January 2020 – 31 March 2020
Ongoing support for Nga Hau E Wha to continue to strengthen the consumer voice and improve consumer engagement and involvement locally, regionally and nationally		
Quarterly meeting management	**Provision of Secretarial Services for Quarterly Meetings** • Funding and arranging suitable return flights for the representatives including: ➢ Accommodation ➢ Airport transfers ➢ Venue hire and catering *(MoH venues to be utilised where possible)* ➢ Any other services required to ensure efficient management of the meetings.	
Stakeholder Engagement/Liaison	**Relationship Management** • Provide support and development between the relationship between Nga Hau E Wha and Ministry officials.	
Review of developed Business Guidelines	**Review of Finalised Business Guidelines:** • Support Nga Hau E Wha with an internal review on the developed and implemented Business Guidelines to inform six monthly guidelines.	
Reporting	**Refer Output 2: Three Monthly reporting**	

Provider Number: 480030 Contract Deliverables	**Contract Number:** TBC	**Work/Reporting period** 1 April 2020 – 30 June 2020
Ongoing support for Nga Hau E Wha to continue to strengthen the consumer voice and improve consumer engagement and involvement locally, regionally and nationally		
Quarterly meeting management	**Provision of Secretarial Services for Quarterly Meetings** • Funding and arranging suitable return flights for the representatives including: ➢ Accommodation ➢ Airport transfers ➢ Venue hire and catering *(MoH venues to be utilised where possible)* ➢ Any other services required to ensure efficient management of the meetings.	
Stakeholder Engagement/Liaison	**Relationship Management** • Provide support and development between the relationship between Nga Hau E Wha and Ministry officials.	
Reporting	**Refer Output 2: Three Monthly reporting including:** ➢ a full Financial Year End report from 1 July 2019 to 30 June 2020	

Nga Hau e Wha
Statement of Financial Performance
1 Jul 2019 to 30 Sep 2019

	3 months YTD Actual	3 months YTD Budget	Variance
Nga Hau e Wha Contract Income	$15,000	$15,000	$0
Less Operating Expenses			
Accommodation	$1,277	$1,200	
Catering	$159	$440	
Flights	$2,731	$5,000	
Meeting Fees & Taxi Fares	$1,824	$400	
Nga Hau e Wha Contract Expenses	$5,991	$7,040	$5,991
Operating Surplus	**$9,009**	**$7,960**	**$1,049**

Nga Hau e Wha
Balance Sheet
as at 30 Sep 2019

	30 Sept 2019
Current Assets	
Nga Hau e Wha Funds Held	$9,700
Less Liabilities	
Sundry Creditors	$691
Closing Balance Nga Hau e Wha Funds	**$9,009**

Championing Many Voices

Ngā Hau e Whā

1 July 2019 to 30 September 2019

Report to the Ministry of Health

Table of Contents Page number

Separate Regional Reports from Nga Hau e Wha members are embedded at the end of this document

Nga Hau e Wha – the story behind the name

This purakau begins with **Ranginui** (Sky father) and **Papatuanuku** (Earth mother) who are connected to each other in a tight and loving embrace. Between them, in the darkness, lives their 70 children but as time went on the children begin to become unsettled and with growing frustration towards their restrictive space they began to discuss ways of how they could free themselves and make things better for them.

One of the brothers, Uepoto, saw a speckle of light beneath Papatuanuku's armpit and he wanted to find out what it was. Afraid to go by himself he managed to gain support from two of his other brothers, Pekatua and Te Mamaru, to go with him to investigate this speckle of light where they found the Hinetore (glow worm). Tane then came up with the idea that to distinguish this light you had to flood it with daylight but to do this they had to find a way to separate their parents. This idea gained momentum amongst some of his brothers who saw Tane as being intelligent, a thinker and a strategist.

Tangaroa initially agreed to separate his parents but he swayed back and forth during the discussion and finally decided that he wanted to leave things as they were. Tawhirimatea on the other hand was happy to live in the dark, just like any blind person does. He also cared about his parents and realised the hurt they would endure if separated and so was against the idea. Te Ihorangi was another who wanted to leave things as they were. Whiro too was happy to live in the dark as he could foster all sorts of fear. Alliances were beginning to be formed – to separate the parents or to leave things as they were. On the extreme, Tumatauenga's solution to free themselves was to simply kill their parents but none of his brothers were prepared to go that far.

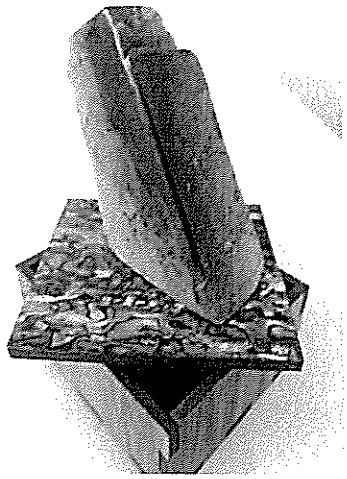
Still, despite Whiro's attempts to put fear into his younger brothers to gain their support, Tane began accumulating critical mass amongst his brothers to the extent that apart from Whiro and 7 others, he now had the numbers to "whakanoa" (free) their situation and to separate their parents.

Tane tried unsuccessfully a couple of times to separate his parents as their embrace was so intense. It wasn't until he lay on his back and began pushing Ranginui with his feet that he succeeded.

However, Ranginui was continuing to fight to hold on to his beloved Papatuanuku that Tane was finding it hard to keep his parents apart so he sought help. There was no sense in asking Tawhirimatea because he was against the separation so Tane said to Paia and Uruao "Go forth and obtain four poles with which to prop up our father. Let one be for the head, one for each arm and one for the legs". He told them to seek out **Tawhirimatea's mother-in-law Hurutearangi** to see if she could help. (Hurutearangi is the daughter of Ranginui's brother, Tapuikura. Her own daughter, Paraweranui, is the daughter that married Tawhirimatea).

She told Tane that she would give to him 2 of her other daughters, **Tokohurunuku** (under the left arm – north wind) and **Tokohurumawake** (under the head – east wind), and 2 of her sons **Tokohururangi** (under the right arm – south wind) and **Tokohuruatea** (under the legs – west wind) who became the pou that propped up Ranginui (they are different kinds of winds to the children of Tawhirimatea and Paraweranui) and this is how Ranginui and Papatuanuku were separated bringing light into the world.

Huru-Te - Arangi



Agreement 605210 / 363326/00 – Ngā Hau e Whā Report to Ministry of Health

Contract Service Specifications

1.1 Quarterly Meetings Held During Reporting Period

September 5/6 2019

Present September 5/6	Te Huia Bill Hamilton (Kaumatua)		Ngā Hau E Whā 9_2019 minutes.docx
	Guy Baker (Midland) (Co-Chair)	Victoria Roberts (Central) (Co-Chair)	
	Sheree Gutsell (Southern - Southland)	Julie Whitla (Southern - Canterbury)	
	Sarah Gillington (Midland)		

In the three months from 1 July 2019 – 30 September Ngā Hau e Whā hosted the following guests:

- Dr John Crawshaw - Director of Mental Health – Mental Health Directorate - Ministry of Health
- Waiatamai Tamehana – Principle Advisor - Lived Experience Lead – Mental Health Directorate - Ministry of Health
- Shaun McNeil – National Advisor, Consumer (Family and Whanau) Engagement – Health Quality Safety Commission
- Kieran Moorhead – Policy Advisor – Mental Health Directorate - Ministry of Health

See the embedded minutes above for the September 5/6 2019 meeting for more information.

Nga Hau e Wha meetings and processes

- In October 2016 Ngā Hau e Whā undertook a complete revamp of our **Strategic Plan 1217-2020**. Our Strategic Plan and follow on **Work Plan** continues to expand and grow.
- We received money from the **Frozen Funds** award 2017 and our application described that we would use the $10,000 award for networking in some barely reached areas of the country. Hui were held in Waitangi, Tairawhiti and Southland. Some unspent money is to fund another Hui in the Central Region. This growth was foreseen as improving and expanding our regional coverage.
- In addition to the Strategic Plan and as an adjunct to it, we have approved a **Communications Plan.**
- Work is still being undertaken on the new **Terms of Reference** and a **Conflict of Interest Process.**
- Dates for the next 6 months of meetings have been set for November 27/28 2019; February 27/28 2020; and May 28/29 2020

1.2 Membership Updates

- 7 regions now have a full complement of members – 7 in total.
- The Midlands/Waikato region needed to replace one member when Donna Starling resigned. We were pleased when this vacancy was filled by Sarah Gillington from Taranaki.
- There is a vacancy in the Central region which we are attempting to fill since the resignation of Jak Wild.
- Jason Haitana has been appointed to fill the Northland vacancy following the resignation of Tui Taurua Peihopa.
- See embedded reports in full from members at the end of this document

Compliance

People

No.	Objective	Indicator
1.	*Increase and strengthen local,*	**Nga Hau e Wha is working collaboratively with individuals who are receiving services and other groups locally, regionally and nationally**

	regional and National relationships	▪ Ngā Hau e Whā continues to work collaboratively with many individuals, groups and organisations. ▪ Ngā Hau e Whā continues to share (through our e-distribution list) with the networks any useful information in regard to issues that affect people with lived experience. The group is pleased to be of assistance to our peers and colleagues. ▪ Regular meetings are held with MoH officials. ▪ The email network continues to grow and Ngā Hau e Whā is always looking to increase the contacts which include individuals using services, as well as advisory groups, peer groups, and service providers with a specific focus on peer led services. People have been approaching Ngā Hau e Whā to be included in this network.
2.	*Be a recognised and respected conduit for the people's voice*	**There is an increase in the level and quality of feedback on issues for people receiving mental health services.** ▪ Current members have networks that contribute to the information that is reported to the Ministry. The quantity and quality of feedback continues to improve. ▪ Individuals and groups with lived experience approach Ngā Hau e Whā with items that they would like the Ministry to know about. Ngā Hau e Whā continually works on increasing its profile. ▪ National Organisations request attendance at Ngā Hau e Whā meetings, to use the Ngā Hau e Whā network and to provide consultancy. ▪ Members sit on external bodies: Multi Agency Group (HPA); Health and Disability Commission Consumer Advisory Group;
3.	*Chompion the use of appropriote languoge in all major documents.*	**Newly written documents contain appropriate language.** ▪ Ngā Hau e Whā endeavours to use appropriate language in all minutes, letters, reports and other documents it produces. The wording in the Ngā Hau e Whā Strategic Plan and Terms of Reference has been revised so labelling language isn't used and all language is appropriate. ▪ Ngā Hau e Whā continues to advocate for appropriate use of language in any feedback on documentation that it provides.
4.	*Initiate projects and promote leadership forums.*	**There is an increase in leadership and initiatives.** ▪ Nga Hau e Wha is represented on the Multi Agency Group LMLM HPA ▪ A member is externally a member of the HDC CAG.

Performance

No.	Objective	Indicator
1.	*Fulfill contractual obligations to the Ministry of Health and be in a strong position to negotiate for the future.*	**The Ministry of Health demonstrates that it values Ngā Hau e Whā, and funding is increased.** ▪ Ngā Hau e Whā continues to build its capabilities to ensure that the Ministry of Health has access to a strong lived experience perspective, whether that comes from within the group or is sourced from the network.
2.	*Connect with the grass-roots and collate issues and common themes.*	**Ngā Hau e Whā has increased the mechanisms for providing and receiving information.** ▪ Due to Ngā Hau e Whā, now having an almost full membership an increase in information is expected. ▪ Regular forums are being held to gauge the priorities and the mood of the consumer movement ▪ New members have come with their existing networks.
3.	*Be a useful and valued commentator on mental health and addiction service issues.*	**Reports and submissions are timely and well-received.** ▪ Informed and comprehensive reports by members in regard to their region are received quarterly. ▪ Ministry of Health reports are delivered on time quarterly. ▪ Ngā Hau e Whā provides feedback from a number of organisations.

4.	*Have strong ond effective representation in NHEW from the four regions.*	**Ngā Hau e Whā is well-known in each of the four regions and representatives are well-supported.** ▪ We have one vacancy with regard to our membership. In the past reporting period we have appointed Sarah Gillington to the Midlands region (Taranaki) and Jason Haitana to the Northland region (Whangarei) ▪ Midland Region is supported by He Tipuana Nga Kakano (Midland Region Consumer Network). ▪ Northern Region is supported by Changing Minds. ▪ Southern is supported by Incite and Awareness. ▪ Central is supported by the Oasis Network Hutt Valley and Wairarapa.
S.	*Improve communication processes.*	**Ngā Hau e Whā produces a regular bulletin, has a website and Facebook page.** ▪ Our www.nhew.org.nz website is still waiting for expertise to update it. ▪ The email network is continually expanding and the website will help drive this expansion further. ▪ It is intended that a Facebook page will be set up though at present the capacity and capability for this is limited.

Strategies

No.	Objective	Indicator
1.	*Became familiar with service user demographics in our regians and identify where we need to in-crease our visibility.*	**Ngā Hau e Whā has undertaken some market research and applied the findings.** ▪ We have identified areas of greatest need. These regions are Northland, Tairawhiti, Palmerston North and Greymouth. We have held three Hui and we have funding left for a final Hui in the Central region from the Frozen Funds Award.
2.	*Maintain the budget ond administrative support to ensure our business processes are efficient.*	**Business processes are working well. A financial report is provided regularly.** ▪ Mental Health Advocacy and peer Support (MHAPS) forward an updated expenditure report for each Ngā Hau e Whā meeting. ▪ All administrative tasks including organisation of travel, accommodation, venue, refreshments, are provided. ▪ Ngā Hau e Whā would like to acknowledge Shelley Englebretson for her admin support.
3.	*Review our strategic plan and objectives regularly.*	**Strategic objectives are addressed and plans in place for the next strategic plan (2016 - 2020)** ▪ The Strategic Plan for 2016-2020 was revised in November 2016. The final draft of the Plan has been ready for distribution since mid-January 2017.

1.7 Overview of National Issues or Challenges in the Mental Health and Addiction Sector as identified by people with experience in that sector

Issues or Challenges: Midlands Region: Guy Baker and Sarah Gilligan

Regional:

Suicide Statistics: Latest figures released from the Coroner's Office for 2018/19 show that incidents have increased. This is reflected in some areas with Waikato and Lakes DHB's either recording or equalling their highest ever number of incidents. Other regions continue to reflect high numbers per head of population.

Housing: and other social determinants continues to be an issue across the region with emergency and social housing in short supply with very high demand.

Areas:

Tairawhiti:

SAC 1 Incidents have seen a significant rise in the number of investigations that is causing concern with the need to have positive outcomes to recommendations being made by panels, where reoccurring themes continue to emerge.

District Council building compliance issues.

It has taken all the winter months for this to be undertaken only for Council to step in with compliance issues e.g. change of use consent, fire design, increased shower and toilet facilities etc.

Bay of Plenty (East)

Maori disparity has been identified across Eastern Bay of Plenty with consumers going longer without effective treatment or access to treatment. Maori consumers, in particular, are becoming profoundly unwell before they are able to access supports and treatments that work for them. No consumer have a shared care plan despite over 12 months of stated goals and high level meetings of service providers. A "clinician knows best" approach creates a barrier when allied staff (including mental health peer support and Kaupapa Maori support workers and clinicians) attempt to lead movement in support of whanau making a recovery. Management are supportive, and so are some mental health nurses and some kaupapa Maori workers, but we have yet to remove all the barriers blocking access to timely treatment of people with mental illness who are Maori in the Eastern Bay of Plenty.

Taranaki

Over-capacity in Inpatient unit has existed for most of the year with social issues impacting on the ability to discharge.

Security Guards in Ward: Some violent incidents have necessitated the need for uniformed security to be present on the ward to ensure safety for all.

Management Restructuring has meant some projects have been slowed in the wake of change.

Issues or Challenges: Wellington Region; Victoria Roberts

Suicide stats

Five of the country's district health boards have posted their highest ever annual suicide rates since records began 12 years ago. Chief Coroner Judge Deborah Marshall released the figure of 685 in the year to June 30. That's 17 more than in the previous 12 months, when there were 668. (Stuff)

Capital & Coast DHB posted their highest suicide numbers. This week Stuff reported that "suicide rates have "risen to the highest-ever level". This is simply not true. But the point of this report is not to become disillusioned that nothing is working. Our rates are TOO HIGH and we do have a problem."

The New Zealand provisional suicide rates by Stuff reported an increase is 17 more deaths in the 2018/2019 year than the year prior. I'm not disputing this, but the change is 13.7 suicides per 100,000 to 13.9 per 100,000 so they have actually stayed remarkably the same. This "increase" is actually a marked improvement on the 2016/2017 year which saw an increase of 1 additional death per 100,000 from 12.6 per 100,000 to 13.7 per 100,000. These are not the highest they've ever been either. In 1927-1929 the rates were 18.5 per 100,000; in the mid 1980's they were 16.7 per 100,000, in 2001-2003 they were 14.2 per 100,000.

Our rates are not increasing as much as the media would have you believe, but just to emphasise, our rates are still too high and every death matters. But our rates increased less this year than the year prior. It can take time for changes to be shift through communities and to be seen in the numbers and to.

Hopelessness breeds suicide. Making us feel that nothing we are doing makes a difference is going to make some of us feel despondent and give up. What we are doing IS making a difference.

Emergency accommodation and WINZ

Work and Income (W+I) are responsible to assist homeless people to obtain emergency accommodation until the person finds a permanent house or flat. The process usually requires the person seeking help to provide a weekly quote from a housing provider and these must be presented weekly in person to a W+I case manager in advance of the accommodation being used. Most often if the person does not get preapproval for their prospective weeks accommodation cost they will end up having to repay the amount not approved. Some people now have debts to W+I of thousands of dollars which in all likelihood the will never be able to repay.

A large number of the people who are homeless also experience mental distress. Being homeless exacerbates their distress and in far too many cases the person ends up being trespassed from W+ I because of their behavior. This then means that they need to find an agent who can deal with W+I on their behalf.

Some people placed in motels etc. have found out that their motels are charging more than the standard room rate when they find out that WINZ are paying which means that the person ends up paying back more. Often times if the person does not get preapproval for their prospective weeks accommodation cost they will end up having to repay the amount not approved, leading to marked anxiety and stress.

Workplace bullying

In discussions with peers this writer has identified workplace bullying as a fairly commonplace behavior within the community and unhappily often within mental health and addiction sector as well. It is not only a problem in the workplace but anecdotally within in groups of people with lived experience sometimes to the highest level. Healthcare providers, government agencies and local councils typically have the highest rates of workplace bullying.

A 1700-person academic survey showed New Zealand had the second-worst rate of workplace bullying in the developed world with one in five workers afflicted. Intimidation, humiliation, exclusion and ridicule caused trauma and were often endured for too long with tragic consequences. "We hear about lots of deaths from cyber-bullying and, not to diminish that, but workplace bullying is probably more common."

Culture Safe New Zealand director Allan Halse and colleagues deliver an anti-bullying seminar council staff, health professionals and industry leaders use to learn robust processes to target workplace bullying without traumatising or blaming victims. It is exciting to see employers take a proactive approach, but getting workplaces to treat psychological harm as seriously as physical attacks is not easy. Workplace bullying is characterised as a serious hazard under the Health and Safety in Employment Act.

Issues or Challenges: Southern - Canterbury –Julie Whitla

RFP information from the Mental Health Review Tribunal (MHRT) has been released and welcomed. Some people were hoping for more community based initiatives as GPs are often over stretched and busy places and people are guessing at how this will be rolled out.

Consistent dominant mental health discourse that leaves the addiction recovery journey and consumer input out of many discussions.

Rehabilitation - Nova Star - Christchurch

High turnover of staff. People who have been there are struggling with any wrap around services afterwards, anecdotally it is not seamless especially if they are deemed risks such as run away, sneaking alcohol or physical health conditions. Families are struggling to visit their loved ones and also navigating the act and services. Consumers say they are locked in.

Promises made prior are not kept and people are expected to work in the gardens at the glass houses.

Issues or Challenges: Southern – Southland – Sheree Gutsell

- Waiting times to get mental health crisis support at Emergency Department. This can vary from 30 minutes (very rare) to many hours. One person commented that they just went back home because of the large numbers of people in ED and that was during the week in the middle of the day
- Person centred care(services are too service centred)
- The environments here are not fit for purpose
- Issue with all emergency mental health service having different names around the country
- Communication by DHB services
- Still way to much stigma attached to self-harm and AOD in emergency services
- Strong opinions about emergency psychiatric services
- Planned respite is being rescinded due to people transitioning from the Mental Health Inpatient Unit requiring emergency type housing and using the respite beds; often for an extended period of time.
- Supporting Parents Healthy Children programme – developing a fear based and biased response to people with Lived Experience parenting (particularly when presented to mental health professionals); making parents fearful of disclosing and it is noted that this programme is very closely attuned to the "mental *illness* paradigm" and is based on the perceived deficits of the parents. Very little evidence of parents with lived experience participating in the development of this programme. It's stigmatizing and discriminatory.
- Few opportunities for lived experience student placements
- No peer support services in Southland – regional disparities (same DHB) cannot be accepted.

decision made about these services leaving people using these services in a state of limbo and very unhappy with the process and communication from the DHB.

- Cohort of people who have lived in residential services for extended period of time(and now requiring more specialist services due to declining physical/mental/spiritual health) have not been well served by a focus on rehabilitation in residential services. Overwhelmingly services have moved into a custodial role and failed to account for the long term effects of living in a restricted environment and the standard response is send them off to another residential home generally with even more restrictive practices. It is the strong belief of the author that these people can be identified earlier and strategies for managing the risks of living for extended periods of time in residential services should form part of the risk management plan and agencies policies directed to reflect this. These strategies should consider the positive effects of empowerment, choice and consent.
- Inpatient Mental Health Unit usually full beyond capacity – placing other services under stress. The Unit is becoming the focal point of our service with all other systems prioritizing the support of the Inpatient Unit.
- Reports of discrimination against mental distress in medical wards. Serious complaint with a person experiencing a PTSD response and the response of medical staff in withholding medical care as a punishment.

1.8 Overview of areas of best practice in the Mental Health and Addiction sector as identified by people with experience in that sector.

Best Practice: Midlands region: Guy Baker and Sarah Gilligan

Regional:

Zero Seclusion: HQSC initiative and target of Zero Seclusion by 2020 appears to be on target with all DHB's tracking quite well. A lot of change initiatives have been implemented

E-space: Midlands MH & A services has been developing a standardized clinical framework and clinical portals that would provide a common MH & A information system across the Midland region. Key deliverables include:

- Identifying and defining a common set of core MH & A service requirements and processes;
- Inform the development of a regional Information Service solution that supports the business needs of the MH & A services across the Midland Region;
- Defining and assessing the business process for MH & A across the Midland region with the intent of agreeing a core aligned set of business requirements;
- Utilizing the agreed functional requirements, inform the development of a common IS toolset to support MH & A service delivery;
- Defining an agreed data set for MH & A services;
- Developing an approach for identifying and integrating those areas of practice where regional alignment cannot be reached.

Te Kopara o Te Rito: a newly formed regional leadership group that saw the previously Te Ao Whanau (Whanau) and He Tipuana Nga Kakano (Consumer) leadership groups amalgamating. The Midlands region acknowledging that these groups have much in common but also recognizes and accepts that there are some differences that allow them to continually address these. The regional theme being that whanau is the smallest unit.

Midland Mental Health & Addiction Regional Planning: Midlands's regional leadership networks are developing a Regional Wellbeing Framework. Currently, individual Youth, Whanau, Maori and Addiction Wellbeing Frameworks are being developed to inform this project.

Flourishing Communities: Feedback is being obtained across the region from mental health and addictions stakeholders on what is considered a "Flourishing Community". Initial feedback from Taranaki and Tairawhiti has highlight some great responses.

Regional Training Workshops: These continue to be rolled out across the region which have included Single Session Family Consultation, Early Intervention in Psychosis Education, SPEC Training, and Suicide Prevention/Postvention Training etc.

MH & A Reviews: Taranaki, Bay of Plenty and Tairawhiti DHB's are undertaking reviews on the delivery of MH & A services within their regions.

Areas:
Tairawhiti:

Te Kuwatawata continues to develop. Some comments from the Final Evaluation Report in February 2019 said that in terms of responsiveness and efficiency, the aspects that stakeholders liked and felt worked well were the services easy access and quick response (no entry criteria, the ability to walk-in off the street and the relatively fast response time); a friendly, culturally resonant and non-clinical environment, working with a broader whanau, the breadth of skills provided by the multidisciplinary teams, the use of Mahi-a-Atua as a therapeutic approach, the transparency of the Hinekauorohia process (reflections of and open discussion of the case in front of the whanau) and the use of Feedback Informed Treatment as a quality improvement tool. On the other hand although there was some robust relationships with some GP's, with a few training as Mataora, a range of discussions with the intended primary care partner remained unsolved and questions arose over the viability of the intended SPoE to mental health services with Pinnacle (PHO) not encouraging its GP members to refer all people to Te Kuwatawata as a SPoE.

Mates in Tairawhiti is a community-based initiative established by the Eastland Community Trust whereby those within the health sector experience and health and safety credentials go into workplaces to promote awareness of suicide prevention.
Their aim is to establish "connectors" within work premises who not only provide support within their workplaces but also connect with other "connectors" in promoting suicide prevention.

New Facility: Minister of Health Dr David Clarke visited Gisborne to provide government response to the He Ara Oranga Report. Whilst there he announced that $20m had been ear marked for a new MH & A facility for Gisborne.

Bay of Plenty (East):
Consumer Networks: Confirming a strategy on how to strengthen consumer networks right across the Bay of Plenty.

Management Plan: Hui being held in Opotiki and Tauranga that includes consumers and whanau for the development of a new change management plan. In conjunction with this a hui-conference is planned on the topic of Peer Support.

Survey: Lived experience of consumers of mental health services across Bay of Plenty is to be conducted.

Taranaki:
Cross Sector Governance Group: To be established with representation to include the likes of DHB, CEO, Iwi, Whanau, Service Providers, Education, Police etc with intent to help reshape MH & A services in Taranaki to better align with the recommendations of He Ara Oranga.

AOD: Provides a walk-in service that continues to be beneficial. Immediate response and ease of access are some outcomes.

Families Overcoming Addictions: A support group grows from strength to strength. Funding would add value through education, advocacy and peer support.

Staged upgrades: A raft of upgrades and maintenance is improving the environment for whanau providing additional options for treatment, care and wellbeing.

Best practice: Wellington Region: Victoria Roberts

Buddies Peer Support Service

Buddies peer support service, shares the hope of recovery with 'peers' who are currently experiencing mental health difficulties.

Buddies provides peer services to the acute wards in Wellington (Te Whare O Matairangi) and the Hutt Valley (Te Whare Ahuru).

Buddies have five volunteers in the Hutt. Two new Buddies came on at the end of June and are doing very well. The team have had positive feedback from peers they have talked with on the ward. After six months the volunteers graduate and they may then step into a mentoring role.

Buddies start their next training in November.

Buddies are about to announce their permanent home in the Hutt.

Peer Mentoring Group

Hutt Valley for locals peers: Peer Mentoring Group. Several people are interested. There is a need to spell out the benefits of such a group so managers can see its worth to their organisations.

Atareira:

Atareira are leaders in modelling and promoting mental health recovery through partnership services with families, service-users and their communities. Atareira have successfully moved into their new premises and have employed two new staff members. There is already a full case load for the manager.

Strengthening Families meeting is on at Pomare Community Hall on the last Friday of each month. Navigators are based at Maoribank School in Upper Hutt.

Te Roopu Awhina hold whanau ora contracts.

Atareira is running a Managing Anxiety Programme in Porirua.

Atareira operates Easy Access Housing. It has five houses, one of which is for women only. It offers temporary accommodation (six months) for people with lived experience who are homeless.

Oasis:

Oasis is a mental health and addictions support service that provides Peer Support, Advocacy and Education to people who live or work in the Hutt Valley, who self-identify as having experience of mental distress, illness and/or addictions.

There is a new facilitator for the women's group which runs on a Wednesday afternoon (1-3 pm) and another who facilitates the craft group which runs on a Monday, starting at 9 am.

There is a shortage of emergency housing for women in the Hutt Valley. Oasis is helping two homeless women to find accommodation. Oasis runs accommodation services for men with lived experience and this area is expanding.

EarthLink :

Supports people with experience of mental distress and addictions. They offer training, recycling service, supported employment and a curtain bank.

Workforce catering and EarthLink is offering a hospitality programme to help people into employment.

MIX:

Mix is a not for profit organisation that supports those who live with the experience of mental illness, through a variety of creative and life skill opportunities.

MIX's June timetable is out and highlights include cooking on a budget (Fridays) and tikanga Māori – Matariki.

MIX is offering a fixed term contract to help with its arts programme.

MIX now uses Recordbase for stats.

"Inner Canvas" an art therapy based group at Mix, Lower 10:30 to 2.30 pm.

Another group at Mix in Upper Hutt on Friday's is called "clay landscapes". It's about creating small clay landscapes about your personal journey and what's important in a relaxing, sensory, meditative, and reflective way. This is a structured day.

Various MPs are visiting MIX to talk about their policies.

Amigos Peer Support Group
Amigos is a series of weekly peer run and led groups made up of people who have experienced mental distress and are interested in connecting with other adults of all ages who have had similar experiences. The activities include a book group; a mindfulness group; creative writing; a coffee group; a once a week meeting at an Indian café for lunch; and other one off activities from time to time

Inner City Mental Health Liaison Group (ICMHLG)

ICMHLG which through its monthly meeting provides the opportunity for sharing information and networking across the variety of organisations and services that are operating locally. The sharing of each other's work and having the chance to seek advice and support from within the group has been one of the group's strengths.

This is a cross city meeting for all NGOs who might have dealings with people who experience distress. It meets monthly. Some attendees come from the DHB, the local MP's office (Grant Robertson), people working in other mental health services and service users as well.

- Wellington Women's Hostel (WWH) is busy and constantly full.
- Reminder about the phone/text number 1737. People can get referred to Te Haika (crisis service) if needed.
- People now have to provide photo ID when applying for a NZ Housing house. They can be referred to Downtown Community Ministry (DCM) who can help.

The World Health Organisation

Quality of Life survey is suitable tool to measure the difference a course makes on person's well-being. It can be found at:

https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/

Best Practice: Southern – Canterbury Julie Whitla

Alcohol Harm Reduction Plan
The CDHB has its first alcohol policy from Public health with guiding principles.
It is starting to promote the plan to all work streams and target their own workforce to be confident about talking to people and other staff around best practice around talking to people around the harms of alcohol use, and also to get consistency to the media around harm from alcohol use.

Equally well group: a new dental care project initiative for people who are inpatients, who are on anti-psychotics and methadone and suboxone (Canterbury Opioid Recovery service) to help with dry mouths. Free toothbrushes, anti -dry solutions and toothpaste.

New build
The plans for the new build at Hillmorten of services that are delivered at Princess Margaret Hospital are about to be released publicly this month.
Mothers and babies, Seager ward, Eating disorders, Child and Youth are moving from Princess Margaret Hospital to a purpose built space at Hillmorten. Relocation is probably three years away.

Peer led
Major new initiative is an acute care, 5 bed peer led alternative to inpatient service. It is a welcomed initiative by people giving them choice to an inpatient stay at Hillmorten. No consumer survey yet to see if the environment makes a difference holistically. It is modern, welcoming and plush.

Peer support initiative for people on the Southern Mental Health Service (SMHS) Opioid recovery programme. Pharmacists are supporting peers with a referral to peer support workers.

A whole of system response was implemented to address increased levels of distress and presentations across the community from the Mosque shootings. It continues to place pressure on stretched resources. A cross sector group SMHS, NGOS, CDHB are working together to have services that support children affected by the mosque shootings while waiting access to SMHS.

The Christchurch city council has re-released there 2017 multi-cultural plan, called the Unity Accord it aims to look at how more connection to lessen loneliness, especially for young people. Its aims are to create a more unified city and lessen racism.

Mana ake supporting mental health in schools is fully operational. A booklet has been produced for parents of children starting school supporting parents to support children to be school ready, and modelling brave behaviour to alleviate anxiety.

St John ambulance now have a policy around patient safety, using chemical restraint i.e. sedatives prior to transporting, so the problem is not always obvious immediately on presentation to ED.

Health Quality Safety Commission (HQSC)
CDHB is one of 4 sites that is assisting with the development of a HQSC consumer engagement marker as currently there is no validated measure of consumer engagement across the CDHB health system. There is three phases in this process. Consumers from the Consumer council are involved in this process.

The Consumer engagement Quality marker system will take the form of a dashboard self-reporting system, with a matrix to indicate whether or not a domain is being met, supported with qualitative comments.

RFP information has been released. Lots of guessing how this will look in practice. Definitely welcome the three priority groups which have been stretched in Canterbury, especially children and youth. Some concerns raised about no focus for babies (first 500 days),

There has been a group workshop on improving access for people in Canterbury run by the Canterbury Clinical Network. Lots of speculation in the community of what this will look like, where it's going to happen, and too clinical, medicalizing more people will stretch further resources in years to come. Also the big national NGOS may be favoured as they can provide national initiatives with some consistency.

Disappointment expressed as well as peer support as a model of care will be difficult in a medical model.

Kelly Pope (amazing creative and natural leader) has been appointed to the new commission and I welcome this appointment.

Suicide Prevention
The new cross agency Suicide Prevention Governance committee is finalizing a website, in house data dashboard and whole of system Canterbury Suicide Prevention Strategy, due for release 2020. A workshop will be held in October.

<u>Best practice: Southern – Southland – Sheree Gutsell</u>

- More interest in Peer Support has been indicated. The large forum on peer workforce had over 60 attendees from over Otago and Southland. A summary of the Report is attached along with other news from the Network Leadership Group (NLG) newsletter which is the steering group for the role out of the regions mental health strategic plan.
- Raise Hope 2 Strategic Plan is set to be released during Mental Health Awareness Week. This will state actions which hopefully make a positive difference to people who experience services
- Otago Mental Health Support Trust have recently employed 2 peer support workers in the Waitaki region (around Oamaru) for 9 hours and 6 hours per week respectively. This came from funding sources outside of SDHB Mental Health. .
- Te Kete Pounamu Otepoti
- Consumer councils in DHB's
- Increasing focused listening groups in the area
- Mental health advance preference 50 - 60 new ones this year
- Nga Poutama consumer and whanau survey
- Explore positive and negative aspects of 9b as an open ward (acute unit the door has been locked since 1991 over one incident)
- Working to improve physical health outcomes for people. We are doing this by making registration easier and informing people about what they are entitled to. Connecting with healthy lifestyle groups to make sure there service is maximised by our people
- Working on improving housing and employment option in the district
- Working on alternatives to admission
- Supporting whanau, actively involving whanau in decisions, and service working closer to home

2.3 Consumer and/or sector feedback to the Ministry on the strategic direction of Mental Health and Addictions including He Ara Oranga recommendations:

Southern (Southland – Sheree Gutsell

- No local responses to the recommendations noted in the Southern area. Rather a "wait and see what the Government approach is going to be" attitude. This is particularly disturbing given the information contained Chapter 8 People at the Centre; where "far too many people told us that they were not treated with kindness, dignity and respect". I hope that this is addressed soon at a national level perhaps through the new Mental Health and Wellbeing Commission holding a series of national (including the regions) where organizations and staff can co design a process where person based care becomes an actual achievable reality. It is concerning that the current work seems focused on increasing access and choice when it appears that many organizations are not even achieving a basic appropriate standard of care or indeed meeting the basic Code of Health and Disability Consumers' Rights. "Real and Decisive change" seems unlikely.

- Generally, the lived experience workforce is aghast at the Ministry of Health's RFP for Integrated Primary Mental Health and Addiction Services (14th September 2019) for its failure to acknowledge peer support work as a separate entity with its own models and values and even dilutes the meaning of "peer" as someone who people may share some characteristics with; rather than lived experience of mental health and/or addiction distress. It appears that the RFP does not allow for explicitly peer-led peer support options which is extremely disappointing.

Any other information you would like the Ministry to be aware of:

Southern – Canterbury – Julie Whitla

Seclusion

s 9(2)(a)

Emergency Department: discussions have been around training small select security staff around de-escalation of confused dementia patients.

Victoria Roberts Sep 19 Wellington.docx | Guy Baker Midlands Regional Report Sept | Sarah Gillington Sertember 2019.docx | Julie Whitla Southern Regional Report Sept | Sheree Gutsell Regional Report Sept

Sent by: s 9(2)(a)

11/10/2019 02:46 p.m.

To: Marie.Farquhar@health.govt.nz,
cc: "Guy Baker" <guy.baker@tekupenga.co.nz>,
bcc:

Subject: Nga Hau e Wha

Kia ora Marie

Just to introduce myself : I am a Co-Chair of Nga Hau e Wha alongside Guy Baker from Tairawhiti. I live in Wellington and represent the lower part of the Central region. Guy lives in Gisborne and represents the Midlands region.

Our next meeting is on 27th/28th November in Wellington. We would like to invite you to attend and hope you might be able to schedule time with us from 9.30 - 10.30 am on the 27th. We expect that the manager of Te Kupenga Net Trust, Hine Moeke - Murray will be there at that time as well. We are also inviting Waiatamai Tamehana to join us then to.

Congratulations on your new role. I look forward to hearing from you and also to meeting you soon.

Nga mihi nui

Victoria Roberts

"You seriously don't know what load someone is carrying today - so just be kind"

Victoria Roberts I Co- Chair l Nga Hau e Wha

www.nhew.org.nz l victoria.works@gmail.com l s 9(2)(a)

The national voice of people with lived experience of mental distress and addictions

Sent by: s 9(2)(a)

12/10/2019 08:13 a.m.

To: Marie.Farquhar@health.govt.nz,
cc: "Guy Baker" <guy.baker@tekupenga.co.nz>,
bcc:

Subject: Re: Nga Hau e Wha

Morena Marie

It has been drawn to my attention that our meeting dates are 28/29 November not as I indicated 27/28.

So can I rescind my invitation to you for 27th November and change it to 28 th November at 9.30 am.

Apologies for the misunderstanding.

Nga mihi nui

Victoria Roberts
Co - Chair
Nga Hau e Wha

On Fri, 11 Oct 2019, 3:01 PM , <Marie.Farquhar@health.govt.nz> wrote:

Thank you Victoria, my new Manager returns Monday, if I may discuss with her and advise following that hui. Have a good weekend.

Sent from my iPhone

On 11/10/2019, at 2:47 PM, Victoria Roberts s 9(2)(a) wrote:

Kia ora Marie

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The national voice of people with lived experience of mental distress and addictions

Ngā Hau e Whā

1 October 2019 – 31 December 2019

Report to the Ministry of Health

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Page number

Agreement 605210 / 363326/00 – Ngā Hau e Whā Report to Ministry of Health

Executive Summary:

2019 was a significant and monumental year for Nga Hau e Wha that culminated in the re-negotiation of a new contract with the Ministry of Health (MoH) – Mental Health Directorate. This resulted after more than 12 months had transpired since the expiry of our last contract in June 2018, however the delay could be attributed to the exciting times that were occurring within the sector with the Mental Health and Addictions Inquiry, the subsequent release of He Ara Oranga report and Governments response. Despite this, the new provisions of our contract enabled us to hold 2 meetings in September 2019 and again in November 2019.

Our meeting in September 2019, the first since May 2018, provided the opportunity to address any lingering issues from the previous contract, to welcome additional members to the group and to refocus our energies towards the expectations of our new contract. The meeting in November 2019 allowed us to strategize a new plan of action where it is intended to concentrate on advocacy at all levels, strengthen and enhance our own networks and to build closer relationships with other like-minded national groups within the sector. The logistics and planning of how we propose to do this are highlighted in our November 2019 minutes (embedded).

To support our endeavours, we have constructed a Statement of Intent that we will use as a basis of the advocacy work we will do. The statement outlines some key simplistic concepts that, in our opinion, are inexpensive and where we would like to see entrenched in our services. We strongly believe that these will improve outcomes for whanau accessing services as well as for those working alongside them. These include incorporating principles such as aroha, manaaki and the importance of valuing and including whanau (see Statement of Intent).

Nga Hau e Wha has, over the past 3 years, had a well-established Maori Caucus that now includes four very active and committed members plus a distinguished Maori Leader as Kaumatua. They have instilled meaning into our name (Ko wai tatou? Who are we? - attached) which enables us to stand strong for whanau that we represent. 2020 provides the opportunity to build robust links with the likes of Te Kete Pounamu (National Maori Voice of Lived Experience) and with the National Association of Mental Health Services Consumer Advisors (NAMHSCA) among others.

Our new drive and focus moving into 2020 is expected to push us forward to not only support the recommendations of He Ara Oranga but to continually seek higher quality outcomes for whanau.

Recommendations to the Ministry of Health

1. That the Ministry provides feedback on our advocacy statement of intent
2. That the Ministry provides comment on what policies and resources support the following good practices reported by our members with lived and living experience:
    - Buddies Peer support services
    - Whanau support
    - Methamphetamine demand reduction programmes like Northland's Te Ara Oranga
3. That the Ministry comment what policies and practices address the following challenges and issues reported by our members with lived and living experience:
    - Inpatient unit and respite bed capacity and professional support
    - Inadequate funding of Tangata Whenua Rangatiratanga initiatives, by DHBs
    - The impact of homelessness and poverty on mental health

STATEMENT OF INTENT

Nga Hau e Wha has identified a suite of changes that will make a significant difference to the wellbeing of people experiencing distress. They include:

- Organisations that provide mental health services need to practice a culture of "aroha"
- Reduce discrimination especially as it impacts on Maori, Pasifika, Youth, Rainbow and Rural communities; the prison population, migrants and refugees and people receiving benefits.
- Focus on whanau inclusion in all levels and aspects of services; and
- Ensure services are accessible to all

People and organisations providing services are in positions of power. As indicated in He Ara Oranga they often fail to demonstrate dignity, respect and empathy towards the users of their services, whose rights are paramount. The Ministry of Health could show the lead in developing a culture of aroha as should organisations who provide services. Aroha could be demonstrated by valuing kindness, compassion and contributions from those with lived or living experience, actively sharing power, demonstrating a commitment to working in partnership and identifying and mitigating restrictive and coercive practices.

While we recognise the dedication of many workers, there are many who are too institutionalised and risk and deficit focussed to be effective. They refuse to provide person-centred care in favour of rigid compliance to a paternalistic, colonising and outdated model that is convenient and safe for them but does not produce the outcomes necessary for people experiencing distress to live well in our communities. They need to move on or change. They have no place in an organisation that has a culture of "aroha." At the core of aroha is Manaaki.

Institutional discrimination is still entrenched in the health system. Maori, Pasifika, Youth, Rainbow, Rural, the prison population, migrants and refugees continue to have poor access to the system and are likely to receive services that don't acknowledge their social and cultural contexts or provide a holistic approach to wellbeing which results in poorer outcomes for them. Providers need to plan, implement and evaluate with an "equity lens" and establish clear performance indicators that are based on improving outcomes.

Many services only know how to work with individuals. They need to recognise the value of including whanau – "Ko au te whanau, ko te whanau ko au (I am the family and the family is me)" Supporting whanau may not always be toto, but they are whanau. Part of being whanau is the right to self-determination (Rangatiratanga) and enabling whanau to have access to resources including knowledge and skills. Whanau are often part of the lived and living experience of people experiencing mental health, addiction and disability distress and they should be part of the planning and design of support required by them. Nga Hau e Wha fully endorse the directive in He Ara Oranga to support the wellbeing of families and whanau.

People experiencing distress often fall short of having access to quality health care. Many of them are not in employment or earn low wages. This is often a barrier to access due to costs of services and travel. Beneficiaries are often not told about their full entitlements. Poor access exacerbates conditions for people experiencing mental distress. Service providers need to learn to reach out and not leave it to consumers to find and access them.

These changes are low-cost and values based but they will make a significant impact.

We would expect the data sets to change; reductions in seclusion rates, suicide and self-harm, Compulsory Treatment Orders, in-patients stay, admissions and wait times and time in the justice system. We would also expect improved living standards, life expectancy, employment and more of us achieving our potential and contributing positively to and feeling valued in our communities.

Ngā Hau e Whā - Report to Ministry of Health - September – November 2019

Contract Service Specifications

1.1 Quarterly Meetings Held During Reporting Period

November 27/28 2019

Present November 28/29 2019	Te Huia Bill Hamilton (Kaumatua)		
	Guy Baker (Midland) (Co-Chair)	Victoria Roberts (Central) (Co-Chair)	
	Sheree Gutsell (Southern - Southland)	Julie Whitla (Southern - Canterbury)	
	Sarah Gillington (Midland)	Jason Haitana (Northland)	

In the three months from 1 July 2019 – 30 September Ngā Hau e Whā hosted the following guests:

- Hine Moeke-Murray - Manager Te Kupenga Net Trust Gisborne
- Waiatamai Tamehana – Principle Advisor - Lived Experience Lead – Mental Health Directorate - Ministry of Health

See the embedded minutes above for the September 27/28 2019 meeting for more information.

Current invitations to our February meeting:
John Crawshaw - Waiatamai Tamehana - Shaun McNeil - Caro Swanson

Nga Hau e Wha meetings and processes

- In October 2016 Ngā Hau e Whā undertook a complete revamp of our **Strategic Plan 2017-2020**. Our Strategic Plan and follow on **Work Plan** continues to expand and grow.
- We received money from the **Frozen Funds** award 2017 and our application described that we would use the $10,000 award for networking in some barely reached areas of the country. Hui were held in Waitangi, Tairawhiti and Southland. Some unspent money is to fund another Hui in the Central Region. This growth was foreseen as improving and expanding our regional coverage.
- In addition to the Strategic Plan and as an adjunct to it, we have approved a **Communications Plan.**
- Work is still being undertaken on the new **Terms of Reference** and a **Conflict of Interest Process.**
- Dates for the next 6 months of meetings have been set for November 27/28 2019; February 27/28 2020; and May 28/29 2020

1.2 Membership Updates

- 7 regions now have a full complement of members – 7 in total.
- Jason Haitana has been appointed to fill the Northland vacancy following the resignation of Tui Taurua Peihopa. He has now attended his first meeting with us.
- There is a vacancy in the Central region which we are attempting to fill since the resignation of Jak Wild. It is planned to use the remainder of the Frozen Funds grant to hold a hui in the upper part of the region (e.g. Napier, Palmerston North or Wanganui) It is hoped that this will attract new members in the area of the hui.
- See embedded reports in full from members at the end of this documen

Agreement 605210 / 363326/00 – Ngā Hau e Whā Report to Ministry of Health

Compliance

People

No.	Objective	Indicator
1.	*Increase and strengthen local, regional and National relationships*	**Nga Hau e Wha is working collaboratively with individuals who are receiving services and other groups locally, regionally and nationally** ▪ Ngā Hau e Whā continues to work collaboratively with many individuals, groups and organisations. ▪ Ngā Hau e Whā continues to share (through our e-distribution list) with the networks any useful information in regard to issues that affect people with lived experience. The group is pleased to be of assistance to our peers and colleagues. ▪ Regular meetings are held with MoH officials. ▪ The email network continues to grow and Ngā Hau e Whā is always looking to increase the contacts which include individuals using services, as well as advisory groups, peer groups, and service providers with a specific focus on peer led services. People have been approaching Ngā Hau e Whā to be included in this network.
2.	*Be a recognised and respected conduit for the people's voice*	**There is an increase in the level and quality of feedback on issues for people receiving mental health services.** ▪ Current members have networks that contribute to the information that is reported to the Ministry. The quantity and quality of feedback continues to improve. ▪ Individuals and groups with lived experience approach Ngā Hau e Whā with items that they would like the Ministry to know about. Ngā Hau e Whā continually works on increasing its profile. ▪ National Organisations request attendance at Ngā Hau e Whā meetings, to use the Ngā Hau e Whā network and to provide consultancy. ▪ Members sit on external bodies: Multi Agency Group (HPA); Health and Disability Commission Consumer Advisory Group;
3.	*Champion the use of appropriate language in all major documents.*	**Newly written documents contain appropriate language.** ▪ Ngā Hau e Whā endeavours to use appropriate language in all minutes, letters, reports and other documents it produces. The wording in the Ngā Hau e Whā Strategic Plan and Terms of Reference has been revised so labelling language isn't used and all language is appropriate. ▪ Ngā Hau e Whā continues to advocate for appropriate use of language in any feedback on documentation that it provides.
4.	*Initiate projects and promote leadership forums.*	**There is an increase in leadership and initiatives.** ▪ Nga Hau e Wha is represented on the Multi Agency Group LMLM HPA ▪ A member is externally a member of the HDC CAG.

Performance

No.	Objective	Indicator
1.	*Fulfill contractual obligations to the Ministry of Health and be in a strong position to negotiate for the future.*	**The Ministry of Health demonstrates that it values Ngā Hau e Whā, and funding is increased.** ▪ Ngā Hau e Whā continues to build its capabilities to ensure that the Ministry of Health has access to a strong lived experience perspective, whether that comes from within the group or is sourced from the network.
2.	*Connect with the grass-roots and*	**Ngā Hau e Whā has increased the mechanisms for providing and receiving information.** ▪ Due to Ngā Hau e Whā, now having an almost full membership an increase in

No.	Objective	Indicator
	collote issues and common themes.	information is expected. ▪ Regular forums are being held to gauge the priorities and the mood of the consumer movement ▪ New members have come with their existing networks.
3.	*Be a useful and valued commentator on* *mental health and addiction service issues.*	**Reports and submissions are timely and well-received.** ▪ Informed and comprehensive reports by members in regard to their region are received quarterly. ▪ Ministry of Health reports are delivered on time quarterly. ▪ Ngā Hau e Whā provides feedback from a number of organisations.
4.	*Have strong and effective representatian in NHEW from the four regions.*	**Ngā Hau e Whā is well-known in each of the four regions and representatives are well-supported.** ▪ We have one vacancy with regard to our membership. In the past reporting period we have appointed Sarah Gillington to the Midlands region (Taranaki) and Jason Haitana to the Northland region (Whangarei) ▪ Midland Region is supported by He Tipuana Nga Kakano (Midland Region Consumer Network). ▪ Northern Region is supported by Changing Minds. ▪ Southern is supported by Incite and Awareness. ▪ Central is supported by the Oasis Network Hutt Valley and Wairarapa.
5.	*Improve communicatian processes.*	**Ngā Hau e Whā produces a regular bulletin, has a website and Facebook page.** ▪ Our www.nhew.org.nz website is still waiting for expertise to update it. ▪ The email network is continually expanding and the website will help drive this expansion further. ▪ It is intended that a Facebook page will be set up though at present the capacity and capability for this is limited.

Strategies

No.	Objective	Indicator
1.	*Became familiar with service user demagraphics in our regians and identify where we need to increase aur visibility.*	**Ngā Hau e Whā has undertaken some market research and applied the findings.** ▪ We have identified areas of greatest need. These regions are Northland, Tairawhiti, Palmerston North and Greymouth. We have held three Hui and we have funding left for a final Hui in the Central region from the Frozen Funds Award.
2.	*Maintain the budget and administrative support to ensure our business processes are efficient.*	**Business processes are working well. A financial report is provided regularly.** ▪ Mental Health Advocacy and peer Support (MHAPS) forward an updated expenditure report for each Ngā Hau e Whā meeting. ▪ All administrative tasks including organisation of travel, accommodation, venue, refreshments, are provided. ▪ Ngā Hau e Whā would like to acknowledge Shelley Englebretson for her admin support.
3.	*Review our strategic plan and objectives regularly.*	**Strategic objectives are addressed and plans in place for the next strategic plan (2016 - 2020)** ▪ The Strategic Plan for 2016-2020 was revised in November 2016. The final draft of the Plan has been ready for distribution since mid-January 2017.

1.7 Overview of National Issues or Challenges in the Mental Health and Addiction Sector as identified by people with experience in that sector

Issues or challenges: Southern: Julie Whitla

More money required to meet demand for youth.

Dr Sue Bagshaw (298 Youth health hub) said they were given referrals from schools and hospitals but simply did not have the resources to cope. Dr Bagshaw said those PTSD-afflicted children were now becoming teenagers. "We're sitting on a time bomb. I've been talking to the Ministry of Health over and over about the fact that we need to do something now to prepare for this coming through. "Because it is obvious nothing is being done for them. We need to have psychiatrists and psychologists in primary care right now, ready for these kids," Dr Bagshaw said.

According to Canterbury DHB figures, demand for child and youth mental health services has risen by 73 percent since the earthquakes. Truancy rates are high in the city as well.

Concerns about gaining independent 2nd opinion from a psychiatrist.

Pragmatically very difficult in the Canterbury Region and people sometimes have to travel to another region as they feel the process will be tainted by all psychiatrists knowing each other. Very few people bother to see this through, feeling this will hold up there treatment and the process should be more streamlined and timely.

Concerns raised about mental health medications and gastric by pass

PTSD and behaviours

There needs to be more groups for traumatic stress and also people with undiagnosed behavioural issues. Many people in this situation end up in the justice system.

HOUSING FIRST

In Christchurch, Housing first have a policy that they will only deal with homeless people who are on the streets for six months. Couch surfing or living in diffilcult circumstances with others seams to be discounted for entry requirements. It does not have consumers at the middle of their model of care and there is no visibility of the service at drop ins, churches that provide lunches or places where homeless people gather and on the streets according to long term homeless.

If we want to make a difference to housing issues then services need to have flexibility to leave their services and connect with other groups already working with the clients.

New Build at Hillmorten and the Disestablishment of Princess Margaret Hospital

Consumer group established for feedback/input into the new build at Hillmorten. Plans are finalised but build will not be started until 2021.

Issues or Challenges: Midlands region: Guy Baker and Sarah Gillington

Lack of Social determinants such as housing, employment etc. continue to have ongoing long-term influence on people's lives and are a barrier that prevent one having a positive impact in the community despite the efforts of community organizations and groups to provide relief.

Over-capacity of In-patient facilities are being reflected across the region. This is concerning especially going into the festive season.

Addictions

The new Substance Abuse Compulsory Assessment and Treatment legislation requires a refresh of the South Island model of care. This work is being led by Canterbury and will provide recommendations for improving responsiveness to people with Alcohol and Other Drug (AOD) issues, including those whose cognitive functioning is impacted.

It was mentioned that there have been some issues / confusion re transitioning clients from NOVA STAR (people under the SACAT) back to the places around NZ and delays for people getting appropriate wrap around services or entry into rehabs. This needs to be looked at some equitable funding needs to be on par with mental health people who get discharged back to the community.

Six week wait for comprehensive assessments in Canterbury, creates frustration for people wanting to accessing help to stop immediately especially people who wish for help via medical detox.

Issues or Challenges: Wellington Region: Victoria Roberts

At Benefit Rights Service (Wellington) it has been estimated that at least 30-50% of clients who are seen over a period of 12 months have mental distress issues in varied forms and with different diagnoses. This means that the people the service sees are largely in distress because of financial issues and have their mental distress exacerbated. This can largely be addressed by ensuing that people get their full and correct entitlements with regard to their incomes from the state. Disability Allowance is a supplementary benefit which is supposed to assist people with long-term health conditions meet the extra costs related to their health condition. It reimburses costs such as doctors' visits, prescription costs, transport, telephone and many other costs that a doctor needs to certify are of "therapeutic" value to the client.

Disparities for people receiving Disability Allowance from WINZ – Graham Howell

(Presentation to the Maori Affairs Select Committee November 2019

Introduction

The Disability Allowance (DA) is assistance paid by Work and Income (MSD) that reimburses costs associated with an on-going health issue. Analysis of data provided to the writer by the Ministry of Social Development shows an alarming disparity for Maori and Pacific working aged beneficiaries and their children compared to New Zealand Europeans. This situation has existed for the best part of twenty years.

At Benefit Rights Service (Wellington) it has been estimated that at least 30-50% of clients who are seen over a period of 12 months have mental distress issues in varied forms and different diagnoses.

The DA requires a health practitioner to indicate items or services they believe have a "therapeutic" value to the individual in relation to their health issue/issues. The issue or issues need to be for six-months or more. The applicant then needs to show evidence of the costs for which they are provided reimbursement based on a weekly average of the costs. It is income tested

So to get this assistance requires a triangle of relationship: Work and Income, the health practitioner and an applicant.

The table below shows the percentages of working aged beneficiaries, and children for years this data has been provided and analysed.

The Table below shows the percentage for working aged beneficiaries for the three main ethnic groupings[1] (New Zealand European (NZE), Maori and Pacific) and then the estimated number of Maori and Pacific to be "missing out" assuming no disparity in health status – a somewhat mythical belief and no NZE missing out, also an optimistic assumption. Table Two shows the same data for children of working aged beneficiaries. The estimated of those "missing out" is the ratio of the Maori or Pacific percentage and the NZE one. Incomplete data sets exists or the amount of DA paid, and these also show ethnic disparity suggesting that even when the DA is provided Maori and Pacific are less likely to claim costs compared to NZE.

[1] The ethnic groupings are as beneficiaries themselves disclose on their application forms. Children are that of the primary care-giver. The raw data was provided by the Ministry of Social Development after OIA requests and is available by Work and Income Service Centre. Due to privacy issues data is not available by individual Pacific groups nor Iwi.

Table One: Percentage and numbers receiving Disability Allowance

Working Aged Beneficiaries (as provided form OIA requests by MSD)

Year	NZE %	Maori %	Pacific %	NZE#	Maori #	Pacific #
2003	37	21	20	61,583	22,931	5,122
2006	44	24	22	56,780	21,177	4,985
2008	49	27	26	63.530	20,120	5,151
2017	50	27	28	42,205	24,736	4,948
2018	50	26	26	54,647	26,836	5,682

Table Two: Number of children of working aged beneficiaries receiving Disability Allowance

And those "missing out" (as provided from OIA requests by MSD)

2003	Receipt	Missing Out	ASH	Total
Maori	3,234	2,282	3,991	6,273
Pacific	563	1,136	1,373	2,514
2018				
Maori	1,931	3.681	N/A	
Pacific	303	1,192	N/A	

As can be seen in Table One the percentages are fairly consistent across the years the data was collected and analysed. If the same percentage of Maori and Pacific in 2003 were receiving the DA as their fellow citizens of paler skin there would have been 17,117, more Maori and 4,555 more Pacific, receiving the DA and this is without taking into account health disparities. The numbers of Maori "missing out" in 2006 were 17,575 and 4,667 Pacific. The respective numbers in 2008 were 20,129 and 5,153 Pacific. The figures of those missing out in 2017 were 21,745 for Maori and 4,023 Pacific. In 2018 the figures were 23,003 Maori and 5,380 Pacific.

Table Two data is for children. Regrettably this was not collected between 2003 and 2018, and the ASM (Ambulatory Sensitive Hospitalisation data was not collected by the 2008-17 government, however it is not believed the ratios have reduced hence the estimates of the total children missing out are about 7,000 Maori children and 2,500 Pacific children..

ASH is measure of those attending Emergency Departments who the clinicians believe would not had they received primary medical care. DHB ASH data for when it is available indicate the type of health conditions, and this shows significant life-long effects if conditions are untreated. These include respiratory disorders, skin conditions and other issues which can affect long-term employment prospects. All of these health concerns feature in academic/health research over the years.

Issues or Challenges: Midlands Sarah Gillington

People using services and others working in other mental health services provide feedback around these continuing issues:

- 'Criteria' to be met to receive Mental Health Secondary services
- Having to be 'at the bottom of the cliff' to receive services
- Medication being the main treatment option
- Lack of other treatment options provided by DHB
- Services/NGO's at capacity and not being able to take on more referrals
- Services/NGO's requiring more FTE to be able to provide timely and appropriate services
- Lack of services in Taranaki; especially South Taranaki, rural and coastal communities
- Lack of respite beds
- Family/whanau not being included or listened too with concerns for their loved one
- ED wait times, minimum of 3 hours, totally unacceptable when in distress
- Responsiveness of crisis team and brief care follow up
- Lack of addiction services such as step up/step down
- Unacceptable lack of supported living options, always at capacity
- Social issues such as housing, homelessness and poverty
- Stigma and discrimination of people using services
- Staff culture and attitudes
- 'Mild to Moderate' can't access services unless privately
- Lack of support services if under 18
- Family/Partner violence
- Access to rehab beds

Issues or challenges: Te Tai Tokerau: Jason Haitana

There have always been issues in Northland in particular with the relationship between tāngata whenua and tāngata Tiriti, and the Crown. This translates in a real friction between some groups in the community and the DHB, and a real sense that pressure needs to be applied on the DHB for mainly these reasons:

- A redistribution of government funding to other groups outside of the DHB
- An acknowledgement of mana tāngata in the area and of the historical issues that have not been addressed
- A growing frustration and disaffection between some people and the health providers currently offered including iwi providers
- The radicalization of a group of people who advocate for change in the health system

The other issues we have are to do with the speed in which Te Tumu Waiora has had to push in order to make Ministry of Health requirements. There has been no time to reflect, just the need to expedite the work and move forward. New funding, overall, has seen a number of real opportunities that we still are waiting to see.

1.8 Overview of areas of best practice in the Mental Health and Addiction sector as identified by people with experience in that sector.

Best Practice: Southern: Julie Whitla

Changing practices with clinicians

Many clinicians in community mental health and the CAT team are using more cooperative, open and communicative styles when working with people using the service and the support people who are attending It is appreciated by people with

Free Brief Intervention counselling:
Many people have found this extremely valuable in Canterbury when struggling with an addiction or mental health issue.

RFP GPS Lacking process: Mild to moderate: No consultation about the finer details in Canterbury. People have been hired for the new roles and no-one knows if their was any mental health or addiction person involved on the interviewing panel, feedback processes gPs are using for consumers on the service or ongoing governance. These are the issues why most consumers opted for the money going to the community rather than GPS as they are businesses.

New initiativcs/developments in your region

Youth Hub Space in Christchurch has finally gone to Christchurch City council for resource consent. Cross collaborative NGOS, MSD, Health and City Council. [2]Youth need a connection to the new city, a preventative space were big emotions can be shared and have a space where youth can gather in the evenings and after school. Sue Bagshaw is spearheading this space and requires 20 million for it to happen with the purpose of assisting healthy development of young people

Young people all need support as they develop and leave home. Many get that support from their parents and family. Some do not, for many different reasons, and as a result need extra support. They often have poor mental and physical health, no home to live in, no job, no money, and are lacking in education.

The aim is to help by providing easily accessible free services and supported housing. Then, once they have established regular income with the support of supervision and training available on site, they will be able to transition into housing of their own. This hub of independent organisations will work together to help overcome the barriers of cost, lack of transport and lack of knowledge about where to go. It will avoid gaps and overlaps in the provision of services and to encourage co-operation and collaboration rather than competition between organisations.

Best Practice: Midlands region: Guy Baker and Sarah Gillington

- EOI's have been collected for the establishment of the Cross Sector Governance Group, with a membership of 12-15 people. Selection is being completed by the end of November with the hope of having the first meeting before the end of the year. I am supporting 2 service users that have an interest in being on the group.
- Certification happened in late October with a glowing report from the auditors. The inpatient ward information booklet and 'Taranaki RAP' booklet were highly praised.
- We are still currently undergoing a management restructure with some key roles still unfilled as yet. This is putting pressure on the managers already in roles as they have to fill the gap.
- Inpatient unit is consistently at capacity or over capacity. The last month has been especially busy and with respite services closing down, we now only have one 4 bed respite facility available for adults, with youth still on a 'when staffed' basis. The impact of homelessness and lack of housing is causing issues in being able to discharge patients as they have no fixed abode and nowhere to stay.
    - Our inpatient unit is not having a rebuild as some other centres as we have a relatively new refurbished acute and MHSOP unit. Work is continuing in the open ward to freshen and make the environment more welcoming and looked after. Each of the 12 rooms are being refurbished, with one every 2mths being completed. The first room has

been completed with the next room starting next week. A new lounge with smart tv and gym room have now also been completed with minor updates to be finalised.

- . to be slow moving or have stalled due to restructuring at management level and no resources. We are currently trying to do quick win PDSA cycles under the Zero Seclusion project, with the first 2 underway and looking at being implemented on a permanent basis with another 2 under discussion. Hoping to gain momentum with the HQSC projects again in the New Year.

- Talking therapy (psychology) continues to operate under FTE with the nationwide shortage. We currently have a mininum 3 month wait for any new psychology referrals, and limited free counselling sessions through your GP (Taranaki Primary Care). Most people can't access these free sessions due to the small number available per GP clinic and clinician.

    - There has not been a dedicated inpatient psychologist on the ward for at least 18mths, with psychologists only seeing their patients if admitted. I believe this is something we are really lacking in, but could provide earlier recovery and discharge, also learning skills to manage things like anxiety, worry, moods etc

- Peer Support – Consumer and Whanau advisors are continually advocating for peer support within the DHB setting, especially with AOD, Inpatient and community services. Services are under resourced for this type of work leaving very skilled clinicians doing the work of support services as well as their clinical responsibilities. We believe an investment into peer support roles would be invaluable for people using services, and to complement the skills and expertise of our clinician's.

- Primary Addiction funding – RFP has come out from MOH for primary addiction services. Planning and funding have organised a meeting (25/11/2019) with interested parties including a great representation of family members and people using services attending the day to help form a direction for addiction services in the community setting. *Peer support for AOD services has been agreed as part of the RFP, as well as expansion of the Families Overcoming Addiction Group for whanau and peer support whanau.

- ECT to be available as a form of treatment again soon (unsure of the time frame of this not being available). I have been included in the formation of policy and information documents and asked to be on the working group/committee for this particular service due to experience. I would like to make sure that the difference in prescribing for this treatment is taken in to account considering the side effects of memory loss and anxiety.

Best Practice: Te Tai Tokerau: Jason Haitana

Restraints – Community Settings, Emergency Department

At the moment we are beginning to report restraints alongside seclusions in our primary Safe Today forum, which looks at all these as well as near misses and adverse events in the DHB. One of the initiatives was seeing security learning SPEC on the main wards, which has seen a vast improvement to that group in particular in ED. However there were concerns that the fidelity of the model was compromised in part, and we are focusing on keeping this and the SPEC training, well within the bounds of our initial training. The use of breakaway techniques and so forth within the community setting however are continuing but with no clear fidelity to the model used in SPEC. I am also the consumer trainer for SPEC for Northland.

Seclusion

Seclusion is actually driving lower and lower, with significant trends showing massive reductions in our seclusions. This came after some of our stats showing no major movements for Māori seclusion. The reasons for the continued driving down of the numbers, and which shows within our own local seclusion data as having 'significant trends', are a number of reasons:

- The introduction of a Whakaora programme within the ward on the floor where practice is challenged in seclusion, and where the whole aim and heart of the programme is to 'not seclude'. This is run successfully by a number of nurses, who are in the main, predominately Maori and female. They work out of the HCA in particular what we call the seclusion lounge or open secure lounge Waenganui.
- The use of team huddles to approach issues and problems, in particular problem behaviours from a clinical perspective that is immediate and effective

- A real drive by our auxiliary workers (HCAs) to develop ways to creatively and deliberately de-escalate and support tāngata whaiora in distress

Least Restrictive Practice for Māori

One of the biggest drivers for least restrictive practice for Māori is the focus that we making on Compulsory Treatment Orders and the use of certain medications to maintain people at a certain equilibrium.

Talking with people in the community around the extensive use of CTOs on Māori has identified that Māori are more likely to be on an indefinite CTO. What this means in terms of long term care and support for people is difficult to gauge at this time, but not positive.

Recovery Framework for Northland – Te Anga Whakaoranga o Te Taitokerau

The development of a recovery framework that meets the needs of people here in the north. Still underway but really exciting in terms of the work ahead with this. We are looking specifically at making the Tiriti o Waitangi part of all processes rather than a separate entity on its own; the principles of recovery and wellbeing, across a variety of measures as well, marry well with the Articles which are our focus – the letter of the words themselves. So what this means is that the Tiriti is fused in everything we do with recovery for all people in Northland.

Te Tumu Waiora

Te Tumu Waiora has been underway here in the north for some time, with great success in terms of the evaluation of the services rendered and the service user responses to phone interviews that I undertook earlier this year. As a service we will be evaluating this frequently to hear from people how this fits in with their care, and its efficacy. Te Tumu Waiora is an initiative whereby Health

Improvement Practitioners (HIP) are sited and employed directly into GP clinics and are supported in the work by Health Coaches (HC) who come from a variety of backgrounds. Here in Northland they are recruited from Arataki Ministries, a Non-Government Organisation, from their existing pool of Community Support Workers. What is different with us is that we use support hours to provide the wrap around care rather than employing a HC into the GP Clinic.

Te Tumu Waiora currently has four pilot sites, two with KeriMed and Bush Road practices, one with a school Bream Bay College, and the last with Te Ao Āwhiowhio which is a Māori provider. These have now moved past the pilot phase into spreading and growing the HIP services into the second tranche which sees the number of GP practices with HIPs and HCs growing into the New Year.

The benefits of Te Tumu Waiora have been, and this is from interviews and discussions with users of the service, been outstanding and bodes well with continuing the growth of this service well within Northland.

Clinical Cultural Governance – a Tikanga-informed Forum for Te Taitokerau

We have been, over the course of the year, engaged with the Maori Health Directorate and the Mental Health and Addictions Directorate around forming a group that sits across both, and provides strong leadership and decision making around Tikanga Maori for the DHB. In the past few weeks we have designed and planned how this would look though, as is the case in Northland, this has been problematic at times. Now we have a group where the most important thing is being able to serve Māori and non-Māori well in terms of tikanga and following both the Articles of the Tiriti and also the history that those in the north have with their relationship with the Crown.

Hopefully we can start making inroads into the issues we have with equity and issues of sovereignty and tino rangatiratanga.

Youth Consumer Advisors – a Year In

We have been consistently working on growing and developing two Youth Consumer Advisor roles here in Northland and this has come with some success. What we are seeing is a real need for a Youth Consumer Advisor (YCA) role in Northland, in terms of representing and bringing to the fore the voices of youth and rangatahi in Northland. Watch this space as we continue to develop and refine it further.

Opening of new respite center in Kaikohe – Tū Kaha (Stand Strong)

The opening of a new respite center in Kaikohe has been both a blessing and a long time coming for all. It provides cover for a serious gap in our work, where resourcing and facilities are available in both Whangarei and Kaitaia but limited in the mid north region or Kaikohe.

Family Whanau Representation and a Shifting in the Role – Consumer and Family Leaders in Northland District Health Board

There has been a change in the role, with the addition of a whānau aspect to the Consumer Advisor role in Northland. This means more flexibility and greater chance for the whānau voice to be heard, though this still will need refining to find out how to work better with this role.

Best practice: Wellington Region: Victoria Roberts

Buddies Peer Support Service

Buddies peer support service, shares the hope of recovery with 'peers' who are currently experiencing mental health difficulties

Buddies provides peer services to the acute wards in Wellington (Te Whare O Matairangi) and the Hutt Valley (Te Whare Ahuru).

Buddies have five volunteers in the Hutt. Two new Buddies came on at the end of June and are doing very well. The team have had positive feedback from peers they have talked with on the ward. After six months the volunteers graduate and they may then step into a mentoring role.

Atareira:

Atareira are leaders in modelling and promoting mental health recovery through partnership services with families, service-users and their communities. Atareira have successfully moved into their new premises and have employed two new staff members. There is already a full case load for the manager.

Strengthening Families meeting is on at Pomare Community Hall on the last Friday of each month. Navigators are based at Maoribank School in Upper Hutt. Te Roopu Awhina hold whanau ora contracts.

Atareira operates Easy Access Housing. It has five houses, one of which is for women only. It offers temporary accommodation (six months) for people with lived experience who are homeless.

Oasis:

Oasis is a mental health and addictions support service that provides Peer Support, Advocacy and Education to people who live or work in the Hutt Valley, who self-identify as having experience of mental distress, illness and/or addictions.

There is a shortage of emergency housing for women in the Hutt Valley. Oasis is helping two homeless women to find accommodation. Oasis runs accommodation services for men with lived experience and this area is expanding.

EarthLink:

Supports people with experience of mental distress and addictions. They offer training, recycling service, supported employment and a curtain bank.

Workforce catering and EarthLink is offering a hospitality programme to help people into employment.

MIX:

Mix is a not for profit organisation that supports those who live with the experience of mental illness, through a variety of creative and life skill opportunities.

"Inner Canvas" an art therapy based group at Mix, Lower Hutt. MIX is offering a fixed term contract to help with its arts programme

Another group at Mix in Upper Hutt on Friday's is called "clay landscapes". It's about creating small clay landscapes about your personal journey and what's important in a relaxing, sensory, meditative, and reflective way. This is a structured day.

Amigos Peer Support Group
Amigos is a series of weekly peer run and led groups made up by people who have experienced mental distress and are interested in connecting with other adults of all ages who have had similar experiences. The activities include a book group; a mindfulness group; creative writing; a coffee group; a once a week meeting at an Indian café for lunch; and other one off activities from time to time

Inner City Mental Health Liaison Group (ICMHLG)

ICMHLG which through its monthly meeting provides the opportunity for sharing information and networking across the variety of organisations and services that are operating locally. The sharing of each other's work and having the chance to seek advice and support from within the group has been one of the group's strengths.

This is a cross city meeting for all NGOs who might have dealings with people who experience distress. It meets monthly. Some attendees come from the DHB, the local MP's office (Grant Robertson), people working in other mental health services and service users as well.

- Wellington Women's Hostel (WWH) is busy and constantly full.
- The phone/text number 1737. People can get referred to Te Haika (crisis service) if needed.
- People now have to provide photo ID when applying for a NZ Housing house. They can be referred to Downtown Community Ministry (DCM) who can help. The DCM are local providers of Housing First a new MSD solution for homelessness.

2.3 Consumer and/or sector feedback to the Ministry on the strategic direction of Mental Health and Addictions including He Ara Oranga recommendations:

Jason Haitana – Northland

Te Ara Oranga – Methamphetamine Programme

Northland's unique methamphetamine demand reduction programme, Te Ara Oranga, could be rolled out to other parts of the country following its success. Te Ara Oranga is jointly run by Northland police and Northland District Health Board with the aim of reducing demand for the class A drug. During the programme, offenders, witnesses and victims of crime were screened to see if they used meth and referred to a health-based treatment if they needed it. Treatment ranged from mental health counselling or therapy and medication, to detox programmes and in-house resident treatment. The combination of police and health staff working together to reduce meth demand "appears to have worked very well". The last figures showed 36 meth users have got off the substance and are on track to getting their lives together. That's not just 36 individuals but 36 families that are now returning to normality.

The meaning of our name:

Nga Hau e Wha - the meaning of our name

Regional Reports as provided by individual members:

Sarah Gillington November 2019 (4).d | Guy Baker November 2019.docx | Victoria Roberts November 2019.docx | Jason Haitana November 2019.docx | Julie Whitla November 2019.doc

Nga Hau e Wha
Statement of Financial Performance
1 Jul 2019 to 31 Dec 2019

	Act 3 months Oct- Dec 2019	Act 6 mths YTD July- Dec	6 months YTD Budget	Variance
Nga Hau e Wha Contract Income	$15,000	$30,000	$30,000	$0
Less Operating Expenses				
Accommodation	$1,728	$3,004	$2,400	-$604
Catering	$496	$655	$880	$225
Flights	$2,372	$5,103	$10,000	$4,897
Meeting Fees & Taxi Fares	$2,949	$4,773	$800	-$3,973
Nga Hau e Wha Contract Expenses	$7,545	$13,536	$14,080	$544
Operating Surplus	**$7,455**	**$16,464**	**$15,920**	**$544**

Nga Hau e Wha
Balance Sheet
as at 31 December 2019

	31 Dec 2019
Current Assets	
Nga Hau e Wha Funds Held	$1,464
Accouns Recdeivable	$17,250
	$18,714
Current Liabilities	
GST Account	$2,250
Net Equity - Nga Hau e Wha	**$16,464**