SUPPORTING CHILDREN'S AND YOUNG PEOPLE'S WELLBEING

DPMC/Health Sector Engagement on the Development of New Zealand's first Child & Youth Wellbeing Strategy

Summary of feedback from the Health Sector Engagement Workshops

NOT GOVERNMENT POLICY
Draft document for discussion
December 2018

Contents

1. Overview

BACKGROUND

The Department of the Prime Minster and Cabinet (DPMC) is leading the development of New Zealand's first **child and youth wellbeing strategy** (the Strategy). The Strategy is an opportunity to significantly improve the lives of New Zealand's children and young people. The development and publication of a Strategy by the government of the day is a requirement of the Child Poverty Reduction legislation. The Strategy will set out the outcomes the Government is seeking and the actions it is taking to improve the wellbeing of all New Zealand children. DPMC has led a series of engagement workshops across multiple sectors. The Ministry of Health agreed to support DPMC to hear directly from the broadest possible range of people across the Health Sector. Together with District Health Boards (DHB) we organised a series of ten regional workshops, from Whangarei to Dunedin. These were held between 12 November and 3rd December 2018 and facilitated by Ministry of Health staff, with planning assistance for venues and invitations provided by DHB staff.

OBJECTIVES & PROCESS

The main objectives of these engagement workshops were to:

(1) provide an overview and update on the Child Poverty Reduction Bill & planned Child and Youth Wellbeing Strategy;

(2) seek input and feedback on the draft wellbeing outcomes framework and 16 proposed areas of focus for the Strategy; and

(3) seek feedback how we can achieve child and youth wellbeing across the life-course.

A programme was developed based on the objectives of the workshops. This incorporated presentations from DPMC, the Chief Science Advisor and clinical leads; and the Ministry of Health, plus group-work that was designed to collect feedback from participants on the following:

A. What are current barriers to achieving child and youth wellbeing?
B. Feedback on the draft vision, domains, outcomes and focus areas for a Child and Youth Wellbeing Strategy
C. What solutions are needed to achieve the vision?
D. How can the health sector best contribute to child and youth wellbeing?

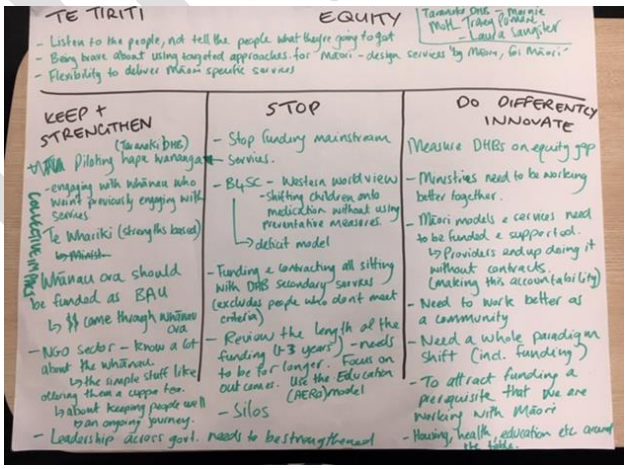
All workshops were facilitated and feedback was recorded. For the group-work on barriers and solutions, participants were asked to provide feedback on coloured card (red/orange for barriers and green for solutions). Verbal summaries of the key issues/solutions, feedback on the strategy, and contributions that could be made by the health sector, were also recorded.

We opened with a video from the Prime Minister

We heard about the science of child and youth development

We recorded all of the barriers we face and summarised those

We recorded solutions we could put into action



We thought carefully about the health sector

RESULTS

Over 700 participants attended the ten workshops.

On the issue of barriers to wellbeing, an initial review of data collected at these workshops revealed a range of themes. These include poor access to services, inadequate distribution of funding (e.g. the majority of health funding is spent in acute care, not prevention, and in mainstream providers, not Māori or Pacific providers), inflexible contracting, a 'issues-based' funding approach that does not allow for delivery of holistic care, institutional racism, and a lack of regard for kaupapa Māori approaches, and Pacific values, to health and wellbeing. Participants were very clear they want to establish a different kind of relationship with behavioural and cultural change in the way we all work.

There was strong support for a life-course approach to child and youth wellbeing with enthusiasm for system change that favours a way of working that addresses the current inequity. Such changes would address racism, include kaupapa Māori approaches and provide services that are proportionate to need. There is an acceptance that this may mean doing less in some populations. Taking a life-course approach, the health system could focus on preparing young people for parenthood, ensuring that they are in the best mental, physical and spiritual health, supporting the child and whānau through the first 1,000 – 2,000 days in a way that is whānau centric. The need for development and ongoing support of the capacity and capability of the wider health workforce, particularly our Māori and Pacific workforce, is needed. Developing funding and contracting models that enable locally-led solutions, with funding and contracting models that are flexible and promote innovative practice is another key theme.

NEXT STEPS

The Ministry of Health is seeking feedback from workshop participants on this draft, to check that we have captured a fair record of the discussions at the ten workshops. **Any feedback on this draft is requested by the 18th of January 2019.**
Your feedback will be incorporated into a revised version of this workshop summary and sent back out to all participants at the end of January, as well as to the DPMC. This final summary will then be provided to the Ministry of Health's Health Leaders Advisory Group for Child and Youth Wellbeing, with the expectation that recommendations from this group will be provided to the Director-General of Health in February.

2. Background and objectives

The Government is committed to reducing child poverty and improving the wellbeing of all children, young people and their whānau, with the vision that New Zealand will be the best place in the world to be a child. The Department of the Prime Minster and Cabinet (DPMC) is leading the development of New Zealand's first child and youth wellbeing strategy (the Strategy), which will be required under the Child Poverty Reduction legislation. The Strategy is an opportunity to significantly improve the lives of New Zealand's children and young people. It will set out the actions that Government intends to take to improve the wellbeing of all New Zealand children.

DPMC provided a proposed outcomes framework which was comprised of a vision statement, seven underlying principles, five wellbeing domains with a series of outcome statements under each domain that would be measured over time, and 16 potential focus areas that could form part of the first Strategy with six as an immediate priority. This is publicly available online: https://dpmc.govt.nz/sites/default/files/2018-11/appendix-b-proposed-outcomes-framework.pdf

DPMC's aim was to seek feedback on the proposed outcomes framework and feedback to inform the development of the Strategy more widely, including ideas or knowledge about what works well for improving the wellbeing of children and young people. It has led a series of engagement workshops across multiple sectors, along with formal submissions and postcards to the Prime Minister, to hear what people think. The Ministry of Health and DHBs agreed to support DPMC to hear directly from the broadest possible range of people across the Health Sector.

The Health Sector has always had a key role in improving short and longer-term health and development outcomes for children, particularly in maternity and the early years. We are

responding to child wellbeing by taking a 'life course' approach – what happens during pregnancy, infancy and childhood affects people's health outcomes later in life. Our aim is to have pēpē, tamariki, rangatahi and their whānau (babies, children, youth and their whānau) living well and growing up healthy. However, we know some children and their families are missing out and, as such, we need continuous improvement at both a system and service level.

OBJECTIVES

The main objectives of the health sector engagement workshops were to:

1. provide an overview and update on the Child Poverty Reduction Bill & planned Child and Youth Wellbeing Strategy;
2. seek input and feedback on the draft wellbeing outcomes framework and 16 proposed areas of focus for the Strategy; and
3. seek feedback how we can achieve child and youth wellbeing across the life course.

3. Methodology

WORKSHOP ORGANISATION

The Ministry of Health (Ministry) worked with DPMC over a series of face-to-face meetings to determine the objectives of the health sector engagement workshops.

A list of key stakeholders was created from a range of databases held by the Ministry. This list was then circulated among Ministry personnel working in areas relevant to child, youth and whānau wellbeing to identify and address any gaps.

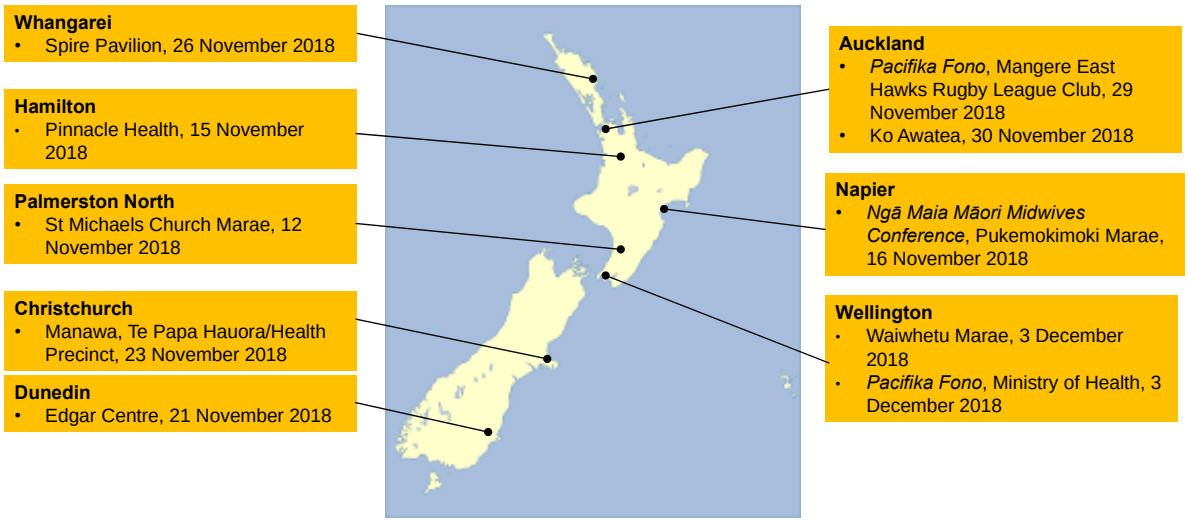
An invitation (see appendix 1) was distributed to the list of stakeholders. We also asked our DHB Child & Youth Wellbeing partners[1] to distribute to local colleagues and organisations

[1] Adri Isbister (Wairarapa) and David Meates (Canterbury) are the two DHB Chief Executives who are leading the Child & Youth Wellbeing work. They are supported by seven General Managers: Debbie Holdsworth (Waitemata/Auckland); Karen Evison (Lakes); Helene Carbonatto (Hutt Valley); Kerry Dougall (Hutt Valley); Rachel Haggerty (Capital & Coast); Taima Fagaloa (Capital & Coast); and Carolyn Gullery (Canterbury).

with an interest in child & youth Wellbeing. At this phase, we were asked if people working outside, but in partnership, with the health sector could be included, and agreed that it was useful to have input from these groups.

An online registration form was created to allow people to choose which workshop to attend. We originally planned for eight workshops, but due to opportunity and demand we later expanded to ten workshops (see figure 1).

Figure 1: Engagement Workshop Locations



A programme was developed (see appendix 2) based on the workshop objectives. This incorporated presentations from the DPMC and Ministry, and group-work that was designed to collect feedback from participants on the following:

A. Current barriers to achieving child and youth wellbeing
B. Feedback on the draft Strategy outcomes framework vision, domains, and focus areas
C. What solutions are needed to achieve the vision?
D. How can the health sector best contribute to child and youth wellbeing?

The programme was sent to participants a few days prior to each workshop and was accompanied by some pre-workshop reading material. This material included the draft Child and Youth Wellbeing Strategy outcomes framework and summaries of four key papers on child and youth wellbeing (see appendix 3). These summaries provided background on:

1. Childhood Well-being: What it looks like, how it can be undermined, and how to promote it; (written by the Government's Chief Science Advisors)
2. The Royal Australasian College of Physicians (RACP) Early Childhood Position Statement;
3. Rethinking New Zealand's approach to mental health and mental disorder: A whole-of-government, whole-of-nation long-term commitment; (also written by the Government's Chief Science Advisors) and
4. From Complexity to Collaboration: creating the NZ we want for ourselves and enabling future generations to do the same for themselves (from Victoria University School of Government and the Office of the Children's Commission)

The presentations in the programme were developed by DPMC and Ministry staff to provide updates on the development of the Strategy, the science supporting a life course approach to child and youth wellbeing, and updates from the maternity, well child tamariki ora and mental health programmes (sent as a separate attachment to this draft document).

WORKSHOP FACILITATION

All workshops started with either a pōwhiri, mihi whakatau, or brief devotion and prayer. DMPC and DHB leaders also provided a welcome and introductory comments to help set the scene for the day.

Following activities to help participants get to know each other (whakawhanaungatanga), participants were able to voice their concerns with the current system highlighting barriers and 'burning issues' that get in the way of achieving child and youth wellbeing and contribute to the inequity of health and wellbeing. DPMC staff then provided an update on the Child Poverty Reduction Bill and Child and Youth Wellbeing Strategy work, followed by the science slides setting out what we know about child and youth development (developed by the MoH Chief Science Advisor Professor John Potter, MoH Chief Advisor Child and Youth Health Dr Pat Touhy, and the MoH Clinical Champion and chair of the Health Leaders Advisory Group Professor Hayden McRobbie). This was followed by further small group-work that focussed on solutions to making the strategy vision a reality, and an opportunity to provide direct feedback on the draft strategy.

The afternoon sessions focussed on the health sectors response to child and youth wellbeing. Following presentations from the Ministry, participants worked in small groups to provide feedback on how the health sector can best contribute to child and youth wellbeing.

Participants were asked to look at what is working well and should be kept and/or strengthened, what should be stopped, innovation needed, and how we can achieve equity in outcomes.

DATA COLLECTION

Data were collected in the following ways. For the group-work on barriers and solutions, participants were asked to provide feedback on coloured card (red/orange for barriers and green for solutions), instructed to provide one issue/solution per piece of card. Participants were then asked to provide a verbal summary of the key issues/solutions and Ministry staff captured these summaries on flip-charts or whiteboards, which were then photographed. Data from the cards were entered into an excel spreadsheet.

Feedback on the draft strategy and on how the health sector can best contribute to child and youth wellbeing was captured on flip-charts or whiteboards, and then photographed.

DATA ANALYSIS

This work is currently ongoing. Data from the individual red and green cards is continuing to be entered (approximately 4,000 entered and 6,000 to go!) The summaries of those red and green card discussions collected on the flip charts and white boards have been collated, and the themes and quotes in the following Results section have been used for this draft report, as we promised we would get information back to you before Christmas. We will be continuing to enter and analyse all of the rich material participants provided over January.

DPMC has collated the feedback on the draft Child and Youth Strategy outcomes framework (vision, domains, outcomes, principle and focus areas) and this is provided in section 4.3.

The specific discussion of the Health sector (keep and strengthen; stop; innovate and do differently; and actions to achieve equity of health outcomes) have been collated by each location (noting that this activity was done by a subset at the Palmerston North hui and not done at the Napier hui). This is provided in section 4.4.

4. Results

Over 700 participants attended the workshops. The feedback regarding barriers, facilitators, the draft strategy, and what the health sector could do differently are presented in sections 4.1 – 4.4, below. Quotes from participants are highlighted in blue italic text.

4.1 Current barriers to child and youth wellbeing

There was a considerable degree of frustration within the sector, with many participants feeling that they have not been listened to in the past. Questions were raised as to whether this engagement would be like many others that government agencies undertake, which have very few outcomes.

"Could you please listen to us"

"Honour the place and voice of Māori"

"Come down to where the rubber meets the road to find the answers"

However, there was a challenge to *"Begin a process of radical change in child wellbeing"* and most participants were passionate about looking for solutions.

GOVERNMENT AGENCIES

A common criticism is that Government agencies are not operating in a way that meets the needs of children, young people, and their whānau. There was a commonly held view that many Government agencies have a role to play in ensuring the wellbeing for children and young people, but there is scepticism that there will be change. Institutional racism (see below) and agencies not working together remain significant problems.

"Government departments working in silos- true lack of collaboration integration"

"Not able to club fund across sectors"

"Agencies need to work better together"

"All Ministries are champions of Child Wellbeing not just Oranga Tamariki"

"The challenges of working across sectors- we speak different languages"

"Kei whea Pūao Te Ata tū[2] "

[2] Pūao te Atatu (1988 Ministerial Advisory Committee on a Māori Perspective for the Dept of Social Welfare in NZ)

Government departments were also criticised for not having their own policies that support wellbeing. This was seen as something that could be relatively easily changed.

"Government policy should be reflected in each Government department e.g. healthy eating, smoke free, support breastfeeding"

POLICY

Many participants were critical of the lack of progress made in policy that could have a positive impact on child wellbeing. These include regulation of the food industry, a sugar tax, greater restrictions on tobacco and alcohol, and fluoridation of water. Participants often commented that they thought prevention received lower priority than treatment.

"Not enough focus on prevention and wellness"
"Prevention (health education) is a lower priority than treatment"
"Too many interventions are downstream of the upstream issues"

Some commented on steps made to date have not been bold enough ("*lack of courage*") and that 'risk aversion' and bureaucratic processes meant that progress is slow. There was a call for greater 'youth voice' in the policy process and that policy should take a strengths-based approach.

"Are you really committed to change?"
"Not bold enough to stop doing stuff that harms children i.e. smoking, alcohol"
"Eliminate deficit modelling and position in the positive"
"Too much risk aversion"

Some noted that policy makers still perceived universalism as meaning the same for all, rather than a service delivered at different levels of intensity to ensure similar outcomes for all, and that this 'one size fits all' approach should be challenged.

"Perception that health must be universal (same for all)"

RACISM

Racism was a strong and consistent theme throughout all workshops; that Māori and Pacific continue to be marginalised, there is institutional racism at most levels of the system, and that there is a lack of regard for Māori and Pacific cultural intelligence. There was a strong call for these issues to be addressed.

"Entrenched institutional racism whose conscious and unconscious biases prioritise the needs of the worried, white well"

"Our bureaucracy and institutions are racist"

"Ongoing colonisation of Māori and Pacific families"

"Māori continue to be marginalised"

TE TIRITI O WAITANGI

There was clear frustration that the Te Tiriti o Waitangi continues to be ignored, or that its inclusion is tokenistic. Issues raised by participants included lack of true partnership with Māori, not adhering to Te Tiriti principles, and a need for greater emphasis on Te Tiriti across the whole of government.

"Lip service to the Treaty"

"No balance in power- Te Tiriti o Waitangi"

"Lack of understanding of Treaty and its effects"

"The system is set up to always be a low, mid, upper class. Recognise the Treaty and implement Māori base framework"

"Other government agencies and DHBs not able to operationalise The Treaty of Waitangi"

EQUITY / INEQUITY

The issue of equity/inequity was a theme across a number of issues, including funding, racism, service development and delivery, workforce development and social determinants of health. There was a clear desire to address inequity of outcomes.

Participants raised concern that not all people working in the health sector have a good understanding of equity.

"People in DHB meetings do not understand difference between equality and equity"

There was acknowledgement from many participants that to achieve equity would require a greater effort for those with greater need. Some participants questioned the need for a universalism in some areas. Others thought that proportionate universalism would be more likely to address the inequity that exists.

"Health equity focus only on those who need help not everybody"
"Universalism fails our most vulnerable Māori"
"Fails Māori and will continue to do so unless we develop [different] strategies"

The problem of inequity was not just seen in health. For example, inequitable access to sports and recreation was also highlighted as a barrier to wellbeing.

"Inequity with regard to access to physical activity and sport opportunities"

POVERTY & SOCIAL DETERMINANTS OF HEALTH

Lack of good quality housing, overcrowding, rental costs exacerbating poverty, and homelessness were all identified as barriers to wellbeing.

"Housing crisis not enough houses overcrowding and increasing costs"
"Lack of housing whānau living in temporary accommodation (children moving school- uncertainty)"

Food insecurity was also raised as a significant barrier. Several participants mentioned the cost of healthy food being greater than unhealthy food. Lack of healthy food options in some settings (e.g. schools) was also raised as a concern.

"Food prices healthy food is more expensive"
"Poor nutrition school lunches and sugar"

An overarching factor in poverty was lack of adequate income and high cost of living. Many whānau have low incomes and poor job security, with many having to work multiple jobs to 'make ends meet'.

"Whānau struggle, low income job protection housing substandard, petrol, education"

"Insufficient whānau income"

"Children need adults with time for them. Not working multiple jobs"

Some commented on how the price of tobacco was also a significant contributor to whānau poverty.

"Smoking Whānau say I won't stop till it's made illegal. So expensive, it adds to poverty."

Many whānau live in environments that do not support wellbeing. This includes poor urban design, pollution of our rivers, higher density of fast food and alcohol outlets in more social deprived areas.

"Council - urban design for child friendly cities"

"Revitalisation of our Awa Tūpuna!"

"Clean our AWA, lakes, springs. Wai Māori our rongoā keep us healthy and strong wairua"

FUNDING & CONTRACTING

The current approach to funding services and programmes was one of the most frequently cited barriers across all workshops. Barriers identified included:

Lack of funding for iwi and Māori organisations. Some commented that iwi would be better placed to deliver wellbeing than DHBs, and with that they should receive the appropriate funding.

"Full devolvement of funding to Iwi for Iwi"

"Inequality of funding into Māori providers"

"Lack of investment in Māori providers and Whānau Ora public services not enabling whānau ora"

Not honouring tino rangatiratanga in funding arrangements was frequently highlighted. Low levels of trust with funding Māori providers compounded this issue.

"Give Māori money to do what we need"

"Power to Māori providers not let DHB dictate"

"Release the pūtea- trust us"

For Pacific Health, it was felt that, in many cases, the commitment to improving the health of Pasifika people was lacking. Some described it more like a 'tick box' added onto contracts.

"Pasifika feels like tick box added onto contracts etc."

"Pacific is a 'tack on'"

Funding is often 'issues-based' or 'siloed' and not focussed on a holistic or whānau centred approach. It was also noted that there are often different funding streams for similar focus areas from different agencies. A more co-ordinated approach for funding might get better return on investment.

"Contract and funding limitations silo; need holistic approach"

"Improved funding and engagement between education and health"

"Government funding contracts not joined up"

Health funding is predominantly focussed on acute care and there is a need to look at where the resource is applied. Related to this was the need to make funding decisions at a local level, or at least in partnership.

"Need to use funding differently challenging what already exists. Is it right for the population?"

"Too much funding allocated to secondary services. Invest more in prevention"

"Proportional investment in prevention and early intervention"

"Need to redirect investment into life course model"

"Total spend in the youth space inequitable"

"Decisions not made locally"

Concerns were also raised about 'overpriced consultations'.

"Overpriced consultations (GP, Psychiatrist, Psychologist)"

Questions were asked about the amount of health funding that is used on administration. Consolidation of co-ordination and management roles could free up more funding for service

provision. Some thought that there was enough resource in the system, but that this was not been used wisely due to the competitive nature of many contracts.

"So much funding is sucked up administering contracts"

"There is enough funding but services not using it wisely due to organisation patch protection"

Participants also commented that many of contracting arrangements are restrictive, do not allow innovation, are focused on rigid targets that may not deliver meaningful results, and many contracts are short-term (e.g. only for a year) which makes it difficult to keep and develop staff, and implement strategies with long-term impacts.

"Current funding model difficult to plan and deliver services with annual contracts"

"No resources to deal with immediate issues e.g. a flexi-fund"

"Lack of security around contracting for NGOs short periods i.e. 1 year contract"

"Funding environments and priorities are unstable and don't allow for long term planning or long-term staffing"

"Lack of sustained funding- gets lost after a 3-year election cycle"

Funding models were often seen as competitive, which does not allow for collaboration to achieve outcomes.

Lack of funding for innovative approaches was clearly a frustration, and it was noted that when services do deliver successful innovative approaches there is often no funding to keep them going (pilots that are not evaluated, not incorporated into or used to replace mainstream service provision).

"Lack of funding for initiatives"

"It is frustrating when youth health services that are successful and well attended lose their funding!"

SERVICE DESIGN & THE NEED FOR KAUPAPA MĀORI APPROACHES

There were a range of barriers identified that related to service design and delivery. These included:

There is a lack of understanding of the true problems and what is wanted and/or needed to address these. Related to this is the identified need for the voices of young people, whānau, and the most vulnerable to be heard when designing services.

"Listen to the voice of our most vulnerable whānau what do they want?"
"Please understand and work in a truly co designed way"
"A whole of life approach to our children and youth that is real on the ground"
"No rangatahi (where is our voice)"
"Disconnect between identification of issues and what might help (whānau and health professional) and the available expertise and resources to respond supportively"

There was a general feeling that many parts of the health and wellbeing sector are not fit for purpose for rangatahi. For example, young people don't, typically, frequently engage with GPs. There are a lack of health resources for this group. Some felt that the system has not embraced technology enough.

"Technology more appealing to youth than anything else"
"Young people not engaged with GPs"

Services that don't work together in a more integrated and holistic approach was a common theme. Related to this was feedback that some services do not focus on building authentic and meaningful relationships with patient/clients/whānau. A general lack of clearly defined care pathways for rangatahi were also seen as a barrier to wellbeing.

"Need for more holistic approach to health service delivery i.e. consider the person and their world"
"Too many organisations involved with whānau who are not working collaboratively"
"Lack of focus on building authentic and meaningful relationships as part of effective service/initiative delivery"

Within service design and delivery there was acknowledgement that focussing on universal care may not be the best way to get the best outcomes for a population. Proportionate universalism was highlighted as a potential solution to this.

"Proportionate universality is a real thing"

Every workshop raised the need for services to be flexible and adaptable, in order to deliver local solutions that work. There are contractual barriers to this approach (*see funding and contracting above*) as well as some giving an indication that funders were generally conservative when it came to innovation. Service innovation was also stifled by lack of time and funding and ability to test before rolling out.

"More autonomy to think outside the square"

"Management hierarchy -power and control closed to new ideas"

"There needs to be flexibility in funding for school based services- need to be able to fund more GP hours when and where this is needed (identified demand)"

"No space /time/funding to innovate, test small before rolling out big failing fast to learn better approaches"

A strong response under this theme was the **lack of Māori solutions for Māori**, including the design and delivery of interventions. The western medical approach to health and wellbeing has been prioritised over the Māori world view. To create an environment that supports Māori whānau wellbeing then there needs to be a culture shift with the inclusion of Māori values-based relationships right across the sector, from the top to the bottom.

"Honour the place of Mātauranga Māori"

"Genuine commitment and investment in building cultural competency"

"Too many non-Māori designing solutions and holding power for Māori"

"Need for Māori frameworks (Kaupapa) to direct prevention, intervention and post-intervention"

"Antenatal and Postnatal maternal mental health programmes targeted for Maori and Pasifika using Kaupapa Māori constructs"

It was highlighted that in many instances a kaupapa Māori approach is more time consuming and funding needs to reflect this.

At a structural level, it was said that there is lack of Māori representation in governance roles, management, service planning, a general lack of consultation with the workforce, and a feeling that funders lack trust that Māori can meet the needs of Māori.

"Lack of Māori voice on key governance boards"

"Too many Pākekā making decisions at management level. Prioritises service- trust in our ability to lead."

"Lack of Māori representation in service planning"

"Irrational fear of funders that Māori are incapable or can't be trusted to meet the needs of their own"

"Lack of consultation with on the ground staff doing the mahi"

Hapū wānanga were consistently raised as examples of kaupapa Māori services that were operating with good success. It was also highlighted that kaupapa Māori services could also extend to parenting programmes.

"Kaupapa Māori pre-conception antenatal and post-partum classes"

"Hapū wānanga in all DHBs, servicing all their areas! Māori CBA training!! Hapū wānanga curriculum!!"

"Kaupapa Māori parenting programmes MANA RIRIKI resourced and funded"

VALUES AND TRUST

Many participants questioned the values and beliefs of our current system. There was also a degree of mistrust - people felt that they had heard these messages and promises of change before, but little change had eventuated.

"Lots of hui? Enough do-i?"

"Changes for Pasifika- is that real?"

The system does not appear to value the health and wellbeing of children, young people and their whānau. Instead it focuses mainly on treating illness and counting outputs.

"Life is not valued: Do we care or are we doing a job? Let's focus on better and best possible lives"

"A focus on services to dysfunction, and illness rather than services building wellbeing"

"Why don't we value our whānau and tamariki voices? Have you gone to hear stories of LSE [lower socio-economic] whānau realities?"

"Government Contracts are the currency. Rather than love and connection of whānau"

"Politicians, and NZ public lack courage compassion for our most vulnerable- children, rangatahi their whānau decreased"

Health care environments very often don't reflect the values of health and wellbeing. There are some exceptions to this (e.g. Te Kuwatawata in Tairawhiti), but on a whole these environments are not whānau centric or spaces that put people at ease.

"The hospital child health building is horrible"

Some commented that tikanga and Te Reo Māori were still not 'normalised' in society and that this continued to create barriers for whānau. This is still the case within many health care setting where medical protocols are prioritised over tikanga.

"Normalisation of tikanga and Te Reo Māori required"

"Tikanga vs. medical protocol"

"Lack of cultural competancy in sector"

"Lack of support for identity (cultural, sexual, etc)"

Similar concerns were expressed by Pacific attendees, where Pacific values are often ignored or their importance diminished.

Some new themes, related to values and beliefs, emerged at the Pasifika workshops. These included:

Differences in beliefs and values between generations. Grandparents often care for children, which was seen as positive, but noted that the older generation has a different approach with raising children.

"Bias conscious and unconscious- older people <are> raising the children but not in line with the parents' beliefs (pressure of working)"

"What does a Pacific parent need in the future?"

Impact of immigration issues are a significant issue raise by Pacific participants.

"Immigration back and forth to home - fluidity how we reconcile both sets of belief"

"What can we do about children born in our hospitals with no rights to citizenship/stateless – about 400 per annum in CMDHB?"

The quiet voice of Pasifika people was noted. There a general feeling that Pasifika families often did not feel able to speak out about poor treatment within health and social services.

"Teach our communities to complain"

Participants discussed what they described as *'misunderstood narratives of communities'*, with a lot of deficit models that missed the strengths present in many Pasifika communities and demonstrated a lack of value on what Pasifika people can bring.

The role of spiritually is very important for most Pasifika people and therefore must be acknowledged in wellbeing models. However, it was acknowledged that spirituality is somewhat different for older and younger generations.

ACCESS TO SERVICES

Participants commented on a number of issues that were related to access to health and other services. These included:

Services are unable to cope with increases in referrals of children with issues such as Foetal Alcohol Spectrum Disorder (FASD), mental illness and behavioural problems. Furthermore, services are often focussed on intervention during crisis, and not on preventing these major events.

"Accessible mental health services for youth with moderate mental health issues (i.e. not severe/crisis)"

"Gaps in provision e.g. maternal mental health adolescent health mental health unmet need"

Long waiting lists and high thresholds, or restrictive eligibility criteria, are significant barriers. These factors are also likely to contribute to increasing the inequity (e.g. vulnerable families are less likely to persist with waiting and so in the end do not access services at all).

"Unwillingness to prioritise access for those at most social need"

Children, and whānau, are unable to see their usual GP during working hours.

"Supportive services, childcare transport, and leave to attend health care appointments"

Specific comments were raised regarding the low uptake of Māori and Pacific children using oral health services, even though they are fully funded. Related to this was the high proportion of Māori and Pacific children requiring dental treatment under general anaesthesia, with large waiting lists for this intervention. Dental health is poorly accessible to those 18 years and over, but still dependant.

"Access to child oral health services getting worse not better"

High DNA (Did Not Attend) rates at paediatric clinics was reported as a barrier to child and youth wellbeing, although this is likely to be a symptom of other issues (one provider noted that DNA also stands for Did Not Assist). There was an identified need to better understand why whānau do not attend visits. Some participants provided insight into the barriers, for example:

"Need for support for parents to attend appointments, cost, transport, time off work"

Poor health literacy is also a challenge for accessing services. Related to this is the difficulty in navigating systems (health and social services) for many whānau. Addressing health literacy is a particularly important issue for many Pacific populations.

"Whānau aren't taught about what is available and many times choices are made for them"

"All State Sectors make it so difficult for our whānau to access /navigate the systems"

Not all services are appropriate for young people, which decreases the likelihood that you will assess these.

"Lack of youth centric equitable services and systems"

Costs associated with accessing primary care and oral health care, lack of transport or inability to afford travel, and lack of time access services were frequently cited as barriers to

accessing services that support health and wellbeing. In some rural regions there is simply a complete lack of services.

"Review of NTA for rural whānau to access services, e.g. pregnancy ultrasound scans"
"Equity of service delivery across the district. Mental health in rural areas- population demand increasing e.g. Wanaka"

Lack of kaupapa Māori services is a barrier for many Māori, and in mainstream services the reduced, or lack of, cultural safety is creating a barrier for Māori to participate.

Inequitable access to termination of pregnancy services was raised as a barrier at several workshops.

ADVERSE CHILDHOOD EXPERIENCES (ACES)

There was an appreciation of the harm that ACEs cause, and that children and whānau with complex needs often have multiple ACEs.

The issue of family harm, and its negative impact it has on children, young people and whānau was raised and discussed at all workshops. Family harm also links to ACEs and drug and alcohol misuse.

"Adverse Childhood Events are a Health issue!"
"Tamariki experiencing witnessing family violence in the home"
"Impact of family violence on children"

The contribution of parental mental illness and addiction on ACEs was also highlighted.

"Huge increase in traumatic domestic violence related mental health issues"

MEDIA, MARKETING AND COMMUNICATION

Some participants commented that media focussing on the negative aspects of health and wellbeing in children and young people was a barrier.

Traditional styles of health communication, e.g. use of printed material, were not seen as relevant to young people.

DATA COLLECTION AND MEASUREMENTS

There was frustration regarding a range of IT issues, in particular the lack of a single health record and inability to share data. The inability to share data is within and between sectors. Generally, people felt that IT systems were not operating as they could and acting as a barrier, when technology should help facilitate health and wellbeing.

"No link across the continuum of care from maternity to well-child to primary care"
"Communication between OT, social work, CADS Police etc. Everyone who cares and supports pregnant women need to share all information"

Feedback was also provided on the gaps in our current IT/data systems that limit our ability to track progress and make change. Participants also commented that across multiple areas the system is focussed on measuring inputs and outputs, as opposed to more meaningful outcomes.

"Measuring the wrong things inputs outputs vs outcomes"

EDUCATION

There was a strong understanding that areas outside the health sector have a critical role in child and youth wellbeing. A number of barriers within our education system were identified. These included:

Outdated teaching methods.

"Outdated education systems/outdated methods to keep our kids engaged. Standing at the front teaching no longer works for our kids, they have evolved so should teachers"

Lack of resources.

"Lack of funding from the Ministry of Education to provide support and resources into the school"

Lack of integration of health education, including physical activity and life skills. Some participants commented that as these topics are not part of New Zealand Qualifications Authority (NZQA) then they are not prioritised. Therefore to have a meaningful impact these topics/subjects need to be integrated into curricula.

"Not teaching our tamariki at an early age about mental health"
"Increase quality of the physical education health curriculum delivery"
"Not exposing our rangatahi enough into health education"
"Topics in kura should include life skills e.g. maara kai and nutrition"
"Budgeting skills: rent food care etc. WINZ budget different jobs incomes"

Inadequate teaching of Te Reo Māori and Te Tiriti o Waitangi was raised.

"Te Reo Māori compulsory in all schools"
"Compulsory Māori learning in kura eg te tiriti Waitangi"

Some expressed that there needed to be greater opportunities for whānau, as a whole, to continue education. There was also specific focus on the role that Early Childhood Education could play in enhancing child health and wellbeing.

LACK OF HEALTH LITERACY

Poor health literacy was seen as a significant barrier for many issues, and affected access to care (see above), making healthy lifestyle choices, as well as on specific areas such as immunisation.

MENTAL HEALTH

In general participants noted the lack of good and safe support for those with mental illness, especially for young people. There was also recognition of the need for better support for mothers suffering with post-natal depression.

"Not enough primary Mental Health services for children"
"Increasing people in our community suffering mental distress"

The real concern about high **youth suicide** rates was highlighted at most workshops, with 'lack of prevention' and 'lack of action' as two main themes throughout.

"Youth suicide intervention is too late- increase whanau support to prevent this"

"Youth suicide our babies are ending their lives why? What are we doing?"

Alcohol and other drug use were seen as significant barriers to achieving wellbeing. Often drugs, alcohol, and smoking are used as coping tools. Substance use and misuse can have a significant impact on the health and wellbeing of the child and whānau, as well as affecting communities.

Gambling was also highlighted as several workshops as contributing to poor whānau wellbeing.

"Gambling machines are continuously and strategically placed in the vulnerable communities increasing temptation and addiction tendencies risking whānau ora! Get rid of the pokies!!"

PARENTS AND WHĀNAU

Children and young people live within families and the majority of participants agreed that there should be a focus on **families** living well. Barriers to wellbeing in this thematic area included parental stress (financial and psychological), parenting challenges, disconnection from whānau, parents that are unable to stay at home, breastfeeding not fully supported in health servcies, and the lack of focus on fathers and the role that they play. A number of points raised suggested that the Health sector should focus on hapū māma and parenting during the first 1,000 days.

"A fragmented system focussed in individuals rather than a whānau"

"Mothers and Fathers not valued to stay to home"

"Disconnection from whānau"

"Pregnancy- hapū māma not supported, protected and nurtured"

It was felt that there was significant pressure on parents, but limited provision of support to help them become good parents.

"Support parents who need additional help- not just financial- non-judgemental"

"Time and resources to train and support parents of teenage young people"

There was a call for greater support for fathers, acknowledging the role that they play in raising children. It was felt, by some that many of the currently funded services focus, predominantly, on the mother.

"Minimum support of Dads- birth/antenatal etc. lots of ways Dads help"

PARTNERSHIPS AND COMMUNITIES

Discussion in this thematic area concerned lack of quality connections to whānau, hapu, iwi and marae, a lack of support for whānau to engage with health, and no common understanding of partnership. The lack of input from Māori, relative disregard of Māori and Pacific solutions for child wellbeing were also highlighted as barriers. Weak relationships between Government agencies, DHBs and NGOs, and other partners were also mentioned.

"Lack of service collaboration"
"Lack of Quality connection to whānau, hapu, iwi, marae"
"There is no support for whānau to engage with health"
"Change legitimate to require Māori engagement and partnership"
"Poorly connected - agencies, whānau, services"
"Lack of support from community"

QUALITY OF CARE

Some participants questioned the quality of health and social care that was provided to whānau. This included poor service providers, medical neglect, and a lack of continuity of care.

"Medical neglect not being taken seriously enough"
"Recognise that continuity of care is central to maternity services"
"Agencies get distracted- lose sight of a child- inconsistent care"

WORKFORCE DEVELOPMENT AND PAY

Issues related to workforce development, retention, and pay equity were commonly reported barriers to achieving health and wellbeing.

There were a number of areas of the work force that were specifically mentioned:

(1) Māori and Pacific workforce

"Lack of Māori and Pacific workforce to work for Maori and Pacific families"
"Lack of funded training to upskill Kaimahi"
"Not enough Māori working for our people in health"
"Not having a workforce that better reflects our population Māori, Pacific"
"Build Pasifika workforce better understanding of diversity of health workforce. Wider than nurses and Drs"

(2) Lead maternity carers

"Lack of LMC workforce especially in rural locations"
"Māori birthing units- fund teams of Māori Pacific midwives and lactation consultants to work"
"All women have a midwife that is of her culture and meets her cultural needs. This will solve issues of inequity"
"LMC mahi not being able to work part time"

(3) Mental health workers

"Lack of trained expertise available for mental health and youth in the provinces"

(4) Primary care

"GP workforce are overwhelmed, ageing, struggle to retain and recruit staff especially in rural areas"
"Workforce shortages in primary health (specifically GPs)"
"Need more Nurse Practitioners"

Other areas of focus in the workshops included lack of pay equity for those working in the wellbeing areas, lack of capacity with resulting workforce fatigue and burnout, lack of training to upskill, and workforce shortages, especially in rural areas.

"Pay scale Māori provider vs mainstream staff follow the money"
"Workforce burnout- staff/providers are stretched and stressed"
"Workers so busy not enough development and support"

Some specific comments referred to basic training of all health care staff, so that people accessing care felt welcome, cared for and not judged.

"Less judgemental GPs nurses and receptionists from Medical Centres"
"Care empathy understanding time"
"Bias judgements- not whānau client child focussed/centred"
"Lack of cultural competency training for health staff including pronunciation training for Māori language"
"Tūranga Kaupapa mandatory (Nga Maia cultural training for all in the Maternity Sector)"

Student debt, especially among Māori health professionals, was highlighted as a significant barrier for entering training and maintaining the workforce.

"Student midwife: full time study limited money to fund travel, living costs etc. Impacts us. Especially as mature students who exhausted entitlements."

4.2 Facilitators of child and youth wellbeing

Many of the suggested solutions for child and youth wellbeing addressed the barriers identified above. As such, many of the themes are similar.

Overall, there was a lot of enthusiasm for, and commitment to, improving wellbeing for children and young people. However, there was a clear call to take action and be brave with our decisions.

"Cared for one another- took ownership and responsibility"
"We were not scared to be different"

ENABLING ACCESS TO HEALTH, EDUCATION, AND SOCIAL SERVICES

In summary, participants agreed that there needed to be easy access to a range of health, education, and social services for children.

"Access for all to early childhood services"
"Total accessibility for health care services eg remove stigma from mental health"

Co-locating services where children spend their time, such as schools. Increasing home visits was another solution to increasing access.

"Public Health nurses enabled to take more active role on school settings"
"Social workers in all schools"
"Whānau/home based model of care. At home. Without judgement."

Others also expressed the importance of enabling access to services for whānau and others in the community. Affordable, or free, transport to services, co-location of service hubs, health care in schools, and mobile services were all examples of ways in which we can increase access to care.

COMMUNITY PARTICIPATION

The African proverb 'It takes a village to raise a child' summarises this theme well. That is, it takes a whole community of different people engaging with child, young people and whānau

in order for a child to reach their full potential. Participants thought that greater investment in community development and resilience would better support child and youth wellbeing. There was also recognition that communities can find their own solutions.

"Engaged with communities to empower strength based responsibility"

"Much more community development work [to] empower communities to solve their own problems"

"Takes a community to raise a child - support from all for wellbeing"

Related is the need for people to feel connected to their communities, whānau, and culture.

"Connected communities based on community values to inspire a vision that is achievable"

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

This was a consistent theme across the workshops, and participants stated the need to address poverty, housing, unemployment, and pay inequity (between sexes and ethnicities).

"Healthy homes for all babies"

"Address determinants of health - housing nutrition and safety"

"Increased women's salaries/wages and reduced wealth gap patriarchy"

"Tamariki Māori and whānau from highest dep areas start to flourish evidenced by safe homes, healthy communities safe play areas, whānau seen out playing with tamariki community pride, wellbeing"

Some participants also acknowledged that communities may be able to play a greater role in this regard.

"Enable community to work on social determinants of health which impact on most vulnerable at a community level whānau"

CHANGES TO THE EDUCATION SYSTEM

Some participants called for changes to the way children and young people are educated. Suggestions covered the following:

Greater integration of health and wellbeing-related topics in every level of the school curricula. Reintroducing home economics in school was an idea frequently raised, along with food in schools. The implementation of health-related policies in school, such as 'water only' could be prioritised.

Participants also thought schools were an opportunity to teach life skills such as parenting and basic budgeting and financial literacy.

"Mental Health becomes a core focus in schools"
"Sexuality education should broaden to family education"

A change in way of teaching and how outcomes are measured.

"Education moved from a one box first all approach. We encourage innovation"
"Education- disabled children and vulnerable /isolated populations - success needs to be measured not only academically, celebrate the arts etc. [and] other achievements"

Some participants believed that children who were not academically minded were not valued in our school system and different options were needed for young people with different abilities.

"Vocational apprenticeships programmes in schools for our Young People who don't aspire to go to University"

The appropriate recognition of Te Reo Māori as an official language of Aotearoa. Making Te Reo Māori compulsory in schools and increasing its use in communities would make a positive contribution to child and youth wellbeing.

"Compulsory Te Reo Māori and NZ history in schools"
"Facilitated for Te Reo Māori in all places and spaces"
"Māori history in schools teach our kids the real story"

ADDRESS FAMILY HARM

There was a clear message that every young person should be safe from violence, either domestic or other. There was also a very clear message that family harm is a health issue, as it has lifelong consequences on mental and physical health. Addressing alcohol and other drug use were seen as key steps in preventing family harm.

FUNDING CHANGES

There was a strong recommendation to increase funding for all activities that have a positive impact on chid and youth wellbeing. Many of these activities are community driven.

"Increase funding for all activities that impact in children and youth positively"
"Invested in the "village"- teachers, parents, sports etc."
"Invested in creative strong and resilient communities to empower whānau"

A call was also made for the funding to be more targeted to those who need it most. Some questioned if universalism in health services was needed, others felt that the system needed to move to a proportionate universalism approach to funding.

"Targeted funding to improve change for those who most need it!"

As noted in the challenges above, the majority of funding in the health system is directed to acute care with a focus on treating illness. To deliver the child and youth wellbeing strategy there needs to be a great emphasis on funding activities that improve and maintain wellbeing. Part of this solution will require funders to divest.

"Focus more on investing in Wellbeing"
"Be willing to divest from things"

Some specific funding options included an increase in public health funding, introduction of a universal child benefit payment, free GP visits to age 24, increased free early childhood education, and free dental care for pregnant women.

"Increase funding for public health by 10% every year for 5 years"
"Access to health services are free – GP, dental, mental health"

There needs to be greater investment in Māori and Pacific providers, kaupapa Māori approaches, and programmes of work that achieve equity. Alongside this, communities should be given greater control over how funding is utilised.

"Only equity positive programmes are funded"

"Increase investment Iwi led in Whānau Ora relative to the levels required to reduce inequity for Whānau Māori experience"

"Give Maori a dedicated pūtea and authority to make own decisions re what/how to do"

It was suggested that the funding model could change from a business model to instead base measures of success on population outcomes. An example to look to is the Alaska Native Health Care System (http://www.anhb.org).

A change in the way agencies contract with providers is also required (the contractual barriers are identified above). Potential solutions include giving greater flexibility within contracts to address changing need, better co-ordination of contracts between agencies (e.g. MoH and MSD) and to reduce the burden associated with reporting.

The additional resource needed for this work could be hypothecated from a sugary drinks tax.

"Sugary drinks tax, ring-fence that money for youth wellbeing e.g. lunches in school after school activities"

THE NEED FOR KAUPAPA MĀORI APPROACHES

The solutions in this theme covered greater Māori representation at the leadership and decision-making level, the inclusion of Māori values and beliefs into service delivery models, and acknowledgement and integration of Mātauranga Māori.

"More Māori leaders"

"Incorporation of the uniqueness of Māori values and beliefs into service delivery"

"Ensure Te Ao Maori perspective and Māori Mātauranga are a key driver of the mokupuna tamariki Māori aspects"

The engagement with Ngā Maia (Maori midwives) in particular, called for more hapū wānanga, Māori traditional birthing, and embedded mokopuna ora models across the nation. Five DHB reported they were using hapū wānanga as their approach to antenatal classes.

"Kaupapa Māori birthing wānanga the norm"
"Waiora Māori Kaupapa delivery across all health"
"Kaupapa Māori antenatal classes in every DHB"

We frequently heard that if the system work for Māori it will work for all. However there needs to be effort in helping people understand how it can work for everyone.

"Educate Pākehā to understand that Tīkanga Māori can work for everyone"

AGENCIES THAT LISTEN AND RESPOND ACCORDINGLY

An overarching theme across all workshops was that government agencies do not listen, or if they do listen they do not act on what they heard. Part of the described solution was to listen to the voices of our tamariki, rangatahi, and whānau. Furthermore, there was a clear call for greater partnership with communities in co-design, decision-making and delivery of services.

"Whakarongo!"
"Listened to: our youth, our communities including rural, disability, Māori, Pasifika"
"Youth representative at all levels of decision making"
"Get feedback from the most vulnerable"
"Nurture whānau listen to what they have to say"
"We embraced the power of positive youth development to help find solutions, whatever is the issue of the day. i.e. Young People connected, supported empowered, resilient."

DELIBERATELY ADDRESS THE INEQUITY

Many participants stated that systems need to be deliberate in addressing the inequity. This may involve difficult decisions, especially regarding the allocation of funding and service delivery models.

"We prioritised reducing inequity first (i.e. we didn't lift wellbeing for all until equity achieved)"

"Prioritise increasing equity for Māori and Pacific Tamariki and Rangatahi"

Related to this, the system needs to be able to measure progress, and there needs to be a move to **outcomes-based reporting**, as opposed to outputs.

"Measurable health outcomes same for Māori and non-Māori"
"Have measureable outcomes that are monitored and ensure accountability"

"Accountability to Te Tiriti Articles across sectors/ cross sector monitoring of outcomes"
"All contracts have to be accountable to the Strategy"

There was also a call for 'checking the checkers'. This is reflecting the issues that agencies who do the checking also need to be held to account, and that those for whom the service focus is intended should be part of this accountability check.

"Balance of accountability (checking) and trust to ensure time to do."
"Tamariki/rangatahi involvement in checking the checkers"

SYSTEM CHANGE

Changes to existing policies were needed. As a starting point policy needed to be responsive to Te Tiriti, with solid commitments to the Articles of Te Tiriti.

"Re-visioning our system according to Te Tiriti Articles"
"Enacted partnership, participation and protection"
"Commitment to Treaty of Waitangi from heads in MOH DHB staff to community."

There was also a call for a kaupapa Māori system for health and wellbeing. This would reflect Te Ao Māori and use *Te Whare Tapa Wha*, for example, to underpin the design of health services.

"Transform the systems and institutions to kaupapa Māori: Te Reo in schools, our histories-decolonisation, build on what's working Kohanga reo, what does that look like? how do we support that? Leadership and performance measurement around unconscious bias, building connections between MOH and communities."
"Use the Mason Durie whare model to underpin design of health services for all NZ"

"Partnership with Māori ensuring the involvement of Māori- leaders, councils, iwi, hapu, whānau, services"

Racism was a barrier to child wellbeing and there was a strong call for agencies to act to address and **eliminate institutional racism**.

"Agencies need to take on institutional racism"

Policy should also align with the life-course approach, and reflect the need for a greater emphasis on prevention of illness and promotion of wellbeing. This will include greater focus on what can be achieved in communities.

"Commit to a life span approach"
"Be genuine about health promotion and prevention- stop the disease focus"
"Indigenous models utilised Whānau Ora supported by organisations"
"Be brave and invest in whānau ora. Do it, have it as it was originally designed.
"We built health resource, facilities and presence into local communities away from hospital "

To achieve wellbeing, policies will need to have a more integrated approach across government agencies, for example the inclusion of systems that support child health in early childhood education. The need for a holistic, 'non-siloed' system was frequently mentioned.

"Wellbeing policy embraces child health in early childhood services"
"Good will be when there are no silos in Government around children and youth. There are no silos in supporting children and youth."

Policies that address unhealthy eating could have a major benefit. Examples provided by participants including a tax on sugary drinks, and subsidies, or removing GST, on vegetables. Related to this was the call for better regulation of the food and beverage industry and restrictions on advertising of unhealthy food.

"Changing price of kai making milk cheaper that fizzy drinks"
"Regulation will force industry to comply"

Some participants commented that some radical change would be needed to realise the vision of the Child & Youth Wellbeing Strategy. These changes included a change in the primary health care model (e.g. more nurse-led services), reducing the bureaucracy within

DHB systems, and devolving health funding to Māori and allowing for self-determination – mana motuhake.

"Primary care business model scrapped"

"Elected /appointed Boards scrapped"

"We have restructured the health system to enable true integration of health and social care"

"Ministry leadership (not 20 DHBs and PHU duplicating efforts)"

Trusting relationships will also be a key element of a successful system change at all levels.

"Trust in children young people and communities to know what they need and listen to them"

"High trust contracting/relationship building"

Participants also provided comment on legislation change that would increase the reach influence of young people on decision makers, and make it easier for whānau to provide care for their children.

"Young people in parliament"

"Abolish the voting age anyone who wants to vote can vote"

"Family friendly employment law allowing family to attend key health appointments for children"

PARENTAL SUPPORT

Parents need support in raising children.

"Adults get the support they need to provide good environments for children"

Types of support that were suggested within this theme were learning life skills from an early age (e.g. at school), parenting programmes, giving parenting an economic value so parents can be rewarded for spending time with their children, services could engage in the lives of families in their homes to meet needs, and a focus on whānau wellbeing in order to parent well rather than children going into State care.

"Parents need support in parenting skills"

"Free parent hubs. Mindfulness and self-regulatory strategies taught to parent children parents in schools"

Others solutions included increased parental leave, flexible working arrangements, paid maternity leave, and wages to be adequate for families to support children on one full-time wage.

The important role that fathers have to play was raised at several workshops. Support services for fathers are available, but not nationally and these are not very well funded.

"Fathers get what they need (and we have great services that are unfunded at the moment) UNCROC [3] says fathers have access to support too)"

"Parents get the support they need to provider a good environment (and parents have knowledge that can help them) Wellbeing is relational and the material basics are important"

SERVICE DESIGN

The life-course approach to addressing child and youth wellbeing was generally endorsed by the health sector. Therefore, solutions should focus on evidence-based strategies within each stage of the life-course, starting with pre-conception, and progressing through pregnancy, infancy, childhood and adolescence. Some participants thought that we could do better to learn from what has worked in other countries (e.g. Scandinavian counties and Indigenous Alaskan models).

"Considered the evidence of what worked, - tested, test to ensure the right outcome"

"Start with pregnancy- reward great care, reduction in obesity, alcohol and drugs"

"Focus on first 1000 days conception to 2 yrs. Quality kaupapa parenting programmes"

"Foetal Alcohol Syndrome problem in NZ which needs to be addressed"

Related to kaupapa Māori approaches (above), many believed that services should be designed to meet the needs of Māori first and that such a service design is likely to work for everyone else to.

"Service design for Māori will work for everyone else too (that should be the Strategy)"

[3] UNCROC United Nations Convention on the Rights of the Child

Services should meet the needs of the community. This means that a standard 'model of care' was unlikely to be appropriate. There needed to be a less 'siloed' way of addressing community needs. Instead a whole system (co-ordinated) approach should be implemented, which would protect against each agency only focussing on its own priorities.

Many participants thought that communities would be able to play an important role in producing solutions for services design and should be either actively engaged, or lead the process.

"Developed services that are community owned and meet the need"

"Services that reflect the community they serve"

It was recognised that child, young people, and whānau should be at the centre of service design, and not what best meets the needs of organisations delivering services. Similarly, Māori need to making decisions regarding service design, as opposed to only being consulted.

"Children and Youth at centre- Services best fit for whānau not organisations"

"Family way of working rather than practitioners working with individuals they whole of family is considered"

"Home visit all children from birth to 5 years with shared focus on entire family"

"Māori no longer walking alongside the decision makers, but actually walking in the same groups as the decision makers"

Participants recognised the importance of ongoing development of Māori and Pacific providers.

"Built /strengthened incredible autonomous Māori led service providers"

Services for young adults, e.g. university students, could be developed further.

"University doesn't meet students need eg content and healthy relationships, mental health and rainbow issues. Mental health is not talked about, Universities need to do better, should address all aspects of health should be cornerstones"

Solutions for prevention of youth suicide are desperately needed, with a particular focus on at risk groups.

"Suicide isues need to be addressed. Some school students are more at risk. In 10 years they should be less suicide particularly amongst the traditional at risk groups ie Māori transgender."

VALUES & BELIEFS

This theme covered a range of factors that participants believed are important to achieving child wellbeing. At a high level the normalisation of the values of aroha, manaaki, and whanaungatanga would support a change. Communities and whānau would all believe in the importance, or special value, of their tamariki. Parents and whānau are valued and supported to spend time with their children and young people.

"Values of aroha, manaaki and whanaungatanga were normalised"

"We educated whānau about "the importance of their tamariki""

It was recognised that a coordinated approach, which is wider than just health, would be needed across settings (including business etc.) so parents and whānau are setting the same message at multiple levels.

An understanding of the differences in approaches to achieving health and wellbeing is needed and that many of the solutions will come from whānau. However, the youth voice is needed, and valued, to inform decisions.

"We took feedback from health clients then made changes to ensure all health services were culturally responsive and culturally safe services"

ENVIRONMENTAL CHANGES

Participants recognised the importance of change the environment to better support wellbeing. For example, local government could play a role in reducing the density of fast-food outlets, retailers that sell alcohol or tobacco, and increasing the opportunities for physical activity by investing in places and spaces for children to play and be physically active. Adult outdoor gyms are also an opportunity to encourage family exercise. Furthermore, young people and families should be able to co-design spaces and places in partnership with councils urban planning and design teams.

"More fruit trees in public places- education especially low socioeconomic areas"

"Free and lots of community vege gardens and fruit trees in cities and towns"

A number of participants also called for the protection of rivers and sea, which are sacred spaces for food sources.

"Save our sacred spaces food sources – ngahere [forest] moana [sea] awa [rivers]"

WORKFORCE

Many of the solutions offered involved workforce protection and development, especially of our Māori and Pacific workforce. Solutions included:

Positive discrimination in employment.

"We increased Māori health workforce numbers to be at least equal to proportionate representation"

"Recruited a workforce that reflected our community- Māori and Pacific"

Redesigning staff training and support to ensure that it meets the needs of the workforce (e.g. training that supports cultural competencies).

"Culturally competent and SAFE organisations services i.e. workforce"

"Upskill non-Māori workforce and decision makers in tīkanga Māori"

"Provided Maori Language (including pronunciation) training for all health staff to improve patients and whānau experiences of health staff/services"

Greater representation of Māori and Pacific in leadership and decision-making roles

"Valued our exiting rangatahi Māori and Pacific in workforce and pathwayed into leadership"

"More Māori are sitting at the decision makers table. More Māori on governance boards."

Plan for the future. There will be an increased need for a diverse workforce that includes practitioners that are highly skilled in technical areas and those that are skilled in community work. This has been, for example, success in kaiāwhina working alongside midwives.

"Nga Maia Midwives to have a kaiāwhina who works with them to tautoko their women"

"More whānau Ora navigators to work alongside whānau Māori"

Additional funding will be needed to have workforce that is fit for purpose.

"Better funded and trained workforce: links to other workforces is increased, nurse practitioner model, increased capacity"

A greater role for midwives that enables them to care for women of child-bearing age.

"Midwives can be medical provider from preconception to post natal period but also maintain women's sexual health, age from puberty and menopause"

A greater focus could also be applied to increase the number of young people (especially Māori and Pacific) that are interested in a health and wellbeing career path. Having Māori training organisations for health care workers that have no training fees for Māori

"Internships for rangatahi within the needs of the workforce"

"Pay for our rangatahi to train and then bond them"

"Māori midwifery school/zero fees"

IT SYSTEMS

Overall, there is a need for integrated data systems that work towards outcomes and are therefore measureable. Whilst it was thought desirable to have a multi-agency database, we have IT solutions that are needed within our health care system.

"Shared health and social record on one platform implemented"

OUTCOMES AND MEASUREMENTS

There was a clear message to move away from measuring outputs ('widgets') and towards outcome measures. A common definition of wellbeing is needed, and should include what wellbeing means to a child. Wellbeing outcomes need to be shared by all sectors - business, other government agencies. These outcomes need to be measurable, and we should aim for continuous improvement.

4.3 Feedback on the draft child and youth wellbeing strategy

This section includes summary of the feedback that was specific to the proposed outcomes framework. A copy of the proposed outcomes framework can be found here: https://dpmc.govt.nz/sites/default/files/2018-11/appendix-b-proposed-outcomes-framework.pdf.

Please note that the outcomes framework is not the Strategy – it is a high-level overview of what the Strategy hopes to achieve and what areas it may focus on – not how it will do so.

Many people also provided significant feedback, comments and suggestions about what the Strategy should focus on, what actions should be taken and how the outcomes could be achieved through the other parts of the hui (e.g. the red and green cards exercises). These have not been incorporated into this section of the report but will be considered when reviewing and revising the proposed outcomes framework.

A number of comments on the draft outcomes framework were captured at the workshops. While there was typically strong support for many of the elements of the framework, including the desired outcomes and proposed areas of focus, there were also many suggestions for changing or improving it. Key suggestions for change are grouped as follows:

GENERAL COMMENTS ON THE FRAMEWORK

- Does not reflect Pacific & Māori views of wellbeing well
- The linear nature of the document does not resonate with Māori and Pacific concepts of wellbeing
- It's not just about translation, it needs transformation
- A Māori advisory group should support the redevelopment of this
- It is too light on whānau – need greater focus on family
- The unique relationship of the Crown with Tamariki Māori needs to be acknowledged
- It should be values driven
- The language is too passive
- Important to ensure we capture the voice of children & young people in this – their voice is not coming through
- The language needs to be more accessible – a lot of jargon and vague language
- Equity needs to be actively woven / applied throughout the framework
- The Treaty / Te Tiriti needs to be actively woven / applied throughout the framework
- Age should be extended to cover all youth (ie. up to 25 for all, not just those in state care)
- It should also include the pre-conception stage.
- This document alone does not motivate, inspire or direct – the eventual Strategy will need to be tied to specific actions to inspire and direct peoples behaviours

- Replace references to “work”, “job” or “employment” with “career”. Shift language away from employment as a desired outcome to strengths and skills as the desired
- Less focus on pathology and deficit based measures, more focus on holistic wellbeing and strength based outcomes & language
- Nothing for rainbow youth – bring out more in the framework
- Hopes and dreams are missing.

“Where is the wairua in policy?”

“Why is there not a separate Māori strategy?”

VISION STATEMENT

Regarding the vision statement *“New Zealand is the best place in the world for children and young people / Ko Aotearoa te tino whenua o tea o mō te Tamariki me te rangatahi”* participants made the following comments:

- Feels unfinished… to what? “to thrive”? / “to flourish”? / “to grow up”? / “to live”?
- Should be “…children, young people, and their whānau”.
- Emphasis that this is about all children. “…for ALL children and young people”
- Emphasis on the collective responsibility. “…for OUR children and young people”
- “Best” implies competition – Why do we need to measure ourselves by international standards. We want New Zealand’s definition of best / great. It can also be perceived as insulting to the New Zealanders who believe that it already is the best in the world.
- It should be “Aotearoa” not “New Zealand”.
- Use “Tamariki” & “Rangatahi” in the English vision statement.
- Flip the vision around – “Children & Young People” should be first. At the moment the focus is on New Zealand. i.e. “Children and young people think that Aotearoa is the best place in the world for them and their family and whānau”.
- Pacific don’t see themselves in this vision.
- For some Pacific people spending time in the islands their family comes from is very important culturally
- The vision limits their potential – young people get inspiration and opportunities overseas too. Vision suggests that New Zealand has to be the best place but it is not the only place that they can thrive. Children are part of a global society.

PRINCIPLES

Regarding the seven principles, participants made the following suggestions:

- There should be an ethnicity specific principle about valuing and recognising diversity
- Principles need to be more prominent and obvious about how they are actually influencing the outcome statements & focus areas. i.e. Don’t see equity and partnership with Māori in the outcome statements.
- The Treaty as a “principle” is not quite right. Having it as a principle undermines the importance of the Treaty & the obligations of the Crown. It makes it seem optional.

WELLBEING DOMAINS

Regarding the five wellbeing domains, participants made the following suggestions:

- Don't have the domains in blocks. They need to reflect how they are interwoven… we need to stay away from making the domains (and agencies) siloed. We all need to work together to make it work. Should be a weave, circular or interconnected somehow.
- If linear, then have what they need should come first (Maslow's hierarchy of needs)
- Overall good, but what does this look like applied to pacific – consider "Belong, Contribute & Valued" in reference to NZ part of the pacific
- Spirituality is missing – There should be a sixth domain that is specific to "Culture Identity & Spirituality" (separate from "Belong, Contribute & Valued").
- Risk around the use of the word "Safe". Safe means different things to different people and different cultures. Also children need to take risks within reasonable parameters.

OUTCOMES FRAMEWORK

Feedback on the desired outcomes included the following points:

- The outcomes are unclear – important that they are well defined and clearly measurable
- The inclusion of environment is weak – needs a stronger focus
- Should include an explicit mention of oral health
- Should include an explicit mention of sexuality particularly in reference to LGBTQI+ & Takatāpui.
- Should include an explicit mention of Youth Justice.
- References to mothers & families/whānau but no reference or focus on fathers
- Needs to be a greater focus on **quality** education
- More stuff about youth needed. In particular there is not a lot of positive stuff about youth
- Make community more present in the outcomes
- Be clearer about the actors – who will achieve these things
- There needs to be more focus on children's inherent value and self-worth
- Greater emphasis on the "from conception"
- Explicit focus on parents – i.e. Parents mental health needs to be included.

FOCUS AREAS

The draft strategy has 16 focus areas. Overall participants thought that these captured what needs to be done, but made the following specific comments:

Focus areas

- #3 - needs to explicitly state bullying through social media
- #4 - live in affordable, safe, secure (i.e. tenure stability) and quality housing
- #4 - include access to community spaces (e.g. parks, libraries) as part of the 'quality' of homes
- #5 - last bullet point is vague
- #7 - actively celebrate diversity
- #8 - include spirituality and history

- #10 - not just physically active needs to explicitly reference “play”, as play is kids work
- #11 - include support for the families of children with disabilities
- #11 - “children with disabilities” NOT “disabled children” – people first
- #14/15 should be a single focus area - there needs to be cohesion across the full age brackets
- #15 - the focus on “resilience” has an element of victim blaming to it
- #16 - include “unlocking potential” & “recognising excellence”
- [#missing] - explicit focus on ACEs, including proper interventions to build resilience and not just for extreme trauma or once problems present.
- [#missing] - supporting migrants to understand rights & responsibilities, getting access to services, and to positively transition into New Zealand society without losing their unique culture, identity and diversity.
- [# missing] - a specific focus area on empowering communities.

4.4 Health sector response

This workshop session asked participants to think about what the health sector could do to better support child and youth wellbeing. The details of what could be kept and strengthened, stopped, examples of innovation, and what could be done to ensure equitable outcomes are provided in **Tables 1- 4** as recorded by each workshop. A brief summary is provided below, under each heading.

KEEP AND STRENGTHEN

At a high level, most workshops reflected on the need to strengthen commitment to Te Tiriti, applying the principles across the many layers of the health system. Related to this was the ongoing need to ensure that all staff are culturally safe in their practice.

There was a view that whānau centric and holistic services, such as Whānau Ora and kaiāwhina, should be kept and strengthened. There was consistent feedback that Hapū Wānanga services were working well and meeting the needs of Māori and non-Māori. In general, there was strong support for kaupapa Māori services and the value of Mātauranga Māori in health and wellbeing services.

Kura/School-based and home-based health services appeared frequently and, in general, any service that helped connect people to other health and social services. Regarding Well Child services, the principle of visiting whānau at home should be kept, but other areas (e.g. intensive wrap around support) needed to be strengthened.

For areas that were investing in health services that are co-located (e.g. Te Aka Mauri Library and Children's Health Hub in Rotorua) these were seen as successful innovations. Some participants commented on the role schools could play, as a community hub for health and education, although this may be more 'innovative' than 'current' at present.

Approaches utilising e-health, e.g. text-based support systems, iMoko, and systems that better use people's health and wellbeing data, were mentioned some workshops as systems that should be kept. Others noted these as innovative approaches. However, regardless how participants categorised these, they undoubtedly will play a greater role in the delivery of care.

Activities that focussed on encouraging healthy behaviours and preventing poor health were routinely flagged as things that must be kept and strengthened. Many thought that there should be a greater investment in these activities. There was also a call to strengthen the collaboration and integration of these activities (e.g. 'strengthen collaboration around smoking cessations and breastfeeding services').

Some participants called for strengthening and expansion of free, or at least very low cost, GP visits and oral health. Taking on board the life-course approach, some participants raised the possibility of community dental services being free for pregnant women.

For areas that had school based health services and Youth One Stop Shops (YOSS) these were seen as successful, requiring ongoing support and replication.

There was a strong message to keep and strengthen Māori and Pacific providers, but to change the current low-trust approach to contracting. There were numerous issues raised regarding funding and contracting, which are discussed in the following to sections.

Ongoing investment in workforce development, especially within our Māori, Pacific and community workforce is critical.

STOP

Current funding models were seen as barriers to cultivating wellbeing in children and young people. Criticism was directed at the current distribution of health funds (i.e. treating illness vs. prevention and wellbeing), issues-based funding, and paying for outputs as opposed to outcomes. Examples were provided where we should stop funding some transplant or 'heroic end of life surgery'. The point being made here is that these interventions are expensive and the return on investment are, of course, many times lower than investments earlier in the life-course. Māori and Pacific services are also underfunded.

Contracts that are inflexible and do not allow providers to refocus on the most pressing needs must stop. 'Stop cluttering contracts with structures that inhibit people delivering the best care'. Layers of bureaucracy, endemic in many organisations, are barriers to innovative approaches that will be needed to deliver activities that promote health and wellbeing of children, young people and their whānau. There is also a call to stop short-term (e.g. 1 year) contracts that don't allow for full development of services or staff.

Systems that are not joined-up or integrated must stop. This included stopping services that work in isolation of others. Replication of services across agencies also needs to cease. This will require greater co-operation between government agencies.

Services that are not effective for Māori must change. There should be routine monitoring and evaluation of services to assess their effectiveness in the desired health outcomes and on equity. Those services that are not reaching and/or helping Māori should be stopped.

Anything that widens inequity needs to be identified and stopped. Given the limited funding pool, there is a need for prioritisation frameworks.

Racism. Institutional racism, in particular, was called out in every workshop. This urgently needs to be addressed.

The statement 'Stop measuring success in quantities of widgets' summarises many participants pleas to move to more meaningful measures that focus on outcomes, not process.

Stop easy access to alcohol and marketing of junk food to kids. These were just a couple of examples that concern the need to have stronger policies that promote health and wellbeing.

To end on a very pragmatic note, a recommendation from participants at the Waiwhetu Marae workshop - **'Stop talking and do something'**

DO DIFFERENTLY / INNOVATION

The workshops generated a ranged of ideas, from high level changes (e.g. looking at iwi boards in DHBs, and young people in decision making roles) to changes that are more pragmatic in nature (e.g. increasing the number of nurse prescribers).

Valuing the importance of the voices of children and young people should be an important part of service design and delivery. Many participants recommended co-design with the end-users. Children as health navigators for their whānau was also suggested.

Increasing the number of school-based health services, one-stop-shops (for all children), and hapū wānanga in the antenatal period were also seen as opportunities that could be started soon. Participants in the Pasifika workshops recognised the early success of pastoral care in schools.

Health and wellbeing could be integrated into all policies, including workplace policies. Some participants called for the health sector to get its own policies in order first (e.g. employee wellbeing, flexible working hours for parents, access to childcare).

There should be an increased investment in kaupapa Māori services.

Improvements in IT systems that allow for easier data sharing. Systems could be reconfigured to allow whānau to see how they are progressing. Children and whānau would have control over their own health data.

Use the expertise in the community, rather than just replying on health care workers (e.g. breastfeeding buddies).

Investment in, and provide ongoing support for, community solutions. Innovative approaches are needed to deal with the issues of rurality (e.g. distance to travel for health care).

Develop a workforce to operate in a new, holistic, service model. New approaches (e.g. grants, scholarships, mentoring) are needed to encourage more Māori and Pacific people, in particular, to join the health and disability workforce.

EQUITY

To address the inequity that we have in our health system, resulting in inequity of health and life outcomes, participants generally recommended addressing the barriers concerning Te Tiriti, kaupapa Māori approaches, and calling out racism and the lack of understanding of mātauranga Māori.

Solutions included strengthening partnerships with iwi/hapu, increased Māori leadership and Governance within health, increased funding to Māori health services, increased culturally safe services and workforce, reprioritised funding for Pasifika to improve outcomes, addressing unconscious bias within DHB Planners and Funders, and ensuring all levels of

the health and disability system have clear accountability for addressing the inequity of outcomes.

TABLE 1: ACTIVITIES THAT SHOULD BE KEPT AND STRENGTHENED

Workshop	Content to keep and strengthen
Palmerston North 12 Nov 18	• Whānau ora should be funded as BAU- funding came through Whānau Ora. • Mindfulness in under two year olds (this is being done at Gails Childcare and us supporting transition to primary school) • Health delivery in a non-health setting • Outcomes focussed • Group-based work • Service delivery in home (e.g. nurse led bed wetting programme, outreach immunisation programme) • VLCA primary care • Text-based support systems • Joined up sector (e.g. Good lives) • Kaupapa Māori • Mātauranga Māori value base • Resource and invest in leadership – Māori leadership all the way through the system • More people who are Māori and understand Mātauranga Māori in the workforce • Piloting hapu wananga (Tarankai DHB) • Engaging with whānau who weren't previously engagement with services • Te Whariki (Strength based) • NGO sector know a lot about the whānau- the simple stuff like offering them a cuppa tea. About keeping people well- an ongoing journey • Leadership across government needs to be strengthened. • Social sector trails were good- go back to these and provide more support. Quality improvement approach • Holistic approach of Māori • Workforce flexibility needs to be strengthened- specialists should be funded to go to whānau. Workforce should be able to move across services • Generalist primary care can't deal with workload- need to be strengthened, diversified and sit with specialists • Whānau, hapu marae, iwi take care of each other. Collaboration so all doors are the right door.

	• Keep things like Green Prescription, Project Energise • Invest in technology. We need environments that empowers children and whānau to be healthy • Accountability we're all responsible whether we work in health, justice etc • Work with other agencies at start to decide right person to work with whānau • Support whānau its their story
Hamilton 15 Nov 18	• Technical expertise • Māori health strategy – implementation needs improvement • Project under five energise – has some good outcomes • Whānau ora (whānau centric services) • Hapū wānanga (working well in Lakes, BoP, Taranaki and Waikato DHBs) • PHU initiatives (e.g. health promoting schools, building blocks programme) • Holistic Health • Give people data to drive behaviour change • Puna Waiora – Māori workforce development programme • Whare Ora (Healthy Homes) • iMOKO – virtual health • Te Ahuri a Rangatahi • School-based health services • Youth one-stop-shops • E-health strategy • Strengthen TOW (Treaty of Waitangi) philosophy • Strengthen Whānau Ora navigation • Kura based hauora services • TPM evaluation framework
Dunedin 21 Nov 18	• Paid parental leave (plus more) • Free under 14s (innovate to 18) • Hospitals in regions (improve equity issue) • Imoko (innovate to integrated services – responsive) • Multimedia • Incredible Years – building – innovative – children's social competency • Community hubs including health, education etc – school clinics • Dental clinics in schools and communities (innovate to multiple screening checks) • Social workers in schools • Healthy Housing assessments (strengthen) • ALL Youth-led based programmes • Youth survey – asking children themselves

	• Sustainable workforce – more of professions • Partnership community workers (accessibility) • ACEs framework/trauma informed care • Transition services • Relationships/trust • More focus on the transitions that work well • We don't have to become youth to get it • Keep Health Ed but…can be consistency • Funded for time not just service/outcome • Extend pastoral care into secondary schools • Intergenerational is the village lost • Whole system operates around each child in a school environment • Keep talking about mental health • Keep the wrap around service in schools – coordinate it better – from early childhood to school leavers • Talking/working together • Homebased services e.g. antenatal care • Data sharing and follow up between referrers and referrals • "1737" – mental health line. Recording system. • 'Find your midwife' (advertising would help) • School counselling and mental health services. School based services • Midwifery continuity of care with incentives for how SES/high needs women • Local government role • Communities trust in the health professionals. Build trust first. • WCTO (proportional support) • Sharing and linking e.g. SDHB WC steering group • "working with" • Consumer feedback (e.g. midwives) • Health promotion • Social wellbeing strategy (DCC) • Processes and partnerships to share information • Partnerships and connections • HHI extend • LMC model • Services that support kids • Antenatal classes (extend) • Oral health – new model – recruit and retain staff • Whānau role P modelling

	• Use contact with kids to bring in whānau – help with dong more prevention, including before babies have teeth • Services/agencies that can help with tooth brushing at school (teachers are busy) • Gather people's stories not just data • Person-centred approach • Paediatricians role • Modelling • Communication • Whānau-centred care • options for including whānau • Youth perspective • Conversations – reframe way from 'it's the child's fault' • Diversity in the workforce • More Māori professionals • Train whānau • Conversations without blame • Listen to the voices: Children, Māori whānau, Communities we find it hard to reach • Focus on prevention/early intervention • First 1000 days focus – strengthen model / models • More diverse workforce increase diversity • Strengthen and keep doing what already doing well • Workforce education around family harm (increase and strengthen) • Use IT technology and services – information - increase access – need to use better – connect better • Identification of need to be strengthened – targeted resources • Resilience – build internally and within communities • Health presence in schools so all kids can talk to someone about health • Health literacy • Advocacy increased • Use champions • Increase relationships between WCTO and ECE and LMC across the board • Take opportunities to support existing services particularly in remote rural areas e.g. practice nurses can provide other services like vision/hearing testing • Public Health • PN (Public Nurses) in schools • Free GP under 14s (extend to 18)

	• Low cost primary health access strengthen oral health keep to 25 years • Community groups working with families and youth more places learning skills; involvement, engagement • WCTO whānau centred approaches, strengths-based model; goal oriented, outcomes determined by whānau • Whole of society focus on children aka Sweden • Focus DHBs on prevention move funding and energy to address early years and inequality (explicit requirement) • Collaborative approach eg family resource centre ide (Canada) – coop v competition - Better integration across systems using communities. Do vt approach
Christchurch 23 Nov 18	• More one stop shops • Keep value, fund appropriately so your interconnected issues are dealt with and no wrong door • YOSS recognise, support and replicate • LMCs strengthen and use hub and spoke to deal proportionately with issues in the community • COPMIA extend to primary level as well as caregiver of children included • Measure what we value- which means we need to be clear what we value • Giving all of us the power to do what is right to get great outcomes • CDHB broad work to build community based care • Build health, education, OT, Police working together, no passing a hot potato but working on outcomes for kids. • Strengthen Whānau Ora • Strengthen Treaty of Waitangi philosophy • Strengthen Whānau Ora navigation brokering access to clinical experts • Kura based Hauora services • TPM evaluation framework
Whangarei 26 Nov 18	• MQC – Kaiawhina works alongside RN in outreach programme • Pasifika approach similar to above – allow greater ability to meet specific ethnicity needs • Go to people (where they are at) and walk, journey with them • Navigate services alongside whānau and culturally appropriate way • Identified look at confidence by doctors in pronouncing Māori names => teaching strategy to teach pronunciation and measuring outcomes • Opportunities for all staff to be culturally safe in their practice • Practice – whakawhanaunga (*to have a relationship, get together, get to know one another, get along with, make friends*) tonga??? at all first appointments – before commencing mahi

	• CYF – everyday connections inter-govt. discussion/action to run initiatives in the community that brought people together and good things happened (Whangarei. Kaitaia, Dargaville) got built on PUBLIC EDUCATION AND HEALTH PROMOTION, and it was great • Health promotion / education • Free Dr visits and scripts – keep and extend to 24 • Te Whare Ora Tangata maternity initiative re drug & alcohol / mental health • Whānau Ora both appropriate • Hapū Wananga model • OT hospital liaison – keep and enhance (only in Whangarei) • P project – MoH funded: Police via proceeds of crime, working well but running out of funds • Otangarei – initiatives run by Health, Rakau Rangatira, Rakau Maru – need to keep going and extended • Whānau Ora framework – great outcomes include story telling in feedback • Strengthen and spread inter-agency collaboration e.g. CYMR: Fusion enable relationships • Strengthen workforce – e.g. coaching and mentoring and PD and supervision (could be shared across professions) – give people permission to be innovative and create inventions for own environment • Established relationships that support innovation
Pasifika Fono Auckland 29 Nov 18	• Principle of WCTO of going into homes, but strengthen intensive wrap around support • Combined psychological and social services in low decile schools – target high needs schools • Keeping cultural specific health promotion (e.g. immunisation) • Evaluation is an essential part, from the start • Widen nutrition/cooking in schools • Strengthen a family approach and multi-disciplinary teams • Keep and strengthen Pasifika providers • Strengthen models of care that are family based • Keep DHB/ Ministry Pacific Health Plans funded properly to achieve outcomes for Pasifika. • Reprioritise funding resources for Pasifika • Iwi/Māori providers research on what's working, use evidence • Koha • Pacific and Māori leadership and other leadership eg Asian • Entitlements and rights • Community engagement

	• Development which strength • Engagement • Working across sectors- mandated • Knowing what services are there. • Whānau Ora approach in providing wrap around services 18 months and onwards. Continuity of care continuum of care • Services where young people are in our communities facilities • Continue funding based on good evidence evaluation models • 'There is no wrong door' approach
Auckland 30 Nov 18	• Protective factors • Connectedness • Individualised funding • Workforce development keep workforce and strengthen including increasing Māori and Pacific • Reinvestment • Information sharing • Incentives eg vouchers • Implementing well researched approaches • violence intervention (men, women, and children) • Home visiting as a component of LMC and We Care • Strengthen community development and voices and give them agency and learn from other communities where working well • Healthy homes- getting some tractions • Advocates who help families to get repairs done • WOF for homes too • Could be made a stronger requirements- a policy • HNZ should subsidise Kiwibuild should endorse • Keep acute services while change is happening • That women can select LMC/primary care provider • Health navigator and coach function working well- has cultural element • Fruit and Veges in schools(decile1-2) huge positive impact beyond school • Strengthen collaboration eg around smoking cessations and breastfeeding g services • 0-3 funding • Access to long acting reversible contraception • School based health services (Mana Kids in Counties Manukau) • School based health in secondary school- all schools irrespective of decile • HP Schools- reset • Community dental services- free to pregnant women

	• Community breast feeding support services (hell yes strengthen) • Increase access to family planning and sexual health services • Whānau Ora- dramatically expand • Public Health nurses • Home visiting done more • Kaupapa Māori initiatives • Do take the best from Children's Teams and high complex needs model • Integrate health and education, mental health, sex education coping with life skills Health into curriculum review • Schools as community hub for services and education • Tomorrow schools a barrier • Health throughout the curriculum across all years • Focus on what is going well, promote whānau WHAT GOOD LOOKS LIKE, Do not just report do! (UNCROC) • Ensure PPL is organised lengthened, strengthened. (Scandinavia greater support and hoe visits and referral pathways and helpful parents to parent!) What do you do with a crying baby!. Parenting is stressful- greater recognition) Longevity of person involved- navigator role fro parents to bring skills together. • Front load services (Early detection prevention and access)
Waiwhetu Marae Wellington 3 Dec 18	• WCTO enhance • Free visits for children and young people including oral health • Assessment and services for young people>5 to Year 9 Universal, Whānau Ora navigators • Healthy homes- enhance • Focus on outcomes (Stories) • One report- audit, financial, service delivery • Viewable (transparent by all parties) • Whai Ora- life course contracting • Identifying need and responding to it and funding it before the baby is born E.g. whānau who will need intensive support • Free Imms, WCTO, in home outreach vacs for those who need it. • Contracting for integration • Passion of the health workforce • Have the right people • More capacity • More value in what we do • Strength based approaches in Māoridom and Pasifika • Flexible service specifications and reporting on equitable outcomes by Māori for Māori

	• Innovation funding • Whānau Ora – reach and funding • Cross agency collaboration • Measuring ACES Respect workforce, no reply on volunteerism
Pasifika Fono Wellington 3 Dec 18	• Culturally appropriate and relevant health promotion (e.g. RF campaigns) • Culturally appropriate workforce development and investment • Pacific workforce development • Enhance the non-pacific workforce to be able to deal with Pacific- cultural competences • Creation of a cultural framework • Share frameworks between agencies and apply them! • Tamariki Ora services (need strengthening) • More Pacific midwives and support that goes with it • More Pacific health staff /workforce

TABLE 2: ACTIVITIES THAT COULD BE STOPPED

Workshop	Activities to stop
Palmerston North 12 Nov 18	• Elective services priority (is there any evidence that this is working?) • Current funding models • Universal model (we need an unequal system) • Disjointed IT systems • Working in isolation • Inflexible tick-box services • Blaming people who DNA (did not attend) • Stop funding mainstream services • B4SC is a deficit model- western world view- shifting children onto medication without using preventative measures • Funding and contracting all sitting with DHB secondary services (excluded people who don't meet criteria) • Review the length of the funding (1 -3yrs). Needs to be for longer. Focus on outcomes Use the education AERO model • Silos • Difficult contractual arrangements • Māori left out of decision making • Taking models from overseas (Māori have their own models) • People who are not in grass roots making all the decisions

	• Only funding DHBs PBFF (population based funding formula) could go directly to Treaty partners • Lens that services use is mainstream not Te Whare Tapa Wha • Not using a cultural model(eg when young Māori go to crisis centre) • Stop interventions which keep cycles of intervention- instead look at determinants • Funding issues which get in the way • Telling people what they need • Presuming health literacy is the same level as one's own. Once size does not fit all • Repetition where people keep being told they're at the wrong service- 'we can't help' • Scale- stop thinking more funding for more services • Declining referrals
Hamilton 15 Nov 18	• Seeing health as illness services • Anything that widens inequity (need prioritisation frameworks) • Funding 'new and shiny' • Inflexible funding contracts • Multiple reporting requirements • Universal services (needs redesign) • Funding services that are ineffective for Māori • 20 different health services (DHBs) that are not working • Stop funding inputs / fund outcomes • Stop medication advertising • Silo culture • Counting wrong things with patients • Rigid measurements • Change funding model to accommodate holistic approaches
Dunedin 21 Nov 18	• Inflexible funding models • Working in isolation • Inflexibility of services • Underfunding child and youth services • The difficult process of receiving care for children with higher needs • 'Every door is the right door' • Doctor-centric healthcare • Doing things that we know don't work • Introducing programmes without a mechanism to measure impact – monitoring, evaluation and continuous improvement • Making respite care difficult

	• B4SC -> obesity / caries • Negative framing • Measuring deficits • Short term commissioning decisions • Hearing there is no money • Don't just screen – do something • Uplifting children • Reinventing the wheel • Multiple screening • Asking the same questions • Consistent referrals • Consistency in policy/procedures • OT impact on trust of other professionals • Separation • Dependency on others to access health • Speaking on behalf of our youth • Being the ambulance • Lack of clarity in what the individual needs • OT are not trusted • Stop paying GPs for referring smoking services – PSAAP agreement • PROCESS BASED TARGETS • ABC targets • Unconditional bias • Talking about fat children / identifying fat children / shaming • Start focusing on the other end, nutrition, physical exercise • Prosocial rather than deficit measures • Expecting schools to have the capacity or schools without resourcing it • Short TERM / ANNUAL CONTRACTING OF SERVICES • OUTCOMES BASED FRAMEWORK FOR REPORTING • Funding model not isolated – the way funding is targeted, restricting a needs-based approach • Fragmentation • Screening and not taking action about it • Stop measuring activity rather than outcomes • Do away with DHB system • Creates challenges – find balance between consistency and diversity • Different to other agencies' boundaries • Stop worrying about DHBs being in deficit – it's just the reality

	• Funding out of existing baselines • Fragmentation of services – there is a lot of good happening that no one knows about • Creating barriers top oral health in the way we offer services – esp. cost, transport • Giving the power of the whānau to the state • Judging people • Young people feel extra judged • Don't just make assumptions – learn how to not do that • Time constrains – e.g. 15 minute time slots for GPs • Funding constraints • Time constraints • Short-term funding – reduces time to do job and pilots – stifles continuity • Seral risk assessments • Stop 'useless and harmful' interventions across the lifespan and re-invest in children / youth • Stop making decisions for people – let make their own decision – don't be paternalistic • Stop stereotyping especially in a negative way – don't assume • Stop 'useless and harmful' procedures and refocus to child/youth wellbeing – refer to list • Sponsorship that is not health appropriate • Stop fee for service in primary care – all services should be free • Stop overuse of antibiotics • Silos • Avoiding hard issues like family violence, relationship issues – have conversations and support change and healthy relationships • Brief intervention services – time is needed; long-term services i.e. mental health; connectedness • Idea youth get themselves to services – many barriers that don't enable • Force youth to do things results in defiance; spend time to form trust • Stop box ticking reports – numbers • Health targets – lose sight of what we're doing/aim • Advertising alcohol • Junk food sports sponsorship • Smoking – smokefree spaces • Prohibition of substances stops people asking for health • 5 star health rating education on what ratings mean – Food Industry has too much power; Health needs to lead this

Christchurch 23 Nov 18	• Disestablish Children's Teams without losing the principles • Data that doesn't add value, measure what matters not just count processes • Funding based on such broad parameters- make funding proportional (Debbie Wilson Example) • Areas of inequity of outcomes without doing anything to address it • Stop auto referral to the Big House hospital which is not accessible model of service delivery for maternity well women (right when you need it) • Uplift of babies with no skin to skin repeat of the cycle (create memories to enable maintain contact) • Not supporting kids with trauma (e.g. kids in care who go on to have kids) • Stop cluttering contracts with structures that inhibit people delivering the best care • Keep the circle going Combine strategies- treat trauma- wrap around support- prevention- early detections and treatment. • Silos culture • Counting wrong things with patients e.g. 'Handle the Jandle' Rigid measurement • Change funding models to accommodate holistic /whānau Ora approaches • Stop racism and call it.
Whangarei 26 Nov 18	• Generalising names focus on individual needs • Bureaucracy -> barriers • Change of culture to protect and nurture our young people to be leaders and ongoing workforce development • Underfunding and under-supporting FASD • Working in silo's -> lack of awareness of what is available • Advertising services as free when they are only red to "eligible" populations • Need to change with the times • Prescriptive service specifications • Stop funding programmes that are equity neutral or foster inequity • Obstetrician by choice • Underfunding of Māori services • Inequity of pay – pay parity across service and NGO/DHB • Centralising in Whangarei • Underutilising Kaitaia, Dargaville and Bay of Islands hospitals – strengthen them • Commissioning in little silos that don't allow innovation • Centralised contracts that don't have/enable regional focus of action

	• Pilots that don't get evaluated and grown (e.g. perinatal service, ASD co-ordination) • Funding for claw-back • Short-term contracts – no certainty • Replication of services across agencies e.g. MSD/Health/Education • Measuring success in quantities of 'widgets' • Asking for reports/info that not needed/required • Siloed services that do not meet whānau needs (e.g. young mums and pepe) • Institutionalised racism • Stop 'control' behaviour – allow flex and different ways of working
Pasifika Fono Auckland 29 Nov 18	• Stop commercial interests in health (e.g. Fonterra, social media) • Making funding decisions in isolation of the whole context • Stop transplants • Siloing services • Short term contracts • Funding mainstream services that don't work especially at the expense of providers that do provide outcomes e.g. put little funding in building capability of Pacific providers then won't expand vulnerable services 2-4 FTE • The distrust in Māori and Pacific providers • Siloed contracting streams • Political volatility that impacts good programmes and smaller providers (equity) • Stop measuring stuff without outcomes • Deficit models • DHB boundary limitations • Gate keeping that restricts access to services • Eligibility rules • Stop overseas buying GP practices • Working in isolation • Multiple contracts for NGO go to integrated contracts • Putting kids in unhealthy homes • Stop Event based funding and half-hearted funding • Transitioning families • Just focussing on immediate risk • Creating barriers because of age. i.e. moving from service to service and loosing continuity • Separating out mental health- it needs to be whole of health services

	• Having to repeat information when accessing services
Auckland 30 Nov 18	• Silos • Short term contracts • Tenders that don't make sense • Fragmentation • Duplication eg assessments • Restrictive contracts free services for those who can afford them • Being too rigid • Easy access to alcohol • Stop duplication at DHB level with reviews etc. balance with bottom up • Stop mixed messages re sports drinks and marketing of sugary drinks etc. Need tighter regulations too. Lobbying by one sector of community eg care lobby • Stop instant finance company approving loans to families in poverty who can't afford repayments. Regulate rates, practices. • Use of obstetrician when not needed- chewing up resource • Stop looking at aces by locality- take regional view to promote choices • Stop linking health data to IDI without permission- data sovereignty issues for Māori particularly- reduced trust • Siloed approach- artificial distinction between primary and secondary care • Heroic surgical interventions at the end of life (political interference) • Inflexible contracting practices • Marketing junk food to kids • Government silos ie GP WINZ forms- combine • Over prescribing of meds anxiety, antibiotics • Low value spend • Industries that profit off the 'bad stuff' (doing this is good for equity!) • Stop service creep (because it cases burnout and loss of staff
Waiwhetu Marae Wellington 3 Dec 18	• Annual funding cycles • Getting in the middle of contracts that should be left with the DHBs • Stop talking and do something • Stop contracting by FTE by DHB • All the reporting • Being fearful • Short term contracts i.e. one year • Money for outputs. • Them and Us divisions between service providers • People who don't need it getting full services

	• Co-payments in primary care • Fragmenting contracts • Reporting just to report • Universal check-ups for everyone • Targets • Annual Service Plans • Designing services for professionals • Institutional Racism
Pasifika Fono Wellington 3 Dec 18	• Centralised funding

TABLE 3: WHAT CAN WE INNOVATE OR DO DIFFERENTLY?

Workshop	Content to innovate or do differently
Palmerston North 12 Nov 18	• LMC, GP, WCTO one-stop-shop • Locate services in same place • Retain people we really need • Shift to a 'could not attend' and why • Treaty based relationships so not reliant on leadership, more enduring • Closer look at iwi boards in DHBs (partnership or advisory?) • VOTE Whānau instead of VOTE HEALTH • Lighten demands from the centre (e.g. MoH) • Allow for innovation • Change 'I' to 'We' and wellness begins • Bring money to local responses • Pay equity (e.g. tamariki ora vs. plunket) • Primary health model (e.g. whānau GP/nurse) • Professional development (e.g. increase nurse prescribers) • Transitions along the life course • More prevention approaches in schools • Need more moment for rangatahi • Measure DHBs on equity gap • Ministries needs to be working better together • Māori models and services need to be funded and supported. Providers end up doing it without contracts, (making this accountability) • Need a whole paradigm shift (including funding) • To attract funding a prerequisite that we are working with Māori

	• Housing, health, education etc. around the table. • If it works for Māori, it works for anyone • Need Pacific clinical psychologists (workforce issues) • DHBs need to critically review services and not keep funding same things • Maori providers are scrutinised more- reporting etc- Not funded to have specialist services- whānau want to stay with Māori providers • Pacific neighbourhoods services including specialists (CCDHB) • Māori world whānau is more important • 'Kaitiake' model whānau services- ie taking people to appointments going to whare • Amplify return to Māori practice, not just for Māori but everyone. All services should be behind' one door' • Ensure workforce is representative of community • Empower whānau to make educated choice- requires more health promotion/communication/education • BE BRAVE WHEN DESIGNING STRATEGY • Right people doing right thing at the right time
Hamilton 15 Nov 18	• Consider better how we roll-out programmes • Increase school-based services • Change environments to support wellbeing • Conversation regarding investment (we will need a transition period) • Change values of health services • Health in all policies • Fluoridation of water • Get our own policies in order (e.g. employee wellbeing) • Lakes Children's Hub (as an example of innovation) • MoH should fund organisations that deliver to the right population • Hapū wānanga programmes • Healthcare home with marae outreach • Develop/invest in programmes that connect you back to your culture • Consider independence from DHBs • Free healthcare for everybody (free primary care) • Improving transition from pregnancy to primary care • Co-design with rangatahi • Trust and enable young people • One-stop-shops • Education • DHBs to increase investment into kaupapa Māori • Seamless collaboration

	• Systems redesign is needed • Value relationship building • Consolidate provision of services • Nurses and GPs and schools • Feedback informed treatment • The art of hui (whakawhanaungatanga)
Dunedin 21 Nov 18	• Fund starter sessions • WINZ improved: relationship skills, knowledge of entitlements, more communications • Professional to community, rather than high needs to clinics – walk-in clinics • Enhanced training i.e. bringing MIT for example to regions to deliver workforce training – nurses, social workers, trauma abuse • How to allocate resources to children with high ACEs scores, but no diagnosis – emotional stress • Wait lists proportionate to age – eg a 6 months wait at age 2 is like a 10 yr wait for an adult • Integrated IT systems • VIP status for OT children • School readiness • Show good, change the narrative to prosocial approach • Planning at government and NGO level • Consistency in health ed in schools incl. sex ed • Focus on OT and how they work • Should not depend on where we live • How we share information not just what • Improve our language around mental health/illness • Change how we uplift • System that supports care in the community, closer to home • OT must change • GPs/midwives- more connected with providers • Better transfer of information from age to stage to agency • How we 'label' consent needs clarity • Greater emphasis on whole life journey • Must focus on compassion - who we are • Start shaping information between ECE – schools – health care providers – Plunket etc • Having conversations about the why's of what we do

	• Connecting maternity services into other services and the records of expertise that come from that • Social media – different channels 'targeted adds • SUPPORT COMMUNITIES TO SUPPORT PARENTS • FREEE TRAVEL OR BEING SERVICES TO THE PEOPLE. The people who need travel assistance don't know how to get it • USE OF TECHNOLOGY TO GET IT TO PEOPLE MORE • A holistic care rather than health-parenting skills • Extend the age of children services • FREE NURSE SERVICES – particularly for youth (18 – 25) • Increase workforce • Decrease case loads • Community development approach (resilience) • Generalists • Capture good ideas and emergent practice and share them • Child health record • Lactation consultation free • Engagement / trusted relationships • Environments that support health and wellbeing • National database • Collective contract outcomes • Partnerships with shared delegation /vision/values • Better information sharing with Māori providers – there's a technological barrier • Actually engage with young people to know what they need to turn up • Why are we not sharing pilots instead of reinventing the wheel – waste of money • Include oral health in health and wellbeing – esp after age 18 • Whānau data / clinics being done in Dunedin • Funding preconception care – a barrier • Provision of resource ongoing – eg tooth brushes • Look at the environment – it should support people to live well • Services should be welcoming for all – e.g. GPs geared to adults • Lots of free opportunities for sexual health • Cultural context, competency not taught – little focus on Hau Ora Māori • Has to include attitudes, self-reflection • Have better conversations about things like smoking – don't just say stop • Peer support – e.g. for breastfeeding • Hapu Wānanga for everybody

	• Single electronic record • WCTO – integrate with primary care and other community supports • Reproductive health integrated with mental health • Child development services integrate – consistent across the country e.g. age/weight • Better training for difficult conversations with families especially at diagnosis • Increase health promotion – prevention – get in early • Provide services for families when they need them – requires more flexible workforce too • Free dental care for everyone - including orthodontists • Support those caring for children /young people like grandparents and other family members who may not get support from Oranga Tamariki • Spend time getting to know the youth – conversations, inspire – address situation at time (options) strengths based • What will work for you? • Think outside the box eg Pokemone Go • Innovative strategies • Relevant peer/young people support directed by the peer groups – Tuakana Tuira model • Funding – evidence based (strengthen) sustainable for long periods • Report on outcomes – qualitative family achievements • Ask daily living questions include in ways understandable to families than counting eg measuring weight for B4SC • Health education for mental health – absent in schools • Education instead of prohibition • Peer services? Youth do not have the training needed; no solutions • Provide training for peer workers • Matching interests e.g. guitar playing • YOSS – other (20-25 older) trained to support younger youth • Permission to talk to children/youth – include not just talk to parents • Explicit accountability and expectations
Christchurch 23 Nov 18	• Fund differently to enable supervisions/support for workforce • Once stop shops -298 Youth Health Centre and The Loft at Eastgate Mall- both models of no wrong door vs multiple agency/expert support North Canterbury • Could we do one stop shop for pre-schoolers? • Extend Mana Ake to preschool as well as primary schools • More hub and spoke approach

	• More information sharing • More focus on social/emotional development of kids in WCTO • Build ownership by collaboration on developing actions/plans whānau ora approach • Requires a culture of autonomy and trust to: Encourage leadership and autonomy to interpret- shared visions, shared outcomes and autonomy of actions • Concept of asylum for little kids who need safety (haven) (OT and Mental; Health system) • Seamless collaboration • Systems need change redesign • Value relationships building – make time • Consolidate provision • Nurses/GPs in Kura • Feedback informed treatment • The art of Hui (Whakawhanaungatanga)
Whangarei 26 Nov 18	• Focus on entire journey across first 1000 days • Collaboration – true partnership • Unbroken chain of core across first 1000 days • Using community support for families rather than always using experts e.g. breastfeeding buddy • Go to families! Not expecting families going to designated spots • Flexible – meet needs of family • Encourage self-management • TRUST – families know what they need • Young people in not only advisory roles but also in decision-making • Mentoring our young people to be leaders • Spotlight things working well • Grow the wellbeing of the whole whānau -> whānau-centric model -> fit for purpose care • Redesign reporting so that it is meaningful for all (measure different things in different ways) • Youth designed and delivered services • 1 “the raid movt” for youth by youth in response to youth suicide also 2 FUSION – daily course of action inter-government group - police, OT, Iwi, Health, Education, MSD. Two very good initiatives, funded the suicide prevention contract with Iwi. NB Fusion does work in a number of areas across Northland

	• Family violence – integrated response policy led, sharing info but hard to get action. We really need to grow this in Northland – needs resources integrated and enhanced (stop multi-agencies – take one integrated
	• Northland very Whangarei centric at the moment – make those accessible to other areas (Green Bay, Kaipara) many be hub and spoke model
	• Social Wellbeing Governance be reinvigorated please – budget holders making regional decisions (SWAS & Iwi) along with increase discretionary funding
	• Morewa medical services had innovation – Marae based delivery GP clinics – Ngata Hine how doing that in iwi
	• Health clinics in schools
	• Out of hours access – nowhere other than ED after 7pm
	• Funding of services must reflect the need increase Māori children decrease secondary
	• Kaitaia model of working inter-iwi and agencies have built a strong collective – model this in other areas
	• Workforce development increase funding, incentives and pay equity especially for iwi
	• Contracts that allow flex -> support innovation (contract for outcomes)
	• Measure quality not quantity
	• Narratives on 'success' and feedback from MOH (positive reinforcement and actions)
	• Commissioning for outcomes -> providers say what is needed for community, based on a co-design process
	• Support volunteers; create space for good ideas and support and encourage these
	• Require services to demonstrate willingness to collaborate and link with others (not 'close the door' on people) -> smooth referrals/handovers
	• Whānau and whare taputa as concepts that could apply to services
	• Support for grandparents looking after mokopuna
	• Developing workforce to operate in new, holistic service provision
	• Dealing with distance –
	  ○ outreach clinics that bring services together
	  ○ investment in public transport
	  ○ investment in roading and infrastructure,
	  ○ vans required to support services, but government contracts will not support capital investment
	  ○ iwi providers try to provide transport to ensure access to services

	○ DHB provided bus to Auckland for specialist service (but have to live far enough away to qualify – 100 kms)
Pasifika Fono Auckland 29 Nov 18	• Learn from marketing – what are the key hooks • Pastoral care in schools • Co-design services • Measures that work for the community • Capture the stories behind the numbers • Include more health in education • Work out what is actually needed • Use children and health navigators • Salary GPs • Give students part time jobs in canteens to teach healthier nutrition • One stop shop youth hubs • Engaging with Pasifika communities to co-design accessible, acceptable services- what Pasifika want • Prioritising Pasifika youth- community based holistic, one stop services • Fund multigenerational; approaches. • Cultural competencies training (biased/unconscious biased) across the sector • Taking ethnic specific approach • Integrated health MSD etc.) funding model that is whānau based and meets the needs of the family • Shifting resources closer to where the need is • Create new workforces to navigate people to get their needs met • Research and evaluation of services properly resourced. • More scholarships and grants • Education, flexibility, price and innovation • The Ministry of Health funds/contracts with Hospitals and Primary Health care. Question the fee for services model. Does not allow innovation/change. Inability to shift from crisis mode • Investment in continuing innovation • Fees for outcome extra funding for weekend GP services • Using and collaborating with tech e.g. (liquor stores gambling, fast food, smoking programmes) • Targets around socials determinants e.g. (liquor stores gambling, fast food, smoking programmes) • Developing strength based outcomes • Targets quality funding pool for primary care

	• Community forums Combine wellchild, ECE in same department in government • Youth voice • Systems to support community approaches/ideas • Nurse other practitioner CEO services • Models that are flexible/needs based hub model for services. • Flexible DHB boundaries • Funding the whole of system • Outcomes focus methods of changing how programmes continue • Look at eviction services • Community model shared facilities 'foyer model' for transitioning youth into independence • ECE/intergenerational solutions including students living in residential houses • Listen to the kids about transitioning especially at 18 years • Be more consistent in our messaging, language, expectations of child development
Auckland 30 Nov 18	• Procurement approaches • Improve integrated models of care • Be able to adapt services to needs • Less contractual constraints • Implementation support • Transport and access • Virtual consultations different ways of working • Need information system to support handover between LMC and Well Child /Tamariki Ora • Leadership from MOH re type of environment we want children to grow up in • Communities could choose what marketing is allowed in their neighbourhood • Innovate health promotion to reach whānau as been stripped right back • Alcohol regulations review- strengthening • Complete choice rather than access only to presented service • Universal subscription to government service and you determine how/when you get contacted • Standardised assessment across LMC/WCTO service that women can fill in for selves with services there that they can access as needed • Change terminology of Well Child checks eg DNAs 'did not attend' to 'did not require' or 'did not inspire' so unneeded checks are avoided.

	• Primary care model doesn't always incentivise innovation or looking at bigger health determinants- needs to work more closely with specialist care • Reduce barriers to nurses providing primary care • Nurse Practitioners do some of that and refer on • Having same IT platform • Child at centre and services wrap around • Government agencies working collaboratively in schools • Funding come into health and wrap around child (WINZ GP forms) • National electric health records- tick box all across GPs ,dental ,all services (but protecting human rights) • Uber health- control over health, AI, not the same as home visiting (uber user ratings) • PMH services for Dad • Myrvr- police app, could adapt for well child providers etc user rated social services • Public campaigns around early interventions, health and education • Increase tax on sugary drinks • Do Impact assessment across new legislation (child wellbeing) pre and post • Continuous improvement (Use feedback loops that actually drive positive change) • Build constituency against toxic environments (Shit fight to fight them!) • Pay to train the workforce we need (Māori and Pacific)
Waiwhetu Marae Wellington 3 Dec 18	• Using Mātauranga Māori to develop criteria • Covenant in legislation that endures beyond political change • Improve the seamless journey for whanau from conception through first 1000 days and beyond • Single information system • Single referral process and community setting, marae etc. based settings • How do we think about what a 'health' service is and what should be included? • Co design (PDSA) Funded by iwi funding authority • CRU (?CRM?)One system accessible to all (Consent by whānau) • A shared vision and shared kaupapa between WCTO • More Well Health clinics and nurse led • Get through to parents/caregivers on the key things- attachment, breastfeeding engagement with kids

	• How to incentivise workforce to work in hard to staff areas? High deprivation rural. • Fund innovation and leave it up to regions /communities • Build trust and respect- tight loose tight contracting • Hold people accountable for outcomes not outputs • Explain addressing inequity of outcomes # same degree of service- need to be proportionate that means targets may drive perverse incentives. Big budget funding that allows flexibility. Longer planning and contracting outlook plus acknowledge infrastructure (Management workforce training etc.) Commentary on system changes/transformation to achieve strategy we need major infrastructural change to drive the delivery. • MOH needs to be brave and focus on lead with key messages to change at all levels • Positive focus on connection and relationships plus positive rhetoric • Share examples of what's working • Patu in Hawkes Bay health fitness for families getting together over a coat of exercise gear not booze. Tell our stories of success and celebrating! • Health stories in social services positive messages for marketing wellbeing
Pasifika Fono Wellington 3 Dec 18	• Pastoral care in schools and mentoring support services • Pacific wellchild with nurses and community health workers that are appropriately trained • Innovative approaches to attract more pacific people to the heath workforce (e.g. support, champions, scholarships) • Use some NZ Aid money to provide treatment for pacific people in New Zealand (e.g. renal dialysis) • Pacific public-sector leadership • Relevant age appropriate models of care • Child health capacity pacific provider development • Policy capacity • Operational service development and design

TABLE 4: HOW TO ACHIEVE EQUITY?

Workshop	Content needed to achieve equity
Palmerston North 12 Nov 18	• Lack of understanding of Mātauranga Māori • Institutional racism makes it hard to embed Mātauranga Māori in every day practice

	• Te Tiriti: Listen to the people, not tell the people what they're going to get. Being brave about using targeted approaches for Māori design services 'by Māori" for Māori' Flexibility to deliver Māori specific services. • More Kaitiaki model -about respect 'I'll respect you' • Tamariki Ora works great • Barriers to access hindering equity • Key to equity- collaboration, government leadership, be brave, return to kaupapa, systems and practice. • Learn from Te Ku Watawata- Māori led, driven, gets people in the room every week to wananga: importance of relationships. Enabled matauranga Māori; solutions sit within this. By Māori for Māori.
Hamilton 15 Nov 18	• Accessibility • Cultural safety • Values • Measurement of outcomes • Flexible services • Leadership within health • Iwi partnership • Strengthening partnership with hauora • Not just for students in schools, but what about marginalised youth • Apply the wahakura lens to program development • For everything we do ask how does this improve outcomes from Māori children and young people • Evaluation braided river (Māori and western combined) • Teach New Zealand history • Make kaupapa Māori mainstream • Teach Te Reo in our schools • Increase access to services • Give voice to young people • More money and time is needed for the 20% most vulnerable • Establish relationships • Acknowledge the value of Mātauranga Māori
Dunedin 21 Nov 18	• Targeted funding – rural • Enhancing workforces that reflect the community • Taking training (long term) to the regions – modern learning – links to hospitals • Expose teens to multiple career paths – what things mean practically • Universal base income / living wage • It shouldn't be about postcode

	• More time to explore 'who' people are • 'Free' service • How we practice and respond to community need • Wellness not illness model • Youth health workers available • Mentors through life • It's about face time! • It's about relationships • Centrality of the connection • Don't lose our focus on experience • Counselling services and health services availability outside school and working hours • Free Healthcare Primary care – stop using hospitals and emergency services because they are free • Mental health services need to be free of counselling • Free contraception • Free feminine products (Targeted) • Needs based • Opt out versus opt in systems • Parental mental health plans include dependent children • Access to opportunities • Use youth voice to inform decisions • Housing • National database • Listen to parents • The health system is not delivering for Māori • Improve equity of oral health access after age 18 for pregnant women • Understand that hard choices families make to get by – e.g. fiving without food • Level the playing field – remove GST from fruit and veg, workable sugar tax • Community cohesiveness • Listen to children's voices, geographic areas – rural, ethnic voices • More diverse workforce needed • Support those most in need • Health literacy to support families and others • Provide services when family can access them • Stop differences in pay rates between NGOs and government agencies eg social workers (terms and conditions of employment should be the same)

	• Improve people's knowledge of what equity means; DHB top down • Expectation! It's not optional • Equity must be prioritised from the beginning – mandated accountability should be clear • Treaty lens form outset • Contract, initiatives • Ministry should ensure • Reflect in outcomes reports • Annual plans – equity is rushed use tools eg HEAT layer use of tools in annual planning • People need to make equity happen for are not involved in planning – nothing about us, without us! • Policies / strategies – it's about getting the implementation right – how do we know? • Let iwi set the agenda relevant to their needs • Workforce development for child and youth health • Youth involvement in decision making about youth; represent 12-24 years, talk to all ages • Req funders DHBs accountability • Workforce development – Treaty progressive learning
Christchurch 23 Nov 18	• Increase cultural competency in culturally appropriate service response • Educate and support our workforce- value, give feedback reward (access all) and reinforce how what we do makes a difference • Not just educate but put into practice and hold ourselves to account for reducing inequity of outcome • Measure action to address inequity • Neurodevelopmental very disadvantages • Increase access to services (Mobility) • Give voice to young • More money and time for 20% (most vulnerable) • #1 relationships • Acknowledge value mātauranga Māori
Whangarei 26 Nov 18	• Flexible models of contracting – not just aimed at mainstream providers • Increase proportion of representation • Extra time for those that need it e.g. GP visits longer for those with intellectual disability • Awareness increase • Costs for getting service a barrier to most • Increase need for services more responsive to Māori language

	• Assessment / services in primary language of child / whānau – if you are not at the table – you are the menu • Invest in positive outcomes for Māori, not in 'fixing' the negative outcomes • Whoever decides what "HEALTH" is, should talk to Māori • Go back, learn, go forward – me hoki whakamuri kia anga whakamua • Is it time for a commissioning agency for Māori? • Self-governance • Create transformative change for our whānau -> TRUST (art and science, knowledge) • Hear the voices -> have the right people at the table • Take a risk and invest • Focus funding on areas of need e.g. Māori children • Mental health for primary schools • Public Health nurse – secondary keep and extend, need ECE, ? based in Primary schools • Assist services to overcome barriers e.g. inc. funding midwives, better co-ordination • "Take to mountain to the people" • Increase funding to Māori health services (currently 1% of funding in NDHB) • Fund based on ACE index or PBFF -> high % youth population • Ring-fence funding to go to Directorates • Get to the table if to be involved in decisions (e.g. Māori, Pacific, disability) • Take services to the people (accessible) -> overcome barriers – culture, education, dollars, distance
Pasifika Fono Auckland 29 Nov 18	• Increase culturally safe services and workforce • Look at the results of the 100 million lives project – this identified bright spots • Patient owned, empowered services • Health professional as the journey to health/ wellbeing. Know how the health system works, complexity of navigating the health system. Unity and whanau approach- walk together • Appropriate accessible information about the health system in NZ before coming to NZ through ECEs, schools, Sunday schools, clubs, mothers, GPs, family oriented through existing relationships. • Revive HEHA • Need time to build trust, relationship more than one appointment more resources, staff capacity, time too many restrictions currently staff have to rush with engagements.

	• Build connections (loyalty), reciprocating relationships for better engagement • Unpack Pacific narrative- works views, perspectives, what wellbeing means or sickness • Support people to be proactive about health mind set of sickness, poor health, men especially, trusting God. • Investment not an afterthought "is the Dr the best person I should see?" • Transport • Addressing health literacy for individuals/communities so they can make decisions about health and wellbeing • Community worker, not wanting to burden the doctor, institutional racism, lack of empathy, negative environments • Racism: unconscious bias in system Judgements/profiling/labelling/ predetermine outcomes based on who you are. Side-lined, misperceptions. Expect to be 'snapped' • Improve equity of outcomes: uncover and address biases conscious and unconscious • Reprioritise funding for Pasifika to improve outcomes • Improve access to services- community based • Equitable funding to address inequitable outcomes • Reprioritise DHB funding to support engagement with Pasifika communities • Adequate funding for Māori and Pacific providers, unconscious bias within Planners and Funders • Larger organisations are not criticised to the extent of Māori and Pacific providers even when their outcomes are far worse • Skilled workforce not recognised- in particular value on cultural competency • New type of workforce navigators etc. • Leadership across ethnicities specific groups • Targets are: equity, workforce- (right workforce right areas, more services delivered by ethnicity providers to groups (Links to nurse/other practitioners models) • Support for navigation e.g. social workers • More consumer focussed GP services more welcoming- navigators • Population based funding for Māori Pacific • Be welcoming to all • Create time for engaging, listening • Holistic view of health and social wellbeing

	• Listen to the community when allocating funding • Community innovation sustainable funds • Mandatory equity training
Auckland 30 Nov 18	• Stop funding services for people who can afford it/ easily access and fund for those who need it most • Co-design • "Find the child" not leaving children behind • Family Centric • Services are more responsive to needs of individuals and family • Breastfeeding support for complex history • Recognise " time poverty" • Unequal distribution of healthy food options and liquor outlets by suburb- low decile have poorest choices needs tighter regulation • Of outcomes and access • Graduated system needed to give more support to those in need • Independent evaluation to access whether needs are being met- controlled so that services can adapt/evolve • Hospitals see outcomes of inequity- need to measure those inequities in order to redistribute resources to address eg smoking- for Māori the statistics are still very high so need stronger action • Hub and spoke approach and multidisciplinary response with more holistic service primarily in homes and community. • Kaupapa Māori app works for Māori, works for all, and Pacific • Kaupapa Māori app to service delivery and programme development and workforce • Develop existing workforce culturally continuously • Balance engage and inform about being a good Dada. • Being poor+ highest costs (perverse logic) Stop systems that pray on the poor. (eg credit, housing, loan sharks, electricity, consumer goods, etc.) Give communities authority to reject negative influences (Booze, gambling, etc)
Waiwhetu Marae Wellington 3 Dec 18	• RFP criteria how do we decide what the criteria is? • Difference between knowledge, narrative and evidence basis (value both) Fund to recognise both; what is takes to deliver services. • Mātauranga Māori informing evaluation • Access to sufficient resource to life out of poverty • Funds go to provider (not via DHB) • DHB's flawed funding model (for Māori) • Sustainable funding- long term contracts • Provider arm gets the bulk of funding. Needs to go to community/Māori (Community based public health) • DHBs held accountable for outcomes=Equity! • iMoko. Evaluation: McFarlane Braden River. • Single doorway to services to address equity- the door you go through is the gateway to everything • Valuing and supporting parenting • Health workforce that reflects the demographics of the population- specifically Māori and Pacific • Pay equity across the health workforce • Focus on outcomes • Prioritise support for whānau with ACES and fund appropriately e.g. Family Start

	• One source of information /data system- one universal way of reporting • One portal where everyone can input/see including NGO • Increase funding for providers who access the most at risk whānau • Improve connect between home visiting and hospital/Outpatient consults • Replace current Family Group conferences- 'te whānau awhina' original version of family groups conferences Enhance whānau or a reach and lengthen of service
Pasifika Fono Wellington 3 Dec 18	• Services should be culturally responsive and funded accordingly • More job opportunities for Pacific- change HP policies • More Pacific health leaders- mentoring pathways- e.g. Aniva nurses succession planning • Pacific Funding that comes straight to Pacific- more resources to Pacific • Pro-equity strategy MOH DHB Providers • KPI Measure specific to Pacific SMART • Joined up approach CE across relevant government agencies • CE performance monitoring • No more stretch targets based on Pacific outcomes

Next steps

The Ministry of Health is seeking feedback from workshop participants to check that we have captured a fair record of the discussions at the ten workshops. Any feedback is requested by the **18th of January 2019**.

Feedback will be incorporated into a revised version of this workshop summary and sent to participants at the end of January. This summary will be provided to the Ministry of Health's Health Leaders Advisory Group for Child and Youth Wellbeing. Any recommendations from this group will be provided to the Director-General of Health in February.

Appendix 1: Invitation

To a group

Tēnā koutou,

The Department of the Prime Minister and Cabinet (DPMC) would like to engage with leaders in health regarding the development of Aotearoa New Zealand's first Child and Youth Wellbeing Strategy.

In response to this we would like to invite leaders in the health sector including Iwi Māori, Pasifika providers of health, DHBs, PHUs, Primary Care, NGOs, health sector alliances and community partners to provide feedback on the draft Wellbeing Outcomes Framework and 16 proposed areas of focus for the Strategy. We will also be seeking feedback on specific areas of focus for health moving forward, gaining an understanding of what is working well across the regions and your thoughts on what we can do new and differently moving forward. The dates and locations of these hui are as follows:

12 November - Palmerston North (Kaupapa Māori)
15 November - Hamilton
21 November - Dunedin
23 November - Christchurch
26 November - Whangarei
29 November – Auckland (Pacifika Fono)
30 November - Auckland

Registration numbers will be limited. Therefore please can you register to attend one of the hui via this link or you can copy and paste this URL into your browser https://goo.gl/forms/IT8BCm1E36UzcIIi1

Confirmed venue details will follow shortly.

I look forward to discussions with you on the future forward for Child and Youth Wellbeing for Aotearoa. Confirmed venue address details will follow shortly.

To an individual

Tēnā koe,

The Department of the Prime Minister and Cabinet (DPMC) would like to engage with leaders in health regarding the development of Aotearoa New Zealand's first Child and Youth Wellbeing Strategy.

In response to this I would like to invite you to participate in one of seven regional hui that are planned to take place in November to provide feedback on the draft Wellbeing Outcomes Framework and 16 proposed areas of focus for the Strategy. DPMC, DHBs and the Ministry of Health will also be seeking feedback on specific areas of focus for health moving forward, gaining an understanding of what is working well across the regions and your thoughts on what we can do new and differently moving forward.

12 November - Palmerston North (Kaupapa Māori)
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Registration numbers will be limited. Therefore please register to attend one of the hui via this link or you can copy and paste this URL into your browser https://goo.gl/forms/IT8BCm1E36UzcIIi1

Confirmed venue details will follow shortly.

I look forward to discussions with you on the future forward for Child and Youth Wellbeing for Aotearoa.

Appendix 2: Workshop programme

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

MINISTRY OF HEALTH
MANATŪ HAUORA

Developing New Zealand's first Child and Youth Wellbeing Strategy
Health Sector Engagement

Programme Monday 26 November 2018

Venue: Spire Pavilion, 79 Okara Drive, Whangarei

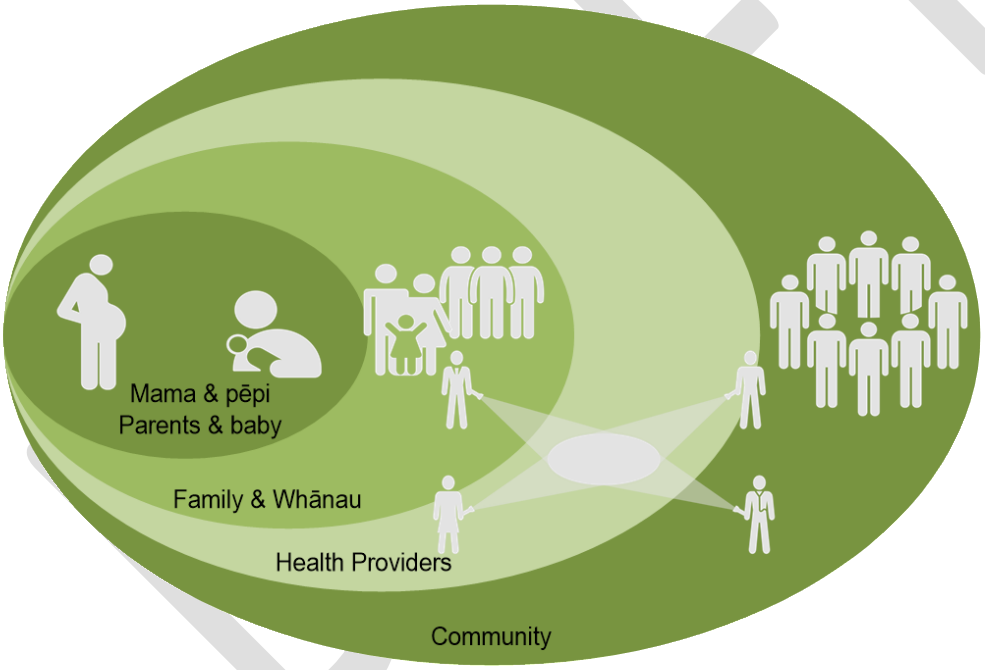
Time	Programme	Led by
8.30am	**Registration opens**	Ministry of Health (MoH)
9.00am	**Mihi Whakatau, welcome and opening** *Followed by morning tea*	Kaumatua
9:30am	**Introductions, purpose of the day** *a) to provide an overview and update on the Child Poverty Reduction Bill & planned Child and Youth Wellbeing Strategy;* *b) to seek input and feedback on the draft wellbeing outcomes framework and 16 proposed areas of focus for the Strategy; and* *c) to seek feedback on how we can achieve child and youth wellbeing across the lifecourse.* **Background, progress and engagement to test our initial thinking** **Health Sector response to child & youth wellbeing** *What is working well? What can we do differently? How can we achieve equity?*	Department of the Prime Minister & Cabinet (DPMC) DPMC DHB
9:45am	**Getting to know one another** *Whole of health system approach*	Facilitator
10:15am	**Where are we today?** *Our lived realities*	Facilitator
10:45am	**Future forward** **Session One: Progress to date** *Update on the Child Poverty Reduction Bill and Child and Youth Wellbeing Strategy work* **Session Two: Breakout groups** *What have we heard so far and building on this* *Seeking the big ideas you think New Zealand needs to make this vision a reality*	DPMC Facilitator
12.15pm	**Karakia followed by lunch and networking**	
1.00pm	**What else is happening?** *A life course approach to child & youth wellbeing* *Other key work programme updates - Maternity, Well Child Tamariki Ora, Mental Health and Addictions*	MoH

Appendix 3: Pre-workshop reading material

Understanding the life course and actions for better life outcomes for New Zealand's children and youth

Children don't exist in a vacuum – we all create the environment in which they live. We know that it takes all of us to support our children to have healthy bodies and brains, to learn and develop, to belong to their culture and community and be valued.

The Department of the Prime Minister and Cabinet would like to hear your views on what needs to happen to enhance the wellbeing of children and young people in New Zealand. Working with a range of other government agencies, the Department has developed a series of domains that describe various aspects of wellbeing (you have this as a separate attachment). This is the starting point for our discussion in the hui – what do you think needs to happen if we are to give our children the best chance of great life outcomes?



As health providers we have the privilege of interacting with all people, literally from life to death. That means that we have a unique opportunity to support children, young people and their whānau. That's why the Department of the Prime Minister and Cabinet is wanting to hear from us about what we think matters.

Appendix 4: Workshop Presentations

For ease of access and use, these have been sent to participants as separate attachments, and will be embedded in the final document.