West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING

17 NOVEMBER 2011

AGENDA
AND
MEETING PAPERS

All information contained in these committee papers is subject to change

AGENDA

FOR THE WEST COAST DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING TO BE HELD IN THE BOARD ROOM, CORPORATE OFFICE, GREY BASE HOSPITAL BETWEEN 9.00 AM AND 10.45 AM ON FRIDAY 17 NOVEMBER 2011

1 Welcome / Introductions / Apologies

2 Agenda

3 Karakia

3 Disclosure of Interest

4 Minutes of the Meeting held Thursday 30 September 2011

5 Matters Arising / Actions and Responsibilities

6 Committee Chairs Report

7 Correspondence

8 Organisational Leadership Report

9 ***General Business:***
Items to be reported back to Board
Need for a patient advocate
Cover with nurses in rural areas
The patient journey

10 Information Papers

11 Workshop on West Coast District Health Board Child Health Plan and Aged Care will take place directly after this meeting. Papers for the Aged Care will be sent separately.

NEXT MEETING – TBA

KARAKIA

E Te Atua i runga rawa kia tau te rangimarie, te aroha, ki a matou i tenei wa Manaaki mai, awhina mai, ki te mahitahi matou, i roto, i te wairua o kotahitanga, mo nga tangata e noho ana, i roto i tenei rohe o Te Tai Poutini mai i Karamea tae noa atu ki Awarua.

That which is above all else let your peace and love descend on us at this time so that we may work together in the spirit of oneness on behalf of the people of the West Coast.

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS' DISCLOSURES OF INTERESTS

Member	Disclosure of Interest
CHAIR Elinor Stratford (Board Member)	• Manager, Disability Resource Service West Coast • Clinical Governance Committee, West Coast Primary Health Organisation • Committee member, Active West Coast • Chairperson, West Coast Sub-branch-Canterbury Neonatal Trust • Deputy Chair of Victim Support, Greymouth • Committee Member, Abbeyfield Greymouth Incorporated • Trustee, Canterbury Neonatal Trust • Board's Representative on Tatau Pounamu
DEPUTY CHAIR Kevin Brown (Board Member)	• Councillor, Grey District Council • Trustee, West Coast Electric Power Trust • Wife is a Pharmacy Assistant at Grey Base Hospital • Member of CCS • Co Patron and Member of West Coast Diabetes • Trustee, West Coast Juvenile Diabetes Association
Barbara Holland	• Co-Convenor - Federation of Women's Health Councils Aotearoa (Consumer advocacy interests) • Member - Public Health Association of New Zealand • Member - Well Women's Centre • Member - National Screening Advisory Committee • Alcohol Action New Zealand
Cheryl Brunton	• Medical Officer of Health for West Coast - employed by Community and Public Health - Canterbury District Health Board • Senior Lecturer in Public Health - Christchurch School of Medicine and Health Sciences (University of Otago) • Member - Public Health Association of New Zealand • Member - Association of Salaried Medical Specialists • Member - West Coast Primary Health Organisation Clinical Governance Committee • Member – National Influenza Strategy Group • Member, Alliance Leadership Team, West Coast Better Sooner More Convenient Implementation
John Ayling	• Chair of West Coast Primary Health Organisation • Chair of Access Home Health, a subsidiary of Rural Women New Zealand which has a contract with the West Coast District Health Board • Shareholder/Director in Split Ridge Associates Limited (which provides services to the disability sector). • To be announced
John Vaile (Board Member)	• Director, Vaile Hardware Limited
Lynnette Beirne	• President West Coast Stroke Group Incorporated • Member South Island Regional Stroke Foundation Committee • Partner in Chez Beirne (provider of catering and home stay services for the West Coast District Health Board and West Coast Primary Health

Member	Disclosure of Interest
	Organisation) • Contract for the Café and Catering at Tai Pountini
Marie Mahuika-Forsyth	• Seconded to Community and Public Health • Promoter for Healthy Eating Healthy Action (20 hours per week) • Executive Member of Makaawhio • Member of Tatau Pounamu • Part-time employee of Supporting families – Non Government Organisation
Mary Molloy (Board Member)	• Director - Molloy Farms South Westland Ltd • Trustee - L.B. & M.E Molloy Family Trust • Trustee - West Coast Community Trust • Spokes woman - Farmers Against Ten Eighty • Executive member - Wildlands Biodiversity Management Group Incorporated • Deputy Chair of West Coast Community Trust
Patricia Nolan	• Member - Brain Injury Association • Member - Hokitika CCS Disability Action
Robyn Moore	• Family member is the Clinical Nurse Manager of Accident and Emergency

DRAFT MINUTES OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 30 SEPTEMBER 2011 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH, COMMENCING AT 9.00 AM

PRESENT	Elinor Stratford, Chair Kevin Brown, Deputy Chair Peter Ballantyne, (ex officio) Barbara Holland John Ayling John Vaile Lynette Beirne Marie Mahuika-Forsyth Mary Molloy Patricia Nolan Robyn Moore
IN ATTENDANCE	Wayne Turp, General Manager Planning and Funding Dr Paul McCormack, Board's Chair (ex officio) Hecta Williams, General Manager Bryan Jamieson, Community Liaison Officer Yolandé Oelofse (minute secretary) Gary Coghlan, General Manager Maori Health Claire Robertson, HEHA and Smokefree Project Manager
APOLOGIES	Dr Cheryl Brunton Dr Carol Atmore, Chief Medical Advisor Colin Weeks, Chief Financial Manager

1. APOLOGIES, WELCOME & KARAKIA

The Chair welcomed everyone to the Community and Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC) combined meeting and asked a Committee member to lead the Committee in the Karakia.

An apology was received on behalf of Colin Weeks -Chief Financial Manager and Dr Carol Atmore - Chief Medical Advisor.

Moved: Elinor Stratford **Seconded: Kevin Brown**

Motion:
"THAT the apologies be noted"

Carried.

2. STANDING ORDERS

The Chair waived standing orders noting reinstatement if required.

3. DISCLOSURES OF INTEREST

Elinor Stratford	To remove: Executive Committee Member, New Zealand Federation of Disability Information Centres
Barbara Holland	To add: Alcohol Action New Zealand

4. MINUTES OF THE PREVIOUS COMBINED COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 18 AUGUST 2011

Corrections to minutes:
Item 7.4 ii) Second paragraph of 7.4.ii should have read: "Cardiac risk assessments rates have improved. The Committee noted an improvement towards achieving targets ….instead of *"Cardiac disease rates have improved. The Committee noted an improvement in target figures*".

And deleted "*Areas of concern that targets for cardiovascular would not be reached, due to concentration on numbers and not the quality of service."*

And that following the sentence "concern was raised to receptionist triaging patients and whether Patient privacy is (appropriate) maintained "The Senior medical advisor said that staff work according to guidelines and that appropriate care" rather than *"The PHO said that staff work according to guidelines and that appropriate care.".*

and deleted: *"and that appropriate care is a reminder".*

Item 7.4 vi) Is the ALT priority the BSMC business plan or the DHB annual Plan? The Board Chair would like to see less writing and more doing.

HEHA Funding:
In answer to a question on the use of unspent HEHA funds The General Manager Planning and Funding explained that according to the funding agreement with the MoH any under spent funding is to be returned to the Ministry or carried over for utilisation in the following financial year. Under spent funding from 2010/2011 has been carried over to 2011-2012. investment in future HEHA activities.

Moved: John Ayling ***Seconded: Elinor Stratford***

MOTION:
"THAT the Minutes of the Combined Community and Public Health and Disability Support Advisory Committee meeting held 18 August 2011 with amendments as noted be accepted as a true and accurate record"

Carried.

5. MATTERS ARISING

The General Manager Planning and Funding suggested to convene a workshop for the Child and Adolescent Youth plan together with Older Health Care plan along side the Committee, as more time is required to work through the details.

Action: The General Manager Planning and Funding to make the necessary arrangements for Child and Adolescent Youth plan together with Older Health Care plan workshop.

A late apology and introduction of the new HEHA and Smokefree Project Manager, Claire Robertson.

6. CORRESPONDENCE

The Committee noted the Chair's response to the Nelson Marlborough DHB letter regarding the Sign Language Interpreters.

Moved: Lynette Beirne **Seconded: Patricia Nolan**

Motion:
"THAT the Committee receives the Correspondence"

Carried

7. CHAIRS REPORT

The last meeting of the District Health Board took place on the Tauraka Waka a Maui Marae (the landing place of Maui) in Bruce Bay.

The formal Board meeting was preceded by a community meeting to discuss Maori health needs and perspectives. This was a good meeting, and allowed a sharing of issues and ideas between the Board members and the community.

The Board was officially welcomed onto the Marae, the hospitality the Board received was amazing.

Members who were not able to attend the opening of the clinic in Franz Joseph in July took the opportunity to visit the new clinic and hear first hand from the Doctor on call spoke of how things are now working.

A Public meeting was took place in Westport on Monday September 19th to continue the process of community engagement over the future model of health care delivery for the Buller District.

A number of Board members attended the public meeting and reported that the overall reaction was positive towards the ideals and concepts for how future services should be delivered through an Integrated Family Health Centre.

Moved: Elinor Stratford **Seconded: Kevin Brown**

Motion:
"THAT the Committee receives the BSMC Chairs report"

Carried.

8. ORGANISATIONAL LEADERSHIP REPORT

The General Manager Planning and Funding reported that good work over the year in trying to get the right linkages into various services has reached the tipping point and that we are now starting to enjoy a good level of engagement between West Coast and Canterbury Clinicians.

A notable example of this is the liaison on Older Persons health services where the CDHB Consultant Jackie Broadbent has been providing advice on how we might create linkages between specialist staff on the Coast and ('over the hill') Canterbury. We are definitely seeing a positive shift towards true partnership occurring between WCDHB and CDHB in this area.

A question was raised regarding progress on developing effective clinical governance across the system as a whole.

A Committee member wanted to know if the governance framework would be in place by December. The Committee was reassured that this would be the case. The Board Chairman explained that the Board is expecting to see the Clinical Governance report by Dec 2011.

Buller IFHC:
The General Manager Planning and Funding attended the second public engagement meeting in Westport last week. Although the attendance numbers were not as high as the (fist) first meeting there was a very positive response to the presentation by the CEO and a number of Advisory Committee members have since heard positive feedback on the meeting.

The Chair explained the process from here – namely that the Board would be receiving a set of recommendations from the BSMC Alliance leadership team at its meeting on the 14th October. Following this it is expected that there will be a phase of detailed planning around the funding and delivery of services including the identification of capital funding for the construction of a new facility. It is expected that a formal public consultation process will occur with the Buller community as part of this detailed planning phase.

A Committee member commended the way in which the CE of WCDHB ran the meeting.

IFHC in Greymouth:
The development process for an Integrated Family Health Centre for the Grey District is now underway. This will follow some similar processes to the development of an IFHC in Westport but with a key point of difference being around the need to ensure effective linkages between (West Coast Regional Hospital services based in Greymouth) and the IFHC. There will be a similar process with public engagement and input into the design for future health service delivery over the next 20 to 30 years. We plan to run a similar process of engagement though the Kaizen Institute with Clinical Leaders (medicals, nursing and allied health professional) within hospital and community services. We will also be engaging with the community to achieve early input into the process. This process will commence in November.

The Committee was reminded that in 2010 the Mayor Tony Kokshoorn had initiated a joint working process to look at establishing a community trust to assist in the recruitment of GPs. There was a question on the status of the Health Trust that the Mayor Tony Kokshoorn had set up and whether this group is still operating.

To check the status of the Health Trust established by Mayor Tony Kokshoorn last year.

Finance:
An apology was received from the Chief Financial Manager for not attending this meeting.

The General Manager Planning and Funding spoke to the report on behalf of the Chief Financial Manager. Explaining that overall there was a positive variance for the period ending August 2011 showing expenditure for the year to date to be $249,000 below budget. The General Manager Planning and Funding cautioned the Committee not to read too much into such variances at this stage in the year. The Committee also expressed its interest in being reassured that any under spend in particular areas service delivery is not at the cost of good patient care and meeting of their health needs.

Whole of System Report.
The Committee noted the following highlights and key issues:

Whooping cough, we are engaging with the public health and strategy is underway, resourcing targets immunisation programme.

Home insulation programme: This will commence in October, the cost to eligible recipients will be covered and up to 500 homes on the Coast will be insulated. The West Coast District Health Board is in partnership and agreement with EECA and the Home Insulation Company. The scheme will be run as a collaboration between District Health Board, Primary Health Organisation and Community and Public Health identifying families who would benefit from and be eligible for this programme.

Action: To look at a ways of monitoring and evaluating the implementation and outcomes achieved by this initiative.

Ministry of Health (MoH) Report on Performance against National Targets:
The Committee received the MoH end of quarter report that is collated on the whole of New Zealand basis by the Ministry of Health. It provides a comparison of DHB performance against key targets across the country.

Moved: John Ayling **Seconded: Barbara Holland**

Motion:
"THAT the Committee receives the Organisational Leadership report"

Carried

9. GENERAL BUSINESS

A Committee member raised a matter regarding the provision of home support services, noting that the NZ Home Health Association had recently published a report on both the issues and opportunities of home support services in New Zealand. It was agreed that copies of the Report would be sourced from the Associations website and made available

to Committee members in order that it be taken into account at the workshop to be held after the next Committee meeting

Action: This report would be part of the workshop to be held in November on HOP.

The Chair asked if age related funding, allows for individual packages. The General Manager Planning and Funding explained that this was possible within the funding for elder care provision.

The Board Chair said useful work is carried out in the model of care, we can pick this up at the workshop and bring it back to the Board.

A Committee member raised a concern over reports that people in Arahura have been experiencing ill health as a consequence of the quality their drinking it. There has been previous investigation into the issue but the Committee was not aware of the outcome of previous investigations. The Committee recommended that this be followed up. The Board Chair said that this will be undertaken by the CE.

Moved: Lynette Beirne **Seconded: Patricia Nolan**

Motion:
"THAT the Committee receives the General Business Report"

Carried.

10. INFORMATION PAPERS

The Chair requested that the Committee work plan be placed at the front section of the Committee papers in future. In front of the Leadership Reports

11. OTHER BUSINESS

The Chair asked the Committee if there were any items discussed to be referred to the Board

Items to refer to the Board:

1. Kevin Brown wanted the CE of WCDHB to know that his presentation at the Westport Public meeting was well received.

Communication

The Committee commented on how communication has improved on the Coast over recent months. They feel that there is a perceivable change in culture within the organisation at a leadership level, with more openness and transparency and less defensiveness than in the past around things that have "gone wrong". The Committee wanted to formally acknowledge the improvement in communication processes being lead by Erin Jamieson and that she and the other members of the communication team have done some excellent work in providing the kind of information that the Committee our community needs.

Induction for Advisory Committee members

The Board Chair invited Committee members to attend an induction workshop for Committee members

Action: To schedule a date and time for Induction workshop to take place.

Other business

A Committee member asked for advice on what was appropriate to raise at Committee meetings when it was unclear whether the issue was one of governance or operational matter.

The Board Chair said that Committee members should feel free to raise concerns and questions at this meeting and should the question raised be considered operational then advice on where it would be appropriate to deal with the issue can be provided.

Meeting closed at 10:50am

11.1 NEXT MEETING

The next meeting will be held on Friday, 17 November at 9am in the Boardroom, Corporate Office, Grey Base Hospital, Greymouth.

MATTERS ARISING FROM THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 30 SEPTEMBER 2011 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH, COMMENCING AT 9.00 AM

Item No.	CPHAC and DSAC Meeting Date	Action Item	Action Responsibility	Reporting Status	Agenda Item Ref
1	14 April 2011	Tor Wainwright as the portfolio manager for disabilities will prepare a briefing paper on the West Coast's and the national position with disability services	Tor Wainwright		General Business 7.1
2	14 July 2011	Quality and Risk Report: How do practitioners know that advance directives are in place, to seek further clarity. Early Development of making advance directives is currently been addressed. Item to be referred to the Clinical Governance Committee	Chief Medical Advisor		General Business 7.5 item vi
3	30 September	Child and Adolescent Youth plan together with Older Health Care plan Action: The General Manager Planning and Funding to make the necessary arrangements for this workshop.	General Manager Planning and Funding		Matters Arising
4	30 September	Home Insulation Programme: To look at ways of monitoring and evaluating the implementation and outcomes achieved by this initiative.	General Manager Planning and Funding		Item 8

Report received and recommendation to be considered at the next meeting.

COMMITTEE CHAIRS REPORT

TO: **Members, Community and Public Health Advisory and Disability Support Advisory Committees**

FROM: **Elinor Stratford, Chair**

DATE: **17 November 2011**

MATTERS REFERRED TO BOARD FROM CPHAC/DSAC

Nil

ITEMS OF INTEREST FROM THE BOARD MEETING

- Health of Older Persons Services are being reviewed – type, quality and sustainability
- Digitalised X-Rays to go live in December – will reduce duplication if people referred to Canterbury and will extend across the South Island
- ManageMyHealth to go live at end of November. Publicity will be underway

Author: **Elinor Stratford, Chair, November 2011**

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE CORRESPONDENCE SEPTEMBER 2011

OUTWARD AND INWARDS CORRESPONDENCE

Date	Sender	Addressee	Details	Response Date	Response Details
None					

ORGANISATIONAL LEADERSHIP REPORT

TO: **Members, Community and Public Health Advisory and Disability Support Advisory Committees**

FROM: **WayneTurp, General Manager Planning and Funding**

DATE: **November 2011**

CLINICAL LEADERSHIP OVERVIEW

ACHIEVING EFFECTIVE CLINICAL LEADERSHIP

NURSING:

Collaboration with Canterbury District Health Board (CDHB) continues to benefit the West Coast with the offer of four CDHB funded Nursing Entry to Practice (NETP) positions for the West Coast in 2012. These graduates will be employed by the WCDHB but funding for the positions will be supported by CDHB until such a time as a vacancy within the WCDHB becomes available for these nurses. Chief Executive David Meates and Executive DON for CDHB Mary Gordon have offered, agreed and enabled this for the West Coast, in their support of our ongoing growth of the future nursing workforce. This approach has been in response to our current situation of being at our full FTE for nursing.

The West Coast has a vacancy model for the new graduate programme, which means when we are fully staffed we have a reduced ability to employ new graduate nurses. With our commitment to reducing our deficit, nursing is concentrating on managing FTE and operating within budget. The implications with this and the vacancy model meant we were risk of not being able to maximise our new graduate programme for 2012.

Health Workforce New Zealand allocate 11 NETP positions for the Coast annually, we will be recruiting 6 in total for 2012 with this generous support from Canterbury. With the HWNZ regional approach, unused HWNZ allocated positions will be distributed to our partnering/neighbouring DHB's for utilisation.

The plan going forward is that NETP advertising, recruitment and implementation of the programme will be run in partnership between WCDHB and CDHB. This approach is in line with Health Workforce New Zealand regional workforce planning and the two DHB's desire to work more collaboratively and innovatively to benefit the people of each region in their health care. It will also enable the ongoing development of well rounded nurses who have had exposure to an important rural/urban mix of experience, and contribute to the close partnership between DHB's.

We sincerely thank Chief Executive David Meates and Executive DON for CDHB Mary Gordon for their support and vision.

Medicine:

Ongoing efforts continue to recruit senior doctors, both into hospital and general practice vacancies, in collaboration with the CDHB Recruitment team. Some promising leads are being followed on.

There is current focus on how to improve the structure and processes of the WCDHB owned primary practices to work to a common vision within a business model that is well matched for the tasks required.

Focus is also on developing the appropriate model of care for Grey region's health services in the future. This work is looking at primary, community and hospital level services as a whole, with support from Canterbury. It involves the Better Sooner More Convenient (BSMC) work around a Greymouth Integrated Family Health Centre, but is necessarily broader than the remit of BSMC because of the integration of hospital level services. Part of this is developing a process for community contribution to this discussion.

A recent South Island Chief Medical Officers meeting was useful for further developing the linkages across the South Island health sector.

Another very successful Annual Celebration Day was held by the West Coast Primary Health Organisation (WCPHO) recently, with good levels of engagement from the primary practices across the West Coast. John Ayling was re-elected chair of the PHO at the associated AGM.

ALLIED HEALTH, TECHNICAL & SCIENTIFIC:

Collaboration with Canterbury continues with a number of allied health staff receiving remote clinical supervision from Canterbury clinicians.

Focus on the transition of care between hospital and community clinicians is a core component of the Buller model of care and is being co-led by allied health and nursing. This will include the revamp of systems and processes to support seamless care coordination as part of a patient's journey.

The role of an 'advanced practitioner' for physiotherapy in orthopaedics has been signed off and the development of a position description and recruitment plan is underway. This will improve the wait times for pre and post surgery review.

A review of patient transport assistance provided by Canterbury and the West Coast is underway and led by social work with the aim of providing more consistency and clarity for patients and families who need to travel to Canterbury for care.

Work continues on the implementation of the medication safety actions from the Health Quality and Safety Commission and includes ongoing roll out of the national medication chart; medicines reconciliation and e-pharmacy.

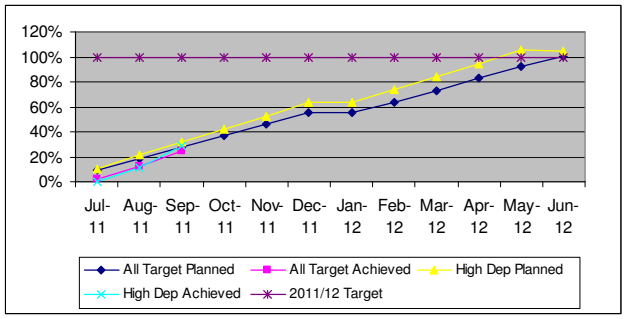
Report of Progress against Annual Plan 2011-12
(progress reported in italics)

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident?*
Strong clinical governance in the planning and delivery of services across the West Coast DHB	Develop an integrated whole of system clinical governance framework for the West Coast. ▪ *Work continues with the establishment of a 'interim clinical board' with representation from across the health system to agree clinical governance; patient safety and quality systems priorities for 2012.*	A documented clinical governance framework for the West Coast Health system will be in place by December 2011. Staff survey results indicate improved participation in decision making; clinical leadership and clinical quality initiatives.
Provision of clinical leadership across nursing, allied health and medical staff	Strengthen senior clinical contribution into the West Coast DHB and Advisory committees. ▪ Strengthen clinical inputs into the planning of future services provision across the West Coast Health system ▪ *Work continues with regular participation from all disciplines in the various workstreams underway for future care delivery for the West Coast*	Regular attendance and reporting from Clinical Leaders group to Board and Advisory Committee meetings. Future health service models of care are developed by the doctors, nurses and allied health professionals who provide the service.
Increased professional development opportunities for clinical staff to increase staff retention	Develop the West Coast as a Rural Learning Centre. ▪ *The South Island Regional Training Hub Progress Report for nursing has been completed with 100% of new graduate nurses and post graduate trainees to complete comprehensive career plans from 2012. Innovative clinical posts/placements have been identified across the region with a focus for the West Coast on Nurse Practitioner development for Primary Care and Aged Care. Regional workforce planning includes strengthening the rural workforce, replacing the ageing workforce, increasing the Maori and Pacific workforce and further development of advanced practice roles such as Clinical Nurse Specialists. Clinical Leadership development is also prioritised across the region. This activity for nursing will be coordinated through the Rural Learning Centre.* ▪ *The Regional priorities have been agreed for Allied Health, Technical and Scientific professions and have been included in the Regional Training Hub progress report – the leadership of remote and rural services will be led by the WCDHB Rural Learning Centre* Facilitate increased opportunities for the professional development of clinical staff. ▪ *The final stages for HWNZ funded Nursing Post Graduate education is currently underway, with last minute applications being processed. A regional approach will*	Rural learning centre meets its work plan. Number of professional development workshops/ sessions provided. Increased staff retention. Workforce plan developed that will outline actions to retain and attract clinical staff and report against these – reduced staff turnover and reduced time to recruit into vacancies.

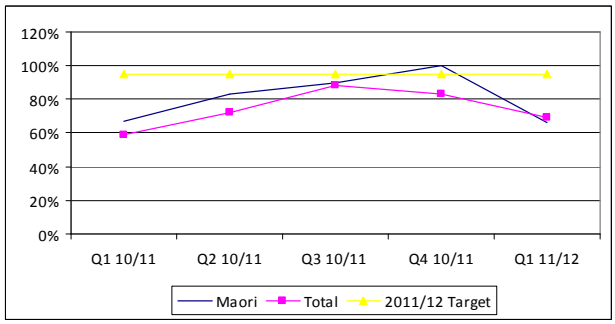
	see the redistribution of under spending in any areas to other DHB's for PG nursing where there is an increase in demand. This will facilitate the regional approach to nursing workforce development. Work with Human Resources and Primary Care recruitment and retention coordinator to focus on activities that enhance recruitment and retention. ▪ *The decision to recruit 6 new graduate nurses has been made and offers have been sent to the successful applicants. This has been enabled by support and collaboration with CDHB*	

Prevention Services

B4 School Check coverage



Percentage of hospitalised smokers given advice and help to quit



ACHIEVEMENTS/ISSUES OF NOTE

B4 School Check: Achieved the target for quarter 1 2011/12 for all target population (25%) and exceeded the target for the high deprivation by 4%.

ABC Implementation: The percentage of hospitalised smokers given advice and help to quit for the first quarter is 69%, 14% less than the previous quarter (see table). The priority for the newly appointed 0.2 FTE Smokefree Service Development Manager and 0.8 FTE Smoking Cessation Coordinator will be to review the current systems in secondary care and ensure the correct systems are in place to support successful implementation and sustainability of the ABC approach. This will include; meeting with management and clinical leaders to ensure leadership and endorsement of ABC, attending team meetings and changeovers and having a visible profile on the wards for feedback from staff as to what works well and what could be improved with the current systems.

	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11	Q1 11/12
Maori	67%	83%	90%	100%	66%
Total	59%	72%	88%	83%	69%
2011/12 Target	95%	95%	95%	95%	95%

West Coast Tobacco Control Plan: The three year West Coast Tobacco Control Plan is currently being signed off by the Healthy West Coast group and is then to be submitted to the Ministry of Health to ensure a whole of system approach is being taken around Smokefree on the West Coast.

Healthy Eating Healthy Action (HEHA)

Schools & ECE Grants: A total of 17 applications were received from West Coast schools and ECEs for the Nutrition & Physical Activity Grants. A total of 16 applications have been approved for projects that support increased physical activity and improved nutrition in West Coast schools and ECEs. A number of these projects build on existing nutrition fund projects and the Tucking In – A West Coast Grow Your Own initiative.

Breastfeeding Pathway: The Breastfeeding Pathway of Care is progressing with focus groups and surveys conducted in the Grey, Buller, Westland and South Westland Districts. The pathway examines the experience of West Coast mothers during their breastfeeding journey from conception through to moving on from breastfeeding. Enablers and constraints within the breastfeeding journey have been identified and discussions around improving systems to eliminate the constraints identified in the report are currently underway.

Warm Up West Coast – Home Insulation Project

The *Warm Up West Coast* project started at the end of October. The project will run as a

collaborative project under the banner of Healthy West Coast, with The Insulation Company, GreenStuf and EECA to insulate 500 West Coast homes for free.
Healthy West Coast has identified key community organisations, medical practices and departments within the DHB who will receive information on the project and application forms to refer clients and patients. The project prioritises households with children under 2 years, someone over 65 years and those with a housing related health problem such as a respiratory illness.
With input from the Ministry of Social Development into the questionnaires, baseline information regarding the participants will be captured once they have been accepted into the project and one year following the home insulation.

Pertussis Outbreak: Pertussis notifications continue to be received, with 268 notifications of suspected Pertussis received between 1st May 2011 and 28 October 2011. Of these notifications 140 are either confirmed or probable cases. Notifications in the Westland District are reducing however notifications in the GreyDistrict are on the rise.

Early Detection and Management

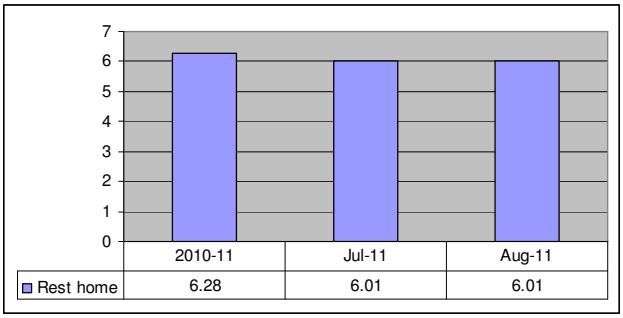
ACHIEVEMENTS/ISSUES OF NOTE

Intensive Assessment and Treatment Services

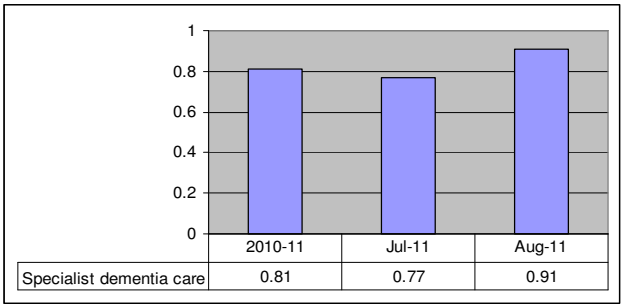
ACHIEVEMENTS/ISSUES OF NOTE

Rehabilitation and Support Services Older Persons' Health

Proportion of people aged 75+ in Rest Home level care



Proportion of people aged 75+ in Specialist Dementia care



ACHIEVEMENTS/ISSUES OF NOTE

Specialist Health of Older People's Services – discussions have been held with stakeholders on the extension of specialist older people services to provide greater support to the primary, community and residential sector through a virtual ward concept, with input from CDHB geriatricians. This was presented to an EMT workshop and a business case is being considered by EMT with the aim of starting a 'demonstration' trial of the virtual ward concept in early 2011.

Restorative homecare model– discussions are being held with home support providers on the move to the regional service specification for restorative home support services and a package-based model of care. WCDHB provider-arm home support service is being reconfigured to be able to meet the requirements of this spec, including clinical input to care plans and reviews as well as effective reporting and monitoring systems.

Community-based Respite care – an agreement has been negotiated with Presbyterian Support to provide a community-based respite care service, using the homes of a number of HomeShare hosts in Greymouth, Westport and Hokitika. This will start in December and provide up to 300 beddays per year of community respite care

Dementia training – approvalis being sought for the establishment of 0.6 FTE dementia trainer position, to provide training to the staff of rest homes, home support agencies, NGOs and other agencies, under the aegis and supervision of the regional dementia programme based out of Canterbury DHB.

Granger House/Richard Seddon Hospital - WCDHB has contracted with an independent nurse consultant to maintain a 12 month surveillance of the facility to ensure quality of care and to follow up the findings of the April and July audits. The service now has a new permanent manager and clinical nurse manager and is operating much more smoothly.

Financials for Year to Date August 2011

Financial Overview for the period ending 30 September 2011

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,697	6,167	530	√	19,219	18,639	580	√
Governance & Administration	208	212	(4)	×	633	637	(4)	×
Funds & Internal Eliminations	4,307	4,284	23	√	12,962	12,852	110	√
	11,212	10,663	549	√	32,814	32,128	686	√
EXPENSES								
Provider								
Personnel	4,417	4,249	(168)	×	12,921	13,033	112	√
Outsourced Services	1,290	954	(336)	×	3,663	3,035	(628)	×
Clinical Supplies	754	594	(160)	×	2,090	1,775	(315)	×
Infrastructure	957	948	(9)	×	2,913	2,813	(100)	×
	7,418	6,745	(673)	×	21,587	20,656	(931)	×
Governance & Administration	173	212	39	√	577	637	60	√
Funds & Internal Eliminations	3,753	3,781	28	√	11,139	11,474	335	√
Total Operating Expenditure	11,344	10,738	(606)	×	33,303	32,766	(537)	√
Deficit before Interest, Depn & Cap Charge	132	75	(57)	×	489	638	149	√
Interest, Depreciation & Capital Charge	519	551	32	√	1,579	1,654	75	√
Net deficit	**651**	**626**	**(25)**	×	**2,068**	**2,292**	**224**	√

ORIGIN OF REPORT

This is a regular report and standing agenda item providing an update on the latest financial results and other relevant financial matters to the committee.

CONSOLIDATED RESULTS

The consolidated result for the month of September 2011 is a deficit of $651k, which is $25k worse than budget ($626k deficit).
The consolidated result for the year to date is a deficit of $2,068k which is $224k better than budget ($2,292k deficit).

RESULTS FOR EACH ARM

Year to Date to September 2011

West Coast District Health Board Arm	Actual	Budget	Variance	Comment
	$000	$000	$000	
Provider Arm surplus / (deficit)	(3,947)	(3,668)	(279)	Unfavourable
Funder Arm surplus / (deficit)	1,823	1,376	447	Favourable
Governance Arm surplus / (deficit)	56	0	56	Favourable
Consolidated result surplus / (deficit)	**(2,068)**	**(2,292)**	**224**	**Favourable**

WEST COAST DISTRICT HEALTH BOARD
FUNDER ARM - PAYMENTS TO EXTERNAL PROVIDERS
as at 30 September 2011

Sep-11 Actual $000	Budget $000	Variance $000	%		SERVICES	Year to Date Actual $000	Budget $000	Variance $000	%		2011/12 Annual Budget $000	2010/11 Actual Result $000	Change (actual 10/11 to budget 11/12) %
					Referred Services								
41	40	-1	-4%	√	Laboratory	108	121	13	10%	√	486	511	5%
678	764	86	11%	√	Pharmaceuticals	2,121	2,291	170	7%	√	8,473	7,705	-10%
719	**804**	**85**	**11%**	√		**2,229**	**2,411**	**182**	**8%**	√	8,959	8,216	-9%
					Secondary Care								
5	20	15	74%	√	Inpatients	10	59	49	83%	√	237	38	-523%
97	82	-15	-18%	√	Travel & Accommodation	304	314	10	3%	√	1,391	1,189	-17%
1,285	1,285	0	0%	√	IDF Payments Personal Health	3,855	3,854	-1	0%	√	15,414	15,606	1%
1,387	**1,387**	**0**	**0%**	√		**4,169**	**4,226**	**57**	**1%**	√	17,042	16,833	-1%
					Primary Care								
41	50	9	18%	√	Dental-school and adolescent	125	141	16	12%	√	467	399	-17%
0	2	2	100%	√	Maternity	0	7	7	100%	√	26	0	
0	1	1	100%	√	Pregnancy & Parent	0	2	2	100%	√	8	0	
0	3	3	100%	√	Sexual Health	0	8	8	100%	√	33	13	-152%
16	0	-16	-3900%	×	General Medical Subsidy	20	1	-19	-1567%	×	5	76	94%
594	523	-71	-14%	√	Primary Practice Capitation	1,636	1,569	-67	-4%	√	6,275	6,135	-2%
7	7	0	-1%	×	Primary Health Care Strategy	20	21	1	3%	√	83	251	67%
77	77	0	0%	√	Rural Bonus	231	232	1	0%	√	928	970	4%
13	13	0	3%	√	Child and Youth	39	40	1	3%	√	162	162	0%
13	7	-6	-86%	×	Immunisation	34	23	-11	-48%	×	96	154	38%
14	14	0	4%	√	Maori Service Development	41	41	-1	-1%	√	162	165	2%
18	31	13	42%	√	Whanua Ora Services	54	94	40	42%	√	373	215	-74%
1	13	12	92%	√	Palliative Care	9	39	30	77%	√	157	110	-43%
0	15	15	100%	√	Chronic Disease	15	46	31	68%	√	286	3	-9440%
11	11	0	2%	√	Minor Expenses	33	34	1	2%	√	134	206	35%
805	**767**	**-38**	**-5%**	√		**2,257**	**2,297**	**40**	**2%**	√	9,195	8,859	-4%

					Mental Health								
0	1	1	100%	√	Eating Disorders	0	3	3	100%	√	12	23	48%
50	50	0	0%	√	Community MH	144	150	6	4%	√	601	538	-12%
1	1	0	0%	√	Mental Health Work force	3	2	-1	0%	√	8	15	44%
48	47	-1	-1%	×	Day Activity & Rehab	143	142	-1	0%	√	569	518	-10%
10	10	0	71%	√	Advocacy Consumer	31	31	0	0%	√	122	120	-2%
5	5	0	-126%	×	Advocacy Family	16	16	0	-139%	×	64	71	10%
0	5	5	100%	√	Minor Expenses	0	15	15	100%	√	61	0	
106	118	12	10%	√	Community Residential Beds	330	353	23	6%	√	1,411	1,261	-12%
66	66	0	0%	√	IDF Payments Mental Health	198	199	1	0%	√	796	813	2%
286	**303**	**17**	**6%**	√		**865**	**911**	**46**	**5%**	√	3,644	3,359	-8%
					Public Health								
7	29	23	79%	×	Nutrition & Physical Activity	132	86	-47	-54%	×	342	328	-4%
0	7	7	100%	×	Public Health Infrastructure	75	21	-54	-262%	×	83	82	-1%
0	0	0		√	Social Environments	0	0	0		√	0	-15	100%
0	6	6	100%	√	Tobacco control	5	17	12	70%	×	68	58	-17%
7	**42**	**35**	**83%**	√		**212**	**123**	**-89**	**-72%**	×	493	453	-9%
					Older Persons Health								
8	0	-8		×	Information and Avisory	8	0	-8		×	0	0	
112	46	-66	-141%	√	Home Based Support	101	151	50	33%	√	595	708	16%
9	10	1	5%	√	Caregiver Support	28	29	1	2%	√	114	130	12%
252	165	-87	-53%	×	Residential Care-Rest Homes	744	513	-231	-45%	×	2,030	2,344	13%
-5	0	5		√	Residential Care Loans	-23	0	23		√	0	-113	100%
4	10	6	61%	√	Residential Care-Community	11	31	20	64%	√	122	48	-155%
298	377	79	21%	√	Residential Care-Hospital	923	1,168	245	21%	√	4,622	3,949	-17%
0	5	5	100%	√	Ageing in place	0	16	16	100%	√	65	12	-440%
7	7	0	1%	√	Environmental Support Mobility	21	21	0	1%	√	85	28	-204%
4	6	2	35%	×	Day programmes	30	19	-11	-61%	×	74	75	1%
19	12	-7	-59%	√	Respite Care	41	36	-5	-15%	√	143	118	-21%
0	0	0		√	Community Health	0	0	0		√	0	0	
108	108	0	0%	√	IDF Payments-DSS	324	325	1	0%	√	1,300	1,060	-23%
816	**746**	**-62**	**-8%**	√		**2,208**	**2,309**	**109**	**5%**	√	9,151	8,359	-9%
4,020	**4,049**	**37**	**1%**	√		**11,940**	**12,277**	**345**	**3%**	√	**48,483**	**46,079**	**-5%**

please note that payments made to WCDHB via Healthpac are excluded from the above figures

please note that payments made to WCDHB via Healthpac are excluded from the above figures

WHOLE OF HEALTH SYSTEM

PLANNING AND FUNDING – FINANCIAL

The District Health Board's result for services funded with external providers (including Inter-District Flows) for the month of September 2011 was an under spend of $37k (1%) and year to date under spend of $345k (3%).

Commentary on year to date variances

Referred Services
Community pharmaceuticals are $170k less than budget. Payments to date include $56k paid to Pharmac towards the Discretionary Pharmaceutical Fund for 2011/12.

Secondary Care
Secondary Care services are $57k better than budget, with travel and accommodation paid under the National Travel Assistance scheme being $10k better than budget.
The expenses shown under Secondary Care are demand driven and the Inter-District Flows (IDFs) reflected for the month are based on the budgeted monthly IDFs and will be adjusted once confirmation of the actual IDFs is received.

Primary Care
Whanau Ora service costs are $40k less than budget, with Maori health services under review. Discretionary costs (chronic conditions and palliative care) are under budget (depends on actual need).

Mental Health
Community residential beds are under budget, with two beds funded on a discretionary basis and the remainder block funded.

Public Health
Expenditure varies throughout the year depending on when grants are dispersed and contracts begin. Included in the payments to date are upfront payments to the West Coast PHO for contracts which will cover the duration of the year. This has resulted in a timing difference between the actual payments and budgeted payments.

Older Persons Health
Overall expenditure (residential and non residential) is under budget to date. These costs are mainly demand driven.

ACHIEVEMENTS/ISSUES OF NOTE

DEMAND-DRIVEN EXPENDITURE

ACHIEVEMENTS/ISSUES OF NOTE

Better, Sooner, More Convenient Progress Report –October 2011

West Coast
Te Tai o Poutini
Primary Health

Contents

SUMMARY- UPDATE

The BSMC deliverables for the 2011/12 year have been taken out of the West Coast DHB Annual Plan and Statement of Intent (APSOI).

Three colour coded sections are included in this report.

1. Year 2 Deliverables are included in the red section. These include both outstanding deliverables from Year 1 as well as the new deliverables as listed in the West Coast District APSOI.
2. Unfinished Year1 Deliverables are listed in the blue section. These include all unfinished deliverables from Year 1 and include those workstreams that were not reported on due to the focus being on Buller IFHC during the second half of Year 1. Work in these areas are expected to continue, but at a slower pace than originally intended.
3. Completed Year 1 Deliverables are listed in the green section.

Although the Deliverables for Year 2 are not taken directly out of the Better Sooner More Convenient Business Case they do align with the Business Case targets.

YEAR TWO DELIVERABLES

Status indicators

Result	Meaning
✓ ✗	Have we completed the activity or reached the target? Yes = ✓ or No = ✗
▭	Positive progress is underway towards delivering the output as planned.

1. IFHC FACILITIES

Owner: Workstream Team Leader – Wayne Champion/A Cooke

Key Result	Date	Status	Current Achievement/Progress
Buller IFHC			
Undertake process mapping exercise completed	Jul/Aug11	✓	Three workshops have been held with Buller, DHB/PHO staff and some external providers. The outcomes of these workshops are currently being reviewed by Sapere.The intention is for a list recommendation for implementation will be completed by end of Aug 11.
Concept plan options for various sites developed	Sept 11	✓	Three workshops with Buller, DHB, PHO staff, external providers and the architects have been held. These workshops have providedvaluable input into the concept plan options for the various sites.
Concept plan options costed	Sept 11	✓	Concept plans have been completed and have been completed.
Engineers Review of Site options completed	Sept 11	✓	Engineers have looked a site flood plains and how existing buildings at both sites stack up against the building codes, with particular relevance to required earthquake strengthening..
Preferred concept recommended by ALT	Sept 11	✓	This was presented to ALT on the 22/9/11. Recommendation is for a single site, but no recommendation was made as to which site. This was due to some aspects of operational cost had not yet been completed.

Business Case for capital submitted to WCDHB	Oct 11		Work has commenced
Detailed Architect plans finalised	Nov 11		Work has commenced
Cost /Value review completed	Jan 12		
Building contracts let	Feb 12		
Construction starts during	Mar 12		

Owner: Workstream Team Leader – Wayne Champion/A Cooke

Key Result	Date	Status	Current Achievement/Progress
Greymouth IFHC			
Community engagement and support for a proposed new Grey IFHC/hospital model of care is achieved	Dec 11		Initial planning meeting has been held in Chch. Plans are for a number of 'to be' workshops facilitated by Kaizen. This will be followed by a community expo similar to what was done for Chch city planners. A draft document of a high level model of care is expected to be completed by the end of Nov 11.
Agreement is obtained for the Grey district whole of system model of care	Dec 11		
Process mapping exercise completed	Mar 12		Work has begun in this area.
Concept plan options developed	May 12		
Concept plan options costed	July 12		

2. GOVERNANCE

Owner: Workstream Team Leader – A Cooke

Key Result	Date	Status	Current Achievement/Progress
Interim organisational form decided	Mar 11		This component of work did not progress during the first half of the 2010/2011 year. This workstream is scheduled to meet in Christchurch on 10/10/11.
Interim approach in place	Jun 11		As above
Ownership, governance and management arrangements for IFHC and services are agreed and applied	Jun 12		

3. CORE GENERAL PRACTICE REDESIGN

Owner:Workstream Team Leader – Dr Carol Atmore

Key Result	Date	Status	Current Achievement/Progress
Review of standing orders use in each practice October 2011.	Oct 11		A meeting has been scheduled for October to start this process
Standing order updated in practices	May 12		Review is being done in the second quarter
Safe practice and clinical consistency across the West Coast Health System is achieved.	Jun 12		
An action plan to address the appropriateness of ED presentations is developed and implemented	Dec 11.		
A reduction in the number of acute primary care presentations (triage 5 patients) in ED during week days to <35	Jun 12.		

95% Patients discharged or transferred from ED within 6 hours.	Jun12		
A safe and sustainable model of care for staffing is developed in the Buller district	Oct 11	✓	This work is in its final stage and has been developed with input from the Buller JAG and Buller staff and external health care providers in the "To Be" workshopswith Sapere and Kaizen NZ..
A safe and sustainable model of care for staffing is developed in the Grey districts	Dec 11	⬚	Initial meeting has taken place late August in Chch.
Phased implementation commenced by in Buller	Nov 11	⬚	This work is in its final stage and has been developed with input from the Buller JAG and Buller staff and external health care providers in the "To Be" Workshops with Sapere and Kaizen NZ
Phased implementation commenced in Grey	Jan 12	⬚	Initial meeting has taken place late August in Christchurch
All seven practices are Cornerstone accredited by (*five a currently accredited*)	Jun 12	⬚	
Maori Health care plans for general practices	Dec 11	⬚	First meeting with Academic Rural General Practice took place on 31 Aug. Meeting with Buller general practice planned.
Kaiawhina positions established in Buller Integrated Family Health Centre	Dec 11	⬚	Position descriptions progressing.
Kaiawhina positions established in Grey Integrated Family Health Centre	Jun 12	⬚	Work in progress
Appointment of a dedicated Maori clinical position at the Buller Integrated Family Health Centres	Dec 11	⬚	Draft job description has been completed. These positions are linked to the Maori Provider with whom a new contract is being negotiated.Discussion occurring re: funding and model of care
Appointment of a dedicated Maori clinical position at the Grey Integrated Family Health Centres	Jun 12	⬚	Draft job description has been completed. These positions are linked to the Maori Provider with whom a new contract is being negotiated. Part time position in place currently running clinic for Maori women one day per week.
Māori enrolment rates as a percentage of the population as a whole.	1/4ly Reports		To be reviewed in the first Quarterly report.
Māori engagement and uptake in the whole range of primary health care initiatives as per PHO	1/4ly Reports		To be reviewed in the first Quarterly report.
Measurable improvement in Māori health status.	1/4ly Reports		To be reviewed in the first Quarterly report.

4. INFORMATION TECHNOLOGY

Owner: Workstream Team Leader – Miles Roper

Key Result	Date	Status	Current Achievement/Progress
Access to ManageMyHealth is provided to relevant ED, pharmacy staff and mental health staff and training provided	Jun 12		It is anticipated that ManageMyHealth access will be available to ED,hospital and community pharmacy, and mental health by end Nov 11. Workshops are being held under the Clinical Governance Committee and work is progressing well. An Implementation and support person has been employed for 6 months (30 hours per week) to help with the implementation.
The mechanisms for enabling community nursing and allied health are analysed by December 2011, with agreement and implementation	May 12		The Clinical Governance Committee will commence with this work following the completion of the roll out to ED and pharmacy. In addition, components of this have also been raised at the Buller "To Be" workshops, which will also be reflected in implementation plans.
MedTech/ManageMyHealth extension across health centres achieved	Mar 12		This is progressing well, with the exception being the private practice in Hokitika. This is due to the use of Apple computers and a reluctance to switch. Efforts are continuing and an interface between MedTech and Profile is being investigated.
West Coast health system agreement as to the fundamental elements of a safe shared record for patient information and implement in line with NHITB direction.			Under progress and covered by PHO Clinical Governance Committee.
Clinical governance and stewardship is established to determine and develop policy for ManageMyHealth content, consent, access and audit aspects of ManageMyHealth by.	Sept11		The PHO Clinical Governance Committee is overseeing this work. Currently, ManageMyHealth content, consent and access has all been completed. The audit component will be worked through in November 11.
Coast lab results are able to be accessed through ManageMyHealth.	Jun 12.		Will be completed as Phase 2 early in 2012.

5. WCDHB COMMUNITY BASED SERVICES

Owner: Workstream Team Leader – Karyn Kelly

Key Result	Date	Status	Current Achievement/Progress
Develop common, integrated service specifications. Consolidate and reduce reporting requirements.	Dec 10		This work is in progress and is being led by Wayne Turp. The new model of care for the IFHC provides an opportunity to review and improve reporting requirements.
Pathway for nurse care for different patient groupings across settings (perhaps start with early discharge of surgical patients).	Jun 11		• The focus of this work over the next few months will be on a Transfer of Care (Discharge Planning) pathway as this will improve patient journey significantly <u>Discharge Boards:</u> • Baseline done • Increased focus on utilisation continues with CNM's promoting • Discharge 'champions' to be identified <u>MDT approach</u> • Clinical areas utilising MDT meetings to facilitate discharge coordination • Planning underway for improved communication between agencies and service providers (such as DHB ward staff and Carelink) to improve patient journey • The 'pathway/process' that needs articulating includes the 'one patient point of entry' for IFHC, The 'To Be' workshops in Buller was a starting point for this work and ongoing development is occurring • 'To Be' workshops are being arranged for Grey alongside the model of care development • The development of a diabetes model of care is underway for the refinement of care delivery, this model is to be 'whole of system' with the patient at the centre.
Integrated model of care for community nursing, allied health and mental health is developed by September (in Buller)	Sept 11		The Buller "To Be" workshops did cover this key result area. However, further work will be required and is likely to be reflected in Sapere's report following these workshops.
Integrated model of care for community nursing, allied health and mental health is phased implementation from January (in Buller)	Jan12		Buller "To Be" workshops did cover this key result area. However, further work will be required and is likely to be reflected in Sapere's report following these workshops. Pending approval from ALT and the Board.

More patients are able to access these services through primary care	Jun 12		• Data is being gathered to measure access to specialty nursing services delivered in the community based setting. • Referral system to nursing, allied and mental health community based services from primary care (GP) requires refining and streamlining, alongside the action of the primary based (GP Practice) clinicians in actually referring to these services. • Data is also to be gathered to ascertain what is not being referred that should be.
Patients experience a seamless and coordinated approach to services that are provided by the integrated family health system as measured by the community satisfaction survey and develop action plans to make additional improvements from.	Aug11		The 2011 survey is going to be amending next year to enable effective assessment of the patient experience of an integrated family health centre
All relevant clinical staff training in use of ManageMyHealth	Jun 12		Roll out of the first phase to ED and pharmacies. Deb McCarthy and Aileen Egan have been contracted to provided support and training for implementation.
Integrated mental health system in Buller commenced in November 2011	Dec 11		• A single mental health referral form is being developed at present. • Primary mental health coordinator and district manager CMH continue to meet weekly to allocate referrals; a practice nurse will also join the meetings. • Details of a layered/stepped care model are being considered. • Mental Health resource kit will be updated and "beating the blues" internet therapy to be commenced via PHO and GP's/practice nurses. There needs to be further consideration about crisis work and what is and is not possible given current resources
The patient pathway for alcohol, drug and other addictions is in place	Jun 12		Yet to commence

6. FRAIL OLDER PEOPLE

Owner: Workstream Team Leader – Robyn McLachlan

Key Result	Date	Status	Current Achievement/Progress
Read only access to InterRAI established	Jun 10	▭	Read only access has been established. Work plan to continue with the roll out has not yet been established.
Plan for moving assessments for short term to Carelink ready for consultation 30 June	Jun 10	✓	Assessments for Short Term Services will not be completed by Carelink as the WCDHB Support Provider 'Coasters' is responsible for this. Carelink will continue to work with Coasters to ensure clients receive a timely service that meets needs.
Restorative package based model in place	Feb 12	▭	Restorative packages of care have been identified from NMDHB and these will be introduced into Carelink prior to the end of 2011. Alongside this it is essential to ensure the home based support providers Access and WCDHB are able work in this model. They will need to up skill their staff to cope with the high and complex packages. Plans are being developed with Jackie Broadbent Geriatrician to develop a community AT&R service which will offer a restorative approach to client care.
Reduced unplanned acute admissions for people aged over 65 by 5% on baseline.	1/4ly report	▭	Baseline data is being collected on this and has not yet been analysed.
Reduction in waiting time for support services and for community allied health services.	1/4ly report	▭	The virtual ward will have Allied Health attached and this will have a community focus so will improve access to Allied Health. The NASC team are experiencing high case loads and this will increase when they are required to move to packages of care which has a strong focus on case management and reviews. A 0.5 NASC position has been granted for Westport and 1 FTE for Greymouth. A report is available to measure the time between referral client assessment which has not been analysed.
Delayed entry to ARC and extension of independent living. Rate of admission to permanent rest home level of care for people aged 75+ at 5.5%	1/4ly report	▭	Recent analysis of the rate of rest home entry shows that it has dropped from 5.8% of people aged 75plus years in 2009-10 to 5.5 % for 2010-11. These rates are now being monitored regularly as part of CareLink systems.

Reduced unplanned acute admissions for people aged over 65 by 5% on baseline.	1/4ly report		
Reduction in waiting time for support services and for community allied health services.	1/4ly report		
Delayed entry to ARC and extension of independent living. Rate of admission to permanent rest home level of care for people aged 75+ at 5.5%	1/4ly report		

7. LEADERSHIP

Owner: Workstream Team Leader – Anthony Cooke & Wayne Turp

Key Result	Date	Status	Current Achievement/Progress
The West Coast health system clinical governance responsibility will include clinical oversight over the implementation of BSMC	Sept 11.		PHO Clinical Governance Committee is overseeing ManageMyHealth implementation. Coast wide clinical governance not yet in place.
West Coast DHB and PHO display effective ownership and stewardship of BSMC through the ALT.	Ongoing		ALT meets monthly and the leadership group comprising DHB and PHO meet weekly.
Plan developed, in consultation and agreement with the PHO, for the use of PHO cash reserves during 2011/12 and beyond			

UNFINISHED YEAR ONE DELIVERABLES

The following Workstream Key Results are outstanding from Year 1 They are not being reported on at present however when work or progress is being made these tables will be updated.

1. ACUTE CARE

Owner: Workstream Team Leader – Dr Carol Atmore

Key Result	Date	Status	Current Achievement/Progress
ED access to MedTech notes (Approve in May ALT and work to commence in May 11)	Dec 10	▭	Expected to be in place in Dec 11

2. WORKFORCE

Owner: Workstream Team Leader – Dr Carol Atmore

Key Result	Date	Status	Current Achievement/Progress
Orientation package for new GPs in place	Dec 10	▭	In place but being revamped by specialist recruitment team in Chch and will include a workforce retention strategy and implementation plan.
Plan to increase Maori workforce developed	Dec 10	▭	Plan drafted and being refined. Maori health deliverables are now being addressed as the funding status has been resolved.
Annual getaway weekend conference held	Apr 11	✓	Scheduled for Aug 11

3. MENTAL HEALTH

Owner: Workstream Team Leader – Bev Barron/ Elaine Neesam

Key Result	Date	Status	Current Achievement/Progress

Community MH nurses allocated to each practice	Jul 10		This model currently exists in Reefton and in South Westland. The expansion of this model to other practices is underway with the first arrangement to be implemented through the Rural Academic Practice in Greymouth.
Enhance patient access self-care information	Sept 10		Completed by providing a range of self-help materials. Free access to the Health Navigator website – teams at PHO and CMH were actively disseminating information about this site is progressing.
Implement annual physical health checks for long term MHS users	Dec 10		This client group is identified by NHI number, and are included in the LTC management funding, to ensure that they could access free yearly checks. Many are already included due to co morbid conditions. Work on identifying additional physical health checks specifically relevant to long term mental health service users, such as metabolic monitoring for individuals on certain medications has also begun.
Set up integrated transfer of care processes	Dec 10		This cannot happen until other systems and new ways of working are in place. Transfer of care, is about reducing need for formal referrals between teams.
Develop Integrated Care Model and establish a pilot site	Dec 10		Buller Health Services has been established as a pilot site, with increased liaison between General Practitioners and Psychiatrists and inclusion of primary practice and ED in crisis care planning. DHB specialist services and the PHO Brief Intervention Counseling Service are also working closer together, undertaking joint assessments, and 'blurring' traditional eligibility boundaries to ensure the patients' needs are meet. Work continues on developing this model of care. Coast wide a system to improve access to Activity and Living skills services (provided by Richmond NZ) has been improved, with those assessed by the PHO Brief Intervention team as potentially benefitting from the service now having access to it.
Extend Kaupapa Maori mental health services to primary settings	Jul 11		A review of the Model of Care provided by Specialist Kaupapa Maori mental health services has begun.

4. LONG TERM CONDITIONS

Owner: Workstream Team Leader – Helen Reriti

Key Result	Date	Status	Current Achievement/Progress
Completion and implementation of discharge planning project	Sept 10	✘	This work is being looked at by the Community Based Services Workstream
Pulmonary rehab programme re-established	Sept 10	▭	N/A Respiratory groups attend Green Prescription

5. HEALTH PATHWAYS

Owner: Workstream Team Leader – Nick Leach

Key Result	Date	Status	Current Achievement/Progress
First referral letter audit completed	Dec 10	-	Further activity on this workstream suspended pending completion of priority workstreams
Eight workshops held	Jul 11	-	Further activity on this workstream suspended pending completion of priority workstreams

6. ACCESS TO DIAGNOSTICS

Owner: Workstream Team Leader – Nick Leach

Key Result	Date	Status	Current Achievement/Progress
Educational session held with primary care	Jul 10	▭	Number educational session held (2)
First general audit complete	Aug 10	-	Further activity on this workstream suspended pending completion of priority workstreams
Review of CT access	Jun 11	-	Number CTs ordered by GPs (150)

7. REFERRED SERVICE

Owner: Workstream Team Leader – Nick Leach

Key Result	Date	Status	Current Achievement/Progress
Investigate the opportunities and benefits of implementing a comprehensive programme of process improvement for referred services	Sept 10	-	Further activity on this workstream suspended pending completion of priority workstreams
Identify the greatest opportunities for cost saving	Sept 10	-	Further activity on this workstream suspended pending completion of priority workstreams
Provision of better guidance on prescribing and test ordering as part of the Health Pathways initiative	Dec 10	-	Further activity on this workstream suspended pending completion of priority workstreams
Provide detailed performance indicators for future use of referred services	Jan 11	-	Further activity on this workstream suspended pending completion of priority workstreams

COMPLETED YEAR ONE DELIVERABLES

1. CORE GENERAL PRACTICE REDESIGN

Owner:Workstream Team Leader – Dr Carol Atmore

Key Result	Date	Status	Current Achievement/Progress
First region wide workshop held	Jun 10	✓	Fourregional facilitated practice workshops have taken place. A further Quality Improvement workshop was held on 31 May 2011.
First workshop in each practice	Aug 10	✓	Completed
Kaiawhina and health navigators aligned to practices	Jul 10	✓	The results of this is that Maori enrollments are up -Percentage Maori enrolled in PHO compared with census (Buller: 95% Gymth: 85% Wstlnd: 95%).

2. ACUTE CARE

Owner: Workstream Team Leader – Dr Carol Atmore

Key Result	Date	Status	Current Achievement/Progress
HML triage systems in place in each practice	Jun 10	✓	Number of triage 5 patients seen in ED (10% Decrease)
Establishment of standing order processes in practices	Apr 10	✓	Numbers of training sessions for standing orders and number participants
Standing orders training commenced	Apr 10	✓	12 day long sessions, 25 nurse participants
Stock take of nurse post graduate qualifications and future needs	Jul 10	✓	Completed
Community education campaign completed	Aug 10	✓	Completed

3. WORKFORCE

Owner: Workstream Team Leader – Dr Carol Atmore

Key Result	Date	Status	Current Achievement/Progress
Workforce steering group established with terms of reference	Jun 10	✓	Completed

4. WCDHB COMMUNITY BASED SERVICES

Owner: Workstream Team Leader – Karyn Kelly

Key Result	Date	Status	Current Achievement/Progress
Initiate pilot of MDT meetings	Jun 10	✓	Full implementation complete in Westport and Reefton. However Westport needs to be resurrected. Development and pilots underway for Greymouth Hokitika works in an integrated way as is, with meetings already occurring
Plan for alignment of community nursing services to practice populations	Dec 10	✓	This is in place in all areas. Community nurses are conscientiously improving the communication links in the interim, but this outcome needs review with regard to a workable documented model

5. MENTAL HEALTH

Owner: Workstream Team Leader – Bev Barron/ Elaine Neesam

Key Result	Date	Status	Current Achievement/Progress
Review age group covered by primary care Youth Counsellor	Aug 10	✓	Completed

Up-skill practice team in management of anxiety/panic/depression	Oct 10	✓	Completed PHO staff did a 'road show' around the practices.

6. IFHC FACILITIES

Owner: Workstream Team Leader – Wayne Champion/A Cooke

Key Result	Date	Status	Current Achievement/Progress
Academic practice on GreyBaseHospital site completed	Sept 10	✓	Completed
Franz Josef joint venture facility with St John completed	Jun 11	✓	Scheduled to open in July 11

7. INFORMATION TECHNOLOGY

Owner: Workstream Team Leader – Miles Roper

Key Result	Date	Status	Current Achievement/Progress

8. GOVERNANCE

Owner: Workstream Team Leader – A Cooke

Key Result	Date	Status	Current Achievement/Progress

9. KEEPING PEOPLE HEALTHY

Owner: Workstream Team Leader – Kim Sinclair

Key Result	Date	Status	Current Achievement/Progress
Joint plans in three priority areas established	Jul 10	✓	Completed

10. LONG TERM CONDITIONS

Owner: Workstream Team Leader – Helen Reriti

Key Result	Date	Status	Current Achievement/Progress
Medication reviews established	Jul 10	✓	Number of patients receiving annual reviews for diabetes, cardiovascular disease and COPD - Diabetes 700, CVD 627, COPD 200 1990 patients (200 Maori) ASH rates: ISDR (aged 45-64yrs) <89
Review of Level 3 complete and changes implemented	Sept 10	✓	Number of patients enrolled in LTC management programme
Develop MDT meetings established in each practice	Sept 10	✓	Number (50) of medication reviews
Reporting capability for Maori health outcomes established	Sept 10	✓	Clinical indicators for diabetes, CVD and COPD with breakdown by ethnicity (See business case for details)
Reporting capability for monitoring self-management capability (Flinders Partners in health Q) established	Sept 10	✓	ASH rates - ASH rates: ISDR (aged 45-64yrs) <89 Due any day

Health navigators in new LTC roles	Jul 10	✓	In place
Evaluation of health navigators working in LTC context	Apr 11	✓	Due end May.

11. HEALTH PATHWAYS

Owner: Workstream Team Leader – Nick Leach

Key Result	Date	Status	Current Achievement/Progress
Adaptation methodology established	Apr 10	✓	Number of areas adapted for West Coast (8)
First two workshops held	May 10	✓	
Web site live for West Coast	May 10	✓	Website hits per month for West Coast (500)
First educational session held	May 10	✓	FSA rates (No increase)

12. ACCESS TO DIAGNOSTICS

Owner: Workstream Team Leader – Nick Leach

Key Result	Date	Status	Current Achievement/Progress
Direct access guidelines approved	Jun 10	✓	

13. REFERRED SERVICE

Owner: Workstream Team Leader – Nick Leach

Key Result	Date	Status	Current Achievement/Progress

14. FRAIL OLDER PEOPLE

Owner: Workstream Team Leader – TorWainwright

Key Result	Date	Status	Current Achievement/Progress
Alignment of Care link assessors to general practices	Aug 10	✓	Completed
If agreed, short term assessments done by Care Link	Jun 10	✓	Carelink has adopted interRAI as the standardised assessment tool.

RECOMMENDATION

That the District Health Board Leadership Report be received

Author: **General Manager Planning and Funding – November 2011**

GENERAL BUSINESS

TO: **Members, Community and Public Health Advisory and Disability Support Advisory Committees**

FROM: **Chair Community and Public Health Advisory and Disability Support Advisory Committees**

DATE: **14 November 2011**

ITEMS TO BE REPORTED BACK TO BOARD

GENERAL BUSINESS

Need for a patient advocate

Cover with nurses in rural areas

The patient journey

Author: **Elinor Stratford, Chair, November 2011**

INFORMATION PAPERS

Community Public Health Advisory Committee and Disability Support Advisory Committee Terms of Appointment

West Coast District Health Board and Advisory Committee Draft Timetable January 2011 to December 2011

Human Resource Report

Workplan

Westport Integrated Family Health Centre Community Engagement Report

West Coast Primary Health Organisation Annual Report (attached as a separate document)

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE TERMS OF APPOINTMENT

Member	**Date of Appointment**	**Length of Term**	**Expiry Date**
Elinor Stratford **Deputy Chair** **(West Coast District Health Board member)**	27 January 2011	1 Year	31 December 2011
Kevin Brown **Chair** **(West Coast District Health Board member)**	27 January 2011	1 Year	31 December 2011
Barbara Holland	Co-opted September 2004 Appointed 4 March 2005 (Re-appointed 1 October 2007 and 30 June 2009	3 Years	30 June 2012
Cheryl Brunton	1 February 2005 (Re-appointed 3 November 2006 and 13 June 2008)	Whilst remaining as the Medical Officer of the Health for the West Coast DHB	
John Ayling	24 March 2011	1 Year	31 December 2011
John Vaile **(West Coast District Health Board member)**	27 January 2011	1 Year	31 December 2011

Member	Date of Appointment	Length of Term	Expiry Date
Lynnette Beirne	24 March 2011	1 Year	31 December 2011
Marie Mahuika-Forsyth	20 April 2009	Until advised by Te Runanga o Makaawhio	
Mary Molloy **(West Coast District Health Board member)**	27 January 2011	1 Year	31 December 2011
Robyn Moore	3 June 2011	3 years	3 June 2014
Patricia Nolan	18 July 2005 (Re-appointed 18 July 2006 and 19 July 2008)	3 Years	18 July 2011

WEST COAST DISTRICT HEALTH BOARD AND ADVISORY COMMITTEE DRAFT TIMETABLE JANUARY 2011 TO DECEMBER 2011

DATE	MEETING	TIME	VENUE
Thursday 27 January 2011	BOARD	10.00 AM	St John lecture rooms
Tuesday 8 February 2011	Tatau Pounamu	10.00 AM	Boardroom, Corporate Office
Thursday 17 February 2011	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 17 February 2011	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 17 February 2011	ARF	1.30 PM	Boardroom, Corporate Office
Thursday 24 March 2011	BOARD	10.00 AM	Westport, Solid Energy Centre
Wednesday 23 March 2011	Tatau Pounamu	10.00 AM	Makaawhio Office, Hokitika
Thursday 14 April 2011	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 14 April 2011	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 14 April 2011	ARF	1.30 PM	Boardroom, Corporate Office
Wednesday 4 May 2011	Tatau Pounamu	10.00 AM	St John lecture rooms
Friday 6 May 2011	BOARD	10.00 AM	St John lecture rooms
Thursday 19 May 2011	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 19 May 2011	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 19 May 2011	ARF	1.30 PM	Boardroom, Corporate Office
Friday 3 June 2011	BOARD	10.00 AM	St John lecture rooms
Wednesday 15 June 2011	Tatau Pounamu	10.00 AM	Westport Motor Hotel, Westport
Thursday 14 July 2011	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 14 July 2011	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 14 July 2011	ARF	1.30 PM	Boardroom, Corporate Office
Friday 29 July 2011	BOARD	8.30 AM	Franz Josef
Thursday 18 August 2011	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 18 August 2011	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 18 August 2011	ARF	1.30 PM	Boardroom, Corporate Office
Thursday 8 & Friday 9 September 2011	Tatau Pounamu	10.00 AM	Te Tauraka Waka a Maui Marae
Thursday 8 September 2011	BOARD WORKSHOP	2.00 PM	Te Tauraka Waka a Maui Marae
Friday 9 September 2011	BOARD	10.00 AM	Te Tauraka Waka a Maui Marae
Friday 30 September 2011	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Friday 30 September 2011	HAC	11.00 AM	Boardroom, Corporate Office
Friday 30 September 2011	ARF	1.30 PM	Boardroom, Corporate Office
Wednesday 19 October 2011	Tatau Pounamu	10.00 AM	Arahura Pa
Friday 14 October 2011	BOARD	10.00 AM	St John lecture rooms
Thursday 17 November 2011	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 17 November 2011	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 17 November 2011	ARF	1.30 PM	Boardroom, Corporate Office
Monday 28 November 2011	Tatau Pounamu	10.00 AM	Boardroom, Corporate Office
Friday 2 December 2011	BOARD	10.00 AM	St John lecture rooms

HUMAN RESOURCES REPORT

TO: **Chair and Members**
Community and Public Health Advisory Committee and Disability Support Advisory Committee

FROM: **Kim Hibbs and Carolyn Findlay, Human Resource Advisors**

DATE: **31 October 2011**

RECRUITMENT / VACANCIES FOR OCTOBER 2011

POSITION	STATUS
Senior Medical Staff	
Anaesthetist	Applicants are being interviewed when they apply – recruitment ongoing.
GP's – Reefton, Buller Medical, Greymouth Medical	Applicants are being interviewed when they apply – recruitment ongoing.
Medical Officer – A & E	Applicants are being interviewed when they apply – recruitment ongoing.
Orthopaedic Surgeon	Offer has been made to a potential applicant
O & G Consultant	Applicants are being interviewed when they apply – recruitment ongoing.
Physician	Applicants are being interviewed when they apply – recruitment ongoing
Psychiatrist	Appointed – Employee to commence in the new year
Nursing Staff	
Public Health Nurse	Employee to commence in December
Enrolled Nurse – Buller	Employee has commenced work
Registered Nurse – Parfitt	Employee to commence early November
Director of Nursing and Midwifery	

POSITION	STATUS
Registered Nurse – Dunsford	Employee has commenced
Registered Nurse – Reefton	Currently Shortlisting
New Graduate Programme	Employee has commenced
CNM Kynnersley	Offers have been made
CNS Cardiac / Respiratory Buller Health	Appointed
Casual Practice Nurse BMC	Appointed
CNS Palliative	Currently Shortlisting
Enrolled Nurse – Kynnersley	Currently Shortlisting
Nurse Practitioner - RAGP	Currently Shortlisting
	Currently Advertising
Mental Health	
Casual RN - Kahurangi	Applicants are being interviewed when they apply – recruitment ongoing.
Casual Psychiatric Assistant Kahaurangi	Currently shortlisting
Diversional Therapist	Currently Shortlisting
Allied Health	
Physiotherapist – Buller	Applicants are being interviewed when they apply – recruitment ongoing.
Physiotherapist – Orthopaedics and Outpatients	Applicants are being interviewed when they apply – recruitment ongoing.
Rotational Pysiotherapist	Currently Shortlisting
Dental Assistant – Greymouth	Interviewing
CAMHS- AOD	Currently Shortlisting
Occupational Therapist – Greymouth	Currently Shortlisting

POSITION	STATUS
Occupational Therapist – Casual	Employee has commenced
Carelink NASC	Currently Interviewing
Enrolled Nurse – HBSW Service	Currently Shortlisting
Physio Assistant - Buller	Currently Shortlisting
Other	
Electrician	Employee has commenced
Lead Receptionist	Employee has commenced
PA to CMA and CFA	Employee has commenced
Casual Driver	Employee has commenced
Quality Coordinator – Hospital Services	Currently Advertising
Quality and Patient Safety Manager	Currently Advertising
Receptionist – RAGP	Currently Shortlisting
Receptionist – GMC	Currently Shortlisting
Management Secretary	Currently Shortlisting
Booking Clerk – Visiting Specialists	Currently Shortlisting
Booking Clerk – Referrals	Currently Shortlisting
Cleaner – Karamea	Interviewing
Business Manager – GMC and RAGP	Currently Advertising
Coordinator – Rural Learning Centre	Currently Advertising
Home Based Support Workers	Applicants are being interviewed when they apply – recruitment ongoing.

Author: Kim Hibbs / Carolyn Findlay – 31st October 2011

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE WORKPLAN

Objective	Responsibility	Due Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
To receive a report on relevant section for CPH/DS Advisory Committee							
1. Disability Support Issues	Portfolio Manager	14 November 2011	Quarterly				
2. Clinical Leadership	Chief Medical Advisor	14 November 2011	Quarterly		√		(Dr Carol Atmore to provide an update on Clinical Governance in the interim)
3. Primary Health Organisation Quarterly Report	Chief Executive Officer West Coast PHO	14 November 2011	Quarterly		√		Anthony Cooke to attend
4. Quality and Risk Management to monitor	Quality and Risk Manager	14 November 2011	Each meeting		√		
5. Human Resources	Human Resource Manger	14 November 2011	Each meeting		√		
6. Financial performance	Chief Financial Officer	14 November 2011	Each meeting		√		
Provide input into							
7. South Island Health Alliance Leadership Team / Regional Clinical Services Plan	Chief Medical Advisor /General Manager Planning and Funding		Quarterly		√		
8. Annual Plan / Statement of Intent	General Manager Planning and Funding	2012	Annually		√		2011/2012 Annual Plan / Statement of Intent approved July 2011. Commencing on 2012/2013
9. Annual Report	Chief Financial Officer / General Manager Planning and Funding	18 November 2011	Annually				The Annual Report has been submitted to the Ministry.
10. Provision of advice to the Board on how to reduce the deficit	Chief Finance Officer		Each meeting		√		
11. Provision of advice to the Board on how to effectively collaborate with other DHBs	Clinical Leaders		Quarterly		√		

To monitor							
12. Better Sooner More Convenient / IFHCs	General Manager Planning and Funding	14 November 2011	Each meeting		√		
13. The Health targets to monitor	General Manager Planning and Funding	20 October 2011	Quarterly		√		
14. Ministry of Health quarterly reports against other aspects of the Annual Plan / Statement of Intent	General Manager Planning and Funding	30 September 2011	Quarterly		√		
15. Mental Health Service Issues	Portfolio Manager		As required				
16. Maori Health Issues	General Manager Maori Health		As required				
17. Child and Youth Health	Portfolio Manager	14 November 2011	As required				Workshop 14 November 2011
18. Access to primary health – GP waiting times	West Coast Primary Health Organisation	18 August 2011	Quarterly		√		Anthony Cooke - PHO
Advisory Committee presentations			Each meeting?				
19. Clinical Leadership	Dr. Carol Atmore	14 April 2011				√	
20. Elder care strategy	Dr. Jackie Broadbent	19 May 2011				√	
21. Pharmacy services	Nick Leach	14 July 2011				√	
22. Laboratory services	Phil Clarke	30 September 2011			√		

WESTPORT INTEGRATED FAMILY HEALTH CENTRE COMMUNITY ENGAGEMENT REPORT

TO: **Members, Community and Public Health Advisory Committee and Disability Support Advisory Committee**

FROM: **Bryan Jamieson, Communication Officer**

DATE: **October 2011**

WESTPORT INTEGRATED FAMILY HEALTH CENTRE COMMUNITY ENGAGEMENT UPDATE REPORT

Following the Board meeting of October 14 2011 the West Coast DHB released the report "*Building a Better Buller Health System:Buller Integrated Family Health Centre Development Plan & Indicative / Strategic Business Case*" together with copies of the written submissions received from the public, staff and unions regarding the proposed Buller Integrated Family Health Centre.

The business case had some sections removed for commercial sensitivity and names were removed from the submitted feedback to protect the privacy of individual respondents.

At the October 14 meeting the DHB Board adopted the following recommendations concerning the Buller Integrated Family Health Centre:

a. **endorse** the Buller IFHC model of care;

b. **approve** changes in information systems, organisation development, and systems and processes required to achieve the new model of care;

c. **agree** that a single site solution is the preferred option for the Buller;

d. **approve in principle** the development of a global budget for Buller health services under a service alliance framework

e. **approve in principle** the aggregation of aged residential care services in Buller under a single provider,

f. **note** that the process for identifying the preferred provider of ARC services will include:

   i. Discussions between the Chair and CE and all the O'Conor Trust trustees

   ii. Consultation with staff and unions as required

g. **note** the facility redevelopment options and the financial implications set out in the business case

h. **note** that the capital cost estimates are provisional pending detailed design, but that they include contingency allowances;

i. **authorise** management to enter into negotiations with possible facility development partners;

j. **note** that the required processes with the National Capital Committee and Treasury will be put in place ;

k. **note** that management will report back to the December board meeting with an update on a proposed site and proposed greenfields / brownfields solution.

RECOMMENDATION

That the Westport Integrated Family Health Centre Community Engagement Update Report be received.

Author: **Communication Officer - October 2011**

WEST COAST DISTRICT HEALTH BOARD REVIEW OF CHILD HEALTH PLAN WOKSHOP

TO: **Chair and Members**
Community and Public Health Advisory Committee and Disability Support Advisory Committee

FROM: **Shona McLeod, Planning and Funding Analyst**

DATE: **17 November 2011**

EXECUTIVE SUMMARY

In 2005/06 the West Coast DHB undertook an assessment of child health outcomes, health service utilisation and a community consultation process identifying health priorities and service gaps. This resulted in the development of a three year plan to improve Child Health.

The health service utilisation data for the West Coast identified areas of particular concern, where there was poorer health outcomes when compared to national outcomes. Surveys of health, social service and education providers identified key child health issues and with the exception of parenting education and support these priorities were consistent with nationally identified priorities.

The following six objectives to improve Child Health were set;

- Improve Oral Health
- Improve Nutrition
- Improve access to Primary Mental Health services for children
- Improve Immunisation Coverage
- Improve access to Parenting Support & Education Services
- Improve responsiveness to Family Violence, Child Abuse & Neglect

The plan made 18 recommendations to meet these objectives along with 3 more general objectives to improve West Coast children's health.

This review of progress on implementing the Child Health Plan has reviewed both the progress against the 21 recommendations as well as a review of progress on meeting the six objectives.

In general there has been good progress on implementing the recommendations of the Child Health Plan. Eighteen of the recommendations have been fully implemented and a further two have been partially implemented. There is one recommendation that has not been implemented.

Considerable progress on meeting the six objectives has also been made, with improvements in oral health, nutrition, access to primary mental health services for children, immunisation coverage and improving responsiveness in Family Violence Child Abuse and Neglect.

However, there are still inequalities evident in the health status of West Coast children in Oral Health, breastfeeding rates …. Considerable work improve oral health and improve responsiveness to Family Violence, Child Abuse & Neglect is still needed.

PURPOSE AND SCOPE

The development of the West Coast Child Health Plan was an important step towards achieving the DHB vision of 'children are the future'. The purpose of this review is to document the progress made on implementing the recommendations of the Child Health Plan, identifying progress on improving the health of West Coast children and measuring progress on reducing inequalities in health outcomes.

PROGRESS ON ACHIEVING CHILD HEALTH OBJECTIVES:

OUTCOMES MEASURES LONG TERM (5-10 YEARS) IMPACT MEASURES MEDIUM TERM (3-5 YRS)

We will know we are succeeding when there is:

IMPROVED ORAL HEALTH

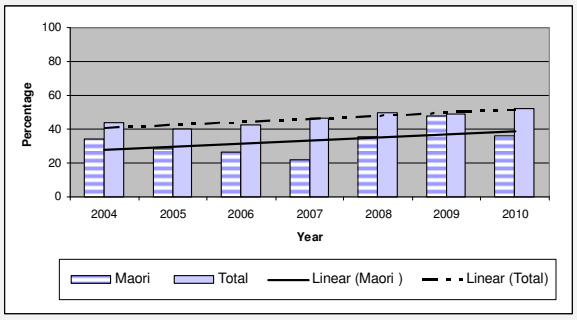
An increase in the proportion of children who have good oral health.

- *There has been an 8% increase in the percentage of 5 year olds seen by the dental service who are dental caries free between 2004 and 2010.*
- *The increase for tamariki Maori 5 year olds over this same time period has been at a slower rate creating an increasing inequality between Maori and the total population.*

	2004	2005	2006	2007	2008	2009	2010
Maori	34.5	28.5	26.4	22.2	35.4	48	36
Other	43.6	43.6	50.1	45.7	53	50	56
Total		40.2	42.4	46.2	50	49	52

Data sourced from WCDHB Dental Service.[1]

Percentage of West Coast 5 year olds dental caries free



IMPROVED NUTRITION

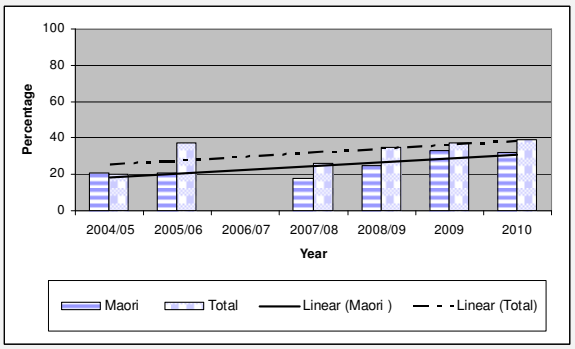
An increase in the proportion children who are breastfeed at 6 months.

- *There has been a 19% increase in the percentage of babies fully breastfeed and at 6 months between 2004/2005 and 2010.*
- *The increase for Maori during this same period of time is 11% creating an inequality between Maori and the total population.*

	2004/05	2005/06	2006/07	2007/08	2008/09	2009	2010
Maori	21	21	-	18	25	33	32
Total	20	37	-	26	35	37	39

Data sourced from Plunket[2]

Percentage of children fully breast feed at 6 months



[1] Oral health data is reported annually for the school year (i.e. calendar year) and is based on the national DHB performance indicator PP11.

[2] During 2009 the Ministry of Health began reporting breastfeeding data by calendar year

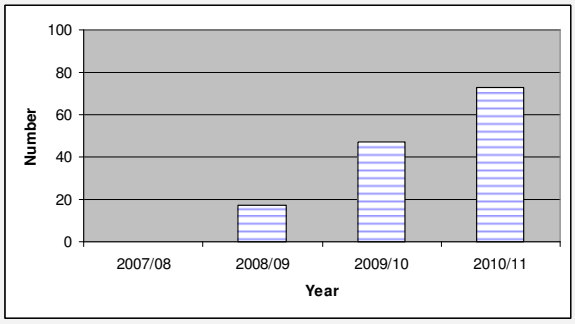
IMPROVED ACCCESS TO PRIMARY MENTAL HEALTH CARE

An increase in access to family and individual counselling services

- *Child and adolescent brief intervention services were established in 2008/09.*
- *Individual services for adolescents 14-17[3] have increased from 17 individuals in 2008/09 to 73 in 2010/11.*
- *Family counselling and individual counselling for parents of children and adolescents with a mental illness is also provided*
- *In 2008/09 infant mental health services were established as part of the Child and Adolescent Mental Health Service.*
- *Early detection and treatment AOD services for child and adolescent are currently being established*

	2008/09	2009/10	2010/11
14-17 Family/Parents	17	47	73

Number of children and adolescent accessing brief intervention counselling



Data sourced from West Coast PHO

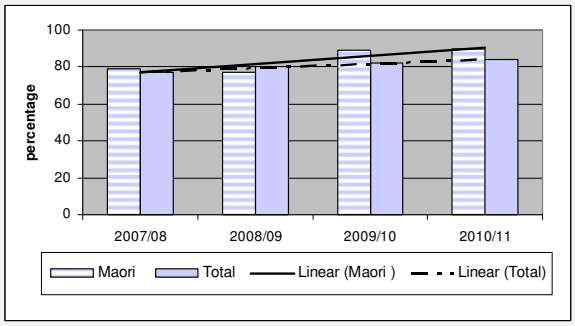
IMPROVED IMMUNISATION RATES

An increase in the proportion of the population fully immunised at age 2 years.

- *Our ability to accurately measure immunisation coverage has improved since the Child Health Plan was written in 2005.*
- *Immunisation coverage has increased by 7% between 2007/08 and 2010/11 for the total population.*
- *Coverage for tamariki Maori has increased by 11% over the same time period.*
- *7.8% of children declined vaccination and 6.1% of children were opted off the NIR*

	2007/08	2008/09	2009/10	2010/11
Maori	79	77	89	90
Total	77	80	82	84

The percentage of children fully immunized at age 2.



Data sourced from National Immunisation Register

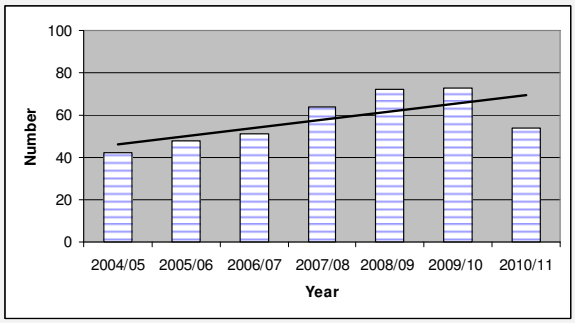
IMPROVED ACCESS TO PARENTING SUPPORT AND EDUCATION

An increase in access to parenting support and education.

- *Access to antenatal Education and Support increased year on year with the number of mothers accessing antenatal education through the WCDHB maternity services increasing from 42 2004/05 to 73 2009/10.*
- *There was a reduction in numbers accessing antenatal education in 2010/11.*
- *Family Start services were established in the Buller and Grey Districts in 2005 and provide intensive support to 94 families with children aged 0-5 each year.*
- *The availability of other parenting support and education services including Triple P, Incredible Years and Nurturing the Future parenting education programs and SKIP and PAFT services continue.*

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11[4]
Total	42	48	51	64	72	73	54

The number of parents accessing DHB maternity services provided antenatal education and support classes.



Data sourced from WCDHB Maternity services

[3] The age range of this service is currently being reviewed.
[4] YTD 1 June 2010 – 31 March 2011

IMPROVED RESPONSIVENESS TO FAMILY VIOLENCE, CHILD ABUSE AND NEGLECT

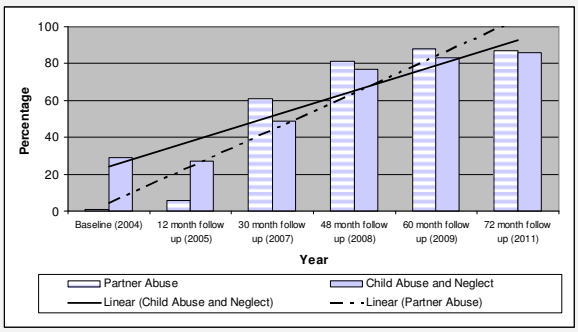
An increase in the audit score for both Partner Abuse and Child Abuse and Neglect

- *The audit score for Partner Abuse has increased from 1% at baseline in 2004 to 87% at the 72 month follow up audit undertaken in2011.*
- *The audit score for Child Abuse and Neglect has increased from 29% at baseline in 2004 to 86% at the 72 month follow up audit undertaken in 2011.*
- *Screening rates for Partner Abuse remain low with 16% of women accessing hospital services routinely screened for family violence in 2010/11.*
- *Child Protection services have been strengthened with a 0.6FTE position established alongside the co-location of a Child Youth and Family Social Worker at Grey Base Hospital.*

	Baseline 2004	2005	2006	2007	2009	2011
Partner Abuse	1	6	61	81	88	87
Child Abuse	29	27	49	77	83	86

Data sourced from WCDHB

Hospital Responsiveness Audit scores for Partner Abuse and Child Abuse and Neglect.



PROGRESS ON ACHIEVING CHILD HEALTH PLAN RECOMMENDATIONS:

		RECOMMENDATIONS	PROGRESS
ORAL HEALTH	1	Provide training and education for practice nurses, pharmacists, well child providers, parents and early childhood educators around oral health, regular brushing, nutrition, and the benefits of fluoride on developing teeth.	**Achieved**
	2	Establish a high fluoride varnish service free to preschoolers ideally Coast wide, otherwise targeting those of highest need, ensuring the service is accessible for tamariki Maori.	**Achieved**
	3	Investigate the possibility of supplying toothbrushes and toothpaste for distribution by Well Child providers at 2 year checks, and for children upon admission to hospital.	**Achieved**
	4	Establish a range of fixed and /or mobile child and adolescent oral health facilities to ensure accessibility for all children living on the West Coast.	**Partially Achieved** Implementation is continuing
NUTRITION	5	Implement the BREAST feeding initiative for Tai Poutini, to increase community support and develop peer support for breast feeding and improve access to Lactation Consultation (with a focus on increasing rates among women living in NZDep 8,9 and 10 areas, young women and Maori women).	**Achieved**
	6	Renew the push on Health Promoting Schools, with a particular focus on decile 1-4 schools, increasing the number of schools achieving, or working towards achieving health promoting schools status.	**Achieved**
	7	Implement Fruit in Schools programme (dependent on securing funding) with a focus on schools with a decile rating of 1-3 or those in NZDep, 9 and 10 areas.	**Achieved**
	8	Expand the implementation of HEHA through the continuation of the school challenge within the Spring into Action programme, with a focus on increasing the number schools and number of children involved in the activity.	**Achieved**
MENTAL HEALTH SERVICES FOR CHILDREN	9	Review the availability of Family and Individual Counselling Services available to children, with a view to increasing availability and accessibility of these services where needed.	**Achieved**
	10	Increase awareness of the support agencies, and telephone support services available to children and their parents.	**Achieved**
IMMUNISATION	11	Implement an Outreach Immunisation Service that targets populations with low coverage (currently Maori children, and children residing in	**Achieved**

		NZDEP 7-8), and includes active recall, community vaccination clinics & home based vaccinations.	
	12	Provide catch up vaccinations in schools and community clinics to 5 year olds who have missed their 4 year old vaccinations,	**Achieved**
	13	Provide catch up vaccinations in schools and community clinics for 11 year old vaccinations.	**Not Achieved** Rates in practices checked and decision made to continue to provide the service in primary care
	14	Implement lunch time training session and vaccination updates for primary care providers.	**Achieved**
PARENTING SUPPORT & EDUCATION SERVICES	15	Support the Implementation of Family Start Services in the Buller and Grey Districts, and establish referral processes to the service upon its implementation.	**Achieved**
	16	Continue to support the development of parent education services in the Buller District.	**Achieved**
FAMILY VIOLENCE CHILD, ABUSE & NEGLECT	17	Implement a hospital response to Family Violence including screening and referral (to police, child youth and family, women's refuge, family start, or other community organisation)	**Achieved**
	18	Actively participate in the development and coordination of strategies to raise awareness of and respond to family violence, child abuse and neglect through the West Coast Te Rito Group.	**Achieved**
GENERAL RECOMENDATIONS	19	Identify key indicators of West Coast Child Health Status and monitor these areas to identify inequalities and improvements in outcomes.	**Achieved**
	20	Establish an intersectoral network, including PHO, NGO and DHB providers to review the provision of child health, and parent education and support services and work to fill identified gaps.	**Partially Achieved** Services have been established to fill gaps including Family Start
	21	Plan for the ongoing input of a generalist paediatrician into clinical care and community liaison on the West Coast.	**Achieved**

RECOMMENDATIONS

That the Review of the Child Health Plan Presentation be received.

Author: **Shona McLeod, Planning and Funding Analyst – November 2011**

CHILDREN'S HOSPITALS AUSTRALASIA

Paediatric Society New Zealand

Charter on

The Rights of Tamariki Children & Rangatahi Young People

in Healthcare Services in Aotearoa New Zealand

Atawhaingia te Pa Harakeke

Nurturing the family

The photo on the cover taken in the Haast Pass (Tiora-patea) includes a Harakeke (flax plant). The flax plant is an image that is used in Māori proverbs to illustrate the importance of tamariki/ children and rangatahi/young people to the overall wellbeing of the family/whānau. The central shoot of the flax plant is likened to a child, one either side of the child are its parents, and beyond them are extended family members – all of whom protect the budding child from the ravages of nature.

Charter of Tamariki/Children's and Rangatahi/Young People's Rights in Healthcare Services in Aotearoa New Zealand

A consensus statement by Children's Hospitals Australasia (CHA) and the Paediatric Society of New Zealand

Foreword

In November 1989, the United Nations Conventions on the Rights of the Child (UNCRC) was opened for signature and in April 1993 it was ratified by New Zealand. Eighteen years on we reflect on how far we have come in relation to Children's Rights and where we need to go to, to fulfil our international obligations under the UNCRC.

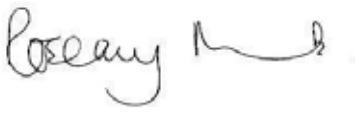
The UNCRC includes articles that offer reference points to enable development of area specific policy in many aspects of health care for children and young people. An International Taskforce on Health Promotion for Children and Adolescents in and by Hospitals and Health Services commenced work in 2004 developing a Self Evaluation Model and Tool on the respect of Children's Rights. Children's Hospitals Australasia (CHA) has utilised this tool in member's health services in Australia and New Zealand. The Self Evaluation Tool identified health services are doing some things very well, but there is room for improvement.

One improvement that was absent in Aotearoa New Zealand was a "Charter of Children's and Young People's Rights in Health Care Services". The development of this Charter is a product of collaboration by members of a CHA Expert Reference Group and writing subcommittee and aligns the rights of children and young people in healthcare services with the UNCRC. We wish to acknowledge the members of the Expert Reference Group: Lauren Andrews, Virginia Binns, Liz Chatham, Anne Cutler, Trish Davidson, Judith Duncan, Lynn Gillam, Elizabeth Harnett, Elizabeth Kepreotes, Bruce Lord, Ros McDougall, Joyce Murphy, Shanti Raman, Stephen Simpson, Paul Watson, Les White and Karen Zwi.

We also acknowledge the excellent work by Judith Duncan, Alison Vogel and Paul Watson in consulting with and drawing together comments from individual and organisational stakeholders across Aotearoa including children, young people, Tangata Whenua and members of the Paediatric Society of New Zealand. We are very appreciative to all those individuals and organisations that so generously provided feedback on earlier drafts of the charter and have contributed to ensuring this charter makes an important statement for children, young people and their families who use health services in Aotearoa New Zealand.

Responsibility for promoting and maintaining the health of children and young people in New Zealand lies with many organisations. Having reached agreement on a uniform charter across New Zealand we have a collective responsibility to promote, implement and monitor its effectiveness. We commend this Charter to all Child Health Professionals and Providers of Child Health Services in New Zealand and ask you to join us in making this commitment to promote, protect and respect the rights of Tamariki/Children and Rangatahi/Young People.

Anne Morgan
CHA Board Member
Service Manager Child Health
Canterbury District Health Board



Rosemary Marks
President Paediatric Society of New Zealand
Developmental Paediatrician
Starship Children's Hospital

Background

Children's Hospitals Australasia (CHA) is the widely regarded not-for-profit peak body for children's hospitals and paediatric units in Australasia. CHA's vision is to enhance the health and well-being of children and young people. CHA achieves this by supporting member hospitals to aspire to excellence in the clinical care of children by benchmarking, and sharing knowledge. Membership includes the leading children's hospitals and health services located throughout New Zealand and Australia.

The Paediatric Society of New Zealand is a multidisciplinary organisation of Child Health Professionals from throughout New Zealand. The Society's objectives include promoting the highest standards of clinical practice in paediatrics and child health and advocating for children on all issues related to their health at a local, regional and national level. The Society is pleased to be an active champion in the development, promotion and implementation of a Charter of Rights, designed to focus on the specific health care requirements of all tamariki/children and rangatahi/young people that is appropriate and acceptable to them and their families/whānau.

Early in 2010, the 21st anniversary of the UN Convention on the Rights of the Child, the CHA Board initiated a project on children's rights in health care services. This Charter of Rights and a children and young person's version of the charter forms part of that project. The project is part of a broader initiative undertaken by the Taskforce on Health Promotion for Children and Adolescents in and by Hospitals and Health Services which is a part of the International Health Promoting Hospitals Network, within the World Health Organisation.

The Charter seeks positive approaches in the practical implementation of rights for children and young people in health care services. The Charter has been developed with input from CHA and the Paediatric Society of New Zealand members and their networks. Consultation has occurred with children and young people, Manawhenua Ki Waitaha[1], government and non-government organisations, including the Commissioner for Children, and the office of the Health and Disability Commissioner.

[1]A collective of health representatives from the seven Papatipu Runanga in the CDHB catchment who have a memorandum of understanding with the CDHB to assist the CDHB in their responsibilities under the New Zealand Public and Disability Act 2000 and the Ngai Tahu Claims Act 1998

Glossary

'Aroha' – Māori term meaning to love, feel pity, feel concern for, feel compassion, empathise, show affection, sympathy, charity, compassion, love and empathy.

'Best interests' – the assessment of what is most beneficial to the child or young person, including consideration of the risks involved and the child's or young person's own values.

'Child or young person' – every human being from birth to the age of eighteen years unless under the law applicable, majority is attained earlier.

'Cultural safety' – is the effective health care of a person or family from another culture, and is determined by that person or family. Culture includes but is not restricted to age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief, and disability (adapted from Nursing Council of New Zealand, 2009).

'Decision-making' – any choice to receive treatment, to refuse treatment, or to withdraw consent to treatment.

'Family' – the group of people who constitute the child's or young person's family is defined by the child or young person and those close to him or her. It is not necessarily limited to blood relatives.

'Hauora' – is a Māori philosophy of health and wellbeing.

'Mana' – Māori word (noun) meaning: prestige, authority, control, power, influence, status, spiritual power. Mana is a supernatural force in a person, place or object. Mana gives a person the authority to lead, organise, and to make decisions regarding social and political matters.

'Parent' – an adult in a primary caring role, including biological parents, adoptive parents, legal guardians, carers and foster parents. Members of the extended family or community may also be involved in the child's or young person's care, depending on the family's circumstances.

'Privacy' – protection of body, space, experience and personal identifying information.

'Rangatahi' – Māori word for young people.

'Taha Hinengaro' – Māori term for mental and emotional well-being including coherent thinking processes, acknowledging and expressing thoughts and feelings and responding constructively.

'Taha Tinana' – Māori term for physical well-being including the physical body, its growth, development, and ability to move, and ways of caring for it.

'Taha Wairua' – Māori term for spiritual well-being including the values and beliefs that determine the way people live, the search for meaning and purpose in life, and personal identity and self-awareness (For some individuals and communities, spiritual well - being is linked to a particular religion; for others, it is not).

'Taha Whānau' – Māori term for social well-being including family relationships, friendships, and other interpersonal relationships; feelings of belonging, compassion, and caring; and social support.

'Tamariki' – Māori word for children

'te Tiriti o Waitangi' – the Treaty of Waitangi

'Tikanga' – refers to customs and tradition, the right way of doing things in Māori culture.

'Whānau' – Whānau is a Māori concept that means more than simply an extended family; "a whānau is a diffuse unit, based on a common whakapapa, descent from a shared ancestor, and within which certain responsibilities and obligations are maintained" (Durie, 1994, p. 1). The term whānau has been broadened in more recent times to extend beyond the descent group. In this context the model of whānau, that is the values and obligations which underlie descent-based whānau, are transported into non-descent based groups; "the term whānau is used to express the group members' commitments to one another and perhaps to a shared purpose" (Ratima et al., 1996, p.7).

'Whangai' – Māori word meaning any person adopted in accordance with Māori custom.

Preamble

There are three reasons why a charter of healthcare rights specific to children and young people is necessary. Firstly, children and young people experience illness, injury and disability differently to adults, making them particularly susceptible to harm. They are entitled to special care and support. Secondly, children and young people are vulnerable because of their developmental immaturity. This vulnerability is compounded by the way in which our society is structured. Children and young people lack political and economic power within society, including within the health system. This powerlessness is not an inherent or inevitable consequence of childhood; rather, it can be a consequence of social structures. Thirdly, children's and young people's level of dependence on the adults around them is constantly evolving along a continuum from dependence to independence. This is a result of the rapid physical, cognitive, developmental, social and experiential changes which characterise childhood and adolescence.

Many people are involved in decision-making for children and young people. Therefore co-operation and respect amongst children, young people, families/whānau and healthcare professionals are particularly crucial in relation to children's and young people's healthcare. Children and young people ought to be involved in decision-making about their healthcare to the greatest possible extent, in line with their capacities for understanding and participation. Healthcare providers have an obligation to fulfil their responsibilities to children and young people by providing care that takes into account children's and young people's rights, their evolving capacities, and the rights and responsibilities of parents and guardians to provide direction and guidance to their children.

The charter is a package of eleven rights. Taken together the rights aim to ensure that children and young people receive healthcare that is appropriate and acceptable to them and to their families/whānau. Children, young people and their families/whānau should be able to exercise choice in healthcare services to the greatest extent possible.

Three general principles underpin the charter. The first is the primary consideration of the child's or young person's best interests. The second is hearing and taking seriously all children and young people. The third is the recognition that the family/whānau is the fundamental group in children's and young people's lives. Family/whānau is usually the environment most conducive to children's and young people's growth and wellbeing and ought to be protected and supported by our healthcare system. All three of these principles should be considered in the interpretation and implementation of all of the other rights.

The charter applies to all children and young people in all healthcare services in which they are treated. It also applies to health promotion and health education activities

aimed at children and young people. Healthcare services include (but are not limited to) hospitals, community health centres, general practices and specialists' rooms. The rights are aspirational to the maximum extent of each organisation's available resources, they are based on the rights as expressed in the United Nations Convention on the Rights of the Child to which New Zealand is a signatory but they may not represent legal rights in New Zealand law. A right not included in this charter must not be taken to be abrogated or limited only because it is not included in this charter or is only partly included. Children, young people, families/whānau and healthcare professionals must be encouraged and supported to speak up whenever these rights are breached.

The references to tamariki and rangatahi in the charter are indicative of the fact that tamariki and rangatahi face significant challenges in exercising their rights and that they continue to experience serious disadvantage in their health status (Ministry of Health, 2009). Tamariki and rangatahi rights in healthcare services are the same as for every child and young person, but specific actions are needed to address disparities in access to care. In all contexts, Tino Rangatiratanga (Māori self-determination) is based on te Tiriti o Waitangi right and is a vital ingredient for their healthcare access and provision.

Some groups of children and young people (such as those in out-of-home care, those with disabilities, those from culturally and linguistically diverse backgrounds, and refugees) will require additional services that address their specific health needs. Particular sensitivity to the backgrounds and abilities of these children and young people will be required in the delivery of these services.

Infants and very young children will also require special consideration and services that meet their specific health and developmental needs. These services include provision of support services and information to their parents or carers.

This charter is based primarily on the United Nations Convention on the Rights of the Child, the New Zealand Code of Health and Disability Services Consumers' Rights, the Australian Charter of Healthcare Rights, and the Charter of the European Association for Children in Hospital.

Tamariki/Children's and Rangatahi/Young People's rights in healthcare services

Every child and young person has a right to:

1. **Consideration of their best interests as the primary concern of all involved in his or her care.**

2. **Express their views, and to be heard and taken seriously.**

3. **The highest attainable standard of healthcare.**

4. **Respect for themselves as a whole person, as well as respect for their family/whānau and the family's/whānau individual characteristics, beliefs, tikanga, culture and contexts.**

5. **Be nurtured by their parents and family/whānau, and to have family/whānau relationships supported by the service in which the child or young person is receiving healthcare.**

6. **Information, in a form that is understandable to them.**

7. **Participate in decision-making and, as appropriate to their capabilities, to make decisions about their care.**

8. **Be kept safe from all forms of harm.**

9. **Have their privacy respected.**

10. **Participate in education, play, creative activities and recreation, even if this is difficult due to their illness or disability.**

11. **Continuity of healthcare, including well-planned care that takes them beyond the paediatric context.**

Explanatory notes

1. Every child and young person has a right to consideration of their best interests as the primary concern of all involved in their care.

In this context 'best interests' refers to the child's or young person's overall wellbeing. Well-being (Hauora) is a holistic concept incorporating four equally important and inseparable elements: physical (Taha Tinana), spiritual (Taha Wairua), family (Taha Whānau) and mental (Taha Hinengaro).

The course of action that is in the child's or young person's best interests is the course of action that produces the greatest benefit to that child or young person, taking into account any risks or costs as well. Benefit is in part determined by what is important to the child or young person himself or herself, and so the child's or young person's own tikanga, values and aspirations must contribute to any assessment of what is in his or her best interests.

The child's or young person's own assessment of what would be in their best interests ought to carry great weight, in line with their capacity. The child's or young person's capacity is situation-specific and will depend on his or her experience in the same or similar situations, rather than on his or her age or intelligence. The capacity of children and young people can be enhanced when they are guided and accompanied by parents and extended family or whānau in a manner consistent with their evolving capacities. Friends or other adults who have a close relationship with the child or young person can also offer valuable support. Children and young people have the right to have a person of their choice with them at all times, unless this places at risk their wellbeing or that of another person. The task of assessing a child's or young person's evolving capacity is specific to the particular situation and is best conducted within an ongoing social group of which the child or young person is a part, such as a family or whānau. This could include seeking input from family/whānau members or having family/whānau members present.

Considering the collective cultural rights of the child or young person is part of determining the child's or young person's best interests. However, the best interests of the group cannot be used to justify neglecting or violating the best interests of the child or young person.

In most cases, parents are well-placed to assess what would be in their child's best interests as they know their child most intimately. Healthcare professionals also provide an important perspective on the child's or young person's best interests. Their expertise and experience with many children and young people enable valuable insights. Consequently any assessment of what is in the child's or young person's best interests should be a collaborative process that respects and involves the child or young person, and takes into account the rights and duties of parents and the healthcare professionals responsible for the child's or young person's care.

The consideration of the best interests of the child or young person is both an individual and a collective right. For all policies and programmes that affect them, children and young people should be consulted and given an opportunity to participate in the process of deciding what is in their best interests. Such consultation should include meaningful participation by all children and young people and their families/whānau.

2. Every child and young person has a right to express their views, and to be heard and taken seriously.

Health service providers have an obligation to respect the child's or young person's right to express their view in all matters affecting them. Health service providers also have an obligation to give due weight to this opinion in accordance with the competence of the child or young person. Children and young people may express their views directly or through a representative. To enable children and young people to participate in decision-making processes, healthcare providers need to create an environment based on trust, the capacity to listen, information-sharing and sound guidance.

Health service providers must be attentive to the many bodily ways in which children and young people express their views. Expression begins at birth and can include cries, gestures, posture, verbal communication, changes in physiological parameters and interactions with others, particularly parents. Children's and young people's views may also be expressed through play, art and other activities. Health service providers should attempt to understand and make sense of children's and young people's communications, rather than assume that they do not make sense.

Some children and young people may need or want help to express their views both verbally and non-verbally. Some children will require communication assistive devices in order to meet their right to be heard. The right to be heard includes the right to a representative who will advocate on the child's or young person's behalf in such cases. The right to be heard also includes the right to culturally appropriate interpretation. Further, the right not to express one's opinion is also part of the right to be heard. The right to be heard and taken seriously also applies at a policy level. Children's and young people's views should be sought when making decisions about healthcare in general and to improve their experience of healthcare. This consultation needs to be appropriate and enabling for children and young people; what works for adults is not necessarily the right approach for engaging children and young people.

Children and young people have the right to be empowered to voice any concerns that they have about their healthcare and to have these dealt with appropriately. A child's or young person's complaint should always be investigated and addressed. Children and young people should be encouraged to speak up about their concerns to family members or staff. In some circumstances, a child or young person may need assistance to do this from an advocate. The advocate might be a parent or an independent person. When a child or young person makes a complaint, he or she (not just their family/whānau) should be informed about the investigation and outcome.

3. Every child and young person has a right to the highest attainable standard of healthcare.

Every child and young person is entitled to high quality, safe and expert care. Children's and young people's health services should take a comprehensive approach to the well-being and development of children and young people, addressing the four inseparable and equally important elements of the physical (Taha Tinana), spiritual (Taha Wairua), family (Taha Whānau) and mental (Taha Hinengaro).

Children and young people should be cared for by health professionals whose professional and continuing education prepares them with knowledge and skills related to children's and young people's health, tikanga, culture, development and learning. The physical environment in which children and young people are cared for should be welcoming for children, young people and their families/whānau. The layout, decoration and art works should facilitate children's, young people's and their families/whānau comfort, safety and feelings of control and be appropriate for Aotearoa New Zealand's bicultural society.

Health services should be accessible to children and young people and provide equality of inputs and outcomes without discrimination on the basis of their ethnicity, race, economic status, religion, gender, age, sexual orientation, disability, illness, appearance, language or culture. As much as possible, healthcare should be provided in the home and community. Health services should be planned and administered in co-operation with the communities concerned. When a child or young person is admitted to hospital, this should be as close to home as possible within the bounds of quality and safety, and consistent with good clinical outcomes. Travelling to access healthcare services can involve significant stress and cost for a family/whānau, but is sometimes necessary for the child or young person to receive the best possible care. Children and young people living in cities, regional areas and remote locations are all equally entitled to high quality healthcare that addresses their needs.

Health service providers have a positive duty to ensure that tamariki and rangatahi have equal access to health services. Tamariki and rangatahi are also entitled to specific services aimed at redressing current health inequalities. Employment of Māori healthcare workers and access to traditional healthcare practices should both be encouraged. Health service providers have a duty to ensure information is available in Te Reo Māori and special consideration should be given to providing information in other languages. Special consideration should be given to ensuring that all healthcare services are both developmentally appropriate and culturally safe (Ramsden, 2002).

All healthcare services should encourage optimal nutrition for infants, children and young people. Breastfeeding should be protected, promoted and supported. Extensive resources that are culturally safe and free of charge should be available to help new mothers initiate, establish and maintain breastfeeding. Breastfeeding mothers and their infants and young children should also be supported to continue breastfeeding while the child is in a healthcare service.

4. Every child and young person has a right to respect for themselves as a whole person, as well as respect for their family/whānau and the family's/whānau individual characteristics, beliefs, culture and contexts.

All children, young people and their families/whānau are entitled to respect for their culture, beliefs, tikanga and to culturally safe care. Discrimination against children or young people and their families/whānau on the basis of ethnicity, race, economic status, religion, gender, age, sexual orientation, disability, illness, appearance, language or culture is unacceptable. Healthcare professionals must be sensitive to the values of different cultural groups, and provide services in ways that respect the dignity and mana of each child or young person and

their family/whānau.

Some groups of children and young people (such as those in out-of-home care, those with disabilities, those from culturally and linguistically diverse backgrounds, and refugees) will require additional services that address their specific health needs. Particular sensitivity to the backgrounds and abilities of these children and young people will be required in the delivery of these services.

5. Every child and young person has a right to be nurtured by their parents and family/whānau, and to have family/whānau relationships supported by the services in which the child or young person is receiving healthcare.

Every child and young person has the right to be cared for by their parents or legal guardians in a manner consistent with the evolving capacities of the child or young person and with regard to their individual circumstances. Members of the extended family/whānau, whangai or community may also be involved in the child's or young person's care, as provided for by local custom or tikanga. Healthcare organisations and healthcare professionals need to support family/whānau and whangai relationships, and respect the responsibilities of parents and guardians to care for and guide their children and young people. This is achieved by actively facilitating participation by families/whānau in decision-making, planning and the day-to-day care of their child while he or she is in a healthcare service. Parents should be encouraged to stay with their child and offered support and services to facilitate this.

Children and young people are entitled to their parents' and family/whānau members' advice and emotional support when participating in decisions about their healthcare. Close family/whānau relationships mean that parents are often uniquely positioned to provide advice and support to their children. Family/whānau and whangai relationships need to be recognised, encouraged and supported in healthcare services by involving families/whānau in decision making, in a way that reflects and respects the capabilities of the child or young person. Healthcare for children and young people needs to be family/whānau-centred. The provider needs to encourage a parent (or person trusted by the child or young person) to accompany and support the child during procedures when appropriate.

6. Every child and young person has a right to information, in a form that is understandable to them.

Children and young people have a right to information that they can understand about their health and healthcare. This includes information about the choice of health care services available. Special attention and some creativity are often necessary to ensure that children have the freedom to seek, receive and impart information and ideas, not only orally but also through other means of the child's or young person's choice, such as play and art. Ensuring that the language and format used are appropriate to the child's or young person's abilities and level of understanding is essential, as is ensuring that they have understood the information given and had every opportunity to participate

in the conversations about their health and care. This right to information includes the right of tamariki and rangatahi to have access to information in Te Reo Māori and for those from culturally and linguistically diverse backgrounds to have access to information in their own language.

It is crucial that health professionals talk directly to children and young people, as well as to their families/whānau, even if the child or young person may seem unable to comprehend. Health professionals and families/whānau should be as open as possible with children and young people about their health and healthcare. Like all patients, children and young people are entitled to know what is going to happen to them before a procedure occurs and to be given honest information about their condition and treatment outcomes, and to be helped to select and practice strategies for coping.

Giving children and young people timely and accurate information means that they can retain a sense of control about their healthcare, particularly in hospital. Advance preparation for hospitalisation, healthcare procedures or impending surgery provides children and young people with a sense of mastery over the healthcare environment and helps them to cope more effectively with potentially stressful situations.

7. Every child and young person has a right to participate in decision-making and, as appropriate to their capabilities, to make decisions about their care.

Children and young people have a right to be involved in decision-making about their healthcare, to the greatest extent possible in line with their capacities for understanding. The right to be involved in making decisions also includes the right to be involved in decisions about the use, return or disposal of any bodily parts or substances removed, changed or added in the course of health care. Children and young people should be offered healthcare choices wherever possible. Further, they are always entitled to a second opinion. Whenever a child or young person has questions and ideas about their healthcare, these should be heard. If their views cannot be acted on, they are entitled to an explanation.

In order for children and young people to participate in decision-making, the health professionals caring for them ought to be available, trained and committed to communicating with children and young people. Effective communication is critical in healthcare, as children, young people and their families/whānau require appropriate information in order to provide informed consent to treatment. A child or young person needs to be able to talk with the staff caring for him or her, to understand who the staff are and what they do, and to question them about his or her condition and treatment. Participation can include both verbal and nonverbal communication by children and young people with health professionals. It should also include opportunities to communicate through play, art and other media of the child's or young person's choice. Health professionals need to pay attention to ensure that appropriate responses are made to the nonverbal cues and communication by children and young people who use this as their main form (for example, infants, very young children and those with disabilities).

The right to participation extends beyond the right of every individual child and young person to participate in his or her care. It includes encouraging and supporting children and young people as groups to be involved in consultation on the development, implementation and evaluation of the services, policies and strategies that have an impact on them.

Informed consent is to be sought from children, young people and their families/whānau before they are involved in teaching or research. Also, those who do agree to participate must have the opportunity to withdraw at any time without having to give a reason, even if they consent initially. The decision not to participate in teaching or research must not alter access to treatment. Ethical oversight by a Human Research Ethics Committee of all research projects conducted in child healthcare services is part of protecting the children and young people involved.

8. Every child and young person has a right to be kept safe from all forms of harm.

Children and young people are entitled to the highest quality healthcare. They have a right to safe and appropriately expert care, delivered in a child and family/whānau centred organisation and in their own homes. Healthcare organisations should ensure that their staff and physical environments comply with appropriate standards relating to the care of children and young people. This includes providing a developmentally and culturally safe environment.

Children and young people have the right to be protected from abuse, neglect and exposure to family violence. If abuse, neglect or family violence is disclosed, confirmed or suspected health professionals must intervene appropriately in the best interests of the child. Co-operation between healthcare and other agencies, including timely sharing of information, is also essential to ensure children and young people are kept safe and receive safe healthcare.

Taking steps to minimise distress to children and young people in healthcare services is critical. Children and young people also require protection from the potential harm and burden associated with research or teaching (including training of healthcare professionals) while engaged in the healthcare system.

All children and young people, including newborns, are entitled to adequate pain relief. They should be protected from unnecessary pain, investigations, and treatments. They should have access to timely pain management and to services that can address acute (post operative and procedural) pain, persistent and recurrent pain syndromes, and pain during palliative care. When feasible, parents should be supported to hold their child during painful procedures and breastfed infants should be given the option to breastfeed before, during and after painful procedures.

Wellbeing, however, encompasses more than just the absence of physical suffering. Children and young people should be treated kindly, sensitively and in an individually appropriate and culturally safe way at all times. As far as possible, children and young people ought also to be protected from upsetting experiences during their care. If such experiences are unavoidable, the impact should be minimised using all available strategies. Debriefing should be available

for children, young people and their families/whānau if distressing events occur. Seclusion and restraint should be minimal and used only as a last resort.

Children often come to harm during daily activities in their homes and communities. Health services should extend their knowledge and delivery of best practice ways for preventing children and young people from experiencing harm within their homes and community. This includes the provision of accurate and up-to-date information to communities about the ways children and young people are subject to preventable injuries and ways that are effective and available to keep them safe from harm.

9. Every child and young person has a right to have their privacy respected.

The privacy of children and young people must be respected. Privacy is not limited to personal information. A child's or young person's body is an important part of their identity and bodily privacy should be addressed in all aspects of care. This is particularly important in physical examinations and personal hygiene activities such as dressing, toileting and bathing. Children's and young people's religious, cultural beliefs and tikanga may also require special responses in relation to the privacy of their bodies. Children and young people may request a staff member of the same gender and this should be accommodated whenever possible. Healthcare providers should be alert to the fact that children's and young people's wishes around bodily privacy may change as their bodies develop. These wishes should be respected.

The confidentiality of children's and young people's personal information is also important. Proper handling of children's and young people's personal health and other details is necessary to ensure that their information remains private. Keeping children's and young people's details confidential (except where this places them or others at risk), and assuring children and young people that their privacy is important, encourages them to share all of the information relevant to their care with health professionals. Information should not be communicated without the child's or young person's permission, except when he or she is at risk of harm or when the law requires disclosure.

Health service providers should ensure that children and young people have access to appropriate and confidential health advice and counselling without their parents' consent or presence, irrespective of age, where this is needed for the child's or young person's safety or wellbeing. Children and young people may need such access when, for example, they are experiencing abuse at home or are in need of reproductive health education or services. They may also need such advice and counselling in cases of conflict between the child or young person and their parents over access to health services. The right to counselling and advice is distinct from the right to give consent and should not be subject to any age limit.

10. Every child and young person has a right to participate in education, play, creative activities and recreation, even if this is difficult due to their illness or disability.

To the greatest extent practicable, children and young people should be assisted to participate in their regular activities and routines while in a healthcare services. This minimises anxiety and maintains their development and learning. Children and young people ought to remain engaged in education while they are in a healthcare service. They also need an environment in which play and recreation are facilitated, by staff with appropriate knowledge and skills where possible. Play has a particular role in healthcare: it supports the ability of children and young people to cope with their experiences in healthcare services. This requires both a physical environment conducive to play and recreation as well as a commitment across the organisation to giving children and young people the time, encouragement and support to play and participate in therapeutic activities. Opportunities to participate in education, play, creative activities and recreation should be suited to the child's or young person's age and condition. To the greatest extent possible, these activities should take place in an environment designed, furnished, staffed and equipped to meet the child's or young person's needs, interests and abilities.

11. Every child and young person has a right to continuity of healthcare, including well-planned care that takes them beyond the paediatric context.

Healthcare providers need systems to promote continuity of care. This includes care co-ordination both between and within the various services working with children, young people and their families/whānau. Continuity of healthcare between all healthcare services in hospital and community settings is essential. Children and young people who move across different geographical locations and health services are also entitled to continuity of care.

For neonates, children and young people with long term health issues, planning for their care as they develop and move between neonatal, paediatric and adult services is crucial to their wellbeing. Ideally, healthcare professionals should aim for a smooth transition of the neonate, child or young person and their family/whānau to appropriate services. In the context of a transition to adult services this process should begin some years before transfer to adult services is complete. The process of transition should be based on the rights described in this document.

This right to continuity of healthcare also requires health services to adopt a 'whole person' approach, recognising that children's and young people's health and development needs go beyond the health sector. Children and young people need solutions that cross sectors such as health, education, welfare and housing.

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APPENDIX 1: Version for children

Let everyone know these are the rights of every child in health care

1. **Know that children are special and always do what is best for us.**

2. **Listen to us when we tell you how we are thinking and feeling, when we are upset, when we have problems or worries or when we need to talk to you. We may not be able to use words, so take notice of what we do and how we look because this can tell you what we are thinking and feeling.**

3. **Give us the very best possible care and the comfort we need.**

4. **Let us and our families/whānau be who we want to be, whatever our beliefs and customs, so that we feel safe at all times.**

5. **Let our families/whānau and others who are important to us be with us, to care for us and love and aroha us.**

6. **No matter how big or small we are, tell us what we need to know in a way we can understand.**

7. **Let us have a say in things that are happening to us now and in the future. Respect our decisions and let us make decisions for ourselves.**

8. **No one has the right to harm us, not doctors or nurses and not even our mums or dads. Protect us always from anyone who would harm us or treat us badly.**

9. **Our bodies belong to us. Ask us if you want to share information about us and make sure we stay safe. Give us space and privacy, as well as the chance to be with others.**

10. **Help us grow up to be the best we can. Let us learn, let us play and discover some things for ourselves.**

11. **When you care for us make sure that everyone is working together to do what is best for us until we are grown up and can decide things for ourselves.**

APPENDIX 2: Version for young people

Young People's rights in health care: Be in the Know

Young People's Rights	Details
You have the right to what's best for YOU.	Together with you, everyone involved in your health care should always work towards what is best for you. What you value in terms of your physical (Taha Tinana), spiritual (Taha Wairua), family (Taha Whānau) and mental (Taha Hinengaro) well-being is important in deciding what is best for you.
You have the right to express your views respectfully, be HEARD and have something done about it.	You have the right to express yourself and share what you are thinking and feeling with others in any way you are able to communicate. Others around you are responsible for learning how you communicate so your views can be understood. You have the right to have your views heard, considered and taken seriously, especially when decisions are being made that affect you. If you feel like you are not being heard you can choose to have an independent person advocate for you. The right to be heard includes the right to complain about your health care. Health services should provide you with a safe and simple way to complain and a fair and speedy way to sort out your complaint.
You have the right to use, and receive the BEST available health care.	You have the right to the best health care available in all situations. The best health care available should attend to all aspects of your well-being, including physical (Taha Tinana), spiritual (Taha Wairua), and mental (Taha Hinengaro) and relationships with family/whānau and friends. You also have the right to a safe environment to help you enjoy the highest achievable standard of health. The people caring for you should understand your needs and requirements and try to meet them.
You have the right to be treated with RESPECT in regards to your values, beliefs, tikanga and culture. **You have a right to be you.**	You should be treated with respect and dignity and encouraged to respect others' rights and values. You have the right to practice your own tikanga, culture, customs, language and religion. Whoever you are and whatever your tikanga, culture, customs, language or religion, you have the right to special protections that makes sure you can practice your ways of life, unless those practices are likely to put you at risk.

You have a right to be with and guided by your FAMILY / WHĀNAU, unless this is against your best interest.	You have the right to have your parents and those important to you with you, unless this will harm you. You have the right to be given guidance by your parents and family/whānau. You have the right to have a support person of your choise with you in any situation you wish, unless this breaks the rights of others or will harm you.
You have the right to be FULLY informed, ask questions and be given answers about all matters concerning you. Because being in the know is important.	You have the right to find thing out and to be informed. This means having access to information you can understand, trust and that's important for you to know. This includes: • Being given realistic information about your condition and treatment in a way that you can understand. • Being able to ask questions and be given honest answers you can understand. • Being provided with choices for treatment, where available and realistic. • Being aware of how to access information about you, if you wish to.
You have the right to be INVOLVED in making decisions that affect you.	You have the right to be involved as much as you wish in making decisions that affect you. Depending on the situation, your experience and understanding and the adults available to support you, you may wish to be informed, to express your views, to have your views taken seriously, to share decision making with parents and health professionals or to be the main decision maker. However you wish to be involved, your involvement should be taken seriously. If your views can't be taken into account, you have the right to be told why. The right to be involved in making decision includes the right to be involved in making decisions about taking part in teaching or research and about the use, return or disposal of any bodily parts or substances removed, changed or added in the course of your health care. Health services should enable young people to be involved in decisions about planning services and developing policies that impact on young people.
You have the right to be PROTECTED from harm.	You have the right to be safe from all forms of harm. This includes being protected from anyone who would harm you, including people in your family/whānau. Some things that happen to you in health care services may be painful but things should always be done to prevent or relieve your pain.

You have the right to PRIVACY.	You should be treated with dignity. You have the right to a private life, which includes keeping your body, mental, spiritual and social life private. Health professionals should take all necessary steps to ensure your privacy during medical examinations and treatments. Health professionals caring for you are aware that your privacy and confidentiality are necessary if you are going to trust them. In some situations, a parent of a young person under 16 years of age will be involved in making decisions about the young person's health care and information about them may be shared with a parent. However, your parents do not have an automatic right to information about your healthcar if you not wish them to. There are some situations in which information about you cannot be shared with your parents without your permission e.g abortion or contraceptive advice." In other situations health professionals may have to share information with others to prevent a serious threat to your life or health. Health professionals should tell you what information you give them might be shared with others, including your parents, in order to provide you with the best possible care. You have the right to legal protection from unlawful or unreasonable interference with your privacy.
You have the right to education, rest, play, creative acitivities and recreation.	Whether you are well, ill or disabled you have the right to good quality education that helps you develop your personality, talents and abilities to the full. You have the right to rest, play and to be involved in things you enjoy. Sometimes you may not be able to do things you enjoy because they can harm you, especially if you have an injury or illness.
You have the right to planned co-ordinated health care.	You have the right to co-operation among the people providing health care to you. This includes having continuity of carers and support, as well as access to ongoing health services, you should be introduced to the new services and health professionals. Your transition from children's to adult services should be made as easy as possible and start early.