TATAU POUNAMU
Ki Te Tai o Poutini

MANAWHENUA ADVISORY GROUP

26 June 2014
@ 3.00pm WCDHB – Board Room

Agenda and Meeting Papers

ALL INFORMATION CONTAINED IN THESE COMMITTEE PAPERS IS SUBJECT TO CHANGE

TATAU POUNAMU MANAWHENUA ADVISORY COMMITTEE AGENDA

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TATAU POUNAMU ADVISORY GROUP MEETING
To be held at West Coast DHB - Corporate Services, Board Room
Thursday 26 June 2014 @ 3.00 pm

KARAKIA

ADMINISTRATION

Apologies

1. **Interest Register**
   Update Interest Register and Declaration of Interest on items to be covered during the meeting.
2. **Confirmation of the Minutes of the Previous Meeting**
   10 April 2014
3. **Carried Forward/Action List Items**
4. **Discussion Items**

- Terms of Reference Update from Board Meeting – 12 June 2013 (Next Board Meeting 28 June)
- Polly Ormond, Introduction to the Group 3.10pm
- Stella Ward, ALT Discussion - *Video Conferencing* 3.30pm
- Lois Scott, Mental Health Services & Mental Health Review Update 4.00pm

REPORTS

5.	**Chair's Update – Verbal Report**	Chair
6.	**GM Maori Health Report**	General Manager Maori Health
7.	**Annual Plan/Maori Health Plan 2014/15**	Maori Health
8.	**Work Stream Reporting Update**	Planning & Funding Service Development Manager
9.	**Draft Appointments Policy for Maori Representation for Health Workstreams**	Tatau Pounamu Feedback

INFORMATION ITEMS

- Media articles
- West Coast DHB Mental Health & Addictions Service Review
- Maori Health Action Plan 2014/15
- Tatau Pounamu Meeting Schedule

Information items (hard copies will be distributed on day)

ESTIMATED FINISH TIME 5.00pm

NEXT MEETING

TATAU POUNAMU ADVISORY GROUP MEMBERS INTEREST REGISTER

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Member	Disclosure of Interest
Lisa Tumahai **(Chair)** Te Runanga O Ngati Waewae	Directorships ▪ Chair - Arahura Holdings Ltd 2005 – currently ▪ Chair -Te Waipounamu Maori Heritage Centre 2006 – currently Committees ▪ Te Waipounamu Maori Cancer Network Committee 2012 - currently ▪ Te Runanga O Ngati Waewae Incorporated Society 2001 – currently ▪ Chair – Te Here (subcommittee Te Runanga o Ngai Tahu 2011 - currently) ▪ Member Maori Advisory Group to Vice Chancellor Canterbury University 2012 - currently Trustee ▪ West Coast PHO 2013 – currently ▪ Poutini Waiora – April 2013 - currently ▪ Te Runanga O Ngai Tahu - Deputy Kaiwhakahaere (2011 - currently) ▪ Te Poari o Kati Waewae Charitable Trust – (2000 – currently) ▪ Husband Francois Tumahai.
Francois Tumahai Te Runanga O Ngati Waewae	▪ Chair, Te Runanga o Ngati Waewae ▪ Director/Manager Poutini Environmental ▪ Director, Arahura Holdings Limited ▪ Project Manager, Arahura Marae ▪ Project Manager, Ngati Waewae Commercial Area Development ▪ Member, Westport North School Advisory Group ▪ Member, Hokitika Primary School Advisory Group ▪ Member, Buller District Council 2050 Planning Advisory Group ▪ Member, Greymouth Community Link Advisory Group ▪ Member, West Coast Regional Council Resource Management Committee ▪ Member, Poutini Waiora Board ▪ Member, Grey District Council Creative NZ Allocation Committee

Member	Disclosure of Interest
	▪ Member, Buller District Council Creative NZ Allocation Committee ▪ Trustee, Westland Wilderness ▪ Trustee, Te Poari o Kati Waewae Charitable ▪ Trustee, Westland Petrel ▪ Advisor, Te Waipounamu Maori Cultural Heritage Centre ▪ Trustee, West Coast Primary Health Organisation Board ▪ Wife is Lisa Tumahai, Chair
Elinor Stratford West Coast District Health Board representative on Tatau Pounamu	▪ Member 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 Member of the West Coast District Health Board ▪ Advisor to the Committee MS Parkinsons ▪ Contracted to Disability Resource Centre ▪ Trustee Queenstown and West Coast Disabilities Resource Centre Charitable Trust ▪ Member of the Southern Regional Liasion Group for Arthritis New Zealand
Gina Robertson Nga Maata Waka o Kawatiri	▪ Maori Community Representative – Incident Reporting Group, Buller Hospital ▪ Chairperson North School Whanau Group ▪ North School Iwi Representative, Board of Trustee
Wayne Secker Nga Maata Waka o Mawhera	▪ Trustee, WL & HM Secker Family Trust ▪ Member, Greymouth Waitangi Day Picnic Committee
Paul Madgwick Te Runanga o Makaawhio	▪ Chairman, Te Rrunanga o Makaawhio ▪ Editor - Greymouth Star, Hokitika Guardian, West Coast Messenger. ▪ Board member, Poutini Waiora
Susan Wallace Te Runanga o Makaawhio	• Tumuaki, Te Runanga o Makaawhio • Member, of the West Coast District Health Board • Member, Te Runanga o Makaawhio

Member	Disclosure of Interest
	• Member, Te Runanga o Ngati Wae Wae • Director, Kati Mahaki ki Makaawhio Ltd • Mother is an employee of West Coast District Health Board • Father member of Hospital Advisory Committee • Father employee of West Coast District Health Board • Director, Kōhatu Makaawhio Ltd • Appointed member of Canterbury District Health Board • Chair, Poutini Waiora ▪ Area Representative-Te Waipounamu Maori Womens' Welfare League

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING held at Poutini Waiora Boardroom, Hokitika, on Thursday 10 April 2014 @ 3.00pm

PRESENT: Lisa Tumahai, Te Rūnanga O Ngāti Waewae (Chair)
Elinor Stratford, West Coast DHB Representative
Francois Tumahai, Te Rūnanga O Ngāti Waewae
Susan Wallace, Te Runanga O Makaawhio
Wayne Secker, Maori Community, Mawhera

IN ATTENDANCE: Gary Coghlan, General Manager Māori Health, West Coast DHB
Kylie Parkin, Portfolio Manager Maori Health
Michael Frampton, Programme Director, West Coast DHB
Nigel Ogilvie, Non Member (Observing)
Mere Wallace, Non Member (Observing)

MINUTE TAKER: Kylie Parkin, Maori Health
APOLOGIES: Dr Paul McCormack, West Coast DHB Chair
Paul Madgwick, Te Runanga O Makaawhio

WELCOME / KARAKIA

AGENDA / APOLOGIES

1. DISCLOSURES OF INTEREST

No disclosures of interest

2. MINUTES OF THE LAST MEETING - Thursday 20 February 2014

Motion: THAT the minutes be accepted as a true and accurate record

Moved: Lisa Tumahai **Second:** Francois Tumahai
Carried.

3. Carried forward/Action List Items

4. Matters Arising

4.1 Amended Terms of Reference

Terms of Reference were not ratified at the West Coast DHB Board meeting. David Meates or Michael Frampton will speak with the Chair of Tatau Pounamu regarding the reasons for this.

A member questioned the wording of 4.1.4 and this has been amended as below.

4.1 Membership

The total membership of Tatau Pounamu shall be seven (7) and the composition shall be determined as follows:

4.1.3 In addition Tatau Pounamu will select 2 Maori community representatives (3) from Tai Poutini communities

4.1.4 One member of the West Coast DHB shall be appointed by WCDHB to be a member of Tatau Pounamu

This has been incorporated into one point as follows:

"In addition Tatau Pounamu will select two Māori community representatives (2) from Tai Poutini communities and one member of the West Coast DHB Board shall be appointed by West Coast DHB to be a full member of the Tatau Pounamu manawhenua advisory group".

Action

Terms of Reference changes as above to be tracked and a copy sent to both Chair of Tatau Pounamu and the WCDHB CEO for discussion.

4.2 Appointments

The group were advised that the advertisement for the Buller Community Representative has been placed and one applicant was received. Additionally applications have been received for the Clinical Governance Committee and the Alliance Leadership Team. These will be discussed further on in the meeting and feedback to the policy will be given.

5 Chair's Update - Verbal Report

No update was given

6. GM Maori Health Report

Open for discussion

A board member requested information on the number of recent suicide cases that were engaged with Mental Health Services?

GM Maori Health - unsure but can check if this data is available. Discussion around Suicide Governance Group and the composition of that group. Anecdotal evidence tells us that we need action - what is the responsiveness of the WCDHB to the NZ Suicide Prevention Action Plan - how are Maori included in this?

Action

GM Maori health will confirm who is on the Suicide Governance Group and get a copy of the Terms of Reference and access any data that is available for Maori Suicide rates.

Also discussed the Waka Hourua fund, the GM Maori advised that an initial scoping meeting had been held with Melissa Cragg, Gary Coghlan and Lois Scott, Manager Community Health regarding a potential application to this innovation fund. It was agreed that Poutini Waiora would submit an application and that Melissa would work with Gary and Lois to develop it. The first funding round closed on the 31 March however due to Melissa Cragg's absence an application was not submitted.

The Chair asked that we check the closing dates for the second round and proceed as planned.

A member asked that whoever is developing application needs to ensure a strong Maori focus as this fund is specifically for Maori.

Action

Maori Health - check closing dates for the second round of the Waka Hourua fund and meet with Poutini Waiora and Community Mental Health Services to discuss if it is still appropriate to be putting in an application.

A member also talked about the Mental Health review and that the recommendations were to be presented within the next couple of weeks.

Action

Include a copy of the Mental Health Review recommendations in the next papers.

7. Annual Plan/Maori Health Plan 2014/2015 - Feedback

Violence Intervention Prevention

- Violence Intervention Prevention group talks about the Whanau Ora tool - What is the tool and who is using it?
- Who is the Whanau ora workstream?
- Who is doing the assessing?

Whanau Ora

- Discussion around the use of the word Whanau ora throughout the plan in many different contexts

Action

We will spend some time at the next meeting defining Whanau ora and it's context within the DHB/Annual Plan and different areas of the service delivery. Definition of Whanau ora as a principle that describes an approach to the way a service may be delivered rather than a set of services. Spend some time developing an overarching principle statement.

Page 39

Rangatahi Youth Action Education sessions - a member asked for some clarity around this.

Action

Ask Claire Robertson to either attend the next meeting or phone the member directly to discuss

Section 6.10 page 41
Health of the Older Person
No priorities or actions for Maori

Section 6.12 page 43
Whanau ora health services
Remove the first section 'enhance the capacity and capability'
Take out He Oranga Pounamu and replace with Tatau Pounamu

Section 6.13 - Joined up single health services
Reference to WCDHB throughout this section however the group thinks it would be appropriate to also highlight and include other providers i.e., PHO, Poutini Waiora. Inclusion of health system partners.

8. West Coast Alliance Update

The report was taken as read. A member pointed out that the reports provide minimal information as to the work that is occurring within the Alliance.

Maori Health advised that the workstreams are where the real work is occurring and that through the Maori health team we have a strong presence within these committees. A lot of work is occurring to strengthen the reporting that comes through the workstreams.

8.1 Update from the Michael Frampton Programme Director

Michael arrived at the meeting at 4.00 and provided brief verbal updates on the following before leaving to catch a plane at 4.50 pm.

Hospital facilities
Michael and the Board are optimistic of good news regarding the reworked facilities proposal and are awaiting the outcome from the Ministry.
Broader Maori and community engagement will occur when confirmation is received.

The Chair made the comment that she found the first meeting with the designers a bit awkward but is sure that as the design team develop up the concept plans into something more visual that this will improve.

Mental Health Review
A summary version of the Mental Health Review has been released. The Board has discussed the outcomes within the Mental Health Review and endorsed the recommendations. WCDHB staff have been informed of the recommendations and have been given the opportunity to provide feedback. The community will also be given the opportunity to provide feedback. When all feedback has been received and considered change implementation work will begin. The review has a strong element of integration and primary and community focus which will include a reorientation of services.

Alliance Report - ALT
A member requested more relevant reports with up to date data.
Michael talked about the focus of the 6 workstreams and that this is where the action is occurring. More relevant action focused reporting will be implemented in line with workstream workplans and these will be provided to Tatau Pounamu within quarterly reporting.

Terms of Reference

Chair of Tatau Pounamu confirmed with Michael Frampton that the rationale to having DHB representation included within the Terms of Reference was to ensure a good two way flow of information between the 2 Board's and that they would have voting and speaking rights within the Manawhenua Advisory Group.

9. Buller Representation Tatau Pounamu

One application was submitted for the vacancy on Tatau Pounamu Committee.
Gina Robertson was subsequently voted on to the Manawhenua Advisory Group

Moved: Francois Tumahai **Second:** Susan Wallace
Carried.

Action

Officially inform Gina and anyone else who needs to be notified and send out any documentation that she may require.

10. Draft Appointments Policy for Maori representation for Health Workstreams

Open for discussion

Draft policy needs a number of changes.

Action

Megan to email the policy to Tatau Pounamu members for them to track changes and send back to Megan.

11. Clinical Board & Alliance Leadership team appointments

3 candidates applied for the Clinical Governance Board.

Candidates cv's were reviewed and discussed and the decision was made to appoint Polly Ormond to the Clinical Board as the Maori representative.

Moved: Susan Wallace **Second:** Francois Tumahai
Carried.

Action

Formalise appointment and inform those who need to know. Invite Polly to the next Tatau Pounamu to set out expectations from both Polly and the Board.

Alliance Leadership Team

The committee require more time to decide on an appropriate representative for the Alliance Leadership Team.

Action

Send out Terms of Reference and any other supporting documentation for ALT and ASG to the members. Include in the next agenda.

MATTERS ARISING APRIL MEETING 2014

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
4	10 April 2014	Amendments for Tatau Pounamu Terms of Reference ▪ That amendments are made to section 4 and that the amended TOR are submitted to the WCDHB and a tracked change version immediately sent to David Meates	GM Maori Health Terms of Reference to be submitted for approval at the next Board Meeting. All changed have been incorporated and track changed as per previous meeting discussions.	June Meeting
6	10 April 2014	• a member requested information regarding the recent suicides and the number that were engaged with mental health services • a member requested confirmation of the members on the Suicide Governance Group	GM Maori Health	June Meeting
6	10 April 2014	• Information requested regarding Waka Hourua - closing dates for the 2nd funding round • Request regional suicide data broken down by ethnicity	GM Maori Health This has been emailed to Gary and Lisa GM Maori Health	June Meeting
7	10 April 2014	• A member requested further detail within the Child & Youth Health Section - Rangatahi Youth Action Education Sessions • Health of the Older Person - Board has identified that content is very light for Maori and requested that this be revisited	Portfolio Manager - Kylie has emailed Claire Robertson and conversations are in process Feedback has been given to Mellissa McFarlane for the Annual Plan relating to all of these discussed points by Portfolio Manager	June Meeting

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
		• Whanau ora - take out He Oranga Pounamu and replace with Tatau Pounamu - reword the first section • Section 'Joined up Health Services' see minutes regarding proposed change to this section to incorporate health system partners and not just the DHB • arrange a time for an open discussion regarding the use of Whanau Ora within health plans and documentations - develop an overarching principle statement	As above As above As above	
8	10 April 2014	• Work with Planning & Funding to develop a more informative and relevant report from the Alliance with regards to Maori outcomes across the workstream workplans	Discussions are in process with Planning & Funding Manager and GM Maori Health and Portfolio Manager	June Meeting
9	10 April 2014	• Advise the Tatau Pounamu Board applicant of her success and formalise the appointment	GM Maori Health This has been done by email and by conversation with GM.	June Meeting
10	10 April 2014	• members to track changes to the Appointment policy and send back to Megan • Megan to send the policy out to members	Tatau Pounamu members Completed	June Meeting
11	10 April 2014	• Advise the Clinical Governance applicant of her success and formalise the appointment - invite the successful applicant to the next Tatau Pounamu meeting	GM Maori Health Polly Ormond has been advised when the next Clinical Governance meeting is and has also been invited to come to the next Tatau Pounamu meeting.	June Meeting

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
		• Alliance Leadership Team - Board requires more time to discuss this appointment • send out ASG and ALT Terms of Reference	Stella Ward coming to speak to these.	June Meeting

MAORI HEALTH REPORT

TO: **Chair and Members**
Tatau Pounamu

SOURCE: **Maori Health**

DATE: **26 June 2014**

Report Status – For:	Decision	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

[Note for report author: consider - is this a standing report and regular agenda item, is it generated through a request from the Board/Committee, strategic direction or ministry requirement – why was the report written e.g. through which committees or groups has the report been presented/endorsed. It is not the Executive Summary.]

2. RECOMMENDATION

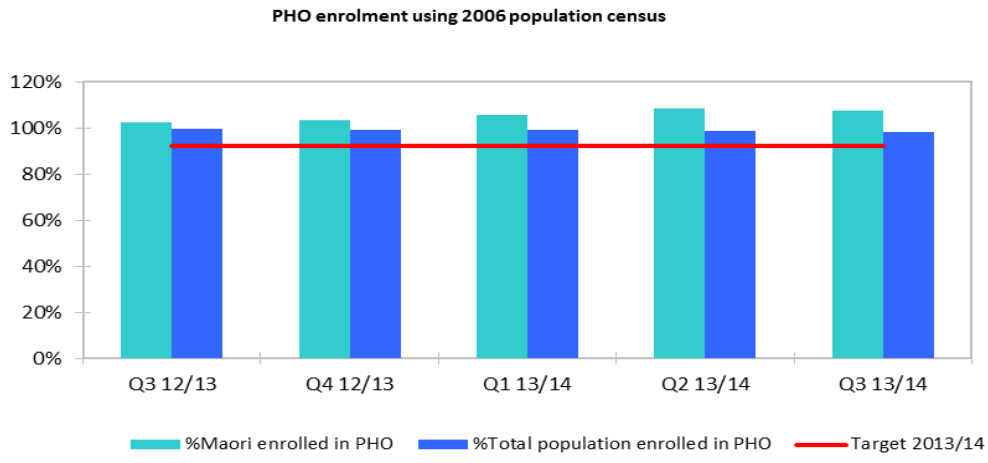
[Note for report author: The recommendation of a Decision Paper is to be in such a form that the Committee will vote for or against, i.e. the actual resolution for the Committee to pass. The recommendation needs to state if the recommendation needs to be forwarded to the West Coast DHB for the Board's approval. For a Noting Paper the usual recommendation will be that Tatau Pounamu note the paper. An Information Paper does not contain a recommendation]

3. SUMMARY

Maori Health Quarterly Report – Q3, 2013/14

Access to care

Percentage of Maori enrolled in the PHO



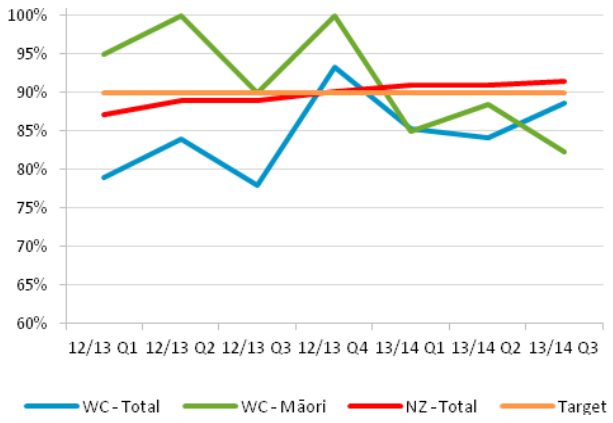
*** 2006 census population was used as the denominator.**

ACHIEVEMENTS/ISSUES OF NOTE

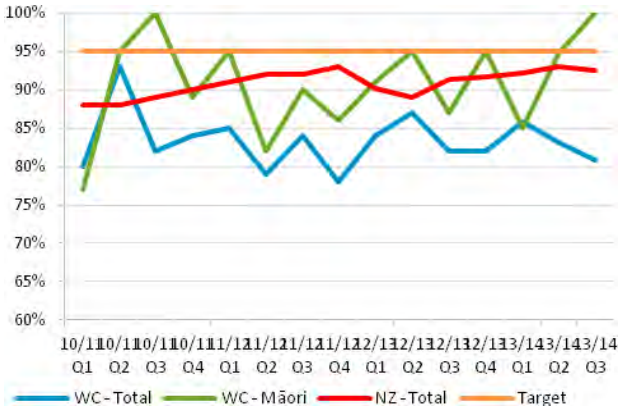
Enrolment in PHO: Using the 2013 population census figures 99% of Maori were enrolled with the PHO as at March 31 2014. Enrolments for Maori and Pacific people continue to increase at a faster rate than other ethnicities and exceed that of other ethnicities.

Child, Youth and Maternity

NEW Immunisation HT: Eight-month-olds fully immunised



Immunisation: Two-year-olds fully immunised



Eight-month-old immunisation: 82% of Maori babies have been immunised on time at 8 months of age in quarter 3 – 14 babies out of 17 eligible. This is compared to 95% of non-Maori babies where 59 from 62 eligible babies have been immunised.

Two-year-old immunisation: 100% of Maori 2 year olds have been immunised on time in Quarter 3 – 13 from 13 eligible babies. The West Coast DHB's total coverage for Quarter 3 is 81% - 97 out of 120 eligible children and 90% of non-Maori 2 year olds.

A process timeline for all practices to use as guidance to ensure timely immunisation by eight months of age;

- NIR Administrator working with a key contact in each practice to identify children due, pending or overdue;
- Timely referral to Outreach Services;
- Collaboration with other Well Child service providers to refer children for immunisation; and
- Improving the enrolment process at birth

Breastfeeding: Breastfeeding results for the 12/13 year were released by the MoH during this reporting period. It is important to note that unfortunately the DHB is unable to present a full picture of breastfeeding results this year and it is Plunket services only. Poutini Waiora and the WCDHB also provide WCTO services, but due to national data issues with Plunket data the three data sources cannot be accurately combined as they have been in the previous years.

WCDHB 2012/13 results (Plunket data only):

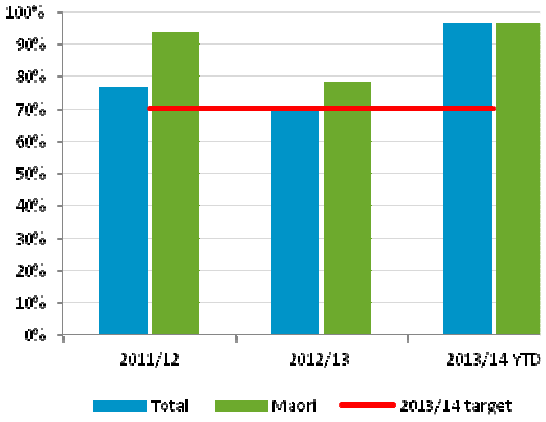
	Target	Maori	Total
6 weeks	74%	70%	61%
6 months	40%	15%	22%

Breastfeeding Support: A multi pronged approach is being taken to improve Maori uptake of breastfeeding. The West Coast and Canterbury DHBs are working together on some key areas of the maternity journey that have been identified as opportunities for improvement. Pregnancy and Parenting Education with a prioritised focus on improving attendance of Maori and prioritising Breastfeeding are the two key areas that could potentially have a positive impact on the rates of Maori who decide to breastfeed. The West coast DHB are currently finalising the West Coast Priority Plan for Breastfeeding 2014-2016 with some key recommendations for improving Maori breastfeeding rates.

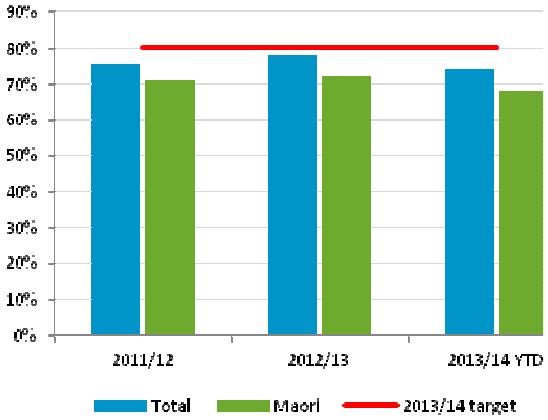
Newborn Enrolment: The Newborn enrolment form will now include a section where new Mums can consent to being contacted by a Lactation Consultant within a week of birth. The lactation consultant will then be able to determine whether support is required or not. This service can be provided in the home or clinic. In Quarter 4 we will be reviewing how this form is delivering and we should have some data to include in the next reporting period.

More Heart & Diabetes checks

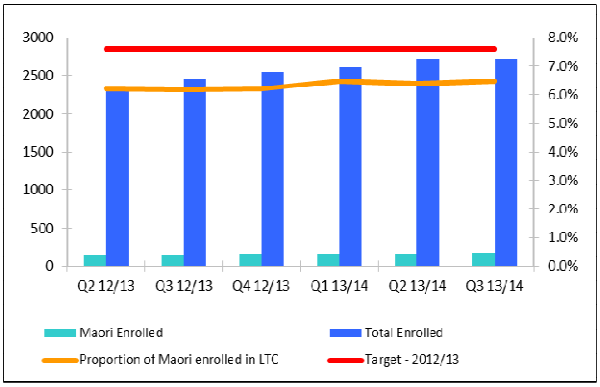
Diabetes Annual Review: % of people estimated to have diabetes who have had an annual check during the year



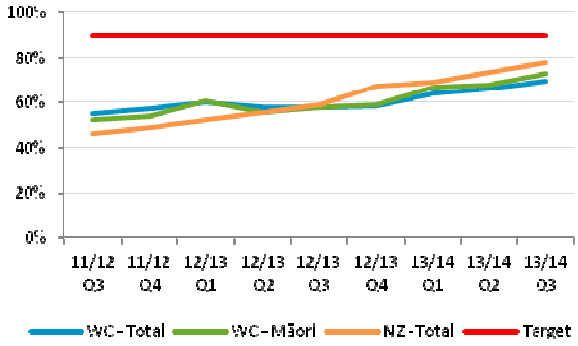
Diabetes Good Management: % of people who have HBA1c levels at or below 8.0 when assessed at their annual check



Number of people enrolled in the Long Term Condition Programme



CVD Health Target: % of eligible PHO population having had a CVD risk assessment in the last 5 years



More Heart & Diabetes Checks:

MoH is providing additional funding over four years (2013/14 = $57,052 and decreasing annually) to support the achievement of the national Health Target *More Heart & Diabetes Checks* in Primary Care some of the initiatives that have been implemented are:

- Communication with practice teams Engagement with Heart Foundation to facilitate and deliver training - training delivered to 11 practice nurses and rural nurses in quarter 4.
- Entering CVR screening terms for patients with CVD who have not had a CVRA but are being seen in practices and obtaining treatment.
- Engagement and co-ordinating integration of Kaupapa Maori Nurses with practices to outreach high need people who are not responding to recall.
- Planning for specific nurse led CVR clinics and engagement of nurses to deliver this service - happening in several practices now.
- Training and support provided to Kaupapa Maori Nurse in Buller to complete CVRAs on high need people.
- Text to remind installation complete for WCDHB practices, training completed for staff as well as PHO staff.
- Use of Karo reports and Query Build to obtain patient lists. Clinical Manager engaging with Practice teams to review audits and discuss ideas to improve uptake and reach eligible population.
- Practice subsidy for initial CVRA and follow-up of high risk CVR.
- Additional nursing resource to conduct CVRA clinics in practices occurring with extra clinics being funded by PHO.

CVD Health Target

Performance against this health target has shown an increase from 58% in the June quarter to 71.8% of the eligible enrolled West Coast population now having had a cardiovascular risk assessment in the five years to 30 December 2013. Quarter 2 rates for West Coast Māori show 68.1% having had their CVD risk assessments undertaken which is an increase from 68% last quarter. Collaboration with Poutin Waiora , the PHO and several practices is enabling better outreach to high-need Māori, including an awareness campaign (which began during Quarter 1) and a tailored package of care from Poutini Waiora through its Kaupapa Māori Nurses and its Kaiarataki (non-clinical Māori Health Navigators). Greymouth Medical Centre and Poutini Waiora began working together in Quarter 4 2012/13 to provide support and health care for Māori and Pacific people with long-term conditions, with the Kaupapa nurse working within the practice and 'out-reaching' directly to practice patients. This pilot model expanded to Hokitika during Quarter 1 and is working well.

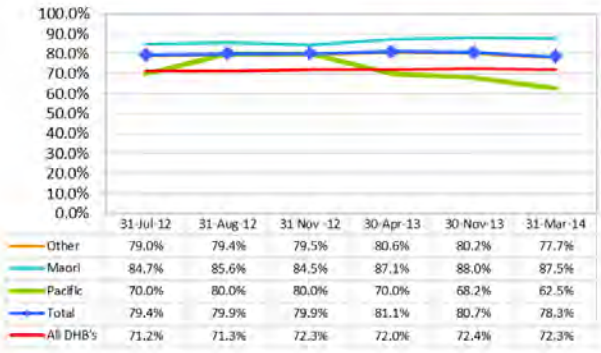
Practice teams continue to actively identify and invite eligible people to nurse-led clinics to have their cardiovascular risk assessed, with a special focus on high-need people who haven't been screened.

Green Prescription: Quarter 3 has seen a steady increase in Maori referrals in to the Green Prescription programme with 10.5% (9) in the Grey/Westland district and 26% (4) in the Buller district. The major group of conditions this quarter is people with elevated body mass index (BMI), followed by depression/anxiety and cardiovascular disease.

Long Term Condition Management (LTC): 177 Maori are enrolled in the Long Term Conditions programme as at March 31 2014. Year to date Maori enrolment makes up 6.5% of all enrolment in the LTC programme. The target is 7.6%. For comparison Maori make up 5.8% of the enrolled population at the primary practices aged 45 years and above. This means that from the 2722 enrolments on the LTC programme 177 are Maori and 8 are Pacific. We are working closely with the CEO and Clinical Manager of the PHO, and Poutini Waiora to identify those Maori who are enrolled in the programme and link them in to the Kaupapaa Maori Nurses and Kaiarataki and also to identify any Maori who should be enrolled in the programme but aren't.

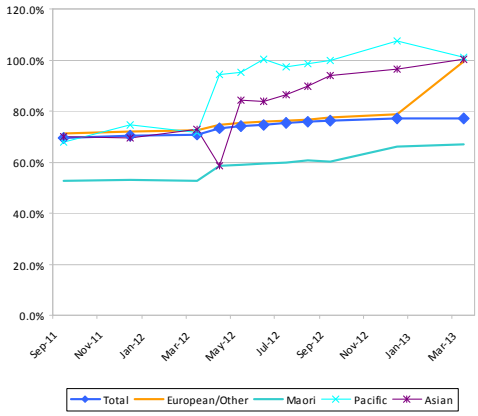
Cancer

Percentage of eligible Maori women (45-69) receiving breast screening examination in the last 24 months ending



	31-Jul-12	31-Aug-12	31-Nov-12	30-Apr-13	30-Nov-13	31-Mar-14
Other	79.0%	79.4%	79.5%	80.6%	80.2%	77.7%
Maori	84.7%	85.6%	84.5%	87.1%	88.0%	87.5%
Pacific	70.0%	80.0%	80.0%	70.0%	68.2%	62.5%
Total	79.4%	79.9%	79.9%	81.1%	80.7%	78.3%
All DHB's	71.2%	71.3%	72.3%	72.0%	72.4%	72.3%

Percentage of eligible Maori women (25-69) receiving cervical screening in the last 3 years ending Dec 2013



ACHIEVEMENTS/ISSUES OF NOTE

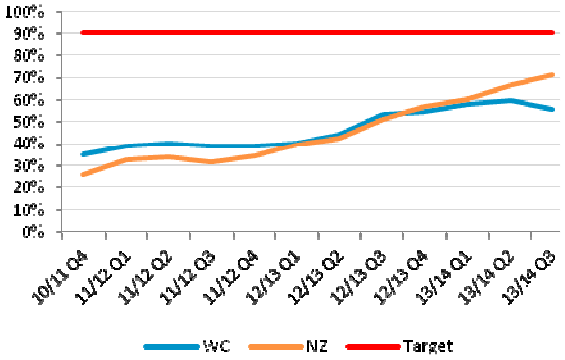
Breast Cancer Screening: Approximate 78.3% of all eligible women aged 45-69 age-groups on the West Coast have undergone breast screening for the period ending 31 March 2014.. The coverage for eligible Maori women (87.5%) is higher compared to all other ethnicities on the West Coast. The National Maori Health Plan Indicators report shows that the West Coast DHB is the lead DHB from 20 DHB's for this Indicator.

Cervical cancer screening: At the end of Dec 2013, the preliminary three year coverage result for cervical screening on the West Coast non-Maori was 78%. The coverage rate for eligible Maori women is at 71% an increase from last quarter and a sustained increase from June 2012. The process for cervical screening is being

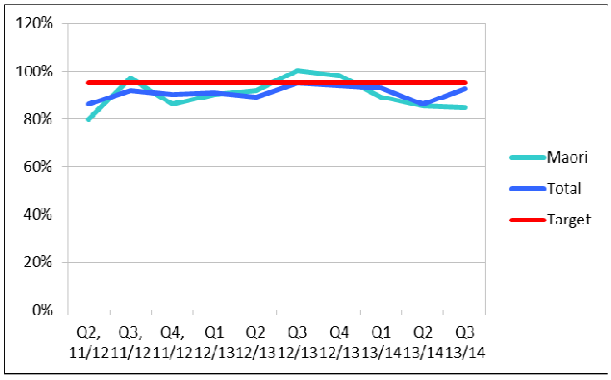
embedded into the practices with overdue priority lists regularly being forwarded through to the Maori cervical screening. Additionally to this the Maori cervical screener is working very closely with Poutini Waiora to locate those hardest to reach and holding community clinics.

Smoking cessation

Primary Smokefree Health Target: Smokers attending primary care given advice & help to quit



Secondary Smokefree Health Target: Hospitalised smokers given quit advice & help



ACHIEVEMENTS/ISSUES OF NOTE

Primary Smokefree Health Target: Results for Quarter 2 2013/14 show the target has increased by 2% to reach 60% with 58% of Maori smokers who have attended general practice offered advice and support to quit. There is a comprehensive plan in place to improve this target. Joe Mason Aukati kaipaipa Smoking Cessation Co-ordinator is working with Poutini Waiora to streamline the pathway for whanau into this service. Additionally through the Healthy West Coast Workstream a plan is being developed that will give recommendations on the prioritisation of Maori access to all smoking cessation services

Secondary Smokefree Health Target: The secondary target of 95% was not achieved this quarter with 92.5% of the total population being offered advice and 85% of Maori in the hospital being offered brief advice. More work is occurring with senior hospital management to ensure greater progress is achieved against this target.

Aukati Kai Paipa: For the period December 2013 the AKP service is working with 85 clients, 47 who identify as Maori with 20% validated abstinence rate at 3 months. The Aukati Kai Paipa cessation adviser is working more closely with Poutini Waiora which is resulting in increased referrals to the service.

4. DISCUSSION

[Note for the report author*: the body of the report – consider issues such as, background, implications, ministry requirements, financial costs, options, recommended actions, consultation and communication plans, cultural and disability issues, impact on other divisions, technology requirements, legal and policy issues, risk and mitigation strategies etc]*

5. CONCLUSION

6. APPENDICES

Report prepared by: Kylie Parkin, Maori Health

Report approved for release by: Gary Coghlan, General Manager Maori Health

GENERAL MANAGER MAORI HEALTH REPORT

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
Tatau Pounamu Advisory Group

SOURCE: **General Manager Maori Health**

DATE: **26 June 2014**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to Tatau Pounamu Manawhenua Advisory Group as a regular update.

2. RECOMMENDATION

That the Tatau Pounamu Manawhenua Advisory Group notes the report.

3. SUMMARY

Maori Health Plan/Annual Plan 2014/2015 - Draft

The 2nd draft of the Maori Health Plan was submitted to the Ministry on the 28 May. We received positive feedback from the Ministry with the only change requested from the Ministry ***'to include an action item around sharing best practice for the 'Cervical Screening' target'.***

A revised version will be available for the next Board meeting on the 27 June 2014.

Maori Health Plan 2013/2014 – Key Achievements Quarter 3

- Using 2013 Census data 99% of Maori are enrolled in the PHO
- 87.5% eligible Maori women (45-69) have been screened by Breast screen Aotearoa
- 72.9% Maori have had their Cardiovascular Risk Assessment – an increase from 68%
- 100% Maori 2 Year olds have been immunised

Poutini Waiora

Alayna Watene has been appointed as interim Te Kaihautu after Doctor Melissa Cragg resigned in May. Melissa's farewell was on the 9th of June and was very well attended. She managed to achieve a great deal in in her time as Te Kaihautu for Poutini Waiora. Alayna has had extensive experience as the Chief Executive of Te Taiwhenua o Heretaunga (TToH), an Iwi Authority and an accredited provider of health, social and education provider in Hastings.

Mana Tamariki – Mana Mokopuna

"Te Ao Auahatanga Hauora Maori" – The Maori Innovations Fund project.

Mana Tamariki – Mokopuna, Mana Whanau o Te Tai O Poutini is about taking a Te Ao Maori/Kaupapa Maori approach to scoping, designing and implementing an approach that will have direct benefits for tamariki, mokopuna and whanau health and wellbeing. The focus of the innovation will be tamariki and mokopuna within a whanau context – where Young Maori pregnant wahine and young Maori mothers and their whanau are engaged to identify and design an appropriate and responsive programme and approach to meet their needs and aspirations.

There will be four main components to the project – scope, development, implementation and evaluation. The scoping and development of the programme will occur over the first two years with implementation occurring over a two year period and an evaluation process running alongside, with formative, process and outcome evaluation being undertaken.

This initiative was primarily developed by Dr Melissa Cragg in partnership with the WCDHB and there has been uncertainty about the contract and how the scope and design phase will roll out after her resignation. Deborah Baird, Contract Manager for the Innovations Fund has since visited Poutini Waiora and attended a meeting with Gary Coghlan and Claire Robertson as part of the initial project team and agreed to an extended timeframe for the rollout of this project. Alayna Watene, interim Te Kaihautu will be responsible for the next phase of this project.

Primary Care Ethnicity Data Audit

This tool aims to provide the practice a greater understanding of how closely ethnicity data on the PMS reflects current self-identified ethnicity data. It then aims to assist in identifying actions to improve the quality of ethnicity data.

Stage 1 & 2 of the Ethnicity Data Audit are well underway. The PHO are managing the process. Stage 3 will involve the auditing of 900 patient files and will be very time consuming. We aim to have this stage complete by late October with the findings informing the next phase of improvements.

An opportunity has also arisen to attend a workshop hosted by the Waitemata DHB who piloted the EDAT toolkit in 2012. The training would be tailored to meet local needs and they will share their experiences, train the trainer for the EDAT tool and look at ways to ensure that the learning is weaved into a continuous Quality Improvement practice.

FINAL MĀORI HEALTH ACTION PLAN

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Planning & Funding**

DATE: **27th June 2014**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper has been prepared to provide the Board with the final version of the Māori Health Action Plan for approval.

2. RECOMMENDATION

That the Board approves the final version of the Māori Health Action Plan 2014/15.

3. SUMMARY

The DHB has prepared its Māori Health Action Plan in accordance with the legislation and the expectations set for the health sector by the Ministry and Minister of Health.

Unlike the Annual Plan, which has two Ministry submission rounds, the Māori Health Action Plan has three submission rounds - with the final due 30 June. The first draft was presented for the Board's review and feedback at the Board meeting 25 March. The Ministry feedback received on the first draft was responded to with a second draft submitted 26 May. Feedback on the second draft was received and the third and final draft is presented to the Board for approval.

Since the first draft was reviewed by the Board, the main changes have been focused on aligning baselines and targets with the Annual Plan, additional information on monitoring, engagement and identifying key stakeholders and additional activity in relation to breastfeeding, avoidable hospital admissions, and smoking.

The feedback from the Ministry on the second draft was very positive with no outstanding issues from the Ministry's perspective – this draft is all 'green' and has been given approval.

With Board approval this final version can be submitted as complete to the Ministry's Maori Health Directorate who will upload this version to the Ministry's national site. The DHB will also upload this version to the DHB website and copies will be printed.

Report prepared by: Melissa Macfarlane, Team Leader, Accountability

Report approved for release by: Gary Coughlan, GM Maori Health

David Meates, Chief Executive

Maori Health
ACTION PLAN 2014/15

THE WEST COAST HEALTH SYSTEM
– supporting you to be well

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

POUTINI
WAIORA

Tatau Pounamu
Ki Te Tai o Poutini

West Coast
Te Tai o Poutini
Primary Health

Table of Contents

Overview

The Plan

This plan describes West Coast District Health Board's priorities for Māori health for the 2014-2015 year. This plan aligns with the requirements of the New Zealand Public Health and Disability Act (2000) which directs District Health Boards (DHBs) to reduce disparities and improve health outcomes for Māori.

The format of this plan and the indicators listed within it follow the guidelines given in the 2014-2015 Operational Policy Framework provided by the Ministry of Health.

The West Coast Māori Health Plan 2014/2015 has been developed in partnership with the West Coast Primary Health Organisation, Tatau Pounamu *(Māori Relationship Board)*, Poutini Waiora *(the sole Māori Health Provider)*, and the West Coast Alliance.

Over the coming year we will continue to work closely with the West Coast Health Alliance to achieve the outcomes described in the Māori Health Plan. The West Coast Alliance has six workstreams (WS) that report through to the Alliance Leadership Team (ALT). These workstreams provide focus on key areas the Alliance wish to transform.

The six workstreams are; Health of Older Persons, Pharmacy, Child & Youth Health, Buller IFHS, Grey/Westland IFHS, and Public Health/Health Promotion. The ALT monitors the workstreams, provides system-level oversight, and works to ensure connectedness and a whole of system approach to alliance activities. In addition to the ALT, is the Alliance Support Group (ASG) who allocate resources, provide feedback to the workstreams, and advice to the ALT.

Health equity is prioritised within the Alliance Leadership Team, Alliance Support Group and each of the six workstreams through Equity reporting and key Māori representation throughout the West Coast Health Alliance and local committees.

Our 2013-2014 the Māori Health Action Plan has laid a solid foundation from which we will continue to build on in 2014-2015. In the past several years real gains have been made in improving Māori health:

- More Māori are enrolled with primary care. 93% of Māori are now enrolled with the West Coast Primary Health Organisation – up from 85% in 2012/2013.
- More Māori have had their cardiovascular (CVD) risk assessed. 68% of eligible Māori adults have had CVD risk assessment in the last five years in 2012/2013 – up from 42% in 2011/2012.
- More Māori are being supported to quit smoking. 89% of hospitalised Māori smokers were offered advice and help to quit in 2012/2013, a significant increase from 46% in 2009/2010.
- Māori Health Provider services have been reconfigured to align more closely to the Ministry's Better, Sooner, More Convenient Primary Health Care initiative and Whānau Ora strategy, including, Kaupapa Māori Services within Integrated Family Healthcare Centres.
- More Māori are accessing Cancer screening services with 71% of Māori women having been screened through the National Cervical Screening programme up from just 59% in 2011/2012.
- 88% of Māori have been screened through the Breastscreen Aotearoa programme in 2013/2014, above the National target of 75%.

Key areas have been identified where further investment is required to ensure that we are achieving the targets set and continuing to build on the momentum created in 2014/2015.

A key focus will be on Child and Youth Health. We will work closely with the Māori Health Provider to assist them to implement their Mana Tamariki – Mokopuna Mana Whānau o Te Tai Poutini project – a 4 year project funded through the Ministry of Health's Te Ao Auahatanga Hauora Māori 2013-2017 innovations fund. This pilot project will scope, develop and then implement a pilot that addresses the needs and aspirations of young Māori whānau on the West Coast who have or are about to have tamariki and mokopuna.

Additionally we will work closely with the Child & Youth Health Workstream to deliver the Māori components within their work plan. Disease prevention through prioritisation of Māori in the areas of smoking cessation, nutrition and physical activity will ensure new and innovative approaches to ensure Māori are accessing and effectively engaging with services.

We will continue to focus on improving the capacity and capability of the West Coast health system to provide appropriate, accessible and integrated health services for Māori on the West Coast.

This includes improving the responsiveness and effectiveness of mainstream service providers, reorienting and integrating Kaupapa Māori health services and delivering on the national Whānau Ora initiative.
Delivery on Whānau Ora will continue to be a priority. We will work to improve access and health outcomes for our population by supporting people working together to strengthen interconnectedness and the provision of seamless services between providers and sectors. We will work alongside providers to support the organisational transformation required for the delivery of a Whānau Ora integrated model that is clinically sound, culturally robust and most importantly empowers Whānau.

Baselines and Targets

All of the baseline data in this Action Plan (unless otherwise stated) has been calculated on either the full 2012/13 year, the Calendar 2013 year or the final quarter of the 2012/13 year, to align reporting with the West Coast Annual Plan. Graphs provide the most recent performance data in order to give the reader context as to current performance.

Performance Reporting

In addition to the presentation of quarterly performance results to Alliance Workstreams, the Māori Health Action Plan indicators will be disseminated to four key audiences.

Quarterly performance reports will be presented at the West Coast DHB's executive management meetings and will be reviewed by the Māori Relationship Board – Tatau Pounamu.

Results will be submitted to the West Coast DHB Board for review and discussion quarterly. Performance against the DHB's Māori Health Plan will be shared with the public and parliament through the Annual Report.

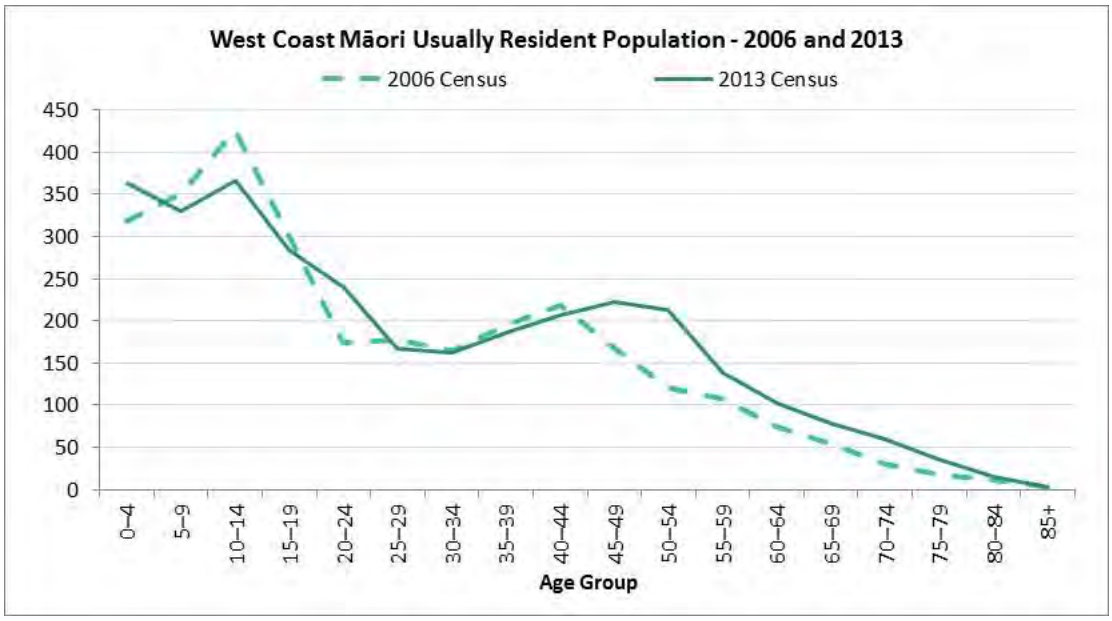
Abbreviations

ABC	An approach to smoking cessation requiring health staff to **A**sk, give **B**rief advice, and facilitate **C**essation support
AP	Annual Plan
ARF	Acute rheumatic fever
ASH	Ambulatory sensitive hospitalisation
BFHI	Baby friendly hospital initiative
WCDHB	West Coast District Health Board
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
CVRA	Cardiovascular Risk Assessment
DAR	Diabetes Annual Review
DHB	District Health Board
DMFT	Decayed, Missing or Filled teeth
DNA	Did not attend
ENT	Ear Nose and Throat
GM	General Manager
HbA1c	Glycated haemoglobin
IGT	Impaired Glucose Tolerance
IHD	Ischaemic heart disease
ISDR	Indirectly standardised discharge rate
MoH	Ministry of Health
NSU	National Screening Unit
WCPHO	West Coast Primary Health Organisation

Population Profile & Health Needs

1. Our Population

According to the 2013 Census, the West Coast DHB has a usually resident population of 32,145, of which 10.5% identified as Māori. This is a higher proportion of our population identifying as Māori than in the 2006 Census (9.7%). The proportion of our population identifying as Māori increased across all three West Coast territorial authorities.



Similar to the national Māori population, West Coast Māori have a younger population age structure. Almost half of West Coast Māori (42.2%) are under twenty years of age, compared to 22.9% of non-Māori population. In contrast, only 3.4% of Māori on the West Coast are aged 70 years and over compared to 11.2% of non-Māori.

Age Group:	0-9	10-19	20-39	40-69	70-79	80+
Māori	21.8%	20.4%	23.9%	30.1%	2.9%	0.5%
Non-Māori	11.8%	11.1%	20.9%	44.9%	7.3%	3.9%

2. Health Service Providers

Key health service providers in the DHB include;

- 3 public hospitals within the West Coast DHB,
- General Practice – 2 privately owned, 4 DHB owned,
- West Coast Primary Health Organisation,
- Poutini Waiora Trust Māori Health Provider,
- Multiple local and national non-profit and private health and social providers.

3. Iwi Within the WCDHB

Poutini Ngāi Tahu

Under section 9 of the Te Rūnanga O Ngāi Tahu Act 1996 the two Runanga who hold such status on the West Coast are Te Rūnaka O Ngati Waewae and Te Rūnanga O Makaawhio.

Te Rūnanga O Makaawhio

The takiwa (tribal area) of Te Rūnanga o Makaawhio centres on Mahitahi (Bruce Bay) and extends from the south bank of the Pouerua River to Piopiotahi (Milford Sound) and inland to the Main Divide. Te Rūnanga O Makaawhio have a shared interest with Te Rūnanga o Ngati Waewae in the area situated between the north bank of the Pouerua River and the south bank of the Hokitika River.

Te Rūnanga O Ngati Waewae

The takiwa (tribal area) of Te Rūnanga o Ngāti Waewae centres on Arahura and Hokitika. It extends from the north bank of the Hokitika River to Kahuraki and inland to the Main Divide. Te Rūnanga O Ngati Waewae have a shared interest with Te Rūnanga o Makaawhio in the area situated between the north bank of the Pouerua River and the south bank of the Hokitika River.

Tatau Pounamu Manawhenua Health Group

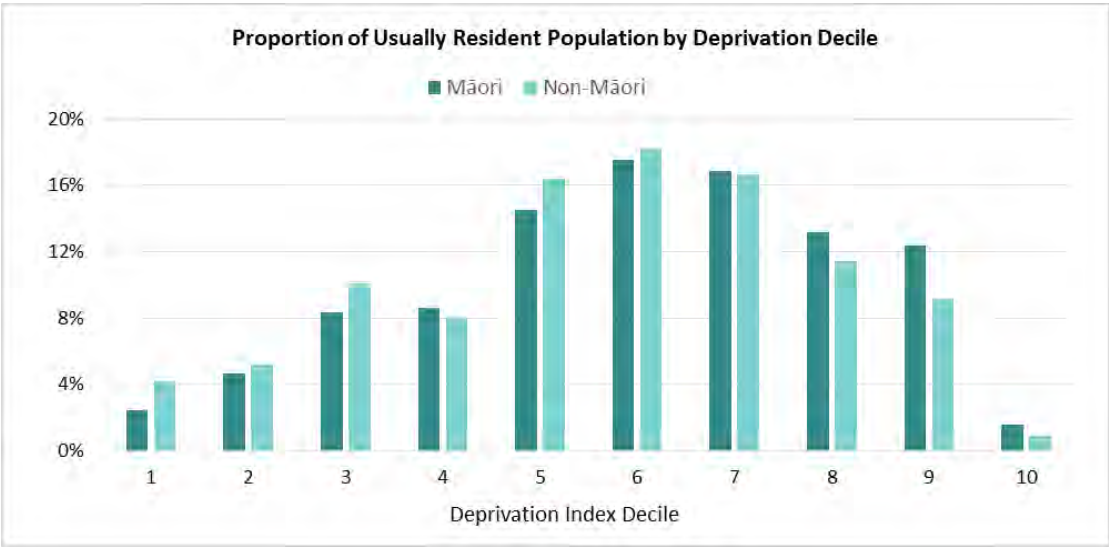
The West Coast District Health Board has Treaty-based relationships with Te Rūnanga o Ngāti Waewae and Te Rūnanga o Makaawhio. West Coast DHB support and regularly consult with Tāngata Whenua and the Māori community directly and through Tatau Pounamu, its manawhenua consultative group.

4. Population Growth Projections

The Māori population is predicted to continue to increase with the greatest change expected to occur in the elderly Maori population. However up to date predictions (based on the 2013 Census) are not due for release until December 2014.

5. Deprivation Distribution

West Coast Māori have a similar deprivation profile to the total West Coast population, in contrast to the national picture in which Māori have a more deprived profile. However, the West Coast population is relatively deprived overall, as defined by the New Zealand Deprivation Index 2013.



6. Leading Causes of Hospitalisations

Leading causes of hospitalisations for children 0-4 years by ethnicity, 2007-09

	WCDHB		Nationally	
	Condition	Rank	Condition	Rank
Māori	Respiratory Infections	1	Respiratory Infections	1
	Disorders related to length of gestation & foetal growth	2	*Persons encountering health services in other circumstances	2
	Persons encountering health services in other circumstances*	3	Disorders related to length of gestation & foetal growth	3
	Gastro-oesophageal reflux disease	4	Gastro-oesophageal reflux disease	4
	Dental conditions	5	ENT Infections	5
Non-Māori	Respiratory Infections	1	Persons encountering health services in other circumstances	1
	Persons encountering health services in other circumstances	2	Respiratory Infections	2
	Gastro-oesophageal reflux disease	3	Disorders related to length of gestation & foetal growth	3
	Disorders related to length of gestation and foetal growth	4	Gastro-oesophageal reflux disease	4
	Respiratory & cardiovascular disorders specific to the perinatal period	5	ENT Infections	5

Note: *ENT infections = ear, nose and throat infections. *Persons encountering health services in other circumstances (Z70-Z76) e.g. health supervision and care of other healthy infant and child.*

Leading causes of avoidable hospitalisations, ethnicity, 0-74 years, 2007-09

	WCDHB		Nationally	
	Condition	Rank	Condition	Rank
Māori	Respiratory Infections	1	Respiratory Infections	1
	Dental conditions	2	Dental conditions	2
	Asthma	3	Asthma	3
	ENT infections	4	ENT infections	4
	Diabetes	5	Angina	5
Non-Māori	Respiratory infections	1	Respiratory infections	1
	Gastroenteritis	2	Gastroenteritis	2
	Dental conditions	3	ENT infections	3
	Obstructed hernia	4	Dental conditions	4
	ENT infections	5	Angina	5

7. All-Cause Mortality, 1996-2004 *(Source: New Zealand Health Information Service)*

	WCDHB		Nationally	
	Māori	Non-Māori	Māori	Non-Māori
Mean annual rate per 100,000	410.0 (334.1-498.0)	236.6 (225.6-248.0)	475.8 (469.6-482.0)	201.3 (200.3-202.3)

Note: *Small numbers prevent the calculation of an avoidable mortality rate for West Coast Māori females, and contribute to wide 95% confidence intervals around the rate for West Coast Māori males.*

8. Primary Care – PHO Enrolment

Over the past six and a half years, enrolments in the West Coast PHO by Māori and Pacific Island people have grown by 52%, while those by people of all other ethnicities have grown 15%.

Enrolled population as at 30 June 2013

Total Enrolled	Māori	Māori % of Total
31,088	3,019	9.7%

9. Social Determinants of Health *(Source: Statistics New Zealand)*

The most recent determinants summary by ethnicity (from the 2013 Census) is not yet available the following is based on the 2006 Census.

	WCDHB		Nationally	
	Māori	Non-Māori	Māori	Non-Māori
Income more than $50,000	4.6%	9.1%	5.9%	12.7%
Income less than $20,000	29.3%	35.2%	27.7%	30.4%
Degree or higher qualification	1.9%	5.3%	4.1%	11.1%
No qualification	23.4%	25.5%	23.0%	17.6%
No access to telephone	20.7%	12.1%	23.3%	10.9%
No access to car	8.0%	4.6%	8.2%	4.7%
Home not owned	39.5%	23.9%	49.0%	29.9%
Income more than $50,000	4.6%	9.1%	5.9%	12.7%

National Priorities

Data Quality

Objective	**Improved accuracy of ethnicity reporting in PHO registers.** There is an ongoing need for high quality, standardised ethnicity data in the health sector. This data is essential for measuring, monitoring, and addressing health inequalities in Aotearoa/New Zealand. It is also important in developing policies and programmes that are responsive, relevant to, and in line with Māori priorities.
Responsibility	West Coast DHB, West Coast PHO.

Action/Evidence	Outcome
Q1-Q4: Quarterly review PHO ethnicity data reports and Māori enrolment data to ensure quality is maintained.	Findings from the Ethnicity Data Audit Toolkit reviewed and improvements identified. A plan agreed for the use of the audit tool over 3 years (13/14, 14/15, 15/16).
Q2: Distribute updated Māori Census data summaries and cross-referenced analysis sector-wide.	
Q1-Q2: Support the PHO and general practice to implement the Primary Care Ethnicity Data Audit Toolkit (EDAT) to improve ethnicity data collection and quality.	
Q3-Q4: Complete the EDAT Audit Process and introduce regular reporting using the EDAT tool (once implemented) to highlight issues and opportunities to improve data quality.	
Q3: Discuss how the audit tool will be incorporated into the annual planning process with proposed activities and targets for inclusion in the 2014/15 MHPs.	
Q4: Decreased percentage of PHO enrolled population with an ethnicity code of *'not stated'*.	

Access to Care

Objective	**More Māori are engaged in primary healthcare to ensure earlier intervention.** Primary care is the point of continuity in health – providing services from disease prevention and management through to palliative care. Increasing PHO enrolment will improve access to primary care services that enable early intervention and reduce health disparities between Māori and non-Māori.
Responsibility	West Coast DHB, West Coast PHO, Poutini Waiora.

Action/Evidence	Outcome
The West Coast has achieved high PHO enrolment rates for Māori compared with national figures and continues to increase Māori PHO enrolment at a faster rate than any other ethnicity.	Increase the PHO enrolment rate for Māori. **Baseline 2012/13:** Māori 93% [1] Total Population: 88% **Target:** 95%
Q1-Q4: Continue to review and compare PHO ethnicity data on a quarterly basis.	
Q3–Q4: Support the general practice teams by providing cultural competency training to Practice staff to improve the levels of engagement with Māori.	
Q1: Implement the Newborn Services Enrolment form[2] in maternity services to ensure timely newborn enrolment with multiple health services.	
Q3: Evaluation of Newborn Enrolment form.	
Q4: 100% of newborns enrolled with a general practice by 6 weeks.	

[1] PHO enrolment calculated from 2006 Census data – will be updated this year against 2013 Census.
[2] The Newborn Services Enrolment form includes the National Immunisation Register, Well Child Tamariki Ora, General Practice, Breastfeeding Support Services and the Community Dental Service.

Avoidable Hospital Admission

Objective	**Maintain low rates of avoidable hospitalisation for Māori of all ages** By reducing risk factors and taking appropriate early intervention, many conditions can be prevented and/or managed without the need for hospital care. Keeping people well and out of hospital is a key priority as it is not only better for our population, but it frees up hospital resources for people who need more complex and urgent care.
Responsibility	West Coast DHB, CCCN, Child and Youth Workstream, West Coast PHO, Grey/Westland & Buller IFHS Workstream, Poutini Waiora.

Action/Evidence	Outcome
Work with the West Coast Primary Health Organisation and Poutini Waiora and through the Health of Older People and Child and Youth Health Workstreams to identify opportunities to reduce ambulatory sensitive hospital admissions (ASH) for Māori.	Decrease in ASH rates for 0 – 4 years **Baseline 2012/2013**: Māori 197%[3] Total Population: 102% **Target**: ≤101%
Q1 –Q4: Monitor and review ASH rates for the West Coast through the Health of Older People and Child and Youth Health Workstream.	
Q1-Q2: Develop and implement an action plan to facilitate improved management of ASH conditions in primary care.	
Q1-Q4: Maintain 100% coverage of under-sixes to access free after hours primary care – report quarterly on 100% coverage of under-six access to free after hours primary care.	
Q1-Q4: Work collaboratively with the Well Child Tamariki Ora (WCTO) Quality Improvement Group to develop and implement a WCTO Quality Improvement Plan focused on improved access, improved outcomes and improved quality for Māori. **Q4:** 86% of infants (0-12months) receive all WCTO core contacts in their first year of life by December 2014. **Q4:** 90% of Māori children and children living in high deprivation areas receive a B4 School Check (B4SC). **Q4:** 100% of all children referred following a B4SC are seen before their fifth birthday.	
Q1-Q4: Poutini Waiora Tamariki Ora Nurse, mother and pēpi and Whānau ora kaimahi will work with the West Coast DHB and the West Coast PHO to facilitate improved management of Māori tamariki who have been admitted to hospital.	
Q1-Q4: Work with primary care partners LMC's and hospital provider arm to encourage every pregnant woman to register with a GP.	

[3] These measures are based on the national performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity, while this has little impact on total population results it is having a significant impact on Māori results against this measure. The DHB is working with the Ministry to resolve this issue.

Action/Evidence	Outcome
Q1 – Q4: Implement the recommendation from the West coast Oral Health Review to address ASH admissions for children and young people.	A reduction in ambulatory sensitive (avoidable) hospital admissions for Māori (rate per 100,000 people): Decrease in ASH rates for 0-74 years. **Baseline 2012/2013**: Māori 147% Total Population: 87% **Target** <95%
Q1 – Q4: Work with the Clinical Complex Care team and Poutini Waiora to identify Māori referrals and pathways in to the service and removed barriers that delay access to care.	
Q1-Q2: Engage Poutini Waiora in the Long Term Conditions Management Programme (LTCM) care planning to support Māori to better manage their conditions and prevent admission.	
Q3 – Q4: Utilise the LTCM programme enrolment information to increase the number of Māori enrolled in LTC programme and case managed by Kaupapa Māori Services.	
Q2: Work with secondary care services to develop a clear pathway for post treatment support for Māori on admission to and discharge from hospital to ensure a care plan is in place and reduce the chance of readmission.	Decrease in ASH rates for 45-64 years. **Baseline 2012/2013**: Māori 166% Total Population: 69% **Target** <95%
Q4: Implement processes to notify primary care practices of the hospital admission of their patients. System will also include notification to other health professional involved in that patients care e.g. CCCN, Poutini Waiora.	
Q1-Q4: Monitor reduced acute admissions of vulnerable older people – with ethnicity data reported to the Older Person's Health Workstream.	
Q1 - Q4: Support development of community based falls prevention service to reduce the number of older Māori being admitted to hospital as a result of a fall. **Q4**: Falls Prevention Programme in place.	

Child Health

Objective	**Improve health amongst mothers and their babies by increasing the number of mothers who fully and exclusively breastfeed their baby to six months.** Breastfeeding lays the foundation for a healthy life, contributing positively to infant wellbeing and potentially reducing the likelihood of obesity later in life. Although breastfeeding is natural, it sometimes doesn't come naturally so it's important that mothers have access to appropriate support and advice.
Responsibility	Breastfeeding Interest Group, West Coast DHB, West Coast PHO, WCA Child & Youth Health Workstream, WCA Healthy West Coast Governance Workstream.[4]

Action/Evidence	Outcome
Through the West Coast Breastfeeding Interest Group, strengthen stakeholder alliances, undertake joint planning and promote available services to improve breastfeeding rates amongst Māori**.**	An increase in the percentage of Tamariki breastfed Age 6 weeks – Exclusively or fully breastfed **Baseline 2012/2013**: Māori 69% Total Population: 61% **Target** 74%
Q1-Q4: Monitor local breastfeeding data to identify issues, underperformance and to support future service planning.	
Q1-Q2: Review current pregnancy/parenting programme content to ensure programmes are appropriate and responsive to the needs of Māori.	
Q1-Q2: Develop strategies to improve attendance of Māori, Pacific Island and younger women at pregnancy /parenting programmes.	
Q4: >30% of new mothers' access DHB-funded pregnancy /parenting courses.	
Q1: Newborn Multiple Enrolment form implemented with all new Mothers receiving contact by an LMC within a day of discharge to establish additional support requirements with breastfeeding.	Age 6 months – Exclusively, fully, or partially breastfed **Baseline 2012/2013**: Māori 57% Total Population: 60% **Target** >59%
Q1-Q4: 100% of Māori mums at McBreaty are provided with an option to enrol with Poutini Waiora Mother and Pepī service.	
Q4: >75% of Māori babies exclusively breastfed on hospital discharge.	
Q1-Q4: Provide access to the PHO free lactation consultants and specialist advice for mothers.	
Q1: Work with the Breastfeeding Interest Group to reprioritise breastfeeding services and improve access for Māori.	Note: this data represents Plunket Data only.
Q1-Q4: Support 'Mum-4-Mum' training for peer support counsellors and work with the Poutini Waiora Mother & Pēpi Service to increase the number of Māori Mum-4-Mum counsellors.	
Q1- Q4: Support Mana Tamariki - Mana Mokopuna, Mana Whānau o Te Tai Poutini project to address the needs of young Māori mothers.	

[4] The Breastfeeding Interest Group (BIG) is made up of consumers, DHB, Midwives, Lactation Consultants, GP representation and PHO Breastfeeding services

Cardiovascular Disease (CVD)

<table>
<tr><td>Objective</td><td colspan="2">Improve early detection and support long-term condition management amongst Māori.
Cardiovascular Disease (CVD) is the leading cause of death on the West Coast. West Coast Māori have a higher burden of cardiovascular disease than West Coast non-Māori. This includes higher mortality rates for all cardiovascular diseases and higher ischaemic heart disease hospitalisation rates. The Long Term Conditions Management (LTCM) programme is now well established within all of the general practice teams on the West Coast and provides a key opportunity to reduce inequalities for Māori through prevention, early intervention and condition management support.</td></tr>
<tr><td>Responsibility</td><td colspan="2">West Coast DHB, West Coast PHO[5], Poutini Waiora, WCA Complex Clinical Care Network.</td></tr>
<tr><td colspan="2">Action/Evidence</td><td>Outcome</td></tr>
<tr><td colspan="2">Continue to monitor and review CVD risk assessment rates quarterly against the national health target.</td><td rowspan="5">An increase in the percentage of the eligible Māori population who have had a CVD risk assessment in the past five years.
Baseline 12/13 Q4: Māori 59%
Total Population: 58%
Target 14/15: 90%</td></tr>
<tr><td colspan="2">Q1-Q4: Support the PHO and general practice to ensure management of people with diabetes, CVD and other long term conditions is person/whānau centred through:
▪ The ongoing development and maintenance of clinical pathways to ensure appropriate and consistent access to all services and support,
▪ Supporting Kaupapa Māori Nurses to work with Māori enrolled on the Long Term Conditions Management programme to develop Whānau Ora care plans with the patient and their families/whānau,
▪ Improved care coordination for Māori who have complex conditions through ensuring better access for Māori to Complex Clinical Care Network and multi-disciplinary planning teams.</td></tr>
<tr><td colspan="2">Q1-Q4: Support Poutini Waiora Kaupapa Māori Services work with Practice teams to identify and engage those Māori with chronic conditions who are not supported in the Long Term Conditions Management programme.
Q4: More LTCM level 2/3 Māori have a named Case Manager.</td></tr>
<tr><td colspan="2">Q1: Enagage Poutini Waiora Māori and Kaupapa Māori teams in CCCN multi-disciplinary team meetings for people with complex conditions.
Q2-Q4: Poutini Waiora Kaupapa Māori teams develop Whānau Ora plans with Māori who have chronic conditions.</td></tr>
<tr><td colspan="2">Q1-Q4: Kaupapa Māori Nurses from Poutini Waiora work with practice teams to assist with primary care recall and outreach services to improve outcomes for Māori with diabetes, CVD, chronic obstructive pulmonary disease, and other significant long term conditions.</td></tr>
</table>

[5] *Poutini Waiora Maori Health Provider work in partnership with the West Coast PHO as a partner within f the Integrated Family Health Service*

Action/Evidence	Outcome
Q1 – Q2: Review the primary/secondary cardiology patient pathway to support an integrated approach to CVD management. **Q1-Q4:** Work within the South Island Cardiac Alliance Workstream to align cardiac activity across the South Island. **Q1-Q4:** Implement regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification, stabilisation and appropriate transfer of ACS patients. **Q1-Q4:** Participate in the provision and collection of data for the national Cardiac (ANZACS QI) and Cath/PCI Registers to enable monitoring of intervention rates and quality of service delivery. Q1-Q4: Monitor waiting times for West Coast patients and work with the regional provider on any issues identified.	High-risk ACS patients accepted for coronary angiography receive an angiogram within 3 days of hospital admission. **Baseline 12/13:** new **Target 14/15:** 70% Patients presenting with ACS who undergo coronary angiogram are captured on the ANZAC QI Register within 30 days. **Baseline 12/13:** new **Target 14/15:** 95%

Cancer

Objective	**Improve early detection and reduce the disease burden of cancer amongst Māori.** Cancer is the second leading cause of death on the West Coast and a major driver of hospitalisation in New Zealand. While cancers attributable to tobacco smoking are expected to decline (with declining tobacco consumption), cancers related to poor diet, lack of physical activity and rising obesity levels are on the increase. While West Coast Māori have similar occurrence of cancers, they are 50% more likely to die than West Coast non-Māori. This suggests an area of unmet need for Māori and highlights the importance of cancer screening to ensure early detection and treatment.
Responsibility	West Coast DHB, NCSP Service, Poutini Waiora, West Coast PHO, Breastscreen Aotearoa, Local Cancer Team.

Action/Evidence	Outcome
Through the Cervical Screening Clinical Nurse Manager and Breastscreen Aotearoa South we will continue to focus on strengthening the pathway between the DHB Māori Cervical Screening Nurse, Poutini Waiora and the PHO practices with a special focus on screening wahine Māori for cervical and breast cancer as a high priority group.	An increase in the percentage of Māori women aged 25-69 screened in the last three years under the National Cervical Screening Programme (NCSP). **Baseline 12/13** Māori 69.4% Total Population 77.9% **Target 14/15**: 80%
Through the Local Cancer Team and Southern Cancer Network strengthen stakeholder alliances, review pathways and ensure equitable access to cancer treatment is prioritised.	
Q1 – Q4: Six monthly monitoring of cervical and breast screening targets.	
Q1 – Q4: Poutini Waiora kaimahi will work with DHB outreach cervical screening services to deliver clinics that will target hard to reach Māori women. **Q4**: 4 clinics delivered.	
Q1 – Q4: the Māori Cervical Screener will work with the Poutini Waiora Kaupapa Māori Nurses and Kaiarataki to engage high needs hard to reach wahine Māori.	
Q1 – Q4: Overdue priority women lists will be forwarded from the practices to the Māori Cervical Screening service or Poutini Waiora service to assist with primary care recall and access to services for those most hard to reach.	

Action/Evidence	Outcome
Q1 – Q4: Work with the regional Breastscreen Aotearoa Co-ordinator to continue to ensure support services are engaged and co-ordinated effectively for Māori.	An increase in the percentage of Māori women aged 45-69 screened in the last two years under the BreastScreen Aotearoa (BSA) programme.[6] **Baseline 12/13**: Māori 88% Total Population: 81% **Target 14/15:** >75%
Q1 – Q4: Work with the regional Breastscreen Aotearoa Co-ordinator to ensure equitable access to services for rurally isolated women.	
Q1-Q4: High suspicion of cancer and faster cancer treatment reporting will provide accurate ethnicity reporting of cancer diagnosed patients.	
Q1-Q4: The Cancer Nurse Coordinator will work with Poutini Waiora Kaupapa Māori services to develop a combined care plan for Māori newly diagnosed with cancer.	
Q1 – Q2: Host a hui for Māori to promote wellness, survivorship and promote awareness of signs and symptoms.	

[6] *Data supplied by Breastscreen Aotearoa by Ethnicity for 24 months to 30 Nov 2013*

Smoking

Objective	**Reduce the prevalence of smoking and smoking related harm amongst Māori** The 2013 Census showed that 19.6% of West Coast residents were regular smokers, compared to 14.4% of New Zealand as a whole. Amongst West Coast Māori, 32.4% of the population were regular smokers. The negative health outcomes associated with risk factors such as tobacco smoking place considerable pressure on our health system. Smoking is also a substantial contributor to socio-economically based health inequalities.
Responsibility	West Coast DHB, West Coast PHO, WCA Healthy West Coast Governance Group, Community and Public Health, Poutini Waiora, West Coast Tobacco Free Coalition

Action/Evidence	Outcome
Q1-Q4: Support the development of practice specific smokefree policies to ensure the primary care health target is owned within the practice and increased delivery of ABC within practices.	An increased percentage of current Māori smokers enrolled in a PHO provided with advice and help to quit. **Baseline 12/13 Q4**: Māori 56% Total Population: 55% **Target 14/15:** 90%
Q1: Health Target Champions identified through primary care.	
Q1-Q4: The PHO Smokefree Co-ordinator will share lists of uncoded patients (no current smoking status recorded) with Poutini Waiora Kaimahi for targeted follow up of Māori.	
Q1-Q4: Continued circulation of monthly performance bulletins at practice level, including relevant and current research to monitor progress and engage practice staff in delivery of ABC.	
Q1-Q4: Hospital Kaiawhina deliver ABC to all Māori patients and engage with the Smokefree Services Co-ordinator and Charge Nurses to investigate 'missed patients'.	An increased percentage of hospitalised Māori smokers are provided with advice and help to quit. **Baseline 12/13 Q4**: Māori 98% Total Population: 95% **Target 14/15**: 95%
Q1-Q4: Maintain monthly performance monitoring and follow-up by Charge Nurse Managers to improve practice and systems.	
Q3: Review existing systems and processes to identify opportunities to strengthen practises to sustain target performance. Consider cultural training for staff where ABC for Māori is low. **Q4:** ≥80 staff attend training Q4.	
Contribute to the work of the West Coast Tobacco Free Coalition to ensure an integrated and systamatic approach towards Smokefree Aotearoa by 2025. Work closely with the Healthy West Coast Workstream to regularly monitor progress against targets.	An increased proportion of total smoking cessation enrolments are Maori. **Baseline 12/13:** Māori 12% **Target: 14/15:** >12%
Q2: West Coast Tobacco Control Plan Updated.	
Q1: Māori smoking cessation is prioritised through the Healthy West Coast Alliance Workstream and a plan developed to improve Māori access across all services.	
Q1: Provide ongoing support via the Smokefree Services Coordinator, DHB Smoking Cessation Service and Aukati Kaipaipa to identify clear cessation pathways and support for Māori who smoke.	
Q1-Q4: 90% of pregnant Māori women (who identify as smokers at confirmation of pregnancy in general practice or booking with an LMC) will be offered advice or support to quit smoking.	

Q1-Q4: Work with Poutini Waiora to support direct referral to Coast Quit and the Aukati Kaipaipa cessation service to increase clients referred to cessation services.	
Q4: 100 Māori enrol in the Aukati Kaipaipa cessation programme.	
Q1-Q4: % of those Māori enrolled in Aukati Kaipaipa programme with validated abstinence at 3 months.	
Q4: >75% of year 10 students have never smoked.	

Immunisation

Objective	**Increase immunisation amongst vulnerable Māori population groups to reduce the prevalence and impact of vaccine pre-preventable diseases.** Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups. While the West Coast has high immunisation rates for both Māori and non-Māori, these high rates must be maintained or improved in order to prevent or reduce the impact of preventable diseases.
Responsibility	West Coast DHB, WCA Health of Older Persons Workstream, Immunisation Advisory Group, West Coast PHO, Poutini Waiora.

Action/Evidence	Outcome
Through the West Coast Immunisation Advisory Group review systems for seamless handover between maternity, general practice and Well Child services. Support timely multiple enrolments of newborns on the National Immunisation Register (NIR) and with a general practice and WCTO provider.	An increase in the percentage of eight-month olds who are fully immunised. **Baseline 12/13 Q4:** Māori: 100% Total Population: 93% **Target 14/15:** ≥95%
Q1 – Q4: Monitor immunisation rates and support general practice and outreach coordinators to identify areas of underperformance for improved delivery.	
Q2: Provide practice-level and PHO level coverage reports to identify and address gaps in coverage.	
Q1-Q4: Link maternity, general practice and Kaupapa Māori Provider services to support enrolment of newborn Tamariki with general practice and locate and enrol hard to reach children. **Q4:** 95% of newborn babies are enrolled on the NIR at birth.	
Q1-Q4: Monitor newborn enrolment processes and develop systems for seamless handover of mother and child as they move from maternity care services to general practice and WCTO services.	
Focus Outreach Immunisation Services on locating and vaccinating hard to reach children and reducing inequalities for tamariki Māori. **Q1-Q4:** Practice teams refer Tamariki to Kaupapa Māori services.	

Action/Evidence	Outcome
Q1-Q4: Promote and provide free seasonal flu vaccinations for Māori with chronic conditions, pregnant wāhine and Māori 65+.	An increase in the percentage of the eligible population (aged 65+) who have had a seasonal influenza vaccination. **Baseline 12/13:** Māori 72% Total Population 63% **Target 14/15**: 75%
Q4: Support the PHO to report and monitor flu vaccination rates for people aged 65+ by ethnicity to focus on uptake by Māori.	
Q4: Work with practice teams and health promotion teams to increase uptake by Māori of the seasonal influenza vaccination targeting 65+.	
Q4: 3 Outreach clinics targeting Māori 65+ will be hosted by Poutini Waiora and the West Coast PHO.	

Oral Health

Objective	**Improve oral health for Tamariki and Rangatahi.** Regular dental care has lifelong health benefits. It also indicates early contact with effective health promotion and reduced risk factors, such as poor diet. Tamariki Māori are three times more likely to have decayed, missing or filled teeth. Oral health therefore presents an opportunity to reduce inequalities and better target those most in need.
Responsibility	West Coast DHB, West coast PHO, Community & Public health, Poutini Waiora, Child and Youth Health Workstream.

Action/Evidence	Outcome
Through implementation of the Oral Health Review, working alongside health promotion agencies, and the West Coast DHB Dental Service we will continue to improve oral health enrolments, timeliness of examinations and ensure robust systems are in place for those who require further assessment or treatment.	Improve the number of pre-school Māori enrolled in DHB funded dental services **Baseline 12/13:** Māori 66.4% Total Population 85% **Target:** 90%
Q1-Q4: Implement the Oral Health Review findings.	
Q1-Q4: Nutritional and Oral health promotional activities delivered to Māori.	
Q1: West Coast DHB Dental Services will provide education and information on 'Lift the Lip' to Poutini Waiora Kaimahi. **Q4:** 86% of children with a 'Lift the Lip' score of 2-6 are referred to specialist services as part of the B4SC.	
Q1-Q4: West Coast DHB dental services will provide enrolment packs for all ages to Poutini Waiora Kaimahi and identify clear pathways into the service.	
Q1: West Coast DHB Dental Services and Poutini Waiora will introduce the level one mobile screening unit into community settings to ensure that barriers are removed for pre-schoolers to attend appointments.	

Rheumatic Fever

Objective	**Reduce rheumatic fever rates in the South Island.** In a small number of people, an untreated Group A streptococcal sore throat develops into rheumatic fever, where their heart, joints, brain and skin become inflamed and swollen. This inflammation can cause rheumatic heart disease, where there is scarring of the heart valves. This may require heart valve replacement surgery, and in some cases, premature death may result. Māori children and young people are more likely to get rheumatic fever. Raising awareness and supporting people to manage their illness can improve outcomes for Māori.
Responsibility	South Island Regional Alliance, Community and Public Health

Action/Evidence	Outcome
Q1-Q4: Support the implementation of a South Island Regional Rheumatic Fever Prevention and Management Plan through the South Island Public Health Workstream.	Maintain low rates of rheumatic fever in the South Island. **Baseline 12/13:** 0.7 per 100,000 **Target 14/15:** <0.3 per 100,000[7]

[7] Because of the very low numbers of rheumatic fever cases, South Island DHBs do not have individual rheumatic fever targets. Instead, the South Island DHBs are taking a regional approach, outlined in the South Island Regional Health Services Plan.

Mental Health

Objective	Improve health outcomes for the Māori population by assisting services to enhance service quality and responsiveness.
Responsibility	West Coast DHB, West Coast PHO, Poutini Waiora, Child and Youth Workstream, Suicide Action Group.

Action/Evidence	Outcome
Through the Child and Youth Health Workstream and by implementing the outcomes of the Mental Health review we will review Māori youth access and uptake of primary mental health services for Rangatahi.	An understanding of the drivers behind CTO rates. **Baseline 12/13:**
Q1-Q4: Implement the Prime Minister's Youth Mental Health Project.	
Q3: Review and localise HealthPathways including youth mental health and youth sexual health pathways.	
Q3: Specific services to Rangatahi Māori pathway links developed.	
Q1-Q4: Implement recommendations from the West Coast Mental Health Review.	
Q2-Q3: Work with primary care providers to strengthen their responsiveness to youth.	
Q3: Develop an integrated and responsive stepped care model to improve engagement rates for Māori earlier in the continuum for youth mental health services (Child and Youth Health Workstream).	
Q3: Review utilisation rates for Māori to primary care mental health.	
Q3: Review tāngata whaiora pathways through specialist mental health and alcohol and drug services; identify areas where pathways can be strengthened.	
Q1-Q3: Work with specialist mental health services to better understand the differences between Māori and non-Māori Community Treatment Order rates.	

	Number of clients under 29	Rate per 100,000 population
Māori	5	147
Non-Māori	31	105

Local Priorities

Disease Prevention

Objective	**To reduce the risk factors of long term conditions by improving nutrition, increasing physical activity and reducing obesity.** The World Health Organisation estimates that more than 70% of healthcare funds are spent on long-term conditions. Many long-term conditions share common risk factors and are preventable; smoking, inactivity, poor nutrition and rising obesity rates are major contributors to an increase in long term conditions.
Responsibility	West Coast DHB, West Coast PHO, Poutini Waiora, Community Public Health, Health West Coast Governance Group.

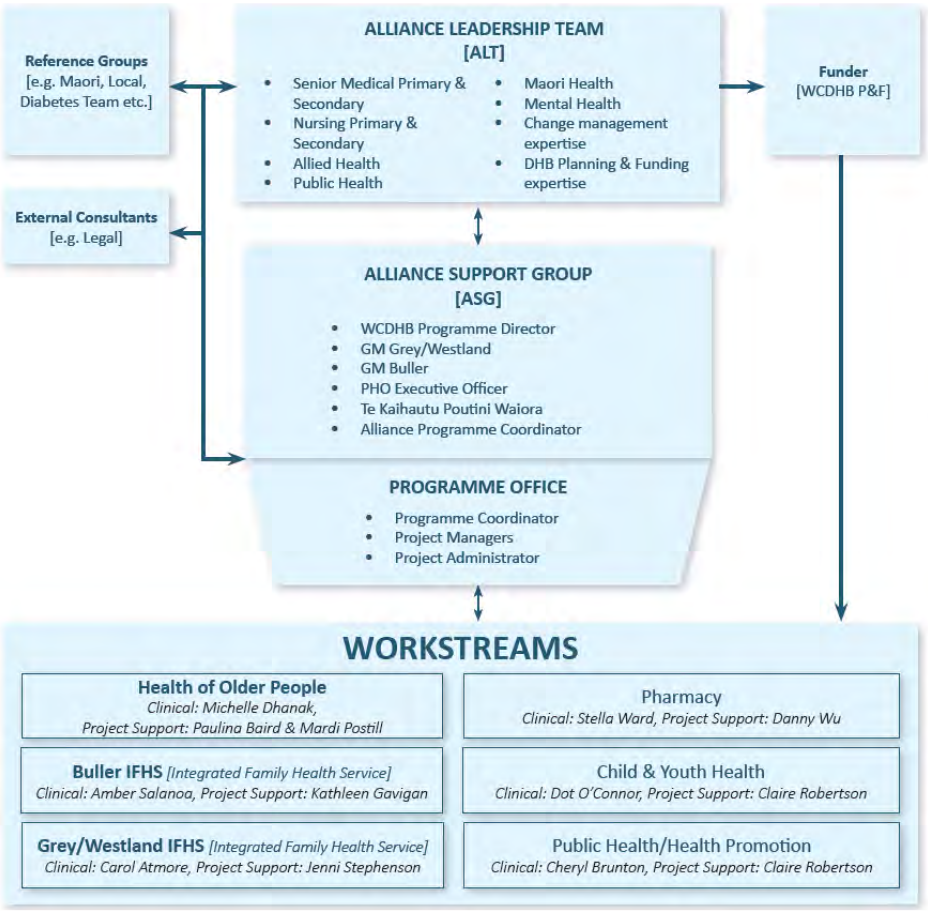
Action/Evidence	Outcome
Through the promotion of healthy lifestyles, including nutrition and increased physical activity, we will increase awareness of physical activity opportunities in the community.	Regular reporting on activity to Healthy West Coast Workstream.
Q1-Q4: Collaborate in joint planning with the Healthy West Coast Governance Group to coordinate public health services, create health-promoting environments and improve outcomes for Māori.	
Q1-Q4: An increase in the proportion of Green Prescription referrals for Māori.	
Q1-Q4: A measurable improvement in quality of life measures for Māori receiving intensive support through the Te Whare Oranga Pai programme.	
Q1 – Q4: Increased proportion of Māori participating in Appetite for Life.	
Q1 – Q4: Increased proportion of Māori referred to dietetic services.	

DNA Rates

Objective	**A measureable reduction in Did-Not Attend (DNA) rate for outpatient appointments.** Despite higher incidence and higher morbidity for a range of conditions data would suggest that Māori do not access secondary elective services at a level proportional to need. Māori have significantly higher DNA rates in comparison to the non-Māor population.
Responsibility	West Coast DHB, Poutini Waiora

Action/Evidence	Outcome
Q1-Q4: Refine data collection systems to provide monthly DNA reports by ethnicity, service and location.	A reduction in Did-Not-Attend (DNA) rates for Māori attending Outpatient clinics. **Baseline 12/13:** Māori 14% Total Population 8.2% **Target 14/15:** <14%
Q1-Q4: Tailor specific interventions to lower DNA rates for Māori.	
Q1-Q4: Establish processes and protocols to follow up Māori who did not attend clinics.	
Q1-Q4: Identify integrated approaches to supporting high risk patients attend outpatient appointments.	
Q1-Q4: Approach Māori providers to discuss how they and their Kaimahi can assist with reducing DNA rates amongst their clients.	
Q1-Q4: Monthly tracking of Māori DNA across all outpatient clinics.	

Appendix 1 – West Coast Health Alliance Structure



West Coast Alliance

To provide increasingly integrated and coordinated health services through clinically-led services development and implementation, within a 'best for patient, best for system' framework.

ALT

Selected to lead our alliance and the work that falls within the agreed scope of alliance activities.

- Provide system-level oversight, monitoring of workstreams and ensuring connectedness and a whole of system approach by alliance activities.
- Collectively members provide the range of competencies/expertise required for the alliance to achieve its objectives.

ASG

Facilitates, administers & supports the workstreams and leadership team (the 'glue').

- Allocate resources to operationalise/ implement priorities ie. Who is going to do what, how will the costs be managed?
- Provide feedback to workstreams and advice to ALT

Workstreams

Propose transformational service improvement, identify areas requiring redesign and innovation.

- Report regularly to ALT
- Feed into Annual Plan around deliverables

ALLIANCE UPDATE

TO: **Chair and Members**
West Coast Primary Health Organisation Board

SOURCE: **Alliance Leadership Team**

DATE: **19th June 2014**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the progress made by the West Coast Alliance.

2. RECOMMENDATION

That the Board;
i. Notes the Alliance Update.

3. SUMMARY

Reinvigorate the West Coast Alliance

- **Annual Planning -** The ALT formally endorsed the final draft of the West Coast DHB Annual Plan, confirming that the content is aligned to the individual workstream plans.
- **Mental Health workstream –** Following the recommendations made by the Mental Health Review team, ALT endorsed the establishment of Mental Health workstream under the Alliance framework. Work is now underway to develop membership of the workstream and Terms of References to detail the scope of the workstream.
- **Integrated Family Health Centre (IFHC) visits -** The ALT were pleased to note the success of the visits a working party made to the IFHC Project team at Pegasus Health (Christchurch) and the Midlands Health Network (Hamilton).
- **The Complex Clinical Care Network –** The ALT were pleased to note the progress of the development of the CCCN.

Implement the Complex Clinical Care Network [CCCN]

- The Complex Clinical Care Network (CCCN) client base has increased with Home Based Support client numbers growing with the new restorative model of care. There has been a decline in the number of people being admitted into ARC as they are now able to receive care longer in their own home
- The casemix 8 (CREST like model) pilot is still continuing and the next stage is the evaluation of the service.
- Earlier in May a Long Term Conditions workshop was held with key stakeholders to communicate the current model of care and define where there were gaps in service

delivery. Three key areas of work resulted from this workshop and these will be developed more over the next four weeks to ensure that going forward there is a more consistent model, reduced duplication and further integration with Primary Care.

Establish an Integrated Family Health Service [IFHS] in the Buller Community

- Work plans are in place and members of the Buller workstream and project teams are being convened to deliver key focus areas. As part of the planning for integration of services members of the Buller workstream attended the visit to Pegasus Health IFHC project team and the Midlands Network open day. This provided best practice and lessons learnt that will be used as part of the initiatives the Buller IFHS team will be implementing.
- Meetings are taking place with St John to explore ways to better manage presentations to Buller Health Services' Emergency Department. Regular meetings between Buller Medical Service and the community pharmacist commenced this month initially focusing on reducing prescription errors and increasing support for the pharmacy's long-term conditions programme.

Establish an Integrated Family Health Service [IFHS] in the Grey/Westland Community

- Following visits to the Pegasus Health IFHC project team and the Midland Health Network open day feedback from the visits is currently being collated and recommended next steps for the next quarter are being formulated. The visits have confirmed commitment from the three Greymouth primary practices to work together on system changes prior to physical co-location in the new IFHC.
- The workstream are investigating the training requirements of three nursing groups (Clinical Nurse Specialists, Public Health Nurses and District Nurses who currently have varying levels of access and understanding of Medtech software. The workstream will facilitate the training necessary to allow these groups to both read and write clinical notes for patients on their caseload.

Develop an Integrated Model of Pharmacy on the West Coast

- The Pharmacy workstream have begun work to enable Pharmacists on the Coast to become accredited to do work beyond their usual scope.
- Pharmacists continue to increase their engagement with CCCN interdisciplinary meetings as well as undertaking some home visits to CCCN clients.
- In response to requests from both hospital and community pharmacists, some impromptu training in Maori Health has been delivered by Gary Coghlan as well as some basic Te reo for hospital pharmacy staff.

Develop Healthy Environments and Healthy Lifestyles

- Discussions have taken place and will continue, looking at the roles of Health Promotion staff at both the PHO and Community & Public Health to improve the

focus and visibility of actions to target improved access to primary care and Maori specific programmes.

- Discussions have progressed regarding better support in the community for people with a high risk of Cardiovascular Disease. Increased resource around nutrition advice has been identified as a current gap and a proposal will be developed about how to best address this.
- Following the DHB Clinical Board's decision to prioritise the reduction of harm caused by both alcohol and tobacco, Healthy West Coast are working with Greymouth ED on an improved system to collect data on alcohol related injuries and investigating ways of targeting Maori smokers to increase the uptake of smoking cessation services by this group. It is the workstream's target to have 25% of smoking cessation services delivered this year to Maori.

Report prepared by: Jenni Stephenson, Planning & Funding

Report approved for release by: Stella Ward, Chair, Alliance Leadership Team

Draft APPOINTMENT POLICY FOR MĀORI REPRESENTATIVES TO Operational Health Committees

1. INTRODUCTION

This draft policy sets out an objective and transparent process for identifying and appointing appropriately skilled and experienced representatives for Māori to West Coast operational health committees.

These appointments will be made on the basis of merit and an Appointment Panel will follow governance best practice.

2 POLICY CONTEXT

The WCDHB Board (WCDHB) is responsible for all public hospital and health care provision across primary, secondary and community services in the West Coast region. Committees across these sectors are responsible for strategic planning through to responsive best practice that meets the needs of patients and the community. The participation of credible, competent Maori representation on these committees is necessary to ensure the Māori community voice is present.

The Māori Community want to ensure that Māori Representatives have the support of the Māori community whom they represent, in conjunction with having the skills, knowledge and experience necessary to positively influence Māori health outcomes.

2.1 DEFINITIONS

WCDHB Operational Committees" include a range of committee and not limited to, reference groups, working groups, service development initiatives etc. in which WCDHB has oversight.

"Key Māori Stakeholders" are representative of the Māori community and includes but is not limited to:

- Te Runanga o Ngati Wae Wae and Te Runanga o Makaawhio
- All Maori communities of Te Tai Poutini

"Appointment Panel" include members drawn from the "Key Māori Stakeholders", which is convened to fill specific vacancies; ensuring candidates have strong Māori community support. Key Māori Stakeholders, if appropriate, may include the Tatau Pounamu Committee Chair to an appointment panel.

"Māori Representatives" are applicants *(Māori whakapapa desirable but not a pre-requisite)* that are able to demonstrate understanding of Tikanga Māori, Māori health issues and the health system.

APPOINTMENT POLICY FOR MĀORI REPRESENTATIVES

3 POLICY OBJECTIVE

The objective of this policy is to ensure Māori Representatives had the support of the Māori community whom they represent, in conjunction with having the skills, knowledge and experience necessary to positively influence Māori health outcomes on WCDHB Operational Committees to which they are appointed to.

The appointment policy formalises the appointment process to secure appropriate representation on the WCDHB operational health committees.

4 POLICY STATEMENT

4.1 Selection and Appointment of 'Māori Representatives' to WCDHB Operational Committees

4.1.1 A subcommittee of the Key Māori Stakeholders, hereafter called the Appointment Panel, shall be convened to appoint Māori Representatives.

4.1.2 Where an Appointment Panel is responsible for appointing a 'Māori Representative', and has not delegated that responsibility to any other body, nominations for candidates to be appointed as 'Māori Representative(s)' to a WCDHB Operational Committee will be received via email and/or post at the West Coast DHB, Maori Health Department as the current secretariat provider.

4.1.3 An Appointment Panel will consider matters including the skills, knowledge, experience and interest of the candidates as it relates to the specific committee and decide on the successful candidate.

4.2 People appointed to such WCDHB Operational Committees are entitled to the remuneration (if any) offered by the committee to which they are appointed.

4.2.1 Where there is a vacancy, the Appointment Panel shall undertake a selection process that will include:

- Requesting curriculum vitae (e.g. through advertising via email to community networks)
- Interviewing and assessing candidates
- Reference checking

4.2.2 The Appointment Panel shall consider candidates' skills, knowledge and experience when making its decisions.

5 ADOPTED BY AND DATE

5.1 Adopted by Tatau Pounamu on XX 2014 recommendation to the WCDHB Executive Management Team on XX 2014 and adopted by WCDHB on XX 2014.

6 REVIEW

6.1 Review every three years or sooner on request.

APPENDIX 1

APPOINTMENT POLICY FOR MĀORI REPRESENTATIVES TO OPERATIONAL HEALTH COMMITTEES

1. ROLES AND RESPONSIBILITIES

1.1 To operationalise the Policy there are three key contributors, the Key Māori Stakeholders, the Appointments Panel, the Tatau Pounamu Advisory Group, West Coast DHB

2. THE ROLE OF THE KEY MĀORI STAKEHOLDERS

2.1 The role of the Key Māori Stakeholders is to:

- nominate members for an Appointments Panel pool based on experience and skills
- ensure a mix of Appointment Panel members across various disciplines and sectors, such as clinical, community, consumer and cultural
- provide a mechanism for community and cultural advice to an Appointments Panel as required
- supply a personal profile or curriculum vitae of an Appointments Panel nominee.

2.1.1 The membership of the Key Māori Stakeholders is representative of the Māori community and includes but is not limited to:

- Māori Provider
- Papatipu Runanga
- Māori Community

3 THE ROLE OF THE APPOINTMENT PANEL

3.1 The role of the Appointment Panel is to appoint an appropriate person to represent the interests of Māori on WCDHB operational health committees.

3.1.1 The Appointment Panel Chair is a WCDHB mandated position that is held by the WCDHB Māori Health General Manager. The Chair is responsible for selecting the Appointment Panel members. The minimum number of Panel members required is three.

3.2 The Panel tasks include:

- reviewing and assessing applicant information
- interviewing applicants
- utilising specific interview and competency tools provided
- appointing a representative with relevant skills and experience that has the support of the wider Māori community
- notify secretariat of successful applicant within five working days.

APPENDIX 1 cont.

4 THE ROLE OF Tatau Pounamu Manawhenua Advisory Group

4.1 The aim for the Tatau Pounamu Advisory Group is to engage in a culturally appropriate process to ensure that Māori are well represented within operational health committees.

4.1.1 The role of the Tatau Pounamu include:

- providing Appointments Panel Chair, who will liaise with the secretariat as required
- advising the secretariat that the WCDHB operational health committee is seeking Māori representation and provide all relevant documentation
- advising successful and unsuccessful applicants
- supporting the Key Māori Stakeholders, Appointments Panel and Secretariat in their respective roles
- respond to queries/feedback as required
- providing orientation for the selected Māori representative.

5 THE ROLE OF THE SECRETARIAT

5.1 Tatau Pounamu provides the secretariat role.

5.1.1 The role of the secretariat is to ensure:

- the Key Māori Stakeholders are appropriately engaged
- notifying all key stakeholders, including Māori providers and wider Māori community of a request for Māori representation
- inform Appointments Panel nominees of selection to Appointment Panel
- receiving all relevant documentation from the applicants for secure storage
- notify all key stakeholders, including Māori providers and wider Māori community of successful appointee
- ensure a robust and transparent process is undertaken to appoint a Māori representative to the WCDHB Operational Committees.

5.2 The function of the secretariat is to assist in facilitating the seamless management of the appointments process. The secretariat tasks include:

- providing key competencies based on vacancy specification
- relevant documentation to assist with candidate assessment and appointment
- receive and collate candidates' curriculum vitae and/or additional supporting information
- complete a due diligence for each candidate, if required
- facilitate feedback to WCDHB for a response
- shortlist candidates against key competencies

- Assemble and distribute an information pack to the Appointments Panel with recommendations for consideration.

TATAU POUNAMU
MANAWHENUA ADVISORY GROUP
2014 MEETING SCHEDULE

DATE	TIME	VENUE
Thursday 20 February 2014	3.00 - 5.00pm	Board Room, Corporate Office, Greymouth
Thursday 11 April 2014	3.00 - 5.00pm	Poutini Waiora, Hokitika
Thursday 26 June 2014	3.00 - 5.00pm	Boardroom, Corporate Office, Greymouth
Thursday 24 July 2014	2.00 - 4.00pm	Board Room, Corporate Office, Greymouth
Thursday 23 October 2014	3.00 - 5.00pm	Boardroom, Corporate Office, Greymouth
Thursday 4 December 2014	3.00 - 5.00pm	Board Room, Corporate Office, Greymouth
		POTENTIAL ADDITIONAL MEETING TO BE ADDED

MEETING DATES & TIMES ARE SUBJECT TO CHANGE

MINISTRY OF HEALTH
MANATŪ HAUORA

COPY

No.1 The Terrace
PO Box 5013
Wellington 6145
New Zealand
T+64 4 496 2000

12 June 2014

Dr Paul McCormack (ext)
Chair
West Coast District Health Board
PO Box 387
GREYMOUTH 7840

Dear Dr McCormack (ext)

Primary Health Organisation (PHO) Health Target Performance Quarter three 2013/14 and Newborn Enrolments

Please find enclosed the Quarter three results for the three Primary Care Health Targets.

- **All PHOS have improved results for the More Heart and Diabetes Checks but none have yet met the target of 90% which is required by July 2014.**
- **Three PHOs have reached the Better Help for Smokers to Quit target**
- **Immunisation rates are static nationally**
- **For the first time you will find enclosed a table with the newborn enrolment percentages by PHO**

Newborn enrolment
The preliminary newborn enrolment policy (the B code) supports the 'Increased Immunisation' target. The expectation is for all newborns to be enrolled with a general practice within 2 weeks of birth. Performance against this will now be included in this letter each quarter.

Nationally the number of babies enrolled within 3 months is currently at 69 percent (Quarter three 2013/14) which is a small increase from Quarter two (63 percent). As per our letter to PHOs on 2 May 2014, PHOs need to focus on improving this.

Attached is a table with newborn enrolment figures by PHO. As already communicated on 2 May 2014 there is work underway to improve the monitoring process for newborns enrolled with general practice. In the meantime the current method of monitoring provides a good indication of how many newborns are benefitting from early enrolment.

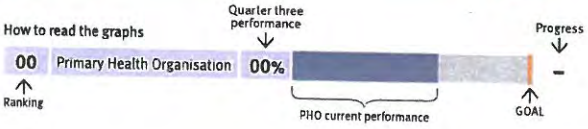
Better Help for Smoker to Quit
Performance on the 'Better Help for Smokers to Quit' target has improved by six percent across all PHOs in comparison with Quarter two. National performance is now at 72 percent. Twenty three PHOs improved their performance, with nine PHOs losing ground compared to last quarter. Three PHOs reached the target and total performance remains well below the 90 percent target. Further work needs to be done to improve performance on this target.

More Heart and Diabetes Checks
The national Quarter three result for the 'More Heart and Diabetes Checks' target is 78 percent, an increase of five percent from the previous quarter. All PHOs improved their performance,

How is My PHO performing?

2013/14 QUARTER THREE (JANUARY TO MARCH) RESULTS

MINISTRY OF HEALTH
MANATŪ HAUORA



Increased Immunisation

Using PHO Performance Programme (PPP) Data

		Quarter three performance	90%	Change from previous quarter
1	Central Primary Health Organisation	97%		▲
2	Christchurch PHO Limited	97%		▲
3	Compass Health – Wairarapa	97%		–
4	Kimi Hauora Wairau (Marlborough PHO Trust)	95%		–
5	Pegasus Health (Charitable) Limited	95%		▲
6	Health Hawke's Bay Limited	95%		▼
7	Southern Primary Health Organisation	95%		–
8	East Health Trust	94%		▼
9	Primary and Community Services (Sth Cant)	94%		▼
10	Ora Toa PHO Limited	94%		▲
11	West Coast PHO	93%		▲
12	Compass Health – Capital and Coast	93%		–
13	Rotorua Area Primary Health Services Limited	93%		▲
14	Cosine Primary Care Network Trust	93%		▼
15	Procare Networks Limited	93%		–
16	Waitemata PHO Limited	93%		–
17	Midlands Health Network – Lakes	92%		▼
18	Total Healthcare Charitable Trust	92%		–
19	Whanganui Regional PHO	92%		▼
20	Rural Canterbury PHO	92%		▼
21	Alliance Health Plus Trust	92%		–
22	Te Awakairangi Health Network	92%		▼
23	Western Bay of Plenty PHO Ltd	91%		▲
24	Te Tai Tokerau PHO Ltd	90%		▲
25	Manaia Health PHO Limited	90%		–
26	Well Health Trust	90%		▼
27	Auckland PHO Limited	90%		▼
28	Midlands Health Network – Waikato	90%		▼
29	Midlands Health Network – Tairawhiti	89%		▼
30	Midlands Health Network – Taranaki	88%		▼
31	Nelson Bays Primary Health	88%		▼
32	Eastern Bay Primary Health Alliance	88%		▼
33	National Hauora Coalition	87%		–
34	Hauraki PHO	85%		▼
35	Ngati Porou Hauora Charitable Trust	83%		▼
36	Nga Mataapuna Oranga Limited	69%		▼
	All PHOs	92%		–

Increased Immunisation

The national immunisation target is 90 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014. This quarterly progress includes children who turned eight months between January and March 2014, are enrolled in a PHO and who were fully immunised at that stage. Consequently, the All PHOs percentage above (92%) will be different to the All DHBs percentage (91%).

Better Help for Smokers to Quit

Using PHO Performance Programme (PPP) Data

		Quarter three performance	90%	Change from previous quarter
1	Manaia Health PHO Limited	94%		▲
2	Compass Health – Wairarapa	92%		▼
3	Primary and Community Services (Sth Cant)	90%		▲
4	East Health Trust	85%		▼
5	Whanganui Regional PHO	84%		▲
6	Western Bay of Plenty PHO Ltd	82%		▲
7	Alliance Health Plus Trust	82%		▼
8	Central Primary Health Organisation	81%		–
9	National Hauora Coalition	81%		▲
10	Nelson Bays Primary Health	80%		▼
11	Compass Health – Capital and Coast	80%		▼
12	Eastern Bay Primary Health Alliance	78%		▲
13	Midlands Health Network – Waikato	77%		▲
14	Te Tai Tokerau PHO Ltd	74%		▲
15	Health Hawke's Bay Limited	74%		▼
16	Midlands Health Network – Lakes	74%		▲
17	Midlands Health Network – Taranaki	72%		–
18	Total Healthcare Charitable Trust	71%		▲
19	Christchurch PHO Limited	70%		▲
20	Midlands Health Network – Tairawhiti	69%		▲
21	Procare Networks Limited	69%		▲
22	Nga Mataapuna Oranga Limited	68%		▲
23	Kimi Hauora Wairau (Marlborough PHO Trust)	66%		▼
24	Te Awakairangi Health Network	65%		▲
25	Pegasus Health (Charitable) Limited	65%		▲
26	Ora Toa PHO Limited	64%		▲
27	Southern Primary Health Organisation	63%		–
28	Rural Canterbury PHO	63%		▲
29	Rotorua Area Primary Health Services Limited	63%		▲
30	Ngati Porou Hauora Charitable Trust	62%		▲
31	Hauraki PHO	61%		▲
32	Auckland PHO Limited	61%		▲
33	Waitemata PHO Limited	57%		▲
34	West Coast PHO	55%		▼
35	Cosine Primary Care Network Trust	52%		▼
36	Well Health Trust	47%		–
	All PHOs	72%		▲

Better help for smokers to quit

The national target is that 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

More Heart and Diabetes Checks

Using PHO Performance Programme (PPP) Data

		Quarter three performance	90%	Change from previous quarter
1	Manaia Health PHO Limited	88%		▲
2	Auckland PHO Limited	87%		▲
3	East Health Trust	86%		–
4	Procare Networks Limited	86%		▲
5	Whanganui Regional PHO	86%		▲
6	Total Healthcare Charitable Trust	85%		▲
7	Midlands Health Network – Lakes	85%		▲
8	Compass Health – Wairarapa	85%		▲
9	Alliance Health Plus Trust	84%		▲
10	Ngati Porou Hauora Charitable Trust	84%		▲
11	Central Primary Health Organisation	84%		▲
12	Western Bay of Plenty PHO Ltd	83%		▲
13	Rotorua Area Primary Health Services Limited	83%		▲
14	Cosine Primary Care Network Trust	83%		▲
15	Compass Health – Capital and Coast	82%		▲
16	National Hauora Coalition	82%		▲
17	Eastern Bay Primary Health Alliance	81%		▲
18	Midlands Health Network – Taranaki	81%		▲
19	Midlands Health Network – Tairawhiti	81%		▲
20	Midlands Health Network – Waikato	81%		▲
21	Te Tai Tokerau PHO Ltd	79%		▲
22	Health Hawke's Bay Limited	79%		▲
23	Nga Mataapuna Oranga Limited	79%		▲
24	Primary and Community Services (Sth Cant)	78%		▲
25	Waitemata PHO Limited	77%		▲
26	Ora Toa PHO Limited	75%		–
27	Nelson Bays Primary Health	73%		▲
28	Hauraki PHO	73%		▲
29	Rural Canterbury PHO	73%		▲
30	Well Health Trust	72%		▲
31	West Coast PHO	70%		▲
32	Te Awakairangi Health Network	69%		▲
33	Southern Primary Health Organisation	69%		▲
34	Kimi Hauora Wairau (Marlborough PHO Trust)	69%		▲
35	Christchurch PHO Limited	69%		▲
36	Pegasus Health (Charitable) Limited	53%		▲
	All PHOs	78%		▲

More heart and diabetes checks

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years by July 2014.

Health Target results use information provided by the PHO Performance Programme (PPP) which is sourced from national collections and primary care organisations.

More information on the health targets can be found on www.health.govt.nz/healthtargets

New Zealand Government

PHO Name	PHO Enrolment (Including B Codes)	Number of Newborns on the NIR	Newborn Enrolment Coverage	Rank
Cosine Primary Care Network Trust	107	101	106%	1
West Coast PHO	75	78	96%	2
Total Healthcare Charitable Trust	392	409	96%	3
Midlands Health Network - Lakes	86	94	91%	4
Well Health Trust	51	57	89%	5
Rural Canterbury PHO	227	255	89%	6
Te Awakairangi Health Network	335	383	87%	7
Midlands Health Network - Tairawhiti	83	95	87%	8
Rotorua Area Primary Health Services Limited	219	252	87%	9
Christchurch PHO Limited	78	90	87%	10
Ora Toa PHO Limited	64	77	83%	11
Auckland PHO Limited	145	179	81%	12
Whanganui Regional PHO	151	189	80%	13
Pegasus Health (Charitable) Limited	834	1,058	79%	14
Waitemata PHO Limited	516	658	78%	15
Midlands Health Network - Waikato	587	761	77%	16
Procare Networks Limited	1,982	2,602	76%	17
Midlands Health Network - Taranaki	267	352	76%	18
South Link Health Incorporated	112	151	74%	19
Compass Health	101	137	74%	20
Nelson Bays Primary Health	171	233	73%	21
Te Tai Tokerau PHO Ltd	149	204	73%	22
Kimi Hauora Wairau (Marlborough PHO Trust)	91	125	73%	23
Manaia Health PHO Limited	215	296	73%	24
Western Bay of Plenty PHO Limited	309	429	72%	25
Southern Primary Health Organisation	573	830	69%	26
Compass Health - Capital and Coast	503	746	67%	27
National Hauora Coalition	270	403	67%	28
Hauraki PHO	203	303	67%	29
Health Hawke's Bay Limited	355	530	67%	30
Nga Mataapuna Oranga Limited	22	37	59%	31
East Health Trust	159	268	59%	32
Ngati Porou Hauora Charitable Trust	12	21	57%	33
Central Primary Health Organisation	269	481	56%	34
Alliance Health Plus Trust	146	285	51%	35
Eastern Bay Primary Health Alliance	74	151	49%	36
Unknown or Blank	0	1,082	n/a	
Total	**9,933**	**14,402**	**69%**	

talking."

GP waiting times continue to improve

Waiting times for routine appointments at local GP practices continue to improve in Buller, Reefton and South Westland, says West Coast District Health Board (DHB) chief executive David Meates.

There had been a slight rise in wait times for routine appointments in Karamea and Greymouth, mainly due to the need to better manage leave arrangements, Mr Meates told last week's DHB meeting.

Recruitment of both permanent and locum GPs continued, with strengthened partnerships between Better Health – which helps manage the DHB practices – and DHB recruitment teams.

Resolving the reliance on locum GPs in Buller remained a priority, but this hadn't reduced access to primary care in Buller, Mr Meates' report said.

Key stakeholders and decision-makers in primary care would meet this month to set the direction and priorities for West Coast primary care services in the coming year, and to agree how this would happen.

Vacancies

The DHB's job vacancies had fallen to 31 after a number of successful appointments.

Nursing vacancies had dropped from 17 to nine.

Nursing roles in Buller had proved particularly difficult to fill.

"It is difficult to find suitable applicants who are serious about relocating to the area."

Interest continued in medical vacancies. An anaesthetist and a general surgeon had accepted job offers. A face-to-face visit by an obstetrician and gynaecologist, who had been interviewed and deemed suitable, was scheduled next month, Mr Meates said.

Coast has high rate of Maori breast screening

By Lee Scanlon

The West Coast District Health Board (DHB) has the second highest rate nationwide for Maori breast screening.

The DHB had screened 81 percent of the target Maori population, according to a report from chief executive David Meates to last week's DHB meeting.

The national target was 70 percent.

The Coast DHB was among only four in New Zealand to meet the national target for breastfeeding by Maori mothers, Mr Meates said. Seventy-one percent of all West Coast Maori mothers were fully or exclusively breastfeeding their baby at six weeks, up from 56 percent in the last quarter.

The target was 68 percent.

However, the DHB did not reach two other Maori health targets.

Only 68 percent of Maori had had their cardiovascular risk assessment. The target was 90 percent, but no DHBs had achieved it to date. Auckland DHB came closest at 80 percent.

The Coast DHB had a plan in place with Poutini Waiora and the primary health organisation (PHO) to target Maori overdue for their assessment, Mr Meates said.

Ninety-three percent of West Coast Maori had registered for the PHO. The target was 100 percent.

Buller St John meets response targets

By Kim Fulton

Buller's ambulance service is meeting most of its target times, unlike St John services in some other parts of the country.

St John is failing to get to emergency callouts in Auckland and some rural areas inside the time limits set for it, according to an internal report aimed at improving its service.

St John Buller territorial manager Robbie Blankenstein said the Buller District was generally compliant with targets.

"Where we tend not to meet the targets is simply a function of geography," he said.

New Zealand was broken into urban, rural or remote areas, each with different target times.

St John aimed to get to half of all red and purple (life threatening) calls in rural areas, including Westport, within 12 minutes and 93 percent within 25 minutes.

However, Charleston, for example, was classified as rural but impossible to get to in 12 minutes.

Mr Blankenstein said it was his job to look into cases where St John should have met target times but didn't.

"One of the cool things about the Buller, or perhaps quieter rural communities such as ours, is we have the ability to look into each and every single one of those cases."

In Auckland, where the service dealt with hundreds of cases each day, it assessed trends rather than individual cases.

Most of the Westport station's work occurred in the town and staff got to most of those jobs within the 12-minute target, even at night when volunteers were responding from home.

While people responding from home could take a couple of minutes extra, asking them to stay at the station might mean there would be fewer volunteers.

"We need people to volunteer so we need to be volunteer friendly," said Mr Blankenstein.

St John had systems for responding to incidents in distant places.

Community responders near the Lewis Pass and Punakaiki had basic equipment in their private vehicles.

Sometimes when St John missed targets locally it was because the emergency ambulance was already committed to another job.

Population size could also affect whether targets were met. For example, Karamea's population increased by a couple of hundred people over summer.

Mr Blankenstein said it would be interesting to see how changes to the mining industry affected Westport's population over the coming years.

Bathurst Resources was yet to start on its Deniston mine, Solid Energy had downsized and Holcim would soon leave the town.

Whatever happened with the population would be reflected in St John's workload statistics, as well as its ability to get volunteers, he said.

Deployment plans

Mr Blankenstein said St John had been doing a lot of work on deployment plans, which involved planning where and how St John used available resources effectively. St John in Westport didn't have a lot of flexibility, due to the staffing level and the fact there was only one emergency ambulance.

It had to look for small time-savings such as using the most efficient forms of paging. Call centres were also now pre-alerting which meant an ambulance could be dispatched before all information about an incident was collected.

St John funding

Labour health spokeswoman Annette King has said she wants the emergency part of the ambulance service fully funded, The New Zealand Herald reported.

St John is funded for 80 percent of the money needed to provide services to the public - with the exception of accidents - and is forced to seek donations and grants to meet costs.

Mr Blankenstein said that if somebody's house was on fire, or their car was being broken into, the response was fully government funded.

"But if you're having a heart attack you're relying on a part-funded organisation to come to your rescue."

St John attended far more incidents than the fire service and its level of service and equipment were dependent on funding.

He said the volunteer staff model was sensible but it was "unique" that the provision of vehicles and equipment wasn't 100 percent government funded.

nzDoctor.co.nz

News

Regular news from the New Zealand Doctor newsroom

Maori slipping through disease prevention net

Virginia McMillan
vmcmillan@clear.net.nz
Tuesday 08 April 2014, 3:29PM

PHO enrolment of Maori patients is below target in 16 DHBs, and no DHB has reached the target in six other indicators of Maori health.

The measures include cardiovascular risk, where Maori are not receiving close to their targeted level of assessments.

The Ministry of Health collected the data as at 31 January from 20 individual DHB reports and released a summary table to *New Zealand Doctor* after an Official Information Act request.

Counties Manukau DHB had the highest ambulatory-sensitive hospital admissions (ASH) rate for Maori aged 45 to 64, at 2.94 times the target, while Waitemata's was 2.59 times and Waikato's, 2.57

A long way from the target

This shows in Hutt Valley, Nelson Marlborough and Southern DHBs - which all missed the PHO enrolment target - the proportion of eligible Maori risk-assessed for cardiovascular disease was just 57 per cent.

The national target is 90 per cent.

The best-performing DHBs were assessing 78 per cent and 74 per cent of eligible Maori within the required five years.

Public health research professor Tony Blakely, of the University of Otago Wellington, says many of these indicators are getting better, but there is still a way to go.

"Hats off to the minister"

The CVD/diabetes target is a good one, Professor Blakely says: "Hats off to the current health minister for pursuing this and several other targets in primary care…

"It should be possible to lift the rates for everyone without inequalities opening up."

But Professor Blakely says there is a lot of concern among clinicians that active management, with lifestyle modification and drugs, that should follow when risk is assessed at a certain level, may not be being provided often enough.

The incentive is to record the data, he says.

A look at reports from one DHB with a large Maori population, Bay of Plenty, shows there has been a substantial rise in the number of Maori assessed for CVD risk.

In June 2012, 44.4 per cent of eligible Maori had been assessed. By January this year, this had risen to 63 per cent.

Muriel Tunoho, national coordinator of primary care network Health Care Aotearoa, is also concerned about the follow-up and continuing care of patients once they have been risk-assessed.

This is mostly done by nurses, "and it's hard work when you are already busy", Ms Tunoho says.

Different starting points

Among the problems with targets, she says, is the fact that "people are coming in at different starting points".

Ticking a box may lift the numbers, "but is it improving the health of your population?" Ms Tunoho asks.

Health Care Aotearoa is committed to improving health and access to quality healthcare for Maori, but remains concerned the focus on indicators and targets is too narrow (eg, excluding social determinants of health), she says.

The PHO performance target for percentage of Maori enrolment in PHOs should be replaced by one that addresses unmet need, Ms Tunoho says.

More advice to Maori smokers

The Maori health plan indicators also cover brief smoking cessation advice given in primary care to smokers.

Bay of Plenty again made progress. In 2012, just over 35 per cent of the Bay's high-needs populations (including Maori) received this advice; now this is provided for 73 per cent of Maori.

Meanwhile, Maori continue to be over-represented in hospital admissions that are potentially preventable by primary care.

Counties Manukau DHB had the highest ambulatory-sensitive hospital admissions (ASH) rate for Maori aged 45 to 64, at 2.94 times the target, while Waitemata's was 2.59 times and Waikato's, 2.57.

ASH rates for children under five years of age stood out in Whanganui DHB, where the rate was 2.17 times higher than non-Maori, Hutt Valley DHB (2.07 times) and Southern DHB (2.03).

Screening for breast cancer in Maori women aims for 70 per cent, but only seven of the 20 DHBs reached or exceeded this.

Capital & Coast, Wairarapa, Hutt Valley, Nelson Marlborough, Canterbury, MidCentral and Bay of Plenty had fewer than half their Maori preschoolers enrolled in DHB-funded oral care. Capital & Coast had just 27 per cent enrolled and Canterbury, 30 per cent.

A word about Wairarapa

In Wairarapa DHB (where Maori residents numbered about 5500 at the 2006 Census):

- 100 per cent of the Maori population were enrolled in a PHO
- 71 per cent of Maori women were screened for breast cancer and 80 per cent for cervical cancer (on target)
- 98 per cent of hospitalised Maori smokers received smoking cessation advice
- the target for advice to smokers in primary care was exceeded, and
- 95 per cent of eight-month olds were fully immunised.

Return to homepage

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

West Coast DHB
Mental Health & Addictions
Service Review
Summary Report

Contents

Executive Summary

One hundred and eighty people from all parts of the West Coast Mental Health Addiction Services (MHAS) presented their views. There was considerable agreement on the key issues. The review team's system-wide approach was welcomed and endorsed.

The review team was told by one consumer:

> *'This review is the most important event that has happened to MHAS since… 2000. This is the first time that mental health service users and caregivers have been given the power to speak… This seemingly small decision just to include us has had an incredibly positive effect on its own…*
>
> *'We are a group who really want to be part of our community, not a burden. Being mentally unwell is not easy, but it is made a lot easier when there is an innovative, caring/partnership focused service… a quality integrated, inclusive, primary, community and even workplace care model, creating a quality of life that will bring about hope and well-being without stigma, discrimination or boundaries…'*

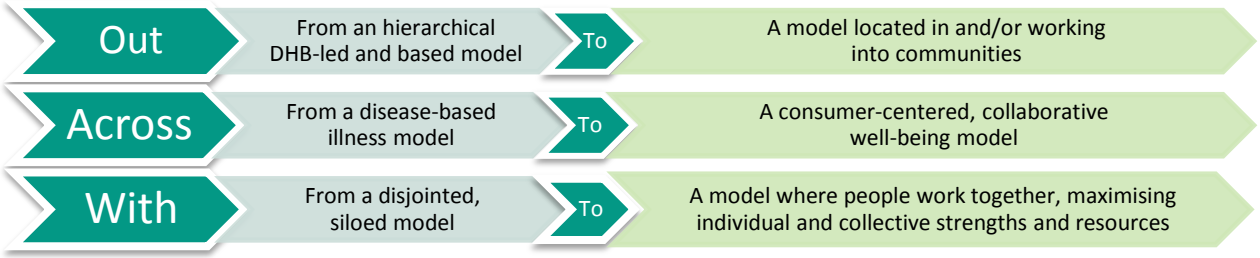
This report presents the views formed by the team about the current state of the system, and the opportunities available to transform it into a healthier, sustainable system. Recommendations are made to introduce a four-faceted framework encompassing:

- system model;
- service model;
- workforce; and
- infrastructure.

The recommended model places the needs of consumers, their families and whānau, and support networks at the centre. It recognises that consumers live most of their life in their chosen communities.

The model has been designed to align with the direction of change underway for the entire West Coast health system. It recommends that a specific focus on MHAS is maintained, and taken into account when determining roles, responsibilities and accountabilities for the whole system.

The review team has placed the desired directions into three simple concepts:



A leadership group is key to achieving the future direction recommended by the review team. This group should be representative of the whole system and have delegated powers to drive the change process.

Changes are also required in MHAS that mirror the broader changes. Clinical governance and leadership will be particularly important so that internal and external health providers work together better for the interests of the consumer.

The recommended service model is a stepped care approach to emphasise that the system and services will be geared to early, skilled support and intervention and avoidance of crises and inpatient admissions. These steps are:

- community well-being, prevention and support;
- primary care pathway;
- community mental health and addiction services; and
- specialist services.

The model demonstrates the review team's strong support for a move to locality services. General practices, Integrated Family Health Centres (IFHCs) and Non-Government Organisations (NGOs), community facilities and consumer bases are obvious sites for service delivery and inter-service collaboration.

The review team recommends that inpatient services are retained on the West Coast, however, the shape of acute and crisis services needs to change. More work is required to achieve the desired transformation of services and reconfiguration of resources to accommodate the changes. Similarly, dementia and Child & Mental Health Services (CAMHS) need to continue to change and adapt to be available to localities and yet retain their specialisation.

The review team is aware that the model has to work within existing resources. Most resources currently sit within MHAS. The implementation of recommendations will focus on utilising these resources differently to ensure the full range of services is available locally.

However, the review team is optimistic that realignment is achievable without compromising safety and quality in acute care. Support from Canterbury, via the Transalpine Agreement, will be a valuable addition to the West Coast energies and resources.

This is very much the beginning of the process, rather than the end.

Key Principles

In preparing the report, the review team developed a set of key principles to guide its work and recommendations. These principles are strongly reflective of the views of the diverse groups consulted with throughout the review process, and also the national direction and strategy for mental health services as outlined in the document 'Rising to the Challenge'. The review team's principles are:

For, about and from the West Coast

- The report will provide for Better, Sooner, More Convenient mental health services for the West Coast. It will reflect the needs of the West Coast and be informed by, and about, the people of the West Coast.
- The voices of Coasters themselves, especially mental health service consumers, their families and whānau, have been and will continue to be heard and be evident in the final document.
- Where recommendations are made for greater integration with and support from Canterbury, it is because these will produce the best result for Coasters and the delivery of safe and sustainable MHAS on the West Coast.
- Local community groups, tangata whenua and Māori health providers, consumer groups, family and whānau, clinical teams and NGOs will have a continuing role in collectively determining the direction and shape of the MHAS on the Coast.
- Success in implementing the recommendations requires a 'whole of health' approach using existing resources, including those outside of the DHB boundaries. This will require a challenge to the siloed culture of current service provision.

A proactive focus on primary care

- The report will focus on the provision of more primary care-based mental health services available in local communities.
- The report accepts that early intervention for people (and their families and whānau) experiencing mental health and/or addiction issues is vital.
- An emphasis on proactive care to aid recovery, to assist people to stay well and to deal with issues before they become crises is at the foundation of this document.

Integration, flexibility and trust

- We will aim for a holistic, integrated, locality-based MHAS, serving communities throughout the West Coast.
- The report will recommend ways for GP teams, community and public health, the Primary Health Organisation (PHO), community groups, NGOs, consumer groups and clinical services to work together. The vision is for a co-ordinated and co-operative MHAS throughout the West Coast, working together within a high trust model.
- We agree that it is preferable for services to be orientated to provide a continuum of care along the lines of a 'stepped care model' where services can be flexibly adjusted to meet people's differing levels of need over time. Movement between services, or use of several services at the same time, will be seamless, with information and patient records moving with the consumer.
- This principle includes an agreement that every consumer will have a single, identified, point of

primary care contact who will co-ordinate their access to the full range of needed services. For people with less complex needs this will most likely be their GP; for people with more complex and/or ongoing needs, this will most likely be the mental health clinician or support worker with whom they have the strongest relationship.

- An 'any door is the right door' approach will be a focus. Consumers, their families and whānau, will be able to enter the mental health system at any level or through any provider. They will be able to trust that all of the available resources will be integrated to provide the best service for their needs with a focus on recovery provided as near to their home as possible and in the least intrusive manner.
- We plan for a system where health professionals will trust and have confidence in each other across services and work together to provide flexible person-centred care. The consumer will be able to trust that providers will ensure appropriate resources are provided at the right level, at the right time, by the right service and the right person/team.
- Consumers will have full and timely access to information collected about them.

Clinically led, management enabled

- Systems will support integrated, efficient consumer-focused service delivery.
- Policies, procedures and administrative systems will support MHAS providers and their staff to deliver a service designed for and with the consumer.
- A high trust model will be a focus where locality-based staff, within clear professional and ethical guidelines, have the flexibility to adapt the system and/or the way they deliver their services to meet the specific needs of the community and/or their consumers. The basis for this will most likely be a 'tight-loose-tight' model where clear expectations for services and expected outcomes are defined. But, providers will have the flexibility to develop local solutions to service delivery in response to local needs.
- Health systems will free up service providers to deliver care, and support them with adequate management and administrative support so that productive, skilled, professional carers can maximise the time they have available for consumers.

Work within resources

- Budgets are largely fixed. More money will not necessarily be available, or even be the best option. We will look at how existing resources can be used differently to achieve better outcomes for consumers, their families and whānau.
- We will plan for greater co-operation within and across service providers to avoid duplication, build in innovation and flexibility and ensure the right services are delivered efficiently, in the right places and in the right way for the consumer.
- The report will recognise that some secondary and specialist services will still need to be centralised in Greymouth and/or off-Coast. The report will look at how to create a system that reduces the need for these specialist secondary services by providing better, more proactive, locally-based primary care.

Measurement, clarity of data and reliability

- We will work to ensure that recommendations in the report will be clear, unambiguous, achievable and measureable.
- The principle of shared information systems across all providers will guide our recommendations to help ensure consistency and continuity of care, and security of data.
- The report will seek to ensure that information can be effectively collated and used for evaluation, to ensure the best services are provided.

Not just another review

- While the report will go through another series of feedback and approval processes following its release, the Review Committee, the WCDHB and allied organisations, and MH and A providers share a determination to see the review result in a plan that can and will be actioned.
- The report will allow for a structure that ensures the ongoing involvement of the community and consumer groups.
- The report will seek to ensure that the new MHAS is transparent and accountable and will continue to actively seek consumer, family and whānau, tangata whenua and community input into the implementation of the plan and its continuous improvement.

Framework for Change and Recommendations

Four areas are recommended for priority attention to turn the current fragmented service delivery model dominated by the SMHAS into an MH and A system and service model that gives effect to West Coast needs and priorities.

This section describes the features of the model recommended by the review team. The model encompasses four aspects: [1] the system model; [2] service model; [3] workforce; and [4] infrastructure. It seeks to enhance sustainability, access, collaboration and communication. It aims to diminish fragmentation and silos.

Figure 1: Current model of service delivery

Figure 2: Proposed model of service delivery

The proposed model's potential is illustrated in the diagram above which emphasises most people accessing services in the first three steps, and a few needing to access specialist inpatient and crisis resolution services from time to time.

1. System Model

The new model emphasises that every stakeholder has a voice and a contribution. The system should no longer be seen as hierarchical with SMHAS appearing to lead and make decisions on behalf of other players.

1.1 System philosophy

A system philosophy should be explicitly adopted that aligns with the guiding principles outlined in 'Rising to the Challenge – The Mental Health and Addictions Service Development Plan 2012 – 2017' as follows:

- Actively challenge stigma and discrimination when encountered.
- Value communities as essential resources to support family and whānau well-being and the effective delivery of service.
- Expect recovery and work in a way that will support it and that will build future resilience.
- Engender hope by demonstrating a belief in the talents and strengths of service users.
- Form authentic partnerships with service users at all levels and phases of service delivery.
- Promote participation and leadership of service users at all levels.
- Personalise services to the particular needs of the service user and their family and whānau.
- Strive to uphold the human rights of service users and their family and whānau.
- Respect diversity and demonstrate cultural competence.
- Encourage and support positive participation by families and whānau.
- When working with Māori take a Whānau Ora approach.
- Work collaboratively while transcending service boundaries and boundaries between Government sectors.

This philosophy is characterised by:

- early identification of MH and A issues
- well-promoted access pathways
- purposeful engagement based on the principle of access to the least intensive or intrusive level of care required to meet need
- the development of effective crisis resolution
- clear communication across the system
- effective intervention by well-skilled services delivering evidence-based care in the least restrictive way possible
- collaboration within and between sectors to extend consumers' support networks and social participation.

1.2 Strengths-based recovery approach

The system needs to operate from a strengths-based recovery approach that is visible in each service, interaction and in the workforce practices and culture.

A strengths-based recovery approach means consumers are supported in living the life of their choice.

1.3 System Leadership / Alliance Group

A multi-faceted leadership system needs to be embedded through the creation of a mental health alliance group.

This group would be responsible for leading the successful implementation of the new system and service model. Group membership will connect the MHAS system and motivate engagement, service development and new ways of working. The group should comprise senior SMHAS, NGO, primary care, consumer, Māori, family and community leaders, would interact regularly with local 'shared vision' roundtables and would engage with the emerging alliance structure for the overall West Coast health system. Potentially, it could become a work stream within that structure to reinforce an ongoing MHAS viewpoint into the WCDHB health system.

1.4 Resource Allocation and Accountabilities

To change the system and services there needs to be a shift in resource allocation and accountabilities between community, locality and specialist services.

2. Service Model

The recommended MHAS model describes how the WCDHB could provide the preferred model of locality-based stepped care services, with specialist services available centrally or virtually.

Implementation of these recommendations should ensure that MHAS are delivered differently, yet safely, to a high standard. Services should be accessible and at the level of intensity required. The workforce might need to change in terms of skills, location, ways of working and partners. Resources will need to be reconfigured to enable the service model to be achieved.

2.1 Service Location

Locality services should be multidisciplinary. They should be integrated to facilitate working together. Ideally they will be co-located with, or working into, primary care, IFHCs and/or NGO community mental health services. Specialist services should be based in Greymouth, or available on a virtual basis.

2.2 Outline of Stepped Continuum of Care

- Community well-being – prevention and support: MHAS should have an emphasis on resilience and well-being. This, together with information and support services, can help people self-manage their care and improve access to community support. This can reduce the demand on, or need for, reactive services at a more formal level within the health system.
- Primary care pathway: A person's state of well-being can be addressed at the primary care level where decisions can be made on what level of intervention and intensity of service is required. People with mild to moderate needs will receive most services at the primary care level. Those with more acute or complex needs will be linked to the community and specialist services they need. The emphasis will be on co-ordinating care and support services in an integrated way rather than continual (but disconnected) referrals and reassessments. The physical and mental health needs of the community should be catered for in

the development of the integrated family health practice. Currently support services are only available to consumers in the SMHAS – these need to be broadened so that support is available at a much earlier preventative or early intervention level.

- Community mental health and addiction services: Consumers with moderate to acute and/or severe needs will work with community MHAS in their localities for the period they require this level of support. Services should be locality-focused and include those currently delivered by NGOs, SMHAS, Community Mental Health Teams (CMHTs) and addictions. They will be aligned and integrated to include the following components:
    - comprehensive clinical assessment, care planning and treatment
    - co-existing pathways
    - community support including peer, family and whānau support
    - cultural support
    - meaningful activity rehabilitation and social participation: vocational and employment services
    - accommodation support: residential and respite care (acute and planned)
    - intensive assertive management/extended treatment
    - crisis resolution.

Specialist services: An important aspect of all health services includes having good access to care within people's own communities, with specialist care readily available for acute illness. The strategy for the development of mental health services as outlined in 'Rising to the Challenge' advises that consumers with low prevalence and/or high needs will continue to access services from specialist community MH and A teams and inpatient units. Consequently, consumers who need acute inpatient services will access them from the unit at Grey Base Hospital but, with evolution of the services, more consumers should be able to access at least some acute services locally.

2.3 Service transformation within the SMHAS

It is imperative that inpatient services are retained on the West Coast, however, the shape of acute services needs to change. Similarly, dementia and CAMHS services need to continue to change and adapt to be available to localities and yet retain their specialisation.

In order to implement the stepped care model three service areas require additional thought, and projects should be established to investigate the evolutionary processes for these services further. These areas are the acute, CAMHS, and dementia services.

Specifically, the review team believes there needs to be:

- Acute services: More locally responsive acute services (crisis assessment and treatment, respite options.
- CAMHS services: It is important to undertake a process to identify the optimal CAMHS focus as a specialist service, balancing maintaining CAMHS specialty expertise and support with more efficient and locally-integrated and responsive service delivery.
- Dementia services evolution: It is important to establish a process to identify the optimal pathway for dementia services development as a specialist service and participant in the implementation of the Older Persons' Health Implementation Plan (OPHIP).

3. Workforce

SMAHS employs a wide range of clinical and non-clinical leaders and workers. New roles might be needed, other roles need enhanced generalist or specialist level skills, leaders need training and mentoring, and supervision is essential in some areas. This is to ensure that the workforce is able to deliver new and existing services in different ways into the future.

3.1 Workforce development plan

A detailed workforce development plan should be developed. The plan should consider service and professional development options such as recruitment, retention, succession planning, professional development and reallocation of resources to support the stepped care locality-based model. The plan would ensure the right workforce resources are in the right place, avoiding duplications and gaps, and deal with:

- Peer and peer support workforce
- Nursing workforce
- Medical workforce
- Primary and allied health workforce
- Support/clerical administration workforce

4. Infrastructure

A modern infrastructure should be adopted to enhance the ability of the workforce and services. The review team found some barriers within the current system. These need to be addressed to implement the recommended service delivery model.

4.1 Information

Information collection, accuracy and reporting into and out of the data collection repositories need to be streamlined. Alternative methods of input need to be explored to avoid high use of clinical time inputting data.

4.2 Quality

Reflective practice and evidence, quality and service improvements are vital to the health of the system. Attention needs to be paid to this part of the model. Accurate information and a compelling quality focus are needed to support system-wide and service quality improvements. The system also needs confidence that strict legislative requirements are being met.

4.3 Technology

Information technology initiatives such as the new IPM system, telemedicine and other new fixed and mobile communication options can greatly enhance workers' effectiveness and the services offered to consumers. However, there needs to be a plan to scope the needs and to make the resources available across locality and specialist services. Staff need training in their use.

4.4 Facilities

Given that the model is recommending a locality focus for most services, the facilities that house them must be fit for purpose. A facilities plan is needed to complement the model development and workforce plan.

4.5 Transport

Adequate and efficiently managed transport resources are required to operate locality-based services and provide access to and from the centralised specialist service.

Next Steps

The review team has given thought to the next steps and identified priorities that need a concerted focus. The team has been conscious that people need to be prepared for change.

Alongside the goodwill and participation, there was a lot of anxiety about this review from consumers, their families and whānau, and the workforce. Engaging people in the change process is crucial. Processes must be found to demonstrate the positives achievable from different ways of providing and receiving services. This builds a momentum for change. A galvanising approach is especially important for the West Coast given its particular sustainability issues and its report fatigue.

Senior leadership must have sufficient time and information to make the decisions that pave the way for change.

The team believes that further recommendations can be achieved within the current financial year and have suggested the locus of responsibility for achieving them.

Summary of recommendations

The table below contains:

Recommendations supported from the review report, either as originally proposed or with explanatory notes to guide implementation

Revised recommendations

	Recommendation	Notes for implementation	Revised recommendation	Timeframe
System Model				
1	All providers of MHAS explicitly agree and adopt the system philosophy.	*System philosophy* .		**6 months**
2	All providers of MHAS explicitly agree and adopt the strengths- based recovery approach.	*Strengths-based recovery approach*.		**6 months**
3	Appoint and establish the Mental Health Alliance group with clear roles and responsibilities.	This would take the form of a workstream within the West Coast Health Alliance framework.		**3 months**
4	Under the umbrella of the Transalpine Agreement, work with CDHB Planning and Funding staff to appoint a project manager to drive the development of the implementation plan.	The joint West Coast and Canterbury Planning and Funding team to provide support.		**3 months**
5	Clarify resource reconfiguration to meet the model's requirements, along with any change in accountabilities.			**Ongoing**
Service Model				
6	Most services should be locality based; i.e. co-located with or working into the six general practice and health centres on the West Coast, integrated into family health centres as	This requires clusters of DHB, NGO and general practice to work together to provide more effective early intervention, crisis		**12 months**

	Recommendation	Notes for implementation	Revised recommendation	Timeframe
	they become established in Westport and Greymouth and/or into community mental health providers.	resolution, respite care and general support at a local level to avoid the need for hospital admission.		
7	Develop the stepped continuum of care with clear and visible expectations and observable changes about new ways of working and culture.	*Stepped continuum of care*.		**6 months**
8	Consider the integration of the mental health Needs Assessment and Coordination [NASC] roles being integrated into the CCCN Needs Assessment service to ensure the mental health and physical health needs of complex clients and the wider community are met.	The integration of mental health NASC services into the Complex Clinical Care Network [CCCN] is a priority.		**12 months**
9	Identify specific strategies to achieve greater integration between mental health and physical health services.	Rather than an unspecified timeframe, 12 months reflects the priority of this activity.		**12 months**
10	Consider a single point of entry for the whole spectrum of Mental Health and Addiction Services [MHAS].		Develop mechanisms for enhanced access to MHAS via integrated local pathways.	**2 years**
11	Consider the application of the CAPA model.	CAPA [Choice and Partnership Approach] is one established way of working that reduces wait times and increases responsiveness. A range of approaches that reduce wait times and increase responsiveness are needed.		**Ongoing**
12	Review the role of NASC to fit with the stepped care model by developing a system wide agreement on eligibility criteria for a range of services so that the wider community has direct access to cultural support, CSW,	Develop system-wide agreement on eligibility criteria for a range of services so that people can access the support they need regardless of where they are in the system (see #8		**12 months**

	Recommendation	Notes for implementation	Revised recommendation	Timeframe
	respite and peer support.	above).		
13	Clarify locality team structures and their fit with IFHC planning and structures.	Buller 6 months. Grey | Westland 12-18 months.		**Buller: 6 months** **Grey | Westland: 12 months**
14	Increase the level of integration within the Specialist Mental Health and Addiction Service [SMHAS] mental health and addiction teams.	Full integration of SMHAS with locality-based primary mental health services, within integrated family health services.		**2 years**
15	Increase the level of integration between specialist Alcohol and Drug [AOD] service and the primary teams.			
16	Review the current range of support services provided – this includes community support workers, home based support workers and peer support workers to coordinate them more effectively, provide supervision and clarification of roles.			**12 months**
17	Investigate the possibility of providing detoxification in the community.	Increase the range of services [eg detoxification] available to local communities through workforce development [see 33-37 below].		**Ongoing**
18	Strengthen the current Maori mental health service by establishing clear processes and recruiting to vacancies.	Ensure that this work adopts a whanau ora approach, is undertaken in partnership with manawhenua, Poutini Waiora, PHO, NGOs and is aligned with commitments contained within the Maori Health Plan.		**12 months**
19	Extend the scope of Maori mental health service to include access for clients associated with the PHO as well as SMHAS.			
20	Utilise the concept of Whānau Ora to further develop the			

	Recommendation	Notes for implementation	Revised recommendation	Timeframe
	services provided by the Maori mental health service.			
21	Investigate ways of increasing the level of occupational therapy [OT] input into the services.	Increase the level of OT input through partnerships across the system and in conjunction with Associate DAH.		**6 months**
22	Establish partnerships with other sectors [eg MSD] to increase the level of meaningful occupation and activity, and rehabilitation and alternatives to supported accommodation.	This includes WINZ, CYF, MOE and NGOs.		**12 months**
23	Reconfigure residential services to enable a more flexible range of support.			**6 months**
24	Develop shared eligibility criteria for access to respite and support services across the system.	Refer #12.		
25	Acute and planned respite facilities need to be extended beyond the Greymouth region and to include access for people in the primary care sector.	Refer #6 and #12.		
26	Develop alternatives to inpatient care including residential or home support and respite.	Refer #6, #12, #23.		
27	Have the SMHAS subsystem work differently to achieve the above goals and to reflect the changes in other parts of the system, with strong clinical governance and nursing leadership and collaborative ways of working both internally and externally.		Reinstate the Transalpine mental health leadership forum to lead the further development of the Transalpine approach to the delivery of mental health services and support the work programme of the West Coast Health Alliance's mental health workstream.	**3 months**
28	Make the necessary changes to the leadership and governance structures of the SMHAS to achieve the			

	Recommendation	Notes for implementation	Revised recommendation	Timeframe
	changes in culture and different ways of working.			
Service Transformation Within Specialist Mental Health Services				
29	Reconfigure the existing resources to provide locally based planned and acute respite services and alternatives to admission, in and after hours crisis resolution and reduction in the level of acute inpatient beds while still retaining a critical mass of inpatient resource.			**24 Months**
30	Reduce the use of seclusion and restraint and introduce sensory modulation training and therapies.			**Ongoing**
31	Identify the optimal CAMHS focus as a specialist service balancing maintaining a critical mass of CAMHS specialty expertise and support with more efficient locally integrated and responsive service delivery.	CAMHS has its primary interface with integrated locality based service delivery.		**18 Months**
32	Identify the optimal pathway for dementia services development as a specialist service and participate in the implementation of the Older Persons Health Integrated Pathway.			**12 Months**
Workforce				
33	Access external leadership through the transalpine arrangements to foster and develop service user and family services [consumer, family and peer] to increase the range of support services available.			**Ongoing**
34	Formalise the leadership structure of SMHAS by confirming membership and roles to support service development.	Note this work must happen in the context of #27 & #28 above.		**6 months**

	Recommendation	Notes for implementation	Revised recommendation	Timeframe
35	Establish a specialist nurse model in appropriate parts of the continuum of care to support the model.	Establish agreed CNS roles for acute services and community/primary. Role purpose to include evidence based practice, mentor best practice, liaison with CHC specialists [including VC]. Community role to also caseload. ADON, CMs, CNE and CNS to lead integration.		**24 months**
36	Senior nursing roles with mental health need to be strengthened and more visible to ensure the nursing focus with the integrated health arena is maintained.			
37	Develop a workforce development plan with specific attention to priority workforce areas including implementation of the Transalpine Agreement where this provides and/or improves services for Coasters.			**12 months**
Infrastructure				
38	Streamline information collection and ensure the workforce is supported to efficiently enter and extract accurate data.	This involves working with CDHB IT, data management and analytical specialists to develop a team approach.		**Ongoing**
39	Develop clinically led projects to attend to information and quality development.			**Ongoing**
40	Develop a capital and operating expenditure planning and budgeting for 2014/15 to support technology, transport and facility development.		Ensure planning for the delivery of mental health and addiction services is linked to—and supports—whole of system planning, and system integration priorities.	**Ongoing**

Appendix: Terms of Reference

Background/context

The current model of service delivery for the West Coast DHB adult Mental Health and Addictions Services [MHAS] was designed and configured in 2001 when the Triage, Assessment, Crisis and Risk Team [TACT] was established, and the acute inpatient unit [IPU] and administrative base for the service were relocated from Seaview Hospital in Hokitika to Grey Base Hospital. The model of service delivery in the Community Mental Health Team [CMHT] has evolved to align with these developments during this time.

In the ensuing years, there has been significant change in the wider health environment. More recently, clear direction has been provided from Government for the mental health and addictions sector to achieve the following priorities within current resources:

- build infrastructure for integration between primary and specialist services;
- cement and build on the gains in resilience and recovery for the three per cent of the population with serious mental illness;
- earlier and more effective responses by increasing access to services for young people, adults and older persons who present with mild to moderate presentations or behaviour; and
- actively use our current resources more effectively to increase productivity.

Changes occurring within the wider West Coast DHB also impact significantly on the delivery of the MHAS on the West Coast. These include:

- pressure from Government to eliminate the long-standing financial deficit;
- closer collaboration with Canterbury DHB as reflected in the Transalpine Agreement;
- implementation of the Better, Sooner, More Convenient initiative by developing integrated family health services/facilities in Greymouth and Westport, including an integrated approach to mental health services.

In addition, the following long-standing and recent events occurring within the MHAS have now increased the urgency and need for consideration of a change to the way mental health and addictions services are structured, and what they deliver:

- the departure of two of the 3.5 psychiatrist FTEs in May 2013 will result in a situation where all of the senior medical input is provided by consultants who work part-time on the Coast but reside in Christchurch;
- the occurrence of two suicides in recent months within a short time of discharge from the IPU, an additional SAC02 event and range of incidents and complaints;
- concerns about the use of seclusion in the IPU, including an increase in both the number of seclusion events and the average length of seclusion events;
- ongoing shortages of registered nurses in the IPU, resulting in a high proportion of inexperienced nurses and new graduates in the IPU while experienced staff are based in TACT where their level of expertise is not always fully utilised;
- the model of crisis resolution provided by the TACT team is designed and resourced to respond to emergency level crises 24 hours a day/seven days a week, but the greater proportion of activity undertaken by this team is below this threshold;
- ongoing difficulties in ensuring safe care and effective communication through seamless transition as clients move between the community teams and the IPU.

The Purpose of the Review

The purpose of the review was to define a model of service delivery that:

- will inform subsequent changes to the structure and function of mental health services on the West Coast to ensure the provision of safe and sustainable services;
- meets the Government's key priorities and is aligned to the changes and priorities of the wider West Coast DHB;
- will enable the West Coast community to easily access an increased range of mental health services and effective treatment closer to their own home;
- is recovery focused, has a flexible and responsive approach to service delivery in terms of hours of work, mobility of teams and a care environment that is matched to individual consumer need;
- best utilises the existing staff resources;
- provides a platform for service and system improvements that will improve the quality and safety of services provided to the West Coast community.

The Scope of the Review

The services included in the scope of the review included:

- adult community MHAS, including those services provided by the non-government [NGO] sector and primary care;
- the services provided by the acute in patients unit [IPU] and TACT team;
- child and adolescent mental health services.

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Youth smoking rates down

West Coast Year 10 students are, on average, smoking less than students in other areas of the country, according to the 2013 Action on Smoking and Health (ASH) survey.

West Coast Tobacco Free Coalition chair, Anne Hines, said the survey showed that 2.6 percent of Year 10 students in the West Coast District Health Board area described themselves as daily smokers.

The national rate was 3.2 percent.

In some areas, the rate was much higher. Wanganui had a rate of 5.73 percent and Gisborne, 5.25 percent.

In 1999, the percentage of West Coast Year 10's who said they smoked daily was 22.5 percent.

Ms Hines was pleased with the West Coast results.

"It is great that our young people are saying 'No' to tobacco and choosing to live smoke-free lives. This is a positive decision for their overall health and wellbeing."

Young Maori were making big progress. They had historically been the group with the highest rates of smoking, said Ms Hines.

Their daily smoking rates had dropped dramatically from 30.3 percent in 1999, to 8.5 percent in 2013.

Each year since 1999, ASH had asked Year 10 pupils to fill in a questionnaire about their smoking. Around half of all 14 to 15-year-olds responded.

It was the largest survey of youth smoking in New Zealand.