TATAU POUNAMU

Ki Te Tai o Poutini

MANAWHENUA ADVISORY GROUP

4 December 2014

@ 3.00pm WCDHB – Board Room, Corporate Services

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
Corporate Services, Board Room
Thursday 4 December 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**
   23 October 2014
3. **Carried Forward/Action List Items**
4. **Discussion Items**

- Whanau Ora
- 2105 Meeting Dates
- Memorandum of Understanding Update
- Peter McIntosh – Planning & Funding Reporting Update 3.15pm
- Stella Ward – Alliance Update (Video Conferencing from Christchurch) 3.30pm
- Mark Newsome General Manager Grey/Westland Health Services Mark Newsome General Manager Grey/Westland Health Services 4.00pm
- Sandy Mclean – Mental Health Workstream Update 4.40pm

REPORTS

5. **Chairs Update – Verbal Report** Chair
6. **GM Maori Health Report** General Manager Maori Health
7. **Maori Health Plan Update – Quarter 1** Portfolio Manager, Kylie Parkin

INFORMATION ITEMS

Information items (hard copies will be distributed on day)

- Maori Smoking Cessation Plan - Draft
- West Coast Breastfeeding Plan – Final
- Whanau Ora Hui – Buller 5 December
- Tatau Pounamu Meeting Schedule

ESTIMATED FINISH TIME 5.00pm

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 ▪ Chair Victim Support Grey & Westland ▪ Committee Member, Active West Coast ▪ Chairperson, West Coast Sub-branch-Canterbury Neonatal Trust ▪ Committee Member, Abbeyfield Greymouth Incorporated ▪ Trustee, Canterbury Neonatal Trust ▪ Board Member of the West Coast District Health Board ▪ Advisor to the Committee MS Parkinsons ▪ 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 ▪ Maori Consumer Representative for the Buller Maori Health Working Group
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	Disclosure of Interest
	• Member, Te Runanga o Makaawhio • 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
The Cave, Mental Health Services @ West Coast DHB, Greymouth, on Thursday 23 October 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
Paul Madgwick, Te Runanga O Makaawhio

IN ATTENDANCE: Gary Coghlan, General Manager Māori Health, West Coast DHB
Kylie Parkin, Portfolio Manager Maori Health
Mark Newsome, General Manager Grey/Westland
Philip Wheble, Team Leader Planning & Funding, West Coast DHB
Julie Lucas, Acting Nurse Manager, Clinical Services

MINUTE TAKER: Megan Tahapeehi, Maori Health

APOLOGIES: Gina Robertson, Maori Community, Buller

WELCOME / KARAKIA

AGENDA / APOLOGIES

1. DISCLOSURES OF INTEREST

Deputy removed from report for Elinor Stratford, and should read Grey and Westland Districts.

Action: Megan to amend and update.

2. **MINUTES OF THE LAST MEETING**

For amendment: It was noted that there was some omission regarding the conversation about the Hokitika Health Centre, in particular the request for a possible second GP for Hokitika based at the DHB health centre

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

Moved: Susan Wallace **Second:** Wayne Secker

Carried.

3. Carried forward/Action List Items

No. 4 – Tatau Pounamu Terms of Reference & MOU
An email trail was provided to the Chair regarding discussions with the Board Chair about the current MOU and expected renewal process.

A correction back to Kay Jenkins (EA, Governance) who provided the email, confirming that the relationship is between Manawhenua and the DHB not Tatau Pounamu. Manawhenua requested that the MOU comes through this meeting to enable the Maori community to be privy to the discussions, and also makes sense as both Runanga Chair's are Tatau Pounamu members.

The Chairs of Te Rūnanga O Ngāti Waewae and Te Runanga O Makaawhio will align their discussion with regards to the MoU to the Tatau Pounamu meeting schedule to set a process of approval and sign off. An indicative timeline was provided and it is anticipated that official sign off will occur at the March 2015 Tatau Pounamu Meeting.

The email also queried the intent for at least three meetings per year between the DHB Chair and the Chair of Tatau Pounamu. It was reiterated by the Tatau Pounamu Chair that there is an open invitation to attend these meetings. The discussion then went to the Terms of Reference. These were realigned to the current agreed MOU. The assumption has been that the process for the Terms of Reference is the same as statutory committees and that is why these have been presented to the board for approval. This needs to be clarified by the Board Chair if endorsement is required by the Board.

ACTIONS:

1. **Megan to contact Kay Jenkins and arrange a meeting between the Tatau Pounamu Chair and the Board Chair.**
2. **Megan to contact Kay Jenkins to arrange a meeting between the Runanga Chairs - Te Rūnanga O Ngāti Waewae, Francois Tumahai and Te Runanga O Makaawhio, Paul Madgwick with Board Chair Peter Ballantyne to discuss and plan a process of renewal.**
3. **Megan to request through Kay Jenkins who is mandated from the Board to be part of the MOU and doing this jointly with Elinor Stratford. And also clarification if the current Terms of Reference need to be endorsed by the Board.**

A suggestion to Kay Jenkins in her draft timeline (see below) that the first meeting needs to be Runanga Chairs & DHB Chair.

DRAFT
SUGGESTED TIMELINE FOR REVIEW OF MEMORANDUM OF UNDERSTANDING BETWEEN RUNUNGA AND THE WEST COAST DHB

October - November 2014	• Representatives from both Poutini Ngai Tahu Runanga and Chair of the WCDHB to review the current MoU and determine if their are any changes required • Chair of Tatau Pounamu and Chair of WCDHB to meet to discuss the MoU (Board Secretariat to arrange meeting).
November 2014	Changes from both parties to be supplied to Board Secretariat.
December 2014	• MoU to DHB Legal for comment • MoU back to Poutini Ngai Tahu for comment
January 2015	Final draft back to Poutini Ngai Tahu for confirmation
February 2015	Final draft back to West Coast DHB Board for confirmation
March 2015	Signing of MoU at Tatau Pounamu Meeting

No. 4 – Draft Appointments Policy
Complete. Close.

No. 4 – Maori Representative Appointment Requests
The appointment vacancies for the Mental Health Workstream and Alliance Leadership Team are still actively in place.

Gary Coghlan advised that he has made progress in contacting potential candidates; however he suggested that it was important to meet with interested candidates together to provide information about the current changes within the health system and gauge people's interest areas. History tells us that it is not always easy to fill these positions for a variety of reasons but there is a small cohort of people who are willing to volunteer some of their time to help out.

A conversation followed about holding a health hui with Maori communities throughout Tai Poutini. Kylie Parkin advised that the Maori health plan for 2014/2015 will be beginning the development phase very soon and that we could include communication about that.

The Chair asked when this may happen and Gary Coghlan advised that this would be sooner rather than later.

The Chair advised that she could be involved in this with a potential date of 5 December suggested as a first meeting date. Wayne Secker also signalled his interest depending on availability.

ACTION: Gary Coghlan to contact the South Island Whanau ora Commissioning Agency - Putahitanga to see if they are able to participate. He will subsequently endeavour to organise a hui in the Buller on the 5 December 2014.

No. 5 Whanau Ora
Ongoing as above

No. 7 – Cancer Screening
Carried over to next meeting. Peter McIntosh will be in attendance to update.

No. 8 – Buller Workstream – Maori Representative
Gary Coghlan advised that Gina Robertson will be a Maori representative on this work stream. He is also a member

It was assured that Gina will endeavour to attend all future meetings.

No. 9 – DNA Update

Julie Lucas - Acting Nurse Manager Clinical Services attended to advice of the DNA project plan.

Omission – ADD to Action Register

It was requested at the Tatau Pounamu meeting in September that someone come and talk about GP Clinics in Hokitika.

ACTION: Megan to add to the register

4. **Discussion Items**

Whanau Ora

Document that was sent through the Chair was tabled for all Tatau members.

Key Themes:

- *Working with whanau*
- *Whanau at the centre*
- *Working across sectors*
- *Maori participation across all levels*
- *Patient Centred Care*
- *Tikanga Maori*

ACTION: Carried over to next meeting.

Rangatahi Programme/Future/Other Programmes of this nature

There was a general discussion around the positive impact the first inaugural placement programme not only for the students but also for DHB staff. A member asked if recruitment for students included local iwi. Megan confirmed that this was sent to both Runanga offices and Vicki Ratana, Kia ora Hauora linked in with the schools and both Rununga.

A member asked about the feedback and technology from the Rangatahi placement programme regarding the Kia Ora Hauora website. She felt that the West Coast part of the website could be improved and updated.

Kylie advised that they have just selected successful recipients of the West Coast DHB scholarships and studentships. Four Maori applicants have been approved and one studentship will be undertaken by a Maori student.

ACTION: Megan to contact Cazna Luke, Mokowhiti Consulting regarding the website.

Maori Representative Appointment Updates

Mental Health and ALT appointments

Tatau Pounamu members asked for a copy of the CV's that have been received. These will be updated as soon as possible and sent out.

Barbara Greer (Hokitika) was suggested as a potential representative. Gary Coghlan is to make contact with Barbara.

ACTIONS:

1. **Megan to provide bios/CV's to all Tatau Pounamu members.**
2. **Gary to make contact with Barbara Greer.**
3. **Stella Ward to be invited to the December meeting for an ALT update.**

Julie Lucas – DNA Programme Update

There has been a lot of progress made on improving the DNA rate on the West Coast. The group have reviewed approaches made by other DHB's and Maori providers. DNA data has been reviewed and four key areas identified needing immediate work. These are outpatients - Gynaecology, Paediatrics, General Medicine and Podiatry.

- Looked at trends over five years and identified that a previous project targeting DNAs impacted on reducing the rates – there was a dip when DNA was a focus but it has steadily increased again.
- Maori DNA rate – is up to 16.47% which is high. However there are questions around accuracy of data and this could be slightly inaccurate.

Key points in the Implementation Plan

1. Need to ensure data is correct and recorded accurately—Review systems issues
2. Review and update the DNA non attendance procedure
3. Establish e-texting
4. Hospital Kaiawhina involved more in assisting Maori with outpatients appointments
5. Comprehensive communications plan

Julie is happy to return for a progress update.

Mark Newsome GM Grey/Westland Health Services Update + Presentation

Mark came and presented a power point titled "Health Update"

Issues were raised about the Westland IFHC model and if there is any capacity to revisit this model. Issues around lack of choice within General Practice are of concern. Options for healthcare within Westland area were discussed. Mark responded that in service planning it is important to include as many people as possible in the conversations.

In terms of offering additional GP service, this is not on the agenda or in our business plan to establish another practice in Hokitika. There are avenues for any concerns to be addressed but unless they are put in writing it is difficult for the WCDHB to respond.

A member raised a concern that with the focus being on the rebuild at Grey base that services in Hokitika/Westland aren't forgotten, again the issue of lack of GP choice was raised -
Philip Wheble, Planning & Funding team leader - said the Alliance work is around the integration of services. The DHB is struggling to get enough doctors in current locations and providing another doctor is also very much about sustainability long term. It is not the DHB's wish to be involved in primary care practices They have become involved as a matter of necessity. Mark Newsome has asked to be notified of people opting for alternative primary care. A member also made comment that it is not widely known by the general public that there is a process for complaint.

Some Tatau Pounamu members reiterated they would like to be included in any future discussions around the Westland IFHS model.

A member enquired about transport and spoke about instances when patients have been discharged at night time with no transport or accommodation. Mark responded that they are looking at a more co-ordinated system around transport and that this work is important and on-going.

NGO Maori Health Plans/Training Issues

The GM Maori Health raised an issue regarding Maori Tikanga based trainings recently undertaken in rest homes without a mandate to deliver and talk about tikanga issues relevant to Tai Poutini iwi. This has highlighted the need for an agreed and consistent approach to be taken with NGOs around their responsiveness to Maori.

The Chair recommended that Runaka write a communication offering support and advice around Maori /Manawhenua Responsiveness.

Chairs Update – Verbal Report

Whanau Ora - Funding Round

It was disappointing to see that what did come forward did not consist of any collaborative approach to application. Four West Coast applications in total were received. For some reason it is believed there has been a miscommunication to the community in that existing providers were not going to be accepted and this has never been the intent or direction of the Putahitanga Board. The Chair advised that they want to see existing community providers working collaboratively on new and innovative ideas and initiatives. The doorway is open for any NGO/PHO. Susan Turner is the new South Island Whanau Ora Commissioning Agency CEO.

The funding round is still open. There are a small number of applicants working on business cases currently

We need to communicate out to our groups that this is still open and encourage them to come forward. There is $15 million to be distributed.

4. ***GM Maori Health Report***

Was noted and agreed.

5. ***Maori Health Plan Update***

Carried over until next meeting in December.

6. ***Alliance/Workstream Reporting Update – Philip Wheble***

The chair asked for a specific update on Mental Health Workstream

There are two streams with one focusing on the review recommendations. Focus currently is on Buller and looking at how they can create a location specific service in the Buller.
Lisa has found it difficult to participate in the workstream meetings however Sandy McLean keeps her updated and Sandy will possibly present to Tatau Pounamu at the December meeting. Gary is a member o f this work stream

ACTION: Invite Sandy Mclean to the December meeting.

2014/2015 Planning

Phillip Wheble said the planning cycle for 2014/2015 is now starting again. This will begin at a high level in November with the Alliance Leadership team and then the workstreams will be looking at their planning in December and they will receive some feedback from the Ministry on what their focus is in December/January. From what he understands there will be no major changes to the current targets.

A member asked about the rest home in Hokitika as there was some talk about dementia beds there as well as in the Buller and ? Is this happening. Philip responded to say that he has not heard this is happening for Hokitika. There has been some discussion for Westport but nothing for Hokitika. It is up to the provider to provide such services and in order to provide these services they need to provide the DHB with an understanding of the work they are doing

MATTERS ARISING SEPTEMBER 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	11 September 2014	**Amendments for Tatau Pounamu Terms of Reference & Renewal of Memorandum of Understanding** Email correspondence was provided to the Tatau Pounamu chair from the Board Chair around the current MoU. A meeting will be arranged between the Tatau Pounamu Chair and Board Chair – Peter Ballantyne. The Chairs of Te Runugna O Ngati Waewae and Te Rununga O Makaawhio will align their discussions with regards to the MoU to the Tatau Pounamu meeting schedule to set a process of approval and sign off.	Chair Megan to liaise with Tatau Pounamu Chair and Kay Jenkins to set this meeting in place. Megan to contact Kay Jenkins and request who is mandated from the Board to be part of the MoU in doing this jointly with Elinor Stratford. And also seek clarification if the current TOR need to be endorsed by the Board	**November Meeting**
4	11 September 2014	**Maori Representative Appointment Requests** Gary Coghlan advised that he has made some progress in contacting other potential candidates. The Alliance Leadership Team & Mental Health Workstream positions still need appointments. A conversation then followed around holding a health hui with Maori communities throughout Tai Poutini.	Gary Coghlan, GM Maori A copy of CV/Bio's to be provided to Tatau Pounamu Group. A hui was proposed for the Buller region on the 5 December. Gary to make contact with Putahitanga (South Island Whanau Ora Commissioning Agency) to see if they are available to participate.	**November Meeting**

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
5	11 September 2014	**Whanau Ora**	On going discussion.	**November Meeting**
7	11 September 2014	**Cancer Screening** Data updates, particularly around local targets and Men's Health. Peter McIntosh, Planning and Funding to be approached to come and speak at our next Tatau meeting and also Ana Rolleston has been emailed for information.	Portfolio Manager, Maori Health Peter McIntosh has been invited to attend the December Meeting.	**November Meeting**
8	11 September 2014	**Buller Workstream – Maori Representative** Gary Coghlan advised that Gina Robertson will be the Maori representative on this work stream. It was assured that Gina will endeavour to attend all future meetings.	General Manager, Maori	**November Meeting**
9	11 September 2014	**DNA Update** Julie Lucas came and presented the latest DNA project. Julie is happy to return for a progress update.	General Manager, Maori	**November Meeting**

WEST COAST DHB – MEETING SCHEDULE

JANUARY – DECEMBER 2015

DATE	MEETING	TIME	VENUE
Thursday 29 January 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 29 January 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 29 January 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 13 February 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 12 March 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 12 March 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 12 March 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 27 March 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 23 April 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 23 April 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 23 April 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 8 May 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 4 June 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 4 June 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 4 June 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 26 June 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 23 July 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 23 July 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 23 July 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 7 August 2015	BOARD	10.15am	St Johns Waterwalk Rd, Greymouth
Thursday 10 September 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 10 September 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 10 September 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 25 September 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 22 October 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 22 October 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 22 October 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 6 November 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 3 December 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 3 December 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 3 December 2015	QFARC	1.30pm	Boardroom, Corporate Office
	TATAU POUNAMU		
Friday 11 December 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth

The above dates and venues are subject to change. Any changes will be publicly notified.

CHAIR'S UPDATE

TO: **Members**
Tatau Pounamu Advisory Group

SOURCE: **Chair**

DATE: **4 December 2014**

Report Status – For:	Decision ☐	Noting ☑☐	Information ☐

1. ORIGIN OF THE REPORT

The verbal update.

2. RECOMMENDATION

That the Tatau Pounamu Advisory Group notes the report.

A verbal update will be given at the meeting.

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: **4 December 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

Ethnicity Data Audit Training

On 22 October approximately twenty general practice office managers and administration staff from across the West Coast attended Ethnicity Data Audit Training hosted by the West Coast PHO. This is delivered through the Waitemata and Auckland DHB as part of the Ethnicity Data Audit toolkit. This training covered background on what ethnicity is, perceptions and how frontline staff can handle negative reactions when asking about ethnicity. The training also covered protocols around collection, reporting, output and data quality. This training has provided a good foundation for the practices to complete the Primary Care Ethnicity Data Audit.

Health Workforce New Zealand

For the year of 2014 the West Coast DHB provided funding and support to eight Maori health workers to complete training through the Hauora Maori training fund. Their were six workers from the Maori Health Provider, one from the DHB and one from Community and Public Health. Two completed level four Hauora Maori, one level six Hauora Maori and five are studying Level six Certificates in Social Services.

Maori Mental Health

For the last twelve months the West Coast DHB Maori Mental Health Service - Te Rauawa o te Waka o Oranga Hinengaro, has been working with the support of the Canterbury DHB Maori Mental Health Service - Te Korowai Ataawhai, to strengthen and develop the service on the West Coast. Although there is not a formal Memorandum of Agreement in place between the two teams, there has been a very positive response from Te Korowai to assist with the following aspects;

Recruitment - The Kaiarahi Matua from Te Korowai Ataawhai travelled to the West Coast to participate in an interview to appoint a Pukenga Tiaki in Westport.

Training & Professional Development - Pukenga and Kaumatua from the Coast have travelled several times to Canterbury to participate in formal and informal training initiatives, particularly in the area of cultural assessment, and working in specific areas of mental health such as Alcohol and Addiction.

Cultural and peer support **-** In relation to the mental health review there is an opportunity to have a look at how current Maori mental health service is delivered and what may in the future occur to make Maori mental health even more accessible and relevant to Maori communities.

Poutini Waiora

Some really positive work is occurring in terms of integration between Poutini Waiora and West Coast DHB. There is now an increasing strong collaboration with the kaupapa nurses, kaiarataki and the complex clinical care network DHB. This is a crucial relationship particularly in terms of supporting Maori patients with long term conditions. The WCDHB Maori Health Team met regularly with Poutini Waiora staff. It is important that there is a consistency of delivery throughout the three main geographical areas of the West Coast.

The new Kaihautu has been appointed. Moya Beech Harrison has intensive experience working in the public service sector. Recently she was Area Manager for Child Youth and their Families Service based in the Nelson area, before that she was the West Coast Area Manager. It is pleasing to see that all but three vacancies are now full.

Maori Health Plan 2015

It was only very recently that we submitted the final version of the Maori Health Plan 2014 to the Ministry of Health. Developing these plans involves a lot of work and it is important to develop the plan with colleagues from Poutini Waiora and the West Coast PHO. The first draft plan is to be submitted to the Ministry of Health on the 13 March 2015 and a copy will be provided to Tatau Pounamu in February 2015.

Tumu Whakarae

Unfortunately I have not been able to attend the last two national conferences for Tumu Whakarae, Maori National General Managers. This group has in particular over the past few years increased significantly their sphere of influence within the health sector. As an example, the chair of Tumu Whakarae along with others from Tumu Whakarae now meet with CEOs, CMOs, HR Managers and the Ministry of Health to name just a few, in order to strategize and progress Maori health outcomes. Maori health accelerated planning and Maori health workforce development are two examples of areas of particular focus.

Māori Health Plan Indicators 13/14

Reporting on the National Māori Health Indicators as at 27 August 2014 - Shaded values indicate DHBs who have met the target

Priority	Indicators - all for the Māori population	Target	Northland	Waitemata	Auckland	Counties Manukau	Waikato	Lakes	Bay of Plenty	Tairawhiti	Taranaki	Hawkes Bay	MidCentral	Whanganui	Hutt Valley	Capital and Coast	Wairarapa	Nelson Marlbourgh	West Coast	Canterbury	South Canterbury	Southern
Access to care	Percentage enrolled in PHOs (1) Q1 14/15	97%	100%	82%	83%	90%	95%	100%	93%	100%	88%	94%	85%	90%	85%	86%	100%	87%	94%	82%	82%	82%
Access to care	ASH rates per 100,000, 0-74 age group (2) Year to March 2014	100%	169%	176%	187%	199%	181%	172%	193%	181%	139%	149%	137%	173%	179%	166%	171%	137%	147%	155%	195%	148%
Access to care	ASH rates per 100,000, 0-4 age group (2) Year to March 2014	100%	158%	117%	100%	119%	127%	152%	177%	176%	111%	127%	122%	211%	190%	153%	127%	177%	220%	143%	119%	183%
Access to care	ASH rates per 100,000, 45-64 age group (2) Year to March 2014	100%	177%	233%	227%	272%	242%	200%	226%	196%	137%	186%	166%	175%	178%	204%	213%	165%	173%	165%	236%	128%
Child Health	Infants are exclusively or fully breastfed at three months of age (3) September 2013	54%	47%	49%	47%	34%	49%	36%	47%	49%	44%	43%	46%	36%	39%	50%	58%	48%	49%	42%	62%	51%
Child Health	Infants are receiving breast milk at six months of age (3) September 2013	59%	54%	59%	58%	46%	51%	41%	55%	57%	48%	48%	49%	53%	55%	61%	72%	55%	57%	52%	55%	51%
Cardiovascular disease and diabetes	Percentage of the eligible population who have completed a cardiovascular risk assessment (CVRA) within the past 5 years (4) Q4 13/14	90%	85%	83%	88%	87%	79%	80%	81%	83%	79%	80%	80%	87%	75%	78%	79%	71%	77%	60%	72%	71%
Cancer	Breast Screening Rate, 50-69 age group, 24 month rate December 2013	70%	74%	64%	68%	67%	58%	64%	59%	68%	65%	66%	65%	66%	64%	63%	74%	84%	87%	78%	81%	64%
Cancer	Cervical screening Rate, 25-69 age group, 36 month rate December 2013	80%	69%	55%	56%	58%	62%	71%	63%	70%	73%	75%	65%	64%	64%	60%	80%	70%	73%	56%	51%	62%
Smoking	Percentage of hospitalised smokers provided with cessation advice Q4 13/14	95%	93%	97%	96%	96%	97%	100%	91%	97%	95%	98%	94%	97%	97%	89%	91%	98%	84%	93%	100%	95%
Smoking	Percentage of Smokers presenting to primary care provided with cessation advice, DHBSS (5) June 2014	90%	97%	89%	86%	85%	82%	82%	86%	79%	90%	82%	85%	81%	73%	71%	100%	75%	62%	73%	103%	74%
Immunisation	Percentage of 8 month old babies fully immunised Q4 13/14	90%	88%	91%	84%	84%	85%	87%	83%	90%	84%	93%	97%	94%	89%	92%	95%	91%	94%	88%	100%	92%
Immunisation	Percentage of the population (>65) who received the seasonal influenza immunisation, DHBSS (5) June 2014	75%	60%	57%	63%	65%	62%	62%	62%	57%	64%	66%	63%	72%	66%	63%	65%	65%	62%	67%	60%	67%
Oral Health - information only	Percentage of Pre-School children (0-4) enrolled in DHB-funded oral health services (6) December 2013	-	68%	66%	62%	65%	n/a	51%	63%	86%	59%	62%	67%	79%	36%	27%	72%	53%	66%	31%	28%	65%

Notes: Data is reported at various times which are noted in subscript after each indicator.

(1) Enrolment data is calculated at the begining of the quarter. All prcentages over 100% have been rounded down to 100%.

(2) Results are expressed as a percentage of the national total population rate. For example, if a DHB Māori ASH rate is 5000 per 100,000 and the national total population rate is 4000 per 100,000, the result is 125% (5000/4000).

(3) Data is for infants at the reported age between January 2013 and June 2013 and sourced from the Well Child / Tamariki Ora Quality Improvement Programme.

(4) Diabetes checks are performed as part of the CVRA.

(5) Reporting is by PHO of Domicile. Where PHOs have practices in different DHBs, practice data is reported to the respective DHB.

(6) Individual targets are currently set for each DHB but we are working towards a 95% target for all DHBs for the 15/16 year. Current figures are not available for Waikato and Tairawhiti DHBs, DHBs report results for the 2013 calendar year in Q3 2014.

National CEO Group

Cathy O'Malley
Oct 2014

MINISTRY OF HEALTH
MANATŪ HAUORA

Post-election new Government priorities

- Children living in Poverty.....big focus since the election
- Under 13 Free care
  - Invest $90 million over three years to fund free GP visits and prescriptions for children under 13 from July 2015
  - More than 400,000 primary school-aged children and their families are expected to benefit.
- A new model of care for Older People
  - Work to improve services for rest home residents by better integrating care between GPs, pharmacies, hospitals and rest homes.
  - A new model of care to be progressed across the 20 DHBs, packaging together an older person's home help funding with healthcare funding, to deliver a new, more flexible package that's tailored to the individual

Post-election new Government priorities

- Long Term Conditions
    - Healthy Families program in 10 communities
    - 3 Health Targets
    - Nutrition and Activity programs
    - Specialist Diabetes Nurses
    - LTC in Community Pharmacy
    - Renal Transplants
- Disability: personal budgets and Disability action plan
- Rheumatic Fever: more drop in clinics covering 90,000 children

Post-election new Government priorities

- Cochlear implants
- Information technology
    - Patient portals: 90% by end 15/16
    - ePrescription services
    - New tele-health service
- Workforce
    - More doctors and nurses
    - Expand voluntary bonding scheme
    - 25 New VLCA new grad positions
    - Nurses trained to undertake colonoscopies

Post-election new Government priorities

- $50million over 3 years to reduce pain and increase prevention
    - Continue significant increases in elective surgery
    - $6mill for primary case based early intervention teams to address pain
- $8mill for colonoscopies
- Faster cancer treatment
    - Target: 90% of patients will receive their first cancer treatment within 62 days of being referred by their GP with a high suspicion of cancer by July 2017
- $20mill per year for Palliative care
    - ?? Broad implementation across community, hospices and hospital specialist teams

Post-election new Government priorities

- Mental Health
  - Rising to the Challenge 2012-2017
  - Health workers have more time
  - More primary care
  - Reduce specialist waiting times and improve access for youth offenders
  - Improve alcohol and drug treatment services
  - Focus on child and youth
  - Continue Suicide Prevention action plan
  - Provide specialist psychological staff and up to 20 cancer support workers to support cancer/MH co-morbidity in the major centres

Post-election new Government priorities

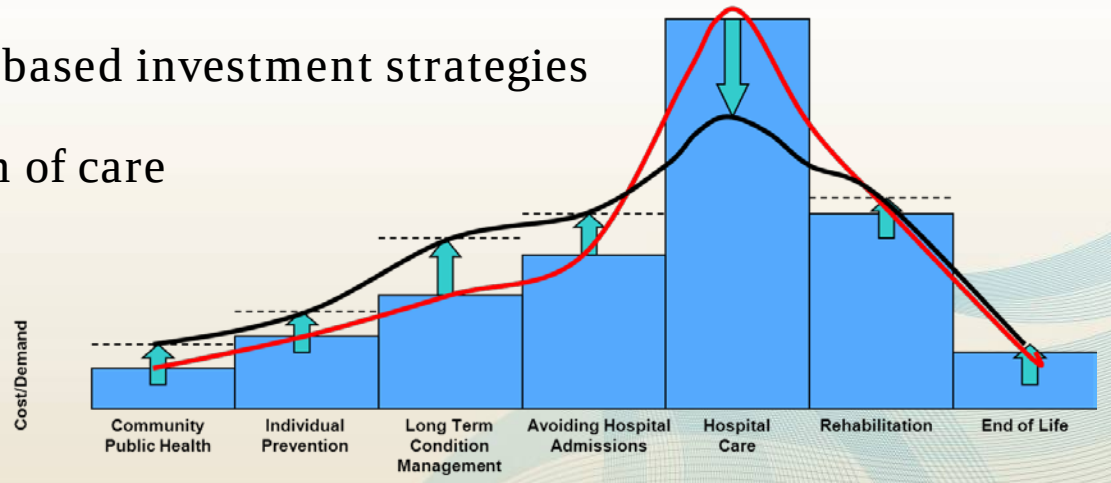
- Canterbury Recovery
- Children's Action plan
- Children with Special needs
- Family Violence
- Corrections
  - Significant focus!
  - Deliver after care for prisoners who have undertaken a drug treatment programme in prison following their release
  - New funding required, with costs being between $2 million and $6 million a year, based on other Alcohol and Drug initiatives
  - New Auckland Prison will include a mental health unit for prisoners with moderate to severe mental health needs

Post-election new Government priorities

- Housing
  - Insulate 46,000 more homes, targeting low-income households with high health needs in addition to the more than 250,000-plus homes already insulated
- Whanau Ora
  - Invest $180 million in Whānau Ora this year, and over the next 3 years, to enhance wrap-around, whānau-led services
  - Establish a Whānau Ora partnership group to monitor achievement of agreed outcomes, targets and priorities, and identify policies, resources and initiatives that support Whānau Ora to be successful
- Progress with the next iteration of the National Medicines Strategy, including the enhanced role of pharmacists in patient medicines management and primary care.

Key focus going forward for Health

- Continuing fiscal constraint
- Sector Performance
- Children a focus
- Healthy families
- Community action
- Focus on population based investment strategies
- Shift across spectrum of care



Under 13 Background..New Zealand Health Survey (2012/13)

- Around **37,000** or **9.1 %** of children aged six to twelve years old were unable to see a GP due to cost at some point in the past twelve months.
- Around **20,000** or **5.0 %** of children aged six to twelve years old had unmet need for after-hours services due to cost in the past twelve months.
- Around **20,000** or **4.9 %** of children aged six to twelve years old had an unfilled prescription due to cost in the past twelve months.

Under 13's Enrolled in a PHO

- Around **410,000** children aged six to twelve years old enrolled in a PHO (as at July 2014).
- This equates to almost **10%** of all people enrolled in a PHO.
- Around **160,000** or **39%** of children aged six to twelve years old are high need, including:
  - over **135,000 Maori or Pacific** children,
  - almost **90,000** children living in a **high deprivation area**.

Under 13's Enrolled in a PHO

DHB of Domicile	Number of 6 to 12 Year Olds Enrolled in a PHO	% of 6 to 12 Year Olds
Northland	16,917	4.1%
Waitemata	51,071	12.3%
Auckland	37,679	9.1%
Counties Manukau	57,327	13.8%
Waikato	36,830	8.9%
Lakes	10,922	2.6%
Bay of Plenty	21,088	5.1%
Tairawhiti	5,365	1.3%
Hawkes Bay	15,523	3.7%
Taranaki	10,345	2.5%
Mid Central	15,185	3.7%
Whanganui	5,728	1.4%
Capital Coast	24,597	5.9%
Hutt	13,557	3.3%
Wairarapa	3,937	1.0%
Nelson Marlborough	12,239	3.0%
West Coast	2,646	0.6%
Canterbury	42,995	10.4%
South Canterbury	4,826	1.2%
Southern	25,383	5.8%
Total	**414,160**	**100%**

Under 13's Enrolled in a Very Low Cost Access Practice

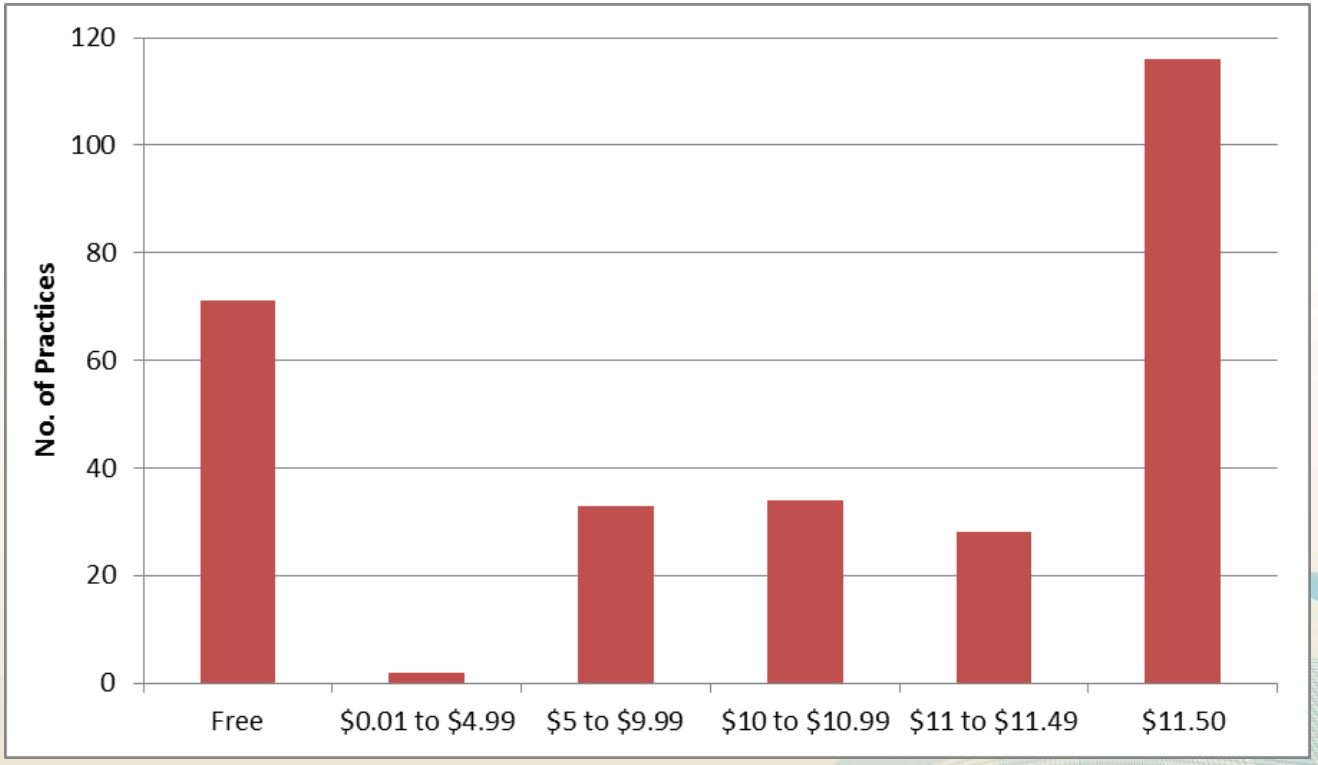
- Around **140,000** children aged six to twelve years old enrolled in a VLCA practice (as at July 2014).
- This equates to **35%** of all children aged six to twelve years old who are enrolled with a PHO.
- Almost **100,000** of these children aged six to twelve years old who are enrolled in a VLCA practice are high need.

GP Co-payments

- As at February 2014 the **average co-payment** for a GP visit for six to twelve year olds was **$22.70**.
- Around **140,000** or **35%** of children aged six to twelve years old are enrolled in a VLCA practice where the **average co-payment** for a GP visit is **$7.72** and the **maximum co-payment threshold** is **$11.50**.

GP Co-payments – VLCA Practices

Figure 1. Number of VLCA practices by GP co-payment band for 6-12 year olds (February 2014)

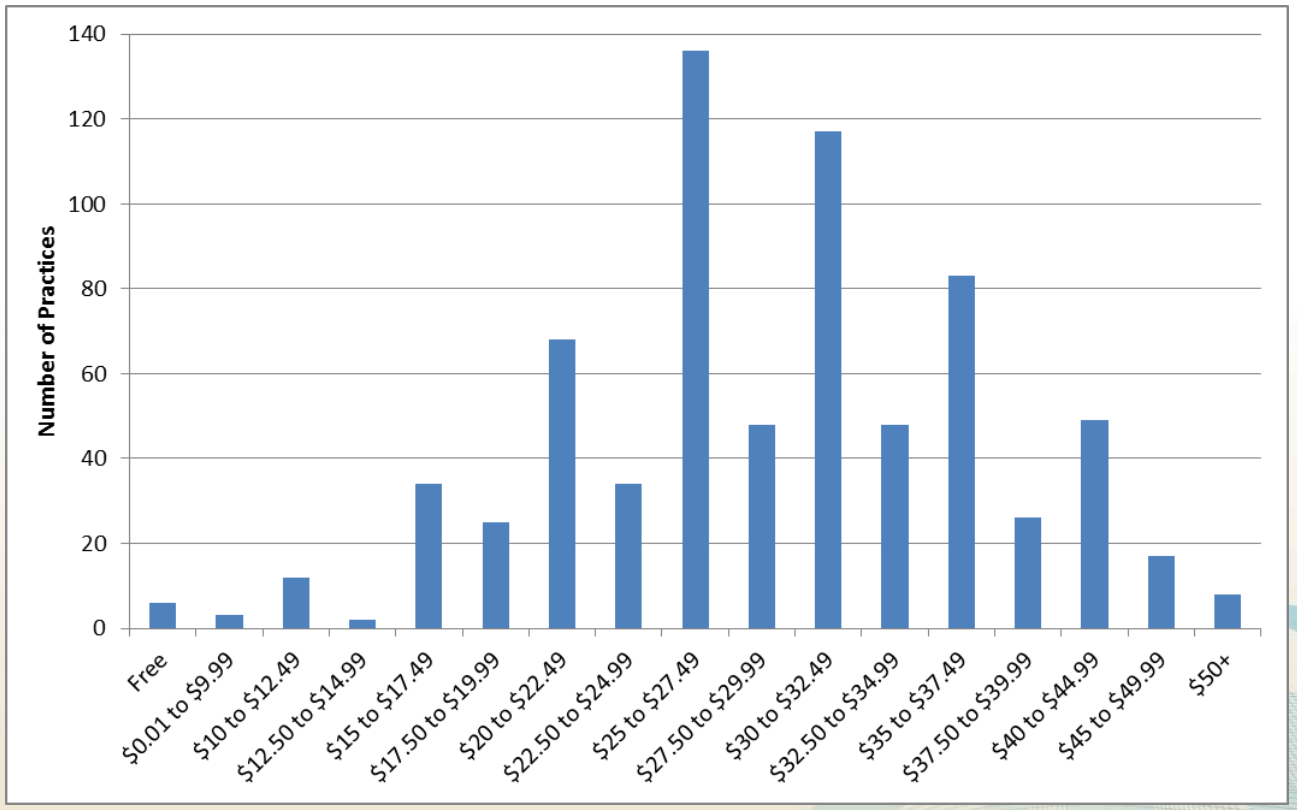


GP Co-payments – Non-VLCA Practices

- Around **270,000** or **65%** of children aged six to twelve years old are enrolled in a non-VLCA practice where the **average co-payment** for a GP visit is **$28.67** and the **maximum charge** is **$56.00**.

GP Co-payments – Non-VLCA Practices

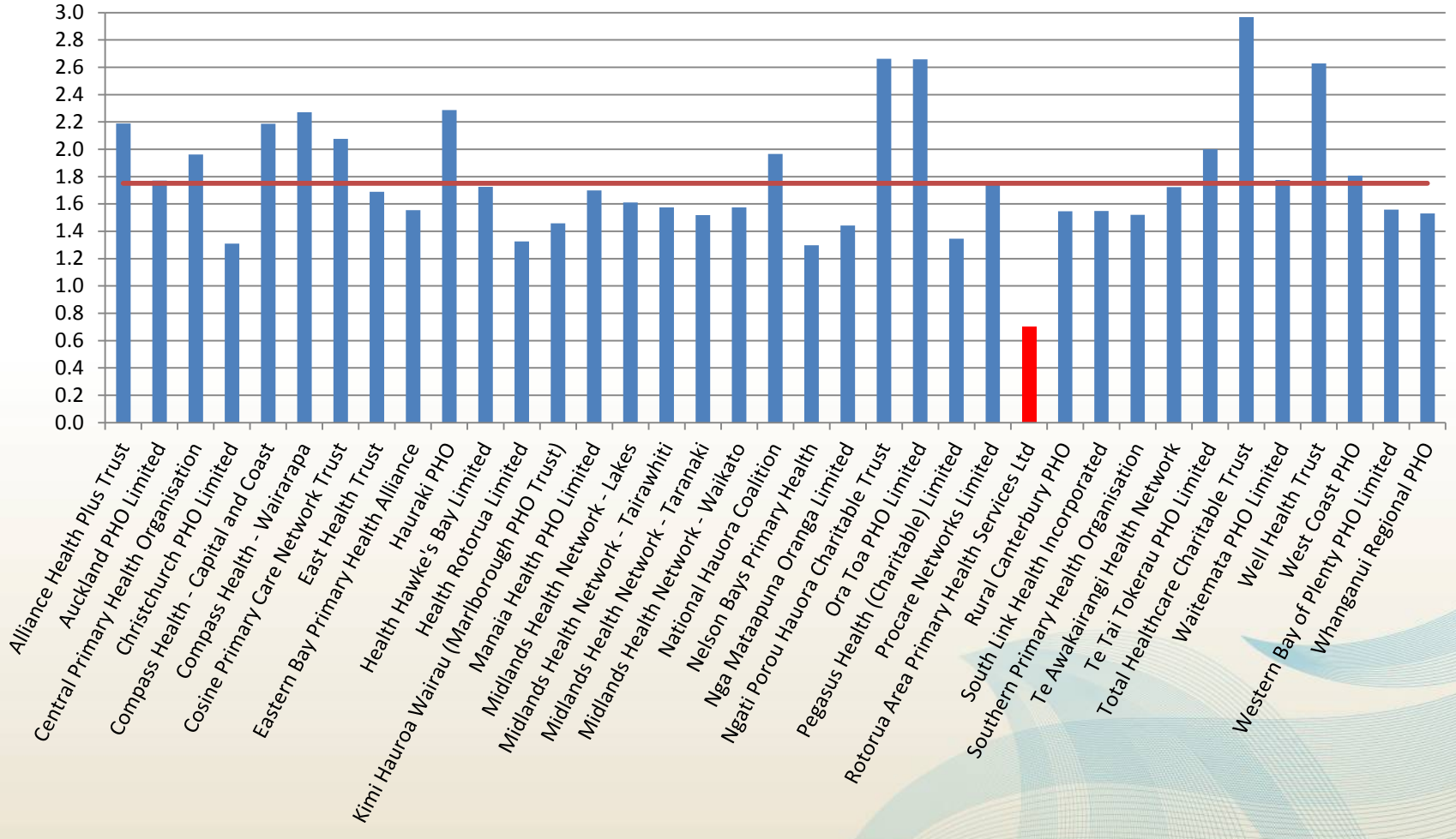
Figure 2. Number of non-VLCA practices by GP co-payment band for 6-12 year olds (February 2014)



Utilisation

- In 2013/14 children aged six to twelve years old are estimated on average **attended a general practice 1.75 times per year:**
  - 1.51 visits with a GP
  - 0.24 visits with a nurse

Utilisation



Utilisation – after hours and casual visits

- An additional **0.3 visits** are estimated to be claimed for children aged six to twelve years old for **after-hours and for casual patients**.

Table 4. GMS Claims for Six to Seventeen Year Olds (2013/14)

Age	Enrolled Patients (July 2014)	GMS Claims (2013/14)	Average Visits Per Year (2013/14)
6 to 17 Year Olds	699,442	182,885	0.3

Under Sixes

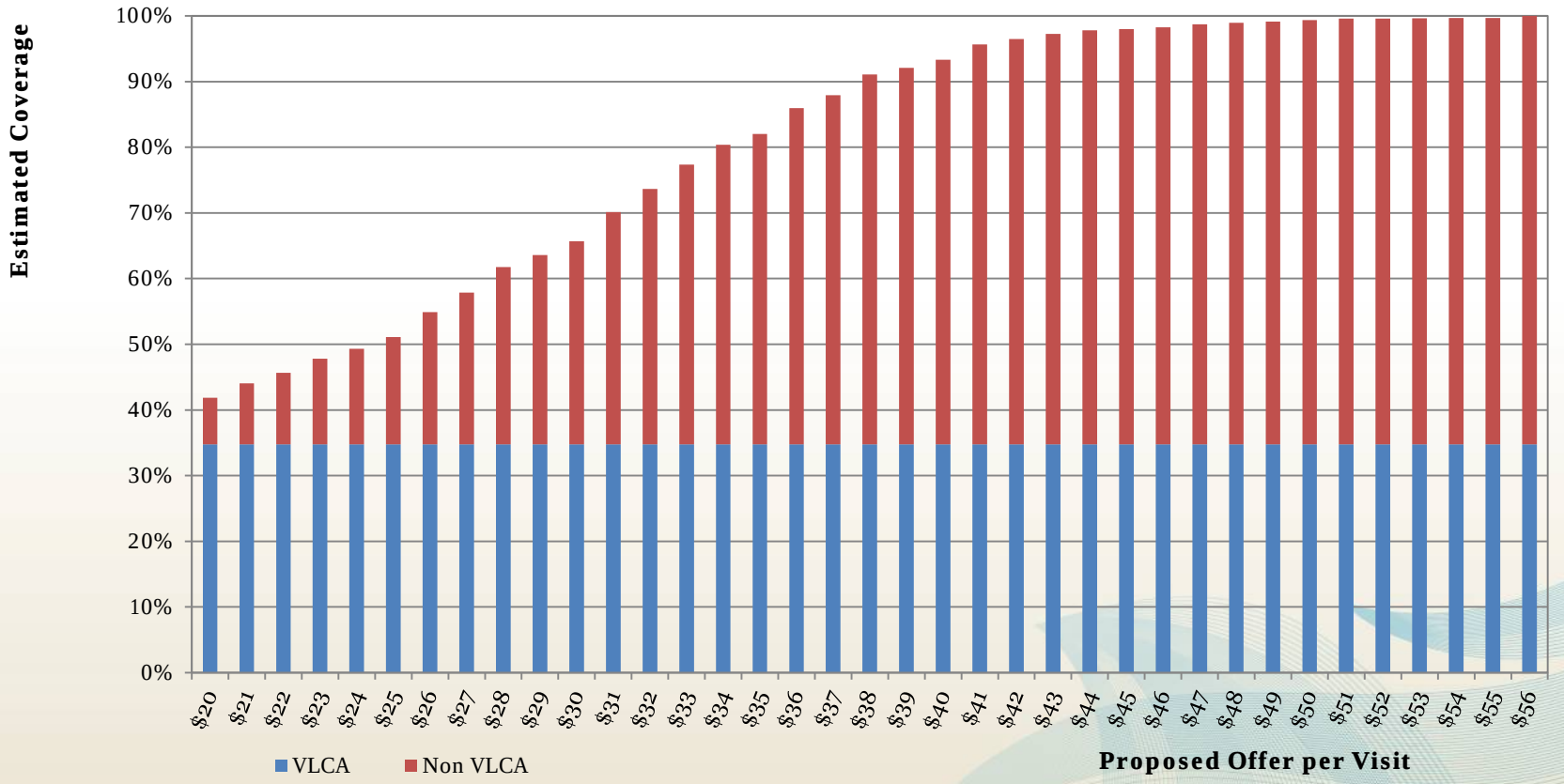
- The roll-out of the Zero Fees for Under 6s scheme in 2008 resulted in:
  - initial coverage of **70%**
  - **95%** coverage after five years
  - **98.4 %** coverage as at July 2014

Under 13's Estimated Coverage

- The estimated coverage for Under 13s is expected to be **70 percent at a co-payment rate of $31**, **80 percent at a co-payment rate of $34**

Under 13's Estimated Coverage

Figure 10. Estimated free coverage for 6 to 12 year olds by proposed offer per visit

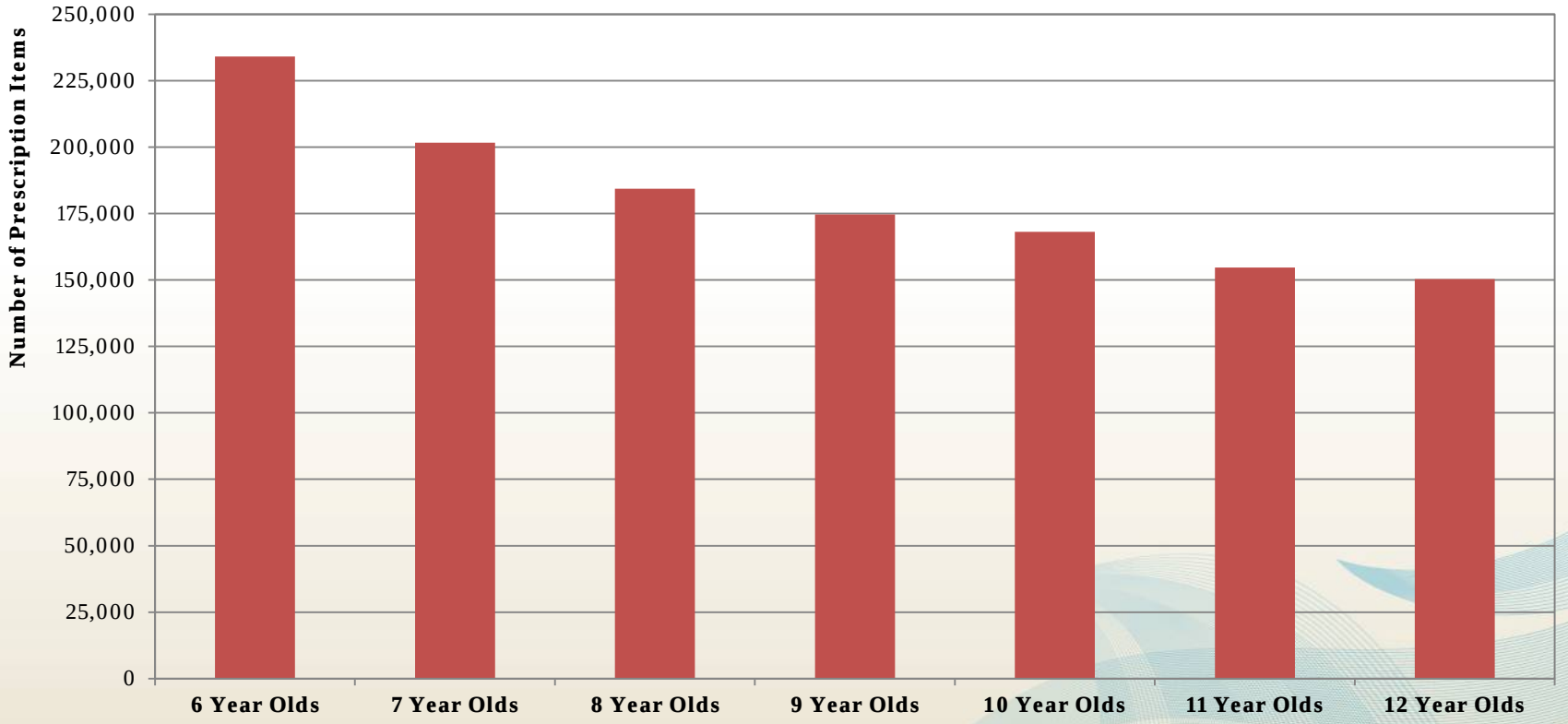


Pharmacy

- Between June 2013 and May 2014 there were a total of **1,267,740 prescription items** dispensed **for six to twelve year olds**.
- This is based on items that were dispensed for this age group between June 2013 and May 2014, and excludes bulk and practitioner supply orders, hospital cancer treatments, brand switch fees, compounded items and owe transactions.

Pharmacy - Prescriptions

Figure 11. Prescription items for 6 to 12 year olds by age (June 2013 to May 2014)



Cost of Providing Free Scripts for Under 13s (Daytime):

- The **estimated cost** (or script abatement) **of providing free scripts** for children aged six to twelve year olds **is $5.6 million**.
- This is based on items that were dispensed for this age group between June 2013 and May 2014, and excludes bulk and practitioner supply orders, hospital cancer treatments, brand switch fees, compounded items and owe transactions.

Under 13 Next Steps

- PSAAP Oct and December
- Post Xmas Implementation
    - After hours negotiations
    - Practices signing up

System Measures

Aim to measure a population outcome

and will require integration of services

and contributions from multiple providers

A small number chosen nationally

IPIF Update

It is the intention that the following system level measures will be introduced in 2015/16:

- Healthy Start
- Healthy Ageing
- Capability and Capacity
- Patient Experience (work led by HQSC)

A range of leaders from across the health sector, and staff from the Ministry of Health have considered a long list of possible component measures to support these system level measures.

Small groups (the measure development groups) are being convened to develop measures.

The measure development groups will be supported by a team of data analysts from the Ministry, DHBs and primary care networks to identify any technical issues.

Health Start

The measure development group is being led by Dr Damian Tomic. Proposed Measures include:

Babies experiencing Hypoxic Ischemic Encephalopathy (HIE, or birth asphyxia);

Babies born at term (37-42 weeks);

Babies born in healthy weight range (2.5-4.5kg);

Babies enrolled in a PHO within 2 weeks;

Babies exclusively breastfed at 3 months;

Cases of substantiated abuse (from CYFS information);

Total postnatal mortality.

8 month immunisation coverage

Registration with LMC within first trimester

Healthy Ageing

The measure development group is being led by Professor Les Toop. Proposed Measures include:

Updated Tobacco Health Target

Cervical and breast screening coverage where applicable (to this age group)

CVD/diabetes management Health Target being developed

ASH

Acute readmission rates

Length of stay

Polypharmacy

Flu vaccination coverage

Capacity and Capability

Support for multichannel access to clinical services

Measures: % of patients with access to online healthcare

% of patients with access to shared care records

Standard Clinical pathways

Measures: views per clinician per month

number of conditions/pathways included

Fit for purpose infrastructure

Measure: % of primary care centres that meet ICT standards

Models of care that support care at the least specialised level

Measure: % of primary care centres with credentialed models of care

Capacity and Capability

Highly capable workforce

- Measure: Work plan in place that forecasts future workforce requirements and has a strategy to match supply and demand
- Measure: Workforce development plan for skill development in place

Spectrum of care via investment

- Measure: Proportion of investment (as per Helen Bevan diagram)
- Measure: % DHB funding in flexible funding
- Measure: % spend on hospital services or % shift from hospital services

When will the system level measures be finalised?

The measure development groups will finalise recommendations by 30 October 2014 regarding the measures for likely implementation from July 2015.

The recommendations relating to IPIF will be presented to the Minister of Health for consideration in November 2014.

Quarter One Performance, Reporting and Payment

For quarter one of 1 July 2014 to 30 September 2014 under IPIF:

PHOs send in data to DHBSS as usual (due 20 October 2014)

New IPIF payments will be made against the new IPIF measures

Payments will be made quarterly

No new data will be required at this stage

DHBSS will continue to work with PHOs with regard to data verification pre-payment

Reporting is under review. A stocktake will be undertaken to determine which type of reports are right for PHOS and the IPIF programme

Reporting will remain the same until the outcome of the review is clear.

Alliances

- The primary care networks that adopted alliancing as part of their business case advancement identified that use of facilitators as a key element to improving success.
- The opportunity for other alliances to benefit from facilitation is being developed now with the IPIF development team working with Ministry procurement services on the development of a “list” process.
- It is proposed that an expression of interest process for facilitators with generalist or specific skills in undertaken. Once that list is established, non-BSMC Alliances will be allocated access to the list for use to support the advancement of their alliance.
- It is anticipated that the procurement process will be completed by early next year for Alliances to use facilitators in preparation for IPIF implementation for 15/16.

Equity

- Area of strong development across SCI and the wider Ministry
- Release of the Equity of Health Care for Maori Framework
- Release of Pathways to Pacific Health and Wellbeing
- Current Ministry work underway in IPIF, Cancer, Health Literacy, Vulnerable Populations

New Born Enrolment

- Current PHO performance against target is 71% (2% increase from previous quarter)
- Discussions with PHOs in bottom third show that poorer performing general practices do not have good systems and processes for enrolment or believe that funding will be clawed back so delay B coding
- Some PHOs have requested access to NIR PHO level reporting to monitor performance and this is being progressed
- Anticipating that as more general practices improve their processes we may see an increase in new-borns without a nominated provider. PHOs and DHBs will need to work on this area
- New results will be released in November.
- Recovery plans will be required for those PHOs who have shown no substantial lift in performance over the three quarters
- Resources are available to support general practices to lift performance

MINISTRY OF HEALTH
MANATŪ HAUORA

CEO Leadership??

MAORI HEALTH PLAN UPDATE

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

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

SOURCE: **General Manager, Maori Health**

DATE: **4 December 2014**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to Community & Public Health & Disability Support Advisory Committee as a regular update.

2. RECOMMENDATION

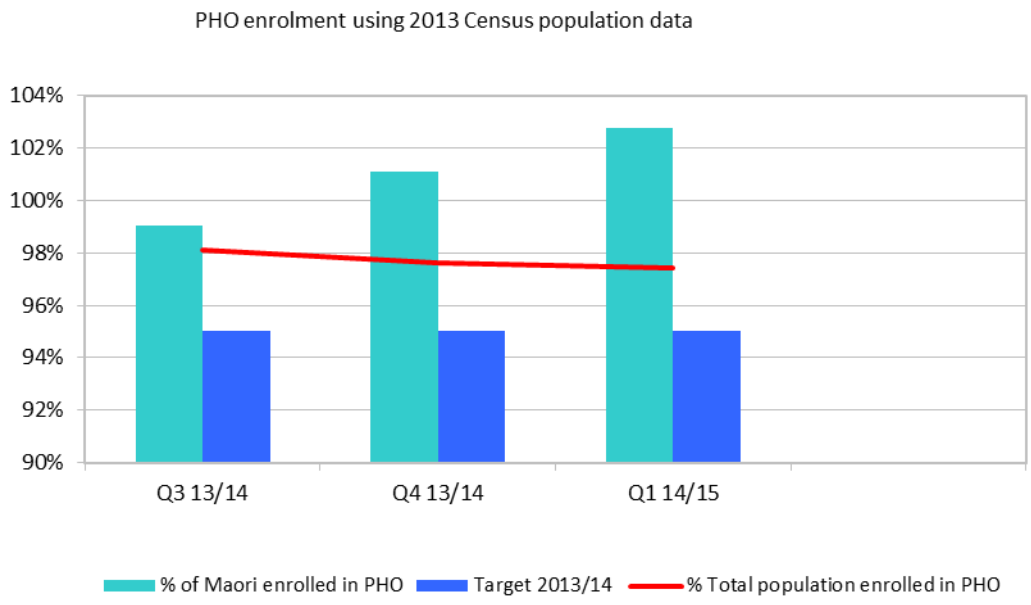
That the Community & Public Health & Disability Support Advisory Committee:
i notes the Maori Health Plan Update.

3. SUMMARY

Maori Health Quarterly Report – Q1, 2014/15

Access to care

Percentage of Maori enrolled in the PHO



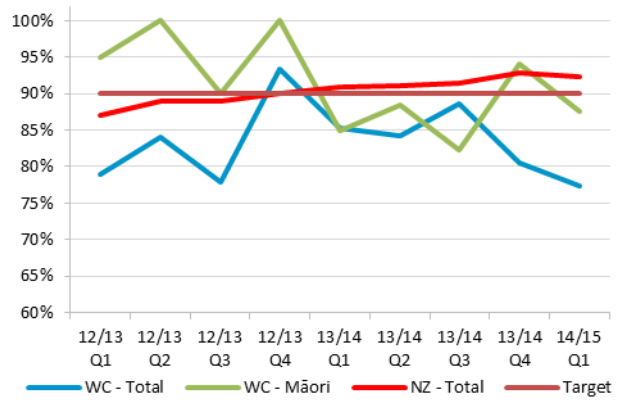
*** 2006 census population was used as the denominator.**

ACHIEVEMENTS/ISSUES OF NOTE

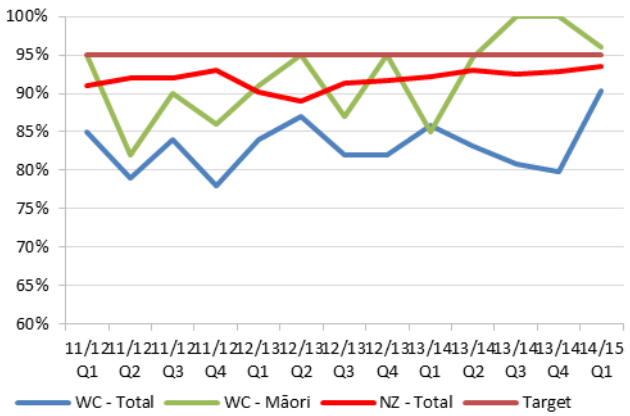
Enrolment in PHO: Using the 2013 population census figures 103% of Maori were enrolled with the PHO as at 30 September 2014. 3258 Maori were enrolled in quarter 1 compared to 3205 in quarter 4. The Census data shows total Maori population is 3171.

Child, Youth and Maternity

NEW Immunisation HT: Eight-month-olds fully immunised



Immunisation: Two-year-olds fully immunised



Eight-month-old immunisation: 88% of Maori babies have been immunised on time at 8 months of age in quarter 1 – 21 babies out of 24 eligible for this quarter. This is compared to 90% of non-Maori babies where 43 from 48 eligible babies have been immunised.

Two-year-old immunisation: 96% of Maori 2 year olds have been immunised on time in Quarter 1 – 24 from 25 eligible babies. This is compared to 93% NZ European babies - 54 from 58 eligible babies

Although only vaccinating 77% of our eligible children for the Increased Immunisation Health Target, we vaccinated 97% of consenting children with only two children missing the milestone age. While this is a slight decrease on last quarter, opt-off and declines were higher at 20.5% which continues to make meeting this target challenging. Strong results were achieved for Pacific and Asian at 100% and NZ European at 90% however Maori performance dropped to 88%.

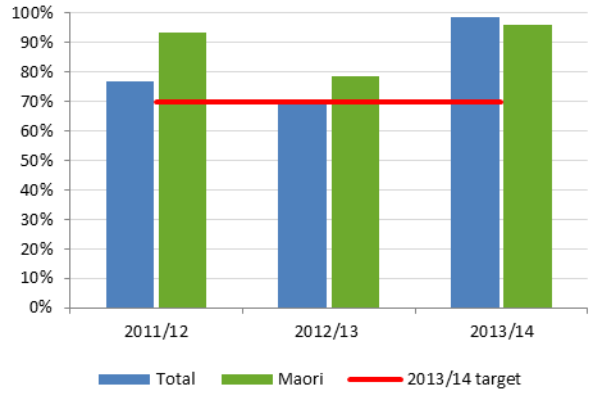
Breastfeeding: Breastfeeding results for the 12/13 year were released by the MoH during this reporting period. It is important to note that unfortunately the DHB is unable to present a full picture of breastfeeding results this year and it is Plunket services only. Poutini Waiora and the WCDHB also provide 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. Data for 2013/2014 will be released soon.

Breastfeeding Support: The community lactation consultancy and breastfeeding advocate have made 190 contacts including 61 face to face (home visits/clinic) to provide breastfeeding support. There have been 5 Maori clients in Quarter 1.The notable increase in lactation consultancy contacts this quarter is attributed to a new process where by all new birth mothers are contacted early irrespective of breastfeeding issues. Of the 72 newborn contacts, 23 required further follow up.

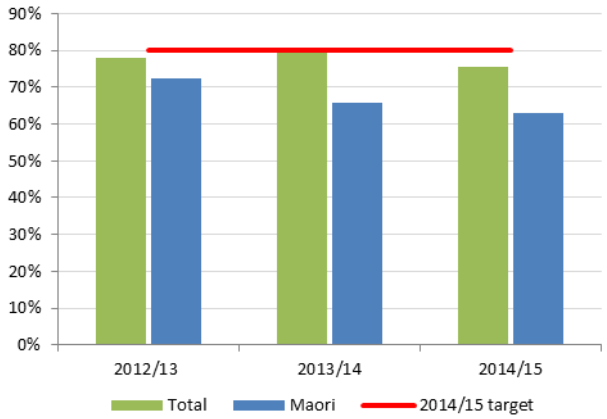
Newborn Enrolment: The Newborn enrolment form and process is now embedded into services. This ensures timely enrolment to 5 services; Community Oral Health service, National Immunisation Register, General Practice, Breastfeeding Support, Well Child/Tamariki ora service. An evaluation is currently taking place.

More Heart & Diabetes checks

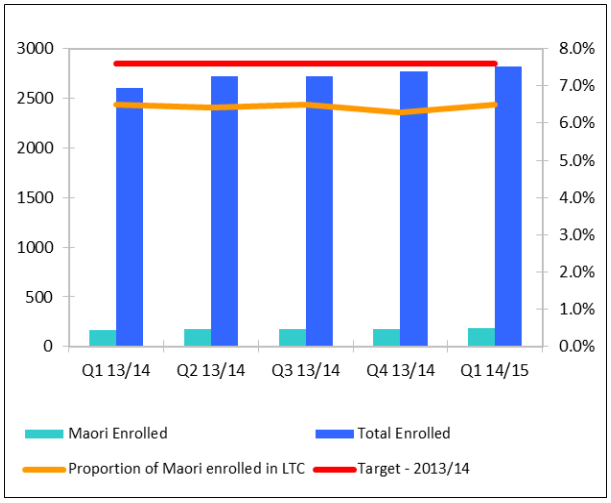
Diabetes Annual Review: % of people estimated to have diabetes who have had an annual check during the year



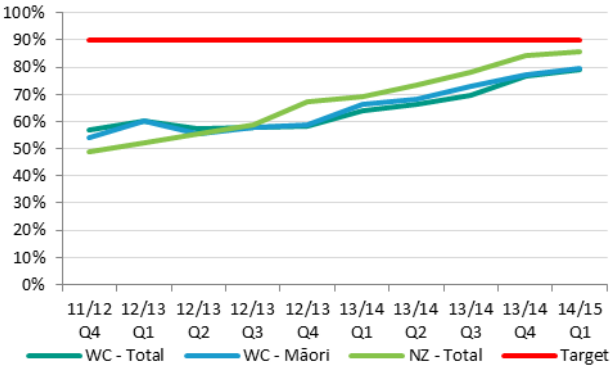
Diabetes Good Management: % of people who have HBA1c levels at or below 8.0 when assessed at their annual check



Number of people enrolled in the Long Term Condition Programme



More Heart and Diabetes Checks Health Target: % of eligible PHO population having had a CVD risk assessment in the last 5 years



Diabetes: Maori still continue to show a good rate of access to Diabetes Annual Reviews however management of their diabetes could be improved. 81% of Maori with diabetes have had Retinal Exams, 63% show HBA1c levels at or below 8.0, 78% are non-smokers and 59% are on statins.

The Ministry of Health no longer measure diabetes annual reviews undertaken as a percentage of the overall population estimated to have diabetes. The More Heart and Diabetes Checks national health target now covers this and as such the quarterly graph for diabetes annual reviews above now shows the actual number of reviews that have been undertaken year to date. Of the 381 people who had their diabetes review during the September quarter, 75.4% of the overall population had good diabetes management. Maori results were lower at only 63%. Our target for diabetes good management is 80%.

CVD Health Target

'More heart and diabetes checks' will measure the number of completed cardiovascular Risk Assessments (CVRA) for all eligible persons within the last five years (which includes a diabetes check). The national goal is 90% since 1 July 2013.

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.

Maori make up 8.1% of completed CVRAs this quarter. By comparison, Maori make up 9.8% (1009) of the eligible cohort for CVRA on the West Coast. (The eligible age range for Maori is male 35-74 years and for female 45-74 years).

The smoking profile for CVRAs completed this quarter for Maori is 65% not smoking compared with other ethnicities screened not smoking 79%.

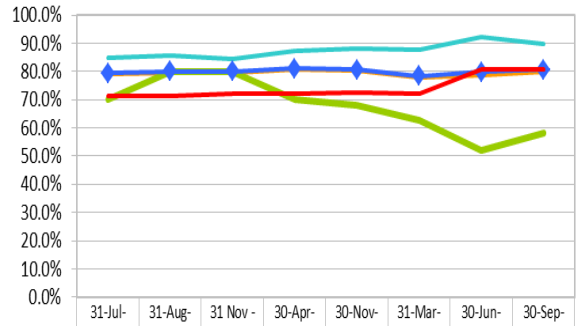
The newly appointed Kaupapa Maori Nurse in Greymouth is working on overdue CVRA lists with the practices.

Green Prescription: Quarter 1 data shows 9 referrals to the Green Prescription programme in the Grey district for Maori and only 1 referral 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): 183 Maori are enrolled in the Long Term Conditions programme as at Sept 30 2014. For quarter 1 Maori enrolment makes up 6.5% of all enrolment in the LTC programme. The target is 7.6%. For comparison Maori make up 6.2% of the enrolled population at the primary practices aged 45 years and above. Collaboration with Poutini Waiora to integrate services to support Maori identified as having LTCs is occurring. There is on-going work within practices to identify eligible people and increase enrolments in level 2 and level 3.

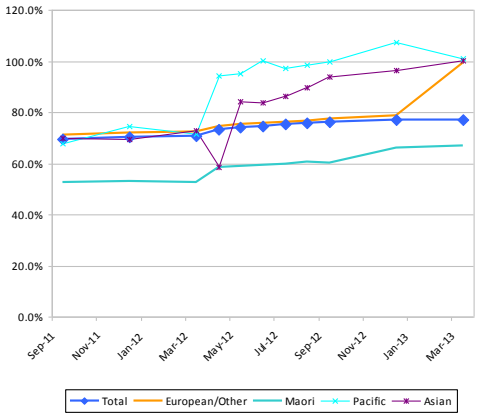
Cancer

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	30-Jun-14	30-Sep-14
Other	79.0%	79.4%	79.5%	80.6%	80.2%	77.7%	78.8%	80.0%
Maori	84.7%	85.6%	84.5%	87.1%	88.0%	87.5%	92.3%	89.7%
Pacific	70.0%	80.0%	80.0%	70.0%	68.2%	62.5%	52.0%	58.3%
Total	79.4%	79.9%	79.9%	81.1%	80.7%	78.3%	79.7%	80.6%
All DHB's	71.2%	71.3%	72.3%	72.0%	72.4%	72.3%	80.6%	80.6%

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



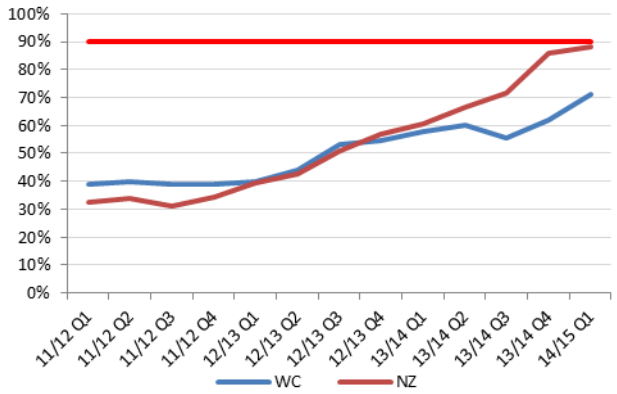
ACHIEVEMENTS/ISSUES OF NOTE

Breast Cancer Screening: Approximate 80.6% of all eligible women aged 45-69 age-groups on the West Coast have undergone breast screening for the period ending 30 Sept 2014. The coverage for eligible Maori women (89.7%) is higher compared to all other ethnicities on the West Coast. The West Coast DHB is the lead DHB for this target across all other DHBs nationwide with the next closest being Nelson Marlborough with 86.4% of eligible Maori women being screened.

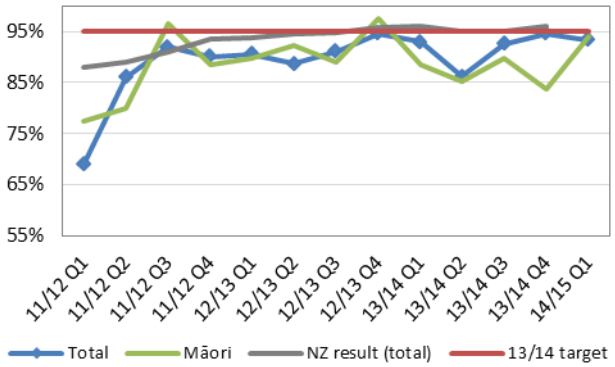
Cervical cancer screening: At the end of June 2014, the preliminary three year coverage result for cervical screening on the West Coast non-Maori was 79.2% - 5755 from 7270 eligible. The coverage rate for eligible Maori women is at 72.8% - 512 from 703 eligible, an increase from last quarter and a sustained increase from June 2011 where the coverage was just 52.1%. 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

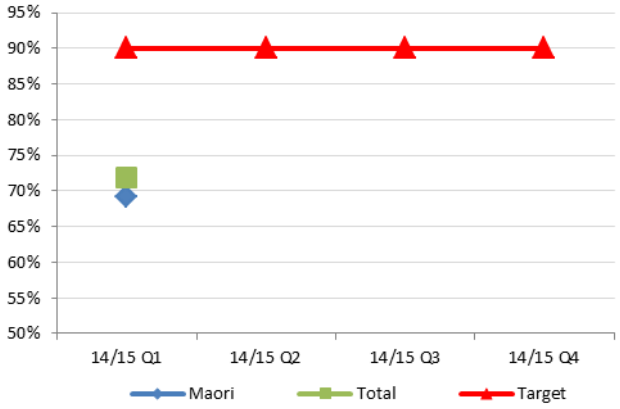
Primary Smokefree Health Target: Smokers attending primary care given advice & help to quit



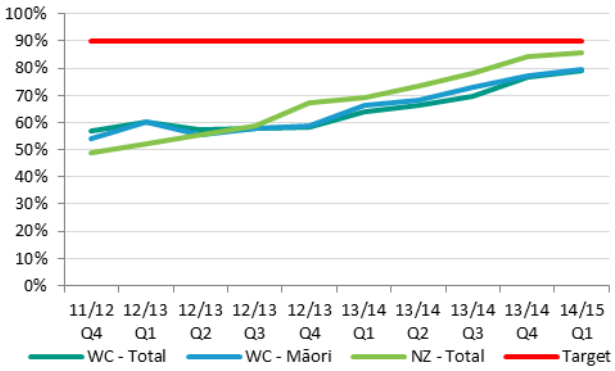
Secondary Smokefree Health Target: Hospitalised smokers given quit advice & help



Primary Smokefree Karo data: Smokers attending primary care given advice & help to quit – by ethnicity



More Heart and Diabetes Checks Health Target: % of eligible PHO population having had a CVD risk assessment in the last 5 years



ACHIEVEMENTS/ISSUES OF NOTE

Primary Smokefree Health Target: Results for Quarter 1 2013/14 show 70% of Maori have attended general practice and have been offered advice and support to quit, this is an increase from 62% last quarter.

There is a comprehensive plan in place to improve this target. Joe Mason Aukati Kai Paipa 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. As part of this plan Joe Mason the Aukati Kai Paipa smoking cessation practitioner has been provided with a practice list of Maori from High Street Medical Centre who are recorded as smokers but had not yet been offered ABC. Of those that Joe has cold called he has had a great success rate of approximately 30% who are now on the AKP smoking cessation programme. The next practice that Joe will be targeting will be Westland Medical Centre.

Aukati Kai Paipa: For the quarter March to June 2014 the AKP service is working with 44 clients, 11 who identify as Maori with a 33.3% validated abstinence rate at 3 months. The Aukati Kai Paipa cessation adviser is working more closely with practices and Poutini Waiora which is resulting in increased referrals to the service.

PHO Coast Quit Programme: For the quarter June to Sept 2014 .12.5% (18) Maori accessed the Coastquit cessation service an increase from last quarter of 7. This service has a poor access rate for Maori and this is one issue that we are aiming to address in the Maori Cessation plan.

The Maori Smoking Cessation plan is in it's final draft.

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

HEALTHY WEST COAST WORKSTREAM
Maori Smoking Cessation Plan
2014-2015

KUA TAWHITI RAWA TU HAERE KIA KORE E HAERE NUI TONU
KUA NUI RAWA O MAHI KIA KORE E MAHI NUI TONU
We have come too far not to go further, we have done too much not to do more

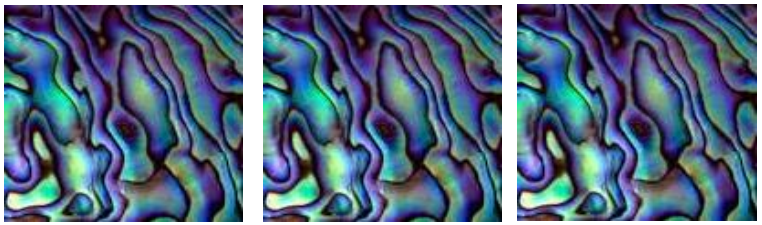
Goal 1: To increase the number of Maori smokers who make supported evidence based attempts to quit smoking
Goal 2: To increase the number of Maori smokers who access cessation services

Action	Timeframe	Responsible	Progress		**Risks** *(Identify any issues that may stop you from achieving target)*	
			On schedule (% complete) ✓	Complete ✓		
1. Review the Coast Quit programme to determine how this service effectively targets Maori smokers	Q2 Dec 2014	John Caygill				
2. Target Maori to participate in the Stoptober initiative • *John to investigate the possibility of West Coast being prioritised for early delivery of the Stoptober training* • *John and Joe to work together to set up groups (locations, facilitators, mode of delivery) targeted at Maori clients.* • *keep the West Coast Tobacco Coalition engaged in*	Sept	John Caygill				

planning for Stoptober • *Confirm the process for collecting ethnicity data for clients enrolling in groups for Stoptober*						
3. Access practice enrolment registers and Poutini Waiora client lists to identify all Maori smokers with the goal of offering stronger support to quit smoking. *- increased presence of Aukati Kai Paipa worker within practices increase primary care referrals to Aukati Kai Paipa and a process is in place to report monthly.*	Q4 July 1 2015	John Caygill, Joe Mason	✓ **(%)**			
4. The incentivisation programme has a target of 50% of pregnant Maori wahine accessing the programme	Q2 Dec 2015	Jenni Stephenson				
5. Hospital Smoking Cessation Practitioner advises AKP of Maori clients referred to her and includes Aukati Kai Paipa Cessation Practitioner details in any messaging to clients (voice messages and letters.)	Q1 Sep 2014	Anne MacDonald				
6. All Poutini Waiora workers will undertake training and haves the necessary skills to provide ABC to whanau. A clear and consistent pathway into cessation services will be established with the expectation of increased referrals.	Q2/Q3 March 2015	Kylie Parkin, John Caygill, Joe Mason				
7. Aim to deliver ABC (Ask, Brief advice, Cessation support) training All Maori Health workers on Tai Poutini	Q4 June 2015	Kylie Parkin				
8. Joe Mason will work with Year 10 students on a short performance that will strongly support the smokefree message to Rangatahi. 2 performances will be delivered.	Q4 June 2015	Joe Mason				
9. The PHO Health Promoter will prioritise Maori Smokefree messaging and provide consistent reporting against this objective.	Q3 March 2015	Pauline Ansley				
10. Investigate opportunities for the use of social media to	Q4 June 2015	Anne Hines, , Kylie Parkin, Joe Mason,				

target cessation.		Jenni Stephenson, Kelsey Moore				
11. Aim to have several teams participating in the March 2015 WERO challenge (Whanau end smoking Regional Whanau ora challenge).	Q3 March 2015	Kylie Parkin, Joe Mason, Kelsey Moore				
12. Identify the baseline figure and increase referrals to cessation services for Maori who have been in hospital.	Q4 June 2015	Kylie Parkin, Jenni Stephenson, Anne MacDonald				
13. Feed information including ethnicity data into Mana Tamariki Mana Mokopuna research and take on board any learning's that could inform a change in approach.	Q4 June 2015	Kylie Parkin, Jenni Stephenson				
14. An accurate data capture system is developed that captures all Maori referrals to cessation services – Aukati Kai Paipa, DHB Cessation Services and Coastquit. Quarterly reports are produced.	Q2 Dec 2014	John Caygill, Jenni Stephenson, Pauline Ansley				
15. An increase in the number of referrals to cessation services from Poutini Waiora. Baseline data to be included.	Q4 June 2015	Kylie Parkin Joe Mason John Caygill				
16. Increase the number of pregnant Maori women who are smokefree at two weeks postnatal – target 75% by June 2015; 86% by June 2016. Baseline data to be included.	Q4 June 2015 Q4 June 2016	Kylie Parkin Jenni Stephenson John Caygill				

West Coast's Priority Plan for Breastfeeding
2014 – 2016



Background

Canterbury and West Coast Maternity Clinical Governance Committee

In 2013 it was decided that as part of the Trans-Alpine partnership, West Coast and Canterbury DHBs would establish a combined Maternity Clinical Governance Committee (MCGC) to support the respective Board's Quality and Safety Plans through assessing, reviewing and identifying improvements to quality and maternity care as well as facilitating discussion and collaboration between service providers.

Canterbury's 'Improving the Maternity Journey for Pregnant Women'[1] project identified breastfeeding as one of nine opportunities for improvement. Each of the opportunities now sits within a project group under the MCGC structure. In April 2014 MCGC endorsed a Breastfeeding Priority Plan to support improving breastfeeding rates in Canterbury.

After reviewing this document. The West Coast Breastfeeding Interest Group decided that there would be value in creating a similar plan. While there are similar goals and outcomes in each DHB's plan, activities for West Coast have been identified to ensure that our unique needs are met. We have also taken into account the impact of having our most complex cases being managed in Canterbury which identifies the need for good quality support for babies and mothers returning home.

World Health Organisation (WHO) recommends that infants be exclusively breastfed until aged six months and receive safe complimentary foods while breastfeeding continues for up to two years of age or beyond[2].

Plunket data [3]shows that on the West Coast from 2012 to 2013 17% of babies are exclusively and 9% of babies are fully breastfed at six months. This is a little below the national average. This means that 74% of our infants are below WHO recommendations.

[1] Improving the Maternity Journey for Women in Canterbury 2012
[2] World Health Organisation Child Growth Standards 2006

[3] Royal NZ Plunket Society (Inc) PCIS Statistics 01.07.13 – 31.12.13 (Note: We do not have good quality data from other Well Child /Tamariki Ora providers) More data can be found in Appendix 5.

West Coast DHB's Annual Plan and Statement of Intent 2013-2014

Improving Health Outcomes for our Population[4].

Outcome Goal: People are healthier and take responsibility for their own health.

Impact Measure: More babies are breastfed.

- Breastfeeding lays the foundation for a healthy life, contributing positively to infant wellbeing and potentially reducing the likelihood of obesity later in life. Breastfeeding also contributes to the wider wellbeing of mothers.
- Although breastfeeding is natural, it sometimes doesn't come naturally, so it's important that mothers have access to appropriate support and advice.
- An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.

The percentage of babies fully/exclusively breastfed at 6 weeks	Actual 2011	Target 2013	Target 2014	Target 2015
	69%	74%	≥74%	≥74%

Delivering Better Public Services: The Child Action Plan [5]

Objective: Implement a collaborative and integrated approach to the delivery of maternity services.

Activity:

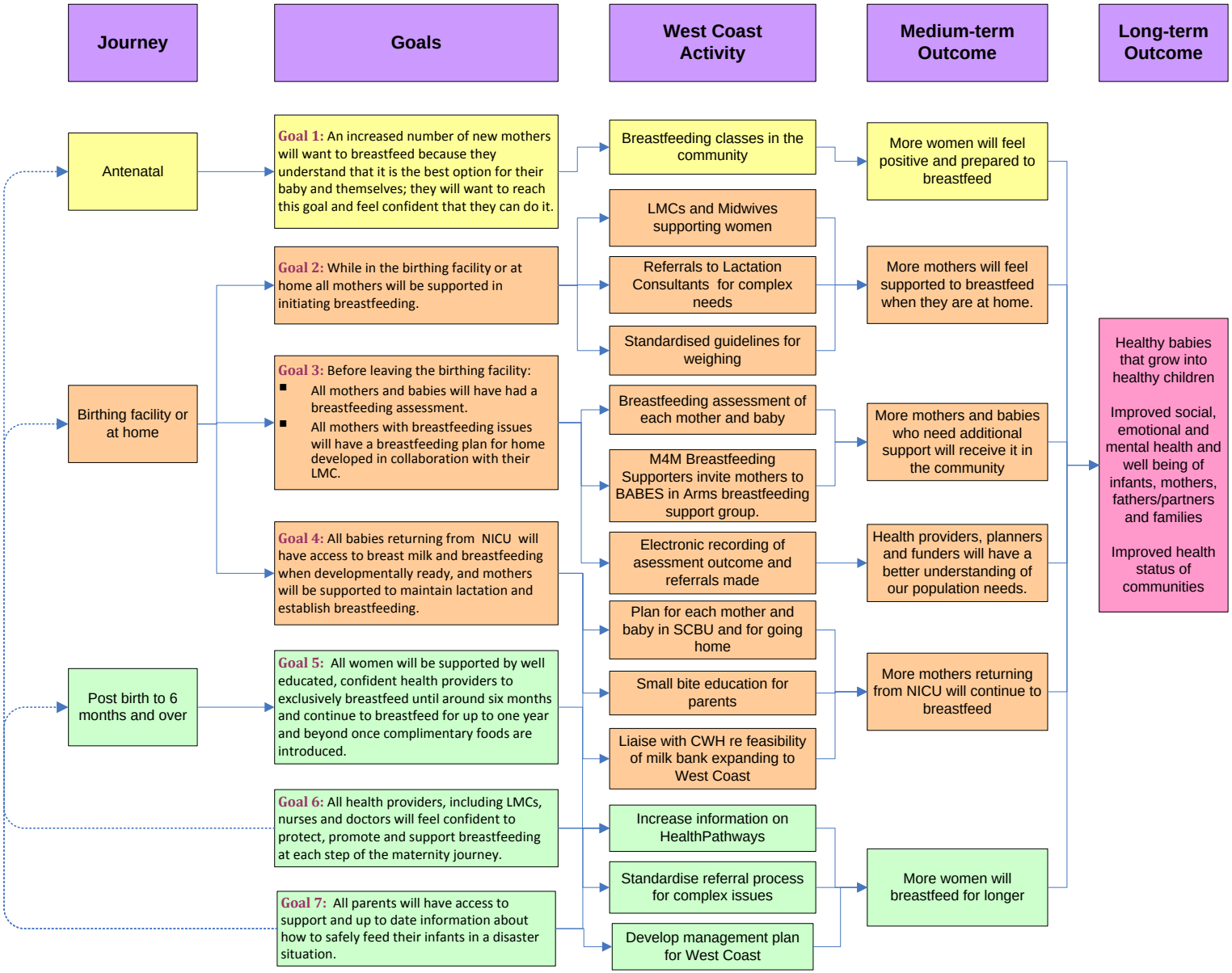
- Support the Breastfeeding Interest group to strengthen stakeholder alliances, identify opportunities to better engage women in breastfeeding and improve integration between providers.
- Provide access to free lactation consultants and specialist advice for mothers, with particular focus on high-needs and high-risk women.
- Continue to invest in supplementary services to support mothers to breastfeed, including peer support programmes that are accessible and appropriate for high-risk and high-needs women.
- Support the establishment and maintenance of breastfeeding-friendly environments on the West Coast.

Evidence:

- ≥ 100 referrals to community-based lactation support
- ≥ 17 Mum 4 Mum Peer support counsellors trained
- ≥ 85% mothers breastfeed on hospital discharge
- 74% of infants are fully or exclusively breastfed at 6 weeks

[4] Outcome Goal 1 Impact Measures (medium term 3-5 years) Page 15

[5] Maternal and Child Health Services: Our Performance Story 2013/14 (Page 41)


Journey
Goals
West Coast Activity
Medium-term Outcome
Long-term Outcome
Antenatal
Birthing facility or at home
Post birth to 6 months and over
Goal 1: An increased number of new mothers will want to breastfeed because they understand that it is the best option for their baby and themselves; they will want to reach this goal and feel confident that they can do it.
Goal 2: While in the birthing facility or at home all mothers will be supported in initiating breastfeeding.
Goal 3: Before leaving the birthing facility:
All mothers and babies will have had a breastfeeding assessment.
All mothers with breastfeeding issues will have a breastfeeding plan for home developed in collaboration with their LMC.
Goal 4: All babies returning from NICU will have access to breast milk and breastfeeding when developmentally ready, and mothers will be supported to maintain lactation and establish breastfeeding.
Goal 5: All women will be supported by well educated, confident health providers to exclusively breastfeed until around six months and continue to breastfeed for up to one year and beyond once complimentary foods are introduced.
Goal 6: All health providers, including LMCs, nurses and doctors will feel confident to protect, promote and support breastfeeding at each step of the maternity journey.
Goal 7: All parents will have access to support and up to date information about how to safely feed their infants in a disaster situation.
Breastfeeding classes in the community
LMCs and Midwives supporting women
Referrals to Lactation Consultants for complex needs
Standardised guidelines for weighing
Breastfeeding assessment of each mother and baby
M4M Breastfeeding Supporters invite mothers to BABES in Arms breastfeeding support group.
Electronic recording of asessment outcome and referrals made
Plan for each mother and baby in SCBU and for going home
Small bite education for parents
Liaise with CWH re feasibility of milk bank expanding to West Coast
Increase information on HealthPathways
Standardise referral process for complex issues
Develop management plan for West Coast
More women will feel positive and prepared to breastfeed
More mothers will feel supported to breastfeed when they are at home.
More mothers and babies who need additional support will receive it in the community
Health providers, planners and funders will have a better understanding of our population needs.
More mothers returning from NICU will continue to breastfeed
More women will breastfeed for longer
Healthy babies that grow into healthy children
Improved social, emotional and mental health and well being of infants, mothers, fathers/partners and families
Improved health status of communities

Antenatal

Goal 1

An increased number of new mothers will want to breastfeed because they understand that it is the best option for their baby and themselves; they will want to reach this goal and feel confident that they can do it.

Linda's story

I came from a big family and breastfeeding was the norm, so I knew that I would breastfeed my own children when I had them.

My husband and I attended the breastfeeding session at the local Pregnancy and Parenting Education class. I learnt so much and the information really changed my husband's attitude to breastfeeding. Previously he thought that if I could breastfeed our baby that would be great, but if I couldn't then it would be no big deal, but he came away thinking that he would do everything he could to support me.

Our daughter never slept a whole night for the first nine months. We had no family living near so my husband's support was crucial. I was exhausted and stressed. If he had said 'just give her a bottle' I could have caved in, but because he had learnt so much about the value of breastfeeding he kept supporting and encouraging me to keep going.

I now have three daughters that I have I breastfed for over 18 months.

Having my husband on board with the plan before our first baby was born is one of the keys to success for managing the challenging times that all new mothers go through.

Current situation

Women have access to multiple sources of information about breastfeeding in the antenatal period. By the time they meet their midwife many have decided how they intend to feed their baby; the majority intend to breastfeed, but often that is as far as they have got.

Most LMCs, as the main educator during the antenatal period, discuss the advantages and benefits of breastfeeding as well as the risks and disadvantages of not breastfeeding for both mother and baby with each woman in their care.

The Pregnancy and Parenting Education classes set two hours aside for breastfeeding as well as introducing the Mum 4Mum team so women know about them and how to access their support once baby is born.

The majority of learning about breastfeeding seems to be after the baby is born.

1.1 Hold breastfeeding education activities that:

- **Are in appropriate and accessible venues in the community**
- **Are held at a range of times (e.g. on week days, weekends, mornings and evenings).**
- **Are culturally sensitive to the needs of mothers; especially for Māori, Pacific, Asian, migrant and young parents to be.**
- **Encourage not only first time mothers, but also other mothers that may not have succeeded with breastfeeding the first time.**
- **Involve partners and support people.**

1.2 Link breastfeeding classes and Mum4Mum peer support to Pregnancy and Parent Education (PPE) classes to ensure a smooth, stress free, flow of education and information for mothers.

Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
1.1.1 Deliver education programmes in the community: • Start with Greymouth and Westport, and then • Investigate other areas where there is a need.	New classes will have been established and women are attending.	Increased % of Women • Māori • Pacific • Asian breastfeeding at key MOH reporting times Data source: MOH Number of women attending the breastfeeding courses. Data Source: Provider data	S: F:	[6]
1.1.2 Deliver education programmes that: • Have a standardised content, covering the 10 Steps to Successful Breastfeeding[7], and the Seven Steps to Breastfeeding in the Community[8] but are flexible enough to meet the needs of different groups. • Are delivered by a Midwife, a Lactation Consultant or Breastfeeding Advocate. • Use a variety of alternative educational formats e.g. podcasts & DVDs. • Distribute the current West Coast Breastfeeding Handbook at 28-32 weeks to support antenatal as well as post natal education • Use Talking Cards as a means of standardising education. • Develop environments that promote communities, role models and relationships. • Has additional detail for ethnic specific groups and NICU parents.				

[6] Once the plan has been endorsed by WC Maternity and Quality Safety group, Health West Coast Workstream and the C&WCDHB Clinical Governance Committee, the BIG will allocate a leader from within their group and key people from DHB and NGOs required to support implementation. BIG will also set timeframes for all activities

[7] See Appendix 2 (Keep in mind that a maternity services facility is not just the birthing facility, but every facility where maternity services are provided)

[8] See Appendix 2

1.1.3 Introduce breastfeeding education[9] early into PPE classes to: • Promote breastfeeding early in pregnancy and continue to support this throughout the course. • Hear a successful breastfeeding mother's story and introduce Mum4Mum peer support counsellors and groups.		Baseline data: CWH BF programme 2012/13		

[9] See Appendix 2 for NZBA Antenatal education sheet on breastfeeding plus additional education points to consider

Birthing Facility

Goal 2

While in the maternity facility, all mothers will be supported with initiating breastfeeding.

Tiffany's story

I was twenty when I had our daughter by caesarean section. The midwife helped me to breastfeed the first time while I was in the recovery room, but once we returned to the ward, the main focus was on my blood pressure and other recordings. I wasn't at all confident with breastfeeding and before long I had cracked nipples. My partner went and got a midwife to help. She watched and adjusted my baby's head, but I felt as though I didn't really have the hang of it.

On the third day all I wanted to do was go home. I was shown a DVD about breastfeeding before I went and the midwife watched me breastfeed again.

The first week at home, every time I went to feed I was crying. I got to the point where I didn't want her to wake up as I knew I would have to feed.

My partner contacted the Lactation Consultant because I had decided that I would have to change to a bottle, and he knew how much I had wanted to breastfeed. The Lactation Consultant was great as she came to my house and had time to spend with me, but I think it was too late. I expressed for a while which took ages, and I eventually gave up.

I really regret not succeeding with breastfeeding. When we have our next baby I am going to make sure I learn as much as I can and know what services and supports are out there before the birth so I am better prepared to get through the first few months until I am confident.

Current situation

All WCDHB's maternity facilities have been designated Baby Friendly Hospitals. The BFHI audit standards are in accordance with the CEF/WHO global criteria. Each facility is audited every three years by the New Zealand Breastfeeding Authority.

The Greymouth Lactation Consultant works on a four day a week roster in McBrearty. A small team enables good communication between shifts.

Neither Greymouth nor Westport record whether or not a woman stays longer because of breastfeeding issues, or returns home with breastfeeding concerns.

There is no protocol for when babies should be weighed at CDHB or WCDHB. Random weighing of babies that are clinically hydrated and settled can cause anxiety for mothers if the weight gain is not what was expected and can often be the first step to losing confidence in their breastfeeding ability.

The freedom of friends and family visiting whenever they want to can be an intrusion for mothers if they are trying to become confident with breastfeeding. They can often feel as though they are entertaining visitors if they stay too long or there is a variety of groups of visitors that don't know each other.

2.1 Develop an educational package for all LMCs and Midwives				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Refer to Activity 6.1.2 and 6.2 Emphasise key points most relevant to initiating breastfeeding. (As per BFHI requirements.				

2.2 Improve process for referring and communicating any concerns or complex breastfeeding issues during stay at the birthing facility.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Improve the process to seek advice from the most appropriate support service. This will include: • Westport: telephone call the PHO Lactation Consultant[10] and she will advise. • Greymouth and other areas: call the PHO Breastfeeding Advocacy Service for advice or redirect to Lactation Consultant.	LMCs and Midwives are more confident about making appropriate referrals. Improved support for complex breastfeeding issues at the primary birthing units.	Number of referrals to Lactation Consultants • Number of women and babies with complex issues • Number leaving facility exclusively breastfed Data source: Baseline data: ??	S: F:	

[10] Raewyn Johnson from Westport is the only West Coast Community Lactation Consultant. She works closely with Erin Turley the Breastfeeding Advocate, to ensure that there is good support for all mothers across the district with complex breastfeeding concerns.

2.3. Develop Canterbury and West Coast wide standard protocol/guidelines for weighing well babies.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Develop a working group to • Review current information • Agree on standards • Write document and flowchart to support decision making. • Distribute for feedback • Communicate final protocol/guideline.	Guidelines written and circulated. Increased agreement between providers regarding appropriateness of decision making	Decrease in referrals to LCs due to mothers concerns about baby's weight when other aspects of feeding are satisfactory.	S: F:	?

2.4 Develop a pathway for babies with tongue ties				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Work with HealthPathways team to investigate current process and develop a formal referral pathway	An agreed pathway will be on HealthPathways Babies that require release are getting identified and referred	Number of babies being treated	S: F:	

2.5 Provide a visitor free time each afternoon.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Seek agreement from Clinical Midwifery Manager to hang notices outside the ward that mothers and babies are resting (for one hour) • Provide additional support and education over this period for babies who require breastfeeding	Women will feel more relaxed and be able to focus on and be supported to breastfeed.	Notice on boards. Rest time occurring. "We care about Your Care' gives positive feedback.	S: F:	

Birthing Facility

Goal 3

Before leaving the birthing facility:

- All mothers and babies will have had a breastfeeding assessment.
- All mothers with breastfeeding issues will have a breastfeeding plan for home developed in collaboration with their LMC.

Miranda's story

While I was in McBrearty Ward I had had some complex breastfeeding issues, so the Lactation Consultant, my LMC and I had agreed on a plan for how to manage things when I went home. It involved breastfeeding, expressing, bottle feeding expressed breast milk and using a nipple shield.

My partner and family were keen for breastfeeding to work, so they gave me lots of support by doing things around the house to give me time to concentrate on my baby. The support I got from M4M was so helpful as she was a young mum just like me and had kept going despite similar challenges. She understood what I was going through. I kept thinking that if she did then I can too.

I could not have kept going if I had left the hospital without the discussion and the plan because it meant my partner and I really understood what I needed to do and why I needed to do it and what was OK and when I needed to seek help. My story is a good example of the value of having a breastfeeding plan made before I went home rather than getting home then everything falling to pieces.

Current situation

Most women have had a breastfeeding assessment before they leave the facility. A checklist is used to ensure each area of the assessment is covered.

Women who have difficulties with breastfeeding can stay longer.

It is interesting to note that women from Gloriavale, who mainly have home births, exclusively breastfeed; other options are not discussed. If a mother cannot breastfeed for some reason, then other mothers donate breastmilk.

The key to establishing and becoming confident with breastfeeding seems to be family and community support for mother and baby.

The West Coast Breastfeeding Handbook is given out at 23 – 36 weeks; but if the woman has lost it, another one is given to them while in the facility.

3.1 Review recording process for breastfeeding assessment				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
3.1.1 Revise the current green sheet used as the breastfeeding assessment for all mothers and babies before they leave the birth facility for home. • Consider how this could be incorporated into the Breastfeeding Handbook to keep all information in one place.	. Education for all LMCs/ midwives is completed. All breastfeeding information for women is in one place.	Number of mothers and babies discharged with assessment completed. Number of referrals Data source:???	S: F:	
3.1.2 Improve the process for transitioning from hospital to community for breastfeeding dyads that have had complex breastfeeding plans instituted in the maternity facility: • Revise referral/notification to PHO Community Lactation Consultant and Breastfeeding Advocate	Lactation Consultant and LMC will discuss the breastfeeding plan to ensure there is a smooth transition from hospital to community.	Increased number of LC/LMC discussions and plans developed. Data source: LC report.		

3.2 Develop a process to record and communicate whether a baby is feeding at the breast when leaving the facility.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Review current documentation and identify areas where it can be improved. Identify the process for recording this information electronically so data can be collected and analysed. Develop a template to guide core midwife and LMC to write an individualised feeding plan for women with complex feeding issues to take home.	Information regarding breastfeeding assessment is being recorded in a systematic way. A template for breastfeeding plans is being used.	Increase in number of babies feeding at the breast on discharge. Increased number of plans for dyads with complex BF issues. Data source: tbc once process established Baseline data:	S: F:	

3.3 Develop a process that links a Mum 4 Mum Peer Support counsellors/service.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
3.3.1 Develop a programme for peer support counsellors to visit each facility and meet women who may struggle with breastfeeding when they go home. This would enable them to introduce the service and the support it can offer rather than LMCs/midwives referring them when problems arise. • Provide the name and phone number of a specific M4M peer support counsellor to reduce barriers to access.	Peer Support Counsellors will be visiting all birthing facilities	Increased number of M4M visits and contacts in facilities. Mothers trained for NICU visits Data source: PHO Baseline data: New service.	S F	
3.3.2 Widen the programme to incorporate Parfitt Ward for babies and parents returning from NICU by having regular attendance of Mum 4 Mum Breastfeeding Supporters who have experienced having a baby in NICU, so can promote and support breastfeeding. This can extend to home contacts (Additional training will be provided for this M4M group)				

Paediatric Unit

Goal 4

All babies returning to Parfitt Ward, (the paediatric unit) Grey Hospital from a NICU will have access to breast milk and support to continue establishing breastfeeding when developmentally ready, and mothers will be supported to maintain lactation and establish breastfeeding as they transition to home.

Simmy's story

All was going well with my pregnancy until 28 weeks. By the end of that week my very premature son was in an incubator in Christchurch Women's Hospital's NICU and I felt frightened and far from my family.

The next three months were a blur of tubes and monitors as well as a large number of staff focused on caring for my baby. The NICU Lactation Consultant was there to support me every step of the way. I expressed milk three hourly and this was fed to him via a tube.

When the team first talked about me returning to Parfitt Ward it felt like a whole new terror. How could they expose my little bundle of joy to the contamination of the outside world? How would he be fed, clothed and kept at the right temperature without all the technical equipment that had been supporting him from the day he was born?

Establishing feeding at the breast held a whole new group of challenges, but I am pleased to say that when we left for Greymouth I hadn't given up. We were both learning how to make it work. Some of the nurses in Parfitt Ward had worked in NICU so they understood how I was feeling and the breastfeeding challenges I was having. It was a good step between NICU and home.

At home I was lucky to have support from the Community Lactation Consultant. One of the real bonuses was that she had time to listen to my story and concerns. Together we made a plan for managing the days ahead. I am pleased to say that I am still breastfeeding at 16 months.

Current situation

Mothers and babies returning from CDHB's NICU to Parfitt Ward have required a higher level of support recently due some skipping the intermediate level of care before returning. This is because NICU has had a higher level of occupancy over the past six months.

Mothers can often arrive feeling completely disempowered if they have experienced a highly technical environment in NICU.

In Parfitt Ward, mothers and babies are cared for by registered nurses with the LMC continuing to take the lead for maternity care if the baby is under six weeks.

By the time they return, most mothers have made the decision regarding whether they are going to breastfeed. There are breast pumps available if required. Donor milk is not encouraged.

Our nurses and doctors have the opportunity to attend LMC training to promote breastfeeding and become familiar with the care required for mothers and babies with a wide range of birthing histories which impacts on the breastfeeding support they require while in the ward and then as they prepare them for returning home.

We contact the McBrearty Ward Lactation Consultant for complex issues that are outside the level of our confidence to manage.

When babies are discharged mothers can feel isolated and struggle with confidence. Linking the Neonatal Community Outreach Nurses, (one in Westport and one in Greymouth/Hokitika, or the Rural Nurse Specialist in Whataroa) in before discharge plays a pivotal part in supporting breastfeeding at this stage of the journey.

4.1 Develop an education programme for nurses and doctors to understand the importance of breast milk and breastfeeding in optimising outcomes for babies who have returned from NICU. (10-15% of all babies) This will require: • **Providing additional education that covers what these babies and mothers need to support them to initiate lactation and establish breastfeeding.**				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
4.1.1 Develop a service for nurses and doctors caring for babies in Parfitt Ward to ensure they feel supported to protect and support breastfeeding for both mother and baby. This may be via • Videolinking with CDHB NICU for education sessions • Attending LMC breastfeeding education sessions	All providers will have watched Back to Basics video.	% of nurses and doctors who have viewed video/attended LMC education sessions.		
4.1.2 Develop an educational module for Peer Support Counsellors who have experienced NICU and gone on to breastfeed well so they can support women with babies in Parfitt Ward and when they return home.	The first course delivered and feedback positive. (We can plagiarise CDHB programme for this)	Number of women completed the module. Number of PSC visits to Parfitt Ward. Data source:		
4.1.3 Develop information sheet related to informal breastmilk sharing[11]. It needs to cover: • Infection control • Storage • How to access more information	Women who ask for information will be supplied with key information for them to follow up on.	??		

[11] Although this is documented as an activity in this section it would be a WCDHB policy and be used across all hospital and community breastfeeding situations.

4.2 Revise the discharge process to streamline the Neonatal Community Outreach Nurse to ensure a smooth transition from Parfitt to home.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
4.2.1 Include NCON (and Rural Nurse Specialist when required) in the telehealth conferencing for complex babies that occurs before they return from NICU.	Doctors, hospital and community nurses and LMCs on West Coast will have a common understanding of the history, issues and management plan of each baby and mother when they arrive at Greymouth, A mother and her baby will be cared for as one unit, with their unique requirements considered and supported.	??? narrative ? feedback		
4.2.2 Support transition from Parfitt Ward to home: • Provide phone number for M4M for peer support.				

4.3 Link with CDHB Human Milk Bank to provide milk for NICU babies when they have returned to West Coast until mothers have established breastfeeding.[12]				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Now that the Human Milk Bank is open, support CDHB to: • Develop a new project and funding model (Phase two) to expand the initial concept to mothers and babies outside NICU (on the postnatal wards, primary birthing units, in the community and the wider South Island).	A phase two project plan is developed and approved. It will include: • Funding source • Goals • Evaluation process • Timeframes.	Pasteurised donor human breastmilk is available in Parfitt Ward for babies returning from NICU if still required.	S: F:	

[12] We have included this at this point to provide a fuller picture of breastfeeding activity in Canterbury that we can work with to support West Coast babies.

Post natal to 6 months

Goal 5

All women will be supported by well educated, confident health providers to exclusively breastfeed until around six months and continue to breastfeed for up to one[13] and beyond once complimentary foods are introduced.

Lucy's story

My daughter became unwell when she was four weeks old. The doctor at ED was not sure what was wrong so following a telepeds conference with the paediatrician in Christchurch, it was decided that she needed to be flown to Christchurch Hospital.

This time period was over five hours. I had no money and was not offered any food. I was then told to stop breastfeeding in case an operation was required. The weather then deteriorated so we had to stay overnight, so I was told to breastfeed again but not after 6am. There were more delays in the morning, so I breastfed again before we finally left at 11am.

By this time I had very engorged and painful breasts but the staff were focussed on my baby's condition. It was a very stressful time.

When we finally arrived at Christchurch Hospital I was relieved to find the nurses were keen and confident to look after not only my daughter but also me as a worried parent and a breastfeeding mother.

I am happy to say that with this support I managed to keep breastfeeding throughout the whole time in hospital; and I'm still exclusively breastfeeding three months later.

Current situation

Since March 2014 the Community Breastfeeding Advocates have contacted all new mums soon after their baby is born. This identifies women who are managing well, those that would benefit from Mum4Mum support and those that have complex issues and require an appointment with the Lactation Consultant.

The PHO manages the Mum4Mum service. They run courses for women who have breastfed, usually for over nine months, and is keen to support other women can attend an eighteen hour over nine weeks to become a M4M Peer Counsellor. M4M mothers have a variety of both good and challenging experiences, so are a great source of advice and encouragement for mothers requiring support for managing normal breastfeeding issues.

[13] The vision for the National Strategic Plan of Action for Breastfeeding 2008-2012 based on WHO Global strategy for infant and young child feeding states two years; however, New Zealand Food and Nutrition Guideline Statements for Healthy Infants and Toddlers states 'exclusive breastfeeding for around six months and continue breastfeeding for one year and beyond'

5.1 Provide education for LMCs, General Practitioners, Practice Nurses, Rural Nurse Specialists and Well Child/Tamariki Ora Nurses regarding what is considered 'normal' and can be managed by them and what is specialised/complex and should be referred to a Community Lactation Consultant. 'Novice to expert'				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
PHO deliver a yearly educational 'roadshow' for providers. Also activity 6.1.3	Greater % of referrals to Lactation Consultants are for **complex** breastfeeding conditions	Number of referrals to WCPHO Lactation Consultants • % that had complex issues Data source: ?? Baseline data: 2012/13	S F	

5.2 Promote HealthPathways as the standard, agreed, referral pathway.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
• Identify new pathways that will support providers to promote, protect and support breastfeeding. • Develop a section on HealthPathways/HealthInfo on normal breastfeeding (physiology and practice).	Increased use of HealthPathways by providers to access information on breastfeeding.	Increased number of hits on HealthPathways' breastfeeding section Data source: HealthPathways	S F	

5.3 Develop a referral document that provides enough detail to enable referrals to be prioritised by the Community Breastfeeding Advocacy Service				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Develop document that will: • Identify complex issues. • Promote HealthPathways as the source for referral forms.	Increased % of complex and decreased % of non-complex referrals to Lactation Consultants.	Number of referrals to Lactation Consultants • Number that had complex issues Data source: PHO Baseline data: 2013	S: F:	

5.4 Develop Breastfeeding Friendly Communities				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
5.4.1 Develop WCDHB as a Breastfeeding Friendly work environment: • Commence with Grey Base Hospital and then • Move to other facilities.	WCDHB Breastfeeding Policy Approved and Circulated to all departments. All areas can show that they meet the requirements of the policy.	Staff surveys. Did they know about the policy? Have they used it? Was it helpful?	S: F:	
5.4.2 Develop a WCDHB breastfeeding policy for caring for mothers and babies that present to ED and/or are admitted to hospital. This needs to consider keeping the two as a unit where baby is dependent on mother for continued feeding and/or expressing when necessary.	Mothers will feel supported to continue breastfeeding throughout ED and hospital admissions.	Data: Number of referrals to M4M for ED or inpatient request. Of them. The number who were referred to LC.	S: F:	
5.4.3 Participate in planning process for new facilities to ensure that breastfeeding for patients, their family/whānau and staff are included in the models of care and the new facilities.	Any member of the population, whether a patient, family, friend or staff will be able to breastfeed or pump in a suitable room/location to support this.		S: F:	

5.4.4 Develop Breastfeeding Friendly Communities in key NGOs where the main focus is mothers and babies: • Include this in Planning and Funding service agreements.	All identified NGOs can show breastfeeding policies and how they implement these within their organisation.		S: Lower Priority F:	

General Education

Goal 6

All clinical providers, including LMCs, nurses, doctors will feel confident to protect, promote, and support breastfeeding at each step of the maternity journey.

Beth's story

I completed Mum 4 Mum training while I was pregnant with my fourth child. I then worked as the local Plunket Nurse while completing the Post Graduate Certificate in Specialty Nursing. The post graduate certificate covered the bigger picture of breastfeeding policies, but not the anatomy and physiology of the every-day processes of breastfeeding.

The Mum 4 Mum training is evidence based. One of its real values is linking with other mothers doing the course. It has made a significant difference to my practice as a Plunket Nurse. I know the mothers in our community that have trained as Mums 4 Mums and which one would be most appropriate to support clients needing extra breastfeeding support and encouragement.

I would highly recommend the Mum 4 Mum training for WellChild TamarikiOra providers and other health professionals.

Current situation

- Currently LMCs have a variety of options for receiving breastfeeding education. It is a core competency requirement of their re-certification process.
- Practice Nurses and General Practitioners receive no formal breastfeeding education and are likely to miss opportunities ante and post-natally to promote, protect and support breastfeeding for as long as possible, unless they have had a positive personal experience. Last year the PHO took a 'road show' to the general practices to provide education and promote local services.
- Staff in the hospital's general wards have no education or support for how to care for breastfeeding mothers or their babies who are admitted. Processes to seek information and advice are minimal.
- Some staff may have difficulty separating their own breastfeeding experience from their interactions with mothers and babies.
- Current breastfeeding support staff do not have the resource to provide comprehensive educational sessions for the continual turnover of staff and the need to educate new staff as early as possible.
- Medical students (this year) attended a breast feeding education session.

6.1 Establish an educational package that is broken into units to enable appropriate information to be delivered to specific health provider groups.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
6.1.1 Establish the **re-certification process for LMC/midwives** that is required as part of their annual core competency requirements: • Provides one half day breastfeeding education sessions per three years plus one other activity related to breastfeeding. E.g. study day, workbook, on line learning, presentations, journal clubs, and case studies.	Midwifery Council's curriculum is being followed Courses are accessible	All LMCs/midwives are recertified. Data source: ??NZCOM data	S: F:	
6.1.2 Deliver the educational breastfeeding programme every six months[14] for core midwives that: • Gets back to basics to enable midwives to: o Manage normal breastfeeding. o Identify complex issues that need referral. • Requires annual attendance by employed midwives.	Curriculum developed Timetable established Feedback from the first course is positive and any refinements made.	At the end of the first year all staff have completed recertification Data source:	S: F:	
6.1.3 Deliver an educational programme for **primary care providers** that provides information that is likely to arise in general practice: • Contraception and its effects on breastfeeding. • Community breastfeeding support services. • Care of non-breastfeeding babies. • Risks, disadvantages of formula feeding. • HealthPathways: o Normal and complex breastfeeding issues. o Referral pathways. o Contraception and its effect on breastfeeding.	At the end of the first year ??% of all staff have attended. ?Number of on-line accesses	Data source:	S: F:	

[14] Students and Registered Nurses, including those in the Nursing Entry to Practice (NETP) programme should also be included.

6.2 Develop a programme for staff that will provide an opportunity for them to understand their own experience/personal issues with breastfeeding and separating their own experience from their professional role.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Provide education at a variety of educational situations that will promote thinking and discussion about what information health professionals are saying and whether they are talking from experience or evidence.	Best practice used by all healthcare providers.	Feedback from attendees shows they have found the course helpful. Data: Course satisfaction survey	S: F:	

6.3 Provide hospital doctors and general practitioners with education				
Planned activities •	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
Provide **hospital doctors and general practitioners** with education re: • Impact of contraception on breastfeeding. • When and how to discuss options with women. Communicate HealthPathways for information on breastfeeding and contraception.	Increased hits on HealthPathways		S: F:	

6.4 Provide education and mentoring for all health students (especially doctors, nurses and midwives) to ensure sustainable growth in knowledge and skills in our future workforce.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
6.4.1 Link with education providers to facilitate educational slots within programmes to introduce breastfeeding.	All students will have basic understanding of breastfeeding and will be developing knowledge and skills to protect, promote and support breastfeeding in any environment they may work in. They will understand what is normal and what is not normal.	Feedback from attendees shows they have found the course helpful. Data: Course satisfaction survey	S: F:	
6.4.2 Identify mentors for students when they are in clinical placements to protect, promote and support breastfeeding.				
6.4.3 Support students to attend any educational opportunities while on clinical placements.				

Civil Emergency/Disaster

Goal 7

All parents will have access to support and up to date information about how to safely feed their infants in a civil emergency or disaster situation

Tracey's story

I was at home with my four week old daughter when Cyclone Ita hit. My husband had gone to work just an hour before the power went off. Little did I know that we would not have power for a week! As the day went by the wind got worse. I was concerned because trees started falling down along our long drive. Luckily my husband arrived home before we were total blocked in.

That evening as I was feeding my daughter by candle light I kept thinking how lucky we were was that I was breastfeeding. I didn't have to worry about sterilising bottles or whether I had enough formula.

It was 24 hours before we could get out of the house and into town. It was an unsettling time for the whole community. I was lucky that my husband looked after things outside the house and kept the fire going so I could concentrate on caring for our daughter.

Current situation

Plunket Line's free phone call service has comprehensive information available for parents

MOH's revised and published Infant Feeding in Emergencies (2011) contains national guidelines.

The Canterbury earthquakes identified areas where unexpected events occurred. E.g. Service providers stated that they had not given thought to providing information to pregnant women about how to be prepared to feed their infant in the event of a civil emergency, and why breastfeeding is the safest option. This needs to occur as part of the planning for their family's emergency pack.

7.1 Establish a planning group with a wide variety of community agencies to consider management of future civil emergencies.				
Planned activities	Expected outcomes from this activity	How we will measure success & data source	Start Finish dates	Leader
The planning group needs to have: • Midwives, Lactation Consultants, Practice Nurses, Red Cross, Well Child /Tamariki Ora, Civil Defence providers etc. The plan needs to: • Review the Canterbury earthquakes and lessons learned. • Use the MOH Infant Feeding in Emergencies (2011) document as a starting point, and then develop further detail relevant to West Coast. • Different emergency scenarios and their management. • What is 'safe' infant feeding: o Safe for age groups and feeding methods o Infection control • Develop a communication plan including: o Public Health communications. o Families being prepared for emergencies. o A simple fact sheet ▪ Pregnant women ▪ Newly birthed women ▪ Getting breastfeeding established ▪ Increasing milk supply if needed ▪ How to hand express ▪ How to re-lactate if weaning has started ▪ How to safely bottle feed ▪ What to do if mother is not there ▪ Dealing with disaster myths about breastfeeding • Consider who will take the lead for what in an emergency. • Develop a process for managing offers/infiltration of infant formula products from manufacturing companies.	All women will be given an information sheet from their LMC when breastfeeding is discussed for the first time during pregnancy. Key services, such as Civil Defence and Red Cross, will have documented information regarding the processes related to infant feeding in a civil emergency. Link to CDHB to develop this work together	Number of education sessions delivered. Number attended Types of groups participating. Data:	S: F:	

Appendix 1: Breastfeeding Interest group Members

Erin Turley	Breastfeeding Advocate WCPHO
Raewyn Johnson	Lactation Consultant & PPE teacher, Buller, WCPHO
Emma Boddington	General Practitioner, Greymouth
Anna McInroe	DHB Midwife & Pregnancy and Parenting Educator , Greymouth
Robyn Bryant	Midwife, Poutini Waiora
Trish Lockington	Community Rep, M4M
Kylie Parkin	Portfolio Manager Māori Health WCDHB
Nicola Harris	Breastfeeding Advocate, WCPHO
Anne-Marie Hewitt	Clinical Leader, Plunket
Clair Robertson	Project Manager, Planning and Funding
Barbara Holland	Manager, Well Women's Centre, Greymouth

Appendix 2: Additional Information

Goal 1: The Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless *medically* indicated.
7. Practice rooming-in – allow mothers and infants to remain together -24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

From: protecting, Promoting and supporting breastfeeding: The special Role of Maternity Services. A joint WHO/UNICEF Statement 1989

Goal 2: The Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in the Community

1. Have a written policy that is routinely communicated to all staff and volunteers.
2. Train all health providers in the knowledge and skills necessary to implement the breastfeeding policy
3. Inform pregnant women and their families about the benefits and management of breastfeeding.
4. Support mothers to establish and maintain exclusive breastfeeding to six months.
5. Encourage sustained breastfeeding beyond six months, to two years or more, alongside the introduction of appropriate, adequate and safe complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families
7. Promote collaboration among health services, and between health services and the local community.

Baby Friendly Community Initiative's Seven Point Plan was adapted with permission from WHO/UNICEF UK Baby Friendly Initiative 1999

Antenatal Education

By the time you are 32 weeks pregnant you should have had antenatal education on breastfeeding.
Research has shown that women who have a good understanding of the importance of breastfeeding and associated topics are more likely to have a successful breastfeeding outcome.

'To overcome obstacles issues surrounding perceived barriers, such as father's attitude, quantity of milk, and time constraints, need to be discussed with each parent. To achieve the goal of 75% of breastfeeding mothers, extensive education regarding the benefits must be provided for both parents and optimally the grandmother by physicians, nurses, and the media before pregnancy or within the first trimester.'[1]

You should ensure the following topics are discussed with you during your pregnancy:

- the Breastfeeding Policy of the maternity unit where you intend to birth and/or stay postnatally.
- the importance of breastfeeding for you and your baby
- the importance of exclusive breastfeeding for the first 6 months
- the effect of drugs, used in labour, on both your baby and the initiation of breastfeeding
- the importance of early skin-to-skin contact for you, your baby and for breastfeeding
- early breastfeeding management
- rooming-in which should include safe and unsafe sleeping practices
- cue-based, or baby-led, feeding
- the importance of frequent feeding to establish and maintain your breastmilk
- positioning and latching advice
- the risks associated with giving formula or other breastmilk substitutes before 6 months of age
- that breastfeeding continues to be important after 6 months when other foods may be introduced
- the implications of using pacifiers, teats and bottles on the establishment of breastfeeding
- breastfeeding support services in your community

Ask your Lead Maternity Carer about these topics (above) and seek out the antenatal education classes in your area.
We also recommend that you contact the local La Leche League and attend a meeting, or two, prior to the birth of your baby.
Contact with your local Plunket group, in the later weeks of your pregnancy, can also mean that you meet another group of women for support after the birth of your baby.
Skin-to-skin contact and Rooming-in pamphlets are available from the NZBA website/resources.

Suggested readings/links include:

- Change for Our Children: www.**changeforourchildren**.co.nz
- La Leche League New Zealand: www.**lalecheleague**.org.**nz**
- 'Impact of Birthing Practices on Breastfeeding' Second edition Linda Smith and Mary Kroeger Jones and Bartlett (2010)
- 'Breastfeeding Made Simple. Seven Natural Laws for Nursing Mothers' N Mohrbacher, K Kendall-Tackett New Harbinger Pub. (2005)
- 'The Oxytocin Factor. Tapping the hormone of calm, love and healing.' K U Moberg. Da Capo Press. (2003)
- 'Baby-led Weaning. Helping your baby to love good food.' G Rapley & T Murkett. Vermilion (2008)

Research:

1. Major factors influencing breastfeeding rates: Mother's perception of father's attitude and milk supply.

Arora S, McJunkin C, Wehrer J, Kuhn P. Pediatrics. 2000 Nov;106 (5):E67.

Goal 6: Additional education point for consideration

- Mothers do not realise breastfeeding is learned and does not necessarily come 'naturally' and that it can take time for milk to 'come-in'.
- Mothers need to make informed choices and have a feeding plan discussed with LMC prior to birth. Informed consent process needs to cover the risks of infant formula and the health care provider (Midwife/G.P.)
- Health providers need to communicate effectively without feeling guilty or sharing personal breastfeeding experiences (especially when personal breastfeeding goals may not have been met)
- Pivotal points in breastfeeding journey:
    - Lactogenesis on day 3 (although delayed for some women).
    - Perception of lack of milk, pain and latching problems at 6 weeks.
    - Paid parental leave finishes at 14 weeks.
    - Pressure for solids teething etc at 4 months
- Need support on how to 'care for your breasts'
- Education on expressing; meeting the needs of different breastfeeding dyads.
- Birth interventions and their effect on breastfeeding
- Educating mothers/fathers/support people
    - How Peer Support Counsellor service works
    - When to access support from a lactation consultant
    - Other support services
    - HealthInfo
- Contraception and its effects on breastfeeding
- Relationship, sex and breastfeeding.
- HealthPathways
    - Normal and complex breastfeeding issues
    - Care of non breastfeeding babies.
    - Referral pathways
- Being sensitive to the 'space' the woman is in at this time
- How to meet the needs of other children while breastfeeding.

Appendix 3: Evidence

Evidence for the effectiveness of Mother to Mother breastfeeding peer counsellor support.

1. ***Early and repeated contact with peer counsellors is associated with a significant increase in breastfeeding exclusivity and duration".***

Morrow, A. L., Guerrero, L. M., Shults, J., Calva, J. J., Lutter, C., Bravo, J., Ruiz-Palacios, G., Morrow, R.C., & Butterfoss, F. D. (1999). Efficacy of home-based peer counselling to promote exclusive breastfeeding: a randomised controlled trial. *The Lancet,* 353: 9160:1226-1231.

2. ***"The overwhelming majority of evidence from randomized controlled trials evaluating breastfeeding peer counseling indicates that peer counselors effectively improve rates of breastfeeding initiation, duration, and exclusivity".***

Chapman, D. J., Morel, K., Anderson, A. K, Damio, G., & Pérez-Escamilla, R. (2010). Breastfeeding peer counseling: from efficacy through scale-up. *Journal of Human Lactation*, 26(3):314-326.

3. ***"Group-based and one-to-one peer coaching for pregnant women and breastfeeding mothers increased breastfeeding initiation and duration in an area with below average breastfeeding rates".***

Hoddinott, P., Lee, A. J. , & Pill, R. (2006). Effectiveness of a breastfeeding peer coaching intervention in rural Scotland. *Birth*, 33(1):27-36.

4. ***"Significant increases in initiation and duration rates were observed among women who expressed an interest in breastfeeding and requested support from a peer counsellor".***

Fairbank, L., O'Meara, S., Renfrew, M. J., Woolridge, M., Snowden, A J., Lister-Sharp, D. (2000). A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. *Health Technology Assessment*, 4,(25):1-171.

5. ***"Multifaceted interventions with peer support as one of the main components have also been deemed effective in increasing breastfeeding initiation and duration".***

Sikorsk, J., Renfrew, M. J., Pindoria, S., & Wade, A. (2003). *Support for breastfeeding mothers (Cochrane review)*. In: The Cochrane Library, Issue 3, 2003. Oxford: Update Software.

6. ***Mothers of very low birth weight infants found the shared NICU experience aspect valuable. Positive effects of breastfeeding peer counsellors with personal NICU experience.***

Rossman, B., Engstrom, J. L., Meier, P. P., Vonderheid, S. C., Norr, K. F., & Hill, P. D. (2011). "They've Walked in My Shoes": Mothers of Very Low Birth Weight Infants and Their Experiences With Breastfeeding Peer Counselors in the Neonatal Intensive Care Unit. *Journal of Human Lactation*, 27, (1): 14-24.

7. ***"The findings suggest that peer counsellors, well-trained, and with on-going supervision, can have a positive effect on breastfeeding practices among low-income urban women who intend to breastfeed"***

Kistin, M., Abramson, R., & Dublin, P. (1994). Effect of Peer Counsellors on Breastfeeding Initiation, Exclusivity, and Duration Among Low-income Urban Women. *Journal of Human Lactation*, 10, (1): 11-15

8. ***"Lack of breastfeeding promotion and support hinder successful breastfeeding. In this study, a breastfeeding peer counsellor program improved both the initiation rate and duration of breastfeeding up to three months postpartum among Native American WIC participants".***

Long, D. G., Funk Archuleta, M. A., Geiger, C. J., Mozar, A. J., & Heins, J. N. (1995). Peer Counsellor Program Increases Breastfeeding Rates in Utah Native American WIC Population. Journal of Human Lactation, 11, (4):279-284.

9. ***"Healthcare providers thought the peer counsellors enhanced care of the infant by empowering mothers to provide milk and by facilitating and modelling positive patterns of maternal-infant interactions". Three critical elements that contributed to the effectiveness of the peer counselling program were identified: having a champion for the program, counsellors being mothers of former NICU infants, and a NICU culture supportive of using human milk.***

Rossman, B., Engstrom, J. L., & Meier, P. P. (2012). Healthcare providers' perceptions of breastfeeding peer counselors in the neonatal intensive care unit. *Res Nurs Health*, 35,(5):460-474.

10. ***Peer counselling support had a significantly positive effect on the rates of exclusive breastfeeding up to two months post-partum.***

Anderson, A. K., Damio, G., Chapman, D. J., & Pérez-Escamilla, R. (2007). Differential Response to an Exclusive Breastfeeding Peer Counselling Intervention: The Role of Ethnicity. *Journal of Human Lactation*, 23,(1):16-23.

11. ***Peer counselling has been recognized as an effective intervention in the promotion of breastfeeding among low-income women.***

Bronner, Y., Barber, T., & Miele, L. (2001). Breastfeeding Peer Counselling: Rationale for the National WIC Survey. *Journal of Human Lactation*, 17,(2): 135-139.
The findings emphasize the importance of person-centered communication skills and of relationships in supporting a woman to breastfeed. Organizational systems and services that facilitate continuity of caregiver, for example continuity of midwifery care or peer support models, are more likely to facilitate an authentic presence, involving supportive care and a trusting relationship with professionals.

Schmied, V., Beake, S., Sheehan, A., McCourt, C., & Dykes, F. (2011). Women's Perceptions and Experiences of Breastfeeding Support: A Metasynthesis. *Birth*, 38,(1):49-60.

Evidence to support breastfeeding education for pregnant women

1. ***The results of this study indicate that targeted educational programs designed for the adolescent learner may be successful in improving breastfeeding initiation in this population***.

Volpe, E. V., & Bear, M. (2000). Enhancing Breastfeeding Initiation in Adolescent Mothers Through the Breastfeeding Educated and Supported Teen (BEST) Club. *Journal of Human Lactation,* 16,(3):196-200.

2. ***Antenatal breastfeeding education and postnatal lactation support, as single interventions based in hospital both significantly improve rates of exclusive breastfeeding up to six months after delivery. Postnatal support was marginally more effective than antenatal education.***

Lin-Lin Su, L-L., Chong, Y-S., Chan, Y-H., Chan, Y. S., Fok, D., Tun, K. T., Ng, F. S. P., & Rauff, M. (2007). Antenatal education and postnatal support strategies for improving rates of exclusive breast feeding: randomised controlled trial. *BMJ*,335:596. (7620).

Mattar, C. N., Chong, Y. S., Chan, Y. S., Chew, A, Tan, P, Chan Y. H., & Rauff, M. H. (2007). Simple antenatal preparation to improve breastfeeding practice: A randomised controlled trial. *Obstetrics & Gynaecology,* 109, [1], 73-80.

Dyson, L., McCormick, F., & Renfrew, M.J. (2005). Interventions for promoting the initiation of breastfeeding. *Cochrane Database of Systematic Reviews*, 2, Art No: CD001688. DOI: 10.1002/14651858.CD001688.pub2, 1-24.

Fairbank, L., O'Meara, S., Renfrew, M. J., Woolridge, M., Sowden, A. J., & Lister-Sharp, D. (2000). A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. *Health Technology Assessment*, 4, [25], 1-5.

Breastfeeding support/barriers and interventions

1. ***Clinicians' practices regarding formula supplementation of healthy infants and their opinions about the importance of their breastfeeding advice are associated with the likelihood that mothers will continue exclusive breastfeeding. Policies to enhance clinicians' abilities to address breastfeeding problems within the constraints of busy practices could improve their ability to support exclusive breastfeeding.***

Taveras, E. M., Li, R., Grummer-Strawn, L., Richardson, M., Marshall, R., Rêgo, V. H., Miroshnik, I, & Lieu, T. A. (2004). Opinions and Practices of Clinicians Associated With Continuation of Exclusive Breastfeeding. *Pediatrics*, 113,(4):e283-290.

2. ***Explores common personal and societal barriers to exclusive breastfeeding and offers evidence-based strategies to support mothers to breastfeed exclusively, such as ensuring prenatal education, supportive maternity practices, timely follow-up, and management of lactation challenges. The article also addresses common reasons nursing mothers discontinue exclusive breastfeeding, including the perception of insufficient milk, misinterpretation of infant crying, returning to work or school, early introduction of solid foods, and lack of support.***

Neifert, M., & Bunik, M. (2013). Overcoming clinical barriers to exclusive breastfeeding. *Pediatr Clin North Am,* 60,(1):115-145.

Protheroe, L., Dyson, L., Renfrew, & M. J. (2003).*The effectiveness of public health interventions to promote the initiation of breastfeeding*. NHS Health Development Agency. www.nice.org.uk/niceMedia/documents/**breastfeeding** summary.pdf

Renfrew, M., Dyson, L., Wallace, L., D'Souza, L., McCormick, F., & Spiby, H. (2005). *The effectiveness of public health interventions to promote the duration of breastfeeding Systematic review.* National Institute for Health and Clinical Excellence (NICE) NHS, UK. http://www.nice.org.uk/niceMedia/pdf/Breastfeeding_vol_1.pdf

Appendix 4: Estimated cost of implementing each goal[15]

Goal 1: An increased number of new mothers will want to breastfeed because they understand that it is the best option for their baby and themselves; they will want to reach this goal and feel confident that they can do it.

Activity	Estimated cost
1.1.1 Education programmes in community	Nil
1.1.2 Printing revised higher quality book for mothers	$?
1.1.3 Breastfeeding early into PPE courses	Nil

Goal 2: While in the birthing facility all mothers will be supported in initiating breastfeeding.

Activity	Estimated cost
2.1 Refer to Activity 6.1.2 & 6.2	
2.2 Process for referrals to LCs and BF advocacy	Nil
2.3 Weighing babies	Nil
2.4 Pathway for tongue ties	Nil
2.5 Time for women to rest	Nil

Goal 3: Before leaving the birthing facility:

- All mothers will have had a breastfeeding assessment.
- All babies will have had a feeding assessment.
- All mothers with breastfeeding issues will have a care plan for home developed in collaboration with their LMC.

Activity	Estimated cost
3.1.1 Assessment on discharge	Nil
3.1.2 Process for referral to PHO LC & BA service	Nil
3.2 Assessment of feeding at the breast	Nil
3.3 Links with M4M before discharge	Nil

Goal 4: All NICU babies will have access to breast milk and breastfeeding, and mothers will be supported to initiate and establish breastfeeding when appropriate.

Activity	Estimated cost
4.1.1 Supporting nurses in Parfitt	Nil
4.1.2 Ed module for M4M who have experienced NICU	Nil
4.1.3 Policy re breastmilk sharing	Nil
4.2.1 NCON & RNS in teleconference re babies returning from NICU	Nil

Goal 5: All women will be supported by well educated, confident health providers to exclusively breastfeed until at least six months.

Activity	Estimated cost
5.1 Deliver Roadshow	Nil
5.2 Develop HealthPathways	Nil
5.3 Develop referral documents	Nil
5.4Develop breastfeeding Friendly Communities	Nil for DHB

Goal 6: All clinical providers, including LMCs, nurses and doctors will feel confident to promote, protect and support breastfeeding at each step of the maternity journey.

Activity	Estimated cost
6.1.1 Deliver education to LMCs (core competency)	Nil
6.1.2 Deliver to hospital employed midwives	Nil
6.1.3 Deliver primary care	Nil
6.2 Deliver education re separating of own experience from professional role	S?
6.3 Education for hospital doctors and GPs	Nil
6.4 Education for health students	Nil

Goal 7: All parents will have access to support to feed their infants in a disaster or civil emergency

Activity	Estimated cost
7.1 Emergency infant feeding	$?

[15] If activity can be reasonably included in current workload of CDHB staff, PHO or NGOs with a service agreement with Planning and Funding then this has not been counted in the funding.

Appendix 5: Baseline Data

		6 weeks				3 months				6 months			
	Year (Jul-Jun)	Exclusive	Full	Partial	Artificial	Exclusive	Full	Partial	Artificial	Exclusive	Full	Partial	Artificial
All New Zealand	2008-2009	54%	11%	17%	17%	40%	14%	17%	29%	16%	11%	34%	39%
	2009-2010	54%	12%	18%	16%	41%	13%	19%	27%	16%	10%	36%	38%
	2010-2011	56%	10%	18%	15%	42%	12%	19%	26%	16%	9%	37%	38%
	2011-2012	56%	10%	19%	15%	42%	13%	19%	26%	16%	9%	38%	37%
	2012-2013	55%	10%	20%	14%	42%	13%	20%	26%	16%	8%	40%	36%
	2013-2014 to mid Jan	56%	10%	20%	13%	43%	13%	19%	25%	17%	8%	40%	34%
Canterbury + Nelson Marlborough + South Canterbury + Southern + West Coast	2008-2009	60%	8%	15%	17%	45%	11%	15%	29%	22%	10%	32%	37%
	2009-2010	60%	7%	15%	18%	48%	7%	16%	28%	21%	8%	33%	38%
	2010-2011	60%	8%	15%	17%	47%	10%	16%	27%	20%	8%	35%	37%
	2011-2012	60%	7%	16%	17%	48%	8%	17%	27%	20%	7%	36%	36%
	2012-2013	56%	10%	17%	16%	44%	12%	18%	26%	18%	8%	38%	35%
	2013-2014 to mid Jan	58%	10%	18%	15%	45%	12%	17%	25%	20%	9%	38%	34%
West Coast	2008-2009	41%	27%	12%	20%	25%	23%	15%	37%	7%	18%	43%	32%
	2009-2010	56%	13%	6%	25%	42%	14%	5%	39%	14%	22%	17%	46%
	2010-2011	66%	11%	7%	17%	52%	13%	12%	23%	18%	18%	26%	39%
	2011-2012	55%	12%	14%	19%	40%	14%	12%	34%	16%	12%	33%	39%
	2012-2013	53%	8%	18%	21%	42%	9%	17%	32%	17%	5%	38%	41%
	2013-2014 to mid Jan	53%	12%	25%	10%	42%	16%	17%	25%	13%	5%	41%	41%

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

Te Pūtahitanga
Your Innovation. Our Backing. Whānau Thriving.

WHĀNAU ORA HUI

Nau mai Haere mai Tauti Mai

The West Coast District Health Board in partnership with Te Putahitanga acknowledge the importance of working together with our communities so invite you to attend this hui so we can update you of the progress of Whānau Ora and how we can work together in the future.

KAUPAPA: Whānau Ora

DATE: 5 December 2014

TIME: 2.00 – 4.00pm

VENUE: Solid Energy Room
Holcim Room
Cnr Pakington and Domett Streets
Westport

Kaikorero: Susan Turner – CEO Te Putahitanga & Gary Coghlan
General Manager Maori Health

Please RSVP to Megan Tahapeehi at
megan.tahapeehi@westcoastdhb.health.nz or 03 7680499 extn 2946

TATAU POUNAMU
MANAWHENUA ADVISORY GROUP
2014 MEETING SCHEDULE

DATE	TIME	VENUE
Thursday 20 February 2014	3.00 – 5.00pm	Board Room, Corporate Services
Thursday 11 April 2014	3.00 – 5.00pm	Poutini Waiora, Hokitika
Thursday 26 June 2014	3.00 – 5.00pm	Board Room, Corporate Services
Thursday 24 July 2014	3.00 – 5.00pm	Kahurangi Room, Mental Health
Thursday 11 September 2014	3.00 – 5.00pm	Kahurangi Room, Mental Health
Thursday 23 October 2014	3.00 – 5.00pm	The Cave, Mental Health Services
Thursday 4 December 2014	3.00 – 5.00pm	Board Room, Corporate Services

MEETING DATES & TIMES ARE SUBJECT TO CHANGE