Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
carolyn.gullery@cdhb.health.nz

5 March 2019

[redacted]

[redacted]

[redacted]

RE Official information request CDHB 10007

We refer to your email dated 19 December 2018 requesting information under the Official Information Act from Canterbury DHB regarding the Waitangi Tribunal Research Report on disabled Māori. Specifically:

1. **How does the DHB involve disabled Māori in decision-making, specifically:**

The Canterbury DHB do not have any formal protocols in place with the Board on how we involve disabled Māori in decision making at that level. However disabled Māori were included in the consultation on the development and implementation of the Transalpine Disability Action Plan which was then endorsed by both Canterbury and West Coast DHB Boards. This plan is explained in the response to Question 4.

What proportion of the DHB Board membership are:

- **Māori.** - 2
- **Non-Māori.** - 9
- **Disabled Māori.** - 0
- **Disabled non-Māori.** - 0

How do the membership requirements of the DHB's statutory committees ensure participation by disabled Māori? Please provide how many members per committee are:

The Canterbury DHB statutory committees do not have any formal protocols in place to ensure participation by disabled Māori.

- **Māori.** - HAC = 1. CPH&DSAC = 1. QFARC = 2.
- **Non-Māori.** - HAC = 8. CPH&DSAC = 13. QFARC = 7.
- **Disabled Māori.** - HAC = 0. CPH&DSAC = 0. QFARC = 0.
- **Disabled non-Māori.** - HAC = 0. CPH&DSAC = 1. QFARC = 0.

HAC = Hospital Advisory Committee
CPHAC = Community & Public Health Advisory Committee
DSAC = Disability Support Advisory Committee
QFARC = Quality, Finance, Audit, and Risk Committee

How do the membership requirements of the DHB's clinical governance group(s) and consumer advisory group(s) ensure participation by disabled Māori? Please provide how many members of these groups are: Māori, non-Māori, Disabled Māori and Disabled non-Māori?

Clinical Governance Committee

The Canterbury DHB over-arching Clinical Governance committee has the Executive Director of Māori Health and a Māori Consumer member Māori who does not identify as having a disability. There are a total of 10 on it. We don't hold the information on all the other committees as we have 54 departments and no central data base. (Declined under section 18(g) of the Official Information Act.

Consumer Council:

- Māori - 1
- Non-Māori - 14
- Disabled Māori - 0
- Disabled non-Māori - 3

How are disabled Māori supported to participate in the DHBs Māori relationship board (or equivalent)?

Māori representation is valued on all of the Canterbury Clinical network work-streams and Service Level alliances. Each Alliance group has at least one Māori representative.
Mana Whenua ki Waitaha are the Canterbury DHB Treaty Partners with Ngai Tahu, the Canterbury DHB Disability Action Plan is supported by Mana Whenua ki Waitaha.
The Canterbury DHB also supports a Disability Advisory Committee who have Māori representation. While the Māori representatives do not always live with a disability they represent a broad cross section of Māori from a variety of Iwi and diverse backgrounds.

How are disabled Māori supported to participate in the DHB's alliance leadership teams? Please also provide how many members are: Māori, non- Māori, Disabled Māori and Disabled non-Māori?

We don't specifically request that members of the Alliance Leadership Team explicitly identify whether they have a disability. All members bring a range of perspectives and competencies that are connected through to other systems and groups (e.g. Māori and Pacific Reference Groups, Māori Caucus, Disability Steering Group). Members are actively supported to participate in the Alliance Leadership Team through open engagement with the Chair and CCN Programme Office. An annual review of the Alliance Leadership Team, that includes feedback from all members, is completed annually.

- **Māori.** One member provides a Manawhenua ki Waitaha perspective to the Alliance Leadership Team
- **Non-Māori.** 12 members do not specifically indicate that they provide a Māori perspective to the Alliance Leadership Team
- **Disabled Māori.** See above where we do not request that members explicitly identify whether they have a disability and no members have voluntarily identified that they have a disability.
- **Disabled non-Māori.** (See above) where we do not request that members explicitly identify whether they have a disability and no members have voluntarily identified that they have a disability.

2. **What support (e.g. financial or travel assistance) does the DHB provide to disabled Māori to ensure they're able to fully participate in its committees and advisory groups?**

All Board / committee members are entitled to support, which includes meeting fees, mileage, parking costs.

3. **Does the DHB offer the Board, statutory committees, alliance leadership teams and clinical governance groups any training to build their skills and expertise in cultural safety/ competence and in disability responsiveness? Please provide evidence of this.**

Alliance Leadership Team

The Alliance Leadership Team accommodates anyone with disabilities and considers how we can best ensure the system is designed and operates in a way that ensures access and positive outcomes for people that have a disability. Whilst we don't provide specific training to build skills and expertise in cultural safety/competence in disabilities, we:

- Have regular and ongoing engagement with the Canterbury DHB Disability Steering Group that informs and guides the development of services across the Canterbury health system to ensure that they support access, participation and outcomes for people with disabilities. The Chair and Facilitator of the Disability Steering Group provide an annual presentations and regular reports to the Alliance Leadership Team to keep the ALT informed of progress and engagement across the Canterbury health system.
- The majority of alliance groups (including the ALT, workstreams, service level alliances and service development groups), have a member that provides a Māori /mana whenua perspective. These members also participate in the CCN Māori Caucus, a collective of Māori representatives/perspectives across alliance groups. The role of the Caucus is to provide support to members that bring a Māori perspective on alliance groups and to utilise the collective Māori skillsets, strengthening contributions to the work of alliance groups. At least annually the Māori Caucus engages with the Alliance Leadership Team. The members are also connected to other influential and relevant groups across the system. The Chair of the Māori Caucus is an Alliance Leadership Team member.
- In 2014 the CCN developed He Kete Hauora Waitaha to support alliance groups to identify and plan for specific activity within their work plans that will work towards improved access to health services for Māori. The Kete supports alliance groups to apply an equity lens to planning and service/system design that can be applied equality to all people and groups. This Kete is regularly updated and refreshed by the Māori Caucus.

Board

At the beginning of each Board term, members attend both Ministry of Health, and Canterbury DHB, induction sessions. Cultural training is included in these sessions.
Additional training is available to Board members throughout their term, with members encouraged to request this at any time. Such requests are dealt with on an individual basis, with the type of training provided dependent on what is requested.
During the Boards term, if it is believed that Board members (or a specific member) would benefit from additional training in a specific area, this will be arranged. Again, the type of training will be dependent on what is required.

Committees

No specific training is provided, however, as stated above – will be provided on request, or where believed that members would benefit from such training.

4. **What other mechanisms does the DHB use to ensure disabled Māori are involved in DHB strategy, policy, implementation, service design, delivery, evaluation and monitoring? Please provide any terms of reference or relevant supporting documents.**

Canterbury and West Coast DHB's have a Transalpine Disability Action Plan which has the strategic objectives identified by disabled people, their whanau and disability providers from wide consultation through 2015/16. The Plan also includes priority actions to achieve these objectives for 2017/18 and these actions are currently being refreshed through ongoing engagement with the disability community. Both these processes are inclusive of disabled Māori.
The Canterbury DHB Disability Steering Group (DSG) who is responsible for the implementation of the Action Plan and its priority actions have continued to actively engage with disabled Māori as is evidenced in the examples provided below i.e. DSG Terms of Reference, agendas, and key messages from DSG meetings. Membership of DSG has a disability community member who was identified through a process with mana whenua, invites local leaders who identify as disabled Māori regularly to meetings and to participate in core DSG processes such as participating in identifying other appropriate disabled DSG members. Also provided as evidence is the agenda from the last combined CPHAC/DSAC which highlights the connection between DSAC and the work of DSG. There is a strong connection between DSG and DSAC which ensures that that priority issues and actions are known and supported at the governance level of the organisation.
Refer to Appendices (below and attached):

Appendix 1 - Transalpine Disability Action Plan 2016-2026
Appendix 2 - Disability Steering Group Terms of Reference Revised June 2018
Appendix 3 - Disability Steering Group Key Messages April 2017
Appendix 4 - Disability Steering Group Key Messages June 2017
Appendix 5 - Disability Steering Group Key Messages July 2017
Appendix 6 - Canterbury DHB Disability Steering Group - Agenda April 2017
Appendix 7 - Canterbury DHB Disability Steering Group - Agenda June 2017
Appendix 8 - Canterbury DHB Disability Steering Group - Agenda July 2017
Appendix 9 - CPHACDSAC Agenda NOV2018

5. **What strategies and policies are in place specifically to give effect to the DHB's obligations to disabled Māori under the following?**

- **NZ Public Health and Disability Act 2000.**
- **NZ Health Strategy 2016.**
- **NZ Disability Strategy 2016-2026.**
- **He Korowai Oranga 2014.**
- **Whaia Te Ao Mārama 2012-17 and 2018-22.**

Refer to **Appendix 1**. The Transalpine Disability Action Plan which identifies all of these strategies and policies as core documents used to inform the content of the Action Plan.

In addition to this the West Coast and Canterbury DHBs have a relationship based on Te Tiriti o Waitangi with Ngāi Tahu through Manawhenua ki Waitaha in Canterbury, and with Tatou Pounamu on the West Coast. The DHB seeks advice and guidance through reference groups, such as Te Kahui O Papaki Kā Tai in Canterbury. The DHB supports Māori who are members and provide input to groups under the Canterbury Clinical Network (CCN) through the CCN Māori Caucus. The DHBs collaborate with the other South Island DHBs through bodies such as Te Herenga Hauora o te Waka a Maui (the South Island Regional DHB Māori Managers Network) and the South Island Alliance.

6. **How are the requirements for compliance with the Ministry of Health Operational Policy Framework 2018/19 met with respect to disabled Māori (especially with regard to Sections 3.9 to 3.13)?**

The Canterbury DHB uses equity tools generally in its planning (e.g. though the development and use of He Kete Hauora Waitaha in Canterbury). It has not explicitly used these tools in planning for disability services, but follows their principles in the process of planning for and improving services for disabled people through its Disability Steering Group and the Canterbury and West Coast Health Disability Action Plan. The Canterbury and West Coast Health Disability Action Plan was developed with specific reference to He Korowai Oranga and Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Service, among other documents. The Canterbury and West Coast Health Disability Action Plan includes a strategic focus on working towards equitable outcomes for Māori with disabilities, with Canterbury DHB's Māori Health Framework being applied to all actions in the plan.

The Canterbury DHB regularly monitors health outcomes for Māori compared to non-Māori (or the total population, depending on the data source). The DHB does not have sufficient data on disability affecting Māori or others, for example because it does not have a suitable marker to systematically identify those who have a disability. This prevents monitoring of health equity with respect to disability for Māori. The Canterbury and West Coast Health Disability Action Plan includes a priority action to "Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture information specific to the Māori population with a disability." The Canterbury DHB is not aware of any research on disability affecting Māori in the district. The Canterbury DHB supports Māori capacity through development of Māori providers, though none of those providers that the Canterbury DHB contracts with are focused specifically on disability. The Canterbury DHB aims to increase the number of people with disabilities that it employs, which will include Māori. Project Search, a Canterbury DHB-supported initiative to equip people with disabilities to join the workforce includes disabled Māori.

The Canterbury DHB works to improve cultural competency through programmes such as courses on Understanding the Treaty of Waitangi in Health, and on Tikanga Māori. It monitors health consumer's satisfaction generally, though processes such as the Patient Experience Survey, but does not monitor satisfaction of people with disabilities specifically on a routine basis. The Canterbury and West Coast Health Disability Action Plan includes a priority action that "All the priority actions of this plan are to include culturally appropriate actions for Māori with a disability and their whānau, and that this promotes and supports whānau ora and rangatiratanga." Under the Plan's objective to develop and implement training that enhances disability awareness among staff there is a priority action that "Training packages are developed and implemented in partnership with Māori people with disabilities and their whānau, to ensure cultural competency is inclusive of any training delivered."

The Canterbury DHB consults and involves iwi and the Māori community generally through relationships with Ngāi Tahu (in Canterbury with Manawhenua ki Waitaha, in the West Coast with Tatou Pounamu), and through reference groups such as Te Kahui O Papaki Kā Tai in Canterbury. The Canterbury DHB supports Māori who are members and provide input to groups under the Canterbury Clinical Network (CCN) through the CCN Māori Caucus. The Canterbury DHB collaborates with the other South Island DHBs through bodies such as Te Herenga Hauora o te Waka a Maui (the South Island Regional DHB Māori Managers Network) and the South Island Alliance Project Office (e.g. Te Waipounamu Māori Leadership Group for cancer services).

7. **What strategies and policies are in place to ensure compliance with the following requirements?**

- **Accessibility of DHB buildings and facilities under NZS4121:2001.**

Refer Appendix 1

The Transalpine Disability Action Plan has a specific strategic objective and priority actions specifically on accessibility of buildings and facilities. The Canterbury and West Coast DHBs support the position of the Earthquake Disability Leadership Group (EDLG) that the current Building Code does not adequately ensure that new and renovated buildings will meet the needs of people all types of disability, especially in health care settings. NZS4121 is an improvement over the Building Code, but it is out of date and not mandatory. The Canterbury DHB therefore welcomed the opportunity to be a founding signatory to the Te Arataki Taero Kore Accessibility Charter which, promotes the use of a 'universal design' approach, technical accessibility advice, and the link between accessibility and health. The Te Arataki Taero Kore Accessibility Charter is attached as **Appendix 10**. An Accessibility Charter Working Group has been formed comprising key staff plus members of the Disability Steering Group, which maintains strong links with the EDLG. Refer **Appendix 11** Accessibility Charter Working Group Terms of Reference They provide the link and accountability for action within the Canterbury DHB and to the disability community. It is important to note for the purpose of this response that the founders and joint Chairs of EDLG are recognised leaders in this area and identify as disabled Māori.

- **Accurate ethnicity data recording and reporting under the Ministry of Health HISO 10001:2017 Ethnicity Data Protocols.**

The Canterbury DHB has used the Ministry of Health HISO 10001:2017 Ethnicity Data Protocols in the planning and ongoing implementation of the South Island Patient Information Care System, which is currently being introduced across the South Island. It also uses the Ethnicity Data Protocols in informing and training staff in the proper collection of ethnicity data. The DHB works to understand the deficits in data quality and the sources of potential misclassification of ethnicity, and to improve ethnicity data collection so that it conforms to the Protocols and best practice. For example, NHI level ethnicity data in primary and secondary care were compared. This found a high level of inconsistency in the recorded ethnicity for Māori between PHOs and hospital data. Similarly, a comparison of the proportion of children in recent single year birth cohorts by ethnicity to expected proportions based on Census and NIR again found discrepancies.
The DHB is conducting small scale audits of ethnicity data to assess the quality of ethnicity data and trial approaches to quality improvement.

- **Accessibility of public consultation for disabled Māori (for example, Ministry of Health Guide to Community Engagement with People with Disabilities 2017).**

Canterbury DHB consults with Māori, and with disabled people in general, this is evidenced during the consultation on the development of the Disability Action Plan. This consultation conducted in 2016 and the current re-engagement with the disability sector on the priority actions in the Plan which commenced in 2018 and will continue into 2019, actively plans engagement meetings in accessible locations, uses a range of mediums to accommodate different abilities, uses plain language and technologies, such as facilities with hearing loops and sign language interpreters, to remove barriers to engagement wherever possible.

- **Implementation of NZ Web accessibility standard 1.0 and usability standard 1.2**

Canterbury DHB does have a policy for its public website www.cdhb.health.nz to comply as far as is reasonably possible with NZ Web accessibility standard 1.0. and NZ Web usability standard 1.2. In October 2018 Canterbury DHB launched a new public website and as part of a process, had a key objective of significantly improving compliance with these two standards.
We continue to work towards better compliance by working to improve our online services and processes, and have consulted Access Advisors NZ (a subsidiary of the Blind Foundation) throughout for

advice on the best approach to providing accessible online services. We recognise that some elements of the web standards are very challenging and involve significant operational and cultural change within our organisation. This will take a sustained commitment to achieve but as an organisation Canterbury DHB is working to continually improve how it provides information in a more accessible way.

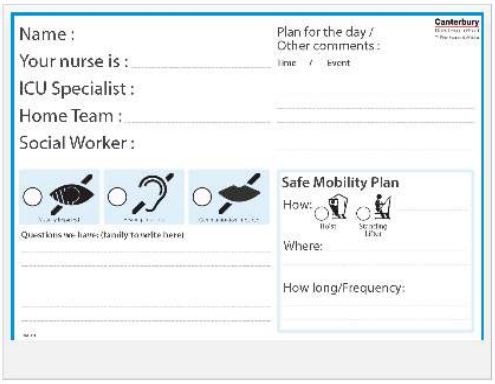
- **Compliance with the Code of Health and Disability Services Consumers' Rights, particularly, Right 4 and Right 5.**

Right 4 (Right services of an appropriate standard)

While there has been substantial gains in ensuring that services are delivered at an appropriate standard for people with disabilities, this has and is an area of continuous quality improvement processes. In part these can be evidenced by the Canterbury DHB high level of achievement of the Certification and Accreditation standards but in addition to this the Canterbury DHB demonstrates its commitment to providing services of a high standard through the following 3 examples provided below:

- Canterbury DHB Disability Steering Group, in partnership with the DHB Quality and Patient Safety Division have requested of the national Health Quality and Safety Commission that questions on disability be added to the Patient Experience Survey. This was agreed in principle, they are progressing in their inpatient experience survey governance group and will also be include it for the primary care patient experience survey. The preferred method will be the use of the Washington Short Questions. This introduction will enable the health system the ability to determine if and when people with a disability have a negative experience in our services and we can focus on areas where quality improvement is required.

- The Bedside Patient Status at a Glance sign is being rolled out as a visual management tool to increase patient/family participation in their care across Canterbury DHB hospitals. These signs are visual management tools to show important patient information that can be used effectively, updated regularly and seen at a glance by the whole team and by the patient and their family. These signs display for all the team, including our catering team whether someone needs extra assistance and at what level. It also includes what is important to the patient and their family who have a dedicated space for their comments on the sign. Initial feedback from patients and families is extremely positive and the DSG plans to use its networks in the disability sector to inform disabled people and their families that their needs can now be effectively and reliably communicated for the duration of their hospital stay. Please refer to **Diagram 1** (below)



- The Canterbury health system is connected by an electronic shared record which has 3 different types of shared plans which enables improved patient care no matter where in the system their needs need to be met. One of these plans is described as the Acute Plan which is developed within the persons General Practice with the patient and it describes their needs when they are in acute need and can be seen by Hospitals and health services across the South Island such as St John.

A pilot is currently occurring between NZ Care residential services for people with intellectual disability and New Brighton Medical Centre to create an Acute Plan for 30 NZ Care residents. This pilot will test if the Acute Plan needs any modification for this population group and once addressed the plan is to promote the creation of Acute Plans for people with disabilities with disability providers. This will improve the experience of people with disabilities when they need urgent and acute care as their self-identified needs will be accessible in these settings across the health system.

Right 5 (Right to effective Communication)

Effective communication is a priority for the Canterbury DHB as evidenced below from the Priority Actions for effective communication contained in the Disability Action Plan 2016 - 2026

Objective

Promote and provide communication methods that improve access and engagement with people with disabilities e.g. use of plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology. Expand the use of sign language.

Priority Actions

10.1 Engage with Canterbury and West Coast communications staff to review health system websites and identify any parts of them which are not fully accessible for people who use communication devices.
Outcome: External accessibility review completed by the Blind Foundation and external website upgraded and launched in November 2018

10.2 Build on the partnership with the disability sector by having the Disability Strategy and a version of this Plan made available in Easy Read format.
Outcome: In plain language, not yet in easy read format

10.3 Work with communications staff to identify which key communications will be made available in plain language and circulated to a network of disability organisations and key contacts.
Outcome: Key Canterbury DHB Communication publications have been identified and specific articles on disability related issues and initiatives are regularly included. Most recent example attached as **Appendix 12** CEO Update 29 January 2019 Article on Project Search. This Publication is circulated widely including into the disability community.

10.4 Develop a Canterbury and West Coast policy on the use of sign language and access to interpreters. Policy completed January 2019 and attached as **Appendix 13**

8. **How much did the DHB spend per year for the past five financial years on health services, specifically for:**
    - **Māori.**
    - **Non-Māori.**
    - **Disabled Māori.**

9. **What proportion of the funding for disabled Māori was used to fund services (all and disability-specific services) by Māori owned, Māori governed health providers?**

10. **What accountability mechanisms does the DHB use to ensure that all of the services that the DHB contracts are appropriate and effective for disabled Māori?**

Canterbury DHB has an Outcomes Framework which it uses to interpret a wide range of data as to the effectiveness of service for delivered for the population. While access rates are a proxy measure of the acceptableness as judged by Māori and these are monitored closely across the health system. Current health outcomes for Māori evidence the need for equity based decision making about how and what services are delivered for Māori and this is a priority focus in the future strategic planning for the DHB. Therefore contracts are assessed for effectiveness at a system level but we also monitor this at an individual contract level. Within Planning and Funding the Canterbury DHB employs a Māori Portfolio Manager to specifically monitor kaupapa Māori services but she also engages with a wide range of services through other contract managers to ensure Māori access services.

There is not a specific focus for disabled Māori but rates of chronic disease and trends or changes are

used to inform effectiveness and set a benchmark for future improvement.

11. **Please provide evidence and examples of how contracts require equity for disabled Māori in workforce, and in outcomes?**

There is no accountability requirement or process that is specifically for disabled Māori however please refer to **Appendix 14** excerpt from the Contract which has collated the clauses which appear in all Canterbury DHB contracts in relation to Māori. It is expected that compliance with these clauses for Māori will be inclusive of disabled Māori.

12. **How does the DHB ensure disabled Māori are able to access Māori-centred health and disability services?**

The Canterbury DHB contract two Kaupapa Māori Providers to deliver home based nursing to Whānau with Chronic conditions. One such chronic condition is diabetes which has led to amputations. There are also three Kaupapa Māori Mental Health Providers
Disabled Māori are also able to access a number of other health services delivered by our Māori Providers e.g. Mental Health support, AOD, Well Child Tamariki Ora, Mama and Pepi, Health literacy, Whānau Mai (early Childhood education).
Note Disability Support Services of MOH contract with DHBs for disability services and that DHB's do not specifically contract for disability services

Generally the Canterbury DHB expects the health and disability services we contract for or hold contracts with as a provider, to be equitable and accessible for all whānau.

13. **How many complaints or letters of feedback have been received in the last five years from disabled Māori or regarding services applicable to disabled Māori? What were the issues raised and how did the DHB work to resolve them? Please provide evidence.**

The Canterbury DHB does not capture ethnicity or disability as part of the complaints process**.**
Declined under section 18(g) of the Official Information Act.

14. **Please provide the number of DHB employees, by category of profession, who are:**
    - **Māori.**
    - **Non-Māori.**
    - **Disabled Māori.**
    - **Disabled non-Māori.**

For Canterbury DHB the number of staff identified as Māori, non-Māori, Disabled Māori and Disabled non-Māori relies on self-identification and is not mandatory, therefore the figures able to be provided are not accurate**.**

15. **What does the DHB do to build capacity and capability for disabled Māori to work in the health and disability sector?**

There is no specific programme targeted at disabled Māori to enable them to work in the health and disability sector provided by either Canterbury DHB or West Coast DHB however the Canterbury DHB has just launched project SEARC in partnership with community groups representing people with disabilities. While the internship programme is focussed on enabling disabled young people to become work ready through working in a hospital environment in this case there are Māori interns within the programme.

16. **How much did the DHB spend per year, for the past five financial years, on services (including consultancy) provided by disabled Māori?**

While Canterbury DHB pays particular attention to, and references the provision of all services to Maori throughout its planning and reporting documentation and processing there is no provision made within this for information to be broken down further to reference disabled Maori. This is due in no small measure to the DHB having no direct responsibility for provision or contracting of disability services for under 65's.

2016/17 Canterbury DHB spent $897.00 for a disabled Māori consultant for services in relation to the development of the Canterbury DHB Disability Steering Group.
There was no expenditure in the other four financial years

17. **What was the DHB total spend per year, for the past five financial years on services (including consultancy)?**

Please refer to **Table one** (below) for the Canterbury DHB total spend per year for the past five financial years on services (including consultancy).

Table one

Audited actual $'000				
2013/2014	**2014/2015**	**2015/2016**	**2016/2017**	**2017/2018**
$1,536,226	$1,576,587	$1,622,965	$1,708,941	$1,800,057

18. **What training does the DHB offer staff to build their skills and expertise to provide appropriate services to disabled Māori, for example, cultural safety / competence training and disability responsiveness training? Please provide evidence.**

- Disability Responsiveness (new course 2018 – healthLearn)
- Working with People with an Intellectual Disability who have Challenging Behaviour (healthLearn)
- HDC Consumer Rights (healthLearn)
- HDC Open Disclosure (healthLearn)
- Treaty Of Waitangi (face to face)
- Tikangi Best Practice (face to face)
- The numbers of people completing the courses is unreliable.

19. **What proportion of the DHB's total training budget was spent on training and development for this purpose, for each of the past five years?**

There is no specific proportion of the training budget allocated for this purpose

20. **What proportion of staff (by profession) have undergone 1) cultural safety / competence training, 2) disability responsiveness training and 3) both cultural safety / competence and disability responsiveness training?**

We do not hold this data. (Declined under section 18(g) of the Official Information Act.)

21. **How do DHB policies align with the UNCRPD, particularly with regard to the following articles? Please provide evidence:**

Article 12. Equal recognition before the law: No specific policy.
Article 17. Protecting the integrity of the person: No specific policy.

Article 19. Living independently: The Electricity Dependency in the Home policy outlines the DHB responsibility to assist medically dependent people when they are discharged. Attached as **Appendix 17**

Article 20. Mobility: the Hospital Falls prevention procedure outlines the focus on standardised patient-centred support for mobility and prevention of falls. Policy Attached as **Appendix 15**

Article 21. **Freedom of Expression:** The Canterbury DHB and West Coast DHB Interpreters Procedure provides limited or non-English speakers or hearing impaired or deaf to access interpreters in a timely manner, enabling full patient participation while in care. Attached as **Appendix 13**

Article 22. Respect for privacy: The Privacy Policy outlines the protection of individual privacy. Attached as **Appendix 18**

Article 25. Health: The Code of Conduct requires employees, in their duties, to respect the rights of other and not discriminate because of disability. Attached as **Appendix 19**

Article 26. Habilitation and rehabilitation: No specific policy.

Article 30. Participation in cultural life, recreation, leisure and sport: No specific policy.

Article 31. Statistics and data collection: No specific policy

Canterbury DHB policies reflect the following:

- Code of Health and Disability Services Consumers Rights which is for all consumers and is not limited to those with disability.
- Health and Disability Services Act which focuses on provision of services to a person receiving a health or disability service.
- Health and Disability Services Standard 2008 which includes support for the New Zealand Disability Strategy.

The Canterbury DHB vision is for an integrated health system that keeps people well and healthy in their own homes. A system that provides exceptional quality, providing the right care and support, by the right person, at the right time, in the right place, with the right patient experience.

The Clinical Governance policy sets the patient safety vision of "aiming for zero harm", and adopts the Health Excellence framework for continuous improvement framework, that is predicated on validated effective clinical and management practices. Attached as **Appendix 16**

Specific policies demonstrating alignment with United Nations Convention on the Rights of people with Disabilities are outlined below:

22. How do DHB policies align with the United Nations Declaration on the Rights of Indigenous Peoples? Please provide evidence.

The Canterbury DHB does not specifically refer to or reference the United Nations Declaration on the Rights of Indigenous Peoples in its policies. The approach the Canterbury DHB has taken in its policies is to work with our Treaty of Waitangi partner, Manawhenua Ki Waitaha, our Māori staff, services, providers and community to ensure our policies meet their aspirations as well as our own legislative responsibilities. Notwithstanding no direct reference to the United Nations Declaration on the Rights of Indigenous Peoples, we have a number of policies which assert many of the rights asserted in the declaration.

The Canterbury DHB policies which specifically point to these are as follows:

- Tikanga policy Attached as **Appendix 20**
- Te Reo policy Attached as **Appendix 21**
- Māori Health policy Attached as **Appendix 22**
- Koha policy Attached as **Appendix 23**

23. How does the DHB identify and collect information on disabled Māori and their needs (including for DHB staff)?

While we collect information for Māori the Canterbury DHB does not collect information specifically on disabled Māori. (Declined under section 18(g) of the Official Information Act.

24. How does the DHB determine health priorities for disabled Māori in its district?

While we collect information for Māori the Canterbury DHB does not collect information specifically on disabled Māori. (Declined under section 18(g) of the Official Information Act.

25. How does the DHB monitor its performance for disabled Māori compared with:

- **Māori.**
- **Non-Māori.**
- **Disabled non-Māori.**

Please provide relevant monitoring reports for each of the past five years.

The Canterbury DHB does not hold sufficient data to monitor its performance for disabled Māori, or for comparator groups. The DHB does not have a suitable marker to systematically identify those who have a disability. (Declined under section 18(g) of the Official Information Act.

26. How does the DHB ensure that its health promotion programmes, and that of its Public Health Units (if applicable) are appropriate and effective for disabled Māori, for example, how does it ensure its campaigns are accessible for kāpō Māori?

At Community and Public Health we focus on the following principles of public health work: focusing on the health of communities rather than individuals; influencing health determinants; prioritising improvements in Māori health; reducing health disparities; basing practice on the best available evidence; building effective partnerships across the health sector and other sectors; and remaining responsive to new and emerging health threats.

We engage with communities to promote health and wellbeing, modify the determinants of health which affect those communities most directly and support community action by strengthening self-determination (Tino Rangatiratanga). There can be significant differences between the issues which have most priority for communities and those which have priority for health and other services. Creating space for communities to identify and articulate the priorities they deem more important requires health promoters to adopt the values of community development – respect, equity, inclusion, meaningful collaboration and hope. These align closely with the emphasis of the Whānau Ora approach – strengths-based, flexible, relational, aspirational and acknowledging the unique situation of each whānau. Te Pae Māhutonga identifies the creative tension between the two lead stars – Te Mana Whakahaere (autonomy) and Ngā Manukura (leadership) – communities need to be able to exercise agency whilst receiving the support they need.
At Community and Public Health, our health promoters use a project plan template based on the Te Pae Māhutonga framework. Best practice health promotion prioritises Tino Rangatiratanga as crucial to the advancement of Māori health aspirations. We prioritise Hauora Māori by:

- continued upskilling of health promoters to better understand Te Ao Māori, the history of Aotearoa and the systematic racism which has created current health inequity
- the continued development of work within Marae, supporting Mana Whenua to achieve their aspirations, and ensuring that all project plans are peer reviewed using the Te Tiriti Peer Support tool or similar to ensure that all work to support community action also promotes equity/ Ōritetanga.
- employing to specific Māori health promotion positions.

Community and Public Health liaise directly with local mana whenua organisations and Māori health providers (e.g. Mana Whenua Ki Waitaha in Canterbury and Poutini Waiora on the West Coast) to ensure equity is prioritised.

I trust that this satisfies your interest in this matter.

If you disagree with our decision to withhold information you may, under section 28(3) of the Official Information Act, seek an investigation and review of our decision from the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

CANTERBURY AND WEST COAST HEALTH DISABILITY ACTION PLAN

A plan for improving the health system for people with disabilites and their family/whānau

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

Foreward

The Canterbury and West Coast Health Disability Action Plan has been developed with people with disabilities, their family/whānau, providers of disability services and our Alliance partners from across the health system. The Plan will be implemented with the ongoing engagement of all these key stakeholders using existing processes, and through developing new ways of working together.

Contents

Developing our Disability Action Plan 2016 - 2026

In 2016 we began the development of a Canterbury and West Coast Health Disability Action Plan for 2016 - 2026.

The draft document, approved for wider consultation, was developed in line with the New Zealand Disability Strategy 2001 and the United Nations Convention on the Rights of People with Disability.

Disabled People Organisations are those recognised by the New Zealand Office of Disability Issues as representing the collective voice of people with disabilities. All such recognised groups have received and been invited to provide feedback on the draft Plan and the priority actions for 2016 - 2017.

Feedback was received via attendance at face to face meetings, forums and network meetings, and through written feedback. This feedback has been incorporated into the final Plan.

Development of the Plan included the review and incorporation of the key elements of core New Zealand documents relating to people with disabilities. Those core documents can be found in Appendix A.

The importance of the United Nations Convention on the Rights of Persons with Disability was consistently referred to by people with disabilities and their supports. These guiding principles are included as Appendix B.

For the purposes of this Plan, disability is defined according to the United Nations Convention on the Rights of People with Disability. It describes disability as resulting 'from the interaction between persons with impairments

and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'
(UN General Assembly 2007).

This definition distinguishes the impairment or health condition from the restrictions on participation in society (e.g. unemployment due to discriminatory recruitment practices). These restrictions are not an inevitable consequence of the impairment; they are a result of unfair and avoidable barriers which results in many of the differences in health status between people with a disability and people without a disability. Using this definition the Plan is applicable to all people with disabilities regardless of age or the type of impairment.

The principles of partnership, participation and protection have been central to the development of the strategic objectives and priority actions in this Plan. These principles are consistent with the Treaty of Waitangi and demonstrate our commitment to working with Māori as treaty partners. This is especially important because Māori have higher rates of disability and poorer health outcomes than non-Māori. While there is a specific objective to achieve equitable outcomes for Māori within the Plan, each of the identified priority actions will have identified actions that are inclusive and culturally appropriate.

The Plan includes a Canterbury and West Coast position statement which addresses the critical issues relating to human and civil rights, treatment, and services and programmes for people with disabilities and their family/whānau. This statement is to inform our population and other agencies of the prevailing organisational view on key issues for people with disabilities.

Progress on achieving the stated objectives and priority actions in this Plan will be reported back to the disability community through a range of tactics including forums, electronic information and written communication. The Plan will be refreshed at least annually and priority actions will be developed and amended as necessary to ensure we continue to strengthen our engagement and inclusion of disabled people in the transformation of our health system.
*Refer to Appendix C for a summary of the consultation process and feedback.

Position Statement

Promoting the health and wellbeing of people with disabilities

Purpose

This position statement summarises our commitment to actions aimed at improving the lives of people with disabilities in Canterbury and on the West Coast. It will be used in making governance, planning, funding, and operational decisions. The Plan reflects this position statement and provides details of how it will be implemented.

Key points

We recognise that a significant proportion of the New Zealand population experience impairments, which may result in disability and disadvantage. In addition, the population is aging which will increase the number of people experiencing impairment. Accessibility and inclusion are rights to be protected. They are also catalysts for new ideas and innovation that can lead to better services and outcomes.

We make the following commitments to people with disabilities, their families and whānau, to:

1. Collect their feedback about the services we deliver
2. Understand their perspectives and needs
3. Deliver appropriate specialist, general and public health services, in a way that suits them
4. Uphold the rights of people with disabilities, and counter stigma and discrimination
5. Equip and upskill staff to meet their needs.

We will also incorporate the perspectives and needs of people with disabilities when we:

1. Contract other organisations to deliver services
2. Employ people with disabilities
3. Design and build our facilities
4. Monitor and report on how well we are doing, and plan for improvements
5. Partner with our communities to improve population health and wellbeing.

CANTERBURY AND WEST COAST HEALTH DISABILITY ACTION PLAN 2016 - 2026

Vision

The Canterbury and West Coast strategic vision for people with disabilites is of a society that highly values lives and continually enhances their full participation. Through this strategic vision, we will ensure that all people with disabilities experience a responsive and inclusive health system that supports them to reach their full potential by providing equitable access to services that focus on keeping people safe and well in their homes and communities.

Safety and Autonomy

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I am safe in my home, community and work environment. I feel safe to speak up or complain and I am heard. Those assisting me (professionals and others) have high awareness and I do not experience abuse or neglect.

Our Strategic Focus

People with disabilities and their family/whānau/carers are listened to carefully by health professionals and their opinions are valued and respected. Individuals are included in plans that may affect them and encouraged to make suggesti or voice any concerns by highly aware staff.

We will...

1. ***Integrate services for people of all ages with a disability***

   Work with people with disabilities and their family/whānau/carers to identify opportunities for achieving an integrated and co-ordinated approach between cross government services and local providers, so that infants/children and youth with impairments and adults with a disability, including those with age related conditions, can live lives to their full potential. (8, 10, 11 – These numbers relate to objectives in The NZ Disability Strategy 2001, see Appendix D).

2. *Improve health literacy*

Improve access to health information in a form that works for them. This includes access to their personal health information. Support is provided when required so that the individual/family/whānau can use information to manage their own health, share in decision making, provide informed consent, and make choices and decisions that are right for them and their family/whānau. (3, 8, 10, 11, 12)

3. *Offer appropriate treatment*

Offer interventions with individuals and their family/whānau which are evidence-based best practice, such as restorative, recovery focused approaches. (6, 7, 10, 11)

4. *Monitor quality*

Develop and use a range of new and existing quality measures for specific groups and services that we provide for people with disabilities, and develop systems and processes to respond to unmet needs e.g. consumer survey. (6, 10, 13, 14)

Wellbeing

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I feel dignity and cultural identity through a balance of family/community, mental, physical and spiritual wellbeing.

Our Strategic Focus

The wellbeing of people with disabilities is improved and protected by recognising the importance of their cultural identity. Health practitioners understand the contribution of the social determinants of health.

We will...

5. Measure and progress

Develop measures and identify data sources that will provide baseline information about people with disabilities who are accessing the health system. Using the Health System Outcomes Framework for each strategic goal, use data analysis to understand the population and evaluate progress towards improving health outcomes for people with disabilities. (1, 8, 13)

6. Improve access to personal information

Enable people with disabilities to have increased autonomy in making decisions that relate to their own health by developing processes that enhance communication e.g. access to their medical records through patient portals. People with disabilities will be given support to do this if they are unable to do this on their own. (2, 14)

7. Work towards equitable outcomes for Māori

Work with Māori people with a disability, whānau and the Kaupapa Māori providers to progress the aspirations of Māori people as specified in He Korowai Oranga, Māori Health Strategy. Apply our Māori Health Framework to all the objectives of this action plan in order to achieve equitable population outcomes for Māori with a disability and their whānau. (11, 13, 15)

8. Implement a Pasifika disability plan

Work with Pasifika people, their families and Pasifika providers to action the Ministry of Health National Pasifika Disability Plan 2014 - 2016 which identifies nine specific objectives for Pasifika people with a disability and ‘Ala Mo’ui: Pathway to Pacific Health and Wellbeing 2014 - 2018 which is aimed at improving culturally appropriate service provision with

emphasis on improved access to Primary Care. Canterbury Pasifika Health Framework 2015 - 2018 will also be used as a core document to inform the work required. (12, 13, 15)

9. Develop better approaches for refugee, migrant and culturally and linguistically diverse groups

Work with people with disabilities and their families who are from different refugee, migrant and other culturally and linguistically diverse groups to identify and implement responsive processes and practi s. This includes informati being appropriately translated and an awareness by staff of how disability is viewed from different cultural perspecti es. (9, 13)

Self Determination

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I make my decisions myself, based on my aspirations. I have access to information and support so that my decisions are informed.

Our Strategic Focus

People with disabilities contribute to their own health outcomes as they and their family/whānau receive the information and support which enables them to participate and influence at all levels of society.

We will...

10. Provide accessible information and communication

Promote and provide communication methods that improve access and engagement with people with disabiliti such as using plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adapti e technology, and expanding the use of sign language. (1)

11. *Develop leadership of people with disabilities who have a role in the health system*

Identify and support opportunities for leadership development and training for people with disabilities within the health system. This includes further development of peer support as a model of care for people with long term conditions. (5)

Community

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I feel respected for my views and my contribution is received on an equal basis with others.

Our Strategic Focus

People with disabilities experience equal workplace opportunities. The health system supports access, equity and inclusion for those living with impairments, their family/whānau, carers and staff.

We will...

12. *Be an equal opportunity employer*

Increase the numbers of people with disabilities being employed and supported in their role within the Canterbury and West Coast health system. (4) Develop and implement an appropriate quality tool for current employees who identify as having a disability, that can inform and identify opportunities to improve staff wellbeing. (2, 4, 10)

13. *Increase staff disability awareness, knowledge and skills*

Develop and implement orientation and training packages that enhance disability awareness of all staff, in partnership with the disability sector e.g. people with disabilities, their family/whānau/carers, disability training providers and disability services. (1)

14. *Services and facilities are designed and built to be fully accessible*

Services and facilities will be developed and reviewed in consultation with people with disabilities and full accessibility will be enhanced when these two components work together to ensure people with disabilities experience an inclusive health system that is built to deliver waiora/ healthy environments. (6)

Representation

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

Disabled People's Organisations (DPO) represent collective issues that have meaning for me (based on lived experience) in a way that has influence.

Our Strategic Focus

The collective issues that emerge from people with disabilities' lived experience of the health system are actively sought and used to influence the current and future Canterbury and West Coast health system.

We will...

15. *Implement the plan in partnership*

Work with the Canterbury and West Coast Consumer Councils to ensure a network of disability-focused consumer groups who are empowered to actively engage with health service providers and be partners in health service improvement and redesign. This network will support the implementation and evaluation of the Canterbury and West Coast Health Disability Action Plan. (1)

16. *Promote the health, wellbeing and inclusion of people of all ages and abilities*

Actively promote and influence at all levels of society, to address stigma and discrimination, increase universal design for public spaces, and advocate for a fully inclusive society. (1, 4, 13)

Priority Actions 2016 - 2017

Key

Will be progressed in 2016 - 2017

Will be progressed in the future as opportunities emerge

Safety and Autonomy

1. Integrate services for people with a disability of all ages

Objective

Work with people with disabilities and their family/whānau/carers to identify opportunities for achieving an integrated and co-ordinated approach between cross government services and local providers so that infants/children and youth with impairments and adults with a disability, including those in related to age related conditions, can live lives to their full potential.

Priority Actions

1.1 Map the pathway for people with disabilities and long term chronic health conditions (LT - CHC) to available services, and work with Disability Support Services and the Needs Assessment and Service Co-ordination Services to improve processes as people transition between health and disability services.

1.2 Work with other providers of services for children and youth to address the gap in service provision for respite for 0-19 year olds with complex needs and for those living in rural communities.

1.3 The agreed pathways across funders and service providers will be placed on HealthPathways.

1.4 Where gaps in service provision are identified, engage with the key stakeholders to identify opportunities and actions that can be progressed.

Outcomes

- Increased planned care and decreased acute care
- Decreased wait times
- Decreased institutionalisation rates.

2. Improve Health Literacy

Objective

Improve access to health information in a form that works for people with disabilities. This includes access to their personal health information. Support is provided when required so that the individual/family/whānau can use information to manage their own health, share in decision making, provide informed consent, and make choices and decisions that are right for them and their family/whānau.

Priority Actions

2.1 People will better understand their health status through the development of the electronic patient portal in collaboration with people with disabilities and relevant experts to ensure that when the electronic patient portal is implemented it is accessible to people with disabilities, including those who use communication devices.

2.2 With the involvement of people with disabilities and their family/whānau, explore the potential for HealthOne as the electronic shared record between primary and secondary care, as the repository for information that people with disabilities want communicated about how best to support them when they are accessing a health or disability service. Evaluate the potential effectiveness of this with the disability community.

Outcomes

- Improved environments support health and wellbeing
- Increased planned care and decreased acute care.

3. Offer appropriate treatment

Objective

Offer interventions with individuals and their family/whānau which are evidence based best practice and that these restorative, recovery focused approaches will result in people living lives to their full potential.

Priority Actions

3.1 Explore opportunities and identify how to support a timely response for people with disabilities and their families/whānau who require

- Aids to daily living
- Housing modifications
- Driving assessments.

Outcome

- Improved environments support health and wellbeing.

4. Monitor Quality

Objective

Develop and use a range of new and existing quality measures for specific groups and services that we provide for people with disabilities, and develop systems and processes to respond to unmet need e.g. consumer surveying.

Priority Actions

4.1 Trial the use of feedback at the time of treatment within an identified service and explore whether this can include asking people if they have a long term impairment.

4.2 The quality of life for people with disabilities while in Canterbury and West Coast long term treatment facilities is measured and monitored and that actions occur to address any identified areas of improvement quality actions occur.

4.3 Ensure people with disabilities and their family/whānau know about and understand the Canterbury and West Coast DHBs' complaints and compliments process by describing the process in Easy Read format, placed alongside existing signage within wards and reception areas.

Outcomes

- No wasted resource
- The right care, in the right place, at the right time, delivered by the right person.

Wellbeing

5. Measure and Progress

Objective

Develop measures and identify data sources that will provide baseline information about people with disabilities who are accessing the health system. Using the Health System Outcomes Framework for each strategic goal, analyse data to understand the population and evaluate progress towards improving health outcomes for people with disabilities. (1, 8, 13)

Priority Actions

5.1 The disability population will be identified by developing an inventory of available data and potential data sources that can be used to better understand those with disability who access the health system.

5.2 Identify additional data collection required to inform further service improvement and ensure that baseline data are developed and used as measures of success. (These processes are inclusive of the actions specified for Māori and Pasifika in 7.1 and 8.1 of this plan).

6. Improve access to personal information

Objective

Enable people with disabilities to have increased autonomy in making decisions that relate to their own health by developing processes that enhance communication e.g. access to their medical records through patient portals. People with disabilities will be given support to do this if they are unable to do this on their own.

Priority Actions

6.1 The process for identifying the solution for a patient portal in primary care includes how the needs of people with disabilities will be met.

7. Work towards equitable outcomes for Māori

Objective

Work with Māori people with a disability, whānau and the Kaupapa Māori provider to progress the aspirations of Māori people as specified in He Korowai Oranga, Māori Health Strategy. Apply our Māori Health Framework to all the objectives of this Plan in order to achieve equitable outcomes for Māori with a disability.

Priority Actions

7.1 Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture information specific to the Māori population with a disability.

7.2 All the priority actions of this plan are to include culturally appropriate actions for Māori with a disability and their whānau, and that this promotes and supports whānau ora and rangatiritanga.

Outcome

- Delayed/avoided burden of disease and long term conditions.

8. Implement a Pasifika Disability Plan

Objective

Work with Pasifika people, their families and Pasifika providers to action the Ministry of Health National Pasifika Disability Plan 2014 - 2016 and 'Ala Mo'ui: Pathway to Pacific Health and Wellbeing 2014 - 2018 which are aimed at improving culturally appropriate service provision with an emphasis on improved access to primary care. Canterbury Pasifika Health Framework 2015 - 2018 will also be used as a core document to inform the work required.

Priority Actions

8.1 Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture informati specifi to the Pasifika people with a disability. To develop and implement local responses appropriate to Canterbury and the West Coast.

8.2 Strengthen the culturally appropriate service responses, as Canterbury is one of the target DHBs working to achieve the four priority outcomes* of 'Ala Mo'ui, and transfer strategies.

*1. Systems and services meet the needs of Pasifika people
2. More services are delivered locally in the community and in primary care
3. Pasifika people are better supported to be healthy
4. Pasifika people experience improved broader health determinants of health.

West Coast only: The West Coast will engage with Canterbury to identify and strengthen its service responses in line with 'Ala Mo' ui.

Outcome

Delayed/avoided burden of disease and long term conditions.

9. Develop better approaches for refugee, migrant and culturally and liguistically diverse (CALD) groups

Objective

Work with people with disabilities and their families who are from different refugee, migrant and other culturally and linguistically diverse groups to identify and implement responsive processes and practices. This includes information being appropriately translated and an awareness by staff of how disability is viewed from different cultural perspectives.

Priority Actions

9.1 Engage with the Migrant Centre and CALD Co-ordinator Resettlement Service to explore opportunities for including the needs of CALD people with disabilities in the way we communicate.

9.2 Use the local Canterbury and West Coast networks to establish communication processes to disseminate health and disability-related information and advice to CALD communities. There will be a focus on Asian communiti

Outcome

- Delayed/avoided burden of disease and long term conditions.

10. Provide accessible information and communication

Objective

Promote and provide communication methods that improve access and engagement with people with disabiliti e.g. use of plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology. Expand the use of sign language.

Priority Actions

10.1 Engage with Canterbury and West Coast communications staff to review health system websites and identify any parts of them which are not fully accessible for people who use communication devices.

10.2 Build on the partnership with the disability sector by having the Disability Strategy and a version of this Plan made available in Easy Read format.

10.3 Work with communications staff to identify which key communications will be made available in plain language and circulated to a network of disability organisations and key contacts.

10.4 Develop a Canterbury and West Coast policy on the use of sign language and access to interpreters.

10.5 Undertake a stocktake within the Divisions of the DHBs which will be aimed at identifying where people with lived experience are providing peer support to service users, and recommend areas for further development.

Outcome

- Improved environments support health and wellbeing.

11. Develop leadership of people with disabilites who have a role in the health system

Objective

Identify and support opportunities for leadership development and training for people with disabilities within the health system. This includes further development of peer support as a model of care for people with long term conditions.

Priority Actions

11.1 Engage workforce development training providers from the disability sector to identify opportunities to support people with disabilities and their family/whānau who are providing a voice for people with disabilities within the health system. This will include exploring options for appropriate leadership training.

Outcome

- Improved environments support health and wellbeing.

Community

12. Be an equal opportunity employer

Objective

- The number of people with disabilities being employed and supported in their role within Canterbury and West Coast health will increase.
- Develop and implement an appropriate quality tool for current employees who identify as having a disability, which can inform and identify opportunities to improve staff wellbeing.

Priority Actions

12.1 Work with Work and Income NZ and the Ministry of Social Development in achieving employment of people with disabilities

12.2 Develop and implement an affi ti e acti plan that will result in more people with disabilities being employed in the Canterbury and West Coast health system.

12.3 Explore how to use the Staff Wellbeing Survey to ask staff how Canterbury and the West Coast DHBs can continuously improve their support of people with disabilities employed in either DHB.

Outcome

- Understanding health status and determinants.

13. Increase staff disability awareness, knowledge and skills

Objective

Develop and implement orientation and training packages that enhance disability awareness among staff, in partnership with the disability sector e.g. people with disabilities, their family/whānau/carers, disability training providers and disability services.

Priority Actions

13.1 Identify Disability Champions across our health systems. These champions will form a network that will disseminate disability-related information and resources and be an essential part of implementing the priority actions.

13.2 Work with the Learning and Development Unit and professional leaders to identify relevant education programmes that are already developed and offered by disability-focused workforce development organisations e.g. Te Pou.

13.3 Work with the Learning and Development Unit and professional leaders to progress the development of an eLearning tool that can then be placed on the healthLearn website and promoted for staff.
West Coast only: The West Coast will work with Canterbury to ensure applicability to the West Coast.

13.4 Training packages are developed and implemented in partnership with Māori people with disabilities and their whānau, to ensure cultural competency is inclusive of any training delivered.

Outcomes

- Delayed/avoided burden of disease and long term conditions
- Access to improved care.

14. Services and facilities are designed and built to be fully accessible

Objective

Services and facilities will be developed and reviewed in consultation with people with disabilities and full accessibility will be enhanced when these two components work together to ensure people with disabilities experience an inclusive health system.

Priority Actions

14.1 Site Redevelopment and Communications will work together to develop a communication plan for the disability community to receive quarterly updates on the development of Canterbury and West Coast health facilities. This will be in formats that are user-friendly for those with disabilities.

14.2 The communication plan will include information on how people with disabilities and their family/whānau can provide feedback and input when they have or potentially will experience barriers to access.

14.3 We will engage experts at key stages of the design, build and fit out of the building or rebuild of faciliti e.g. barrier-free and dementi friendly.

Outcomes

- Delayed/avoided burden of disease and long term conditions
- Community capacity enhanced
- Access to care improved.

Representation

15. Implement the Action Plan in partnership

Objective

Work with our Consumer Councils to ensure a network of disability focused consumer groups who are empowered to actively engage with health service providers and be partners in health service improvement and re-design. This network will support the implementati and evaluati of the Canterbury and West Coast Health Disability Acti Plan.

Priority Actions

15.1 Establish a Disability Steering Group that has members from the disability community who will provide leadership in the implementation of the plan.

15.2 A communication plan is developed and actioned, and this includes regular engagement with the disability sector including people with disabilities, their family/whānau and Disabled Peoples Organisations.

15.3 Monitor progress against the priority actions to be undertaken quarterly and communicated to the sector as a key part of the communication plan.

15.4 The priority actions will be refreshed annually within the health system and the disability sector with engagement and input from the people with disabilities, family/whānau and the wider disability sector.

Outcome

- Building population health, capacity and partnerships.

16. Promote the health, wellbeing and inclusion of people of all ages and abilities

Objective

Actively, promote and influence at all levels of society, to address stigma and discrimination, increase universal design for public spaces, and advocate for a fully inclusive society.

Priority Actions

16.1 Community and Public Health for both DHBs conti s to co-ordinate submissions on behalf of Canterbury and West Coast DHBs. However, they will use the Plan's underpinning principles to inform their submissions.

16.2 In conjunction with Disabled Peoples Organisations, Disability Support Services, the Ministry of Social Development and the Ministry of Education, set an annual seminar which presents new developments and initiatives for people with disabilities.

Outcomes

- Improved environments support health and wellbeing
- Access to improve care.

APPENDICES

Appendices

APPENDIX A

CORE DOCUMENTS

The core documents referenced in the development of this Plan include:

- New Zealand Disability Strategy 2001
- New Zealand Disability Action Plan 2014 - 2018
- New Zealand Disability Action Plan 2014 - 2018. Updated December 2015
- He Korowai Oranga, Māori Health Strategy 2014 - 2018
- Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Service 2012 - 2017
- Faiva Ora National Pasifika Disability Plan 2014 - 2016
- Ala Mo'ui: Pathway to Pacific Health and Wellbeing 2014 - 2018
- United Nations Convention on the Rights of People with Disabilities (ratified by New Zealand 2007)
- Second Report of Independent Monitoring Mechanism of the Convention of the Rights of Disabilities, August 2014
- United Nations Convention on the Rights of the Child (ratified by New Zealand 2008)
- Human Rights Act 1993

APPENDIX B

GUIDING PRINCIPLES OF THE CONVENTION

There are eight guiding principles that underpin the Convention:

1. Respect for inherent dignity and individual autonomy, including the freedom to make one's own choices and be independent
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of a diverse population
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capaciti s of children with disabiliti and respect for the right of children with disabiliti to preserve their identiti

APPENDIX C

CONSULTATION PROCESS AND SUMMARY OF FEEDBACK

Recommended amendments to the Draft Canterbury and West Coast Health Disability Action Plan

All feedback received to date, both written and verbal, has endorsed the vision and objectives of the Plan with some recommended amendments. The respondents stated that the principles of the New Zealand Disability Strategy 2001 of participation, partnership and protection of the rights of people with disabilities were present throughout the document.

Respondents unanimously commended the development of a Disability Action Plan and the process undertaken to seek the opinions of people with disabilities, their family/whānau and other key stakeholders on the Plan and the priorities for implementation over the next two years.

The consultation process has resulted in a number of recommendations on how the draft Plan could be strengthened in terms of the language used, and by broadening the scope of some of its stated goals.

These include:

1. The New Zealand Disability Strategy 2001 is considered an important landmark document but it is fourteen years old and requires updating. It is recommended that, in addition to identifying the alignment with the New Zealand Disability Strategy, each objective should also be aligned with the Articles of the United Nations Convention on the Rights of People with Disabilities and that the language used is consistent with the relevant articles.
2. Include with the dissemination of the Plan the definition of disability we used, and the Position Statement.

3. The draft Plan is primarily adult-focused and it is recommended that the United Nations Convention on the Rights of the Child (UNCROC) be included as a core document to inform the development of the final Plan and the priorities for action.
4. The Plan needs to place more direct emphasis on addressing the health disparities for people with disabilities compared with those people without a disability. It is recommended that the need to have a targeted approach to addressing the barriers of access to healthcare is explicitly stated.
5. Feedback from Māori Advisory Groups both in Canterbury and on the West Coast was that for each of the strategic goals there needs to be inclusion of what would be an appropriate objective for Māori.
6. Wherever possible the language is amended to ensure it is explicit that the objectives are inclusive of all people with disabilities. This will require careful consideration, as feedback has also complimented the Plan on recognising the diversity of the people with disabilities by identifying the different population groups. There was consistent feedback that the Plan needed to reference Asian people specifically.
7. Outcomes need to be identified for each objective including how their achievement will be measured. Measures will form part of the work plans that are developed.
8. Amend the vision statement to include a statement about supporting people with disabilities to reach their full potential.
9. Amend the draft Objective 4 so that the goal positively promotes the use of only appropriate treatments rather than a goal that is more about stopping inappropriate treatments.
10. An additional objective needs to be added under the heading of an Equal Opportunity Employer which states health system employers will take affirmative action to increase the number of people with disabilities employed within the organisations.

11. Add into the Strategic Goal for Safety and Autonomy the commitment to addressing stigma and discrimination.
12. To include families/whānau as a central part of the Plan, including the identification of needs, gaps in services and how to implement and monitor progress.
13. Amend draft Objective 14 that accessibility is more than just buildings and facilities, so that this objective reads as accessible services and buildings.
14. Significant concern was expressed at the number of high level strategic objectives contained in the Plan, but it is less clear how these will be achieved. There was support for identifying the priorities for action and concentrating on progressing a limited number of objectives to avoid the risk of spreading resources too thinly.
15. Feedback on the consultation process showed appreciation for the plain language version being available electronically to networks within the disability community. It has been recommended that the final approved version also be made available in other formats such as large print and on CD.
16. There was concern that those individuals who don't belong to any specific disability groups did not have the opportunity to comment. Those within the disability sector recognise that reaching people with disabilities is one of the significant challenges within the sector, as they are often an invisible part of the community due to the very barriers this Plan has been developed to address. Further planning and ongoing engagement about how to reach this group is required.
17. It is recommended that a process for amending the Plan should be put in place to ensure opportuniti for improving the Plan or prioriti for acti that have not yet emerged, can be added at a later date.
18. The Plan requires ongoing engagement with people with disabilities and their supports on the emerging issues for them. As a minimum, an

annual refresh of the priority actions and any amendment to the overall strategy would occur.

Identifying the Priorities for Action

The key themes and opportunities for priority action

The following areas have been consistently raised by those providing feedback on the priority areas for action:

1. Accessibility of buildings and facilities

- Increasing engagement – providing regular updates in the form of a newsletter, written in a way that is accessible for people with disabilities.
- Identifying and promoting the process for people with disabilities to provide feedback and input when accessibility is impacted e.g. parking, after hours security, etc.
- Designing above code – having experts audit and make recommendations at key stages of the design and fit-out of new buildings and rebuilds e.g. barrier-free, dementia-friendly.

2. Promoting disability awareness

- Develop a network of Disability Champions at a service level across the Canterbury and West Coast health systems. These people will be the conduit for disseminating disability-related information and resources available to staff when working with people with disabilities.
- Work with the Learning and Development Unit and professional leaders of the Canterbury and West Coast health system to identify appropriate and relevant education programmes that are already developed and offered by disability-focused workforce development organisations e.g. Te Pou. This is initially envisaged as an e-learning tool available on healthLearn. Any education tool developed will have input from people with disabilities and their family/whānau.

3. *Communication*

- The use of plain language, Easy Read and formats such as large print will be promoted and expanded for all forms of health information available across the health system.
- Appropriate formats are used when disseminating information to the Canterbury and West Coast population so that it is readable by communication devices.
- Health Passports are a mechanism where people with disabilities can have their individual needs specified. Identify, within the growing suite of information technologies, the best way this information can be included and made available when people with disabilities are accessing any part of the health system e.g. through HealthOne.
- The Patient Portal is being developed in a format that meets the needs of people with disabilities.
- Making information available in different languages, including increased use of sign language interpreters, is also a priority.

4. *The Canterbury and West Coast health system as employers of people with disabilities*

- Under the heading of an Equal Opportunity Employer state that the Canterbury and West Coast health system employers will increase the numbers of people with disabilities being employed and supported in their role within Canterbury and West Coast health.

5. *Specific feedback which related to particular population groups*

- Ensure timely access to equipment that is necessary to enable people to live lives to their full potential.
- Work together with Disability Support Services to develop improved access to appropriate respite opti for children with complex conditions.
- Understand and improve the experience of health services for people with learning disabilities

- Work to achieve equitable outcomes for Māori.
- Work with Pacifika people, their families and Pacifika providers to improve engagement.

6. Other Opportunities

- Establish a Disability Action Group that has a membership of people with disabilities and their family/whānau who can contribute to progressing the identified actions.

APPENDIX D

OBJECTIVES FROM THE NEW ZEALAND DISABILITY STRATEGY 2001

The objectives are to:

1. Encourage and educate for a non-disabling society
2. Ensure rights for disabled people
3. Provide the best education for disabled
4. Provide opportunities in employment and economic development for disabled people
5. Foster leadership by disabled people
6. Foster an aware and responsive public service
7. Create long-term support systems centred on the individual
8. Support quality living in the community for disabled people
9. Support lifestyle choices, recreation and culture for disabled people
10. Collect and use relevant information about disabled people and disability issues
11. Promote participation of disabled Māori
12. Promote participation of disabled Pacific peoples
13. Enable disabled children and youth to lead full and active lives
14. Promote participation of disabled women in order to improve their quality of life, value families, whānau and people providing ongoing support.

Canterbury
District Health Board
Te Poari Hauora o Waitaha

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

Canterbury District Health Board Te Poari Hauora o Waitaha	**TERMS OF REFERENCE** **Canterbury DHB Disability Steering Group**
Scope	The Disability Steering Group of the Canterbury DHB is to oversee, influence and ensure that the DHB progresses and implements the objectives and priority actions of the Canterbury Health Disability Action Plan within the Canterbury DHB and contribute, where appropriate, to achieving the objectives of the Plan across the Canterbury Health system. The Disability Steering Group will also ensure that where work to achieve the objectives of the Disability Action Plan is relevant to West Coast Health system, the work occurring in Canterbury will be shared and where possible support will be given to achieve the priority actions, in a Transalpine approach.
Purpose	The Disability Steering Group will compel DHB activity that will achieve the Canterbury DHB vision that Canterbury people with disabilities will experience a responsive and inclusive health system that supports them to live lives to

	their full potential and be safe and well in their homes and communities. The Disability Steering Group will influence behaviours, system and process design across the health system, to enable this vision and to improve the outcomes for this population.
Objectives	• Oversee the development, implementation and evaluation of the Canterbury DHB Health Disability Action Plan. • Facilitate linkages and information sharing to decision makers within clinical, operational and professional groups of the Canterbury DHB and to the Work Streams of the Canterbury Clinical Network, to ensure a disability focus is incorporated. • Influence the strategies that develop and support the workforce to be competent and responsive to the needs of people with disabilities • Effectively link to the disability community.
Principles	Definition: The United Nations (UN) Convention on the Rights of Persons with Disabilities, which New Zealand ratified in 2007, describes disability as resulting 'from the

	interactions between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (UN General Assembly 2007). The Disability Steering Group will undertake to address and remove these barriers. The key principle to achieve this is to facilitating and supporting the self determination of people who experience disability by ensuring their active participation in the design of the health system and its services. These Principles are specified in the Canterbury DHB Position Statement which forms a part of the Disability Action Plan
Accountability	The Disability Steering Group is accountable to the Executive Management Team and will report quarterly to them. The Disability Steering Group is endorsed by the Disability Support Advisory Committee and will report quarterly. DSAC endorsement will include ensuring the breadth of membership will guarantee the engagement and voice of people with disabilities and their families. The Disability Steering Group will also work with the Service Level Alliances and Work Streams of the Canterbury Clinical

	Network and contribute to the reporting to the Alliance Leadership Team, who have approved the Health Disability Action Plan for the Canterbury Health System.
Membership	CANTERBURY DHB -INTERNAL Chair Executive Sponsor Disability Lead, Planning and Funding Community and Public Health Clinical Leads People and Capability (, Head of Talent, Leadership and Capability) Operations Manager Quality and Patient Safety Communication Staff Member COMMUNITY MEMBERS Canterbury ALT Member People with Disabilities, Māori, Pacific, Family Primary Care Disability NGO

	Other staff and community representatives will be co-opted as required.
Chairperson	Gordon Boxall
Quorum	50% membership
Meetings	Monthly (11 per year)
Agenda	Approved by the chair and circulated 1 week prior to the scheduled meeting date
Minutes	Minutes will be circulated within 5 working days following the meeting

Key messages – Disability Steering Group (DSG)

Canterbury District Health Board
Te Poari Hauora o Waitaha

Memo to:	Key DSG stakeholders
Purpose of memo	To provide a brief summary of the key messages from the most recent Disability Steering Group (DSG) meeting. For more information please contact the facilitator involved for the DSG (details below)

APRIL 2017

1.1 **Mihi mihi –** Welcome to Māori (Moira Geer), and Pasifika representatives (Sekisipia Tangi) on the DSG. Ngaire Button was thanked for her contribution pending these appointments.

1.2 **Māori Health Strategy and alignment with Disability Action Plan –** Gary Williams, Ruth Jones and Waikura McGregor presented from Hei Whakapiki Mauri.
Waikura read out a moving 'thought-piece' written by Gary based on his personal experience which emphasised the importance of his culture and particularly his whānau. The presentation concluded with some recommendations for the Steering Group to consider at its next meeting.

1.3 **Accessibility Charter - Lorraine Guthrie from Barrier Free and Amy Hartnell (Earthquake from Disability Leadership Group)** presented on their progress to gain support from statutory agencies on an Accessibility Charter. They spoke of their consultations with CCC, other public groups and redevelopment organisations to meet minimum access standards. Exec sponsor, Stella Ward and George Schwass from Canterbury DHB Operations will follow up with accessibility points raised from recent site visits.

1.4 **Making it Better for staff who have a disability -** Mark Lewis and Donovan Ryan from People and Capability Team gave an update on "Making it Better for our People with a Disability" plan. Progress on recruiting more disabled people will be presented at a later meeting.

1.5 **Canterbury DHB Submission on proposed changes to respite –** Allison Nichols-Dunsmuir presented on the submission. This was circulated to members in the minutes.

1.6 **Other Items – Parking –** Further to public discussion, members discussed this issue. The Chairperson is meeting with facilities management, including site visits. An update on progress will be given at the next DSG meeting.

Key messages – Disability Steering Group (DSG)

Canterbury District Health Board
Te Poari Hauora o Waitaha

Memo to:	Key DSG stakeholders
Purpose of memo	To provide a brief summary of the key messages from the most recent Disability Steering Group (DSG) meeting. For more information please contact the facilitator involved for the DSG (details below)

JULY 2017

1.1 **Mihi –** Gordon Boxall, Chairman, welcomed the group and spoke of the Human Rights Commission report release this week. The Report is online at https://www.hrc.co.nz/news/new-zealanders-intellectual-disabilities-faced-systemic-abuse-state-care/
It was agreed to ask Robert Martin, author of Becoming a Person to address DSG at a future meeting on his life experiences and role with the United Nations.
http://www.pottonandburton.co.nz/store/becoming-a-person

1.2 **Equally Well and Step Up –** A presentation was made of Equally Well, a collaboration between over 100 organisations, including most DHB's and others that have an interest in their community's physical health.
This is a response to people with serious mental illness who die a lot younger than the general population from physical health problems. In Canterbury, Patients are being offered free primary care consults to see if this makes a difference. Jane Hughes, Clinical Director Intellectually Disabled Persons Health, reminded the group about barriers for participants that need to be supported, many of whom are in real poverty where even the cost of a bus fare may prevent them from receiving assistance.
A presentation was made on Step Up. Canterbury is one of four DHBs working in partnership with MSD in *StepUp*, a social investment approach to getting people off health deferred benefits and into employment. Currently a pilot, that places a navigator employed by Pegasus PHO into GP practices, it is anticipated that more practices will be involved from September 2017. Early days but early findings are that people are keen to be involved with most retaining contact with the programme.
Sekisipia Tangi, Pasifika Representative, offered his expertise with Pacific groups on both groups.

1.3 **Maori Help Plan and Disability Action Plan -**
Sekisipia Tangi, Pasifika Representative and CDHB Maori/Pacific Portfolio Manager Ngaire Button are working with the Pacific Reference Group to develop Pacific findings.
Respite funding was discussed. This will be on the agenda for August meeting.
Canterbury Wellbeing Study was discussed including questions on Maori Health needs.

1.4 **Workplan measures and outcomes –** 38 priority measures were discussed.

Wayfinding signage – Paul Barclay, Disability Community Lived Experience Representative has discussed with the Blind Foundation how braille buttons are not standard due to contractors. The landlord will reply to Paul.

Seki discussed how the Pacific Community can access help and information on falls prevention. Stella Ward offered to Seki to further discuss how Pacific people can access all the information available with HealthInfo and other CDHB platforms. Stella spoke of accessing information and how to get to the right place, such as the example of disability equipment on HealthInfo.

Jane Hughes suggested incorporating assistance technologies into the Workplan. Catherine Swan spoke of the Maia Foundation developing an app for wayfinding in the new Acute Services Building. Hayley Neilsen spoke of the example of oral health using videos to prepare children before procedures. Other champions include Helen Webster and Peter Dooley from MRI preparing virtual 3D technologies. Discussion about development for GPs in the community, such as using technology for driving assessments.

1.5 **People & Capability Update –**

Online module for staff awareness – this has been peer reviewed for People & Capability and ready to go on site to be linked to activities. Mark Lewis asked if the group could take on the reviewer role with CDHB is the host. Mark will source more reviewer information for next meeting. Dave Nicholls spoke about contacting Ara or other community groups. It was decided that for the issue of continuing content review, that DSG or Consumer Council wouldn't be the best choice.

Interviews and surveys – There has been confusion about the role of community members of DSG. Mark Lewis will clarify between meetings. People & Capability's surveys to date have been with CDHB staff.
Project Search – Mark Lewis said it was on track. People & Capability are looking at sourcing an external resource to move this forward as internal expressions of interest havn't worked. The decision to fund should be known in a week or two. It was felt the role could also consider other employment initiatives based on the DHB's current challenges re recruitment in liaison with local employment specialists including Ara and Supported Employment Agencies following discussions between P&C, Gordon and Kathy.
Discussion about the Be Employed programme.

Transformation project – Lifecycle – implementation plan is underway. Recruitment is recognised as the key factor. Allison Nichols-Dunmuir, Community & Public Health asked about offer for DSG to engage with this project.

1.6 **General Business –**

Accessibility charter will be launched in November.
Parking – Hayley Nielsen, Family Member Representative reported back from her parking meeting with CDHB Rachel Cadle. Whilst it is clearly a challenging situation, some practical suggestions were made. Rachel is responsible for staff parking and park n ride. It was noted that CCC are also a key player in this with CDHB CEO to CCC CEO discussions being held. There is also board level involvement from each agency about parking in the hospital area. It was noted that Allison and Paul are members of the CCC Disability Committee.
DHB Members were asked to consider how best to take this work forward possibly asking an outside agency like the Earthquake Disability Leadership Group (which includes representation from CCC and CDHB but is independent) could take a lead role.
The Group suggested it would be good for people to be informed about such as advice on CDHB website showing where mobility parking is available. Particularly for parents with children who have two hour appointments. Parents can write to CCC if they are ticketed. Appointment letters can be stamped by departments.

Key messages – Disability Steering Group (DSG)	Canterbury District Health Board Te Poari Hauora o Waitaha

Memo to:	Key DSG stakeholders
Purpose of memo	To provide a brief summary of the key messages from the most recent Disability Steering Group (DSG) meeting. For more information please contact the facilitator involved for the DSG (details below)

JUNE 2017

1.1 **Welcome –** to members attending and May minutes approved.

1.2 **Māori Health Plan and Disability Action Plan –** Hector Matthews tabled the Māori Health strategy and spoke about aligning Māori health needs to the disability strategy. Data shows a cumulative effect to health and inequity. There was planning discussion on raising the emphasis on improving the poor health outcomes for Māori and Pacific people with disabilities

1.3 **Introducing Equally Well Initiative for Mental Health consumers and Step Up -** Kathy O'Neill will speak to the group at July meeting on the Step Up employment programme for people on health deferred benefits.

1.4 **Introducing Care Panning –** Rose Laing from CCN presented to the group on Personal Care Plans. PCPs are an electronic tool to encourage clinicians to provide continued care. Their aim is to improve knowledge and reduce duplication of resources. The group discussed the challenges of sharing information amongst agencies and the importance of confidentiality.

1.5 **Employment of more disabled people –** Gordon Boxall, Chairperson is meeting with CDHB People and Capability to discuss how the CDHB can employ more disabled people.

1.6 **Engaging the Disability Sector** – Gordon Boxall, Chairperson has been invited to attend a meeting of the Canterbury Provider Network on 26th July. Provider members of the DSG may wish to attend. It was agreed such meetings need to focus on our progress against the plan highlighting any value we are adding in delivering on objectives.

1.7 **Smart Cities project –** Allison Nicholls-dunmuir, CDHB, spoke regarding smart chips being installed in disabled carparks. The aim of this is to improve usage data, compliance, and reduce the use of non-permitted users parking in disabled carparks.

1.8 **Other items –** Communications. DSG profile was in WellNow Winter edition, circulated to Canterbury homes and GP practices. The DSG newsletter has been circulated.

Canterbury District Health Board Te Poari Hauora o Waitaha	**Canterbury DHB Disability Steering Group** AGENDA –28 April 2017 Room BWD 2.1, Assemble in main atrium and Sally Nicholas (Operations Manager) will come to greet you. This is necessary as the meeting room is on one of the Wards

	Approx. Time	Agenda Item	Who
1.	10:30am	Mihi mihi Welcome for Moira Geer, Maori member and Sekisipia Tangi Pacific Member	Hector Matthews Ngaire Button
2.	10.40am	Welcome Lara Williams Administration Support, Apologies, previous minutes, matters arising and any conflicts of interest for today's agenda items	Gordon
3.	10:45am	Discussion on Maori Health Strategy and the alignment with the actions of the Disability Action Plan	Hector Matthews Ngaire Button
4.	11:15am	Accessibility Charter Guests Lorraine Guthrie (Barrier Free) Amy Hartnell (Earthquake Disability Leadership Group)	Allison Nicholls-Dunsmuir
5.	11:35 am	Making it Better for staff who have a disability Identifying who to link People and Capability with for collation of recommendations following staff feedback	Mark Lewis
6.	12:00 am	CDHB Submission on proposed changes to respite	Allison Nicholls-Dunsmuir Kay Boone
7.	12:15 am	General Business items Communication Plan Update – Mick Request has been received for minutes to be circulated – recommend key messages rather than full minutes (decision)	
		Next Meeting 10:30am – 12:30pm Room 115 (Boardroom) Level 1 32 Oxford Terrace.	

Canterbury DHB Disability Steering Group

AGENDA –23 June 2017

Room 211 (large room) Level 2, 32 Oxford Terrace. 10.30-12.30

	Approx. Time	Agenda Item	Who
1.	10:30am	Apologies, previous minutes, matters arising and any conflicts of interest for today's agenda items	Gordon
2.	10.40am	Maori Health Plan and Disability Action Plan –planning discussion Raising the emphasis on improving the poor health outcomes for Maori and Pacific people with disabilities	Hector Matthews Ngaire Button Matt Reid
3.	11:15am	Introducing Equally Well Initiative for Mental Health consumers and Step Up – an employment programme for people on health deferred benefits	Kathy O'Neill
4.	11:30 am	Introducing Care Panning – are these electronic tools that will give people with disabilities a strong voice in determining the care they receive	Rose Laing
5.	12:10 am	General Business Table Report on plan for engaging the disability sector on the refresh of the plan Brief Updates: Project Search, Accessibility Charter, Communications Agenda items for next meeting	DSG Members
		Next meeting **10:30 – 12:30 23 July 2017**	

Canterbury District Health Board Te Poari Hauora o Waitaha	**Canterbury DHB Disability Steering Group** AGENDA –28 July 2017 Room 211 (large room) Level 2, 32 Oxford Terrace. 10.30-12.30

	Approx. Time	Agenda Item	Who
1.	10:30am	Apologies, previous minutes, matters arising and any conflicts of interest for today's agenda items	Gordon
2.	10.40am	Equally Well and Step Up	Kathy O'Neill
3.	11.00am	Maori Health Plan and Disability Action Plan Update on agreed actions following Hector and Ngaire's presentation at last meeting.	Gordon
4.	11:10am	Priority Actions, dashboard reporting A3 copies of the Disability Action Plan Priority Actions document will be printed for you. This has been emailed with this agenda, please read before the meeting.	Kathy O'Neill
5.	11:30	People and Capability Update	Mark Lewis
6.	11:45 am	General Business • Parking • Accessibility Charter • Updates on Quality actions – Monitoring and Sign Language • Agenda items for next meeting	DSG Members Susan Wood
		Next meeting **10:30 – 12:30 18 August 2017** 18th is confirmed date as Stella Ward can attend	

AGENDA

Canterbury District Health Board
Te Poari Hauora ō Waitaha

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING

To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 1 November 2018 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 30 August 2018		
3.	Carried Forward / Action List Items		
4.	Community & Public Health Exception Report	Evon Currie	9.05-9.20am
5.	Sugar-Sweetened Beverages Position Paper	Evon Currie	9.20-9.35am
6.	Planning & Funding Exception Report	Carolyn Gullery	9.35-9.50am
7.	Māori and Pacific Health Progress Report	Dr Matthew Reid	9.50-10.05am
8.	Hauora Alliance – Presentation	Evon Currie Helen Leahy	10.05-10.25am
9.	Canterbury Wellbeing Index Update – Presentation	Annabel Begg Kirsty Peel	10.25-10.45am
	MORNING TEA		**10.45-11.00am**
10.	Disability Steering Group Update - Oral	Gordon Boxall	11.00-11.20am
11.	CDHB Workforce Update 11.1 Project Search – Presentation	Mark Lewis	11.20-11.45am
	ESTIMATED FINISH TIME		**11.45am**

	Information Items • Disability Steering Group Minutes – Jul & Aug 18 • Health Target Q4 Report • Air Quality Monitoring/Respiratory Illness Data • 2018 Workplan		

NEXT MEETING: Thursday, 7 March 2019 at 9.00am

Te Arataki Taero Kore
ACCESSIBILITY
CHARTER

Te Arataki Taero Kore:
The Accessibility Charter

Industry, business, groups and individuals play a role in the creation of an accessible Canterbury.

Accessibility is good for us all; it benefits whānau, business, tourism, economic development, iwi, and health and wellbeing.

Vision

Waitaha-Canterbury will become a model of best-practice accessibility through our community and business leaders advocating for places and spaces that are accessible for all people.

Purpose

By signing this Charter, we are:

- Ensuring that places and spaces in Waitaha-Canterbury become universally accessible
- Enabling Cantabrians and visitors to live, work, learn, explore and play equally
- Setting an expectation of best-practice design and development, which goes beyond minimum expectations of the Building Code.

Commitments and Actions

Our organisation supports the vision and purpose of this Charter. We will implement the following Charter Commitments and Actions and formally review our progress in these areas:

Hautūtanga - Leadership

Our leaders will demonstrate a pro-active commitment to best-practice accessibility when setting policy and practice expectations, budgets and accountability provisions.

Mātauranga - Education

Our organisation will ensure staff are equipped with the skills and knowledge they need to apply best-practice accessibility throughout the design and development process. We will also provide information and training to help staff understand the benefits of accessible design and the consequences and barriers created by poor design.

Tohungatanga - Technical Expertise

We will seek the technical advice and guidance of professional and independent universal-design experts, appropriate to the scale and type of projects we undertake.

Te Oranga o te Tangata - Health and Wellbeing

We will actively promote the link between the creation of accessible places and spaces, and the health and wellbeing of Cantabrians.

Canterbury District Health Board	Christchurch City Council	Development Christchurch Ltd
Environment Canterbury Regional Council	Regenerate Christchurch	Ōtākaro Limited

Barrier Free New Zealand Trust
Charter Lead Agency National

Earthquake Disability Leadership Group
Charter Agency Canterbury

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Accessibility Working Group (AWG) Terms of Reference (approved by EMT 20 June 2018)

Scope

The AWG will focus on the accessibility of CDHB-owned facilities in Canterbury (buildings and grounds), and the programme for new building and planned maintenance/renovations.

The scope includes facilities that are designed and built on behalf of the CDHB.

The AWG will encourage leaders to demonstrate a proactive commitment to best practice accessibility (procurement, planning, project management, budgeting, etc.)

Functions

The AWG will develop and oversee the implementation of a Plan that:

1) identifies the functions and business units affected by the Charter
2) collates information on the CDHB's building, renovation and landscaping projects and identify those that are suitable to include in the Plan
3) makes recommendations regarding use of technical access audits
4) makes recommendations regarding communication and consultation
5) reviews and makes recommendations on draft access audits prior to CDHB decisions on Plan projects
6) identifies policies and procedures affected by the Charter, and advises on amendments where gaps are identified
7) shares its general approach externally and in turn learns from the other Accessibility Charter signatories.

Membership

Chair
EMT representative
Coordinator
Clinician whose service site is being built/rebuilt
Communications
Operations Management
Construction and Property
Maintenance and Engineering

The AWG may seek to co-opt staff for defined pieces of work. An example may include support from the Quality and Safety team regarding identification and review of existing CDHB policies and procedures.

Reporting and accountability

The AWG will be responsible to the Disability Steering Group (DSG).

The AWG Chair will report on progress to each monthly DSG meeting.

The DSG EMT representative will report on progress, raise any issues and make recommendations to EMT. This includes EMT signoff of the Accessibility Charter Implementation Plan.

The DSG EMT representative will report on AWG progress to CPAC/DSAC on a timeframe agreed with the DSAC Chair.

Any external communications related to the AWG will be subject to usual Communications protocols.

Review

The AWG will operate for 18 months from the date of its first meeting.

DSG will then review its achievements and issues, these Terms of Reference, and propose to EMT a plan for the future.

CEO UPDATE
28 January 2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

A NZ-first internship programme at Canterbury DHB is giving young people with disabilities a chance to enter the workforce

Eight interns with learning disabilities have just signed one-year contracts with Canterbury DHB, during which they will learn skills and gain experience while working with us at Burwood Hospital.

I was privileged and delighted to be at the launch of Project SEARCH last Thursday evening and to experience the excitement that comes at the end of an intense period of preparation and the beginning of a new journey. It was a moving and uplifting experience for all to see just how pumped our interns were and to meet their families and whānau who were almost as excited.

The Project SEARCH interns donned their blue uniforms to sign their new contracts and receive their Canterbury DHB ID badges last week. Here, the eight interns are joined by parents and tutors to celebrate the milestone with a toast of sparkling grape juice.

Project SEARCH is a year-long training and experience programme, conceived in Cincinnati USA back in 1996. Since then the Project SEARCH teams have learned from experience and perfected the programme and there are now more than 600 running worldwide, mostly in the USA and UK.

We, and that's a Canterbury 'we', are the first in Australasia to embrace Project SEARCH and this will be only the second programme in the Southern Hemisphere.

It's a tremendous opportunity for us to learn how to be a better, more inclusive employer, and to offer our interns the opportunity to upskill, ready to join the workforce.

Michael Frampton, our Chief People Officer, put it very well in his speech when he said Project SEARCH is a very significant step forward in our commitment to supporting and enabling people with disability. Not because we're a provider of health and disability services, but because we're an employer that's committed to providing leadership to other employers and because we're committed to looking like the community we serve.

Before I tell you more about the programme, how it happened and why it matters so much, I'd like to go straight

In this issue

to the heart of it and introduce the interns themselves. These eight are sure to captivate and are certainly charismatic – though we will be asking much more than that from them in the year to come.

The interns, Deanna, Ricky, Tor, Finn, Hayley, Jason, Emelia and Ethan are aged 18- to 22-years-old and do have more challenges than most in navigating life with a disability, but they also have a lot to offer future employers and just need the opportunity to show it. The work they will do varies according to what they want from the programme, and what they prove themselves capable of but there are stories from the US of interns going on to become technicians.

One of the interns, Ricky Reeves, nearly lost his sight altogether when brain cancer affected his optic nerve at the age of nine. He was interviewed by *The Press* on Thursday and had this to say about Project SEARCH:

"Project Search is more than just a post-high school opportunity for me. I want to make something of my life," he said.

"It is quite hard for blind and visually impaired people to get a job, because a lot of places say it's a safety issue. I want to prove that a blind person can do a normal person's job, it might just take a little bit longer."

Project SEARCH came about for Canterbury DHB just as we'd completed our Health Disability Action Plan which has a key objective of employing more disabled people. We also have a Disability Steering Group with representatives from the health and disability sector as well as a number of community representatives with lived experience of disability.

The Disability Steering Group has an independent chair, Gordon Boxall, to steer the group. The group told us that employing more people with disabilities was a key priority alongside accessibility of services and information.

This group also included members of People and Capability – initially Mark Lewis and now Maureen Love – and putting advocates and enablers in one room is a potent combination. Then we were approached by Dr Colin Gladstone, an education advisor and researcher – and also an advocate for Project SEARCH.

Burwood Hospital was chosen for the pilot programme as it's purpose-built for recovery and rehabilitation and provides a perfect environment for the programme. We have a great team in place at Burwood and I have every confidence that Project SEARCH will be a huge success.

This is an important journey walking alongside these young people where we will learn at least as much, if not more, than they do.

Co-director of Project SEARCH Erin Riehle, who came all the way from Cincinnati for the launch, says that it's all too common for employers to look at the disability when things don't go quite as planned, when in fact it's often managers who need to look again at how they communicate and adapt their thinking to get the most out of people according to their abilities.

I'd like to thank and recognise a number of people who helped get Project SEARCH off the ground: Colin Gladstone for his timely proposal; Erin Riehle for her support and advice; our Project SEARCH coordinator Linda Leishmann; Maureen Love from People and Capability; Riccarton High School for agreeing to provide educational support; Sally Nicholas and Dan Coward for helping select and ready the team at Burwood; Paul Barclay from the Disability Steering Group who helped with the selection of our interns; Planning & Funding's Kathy O'Neill who is also on the Disability Steering Group and was instrumental in making this happen – and there are many, many more who have all played a crucial role in getting us here.

Last and definitely not least, I'd like to thank in advance our interns Deanna, Ricky, Tor, Finn, Hayley, Jason, Emelia and Ethan for the many things they will surely teach us. I look forward to hearing about their progress and to watching their stories unfold and their potential grow and develop.

Outpatients and Manawa official opening this Thursday

I'm very much looking forward to the joint official event to celebrate the opening of the new Christchurch Outpatients and Manawa, the health, research and education facility in the Health Precinct. If you happen to hear bagpipes between 1pm and 2pm on Thursday no cause for alarm – it's all part of the ceremony that is shaping up to rival the Buskers festival.

Congratulations to the winners of the *CEO Update* photo competition

There was a great response to the *CEO Update* photo competition with more than 100 entries of people's favourite photos from the Christmas and New Year break.

It was a wonderful glimpse into what staff got up to over the holidays, be it connecting with loved ones (including some very cute pets) or heading out to explore the sights here in Canterbury and further afield. For those who worked, it was great to see you spent some time celebrating with your workmates.

It was a tough decision but I'm pleased to announce Bronnie Hooker, Administrator, Women's & Children's Health and Elouise Chicksen, Registered Nurse, Orthopaedic Outpatients are the winners with their excellent photos depicting two great summer holiday traditions – exploring the great outdoors and relaxing with mates. I hope you both enjoy your trip to the Christchurch Night Noodle Markets in February, courtesy of Fairfax/Stuff.

Thank you to everyone who sent in photos – there is a selection of entries on page 10. Enjoy!

Photo from Bronnie Hooker

Photo from Elouise Chicksen

Keep hydrated and keep your cool

This week the heat is on – for tips on coping with the warm weather, see page 7.

Haere ora, haere pai
Go with wellness, go with care

David Meates
CEO Canterbury District Health Board

If you have a story idea or want to provide feedback on *CEO Update* we would love to hear from you! Please email us at communications@cdhb.health.nz. Please note the deadline for story submissions is midday Thursday.

If you're a non-staff member and you want to subscribe to receive this newsletter every week please subscribe here.

Bouquets

Maternity, Christchurch Women's Hospital

I recently had a baby here after not wanting to go into hospital. But thanks to all the wonderful staff I had a great experience. The anaesthetic team were brilliant. I really want to thank the two midwives, Jamie and Bree, who looked after me so well. They made me feel so supported and confident. I was incredibly well looked after by them. I can't thank them enough! They were amazing, amazing, amazing! Thank you everyone. Keep up the great work you're doing.

Caroline, Oncology Service, Christchurch Hospital

The receptionist Caroline in Oncology is fantastic. She is friendly, welcoming, efficient, goes the extra mile to help, and is genuinely an awesome person to have on the desk.

Orthopaedic Trauma Unit, Christchurch Hospital

I would like to say a huge thank you to the team on the Orthopaedic Trauma Unit. They were kind, compassionate, and took fantastic care of my son. A big thank you to Kaden, Nick, Roy and the nurses. Fantastic attitudes – you're awesome.

Ward 27, Christchurch Hospital

Many thanks to you all for looking after my husband. We were very grateful for all you did to make his life comfortable until the end. We loved him so much. Needless to say he is missed very much. We did appreciate your understanding and help. You are all so wonderful and trained to be very compassionate.

Ward 20, Christchurch Hospital

Wonderful nurses, nurse aides, nursing students and meal staff. You should be proud of yourselves for providing such excellent service to patients. Great food. Everyone was friendly, responsive and answered questions. The staff cared about the patients and personalised the service by remembering individual things and providing options along the way.

Ward 24, Christchurch Hospital

Thank you for the care and respect you have shown our loving wife and mother over the past eight days. It has been our pleasure seeing all the attention she has received during her stay.

Dental Outpatients, Christchurch Hospital

I was impressed and amazed at the efficiency and customer care I experienced today at my appointment. I was greeted by Elaine and shown to the dentist, then taken for an X-ray, then straight away back to the dentist. Appointment done and dusted in minimal time. Excellent service.

Main Reception, Christchurch Hospital

Thanks to the team at Enquiries for going above and beyond what they needed to. Seriously amazing.

Kris Dalzell and surgical team, Christchurch Hospital

Fantastic team, very busy, well-oiled service. Gave me details about the surgery when I asked for it. Explained about the after-care and what I could do to assist my recovery. Thank you for doing such a wonderful job of putting me back together.

Ward 27, Christchurch Hospital

Excellent care from nurses, doctors and support staff. Good information and kind, thorough care.

Ward 27, Christchurch Hospital

We will always be forever grateful for the attention and care given to our dear father and grandfather. Unfortunately Dad passed away. I know many patients come through your ward, but for all the staff who treated Dad, thank you from our family for your dedication.

Ward 17 and Emergency Department, Christchurch Hospital

I would like to express my gratitude to all the staff at Christchurch Hospital and especially Ward 17. I have been here for five days, at times in a lot of pain. Through it all the staff have treated me really well and seemed to really care, even when very busy.
I spent the first night in the Emergency Department and the staff there were good natured and even laughed at my poor, drug-afflicted jokes. Special shout out to Dr Adam and Nurse Charlotte for being exceptionally onto it and putting in the effort to show they care.

Vascular Clinic, Christchurch Hospital

I came in a day early for my appointment. The receptionist organised the staff to come out especially to see me so I didn't have to come back the next day. The service cannot be beaten.

Frances, Aleisha and Robyn, Ward 20, Christchurch Hospital

Thank you very much for the professional help and caring attitude of Frances, the Breast Care Nurse on Ward 20. She helped me to get better and found out the reason for the blockage of my drains following a mastectomy. Thank you Frances, Aleisha and Robyn from Ward 20, you girls are amazing. Grateful forever.

Day Surgery Unit, Christchurch Women's Hospital

The staff were all so nice and made me feel really comfortable. I'm so thankful to them and they did a wonderful job. Thank you all for the attention to my daughter. It made her very first operation a very positive experience.

Day Surgery Unit (DSU), Christchurch Women's Hospital

I have been in the DSU twice over the last year and all the staff have been great and very friendly. I couldn't speak more highly of the service and care I got from the whole DSU team.

Oncology Infusion Area, Christchurch Hospital

A very big thank you to David Gibb and all the staff for the fantastic support and care you have given [*patient name*] and myself [*carer's name*]. With our love.

Emergency Department, Ward 20, and Theatre

I had awesome care by everyone in the Emergency Department – Nurse Jane, the doctors, reception, and triage staff. Also the X-ray staff, plastics registrars, Drs Raz and Simon, and theatre nurses Lorraine, Megan and Lizzie. On Ward 20, Registered Nurses Jess, Sophia, Penny, Kelly and Eden and Dr Rebecca. In Plastic Surgery Outpatients, Dr Raz and Nurse Ashleigh. In Orthopaedic Outpatients, all the support from my wonderful colleagues. A huge thank you to everyone.

Ward 10, Christchurch Hospital

Some things just never change. Once again I am surrounded by angels of mercy, going above and beyond the call of duty. Absolutely fantastic. Thank you all.

Ward 18, Christchurch Hospital

Kelsi, Megan and Nadia specifically are the best people/nurses I have ever had the pleasure of helping me. Most of the nurses were fantastic but these ladies are by miles the most fantastic people on your team. I will never forget these ladies and what they have done for me. They are true assets – much appreciation.

Christchurch Hospital

We are very happy with the service, excellent, thank you.

Emergency Department (ED), Christchurch Hospital

Thank you Dr Simon (ED doctor) and your team for taking care of me today. Your compassion and kindness are much appreciated.

Ward 23, Christchurch Hospital

The service is excellent, especially from Beth. The staff are great and very obliging. I can't see anything that I would change.

Lloma, Ward 20, Christchurch Hospital

I would like to thank Nurse Lloma very much for her incredible caring and professional help. She was always there every time I needed help, assistance or support. With huge gratitude.

Medical Day Unit, Christchurch Hospital

Alison and the surgeon were very good.

Ward 20, Christchurch Hospital

Super stars. The receptionist in the afternoon was amazing. Nurses absolutely fantastic, supportive, and amazing. Thank you all for your support and help with Dad.

Dietitians, Level 3, Christchurch Hospital

Excellent people to give advice, very helpful.

Christchurch Hospital

Even though it was so very busy, all the team were friendly and polite. Bless you all.

Emergency Department, Christchurch Hospital

Dr James and the nurse were amazingly kind and so thorough. Thank you all very much.

Haematology Department, Christchurch

Fantastic building, great staff. Good for wellbeing here. Well done.

Big Shout Out

Dwayne, Security, Christchurch Hospital

I work in Manawa and pass the new Outpatients building on my way to see patients three to four times per day. I am constantly impressed by Dwayne, the security guard, I've seen him help patients in and out of cars and use umbrellas to protect them from the rain. He always says hello and is such a credit to Canterbury DHB.

#carestartshere

The Library

Browse some of the interesting health-related articles doing the rounds.

"Mechanism helps explain the ear's exquisite sensitivity" – Researchers are learning more about how the ear works in the hope of improving the treatment of hearing impairments. They've been focusing on a miniscule gelatinous structure called the tectorial membrane that is found in the inner ear and how it works, in the hopes of helping people with hearing impairments. From *ScienceDaily*, published online: 16 January 2019.

"A gut punch fights cancer and infection" – The microbiota is the community of microorganisms found in the gut and includes bacteria, fungi and archaea. Researchers are studying 11 strains of bacteria that they have found can boost the immune responses that fight infection and cancer. Their research aims to eventually develop defined bacterial strains for use in microbiota-based therapies, rather than faecal transplantation which can be effective but also risky. From *Nature*, published online: 23 January 2019.

"Hoarding revisited: there is light at the end of the living room" – This article explores the arguments for and against including hoarding disorder as a standalone diagnosis in the American Diagnostic and Statistical manual of Mental Disorders. It also looks at the criteria of hoarding disorder, the difference between hoarding and collecting and the potential treatment options for patients with hoarding disorder. From *BJPsych Advances*, published online: 17 December 2019.

If you want to submit content to **The Library** email communications@cdhb.health.nz.
To learn more about the real-life library for Canterbury DHB:

- **Visit**: www.otago.ac.nz/christchurch/library
- **Phone**: +64 3 364 0500
- **Email**: librarycml.uoc@otago.ac.nz.

Facilities Fast Facts

Acute Services Building

Around this time in January 2015 the detailed design phase of planning had begun for the Acute Services building.

This involved meetings with user groups to resolve issues that emerged in the design phase. Users finalised the layout plans and room data sheets with the design team and worked through what equipment and furniture would be needed for the new building with the Fixtures, Fittings and Equipment (FF&E) team.

User groups also began the work needed to identify which new processes would have a workforce planning implication.

Three years on, the Acute Services building is on the home stretch and all that hard work is evident in the finished wards and spaces.

User groups in the Design Lab in a mock-up of the multi-linear ward

A bed in place in the multi-linear ward on Level 3

Then and now

A lot can change in three years. These photos of the Christchurch Campus were taken from the Anthony Harper lawn three years apart.

A view from Hagley Park of Christchurch Women's and Riverside in January 2015

The same view of the Christchurch Campus showing the new Acute Services building taken at the end of 2018

Link Bridge

Work continues on the steel beams creating the Link between Christchurch Women's Hospital and the Acute Services building.

More steel arrives this week for the remaining sections of the link. The next stage will be the installation of the ComFlor that will enable the concrete pours to create the corridor floors to take place. These are scheduled for the end of February.

The three levels of the Link can be clearly seen in this photo taken from Christchurch Women's Hospital

28 January 2019

Tips for keeping your cool as the heatwave hits

As temperatures around Canterbury and the rest of New Zealand climb into the 30s, it's important to look after yourself and others.

Older people, children and those with underlying medical conditions are most at risk from the impacts of heat stress, however, anyone can be affected by heat stress if they don't take some precautions.

It's especially important to stay out of the sun, avoid extreme physical exertion and ensure that babies, children, and elderly people (and pets) are not left alone in stationary cars, says Canterbury Medical Officer of Health Alistair Humphrey.

Extreme heat can affect blood pressure and hydration and people should seek help if they feel dizzy, weak or have intense thirst or a headache.

"Good hydration is key, try to consume at least two litres of water a day and avoid drinking alcohol in the hot weather as it speeds up dehydration," he says.

As well as being SunSmart (Slip, Slop, Slap and Wrap) when you are outdoors, keep your home cool by opening windows to get a breeze, close curtains to keep the sun out and consider using the cool cycle on heat pumps.

Visit the Ministry of Health's website for more advice on keeping cool this summer.

Keep this advice in mind as summer warms up

New café open for business

Gourmet sandwiches, fresh salads, quality Allpress Espresso coffee and a relaxing atmosphere.

That's a selection of what people can expect when they visit the Health Precinct's latest café, Kānuka, which opened its doors to the public today.

Located on the ground floor of the new Christchurch Outpatients building looking out to Oxford Terrace, Kānuka provides staff, patients and passers-by with a light, bright and open space in a 'High Street' setting to enjoy top-notch coffee and a bite to eat.

Retail Manager, Nick Abernethy, says he's looking forward to people sampling what's on offer at Kānuka.

"We'll be preparing our selection of fresh food on site daily, with the variety on offer sure to have wide appeal.

"Kānuka will cater for a large cross-section of dietary requirements, with a range of gluten-free, dairy-free and vegan options available. From classic scones, speciality donuts from locals Grizzly Baked Goods, freshly prepared salads and soups, right through to nutritious breakfast bowls – there's something for everyone at Kānuka," Nick says.

Customers can look forward to top quality espresso coffee with all of the café's passionate baristas having completed professional training with Allpress, to ensure the coffee appeals to even the harshest critic. Complementing the coffee will be T2 tea, and if you know T2 then you know that it's not your average tea experience!

Nick explains that this is not the only thing that makes Kānuka special, however, with the launch of the café's new ordering app.

"We're really excited about our new app which has also launched today, meaning Kānuka's customers will be able to order their favourite beverage at the touch of a button."

The app is available free from app stores – simply search 'Kānuka' and download.

Kānuka's summer hours of operation will be Monday to Friday 7am–4pm.

See you there!

Your favourite photos from the Christmas and New Year break

Thanks to everyone who sent in photos to be in the chance to win a voucher to the Night Noodle Markets. Here's a snapshot of what some of your colleagues got up to over the break. To see the winning photos, check out page 3 of this issue.

Beach fun, from Elizabeth Connor

Moenui Bay Marlborough, from Dana Campbell

Christmas Day in the Children's Haematology and Oncology Centre (CHOC), from Lucy Swift

Ward 20 Multidisciplinary Team feeling the Christmas Spirit, from Lisa Rooney

Boris the French Bulldog, from Chloe Brown

Corsair Bay, from Keri Page-Kreis

Dorothy Van Dugteren's 92 year old Mum putting the first decoration on the Christmas Tree

Exploring the great outdoors, from Gemma Mackey

Abel Tasman, from Samantha Chapman

Surf Nationals in Naki, from Roxanne McKerras

Seal in Kaikoura, from Carolyn Gunn

Otago researcher suggests cautious path forward for changing cannabis laws

Amid the ongoing debate on legislation for recreational use of cannabis, a University of Otago researcher proposes a cautious path forward for changing cannabis laws in New Zealand.

Associate Professor Joseph Boden from the Department of Psychological Medicine at the University of Otago, Christchurch, has a research interest in the use of cannabis.

Associate Professor Joseph Boden

He has specifically investigated the use of cannabis among participants in the Christchurch Health and Development Study which follows the lives of 1265 children born in Christchurch in 1977. By age 35, almost 80 per cent of the participants had reported using cannabis.

In an editorial in the latest issue of the *New Zealand Medical Journal*, Joseph says most of the debate on changes to cannabis law imply it is a relatively harmless drug and that cannabis law change will only have beneficial consequences.

However, both he and co-author of the editorial, the late Emeritus Professor David Fergusson, former director of the Christchurch Health and Development Study disagree.

"We would argue that, on the basis of evidence generated by longitudinal studies based in New Zealand, both assumptions are incorrect," their editorial states.

David died in October last year, but he and Joseph wrote the editorial prior to his death.

They propose development of laws and policies that both discourage the use of cannabis and avoid criminalising recreational users of the drug.

This would mean:

- Simple possession of cannabis by those over 18 would be decriminalised, as would supply of small amounts to adults, as recommended by the recent Mental Health Inquiry.
- Penalties for the supply of cannabis to those under 18 would be increased.
- Investments in mental health services for those with cannabis use disorder and cannabis-related conditions would be increased, again in line with the recent Mental Health Inquiry.

Joseph says their reasoning is based on their research which shows resoundingly that cannabis use by participants in the Christchurch study is associated with educational delay, welfare dependence, increased risks of psychotic symptoms, major depression, increased risks of motor vehicle accidents, tobacco use and other illicit drug use, and respiratory impairment.

At the same time, evidence from the study suggests the prohibition of cannabis is also a cause of some harm, with males and Māori participants having higher rates of arrest and conviction for cannabis-related offences. Furthermore, the analysis showed that cannabis use did not decrease following this, suggesting prohibition generally failed to reduce cannabis use among participants.

"Given this context, the most prudent course of action for New Zealand to follow is to develop policies which eliminate the adverse effects of prohibition while at the same time avoiding the possible adverse consequences of full legislation," their editorial states.

Give the Bike Challenge a go this February

The countdown is on with only four days to go until the start of the month-long Aotearoa Bike Challenge, encouraging people across the country to get on their bikes throughout February.

The aim of the challenge is to get as many people as possible cycling, even if it's just for a short ride, so they can experience first-hand how easy and enjoyable riding a bike can be.

Each year nearly 1500 organisations across New Zealand take part, battling it out for supreme cycling status.

The competition, run jointly by the New Zealand Transport Association and Love to Ride, is based on the number of staff within an organisation taking part. The number of trips taken and kilometres ridden earn bonus points and there are spot prizes up for grabs such as cycling gear, travel guides, film tickets, and even a family pass for unlimited rides on the Christchurch tram and gondola.

Canterbury DHB staff are all encouraged to give the Bike Challenge a go. It's a great way of supporting your wellbeing. So far, 408 Canterbury DHB staff have registered.

Christchurch is becoming increasingly cycle friendly with its network of cycle-ways (there's one near you find it here). The flat terrain makes cycling a convenient and reliable form of transport for short distances, without the need to don any lycra.

It is also a way to play your part in delaying the impact of climate change by swapping your car for a bike, even if it's just one day per week. The health benefits of active commuting include better cardiac health, lower obesity rates, better mental health and better productivity in the workplace.

Recent research has found that those who cycle or walk to work are 76 per cent more likely to meet physical activity guidelines of 30 minutes per day.

So join the team, hop on your bike and give it a go! You can register at www.lovetoride.net/nz

Let the Healthy Commute team help you get on your bike

Remember for those working at Christchurch Campus, the Canterbury DHB's Healthy Commute Programme is also supporting staff to make the change to biking (as well as bussing, walking and carpooling). Look out for the Healthy Commute team who are moving around Christchurch Campus during February, talking to different teams about how they get to and from work, and working with staff who are interested in trying a new approach to develop a solution tailored just for them.

For more information on participating in the Healthy Commute programme, visit the Max Service Portal and enter the search word 'commute'. For information on biking to work, cycle maps and tips, visit ccc.govt.nz/transport/cycling/cycle-to-work/

Bake stall benefits adults with intellectual disability

Activity items that encourage sensory development will be purchased as a result of a successful Christmas bake stall held by the Pharmacy Department at Christchurch Hospital.

For the second year running, Pharmacy held a stall to raise funds for a good cause. This year the recipient was Psychiatric Services for Adults with Intellectual Disabilities (PSAID) at Hillmorton Hospital.

Pharmacy staff raised an impressive $2010. Congratulations to Jane Duckmanton, Ward 22, for winning the raffle (a Christmas cake).

The money will be used by PSAID to purchase equipment for their external courtyard to encourage sensory development among this patient group.

Pharmacy wishes to thank everyone who supported the bake stall.

From left, Pharmacists Eva Crossan, Clara Ahn and Hemi Mckechnie

Centre, Pharmacy Assistant Kay Rowe

'Three in a row' activity item being purchased to aid sensory development

Tic Tac Toe activity

One minute with... Karen Watson, Food Service Manager, WellFood

What does your job involve?

Managing a busy production kitchen that supplies hot, chilled and ready-to-eat products to all Canterbury DHB hospitals and retail cafes. We are the only DHB in New Zealand that has a cook/chill facility allowing us to send bulk bagged food. We supply 400 to 600 hot meals daily for Meals on Wheels, have two daily tray-line services at Hillmorton Hospital and also send salads and sandwiches to our hospital cafés.

What do you like about it?

I had worked in food services as a young person and found myself back here nine years ago after an accident prevented me from working in the family business. Being among services like Meals on Wheels where we make a difference to people in keeping them healthy in their own homes is very rewarding and humbling. There is never one day the same as another.

What are the challenging bits?

Effectively managing multiple services across Canterbury DHB.

Who inspires you?

My Dad, with his mannerisms, beliefs and the way he lived his life.

What do Canterbury DHB's values (Care and respect for others, Integrity in all we do and Responsibility for outcomes) mean to you in your role?

My role as manager for the Hillmorton WellFood team is to ensure we deliver exceptional service and quality food to our consumers every time.

Something you won't find on my LinkedIn profile is...

I'm hooked on Black Knight liquorice!

If I could be anywhere in the world right now it would be...

On holiday somewhere hot.

What do you do on a typical Sunday?

Spend time with family.

One food I really like is...

Vegetarian curries.

My favourite music is...

Huge Rodriguez fan.

If you would like to take part in this column or would like to nominate someone please contact Naomi.Gilling@cdhb.health.nz

New Year update from Max

Max
People and Capability

Kia ora and a very happy new year from me, your HR service portal, Max.

I'm not sure about you, but my 2019 has been off to a flying start. So flying, that I am already launching three new services for you.

That's right, THREE.

You'll find them where they always are, under Request a Service in the top right-hand menu bar on your Max homepage.

1. **Request Max training**: Refresh your knowledge of the Max portal [and stay across the updates] with a quick session from one of our experts. Find this as a new service, and fill out the digital form and our experts can pop into your team meeting, or even for a one-on-one session.
2. **Turn off paper payslips**: Help Canterbury and West Coast DHBs go Paperlite by turning off your paper payslip. You can view digital copies of all your payslips on Max, under Request a Service in the menu on the top right of your Max homepage.
3. **Increase or decrease hours**: Finally, managers can do both these actions in one form. If someone is reducing hours, and they're being allocated to another staff member this process can be completed all in one place. A new approval step also provides a clearer overview of total staffing across the organisation.

There are also a number of updates to existing services, so you may notice some of your requests are even easier to file than before.

Tau ke! Awesome!

I can't wait to see you using these new services, and the dozens more I will be releasing throughout the year.

Nga mihi nui,
Max

3D Printing in Medicine Summer Course 2019

For health professionals, bioengineering or health-research students, and allied health industry innovators.

- 3D printing basics
- Additive manufacturing of medical devices
- Biofabrication and bioprinting
- Challenges facing clinical and commercial translation
- Discussion of clinical case studies

Learn from international and national experts, clinicians and MedTech professionals leading 3D printing research as well as clinical- and commercial-translation:

- **Visiting Chaffer Fellow, Professor Jason A. Burdick,** University of Pennsylvania
- **Professor Peter F. M. Choong,** University of Melbourne
- **Professor Gary Hooper,** University of Otago
- **Mr Paul Morrison,** Ossis Ltd
- **Professor Tim Woodfield,** University of Otago

Plus more confirming soon

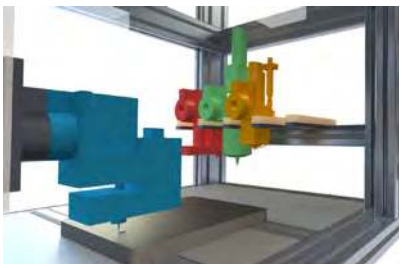
www.otago.ac.nz/3dprintmedicine

11-14 February 2019

University of Otago, Christchurch
2 Riccarton Avenue,
Christchurch,
New Zealand.

Retaining our special inaugural registration fee structure:

$600 gst incl. standard registration
$400 gst incl. student registration
Morning/afternoon teas and lunches provided



Presented by:

TE PAPA HAUORA Health Precinct | Health Research Society of Canterbury | Canterbury Medical Research Foundation

FREE PUBLIC EVENT
FREE PARKING

we're talking health...

An evening of talks from leading Canterbury researchers who are saving lives and improving healthcare.

Topics include: 3D-printing bone, how a lack of sleep is affecting our children, plus the genetics of cancer.
10 topics, 10 researchers, one great evening.

Wed 6th March, 6.30pm – 8.30pm
Engineering Core, Creyke Road, University of Canterbury

Book your seat now
www.talkinghealth.co.nz

The programme is supported by the Health Precinct's partners

Canterbury District Health Board Te Poari Hauora ō Waitaha | University of Otago | UC University of Canterbury | Ara | Matapopore

Smokefree Bulletin – January 2019
Issue Two

Learnable phrase:

NRT can double your chances of successfully quitting

NRT (Nicotine Replacement Therapy) – charges

If the patient/client has a quitcard or prescription for NRT patches, gum and lozenges the pharmacies do charge a $5 co-payment for each product.

Some pharmacies such as Bargain chemists may not charge the co-payment or charge a lesser co-payment fee.

If the patient/client presents to a pharmacy without a script/ quitcard then the pharmacy is able to give them the NRT but it may cost the co-payment plus a consultation fee and this varies with each pharmacy

The hospital retail pharmacy is NOT free – they charge the same as above.

Of course the best course of action is to refer to TeHā Waitaha/ Stop Smoking Canterbury and they will get **FREE NRT** plus the support needed to make a quit attempt.

Any nurse that has completed the MoH elearning course (as below) and register as a Quitcard provider can administer NRT (under "Nurse Administration of NRT" policy) for their patient and complete a quitcard.

Learnonline.health.nz

(MoH elearning course)

- Help people to Stop Smoking
- Effective Stop Smoking Conversations with Pregnant Women

Print a Certificate of Achievement.
Register as a Quitcard Provider (not compulsory).

Healthlearn

(CDHB intranet)

- Prescribing NRT
- Smokefree training for mental health and addiction workforce
- Smokefree – introduction for clinical staff

Champix / Varenicline

There has been a change in name but it is still the same stop smoking medication.
Champix (branding) is no longer the name we use, from now on the pharmaceutical name Varenicline (Pfizer is now the branding) will be used.

Old	New
Varenicline (Champix branding)	Varenicline (Pfizer branding)
12 monthly subsidised	12 monthly subsidised
2 week starter pack	4 week starter pack

What to advise patients?

-advise clients Varenicline Pfizer replaces Champix for the subsidy, but same drug
-advise clients the Starter pack is now 4 weeks, not 2 weeks.

Smokefree Team - Community & Public Health (CDHB)
DDI: 03 3640 263|ext: 80263| Mobile: 021 723 208
Email sue.stevenson@cdhb.health.nz or lorraine.young@cdhb.health.nz

Procedure for Booking and Requesting Interpreters

Contents

Purpose

The use of interpreters is crucial to ensure people with limited or no spoken English or with hearing impairment or deaf can access services, receive an appropriate standard of care, and enhance their understanding of treatment and follow up instructions.

The decision on whether to call a professional interpreter is the responsibility of the health professional involved in the care of the patient.

Family, friends and untrained staff members may only be used in circumstances which;

- Are acute;
- Involve information that is not clinical, technical or confidential;
- Do not breach any other Canterbury or West Coast DHB Policy or Procedure.
- and used only until an approved interpreter can be located.

Interpreters are free to patients who are eligible for publicly funded healthcare at the CDHB. If a client is a non-New Zealand resident, and requires interpreting services, this will be incorporated in any hospital charges incurred.

This procedure describes the process for the limited or non-English speakers or hearing impaired or deaf to access interpreters in a timely manner, enabling full patient participation while in care.

Scope/Audience

Canterbury and West Coast DHB services, both in and outpatient and patients receiving services in the community.

- All Christchurch based hospitals use approved interpreters provided from the interpreter service based at the Christchurch Hospital Campus.
- Asburton Hospital, Rural Hospitals and West Coast DHB use the national NZ interpreters service

Associated documents

- Code of Health & Disability Services Consumers' Right Regulation 1996 Right 5
- New Zealand Sign Language Act 2006 No 18 (as at 30 June 2008), Public Act. "…declaring New Zealand Sign Language to be an official language of New Zealand."
- Tikanga policy – Legal and Quality

Definitions

Interpreting: Processing oral language so that the meaning, tone and register of the original language is preserved, without adding or deleting anything from one language to another.

Interpreter: A person who translates orally (or by sign language) from one language into another. All approved face to face interpreters have a signed contract outlining CDHB responsibilities and confidentiality agreement.

Patient: A person currently or previously having received care. This includes a person's representative, such as a parent or guardian of a person under 16 or someone with activated enduring Powers of Attorney (EPOA) for Care and Welfare.

Health professional: Includes doctors, nurses, midwives and allied health staff.

1 Assessment of interpreter need and language

All clinical staff will ensure that an approved interpreter is used when a consumer has limited (or no) use of the English language or has a hearing impairment or deaf.

1.1 The need for an interpreter is assessed at following contact points

- **Referral:** by referring agency or general practitioner recommendation, or
- **Earliest contact:** For example, if during the course of a telephone conversation, the staff member is alerted to a possible language barrier, the staff member should make an assessment of a possible need for an interpreter by:

1.2 Assessment:

- Ask an open question that requires the patient to answer in a sentence.
- Avoid closed questions, that can be answered 'yes' or 'no' or a very familiar question such as, "Where do you live?"
- Ask if a relative in the house has English language skills, ask to speak with them to provide initial details, and confirm language/dialect required (e.g. Mandarin or Cantonese).

Use of an interpreter is indicated if, in responding to these questions, the patient

- does not construct a sentence in English
- has a hearing impairment **and** uses New Zealand Sign Language
- If you have any doubts about a patient's ability to communicate in and comprehend English, or if the patient requests it, an interpreter should be used.

If unable to establish language need, refer back to GP Practice for confirmation or for Christchurch based hospitals, contact the Interpreter Service (Ext 80669) to check if patient has previously required an interpreter.

Note: If the patient does not speak English and cannot inform you what language he or she speaks, Communication Cards are available to assist in face to face interactions.

1.3 Interpreter is declined

If the patient declines to use an interpreter and the health professional has assessed the patient as requiring an interpreter, it is a clinical decision to continue treatment with or without an interpreter.This decision must be discussed with the clinical leader or a senior medical officer and clearly documented in the clinical record by the attending clinician.

Once treatment has been agreed to (in the absence of an interpreter) the Communication Cards and signs should to be used to communicate. Use of these pictorial explanations is documented in the clinical record.

Note It is not appropriate to use staff who may speak the language unless in an emergency situation, as this creates a power imbalance. It is also not appropriate to use family members where what is being interpreted can not be quantified or confirmed. For some cultures, family may not want to interpret what the patient needs to "hear".

1.3 Interpreter request

Christchurch Hospitals

Following agreement that an interpreter is indicated, send the interpreter request to InterpreterBookings@cdhb.health.nz .or telephone **Ext: 80669.** Document this in the patient's record.

CDHB Ashburton and Rural Hospitals and West Coast DHB Hospitals

There is no interpreter service based at CDHB Ashburton, Rural Hospitals or West Coast DHB.

To access Health interpretation Service staff are required to phone **Interpreting New Zealand**, a 24 hour/7 day telephone interpreting service.

The toll free contact number is: **0508 468 377**.
Inform operator of:

- The language required
- Brief outline of purpose of call
- Location, name and designation

2. Booking Process

As soon as you become aware that an interpreter may be required please follow process outlined below for both emergency or urgent appointments.For planned appointments, please request interpreter 4 to 6 weeks in advance and no later than 72 hours of the patient's appointment date.

2.1 Christchurch Hospitals

During business hours (Mon –Fri 0800 -1630hrs), contact the Interpreter Service directly on **Ext: 80669** or after hours, weekends and public holidays contact the Duty Manager/Shift or Service Coordinators outlined in the App 1.

Interpreter Service requires the following information on the electronic 'Interpreter booking form' via email on InterpreterBookings@cdhb.health.nz , before an Interpreter can be arranged for a face to face approved interpreter:

- Patient's full name & NHI number
- Date and time of appointment

- Language required (if not known, then indicate country of origin)
- Location of the appointment
- Duration – only if the appointment will be longer than an hour
- Your Cost Code/Department for Interpreter payment purposes

2.1.1 Interpreter time sheets – Face to Face only

Once the Interpreter has been arranged by Interpreter Services, an Interpreter's time Sheet ("Pink Form") is completed and will be forwarded to the ward/department making the request.

2.1.2 Telephone Interpreter Service

The NZ interpreter telephone service is used by Christchurch based hospitals as per 2.2. ONLY in exceptional circumstances when it has been confirmed that no approved interpreter is available.

2.2 CDHB Ashburton and Rural Hospitals and West Coast DHB Hospitals

Use **Interpreting New Zealand**, a 24 hour/7 day telephone interpreting service

Toll free phone number is: **0508 468 377**.

Inform operator of brief outline inclusive of

- The language required
- Reason for appointment
- Expected duration of booking
- Location
- Staff name and designation
- Consumers date of birth

3 Following appointment

3.1 Completing Interpreters appointment

When the appointment has concluded the Interpreter and the attending staff member must ensure that the Interpreter's time sheet is signed confirming the start and finish time of the appointment and returned to the staff with responsibility for facilitating Interpreter Services

Completed forms are then forwarded once confirmed as correct by the staff with responsibility for facilitating Interpreter Services to the accounts department for issuing of payment for interpreter services.

3.2 Subsequent appointments

If the staff member, patient and interpreter agree on a further booking for the patient that suits all parties then the staff are responsible for recommencing process as per booking interpreters service 2.

Document this action in the patient clinic record to prevent double booking.

3.3 Maintenance of the Interpreters Contact List

Maintenance of the Interpreters contact list is managed by the Interpreter Services Coordinator at the Christchurch Campus. This list has personal staff details and remains confidential and is NOT to be copied or distributed.

A current list will be held by the Interpreter Services staff and after hours staff.

4. Interpreter Evaluation

In accordance with national Standards of Practice for health care interpreters and the Canterbury District Health Board 'Interpreter Code of Ethics, as a basis for performance evaluation and on-going quality assessment, individual interpreters and treating health professionals will be surveyed at least annually.

Evaluation aims to demonstrate how professional interpreters respond to ethical and other considerations in the performance of their duties, and demonstrate 'best practice' for all consumers.

Appendix

Interpreter Service facilitation

Christchurch based Hospitals

An interpreter service based at Christchurch Campus facilitates interpreters for all Christchurch based Hospitals and dedicated staff are appointed for facilitating the service out of hours as displayed in table below.

Hospitals located in Christchurch			
	Business Hours (Mon –Fri 0800-1630hrs)	After hours	
Hospital	**Phone**	**Phone/Cell Phone**	**Pager**
ChCh Public, Outpatients, Psych Emergency Services Burwood, Dental Services,	80669 or (03) 364 0669	89000 (ChCh Duty Nurse Manager)	8304 (ChCh Duty Nurse Manager)
The Princess Margaret Hospital (PMH)	80669 or (03) 364 0669	66852 or 027 538 6237 (Clinical Team Coordinator)	
Specialist Mental Health Services (SMHS)	80669 or (03) 364 0669	027 541 4484 (Duty Nurse Manager)	4814 (Duty Nurse Manager)
Christchurch Women's Hospital	80669 or (03) 364 0669	85715 (Clinical	

(CWH)		Coordinator Birthing Suite)	

If follow up contact arising from acute emergency presentations and community is required, then email InterpreterBookings@cdhb.health.nz.or leave message at **Ext: 80669** for this to be actioned during normal business hours.

Ashburton and West Coast DHB

There is no interpreter service based at CDHB Ashburton, Rural Hospitals or West Coast DHB.

To access Health interpretation Service staff are required to phone Interpreting **New Zealand**, a 24 hour/7 day telephone interpreting service

The toll free contact number is: **0508 468 377**.
Inform operator of:

- The language required
- Brief outline of purpose of call
- Location, name and designation

Appendix 13 Exerts from Canterbury DHB Contract Document

B2 Treaty of Waitangi and Māori Health Statement

B2.1 The Treaty of Waitangi establishes the unique and special relationship between iwi, Māori and the Crown. As a Crown entity the District Health Board considers the Treaty of Waitangi principles of partnership, proactive protection of Māori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the internal organisation of the District Health Board responds to Māori Health issues.

MĀORI HEALTH

B4 Māori Health Priority

Both of us will abide by the Māori Health statement set out in clause B2 of these Standard Conditions.

B4.1 You agree that Māori Health is a specifically identified health gain priority area. You must therefore establish and implement a Māori Health policy that reflects that fact. In developing this policy, and without limitation, you must take into account our strategic direction for Māori health in terms of minimum requirements for Māori health based on the Treaty of Waitangi, Crown objectives for Māori health and specific requirements negotiated from time to time with us.

B4.2 You must specify how you intend to implement this policy. In particular, you will identify those services you will deliver as explicit contributions to Māori health gain priorities, how these services will be measured to ascertain what benefit is evident and other additional opportunities that may exist for furthering Māori health gain.

B4.3 On commencement of the Agreement, you must develop your Māori health policy and operational plans after consultation with us, subject to agreement between both of us to our respective responsibilities for ensuring that the plans are adequately resourced within the current levels of funding.

C9 Services Meet Needs of Māori

C9.1 Your services will meet the diverse needs of Māori, and apply any strategy for Māori Health issued by the Minister.

C10 Māori Participation

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

This will include:

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

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

i. removal of barriers to accessing your services;

ii. facilitation of the involvement of whanau and others;

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

iv. availability of Māori staff to reflect the consumer population

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

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

d) Support and development of a Māori workforce

C11 Quality Plan

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

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

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

ii. Māori as a Government Health Gain priority area,

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

iv. Māori specific quality specifications,

v. Māori specific monitoring requirements,

vi. Māori service specific requirements.

C19 Support for Māori

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

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

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

C24 Consumer/Family/Whanau and Referrer Input

C24.1 You will regularly offer consumers/families/whanau and referrers the opportunity to provide feedback as a means of improving the outcomes for consumers. When you obtain feedback from consumers by means of written surveys, you will comply with the Ministry of Health Guidelines for Consumer Surveys. Consumer input will be reflected in the maintenance and improvement of quality of service, both for the individual consumer and across the service as a whole. You will actively seek feedback from Māori by appropriate methods to improve

organisation responsiveness to Māori. When requested you will make available to us the results of such surveys.

C26 Complaints Procedure

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

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

b) all parties have the right to be heard,

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

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

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

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

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

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

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

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

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

C28 Ethical Review

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

Hospital Fall Prevention Procedure

Purpose

This procedure describes the standardised, patient centred approach to hospital fall prevention and management across all CDHB hospitals.

Scope

All staff/ personnel and self-employed Lead Maternity Carers.

Definitions

Patient fall: Any unintentional change in position where the person ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others.

Prerequisites

Education and training: All staff involved in patient contact, including self-employed health professionals, must complete the appropriate education and training: fall prevention; and safe handling.

Clinical Governance: All teams have clinical governance processes which include education and training, patient safety, harm reduction and sytems improvement.

1. Assessment and Care Planning

1.1 **Assess** all newly presenting and transferring patients, or those who experience a change in condition, for risk of falling as soon as possible (max 6 hours).

1.2 **Plan** and **identify** individualised falls prevention interventions **with** the patient and family/whānau, as per *Care planning for fall risk factors staff resource.* **Record** in the care plan.

1.3 **Apply** the relevant CDHB visual cues and **keep up to date**:

- Mobility bracelets
- Mobility equipment tags
- Bedside boards – safe mobility plan components
- Fall risk magnet/symbol for Ward Information boards/floView
- Post Fall magnet/symbol for Ward Information boards/floView.

1.4 **Pay** particular **attention** to those patients with a past history of falling, incontinence, communication or cognitive difficulties and be **proactive** anticipating these patients' needs.

1.5 **Work with** the patient to implement the prevention interventions throughout their care.

1.6 Regularly **discuss** with the patient and family/whanau their fall risk and **remind** them of the interventions in place.

1.7 **Provide** the appropriate educational and written material to the patient and their family/whanau.

1.8 **Review** and **record** falls risk factors and prevention interventions each shift in the care plan.

1.9 **Prior to mobilising, fit** appropriate footwear to assist with safe mobilising, as per 'Hospital guidelines for the use of appropriate footwear to promote safe mobility and functional recovery',

1.9.1 Patients without appropriate footwear must have a request made to family/whānau/carer as soon as possible for this to be brought in.

1.10 Include any falls history and key risks in each shift hand over.

2. Transfer between DHB facilities

2.1 **Add** the patient's 'falls risk factors/behaviours' and associated falls prevention care in any transfer records including e-Handovers.

2.2 **Check** the relevant CDHB visual cues are being used.

2.3 **On arrival complete** the Bedside board and Safe Mobility Plan.

3. After a Fall, as per Post Fall Clinical Pathway

3.1 Assess for injuries and safety before moving patient

3.2 Complete a full set of observations to inform the EWS, include neurological observations if there is any suggestion of hitting their head

3.3 Talk to the patient to get their perspective.

3.4 Support patient and manage injuries

3.5 Notify doctor/CTC or Duty Manager within 15 minutes of a fall to determine appropriate timeframe (dependent on injury severity) for medical review.

3.6 Notify family/whanau

3.7 Review incident – why did this person fall now? Mitigate the reasons (e.g. clothing, slippery floor).

3.8 Review previous falls history and the person's current fall risks and behaviours, identify ways to mitigate their risk and ensure the appropriate care is put in place.

3.9 **Instigate** the multi-disciplinary post fall review by placing the post fall alert on the Ward Information Board/floView.

3.10 **Complete all of** the Post Fall Clinical Pathway and file in the continuous clinical record.

3.11 Use the information collected to complete an incident report in Safety1st.

3.12 Complete ACC documentation ACC Forms (ACC 45 & ACC 2152) if there is a significant injury.

3.13 All Post Fall Pathways are to be reviewed by the Clinical Nurse Manager for adequacy and remedial education provided to ensure the review is comprehensively completed.

4. Discharge

4.1 **Include** a record of any falls while in hospital in the patient's discharge notice.

4.2 **Communicate** any ongoing fall risk factors identified as continuing post discharge to the patient's GP and community providers.

4.3 **Make appropriate referrals** for community-based falls prevention in accordance with current Discharge and Follow-up guidelines in the Fall Assessment section in Hospital HealthPathways as necessary.

5. Monitoring

5.1 All patient falls risk status and safe mobility plan is to be reviewed for currency as part of bed side handover.

5.2 Falls strategies used in an area are to be reviewed for effectiveness every 10 months, with a report being provided to the Divisional Committee.

5.3 All clinical area managers monitor and ensure new staff and students complete pre-requisite education: fall prevention; and safe handling.

5.4 All clinical area managers are to monitor adherence to fall prevention care monthly (maximum). Any area with less than 85% achievement in meeting the standards of care must monitor adherence weekly, plan and action improvements so that acceptable results are achieved as soon as possible.

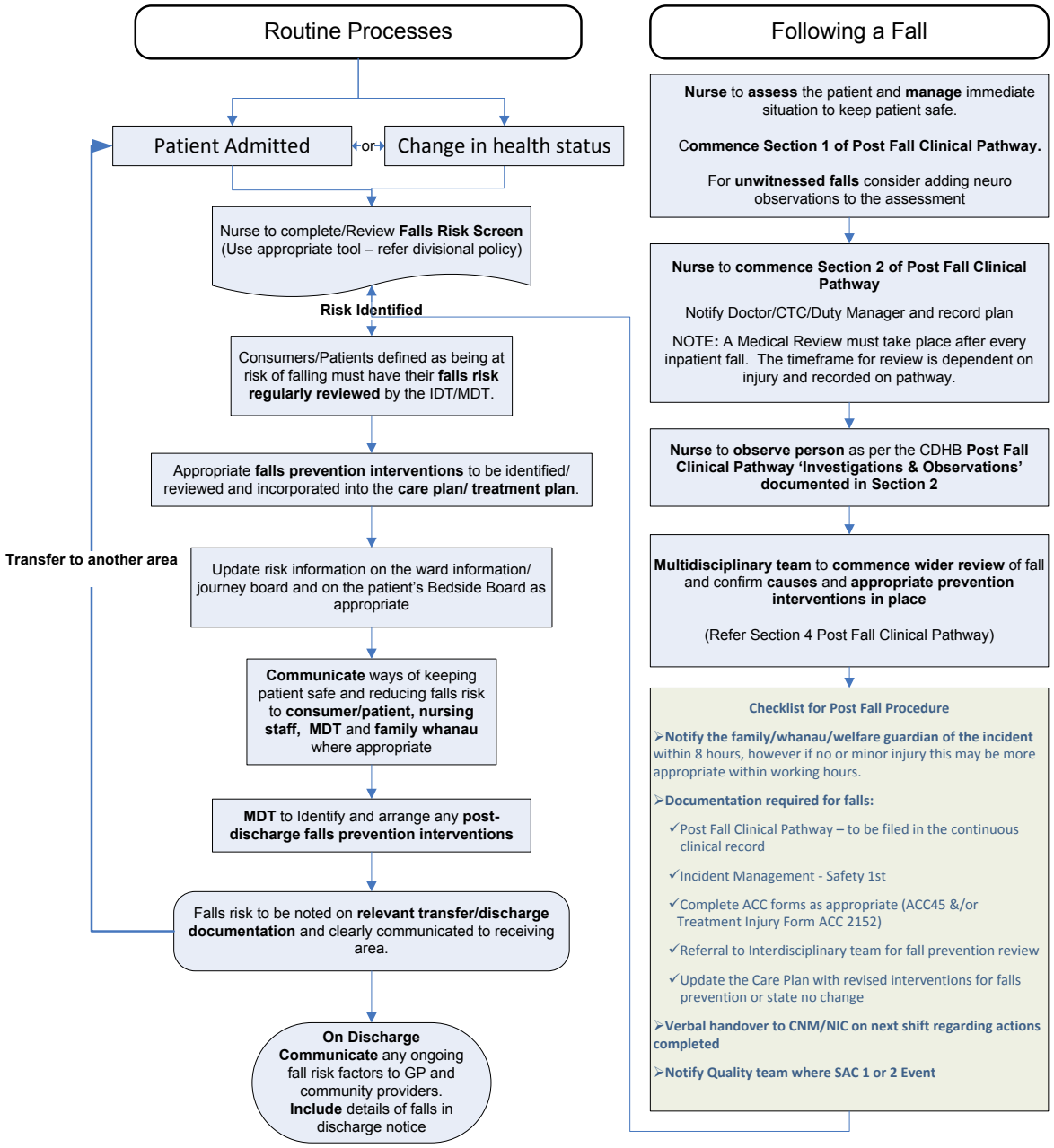
5.5 All teams clinical governance activities include regular review of falls data, prevention care and shared learnings at area and service level meetings.

5.6 Divisional Fall Prevention Committees or appropriate divisional delegated group are responsible for:

- monitoring local fall prevention audit data and adequacy of improvement plans
- providing direction for local population specific improvement initiatives
- implementing and monitoring hospital-wide initiatives
- providing regular updates to the Steering Group using the standard template.

5.7 The Hospital Fall Prevention Steering Group is responsible for providing the direction and oversight for the Hospital Fall Prevention Programme which includes hospital-wide improvement initiatives.

Canterbury DHB Hospital Inpatient Falls Prevention & Management Flowchart



Definition of a fall:
Any unintentional change in position where the person ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others.*

* The definition for a fall is taken from the operational definition used in the InterRAI Assessment Tools. This definition is also referenced by the Health Quality & Safety Commission in Topic 5: After a fall: What should happen?

Version 7~ 18/10/18

Measurement/Evaluation

Outcome Measures: The key outcome measures for hospital falls (Total Falls, Falls resulting in injury and SAC 1 & 2 Falls) are monitored by the Hospital Fall Prevention Programme Steering Group and by divisional fall prevention committees or equivalent and management teams on an ongoing basis.

All SAC 1 & 2 fall events are included in the monthly SAC 1 & 2 report to the Quality and Finance Audit Review Committee.

Balancing Measure*:* Australasian Rehabilitation Outcomes Centre (AROC) Functional Independence Measure (FIM): average FIM on discharge in Older Persons Health wards (excluded AG & BG).

Process Measures*:* The monthly CDHB hospital-wide Falls Compliance audit tool is used to measure adherence to the Hospital Fall Prevention procedure.

The frequency and ongoing monitoring for the following audits is the responsibility of the Divisional Fall Prevention Committees or equivalent.

- Bedside Board in-depth audit tool – used to monitor the Fall Prevention Visual Cues.
- Post Fall Care Audit tool - used to monitor the quality of the content in the Post Fall Care Clinical Pathway. Compliance data on the use of the Post Fall Clinical Pathway is available from the electronic incident management system - Safety 1st.
- Staff education of falls prevention.

HQSC Quality & Safety Markers*:* The HQSC set of quality and safety markers include a set of fall process and outcome measures that are reported on a quarterly basis. The data for the process markers comes from the monthly Falls Compliance audit.

Supporting documents

Falls Guidelines/ Pathways	Post Fall Clinical Pathway C240341 Hospital Health Pathways Refer to Falls Prevention & Assessment under Older Persons Health on https://canterbury.hospitalhealthpathways.org.nz/index.htm Health Pathways Refer to Falls Prevention & Assessment under Older Persons Health on http://cdhb.healthpathways.org.nz/ User Guide: Canterbury DHB Hospitals Visual Cues for Safe Mobility Hospital Guidelines for Use of Appropriate Footwear to Promote Safe Mobility and Functional Recovery
Procedures	Lippincott procedures (on line) Bedside Board procedure

Falls Resources	Care Planning for fall risk factors (staff resource) Bedside Patient Boards Informational video Hospital Falls Prevention Programme Fall Prevention Staff E-learning package (refer healthLearn) Medications and Falls – Managing the Risks (ref 2606)
CDHB Policy	Incident Management (under Workday Essentials on the Intranet) Clinical Governance Policy Safe and Appropriate use of bedrails Restraint Minimisation and Safe Practice
Patient Falls Prevention Information	Safe Mobility; Reducing Your Risk of Falls While in Hospital (ref 236866) Preventing Falls by Managing Medications (ref 2605) Healthinfo Refer to Falls under Older Persons Health Quality & Safety Commission Reducing Harm From Falls

References

Health Quality & Safety Commission Reducing Harm from Falls website

New Zealand Health & Disability Services Standards

National Institute for Health and Care Excellence (NICE) Clinical Guideline CG161 Falls in older people: assessing risk and prevention (2013, reviewed 2016).

Clinical Governance Policy

Contents

Purpose

This policy establishes responsibilities, definitions and frameworks for clinical governance across our health system.

Policy

Leadership for health excellence and improvement occurs in every aspect of our health system by all of our people. Balancing autonomy and control by leadership at a local level, supporting strategic alignment and innovation yet achieving consistency in how we do things is essential to achieving our system's vision and goals, including patient safety.

Our vision is an integrated health system that keeps people well and healthy in their own homes. One that provides exceptional quality, providing the right care and support, by the right person, at the right time, in the right place, with the right patient experience. With this in mind we have set a patient safety vision of 'aiming for zero harm'.

Central to our effort are consumer and staff participation in data driven improvement activity that is supported by our broad distributed leadership across the system.

Process for improvement activity is focussed on strategic goals, patient-centred care and outcomes. Innovation and continuous improvement of work processes and outcomes must be supported by developing our people. Assurance of quality of service, processes and professional standards are foundational to sustaining any improvement.

Health Excellence, our continuous improvement framework, is predicated on validated effective clinical and management practices. These processes are fundamental to achieving our vision and strategic goals, and are underpinned by effective, connected, clinical governance processes within every team of the system.

Health Excellence criteria are applied by every team, service, profession and level in the health system. They support us to focus on best practice in how we do things around here, shaping our positive culture.

Service clusters bring together teams and professions' assurance and improvement activity. They support improvement of the patient journey and integrate organisation wide clinical governance committee requirements into their plans. Each professions' clinical governance activity links into every teams' multi professional clinical governance.

Within organisations across the system, team clinical governance is connected through their usual organisational arrangements. At system level, organisation clinical governance comes together through the District's Clinical Board.

Scope

All staff and teams within CDHB.

Definitions

Clinical Governance

The system through which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care *and outcomes* (Australian Council on Healthcare Standards 2004, *CDHB adaption* 2015).

Health Excellence

Health Excellence is a strategic framework made up of seven categories that are applied for best practice and to continuously improve the quality of services.

Each category has criteria that are outcome or results focused. The criteria encourage us to ensure our organisational systems are evidence based and applied consistently to ensure patient safety and reduce variation, waits and waste.

It is up to CDHB to use best practice and evidence to determine how to best meet that criteria.

Process for Improvement

The Process for Improvement is the CDHB process for continuous improvement. It incorporates both the Improvement Associates Model for Improvement, adopted by the Institute of Health Care and the New Zealand Health Quality and Safety Commission, and the principles of lean six sigma improvement. Activity is directed at achieving the organisational vision and contributing to the strategic goals.

Roles and responsibilities

Our Workforce

- Demonstrate care and respect and work to support patients and families to have the right experience.
- Appreciate their role and priorities, and work collaboratively with their team and across services in the best interests of patients and the system.
- Participate in local planning and evaluation, building a common vision, a shared sense of purpose and agreed action plans.
- Participate in clinical governance activities of the team, service and profession.
- Endeavour to deliver the right care or service in the right place at the right time to the right standard.
- Support and develop colleagues to do the ‘right thing’, using best evidence, regular feedback and sound learning frameworks.
- Take self-responsibility, and continue to learn, develop and improve practice.

- Participate actively in monitoring and evaluating the quality of care and outcomes, completing improvement activity, and sharing learnings.

First Line Managers

For the purposes of this policy first line managers have department, ward or unit teams reporting to them. In addition to Our Workforce responsibilities they:

- provide leadership and give meaning to improvement, integrating the service plans to achieve organisational goals
- enable team-based planning, design, monitoring of service performance and outcomes. This includes evaluating processes that contribute to achieving the system's strategic goals, integrating best evidence, clinical governance committees', professions' and service goals in local plans, engaging consumers and key stakeholders in the process
- support the team's clinical governance, implementing and monitoring policy effectiveness, actively evaluating the quality of care and outcomes, driving audit and improvement activity, tracking completion and sharing learnings. This includes supporting both interdisciplinary and individual profession's improvement activities and involving consumers
- work across the system to support the connected patient journey assurance and improvement work, standardising to reduce variation, waste and waits while retaining patient centred care
- provide a supportive environment, processes and systems to enable and develop our people to meet their responsibilities. This includes feedback processes at individual, team and service level with relevant measures, data sources, and aims/benchmarks
- have active learning and development programmes with appropriate record keeping, relevant credentialing and performance appraisal processes.

Professional, Clinical and Service Leaders

In addition to all the responsibilities above, these leaders agree the allocation of responsibilities for multi-professional clinical governance at service or cluster level. They:

- give meaning and provide direction to improvement, integrating, translating and shaping the service direction to achieve organisational goals
- bring together service teams, creating and communicating the connections and links, actively planning and evaluating

processes, quality of care and outcomes, tracking progress and completion as well as sharing learnings, setting improvement priorities, and quickly adjusting for success

- link with clinical governance activities across teams, services and sites enabling connected patient journeys
- enable teams and services to engage consumers in design, planning and evaluation of improvements
- support cluster level development of systems and relevant procedure, sharing learnings
- monitor clinical governance processes and outcomes to ensure teams are meeting their terms of reference and prepared and enabled for success.

General Managers

- Communicate the strategic direction and goals, give meaning and translate how this applies to the services, ensuring standards are met.
- Bring together cluster teams, creating and communicating the connections and links, enabling planning, improvement, and evaluation of processes, quality of care and outcomes.
- Enable sharing of learnings, setting of improvement priorities, tracking progress, and quickly adjusting for success.
- Ensure clinical governance and health and safety committees are fully functioning and achieving their terms of reference.

Quality and Patient Safety Managers and Teams

- Provide quality, patient safety, and clinical risk management leadership and direction.
- Ensure the ongoing prioritisation, development, implementation, monitoring and evaluation of quality and patient safety systems and frameworks that are dynamic and evolving, focused on achieving “zero harm”, are aligned with national programmes and provide evidence that Canterbury DHB’s meets legislative requirements and best practice standards.
- Actively promote a “whole of system’ approach across services for quality and patient safety initiatives.

Clinical Board

The Clinical Board has overall responsibility for clinical governance in health care services provided or funded by the Canterbury District Health Board (CDHB).

The Clinical Board:

- promotes the primary aim of CDHB to improve the health of the community
- oversees and reports on quality improvement systems in all areas of CDHB responsibility
- oversees and reports on clinical performance in all areas of CDHB responsibility
- oversees and reports on the work of specialist clinical advisory committees such as Alcohol, Child and Youth, Infection Control, Medicines
- identifies, investigates and advises on issues where inter-departmental or inter-organisational initiatives are needed to improve patient or population outcomes
- contributes to CDHB strategic planning and resource allocation decisions
- encourages and supports research, best practice and innovation
- encourages and supports professional development, support and training for the health workforce.

Planning and Funding

Planning and Funding works alongside clinical leaders and alliance partners to plan our strategic direction and determine how we allocate the resources across the health system, to make sure we get the right services in the right place to achieve the best possible outcomes for our population. We support our people to live well and healthy in their own homes and communities, supporting both business-as-usual and transformational change activity to:

- engage with clinical leaders throughout the system to design health services that meet our population's needs
- prioritise resources with our clinical leaders through alliance processes
- support clinical leaders to drive change through the use of data
- develop and implement our strategic objectives with a whole of system approach
- support the patient journey through integration of services across the health system

- evaluate system performance and identify opportunities for system improvement.

People and Capability

The People and Capability function exists to support, enable and empower the people of our health system to achieve its vision and strategic goals. Ultimately, it impacts patient care by supporting the development of an increasingly enabled and enabling environment where the patient is at the very centre of everything we do.

The function does this in a number of ways, supporting both business-as-usual and transformational change activity to achieve:

- wellbeing and resilience of our people
- safety of our people
- effective leadership and support of clinical and operational leadership throughout the system
- understanding of whole-of-system common purpose and clarity of direction and alignment in all parts of the system
- development and alignment of priorities, people and process across the system.

To achieve these outcomes, the People and Capability function focuses on:

- organisational Development: Building and embedding people and process capability, including a specific focus on leadership development
- wellbeing Health and Safety: Taking care of our people and supporting personal and organisational resilience
- people and Capability Operations: Partnering with, and supporting, leaders, managers and our people on the frontline
- People and Capability Services: Delivering all the essential people services and tools effectively and efficiently.

Executive Management Team

The Executive Management Team (EMT) is responsible for the overall performance of our health system and for providing leadership and having accountability for results within the Health Excellence framework. EMT members lead and report on work programmes that contribute to the seven Health Excellence categories.

Measurement and evaluation

- Quality Improvement: Learning and Sharing register
- Health Excellence survey results two yearly
- Staff engagement survey results two yearly
- Health and Disability Services Standards achievement
- Organisational key performance indicators (this includes patient, customer and stakeholder experience)

Policy Owner	Clinical Board Chair
Policy Authoriser	Executive Director of Nursing and Chief Medical Officer
Date of Authorisation	27 November 2015

Electricity Dependency In The Home

Contents

Policy

The Canterbury DHB will follow the recommendations of the Electricity Authority's "Guideline on arrangements to assist medically dependent consumers" (MDC Guideline) in relation to those patients who are identified at point of discharge as being medically dependent on electricity.

Scope/Audience

All Canterbury DHB personnel responsible for issuing electricity dependent equipment to patients.

Definitions

Medically Dependent Consumer

A domestic consumer who is dependent on mains electricity for critical medical support, such that loss of electricity may result in loss of life or serious harm. For the avoidance of doubt, medical dependence on electricity could be for use of medical or other electrical equipment needed to support the treatment regime (e.g. a microwave to heat fluids for renal dialysis or equipment listed in Appendix 2 of the MDC status guideline)

Critical Medical Support

Support which, in the opinion of a health practitioner with an appropriate scope of practice, is required to prevent loss of life or serious harm. This is usually provided by critical electrical medical equipment (CEME).

Critical Electrical Medical Equipment (CEME)

Any equipment supplied or prescribed by a health practitioner with an appropriate scope of practice, which requires mains electricity to provide critical medical support to a person, and includes other electrical equipment needed to support the treatment regime (e.g. a microwave to heat fluids for renal dialysis).

A non-exhaustive list of critical electrical medical equipment may include:

- Bi-level Positive Airway Pressure (BiPAP) machine
- Nasal Continuous Positive Airways pressure machine
- Non-invasive Ventilation (NIV) machine
- Oxygen concentrator
- Automated Peritoneal Dialysis (APD) device
- Renal haemodialysis machine
- Total Parenteral Nutrition delivery system
- Ventilator
- Ventricular Assistance Device.

Roles and responsibilities

For all patients identified at point of discharge as being medically dependent on electricity in the home:

1. It is the **Canterbury DHB's responsibility** to:
   - Ensure that the patient is well enough with sufficient support to be able to communicate with their electricity retailer.
   - Provide the patient/guardian/caregiver with a "Notice of Potential Medically Dependent Consumer Status" form signifying that the patient is potentially medically dependent and that the disconnection of electricity at some future point in time may result in loss of life or serious harm.
   - Ensure that the patient understands and has signed the consent portion of the form.
   - Ensure that the patient understands the importance of completing the Notice of Potential MDC Status and giving the Notice to their electricity retailer.
   - Provide instruction on the proper use of the equipment.
   - Provide information on what action to take in the event of planned or unplanned electricity outages including advice that telephones requiring electricity will not function.
   - Provide the name and contact details of a point of contact within Canterbury DHB.

– Ensure that a copy of the completed Part B section of the Notice of Potential Medically Dependent Consumer Status" form is filed in the patient's clinical record.

2. It is the **patient/guardian/caregiver's responsibility** to:
   – Give the completed Notice of Potential MDC Status form to their electricity retailer.
   – Notify any change in their MDC status to their electricity retailer.

3. It is the **Electricity Retailer's responsibility** to:
   – To record sufficient information about their consumer's MDC status to ensure that they are not disconnected for reasons of non-payment

Associated documents

Notice of Potential Medically Dependent Consumer (MDC) Status C130039

References

Guideline on arrangements to assist Medically Dependent Consumers Version 2.1 Electricity Authority, 1 November 2010.

Policy Owner	Medical Director Patient Safety
Policy Authoriser	CMO & EDON
Date of Authorisation	March 2012

Privacy policy

Contents

The latest version of this document is available on the CDHB intranet/website only.
Printed copies may not reflect the most recent updates.

Policy

All staff and others to whom this policy applies will comply with Canterbury DHB's legal and ethical obligations concerning patient privacy and confidentiality.

Purpose

The purpose of this policy is to ensure the protection of individual privacy within the Canterbury DHB and to ensure that the Canterbury DHB meets its obligations pursuant to the Privacy Act 1993 and the Health Information Privacy Code 1994.

Scope/Audience

This policy applies to:

- All staff employed by Canterbury DHB.
- All visiting health professionals and students undertaking training or education within the organisation.
- All Canterbury DHB volunteers.
- All independent practitioners contracted to provide patient care.
- All contractors with Canterbury DHB, i.e. cleaners, security guards, etc.

Associated documents

- Health Information Privacy Code 1994.
- Health Act 1956.
- Privacy Act 1993.
- Official Information Act 1982.
- Code of Health & Disability Services Consumers' Rights.
- Canterbury DHB Manual, Volume 2 - Legal and Quality
- -Release of Patient Information Policy.
- Canterbury DHB Manual, Volume 11 - Clinical

- Informed Consent Policy
- Canterbury DHB Manual, Volume 3 - Human Resources
  - Employee Health Information Policy.

1 Introduction

The accumulation of details about a person's health, disabilities or treatment constitutes information of the greatest sensitivity.

During the course of carrying out their day to day activities all staff and others who come on to a hospital site will come into contact with confidential information. All such individuals have ethical, legal and contractual obligations to uphold and observe patient confidentiality.

All staff and others to whom this policy applies should familiarise themselves with the Health Information Privacy Code 1994. A full copy of this Code is available from the Patient Information Office, any Privacy Officer or Corporate Legal.

The Health Information Privacy Code is a Code of practice issued by the Privacy Commissioner pursuant to the Privacy Act 1993. The Code is specific to the health industry and regulates how we deal with the health information concerning our patients.

1.1 Privacy Officers

The CanterburyDHB has a Corporate Privacy Officer who is also the Senior Corporate Solicitor.

The roles and responsibilities include:

- Protect and promote individual privacy by encouraging compliance with the Code.
- Deal with requests for information.
- Work with the Privacy Commissioner on any investigations; and;
- Otherwise ensure compliance with the Act and The Code.

Other Privacy Officers in the Canterbury DHB are:

- Corporate Solicitor
- Patient Information Team Leader, Christchurch Hospital
- Customer Services Manager, Christchurch Hospital
- Medical Records Officer - Mental Health Services
- Customer Services Co-ordinator, Older Persons Health TPMH, Specialist Mental Health Services and Community Dental Services

2 Health Information Privacy Code 1994 ("The Code")

2.1 General Policy

The Health Information Privacy Code applies to everyone working in the health sector who handles health information. The Code sets out 12 rules which provide a framework for the management of personal health information. The rules are interlinked, so that policies concerning collection of information can affect what happens when it is disclosed. Some rules set out a principle, then provide exceptions to it.

The Code co-exists with ethical obligations. It does not override them, and ethical obligations do not override the Code. Health professionals must comply with the Code and with their professional code of ethics.

2.2 Information Covered by the Code

The Code covers health information about an identifiable individual (even if they are deceased), including information about:

- a person's health or disabilities;
- a person's medical history;
- any health or disability services provided to someone;
- patients, which is collected while providing health and disability services to them. This might include collecting addresses or information relevant to a subsidy entitlement.

2.3 Meaning of "Representative"

The term "representative" is frequently used in the Code.

It means:

- When a person is dead – the executor or administrator of their estate. (The person dealing with a deceased's assets in accordance with their Will.)
- Where a person is under 16 – a parent or guardian.
- Where neither the above apply but the person is unable to give consent or exercise his or her rights – someone who seems to be lawfully acting on the person's behalf or in his or her interests.

3 Rule 1 – Necessity and Purpose

The Canterbury DHB must not collect health information unless that information is collected for a lawful purpose connected with a

function or activity of the Canterbury DHB and the collection is necessary for that purpose.

Consequently, the Canterbury DHB must not collect superfluous information to that required to treat a patient. Information such as a patient's income, sexual orientation, marital status etc should not be collected unless it is necessary in order to provide care and treatment to that patient.

4 Rule 2 – Information Should Be Collected From the Patients Themselves

Generally, information about patients should be collected from those patients. However, Rule 2 lists a number of exceptions to this general principle, such as:

- Where the patient has authorised collection from someone else.
- Where collecting information from patients would prejudice their interests, prejudice the purpose of collection, or prejudice the safety of any person.
- Where collecting the information from the patient is not reasonably practicable.

An example of when Rule 2 may apply is when family members accompany a patient. Often family members will be anxious to advise a health professional of the nature of an injury or the symptoms of an illness but they may not have an accurate understanding of the nature of the injury or illness. Health professionals should always try to obtain information (in the first instance) from the individual concerned and should verify with the patient if possible, information collected from another source.

5 Rule 3 – Steps to be Covered When Collecting Information

Where information is collected directly from patients, the Canterbury DHB must take reasonable steps to ensure they are made aware of a number of matters, including:

- That information is being collected - this is not always obvious, e.g. if video or audio recording is used.
- The purpose of collection, i.e. if personal non health information is required for completing ACC forms etc, the Canterbury DHB must explain why that information is being collected.
- The intended recipients of the information - there is no need to list every possibility but a general indication should be given.

- The consequences of not supplying the information - i.e. a particular treatment may not be able to be given or a subsidy applied for.
- The patient's rights of access to their information and right to request a correction given by Rules 6 and 7 of the Code (refer pages 38 and 48).

Exceptions to fulfilling Rule 3 requirements include:

- The patient has authorised the Canterbury DHB not to do so.
- Compliance by the Canterbury DHB would prejudice the interests of the patient or prejudice the purposes of collection, e.g. interaction charts in Child Protection Cases.
- Compliance is not reasonably practicable in the particular circumstances, i.e. it would delay emergency treatments.

If it is not practicable to give an explanation when the information is collected, it should be done as soon as practicable afterwards.

6 Rule 4 - Manner of Collection

Health information may not be collected by unlawful, unfair or unnecessary intrusive means.

For example, a receptionist may ask patients a number of questions for their records upon arrival at a clinic. Consideration should be given as to whether the patient can fill in a form or verify existing written information rather than verbally give personal details in a waiting area where other patients can overhear.

While it is acknowledged that given the space limitations within hospitals it may not always be possible to ensure physical privacy, consideration should be given as to the steps that can be taken to maximise privacy.

7 Rule 5 - Security Safeguards

Rule 5 of the Code requires the Canterbury DHB to take reasonable security safeguards against:

- loss of patient information.
- access, use, modification or disclosure of patient information, without Canterbury DHB's authority.
- other misuse.

Refer page 9 for best practice guidelines.

An example of how this Rule may apply is in reception areas where sometimes mail is kept (in readiness for collection) on public counters where it can be read by others. In compliance with this Rule, it should be removed from public view. Likewise, a trolley full of medical records should not be left unattended where the public has access.

8 Rule 6 - Right of Access to Personal Information

(Refer also to Canterbury DHB's Release of Information Policy)

People have a right to access information about themselves. This right is given by rule 6 of the Code .

The Right to access is important both from a privacy perspective and from a treatment perspective. Several of the rights in the Code of Health and Disability Services Consumers' Rights are concerned with the communication of information and with Informed Consent. So, when considering a patient's request for personal health information, the Canterbury DHB should consider whether a refusal would hinder the patient's ability to give informed consent to a procedure.

The request to view or have a copy of personal information may be verbal or written. Proof of identification is required for all requests.

Requests for copies of patients' records should be directed to the Patient Information Office at Christchurch Hospital or the appropriate Privacy Officer.

The Canterbury DHB must not charge for making information available in response to a request from the Patient to whom the information relates.

Information may only be withheld if the withholding falls within one of the exceptions in the Code. Some of the common exceptions include:

- Release of the information would be likely to prejudice the maintenance of the law.
- Release of the information would be likely to endanger the safety of an individual.
- Release would involve the unwarranted disclosure of the affairs of another individual or a deceased individual.
- Release would be likely to prejudice the physical or mental health of the requestor.

For an overview of the steps to be taken in providing access to patient notes refer to Canterbury DHB's Release of Information Policy.

9 Rule 7 – Requests for Corrections

People have the right to ask for their health information to be corrected.

If the Canterbury DHB is not willing to make a correction, it must, if requested, take reasonable steps to attach a statement of the correction sought, but not made. The statement must be attached so that it will always be read with the disputed information.

When a patient disagrees with a diagnosis and wants it removed from the file, careful consideration must be given before altering the original record. Removing the disputed diagnosis could render the notes incomplete. If it is acknowledged that a diagnosis is wrong this should be recorded alongside the original entry.

The Canterbury DHB is required to provide reasonable assistance to any individual wishing to record a statement of correction.

10 Rule 8 – Accuracy

Before using information, the Canterbury DHB must take reasonable steps to ensure information is:

- correct
- up to date
- complete
- relevant
- not misleading.

This can be particularly important where information has been obtained from a source other than the person concerned.

11 Rule 9 – Keeping Health Information

The CDHB policy for disposal of clinical records requires information to be retained for 10 years following death of the patient.

12 Rule 10 – Using Information

Information obtained in connection with one purpose must not be used for any other purpose unless the use falls within one of the exceptions of Rule 10.

Rule 10 does allow uses which are "directly related" to the purpose for obtaining the information. For instance, information obtained for care and treatment may also be used for administrative purposes related to that care and treatment.

Some of the exceptions to Rule 10 include using information for another purpose if it is necessary to prevent or lessen a serious threat to public health or public safety or health of an individual.

13 Rule 11 – Disclosure of Information

This Rule is dealt with in its entirety in the Canterbury DHB Release of Information Policy. Please refer to that policy when dealing with disclosure of information.

14 Rule 12 – Unique Identifiers

This Rule states that the Canterbury DHB must not assign a unique identifier to an individual unless the assignment of that identifier is necessary to enable the Canterbury DHB to carry out one or more of its functions efficiently. Further, the Canterbury DHB must not assign to an individual a unique identifier that, to the Canterbury DHB's knowledge, has been assigned to that individual by another entity.

A unique identifier is defined as an Identifier:

Measurement/Evaluation

How this policy will be measured on how it is used, e.g. an audit.

- That is assigned to an individual by an agency for the purposes of the operations of the agency; and
- That uniquely identifies that individual.

15 Rule 12 expressly excludes the NHI number which can be used.

The reasoning behind this Rule is the concept that individuals should not be “labelled” or identified as belonging to a particular group such as "bad payers” for example.

16 Privacy – Recommended Best Practice

16.1 Office/Reception/Areas

- Clinical records should not be kept in places easily accessible by the public and unrelated staff.
- Patients should not be asked to verify personal details in reception/waiting areas where they can be overheard by others.
- Outgoing mail awaiting collection should not be left where it can be seen.
- All computers should be placed so that PC screens cannot be read except by staff entitled to the information. Screen savers should be used.
- Any correspondence, old labels or other documentation containing patient information authorised to be discarded must go in the blue security bins to be shredded.
- Care must be taken that operation lists, clinic lists or any other administrative forms containing patient information are not left in any place accessible to the public.
- Operation or clinic lists should not be left in consultation rooms where they can be seen by other patients.
- Offices and filing cabinets should be locked when unattended.
- Names and details of patients should not be discussed in lifts or other public places.

17 Clinical Records

- All clinical records being transported by hospital staff or through the mail system within hospitals must be suitably covered and secured.
- If clinical records are being carried through a public area, they should be carried in an envelope, if possible, or at least, with the patient’s name unable to be viewed.
- Trolleys containing clinical records should not be left in areas accessible to the public or other patients.
- Except where necessary, records should not be left at the patient's bedside unless the patient has consented.

- Only those staff members involved in the care and treatment of a patient may have access to that person's clinical records.
- Clinical records should not be transported off-site unless off-site storage is required or is absolutely necessary. If so, they should not be left uncovered in a vehicle which must remain locked at all times.

17.1 Identity of Patients

- Wherever possible, patients should be asked on admission to the ward areas if their name can be displayed on room doors, above beds and on name boards.
- Ideally name boards in wards/units should not be able to be viewed by any members of the public.
- Name boards should only show patient name, room allocation and who is responsible for their care.
- Patients can request that no details be released in relation to their condition.
- Unless specific consent is given, only the general condition of a patient, (e.g. satisfactory) can be released.
- If at all possible, patients should not be asked to verify personal details in waiting rooms/ward areas where they can be overheard.
- When requesting information from a patient, all care should be taken to ensure that this is achieved in a manner that respects the individual's privacy.
- Patient's consent must be obtained if a photograph is to be taken of them and such consent must be in writing if the photograph is to be used for educational or research purposes. (Please refer to the Canterbury DHB Informed Consent Policy.)

17.2 Facsimiles and emails

Sending faxes or emails that contain information about patients should be avoided unless necessary, or a dedicated fax line is used.

When a fax or email is necessary, staff should:

- Check the number / Address of the recipient.
- Check the number / Address before sending.
- Where practicable, telephone prior to sending so the recipient is aware it is being sent.
- Fax machines should be placed in rooms that can be secured after hours.

- Fax machines should be placed in areas where the public are unable to access information coming through.
- All faxes/emails sent should have a disclaimer attached, which contains one of the following:

"Caution: The information contained in this facsimile is confidential. If the reader is not the intended recipient, you are hereby notified that any use, dissemination, distribution or reproduction of this message is prohibited. If you have received this message in error, please notify us immediately."

"This email and attachments have been scanned for content and viruses and is believed to be clean. This email or attachments may contain confidential or legally privileged information intended for the sole use of the addressee(s). Any use, redistribution, disclosure, or reproduction of this message, except as intended, is prohibited. If you receive this email in error, please notify the sender and remove all copies of the message, including any attachments. Any views or opinions expressed in this email (unless otherwise stated) may not represent those of Canterbury District Health Board.

17.3 Answer Phones

- Leaving messages about or for patients on their answer phones should be avoided.
- When urgent contact is to be made the only message that is acceptable is to leave the telephone number and name for the person to phone back.
- Under no circumstances should the name of the organisation, the clinical area, or reference for any health care treatment be made.

17.4 General

- Patient details should be checked with the individual concerned to confirm accuracy and that the details are up to date before use.
- Information obtained from third parties should be verified with the patient before use.
- Patients should not be stopped in lifts, corridors or public places and their care discussed.
- Wherever practicable an explanation should be given before information is collected as to its intended use and to whom it may be disclosed.

- Information disseminated to patients and members of the public such as the Patient Information Booklet should specify to whom information may be released and why.

Policy Owner	Corporate Privacy Officer
Policy Authoriser	Executive Management Team
Date of Authorisation	27 November 2013

1 Code of Conduct & Disciplinary Policy

1.1 Code of Conduct

Introduction

Knowing what responsibilities we have to our fellow employees to conduct ourselves according to certain rules of good behaviour, conduct and performance is an essential part of working at Canterbury DHB.

Scope

All employees.

Associated Documents

Disciplinary Action Policy

Health Practitioners Competency Assurance Policy

Policy

Employees have an obligation to:

1. Be present at work as required and to be absent from the workplace only with proper authorisation.
2. Maintain expected standards of performance. Employees should carry out their duties in an efficient and competent manner, and avoid behaviour which might impair their work performance.
3. Display loyalty to the Canterbury DHB and use their best endeavours to assist the organisation to meet its objectives.
4. Respect the rights of their colleagues and the public. In performing their duties, employees are expected to:
   - avoid behaviour which might endanger or cause distress to other employees, or otherwise contribute to disruption of the workplace.

- Refrain from allowing workplace relationships to adversely affect the performance of official duties.
- Respect the privacy of individuals when dealing with personal information.
- Not discriminate against, or harass clients, visitors or colleagues because of their sex, age, marital status, ethnicity, disability, religious or ethical beliefs, colour, race, political opinion, employment status or sexual orientation.
- Respect the cultural background of colleagues and clients in all dealings
- Have due regard for the safety of themselves and others in the use of Canterbury DHB property and resources.

5. Comply with all lawful and reasonable instructions and policies and to work as directed. Implicit in this is an obligation to obey the law.
6. Maintain proper standards of integrity and conduct in the performance of their duties and in their private lives, where it may reflect badly upon the Organisation.
7. Show reasonable care, and neither use, nor allow the use of departmental property, resources, or funds for anything other than authorised purposes.
8. Incur no liability on the part of the Organisation without proper authorisation.
9. Maintain all necessary qualifications (including registration and annual practising certificates) to enable the Employee to perform his/her duties legally.
10. Notify the CDHB immediately if their registration is revoked or in anyway amended; or if they cease to have a valid practising certificate; or if the scope of practice endorsed on their practising certificate, or any condition, is revoked or altered in anyway, as per the requirements of the HPCA Act 2003.
11. Not to demand, claim or accept any fee, gratuity, commission or benefit from any person or persons other than the CDHB in payment for any matter or thing concerned with the Employee's duties and responsibilities, except with the prior written consent of the Canterbury DHB.
12. Ensure that at any time during their employment or termination they do not knowingly or without due care disclose or allow access to confidential information, or information relating to any of the business affairs, software, property or other activities of the Employer and shall use his/her best endeavours to prevent the publication or disclosure of same.
13. Except with the prior written approval of the Canterbury DHB, engage in alternative employment with/or be a member of an organisation which may impinge on the proper performance of the

Employee's employment or be in conflict with the interests of the CDHB.

The Code of Conduct sets guidelines for all employees to ensure that:

1. The Organisation runs efficiently and effectively
2. Staff are treated fairly and equitably
3. Employees understand the expectations of the CDHB so that disciplinary action does not come as a surprise to staff.

1.1.1 Breaches of the Code of Conduct

Breaches of the Code of Conduct should be read in conjunction with the Discipline and Dismissal Procedures.

As a general rule, misconduct usually falls into one of the following categories:

- Absenteeism
- Dishonesty
- Wilful disobedience
- Misconduct
- Unsatisfactory Work Performance.

However for the purpose of this Policy, misconduct is divided into three areas:

Misconduct

These items of misconduct will usually lead to the disciplinary procedures being invoked.

Serious Misconduct

These items will usually lead to summary dismissal, that is, dismissal without further warning. In cases of serious misconduct, a dismissal will usually be given without notice, however in certain circumstances, notice could be given.

Conduct Detrimental to the Best Interests of the Organisation

These items will generally lead to disciplinary procedures being invoked including the possibility of summary dismissal.

Important Notes

Conduct generally construed as misconduct may be regarded as serious misconduct if these actions are such that they could lead to substantial risks to patients or major ramifications for the CDHB.

It should be noted that professional incompetence/misconduct will probably lead to disciplinary action under this code. All cases of professional incompetence/misconduct should be reported to the Professional Advisor and General Manager who should consider reporting it to the appropriate registration authority.

Where a health professional either resigns, or is dismissed, for reasons relating to competence, The CDHB has a statutory obligation to inform the appropriate registration authority.

1.1.2 Misconduct

Misconduct comprises of actions or omissions which, regarded in isolation, do not warrant severe disciplinary action, such as dismissal.

Where an employee is guilty of an offence classified as misconduct he/she will usually receive two clear warnings (usually but not necessarily an oral and written warning) before being dismissed. Normally the first warning will be oral and the second written. Should an employee offend again after a final written warning, he/she may be dismissed with notice or pay in lieu of notice.

The warning procedure may be applied to offences of a dissimilar nature and is not restricted to the repetition of a specific form of offence.

Instances of such behaviour may include, but are not confined to the following examples:

- Failing to comply with Canterbury DHB Policies or Procedures.
- Failing to maintain an acceptable level of work performance.
- Failing to provide due loyalty to the CDHB.
- Habitually arriving late for duty.
- Damage to Canterbury DHB property.

1.1.3 Serious Misconduct

Serious misconduct is behaviour which undermines the contractual relationship between the Employee and the Employer, and/or seriously threatens the wellbeing of the organisation, staff or patients.

Where an employee is guilty of an offence classified as serious misconduct, he/she may be dismissed without warning.

When it is suspected that an employee is guilty of serious misconduct, he/she may be suspended, usually for a period of up to seven days, pending a full investigation of the alleged offence(s). A suspension of this nature will normally be on full pay.

Whilst an employee is suspended, he/she must not come onto CDHB property or engage in any duty related to his/her position without authorisation.

Where practicable, an employee will be given the opportunity to be represented by an official of his/her employee organisation or other person of his/her choice at an interview preceding a formal warning or notice of dismissal.

Instances of such behaviour may include, but are not confined to the following examples:

- Refusing to carry out lawful instructions.
- Unauthorised consumption of alcohol on CDHB premises.
- Assault.
- Disclosing confidential information to an unauthorised person.
- Not being in possession of a required annual practising certificate and claiming reimbursement from the CDHB.
- Use or possession of illicit drugs.
- Working while under the influence of alcohol or drugs.

1.1.4 Private Conduct Detrimental to the Best Interest of the Organisation

As a general principle, personal behaviour is of no concern of the Canterbury DHB, except where it interferes with the performance of official duties or reflects on the standing or integrity of the Organisation or the Employee's profession or trade. Therefore employees should not bring the Canterbury DHB or profession into disrepute through their private activities.

Whether such actions fall into the category of Misconduct or Serious Misconduct will depend on the circumstances in each case. In making judgements of this kind, regard should be had to the following factors:

- The nature and circumstances of the activity.
- The position, duties and responsibilities of the Employee.
- The consequences of the activity on the Employee to fulfil her/his duties and responsibilities.

The effects of the activity or its consequences on working relationships with colleagues, patients, outside contacts and the general public.

Policy Owner	Group Manager, Human Resources
Date of Authorisation	~~27 November 2001~~ ~~28 April 2004~~ ~~6 September 2005~~ June 2012
Date of Review	June 2013

Tikanga

Contents

Acknowledgements

Canterbury DHB acknowledges the assistance and support of Auckland DHB and its Tikanga Policy, 2003

Policy

Canterbury DHB will use its best endeavours to ensure that the health and disability services it is responsible for delivering, and the staff who deliver them, as well as the community providers with whom it contracts, uphold the wairua (spiritual), hinengaro (psychological) and tinana (physical) wellbeing of tūroro (Māori consumers/ clients/ patients) and their whānau (family and extended family group).

Although this policy is focused on Māori, it is anticipated that treating consumers/ client/ patients of all cultures with dignity and respect will be:

- welcomed by them;
- meet the Health and Disability Consumer Code of Rights;
- improve health outcomes and
- improve the responsiveness of the health & disability sector.

Guiding Principles

Application of this policy is guided by the following principles:

1. Applying the Treaty of Waitangi and its principles of partnership, participation and protection, to the Canterbury DHB context:
   - Partnership – developing relationships between Canterbury DHB, iwi, Māori, whānau, community, Māori health and disability providers.
   - Participation – positive, proactive Māori involvement at all levels of the Canterbury DHB including participation in

governance, planning, funding, design and delivery of services.

- Protection – implementation of proactive strategies seeking to improve Māori health outcomes and the acceptability of health and disability services to Māori so that Māori have the opportunity to enjoy at least the same level of health as non-Māori

2. Acknowledging a person's rights and respecting their beliefs
3. Ensuring informed consent and respectful compliance with tikanga form the basis of all interactions between the tūroro, their whānau and the service/service provider, e.g. permission is always asked for and an explanation given prior to any intervention.

Tikanga and kawa are the lore and mores that form the cornerstone of life for Māori. They are not to be applied lightly, but rather with reverence, as they represent the essence of life for Māori. To translate them into a policy document is fraught because of the inherent difficulties in translation from one cultural medium to another. This policy, therefore, is a contribution from Māori, given in the hope that it will assist Māori and non-Māori workers and providers throughout the health and disability sector to respond appropriately to the needs of Māori tūroro and their whānau, and that it will also assist Māori achieve their aspirations for better health and wellbeing, i.e. **Whānau Ora**.

Associated documents

Related policies and documents include

Type	Document Title(s)
Legislation/Codes	Health & Disability Consumer Code of Rights
CDHB Policy Manual	Māori Health Policy Research and Māori (available on the Intranet or from the Manager, Māori Health.
Policy & Procedure Manuals	Body Parts Deceased Tūpāpaku –Care and Release of Research & Māori Complementary Medicines Policy Tissue Return Policy

Reference	*Hauora o te Tinana me ōna Tikanga*: a guide for the removal, retention, return and disposal of Māori body parts, organ donation and post-mortem: Māori and their whānau and service providers (1999). Te Puni Kōkiri *Body Parts, Tissue, & Substances Review Panel Report* (2002), Auckland DHB.

Policy details

The policy will be applied in the following manner:

1.1 Karakia (Blessings/incantation/prayer)

- During any interaction with a health and disability service, and particularly before or after surgical interventions, and in acute mental health services, **tūroro** and **whānau** will be offered **karakia**.

  Note that: **Whānau** members will determine whom they wish to say **karakia**, including themselves, their support person(s); Māori chaplain, **Kaumātua**, Māori staff, or other nominated staff person
- Blessed water and containers will be made available for the purpose of spiritual cleansing. Staff and providers will need to seek **Kaumātua** advice to ensure these are available
- **Karakia** must be available and made within an environment of safety for all concerned.

1.2 Whānau Support (family & extended family)

- **Tūroro** and **whānau** will be actively included in all aspects of care and decision making, including the development and implementation of care and discharge plans and multi-disciplinary team meetings. In all but exceptional circumstances, the care plan should be available to the **tūroro** and their **whānau**.
- Note: Health Information Privacy Code requires **tūroro** consent
- Staff will ask the **tūroro** and their **whānau** if they wish to nominate a person(s) to speak on behalf of the **tūroro** and/or the **whānau**, and will acknowledge and actively involve the nominated person(s)

By agreement with the **tūroro** and their **whānau**, staff will include the appropriate Māori staff in the care and decision making process.

- Privacy, sufficient time, and meetings with the appropriate staff, will be available for **whānau** consultation and decision making throughout the care process

- In hospital settings, wherever practicable, and taking reasonable account of health & safety and infection control considerations, the following should be available:
  - flexible visiting times and visitor numbers
  - meeting **whānau** requests to stay overnight with the **tūroro**
  - providing for close **whānau** proximity during surgical procedures
  - considerate support to **whānau** when death is expected or imminent, including the ability to bring food and share meals with the **tūroro**
  - **whānau** room available to grieving **whānau** members

1.3 Information & Support

- Staff will always introduce themselves and explain their role and service to the **tūroro** and **whānau**.
- When obtaining client details, staff will accept that the Māori concept of "next of kin" may be broadly interpreted.
- Information will be provided in appropriate formats [spoken, pictorial and written] to facilitate understanding and participation in care delivery. Where appropriate, staff will ensure that **tūroro** and their **whānau** are offered an interpreter.
- Staff will notify the appropriate Māori staff of the presence or referral of the **tūroro** and their **whānau** as soon as possible after the care/interaction commences.
- In all health and disability provider settings, including hospitals, staff will ensure that the **tūroro** and their **whānau** are aware of the Māori services available, including Māori staff; community Māori service providers and organisations; dedicated spaces to support **tūroro** and **whānau** wellbeing; **whānau** accommodation facilities and facilitate referrals if requested.
- Services will maintain a current list of contacts to assist **tūroro** and their **whānau** e.g. Māori chaplains, Māori providers, Māori community leaders.
- Staff will provide written and spoken information to the **tūroro** and their **whānau** of the Advocacy Service and the availability of a Māori advocate, and facilitate contact if requested.
- Staff will provide verbal and written information and support regarding complaints procedures.

1.4 Specific Needs

- Staff will ask **tūroro** and their **whānau** if they have any other special cultural, spiritual, or language needs that they can practicably assist with. These needs will be documented in the

relevant notes e.g. treatment/care plan, needs assessment, clinical file.

- Staff will respect and support the importance and use of **rongoā** (Māori traditional healing) during care and facilitate collaboration with **rongoā** practitioners.
- Staff will actively endeavour to pronounce Māori names correctly, using the preferred names of **tūroro** and their **whānau**, and to ask for guidance when unsure.
- Staff will provide an explanation, and request consent from **tūroro** and/or their **whānau**, before touching **tūroro** anywhere on the body and especially on the head.
- Staff will ensure people are modestly covered when going to showers or being transferred through the facility.
- Staff will seek appropriate consent for disposable undergarments.
- Staff will take all steps to avoid the presence of rubbish bins in a room.

1.5 Kai / Food

- Where appropriate, and where care outcomes will not be compromised, **whānau** should be able to bring food and share meals with the **tūroro**.
- Māori food options should be available to **tūroro**, in consultation with the service's dietetics and food services staff.
- Food/drink should never be passed over the head of the **tūroro**, or placed over the feet (whether on a tray or not).
- Fridges/freezers used to store food or medication for human consumption will be clearly identified and not used for any other purpose.
- Microwaves used for food will not be used for heating anything that has, or will, come into contact with the body.
- Any item that comes into contact with the body, or body fluids, must be kept separate from food e.g. combs or brushes should not be placed on surfaces where food is placed, nor should urinals, urodomes or commodes.
- Receptacles in which drinking water is stored will be solely used for this purpose.
- Flower vases should be available for use in each service area.
- Staff will not sit on tables or workbenches, and particularly will not sit on surfaces where food or medication may be placed.

1.6 Taonga / Valuables

- **Taonga** (valuables/heirlooms e.g. **pounamu** (greenstone)) should only be removed with the permission of the **tūroro** and/or their **whānau**. If no **whānau** member is available to give informed consent or to accept the **taonga** into their safekeeping, **taonga** should only be removed if leaving them on would unquestionably place the **tūroro** at risk. This should be clearly documented in the Valuables book, care notes or other appropriate document, and discussed with the **tūroro** and/or their **whānau** at the first available opportunity.

  If the **taonga** does need to be removed, wherever possible it should be taped to the **tūroro** or placed in safekeeping using the service's usual procedure & documentation process. The **tūroro** and/or their **whānau** will be informed of the risk of the service storing **taonga**.

Miscellaneous

- Staff will offer the return of all hair, fingernails and toenails cut for service delivery purposes, and document this.
- These will be saved in a patient labelled snap closure plastic bag and returned to the **tūroro** and/or their **whānau**.

Linen

- Wherever practicable, different pillows and pillowcases will be used for the head and other parts of the body. Ideally across the CDHB wide blue pillow slips will be used for the head and white pillow slips for the rest of the body.
- Similarly, different flannels will be used for the head compared to other parts of the body
- Staff will support tūroro and/or whānau who bring their own pillows, pillowcases or flannels
- Washing of a tūroro will follow a strict order, starting from the neck to genital and then anal area.

Facilities: Māori Designated Areas

Where the service has designated Māori areas, **Tikanga Māori** protocols, including smokefree, must be observed at all times e.g. Māori Accommodation Services, Marae environments.

Those responsible for cultural leadership within the provider, e.g. Kaumātua, are responsible for determining the relevant **Tikanga Māori** protocols, and conveying these to staff,

clients/consumers/patients and others, including visitors; for identifying and remedying breaches to retain the state of **tapu**.

Facilities: General Areas

Some areas within a service may, on occasions, be used for a Māori specific purpose, but are not permanently governed by Māori tikanga and protocols.

On these occasions staff will ensure the following:

- Tikanga governs and Māori protocols are followed e.g. pōwhiri.
- All areas used in the care of Tūpāpaku (deceased person) e.g. Whānau/Family Areas, waiting areas close to critical care services, Mortuary Bereavement Rooms will follow Tikanga procedures as determined by the appropriate Māori leader or Kaumātua in conjunction with Māori Chaplains.

Whānau/Family Area/Room

Designated Whānau/Family areas are governed by tikanga principles and protocols, although they may be available to all peoples.

The following principles will apply to use of these areas:

- **Tūpāpaku** (deceased persons) and whānau caring for the **Tūpāpaku** have first priority to use the area
- No **Tūpāpaku** is to be brought into Whānau rooms
- **Whānau** caring for **tūroro** throughout the process of dying will also have high priority to use these facilities
- When the Whānau/Family area is occupied by **Tūpāpaku**, staff will ensure that **Tikanga** procedures for Tūpāpaku are followed
- Ordinary use of the Whānau/Family areas will be determined in consultation with Māori staff and the Kaumātua.

Te Whare Tangata Whenua (Placenta) Pito (Umbilical Cord)

The female genitalia are regarded as tapu. Te Whare Tangata [the house of people], is where the procreation begins.

Several related words have more than one meaning. For example:

Whānau - giving birth and family

Whenua - the placenta and land

Hapū - being pregnant and a sub-tribe of the iwi (people)

Each of these terms relates to different stages of the procreation-creation process and each state is seen as **tapu**.

The **whenua** (placenta; after birth) is returned to the land, and, with the **pito** (umbilical cord), it bonds the link between the new born and **Papatuanuku** (mother earth). With this affinity to one's **turangawaewae** [ancestral land, foothold] established, it is believed that each individual will then fulfil a lifelong role of curator for **Papatuanuku**.

The **whenua** is given back to the land which continues to sustain, shelter, nurture and embrace people.

If the separation occurs, i.e. through miscarriage or termination, the **whenua & pito** products are still regarded as tapu, and respect for that life should still be maintained.

Offering the **Whenua & Pito**

- Ask whether the tūroro and/or their whānau wish to have the whenua & pito, and whether they wish to provide their own container or receptacle
- Otherwise, clarify if the service's containers are acceptable e.g. plastic or paper bag. It is most unlikely that containers such as ice cream containers or designated rubbish bags will be acceptable because they have contained food, or would ordinarily be used for waste.
- If the woman requests the **whenua**, place it in double plastic bags and then into the container of the woman's choice.
- Never store the **whenua** in a refrigerator or freezer used for food.
- Label the bag or container with the woman's identification label and date it.
- Offer the **whenua** to the woman and her **whānau** support before they leave the Birthing Suite, so the placenta can be taken home then
- The **whenua** maybe required to undergo histology tests and therefore may not be available for immediate release to the Tūroro and whānau. Refer to CDHB Placenta to Histology process and Placenta Tracking Process form.
- If it is not taken at that point, offer the **whānau** while the woman is on the Ward. However, if it is not collected within 24 hours, contact the woman or their Lead Maternity Carer for further instructions.
- Any disposal by a service should follow the procedures laid out in this document.

- A similar process applies to products of gynaecological surgery if requested, unless this is outweighed by infection control requirements.

Mate Māori

In any instance where a **tūroro** and/or their **whānau** identifies an instance or experience of **Mate Māori** or a **Makutu Māori**, (sickness or possession), staff should call the **Kaumātua** and seek their involvement. If either is not available, then a **Kaumātua** from the tribe (iwi) of the **tūroro** should be contacted.

Community Services

Protocols when visiting Māori in their homes

- Appointments will usually be made beforehand, by telephone or letter.
- Staff will always introduce themselves and explain their role and service to the **tūroro** and **whānau**.
- Staff will actively try to pronounce Māori names correctly, using the preferred names of **tūroro** and their **whānau** and ask when unsure.
- Ask whether the **whānau** prefer shoes to be left at the door.
- Rituals of greeting and introductions may occur before the visit can be proceeded with. These courtesies are very important to developing a positive relationship.
- If refreshments are offered, they should be accepted.
- Ask **tūroro** and/or their **whānau** where or how they would prefer the service to occur. If, for example, a baby is to be examined, where would they like that to be: on pillows, a couch, a bed or on the floor.
- If intimate services are to be conducted, ask directly how this would be preferred, and refer to other relevant parts of this policy.

Removal, Retention, Return or Disposal of Body parts and/or Tissue and/or Substances

(Note: this includes whenua/placenta and genetic material)

The following process will be followed, as requested by tūroro/whānau and in accordance with staff:

- All discussions will occur at the earliest opportunity, be non-directive, non-judgemental, consultative, follow an informed

consent process, and include accurate, clear explanations about the entire process, the definitions of body parts, human tissue and substances and the available options, including any overriding policy, health and safety or infection control considerations. Particular care will be taken to document all actions and agreements.

- Additional support, and the option of **karakia** will be available. Where possible this must happen prior to any intervention.
- The removal, retention, return or disposal of body parts/tissue/substances will follow Canterbury DHB policies and written information will be made available to **tūroro** and/or **whānau**.

  Time will be allowed for the **tūroro** and/or **whānau** to consult and reach a decision unless in exceptional circumstances where immediate care requirements would be severely compromised e.g. urgent amputation, emergency caesarean.
- Explicit consent must be obtained (in writing) for the removal and retention of body parts and tissue.
- Informed acceptance (usually verbal) must be obtained for the retention of tissue.
- Where retention is consented to, the purpose for retention will also be agreed to through an informed consent process i.e. for the purpose of education and teaching.
- Future use will only be the original purpose as agreed to by **tūroro** and/or **whānau**.
- Staff will ensure all body parts/tissue and substances are correctly labelled and documented, and are returned as quickly as possible when requested, if this does not involve a high risk to safety.
- Staff will ensure any special requests regarding the retention, return or disposal of body parts/tissue/substances are documented and monitored.
- The return of body parts/tissue/substances will be carried out in a way that is consistent with tikanga and in consultation with appropriate Māori staff. For advice on skeletal body parts, this will also occur in conjunction with the Mortuary office.
- All body parts/tissue/substances will be stored or retained in accordance with tikanga practices and handled respectfully at all times.

Organ & Tissue Donation

(Live or Deceased donor)

The following applies to both the recipient and donor as applicable.

- Informed consent will always apply to donation of body parts and/or tissue.
- Full, accurate and clear discussion will occur as early as is practicable and be carried out in a sensitive, non-judgmental way.
- Staff will offer the option of further support from the appropriate Māori staff.
- Staff will respect and comply with the decisions made by the **tūroro** and/or **whānau**.
- Staff will offer the choice of karakia prior to and/or following any intervention, and make the arrangements if requested.
- Staff will ensure **tūroro** and/or **whānau** are aware and agree to the possibility that certain body parts and/or tissue may be stored for use in the future. (Future use will only be the original purpose as agreed to by tūroro and/or **whānau**).
- All body parts and/or tissue will be offered for return if unused or unsuitable e.g. when a heart valve is used, the surrounding heart tissue will be offered for return.
- Staff will document all discussions and decisions

Pending Death

- Where possible, **whānau** will have the choice of taking their terminally ill relative home.
- Where death is imminent, **whānau** will be notified immediately, including chaplains if requested.
- Where death is expected imminently, Māori support staff involved in the care of the **tūroro** and/or **whānau** will be notified immediately, including chaplains if requested.
- Staff will make every attempt to ensure a single room is available and allow **whānau** to be present at all times.
- If there is the potential for involvement from the coroner, **whānau** will be informed at the earliest opportunity.
- If there is the potential of a post mortem request, **whānau** will be consulted immediately.

Tūpāpaku (Deceased Person) Following Death

- When death occurs the **whānau** will be notified immediately.
- Māori support staff involved in the care of the tūroro will be notified immediately.
- **Whānau** will be offered access to a phone to make arrangements, and a single private room for them and the

Tūpāpaku at the earliest opportunity. No food and drink will be taken into this room.

- Staff will be guided by **whānau** on the cultural and spiritual practices that are important for them to follow at this time, and every attempt will be made to provide **whānau** with the opportunity and private facilities to exercise their beliefs and practices.
- **Whānau** will be offered the choice of washing and dressing the **Tūpāpaku**.
- There must always be a formal release process for **Tūpāpaku**, with all the necessary documentation completed before release.
- Where possible, **whānau** will have the choice of either taking the **Tūpāpaku** home or contacting a funeral director, and staff will make every attempt to ensure the formal release process is completed as quickly as possible.

Movement of Tūpāpaku

- The wishes of the **whānau** will always be respected as to how the **Tūpāpaku** is moved, and **whānau** must be able to accompany the **Tūpāpaku** when moved.
- **Tūpāpaku** may be clothed in their own clothes if that is the wish of the whānau, and they can travel on their bed or in another agreed manner.
- The **Tūpāpaku** will be wrapped in allocated sheets or shrouds, not every day linen. These sheets should have been blessed.
- Staff will always handle the **Tūpāpaku** in a sensitive and respectful manner, and the **Tūpāpaku** will always be transported feet first.
- Transportation of **Tūpāpaku** will be conducted discreetly along the service's pre-determined "pathway" for **Tūpāpaku**, including pre-designated lifts.
- Every endeavour must be made to ensure that all linen, food cupboards, inpatient and staff pantry and toilet doors will be closed during the moving of **Tūpāpaku**
- The movement of **Tūpāpaku** through public areas will be avoided wherever possible. If not, staff will use the shortest route, avoiding food and waste areas wherever practicable. This will be carried out in an efficient, respectful and dignified manner.

Following Removal of Tūpāpaku

- **Karakia** will be performed in the room/area as soon as the **Tūpāpaku** is removed

- The room will not be physically cleaned until after karakia has occurred.

Autopsy and Referral to the Coroner

- When a post mortem is required by the coroner, or requested by staff, a clear, factual explanation will be given to whānau
- Staff will provide early and continual information to **whānau** about the possibility of a post mortem, and facilitate speedy release following any post mortem
- Staff will respect the privacy of **whānau** during discussions, and provide a private area
- Māori support staff will be notified as soon as possible
- The removal or cutting of **Tūpāpaku** hair is to be avoided unless absolutely necessary to any post mortem. Any samples retained are declared through the Coroner and discussed with the **whānau** by the Coroner

Non Coronial Autopsies

- If a non-coronial post mortem is requested, staff will ensure **whānau** have the correct information to make an informed choice and if agreed, give informed and written consent
- Sufficient clear, accurate information will be provided, including information about the use of photography, and time allowed, for the **whānau** to consult and reach an informed decision
- The retention of body parts/tissue/substances must follow Canterbury DHB policies and procedures, and the **Research and Māori** document.
- All procedures and consents will be discussed and documented in a sensitive, non-judgmental non-directive and consultative way.
- All body parts and/or tissue will be returned as soon as possible.

Coronial Autopsies

- In coronial cases, attending Police or Coroner's Officers will offer **whānau** the choice of having a Police Iwi liaison officer present.
- **Whānau** will be informed that they can usually stay with the **Tūpāpaku**, or in a nearby waiting room, when the **Tūpāpaku** is moved to the mortuary for the post mortem. There may be times when the mortuary is unattended, and **Whānau** will not be able to stay, but every attempt should be made to minimise situations where **Whānau** are not able to be with the **Tūpāpaku**

- The Coroner will inform **whānau** if body parts and/or tissue are required for further analysis in determining death and advise them of their options
- Body parts, tissue and/or substances are only taken if needed to determine the cause of death
- Return, retention or disposal is under the authority of the Coroner, with whom it should be discussed
- Māori protocols after death may differ for Māori of different denominations. Some Māori will not wish to have a chaplain attend. Always ask the **Whānau** what their wishes are.

Research

Also refer to:

Research & Māori, 2003, Canterbury DHB

Health Research Council Guidelines

Te Komiti Whakarite / CDHB Māori Consultation Committee intranet linkage: http://intraweb/quality-maori/te-komiti/default.htm

- The Treaty of Waitangi principles of partnership, participation, protection and good faith will be actively addressed from the outset of the research project and during the project itself
- Researchers must address how the research will benefit Māori, including how information will be shared with Māori
- Before research is initiated, consent may be required from iwi/Māori groups, particularly if the research may potentially breach tikanga or involve sensitive issues. This is over and above individual consent requirements.
- Some issues may also require consent from iwi and/or hapū especially where ownership may belong to collective stakeholders.
- Informed consent (written and verbal) must be sought from Māori participants and/or **whānau** involved in the research. This includes requests for body parts/tissue and/or substances (including genetic material) to be collected for research purposes.
- Return, retention or disposal procedures will be discussed and agreed to by participants. This will be documented.
- Time will be allowed for consultation and decisions to be reached.
- Confidentiality will be maintained, in particular where individuals may be identifiable.

.

Glossary

The following principles are linked to Māori wellbeing and must be respected as part of the healing process.

Term	Description
Mana	Spiritual power and authority to enhance and restore tapu. Health and disability services must empower *tūroro* and their *whānau*. In doing so the service's own *mana* is enhanced.
Tapu	Physical, psychological, emotional, spiritual and cultural wellbeing. Disciplined state of dignity and sacredness which allows certain functions to be performed. Restrictions and prohibitions that protect *tapu* (wellbeing, dignity and sacredness) from violation Can be used as a protective measure Accords respect and mana to certain people, objects, events, places and parts of the body.
Noa	Applies to everyday living and ordinary situations, and is a vital part of the most rituals and social controls of Māori. Ensures that people can be approached and objects are able to be used every day.
Hapū	Sub tribe of a large tribe. Pregnancy.
Hinengaro	Mind/Psychological or mental health/wellbeing.
Iwi	A nation or people with a shared identity and genealogy/tribe.
Kai	Food.
Karakia	Blessings /incantation/ prayer.
Kaupapa	Policy, protocols.
Marae	Place of Māori practice. Often comprising of a carved meeting house, marae ātea (sacred space in front of the meeting house), dining room and ablution facilities.
Pōwhiri	Māori process of welcoming.
Rongoā	Māori methods of healing including mirimiri (massage), te reo (language), karakia and herbal remedies.
Tūroro	Consumers/ clients/ patients. Person seeking or requiring assistance from a health professional.
Taonga	Treasure, valuables.

Term	Description
Tikanga	Issues of principle/integrity of intent. Values and respect. Processes.
Tinana	Physical body.
Tūpāpaku	Deceased person.
Wairua	Spiritual element. Wairua is an integral part of tapu and noa that is inextricably linked to wellbeing.
Whānau:	Family, including extended family group.
Whenua	Placenta. Afterbirth. Land.

Measurement/Evaluation

The practical implementation of this policy will be guided by feedback from patients and whānau. Therefore success and improvement will be based on feedback and/criticism given by patients and their whānau. This will be further reviewed at regular audits and changes made accordingly.

Policy Owner	Executive Director of Māori & Pacific Health
Policy Authoriser	Executive Director of Māori & Pacific Health
Date of Authorisation	June 2015

Te Reo Māori Policy

Contents

Policy

This policy outlines guidelines for the use of te reo Māori throughout the Canterbury DHB.

This policy outlines the process for staff when opting to use te reo Māori within CDHB hospitals and work areas.

Signage or documentation in te reo Māori may be required for any or all of the following:

- policy statements relating to Māori customers
- names of work areas and roles in te reo
- bi-lingual signage across CDHB
- bi-cultural signage motifs.

Purpose

Status of te reo Māori

Te reo Māori has status as an official language of New Zealand and it is important that we support the use of the Māori language in health.

To date the use of te reo Māori in signage and documentation across CDHB has been ad hoc and within individual hospitals without an agreed framework.

The purpose of this policy is to:

- have a uniform approach to the use of te reo Māori across CDHB
- ensure that there are procedures and support for staff in developing appropriate signage and documentation.

Treaty principles

The application of treaty principles in health supports our te reo Māori policy:

- partnership - CDHB acts as the agent of the Crown in the partnership relationship with Māori.
- protection - To fulfil the Crown's obligation to protect the status of te reo Māori and promote the use of this cultural icon within CDHB.
- participation - To provide an environment in CDHB that supports Māori accessibility to health and disability services by providing resources/services that reflect a Māori viewpoint of health.

Scope/Audience

This policy applies across CDHB hospitals and work areas for signage and documentation when written in te reo Māori.

Roles and responsibilities

CDHB Executive Director of Māori and Pacific Health

The CDHB Executive Director of Māori & Pacific Health is responsible for authorising:

- The need for a publication to be produced either in te reo Māori only or bilingually in English and te reo Māori
- The process for accessing Māori translation services.

Māori Health Service - te reo Māori komiti

The Māori Health Service - te reo Māori komiti is responsible for:

- ensuring that publications incorporating Māori content and mihimihi are correct
- all documentation and signage has correct use of macrons.

Associated documents

- CDHB Communications Guide 2013
- NHS Way-finding - Guidance for healthcare facilities.
- New Zealand Building Code Clause F8 Signs

Process

The process for te reo translation is:

- request for assistance with te reo Māori content sent to Executive Director of Māori and Pacific Health
- executive Director of Māori and Pacific Health will convene te reo Māori komiti to decide on te reo Māori content
- te reo komiti confirm Māori content is correct and macrons have been used where required.
- te reo komiti on behalf of Executive Director contact the unit / department seeking assistance
- te reo komiti to work with unit / department team to implement document and/or signage.

References

Te Puni Kōkiri - Māori Language Strategy
http://www.tpk.govt.nz/maori/language/default.asp

Mātātupu Māori Language Policies and Plans: Guidelines to Assist Public Service Departments
http://www.tpk.govt.nz/publications/docs/matatupu.pdf

www.tetaurawhiri.govt.nz

Internal Signage Policy 2011.pdf

(Te Taura Whiri i te Reo Māori, Blueprint for a Languages Policy: New Zealand Public Service, May 1994, p5)

Policy Owner	Executive Director of Māori & Pacific Health
Policy Authoriser	Executive Director of Māori & Pacific Health
Date of Authorisation	August 2013

Māori Health Policy

Contents

Purpose

The purpose of this policy is to provide a framework for implementing Canterbury DHB's recognition of the Treaty of Waitangi and its principles, the Māori obligations contained in the New Zealand Public Health & Disability Act, 2000 and for ensuring appropriate decisions are made with respect to improving Māori health outcomes.

Policy

Māori Health is a strategic priority area for the Canterbury DHB

This policy outlines the Canterbury DHB's expectations arising from this priority status

This policy applies to all Canterbury DHB decisions and activities that potentially impact on Māori and/or Māori health outcomes.

Māori Health will be a core consideration for all activities that the Canterbury DHB undertakes, from Board level down, including the Planning & Funding division, the Provider Arm (hospitals), and Community & Public Health.

The importance of Māori health will be included in the contractual expectations within every Service Agreement for the Provider Arm and community providers of health services.

Framework

Māori participation is aimed for all Canterbury DHB activities and decision-making, including governance and operational activities, in order to provide an effective range of health and disability services are available to Māori in Canterbury.

This policy will ensure that Canterbury DHB decisions and activities reflect national strategies [e.g. He Korowai Oranga & Whakatātaka], and comply with the Canterbury DHB's accountability obligations, Strategic Plan priorities, Māori Health Plan, (Whakamahere Hauora Māori ki Waitaha 2002), and its prioritisation and funding principles, within the resources available and its sphere of influence.

Relationships between Canterbury DHB and Māori will be characterised by the Canterbury DHB values and the values expressed in the CDHB Māori Health Plan:

Canterbury DHB	Whakamahere Hauora Māori ki Waitaha [Values expressed as tukutuku patterns]
Care & respect for others ***Manaaki me te kotua ki te katoa***	**Two way communication** ***Takitoru***
Integrity in all we do ***Hāpai i a mātou mahi katoa i runga i te pono***	**Facilitation of Māori participation** ***Patiktiki***
Responsibility for outcomes ***Kaiwhakarite i ngā hua***	**Commitment to action** ***Nihoniho***
	Recognition of all Māori
	Purapurawhetū

Scope/Audience

The policy applies to all Canterbury DHB governance and operational activities that impact on Māori health or have the potential to impact on Māori health.

These activities include the adoption of policies and strategies by the Board, and all planning, and funding decisions that are designed to provide an appropriate range of health and disability services to Māori in Canterbury.

The responsiveness to Māori by both Māori providers and 'mainstream' (non-Māori) providers, including the Provider Arm and community providers, will be monitored and evaluated

1 Canterbury District Health Board

The role of the Canterbury DHB Board is to provide leadership to the organisation on its responsiveness to Māori. It will achieve this by authorising policies and practices that encourage Māori to perceive the Canterbury DHB as a culturally responsive and supportive organisation in its planning and funding and service delivery roles.

The Board will use its best endeavours to hold the CEO accountable for prioritising Māori Health outcomes, and cascading the responsibility for Māori Health through the executive management team and on to the rest of the organisation.

2 CEO and Executive Management Team

The Canterbury DHB executive management structure will, wherever practicable, implement Māori health strategies, principles, policies and practices approved by the Canterbury DHB Board in a proactive and diligent manner, and demonstrate personal and collective leadership with respect to leading organisational performance in meeting desired Māori health goals.

The CEO will agree Māori performance measures with the executive management team and expect that they in turn will diligently aim to agree complementary measures with their management structures.

The CEO will develop and maintain appropriate mechanisms for receiving internal and external advice from Māori on matters relating to Māori health, and will show due regard to the advice received.

3 Corporate Divisions

Human Resources

Māori Workforce Development

CDHB's HR policies and employment practices will encourage the active recruitment, retention and career development of Māori staff at all levels of the organisational structure.

The HR department will provide leadership and guidance to influence the HR practices of community providers with whom the Canterbury DHB has contracts for the provision of health services.

Cultural Safety

The HR department will endeavour to support CDHB Managers to ensure staff can demonstrate cultural understanding and sensitivity at all times. This can be achieved via policies, training, and incorporating this requirement into the staff performance management system, and monitoring managerial performance of this responsibility in accordance with agreed performance management standards and the requirements of professional bodies, statute and regulations.

Information Services

The HIAP department will comply with the Ethnicity Data Collection policy. It will also provide Information relating to Māori use / utilisation of services in the Provider Arm, and support training of staff in ethnicity data collection practices.

Finance

Finance will provide support to Planning and Funding and to the Provider Arm to enable them to monitor the amount of funding allocated over time to mainstream and Māori services for the benefit of Māori.

Professional Leadership – Nursing and Medical

The CDHB clinical leaders will use their best endeavours to monitor the responsiveness to Māori by the nursing and medical staff. They will also support improvements to responsiveness by health professionals in areas such as curriculum development and teaching, and the documenting of clinical expectations for cultural competence. Where required this will occur in partnership with

tertiary training institutions, and in accordance with the expectations of statutes, regulations and professional bodies.

Communications

Communications will use its best endeavours to ensure that the CDHB communicates with Māori using appropriate Māori mechanisms and media. Liaison with Māori on this process is essential.

Site Redevelopment

Site Redevelopment will ensure that all development and renovation projects that have user groups established will include a Māori user group as an integral part of the sign-off process or Māori representation on a user group.

Planning and Funding Division

The Canterbury DHB Planning & Funding activities will explicitly include measurable Māori health objectives. In addition, they will describe how these objectives are to be achieved, based on consultation with Māori communities.

The applicable activities include the development of the Strategic Plan, Statement of Intent, Annual Plans, and action planning documents, plus the incorporation of Māori health clauses into contractual documents (Service Agreements), including the requirement and ability to monitor performance against Māori health obligations.

Planning and Funding will identify the amount of funding allocated to both mainstream and to Māori providers of services for the benefit of Māori. It will apply additional resources according to the CDHB Funding of Health and Disability Services policy, which takes into account issues of equity and need, the Canterbury DHB prioritisation principles, and Strategic Plan priorities. This information will be reported to the Executive Director, Māori and Pacific Health quarterly.

Planning & Funding will support the continued development and sustainability of Māori providers, and recognise and promote the contribution they can make to increase access and choice of services for Māori. This will require the allocation of adequate and ongoing funding to approved Māori providers for the provision of quality health care services designed to improve the health outcomes of Māori.

Provider Arm

All Provider Arm planning activities will, whenever practicable, explicitly include measurable Māori health objectives and describe how they will be achieved, and will, where appropriate, include consultation with Māori clients and/or communities. This includes the annual business planning and budget setting processes.

The Provider Arm will identify the services it provides for the benefit of Māori and the amount of funding allocated to providing those services. It will identify areas where additional resources are required and engage with Planning and Funding to implement these strategies in accordance with the Funding Criteria policy.

Provider Arm staff will be expected to demonstrate cultural competence at all times, and meet statutory, regulatory and professional body requirements in this respect.

Community & Public Health

The Community & Public Health division activities will explicitly include measurable Māori health objectives and describe how they will be achieved, (where this is applicable). Where appropriate, this will include consultation with Māori clients and/or communities. This includes the triennial contract negotiations and annual service plan review processes between the division and the Ministry of Health, Public Health Southern Locality Team.

Community & Public Health division will identify the services provided, and the amount of funding allocated, for the benefit of Māori. It will identify areas where additional resources are required and engage with Ministry of Health (or Planning and Funding) to implement these strategies.

Relationships with Māori

Canterbury DHB will give full regard to developing relationships with Māori which provide the opportunity for Māori to contribute, in association with the DHB, to the development of principles and practices that improve Māori health status.

In particular, Canterbury DHB will commit to the Memorandum of Understanding with Manawhenua ki Waitaha, the formally mandated Ngāi Tahu group representing the seven rūnanga in Canterbury.

Relationships with Māori providers

Canterbury DHB will maintain strong, proactive relationships with Māori providers with whom it has Service Agreements.

Expectations of Mainstream (non-Māori) providers

Mainstream providers are expected to proactively meet contractual obligations to demonstrate their responsiveness to Māori, including accurate ethnicity data collection and reporting and cultural competency of staff.

Measurement/Evaluation

The practical implementation of this policy will be guided by feedback from patients and whānau. Therefore success and improvement will be based on feedback and/criticism given by patients and their whānau. This will be further reviewed at regular audits and changes made accordingly.

Policy Owner	Executive Director of Māori & Pacific Health
Policy Authoriser	Executive Director of Māori & Pacific Health
Date of Authorisation	11 June 2015

Koha Policy

Contents

Policy

This policy governs how koha will be offered or received by Canterbury DHB interactions with Māori at marae or in Māori community settings. Staff will take account of Māori custom and practice, and include appropriate recognition and acknowledgment by way of koha as appropriate.

Purpose

To provide Canterbury DHB staff with guidance about when koha would be offered, and what should occur should it be received.

Scope/Audience

The policy applies to all Canterbury DHB staff, regardless of their position in the organisation.

Definitions

Koha

An unconditional gift, token, contribution, which recognises and acknowledges the recipient.

Note:

Koha is not to be confused with payment for venues, catering or other services rendered to the Canterbury DHB by a Māori person,

group or organisation. Such payments are treated in the usual business manner as payment for agreed goods, services or fees, and are determined by the responsible Manager.

Payment for agreed goods, fees or services rendered by any person, group or organisation must be supported by an invoice from the party seeking payment, and a contractual agreement between the Canterbury DHB and that person/group/organisation, in line with Canterbury DHB financial policies and practices.

Associated documents

This policy should be read in conjunction with the Gifts and Benefits Policy (Finance).

Policy details

Koha

Koha should be offered when it is appropriate for the Canterbury DHB to recognise and acknowledge the Māori person, group or organisation with whom it is interacting. Acknowledgment is particularly important in formal interactions with iwi and Māori in Māori settings.

Appropriate Koha

The appropriate koha payment can vary on the basis of:

- The size, venue, kaupapa and role of the Canterbury DHB in the hui [sponsor, participant, visitor, nature and extent of staff involvement]
- Whether a personal koha should be made from staff instead of, or as well as, koha from the Canterbury DHB.

The advice of kaumātua or similar Māori community leader, about koha should be sought prior to the hui, and be agreed with the responsible manager.

Koha would normally range from $50 to $100. Larger amounts could be appropriate depending on the mana of the occasion.

Form of Koha

A Direct Credit payment by the Canterbury DHB should be the normal form of koha.

Organiser/Participant's Responsibility

The organiser of, or participant at, the hui/event for which the koha is to be given should, if the payment is reasonably foreseeable:

- Allow adequate time prior to the event to seek kaumātua advice about the appropriate amount of koha and to receive managerial approval for the koha payment.
- Advise the recipient of the Koha that it will be paid via Direct Credit into their nominated account and that the CDHB requires official bank confirmation of the account e.g. internet banking header that shows both the account name and number or a pre printed bank deposit slip.
- Submit a completed "Request for Payment Form" for the amount of
- the koha, appropriately authorised with copies of supporting documentation attached (e.g. a copy of the letter to the participants confirming the arrangements and the bank account confirmation).
- Allow adequate time for Finance to include the Koha in its weekly payment run (payment runs are done every Thursday and on the 20th Month, to be included in this payment run the request is to be received by the Accounts Department no later than 12.30p.m. 1 ½ days before the payment is made.
- Advise Finance that a tax invoice may not be able to be requested because of the nature of koha, nor may the “Acknowledgment of Koha” note necessarily be returned.
- Arrange cash payment if a Direct Credit is not acceptable.
- Include with any koha paid by cash the Canterbury DHB's “Acknowledgment of Koha” note for the recipient to sign and return. The completed acknowledgment note is to be given to the Cashier for attaching to the documents supporting the payment.
- For Koha by Direct Credit the attendee will present a letter to the recipient advising payment of $XX.XX has been deposited directly into their bank account. Please see below for suggested wording.

Where koha has not been anticipated by Canterbury DHB staff prior to the hui and the payment is made from their personal funds they should claim the amount on an expenses reimbursement form. The claim must be supported by the kaumātua or similar Māori leader, in addition to the normal authorisation by the responsible manager. Such cases should be the exception not the rule.

Koha Hand Over

In ā formal situation such as a pōwhiri, the koha should be given in accordance with local tikanga (protocol).

Presenting the Koha

The person who presents the koha will be determined in accordance with local tikanga; it is likely to be the kaumātua with the Canterbury DHB party or the senior CDHB representative who has taken the role of kaikōrero.

Canterbury DHB staff may include personal koha if they wish. This is voluntary and is not reimbursable, as it is given “from the heart”.

CDHB Staff Accepting Koha

Koha accepted in acknowledgment of the Canterbury DHB should be paid in to the Cashier, or if it is "in kind", lodged with the appropriate Board unit.

Koha given to Canterbury DHB staff as personal acknowledgment should be retained by the recipient and declared in the Probity Register, with the agreement of the responsible manager.

The decision as to whether the koha is an acknowledgment of the Board or a personal acknowledgment of the staff member is to be made in consultation with the kaumātua and/or the responsible manager.

When the koha is to the kaumātua, it is their decision as to whether it is personal, or they may choose to seek appropriate cultural or management advice.

Koha given to a Canterbury DHB service as recognition of the service, or the occasion, e.g. Te Whare Mahana, should be accounted for separately from general operating expenditure, and be available for the service for activities or expenditure over and above the usual operating activities. This would recognise the gift appropriately.

Operational Details

Authorisation of Koha

Provided it is within their delegated authority, koha may be authorised by:

Kaumātua and a member of the Executive Management Team or a General Manager or Service Manager provided it is within their delegated authority.

Coding of Koha

Koha payments are classified as an operating expense and are to be charged against the departmental item code.

Tax Implications

Tax obligations relating to koha are the responsibility of the recipient. Canterbury DHB employees needing advice should consult Finance. A formal assessment of PAYE/withholding tax implications for amounts greater than $100 or where a “recurring” nature to the same person will occur. If deemed PAYE/withholding tax liable, CDHB will gross the payment up and return the tax to the IRD.

However, in most instances koha is excluded for services or goods so there are no GST implications. Note the policy includes reference to the IRD koha document so that the implications of goods and services tax, fringe benefit tax, PAYE and withholding tax have been considered and incorporated.

Note:

Inland Revenue publication IR278 "Payments and Gifts in the Māori Community" is available on the internet or from IRD.

Koha

Organiser's Responsibility

The organiser of the hui/event for which the koha is to be given should:

- Allow adequate time for the payment to be processed in the normal way.
- Identify the expected amount of the koha.
- Establish whether payment by direct credit is acceptable.
- Advise the recipient of the Koha that it will be paid via Direct Credit into their nominated account and that the CDHB requires official bank confirmation of the account e.g. internet banking header that shows both the account name and number or a pre printed bank deposit slip.
- Complete a Request for Payment Form for the amount of the koha, have it appropriately authorised and attach copies of supporting documentation (e.g. a copy of the letter to the participants confirming the arrangements and the bank account confirmation).

- Arrange cash payment if a direct credit is not acceptable. Include with the koha, the Canterbury DHB's "Acknowledgment of Koha Note" for the recipient to sign and return.

Koha Acknowledgement

The koha of ……..…….…… (amount in words)
$……..……...…..…… (amount in figures)
presented by the Canterbury DHB on the occasion of the (hui/name of event) ……..…… held on ……. (date)
at ……. (name of venue) is acknowledged.

Signature ……

Date……..

Suggested wording for Koha Letter

We have deposited a koha of $XX.XX inot your organisations account.

Ngā mihi whakawhetui ki a kotou.

Measurement/Evaluation

Audit the process and survey users to determine process suitability.

Policy Owner	Executive Director, Māori and Pacific Health
Policy Authoriser	Executive Director, Māori and Pacific Health
Date of Authorisation	15 December 2014