West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

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

12 APRIL 2012

AGENDA AND MEETING PAPERS

All information contained in these committee papers is subject to change

AGENDA

FOR THE WEST COAST DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING TO BE HELD IN THE BOARD ROOM, CORPORATE OFFICE, GREY BASE HOSPITAL BETWEEN 9.00 AM AND 10.45 AM ON THURSDAY 12 APRIL 2012

1 Welcome / Introductions / Apologies

2 Agenda

Karakia

3 Disclosure of Interest

4 Minutes of the Meeting held Thursday 23 February 2012

5 Matters Arising / Actions and Responsibilities

6 Committee Chairs Report

7 Correspondence

8 Reports:

Workplan
Organisational Leadership
Clinical Leadership Team
Better Sooner More Convenient and Alliance Leadership Team
Facilities Audit
Quality and Patient Safety

9 ***General Business:***
Items to be reported back to Board
Primary Practices: A verbal update from the General Manager
Finance: A verbal update on the Deficit position from the Chief Financial Manager

10 Information Papers

Terms of appointment
Committee schedule
Term of Reference for Community Public Health Advisory Committee and Disability Support Advisory Committee Terms of Appointment

NEXT MEETING – 24 MAY 2012

KARAKIA

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

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

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

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

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

DRAFT MINUTES OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 22 FEBRUARY 2012 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH, COMMENCING AT 9.00 AM

PRESENT	Kevin Brown, Deputy Chair Peter Ballantyne, (ex officio) Barbara Holland Dr Cheryl Brunton John Vaile Lynette Beirne Marie Mahuika-Forsyth Mary Molloy Patricia Nolan Robyn Moore
IN ATTENDANCE	Wayne Turp, General Manager Planning and Funding Dr Carol Atmore, Chief Medical Advisor Yolandé Oelofse (minute secretary) Anthony Cooke, Chief Executive, PHO
APOLOGIES	Dr Paul McCormack, Board's Chair (ex officio) Elinor Stratford, Chair John Ayling Gary Coghlan, General Manager Maori Health

1. APOLOGIES, WELCOME & KARAKIA

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

Apologies were received on behalf of Elinor Stratford, Dr Paul McCormack, John Ayling and Gary Coghlan.

Moved: John Vaile **Seconded: Dr Cheryl Brunton**

Motion:
"THAT the apologies be noted"

Carried.

2. STANDING ORDERS

The Chair waived standing orders noting reinstatement if required.

3. DISCLOSURES OF INTEREST

Barbara Holland	Insert: Member – Breastscreen Aotearoa Advisory Group
Mary Molloy	Remove: Trustee – West Coast Community Trust

4. MINUTES OF THE PREVIOUS COMBINED COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 17 NOVEMBER 2011

Corrections to minutes:

Item 4	Minutes: typo's
	Page 2 Item 4: environ should read environment impact.
	Page 3 first line: 40 has should read have
	Page 3 Action Point: be place should be placed
	Page 3 Item 2 Advance should read Advanced
	Page 3 item 8: we loose should read lose and disadvantage should read disadvantaged.
	Page 4 second paragraph: been should read being
	Page 4 third paragraph: Excelr should read Xcelr8
	Page 4 fifth paragraph: and or should read and/or
	Page 5 item 9: rage should read range and been should read being
Item 8	Page 4, Recruitment and retention of staff: Maori project re retention and recruitment, its actually generic and not Maori specific.
Item 8	second paragraph: community based referrers should read reference
	fourth paragraph: people leaving should read living.
	Author of this report should have read Wayne Turp, General Manager Planning and Funding.

Moved: Kevin Brown **Seconded: Peter Ballantyne**

MOTION:
"THAT the Minutes of the Combined Community and Public Health and Disability Support Advisory Committee meeting held 17 November 2011 with amendments as noted be accepted as a true and accurate record"

Carried.

5. MATTERS ARISING

Item 1	The schedule to come through for April's meeting.
Item 2	Dr Carol Atmore will endeavour to provide more information at the April's meeting.
Item 3 and 4	To delete as action is complete.

6. CORRESPONDENCE

The correspondence has been taken as read.

The Chair will send a reply through to Peter Burton from The Nelson Marlborough District Health Board regarding Sign Language Interpreters

Moved: Lynette Beirne **Seconded: Mary Molloy**

Motion:
"THAT the Committee receives the correspondence"

Carried.

7. CHAIRS REPORT

The Chair's report has been taken as read.

Moved: Kevin Brown **Seconded: Mary Molloy**

Motion:
"THAT the Committee receives the Chairs report"

Carried.

8. ORGANISATIONAL LEADERSHIP REPORT

The Chair's report has been taken as read.

Granger House: An update was provided for by the General Manager of Planning and Funding.

In response to concern of the quality of clinical and leadership management; two new positions have been appointed and the Management of Granger house meets bi-monthly with the DON of West Coast District Health Board. A twelve month certificate to practice has been issued. This is due for renewal at the end of the financial year. The service is improving and delivery is currently satisfactory. Positive feedback has been received from patients at Granger House that there is an improvement. Monitoring of progress against required service improvement is ongoing.

Community laboratory / referred services: The GM P&F advised the committee that only a small proportion of referred services is made via Medlab South. As to the future financial impact of the hospital laboratory picking up these services, it was explained that as the hospital laboratory had capacity to pick this up largely within its existing resources it was beneficial to the DHB overall. In moving to a single provider it is important that all services receive an effective and efficient service and that our community's needs and health interests are held uppermost.

CVD Screening:

- A question was raised regarding the policy, is it only restricted for women and why are the men excluded. It was noted that the policy on screening applies to the entire population. The General Manager Planning and Funding said he would check to see what arrangements are made for CVD screening for the population of the Coast as a whole.

Action: The General Manager of Planning and Funding to clarify the policy and the gender aspect thereof and to report back to the Committee.

That the Committee receives the Organisational Leadership report.

Moved: John Vaile **Seconded: Barbara Holland**

Carried.

Clinical Leadership:
The Clinical Leadership's report has been taken as read.

BSMC primary care: A workshop on the Health of Older People recently took place with positive feedback and outcomes. The team is currently continuing to develop a model of care for Grey regarding primary services, this will service the whole of the West Coast. The team is working towards meeting the timeline for the end of March in having the model of care developed. The Rural Learning Centre building was opened on Tuesday.

- A question was asked regarding the paediatric nurse/trainee, if they had commenced work on the Coast? A person has been trained in CDHB and will be based in Christchurch and travel to the Coast on a regular basis.

- Reference was made to the CPHAC and DSAC minutes of 17 November 2011: Progress with the Grey Health Trust suggested by Mayor Kokshoorn and whether this has taken place? The Chief Medical Officer had met with Tony Kokshoorn and mentioned that although other issues have taken precedence over the last year it is still on list of things to do.

A Grey IFHC steering group with a sub group has been established. The group is currently working on areas of effective business practice and models. They will meet in early March to discuss this further in detail.

Primary Practice review: Practices have received the practice management report and are each working towards practice management and efficiency.

- In response to the long term expectations for practice ownership it was explained that there is no active plan to change ownership of DHB owned practices but that

the Board has an open mind to alternative models should they prove to be more effective in providing good patient care.

It was moved that the Committee receives the Clinical Leadership report.

Moved: Dr Cheryl Brunton **Seconded: Barbara Holland**

Carried.

Community and Public Health (C&PH):
The C&PH's report has been taken as read.

Smokefree public: The Grey council has announced that in future it would encourage people not to smoke in all public spaces. The committee applauded this decision by the District Council.

Whooping cough: Pertussis outbreak is over in the Westland district no cases has been received for the past ten weeks. Rate of Pertussis is epidemic nationally. This year we are the second highest district with Pertussis outbreak. The rate is on a decline and we are currently monitoring the incubation period of beginning of the new school term. A discussion took place on short term residents on the Coast for whom the cost of vaccinations is a deterrent to them getting immunised.

That the Committee receives the C&PH report.

Moved: Dr Cheryl Brunton **Seconded: Patricia Nolan**

Carried.

BSMC progress report:
The BSMC's report has been taken as read.

Points of interest:

- An Alliance Leadership Team (ALT) report will be submitted to the Committee in the future. The ALT meets on a six weekly basis.

- WCPHO funds: There has been some media interest regarding the availability of WCPHO funding to contribute towards the implementation of BSMC.. The General Manager Planning and Funding reassured the Committee that the PHO has indicated that it has lees reserve funding than originally anticipated. This has required a review of funding priorities regarding the future implementation of BSMC but this has been resolved to the satisfaction of the DHB.

THAT the Committee receives the BSMC report.

Moved: John Vaile **Seconded: Mary Molloy**

Carried.

PHO:

The PHO's report has been taken as read. Areas of interest raised by the committee included:

- Take up of 'Shared Care' and the process for opting on or off of this system. The Chief Medical Advisor explained that patient privacy is absolutely maintained according to the patients' wishes and access without cost would only occur in cases of extreme emergency.

- The funding of Correction Service access; This is a small program whereby vouchers are issued by community probation service staff to clients requiring free general practice service, this voucher entitles them to a free health check.

- Green Prescription: this is largely access to a physical activity programmes determined on health grounds. Referrals for inactive patients are referred by their General Practitioner.

- Keeping people healthy: access by young people; The numbers are very small on the West Coast, this is a referral basis done by the General practice. It was noted that the General practice are doing referrals to the gym which is fantastic.

- Cardiovascular risk: A challenge and concern is that CV risk patients should be assessed every five years. The WCPHO is currently looking at running clinics outside the medical practices and will involve the General Practice's running clinics and possibly look at major employers to get involved; these would all lead to acute intervention.

- Feedback from Maori community to ascertain their view about the quality of patient care for Maori - has this being actioned? Not at this stage. A generic patient satisfaction survey to measure patient satisfaction with the care they received at their IFHC has been sent to each practice.

Moved: Peter Ballantyne **Seconded: John Vaile**

Motion:
"THAT the Committee receives the PHO report"

Carried

9. GENERAL BUSINESS

A concern was raised by the Deputy Chair regarding the time of receiving the Agenda. A review of the courier services is currently undertaken by the WCDHB.

Action: The General Manager Planning and Funding to find solutions and to bring back to the April Meeting.

Community Services currently raised the issue of access to the building is difficult. This would need to work through the proper company process by raising a Capex. The Deputy Chair mentioned that this has been raised previously, and that WCDHB should take this into consideration when the new building facility is built.

Action: **The General Manager Planning and Funding to address.**

10. INFORMATION PAPERS

For information only.

11. OTHER BUSINESS

There are no items to be referred to the Board:

The Community and Public Health Advisory and Disability Support Advisory Committee moved into In Committee at 10:20am

Moved: Marie Mahuika-Forsyth **Seconded: John Vaile**

Motion:
"THAT the Committee moves into In-Committee section"

Carried.

The Community and Public Health Advisory and Disability Support Advisory Committee spent 10 minutes in In Committee

The Community and Public Health Advisory and Disability Support Advisory Committee moved out of In Committee at 10:30am

Moved: John Vaile **Seconded: Lynette Beirne**

Motion:
"THAT the Committee moves out In-Committee section and back into the public section"

Carried.

Patient Advocacy: The need for patient advocacy was raised previously. This has not yet been addressed about the adequacy of support for patients and families in remote rural areas. How to ensure that patients had the necessary support and guidance when receiving medical care. We possibly need to address education and/or training in this area. It was agreed that this would be brought back to the Committee in a form of a workshop which will be held directly after CPHAC and DSAC meeting. A general discussion will take place

considering ideas on how to solve such problems. To invite staff involved in such areas to present and discuss what potential gaps there are within the system.

Action: Wayne Turp, Manger of Planning and Funding to arrange workshop directly after a meeting.

Meeting closed at 10:40am

11.1 NEXT MEETING

The next meeting will be held on Thursday, 12 April at 9am in the Boardroom, Corporate Office, West Coast District Health Board, Greymouth.

Apologies were received for April's meeting from Patricia Nolan and Dr Carol Atmore.

MATTERS ARISING FROM THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 23 FEBRUARY 2012 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH, COMMENCING AT 9.00 AM

Item No.	CPHAC and DSAC Meeting Date	Action Item	Action Responsibility	Reporting Status	Agenda Item Ref
1	14 April 2011	Tor Wainwright as the portfolio manager for disabilities will prepare a briefing paper on the West Coast's and the national position with disability services	Tor Wainwright	The schedule to come through for April's meeting	General Business 7.1
2	14 July 2011	Quality and Risk Report: How do practitioners know that advance directives are in place, to seek further clarity. Early Development of making advance directives is currently been addressed. Item to be referred to the Clinical Governance Committee	Chief Medical Officer	The Chief Medical Officer will endeavour to provide more information at April's meeting	General Business 7.5 item vi
3	23 February 2012	CVD Screening: A question was raised regarding the policy, is it only restricted for women and why are the men excluded. To clarify the policy and the gender aspect thereof and to report back to the Committee.	The General Manager of Planning and Funding		Organisation Leadership Report – CVD Screening
4	23 February 2012	Community Services currently raised the issue of access to the building is difficult. A Capex needs to be raised. This has been been raised previously, and that WCDHB should take this into consideration when the new building facility is built.	The General Manager Planning and Funding		General Business 9 - Community services issue of access to the building.

Item No.	CPHAC and DSAC Meeting Date	Action Item	Action Responsibility	Reporting Status	Agenda Item Ref
5	23 February 2012	A concern was raised by the Deputy Chair regarding the time of receiving the Agenda.	The General Manager of Planning and Funding		General Business 9 – Agenda papers
6	23 February 2012	The need for patient advocacy was raised previously. How to ensure that patients had the necessary support and guidance when receiving medical care. We possibly need to address education and/or training in this area. It was agreed that this would be brought back to the Committee in a **form of a workshop which will be held directly after CPHAC and DSAC meeting. A general discussion will take place considering ideas on how to solve such problems. To invite staff involved in such areas to present and discuss what potential gaps there are within the system.**	The General Manager of Planning and Funding	This will be address at the workshop which will be held directly after the Committee's meeting.	Other Business 11 – Need for Patient Advocacy

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

COMBINED COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SERVICES ADVISORY COMMITTEE

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

FROM: **Elinor Stratford, Chair**

DATE: **12 April 2012**

Training

Two Board members and three Advisory Committee Members attended the Disability Awareness Training held on the 21st February. These names have been forwarded to Gaylene for recording.

MATTER REFERRED TO CPHAC/DSAC FROM BOARD

Nil

ITEMS OF INTEREST FROM THE BOARD MEETING

Buller IFHC site has been decided

- Transalpine model of care being developed – this should reduce number people from the Coast travelling.
- IT improvements were around a regional clinical information system. IT moving to Concerto which will allow 1 clinical record shared between the SI DHB's that are participating.

Matters to be referred to Board from CPHAC/DSAC

Author: **Elinor Stratford, Chair, 12 April 2012**

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE CORRESPONDENCE FEBRUARY 2012

OUTWARD AND INWARDS CORRESPONDENCE

Date	Sender	Addressee	Details	Response Date	Response Details
24 February 2012	National Screening unit	Wayne Turp, General Manager Planning and Funding	Cancer Screening Coverage by District Health Board		

National Screening Unit

133 Molesworth Street
Thorndon
PO Box 5013
Wellington, New Zealand
Phone: +64 4 816 2000
Fax: +64 4 816 2340

A SEPARATE UNIT OF
THE MINISTRY OF HEALTH

24 February 2012

Mr Wayne Turp
General Manager
Funding & Planning
West Coast District Health Board
Corporate Office
P.O. Box 387
GREYMOUTH 7840

Dear Wayne

Cancer Screening Coverage by District Health Board

One of the key objectives for the National Screening Unit is to develop our relationship with District Health Boards and assist your understanding of cancer screening programmes and their relationship to your local population.

As part of this process please find enclosed information reports on BreastScreen Aotearoa (BSA).

The National Cervical Screening Programme reports have been developed in a new format and will be sent electronically to you.

Similar to the past DHB level reports (last ones sent to your DHB in February 2010), the enclosed reports give two year screening coverage data for BSA for each DHB and nationally.

In response to requests for time trend data, the enclosed reports also show screening coverage data for BSA for the periods ending June & December for 2008 to 2011.

BreastScreen Aotearoa (BSA) is the publicly funded national breast screening programme that checks women for early breast cancer by providing mammograms to eligible women every two years.

The programme aims to screen 70% of the eligible population (women aged 45-69) every two years to achieve a 30% reduction in breast cancer mortality.

The BSA programme is delivered throughout New Zealand by eight Lead Providers, their sub contracted providers and mobile screening units that deliver services to rural and some urban communities.

The information enclosed, is direct from the BSA database that relates *only* to breast screening provided by the BSA programme.

Please note that whilst the programme screens women from 45-69 years, in this report BSA coverage is for the 50-69 year age group. This is due to there being insufficient international data from which to derive targets for biennial screening of women under 50 years.

The 70% target for women 50-69 years must be achieved for women of all ethnicities, not just at an overall level.

In Table 1 where no number is shown in the column titled Pacific coverage, there is no Pacific population in that district as derived from the 2001 Census.

The designated Lead Provider for West Coast DHB is BreastScreen South Limited (BSSL). The Lead Provider Manager is Joan Miles who can be contacted on 03 379 9025 email Joan.miles@breastscreensouth.co.nz.

If you wish to discuss the BSA information or the provision of your local service in more detail please contact your Lead Provider Manager in the first instance.

Yours sincerely

Rose Kahaki
Manager, Cancer Screening Unit
National Screening Unit

cc Joan Miles, BSSL

Breast Screening Programme DHB Report as at June 2011

West Coast DHB

BSA 24-month or 2 year coverage is the number of BSA screened women aged 50-69 years during the 24-month period as a proportion of all eligible women in New Zealand aged 50-69 years as derived from the 2006 Census population projections for that screening period.

Table 1: BSA Coverage of West Coast DHB Māori women aged 50-69 years for the 24 months ending June 2011

	Eligible Māori Population*	Number of Māori women screened	Coverage of Māori Population
West Coast DHB	250	175	70.0%

**Population projection data based on the 2006 Census produced by Statistics New Zealand according to assumptions specified by the Ministry of Health .*

Figure 1: BSA Coverage of Māori women aged 50-69 years by DHB for the 24 months ending June 2011

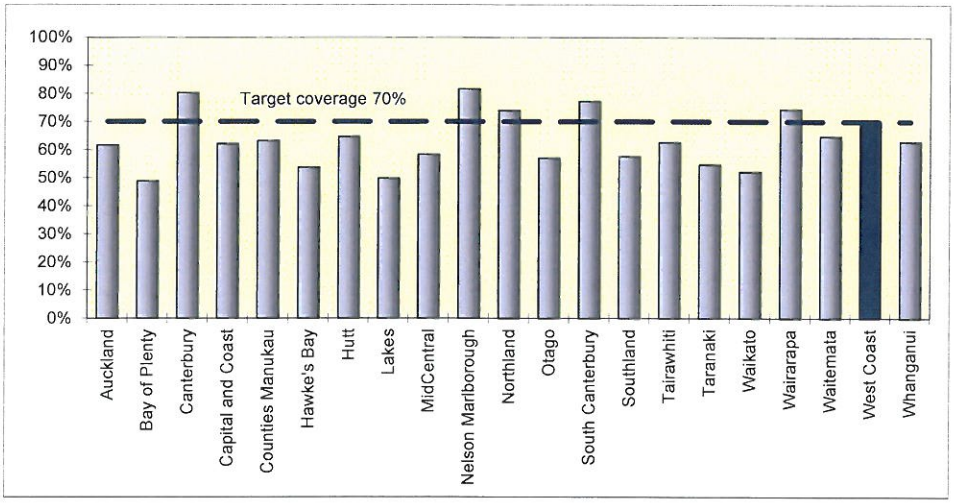


Table 2: BSA Coverage of West Coast DHB Pacific women aged 50-69 years for the 24 months ending June 2011

	Eligible Pacific Population*	Number of Pacific women screened	Coverage of Pacific Population
West Coast DHB	10	9	90.0%

**Population projection data based on the 2006 Census produced by Statistics New Zealand according to assumptions specified by the Ministry of Health .*

Figure 2: BSA Coverage of Pacific women aged 50-69 years by DHB for the 24 months ending June 2011

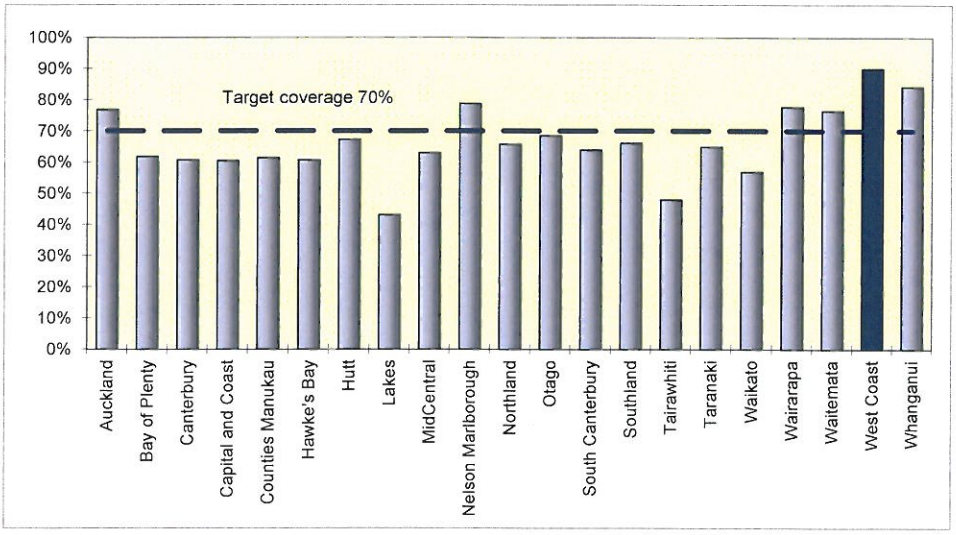


Table 3: BSA Coverage of West Coast DHB of Total women aged 50-69 years for the 24 months ending June 2011

	Total Eligible Population*	Total Number of women screened	Coverage of Total Population
West Coast DHB	4,135	2,916	70.5%

**Population projection data based on the 2006 Census produced by Statistics New Zealand according to assumptions specified by the Ministry of Health .*

Figure 3: BSA Coverage of Total women aged 50-69 years by DHB for the 24 months ending June 2011

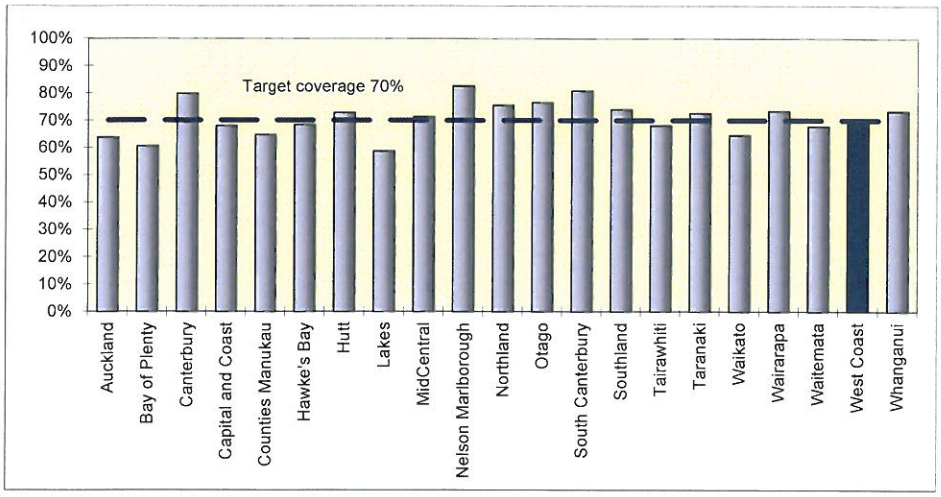


Figure 4: West Coast DHB and National BSA Coverage of Total women aged 50-69 years for the 24 months ending June 2008, 2009, 2010 & 2011 and December 2008, 2009 & 2010

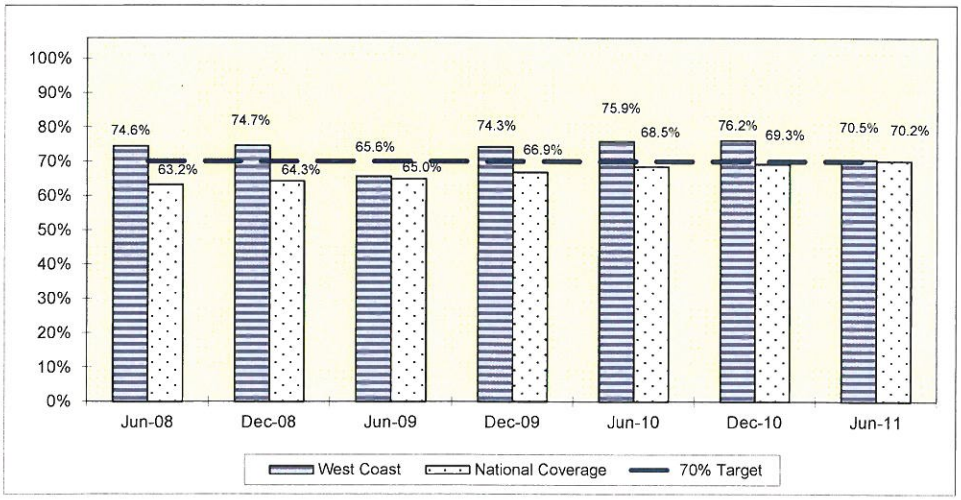


Figure 5: West Coast DHB BSA Coverage of women aged 50-69 years by ethnicity for the 24 months ending June 2008, 2009, 2010 & 2011 and December 2008, 2009 & 2010

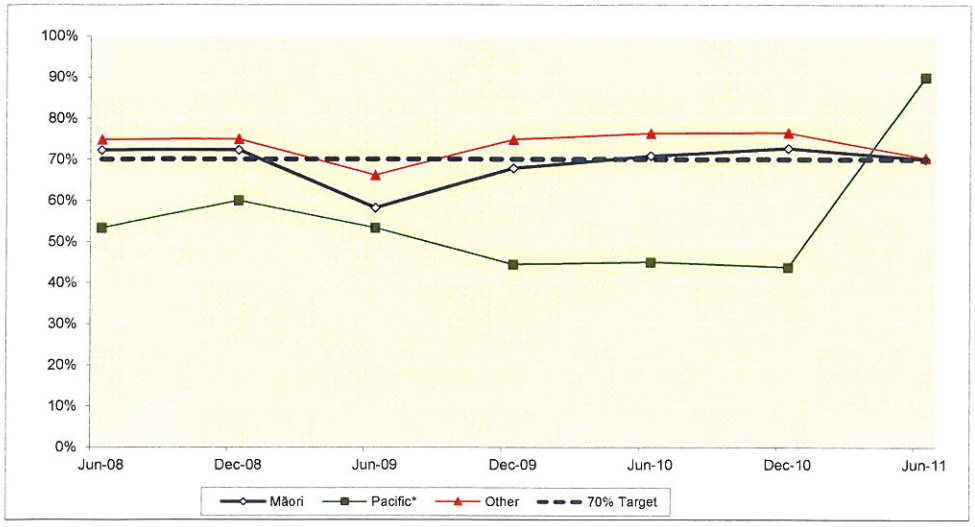


Table 4: West Coast DHB BSA Coverage of women aged 50-69 years by ethnicity for the 24 months ending June 2008, 2009, 2010 & 2011 and December 2008, 2009 & 2010

24 months ending	Māori*	Pacific*	Other	Total
Jun-08	72.3%	53.3%	74.8%	74.6%
Dec-08	72.3%	60.0%	74.9%	74.7%
Jun-09	58.2%	53.3%	66.1%	65.6%
Dec-09	67.8%	44.4%	74.8%	74.3%
Jun-10	70.8%	45.0%	76.3%	75.9%
Dec-10	72.7%	43.8%	76.5%	76.2%
Jun-11	70.0%	90.0%	70.3%	70.5%

** Please note the Māori and Pacific populations for West Coast DHB are small and therefore small changes in the number of BSA screens of Māori and Pacific women can cause wide fluctuation in coverage and therefore caution should be taken in comparing coverage trends overtime for Māori and Pacific women.*

REPORTS

Workplan

Organisational Leadership Report

Clinical Leaders Report

Better Sooner More Convenient (BSMC) and Alliance Leadership Report (ALT)

Facilities Audit Report

Quality and Patient Safety

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE WORKPLAN

Objective	Responsibility	Due Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
To receive a report on relevant section for CPH/DS Advisory Committee							
1. Disability Support Issues	Portfolio Manager	Ongoing	Quarterly		√		
2. Clinical Leadership	Chief Medical Advisor	Ongoing	Quarterly		√		Report provided from the Clinical Leadership Team
3. Primary Health Organisation Quarterly Report	Chief Executive Officer West Coast PHO	Ongoing	Quarterly		√		
4. Quality and Risk Management to monitor	Quality and Risk Manager	Ongoing	Each meeting		√		Report included in papers.
5. Human Resources	Human Resource Manger	Ongoing	Each meeting		√		
6. Financial performance	Chief Financial Officer	Ongoing	Each meeting		√		Report included in papers.
Provide input into							
7. South Island Health Alliance Leadership Team / Regional Clinical Services Plan	Chief Medical Advisor /General Manager Planning and Funding		Quarterly		√		
8. Annual Plan / Statement of Intent	General Manager Planning and Funding	2012-2013	Annually		√		Annual Plan has been submitted to the Ministry, expected feedback end of April.
9. Annual Report	Chief Financial Officer / General Manager Planning and Funding	18 November 2011	Annually				The Annual Report is available upon request.
10. Provision of advice to the Board on how to reduce the deficit	Chief Finance Officer	Ongoing	Each meeting		√		
11. Provision of advice to the Board on how to effectively collaborate with other DHBs	Clinical Leaders		Quarterly		√		

To monitor							
12. Better Sooner More Convenient / IFHCs	General Manager Planning and Funding	Ongoing	Each meeting		√		
13. The Health targets to monitor	General Manager Planning and Funding	Ongoing	Quarterly		√		Will be available for the next meeting – May 2012.
14. Ministry of Health quarterly reports against other aspects of the Annual Plan / Statement of Intent	General Manager Planning and Funding	Ongoing	Quarterly		√		Will be available for the next meeting – May 2012.
15. Mental Health Service Issues	Portfolio Manager	Ongoing	As required				
16. Maori Health Issues	General Manager Maori Health	Ongoing	As required				
17. Child and Youth Health	Portfolio Manager	Ongoing	As required			√	
18. Access to primary health – GP waiting times	West Coast Primary Health Organisation	Ongoing	Quarterly		√		Anthony Cooke - PHO
Advisory Committee presentations			Each meeting?				
19. Clinical Leadership	Dr. Carol Atmore	14 April 2011				√	Report included in papers.
20. Elder care strategy	Dr. Jackie Broadbent	19 May 2011				√	
21. Pharmacy services	Nick Leach	14 July 2011				√	
22. Laboratory services	Phil Clarke	30 September 2011			√		

ORGANISATIONAL LEADERSHIP REPORT

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

FROM: **Wayne Turp, General Manager Planning and Funding**

DATE: **4 April 2012**

PLANNING AND FUNDING EXCEPTION REPORT

2012/2013 Annual Plan and Statement of Intent
The first draft of the 2012/2013 Annual Plan and Statement of Intent (APSOI) has been submitted to the Ministry of Health and is currently under consideration, and their feedback is due back at the end of April.

Community laboratory / referred services
Medlab South have signalled that they will discontinue the provision of services for community referred laboratory testing and have not sought an extension of their contract beyond 31 March 2012. WCDHB Hospital Laboratory has confirmed that it has the capability and capacity to provide testing services for both hospital and community refereed services in future. A process of engagement with primary health and other community based referrers has been initiated to ensure service continuity of service beyond April 2012.

Better Sooner More Convenient
Please refer to BSMC and ALT document Section 8.4.

Healthy Eating Healthy Action
There is uncertainty over the Government's intention on the funding of Healthy Eating Healthy Action beyond the 2011/2012 financial year. HEHA activity on the West Coast has achieved some significant successes in contributing towards improved health outcomes for people leaving within the district. It is also deeply embedded and aligned with integrated health care and improved clinical outcomes through Better Sooner More Convenient service delivery. Confirmation on future direction for HEHA is being sought from the Ministry of Health.

FINANCIAL REPORT JANUARY 2012

Financial Overview for the period ending 29 February 2012

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,182	6,219	(37)	×	50,311	49,916	395	?
Governance & Administration	208	212	(4)	×	1,704	1,698	6	?
Funds & Internal Eliminations	4,450	4,284	166	?	35,354	35,438	(84)	×
	10,840	10,715	125	?	87,369	87,051	318	?
EXPENSES								
Provider								
Personnel	4,388	4,027	(361)	×	34,824	34,778	(46)	×
Outsourced Services	927	813	(114)	×	8,899	7,296	(1,603)	×
Clinical Supplies	681	615	(66)	×	5,308	4,820	(488)	×
Infrastructure	1,102	907	(195)	×	7,694	7,339	(355)	×
	7,098	6,362	(736)	×	56,725	54,232	(2,493)	×
Governance & Administration	103	212	109	?	1,450	1,698	248	?
Funds & Internal Eliminations	3,562	3,599	37	?	29,040	29,975	935	?
Total Operating Expenditure	10,763	10,173	(590)	×	87,215	85,905	(1,310)	×
Deficit before Interest, Depn & Cap Charge	(77)	(542)	(465)	×	(154)	(1,146)	(992)	×
Interest, Depreciation & Capital Charge	547	551	4	?	4,098	4,408	310	?
Net deficit	**470**	**9**	**(461)**	×	**3,944**	**3,262**	**(682)**	×

ORIGIN OF REPORT

This is a regular report and standing agenda item providing an update on the latest financial results and other relevant financial matters of the Provider Arm of the West Coast District Health Board.

CONSOLIDATED RESULTS

The consolidated result for the month of February 2012 is deficit of $470k, which is $461k worse than budget ($9k deficit).

RESULTS FOR EACH ARM

Year to Date to February 2012

West Coast District Health Board Arm	Actual	Budget	Variance	Comment
	$000	$000	$000	
Provider Arm surplus / (deficit)	(10,512	(8,726)	(1,786)	Unfavourable
Funder Arm surplus / (deficit)	6,314	5,464	850	Favourable
Governance Arm surplus / (deficit)	254	0	254	Favourable
Consolidated result surplus / (deficit)	**(3,944)**	**(3,262)**	**682**	**Unfavourable**

WEST COAST DISTRICT HEALTH BOARD
FUNDER ARM - PAYMENTS TO EXTERNAL PROVIDERS
as at 29 February 2012

Feb-12					SERVICES	Year to Date					2011/12	2010/11	
Actual	Budget	Variance				Actual	Budget	Variance			Annual Budget	Actual Result	Change (actual 10/11 to budget 11/12)
$000	$000	$000	%			$000	$000	$000	%		$000	$000	%
					Referred Services								
24	36	12	34%	√	Laboratory	269	322	53	16%	√	486	511	5%
573	634	61	10%	√	Pharmaceuticals	5,337	5,505	168	3%	√	8,473	7,705	-10%
597	**670**	**73**	**12%**	√		**5,606**	**5,826**	**219**	**4%**	√	8,959	8,216	-9%
					Secondary Care								
5	20	15	74%	√	Inpatients	31	157	126	80%	√	237	38	-523%
87	116	29	25%	√	Travel & Accommodation	802	927	125	14%	√	1,391	1,189	-17%
1,285	1,285	0	0%	√	IDF Payments Personal Health	10,253	10,276	24	0%	√	15,414	15,606	1%
1,377	**1,421**	**44**	**3%**	√		**11,086**	**11,360**	**274**	**2%**	√	17,042	16,833	-1%
					Primary Care								
22	25	3	12%	√	Dental-school and adolescent	242	296	54	18%	√	467	399	-17%
0	2	2	100%	√	Maternity	0	18	18	100%	√	26	0	
0	1	1	100%	√	Pregnancy & Parent	0	5	5	100%	√	8	0	
0	3	3	100%	√	Sexual Health	8	22	14	64%	√	33	13	-152%
1	0	-1		×	General Medical Subsidy	19	3	-16	-494%	×	5	76	94%
526	523	-3	-1%	×	Primary Practice Capitation	4,303	4,183	-120	-3%	×	6,275	6,135	-2%
9	7	-2	-29%	×	Primary Health Care Strategy	60	55	-5	-9%	×	83	251	67%
77	77	0	0%	√	Rural Bonus	617	618	1	0%	√	928	970	4%
-14	13	27	204%	√	Child and Youth	76	107	31	29%	√	162	162	0%
2	3	1	33%	√	Immunisation	40	42	2	5%	√	96	154	38%
22	14	-8	-56%	×	Maori Service Development	119	108	-11	-10%	×	162	165	2%
18	31	13	42%	√	Whanua Ora Services	144	250	106	42%	√	373	215	-74%
62	13	-49	-373%	×	Palliative Care	99	105	6	6%	√	157	110	-43%
9	15	6	40%	√	Chronic Disease	86	174	88	51%	√	286	3	-9440%
11	11	0	2%	√	Minor Expenses	88	90	2	2%	√	134	206	35%
745	**738**	**-7**	**-1%**	×		**5,901**	**6,076**	**175**	**3%**	√	9,195	8,859	-4%
					Mental Health								
11	1	-10	-1000%	×	Eating Disorders	11	8	-3	-38%	×	12	23	48%
51	50	-1	-2%	×	Community MH	401	401	0	0%	√	601	538	-12%
1	1	0	0%	√	Mental Health Work force	8	6	-2	-43%	×	8	15	44%
47	47	0	0%	√	Day Activity & Rehab	381	379	-2	0%	×	569	518	-10%
10	10	0	0%	√	Advocacy Consumer	67	82	15	18%	√	122	120	-2%
6	5	-1	-13%	×	Advocacy Family	59	42	-17	-39%	×	64	71	10%
0	5	5	100%	√	Minor Expenses	0	41	41	100%	√	61	0	
102	118	16	13%	√	Community Residential Beds	813	941	128	14%	√	1,411	1,261	-12%
66	66	0	0%	√	IDF Payments Mental Health	528	530	2	0%	√	796	813	2%
294	**303**	**9**	**3%**	√		**2,268**	**2,430**	**162**	**7%**	√	3,644	3,359	-8%
					Public Health								
0	29	29	100%	√	Nutrition & Physical Activity	140	228	88	39%	√	342	328	-4%
0	7	7	100%	√	Public Health Infrastructure	75	55	-20	-36%	×	83	82	-1%
0	0	0		√	Social Environments	0	0	0		√	0	-15	100%
78	6	-72	-1293%	×	Tobacco control	96	45	-51	-114%	×	68	58	-17%
78	**42**	**-36**	**-86%**	×		**311**	**328**	**17**	**5%**	√	493	453	-9%
					Older Persons Health								
0	0	0		√	Information and Advisory	22	0	-22		×	0	0	
4	0	-4		√	Needs Assessment	33	0	-33		×	0	0	
83	36	-47	-128%	×	Home Based Support	409	393	-16	-4%	×	595	708	16%
10	10	-1	-5%	×	Caregiver Support	89	76	-13	-17%	×	114	130	12%
214	156	-58	-37%	×	Residential Care-Rest Homes	1,878	1,355	-523	-39%	×	2,030	2,344	13%
-2	0	2		√	Residential Care Loans	-35	0	35		√	0	-113	100%
13	10	-3	-27%	×	Residential Care-Community	96	82	-14	-18%	×	122	48	-155%
279	342	63	18%	√	Residential Care-Hospital	2,393	3,076	683	22%	√	4,622	3,949	-17%
0	5	5	100%	√	Ageing in place	12	43	31	72%	√	65	12	-440%
7	7	0	1%	√	Environmental Support Mobility	29	57	28	49%	√	85	28	-204%
12	6	-6	-94%	×	Day programmes	88	50	-38	-77%	×	74	75	1%
10	12	2	17%	√	Respite Care	126	95	-31	-32%	×	143	118	-21%
108	108	0	0%	√	IDF Payments-DSS	864	866	2	0%	√	1,300	1,060	-23%
738	**692**	**-46**	**-7%**	×		**6,004**	**6,093**	**89**	**1%**	√	9,151	8,359	-9%
3,829	**3,865**	**37**	**1%**	√		**31,176**	**32,111**	**935**	**3%**	√	**48,483**	**46,079**	**-5%**

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

WHOLE OF HEALTH SYSTEM

PLANNING AND FUNDING – FINANCIAL

The District Health Board's result for services funded with external providers for the month of February 2012 was $37k (1%) better than budget and year to date payments are $935k (3%) better than budget.

Commentary on year to date variances

Referred Services
Community pharmaceuticals are $168k less than budget (actual cost to date has not followed the way the budget has been phased) and laboratory services are $53k less than budget – payments for blood products to private hospitals and tests via Medlab.

Secondary Care
Secondary Care services are $274k less than budget, with travel and accommodation paid under the National Travel Assistance (NTA) scheme being $125k less than budget to date. Claims for NTA are not always received on a timely basis and payments to date may reflect this, with a catch up in future months. Inter-District Flows (IDFs) reflected for the year are cash payments made and based on the budget for IDFs. Inpatient costs are $126k less than budget (electives performed by external providers).

Primary Care
Whanau Ora service costs are $106k less than budget. Maori service development is $11k more than budget reflecting the new contract. Although discretionary costs (chronic conditions and palliative care) are less than budget palliative care costs in February were $49k more than budget as invoices relating to prior months were received in the month... Palliative care is expected to be on budget for the remainder of the year. Capitation payments are $120k more than budget to date; this largely relates to payments for Careplus, Very Low Cost Access and PHO performance payments – as funding for these is non devolved this cost will be covered by Ministry of Health revenue.

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

Public Health
Expenditure varies throughout the year depending on when grants are dispersed and contracts begin. Expenditure is funded by the Ministry of Health.

Older Persons Health
Overall expenditure (residential and non residential) is just less than budget year to date (by $89k or 1%) less. These costs are mainly demand driven with prior approval required to access (via Carelink and Home Based Support services). Funding for these services has also been made more flexible (as seen in some of the variances to budget) with contracts for home and community based care which enable people to remain in the community and delay entry to residential care.

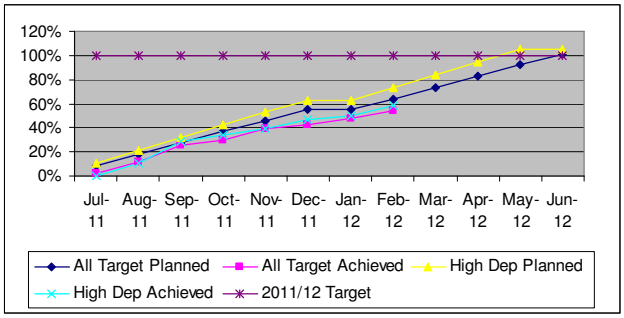
PLANNING AND FUNDING OVERVIEW

Progress against key target areas for the period ending February 2012

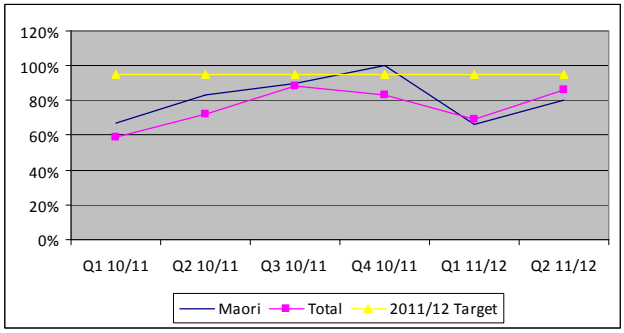
Publication of progress reports against the government's health targets for the period ending March 2012 will not be available until late April.
Progress reports against internal targets are as follows:

Prevention Services

B4 School Check coverage



Percentage of hospitalised smokers given advice and help to quit



ACHIEVEMENTS/ISSUES OF NOTE

B4 School Check: With 67% of the 2011/12 financial year gone, the WCDHB has achieved 54% of all target population and 58% of high needs target. These results are not significantly below the national average of 61% for both indicators, however, there is a risk the WCDHB might not achieve its target for all target population for 2011/12 if the rate of checks completed per month remains the same. The B4SC Coordinator and the public health nurses will be conducting extra checks during the April school holiday period, and at schools during the months of May and June.

Antenatal HIV Screening: There is no update for AHIV – this programme now reports six monthly.

Immunisation: The quarter 3 report is not yet available but for the 3 months ending February 2012, 83% of all children turning 2 years old were fully immunized compared to 79% for the 3 months ending February 2011. The coverage for Maori Tamariki 2 year olds for the 3 month period ending February 2012 is 86%, similar to the coverage for the same period ending February 2011.
The total coverage rate for the 12 months ending in February 2012 is 84% - 2% more than the coverage for the 12 months ending in February 2011. Likewise, the coverage for Tamariki Maori turning 2 years for the 12 month ending in February 2012 (88%) increased by 2% compared to the coverage for the same period ending February 2011.

There is still high opt off and decline rates and work on reducing the decline rates and achieving the highest possible immunisation coverage rate continues to be a focus in both primary care and for the Outreach Immunisation Services. The National Immunisation Week on the 23rd-29th April 2012 will be utilised to promote immunisation and raise community awareness of the importance of immunisation; the importance of immunising on time; role of outreach activities, promoting local immunisation services and have integrated activities.

	3 months ending February 2012				12 months ending February 2012			
	Fully Immunised	Opt Off	Declined	Un known	Fully Immunised	Opt Off	Declined	Un
#	100	8	10	3	389	29	36	11
%	83%	6.6%	8.3%	2.5%	84%	6.2%	2.7%	2.4%

Pertussis update: Between 1st May 2011 and 24th February 2012 there have been 431 notifications of suspected Pertussis received by Community and Public Health's West Coast Office. Of these notifications 264 are either confirmed or probable cases and 5 are under investigation. Although case numbers are declining, the incidence is still well above endemic rates.

Smokefree Health Target – ABC Implementation:

Secondary

Quarter 3 Results to-date:
January 2012 – 86%
February 2012 – 96%

The percentage of smokers given support to quit continues to increase each month (December 83%), with February being the first month of 2011/12 the health target of 95% has been met. Most wards within the DHB are now regularly achieving 100% or close to for ABC, it is important support is continued in these wards but the focus of the smokefree staff will be to bring all wards to this standard and then sustain this positive change. Visibility of the smokefree staff and ABC message will continue to be a priority and identifying training gaps for to result in an increase in our quarter 3 result.

Primary

Activities have continued during this reporting period to improve implementation of the ABC initiative in primary care. The Smokefree Coordinator and WCPHO Clinical Manager are continuing to focus on medical practice visits ('road show'), to raise awareness of the targets, discuss quarter 1 & 2 results and discuss coding. At each visit it has been helpful to arrange a follow-up visit to ensure actions are followed up and to give practices an opportunity to come back with any questions or comments regarding the systems in place for the ABC initiative.

Training

There were two Smokefree training workshops held in March available for DHB staff and others in the community to improve their knowledge around ABC and providing cessation support to the West Coast community. The Smokefree ABC STEPS training (funded by the MOH) was attended by the Smokefree champions and delivered by the national trainer from Hawke's Bay DHB 20 attendees) and was aimed at up skilling those with a good knowledge base around ABC. A more introductory two-day Heart Foundation Quit Card training in Greymouth was also delivered resulting in 14 Quit Card providers on the Coast.

Healthy Eating Healthy Action (HEHA)

Breastfeeding Workshop

Breastfeeding education days were held in Westport and Greymouth in March. These were facilitated by Carol Bartle an international speaker on breastfeeding. The topics included an update on the latest breastfeeding research and also covered issues that were identified by the community Lactation Consultants as problem areas for mothers on the West Coast. Health professionals from both primary and secondary as well as organisations who work with families took part. A total of 49 attended the workshop (Westport – 14, Greymouth – 35).

Warm Up West Coast – Home Insulation Project: During this reporting period information regarding the Warm Up West Coast project was distributed to schools and ECE's on the West Coast with the help of the Health Promoting Schools Team at C&PH.

Data below is as of March 23 2012:

	Number
Applications received by Healthy West Coast	217
Applications forwarded to The Insulation Company	183
Applications to be processed	15
Number of applicants declined *	19
Number of homes insulated	81

HPV:

The on-going cohort for the HPV school-based immunisation programme in 2012 are for girls born in 1999 or those in Year 8 with the HPV target for dose 1 (70%), dose 2 (65%) and dose 3 (60%).

At this stage about 45% of Year 8 girls had their HPV dose one. There is a 90% uptake of dose one for Year 8 girls in Cobden whereas in Grey Main, only about a quarter of Year 8 girls had dose one. Those who declined vaccination will be sent a letter by the Manager Cervical Screening with another consent form before the 2nd round of HPV vaccination.

HPV vaccination for Hokitika is done off school site at the Hokitika Health Centre.

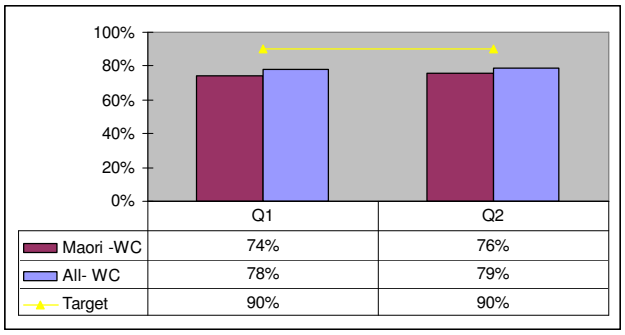
Family Violence Intervention: Routine Screening of women aged 15+ accessing hospital services continues in the identified 'priority' services (mental health, alcohol and other drug, emergency department, child health, maternity and sexual health services). As reported last time 17% of women accessing hospital services were screened for family violence during the period 1 July – 31 December 2011. This is 33% lower than the DHB target of 50%. Of the 398 women screened for family violence 23 women (5%) screened positive. The next six-monthly report will be available in July.

	1 January - 30 June 2011	1 July – 31 Dec 2011
Number of women screened	460	398
% of women screened	20%	17%
Number of women screened positive	25	23
% of women screened positive	5%	5%

Chart audits undertaken in 5 services (20 charts per service) found 39% of women were screened for family violence indicating that screening rates maybe higher, but are not being recorded electronically. Different IT systems are posing some difficulties in correlation of data in this regard. On-going family violence training to staff is aiming to address the quality and accuracy of data relating to our screening rates, as well as the uptake in the number of women screened.

Early Detection and Management

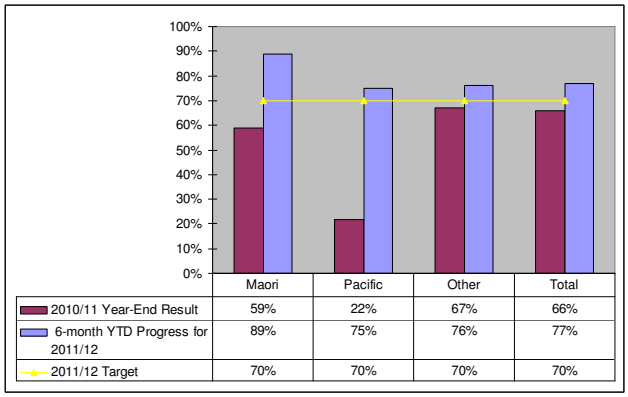
CVD Risk Assessment



	Q1	Q2
Maori -WC	74%	76%
All- WC	78%	79%
Target	90%	90%

Data for period to 31 December only. Quarter 3 data will not be available until late April.

Diabetes Detection

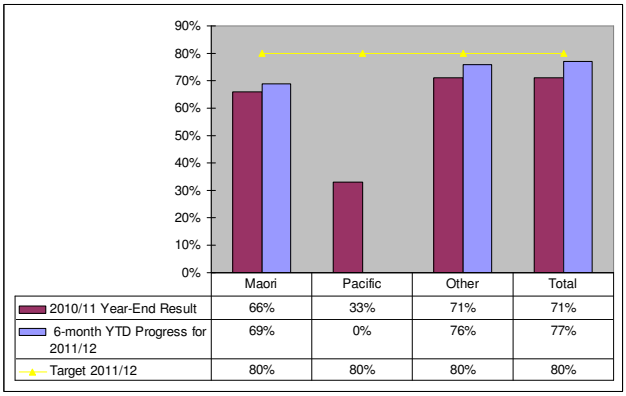


	Maori	Pacific	Other	Total
2010/11 Year-End Result	59%	22%	67%	66%
6-month YTD Progress for 2011/12	89%	75%	76%	77%
2011/12 Target	70%	70%	70%	70%

% of people estimated to have diabetes who have had their free annual check during the current year to date, against YTD target

Data for period to 31 December only. Quarter 3 data will not be available until late April.

Diabetes Good Management



	Maori	Pacific	Other	Total
2010/11 Year-End Result	66%	33%	71%	71%
6-month YTD Progress for 2011/12	69%	0%	76%	77%
Target 2011/12	80%	80%	80%	80%

% of people with diabetes who have HBA1c levels at or below 8.0 when assesses at free annual diabetes check.

Data for period to 31 December only. Quarter 3 data will not be available until late April.

ACHIEVEMENTS/ISSUES OF NOTE

CVD Risk Assessment: As noted last report, the DHB achieved 79% in Q2, 2011/12, 1% higher than the last quarter and 6% more than the national average of 74%. The target for this measure is 90%. The Ministry of Health has noted the good actions and plans that have been implemented. Quarter 3 data will not be available for analysis until late April.

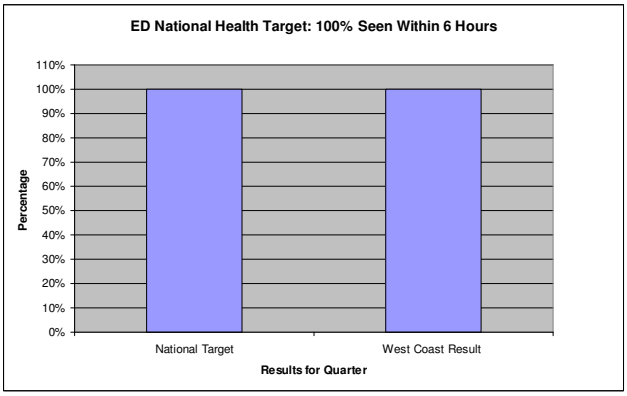
Primary Mental Health: As noted last report, brief Intervention Counselling (BIC) was provided in primary care to 62 new clients in Q2 2011/12, 7 aged 0-19 and 55 aged 20+. Outcome data indicates that significant changes were made to the level of psychological distress and that this was maintained over time.
The averages GHQ score (a 30 point score of psychological distress) on entry to the service was

24, with a reduction in the average score post BIC to 5 and an increase to 11, 6 months post intervention. Quarter 3 data will not be available until late April.

Oral Health The community dental service is continuing to implement a preventative model of care. According to the recent WCDHB School Dental Service data, the percentage of children who are caries free has increased by 9% in 2011 (61% -caries free) calendar year compared to the 2010 calendar year (52%). The Mean DMFT (Decayed. Missing and Filled Teeth) for Year 8 children is 1.39 in 2011 calendar year compared to 1.32 in the 2010 calendar year which is not statistically significant.

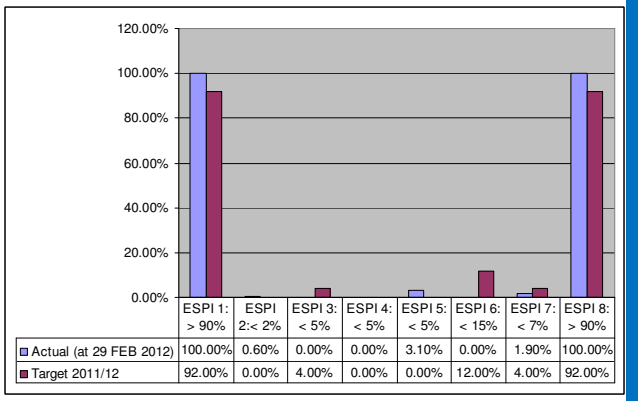
Intensive Assessment and Treatment Services

Emergency Department Waiting Times – YTD Performance to 31 March 2012



Results for the 9 months to 31 March 2012 stand at 99.7% of patients seen, treated within 6 hours.

Improving Outcomes for Elective Services: Elective Service Performance Indicators (ESPI)

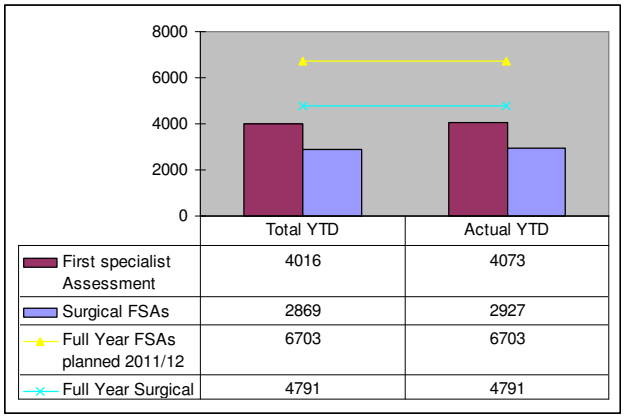


	ESPI 1: > 90%	ESPI 2:< 2%	ESPI 3: < 5%	ESPI 4: < 5%	ESPI 5: < 5%	ESPI 6: < 15%	ESPI 7: < 7%	ESPI 8: > 90%
Actual (at 29 FEB 2012)	100.00%	0.60%	0.00%	0.00%	3.10%	0.00%	1.90%	100.00%
Target 2011/12	92.00%	0.00%	4.00%	0.00%	0.00%	12.00%	4.00%	92.00%

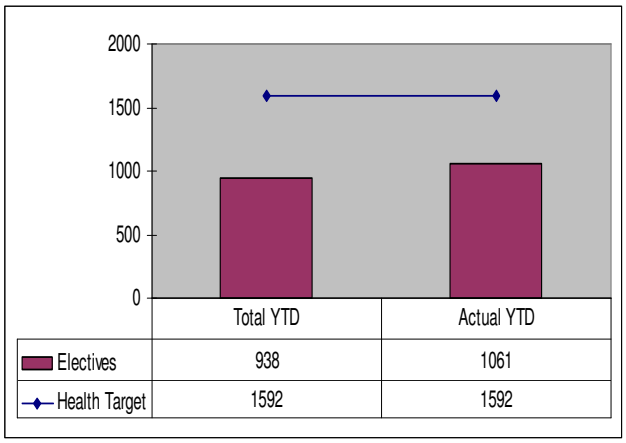
Results as at 29 February 2012.
It is noted that while the results are on target, we would be outside ESPI compliance in ESPI2 and ESPI5 if measured against new targets it comes into force from July 2012 (as would most other DHB's). The Provider Arm is working to address this in the build up to these new targets taking effect.

Improving Outcomes for Elective Services: National Health Target - Elective Surgery Service Throughputs to 31 December 2011.

Improving Outcomes for Elective Services: Ambulatory Initiative Throughput (Specialist Outpatients) to 31 December 2011.

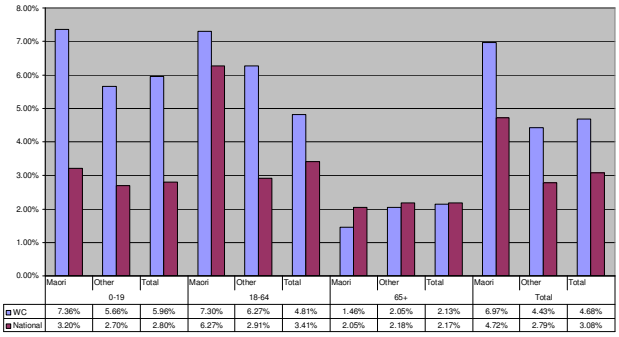


	Total YTD	Actual YTD
First specialist Assessment	4016	4073
Surgical FSAs	2869	2927
Full Year FSAs planned 2011/12	6703	6703
Full Year Surgical	4791	4791



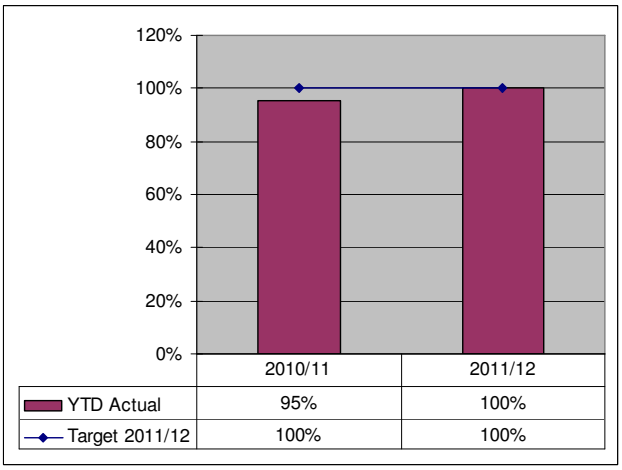
Data for period to 31 December only. Quarter 3 data will not be available until late April.

Access to Specialist Mental Health Services 1 October 2010 – 30 September 2011



Updated national data for this measure is not yet available from the Ministry of Health.

Radiation Therapy Treatment Services Waiting Times



% of patients in Category A, B & C who receive radiation oncology treatment less then 4 weeks of their first specialist assessment (as defined by National Health Target definition of measurement)
Actual results to 29 February 2012.

ACHIEVEMENTS/ISSUES OF NOTE

Radiotherapy Waiting Times Data

There have been 3 patients in the current financial year to 19 March 2012 who have exceeded the 4-week waiting time to commence radiotherapy treatment (two in the July-September 2011 quarter and one in February 2012). None were delayed due to capacity constraints, which is the factor that determines performance against the national health target; but rather, by patient choice and by clinical management considerations. As such, West Coast DHB performance against the national health target remains at 100%. All other West Coast domiciled patients treated in the priority treatment categories (acute; curative; palliative; and radical) have commenced treatment with four weeks of referral.

Mental Health Collaborative Initiative: Te Pou and Matauraki attended the meeting in Greymouth on 22nd February at the request of the Collaboration Initiative to outline how they can assist with training on the West Coast for the Let's Get Real (LGR) and the Co - Existing Problems (CEP) projects. An overview of these projects was provided. A decision was reached to undergo a Process Mapping exercise facilitated by Te Pou/ Matauraki on 26 April as starting point what each service provides so that areas of duplication are identified as well as possible areas for closer

integration. The group is considering changing the terms of reference and membership of the collaboration initiative group to resemble the *Future Directions* model in Southland.

Elective Services: National Health Target - Elective Surgery Service Throughputs to 31 January 2012: (latest confirmed results)

The year to date (YTD) report as of January 2012 shows that there were 1061 actual raw surgical discharges, 113% against the planned 938 surgical discharges. These discharges resulted in case weight discharges (CWD) of 1470; which was over-delivery at 115.8% of planned year-to-date volume, and is equivalent to 66.7% of the total planned CWD delivery for the financial year.

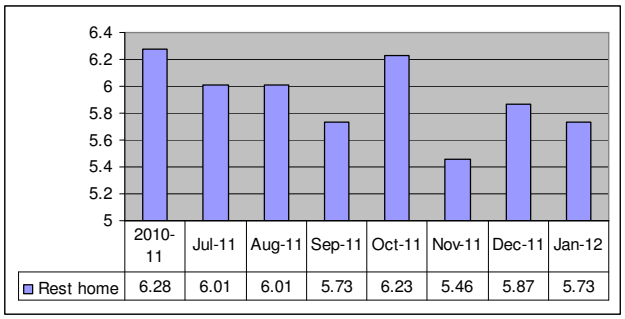
2011/12 Elective Surgery	Raw Discharges	Caseweighted Discharges
Total Planned YTD Volume	938	1269.4
Actual YTD Delivery	1061	1470.1
% Delivered Against Plan	113.1%	115.8%

Elective Services: Ambulatory Initiative Throughput (Specialist Outpatients) to 31 January 2012: (latest confirmed results)

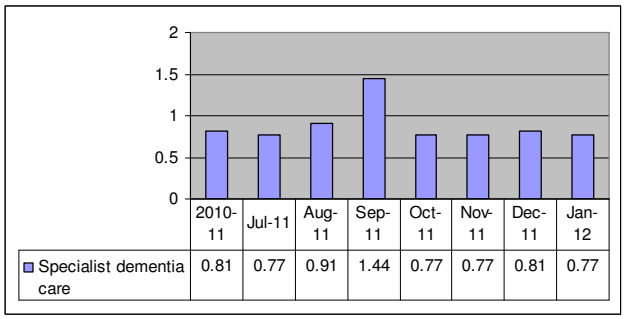
Overall first specialist outpatient assessment services for all specialties have been delivered at 101.4% of planned services for the 7-month period to 31 January 2012; and stand at 60.7% of the 2011/12 total planned. Total delivery YTD is 4073 attendances.
Similarly, the surgical first specialist outpatients has been delivered at 102.0% of planned YTD volume; which is equivalent to 59.9% of the 2011/12 total planned surgical FSAs.

Rehabilitation and Support Services Older Persons' Health

Proportion of people aged 75+ in Rest Home level care



Proportion of people aged 75+ in Specialist Dementia care



ACHIEVEMENTS/ISSUES OF NOTE

Specialist Health of Older People's Services – The establishment of a Chronic Care Clinical Network (with CDHB geriatrician input) has been incorporated into the 2012-13 Annual Plan and budget, following a clinical kaizen workshop and consumer focus group. An external review has been completed to inform the staffing and organisation changes needed for the CCCN to start operating by July.

Restorative homecare model – following the external review, work on this is now being aligned with the changes being made to Canterbury services. Both homecare providers are actively

upskilling their staff, with Planning & Funding support.

Community-based Respite care – Presbyterian Support Upper South Island are now providing a community respite service based out of the homes of three of the current HomeShare hosts.

Dementia training – the newly appointed dementia training coordinator will start training in residential care facilities in April/May.

Residential facilities – Planning & Funding continue to monitor the quality of care at aged care residential facilities.

RECOMMENDATION

That the Organisational Leadership Report be received.

Author:	**Wayne Turp, General Manager Planning and Funding – 3 April 2012**

CLINICAL LEADERSHIP TEAM REPORT

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

FROM: **Carol Atmore, Chief Medical Officer**
Karyn Kelly, Director of Nursing and Midwifery
Stella Ward, Executive Director of Allied Health (WCDHB and CDHB)

DATE: **12 April 2012**

ACHIEVING EFFECTIVE CLINICAL LEADERSHIP

The successful first meeting of the revised Alliance Leadership Team for the Better Sooner More Convenient work implementation was held recently. The more clinically focused leadership team focused on the core workstreams of Health of Older People, the implementation of the Buller Integrated Family Health Centre, and the development of the Grey Integrated Family Health Centre, aligned with the Regional Hospital redevelopment.

A second workshop was held in Christchurch in early February to further discuss how Canterbury and West Coast health services can be better aligned to provide reliable, high quality sustainable health services for the people of the West Coast. Over 50 senior doctors, nurses, allied health professionals and managers from both sides of the Alps were at the day. This work is continuing through a smaller working group. This work will combine with the primary and community services, and mental health services work to define the future model of care for Grey regional health services to present in draft to the April Board meeting. Community input into this process will be sought in parallel during mid-March.

NURSING AND MIDWIFERY

Nursing forums are being held to ensure Greymouth based nurses across the health sector are fully informed of Better Sooner More Convenient, the proposed redevelopment of the Grey Base hospital building and the developing model of care. A whole of team approach is being encouraged and enabled in the development and articulation of the nursing component of the model of care for the Greymouth workstream. Principles such as integration, being patient focussed, ensuring a seamless patient journey, best practice, innovation, sustainability, lean thinking and efficient use of the whole health care team are being prioritised. Clear links with the ongoing Buller workstream are also being identified with learnings and principles informing the Greymouth project.

Supporting this is the identification of the required demographic of skills and roles required, and the ongoing workforce development plan to ensure a fit for purpose nursing workforce across the region.

MEDICINE

Ongoing efforts continue to recruit general practitioners and senior hospital doctors, in collaboration with the Canterbury DHB Recruitment team, with some successes.

Focus is continuing on improving the structure and processes of the West Coast DHB owned primary practices to work to a common vision within a business model that is sustainable.

The Rural Learning Centre (RLC) facility was blessed and opened on 21 March. Our four fifth year rural immersion medical students have joined us for their academic year in 2012. The new facility will greatly enhance their learning experience with us.

ALLIED HEALTH, TECHNICAL & SCIENTIFIC

Collaboration with Canterbury continues in the development of processes and care pathways as part of the initial development of the 'Transalpine' models of care.

Allied Health staff have been participating in the various meetings looking at the 'redesign' and 'realignment' of models of care for Buller IFHC; Grey hospital and community services and the Health of Older People. Core elements of this include one allied health team providing services locality based; a philosophy of maximising independence and developing the tools to support active workload management such as capacity planning; process improvement and clinical leadership.

Work continues on developing and implementing components of integrated care across the West Coast Health system. The focus is on the transition of care between hospital and community clinicians which is a core component of the Buller model of care and is being co-led by allied health and nursing. Included in the work plan is the revamp of systems and processes to support seamless care coordination as part of a patient's journey.

Work continues on the implementation of the recommendations of the external reviews for Social work and Occupational therapy with recruitment for two clinical manager roles underway; updating of policies and procedures and clinical audit.

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

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident?*
Strong clinical governance in the planning and delivery of services across the West Coast DHB	Develop an integrated whole of system clinical governance framework for the West Coast. ▪ *The Interim Clinical Governance Group have agreed TOR and a process for membership with the aim to have the first meeting of the Clinical Board occurring in April.* ▪ *TOR attached for the Boards information*	A documented clinical governance framework for the West Coast Health system will be in place by December 2011. Staff survey results indicate improved participation in decision making; clinical leadership and clinical quality initiatives.

Provision of clinical leadership across nursing, allied health and medical staff	Strengthen senior clinical contribution into the West Coast DHB and Advisory committees. ▪ Strengthen clinical inputs into the planning of future services provision across the West Coast Health system ▪ *Work continues with regular participation from all disciplines in the various workstreams underway for future care delivery for the West Coast* ▪ *Two facilitated workshop were well attended by clinicians from the WCDHB and CDHB in December and February* ▪ *Ongoing work is developing the models of care for future services*	Regular attendance and reporting from Clinical Leaders group to Board and Advisory Committee meetings. Future health service models of care are developed by the doctors, nurses and allied health professionals who provide the service.
Increased professional development opportunities for clinical staff to increase staff retention	Develop the West Coast as a Rural Learning Centre. ▪ The Regional priorities have been agreed for Allied Health, Technical and Scientific professions and have been included in the Regional Training Hub progress report – the leadership of remote and rural services will be led by the WCDHB Rural Learning Centre. ▪ The Clinical Leaders met with the Director of the RLC to progress the development of the Centre and proposed activities moving into 2012. ▪ *The official opening of the RLC with a Powhiri and Blessing was held on February 21st. The Powhiri also welcomed new staff to the West Coast. The interdisciplinary learning concept will be led by the RLC and faculty members/support team.* Facilitate increased opportunities for the professional development of clinical staff. ▪ *HWNZ funded Nursing Post Graduate education has been finalised for 2012 with 21 nurses receiving funding for clinical PG papers, semester one is underway.* Work with Human Resources to focus on activities that enhance recruitment and retention. ▪ *The 6 new graduate nurses, 4 Midwifery first Year of Practice Midwives, and 2 Nursing Entry to Specialty Practice have now started in their respective practice areas.* ▪ *One Rural General Practice Registrar has started their GPEP 1 year at the Rural Academic Practice* ▪ *Another Rural Hospital Medicine and Rural General Practice combined fellowship Registrar is continuing their GPEP 2/registrar training on the West Coast*	Rural learning centre meets its work plan. Number of professional development workshops/ sessions provided. Increased staff retention. Workforce plan developed that will outline actions to retain and attract clinical staff and report against these – reduced staff turnover and reduced time to recruit into vacancies.

RECOMMENDATION

That the Committee receives the Clinical Leaders' Report for their information.

Authors:	**Chief Medical Officer,** **Director of Nursing and Midwifery, and** **Executive Director of Allied Health (WCDHB and CDHB) – 1 March 2012**

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

West Coast Health System
Clinical Board
Terms of Reference

Mission Statement

Provision of a proactive people focused quality healthcare system for people on the West Coast

Mission Scope

Safe Sustainable Responsive Health Care

Great standards of care, clinical leadership for people of the West Coast.

Clinical governance is the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish (Donaldson S, 1998 (adapted)).

The Clinical Board leads clinical governance in health care services provided or funded by the West Coast District Health Board (WCDHB).

The functions will include:

- promoting the primary aim of the West Coast Health System to improve the health of the community
- ensure accurate and appropriate clinical data is captured and available to clinicians for decision making
- overseeing and reporting on quality improvement systems in all areas of WCDHB responsibility
- overseeing and reporting on clinical performance and outcomes in all areas of WCDHB responsibility
- encouraging and supporting best practice and innovation by ensuring appropriate systems for professional development, support and training for the health workforce
- contributing to strategic planning and resource allocation decisions

Principles

- The Clinical Board's role is one of governance, not line management.
- The Clinical Board undertakes its role on behalf of and is accountable to the Chief Executive, WCDHB.
- The uniqueness and diversity of the various agencies across the system will be embraced.
- The Clinical Board will:
  - take a solution-oriented proactive approach
  - base its recommendations on the best available evidence
  - seek and value the contributions of all Clinical Board members
  - report regularly to the Chief Executive, Board and the health community on progress against its objectives
  - develop an annual work plan which reflects current priorities for improving patient and population health outcomes
- The Clinical Board may:
  - request reports and presentations from particular groups
  - establish sub-groups to investigate and report back on particular issues
  - commission audits or investigations on particular issues

Objectives	Across all areas of WCDHB responsibility (including strategic planning and resource allocation) is to promote: 1. an improved focus on patient and population health outcomes 2. robust quality improvement systems 3. a culture of innovation and best practice 4. a skilled and well-supported health workforce 5. a collaborative relationship with Canterbury Clinical Board
Accountability	To the Chief Executive, WCDHB
Functional Relationships	WCDHB Board (regular reports) Clinical Leaders – WCDHB, CDHB and other organisations Clinical Governance Group of WCDHB Health System Quality improvement staff in other health care organisations Relevant National WCDHB bodies
Membership	**Ex Officio Members:** Chief Executive Chief Medical Officer Director of Nursing and Midwifery Executive Director Allied Health Quality and Patient Safety Manager
Sectors	**Primary and Community Care** **Aged Residential Care** **Hospital and Specialist Service** **Consumers** Three places to be reserved for consumer representatives **Maori Representative** to be nominated by Mana Whenua **Public Health Representative** **Mental Health Services** **Rata Te Awhina** **Health and Disability from NGO representative each TLA** **Buller IFHC** All appointments to the Clinical Board are confirmed by the Chief Executive **Power to Co-opt** The Clinical Board may co-opt person or persons from time to time as required for a specific purpose.
Nomination process	Nomination will be sought from the above groups. These will be considered by a sub-committee consisting of the ex-officio members **Achieving Balance** The recommending sub-committee will seek to achieve balance in its recommendations through a range of professions and areas of association.
Chairperson and Deputy Chair	To be elected annually by a majority of the Clinical Board
Term of Office for	Three years with the right of nomination for reappointment at the end of the term of their

members	appointment provided they do not serve more than two terms consecutively.
Quorum	No less than 10 members. No less than 6 meetings per annum. Additional meetings may be held if required. Meetings will support videoconferencing to ensure whole of Coast participation.
Agenda	A written agenda will be circulated 10 days prior to the meeting to members.
Minutes	Minutes of all meetings will be circulated to Clinical Board members.

BETTER SOONER MORE CONVENIENT AND ALLIANCE LEADERSHIP REPORT

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

FROM: **Wayne Turp, General Manager Planning and Funding**

DATE: **12 April 2012**

Key Messages from the West Coast Alliance Leadership Team Meeting, Thursday 29th March 2012.

Progress reports were delivered by the three work-streams; Health of Older Persons', Buller IFHC and Grey IFHC & Regional Hospital. It was agreed that all work-streams are progressing well with a recommendation from ALT that a 'road map' be produced for each work-stream regarding the processes / implementation plans in order to provide clarity to the west coast health system, particularly regarding the workforce development and roles required under the new system.

The recommendation for a new Pharmacist 2GP Liaison service was presented by local pharmacists and discussed by ALT. The service involves having a pharmacist based at medical practices on a regular basis as a liaison for tasks such as alerting GPs to changes and new meds and MedTech set up. This would benefit the patient journey by saving time and improving the quality of care. ALT supports the principal of the proposed service and has requested the team develop more information regarding the evaluation framework, as to how to best capture the outcomes of such a service prior to sign off.

The ALT endorsed the PHO Flexible Funding Pool 2012/13 plan and the continuation of the programmes. Evaluation of the programmes was discussed with ALT expressing an interest in receiving evidence around the delivery of these programmes toward the end of 2012.

Access to MedTech for medical, nursing, allied and other staff has been identified as a priority for the successful implementation of an integrated health system and a number of staff currently using the DHB's hospital patient information system should access MedTech. An update on the progress towards this was provided to the ALT and a proposed workplan for expanding the use of MedTech. Of particular note was the discussion with the MOH regarding reporting requirements and the permission to collate and supply information by other means which has traditionally been restricted to the IPM system.

The West Coast ALT's next meeting is being held on Thursday 17th May.

Author: **Wayne Turp, General Manager Planning and Funding, April 2012**

FACILITIES AUDIT REPORT

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

FROM: **Wayne Turp, General Manager Planning and Funding**

DATE: **12 April 2012**

REPORTING

A verbal update will be given by Wayne Turp, General Manager Planning and Funding.

Author:	**Wayne Turp, General Manager Planning and Funding– 12 April 2012**

QUALITY AND PATIENT SAFETY REPORT

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

FROM: **Rachelle Hunt, Quality and Patient Safety Manager**

DATE: **12 April 2012**

REPORTING TEMPLATE

After a gap of several months, the commencement of refocused Quality and Patient Safety Manager role provides timely opportunity to establish effective reporting mechanisms for the subcommittees of the West Coast District Health Board, inclusive of the Community and Public Health and Disability Support Advisory Committees.

The following outline is submitted as a draft for discussion by CPHAC and DSAC encompassing the nature of information supplied the necessary (and prudent) level of detail, and the frequency of reporting to enable CPHAC and DSAC to fulfil its monitoring and advisory functions. The Quality and Patient Safety Manager would also welcome the opportunity to attend the next meeting (May 2012) to further understand the wider roles and functions of these (combined) sub committees, with a view to refining and improving helpful communication.

Proposed template:

INTRODUCTION

A brief paragraph detailing the period covered by the report, any key features or issues specific to this month's report, and areas where discussion is requested or recommendations made. In essence an executive summary.

CERTIFICATION STATUS

The certification process, governed by the Ministry of Health and operationalised by a designated audit agency (in our case, Verification NZ) is an external audit process which measures our performance against the Health and Disability Sector Standards (HDSS). Under the Health and Disability Services (Safety) Act 2001, services must comply with the HDSS at a minimum, to legally provide services. The certification process replaces the old Hospital Licensing process, and as such covers Hospital Care (Child Health, Medical, Geriatric, Surgical, Maternity and Mental Health) at Grey Base, Reefton and Buller Hospitals. It also covers Rest Homes operated by the Provider Arm. It includes facilities, support services, and quality systems, but doesn't community based or primary care services.

This section of the report is proposed to keep you updated on our certification status, any areas where recommendations for improvement have been made, and progress on this. Note that some

recommendations are very detailed and operational and probably don't warrant detailed inclusion, however others relate to wider system changes and their inclusion would be beneficial.

Are there any specific areas of interest for DSAC/CPHAC around certification?

INCIDENT MANAGEMENT

National Reportable Events Projects
The Health Quality and Safety Commission (HQSC) is facilitating some work at a national level to refine the process for reporting and investigating serious incidents, with a view to gaining greater consistency across DHBs, and improve learning. This section is proposed to include any updates on these projects.

Serious Incident Indicators
Nationally all incidents are coded according to their severity, using a Severity Assessment Code (SAC) score. Those rating 1 or 2 are regarded as serious, are reported to the HQSC, and are investigated using Root Cause Analysis methodology, designed to identify any system gaps, and make recommendations to prevent recurrence. This section is proposed to report (in the same manner as to HQSC – summarised and non identifiable) any SAC 1 or 2 events, and any wider system changes recommended as a result of investigation.

Incident numbers and trends
A variety of systems for reporting and investigating incidents have been in place across the DHB in the past. Since July 2011 Hospital Services have embraced the simple yet effective system used previously by Mental Health services and have seen a rise in incident reporting, and some resulting system changes as a consequence. The same system is poised to be rolled out to Community services, Buller and Reefton over the next few months. A single data base will be used, enabling more effective reporting and understanding of the types of incidents occurring, and common issues arising, so that focused attention can be given to system change. While data is not complete at this stage as the system rolls out, gets embedded, and clinician confidence is raised, it is expected that the quality and amount of data will improve.

This section is proposed to give an overview of incident occurred across the DHB, by service area and incident type.

SPECIFIC CLINICAL INDICATORS

Currently specific clinical indicators are being established for hospital services (as will be reported to CQIT). These are still being established, but will include those in focus nationally (such as Hand Hygiene, Hospital Acquired Infections, Falls Rates, Pressure Areas). Mental Health Services also regularly report Key Performance Indicators as agreed nationally (such as total bed days, access rates, average length of stay, respite use).

These will be reported through their relevant clinical governance structures – is this also something of interest/usefulness for CPHAC/DSAC, and if so, in what level of detail, and with what frequency?

CONSUMER EXPERIENCE

National and local activities
Nationally, there are discussions and projects around improving ways to capture feedback from consumers of services regarding their experience. This section proposes to provide updates (if any) around new or developing concepts.

Satisfaction Surveys
Satisfaction surveys occur on a rolling basis throughout the year in hospital services, and annually in mental health services, as outlined by the Ministry of Health. We seldom get high return rates, making it develop recommendations from findings, however information gleaned remains a source of feedback to improve services. This section proposes to outline themes of feedback, where relevant, and any activities to address issues raised.

Complaints
Service users have their right to complain enshrined in the Health and Disability Consumer Rights, and this is a rich source of feedback regarding their experience of our health system. This section proposes to detail the both the number of complaints received (by service area), the themes, and any system changes recommended as a result.

Other feedback
From time to time consumer experience is communication by other means, such as letters, consumer and/or family forums, and bouquets. This section proposes to outline other significant feedback, where available and relevant.

OTHER QUALITY IMPROVEMENT ACTIVITIES

Audit activity
In addition to certification processes, the DHB has a developing programme for auditing, both internally and through external sources. The audit programme includes routine and targeted audits, and seeks to assure that we are providing safe and high quality services to the West Coast population. This section proposes to provide a high level summary of relevant audit activity, findings and the implementation of any recommendations made.

Other improvement activities
Throughout the organisation there are a large number of projects on the go that seek to improve and streamline services provided. Many will be reported through other mechanisms (such as Integrated Family Health Service progress reports) and as such do not warrant inclusion here. However, some projects that occur at service level, or are birthed from programmes such as Xcelr8, may be of wider interest to DSAC/CPHAC. This section proposes to summarise a selection of relevant activities with links to further information or individuals should more information be requested.

Author: **Rachelle Hunt, Quality and Patient Safety Manager – 12 April 2012**

GENERAL BUSINESS

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

FROM: **Elinor Stratford, Chair**

DATE: **23 February 2012**

ITEMS TO BE REPORTED BACK TO BOARD

GENERAL BUSINESS

To be tabled at the meeting for any items to be discussed under General Business.

Primary Practices: A verbal update by the General Manager

Author: **Elinor Stratford, Chair, April 2012**

INFORMATION PAPERS

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

West Coast District Health Board and Advisory Committee Timetable

Term of Reference for Community Public Health Advisory Committee and Disability Support Advisory Committee Terms of Appointment

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

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

Member	Date of Appointment	Length of Term	Expiry Date
Lynnette Beirne	24 March 2011	1 Year	31 December 2011
Marie Mahuika-Forsyth	20 April 2009	Until advised by Te Runanga o Makaawhio	
Mary Molloy **(West Coast District Health Board member)**	27 January 2011 (re-appointed 27 January 2012)	3 months	30 April 2012
Robyn Moore	3 June 2011	3 years	3 June 2014
Patricia Nolan	18 July 2005 (Re-appointed 18 July 2006, 19 July 2008, July 2011)	3 Years	18 July 2012

WEST COAST DISTRICT HEALTH BOARD AND ADVISORY COMMITTEE SCHEDULE
JANUARY TO DECEMBER 2012

DATE	MEETING	TIME	VENUE
Friday 27 January 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 23 February 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 23 February 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 23 February 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 23 February 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 9 March 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Wednesday 11 April 2012	TATAU POUNAMU	1.00 pm	Arahura Marae, Hokitika
Thursday 12 April 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 12 April 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 12 April 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Friday 20 April 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 24 May 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 24 May 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 24 May 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 24 May 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 8 June 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Wednesday 11 July 2012	TATAU POUNAMU	1.00 pm	Westport Motor Hotel, Westport
Thursday 12 July 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 12 July 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 12 July 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Friday 20 July 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 23 August 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 23 August 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 23 August 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 23 August 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 7 September 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 11 October 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 11 October 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 11 October 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 11 October 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 19 October 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 22 November 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 22 November 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 22 November 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 22 November 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 7 December 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth

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

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE

INTRODUCTION

The Community and Public Health Advisory Committee and the Disability Support Advisory Committee are Statutory Committees of the Board of the West Coast District Health Board established in terms of Sections 34 and 35 of the New Zealand Public Health and Disability Act 2000 (the Act). These Terms of Reference are supplementary to the provisions of the Act, Schedule 4 to the Act and the Standing Orders of the West Coast District Health Board and are effective from 28 July2011.

The West Coast District Health Board has determined that the same body of persons shall comprise both Committees and that the meetings shall be combined into one meeting. The membership of the joint committee shall include some members with a specific interest or knowledge of disabilities and some with a specific interest or knowledge in Community and Public Health. For ease of reference the Committee shall be referred to as the "Community and Public Health and Disability Support Advisory Committee".

FUNCTIONS

The Community and Public Health and Disability Support Advisory Committee have specific aims and functions prescribed within the NZ Health and Disability Act 2000 (Schedule 4, Clauses 2&3). These apply to the roles of the two separate advisory Committees, which form the joint committee and exist in addition to these terms of reference. A summary of these functions and aims is set out below.

"The functions of the Community and Public Health and Disability Support Advisory Committee, with respect to Community and Public Health, are to provide advice and recommendations to the Board of the West Coast District Health Board on:

- *the health needs of the resident population of the West Coast District Health Board; and*
- *any factors that the Committee believes may adversely affect the health status of the resident population, and*
- *the priorities for the use of the health funding available*

The functions of the Community and Public Health and Disability Support Advisory Committee, with respect to Disability Support, are to provide advice and recommendations to the Board of the West Coast District Health Board on:

- *the disability support needs of the resident population of the West Coast District Health Board, and*
- *the priorities for the use of the disability support funding provided".*

The aim of this advice is to assist the disability support services that the West Coast District Health Board provides or funds, along with the policies it adopts, to promote the inclusion and participation in society, and maximise the independence, of people with disabilities within the resident population of the West Coast District Health Board.

The Committee will effect these functions by:

- Reviewing the Health Needs Assessment and making appropriate recommendations to the Board.
- Reviewing the District Annual Plan and District Strategic Plan and making appropriate recommendations to the Board
- Reviewing information regarding environmental and demographic changes within which the West Coast District Health Board is working

- Identifying Key Priority Actions from the District Annual and Strategic Plans to monitor progress. (Management will report on key deliverables and measurable achievements associated with these Key Priority Actions).
- Where there are issues raised in other Board committees, such as the Hospital Advisory Committee, that signal a risk to the health of our community or affect the health or disability support needs of the resident population that may be more appropriately considered by Community and Public Health Advisory Committee & Disability Support Advisory Committee, then updates may be presented to Community and Public Health Advisory Committee & Disability Support Advisory Committee on the issue and potential work programmes as it relates to the District Annual Plan.
- Ultimately the Committee will develop a clear set of community outcomes that reflect the West Coast District Health Board priority needs of our population which could then be reported on and monitored.
- Monitoring, reporting and making appropriate recommendations to the Board on those issues that fall within its terms of reference arising from; referrals from other Committees, matters delegated to it by the Board and from direct reporting to it. To facilitate this, Management will provide exception reporting to the Committee to measure against financial and operational issues. (Responsibility for the monitoring of individual contracts rests with management).
- Reviewing and evaluating summary information from internal and external audits on those areas which relate to community and public health and disability contracts and operational issues and monitoring progress made by management in implementing any recommendations arising from those audits.
- Providing advice to the Board on the priorities for funding that maximise the overall health gain for the population that the Committee serves, as prescribed in the Boards accountability documents.

KEY PROCESSES

- The Board approves the Annual Plan and any individual strategies developed to meet the health and disability needs of our population.
- The Committee's advice to the Board must be consistent with the priorities identified in the New Zealand Health Strategy, the New Zealand Disability Strategy and with the approved Strategic Plan and the Disability Support Action Plan of the West Coast District Health Board.
- Any paper or piece of work being presented to the committee should identify how it links to the Annual Plan (the annual workplan of the West Coast District Health Board).
- Any update on progress with implementation must identify the risks or barriers to the delivery of the strategies.

ACCOUNTABILITY

The Community and Public Health and Disability Support Advisory Committee are a Statutory Committee of the Board and as such its members are accountable to the Board and will report regularly to the Board.

- Members of the Community and Public Health and Disability Support Advisory Committee are to carry out an assessment role but are not to be advocates of any one health sector group. They are to act in an impartial and objective evidence based manner (where evidence is available) for the overall aims of the Committee.
- Legislative requirements for dealing with conflicts of interest will apply to all Community and Public Health and Disability Support Advisory Committee members, and members will abide by the West Coast District Health Board's External Communications Policy and Procedure and Standing Orders.
- The Committee Chair will annually review the performance of the Community and Public and Disability Support Advisory Committee and members.

LIMITS ON AUTHORITY

The Community and Public Health and Disability Support Advisory Committee must operate in accordance with directions from the Board and, unless the Board delegates specific decision making power to the Committee, it has no delegated authority except to make recommendations or provide advice to the Board.

- The Community and Public Health and Disability Support Advisory Committee provides advice to the Board by assessing and making recommendations on the reports and material submitted to it.
- The Community and Public Health and Disability Support Advisory Committee should refer any issues that fall within the Terms of Reference of the other Board committees to those committees.
- Requests by the members of the Community and Public Health and Disability Support Advisory Committee for work to be done by management or external advisors (from both within a meeting and external to it) should be made via the Committee Chair and directed to the Chief Executive or their delegate. Such requests should fall within the. Annual Plan.
- There will be no alternates or proxy voting of Committee members.
- All Community and Public Health and Disability Support Advisory Committee members must comply with the provisions of Schedule 4 of the Act relating in the main to:
- The term of members not exceeding three years
- A conflict of interest statement being required prior to nomination.
- Remuneration
- Resignation, vacation and removal from office**.**
- The management team of the West Coast District Health Board makes decisions about the funding of services within the Board approved parameters and delegations.

RELATIONSHIPS

The Community and Public Health and Disability Support Advisory Committee are to be cognisant of the work being undertaken by the other Committees of the West Coast District Health Board to ensure a cohesive approach to health and disability planning and delivery. and as such will be required to have effective relationships with:

- the Board
- clinical staff of the West Coast District Health Board
- other Committees of the West Coast District Health Board
- Manawhenua ki Te Tai o Poutini
- Tatau Pounamu Ki Te Tai o Poutini Manawhenua Advisory Group
- the community of the West Coast District Health Board
- consumer groups
- management of the West Coast District Health Board.

This will also be achieved through the sharing of agendas and the regular meetings of the Chairs of the Committees.

Management will provide the Community and Public Health and Disability Support Advisory Committee with updates on the work of other government agencies, funders or territorial local authorities that may affect the health status of the resident population of the West Coast District Health Board.

TERM

These Terms of Reference shall be reviewed in February 2014 at which time they will be reviewed by the newly elected Board of the West Coast District Health Board who will also review the membership of the Committee. These terms of reference may be reviewed earlier if deemed necessary by the Board.

The Act states that Statutory Committee members must not be appointed for a term exceeding three years. Although members are eligible for reappointment it is appropriate that membership is reviewed by newly elected Boards to consider the skills-mix of the committee and allow for a diverse and representative cross section of the community to have input into decision making.

MEMBERSHIP OF THE COMMITTEE

The Community and Public Health and Disability Support Advisory Committee will ordinarily comprise a mix of Board members and appropriate members selected from the Community up to a maximum of eleven members. The Board in selecting members will have regard to the need for the Committee to comprise an appropriate skill mix including people with special interests in community and public health and also in disability and Maori and Pacific health issues. However, the Board may appoint advisors to the Committee from time to time, for specific periods, to assist the work of that Committee.

Members of the Community and Public Health and Disability Support Advisory Committee will be appointed by the Board who will comply with the requirements of the Act.

The Chair of the Community and Public Health and Disability Support Advisory Committee will be a member of the Board and will be appointed by the Board, who may also appoint a Deputy Chair of the Committee. If not appointed as members of the Committee, the Chair and Deputy Chair of the Board are be appointed as ex-officio members of the Community, Public Health and Disability Support Advisory Committee with voting rights.

The Chair, Deputy Chair and members of the Community and Public Health and Disability Support Advisory Committee shall continue in office for a period specified by the Board until such time as:

- The Chair, Deputy Chair or member resigns; or
- The Chair, Deputy Chair or member ceases be a member of the Community and Public Health Advisory Committee or the Disability Support Advisory Committee in accordance with clause 9 of Schedule 4 of the Act; or
- The Chair, Deputy Chair or member is removed from that office by notice in writing from the Board.

The Act states that Statutory Committee members must not be appointed for a term exceeding three years. Although members are eligible for re-appointment it is appropriate that membership is reviewed by newly elected Boards to consider the skills mix of the Committee and allow for a diverse and representative cross section of the community to have input into the Committee's deliberations

MEETINGS

The Community and Public Health and Disability Support Advisory Committee will meet regularly as determined by the Board or committee with the frequency and timing taking into account the workload of the Committee.

- Subject to the exceptions outlined in the Act, the date and time of the Community and Public Health and Disability Support Advisory Committee meetings shall be publicly notified and be open to the public. The agenda, any reports to be considered by the Committee and the minutes of the Committee meeting will be made available to the public as required under the Act.
- Meetings shall be held in accordance with Schedule 4 of the Act and with the West Coast District Health Board's Standing Orders, adopted by the Board in May 2001 (and as amended from time to time).
- In addition to formal meetings, Committee members may be invited to attend workshops or for briefing and information sharing.

REPORTING FROM MANAGEMENT

- Management will provide exception reporting to the Community and Public Health and Disability Support Advisory Committee to measure against performance indicators and key milestones as identified by the Committee.
- Management will also provide the Community and Public Health and Disability Support Advisory Committee with updates on the work of other government agencies or territorial local authorities that may affect the health status of the resident population of the West Coast District Health Board.
- Management will provide such reports and information as necessary to enable the statutory committees to fulfil their statutory obligations.

MANAGEMENT SUPPORT

- In accordance with best practice, and the delineation between governance and management, key support for the Community and Public Health and Disability Support Advisory Committee will be provided by the General Manager, Planning and Funding as required. The General Manager will be involved in the preparation of agendas, reports and minutes of the Committee in liaison with the Chair of the Committee.
- In practice, attendance at the part or whole of the meetings by management and other support staff should be determined by the Chair based on items on the agenda.
- The Community and Public Health and Disability Support Advisory Committee will also be supported by Community and Public Health staff and by internal secretarial, clinical support, hospital, planning and funding and financial management staff as required.
- The Board may appoint advisors to the Community and Public Health and Disability Support Advisory Committee from time to time, for specific periods, to assist the work of that committee. The committee may also, through management, request input from advisors to assist with their work. Such advisors may be sourced internally using internal resources or at management's discretion out-sourced from external consultants in which case the West Coast District Health Board policies on probity and tendering will be followed.

REMUNERATION OF COMMITTEE MEMBERS

In accordance with Ministerial direction and board resolutions, members of the Community and Public Health and Disability Support Advisory Committee will be remunerated for attendance at meetings at the rate of $250 per meeting up to a maximum of ten meetings, total payment per annum ($2,500). The Committee Chair will be remunerated for attendance at meetings at the rate of $312.50 per meeting, again up to a maximum of ten meetings, total payment per year ($3,125). Ex-officio members are not remunerated.

These payments are made for attendance at public meetings and do not include workshops.

- Any officer or elected representative of an organisation who attends committee meetings which their organisation would expect their officer or elected representative to attend as a normal part of their duties, and who is paid by them for that attendance, should not receive remuneration.
- The Fees Framework for Crown Bodies includes the underlying principle that any employees of Crown Bodies should not receive remuneration for attendance at Committee meetings whilst being paid by their employer.
- Reasonable attendance expenses (i.e.: reasonable travel-related costs) for Committee members may be paid. Members should adhere to the West Coast District Health Board's travel and reimbursement policies.

Adopted by the West Coast District Health Board – 28 July 2011