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 JULY 2012

AGENDA AND MEETING PAPERS

All information contained in these committee papers is subject to change

AGENDA

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

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
To be held in the Board Room at Corporate Office, Grey Base Hospital, High Street, Greymouth
Thursday 12 July 2012 commencing at 9.00am

ADMINISTRATION			**9.00am**
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Meeting & Matters Arising** ▪ *24 May 2012*		
REPORTS/PRESENTATIONS			**9.10am**
3.	**Chairs Report** *(CPHAC & DSAC)*	Elinor Stratford *Chair*	*9.10am-9.20am*
4.	**Organisational Leadership Report** *(WCDHB)*	Wayne Turp *General Manager, Planning & Funding*	*9.20am-9.30am*
5.	**Clinical Leadership Report** *(WCDHB)* *As provided to the Board 8 June 2012*	Dr Carol Atmore *Chief Medical Officer, WCDHB*	*9.30am-9.40am*
6.	**Finance:** *(WCDHB)*	Colin Weeks *Chief Financial Manager*	*9.40am-9.50am*
7.	**Better Sooner More Convenient and Alliance Leadership Team Report** *(WCDHB)*	Wayne Turp *General Manager, Planning & Funding*	*9.50am-10.00am*
8.	**Family Violence:** *(WCDHB)*	Claire Newcombe *Family Violence*	*10.00am-10.20am*
9.	**Disability Discussion:** *(WCDHB)*	Tor Wainwright *Portfolio Manager Aged Care*	*10.20am-10.30am*
10.	**Workplan for noting** *(CPHAC & DSAC)*	Elinor Stratford *Chair*	
11.	**General Business**		
	Items to be reported back to Board	Elinor Stratford *Chair*	*10.30am-10.40am*
	CPHAC AND DSAC WORKSHOP		
	Quality and Patient Safety follow up workshop	Rachel Hunt, *Quality and Patient Safety Manager*	*11.15am-12.00pm (Kahurangi Room)*
FINISH TIME			**10.45am**

12. INFORMATION ITEMS

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

Community and Public Health and Disability Support Advisory Committee Schedule

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

NEXT MEETING

Date of Next Meeting: 23 August 2012 commencing at 9.00am, Corporate Office, Board Room at Grey Base Hospital.

KARAKIA

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

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 AND DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS' INTERESTS REGISTER

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

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE REGISTER OF MEMBERS' CONFLICTS/INTEREST

(As disclosed on appointment to the Board/Committee and updated from time-to time, as necessary)

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).
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 Organisation)

Member	Disclosure of Interest
	• Contract for the Café and Catering at Tai Poutini
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
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 • Member of the West Coast Clinical Board

MINUTES

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

MINUTES OF THE COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE held in the Board Room Corporate Office, Grey Base Hospital, on Thursday, 24 May 2012 commencing at 9.00am

PRESENT

Elinor Stratford, Chair, Kevin Brown, Deputy Chair, Peter Ballantyne, (ex officio), Barbara Holland, John Vaile, Marie Mahuika-Forsyth, Mary Molloy Patricia Nolan and Robyn Moore.

APOLOGIES

Apologies for absence were received and accepted from Dr Paul McCormack, Board's Chair (ex officio), Dr Cheryl Brunton**,** Lynnette Beirne and John Ayling

EXECUTIVE SUPPORT

Wayne Turp, General Manager Planning and Funding, Gary Coghlan, General Manager Maori Health, Hecta Williams General Manager and Bryan Jamieson – Community Liaison Officer.

IN ATTENDANCE

Yolandé Oelofse (minute secretary) and Kay Jenkins (CDHB Executive Assistant, Governance Support)

Item 10

Jem Pupich Community and Public Health – South Island DHB "Position Statement on Alcohol"

WELCOME

The Chair welcomed everyone including Kay Jenkins from Canterbury DHB to the Community and Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC) combined meeting and asked a Committee member supported by General Manager Maori Health to lead the Committee in the Karakia.

1. INTEREST REGISTER

There following amendments to the interest register was made.

Robyn Moore	To add Member of the West Coast Clinical Board
Marie Mahuika-Forsyth	To remove Part-time employee of Supporting families – Non Government Organisation

2. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

Moved Kevin Brown; Seconded Robyn Moore; - carried

"That the minutes of the meeting of the Community and Public Health and Disability Support Advisory Committee held on 24 April 2012 be confirmed as a true and correct record with the following amendments"

Page 1 Minutes:	Apologies, Welcome and Karakia: to remove Deputy Lynette spelt incorrectly should read Lynnette
Page 2	Item 2: directive is should read Directives are…. Item 3: the item should read The General Manager Planning and Funding gave a brief outline of the guidelines for CVD Screening. It has been identified that the various practices would need more information on this service. Re the issue raised at the last meeting about apparent gender specificity of screening for family violence: The General Manager Planning and Funding indicated that this is not gender specific and that any males or females presenting with

injuries should be screened for family violence
Item 5: Should read. To remove this item

Page 3 Item 8: the paragraph should read: A concern was raised regarding the contents of the Workplan and that the content is more internally focussed on a monitoring role for operation of the DHB. It was discussed that perhaps the Committee should have a broader role reporting for whole of the community. It was agreed that the current Workplan be reviewed and the Workplan be re-aligned to the Annual Plan which is due in June/July this year

Page 4 Item 9.1: delete current so that is should read, the plans for,
add within to 3-4 years.
Maori Health Plan changed has been to have been
The last paragraph should read: Page 3 – Funder Arm Payments Report Item Tobacco control is noted. A question was raised if there was a budget for alcohol harm reduction? This is not specified as a line item but there are a number of initiatives which are implicit and in place. The Ministry funds C&PH directly for alcohol harm reduction and regulatory activities under the Sale of Liquor Act. There is room for further work on alcohol harm reduction to be considered by the WCDHB in addition to this
Item 9.2 Should read: Clinical Board capitalized.
responsible for quality should read responsible for the quality
Consumer representation nominations. should have read Consumer representative nominations.

Page 5 Item 9.4, ALTs should read ALT and has becomes have
communications are should read communications strategies are
Action point. Should read: Health Services on

Page 5 Item 10: Should read: is assessing information details within the financial

Page 5 Page 5: Item 12: An urgent should have read; There is an urgent

Page 6 Item 12: Should have read: Apologies from John Ayling and Dr Cheryl Brunton
Item 12: Hospital health on should have read Hospital health services on

CARRIED FORWARD/ACTION LIST ITEMS

The Committee noted the carried forward list.

Item 3	In theory the policy covers men and women but at practice level there is 'discomfort' of screening of men. Process to be reviewed, to engage further discussion with A&E around processes. Reporting for children abuse, where is that information located? ***Action: General manager Planning and Funding to report back to the Committee on reporting.***
Item 4	The CEO is aware of the issues raised. Noted that discussions are progressing.
Item 7	This item will be discussed later on in the Agenda
Item 8	The provision of the workplan and financial reporting format to be checked by the Board Chair for across all the Committees to avoid duplication and overlapping of information, a recommendation to go to the Board Chair.

3. CHAIR'S REPORT- COMMUNICATIONS

The Chair attended a Disability Sector: National conference:
Items to note:

- A catalogue relevant to all disability centres to purchase gold fern products is now available through the DRC's.
- The Maori Disability strategy development is now completed, it will be presented to the Ministry in June. Following discussion the Roger Jolley Maori Development Manager Disability Support services will be invited to the August CPHAC and DSAC meeting.
- A discussion took place around the access Policy of Taranaki District this is a good policy to look at.
- An update was provided on the Ministry of Health new model.
- The DRC Auckland has mobility vans which is proven to be a good opportunity to toll out nationally but noted that it is costly to run.
- Individual funding was discussed; the current deficit, a reduction in Ministerial staff to fit with the budget, funds provided to the Disability Sector of 140m over the next 4 years.

The Committee received the report.

4. WORKPLAN

(CPHAC and DSAC)

The Chair mentioned that once the Annual Plan has been signed off by the Ministry, a workshop will be held to review the current workplan and to look at the presentation that have not taken place this year.

The Committee received the report.

5. ORGANISATIONAL LEADERSHIP REPORT

(CPHAC and DSAC)

This report was taken as read. General Manager, Planning & Funding asked if the Committee had any questions. The following items were raised:

- It was explained that the performance payment system to PHOs was part of a national payment incentive programme to reward PHOs for achieving agreed performance targets in primary health care.
- Page 12; HEHA funding has been confirmed by the Ministry that it is to be discontinued. The service ends in June. WCDHB is keen for some aspects to continue which will be done through close collaboration with other services, the funding for these services will reduce. The Ministry is creating a new funding pool to which invitations via proposal are made. This may affect the Oranga Pai. A proposal will be put forward to the Ministry as to which service is worth maintaining. We are currently discussing some services with the Ministry.
- Page 6; Prevention services – do we have a Plunket nurse on the Coast? Yes we do, the General Manager, Planning and Funding is currently working with 3 agencies that are able to fill in the gaps.
- Immunisation; there seems to be a miscommunication between the services and community mothers. The General Manager, Planning and Funding said that any concerns raised need to be raised with the service and work through the system. If anything is raised it will be addressed.
- Concerns were raised regarding births that are taking place in Canterbury DHB are not reflected on the West Coast system. The Committee was reassured that once the mother is discharged from Canterbury DHB the forms are sent back to the West Coast to be processed and that this process does work. The rural specialists provide Plunket services in the areas and cover immunisation. The figures for this service are close to target.
- Page 5; Community Pharmaceuticals are less than budget was queried. A Committee member said that not all patients are receiving cardiovascular medication. The General Manager, Planning and Funding said that spending less than budget could be due to patients not accessing the programme. He went on further to say that coming within budget is positive provided that saving money does not reduce the quality of the service and care of the patient.
  Action: The Chief Medical Officer to raise the concern of access to medication with the PHO clinical governance group.
  The General Manager, Planning and Funding said that they are currently working towards linkages between those providers ie Pharmacy and General Practitioners. A query was raised that in Buller current problems exit between the Pharmacy and those prescribing the medications.
- Page 12; HOP services; the Chair confirmed that with the new model of care people under 65/stroke will they still be eligible.
- In response to a question regarding how do we know what the communities need is?
- The General Manager, Planning and Funding explained that service allocation is prioritised on the basis of regular needs assessment, clinical diagnosis and referrals for clinical services and other support agencies.
- Does the DHB monitor the Aged Care need and how it is delivered? Yes we do with current reviews are underway.

The Committee noted the report.

6. CLINICAL LEADERSHIP REPORT

The Committee considered this report which provided a quarterly update. The following issues/concerns were raised:

- Transport is an ongoing issue for years are we likely to see something? The Chief Medical Officer said that currently a combined plan is underway. The DHB is not able to fund all the transport issues on the Coast. A concern was raised that most patients do not attend appointments as they do not have transport and this was a particular problem for Maori population. The Chief Medical Officer noted that the transport is an issue and hopefully by the second half of this year it will be addressed.
- There are 167 enrolled nurses having their conference in Greymouth.
- Is there a Policy that includes taking on graduate nurses on regular basis, yes there is through the NETP programme. We are currently working collaboratively with CDHB who funds some of these NETP nurses.

The Committee noted the report.

7. BETTER SOONER MORE CONVENIENT AND ALLIANCE LEADERSHIP TEAM REPORT

The General Manager, Planning and Funding and Chief Medical Officer spoke to this report.

Is O' Conor home privately owned? No it is Trust.

The Chair asked when health pathways would be reinstated onto planning? It is not yet necessary.

Has Jackie Broadbent taken up her position with the West Coast DHB yet? Yes she is subject to some appointments made yesterday.

The Committee noted the report.

8. PRIMARY HEALTH COMMUNITY QUARTERLY REPORT

(WCPHO)

The Chief Medical Officer spoke to this report and answered questions from the Committee. The following was noted:

- The PHO funds were not able to sustain BSMC. PHO had to withdraw funding from some services. The DHB has picked up Manage my Health and the project coordination for BSMC which was done internally and has proven to very effective. The ALT is more effective than when it began.
- Page 4; MoH Enrolment audit, why is there a difference? An extensive review is taking place and learning from the practices processes or private areas to improve the DHB practices. Is there a paper trail and financial implication, yes there is.
- Page 43; Health promotion budget was queried; we are waiting to hear from the Ministry regarding the Budget, we will then see what is available. The services are working collaboratively to maintain and to deliver on the services.
- Page 22; COPD; is this an issue and risk for someone turning 50 and do the General Practitioners carry out a risk assessment at this stage? The Chief Medical Officer said that internationally screening for COPD patients takes place. Different practices do the same and when assessing patient take into account their smoking status, this normally trigger off alarms for the COPD assessment.
- Page 19; the retinal screening contract ends in March, what is the progress on this for ongoing future screening? This contract is more than likely to be continued.
- Page 48; Patient care for Maori, it was mentioned that at Tatua Pounumu they have spoken about the Maori Patient Care Model; The General Manager Maori Health will discuss this with the PHO Director.
- It was noted that the data for the graphs was not detailed, the data was pulled manually as IT had some issues with the system.

The Committee noted the report.

9. QUALITY AND PATIENT SAFETY REPORT

The Quality and Patient Safety Manager will hold a workshop at 11:15am at Kahurangi for this item.

10. GENERAL BUSINESS

(CPHAC and DSAC)

Matters Arising:
The General Manager described the process of the Consumer Council. There are currently five members, Lynn Meyer who will provide support and training to this group. This is a web based, inexpensive and supported by additional resource. The meetings are likely to take place on a monthly basis.

Finance:
The General Manager, Planning and Funding spoke to the brief financial report. The way in which the information is produced is of specific interest to CPHAC and DSAC.

Communications Strategy:
This item will be deferred to the next meeting.

South Island DBH "Position statement on Alcohol":
This report is taken as read. Community and Public Health is seeking an endorsement from this Committee a consistent approach through all the DHBs. This is an excellent paper and only would consider change to the closing time to 1am in the morning. It was noted that the DHB would not be the only service involved in this and that it will include other services as well.

Moved Marie Mahuika-Forsyth: Second Barbara Holland: Carried.

Motion:
"That the Committee makes a recommendation to the Board to accept this submission"

Carried.

The Committee moved into In-Committee at 9:40 and the public was excluded.

Moved: Robyn Moore Second: Barbara Holland

An error was noted that this paper is for noting only and that there is no recommendation to the Board required from this paper.

The Committee moved out of In-Committee back into public meeting at 9:50

Moved; Peter Ballantyne, Second; Kevin Brown - Carried

INFORMATION ITEMS

The Committee received information reports in respect to:
- CPHAC and DSAC Terms of Appointment
- CPHAC and DSAC Committee Schedule January 2012 – December 2012
- CPHAC and DSAC Terms of Reference

There being no further business the meeting concluded at 11:55am

The next meeting will be held on Thursday, 12 July 2012, at 9am in the Board Room at Corporate, Grey Base Hospital.

Confirmed as a true and correct record:

_____ _____

Elinor Stratford Date
Chair

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

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE CARRIED FORWARD/MATTERS ARISING AS AT 24 MAY 2012

Item No.	Date	Action	Action Responsibility	Reporting Status	Agenda Item Ref
1	14 April 2011	Portfolio manager for disabilities will prepare a briefing paper on the West Coast's and the national position with disability services	Tor Wainwright	This will be presented at the July Meeting.	General Business 7.1
2	14 July 2011	Quality and Risk Report: How do practitioners know that advance directives are in place? Development on making advance directives is currently being addressed through the clinical leadership process This Item to be referred to the Clinical Governance Committee.	Chief Medical Officer	The Chief Medical Officer provide more information at next meeting	General Business 7.5 item vi
3	23 February 2012	Committee concern that access to the hospital building is difficult. This needs to be taken into consideration when the new building facility is built. Does there need to be interim action taken pending the construction of a new facility?	The General Manager Planning and Funding		General Business 9 - Community services issue of access to the building.

Item No.	Date	Action	Action Responsibility	Reporting Status	Agenda Item Ref
4	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 presented at the August Meeting.	Other Business 11 – Need for Patient Advocacy
5	12 April 2012	Workshop to be arranged to revise the committee work plan once the Annual Plan has been signed off by the Ministry	The General Manager of Planning and Funding	The Board Chair and Committee Chair's, Chair to bring this back to this Committee.	8. Workplan
6	12 April 2012	The Chair, General Manager Planning and Funding and the Chief Financial Manager to review the financial reporting format.	GM Planning and Funding and Chief Financial Manager	Further discussion with Board required on this.	9.3 Finance Report

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

CHAIR'S REPORT

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

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

SOURCE: **Chair**

DATE: **24 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting information from the Chair.

2. RECOMMENDATION

That the Committee
i. notes the Chair's Report.

3. SUMMARY

The recommendation from the Committee to the Board re position paper on alcohol was endorsed

The Annual Plan has been approved by the Minister of Health for sign off by the Minister.

The Committee Chairs will meet to review Committee workplans once Annual Plan sign off is completed.

ORGANISATIONAL LEADERSHIP REPORT

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

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

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

DATE: **June 2012**

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

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the progress made on the Minister of Health's health and disability priorities and the West Coast District Health Board (WCDHB) Annual Plan key priority areas.

2. RECOMMENDATION

That the Committee

i. Notes the Organisational Leadership Report.

3. SUMMARY

Key Achievements

- WCDHB has again achieved the Emergency Department Health Target, with 99.6% of people admitted or discharged within 6 hours.
- WCDHB remains ahead of plan of delivering against our national health target volume of 1592 elective surgical discharges for the year; being at 107.3% of plan for the year to 30 April
- Increased collaboration locally between the Immunisation and Cervical Screening Services have aided in a significant rise in the Human Papilloma Virus (HPV) School Based coverage rate. Currently this remains at 15% above last years overall figures.
- Securing of funding from the Ministry of Health (MoH) to continue the delivery of high priority community Physical Activity and Nutrition services to replace elements previously funded through the Healthy Eating Healthy Action (HEHA) programme from 30 June 2012, this includes the Tai Poutini Breastfeeding Initiative.

Key Issues and Associated Remedies

- Even though the Before School Check (B4SC) programme has made marked improvements within the last month, it is still at risk of not meeting its target. The service is working closely with the Ministry of Health using the Quality Improvement Letter from the Ministry to improve its coverage and the quality delivery of school checks.

Upcoming Points of Interest

- The Child and Adolescent Oral Health Service is investigating the acquisition of a Level 1 self-driven mobile dental clinic. This will be used to provide dental check-ups and preventive care for school children and adolescent while awaiting the development of the Grey Integrated Family Health Centre (IFHC) instead of refurbishing the Grey School

Clinic (which will become redundant once Grey IFHC goes ahead). Dental checks and preventive care accounted for approximately 40% of school-aged children need in any one year.

4. APPENDICES

Appendix 1: **Health Targets**
Appendix 2: **Free After-hours for under sixes**
Appendix 3: **Letter to Primary Care prescribers**
Appendix 4: **High Level Overview Pharmacy Services - for prescribers July 2012**

Report prepared by: **Planning and Funding**

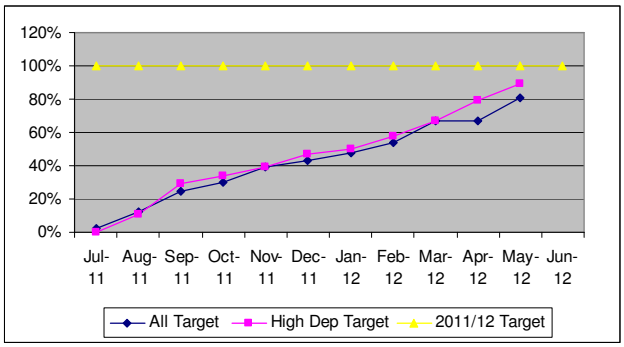
PLANNING AND FUNDING OVERVIEW

Progress against key target areas for the period ending April 2012

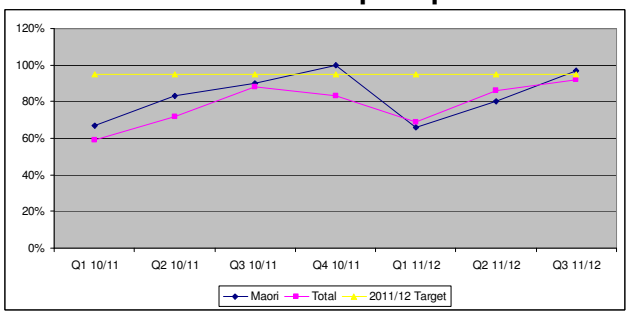
Publication of progress reports against the government's health targets for the period ending April 2012. Progress reports against internal targets are as follows:

Prevention Services

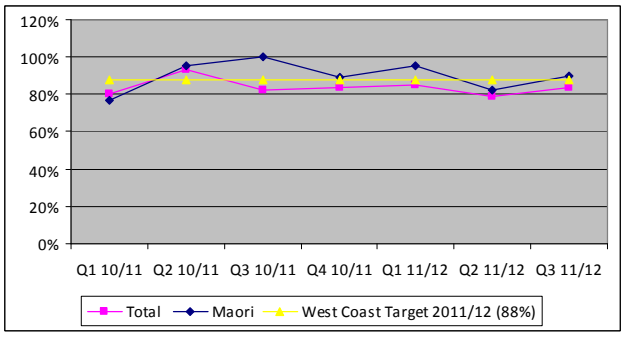
B4 School Check coverage



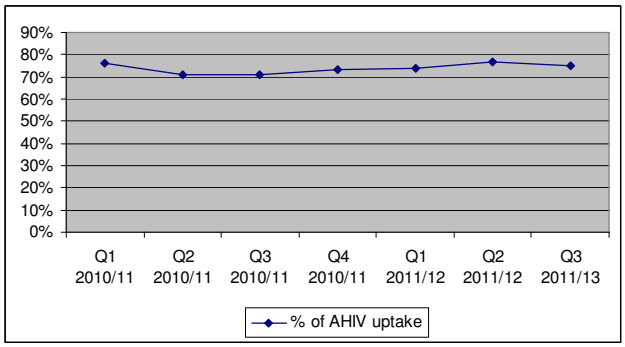
Percentage of hospitalised smokers given advice and help to quit



Immunisation – 2 year olds Fully Immunised.



Antenatal HIV Screening



ACHIEVEMENTS/ISSUES OF NOTE

Before School Check (B4SC): At the end of May 2012, 81% of all target population and 89% of high needs target population have completed their before school check. There is marked improvement in the coverage for both target population with 14% (All Target) and 10% (High Needs Target) increase from previous month.

The service is working closely with the Ministry of Health using the Quality Improvement Letter from the Ministry to improve its coverage and the quality delivery of school checks.

Immunisation – 2 year olds: At the end of Quarter(Q) 3 2011/12, 84% of all 2 year olds were fully immunized. This is an increase of 5% from the previous quarter and 2% more than for the same quarter in 2010/11 (Q3 2010/11 coverage rate was 82%).

The coverage for 2 year old Maori is 90% for Q3 2011/12 – an increase of 8% from the previous quarter.

Only four children who have not declined immunisation or not opted off the National Immunisation Register (NIR) were not fully immunised at the end of quarter three – 2 children declined Measles Mumps Rubella (MMR) while the other 2 declined immunisation. Therefore, it is important to note that 96% (96/100) of West Coast 2 year olds who have not declined immunisation or opted off the NIR were fully immunised at the end of Q3, 2011/12.

Quarter 4 report will be available late July 2012.

Newborn Hearing Screening: No updated report available.

Antenatal HIV Screening Programme.

The uptake rate for antenatal HIV screening has been stable and remains above 70% for the 2012 Calendar Year. For the period of January to March 2012 the update rate was 75% - 2% less than the previous quarter.

There is continued focus on programme education and maintaining linkages and cooperation with health practitioners to ensure effective service delivery for Eligible Pregnant Women

Secondary Smoking Cessation

Quarter 3 Results: 92.13%

During this reporting period meetings were held with senior hospital management staff and the Learning and Development Team to identify those with training gaps around the ABC initiative and invite them via letter to attend an upcoming workshop.

Primary Smoking Cessation

Quarter 3 Result: 38.5%

During this reporting period the smokefree staff have been working with the MOH and other DHB smokefree staff as to how to improve the Primary Smokefree Health Target, with most DHB's finding it challenging to meet the target of 90%. Regular feedback regarding performance is one way to improve practice's performance in this target and encouraging accurate data collection. The Primary Health Organisation (PHO) is currently exploring the best tool to provide this feedback as there is an ongoing cost involved in any IT investment. These options include a Clinical Audit Tool in Med-Tech which provides live data ie. Instant feedback and can compare against the PPP targets. Discussions with Karo Data Management staff are also continuing, although there is a concern regarding the data presented not being 'live.' With the 'road show' / Practice visits complete and good awareness of the Primary Health Target, continued discussions with the MOH and other DHB's around accurate data collection is critical to the success of this target.

Healthy Lifestyle Programmes

For on-going community nutrition and physical activity services are yet to be released by the MoH.

The funding is available from 1 October 2012, although the target areas/populations for this funding remain unknown.

By securing funds through renewed side-contracts with the MoH the WCDHB has successfully retained funding for the high priority / high value community nutrition and physical services which previously sat under the HEHA umbrella.

These include; the Tai Poutini Breastfeeding Initiative, Green Prescription, community nutrition programmes such as Cooking Skills to Life Skills and some health promotion roles.

This funding will ensure there is minimal impact on the healthy lifestyle services on the West Coast with the discontinuation of the HEHA programme.

Green Prescription Devolution
From 1 July the Green Prescription programme is being devolved from the MoH. Canterbury DHB (CDHB) will act as the lead DHB for this devolution (for both South CDHB and WCDHB), due to all three DHB's sharing the same provider – Canterbury West Coast Sports Trust.

On the West Coast the Sports Trust sub-contracts the WCPHO to deliver Green Prescription. The programme will be status-quo for the next two-years, with a set amount of referrals (and therefore funding) being allocated to each region.

From July 2014 it is believed the programme will be fully devolved into our core funding according to our PBFF entitlement.

Warm Up West Coast – Home Insulation Project: During this reporting period there has been an increase in the average number of applications received per week due to the change in season.

270 applicants have met the EECA and Healthy West Coast criteria and have been sent on to The Insulation Company for homes to be firstly assessed and then insulated.

With a target for 500 West Coast homes to be insulated over 18 months, the number of homes accepted is approximately half way after eight months.

Data below is as of 25th June 2012

	Number
Applications received by Healthy West Coast	316
Applications forwarded to The Insulation Company	270
Applications to be processed	12
Number of applicants declined	34
Number of homes insulated	164

Human Papilloma Virus (HPV)

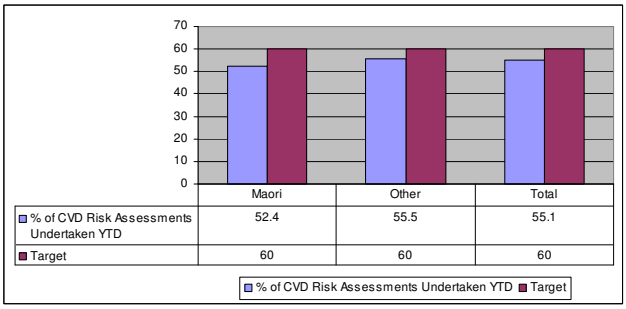
As of the 26th June 2012, 49% of enrolled Year 8 girls on the West Coast have consented to the School based HPV programme. All have received their first dose and all but 12 late starters their second.

This year's uptake has showed a marked improvement in rates, compared to 2011 where

the overall coverage rate was just 34%. The improvement is related partly to enhanced collaboration between the Immunisation and Cervical Screening services locally.

Early Detection and Management

More Heart and Diabetes Checks: Percentage of eligible PHO population who have had a Cardiovascular Disease(CVD) risk assessment.

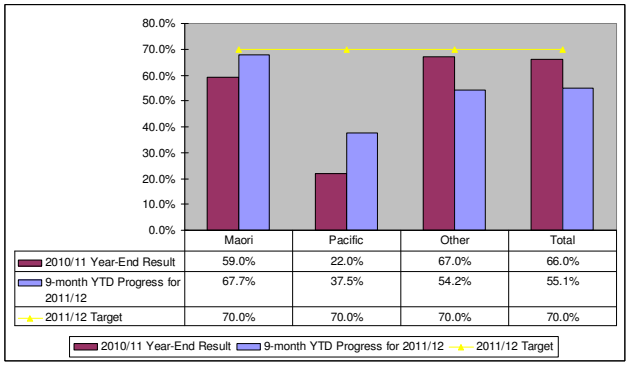


	Maori	Other	Total
% of CVD Risk Assessments Undertaken YTD	52.4	55.5	55.1
Target	60	60	60

Measure: Percentage of enrolled people in the PHO within the eligible population who have had a CVD risk recorded in the last 5 years.

Data for period to 31 March 2012 (latest available data). Only measured Quarterly.

Diabetes Detection

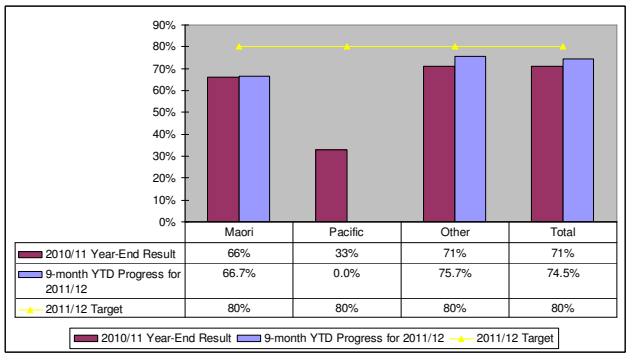


	Maori	Pacific	Other	Total
2010/11 Year-End Result	59.0%	22.0%	67.0%	66.0%
9-month YTD Progress for 2011/12	67.7%	37.5%	54.2%	55.1%
2011/12 Target	70.0%	70.0%	70.0%	70.0%

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

Data for period to 31 March 2012 (latest available data). Only measured Quarterly.

Diabetes Good Management



	Maori	Pacific	Other	Total
2010/11 Year-End Result	66%	33%	71%	71%
9-month YTD Progress for 2011/12	66.7%	0.0%	75.7%	74.5%
2011/12 Target	80%	80%	80%	80%

Measure: % 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 March 2012 (latest available data). Only measured Quarterly.

ACHIEVEMENTS/ISSUES OF NOTE

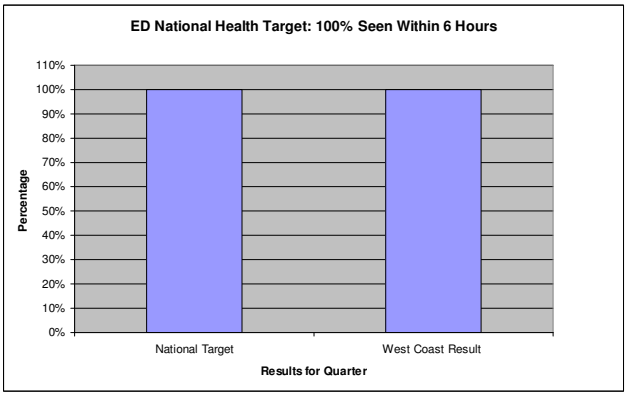
CVD Risk Assessment: From 1 January 2012, there has been a change to the national health target for cardiovascular disease and diabetes. The revised health target, 'More heart and diabetes checks', measures the number of completed cardiovascular risk assessments for all eligible persons within the last five years (which includes a diabetes check).

The national goal target is 90% of the eligible population will have had their cardiovascular risk assessed in the last five years - to be achieved in steps over three years. Our goal this year is to reach 60% by 1 July 2012 as part of that progress. For the period to 31 March, the West Coast

result was at 55.1% for our overall population; including a rate of 52.4% for Maori and 55.5% for other populations. It is noted that there is still a way to go, but that the West Coast PHO is working to improve this rate through its 3-tiered Long Term Conditions programme and concentrating on undertaking Cardiovascular Risk Assessments. This target is only measured Quarterly.

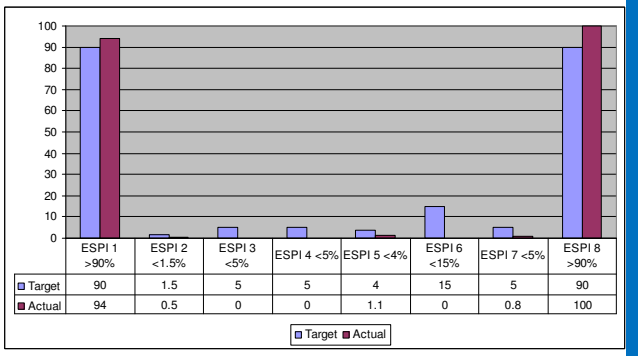
Intensive Assessment and Treatment Services

Emergency Department Waiting Times – YTD Performance to 27 June 2012



Results for the financial year to date to 27 June 2012 continues to stand at 99.6% of patients seen, treated and discharged within 6 hours.

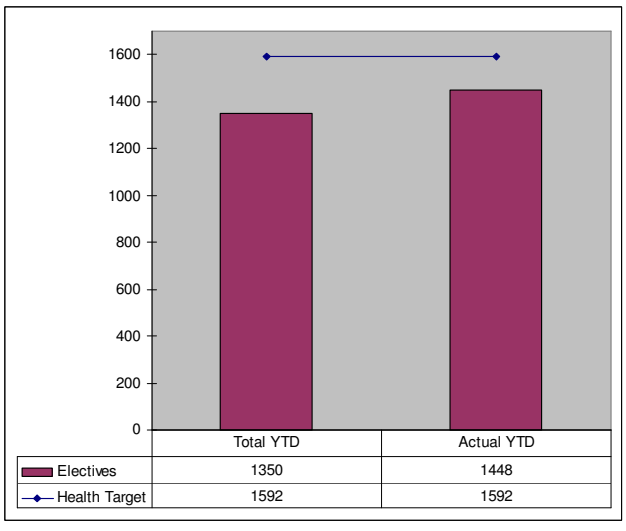
Improving Outcomes for Elective Services: Elective Service Performance Indicators (ESPI)



	ESPI 1 >90%	ESPI 2 <1.5%	ESPI 3 <5%	ESPI 4 <5%	ESPI 5 <4%	ESPI 6 <15%	ESPI 7 <5%	ESPI 8 >90%
Target	90	1.5	5	5	4	15	5	90
Actual	94	0.5	0	0	1.1	0	0.8	100

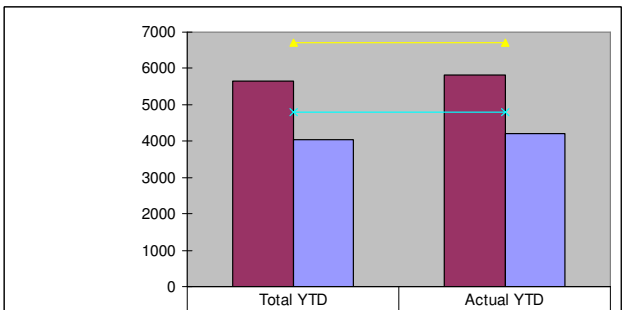
Preliminary results to 31 May 2012 (as updated by Ministry of Health, 25 June 2012).
It is noted that while the results are on target, we would be outside ESPI compliance in ESPI2 and ESPI5 if measured against new targets that come into force from July 2012 (as would most other DHB's). The Provider Arm has been working hard to address this in the lead up to these new targets taking effect, and is on track to achieve compliance by 1 July.

Improving Outcomes for Elective Services: National Health Target - Elective Surgery Service Throughputs to 30 April 2012.



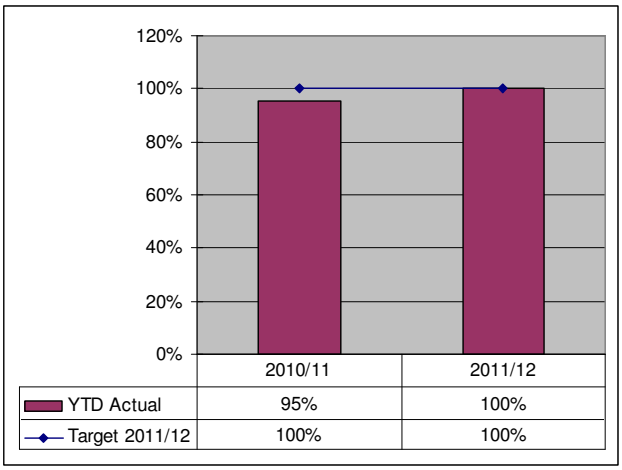
	Total YTD	Actual YTD
Electives	1350	1448
Health Target	1592	1592

Improving Outcomes for Elective Services: Ambulatory Initiative Throughput (Specialist Outpatients) to 30 April 2012.



	Total YTD	Actual YTD
First specialist Assessment	5659	5829
Surgical FSAs	4045	4204
Full Year FSAs planned 2011/12	6703	6703
Full Year Surgical FSAs Planned 2011/12	4791	4791

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 17 June 2012.

ACHIEVEMENTS/ISSUES OF NOTE

Radiotherapy Waiting Times Data

There have been 4 patients in the current financial year to 24 June 2012 who have exceeded the 4-week waiting time to commence radiotherapy treatment (two in the July-September 2011 quarter, and one each in February and in June 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 considerations (such as post chemotherapy recovery, or post-operative and cancer related complications). As such, WCDHB performance against the national health target remains at 100%.

The patient whose treatment has been delayed in June is due to clinical considerations. All other West Coast domiciled patients treated in the priority treatment categories (acute; curative; palliative; and radical) have commenced treatment within four weeks of referral.

Elective Services: National Health Target - Elective Surgery Service Throughputs to 30 April 2012: (latest confirmed results)

The year to date (YTD) report as of 30 April 2012 shows that there have been 1448 actual raw surgical discharges had been delivered by WCDHB, which is ahead of target by 107.3% against YTD planned 1350 surgical discharges. This is 91% of the total national health target of 1592 discharges to be delivered by West Coast DHB for the year. These discharges resulted in case weight discharges (CWD) of 2017.6; which was over-delivery at 110.1% of planned year-to-date volume, and is equivalent to 91.5% of the total planned CWD delivery for the financial year.

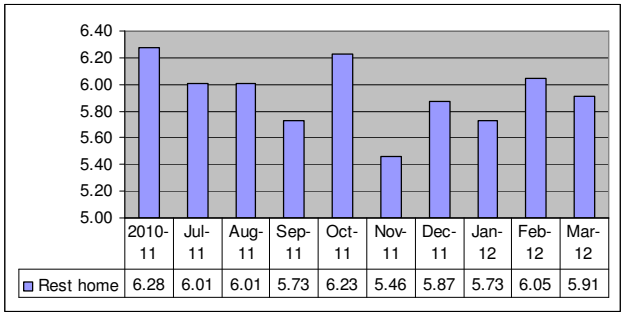
2011/12 Elective Surgery	Raw Discharges	Caseweighted Discharges
Total Planned YTD Volume	1350	1833.0
Actual YTD Delivery	1448	2017.6
% Delivered Against Plan	107.3%	110.1%

Elective Services: Ambulatory Initiative Throughput (Specialist Outpatients) to 30 April 2012: (latest confirmed results)

Overall first specialist outpatient assessment services for all specialties have been delivered at 103% of planned services for the 10-month period to 30 April 2012; and stand at 87% of the 2011/12 total planned. Total YTD delivery to the end of April is 5829 attendances.
Similarly, the surgical first specialist outpatients have been delivered at 103.9% of planned YTD volume (4,204 FSAs); which is equivalent to 87.7% of the 2011/12 total planned surgical FSAs

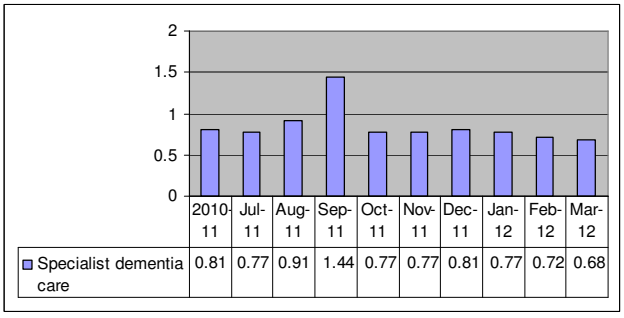
Rehabilitation and Support Services Older Persons' Health

Proportion of people aged 75+ in Rest Home level care



	2010-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Rest home	6.28	6.01	6.01	5.73	6.23	5.46	5.87	5.73	6.05	5.91

Proportion of people aged 75+ in Specialist Dementia care



	2010-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Specialist dementia care	0.81	0.77	0.91	1.44	0.77	0.77	0.81	0.77	0.72	0.68

ACHIEVEMENTS/ISSUES OF NOTE

Specialist Health of Older People's Services – Geriatrician Dr Jackie Broadbent has been appointed to lead the Complex Clinical Care Network (CCCN), an Inter-Disciplinary Team which will provide a community-focused specialist service for older people and others with long-term chronic conditions.

Existing needs assessment and service coordination functions will be integrated within this team to create a broader Single Point of Entry to long-term care and to provide primary health teams, homecare agencies and rest homes with support to enable them to care for patients in the community.

The CCCN is expected to begin operating from September, when additional gerontology nurse positions will be finalised (from within existing resources).

Maximising independence model for homecare – it is envisaged that discussions with the two homecare providers on a new contract for homecare services on the maximising independence model will start in November, with the aim of having a new contract, service specification and funding model in place by 1 July 2013.

Dementia training – the newly appointed dementia training coordinator has started training programmes for rest home carer staff in Westport and Greymouth. These are well-attended and proving popular with staff.

Dementia respite - discussions are being held with various providers and stakeholders on the best way to provide respite and support for the carers of people with dementia.

Residential facilities – Planning & Funding are pleased to report that Granger House now has a 2-year certification. following much improved audit results. The hard work of all involved is much appreciated.

How is my DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2011/12 QUARTER THREE (JANUARY–MARCH) RESULTS www.health.govt.nz/healthtargets

Shorter stays in Emergency Departments

		Quarter three performance	95%	Change from previous quarter
1	West Coast	99%		–
2	South Canterbury	98%		▲
3	Whanganui	98%		▲
4	Nelson Marlborough	97%		–
5	Counties Manukau	97%		–
6	Tairawhiti	96%		–
7	Waitemata	96%		▲
8	Wairarapa	96%		▲
9	Canterbury	95%		–
10	Hawke's Bay	95%		–
11	Auckland	95%		–
12	Hutt Valley	93%		–
13	Bay of Plenty	92%		–
14	Northland	92%		▲
15	Waikato	92%		▲
16	MidCentral	92%		▲
17	Taranaki	90%		–
18	Lakes	89%		▲
19	Southern	89%		–
20	Capital & Coast	87%		▲
	All DHBs	93%		▲
			95%	

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

Improved access to Elective Surgery

		Quarter three performance	100%	Progress against plan (discharges)
1	Lakes	121%		▲
2	Taranaki	121%		▲
3	Counties Manukau	111%		▲
4	Whanganui	111%		▲
5	Northland	111%		▲
6	West Coast	107%		▲
7	Hawke's Bay	106%		▲
8	MidCentral	105%		▲
9	Waitemata	105%		▲
10	Bay of Plenty	105%		▲
11	South Canterbury	104%		▲
12	Southern	103%		▲
13	Waikato	101%		▲
14	Canterbury	101%		▲
15	Wairarapa	101%		▲
16	Nelson Marlborough	100%		▲
17	Hutt Valley	100%		▲
18	Auckland	99%		▼
19	Tairawhiti	99%		▼
20	Capital & Coast	98%		▼
	All DHBs	105%		▲
			100%	

Improved access to elective surgery

The target is an increase in the volume of elective surgery by an average of 4,000 discharges per year.

** DHBs planned to deliver 106,783 discharges year to date, and have delivered 5,011 more.*

Shorter waits for Cancer Treatment

		Quarter three performance	100%	Change from previous quarter
1	Northland	100%		–
1	Waitemata	100%		–
1	Auckland	100%		–
1	Counties Manukau	100%		–
1	Waikato	100%		–
1	Lakes	100%		–
1	Bay of Plenty	100%		–
1	Tairawhiti	100%		–
1	Hawke's Bay	100%		–
1	Taranaki	100%		–
1	MidCentral	100%		–
1	Whanganui	100%		–
1	Capital & Coast	100%		–
1	Hutt Valley	100%		–
1	Wairarapa	100%		–
1	Nelson Marlborough	100%		–
1	West Coast	100%		–
1	Canterbury	100%		–
1	South Canterbury	100%		–
1	Southern	100%		–
	All DHBs	100%		–
			100%	

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy. Six regional oncology centres provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

Increased Immunisation

		Quarter three performance	95%	Change from previous quarter
1	Wairarapa	97%		▲
2	Hawke's Bay	96%		▲
3	MidCentral	96%		▲
4	Lakes	95%		▲
5	Southern	95%		–
6	South Canterbury	93%		▼
7	Waitemata	93%		–
8	Counties Manukau	93%		▲
9	Canterbury	93%		–
10	Hutt Valley	93%		▼
11	Auckland	92%		–
12	Capital & Coast	92%		–
13	Tairawhiti	91%		–
14	Waikato	91%		–
15	Bay of Plenty	90%		–
16	Whanganui	89%		▼
17	Taranaki	89%		▼
18	Northland	87%		▲
19	Nelson Marlborough	85%		▼
20	West Coast	84%		▲
	All DHBs	92%		–
			95%	

Increased immunisation

The national immunisation target is 95 percent of two year olds will be fully immunised by July 2012.

This quarterly progress result includes children who turned two years between January and March 2012 and who were fully immunised at that stage.

Better help for Smokers to Quit

		Quarter three performance	95%	Change from previous quarter
1	Lakes	100%		–
2	South Canterbury	97%		–
3	Whanganui	97%		▲
4	Waitemata	97%		–
5	Capital & Coast	96%		▲
6	Hutt Valley	95%		▼
7	Nelson Marlborough	94%		▼
8	Counties Manukau	94%		▲
9	Hawke's Bay	93%		▲
10	MidCentral	93%		▲
11	West Coast	92%		▲
12	Taranaki	91%		–
13	Auckland	90%		▲
14	Bay of Plenty	88%		▼
15	Waikato	88%		▲
16	Southern	87%		–
17	Canterbury	86%		▲
18	Northland	86%		▲
19	Tairawhiti	86%		▼
20	Wairarapa	72%		▲
	All DHBs	91%		▲
			95%	

Better help for smokers to quit

The target is that 95 percent of hospitalised smokers will be provided with advice and help to quit by July 2012. The data covers patients presenting to Emergency Departments, day stay and other hospital based interventions.

More Heart and Diabetes Checks

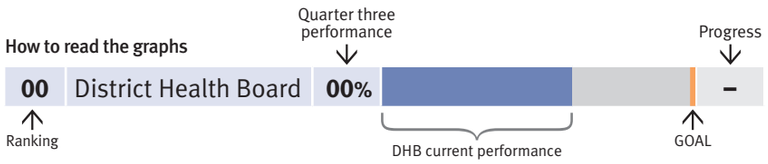
This is the first time the new target is being reported. The results are provisional while we confirm the data.

		Quarter three provisional performance	60%	Change from previous quarter
1	Wairarapa	66%		NA
2	Whanganui	59%		NA
3	Bay of Plenty	59%		NA
4	Waitemata	56%		NA
5	West Coast	55%		NA
6	Taranaki	55%		NA
7	Northland	54%		NA
8	Lakes	53%		NA
9	Waikato	51%		NA
10	Hawke's Bay	51%		NA
11	Counties Manukau	50%		NA
12	Capital & Coast	50%		NA
13	Nelson Marlborough	50%		NA
14	Tairawhiti	45%		NA
15	Southern	43%		NA
16	Auckland	42%		NA
17	MidCentral	39%		NA
18	South Canterbury	36%		NA
19	Hutt Valley	28%		NA
20	Canterbury	18%		NA
	All DHBs	46%		NA
			60%	

More heart and diabetes checks

The target is that, by July 2012, 60 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. This target will increase in stages each year to 90 percent by July 2014. Because this is a new health target, no comparison can be made between the results this quarter and data from the previous quarter. Results for the diabetes indicators from the previous CVD/Diabetes target can be found on www.health.govt.nz/healthtargets

How to read the graphs



This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

New Zealand Government

APPENDIX 2: FREE AFTER-HOURS FOR UNDER SIXES

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

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

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

DATE: **2 July 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

From: Gabrielle_Roberts@moh.govt.nz [mailto:Gabrielle_Roberts@moh.govt.nz]
Sent: Monday, 2 July 2012 12:45 p.m.
To: Free_After_Hours_Under_6s_DHB_Contacts@moh.govt.nz
Subject: Free After-hours for Under Sixes

Dear all

Thank you for your hard work towards ensuring access for families to free After-hours care for Under Sixes from yesterday 1 July 2012. Great progress has been made - please note the Minister's press release sent out yesterday regarding this http://www.beehive.govt.nz/release/free-after-hours-doctors%E2%80%99-visits-rollout-starts

It is important now to ensure there is clear advice for families on where free after-hours services for Under Sixes are available - and I know some of you have already done this. The Ministry expects that DHBs will this week ensure that this advice is available on DHB websites, through telephone services and through clinics and practices. This request aligns with the recommendations made by the 2010 Office of the Auditor-General's report District Health Boards: *Availability and accessibility of after-hours services*at http://www.oag.govt.nz/2010/after-hours-services/docs/after-hours-services.pdf . Could you please confirm this has been done by email to James (see note below) by close of business this Friday 6 July

I am today moving on to another role within the Ministry, that of Acting Programme Manager, Youth Mental Health. The key contact for Free Under Sixes After-hours at the Ministry will now be James Westbury, Senior Advisor, Primary Health Care Implementation team. Email : James_Westbury@moh.govt.nz

I have enjoyed working with you all on this important initiative and thanks again for your efforts and assistance.

Kind regards

Gabrielle

Gabrielle Roberts
Senior Advisor
Primary Care Integration
System Integration Group
Sector Capability and Implementation
Ministry of Health
DDI: 04 816 3548
Mobile: 021 535 365

http://www.health.govt.nz
mailto:Gabrielle_Roberts@moh.govt.nz

APPENDIX 3: LETTER TO PRIMARY CARE PRESCRIBERS.

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

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

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

DATE: **2 July 2012**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

27 June 2012

Dear Prescriber

Re: ***New services to support patients' medicines adherence and compliance***

The purpose of this letter is to provide you with information about the new Community Pharmacy Services Agreement (CPSA) 2012.
The new CPSA will take effect from 1 July 2012 and will have a three year transition period until the model is fully implemented in 2014/2015.
DHBs and the national pharmacy sector agents are well advanced on our planning with community pharmacists for a successful transition to the new patient-centre service model. Already more than 80% of community pharmacists have accepted the new Community Pharmacy Services Agreement although the final deadline for signing is not until 23 July. The exciting opportunities offered by the new patient-centred service model are the most significant change to pharmacy for many years, and this level of support is an important achievement.

Background
Over the last year, DHBs and the community pharmacy sector agents have been working together to develop the new pharmacy service model. Meetings have been held with the GP Leaders Forum, the Community Pharmacy Leaders Group, RNZCGP, NZMA, GPNZ, and the Pharmaceutical Society to seek feedback on the proposed changes and they are all strongly supportive of the approach.

The key elements of the new service and funding model are:

1. Creating three-tiers of services to patients:
   - Core Services
   - Specific Services (e.g. methadone, clozapine)
   - A new Long Term Conditions (LTC) Service - for those with high medicines management needs, multiple co-morbidities and difficulty managing their medicines
2. Patient Registration in the LTC Pharmacy Service and encouraging increased collaboration between all members of the patient's Multi-Disciplinary Team (MDT) in appropriate medicine's management for patients registered in this Service.

The new LTC Pharmacy Service will be of interest to general practice. An Eligibility Tool is used to assess a patient's eligibility for this service, and if eligible, the patient is invited to register with a pharmacy for the service. The pharmacist will document their planned approach to the day-to-day

management of the patient's medication regimen and this is expected to be shared with relevant members of the Multi-Disciplinary Team and reviewed at agreed timeframes.

Changes to Close Control

From 1 July 2012 PHARMAC is removing the Close Control Rule and replacing it with the "Dispensing Frequency" Rule. The key change is the Close Control Rule relating to patients who are "intellectually impaired, frail, infirm or unable to manage medicines". This clause is being removed from the new rule.
In the coming months pharmacists will assess these patients for eligibility in the new LTC Service, or transition them safely into the Core Pharmacy Service. Patients should remain on the same dispensing frequency until they are assessed for eligibility in the LTC Service.
In practice, for prescribers this means that annotating a prescription with 'Close Control' is no longer required and the pharmacist dispensing the medication is able to determine the dispensing frequency for LTC Service patients.
For non-LTC Service patients dispensing shouldn't be more often than monthly. For dispensing more frequently than monthly in this group the pharmacist needs the permission of the prescriber. If you have a strong view about the frequency with which the patient should receive the medicine please talk with the pharmacist. More frequent dispensing can still be done for the following groups:

- *'Safety' medications* already have rules around their dispensing, for example Class B controlled drugs and tri-cyclic antidepressants. PHARMAC has added codeine and buprenorphine with naloxone (Suboxone) to the safety list. There is no need for the prescriber to annotate safety medicines. You just need to specify the period of supply. If patients have other medicines co-prescribed with safety medicines, the pharmacist can dispense them at the same time if they consider the patient would benefit. You don't need to do anything as the pharmacist determines this.
- *Trial medicines*. You can prescribe an initial shorter dispensing period for patients who are starting a new medicine or having a dose change. You need to write 'trial' or 'trial medicine' on the prescription but don't need to initial it. This rule hasn't changed but MedTech has incorporated a 'trial' button in its software.
- *Monthly dispensing into Aged Residential Care and community residential care facilities* remains the same as the current rules. You don't need to annotate the prescription, as long as either the prescriber or pharmacist includes the residential address and patients NHI number.

If you want more information on the Close Control rule changes this is available at www.pharmac.govt.nz/ccc or phone 0800 66 00 50. Information has been included in the July Schedule Update and there will be a BPJ article coming out shortly.
In managing an individual patient's needs and in the transition to the new service model the management of repeat prescriptions is likely to require increased communication between pharmacists and prescribers. If you would like more information about the new Community Pharmacy Services Agreement, please do not hesitate to get in touch with me and I will do my best to answer your questions.

Regards

Wayne Turp
General Manager Planning and Funding

New service model for community pharmacy

Introduction

There are significant and far reaching changes included in the new Pharmacy Services Agreement from 1 July 2012. This follows on from extensive engagement with community pharmacy to consider options for change. The key change is a patient-centred model of care designed to enable pharmacists to better tailor services to patients, particularly to patients with multiple co-morbidities and on many medications, and strengthening communication between members of the patient's multi-disciplinary team in the plans by for managing the patient's medicines.

Key strategic drivers include:

- the desire to give pharmacists incentives to better use their clinical medicines management expertise and work at the top of their scope of practice;
- re-orienting community pharmacy services around the patient and facilitating increased integration with prescribers across all settings of care, but in particular with the general practice;
- the need to ensure that the funding for community pharmacy is linked to patient outcomes; and
- that the funding model is sustainable.

The 20 DHBs first consulted with community pharmacy providers on the development of a new service and funding model in November 2010, and another consultation was undertaken in March 2011. A pharmacy led workshop was held in September 2011 to inform and agree on a new patient-centred service, and this was followed by a number of meetings with community pharmacists, DHBs and other stakeholders to refine the service model concept and transition arrangements. The five workstreams developed following this workshop were:

- Services definitions
- Assessment criteria and referral process.
- Indicators for quality and quantity
- Transition implementation plan
- System for reimbursement/costing of service

DHBs, supported by PHARMAC, then developed the proposed funding arrangements to ensure the incentives to community pharmacies were aligned with patient services and were sustainable for DHBs.

A final stage of engagement occurred between 26 March and 27 April 2012 when each DHB undertook consultation with community pharmacy providers on the proposed new Community Pharmacy Services model.

Background

In the current model pharmacies are paid on volumes of medicines dispensed, and the resulting expenditure growth in pharmacy dispensing costs is unsustainable. The linking of funding to volumes has little relationship with patient outcomes.

In 2009/10 out of total dispensing fees of $320M, $82M was spent on Close Control. Of the $82M spent on Close Control, $46M was spent on weekly Close Control.

The **Close Control** Pharmaceutical Schedule Rule has provided a mechanism which has allowed pharmacies to dispense more frequently to some patients, and it is believed there is an element of over-servicing in this funding. Aside from trialing new medicines, weekly dispensing should be an exception, rather than a rule, for example for people with safety issues.

The **new service model** introduces a new service – **the Long Term Conditions Service** – that will target those patients who need help managing their medicines, and therefore contribute to better patient outcomes. It is expected that many patients who are receiving Close Control dispensing will be registered in the LTC Service in the new service model.

Three new categories for services to patients according to needs

The new service model for community pharmacy introduces three patient categories:

- Core Services;
- Long Term Conditions (LTC) Services; and
- Specific Services

The majority of patients who currently receive episodic care under the existing Agreement and those with chronic conditions who are well managed on their medication shouldn't notice any change in their interactions with their pharmacist.

The new LTC Service is for those patients with the highest needs

The new Long Term Conditions (LTC) Service is aimed at the group of patients that prescribers believe need the most support from pharmacists. Not all patients with a LTC will be eligible. For example, if a diabetic is well controlled and takes their medicine as prescribed, this person doesn't need receive the extra care in the LTC Service.

Patients who are currently high users of pharmacy services, (e.g. patients on weekly or monthly Close Control) will be assessed by their pharmacist, and if eligible will be invited to register with the pharmacy for the new LTC Service. These patients will have a Medicines Management Plan developed by the pharmacist. A Medicines Management Plan won't be time limited – it will allow the pharmacist to work with the patient to address each issue over a period of time. Some solutions will be quick (e.g. using compliance packaging), but others will take much longer (e.g. enhancing health literacy).

As part of the assessment it is expected that the pharmacist will seek information from relevant members of the patient's multi-disciplinary team and make the Medicines Management Plan available to them.

The services that a pharmacist could provide to patients are likely to include: checking that medicines prescribed by different prescribers are not acting against each other; synchronising a patient's repeat prescriptions to avoid unnecessary trips to the pharmacy or GP; reminding the patient how to take the medicine; and referring the patient to other services, such as the Needs Assessment and Service Coordination (NASC) service.

General Practice has been involved in the development of the new service model

Community pharmacists, DHBs, pharmacy sector agents, PHARMAC and the wider health sector have developed the new service model over the past two years. A steering group met every six weeks until November 2011 and included a representative of the RNZCGP.

Meetings have been held with the GP Leaders Forum, the Community Pharmacy Leaders Group, RNZCGP, NZMA, GPNZ, and the Pharmaceutical Society to seek feedback on the proposed changes and they are all very supportive of the approach.

New service model aligns to health priorities

The new model aligns with the Government's health priorities around integrating primary care and improving management of LTCs through:

- Moving interventions upstream with earlier implementation of evidence-informed actions.
- Bringing health services closer to home – the suite of LTC Services are community-based.
- Improving the health and independence of older people – managing medicines for older LTC Services patients would mean better health outcomes and help them to continue living independently.
- Strengthening the health workforce – the proposed model encourages and rewards pharmacies for working at the top of their scope of practice; and would foster the multi disciplinary team approach.
- Improving value for money – the new service model reduces the ongoing growth in dispensing fees while focusing on health gains for the most 'at risk' patients.

Peer review, education and incentive payment used to drive quality

The Community Pharmacy Services Operational Group has been set up to oversee the delivery of the new community pharmacist services model and a strong performance and audit strategy is being developed. Peer review, education, and best practice standards are going to be important parts of that strategy, and audit would be used only when there was a performance issue and standards were not being met.

A new Quality Framework will see up to five percent of the total funding set aside as a quality incentive payment against defined criteria.

No change to Age-Related Residential Care (ARRC) service

There will be no immediate change to the Age-Related Residential Care (ARRC) service, but DHBs are considering a separate service for this group of patients from 2013/14.

MUR and MAT are not included in the new Community Pharmacy Agreement

The new Pharmacy Services Agreement covers services that can be provided within the current scope of community pharmacy services, at Level A of the Pharmacy Council Competency Framework. Medicines Use Review and Medicines Therapy Assessment are not part of the new Agreement. The Medicines Management Plan is not a Medicines Use Review.

Changes to Close Control

From 1 July 2012 PHARMAC is removing the Close Control Rule and replacing it with the "Dispensing Frequency" Rule. The key change is the Close Control Rule relating to patients who are "intellectually impaired, frail, infirm or unable to manage medicines". This clause is being removed from the new rule.

In the coming months pharmacists will assess these patients for eligibility in the new LTC Service, or transition them safely into the Core Pharmacy Service. Patients should remain on the same dispensing frequency until they are assessed for eligibility in the LTC Service.

In practice, for prescribers this means that annotating a prescription with 'Close Control' is no longer required and the pharmacist dispensing the medication is able to determine the dispensing frequency for LTC Service patients.

For non-LTC Service patients dispensing shouldn't be more often than monthly. For dispensing more frequently than monthly in this group the pharmacist needs the permission of the prescriber.

If you have a strong view about the frequency with which the patient should receive the medicine please talk with the pharmacist. More frequent dispensing can still be undertaken in the following groups:

- *'Safety' medications* already have rules around their dispensing, for example Class B controlled rugs and tri-cyclic antidepressants. PHARMAC has added codeine and buprenorphine with naloxone (Suboxone) to the safety list. There is no need for the prescriber to annotate safety medicines. You just need to specify the period of supply. If patients have other medicines co-prescribed with safety medicines, the pharmacist can dispense them at the same time if they consider the patient would benefit. You don't need to do anything as the pharmacist determines this.
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If you want more information on the Close Control rule changes this is available at www.pharmac.govt.nz/ccc or phone 0800 66 00 50.

More information about the LTC Service

GPs to encourage eligible patients to register for LTC Service

It is expected that referral to the LTC Service will be proactive and collaborative, with prescribers and Needs Assessment and Service Coordination (NASC) actively referring patients and sharing relevant clinical information, where appropriate.

Patients who are eligible but who don't want to register for the LTC Service can still receive pharmaceutical services as a Core Service patient, and the pharmacist will use his or her professional judgement to provide service to that patient as the pharmacist sees fit.

Patients identified as meeting the InterRAI Medication CAP (as part of a home-based support needs assessment) would be considered to be automatically eligible for the LTC Service.

Patients in the LTC Service will be registered with a particular pharmacy

Pharmacists will start progressively assessing their high needs patients from 1 July 2012 and invite those eligible to register to receive dispensing and pharmaceutical support. LTC Service patients may still receive medications from another pharmacy, for example if they are out-of-town or after hours. If an LTC Service patient started regularly receiving pharmacy services at another pharmacy, the patient will be invited to transfer his/her registration to the other pharmacy.

Health professionals will share clinical information on LTC Service patients

The pharmacist will use an eligibility assessment tool which assesses medicines-related issues to determine if a patient is eligible for registration. Part of that assessment tool includes recommendations from other health professionals such as GPs and specialists. It is expected that the pharmacist would communicate the result of the assessment to the patient's GP and any other relevant member of the patients health care team, for example a mental health nurse.

Patients might receive their medicines on a different timetable

The new service model allows a pharmacist to tailor dispensing to the individual. For example, a medicine can be dispensed every six to eight weeks instead of monthly or three-monthly. A patient on several medications could have his or her medicines regimen aligned to a common end date, so the patient need only visit the pharmacy and the prescriber once instead of multiple times. This frees up time for the pharmacist to spend with those patients who need extra support with their medicines.

Patients will get compliance packaging if pharmacist says it is necessary

Pharmacists will continue to use their professional judgement to determine if a patient needs to use compliance packaging. Some pharmacists have funded compliance packaging through the current funding model. The situation would not change under the proposed new service model.

CLINICAL LEADERSHIP TEAM REPORT

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

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

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

DATE: **24 June 2012**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board as a regular update.

2. RECOMMENDATION

That the Board:
i. notes the Clinical Leaders Update

3. SUMMARY

Ongoing work to develop the model of care for sustainable health services for the West Coast continues. This is feeding in to the draft indicative business case for Grey Hospital redesign and a Grey Integrated Family Health Service.

Leadership in quality and clinical governance continues, including the West Coast Health System Clinical Board, the West Coast PHO, the BSMC Alliance Leadership Team, the hospital Continuous Quality Improvement Team, and the South Island Regional Training Hub

Medical

Ongoing efforts continue to recruit general practitioners and senior hospital doctors, in collaboration with the Canterbury DHB Recruitment team. Permanent appointments within the hospital show the fruit of this work.

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

Ongoing meetings with health professionals about the future model of care for West Coast health services continue, both locally and with Canterbury health professionals.

The document attached as Appendix 1 'Creating a sustainable health care service' outlines the key aspects of the proposed model of care.

Nursing & Midwifery

Greymouth hosted the 34th NZNO National Enrolled Nurse Section Annual Conference and AGM on 23 - 25 May 2012.

Feedback received was very positive with heartfelt congratulations to Bernie Morgan and John Morel for organising a high quality event. Presentation content included clinical topics such as strokes, blast burns and diabetes, all delivered by local clinicians. Strategic enrolled nursing issues were presented and discussed including potential future roles for enrolled nurses in the developing model of care on the West Coast, with best utilisation of their new scope of practice. A total of 37 West Coast enrolled nurses have transitioned and will not only be more versatile within the system but will also contribute to the future development of this valuable group within the nursing workforce, growing the new generation of nurses completing the Diploma of Enrolled Nursing.

A review of the prioritisation strategy and approval process for nursing and midwifery education spending will commence over the next month. Education planning is tied to individual, clinical area, service and then organisational requirements. We need to ensure that appropriate education spend occurs to get the best value from the budget available. The project will be West Coast wide and be linked to the overarching education plan and workforce plan. A firm and transparent process will be put in place to support decision making for nurses, midwives, line managers and service managers when considering and approving training options.

Allied Health, Technical and Scientific

We had several staff attend the national Allied Health Technical and Scientific Conference in Christchurch where the key themes of resilience; transition; transformation and innovation were of great interest. Key note speakers shared thinking about the Telehealth service working between Canterbury and the West Coast as well as workforce innovation and how clinical information systems can support new models of care.

Social Work services continue to have had significant vacancies and external support has been provided by Canterbury. There is a short term contract in place for leadership locally and a new recruitment plan in development. There are also vacancies in Physiotherapy but we have had a high level of interest in the roles which is a new result for the discipline.

The Allied Health model of care document is referenced as part of the three workstreams looking at new care delivery across the Coast – Buller; Grey and Health of Older People. There have been first level discussions with the hospital and community pharmacists on how they can work differently to support these new models of care.
Work continues on the collaboration with Canterbury – particularly in the area of Telehealth with the concept of RUSFUS being explored for allied health. Work continues on the Allied Health leadership framework implementation.

There are several staff members from technical and scientific professions on the current xcerl8 programme.

4. APPENDICES

Appendix 1: Creating a Sustainable Health Care Service

Report prepared by: Carol Atmore, Chief Medical Officer
Karyn Kelly, Director of Nursing & Midwifery
Stella Ward, Executive Director, Allied Health

FINANCE REPORT

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

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

SOURCE: **Colin Weeks, Chief Financial Officer**

DATE: **12 July 2012**

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

1. ORIGIN OF THE REPORT

This report is a standing agenda item providing an update on the latest financial results and other relevant financial matters of the West Coast District Health Board that are dealt with by this committee.

2. RECOMMENDATION

That the Committee
i. notes the Financial Report.

3. SUMMARY

Financial Overview for the period ending 31 May 2012

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,242	6,167	75	×	69,389	68,623	766	√
Governance & Administration	208	212	(4)	√	2,351	2,334	17	√
Funds & Internal Eliminations	4,746	4,284	462	√	48,822	48,818	4	×
	11,196	10,663	533	×	120,562	119,775	787	√
EXPENSES								
Provider								
Personnel	4,675	4,458	(217)	×	48,635	47,997	(638)	×
Outsourced Services	1,058	813	(245)	×	11,690	9,723	(1,967)	×
Clinical Supplies	635	629	(6)	×	7,187	6,663	(524)	×
Infrastructure	932	916	(16)	√	10,461	10,072	(389)	×
	7,300	6,816	(484)	×	77,973	74,455	(3,518)	×
Governance & Administration	204	212	8	√	2,006	2,335	329	√
Funds & Internal Eliminations	3,616	3,860	244	√	39,944	41,464	1,520	√
Total Operating Expenditure	11,120	10,888	(232)	√	119,923	118,254	(1,669)	×
Deficit before Interest, Depn & Cap Charge	(76)	225	301	×	(639)	(1,521)	(882)	×
Interest, Depreciation & Capital Charge	523	551	28	√	5,580	6,061	481	√
Net deficit	**447**	**776**	**329**	×	**4,941**	**4,541**	**(400)**	×

CONSOLIDATED RESULTS

The consolidated result for the month of May 2012 is deficit of $447k, which is $329k better than budget ($776k deficit).

RESULTS FOR EACH ARM

Year to Date to May 2012

West Coast District Health Board Arm	Actual	Budget	Variance	Comment
	$000	$000	$000	
Provider Arm surplus / (deficit)	(14,164)	(11,894)	(2,270)	Unfavourable
Funder Arm surplus / (deficit)	8,878	7,353	1,525	Favourable
Governance Arm surplus / (deficit)	345	0	345	Favourable
Consolidated result surplus / (deficit)	**(4,941)**	**(4,541)**	**400**	**Unfavourable**

WEST COAST DISTRICT HEALTH BOARD
FUNDER ARM - PAYMENTS TO EXTERNAL PROVIDERS
as at 31 May 2012

May-12						Year to Date						2011/12	2010/11	
Actual	Budget	Variance			SERVICES	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									
21	43	22	52%	√	Laboratory	345	446	101	23%	√		486	511	5%
707	764	57	7%	√	Pharmaceuticals	7,299	7,710	411	5%	√		8,473	7,705	-10%
728	**807**	**79**	**10%**	√		**7,644**	**8,155**	**511**	**7%**	√		8,959	8,216	-9%
					Secondary Care									
5	20	15	74%	√	Inpatients	49	216	167	77%	√		237	38	-523%
90	116	26	22%	√	Travel & Accommodation	1,039	1,275	236	19%	√		1,391	1,189	-17%
1,285	1,285	0	0%	√	IDF Payments Personal Health	14,131	14,130	-1	0%	√		15,414	15,606	1%
1,380	**1,421**	**41**	**3%**	√		**15,219**	**15,620**	**401**	**3%**	√		17,042	16,833	-1%
					Primary Care									
24	50	26	52%	√	Dental-school and adolescent	302	428	126	29%	√		467	399	-17%
0	2	2	100%	√	Maternity	0	24	24	100%	√		26	0	
0	1	1	100%	√	Pregnancy & Parent	0	7	7	100%	√		8	0	
0	3	3	100%	√	Sexual Health	8	31	23	74%	√		33	13	-152%
-5	0	5		√	General Medical Subsidy	18	4	-14	-309%	×		5	76	94%
526	523	-3	-1%	×	Primary Practice Capitation	5,881	5,752	-129	-2%	×		6,275	6,135	-2%
-13	7	20	289%	√	Primary Health Care Strategy	71	76	5	6%	√		83	251	67%
77	77	0	0%	√	Rural Bonus	848	850	2	0%	√		928	970	4%
38	13	-25	-184%	×	Child and Youth	193	147	-46	-31%	×		162	162	0%
22	15	-7	-47%	×	Immunisation	138	81	-57	-70%	×		96	154	38%
0	14	15	107%	√	Maori Service Development	152	149	-4	-2%	×		162	165	2%
18	31	13	42%	√	Whanua Ora Services	198	343	145	42%	√		373	215	-74%
13	13	0	1%	√	Palliative Care	177	144	-33	-23%	×		157	110	-43%
8	16	8	50%	√	Chronic Disease	116	271	155	57%	√		286	3	-9440%
11	11	0	2%	√	Minor Expenses	121	123	2	2%	√		134	206	35%
719	**776**	**57**	**7%**	√		**8,223**	**8,431**	**208**	**2%**	√		9,195	8,859	-4%
					Mental Health									
0	1	1	100%	√	Eating Disorders	22	11	-11	-100%	×		12	23	48%
53	50	-3	-7%	×	Community MH	560	551	-9	-2%	×		601	538	-12%
1	1	0	0%	√	Mental Health Work force	11	8	-3	-43%	×		8	15	44%
48	47	-1	-2%	×	Day Activity & Rehab	524	521	-3	0%	×		569	518	-10%
10	10	0	0%	√	Advocacy Consumer	105	112	7	6%	√		122	120	-2%
5	5	0	6%	√	Advocacy Family	67	58	-9	-15%	×		64	71	10%
0	5	5	100%	√	Minor Expenses	0	56	56	100%	√		61	0	
104	118	14	12%	√	Community Residential Beds	1,130	1,294	164	13%	√		1,411	1,261	-12%
66	66	0	0%	√	IDF Payments Mental Health	726	729	3	0%	√		796	813	2%
287	**302**	**15**	**5%**	√		**3,145**	**3,340**	**195**	**6%**	√		3,644	3,359	-8%
					Public Health									
2	29	27	93%	√	Nutrition & Physical Activity	186	314	128	41%	√		342	328	-4%
0	7	7	100%	√	Public Health Infrastructure	75	76	1	1%	√		83	82	-1%
0	0	0		√	Social Environments	0	0	0		√		0	-15	100%
9	6	-3	-53%	×	Tobacco control	129	62	-67	-108%	×		68	58	-17%
11	**42**	**31**	**74%**	√		**390**	**451**	**61**	**14%**	√		493	453	-9%
					Older Persons Health									
5	0	-5		×	Information and Advisory	32	0	-32		×		0	0	
0	0	0		√	Needs Assessment	33	0	-33		×		0	0	
82	53	-29	-54%	×	Home Based Support	573	547	-26	-5%	×		595	708	16%
16	10	-7	-68%	×	Caregiver Support	112	105	-8	-7%	×		114	130	12%
301	174	-127	-73%	×	Residential Care-Rest Homes	2,696	1,866	-830	-44%	×		2,030	2,344	13%
-2	0	2		√	Residential Care Loans	-41	0	41		√		0	-113	100%
13	10	-3	-27%	×	Residential Care-Community	134	112	-22	-19%	×		122	48	-155%
210	396	186	47%	√	Residential Care-Hospital	3,193	4,245	1,052	25%	√		4,622	3,949	-17%
2	5	3	63%	√	Ageing in place	15	59	44	75%	√		65	12	-440%
7	7	0	1%	√	Environmental Support Mobility	50	78	28	36%	√		85	28	-204%
9	6	-3	-45%	×	Day programmes	113	68	-45	-66%	×		74	75	1%
7	12	5	42%	√	Respite Care	161	131	-30	-23%	×		143	118	-21%
108	108	0	0%	√	IDF Payments-DSS	1,188	1,191	3	0%	√		1,300	1,060	-23%
758	**781**	**23**	**3%**	√		**8,259**	**8,403**	**144**	**2%**	√		9,151	8,359	-9%
3,883	**4,129**	**246**	**6%**	√		**42,880**	**44,400**	**1,520**	**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 May 2012 was $246k (6%) better than budget and year to date payments are $1,520k (3%) better than budget.

Commentary on year to date variances

Referred Services
Community pharmaceuticals are $411k less than budget and laboratory services are $101k less than budget – payments for blood products to private hospitals and tests via Medlab. The contract with Medlab was not renewed when it expired in March; all tests are now referred to West Coast DHB laboratory.

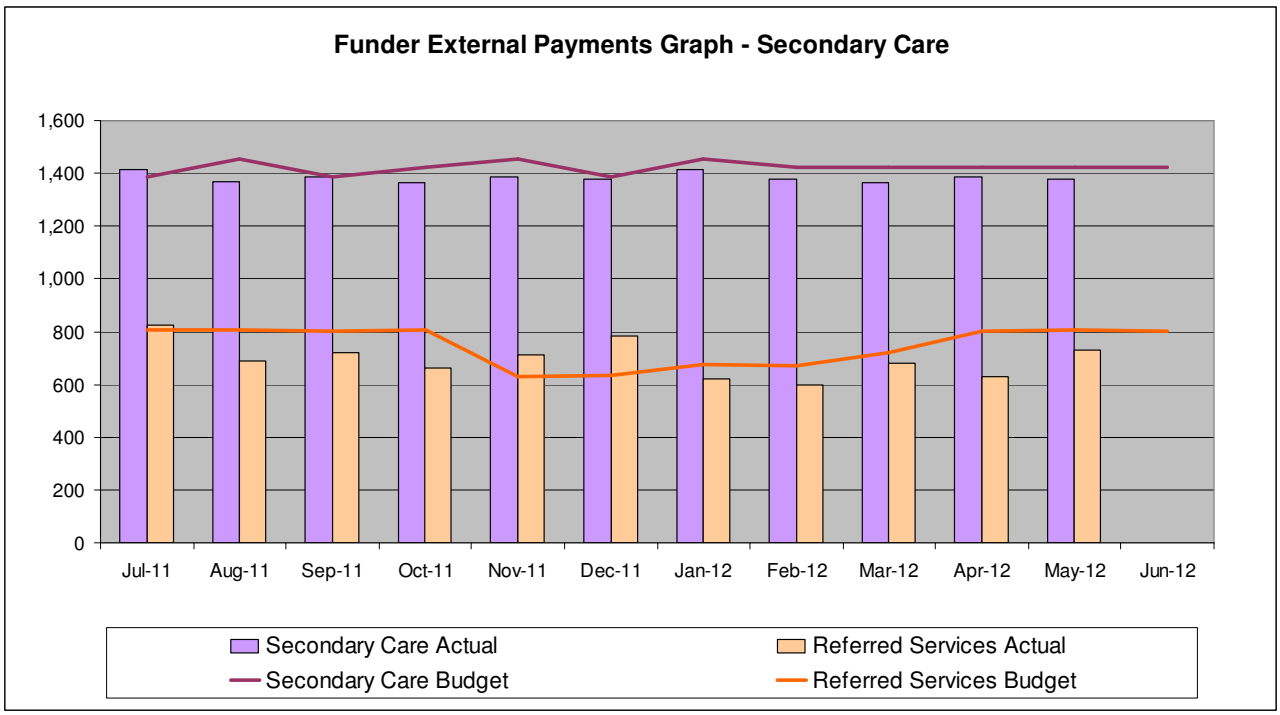
Secondary Care
Secondary Care services are $401k less than budget, with travel and accommodation paid under the National Travel Assistance (NTA) scheme being $236k less than budget to date. Claims for NTA are not always received on a timely basis and payments to date may reflect this, with a catch up 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 $167k less than budget (electives performed by external providers).

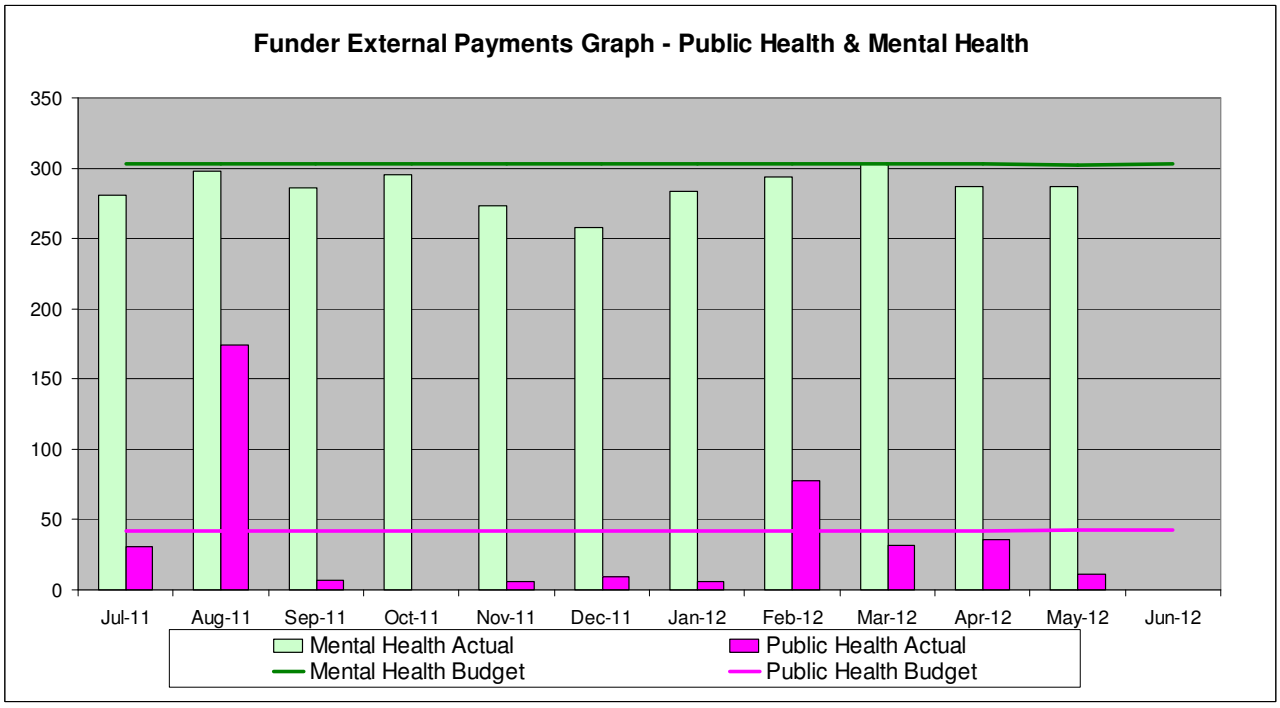
Primary Care
Whanau Ora service costs are $145k less than budget. Discretionary costs (chronic conditions and palliative care) are together $122k less than budget to date. Palliative care costs are now $33k more than budget to date and will continue to be more than budget for the reminder of the year. Capitation payments are $129k more than budget to date; this largely relates to payments for Careplus, Very Low Cost Access and PHO performance payments – as funding for these has not been devolved this cost will be covered by Ministry of Health revenue.

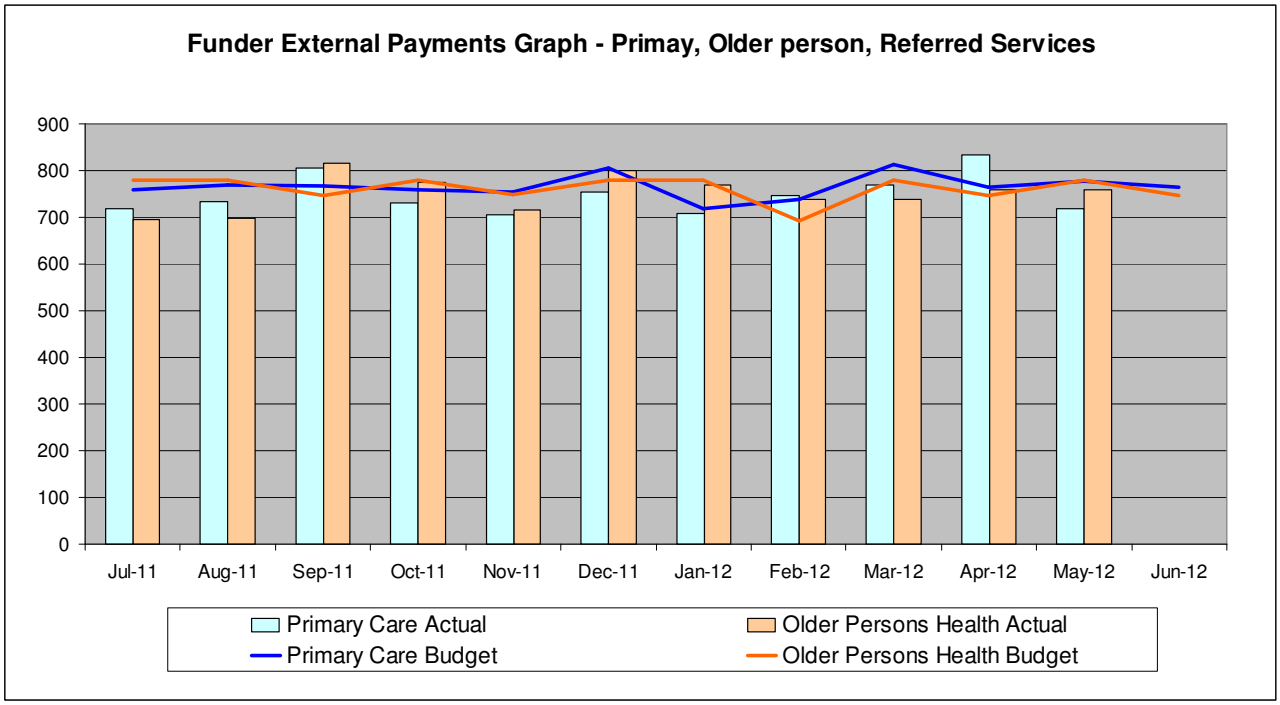
Mental Health
Community residential beds are less than budget, with two beds funded on a discretionary basis and the remainder block funded. Minor expenses relates to costs for a project, funded by the Ministry of Health that has not yet started (we have also not received any of the revenue for this project).

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 less than budget year to date ($144kk or 2% 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.


Funder External Payments Graph - Secondary Care
1,600
1,400
1,200
1,000
800
600
400
200
0
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Secondary Care Actual
Referred Services Actual
Secondary Care Budget
Referred Services Budget


Funder External Payments Graph - Public Health & Mental Health
350
300
250
200
150
100
50
0
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Mental Health Actual
Public Health Actual
Mental Health Budget
Public Health Budget


Funder External Payments Graph - Primay, Older person, Referred Services
900
800
700
600
500
400
300
200
100
0
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Primary Care Actual
Older Persons Health Actual
Primary Care Budget
Older Persons Health Budget

BETTER SOONER MORE CONVENIENT AND ALLIANCE LEADERSHIP TEAM REPORT

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

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

SOURCE: **Dr Carol Atmore, Chief Medical Officer**
Wayne Turp, General Manager Planning and Funding

DATE: **3 July 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the progress made on the Implementation of Better Sooner More Convenient.

2. RECOMMENDATION

That the Committee

i. notes this item

A verbal update will be provided for at the meeting.

FAMILY VIOLENCE

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

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

SOURCE: **Claire Newcombe, Portfolio Manager for VIP**

DATE: **20 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The presentation is for noting only.

2. RECOMMENDATION

That the Committee
i. notes this item.

3. SUMMARY

This item will be tabled at the meeting, a hand out will be made available at the meeting.

DISABILITY DISCUSSION

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

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

SOURCE: **Torfrida Wainwright, Portfolio Manager for Health of Older People**

DATE: **20 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The verbal update is for noting only.

2. RECOMMENDATION

That the Committee
i. notes this item.

3. SUMMARY

The Portfolio Manager of Older Peoples Health, will open a discussion around the disabilities on the West Coast's and the national position with the disability services

4. APPENDICES

Appendix 1: WCDHB Version 2 Draft, Disability Action Plan

Report prepared by: Planning and Funding

WEST COAST DISTRICT HEALTH BOARD

Version 2 DRAFT
DISABILITY ACTION PLAN
2009-2015

Prepared by Torfrida Wainwright, Planning & Funding Revised 4 August 2009

Purpose of this paper

This is a revision of the West Coast Disability Strategy Action Plan 2004-2010, for re-consideration by West Coast DHB's Disability Services Advisory Committee at their August 2009 meeting.

Context

In 2004 the West Coast DHB adopted a Disability Strategic Action Plan 2004-2010, based on a wide consultation with the public and stakeholders. Parts of this plan have been achieved but other parts of the plan had not been achieved at 30 June 2009.

DSAC asked Planning and Funding to revise the Action Plan in the light of more recent national guidelines and to revise and tighten up the timeframes and responsibilities.

This document includes elements of the earlier action plan that have not yet been achieved, takes into consideration the recent national guidelines on disability[1] and adopts a different format which may make it easier to monitor progress on the proposed actions and timeframes.

Key points

The key areas covered in the plan follow those key aspects of the New Zealand Disability Strategy and its updates, which are relevant to DHB health and support services:

- Disability awareness training for DHB staff and contractors
- Overcoming a disabling society – reducing barriers to the use of West Coast DHB-funded facilities by people with disabling conditions.
- A web of information – ensuring that information on all West Coast DHB-funded services are accessible for people with disabilities
- Providing employment opportunities to disabled people – ensuring West Coast DHB is an Equal Opportunity Employer
- Providing disability information, advocacy and support services for people with personal health conditions, and ensuring these services work smoothly alongside the disability support services funded by the Ministry of Health
- Community and consumer engagement – ensuring that West Coast DHB actively engages with people with disabilities in all its consultation activity

Recommendations

It is recommended that:

- DSAC consider this plan for adoption by West Coast DHB to guide the development of West Coast DHB funded services

[1] Disability Services, Ministry of Health (2008). *Strategic Plan 2008-2010 – towards a more flexible disability support system.* Wellington:MoH

1.	**DISABILITY AWARENESS TRAINING**
Strategic goal	To encourage and educate all relevant staff and contractors in disability awareness.
Objectives	**West Coast District Health Board aims to:** • Increase the overall understanding, and knowledge of the New Zealand Disability Strategy disability issues amongst WCDHB's employees and Board Members through 100% training attendance by 2011. • Improve the level of disability knowledge amongst, all staff so that disabled people receive health and disability services that are appropriate and meet their needs.
Actions	**By June 2011, WCDHB will:** • Include a disability issues training component in staff orientation and Board induction training process. • Provide up to date information, training, and continuing education for Recruitment, HR, Managers, Occupational health (staff who deal with employment issues) in order to increase their awareness and understanding of the needs of disabled people • .Provide up to date information, training, and continuing education for clinical and first contact staff (staff who deal with the public) in order to increase their awareness and understanding of the needs of disabled people. • Develop a regular disability column promoting community issues in communications to staff
Measurement	**WCDHB will**: • Measure the number and percentage of new employees and Board members who receive disability awareness training as part of their orientation/induction training. • Measure the number and percentage of HR, Recruitment, Service Managers and Occupational health staff who have received disability awareness training **Targets:** • 100% of new employees/board members receive a disability component in induction/orientation training by June 2011 • 30% of clinical, recruitment, HR, service managers, and first contact staff receive disability competency training by June 2011
Responsibility	Planning and Funding General Manager Human Resources manager Service Managers CEO

2.	**PHYSICAL ACCESS**
Strategic goal	Overcoming a Disabling Society
Objectives	**West Coast District Health Board aims to**: • Provide an accessible journey for all people to all services within its physical environment by 2012.
Actions	**By June 2011, WCDHB will**: • Assess through surveys and audits the accessibility of WCDHB facilities for compliance with access requirements of, and exceed the Building Act NZS 4121:2001, the Building Code, and the Human Rights Act. • Assess through surveys and audits the accessibility of primary and community providers facilities for compliance with the access requirements of, and exceed the Building NZS 4121:2001, the Building Code, and the Human Rights Act. • Ensure best practice barrier free component is a priority in the design and development of any new WCDHB buildings or contracted services. • Develop action plans to deal with issues of non-compliance with access requirements. • Audit all new buildings plans to ensure compliance is maintained
Measurement	**WCDHB will**: • Measure the number and percentage of hospital and health service buildings (including entrances, car parks, toilet, examination tables etc) which are accessible and meet or exceed the NZS 4121, 2001. • Identify and provide resources to support barrier free initiatives for new buildings and existing buildings. • Monitor the accessibility of primary and community provider facilities, to ensure their accessibility increases over time. **Targets:** • 100% of buildings built after June 2010 meet NZS 4121,2001 • Percentage of other provider buildings/facilities that are accessible increased by 2011
Responsibility	Planning and Funding General Manager Facilities Manager Service Managers CEO

3.	COMMUNICATION AND ACCESS TO INFORMATION
Strategic goal	A Web of Information
Objectives	**West Coast District Health Board aims to:** • Ensure that people who cannot use usual formats such as written letters or telephones will be able to send and receive confidential information to/from WCDHB in a timely manner by 2011. • Improve the accessibility of public information produced by WCDHB through publication in alternative formats (audio, plain language, large print, pictorial etc) and accessible electronic facilities by 2011. • Support the New Zealand Sign Language Act
Actions	**By June 2011, WCDHB will:** • Publish an easy to read brochure on access to WCDHB services for disabled people • Ensure that the complaints procedure is accessible. • Increase WCDHB provision of Braille, large print, audio, and assistive hearing systems, and provide access to NZ Sign Language interpreters where requested • Upgrade our intranet, internet, and signage to incorporate accessibility features and guidelines. • Develop and implement a communications style guide for all publications.
Measurement	**WCDHB will:** • Measure our ability to produce, on request and free of charge, information in a range of formats **Targets**: • Brochure published by July 2010 • WCDHB signage, intranet, and internet upgraded by July 2010 • Production/availability of information in alternative formats increased every year through to 2015
Responsibility	Planning & Funding General Manager Community Liaison Officer IT manager Quality and Safety Manager Service Managers CEO

4.	**EMPLOYMENT OPPORTUNITIES**
Strategic goal	Providing Employment Opportunities for Disabled People
Objectives	**West Coast District Health Board aims to**: • Have the number of disabled people employed reflect the percentage of disabled people in the general working age population, if possible. • Reduce barriers for employees with disabilities by ensuring working environments and conditions are appropriate • Ensure learning opportunities and pathways for professional development are available and accessible to all staff. • Become an EEO employer • Capture statistics on disabled employees within WCDHB and identify any potential barriers.
Actions	**By June 2012, WCDHB will:** • Review all employment policies and procedures to ensure they maximise employment opportunities for disabled people. • Review all employment policies and procedures to ensure they maximise employment opportunities for carers of disabled people. • Ensure that reliable statistics are collected for the percentage of disabled employees, and what support needs they may have. • Learning and Development courses and training opportunities are made accessible for staff with suitable notice. • Advertise widely and in many formats when recruiting. • Develop a staff survey to capture the statistics on disabled employees within WCDHB and develop an action plan to remove any potential barriers identified
Measurement	**WCDHB will:** • Measure the number and percentage of employees with a disability and analyse comparisons between those figures and the percentage of disabled people in the general working age population. • Develop pathways for disabled employees to get support in the workplace. **Targets:** • Reliable statistics collected on the number of disabled employees by June 2010 • Increase the percentage of disabled employees by 2012
Responsibility	Planning & Funding General Manager Human Resources General Manager Quality and Safety Manager Service Managers CEO

5.	**INFORMATION, ADVOCACY AND SUPPORT FOR FAMILIES AND CARERS**
Strategic goal	To collaborate with other funders to ensure good support services for people with disabilities and those caring for them
Objectives	**West Coast District Health Board aims to:** • Collaborate with the Ministry of Health and other funders to ensure that good information, advocacy and carer support services are available for people with disabilities and their families, whatever the cause of the disability • Ensure that services work closely together so that people receive the disability information, advocacy and carer support services they need, regardless of funding stream or diagnosis
Actions	**By June 2010, WCDHB will:** • Initiate collaboration with other funders to improve the accessibility and effectiveness of disability information, advocacy and support services on the West Coast, including access to the services of voluntary agencies such as Stroke Foundation, Alzheimer's NZ and Arthritis Society etc • Ensure smooth working relationships between Carelink and Lifelinks
Measurement	**WCDHB will**: • Support the work of agencies providing disability information, advocacy and carer support services for people with personal health related conditions • Identify and implement resources to support the work of disability information, advocacy and support agencies for people with personal health needs **Targets:** • Increased service usage by July 2012 • Clearly designated funding for these services by July 2011
Responsibility	Planning & Funding General Manager DSAC Carelink manager CEO

6.	**COMMUNITY AND CONSUMER ENGAGEMENT**
Strategic goal	To develop pathways for meaningful engagement with key stakeholders.
Objectives	**West Coast District Health Board aims to:** • Ensure people from all parts of the community have the opportunity to participate in public consultation processes. • Build strong relationships and partnerships with the disability community • Provide advice/ inform DSAC and related committees around disability issues
Actions	**By June 2010, WCDHB will:** • Host forums on matters that may affect disabled people • Work with other DHBs proactively to network and raise awareness of disability issues and advocate for removal of barriers in the health sector. • Regularly maintain relationships and seek feedback from agencies, groups and in the disability sector organisations.
Measurement	**WCDHB will**: • Monitor participants rates of disabled people on WCDHB matters that may affect them, particularly participation rates of disabled Maori, disabled Pacific and people with severe or multiple impairments. • Monitor and record stories of people encountering barriers **Targets:** • Increased participation rates every year through to 2015 • Reduction of examples of people encountering barriers to participation.
Responsibility	Planning & Funding General Manager DSAC Community Liaison Officer Quality & Safety Manager Service managers CEO

WORKPLAN

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

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

SOURCE: **Elinor Stratford, Chair**
Wayne Turp, General Manager Planning and Funding

DATE: **24 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the progress made on the Minister of Health's health and disability priorities and the West Coast DHB Annual Plan key priority areas.

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	√			Yet to be confirmed.
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		√		Final Annual Plan is on track.
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			√		

GENERAL BUSINESS

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

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

SOURCE: **Chair**

DATE: **24 June 2012**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

This item is for information only.

2. RECOMMENDATION

That the Committee
i. notes this item.

3. SUMMARY

Items to be reported back to the Board **Chair**

The recommendation from the Committee to the Board re position paper on alcohol was endorsed

INFORMATION PAPERS

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

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

SOURCE: **Chair**

DATE: **18 June 2012**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

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 Reference

TERMS OF APPOINTMENT

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

Report Status – For: Decision ☐ Noting ☐ Information ☑

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	31 January 2014
Kevin Brown **Deputy Chair** **(West Coast District Health Board member)**	27 January 2011 (re-appointed 27 January 2012)	3 months	31 January 2014
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
Lynnette Beirne	24 March 2011	1 Year	31 December 2011
Marie Mahuika-Forsyth	20 April 2009	Until advised by Te Runanga o Makaawhio	

Member	**Date of Appointment**	**Length of Term**	**Expiry Date**
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

COMMITTEE SCHEDULE

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

Report Status – For: Decision ☐ Noting ☐ Information ☑

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