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

23 AUGUST 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 23 August 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** ▪ *12 July 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.	**Māori Disability Action Plan:** *(MOH)*	Roger Jolley *Ministry of Health*	*10.10am-10.40am*
9.	**Workplan for noting** *(CPHAC & DSAC)*	Elinor Stratford *Chair*	
10.	**General Business**		
	Items to be reported back to Board	Elinor Stratford *Chair*	*10.40am-10.45am*
	CPHAC AND DSAC WORKSHOP		
	Maori Health Plan	Roger Jolley, *Ministry of Health*	*11.15am-12.00pm (Kahurangi Room)*
FINISH TIME			**10.45am**

11. 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

PHO Quarterly Report: *(WC PHO)*

NEXT MEETING

Date of Next Meeting: 11 October 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 • Committee Member of C.A.R.E. • Committee Member of MS/Parkinson West Coast • Member of sub-Committee for Stroke Conference
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
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 Specialist 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) • Contract for the Café and Catering at Tai Poutini • Daughter employed as nurse for WCDHB
Marie Mahuika-Forsyth	• Promoter for Healthy Eating Healthy Action (20 hours per week) • Executive Member of Makaawhio

Member	Disclosure of Interest
	• 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
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, 12 July 2012 commencing at 9.00am

PRESENT

Elinor Stratford, Chair, Kevin Brown, Deputy Chair, Peter Ballantyne, (ex officio), Barbara Holland, Dr Cheryl Brunton, John Ayling, John Vaile, Lynnette Beirne, 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)

EXECUTIVE SUPPORT

Wayne Turp, General Manager Planning and Funding, Dr Carol Atmore, Chief Medical Advisor, Gary Coghlan, General Manager Maori Health, Karyn Kelly, Director of Nursing and Midwifery and Colin Weeks, Chief Financial Manager.

IN ATTENDANCE

Yolandé Oelofse (minute secretary)

WELCOME

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

1. INTEREST REGISTER

The following amendments to the interest register were made:

Lynnette Beirne	Daughter employed as a nurse for the WCDHB
Marie Mahuika-Forsyth	Remove Seconded to Community and Public Health
Dr Cheryl Brunton	Change Member of national Influenza Strategy to Influenza Specialist
Elinor Stratford	Committee Member of C.A.R.E.
	Committee Member of MS/Parkinson West Coast
	Member of sub-Committee for Stroke Conference

2. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

Moved Patricia Nolan; Seconded Marie Mahuika-Forsythe - carried

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

Pg 2 The fourth line from the bottom, reads good opportunity toll out should read roll out

CARRIED FORWARD/ACTION LIST ITEMS

The Committee noted the carried forward list.

3. CHAIR'S REPORT- COMMUNICATIONS

The Chairs report was taken as read.

Items to note:

- The submission paper on "Position statement on Alcohol" was endorsed

The Committee received the report.

4. ORGANISATIONAL LEADERSHIP REPORT

This report was taken as read. The following items were raised and noted:

- B4 school checks A question was raised regarding the monitoring of outcomes. B4 school checks is a Ministerial requirement and there are referral pathways in place when issues are identified.
- Oral health mobile dental clinics: Are they still operational in Buller. The mobile units are providing a service rural areas, it was explained that children in main centres of population were currently expected to go to the fixed site dental clinics. WCDHB is currently looking at increasing the flexibility of the mobile units.
  Action: To provide feedback for the August meeting on the cost of dental care for adult oral health.
- Newborn hearing screening, could a report be provided for the next papers:
  Green prescription: the change/devolution of funding - does this mean that there will be a change to the number of people enrolled on the Coast? Through the Healthy West Coast Alliance it will be maintained on an ongoing basis.
  Action: Update on Newborn hearing screening to be provided for the 23 August meeting.
- Green prescription for Buller uses Tasman Sports Trust and not SportCanterbury; consequently there is no guarantee that people in Buller will get the same programmes as those in Grey and Westland Districts. WCDHB aims to ensure consistency when possible.
- Home based support services - it was suggested that the graphs reflect the target figures oppose to the actual and YTD to make them easier to read and to include the number of people receiving home care and support services
  Action: It was suggested that information about the number of people receiving home care and support services be provided
- Dementia care training for staff in rest homes - will this be available to staff in other settings? It was explained that the staff that work in the dementia unit are already competent and they are able to work with the various level of dementia. Is it also possible to look at providing training for families who have members with dementia?
  Action: Information to be provided on the availability of dementia care training for families and caregivers.
- Free after hours care for children under six - press release and National notification has been released.
- Committee noted press release free afterhours care for children under six - this applies to all children on the West Coast.

The Committee noted the report.

5. CLINICAL LEADERSHIP REPORT

The Committee received this report. The following issues/concerns were raised:

- It was explained that there are NETP (nursing entry to practice) nursing vacancies: a question was raised as to how many positions are available and how does one apply for the position? Health Workforce New Zealand allocates new graduate nurse funding and have allocated 11 for the West

Coast. 10 in NETP and 1 expansion (community/primary. Each DHB is responsible for new grad recruitment, with recruitment commencing in September for January 2013. We are now working with Canterbury DHB in the recruitment process and are currently working together to blend our programs which will enable a rural/urban experience. This year sees the trial introduction of the ACE process for new graduate nurses. This process aids in the coordination nationally of new graduate nursing recruitment and mapping of new practitioners into the workforce

- Grad nurses working in General Practice need a full year placement and often don't leave as they fall in love with the role and stay . This means that for the 2013 year our ability to place a new graduate nurse into general practice is limited

The Committee noted the report.

6. FINANCE

This report was taken as read. Comments and issues were raised:

- The change to the report is easier to read and understand.
- What is residential care loans? - This is to aid people who move into rest home with assets, accounts are sent to their estate to manage.
- Primary care: What is PHO performance payment? - this is a National program in which all PHO get a form of bonus on achieving certain target areas set out by the Ministry of Health. These bonuses are paid directly to the practices.
- Whanau Ora services; no extra money is provided specifically for this. GM Maori health is working to ensure the integration of whanau ora in WCDHB health care services.

The Committee received the report.

7. BETTER SOONER MORE CONVENIENT / ALT

The General Manager Planning and Funding and the Chief Medical Advisor spoke to this item. The following items were raised:

There are three key strands of work is currently underway

1. The CCMN (Complex Care Medical Network), this should be up running by August or September this year.
2. The establishment of the IFHC in Buller and IFHS in Grey. Grey IFHS: The completion of the indicative business case including proposed model of care is close to completion
3. Buller; the implementation is going ahead according to plan and the Model of Care is on schedule. It will provide a single point of entry ie one integrated health system. Aspects of that are already in place. Current there are discussions underway with O'Conor Trust to seek their involvement in the IFHC.

- A concern was raised over a media suggestion that there going to be no Mental Health beds. It was explained that this is not the case, the concept plan has focussed on refurbishment/replacement of the facilities that are no longer fit for purpose or which fail to meet design and compliance standards. Both Kahurangi and mental health IPU meet the safety regulations and there is no need for these facilities to be replaced/refurbished.

The Committee received the report.

8. FAMILY VIOLENCE

The Family Violence Coordinator made a presentation on the violence intervention programme. The following items were noted:

- Child abuse on the West Coast is high.
- We are making headway on the Coast though there are still a number of cases not coming to our attention.

- Further work is needed on screening men who experience violence in the home..
- Values and beliefs need to change.
- The General Manager of Planning and Funding has been identified as the new sponsor for Family Violence on the Coast.

The Committee noted the presentation and thanked the Family Violence coordinator for a well prepared presentation.

9. DISABILITY

The Portfolio Manager for Aged Care spoke to a report on Disability Strategy.

Issues raised.
- How should Was DSAC monitoring progress against plan?
- Noted disability awareness training has taken place.
- Communication on disability awareness and issues could be improved.
- ***Action: The Portfolio of Aged Care to obtain a copy of CDHB plan and to forward this onto the Committee***

The Committee received the report.

10. WORKPLAN
(CPHAC and DSAC)

The Chair mentioned that now the Annual Plan has been signed off by the Ministry, a workshop will be scheduled to review the current work plan.

The Committee received the report.

11.GENERAL BUSINESS

Matters Arising:

Terms of Appointment to be reviewed and corrected as follows:

John Vaile, Lynette Beirne and Mary Molloy should be to 2014

Human rights document:

Title of document was noted.

As this was their final meeting the Chair thanked Barbara Holland and Patricia Nolan for their support and service to the Committee and Community.

Moved Mary Molloy; Second Peter Ballantyne: Carried.

Motion:
"That the Committee accepts the reports received"

Carried.

QUALITY AND PATIENT SAFETY FOLLOW UP WORKSHOP
(The Quality and Patient Safety Manager will hold a follow up workshop at 11:15am at Kahurangi for this item.)

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

Items to refer to Board:

- A recommendation on having volunteers in the hospital such as previous "Friends of the Hospital" to provide aid to patients.
- The Committee is requesting a brief on the Human Rights document because of the concerns that were raised around equity and workforce.
- To have information regarding the presentation to CDHB CPHAC/DSAC Disability Plan in order to align West Coast with Canterbury in their disability strategies.

There being no further business the meeting concluded at 10:40am

The next meeting will be held on Thursday, 23 August 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 12 JULY 2012

Item No.	Date	Action	Action Responsibility	Reporting Status	Agenda Item Ref
1	12 April 2012	Workshop on the committee workplan to be held once the Annual Plan has been signed off by the Ministry	The General Manager Planning and Funding	The Board Chair and Committee Chair's, Chair to bring this back to this Committee.	8. Workplan
2	12 July 2012	*To provide feedback for the August meeting on the cost of dental care for adult oral health*	The General Manager Planning and Funding		Item 4 Organisational Leadership Report
3	12 July 2012	Update on Newborn hearing screening to be provided *for the 23 August meeting*.	The General Manager Planning and Funding		Item 4 Organisational Leadership Report
4	12 July 2012	It was suggested that information in the number of people receiving home care and support services be provided	The General Manager Planning and Funding		Item 4 Organisational Leadership Report
5	12 July 2012	Information to be provided on the availability of dementia care training for families and caregivers.	The General Manager Planning and Funding		Item 9 Disability 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: **13 August 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 be meeting to review Committee workplans now that Annual Plan sign off is completed.

On track to deliver on budget with finances for the year

There has been progress on SMO recruitment

Volunteers within the DHB discussed. Suggestion that we reconstitute a volunteer or 'friends of the DHB' arrangement

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: **15 August 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 achieved the Emergency Department Health Target, with 99.6% of people admitted or discharged within 6 hours during the 2011/12 financial year.
- WCDHB delivering well above our national health target volume of 1592 elective surgical discharges for the year; provisionally being at 110% of plan for the year to 30 June with 1751 procedures.
- WCDHB delivered more outpatient First Specialist Assessments (FSAs) that than planned for the 2011/12 financial year. Provisional results show that surgical FSAs were delivered at 110% of plan (at 5251 attendances), with overall FSAs at 109% of plan (at 7302 attendances).
- The WCDHB has achieved its target for Before School Check Programme for 2011/12 for all eligible population and 3% above the target for high needs population. By achieving the additional 3% for the high needs target, the WCDHB can claim the additional 10% funding incentive for the programme.
- The utilisation rate for adolescent Year 9 up to and including 17 years of age is 81.6% for the 2011 calendar year. This is 1% more than the target set by the WCDHB for 2011 calendar year.

Key Issues and Associated Remedies

- The immunisation coverage rate for two-year olds has decreased from 84% to 78% at the end of Q4 2011/12. However, when taking into account the combined opt-off and decline rate of 18.9% and coverage of 78%, the WCDHB achieved 97% coverage rate which suggests that nearly all two year olds in the community that did not opt off and declined immunisation were fully immunised. Letters with relevant immunisation information will be sent to families that have declined immunisation for their children. The letter is endorsed

by the WCDHB's Chief Medical Officer, Liaison Paediatrician, Immunisation Coordinator and the West Coast PHO Clinical Manager. Work on achieving the highest possible immunisation coverage rates continues to be a focus in both primary care and for the Outreach Immunisation Services

Upcoming Points of Interest

- Work has been commenced on exploring ways to support and improve wider transport options for patients to access services. Discussions have been commenced with a number of interested volunteer agencies, with an initial focus being on the Buller region.

- Work is also underway on commencing the Gateway programme here on the West Coast. West Coast DHB is currently awaiting receipt of the contract for the service from Child Youth and Family and provided this is received in time, aims to commence delivery of the service from 1 October 2012. Inter-agency training for staff from the various governmental agencies who will be involved in the Gateway programme, including West Coast DHB, Child Youth and Family, Youth Justice, Education Services, etc, is planned for the last week of September

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**

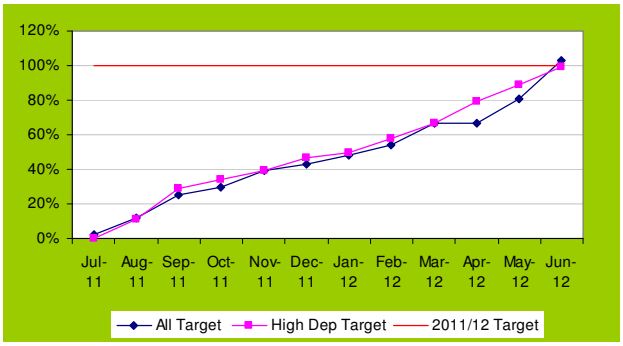
PLANNING AND FUNDING OVERVIEW

Progress against key target areas for the period ending April 2012

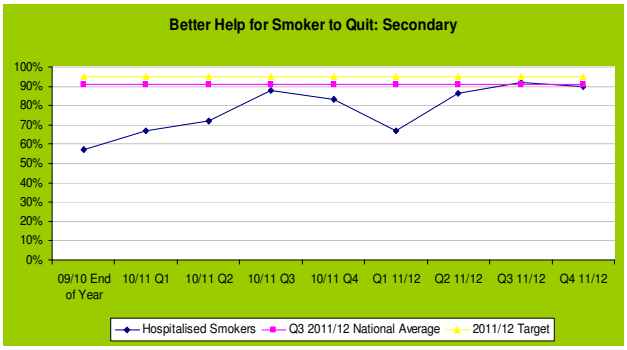
Publication of progress reports against the government's health targets for the period ending April 2012. Progress reports against internal targets are as follows:

Prevention Services

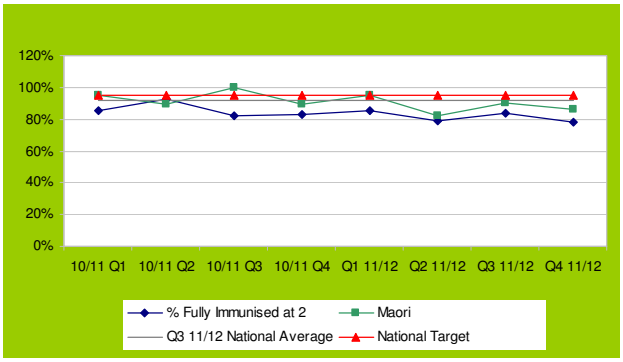
B4 School Check coverage



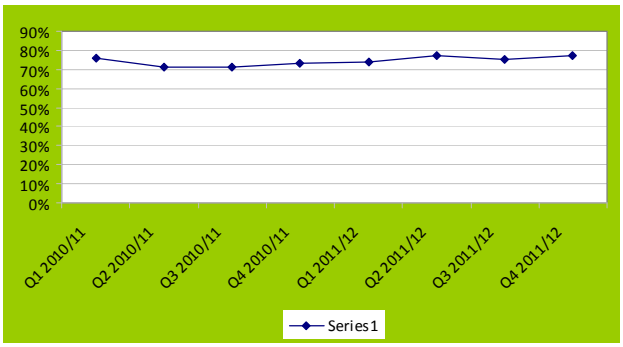
Percentage of hospitalised smokers given advice and help to quit



Immunisation – 2 year olds Fully Immunised.



Antenatal HIV Screening



ACHIEVEMENTS/ISSUES OF NOTE

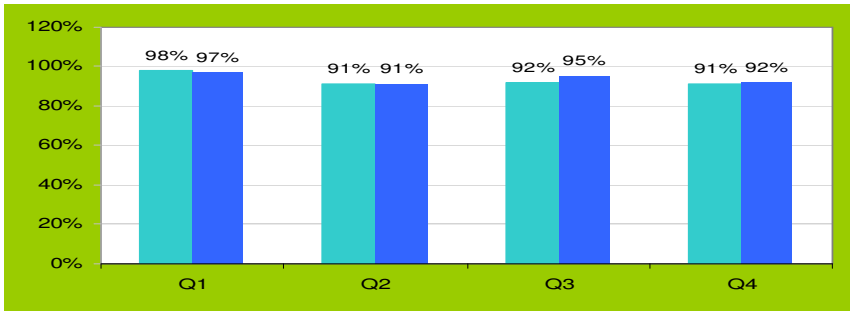
Before School Check (B4SC): The B4SC programme achieved its target for the 2011/12 financial year with 99% of the total eligible population target having their checks completed and closed by the end of Q4 2011/12. This is approximately 80% of the total eligible population – the performance measure criteria for the B4SC programme.

In addition, the WCDHB achieved 3% (103%) above the target rate for high needs (1 extra child) children; which means the WCDHB can claim for the additional10% funding incentive for meeting the high needs target.

The actions that were implemented in the Q4 11/12 have proved to be successful.

Immunisation – 2 year olds: Refer to 'National Health Targets Report.'

Newborn Hearing Screening:



The rate of newborns that completed hearing screening remains above 90% over the 2011/12 financial year.

Antenatal HIV Screening Programme. The uptake rate for antenatal HIV screening has been stable and remains above 70%. For the period of April - June 2012 the uptake rate is 77% - 2% more 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.

Breast Cancer Screening: The latest report from Breast Screen Aoteroa shows that 70% of all eligible women aged 45-69 age-groups on the West Coast had undergone breast screening for the 24 month period ending 31 May 2012, which is similar to the national average. The coverage for eligible Maori women is higher compared to other ethnicities on the West Coast.

DHB	24 months to 31 May 2012 BSA Coverage Rate (45-69 age group)			Total Coverage (45-69)
	Other	Maori	Pacific	
WCDHB	69.9%	75.9%	55.0%	70.3%
All DHBs	70.8%	61.9%	68.7%	69.9%

Data Source: Breast Screening Aoteroa.

Note: There are two set of reports; one uses Territorial Local Authority (TLA) data and the other uses DHB data. The data used in this report is by DHB.

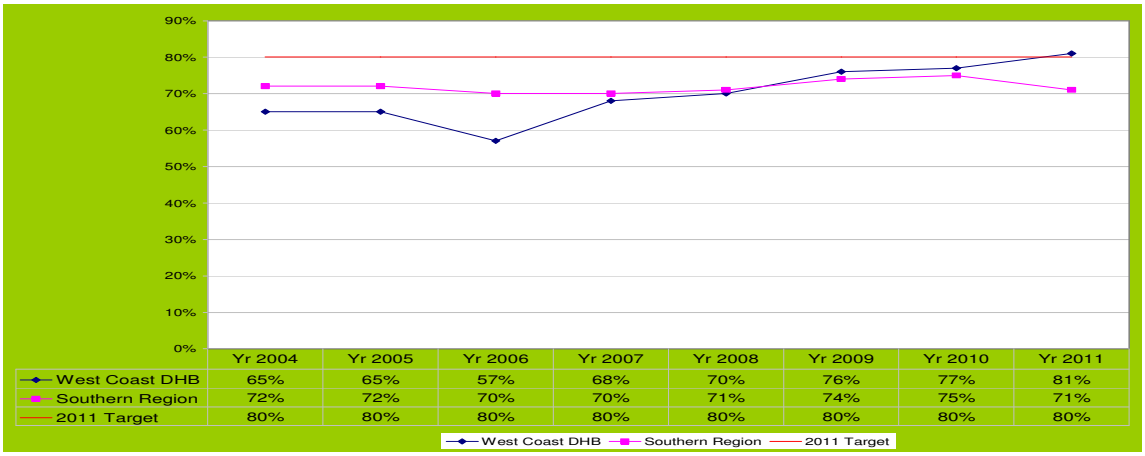
Cervical Cancer Screening: The National Cervical Screening Programme aims to have increased coverage to at least 80% of all eligible women aged 25-69 by the fourth quarter of 2014 and has applied this target from 1st January 2011.

At the end of 31 March 2012, West Coast cervical screening three year coverage rate has increased to approximately 71% which is a 0.5% increase from the previous quarter. The coverage rate for Maori eligible women remains the same from the previous quarter at approximately 53%.

The West Coast DHB has a NSCP Strategic Plan in line with regional strategies and initiatives to increase the coverage rate of priority women to the required 3 yearly coverage rate of 80%, The Strategic Plan aims to continue collaboration with stakeholders and communities to implement the Regional NSCP Strategic Plan that best meets the unique needs of all eligible women on the West Coast.

Ethnicity	3 year coverage ending…			
	Sep-11	Dec-11	Mar-12	Change from Dec 11 - March 12
Total	69.6%	70.3%	70.8%	▲ 0.5%
European/Other	71.3%	72.0%	72.5%	▲ 0.5%
Maori	52.6%	53.0%	52.7%	▼ -0.3%
Pacific	67.8%	74.6%	71.4%	▼ -3.2%
Asian	69.7%	69.4%	72.8%	▲ 3.4%

Child and Adolescent Oral Health: Oral Health utilisation rate by adolescent has gradually and steadily increased since 2007 and at the end of 2011 calendar year, the WCDHB has achieved its target by more than 1% - see below the graph showing Year to Year Progress of adolescent (Year 9 up to and including 17 years of age) oral health service utilisation.



School Based Health Services (SBHS): There is positive progress in the delivery of SBHS with increased access to further two Alternative Education Facilities in Greymouth during Q4 11/12. Public Health Nurses conducted primary health care assessments, provided treatment within their scope of practice and initiated referral where necessary.

Human Papilloma Virus (HPV): No updated report available.

Secondary Smoking Cessation

Refer to 'National Health Targets Report.'

Primary Smoking Cessation

Refer to 'National Health Targets Report.'

Healthy Lifestyle Programmes

Breastfeeding

The official launch of the West Coast Breastfeeding Handbook took place during World Breastfeeding week and was well attended by many organisations within the community who work with whanau in the West Coast. The aim of the handbook is to ensure consistency in breastfeeding messages for families, reducing the number of resources provided and ensuring the information is 'Coast specific.' To date the CDHB Breastfeeding resource has been distributed to expectant mothers.

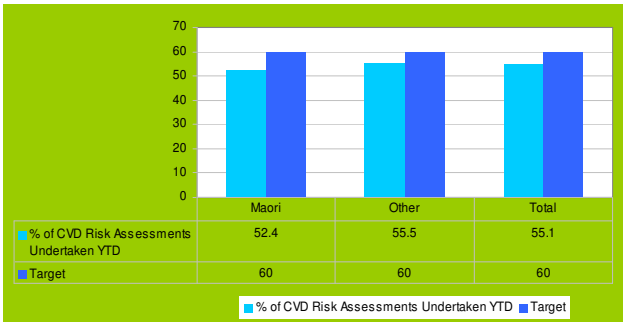
Warm Up West Coast – Home Insulation Project:

Data below is as of 6th August 2012

	Number
Applications received by Healthy West Coast	361
Applications forwarded to The Insulation Company	315
Applications to be processed	12
Number of applicants declined	34
Number of homes insulated	194

Early Detection and Management

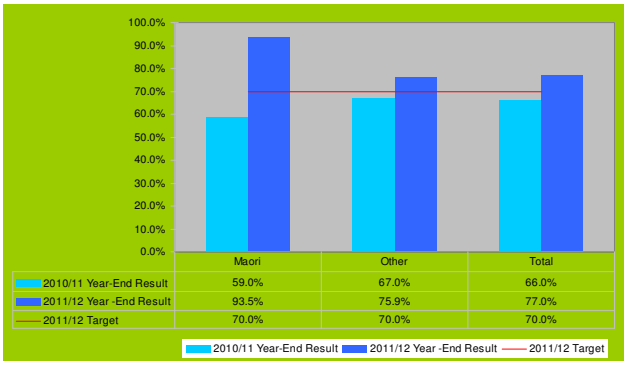
More Heart and Diabetes Checks: Percentage of eligible PHO population who have had a Cardiovascular Disease(CVD) risk assessment.



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 30 June 2012 (latest available data). Only measured Quarterly.

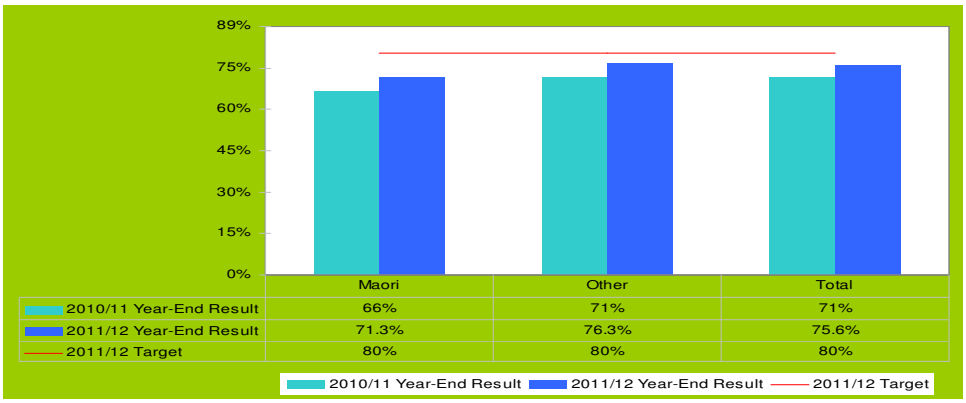
Diabetes Detection



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 30 June 2012 (latest available data). Only measured Quarterly.

Diabetes Good Management



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 30 June 2012 (latest available data). Only measured Quarterly.

ACHIEVEMENTS/ISSUES OF NOTE

CVD Risk Assessment:

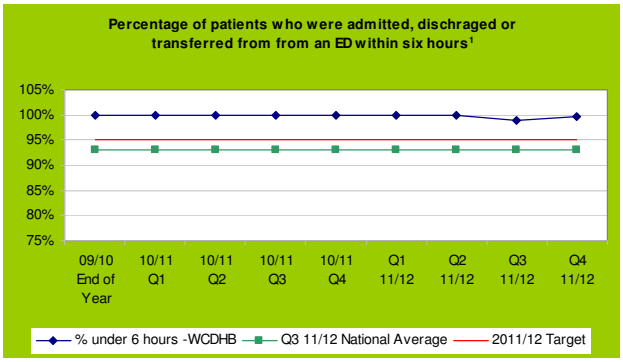
Refer to 'National Health Targets Report.'

Diabetes Detection and Management:

Refer to 'National Health Targets Report.'

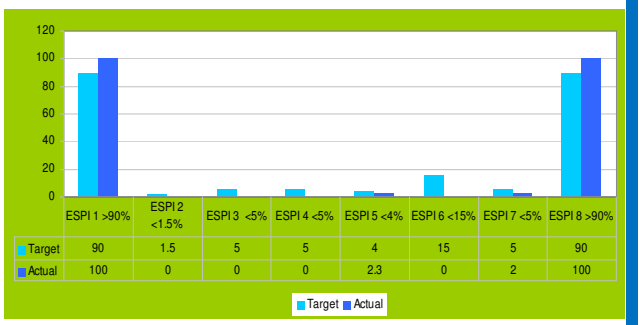
Intensive Assessment and Treatment Services

Emergency Department Waiting Times – YTD Performance to 30 June 2012



Results for the financial year to date to 30 June 2012 continues to stand at 99.6% of patients seen, treated and discharged within 6 hours.

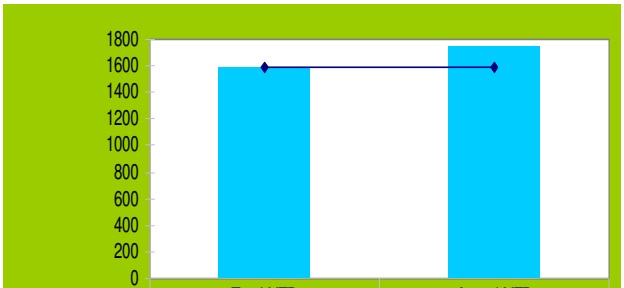
Improving Outcomes for Elective Services: Elective Service Performance Indicators (ESPI)



	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	100	0	0	0	2.3	0	2	100

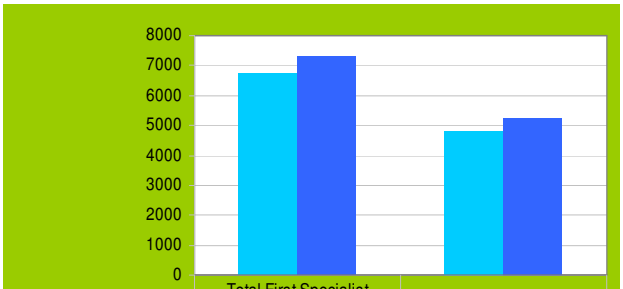
Final results to 30 June 2012 (as updated by Ministry of Health, 6 August 2012).
West Coast DHB achieved ESPI compliance in all measures as at 30 June 2012. New targets will be applied from 1 July 2012, with only ESPI measures 3,5,6 and 8 being monitored and reported against by the Ministry of Health from this time.

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



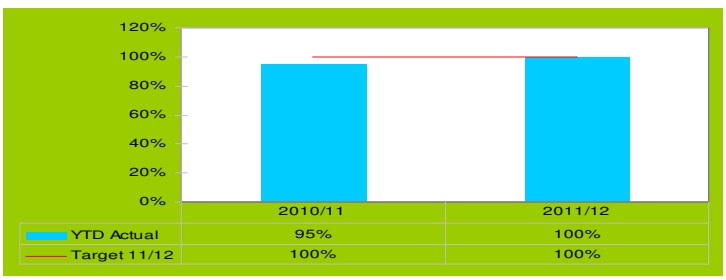
	Total YTD	Actual YTD
Electives	1592	1751
Health Target	1592	1592

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



	Total First Specialist Assessments (FSAs)	Surgical FSAs
Total Year-End Target	6703	4791
Actual YTD	7302	5251

Radiation Therapy Treatment Services Waiting Times



	2010/11	2011/12
YTD Actual	95%	100%
Target 11/12	100%	100%

% 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 30 June 2012.

ACHIEVEMENTS/ISSUES OF NOTE

Radiotherapy Waiting Times Data

Refer to 'National Health Targets Report.'

Elective Services: National Health Target - Elective Surgery Service Throughputs to 30 June 2012: (latest provisional year-end results)

Refer to 'National Health Targets Report.'

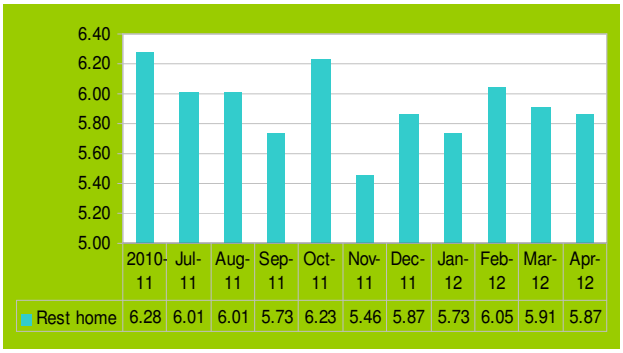
Elective Services: Ambulatory Initiative Throughput (Specialist Outpatients) to 30 June 2012: (latest provisional results)

Overall first specialist outpatient assessment services for all specialties were delivered at 108.9% of planned services for the 2011/12 financial year. Provisional year-end results show that total delivery for the year was 7302 attendances.

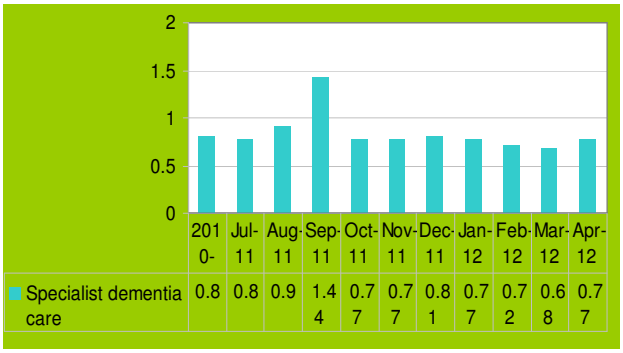
Similarly, the surgical first specialist outpatients have been delivered at 109.6% of planned volume for the year, with 5,251 surgical FSAs having been provided against the planned total of 4,791.

Rehabilitation and Support Services Older Persons' Health

Proportion of people aged 75+ in Rest Home level care



Proportion of people aged 75+ in Specialist Dementia care



ACHIEVEMENTS/ISSUES OF NOTE

Specialist Health of Older People's Services – progress on the establishment of the Complex Clinical Care Network (CCCN) has been delayed owing to Dr Broadbent's unavailable due to serious family illness. A replacement geriatrician is being sought.

An HR process is being implemented to restructure Carelink's staffing and functions to fit the CCCN model. This is expected to be completed by September.

Positions for a Buller-based gerontology clinical nurse specialist and a Nurse Practitioner are about to be advertised, and the work of the Grey based gerontology clinical nurse specialist is being restructured to fit with the CCCN model as far as possible

Telehealth units have been approved and are currently being set up in the CDHB geriatrician's office at PMH and in the 3 primary health facilities that do not yet have them. This will make consultation with CDHB specialists much easier for primary health staff.

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.

West Coast DHB's homecare service continues to work to meet the requirements of an internal audit.

Dementia training – dementia training programmes for rest home carer staff in Westport and Greymouth are well underway.

Dementia respite – the contract with Presbyterian Support for community-based respite service has been extended to include people with dementia, as was planned when the respite contract was first negotiated in December. This service, using selected HomeShare hosts, will help to meet a clear gap in services for dementia respite.

National Health Targets

Quarter 4 2011/12 Performance Summary✓▲✖▼

Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Full Year	Target	Status	Pg
Shorter Stays in ED: Patients admitted, discharged or transferred from an ED within 6 hours	100% (99.8%)	100% (99.8%)	100% (99.4%)	100% (99.6%)	100%	95%	✓	2
Improved Access to Elective Surgery: West Coast's volume of elective surgery	529	945	1309	1751	1751	1592	✓	2
Shorter Waits for Cancer Radiotherapy Treatment: People needing cancer radiation therapy having it within four weeks	100%	100%	100%	100%	100%	100%	✓	3
Increased Immunisation: Two year olds fully immunised (national target = 95%)	85%	79%	84%	78%	82%	88%**	✖	3
Better Help for Smokers to Quit: Hospitalised smokers receiving help and advice to quit	69%	86%	92%	90%	*	95%	✖	7
Better Help for Smokers to Quit: Smokers attending general practice receiving help and advice to quit	31%	40%	39%	39%	*	90%	✖	7
Better Diabetes and Cardiovascular Services: Eligible adult population having CVD Risk Assessment in the last five years ***	N/A	N/A	55%	57%	57%	60%	✖	10
Better Diabetes and Cardiovascular Services: People with diabetes attending an annual review	87%	88%	81%	77%	77%	70%	✓	11
Better Diabetes and Cardiovascular Services: Those receiving a diabetes annual review who have satisfactory or better diabetes management	69%	72%	73%	76%	76%	80%	✖	12

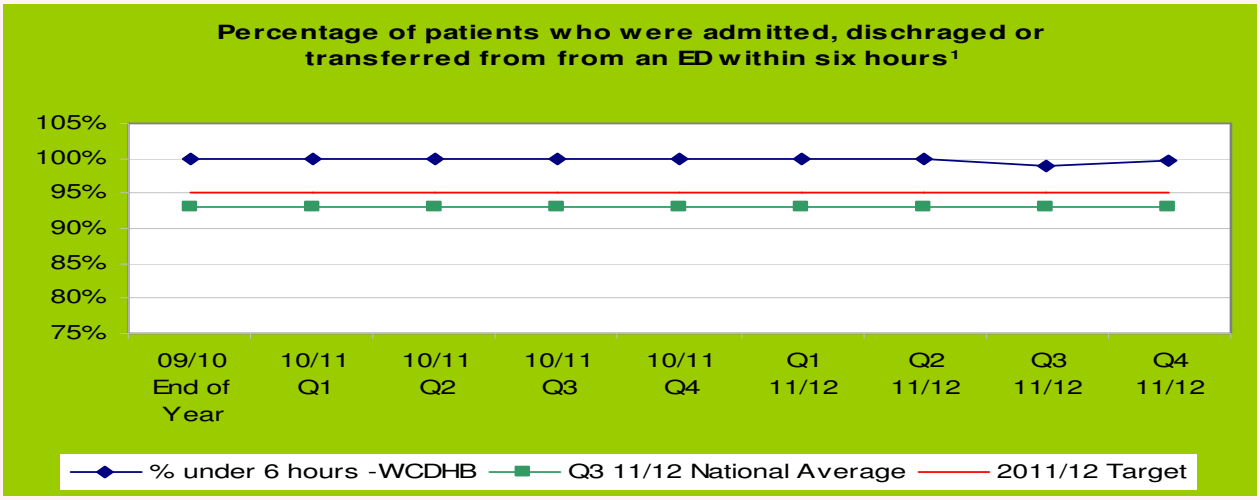
* No data available

** West Coast DHB Target

*** New targets as from 1 January 2012.

Shorter Stays in Emergency Departments

Target: *95% of patients are to be admitted, discharged or transferred from an ED within 6 hours* ✓

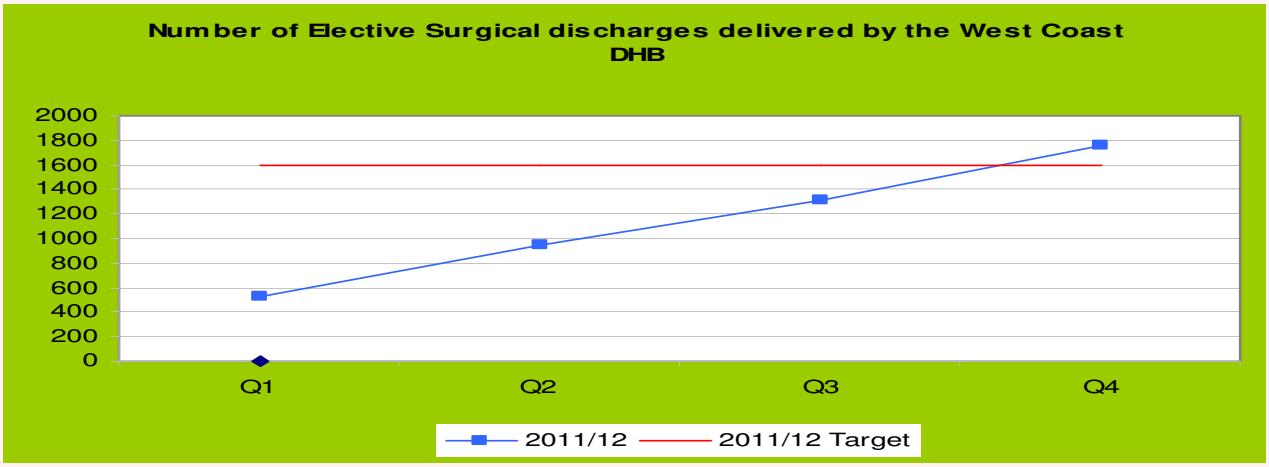


- West Coast has achieved the ED Health Target for the fourth successive quarter, with **99.6%** of patient events admitted, discharged or transferred from ED within 6 hours.
- It is important to note that the ED health target is dropping to 5 hours by June 2013.

Improved Access to Elective Surgery

Target: *West Coast DHB's volume of elective surgery is to be increased to 1592 in 2011/12* ✓

Figure 1: Elective surgical discharges delivered by the West Coast DHB[1]



West Coast DHB exceeded the number of elective surgery procedures for the 2011/12 financial year as part of our contribution to delivering upon the national elective services health target. West Coast DHB delivered 1751 procedures – 159 above our health target of 1592 for the year. This was up from 1710 delivered last financial year. These discharges resulted in case-weighted discharges (CWD) of 2474.3; which was over-delivery at 112.2% of planned year-end volume.

2011/12 Elective Surgery	Raw Discharges	Caseweighted Discharges

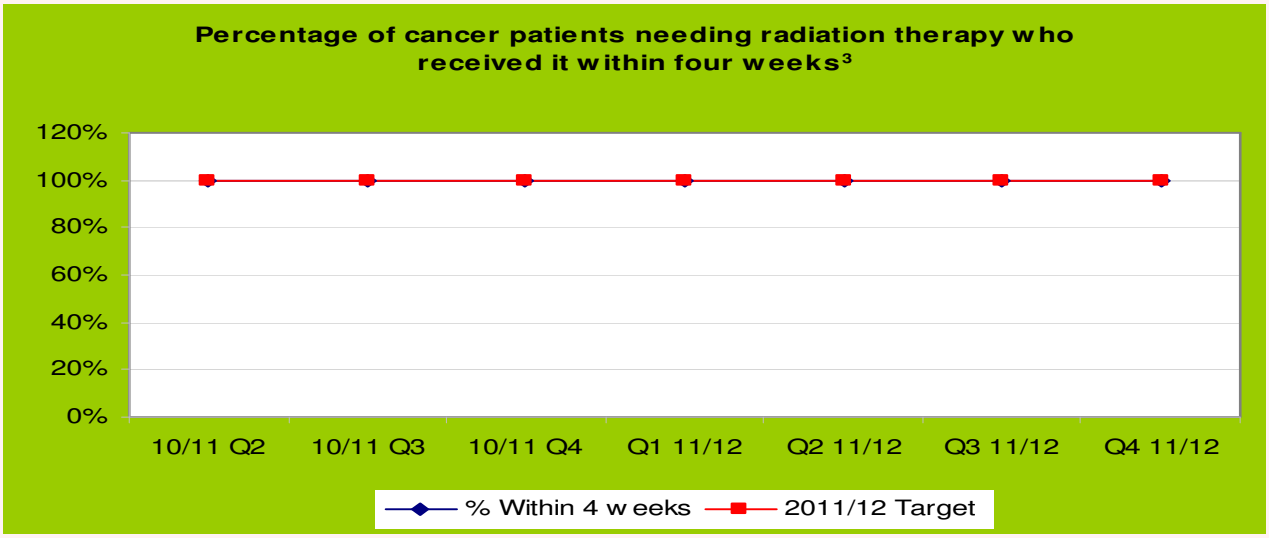
[1] *Excludes cardiology and dental procedures. Progress is graphed cumulatively.*

Total Planned Volume	1592	2205.1
Actual Year-End Delivery	1751	2474.3
% Delivered Against Plan	110.0%	112.2%

Shorter Waits for Cancer Radiotherapy Treatment

Target: *100% of people needing cancer radiation therapy are to have it within four weeks* ✓

Figure 2: Percentage of people needing radiation therapy who received it within four weeks[2]



In Quarter 4, 100% of patients met the 4 week target, continuing achievement throughout the 2011/12.

There were 4 patients in the 2011/12 financial year who 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, West Coast DHB performance against the national health target remained at 100% for the year. All other West Coast domiciled patients treated in the priority treatment categories (acute; curative; palliative; and radical) commenced treatment within four weeks of their referral.

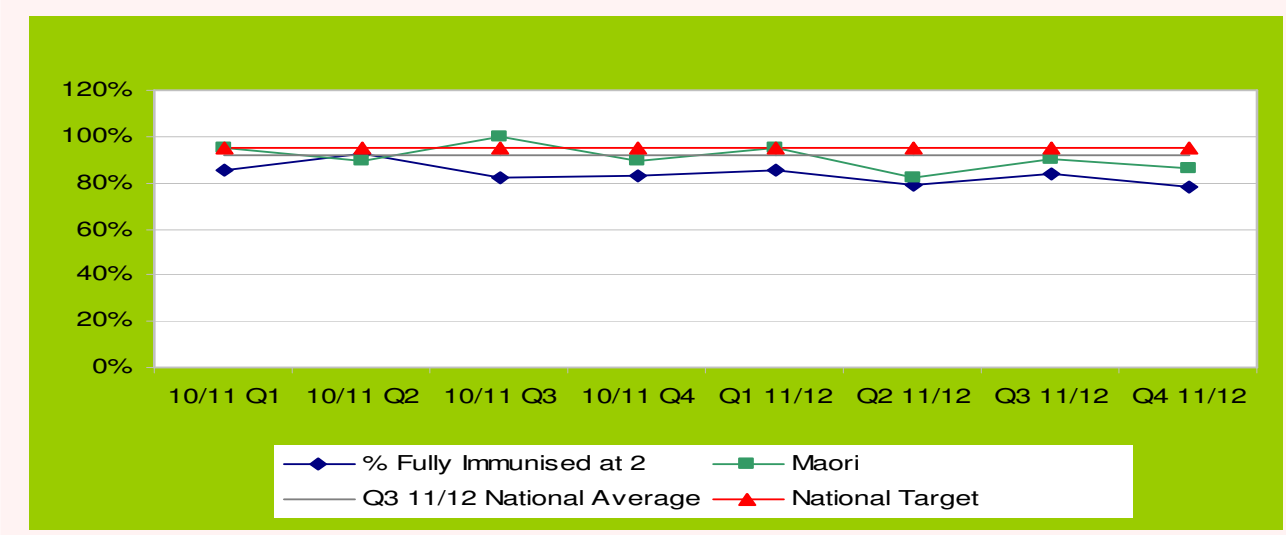
There have already been two patient whose treatment was commenced outside the 4-week target time in July 2012 - however, neither was due to capacity constraint. One patient was delayed due to other medical oncology assessment having to be undertaken prior to radiation therapy being started, while treatment was delayed in the second case due to patient choice and request.

Increased Immunisation

Target: *Two-year old fully immunised.* ✗

Figure 3: Percentage of West Coast two-year-olds who were fully immunised

[2] *The wait time is defined as the time between the decision to commence radiation treatment and the start of treatment. The measure does not include instances in which a patient chooses to wait for treatment or there are clinical reasons for delay. The measure reflects groups A, B and C. Group D patients have planned treatment (either as part of a trial or because of given protocols) and are therefore not included.*



The immunisation coverage for all 2 year olds has decreased by 6% at the end of Q4 11/12 compared to Q3 11/12 due to the high opt off (9.9 % - 11 children) and decline rates (9.0% - 10 children).

While coverage has decreased to 78% in quarter four 2011/12 from 84% in quarter three 2011/12, it is good to see that 19 out of 22 Maori children are fully immunised, and Pacific coverage is 100% for four children. Taking into account the combined opt-off and decline rate of 18.9% and coverage of 78%, the WCDHB achieved 97% coverage rate which suggests that nearly all two year olds in the community that did not opt off and declined immunisation were fully immunised.

Detailed analysis of the ten (10) children who declined immunisation shows that:

- 5 declined all immunizations
- 2 declined 15 months immunisation - referred to Outreach Immunisation Service (OIS)
- 2 left for overseas.
- 1 declined PCV7 immunisation – they are allowed to decline and thus not referred on.

Full Year Result:

The full year result for all two year olds for 2011/12 is 82% - 2% less than the full year coverage rate for 2010/11. Maori two year old coverage is 89% - 1% less than for 2010/11 and Pacific Islands is 100% for 8 children. When taking into account the high opt off and decline rates (15.4%) over the 12 month period for 2011/12, WCDHB continues to achieve 97% and above for all children who have not declined immunisation or opted off the NIR; demonstrating again that nearly all two year olds in the community that did not opt off and declined immunisation were fully immunised.

Strategies:

Strategies to reduce the decline and opt off rates were developed in consultation with key stakeholders through the Immunisation Advisory Committee (IAG) which has membership from Well Child providers like Primary Health Organisation (PHO), OIS, Public Health Nurses, Before School Check Service, Private General Practice, Maori Service Providers and National Immunisation Registry.

Strategies include:

- Identifying those who declined immunisation through the National Immunisation Registry (NIR) and primary practice database
- Letter sent by primary care practices to families who decline immunised. The letter contains relevant immunisation information including Immunisation service contact details. The letter is endorsed by the by the WCDHB's Chief Medical Officer, Liaison Paediatrician, Immunisation Coordinator and the West Coast PHO Clinical Manager
- Monthly review by NIR Administrator of the list of children unimmunized by 18 months and those declining immunisation

- Continue to work with PHO and primary care services to ensure children are recalled early and referred to Outreach with sufficient time to provide a service.
- Collaborative approach by all well child health service providers including use of other services for example Work and Income and WestReap to provide immunisation information to families.
- Use current outbreaks for immunisation awareness (including Immunisation Week)

The WCDHB through IAG will be monitoring and evaluating the implementation of the strategies and its outcome.

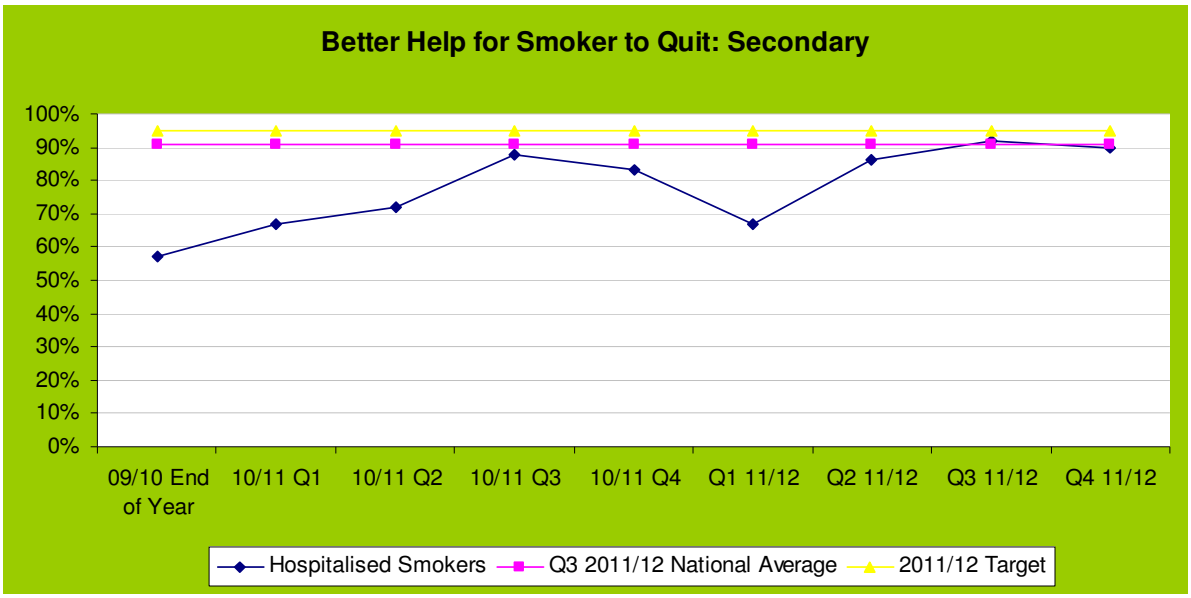
Work on achieving timely immunisation to achieve the Minister's new immunisation health target was discussed at the IAG meeting held on the 12th of July 2012. All stakeholders present at that meeting are now aware of the new target including critical timelines. General Practices are being informed through the PHO.

Key outlines of the actions including the timelines to meet the Eight- Month milestone has been forwarded to the Ministry of Health and will be finalized in the next IAG meeting in August 21st.

The new immunisation health target is that 85% of eight month olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) completed on time by July 2013, 90% by July 2014 and 95% by December 2014.

Better Help for Smokers to Quit: Hospital

Target: *95% of hospitalised smokers are to receive help and advice to quit* ✘



Quarter 4 Result: 90%

- April – 83%
- May – 91%
- June – 92%

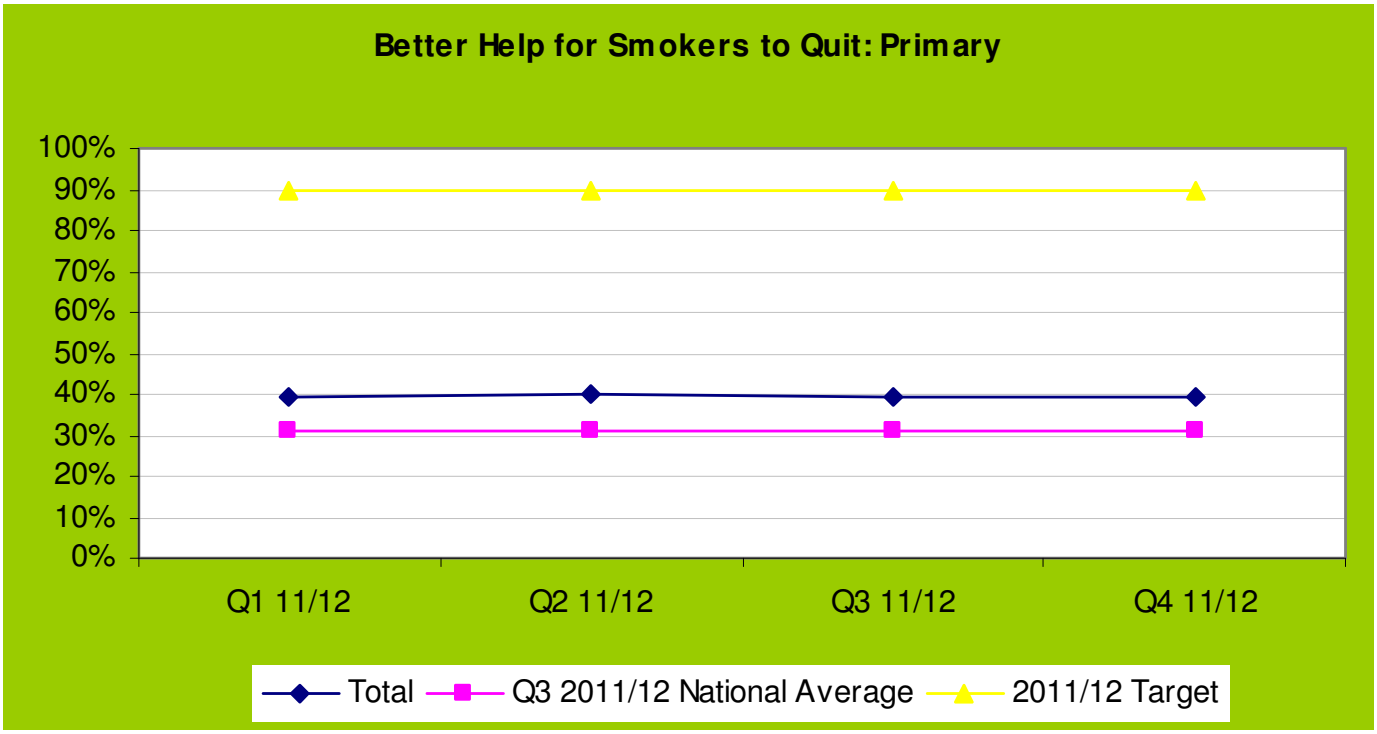
It was disappointing to not reach the target of 95% for Quarter 4 as was expected after progressively improved results for quarter 2 & 3. This primarily was due to a drop in performance in April in previously high-performing areas of the DHB. After a disappointing April result meetings were held with relevant clinical nurse managers of areas not reaching the target to discuss ABC results and offer support to the manager, champion and staff as appropriate. It was positive to see an improvement following this in May and June.

Alongside hospital senior management, work is continuing to improve the uptake of the Smokefree Mandatory training. Although feedback from staff is the ABC process is simple and straightforward, the training gives the important background of why this is a health target and the role both the individual and the organisation can play in significantly improving the health of the West Coast community by implementing this initiative. A letter

from the General Manager of Hospital Services and General Manager of the DHB is being distributed to all staff who has not attended the training and inviting them to do so

Better Help for Smokers to Quit: Primary Care

Target: *90% of smokers attending primary care are to receive help and advice to quit* ✘



Quarter 4 Result: 38.8%

The WCDHB has failed to achieve the target of 90% by July 2012. Improving the Primary Health Target result will continue to be a priority for the Smokefree staff and PHO Clinical Manager.

Meeting with other DHBs

During the next quarter the Smokefree Services Coordinator and the Smokefree Service Development Manager will meet with staff from South Canterbury DHB regarding the health target (20th August), as well as arranging a meeting (face to face or via video link) with Nelson Malborough DHB.

Training

ABC training is mandatory for all WCDHB staff; including those working in the DHB owned primary practices (6 of 8). To address the training gaps that exist, a letter signed by the General Manager of the DHB is being distributed to all those who have not attended the smokefree mandatory training and inviting them to an upcoming workshop.

Further training opportunities will be available this quarter with Heart Foundation Cessation Practitioner Training 1 & 2 workshop and an advanced Motivational Interviewing Course (smoking cessation specific) planned for August.

Prompting Tools and Monthly Feedback

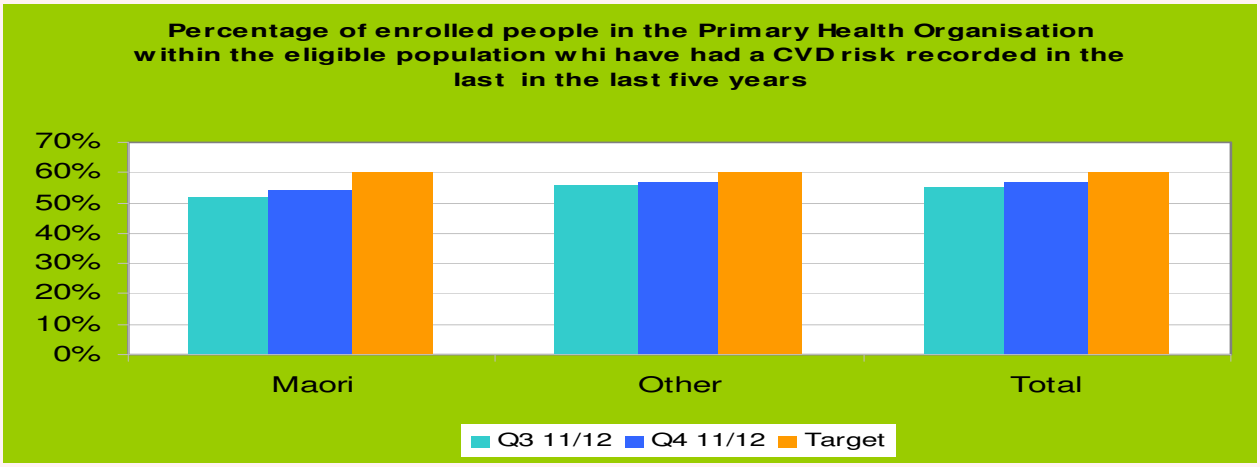
The use of advanced forms on MedTech – 'smoking assessment' tool supports and reminds staff to capture the correct data and prompts the 'brief advice' if required.
It was hoped that with the support of Karo, it would be possible to implement a tool to allow more regular (monthly) and practice specific ABC data to inform and motivate improvements in the implementation of ABC. Work is continuing on this and it will continue to be a high priority for smokefree staff and the WCPHO.

Better Diabetes and Cardiovascular Services: CVD

Target: *Percentage of the eligible adult population having CVD Risk Assessment in the last five years*

✘

Figure 4: Percentage of the eligible adult population in West Coast who have CVD Risk Assessed in the last five years[3]



Note: New Target which was introduced on the 1st of January 2012

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 to 30 June 2014. Our goal this year is to reach 60% by 1 July 2012 as part of that progress. This goal has not been achieved, with the provisional rates for period to 30 June 2012 for the various population groups being 54.3% for Maori and 57.1% for Other population groups; and with an overall rate for the total West Coast population being 56.7%. It is noted that West Coast results are tracking above the national averages for the period for the various population cohorts, except for our Pacific Island population (national averages being 47.9% for Maori, 57.4% for Pacific; 47.8% for Other population, and 48.5% for overall total populations respectively). The West Coast PHO is aware that there is still a way to go, and is working to improve this rate through its 3-tiered LTC programme and concentrating on undertaking CVD Risk Assessments. This target is only measured Quarterly.

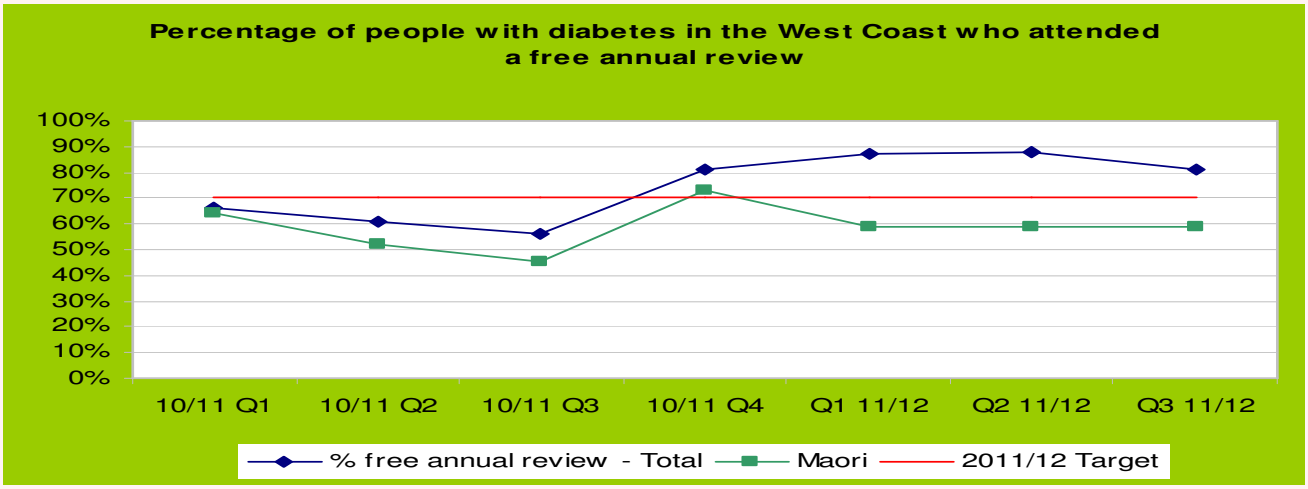
Better Diabetes and Cardiovascular Services: Diabetes Annual Reviews

Target: *Percentage of people with diabetes attending a free annual review.* ✓

Figure 5: Percentage of people with diabetes in West Coast who attended a free annual review[4]

[3] *Data for this measure is supplied by the Ministry on a quarterly basis, one quarter in arrears (i.e., the figures for Q1 2011/12 are for the period up to 30 June 2011). Fasting-lipid/glucose tests serve as a proxy measure for CVD risk assessment.*

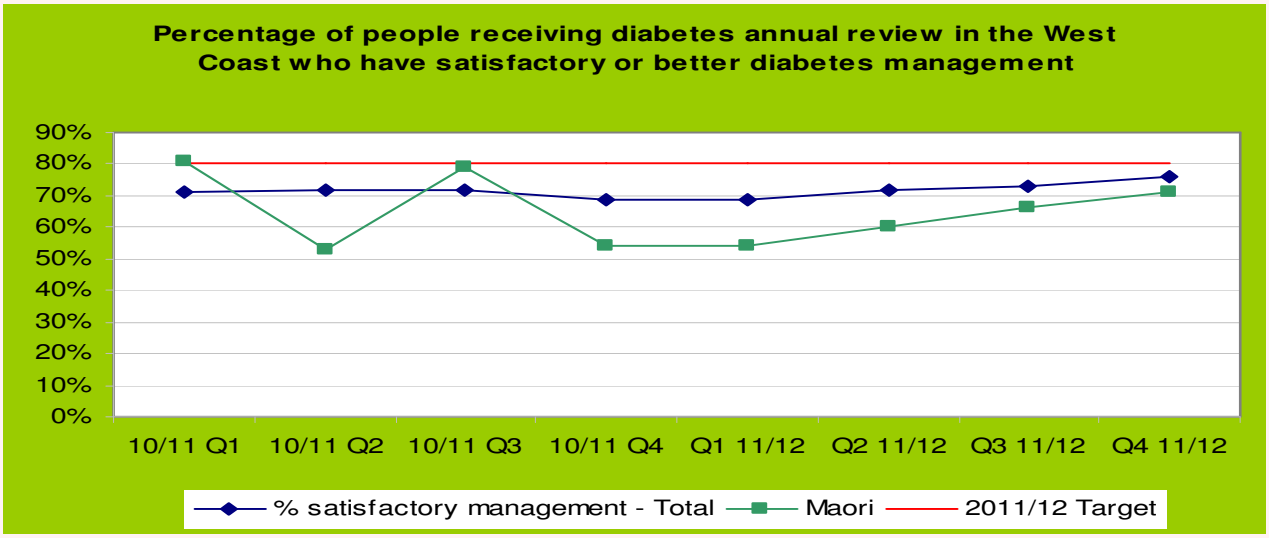
[4] *Diabetes data is reported to the DHB by individual PHOs and the Diabetes Centre one quarter in arrears, i.e., the most recent figures are for the Q4 period from 1 April to 30 June 2011.*



Better Diabetes and Cardiovascular Services: Diabetes Management

Target: *Percentage of those receiving a diabetes annual review having satisfactory or better diabetes management.*

Figure 6: Percentage of people receiving a diabetes annual review in the West Coast who have satisfactory or better diabetes management[5]



Diabetes Detection and Management

Diabetes detection rates exceeded the 70% targets for our core monitored populations for 2011/12, as indicted in the graph above. As a result, more patients with high clinical needs have been provided with annual reviews, and close support and management for their care needs. This has resulted in a correspondingly lower than target result for diabetes management results (HBA1c levels at or below 8.0). Notwithstanding this, the overall management outcome results are an improvement from last financial year, with closer care now being provided to a greater number of people identified through diabetes checks.

[5] *An HbA1c (Haemoglobin A1c, or glycated haemoglobin) level of 8% or less is defined as satisfactory or better diabetes management. A person's HbA1c reflects their average blood glucose level over the past 3 months.*

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: **15 August 2012**

Report Status – For:	Decision ☐	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee
i. notes this item

3. SUMMARY

Sustainability
Ongoing work to develop the model of care for sustainable health services for the West Coast continues. The submission of the Grey Integrated Family Health Service Business Case and the Indicative Business for the Grey Regional Hospital redevelopment marks a key milestone in this work. Ongoing work will focus on the further development and implementation of service delivery improvements, both in primary and community care, and in hospital services, including implementing the transalpine service delivery models.

Transalpine Services
A recent meeting with Canterbury and West Coast senior doctors was held, where the transalpine model of care was discussed in more detail.

Anne Atkins from CDHB has been appointed (seconded) as the interim Clinical Midwifery Manager for the West Coast. Anne has been seconded from her existing midwifery role at Burwood Hospital and brings a wealth of knowledge and experience to her new role, having worked across primary, secondary and tertiary services, both in New Zealand and Australia. It is anticipated the she will work with the local team and its development within the evolving models of care and improved service delivery, as well as further enhancing the Transalpine Maternity relationship.

The Canterbury and West Coast Maternity Quality and Safety Plan is in final draft, with a collaborative approach by the Transalpine team. This will have a significant impact on ensuring robust and safe maternity care across Canterbury and West Coast. Within this two roles are to be recruited into, the Maternity Quality & Safety Programme Coordinator and the Lead Maternity Carer Liaison position.

Leadership and Clinical Governance

Leadership in quality and clinical governance included the second meeting of 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. Clinical leaders from all the professions and across the system continue to participate in the development and design of new models of care; services and patient pathway.

Service Improvements

The Close Observation Unit (COU) in the surgical ward was opened on June 25th. This was in response to specific requests from the general and orthopaedic surgeons to enable closer monitoring of patients with increased acuity postoperatively. The Clinical Quality Improvement Team (CQIT) was actively involved in endorsing the concept and ensuring implementation. The unit will be run within existing nursing FTE and is aligned with similar units in Canterbury. Senior anaesthetic, orthopaedic and general surgical medical staff closely with the nursing team to plan the unit and prepare the guidelines, and these senior doctors will be the clinical leads for the unit. A close relationship between the nursing staff of the Critical Care Unit (CCU) and the COU will ensure shared clinical skill development, with monitoring facilities from the COU enabled through to CCU.

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.

Workforce

Ongoing efforts continue to recruit general practitioners and senior hospital doctors, in collaboration with the CDHB Recruitment team. Significant success has been achieved with senior hospital appointments, and a good number of good quality junior doctors have applied for positions for next year. There is significant focus on General Practice recruitment and a range of avenues to address GP recruitment have been identified through recent meetings with West Coast GPs and the Recruitment team.

There remain significant issues in recruiting to allied health roles and we are developing a recruitment campaign and also different models of service provision in partnership with the Canterbury Health System this will include the development of a RUFUS role for social work and dieticians in paediatrics.

The Workforce Plan final draft for 2012/13 has been completed for submission to the Ministry of Health and Health Workforce New Zealand.

4. CONCLUSION

The Clinical leaders will continue to work across a range of activities to promote a sustainable West Coast 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: **23 August 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 July 2012

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,157	6,354	(197)	×	6,157	6,354	(197)	×
Governance & Administration	179	183	(4)	×	179	183	(4)	×
Funds & Internal Eliminations	4,592	4,642	(50)	×	4,592	4,642	(50)	×
	10,928	11,179	(251)	×	10,928	11,179	(251)	×
EXPENSES								
Provider								
Personnel	4,464	4,463	(1)	×	4,464	4,463	(1)	×
Outsourced Services	1,116	1,130	14	√	1,116	1,130	14	√
Clinical Supplies	568	702	134	√	568	702	134	√
Infrastructure	1,062	936	(126)	×	1,062	936	(126)	×
	7,210	7,231	21	√	7,210	7,231	21	√
Governance & Administration	152	183	31	√	152	183	31	√
Funds & Internal Eliminations	3,693	4,007	314	√	3,693	4,008	315	√
Total Operating Expenditure	11,055	11,421	366	√	11,055	11,422	367	√
Deficit before Interest, Depn & Cap Charge	127	242	115	√	127	243	116	√
Interest, Depreciation & Capital Charge	532	510	(22)	×	532	510	(22)	×
Net deficit	**659**	**753**	**94**	√	**659**	**753**	**94**	√

CONSOLIDATED RESULTS

The consolidated result for the month of July 2012 is a deficit of $659k, which is $94k better than budget ($753k deficit).

RESULTS FOR EACH ARM

Year to Date to July 2012

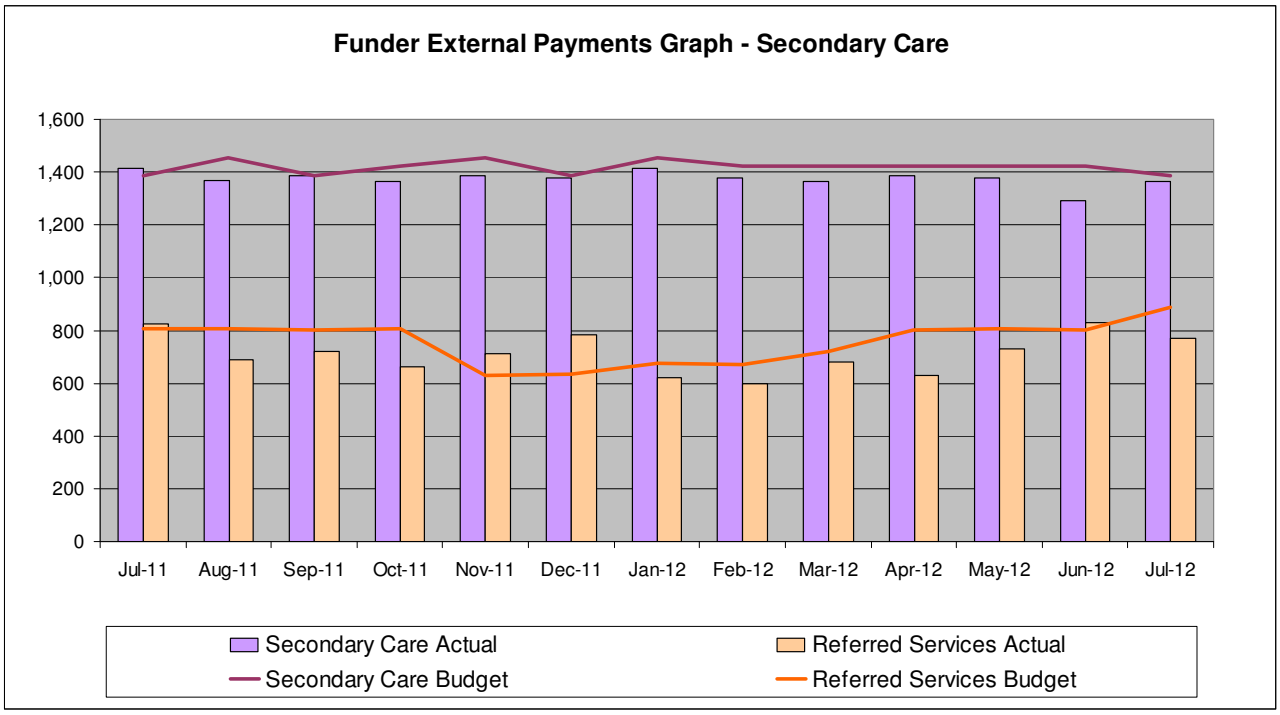
West Coast District Health Board Arm	Actual	Budget	Variance	Comment
	$000	$000	$000	
Provider Arm surplus / (deficit)	(1,585)	(1,387)	(198)	Unfavourable
Funder Arm surplus / (deficit)	899	634	265	Favourable
Governance Arm surplus / (deficit)	27	0	27	Favourable
Consolidated result surplus / (deficit)	**(659)**	**(753)**	**94**	**Favourable**

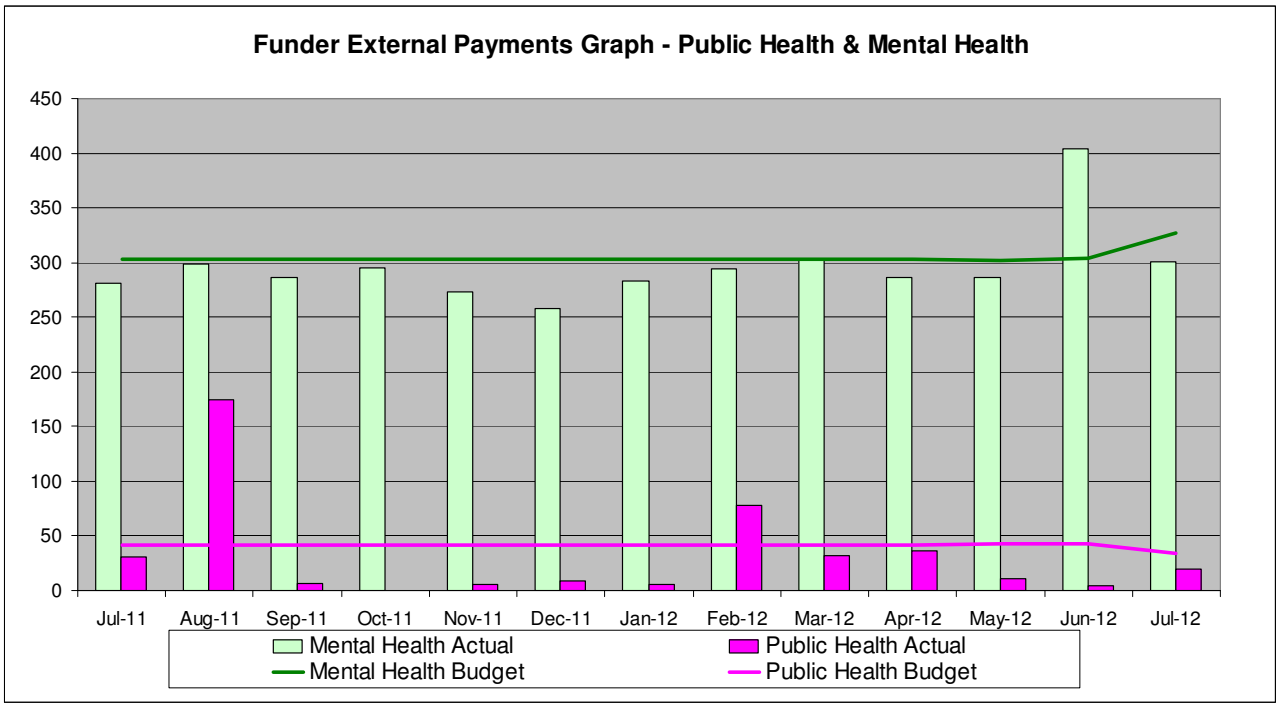
Funder Arm payments to external providers.

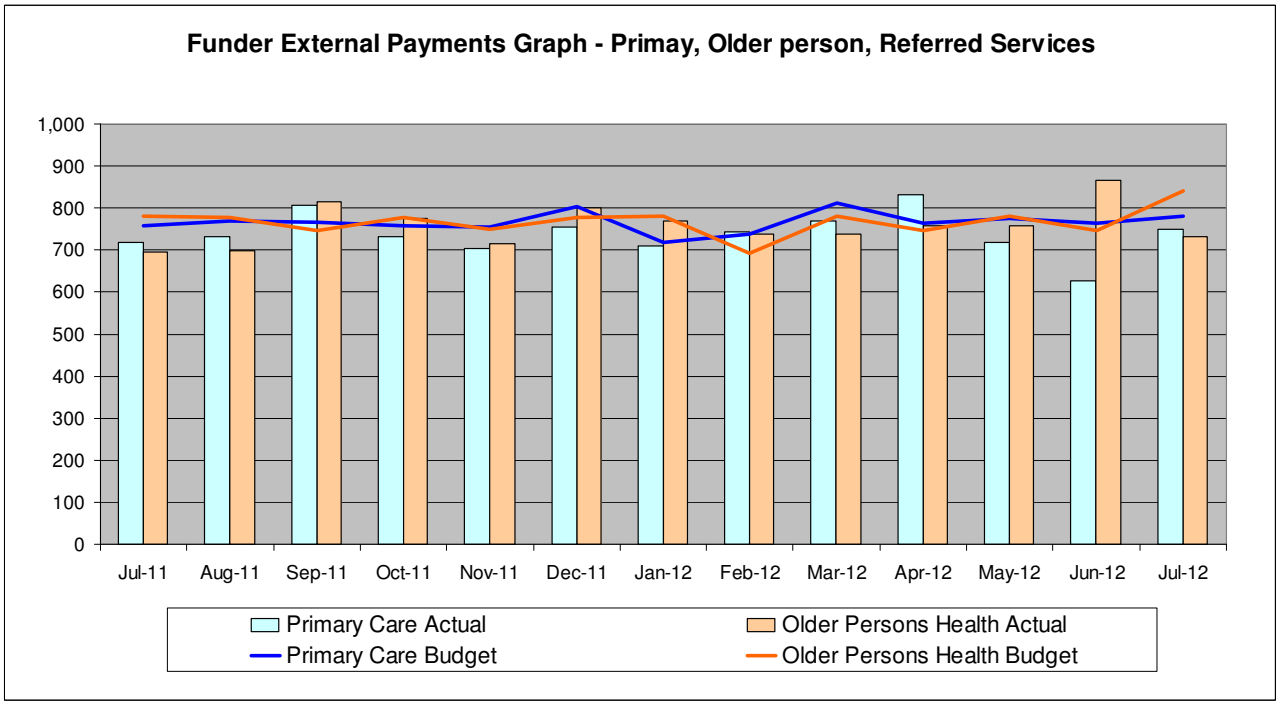
Funder payments to external providers are $3,940k, $316k better than budget.

- Payments to external providers for older persons health services are $108k better than budget (rest home and hospital level care) and community pharmaceuticals are $112k better than budget.

Funder Arm payments to external providers by service grouping




Funder External Payments Graph - Public Health & Mental Health
450
400
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
Jul-12
Mental Health Actual
Public Health Actual
Mental Health Budget
Public Health Budget


Funder External Payments Graph - Primay, Older person, Referred Services
1,000
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
Jul-12
Primary Care Actual
Older Persons Health Actual
Primary Care Budget
Older Persons Health Budget

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

Jul-12						Year to Date					2012/13	2011/12	
Actual	Budget	Variance			SERVICES	Actual	Budget	Variance			Annual Budget	Actual Result	Change (actual 11/12to budget 12/13)
$000	$000	$000	%			$000	$000	$000	%		$000	$000	%
					Referred Services								
23	25	3	11%	√	Laboratory	23	25	2	10%	√	269	408	34%
749	861	112	13%	√	Pharmaceuticals	749	861	112	13%	√	8,129	8,025	-1%
772	**887**	**115**	**13%**	√		**772**	**887**	**114**	**13%**	√	8,398	8,433	0%
					Secondary Care								
7	22	15	68%	√	Inpatients	7	22	15	68%	√	266	65	-309%
90	97	7	8%	√	Travel & Accommodation	90	97	7	8%	√	1,168	1,137	-3%
1,269	1,269	0	0%	√	IDF Payments Personal Health	1,269	1,269	0	0%	√	15,226	15,416	1%
1,366	**1,388**	**24**	**2%**	√		**1,366**	**1,388**	**23**	**2%**	√	16,660	16,618	0%
					Primary Care								
36	39	3	8%	√	Dental-school and adolescent	36	39	3	8%	√	470	352	-34%
0	-7	-7	100%	×	Maternity	0	-7	-7	100%	√	20	0	
0	1	1	100%	√	Pregnancy & Parent	0	1	1	100%	√	8	0	
0	3	3	100%	√	Sexual Health	0	3	3	100%	√	33	8	-307%
9	4	-5		×	General Medical Subsidy	9	4	-5	-135%	×	46	5	-820%
538	538	0	0%	√	Primary Practice Capitation	538	538	0	0%	√	6,458	6,322	-2%
10	12	2	18%	√	Primary Health Care Strategy	10	12	2	17%	√	144	78	-85%
78	79	1	1%	√	Rural Bonus	78	79	1	1%	√	950	933	-2%
3	6	3	48%	√	Child and Youth	3	6	3	48%	√	69	151	54%
3	1	-2	-227%	×	Immunisation	3	1	-2	-227%	×	96	156	38%
14	46	33	72%	√	Maori Service Development	14	46	32	70%	√	551	191	-189%
17	9	-8	-86%	×	Whanua Ora Services	17	9	-8	-86%	×	110	216	49%
22	22	-1	-2%	×	Palliative Care	22	22	-1	-2%	×	214	184	-16%
8	17	9	53%	√	Chronic Disease	8	17	9	53%	√	204	123	-66%
12	11	-1	-7%	×	Minor Expenses	12	11	-1	-7%	×	134	132	-2%
750	**781**	**30**	**4%**	√		**750**	**781**	**31**	**4%**	√	9,507	8,851	-7%
					Mental Health								
0	2	1.903417	100%	√	Eating Disorders	0	2	1.903417	100%	√	23	22	-4%
53	74	21	29%	√	Community MH	53	74	21	29%	√	901	613	-47%
0	1	1	0%	√	Mental Health Work force	0	1	1	100%	√	8	12	30%
47	48	1	1%	√	Day Activity & Rehab	47	48	1	2%	√	574	572	0%
2	14	12	84%	√	Advocacy Consumer	2	14	12	86%	√	173	108	-60%
20	5	-15	-269%	×	Advocacy Family	20	5	-15	-269%	×	65	80	19%
0	-10	-10	100%	√	Minor Expenses	0	-10	-10	100%	√	-128	0	
111	124	13	11%	√	Community Residential Beds	111	124	13	11%	√	1,493	1,296	-15%
68	68	0	-1%	√	IDF Payments Mental Health	68	68	0	-1%	√	811	792	-2%
301	**327**	**25**	**8%**	√		**301**	**327**	**26**	**8%**	√	3,920	3,495	-12%
					Public Health								
8	16	8	50%	√	Nutrition & Physical Activity	8	16	8	50%	√	194	176	-10%
6	6	0	1%	√	Public Health Infrastructure	6	6	0	1%	√	73	75	3%
0	0	0		√	Social Environments	0	0	0		√	0	0	#DIV/0!
6	11	5	47%	√	Tobacco control	6	11	5	47%	√	136	143	5%
20	**34**	**15**	**43%**	√		**20**	**34**	**14**	**40%**	√	403	394	-2%
					Older Persons Health								
3	3	0	0%	√	Information and Advisory	3	3	0	0%	√	30	37	
0	0	0		√	Needs Assessment	0	0	0		√	0	33	
62	59	-3	-6%	×	Home Based Support	62	59	-3	-6%	×	671	630	-7%
7	11	4	35%	√	Caregiver Support	7	11	4	35%	√	115	115	0%
205	261	56	22%	√	Residential Care-Rest Homes	205	261	56	22%	√	2,739	3,020	9%
-4	-2	2		√	Residential Care Loans	-4	-2	2		√	-24	-43	44%
23	26	3	11%	√	Residential Care-Community	23	26	3	11%	√	312	230	-35%
295	328	33	10%	√	Residential Care-Hospital	295	328	33	10%	√	3,828	3,438	-11%
0	4	4	100%	√	Ageing in place	0	4	4	100%	√	50	16	-213%
7	11	4	36%	√	Environmental Support Mobility	7	11	4	36%	√	132	64	-105%
9	8	-1	-12%	×	Day programmes	9	8	-1	-12%	×	97	120	20%
5	13	8	62%	√	Respite Care	5	13	8	61%	√	154	167	8%
119	119	0	0%	√	IDF Payments-DSS	119	119	0	0%	√	1,430	1,296	-10%
731	**840**	**109**	**13%**	√		**731**	**840**	**110**	**13%**	√	9,533	9,123	-4%
3,940	**4,256**	**317**	**7%**	√		**3,940**	**4,256**	**315**	**7%**	√	**48,421**	**46,914**	**-3%**

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

BETTER SOONER MORE CONVENIENT AND ALLIANCE LEADERSHIP TEAM REPORT (ALT)

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: **13 August 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

3. SUMMARY

Key messages from the West Coast - Alliance Leadership Team Meeting (ALT) - Thursday 28th June 2012

Progress reports were delivered by the three workstreams; Health of Older Persons', Buller IFHC and Grey IFHC and Regional Hospital, it was agreed all workstreams are progressing well. The detailed workforce plan was identified as critical in the next phase of the process and there was a request from the ALT that a small working group is established to carry out the development and implementation of this piece of work.

An update on the IS workshop that was held early in the day was shared with the ALT and there is broad agreement that there is good progress being made. The ALT has requested that there be an implementation plan for the IS requirements from each workstream be developed and shared with the South Island IS Service Level Alliance.

Draft 1 of the Grey Integrated Family Health Service Business Case was discussed. It was agreed the document was clear in regards to what work is currently underway and the future work that is still needed to be done that ALT needs to be mindful of. Feedback from ALT was taken on board by Tom Love (author of the Business Case) and an updated document will be distributed to the ALT to then endorse, before the paper is taken to the West Coast District Health Board meeting to be held Friday 20th July.

Engagement with the Unions is critical for developing, completing and implementing the planned Model of Care for the Grey IFHC. Once the plan has been signed by the West Coast District Health Board, formal consultation with the Unions will take place. An ongoing engagement strategy for Unions, staff and the community is being worked on based on the dates set around the Capital Investment Committee.

Stella Ward as the interim Chair of ALT (three months) was nominated to stay as Chair on an on-going basis.

The West Coast ALT's next meeting is being held on Thursday 9th August.

4. APPENDICES

Report prepared by: Carol Atmore, Chief Medical Officer
Wayne Turp, General Manager Planning and Funding

.

MAORI DISABILITY ACTION PLAN

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: **Rodger Jolley, Ministry of Health**

DATE: **6 August 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 Ministry of Health will present the Maori Disability Action Plan following a workshop directly after the meeting at Kahurangi.

4. APPENDICES

Appendix 1:	WCDHB Version 2 Draft, Disability Action Plan
Report prepared by:	Ministry of Health: Rodger Jolley
Information papers:	Accessible Marae Toolkit

Whāia Te Ao Mārama:

The Māori Disability Action Plan for Disability Support Services

2012 to 2017

Citation: Ministry of Health. 2012.
Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017. Wellington: Ministry of Health.

Published in August 2012
by the Ministry of Health
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ISBN 978-0-478-39359-0 (online)
HP 5524

This document is available at:
www.health.govt.nz

Foreword

Whāia Te Ao Mārama literally translated means pursuing the world of enlightenment. It is an apt title for this document, which outlines a pathway towards supporting Māori with disabilities to achieve overall wellbeing, and bringing both them and our communities into a place of shared understanding and action.

Culture is an important component of our overall wellbeing, and providing culturally specific action plans such as this recognises the diverse contexts from which we all come, and the unique responses that are required to address the needs of the Māori disabled community.

One in five Māori are living with some sort of disability, and this represents a large proportion of our whānau, hapū and iwi. Each of these whānau will have different expectations and needs in terms of their health and wellbeing, although all tangata whenua have shared values and beliefs that underpin our respective aspirations.

This action plan provides a strong foundation and a clear direction for providing the support that Māori disabled people and their whānau require. It also outlines key principles that those of us working within the disability support sector need to acknowledge. In developing this action plan, we hope that we have created a resource which weaves us closer together as communities who are respectful and supportive of diversity.

This action plan was developed by Māori disabled people, their whānau, and those who work in the disability support sector; with support from the Ministry of Health. The collaborative approach used to bring this plan together outlines the importance that we place on bringing key stakeholders, particularly those who live with disabilities, into the process of developing shared solutions, and responses.

Helen Keller once said, 'No pessimist ever discovered the secret of the stars, or sailed to an uncharted land, or opened a new doorway for the human spirit.'

This Māori Disability Action Plan operates from an attitude of optimism – it is essentially encouraging us all to dare to be powerful, to operate from a position of strength. Our strength is inherent in our whakapapa; in whakawhanaungatanga; in our kaupapa, our tikanga.

Knowing our collective strength helps us to move us closer towards Te Ao Mārama and closer towards reaching a shared awareness about the needs of Māori disabled people.

Tikanga, after all, is about doing the right thing, at the right time for the right reason, and this is the essence that has been captured in this action plan.

Tēnā koutou katoa

Hon Tariana Turia
Associate Minister of Health

Acknowledgements

E kore e hekeheke he kakano rangatira

I will never be lost for I am the product of chiefs.

The development of this document was driven by the Associate Minister of Health Hon Tariana Turia, and led by the Māori Disability Leadership Group.

Over 200 Māori individuals who participated in hui, focus groups and interviews, and organisations such as Te Piringa, NASCA, NZFDIC and disability support services providers contributed to the content of this over an 18-month period.

The consultation process was supported by the New Zealand Federation of Disability Information Centres. The individual stories and art work for Te Tōrino were produced by Te Rau Matatini.

The development of this document was led by the Disability Support Services Group of the National Services Purchasing Unit within the National Health Board.

Thanks to all the staff who contributed to this work from across the Ministry of Health and Te Puni Kōkiri.

Māori Disability Leadership Group

Sylvia Ratahi

Rainus Baker

Karen Pointon

Maaka Tibble

Ruth Jones

David Tamatea

Contents

Introduction

Why an action plan?

A number of factors determine the outcomes for Māori disabled and their whānau. Some directly relate to how their needs are supported to participate in their own lives, communities and cultural worlds. This participation can shape their chances of attaining a quality of life that matches their aspirations.

The aim of *Whāia Te Ao Mārama: Māori Disability Action Plan 2012 to 2017* is to establish priority areas of action for achieving these aspirations, and to reduce barriers that may impede Māori disabled and their whānau from gaining better outcomes.

'Whāia te ao mārama' means to pursue and enable a good life that is self-determined, through enlightened supports. The tōrino double spiral diagram in the plan illustrates the four core elements needed for supports to be effective for Māori disabled:

- te ao Māori
- te ao hurihuri
- te rangatira
- tūhonohono.

Each element is interwoven and interdependent. Their purpose is to support Māori disabled to uphold their own mana and strong self-determination within their whānau, hapū, iwi and wider communities.

Māori disabled

Disability is a significant issue for Māori. One in five Māori report having a disability, and due to the youthfulness of Māori communities and the higher susceptibility of Māori to disabling health conditions as they age, the incidence of disability is expected to increase.

It is widely acknowledged that culture and health are closely linked, and that those services that fail to take account of the significance of culture in the assessment and support of Māori disabled have the potential to create a greater likelihood of poor outcomes and reduced health gains.

Māori aspirations

Māori disabled are clear about what will make a positive difference to their lives. They want:

- every opportunity to have leadership, choice and control over their lives (te rangatira)
- to be supported as both Māori and as disabled to thrive, flourish and live the life they want
- to be able to participate in te ao Māori (the Māori world)
- to have their whānau valued as their primary support system
- to be connected to natural support networks, including Māori and disability communities
- a holistic approach to their disability that also values the beneficial effects of Māori cultural views and practices on spiritual, mental, physical, emotional and whānau wellbeing.

Government priorities

The Ministry of Health's *Disability Support Services Strategic Plan 2010–2014* outlines the overall purchasing strategy and actions for providing disability support services to eligible New Zealanders. It continues the Ministry's move towards a needs- and outcomes-based approach to purchasing national disability services.

Whāia te Ao Mārama provides direction over the next five years for actions to address the needs and priorities of Māori disabled. It has been informed by community and stakeholder consultations with a Māori Disability Leadership Group comprising Māori disabled from across the disability sector, who provided leadership and peer review for the development of the plan.

Whāia te Ao Mārama is based on three principles from te Tiriti o Waitangi: Māori participation at all levels, partnership in service delivery, and protection and improvement of Māori wellbeing. *Whāia Te Ao Mārama* also reflects New Zealand's obligations as a signatory to the United Nations Convention on the Rights of Persons with Disabilities (2007), and as a nation that has stated its support for the United Nations Declaration on the Rights of Indigenous Peoples (2010).

The five-year action plan is aligned closely with:

- the New Zealand Disability Strategy (2001)
- Disability Support Services' new initiatives designed to supporting disabled people and their whānau
- cross-Ministry of Health initiatives such as the Uia Tonutia: Māori Disability Research Agenda
- intersectoral initiatives, particularly those related to the Government's Whānau Ora programme.

Reducing barriers

Māori disabled can experience discrimination and face significant barriers, both in everyday living and in accessing health, disability and other services. As a result of their disability experiences, Māori have reported feeling disconnected from their whānau, communities of choice and culture.

Reducing barriers to ensure Māori disabled and their whānau get disability information, resources and services is a key strategic challenge in supporting Māori disabled to achieve better outcomes.

Disability support services

Anecdotal evidence indicates that Māori whānau commonly take care of their disabled whānau members without accessing the supports by the Ministry of Health-funded disability support services. Effective disability services are seen as critical to achieving improved disability outcomes for Māori, and these services are expected to be responsive to Māori needs and priorities. A key strategic challenge is to achieve better Māori access to effective disability support services that are appropriate at both the population and individual levels of need.

Supporting New Zealanders with disabilities to receive better disability supports contributes to the Ministry's outcome to promote and protect the good health and independence of New Zealanders.

The Ministry is introducing new ways of supporting clients of disability support services. These initiatives recognise that disabled people and their whānau are the best people to determine how they want to live and develop goals that will meet their needs. The Ministry is developing initiatives to take account of the diverse needs and concerns of Māori, and will play an important role in supporting Māori clients to achieve good outcomes from disability support services. The shift to increasing disabled people's choice and control is consistent with what Māori communities have said they want from the Ministry's disability support services.

Māori data

Some of the following information has been sourced from the Ministry of Health's Disability Support Services database.

The 2006 New Zealand Household Disability Survey indicated that disability was a significant issue for Māori, with close to one in five Māori (approximately 96,700) reporting they had a disability.

Māori disabled make up approximately 5400 (16%) of people who access the Ministry of Health-funded disability support services. As a group, Māori disabled are predominantly youthful, with over a third (37.8%) under 15 years of age and 49% aged under 25 years. Maori disabled mainly have intellectual disability (50.9%) or physical disability (32.2%), and some Māori disabled have significant support needs, with 23% having very high levels of need.

Most live in the Auckland (26.4%), Waikato (12.3%) and Northland (10.6%) regions. Māori disabled predominantly live in urban areas (89%) rather than rural areas (11%). Those living in rural regions are mainly based in Northland (45.2%), Bay of Plenty (24.1%) and Gisborne (25.6%).

As at June 2011, almost two-thirds (64%) of disability support services funding from the Ministry of Health for Māori disabled was allocated to residential care, followed by home support (19.7%) and day programmes (5.2%).

Future changes to disability support services

After talking with disabled people, their families, providers and the wider disability sector, the Ministry of Health has developed, and is testing, a new model for supporting disabled people. The aim of the new model is for disabled people and their families to lead good everyday lives. It will increase people's control and choice, and the flexibility of their supports, as well as ensuring information and support are available in their local communities.

The new model incorporates work to enhance Individualised Funding and Choice in Community Living. The current support services model lends itself more to someone else making the decisions about what, and when, support is given.

Whāia Te Ao Mārama requires Māori disabled and their whānau to be fully involved in the planning and implementation of current and future development programmes to improve the disability support system.

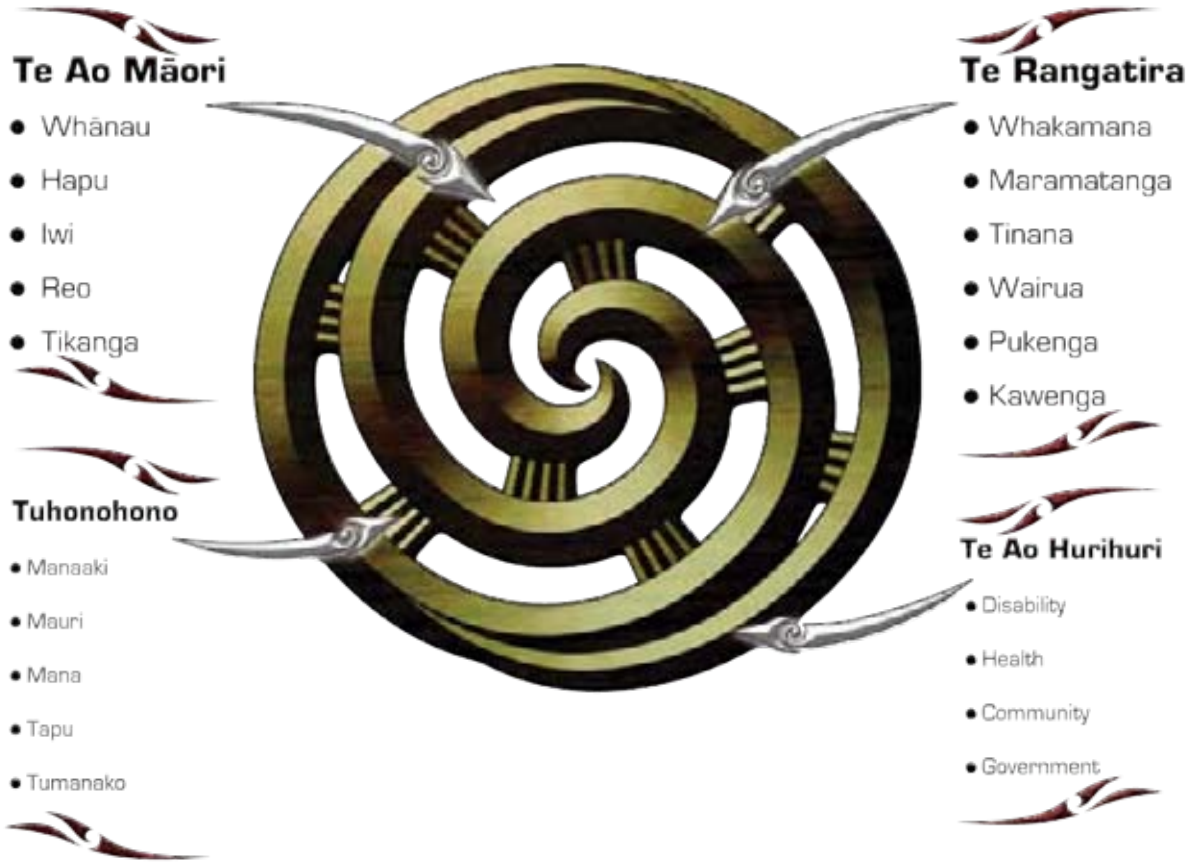
Strategic response

Whāia Te Ao Mārama responds to the wish expressed by Māori disabled and whānau for them to be able to live a good life, participate in te ao Māori and take part in their communities as other New Zealanders do.

There is no definitive word or description of disability in te reo Māori. Commonly te reo refers to a person's ability to flourish or function in relation to their ability to contribute to either their own, or others, wellbeing.

Whāia Te Ao Mārama's vision, kaupapa, guiding principles and priority areas have been developed in collaboration with Māori disabled, key stakeholders and the Māori Disability Leadership Group (see Table 1). It is a culturally anchored approach to supporting Māori disabled and their whānau through Ministry of Health-funded disability support services. The approach has been developed from a Māori world view which also recognises that Māori disabled know what works for them.

Figure 1: Whāia Te Ao Mārama: To pursue a good life with enlightened support



Whāia Te Ao Mārama reflects the four core elements needed for supports to be effective for Māori disabled. Close relationships with and between Māori disabled, their whānau, hapū, iwi and communities, and the Ministry are essential to make a positive difference for Māori disabled. Included alongside the core elements discussed below are excerpts from the stories of Māori disabled who have generously guided and blended their experiences into this action plan.

Te ao Māori

Te ao Māori (the Māori world) is represented by the space between the spirals, shown in Figure 1. This space represents a person's ability to participate in their own whānau, hapū and iwi, and as a Māori New Zealander. The person is included, and is able to draw on the support and opportunities, within whānau and the Māori community through te reo, whakapapa, whanaungatanga, manaaki and wairua.

> 'For example, a taonga for Ngāti Kāpō might be the ability to make choices and the right to be Māori and access cultural resources. 'It's the balance – active participation. Not even my mum and dad would have thought that I would become one of the leaders in health and disability services in Tairawhiti, or that I would have a major influence in terms of indigenous issues around the world!

> 'I would have laughed at it myself, but it is about a vision. Ka pū te ruha, ka hao te rangatahi; mate atu he tetekura, ara ake he tētēkura – beautiful. So that's what our old people were thinking.'
>
> – Maaka, Ngāti Porou me Te Whānau ā Apanui)

Te rangatira

The te rangatira spiral represents Māori disabled as individuals living life and having the whakamana to take up their various roles as they have a right to do within their whānau, te ao Māori and society as a whole, and who are responsible for their own lives.

> 'One of the concepts in Maoridom, which is so vitally important, is about applying tino rangatiratanga, which means that I can take control of my life and destination. We all want that – what's important to give you a good life is the foundation and the legacy that we leave for others. Self-advocacy is also important. It's that notion that talks about we can, ka taea mātau, ahakoa te aha, ka taea tonu e mātau. And then the other one is, mehemea kei kōrero koe mōku, māku anō au he kōrero, so if it's about us,

then don't talk about it without asking us. These are internally understood principles, which have been translated into Māori kupu.'

– Maaka, Ngāti Porou me Te Whānau ā Apanui)

Tuhonohono

This is the solid link between the spirals, which represents the points in a person's life where both the spirals and the space between them must connect to provide balance and harmony. These connecting points are important and represent personal milestones and relationships that Māori disabled have with their whānau, hapū, iwi and caregivers, who are in turn supported through Disability Support Services or other agencies.

'We're still using the same old institutions. Why can't we join the dots together to show that perhaps there is a different way to achieve the outcomes that we all needed to achieve? The imported system can't be working for our people, and there's some indigenous ways which could be working maybe a lot better.'

– Gary, Ngāti Porou)

'Basically we go to people's houses that have ramps that we can access. Or we sit outside – we've sat outside in the rain with an umbrella, or if it's hot. So it really restricts you from doing the social things that you want to do with whānau. You sort of lose contact. And so of course contact with marae and wider whānau is also limited. We've had a lot of tangi and stuff. If I go, Tyler has to sit outside. So we can't do that, can't see the cuzzies or things . . . .'

–Andrea and Tyler, Ngāti Mutunga me Moriori)

Te ao hurihuri

This is the spiral surrounding the disabled person. This spiral represents services, and the political, economic, social and environmental trends that support, influence and affect Māori disabled.

'Sometimes I do get labelled, and I don't like it. I look at myself as being treated like anyone else in the community. I don't have to go, "How come you're this handicapped fellow?" No, I'm a normal person just like you. I don't care if I've got a disability. I'm just a normal and loving person like you, and you should awhi it..'

–Rainus, Ngāti Awa)

Sylvia says she has been able to express her needs to disability services and have her needs met. But she says some other disabled people are not so able to do so.

'They're not speaking up for what they want, 'cause some of them don't know how. Staff should also develop better skills in listening and speaking simple language to encourage disabled people to speak up. They've been shut up, like shut down or "shut out". Sometimes it's because they might bear a grudge against a person or a service, or vice a versa..'

– Sylvia, Whakatōhea

A focus for action

Table one contains key features of the plan that have been developed through extensive consultation. These include:

- a **vision for Māori disabled and their whānau**
- the **kaupapa**
- **guiding principles** that underpin the vision
- the **priority actions** which state how these elements will be accomplished.

Table 1: Māori disabled and their whānau

Vision for Māori disabled and their whānau
> To achieve a good quality of life and wellbeing > To participate in and contribute to te ao Māori > To participate in their communities as other New Zealanders do
Kaupapa
Māori disabled will achieve a good quality of life through whānau support and high-quality disability support services
Guiding principles
Enabling Māori disabled > Greater personal leadership, choice and control over disability supports accessed > Acceptance of Māori diversity and disability experience > Respect for Māori cultural values and preferences > Māori disabled have roles within their whānau and their communities of choice **Valuing whānau** > Whānau as the principal source of support for many Māori disabled > Whānau assisted to support disabled family members > Socioeconomic solutions for Māori disabled **Respecting community** > Good partnerships with whānau, hapū, iwi, and Māori communities > Full Māori participation in planning and delivering disability support services > Change the attitudes of whānau, hapū, iwi and communities to support the vision for Māori disabled **Delivering high-quality, effective disability support services** > Culturally safe and trustworthy disability support services > A high strategic priority placed on improving Māori disability outcomes > Better Māori knowledge of and access to disability support services > Equitable resource allocation for Māori-focused disability support services

Priority actions			
1.1	Require providers to ensure that personal plans to support Māori disabled are culturally appropriate and specifically identify and address the individual's cultural needs (2012–17)	**1.2**	Provide a range of new and innovative support options for supporting disabled people that offer Māori disabled and their whānau more personalised support arrangements and greater choice and control over the supports they use (2013–14)
2.1	Improve caregiver training to ensure whānau have access to culturally appropriate training to address the needs of Māori disabled (2013–17)	**2.2**	Develop the New Model for Supporting Disabled People to respond to whānau needs and priorities (2012–13)
3.1	Improve the quality, reliability and comparability of national information about the demographics of, and disability supports provided to, Māori disabled (2012–17)	**3.2**	Improve the quality of the community engagement process with Māori, particularly with hapū, iwi, and community leaders and groups (2012–17)
4.1	Strengthen the cultural competencies of workers in the disability sector through the development and delivery of Māori cultural training (2012–17)	**4.2**	Support the Māori disability workforce to develop leadership skills and career pathways (2012–17)

The action plan

Priorities for *Whāia Te Ao Mārama* have been informed by:

- available Māori disability and needs data
- feedback from Māori consumers and whānau hui
- guidance from the Māori Disabled Leadership Group
- consultation with Te Piringa, the Māori Disability Provider Network
- special focus groups and Māori disability experience-gathering exercises in 2011
- the current difficult economic climate, which will mean that all actions will be resourced within existing funding.

Priority 1:
Improved outcomes for Māori disabled

1.1	Require providers to ensure that personal plans to support Māori disabled are culturally appropriate and specifically identify and address the individual's cultural needs (2012–17)
1.2	Provide a range of new and innovative support options for supporting disabled people that offer Māori disabled and their whānau more personalised support arrangements and greater choice and control over the supports they use (2013–14)

Priority 2:
Better support for whānau

2.1	Improve caregiver training to ensure whānau have access to culturally appropriate training to address the needs of Māori disabled (2013–17)
2.2	Develop the New Model for Supporting Disabled People to respond to whānau needs and priorities (2012–13)

Priority 3:
Good partnerships with Māori

3.1	Improve the quality, reliability and comparability of national information about the demographics of, and disability supports provided to, Māori disabled (2012–17)
3.2	Improve the quality of the community engagement process with Māori, particularly with hapū, iwi, and community leaders and groups (2012–17)

Priority 4:
Responsive disability services for Māori

4.1	Strengthen the cultural competencies of workers in the disability sector through the development and delivery of Māori cultural training (2012–17)
4.2	Support the Māori disability workforce to develop leadership skills and career pathways (2012–17)

Monitoring and reporting on the implementation of *Whāia Te Ao Mārama*

The high-level actions in *Whāia Te Ao Mārama* are supported by a detailed Ministry of Health Disability Support Services action plan, incorporating accountabilities, time frames and outcome measures.

Internal monitoring and reporting of the implementation of *Whāia Te Ao Mārama* will occur on a quarterly basis, alongside Disability Support Services' quarterly reporting on achievement of its annual service plan.

The Whāia Te Ao Mārama Monitoring and Advisory Group – a new external group of Māori disabled – will meet six-monthly to review implementation progress and provide advice to the Ministry.

Appendix 1: Additional actions for future reference

The following actions were identified by the Māori Disability Leadership Group but were not included in Whāia Te Ao Mārama. These may inform future service planning for Maori disabled.

Priority 1: **Improved outcomes for Māori disabled**	› Develop learning and leadership training and development opportunities for Māori disabled, including tamariki (children) and taiohi (young people)
Priority 2: **Better support for whānau**	› Develop indicators to measure whānau outcomes › Support parents with disabled children, particularly in the areas of behaviour support and whānau-centred respite care › Ensure whānau are involved in the funding, planning and delivery of disability services, including the development of service specifications › Improve Māori provider capacity and capability to participate in Whānau Ora through Te Piringa
Priority 3: **Good partnerships with Māori**	› Additional actions have been identified to enable Maori participation and inclusion in disability service prioritisation, specification and engagement › whānau, hapū and iwi relationships are established to better engage disability awareness and supports through iwi health plans and whānau support options on marae
Priority 4: **Responsive disability services for Māori**	› Review the Quality Assurance Outcomes Framework for Māori disabled to guide the approach for Māori receiving disability supports › Use Māori disability research to inform service development for Māori disabled, including from Uia Tonutia: Māori Disability Research Agenda

Appendix 2: Glossary

Hapū	Māori sub-tribe, clan or kinship group
Iwi	Māori tribe or clan
Mana	Spiritual power, authority, integrity, prestige or group
Manaaki	To support
Marae	Central area of a village and its buildings
Māramatanga	Understanding
Pūkenga	Skills
Rangatira	Leadership
Rangatira-tanga	Influence and control over life
Taiohi	Adolescent
Tamariki	Child
Tangata Whenua	Maori as indigenous people to this land
Te ao hurihuri	Contemporary society, including Disability Support Services and other services and factors that affect the individual
Te ao Māori	The Māori world in which the individual has a role within whānau and hapū, and is able to draw on the support and opportunities of whānau and also take up their role within whānau
Te rangatira	Disabled individual Māori living life and taking up their various roles within whānau, te ao Māori, and society as a whole
Te reo	Māori language
Tikanga	Customs, practices and protocols that reflect Māori knowledge and traditions
Tinana	Physical; bodily
Tūhonohono	Connectedness and relationships that Māori disabled have with their whānau, hapū, iwi and caregivers which provide balance and harmony in their lives
Wairua	Spirituality or spiritual health, which encompasses dignity and respect, cultural identity, personal contentment, and non-physical spirituality

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: **6 August 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		√		Report included in Information papers
4. Quality and Risk Management to monitor	Quality and Risk Manager	Ongoing	Quarterly		√		Report due October 2012
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		√		
14. Ministry of Health quarterly reports against other aspects of the Annual Plan / Statement of Intent	General Manager Planning and Funding	Ongoing	Quarterly		√		
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					√	Report included in papers.
20. Elder care strategy	Dr. Jackie Broadbent					√	
21. Pharmacy services	Nick Leach					√	
22. Laboratory services	Phil Clarke				√		

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: **6 August 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**

At the time of printing there were no items for this report.

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: **13 August 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

Primary Health Organisation Quarterly Report Apr-Jun 2012

Accessible Marae Toolkit

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
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 2014
John Vaile **(West Coast District Health Board member)**	27 January 2011 (re-appointed 27 January 2012)	1 Year	31 January 2014
Lynnette Beirne	24 March 2011	1 Year	31 December 2014
Marie Mahuika-Forsyth	20 April 2009	Until advised by Te Runanga o Makaawhio	
Mary Molloy **(West Coast District Health Board member)**	27 January 2011 (re-appointed 27 January 2012)	3 months	30 January 2014

Member	Date of Appointment	Length of Term	Expiry Date
Robyn Moore	3 June 2011	3 years	3 June 2014

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

PHO 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: **Anthony Cooke, Director WC PHO**

DATE: **9 August 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided on a quarterly basis, highlighting the progress made on the Minister of Health's health and disability priorities.

2. RECOMMENDATION

That the Committee notes the Primary Health Organisation Quarterly Report

3. APPENDICES

Appendix 1: PHO Quarterly Report

Report prepared by: Anthony Cooke, Director PHO

Quarterly Report
April to June 2012

Contents

This quarterly report contains information relating to the activities and performance of the PHO during the quarter. It is prepared for the information of the PHO's Board of Trustees and Clinical Governance Committee, the PHO's contracted providers, the Alliance Leadership Team, the District Health Board and the wider community. The report as a whole is not a contractual requirement, though some of the tables are required to be reported to the DHB and other funding bodies quarterly.

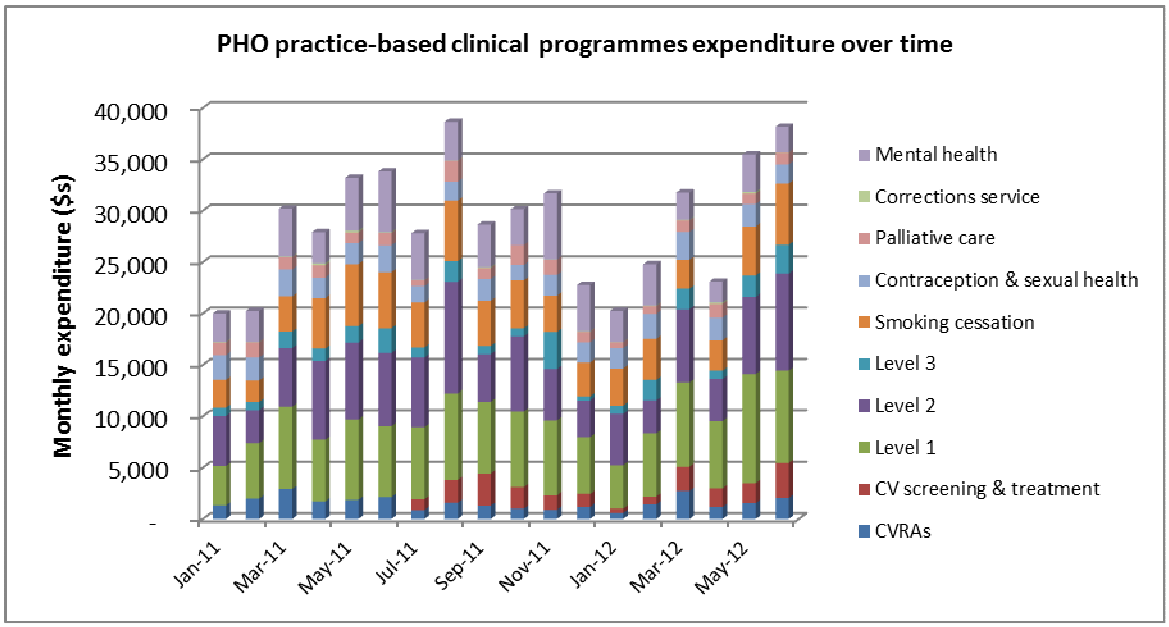
1. Executive summary

Medical centres

The West Coast has a particular shortage of GPs across all its medical centres this winter – every single practice has at least one vacancy. Dr Carol Atmore has called meetings of practitioners to identify and further address the issue with the Canterbury based HR team.

Clinical services

Despite the workforce shortages, strong demand from practices for the PHO's various clinical programmes has been continuing, as per this graph:



This suggests the possibility that nurse clinics for the management of chronic conditions are embedded in most practices (such that they are less affected by acute demand than they might once have been).

Keeping people healthy

The foci of health promotion campaigns has been:

- April – childhood immunisation;
- May – smoking cessation;
- June – men's health.

As a result of uncertainty regarding HEHA funding next financial year, we did not immediately replace our Health Promotion Coordinator, Carla Mitchell, when she resigned to travel overseas. It now appears as though the majority of our HEHA funding will be retained in one form or another, but is only certain for the next financial year or two, and indications are that funding is unlikely to be available beyond June 2014. The physical activity programme for youth is the only one for which funding has definitely been cut in the 2012-13 year.

Carla was also involved in our Buller Green Prescription programme. In planning for the future of this programme, we have developed both a physical activity and a weight loss programme, which we plan to pilot in Westport, commencing July 2012.

Workforce and rural support

The PHO team has begun preparation for the second "GP weekend away conference", though it is planned to include nursing colleagues this year as well. As part of consideration for this, we have formed the view that the "PHO celebration day" may have 'done its dash'. The latter has always been better supported by practice administration staff than by nursing and, especially, medical staff. Our current thinking is that we should merge the two events – hold the PHO Annual Public Meeting at the GP Weekend Away Conference, which should ensure we have good clinical representation. One thing we will need to separately organise is something in the way of continuing professional development for practice administration staff. The GP Weekend Away Conference is planned for November 2012.

Clinical Governance Committee

Richard Wallace has been re-appointed as the Māori health representative.

Business Case for "Better, Sooner, More Convenient Primary Care"

Carol Atmore has been leading work around the model of care for Greymouth, encompassing both Integrated Family Health services for Grey and the hospital services for the whole of the West Coast.

Work continues in parallel on shorter term efficiency gains in DHB owned primary care practices and on longer term analysis of ownership and management options. This is now looking more like a business unit within the DHB, rather than a wholly owned subsidiary company, though possibly still with contracted out management. The phrase being used is an "Autonomous Clinical Unit".

In terms of the more immediate issues (enrolment and claiming), some PHO staff have been seconded to assist, Mary Brown and Mike Northmore, independent practice management experts, brought in by the DHB to improve things at Greymouth and South Westland practices.

MoH enrolment audit

The DHB has advised it will be clawing back funding on the basis of the enrolment audit conducted in Oct-Dec 2011.

The variation in performance across practices was from 0.3% of enrolment forms missing (or incorrect) to 9.9% missing, with type of practice ownership being strongly correlated with different levels of performance. Privately owned practices averaged 0.8% enrolment forms missing, while public sector practices averaged 7.5% missing.

As a result, one private practice will lose no funds; the other will have $648 clawed back. The five DHB owned practices, meanwhile, will collectively lose $62,966.

Strategic relationships

As part of the primary care portion of a "Tranz-Alpine approach" to West Coast health services, PHO personnel have been meeting with primary care colleagues in a variety of Canterbury based organisations to explore options for greater sharing and collaboration. A meeting of all Canterbury and West Coast PHOs Chairs and CEOs is planned for July. Meanwhile, Rural Canterbury and West Coast PHOs have signed a memorandum of understanding.

Governance matters (Trustee appointment processes)

The process of nomination and appointment of three Trustee positions, whose terms concluded 20th March 2012, has been undertaken. Maureen Pugh has been re-appointed by Trustees, upon the nomination of Westland District Council for the 2012-15 period. Richard Wallace has been re-appointed by Trustees, upon the nomination of Te Runanga O Makaawhio for the 2012-15 period. No nominations were received from the practice nurse electoral college, and the Board has again seconded John Boyes to fill that role for a year.

Staffing, vacancies and succession planning

Health promotion coordinator is a vacancy.

Green Rx coordination (Buller) is now likely to be filled by contractors rather than staff.

Fiona Doolan-Noble, who is part of the PHOcus on Health team contracted to support the PHO, has re-located to Dunedin, where she has a picked up a part-time role at the University, which will also enable her to complete her PhD. She will continue with a minor role with the PHO, supporting Helen Reriti and her team. Other aspects of Fiona's role may be picked up by the new Health Promotion Coordinator, once that role is filled (and subject to the skill set of the successful applicant).

This does now mean the PHO's senior management team has lost two members in recent months – first, Frans Dellebeke and, now, Fiona.

2. Statement of strategy & priorities

Adopted by the PHO Board of Trustees October 2010.

The purpose of the West Coast PHO is to promote and enable better health for the population on the West Coast and actively work to reduce health inequalities amongst at-risk and disadvantaged groups.

The PHO and the West Coast DHB have recently co-sponsored a joint 'Business Case' aimed at:

1. achieving clinical sustainability;
2. improving integration of community and primary health care;
3. achieve financial viability.

STRATEGIC OBJECTIVES ARE TO

- work with local communities and enrolled populations;
- identify and remove health inequalities;
- offer access to comprehensive services to improve, maintain, and restore people's health;
- fostering greater clinical leadership;
- co-ordinate care across service areas;
- develop the primary care workforce;
- continuously improve quality using good information and evidence;
- operate within the available funding.

WE WILL FOCUS ON THE REDESIGN AND TRANSFORMATION OF THE PRESENT PATIENT CARE PATHWAY

- in partnership with the community;
- by engaging with clinicians in order to improve:
  - access to primary care services;
  - continuity and consistency of primary care;
  - the co-ordination of care between the general practices, hospitals and community providers;
  - the provision of more community care in 'integrated family health centers;
- closing gaps of inequality for Maori.

BY USING KEY MECHANISMS AND ENABLERS SUCH AS

- better engagement with the community, families/whanau and individuals;
- implementing the 'Better, Sooner, More Convenient Primary Care' Business Case;
- adoption of efficient business/service models based on the principles of Alliance Contracting.

3. Financial summary

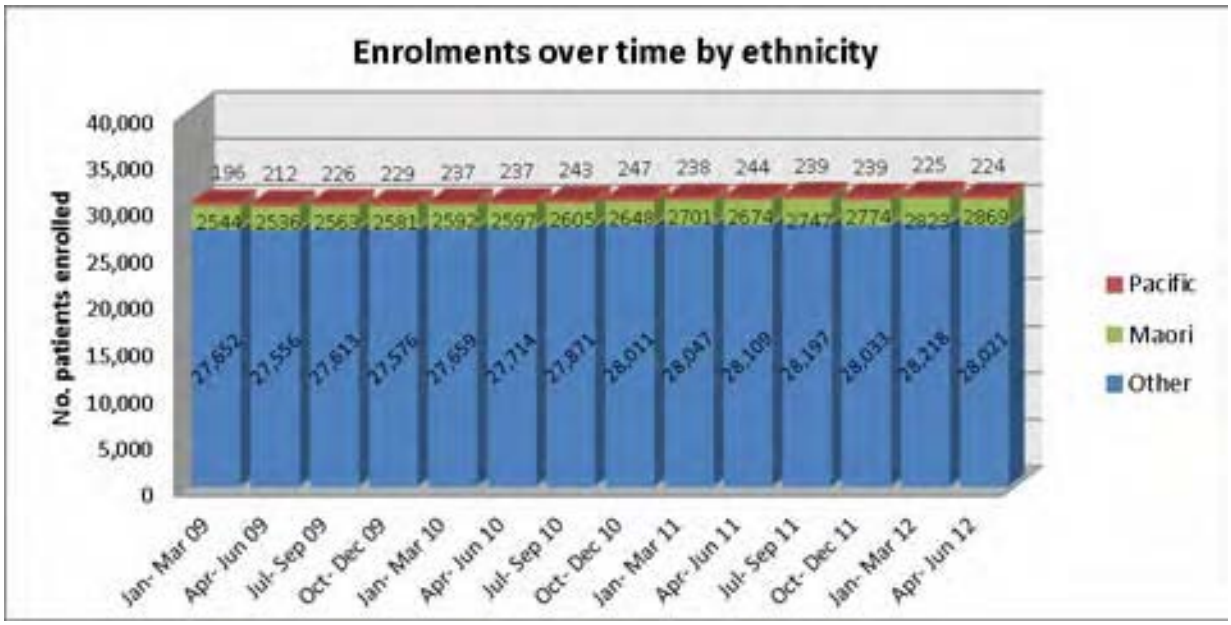
The Financial Summary for the year ending June 2012 was not available as at 20th July 2012.

Profit & Loss
West Coast Primary Health Organisation
1 July 2011 to 30 June 2012

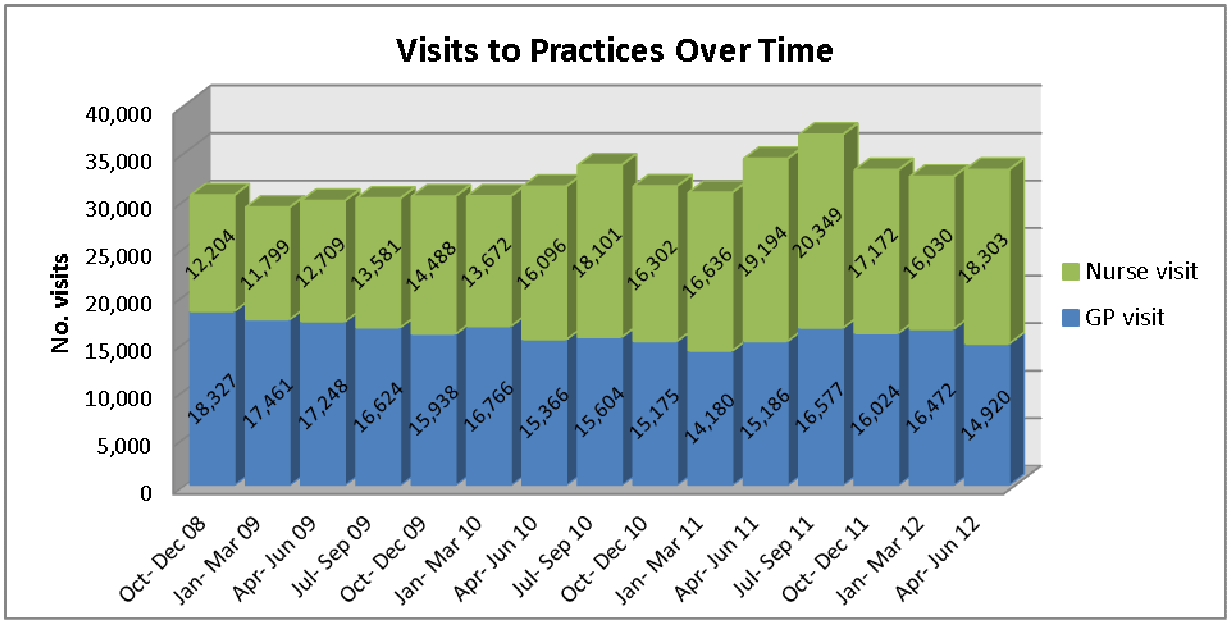
	YTD 30 June 12
Income	
1. Patient care subsidies	
2. Clinical services	
3. Mental health	
4. Keeping people healthy	
5. Workforce & rural support	
6. Administration	
7. BSMC implementation	
Total Income	
Less Cost Of Sales	
1. Patient care subsidies	
2. Clinical services	
3. Mental health	
4. Keeping people healthy	
5. Workforce & rural support	
Total Cost Of Sales	
GROSS PROFIT	
Other Income	
6. Administration	
Total Other Income	
Less Operating Expenses	
Staffing & operations	
Transfers to/from reserves	
Total Operating Expenses	
NET PROFIT	

4. Subsidising core general practice care

4.1. Demographics of the enrolled population



4.2. Service Utilisation (visits to the practices)

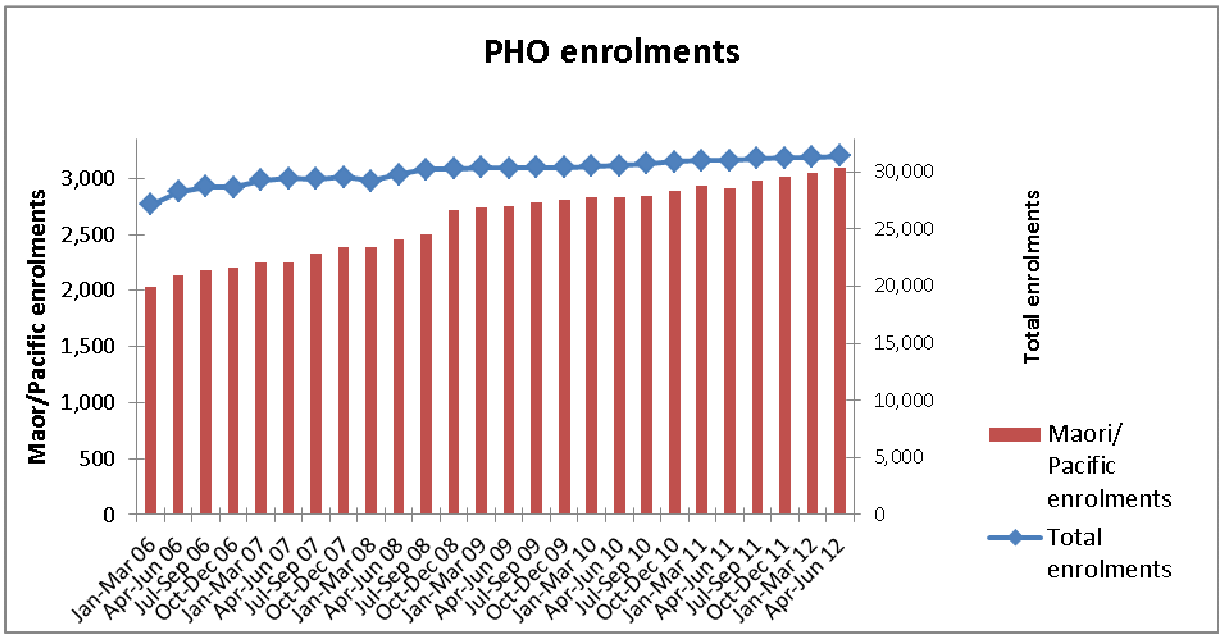


Waiting times to be seen by a medical centre or clinic June 2012

(in working days)

Scenario	Average	Maximum	Minimum
Waiting time to be seen (by a nurse or GP) for child aged 3 yrs with fever and sore ear	0	0	0
Waiting time to be seen (by a nurse and/or GP) for adult aged 65 yrs who rings up saying he has had difficulty breathing for two days. He has no fever and is not on any current medication.	0	0	0
Waiting time if rings today for routine appointment with a Dr for three monthly review and prescription (approx. average across doctors)	12	28	2
Waiting time if rings today for routine appointment with a nurse for three monthly review and prescription	5	13	0

4.3. Access by Maori



Enrolments of Maori and Pacific people continue to increase at a faster rate than other ethnicities.

4.4. Providers

There are six practices in the PHO (or seven, if Rural Academic General Practice is considered separate from Greymouth Medical Centre):

Buller Medical Services (Westport & Karamea)
Reefton Medical Centre (Reefton)
Greymouth Medical Centre (Greymouth & Rural Academic General Practice)
High St Medical Centre (Greymouth)
Westland Medical Centre (Hokitika)
South Westland Area Practice (South Westland)

4.5. Cost of accessing primary care

All practices have now adjusted their fees to the maximum currently permitted under the Very Low Cost Access scheme.

Patient fees	0 to 5	6 to 17	18 to 24	25 to 44	45 to 64	65+
Buller Medical Services	$0	$11.50	$17.00	$17.00	$17.00	$17.00
Greymouth Medical Centre	$0	$11.50	$17.00	$17.00	$17.00	$17.00
High Street Medical Centre	$0	$11.50	$17.00	$17.00	$17.00	$17.00
Reefton Medical Centre	$0	$11.50	$17.00	$17.00	$17.00	$17.00
South Westland Area Practice	$0	$11.50	$17.00	$17.00	$17.00	$17.00
Westland Medical Centre	$0	$11.50	$17.00	$17.00	$17.00	$17.00

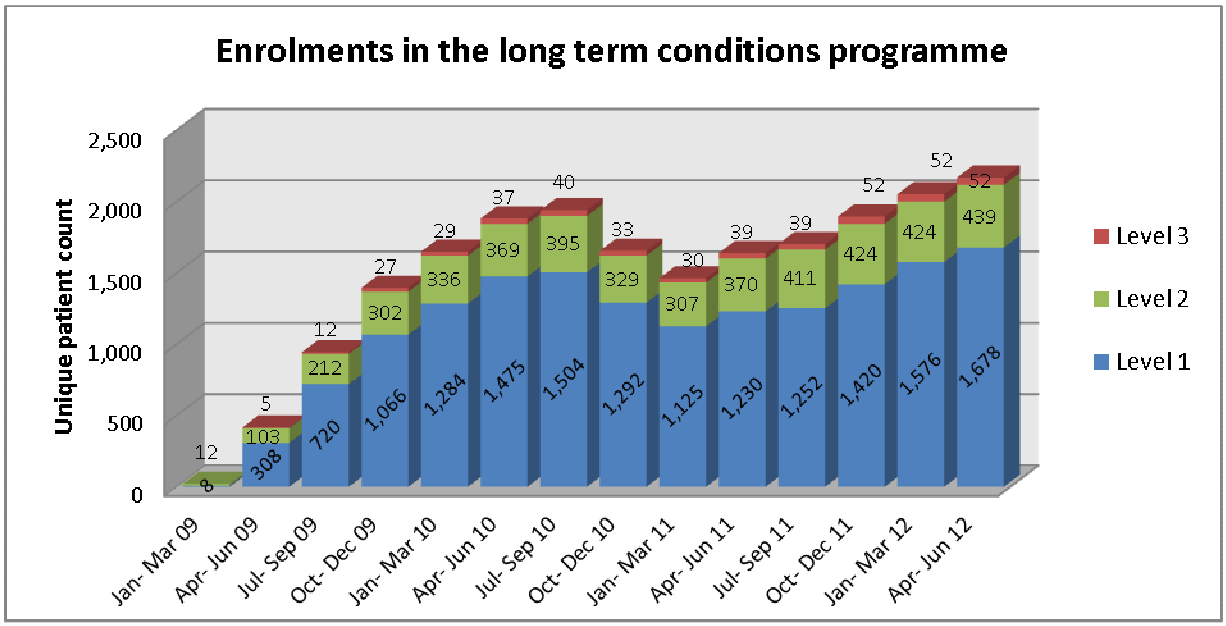
These are the fees patients can expect to be charged at their normal practice during working hours for a normal consultation, if the patient is enrolled with the West Coast PHO. Additional fees may apply to after hours, weekends, long appointments, home visits, procedures and casual patients. The PHO encourages all West Coast residents to enrol with the PHO, registering with one practice and using that practice for all of their health needs. This ensures people will be offered all the health checks they should receive, as well as access to lower fees and other patient advantages. However, if people enrol with one practice and then utilise another they will incur a "casual" rate fee which can vary from practice to practice. Stated co-payments only apply to the practice with which people are registered.

5. Clinical Services

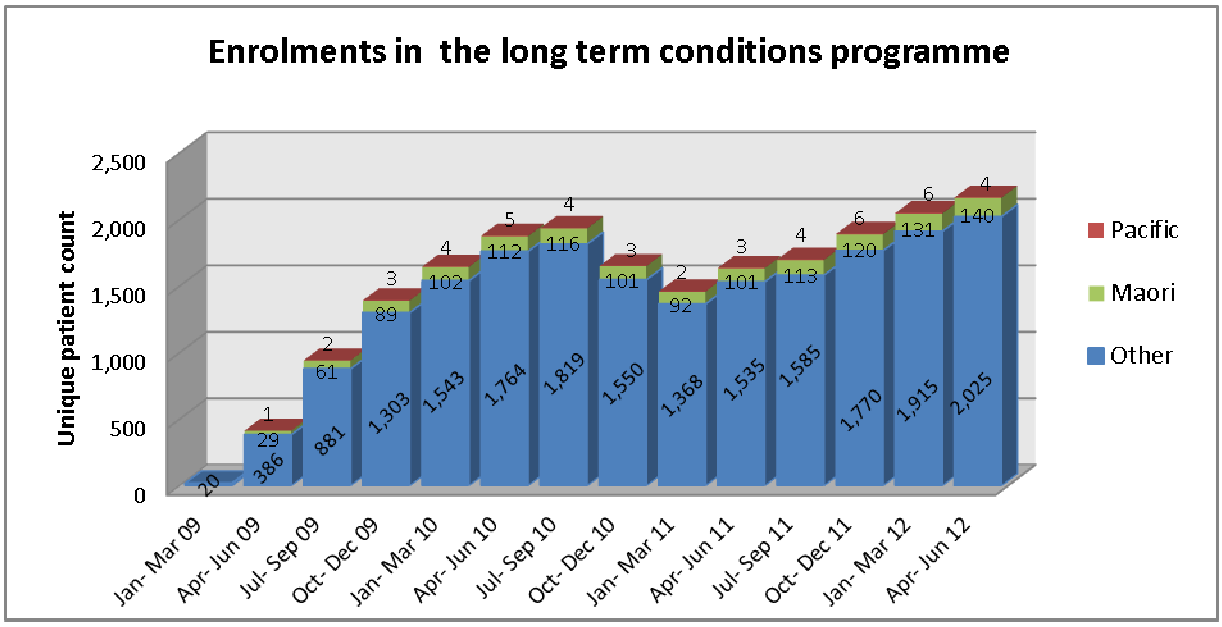
5.1. Long Term Conditions programme (LTC Programme)

On target: Yes

1. Outcomes/Outputs



The 2169 patients who are enrolled in the LTC programme, out of the PHO's approximately 31,000 enrolled patients, means that 6.9% of the enrolled population is engaged in a structured programme of care for their long term condition(s).



Maori enrolments make up 6.4% of all enrolments in the LTC programme to date. For comparison Maori make up 5.2% of the enrolment population aged 45+ years – the prime age group of people in the Long Term Conditions programme.

2. **Key Activities**
   - enrolments this quarter have increased across all levels of care;
   - health navigators continue with their support to practice teams with level 2 and 3 patients, activity for this team is growing every quarter;
   - quarterly reports to practices regarding enrolments, places available and capped numbers for levels 2 and 3;
   - practice teams are actively inviting long term conditions patients who are yet to be enrolled in the structured LTC programme in to a nurse led clinic as well as recalling those who are due for their annual reviews.

   .

3. **Networking/Education** (either with Health Sector or Community)
   - health navigators visiting relevant practices to action all referrals;
   - pharmacies and practice teams.

4. **Issues and Risks**

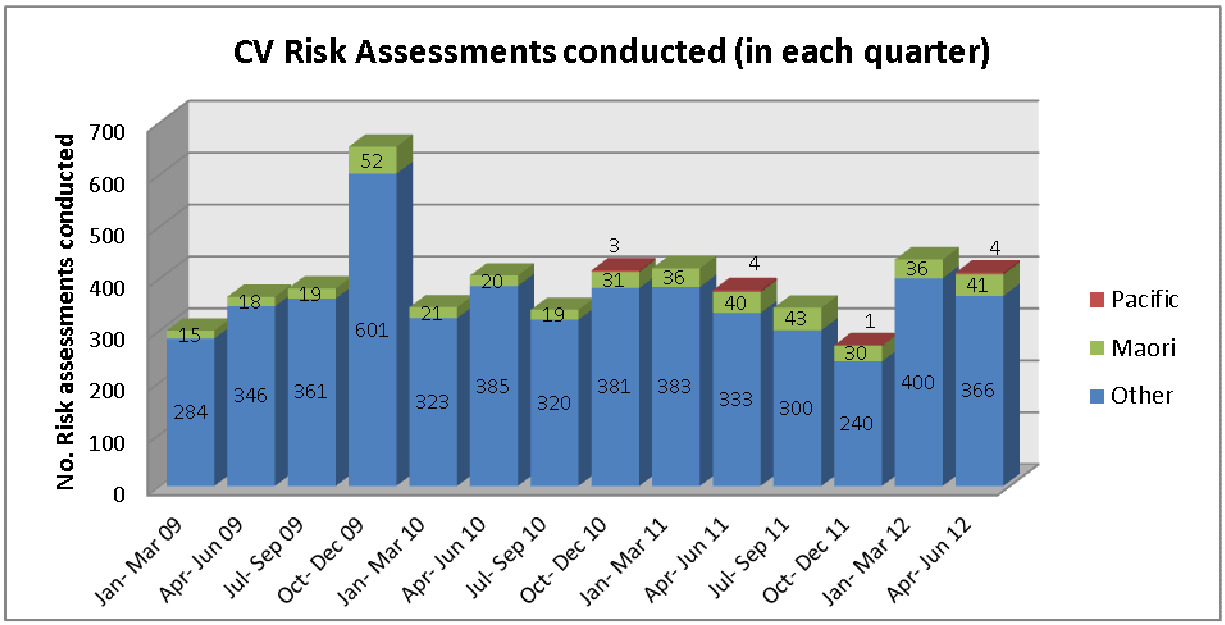
Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

5.2. Cardiovascular risk assessments

On target: Yes

From 1 January 2012, there has been a change to the national health target for cardiovascular disease and diabetes. The revised health target, to be called 'More heart and diabetes checks', will measure 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 will be 90%, to be achieved in steps over three years.

1. Outcomes/Outputs



Activity this quarter has remained high which is pleasing coming into the winter season when 'planned activity' usually falls off due to increased 'acute activity'.

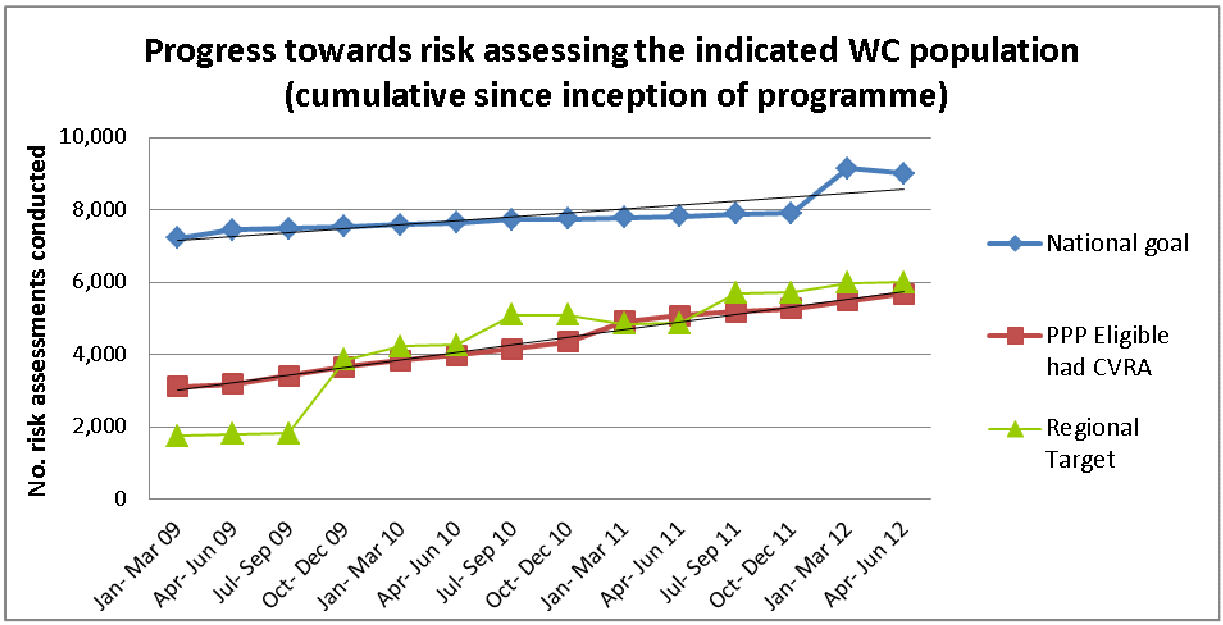
Maori make up 10% of completed CVRAs this quarter. By comparison, Maori make up 7.8% of the eligible cohort for CVRA on the West Coast. (The eligible age range for Maori is male 35-74 years and for female 45-74 years.)

The smoking profile for CVRAs YTD (01/07/11 – 30/06/12) is as follows:

- of Maori screened to date 64% were <u>not</u> smoking compared with other ethnicities screened not smoking 83%.

2. Key Activities

- On-going support from Clinical Manager to Practice Nurses/teams to identify eligible patients for screening;
- practice teams are actively inviting people in to nurse lead clinics to have their 5 year cardiovascular risk assessed;
- High Street Medical Centre held a men's CVRA clinic after hours, inviting in Maori, Pacific and Indian men as a priority (9 of these priority groups were seen out of a total 14 seen).



The new national goal is that 90% of the eligible population will have had their cardiovascular risk assessed in the last five years, to be achieved in stages by 1 July 2014. The first stage to achieving this goal (60% by July 2012) is depicted in the regional target. As at 30 June 2012, 5,668 people who were eligible for their CVRA were completed (regional target being 6,002).

3. Networking/Education (either with Health Sector or Community)

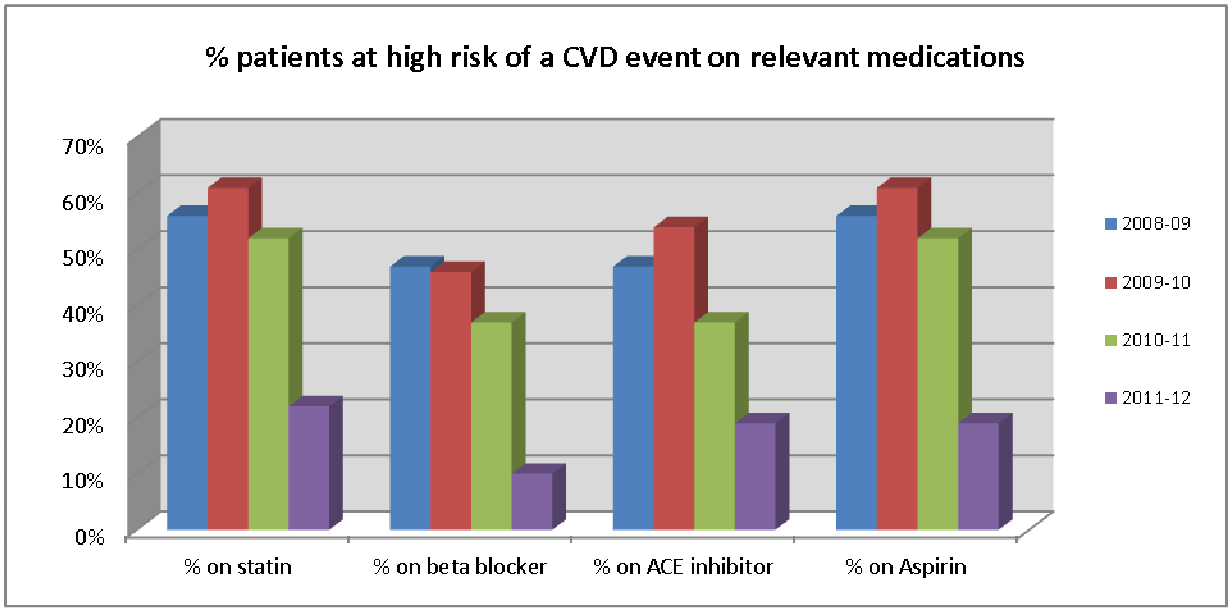
- PHO Clinical Governance Committee;
- quarterly progress reports to practice teams and articles of interest sent to practice nurses;
- practice teams.

4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

5.2.1 Treatment for those identified with increased cardiovascular risk

1. **Outcomes/Outputs**
   - Of the 411 Cardiovascular Risk Assessments (CVRAs) completed this quarter, 105 (25%) were identified as having >15% risk of having a heart attack or stroke in the next 5 years.



The graph above shows the percentage of high risk patients followed up for one year who are on a preventative medication. Of concern, and requiring further investigation, is the apparent significant drop in the percentage of people with CVRA>15% being prescribed medication one year after initial detection.
The plan is to:

a) review the data quality with the reporting;
b) if data is accurate the absolute values, percentage values and the number of people on the right medication, will need reviewing to determine if the increased volume of CVRA risk assessment work has affected the ability of practices to provide appropriate management for people thus identified, or if the issue is related to changing prescribing behaviour;
c) discuss all findings with practice QI teams and PHO Clinical Governance Committee.

2. **Key activities**
   - all identified smokers are given brief advice and support to quit;
   - recommended lifestyle interventions: diet, physical activity and weight management advice given and referrals made to relevant primary and secondary care providers;
   - optimal pharmacological treatment is commenced;
   - regular follow-up monitoring of cardiovascular risk.

3. **Networking/Education** (either with Health Sector or Community)
   - PHO Clinical Governance Committee;
   - quarterly progress reports to practice teams and articles of interest sent to practice nurses;
   - practice teams;
   - heart respiratory team meetings each quarter..

4. **Issues and Risks**

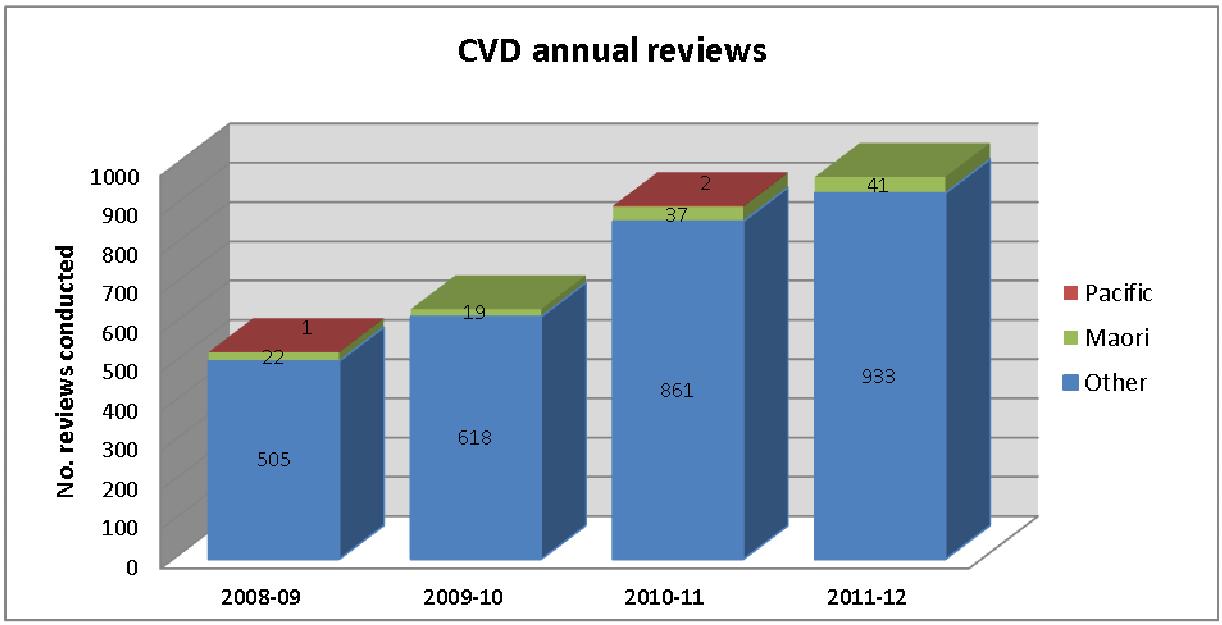
Issues/Risks	**Mitigation/Resolution**
• Suboptimal pharmacological management of those with risk >15%.	• Review of data quality to ensure accuracy, if accurate, a review of the clinical data to determine areas of improvement. • On-going feedback to practice teams through QI team reporting and practice visits.

5.3. CVD annual reviews

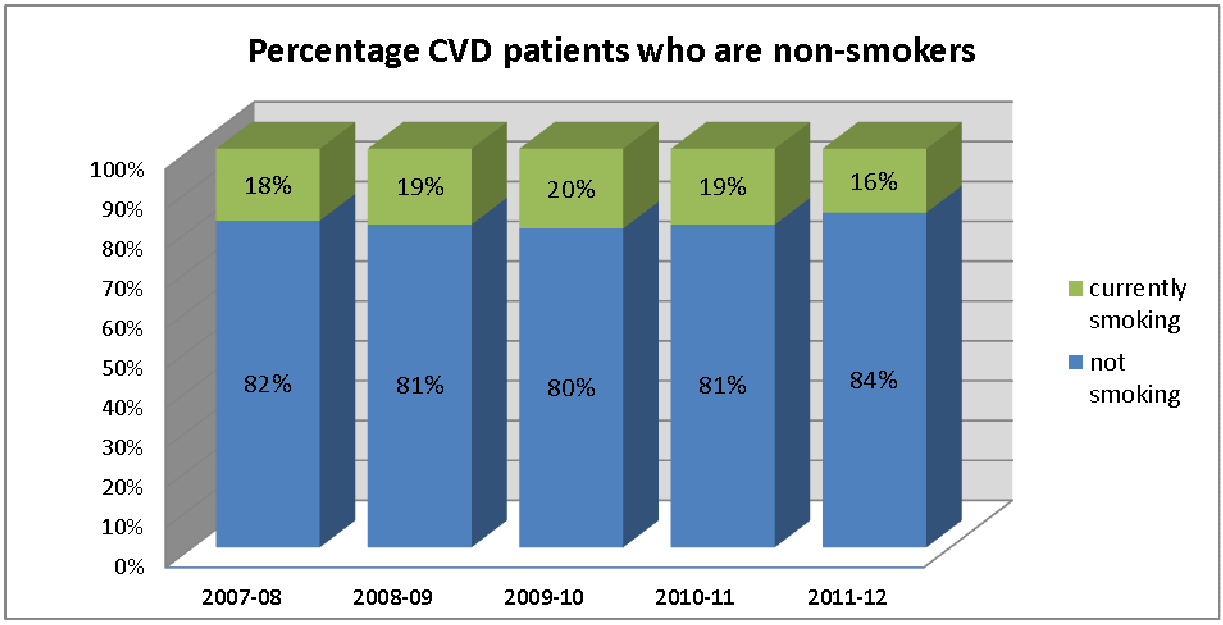
On target: Yes

1. Outcomes/Outputs

People with identified cardiovascular disease have an annual review of their condition as part of the Long Term Conditions Management programme.

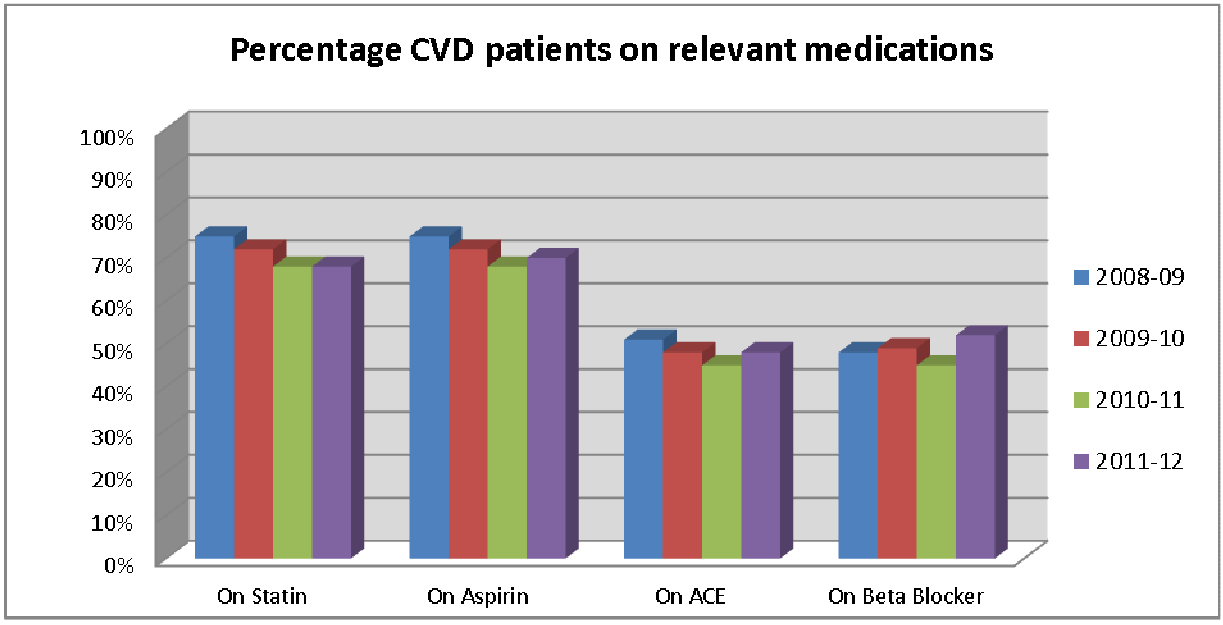


4% of the annual reviews conducted this quarter were for Maori. For comparison Maori make up 5.2% of the enrolment population aged 45+ years – the prime age group of people in the Long Term Conditions programme.



Of those reviewed YTD overall 84% of people were not smoking. Of Maori reviewed YTD 74% were not smoking and other ethnicities 84% were not smoking.

For those who are smoking there is a vast range of cessation services to choose from, all promoted across the West Coast.



It is pleasing to see an increase in the prescribing of medications for people with established heart disease.

2. Key Activities

- on-going support from Clinical Manager to practice teams to identify eligible patients who have not had a CVD annual review;
- practices are actively recalling patients with known cardiovascular disease for their annual reviews at dedicated nurse lead clinics.

3. Networking/Education (either with Health Sector or Community)

- quarterly progress reports to practice QI teams;
- practice teams;

4. Issues and Risks

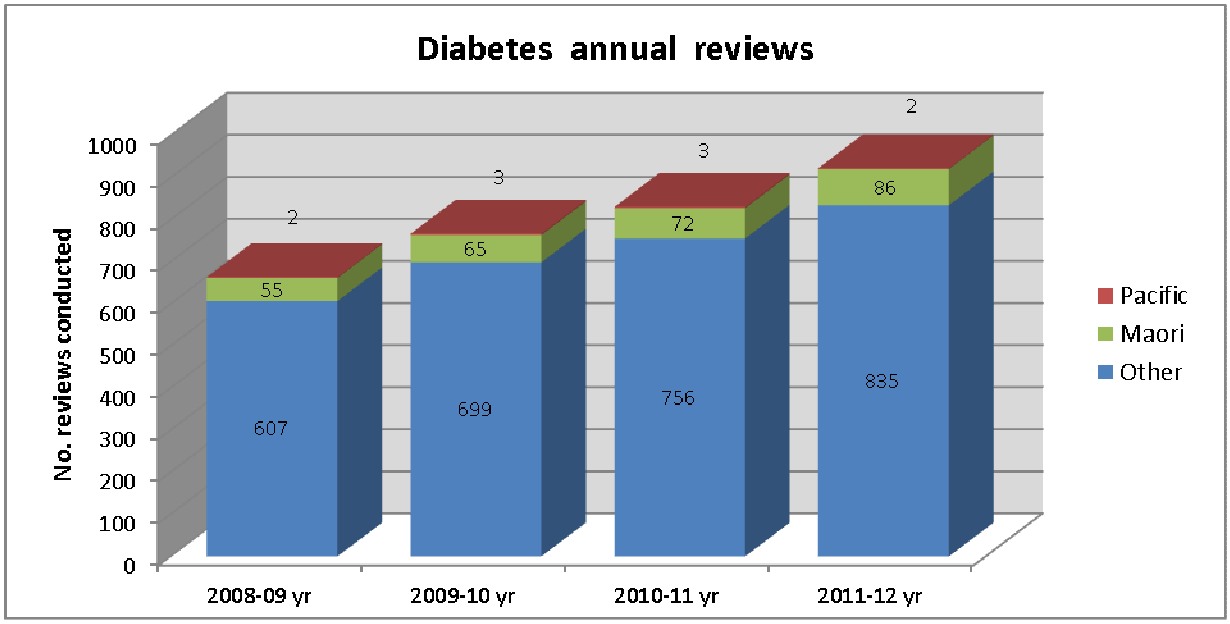
Issues/Risks	Mitigation/Resolution
• Nil	• Nil.

5.4. Diabetes annual reviews

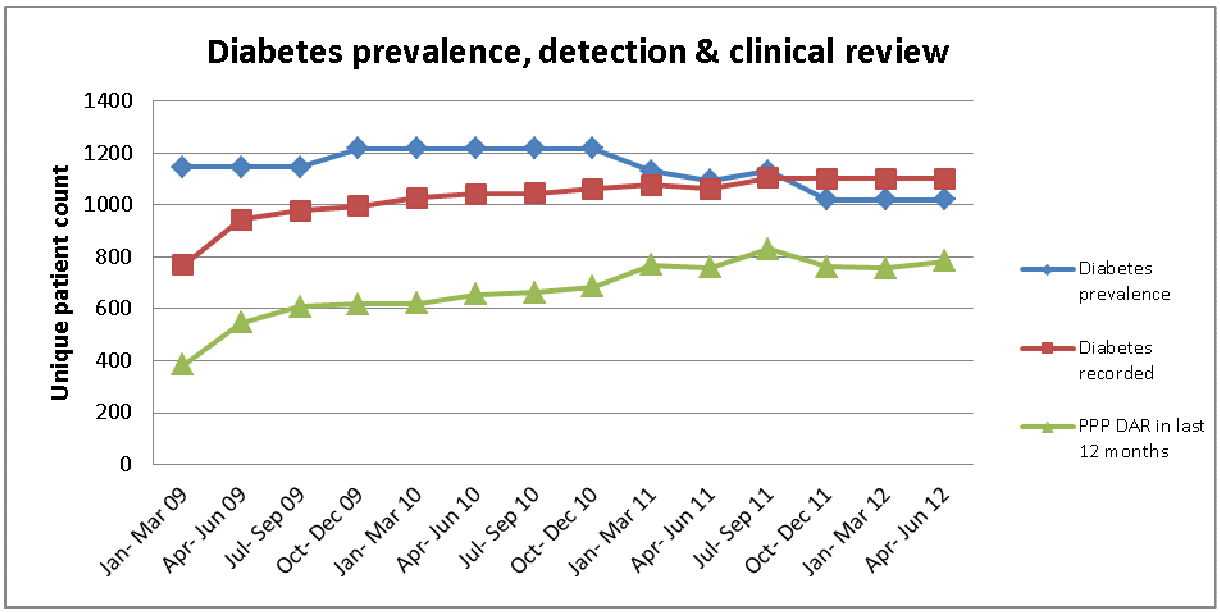
On target: Yes

1. Outcomes/Outputs

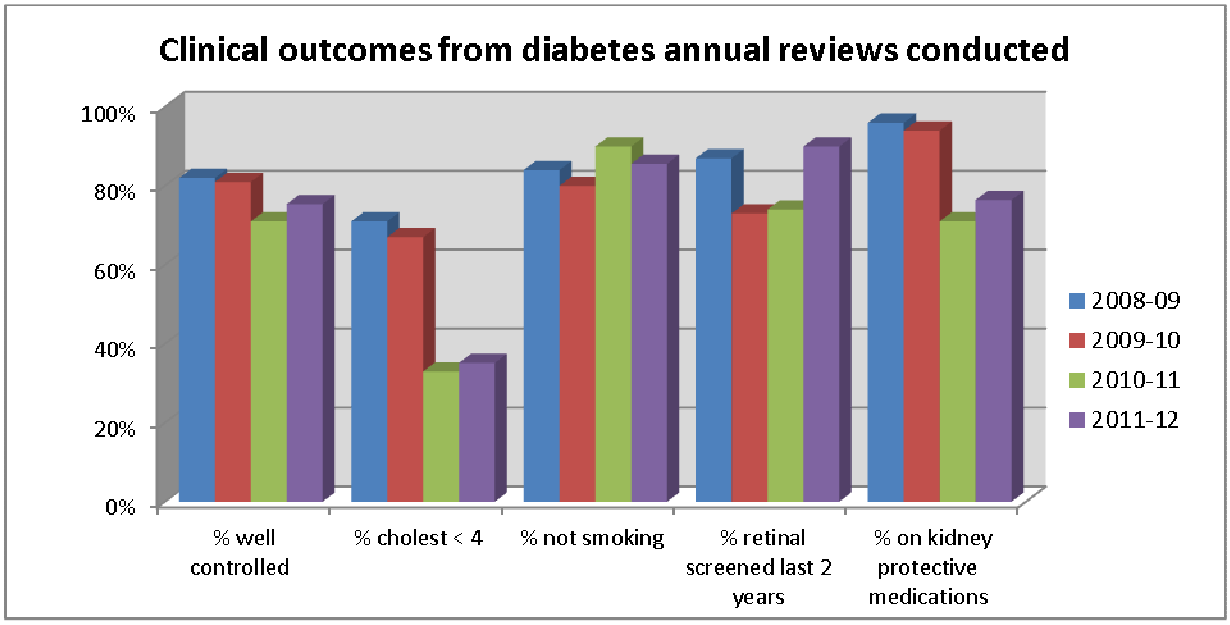
People identified with diabetes have an annual review of their condition as part of the Long Term Conditions Management programme.



9.3% of the annual reviews conducted YTD were for Maori. For comparison Maori make up 5.2% of the enrolment population aged 45+ years – the prime age group of people in the Long Term Conditions programme



A new diabetes prevalence model recently developed by the Ministry of Health was applied to prevalence estimates from 1 July 2011, with the new prevalence estimates becoming available in October – these are now applied and are reflected in the graph above (blue line).



It should be noted that the comparison of percentage cholesterol <4 began from 1st January 2010, prior to this the measurements were % cholesterol <5. (Recommended in the NZ Cardiovascular Guidelines 2009). Since the reporting change, the number of people with a cholesterol in the desired target range (<4) is low, but it is pleasing to note of those identified with elevated cholesterol (>4), 67% are appropriately medicated on a statin.

	Type 1	Type 2	Other Diabetes	Total Diabetes	As % Total Annual Reviews	Retinal Exam in Past 2yrs	% had Ret Exams	HbA1c > 8	As % HbA1c <=8	% non-Smokers	% On Statins
Maori	7	17	0	24	9%	21	88%	4	83%	75%	67%
Pacific	0	0	0	0	0%	0		0	0%	0%	0%
Other	33	206	0	239	91%	215	90%	53	78%	89%	77%
TOTAL	40	223	0	263	100%	236	90%	57	78%	88%	76%

2. Key Activities

- a retinal screening week was held in May: 105 people screened, 29 Greymouth, 23 Hokitika and 53 Westport;
- planning for next retinal screening clinic for 13th to 17th August 2012 which will be held Greymouth 13th and 14th and Westport 15th to 17th;
- Living Well with Type 2 Diabetes course completed in Greymouth with 12 enrolments and 9 completing the course;
- another contract with Matthews Eyewear Eyecare group to provide retinal screening services to the Coast has been negotiated for a further 12 month period.

3. Networking/Education (either with Health Sector or Community)

- diabetes nurse educators at DHB;
- diabetes course facilitators Buller and Greymouth;
- Local Diabetes Team meeting 9th May 2012;
- retinal screening appointments made and confirmation letters sent out;
- notification to practices of patients retinal screened;
- promotion of Living Well with Type 2 diabetes courses (DSME) to practices and community and on PHO website.

4. Issues and Risks

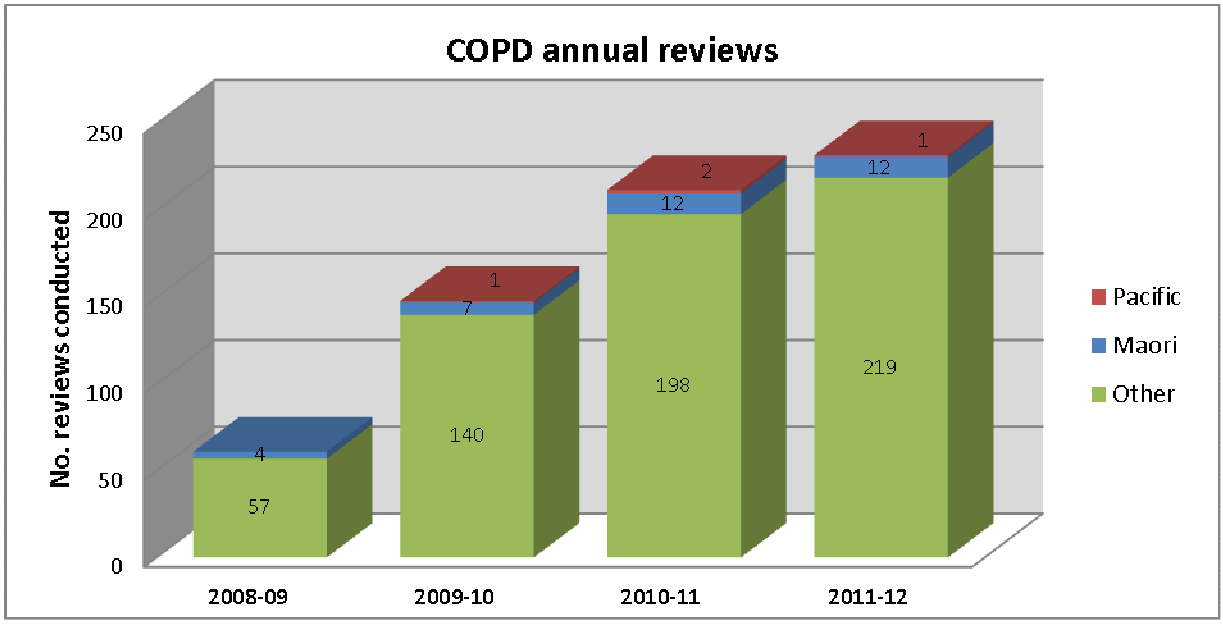
Issues/Risks	Mitigation/Resolution
Nil.	Nil.

5.5. COPD annual reviews

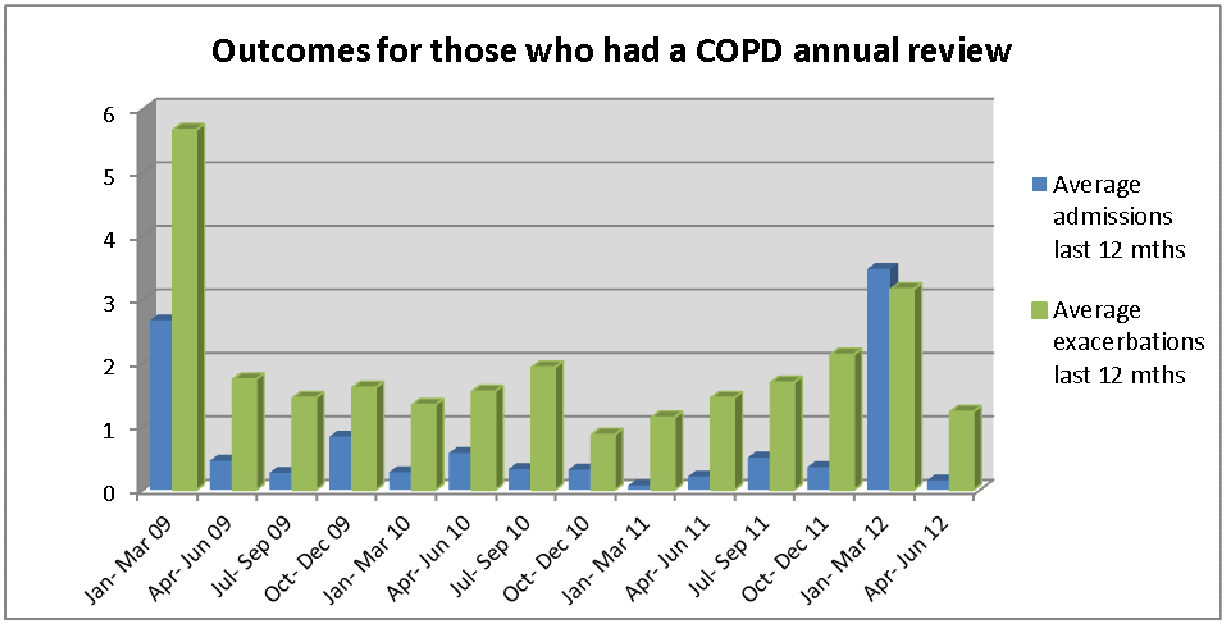
On target: Yes

1. Outcomes/Outputs

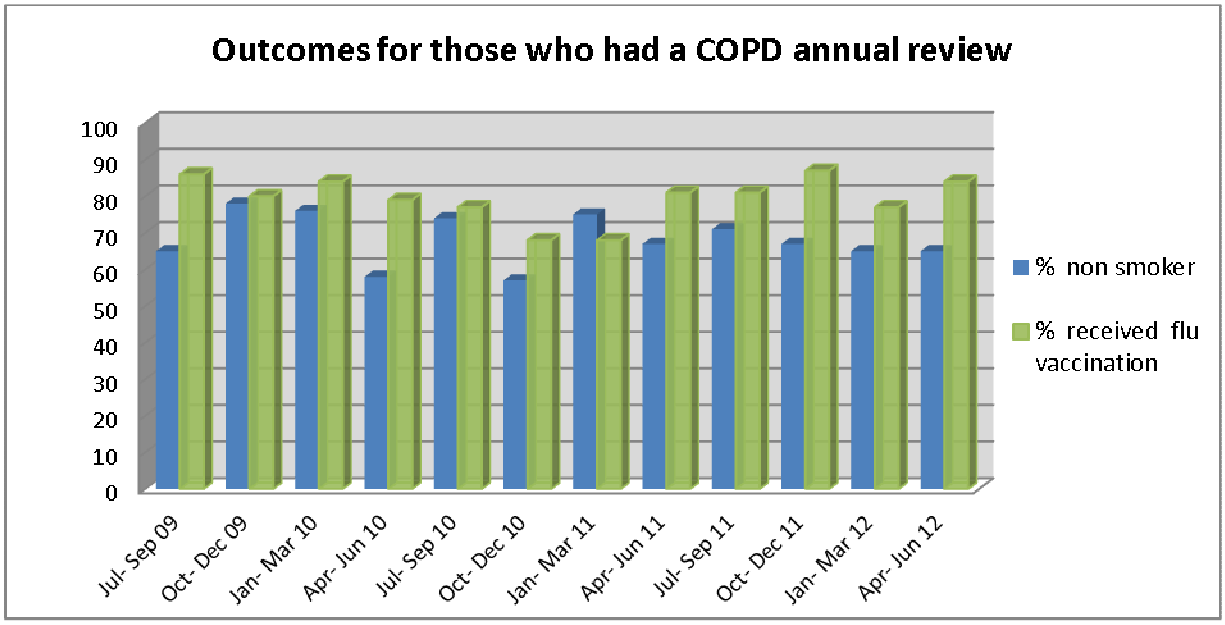
People identified with COPD have an annual review of their condition as part of the Long Term Conditions management programme.



5% of reviews conducted YTD have been for Maori. For comparison Maori make up 5.2% of the enrolment population aged 45+ years – the prime age group of people in the Long Term Conditions programme.



The average exacerbations and admissions have decreased to an acceptable number this quarter.



With the commencement of the seasonal influenza campaign there has been the expected increase in patients with COPD getting their influenza vaccine this quarter

2. Key Activities

- Nurse led COPD clinics at practices;
- Promotion of influenza vaccine throughout March for patients with COPD

3. Networking/Education (either with Health Sector or Community)

- HEHA and Smokefree Service Development Manager for promotion of the Warm Up West Coast Project;
- practices and pharmacies;
- respiratory nurse specialists;
- 1 nurse attended the 2-day spirometry course held in Christchurch the 29th and 30th June 2012;
- next refresher (1 day) spirometry course will be held in August 2012;
- Heart Respiratory Team (HRT) meeting 14th June 2012.

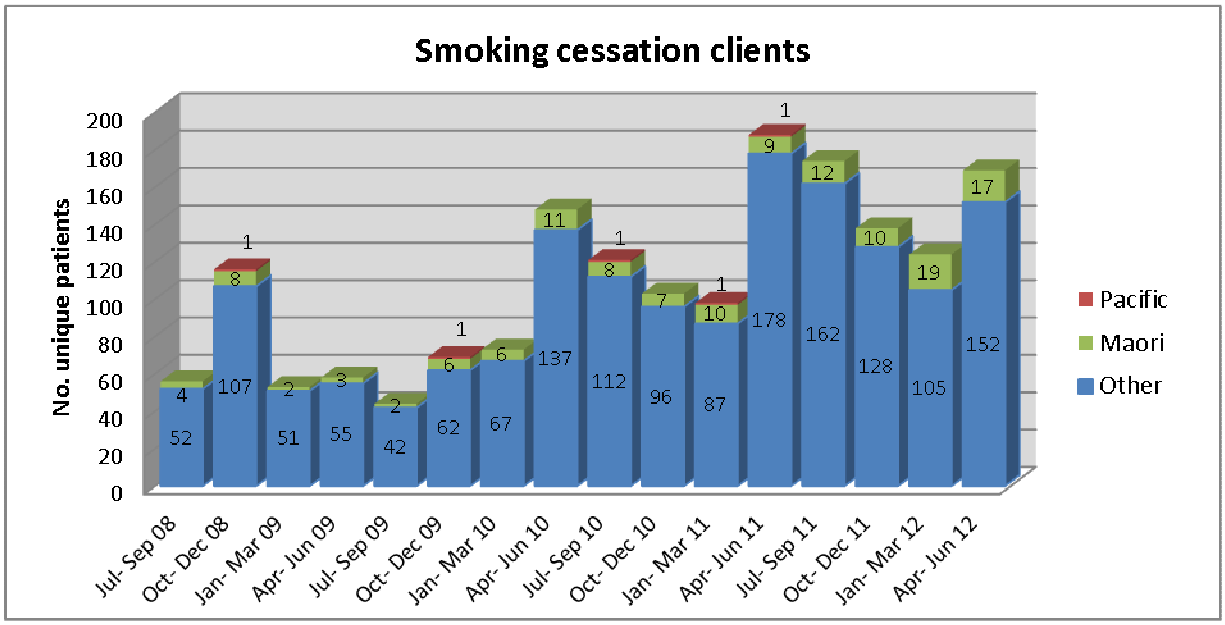
4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

5.6. Smoking cessation

On target: Yes, we have exceeded the year's funded 250 places on the programme with 605 in total.

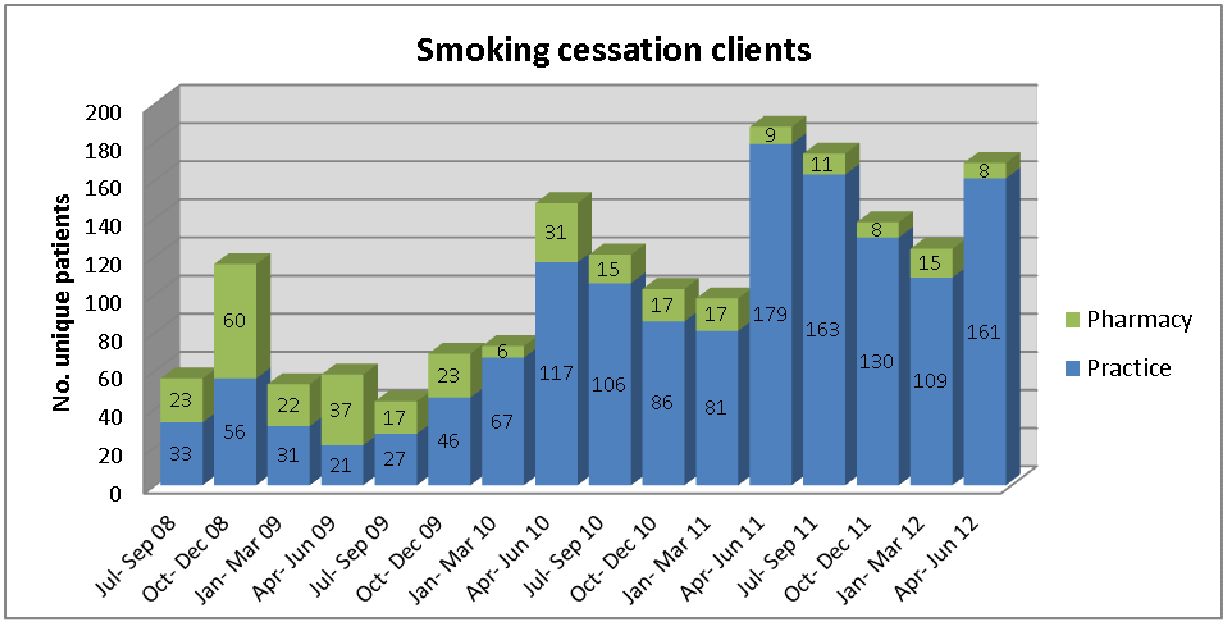
1. Outcomes/Outputs

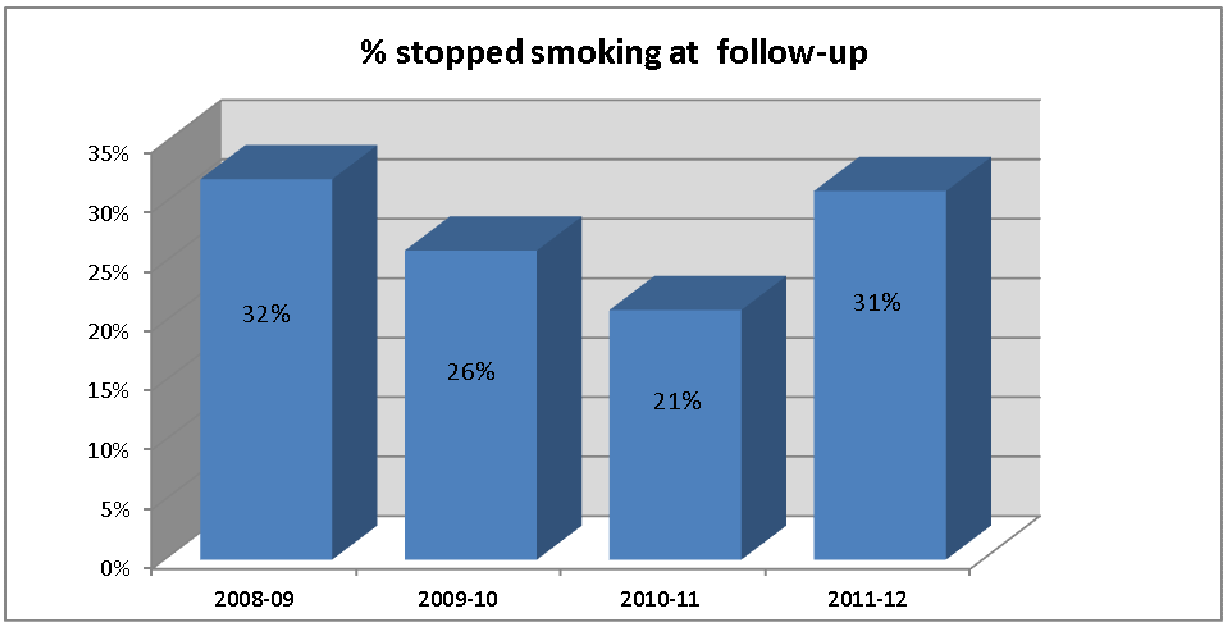


As anticipated there was an increase in enrolments to the programme this quarter, the number of people attempting to become smokefree is very pleasing.

NB. Enrolments reflected in this graph are only to the PHO Coast Quit Smoking Cessation programme (i.e., Maori who enrol in the kaupapa Maori smoking cessation programme, Aukati Kaipaipa, run by Community & Public Health, are not included in these numbers).

Nevertheless, Maori enrolments made up 10% of all enrolments in the Coast Quit programme this quarter.





Quit rates of 31% after 3 months of enrolling in the Coast Quit Programme are very encouraging to date. In March 2011 the ministry recommended standard measurement of outcomes of smoking cessation service in New Zealand. The minimum standard asks for measuring at 4 weeks following Target Quit Date (TQD) and then again at 3 months after TQD. Prior to the current YTD our quit rates were calculated at 6 months following TQD, and current YTD rates are now reported at 3 months for the latest quarter, thus the results in different time periods are not directly comparable. All follow-up calls are now being made at 3 months from TQD.

2. Key Activities

The key activity this quarter was the promotion of Smokefree May across the whole of the West Coast.

Primary Care:

- road-show to promote the ABC model with visits to: Reefton Medical and Greymouth Medical Centres this quarter;
- follow-up phone calls are now consistently being made at 3 months following TQD in the Coast Quit programme;
- NRT supply to practices and pharmacies;
- on-going practice support with Medtech coding for PHO Performance Programme smoking indicators;
- ABC presentation to Community Mental Health team, District Nursing Service and Plunket;
- participation in monthly Ministry led teleconferences regarding primary health targets;
- distribution of new pamphlet for all cessation options.

Secondary Care:

- meetings with several clinical nurse managers, Greymouth and Westport regarding ABC targets, and on-going liaison with ward champions;
- fortnightly meetings with HEHA and Smokefree Services Manager;
- liaison with DHB smoking cessation providers;
- liaison with Family Advisor and Consumer Advisor, Mental Health;
- meeting with senior staff to promote attendance at mandatory ABC training;
- ABC presentations to Barclay, McBrearty, Occupational Therapy staff, and heart respiratory nurse specialists;
- obtaining "no smoking" signage for Grey Base Hospital, and work on DHB smokefree policies;
- participation in monthly Ministry led teleconferences regarding secondary health targets;

3. **Networking/Education** (either with Health Sector or Community)

- West Coast Tobacco-Free Coalition (WCTFC) meetings (3) and liaison with health promotion advisors at C&PH and cancer society;
- meetings (2) with WCTFC mental health sub-group
- preparation and co-delivery of oral submissions from WCTFC to the Grey and Westland District Council's long term plans;
- preparation of submission from WCTFC to parliamentary committee on tobacco excise increase;
- preparation of article for "Ask a Professional" column;
- steering group meetings for Buller REAP Youth Project;
- support and clinical supervision for new Aukati Kai Paipa provider (C&PH);
- Cessation Practitioner Training (Heart Foundation), stage 3 facilitated by Dr Mark Wallace-Bell;
- introduction to Motivational Interviewing training held;
- planning for Quit Card Provider and Motivational Interviewing training for August 2012;
- meeting with Greymouth WINZ manager;
- liaison meeting with PACT and contact with Family Focus;
- organised Dr Prudence Stone's presentation (Smokefree NZ by 2025) held in April 2012.

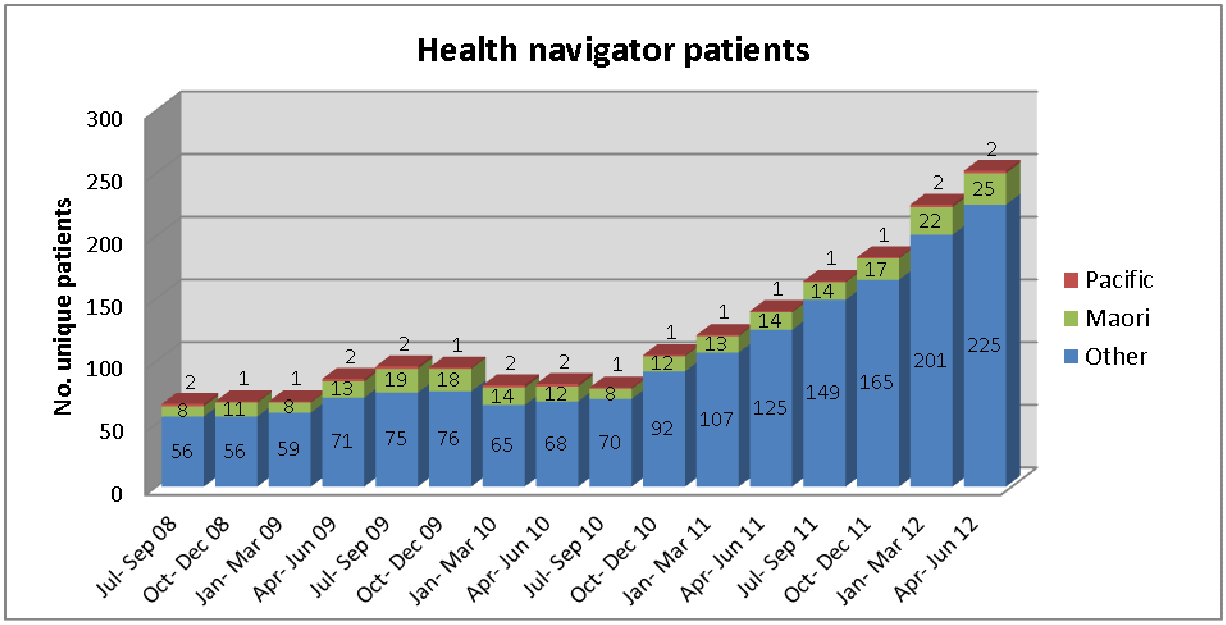
4. **Issues and Risks**

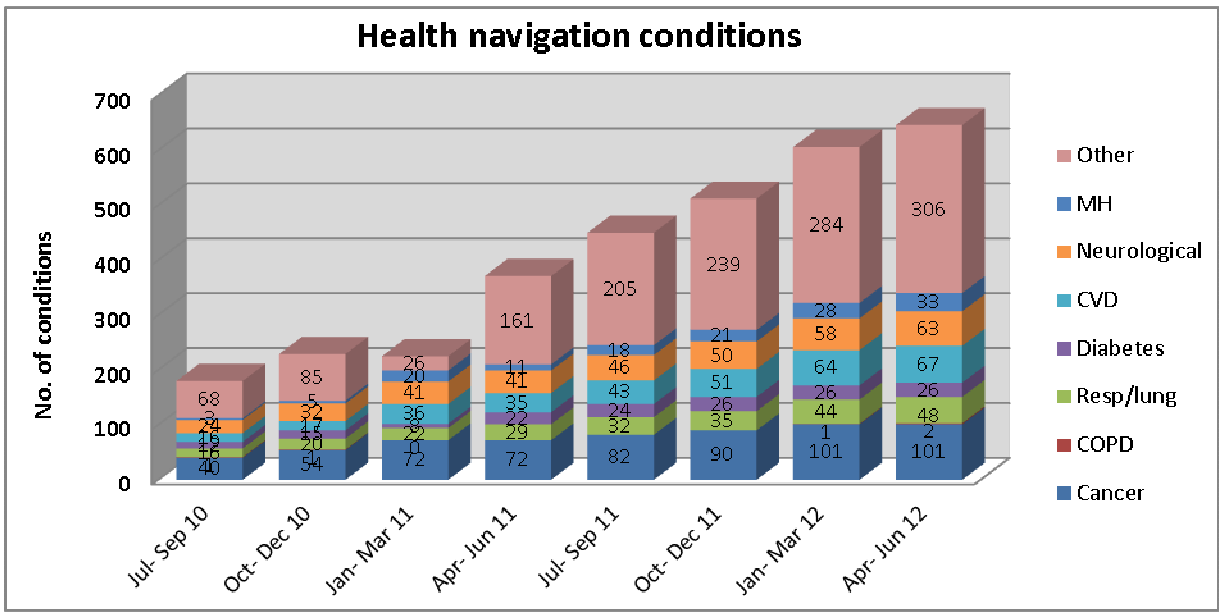
Issues/Risks	**Mitigation/Resolution**
• The funded 250 places for the smoking cessation programme is inadequate for the number of enrolments (double).	• Discussions with Smokefree Services Manager at DHB.

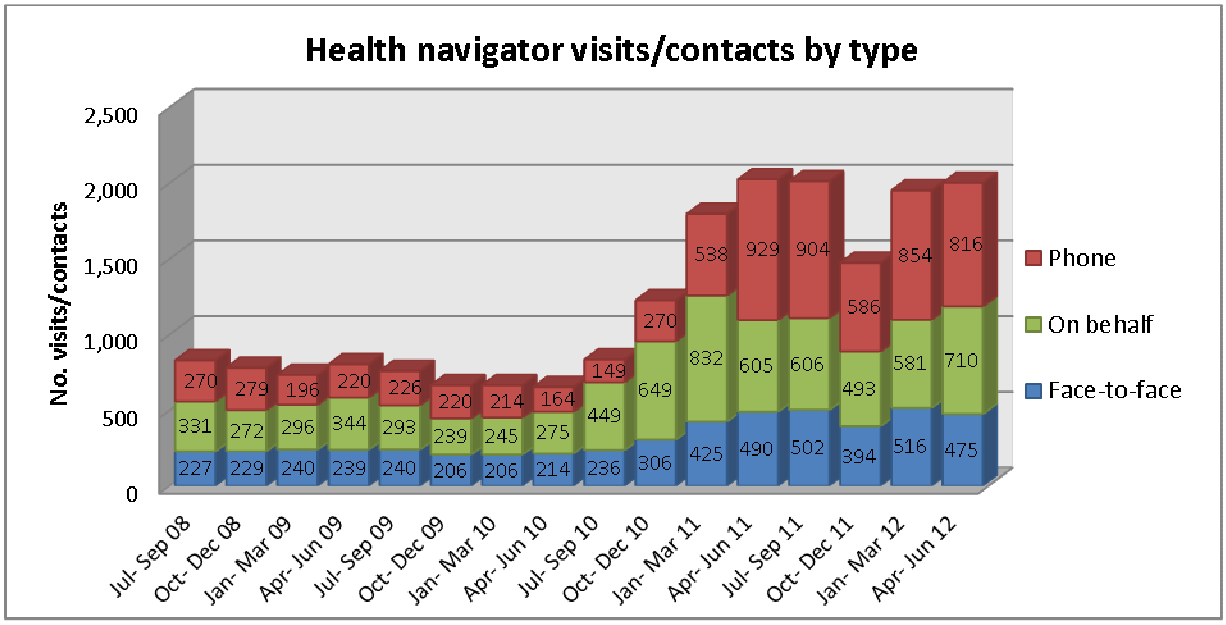
5.7. Health navigator service

On target: Yes, tracking as expected.

1. Outcomes/Outputs







The number of individual patients again this quarter has increased showing a continued growth trend in demand for the service.

2. Key Activities

- provide additional support for LTC patients and their whanau with complex social needs;
- improve access to health care for these patients;
- support the Medical Centres and Rural Clinics in caring for these patients;
- improve access to social support services for these patients;
- improve health outcomes;
- enhance patient health literacy and ability to self-care;
- decrease unplanned ED visits and hospital admissions.

3. Networking/Education (either with Health Sector or Community)

- Age Concern education;
- Cancer Society's volunteer meeting;
- Older persons expo Buller;
- Partners in Care, consumers and clinicians co-designing services, Health Quality and Safety Commission NZ, Consumers Council;
- Te Tohu Pokaitahi Hauora Maori –Te Whare Wananga O Awanuiarangi –Mauri Ora, Open Wanganga;
- Southern Cancer Network meeting Christchurch.

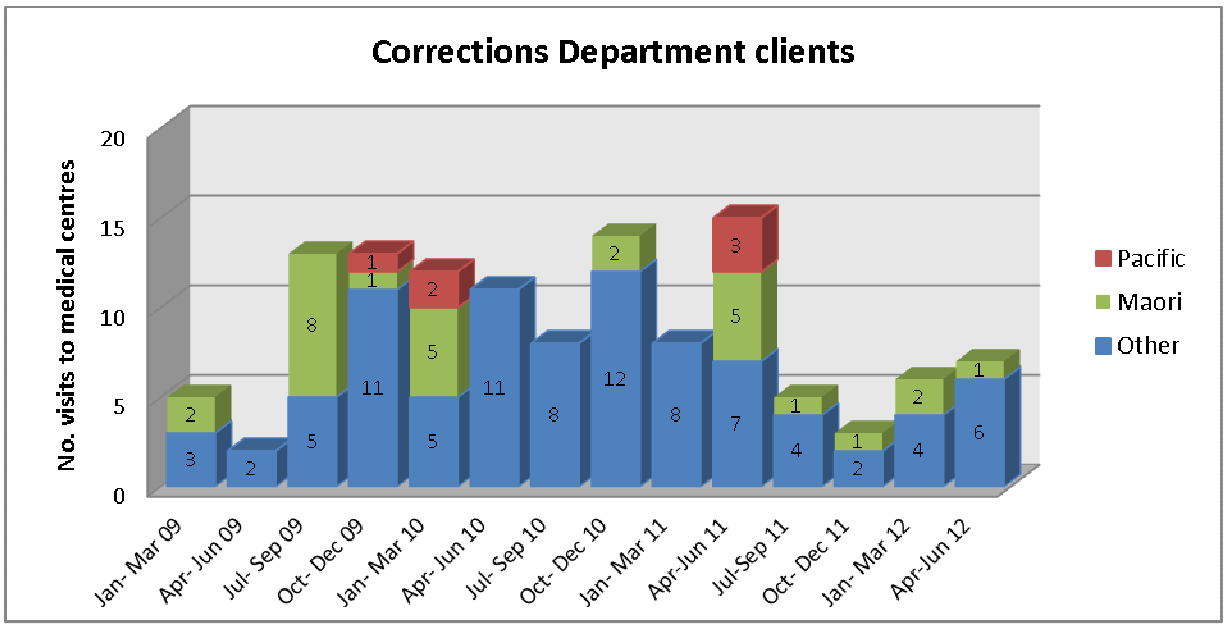
4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• Increasing utilisation in service with no increase in FTE.	• On-going monitoring case load per team member.

5.8. Health checks for clients of the Corrections Department

On target: Yes

1. **Outcomes/Outputs**



Activity this quarter has increased slightly for the corrections programme. 14% of the visits this quarter were for Maori.

2. **Key Activities**
   - Vouchers are issued by community probation service (CPS) staff to clients requiring free general practice services.

3. **Networking/Education** (either with Health Sector or Community)
   - Corrections Department;
   - practices;
   - pharmacies.

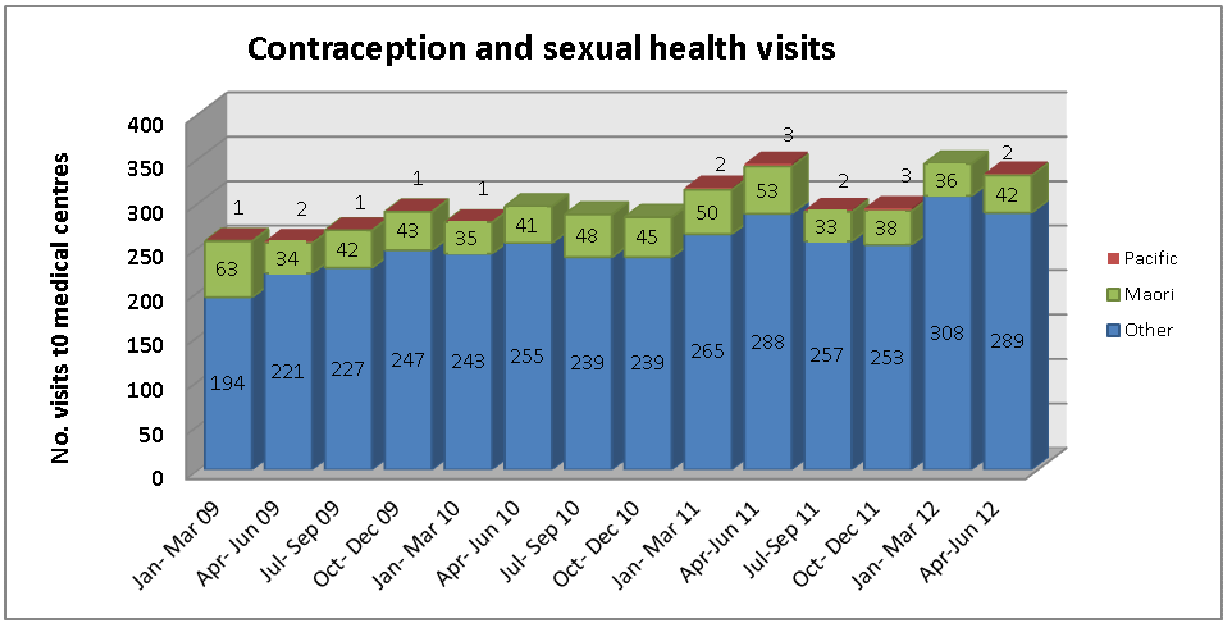
4. **Issues and Risks**

Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

5.9. Contraception & sexual health visits

On target: Yes

1. Outcomes/Outputs



13% of all visits made to practices for contraceptive and sexual health consults were for Maori. For comparison, Maori make up 14.8% of the 15-24 year age band likely to be the principal users of this programme.

2. Key Activities

- pharmacy claims: 26 ECP; 68 script fees;
- 3 Jadelle contraception.

3. Networking/Education (either with Health Sector or Community)

- practice teams;
- pharmacies;
- PHO Clinical Governance Committee.

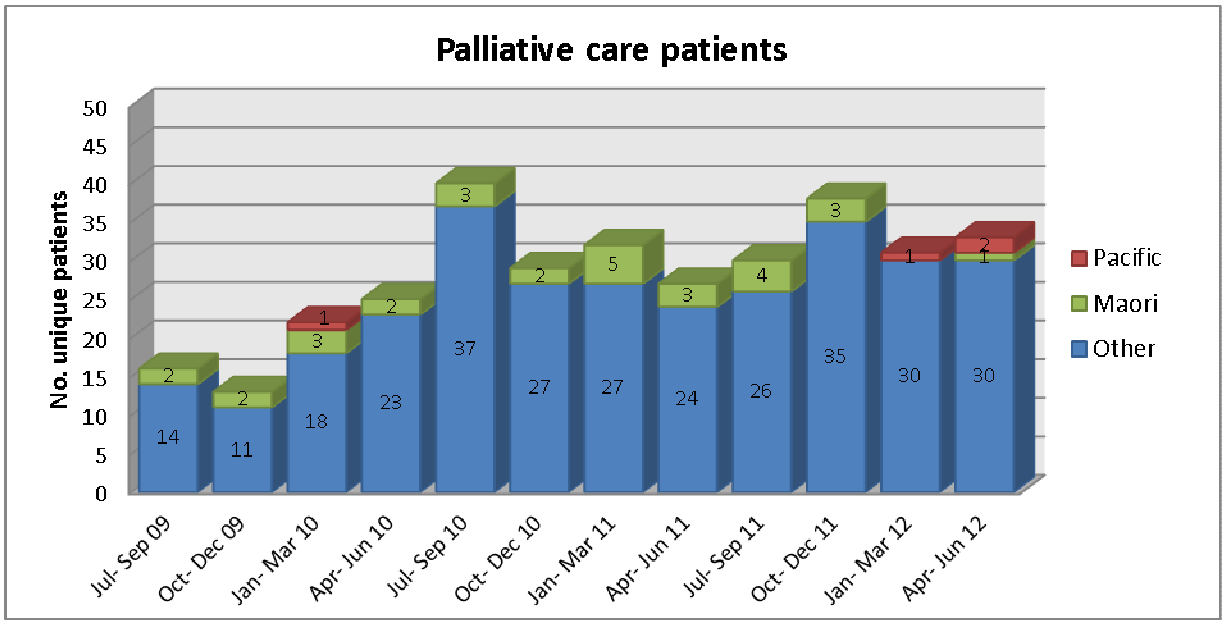
4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

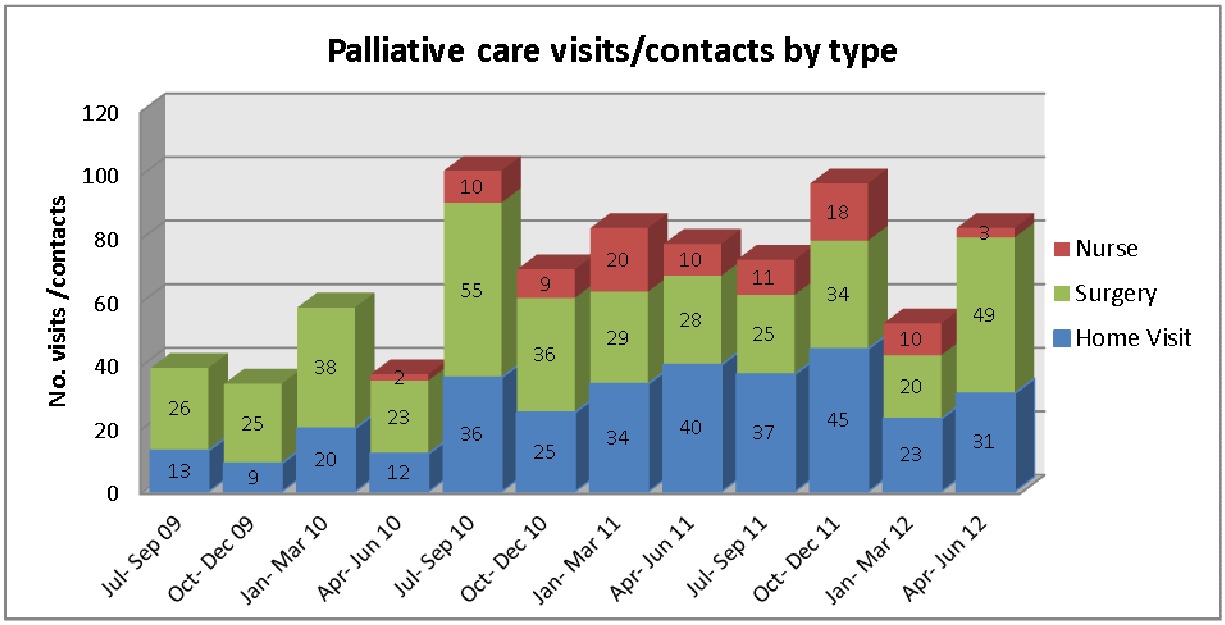
5.10. Palliative care

On target: Yes

1. Outcomes/Outputs



The number of individual patients is tracking around the same number as the same quarter last year.



The claiming for the nurse virtual visits continues to be well utilised and appreciated.

2. **Key Activities**
   - Relieve any potential financial barriers for patients and their whanau in the terminal stage of their illness.
   - To reimburse general practitioners for home visits and surgery consultation for palliative care patients.

3. **Networking/Education** (either with Health Sector or Community)
   Hospice New Zealand Rest Home Care Givers courses run by Dee Dolby continues.

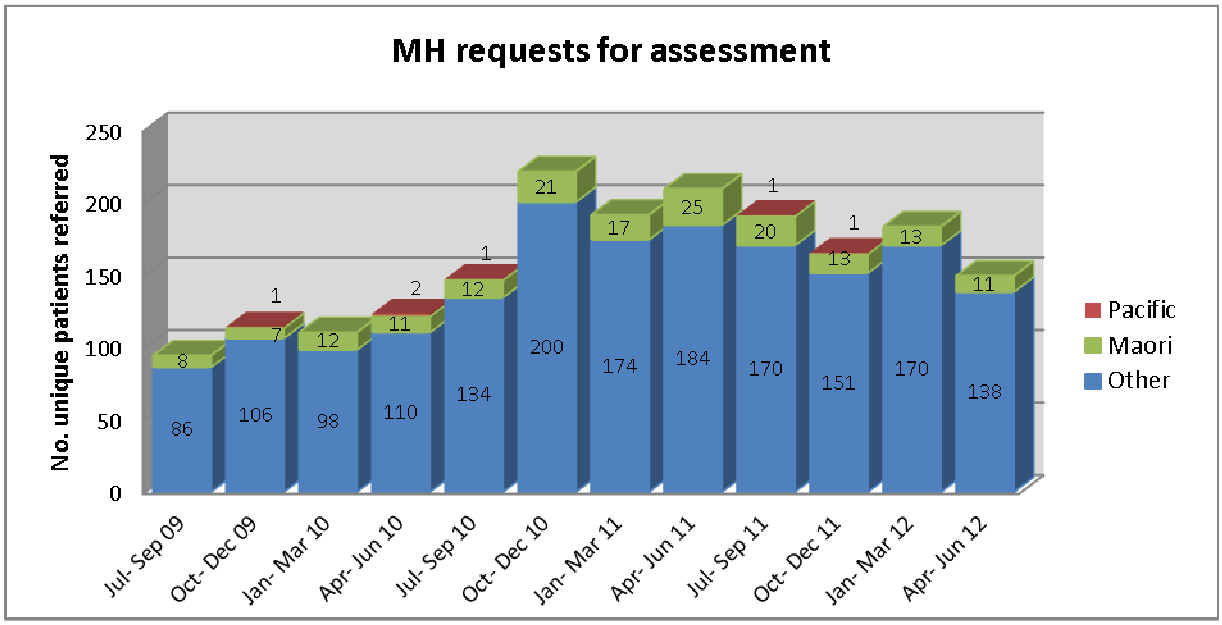
4. **Issues and Risks**

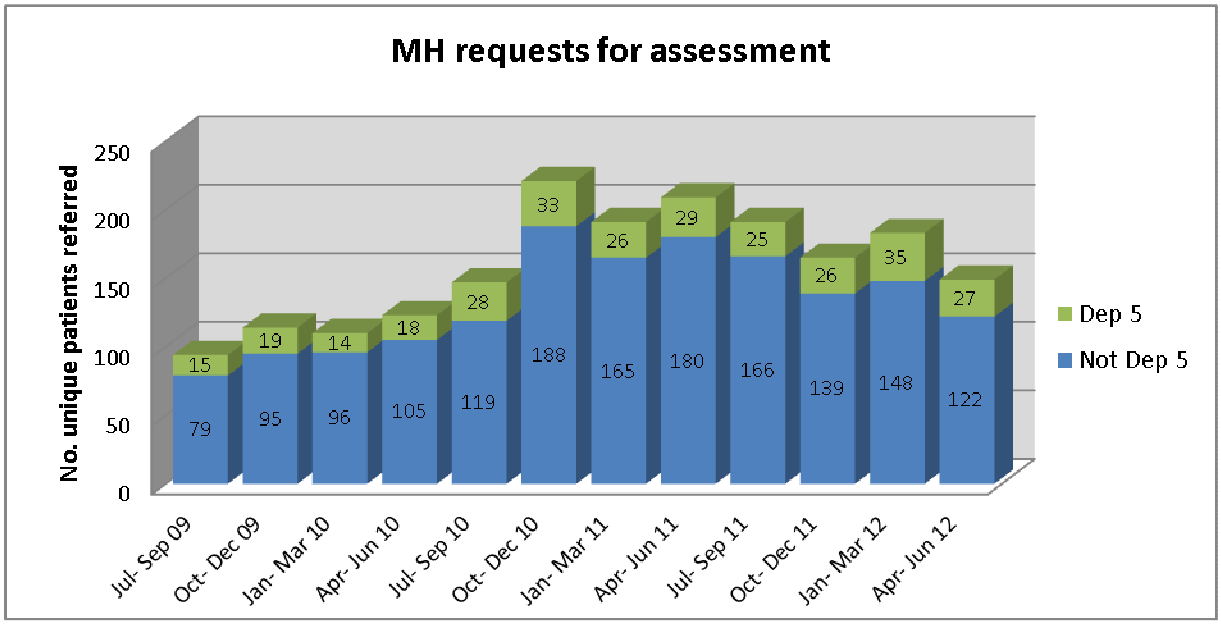
Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

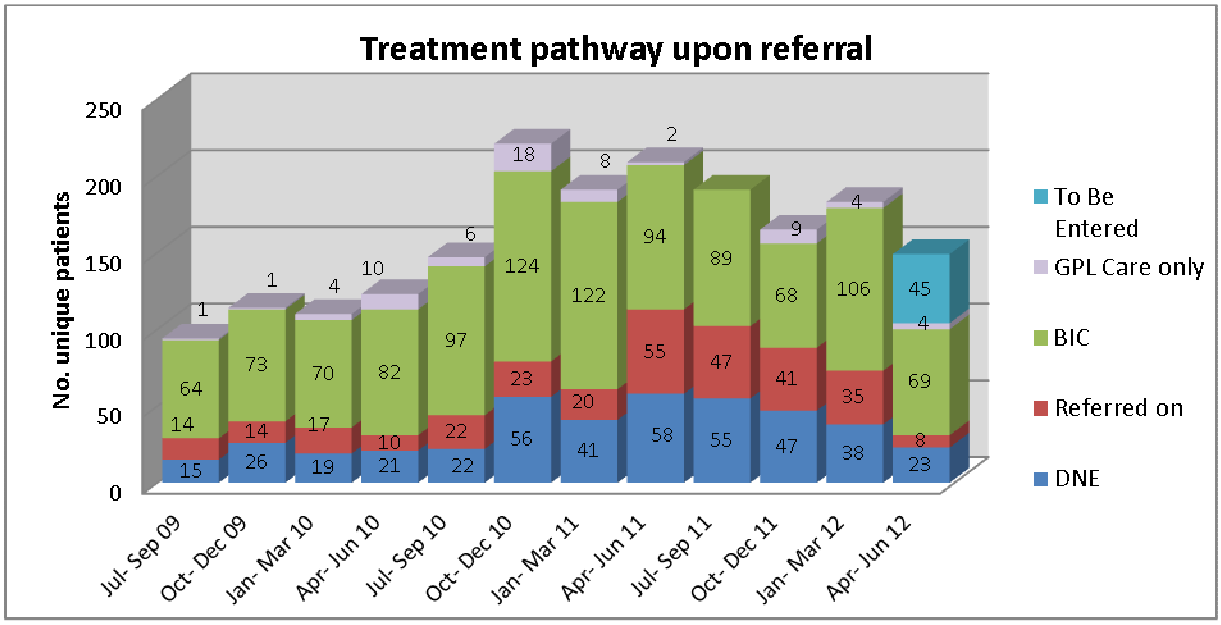
5.11. Mental Health services

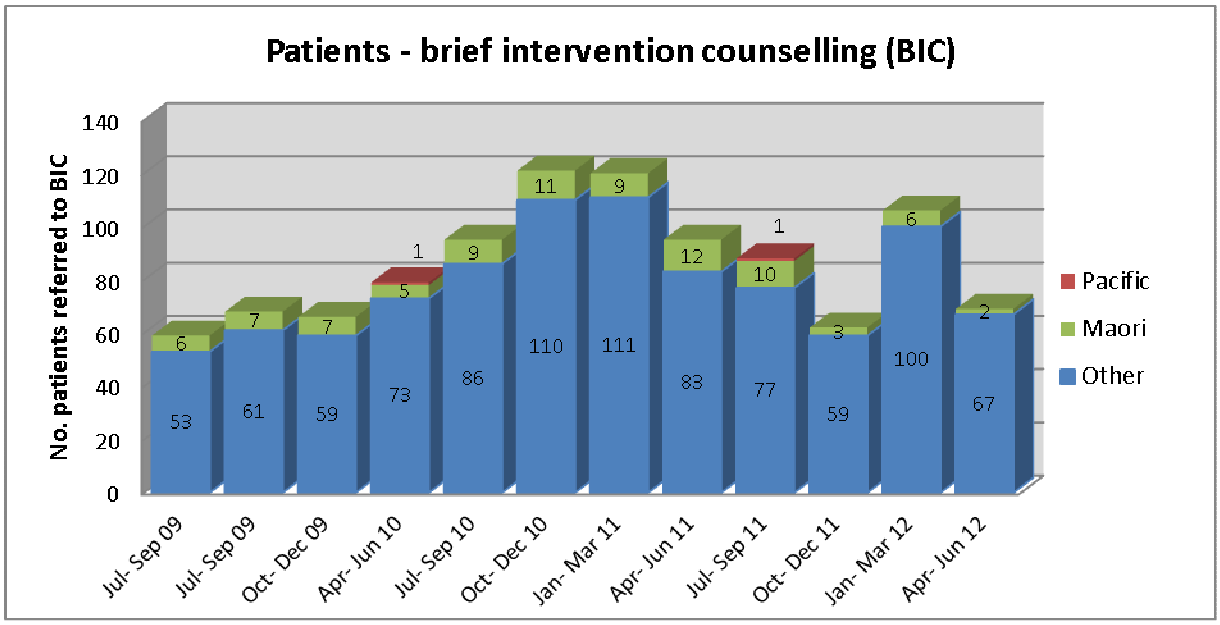
On target: *Yes*

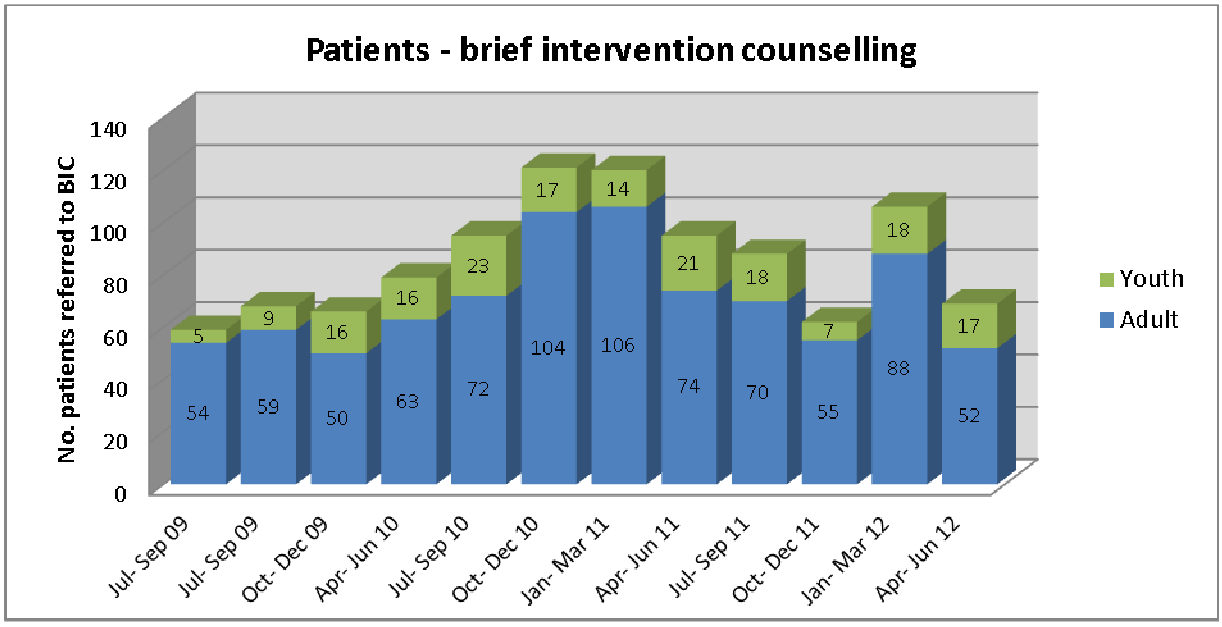
1. Outcomes/Outputs

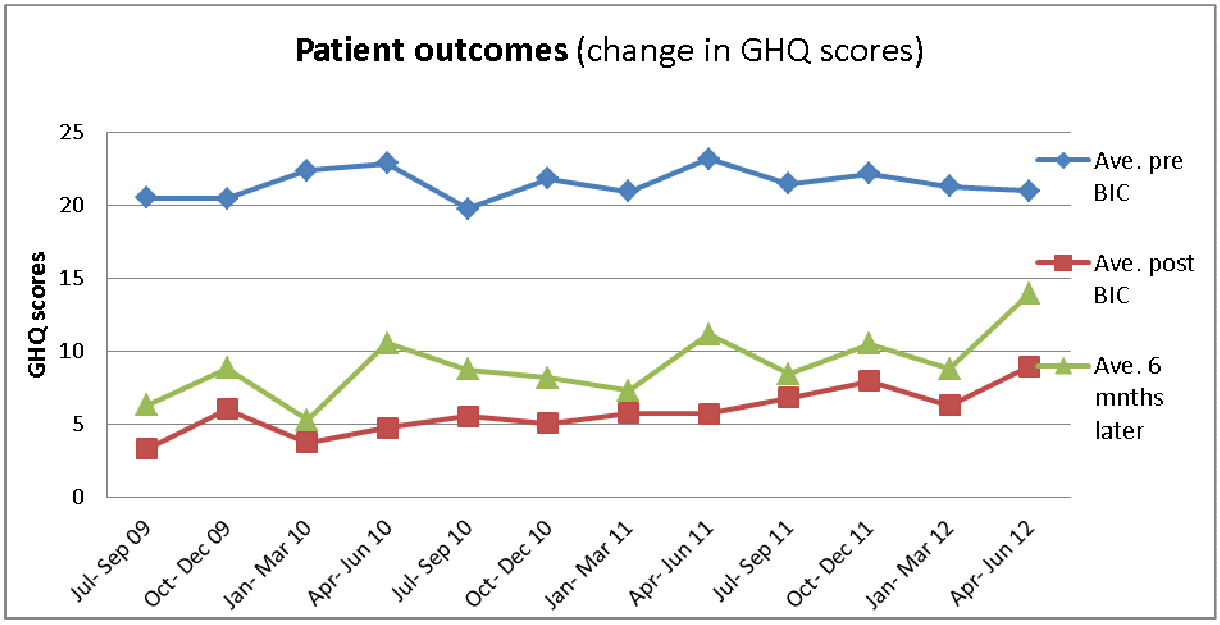





Treatment pathway upon referral
No. unique patients
250
200
150
100
50
0
Jul- Sep 09
Oct- Dec 09
Jan- Mar 10
Apr- Jun 10
Jul- Sep 10
Oct- Dec 10
Jan- Mar 11
Apr- Jun 11
Jul- Sep 11
Oct- Dec 11
Jan- Mar 12
Apr- Jun 12
1
64
14
15
1
73
14
26
4
70
17
19
10
82
10
21
6
97
22
22
18
124
23
56
8
122
20
41
2
94
55
58
89
47
55
9
68
41
47
4
106
35
38
45
4
69
8
23
To Be Entered
GPL Care only
BIC
Referred on
DNE


Patients - brief intervention counselling (BIC)
No. patients referred to BIC
140
120
100
80
60
40
20
0
Jul- Sep 09
Jul- Sep 09
Oct- Dec 09
Apr- Jun 10
Jul- Sep 10
Oct- Dec 10
Jan- Mar 11
Apr- Jun 11
Jul- Sep 11
Oct- Dec 11
Jan- Mar 12
Apr- Jun 12
6
53
7
61
7
59
1
5
73
9
86
11
110
9
111
12
83
1
10
77
3
59
6
100
2
67
Pacific
Maori
Other





The outcomes data indicate that significant changes were made to levels of psychological distress and that these were maintained over time (as measured at six months follow-up after the last counselling session).

2. Key Activities

- There were 149 new requests processed this quarter, with approximately two thirds being for females and one third for males.
- The number of people entering Brief Intervention Counselling this quarter was 69 with 17 of these being young people aged 14-17 years. Counselling sessions continue to number up to six for adults and more, if needed, for young people.
- Patients from all practices of the West Coast are seen in their local areas. A full-time psychologist resident in Westport sees patients at Buller Medical Centre as well as travelling regularly to Karamea. A clinical psychologist resident in Franz Josef sees South Westland patients in the clinics there. The rest of the team, a social worker, a Liaison Nurse and two psychologists, are resident and provide services in Greymouth and Hokitika. This has reduced much of the travel that occurred in the past.
- On-going support is still being provided for a student who is counselling selected patients at Westland Medical Centre.
- Extended Consultation numbers are still high and the practices are not happy with the message that they need to halve the numbers to fit the available funding.

3. Networking/Education (either with Health Sector or Community)

- The GP Liaison Nurse continues to hold regular weekly meetings with secondary mental health (Tact, Community Mental Health in Buller, Grey and Westland, CAMHS) to further collaboration and triage people to the most appropriate service.
- Regular weekly liaison meetings are also held with primary health practitioners in the general practices and feedback from the practices indicate that this is very beneficial for them and their patients.
- Attendance at NGO and other relevant forums as well as Buller IFHC meetings, Grey district meetings regarding future of mental health on the West Coast, ALT meetings, etc.
- Involved in planning a forum for South Island primary mental health practitioners to be held in Christchurch in July 2012.
- Team members have accessed training opportunities and all have regular supervision with external providers.

4. Issues and Risks

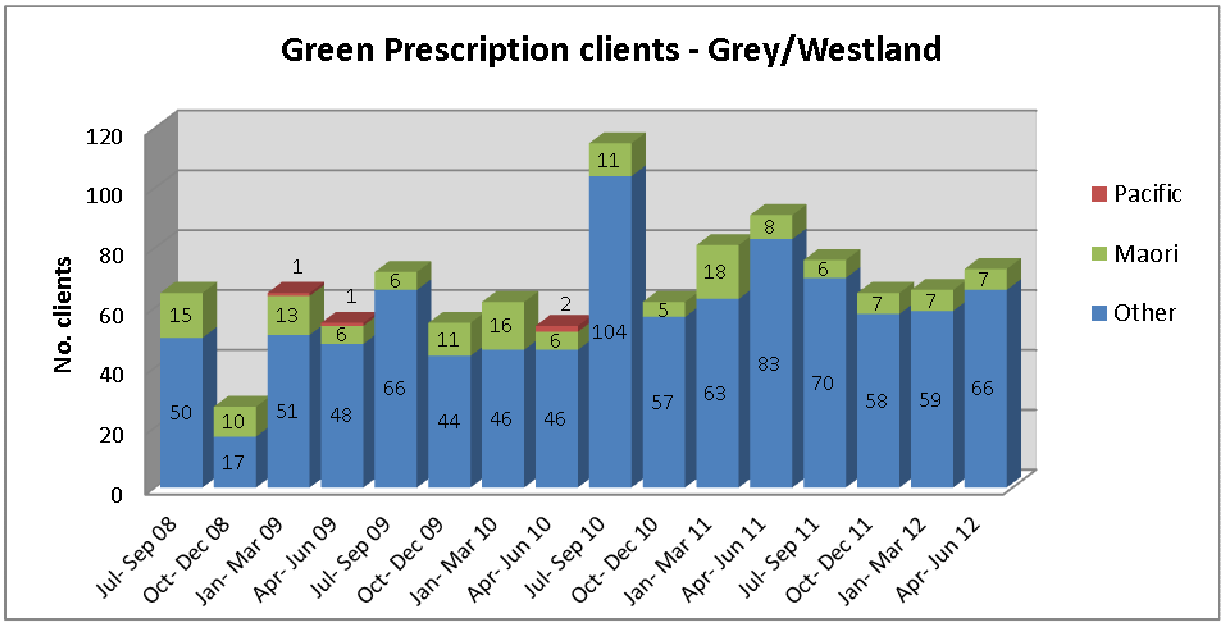
Issues/Risks	Mitigation/Resolution
• Numbers of Extended Consultations for Mental Health issues exceed funding available.	• Decide on best option e.g. halve amount that can be claimed so numbers remain steady.

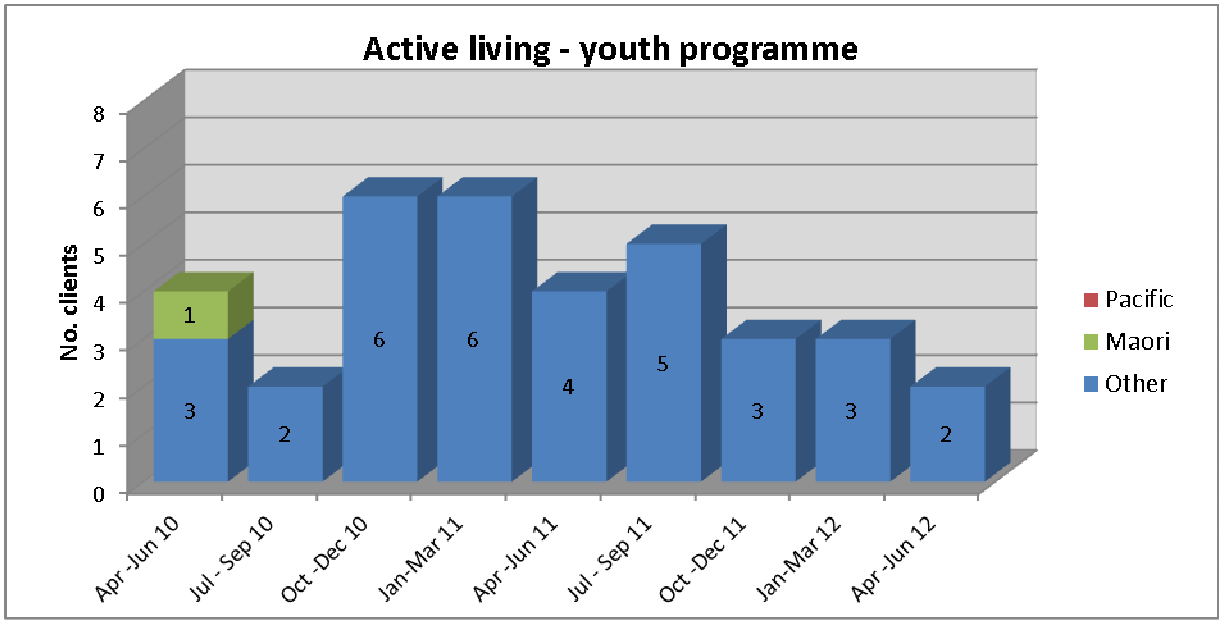
6. Keeping People Healthy

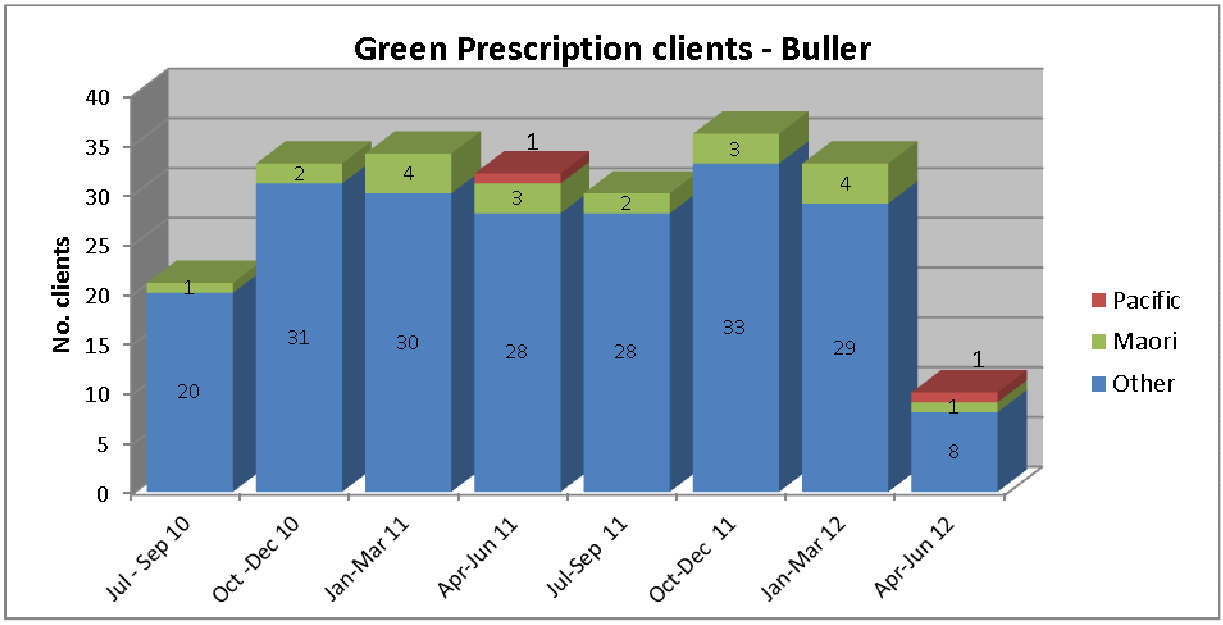
6.1. Green Prescription (GRx)

On target: *Yes*

1. Outcomes/Outputs







2. Key Activities

- continuation of 'Active YOU' programme in Reefton every Thursday;
- Active Youth Programme held Tuesday and Thursday afternoons after school. This programme will be finishing at the end of July 2012 due to discontinuation of HEHA funding, all participants and referrers notified;
- PHO gym every Tuesday afternoon, Wednesday and Friday mornings;
- Green Rx gym sessions held Tuesday mornings in Hokitika;
- initial consults held in Greymouth on Monday mornings and Hokitika on a Tuesday;
- two respiratory groups every Friday (10 week programmes) plus new gym sessions;
- Hari Hari visit for initial consults and follow-ups;
- managing and contacting all new referrals for Buller until new programme begins.

Buller:

- from April 27th 2012 Green Rx in Buller has been on hold until a replacement is employed following the recent resignation of the Health Promotion coordinator who was running this programme;
- clinics held every Monday until the end of April;
- all referrers and clients currently in the programme contacted re: programme on hold until replacement found;
- negotiations under way in Buller to have a contractor deliver the physical activity programme.

3. Networking/Education (either with Health Sector or Community)

- monthly Green Prescription newsletter;
- weekly team meetings and supervision;
- Canterbury West Coast Sports Trust Physical Activity Manager;
- orientation of RNS from Haast to Green Rx programme;
- Buller Medical Centre;
- HEHA and Smokefree Services Manager.

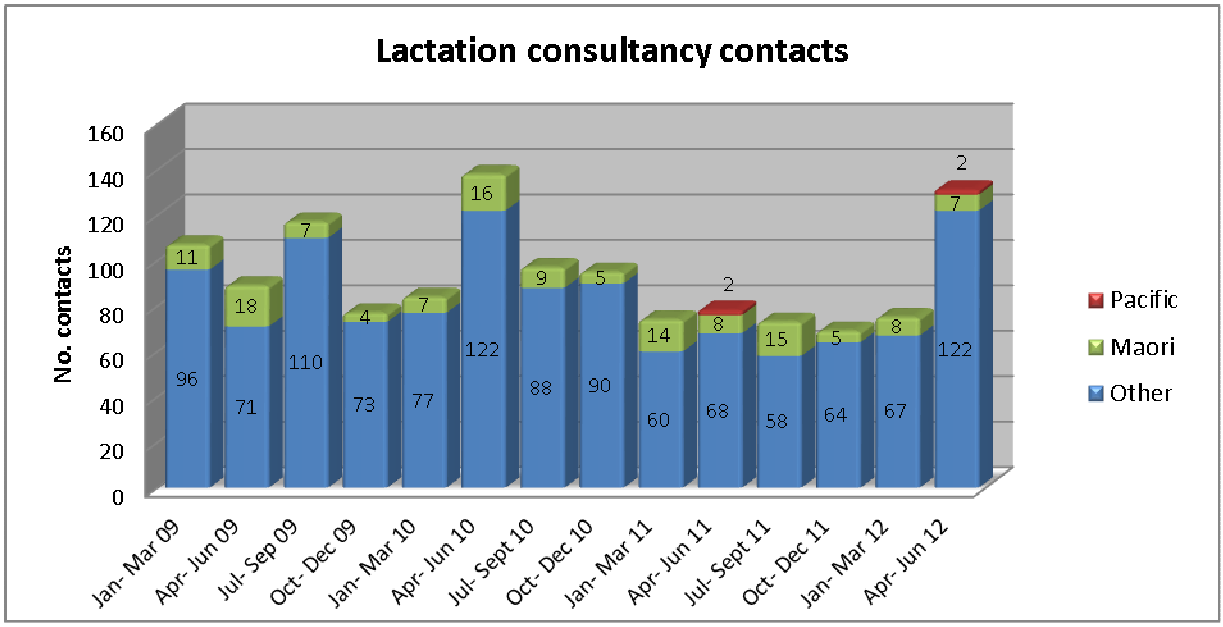
4. Issues and Risks

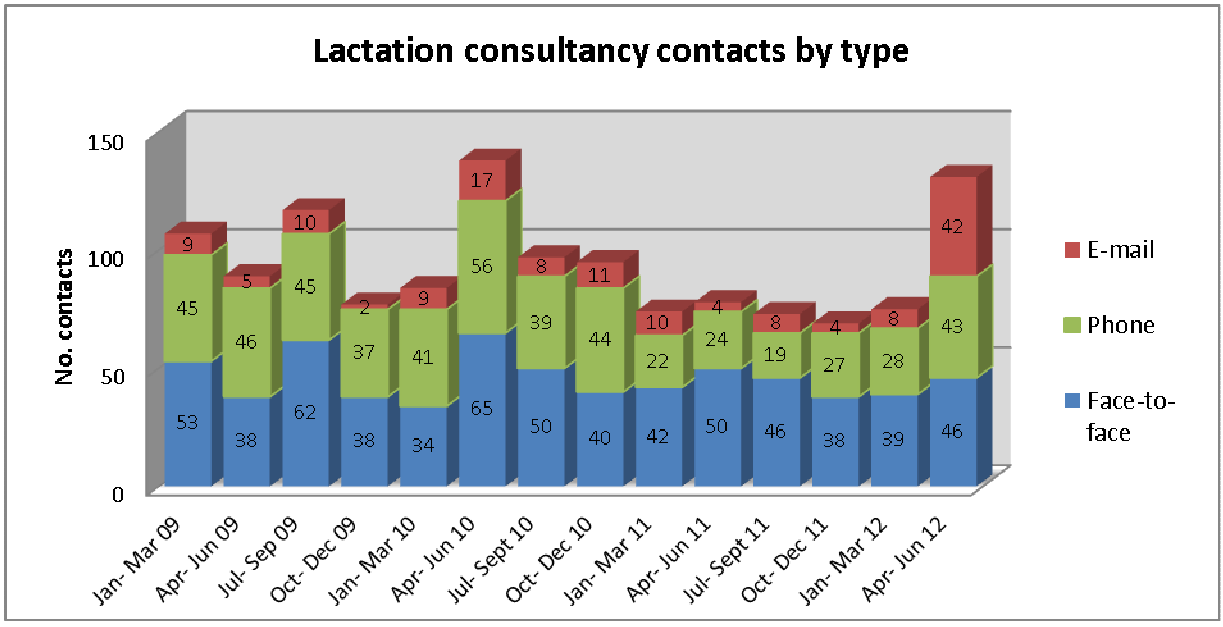
Issues/Risks	Mitigation/Resolution
• Current people in Buller Green Rx programme have been on hold and no new referrals have commenced programme until new facilitator starts.	• Contract negotiations under way for programme facilitator based in Buller to commence mid July 2012.

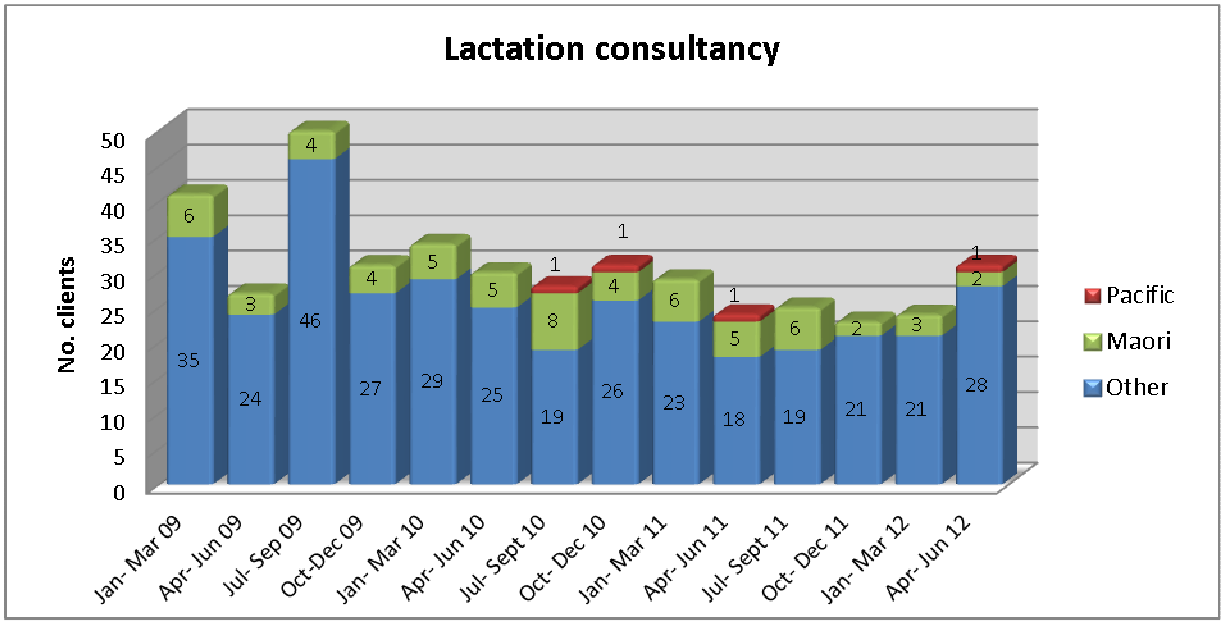
6.2. Breastfeeding Support

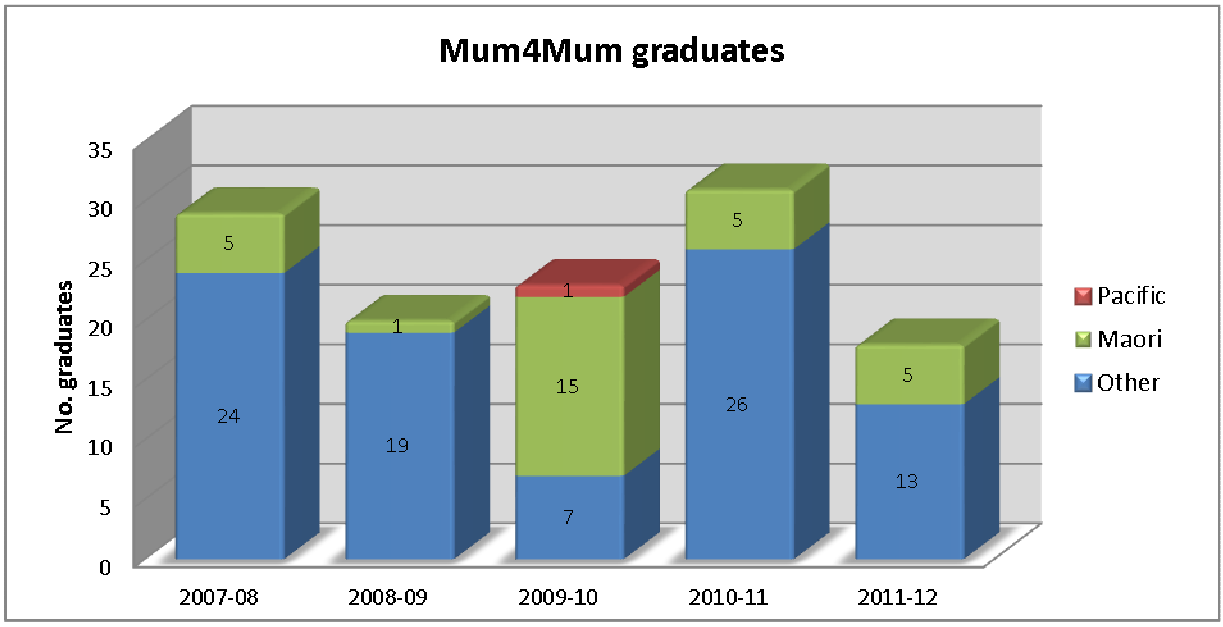
On target: Yes

1. Outcomes/Outputs









2. Key Activities

Lactation consultancy:

- of the 31 new and returned clients, 14 were Deprivation 8-10, 14 rural; 3 were under 20 years of age and 0 were ante-natal women;
- this quarter there were 131 contacts in total; including 7 Maori, 2 Pacific and 122 Other ethnicity. Contacts were in homes, maternity ward, phone, facebook, email, and approximately 39 text messages about breastfeeding related issues;
- referrals were from women themselves, their Well-Child provider, Midwives, Family Start, General Practice Teams and Mum4Mums;
- referrals were made to GPs, midwives, Mum4Mum breastfeeding supporters and age appropriate immunisations and Well Child Checks;

- all clients informed of breastfeeding groups, Mum4Mum supporters, age appropriate immunisations and Well Child Checks.

Peer Counselling:

- 18 new Mum4Mums graduated this quarter on the West Coast: 7 in Greymouth and 11 in Westport;
- Mum4Mums continue to support many women informally. This support is by example of breastfeeding their own babies as well as through conversations and sharing of information with other women they have contact with.
- Mum4Mums reported providing at least 18 women with breastfeeding support with 7 of these being formal referrals from the breastfeeding advocates;
- Mum4Mums have a presence at ante-natal classes and Babes-in-arms breastfeeding support and Plunket support groups, while some facilitate these groups. In Greymouth and Hokitika Mum4Mums have begun hosting BABES-in-Arms with support from Nicola Harris and Anna McInroe, while in Westport a Mum4Mum hosts the BABES-in-Arms group with support from Raewyn Johnson;
- continuing education Mum4Mum meetings in Greymouth (1), Granity (1), Westport (3), and Reefton (1);
- two newsletters to Mum4Mums.

3. **Networking/Education** (either with Health Sector or Community)
   - Greymouth Breastfeeding Advocate now spends 4 hours per week at the Maternity ward in Greymouth to gain clinical hours to go towards her LC training, this has now formally been approved by the IBLC board;
   - two ante-natal breastfeeding classes held this quarter, one each in Greymouth and Westport;
   - on-going contact with others in maternity and well child work, including midwives, Plunket, Rata Te Awhina, childbirth educators, Family Start and Practice Nurses;
   - Raewyn Johnson, in her role as Lactation Consultant acts specifically as a resource person for midwives Coast-wide;
   - attendance at Child and Youth meeting at DHB;
   - liaison with 'Nurturing the Future Hub' regarding breastfeeding support groups;
   - contact with Parents Centre and Kids'n'Coffee group;
   - work continues on the 'West Coast Breastfeeding Handbook' which is expected to be released at the beginning of world breastfeeding week (1-7 August 2012);
   - liaison with 'under 5s' group through Work & Income, including Homebuilders, Early Childhood Educators, CYFS and Infant Mental Health workers;
   - planning for World Breastfeeding week and the Big Latch On in August;
   - the Mum4Mum Facebook page continues to have regular viewers;
   - Nicola Harris completed the 2012 Gold Conference – an online breastfeeding and lactation education conference. This provided 23 hours towards the 90 hours of required education for her LC exams.

4. **Issues and Risks**

Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

6.3. Health Promotion Integration

On target: Yes

1. Outcomes/Outputs

- seven new referrals for Green Prescription in Buller, 1 Maori and 6 Other ethnicity. This programme is on hold until the recruitment of another health promoter has been done.
- 51 over 65s had a free influenza vaccination at the adult expo in Buller;
- 14 high needs men attended a men's health clinic at High Street Medical Centre;
- 80 fully immunised West Coast Children feature on a new immunisation poster.

2. Key Activities

- The focus for April was Immunisations – childhood and influenza. A West Coast themed childhood immunisation poster was created, 4 different posters featuring 80 West Coast children was distributed throughout May 2012.
- A 65+ flu vaccination clinic and older adult expo was held in Westport on 16/04/12 with 21 stalls from local groups displaying their services as well as 51 over 65s getting their free seasonal flu vaccination.
- Throughout May, in conjunction with Community & Public Health, the Cancer Society and the West Coast Smokefree Coalition, there was extensive promotion in practices, pharmacies, community and local media for Smokefree May that covered all 3 districts;
- High Street Medical Centre held a very successful Men's Health Cardiovascular Risk Clinic on 15/05/12 from 5 to 8pm, with 14 men attending, 64% of these were of Maori, Pacific or Indian decent.
- Smoking cessation: continuation of NRT supplies and ordering to practices and pharmacies.
- June was the month for promotion on Men's Health and in conjunction with the Cancer Society saw the launch of the 'Get the Tools' The Nuts and Bolts of Men's Health website.

3. Networking/Education (either with Health Sector or Community)

- Smokefree Coalition meeting in April 2012;
- West Coast DHB HEHA and Smokefree Service Development Manager;
- West Coast PHO Smokefree Services Coordinator;
- Local Diabetes and Heart Respiratory Teams
- Rusty, the Health Promotion dog, made appearances at the Runanga Working Men's Club on April 29th 2012 for the Family Fun Day Out, Smokefree May Warehouse promotion in Greymouth 31/05/12, Parent Centre 'teddy bears picnic' in Greymouth 12/06/12, Launch of Men's Health at Coast Toyota Greymouth on 15/06/12.
- Active West Coast meeting April 7th;
- Disability Resource Centre Greymouth;
- Buller Health for promotion of flu vaccination clinic held at Older Adult expo;
- Practices and pharmacies for all promotional activity as above.

4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• The Health Promotion Coordinator has resigned effective from 27 April 2012; potentially recruitment will take 4-6 weeks.	• Recruitment to commence ASAP, once HEHA funding confirmed.

7. Workforce and rural support

1. Outcomes/ outputs:

PHO Performance Programme - latest report of funded indicators, to June 2012

PHO Performance quarterly data was unavailable at the time this report was realased.

Indicator	Programme Goal	PHO achieved in this quarter	Progress compared to previous quarter	Programme indicator achieved	Comment
Flu Vaccine Coverage – Total Population	≥75				
Flu Vaccine Coverage – High Needs	≥75				
Cervical Cancer Screening Coverage – Total Population	≥75				
Cervical Cancer Screening Coverage – High Needs	≥75				
Age Appropriated Vaccinations – 2 yr olds – Total Population	≥95				
Age Appropriated Vaccinations – 2 yr olds – High Needs	≥95				
Breast Cancer Screening Coverage – High Needs	≥70				
Ischaemic CVD Detection –	≥90				

Total Population					
Ischaemic CVD Detection – High Needs	≥90				
CVD Risk Assessment – Total Population	≥60 by July 2012				
CVD Risk Assessment – High Needs	≥60 by July 2012				
Diabetes Detection – Total Population	≥90				
Diabetes Detection – High Needs	≥90				
Diabetes Detection and Follow Up – Total Population	≥90				
Diabetes Detection and Follow Up – High Needs	≥90				
Smoking Status Ever Recorded - Other	≥90				
Smoking Status Ever Recorded – High Needs	≥90				
Note: both the smoking status ever recorded indicators above need to be above 70% before the PHO will be entitled to the funding related to the indicators below.					
Brief advice to stop smoking – Total Population	≥90				
Brief advice to stop smoking –	≥90				

High Needs					
Smoking cessation support – Total Population	≥90				
Smoking cessation support – High Needs	≥90				

Cornerstone outputs

The Reefton practice underwent a re-accreditation assessment in May, and is now in the post-accreditation phase. No other Cornerstone accreditation activity has taken place this quarter.

Maureen Gillion, Principal Advisor Quality & Safety for the Royal New Zealand College of General Practitioners, met with some members of the Senior Management Team, and the practice manager and lead general practitioner from Buller Medical Services to discuss the revised Cornerstone accreditation process, its relevancy to the integrated family health centre environment, and the associated fees. The meeting was productive, and synergies were noted between the already established WCPHO quality improvement process, and the changes involved in the new Cornerstone accreditation process.

Professional development activities this quarter

	GP	Nurse	Practice management/administrators	Other	**Total**
Prescribing errors	2	4		1	**7**
The Cardiac Society of Australia and New Zealand, SI Roadshow		15		6	**21**
Dementia	6				**6**
Neurology: Getting the signs and symptoms right	2	2			**4**
Rest home communication	5	1			**6**
Totals for quarter	**15**	**22**		**7**	**44**

Maori workforce

The Maori workforce within the West Coast PHO team is currently at 15% with the recent departure of our health promoter. Maori staff have been supported to attend the following courses:

- Te Tohu Pokaitahi Hauora Maori (level 4) – Nancy McNoe graduated May 2012,
- Quit card training

Currently 4 clinical staff employed across WCDHB and private practices identify as Maori and 1 non-clinical staff member. The level of Maori clinical staff working in West Coast PHO practices is currently below the target level set for 2013 (5) as part of the 2010-2013 West Coast PHO Maori Health Plan.

Cultural Fluency

What	Progress
Link with DHB Māori health team for the provision of cultural fluency* and health inequalities training. All West Coast PHO practices will be provided with a timetable of the planned workshops so they can plan for staff to attend the workshops.	This is on-going.
Facilitate linkages between practices and the DHB Māori health team as practices develop and implement their Maori health plans.	All practices have submitted a Maori health plan for the 2012-2013 year. All practices have received an update of the planned training sessions provided by the Maori Health team at the DHB for the 2012 calendar year. No training has occurred this quarter.
Actively engage Manawhenua to give guidance and support regarding Tikanga Māori protocol appropriate to Te Tai O Poutini rohe.	Manawhenua continue to have representation on the Clinical Governance Committee and Board of the West Coast PHO.

Professional development:

What	Progress
Provide monthly professional development evening meetings for GPs, nurses, practice managers, pharmacists and other members of the multi-disciplinary team (MDT), with videoconference links.	See professional development activities this quarter.
Provide annual PHO workshops: PHO day, practice management workshops, practice nurse workshops.	PHO Quality Improvement Day was held on March 14th 2012. Planning has begun for the Weekend Away Conference for all West Coast GP's and nurses to be held on 17th and 18th of November 2012.

Enable training in the use of standing orders by funding staff attendance.	The contract between the West Coast DHB and the West Coast PHO which supports the ability of non-medical staff to provide standing orders has now been signed. Practices were all contacted to enquire if they had incurred any costs in training provision over the 2011-2012 year, as these could be now be claimed for retrospectively. A standing orders contract for the first seven months only of the next financial year has been offered.
Adapt Canterbury HealthPathways for Coast use and provide educational sessions to implement them, (see HealthPathways plan).	Work continue reviewing the termination of pregnancy pathway which is out of date. Vicki Robertson is assisting the Christchurch based team with these. The diabetes pathway is yet to be discussed at the Local Diabetes Team meeting.
The PHO has an organisational commitment to create an environment where health literacy is not assumed	A review of educational materials used within practices in relation to CVD, diabetes and COPD is on-going.

Quality initiatives:

What	Progress
Develop quality improvement and clinical governance systems in every IFHC.	Too soon to do this.
Provide Cornerstone support and co-ordination support to practice quality improvement teams.	See Cornerstone report.
Support practice improvement activities for GPs (MOPS) and nurses (accreditation and expert endorsement).	GPs can now access MOPs points in relation to cardiovascular and diabetes risk assessments. Applications planned for the next quarter include: • documentation of smoking status; • documentation and provision of brief advice and smoking cessation support; • documentation and provision of a yearly review for eligible enrolled adults with established CVD, diabetes and COPD.
Produce practice level PHO Performance Programme reports with peer comparisons.	Ongoing
Provide practice visits by GP and nurse facilitators to review PHO Performance Programme reports and assist in the development of quality improvement plans.	As requested, or if need is determined

Provide PHO Performance Programme incentive payments according to the percentage of targets met by each practice.	The funding for PPP indicators has been received by the PHO and has been distributed to practices. Practices have also received funding to support the activity of their QI team, as they have all submitted their QI plans for the 2012-13 year.
Support pharmacists to provide feedback to GPs on cost effective prescribing.	An established process is in place and is on-going.
Seek feedback from Māori community to ascertain their view about the quality of patient care for Māori.	Nothing further to report.
Develop/adopt a patient survey to measure patient satisfaction with the care they receive at their IFHC	Preparations are underway for the 2012 survey which will be distributed August/September.

3. Issues and Risks

Issues/Risks	Mitigation/Resolution
Nil.	Nil.

Te Whakaaheitanga Marae

Kua wātea te huarahi

To enable kaumātua and whānau with health and disability impairments to actively engage at marae and remain effective contributors to their marae.

Contents

Project information

Te Kauri Marae

Manaaki ki te Tāngata – *Caring for people*

The vision to include facilities for our disabled whānau was the inspiration of the Te Kauri Building Team.

In general, most marae overlook the needs of people who have a disability or impairment.

When you arrive at Te Kauri Marae, we provide a disabled park for you by the main gate, concrete paving to the tūpuna whare (meeting house), easy access ramps, a spacious restroom, wide corridors to the whare kai (dining room), a balcony with shade to provide a magic view of Lake Waahi and time out to watch the sunset in the west.

Māku anō e hāngai tōku nei whare
Ko ngā poupou o roto he māhoe, he patate
Ko te tāhūhū he hīnau

This whakataukī takes into consideration:

- Waikato iwi commitment to rangatiratanga
- Whawhākia hapuu role as kaitiaki of the Kīngitanga
- Te Kauri Marae commitment to people as our major resource to create a safe, friendly and enjoyable environment for our guests and ourselves.

Te Kauri Marae

Back row: Thomas Noda, Dave Thompson, Donna Berryman, Luke Bredenbeck.
Front row: Kwanyke Bishop, Carl Berryman, Keritoke Noda.

Tikanga

E ngā iwi, e ngā hapū o tēnā o tēnā o ngā marae o te motu. Tēnā koutou ngā kaitiaki e manaaki nei i ngā āhuatanga katoa ki runga marae. Ka huri ngā mihi ki te Kīngi ā Tū heitia ā, tae atu ki te kāhui ariki whānui tonu. Ki ngā mate kua tangihia, moe mai.

Ko te rōpu Te Whakaaheitanga Marae tēnei e takoto ana te tāonga, rauemi rānei hei āwhina i ngā ahi kā, e tautoko ana i ngā tāngata hauā atu ki ngā kaumatua kua eke mai ki runga marae. Pū hāngai ana te rauemi nei kī a māmā te nohonga, nekenga ki runga marae ī tona hauātanga. Ko te tūmanako kia hono ai ngā whakāro-a-ruri ki rō i ngā mā here a marae a kaunihera rānei.

Nō reira kāi te mihi

To the iwi and hapu throughout the country, you the guardians of our marae we acknowledge you. We mihi to our King and to the wider kāhui ariki, and to those that have gone to heaven.

We are a group called Te Whakaheitanga Marae presenting a resource that we believe will support our tangata hauā and kaumātua that come to marae. The resource is pitched at supporting tangata hauā through marae incorporating features onto their marae that would improve their stay due to their disabilities. Therefore the intention is to include the specifics from the resource into marae development planning and building project planning.

Nō reira kāi te mihi

Whakatūwheratanga Introduction

The Marae Accessibility Project is a collaborative approach to addressing the social and participatory needs of kaumātua and whānau with disabilities or impairments whilst on the marae.

We aim to do this by developing a toolkit to assist ngā marae to become more accessible by those living with a disability or impairment.

Improving access to the marae for this priority group is essential to ongoing health and wellbeing outcomes for iwi, hapū and whānau with disabilities or impairments.

The marae setting is an integral repository for Māori language, history and traditions. Customs and protocols are regularly performed and used to ensure Māori way of life is maintained and sustained on the marae.

The Marae Accessibility Project was created out of the need to ensure kaumātua and whānau in general, with health and disability impairments can continue to actively engage at marae and remain effective contributors at all forms of Māori hui held there.

Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have (New Zealand Disability Strategy).

The founding documents that will support this project are:
- Treaty of Waitangi
- New Zealand Disability Strategy
- To Have an Ordinary Life
- He Korowai Oranga
- Whakataataki II

People with disabilities or impairments are a diverse group. The New Zealand Disability Strategy notes: “Disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other impairments.

“Many people living with impairments face major discrimination in many areas of their lives. The resulting barriers often leave them isolated and segregated, preventing them from using their skills and talents to benefit their communities”.

Disability is an important health issue for a significant sector of the New Zealand population. One in five people of Māori ethnicity report having a disability resulting in some functional and / or role limitation.

The impact of a disability extends well beyond the individual to their whānau / family and all those they come into contact with.

Whakamuri Background

Te Roopu Tīaki Hunga Hauā Māori Disability Network Group was established in 2005 to strengthen the collective capacity of service providers to achieve the best outcomes for whānau with disabilities and impairments.

This roopu is made up of kaimahi representing 23 organisations from Maniapoto, Waikato, Hauraki and Raukawa regions; however not exclusively.

One such initiative which provided the vision for the Marae Accessibility Project was to support the elimination of barriers at marae so that whānau become fully functional participants of marae hui as opposed to mere observers.

Te Roopu Tiaki Hunga Hauaa acknowledge the real obstacle to full participation on marae by whānau with impairments is not the impairment itself but rather the physical, environmental, and social barriers created by poorly informed attitudes.

As the Māori population increases in age, disease or illness will be the most common cause of disability.

There is therefore an opportunity for marae to increase responsibility for its physical environment where possible, and to embrace the true kaupapa of marae which is to "manaaki tangata ahakoa nō hea ahakoa ko wai - take care of people regardless of who they are and where they are from".

Logo explanation

"What ever the obstacle, together we can find a clear path forward."

The larger part of the logo symbolises an obstacle or mountain with the koru in the middle depicting clear pathways and eliminating barriers.

Te Whakaaheitanga Marae
Kua wātea te huarahi

The logo icon was drawn by Ora Kihi and then designed and formatted by Tamara Miles.

Definitions of terms essential to disability access

Accessible route
Accessible route means a route that is practical for people with disabilities or impairments.

It should be a continuous route that can be negotiated unaided by a wheelchair user, walking device or by a person with a guide dog.

The route should extend from the street boundary and car parking area to those spaces within the building required to be accessible to enable people with disabilities or impairments to carry out normal activities and processes within the building (NZS 4121:2001-1.5.1 p.12.).

Right: Red arrows indicate accessible route in various marae layout concepts.

International symbol for access
This symbol is required to indicate all facilities that are accessible including the accessible route.

Example of sign indicating accessible facilities and its direction.

Marae development process

Marae development project	**Marae governance:** Marae reservation and marae trustees are registered with the Mā ori Land Court.	Trustees are operational, have a strong administrative base and have provided written support for the Marae Development Project.
Marae project manager and project team	**Project manager:** Motivated, passionate driver of the project who acts on behalf of the trustees and whānau. The main role of the project manager is to liaise with stakeholders, i.e. the funders, consultants and construction team.	**Project team:** Comprises trustee representation, treasurer and whānau members. The team will have mandate from the trustees and whānau to progress the project from beginning to end.
Hui a iwi: what / how the project will accommodate your needs	The most important step in the planning process is to hui with the whanau and consider all dynamics of the marae, align everything you need with tikanga and kawa of the whānau, hapū, iwi and others who may utilise your marae.	Consider the needs of kaumātua and especially those with disabilities or impairment – incorporate their needs into the design of your facilities. This will help you to determine the size of the whare nui, whare kai, whare paku and car parks.

Funding and the engagement of reputable and registered constultants	The dominant funder is Lotteries Marae Heritage www.dia.govt.nz Organisations such as ASB, Trust Waikato and iwi authorities also contribute funding for projects.	Reputable and registered consultants are key to engaging consultants. Get advice from marae who have completed their projects. This helps the tendering process and be mindful the cheapest tender is not always the best.
Construction process and monthly reporting	Building consent is approved and sufficient funds have been sourced to complete the project. The project team will work with architects and a construction company to ensure construction is carried out correctly.	Project team will report back to the trustees and whānau. Reporting provides a safety net for all parties and allows whānau to be updated on progress and any issues can be tabled, discussed and worked out at monthly hui.
Completion of the project and financial accountability	Project team will continue to be involved until the three-month retention period is over to ensure defects (if any) are rectified and that all accounts are paid to the appropriate entity.	The funding organisations that have supported the project will require financial accountability reports – all recipients of funding must complete an accountability report to funders as this can also help with any future applications from the marae.

Accessibility examples

Level pathways






Wider doorways / hallways





Ramps / safety rails








Checklists

Checklist introduction

These checklists are intended for use by whānau who have responsibility for guiding a project when building renovations or new buildings are planned.

It is intended that these checklists give an indication of what facilities are required under the Building Act for access by people who have a disability or impairment.

Checklist areas:

1. **Turanga waka** Car park
2. **Paepae** Seating
3. **Whare kai** Eating house
4. **Whare nui** Meeting house
5. **Ngā whare paku me whare kaukau** Toilets and bathroom
6. **General access**

When working through these checklists you should consider whether:

- a whānau member who lives with an impairment or disability, to lead or assist with the checklist assessment
- a minimum of 2-3 people to assist with the assessment
- a measuring tape is available to assist with measurements where required
- a camera is available, if you wish to photograph things to follow-up on for improvement;
- addressing the general access checklist at the same time as other checklist areas as there maybe other useful considerations.

Legislation versus best practice

Legislation often is based on a minimum requirement, where best practice is based on practical application.

Examples of legislation requirements are provided at the bottom of each checklist with an example of best practice for marae to consider.

Turanga waka Carpark

	Yes	No	Comments
 Is there a designated (signed) area where disabled people can park or be dropped off?			
Is the car park surface: • stable? • firm? • slip resistant? (A flat surface under all environmental conditions)			
Are there designated accessible parking spaces?			
Is there an accessible route from the parking area to the waharoa, through to the paepae?			

Legislation	Best practice
Buildings and facilities where disabled or impaired people are likely to visit must have car parks on an accessible route.	Car parks should be as close as possible to the main entrance and should provide shelter from the weather.

Paepae Seating

	Yes	No	Comments
Are disabled people able to participate in proceedings and be seated as part of the audience (NOT separately) as others do?			
Is the seating on the paepae sheltered?			
Are there places designated for wheelchairs in the seating area of the paepae?			
Is the seating on the paepae user-friendly for disabled people / kaumātua / kuia?			
Is there an area where a guide dog can be placed?			
Is there an accessible route from the paepae to the whare nui and whare kai?			

Legislation	Best practice
The law requires that disabled people are seated as other people are and that wheelchair space within fixed seating is a minimum of 1000mm wide x 1500mm long.	This measurement is a minimum allocation. Some wheelchairs are made larger therefore a more adequate space would be 1200mm wide x 1900mm long.
Legislation provides for seating of one disabled person allocated per 250 seats provided.	At least five per cent of the seating area should be reserved for disabled people. The reserved seating should be integrated so that disabled people are not segregated from their whānau and friends.
The accessible route is defined in the New Zealand Building Code as; “an access route usable by people with disabilities. It shall be a continuous route that can be negotiated unaided by a wheelchair user.”	An accessible route is a flat level path that can be negotiated by an unassisted user of a wheelchair or walking frame.

Whare nui Meeting house

	Yes	No	Comments
Is the entrance into the building accessible?			
Are there facilities to enable disabled people to be seated, speak and hear as others do?			
Do you have access to bedding that can be raised and lowered?			
Are emergency exits accessible for users of wheelchair and walking frame users?			

Legislation	Best practice
Legislation requires that there be a means of escape from fire or other emergencies for disabled people.	All entrances to the whare nui should serve as emergency exits for disabled people.
Step ramps should be a maximum height of 20mm.	Good building design can eliminate step ramps altogether.
Doorway width should be a minimum of 760mm clear opening width.	But for a public facility such as a marae where large numbers of people gather, 910mm clear opening width would be a good minimum measurement.
Door handles must be able to be used by disabled people. Therefore they should be at a height between 900mm and 1200mm from the floor.	Door handles should be of a lever type and be set at one meter from the ground.

Whare kai Eating house

	Yes	No	Comments
Are aisles wide enough to accommodate wheelchairs?			
Are any hazards clearly marked? I.e. Glass doors.			
Are all spaces in the whare kai wheelchair accessible?			
Is the dining seating inclusive of wheelchair and walking frame users so that they may sit with their whānau?			
Is there a space for whānau in wheelchairs to support in the preparation of kai and other tasks in the kitchen?			

Legislation	Best practice
Legislation says that disabled people must be able to use the facilities for the purposes from which they were provided. New Zealand Standard 4141:2001 recommends a clear space from the underside of the table and kitchen bench to the floor of 675mm and 540mm depth.	The underside of the dining tables should be a minimum of 750mm clear space from the floor to allow wheelchair users to fit their legs under the table. There also needs to be a minimum of 750mm between the floor and the underside of the kitchen bench.
Legislation requires there be a means of escape from fire or other emergencies for disabled people.	All entrances to the whare nui should serve as emergency exits for disabled people.
Step ramps should be a maximum height of 20mm	Good building design can eliminate step ramps altogether.
Doorway width should be a minimum of 760mm clear opening width.	But for a public facility such as a marae where large numbers of people gather, 910mm clear opening width would be a good minimum measurement.
Door handles must be able to be used by disabled people. Therefore they should be at a height between 900mm and 1200mm from the floor.	Door handles should be of a lever type and be set at one meter from the ground.

Ngā whare paku me ngā whare kaukau
Toilets and bathrooms

	Yes	No	Comments
Is there a clear space on the open side of the toilet bowl for a wheelchair to enable a user to transfer to the toilet seat?			
Are the disabled toilet doors able to be opened from the outside if needed in an emergency?			
Can controls be operated with one hand?			
Are facilities inside the toilet compartment able to be used by a wheelchair user?			
Are there hand rails in the toilet and shower?			
Is there a shower seat?			

Legislation	Best practice
A minimum allowable compartment size for a toilet only is 1600mm x 1900mm.	A toilet compartment size is easier to us if 2000mm square.
The shower toilet combo compartment size minimum allowed is 1900mm x 2100mm.	A toilet / shower combo compartment has less maintenance costs and is easier to use if 2500mm.
Toilet compartment doors are required to be a minimum of 760mm 'clear opened width'.	Toilet compartment doors that have a minimum width of 910mm 'clear opened width' are much easier to use and have much less maintenance costs.

General access

Stairs and ramps

	Yes	No	Comments
Do stairs and ramps have handrails?			
Are stairs slip resistant?			
Does the gradient of your ramp allow wheelchair users and elderly easy access?			

Legislation	Best practice
Ramp gradients are required to be a maximum gradient of 1:12.	Ramp gradients of 1:16 or less are safer and much easier for disabled people to use.

Footpaths, doorways and exits

	Yes	No	Comments
Are your footpaths wide enough to accommodate two wheelchairs to pass without one being required to leave the path?			
Are all doorways at least 760mm minimum 'clear open width' with a clear level space immediately before of 1200mm square?			
Are emergency exists accessible and clearly signed?			

Legislation	Best practice
Footpaths are required to be a minimum of 1200mm wide.	If pathways are three meters wide, two wheelchairs can pass without one having to leave the path.
The maximum riser height allowed on a stair is 180mm and the minimum length is 310mm.	Stairs are much easier to use if the riser height is 100mm and the going length is 350mm or more.

Controls

	Yes	No	Comments
Are all controls able to be used by a wheelchair user?			

Legislation	Best practice
Controls on facilities are required to be set between 900mm and 1200mm from the floor.	Controls set at 1000mm from the floor are easy to use by everyone.

Hearing disabilities

	Yes	No	Comments
Have you thought about using a sound amplification system for hearing impaired whānau?			

Legislation	Best practice
Hearing loops are required at meeting rooms and theatres where the audience is likely to be 250 people or more.	Hearing loops allow people with hearing aids to hear and cut out external noise when sound amplification equipment is used. Hearing impaired people benefit when hearing loops are employed in any meeting rooms where more than 25 people gather.

Sight disabilities

	Yes	No	Comments
Are vision-impaired and blind whānau able to walk safely around and through the marae unassisted?			
Are hazards such as steps clearly identifiable from their surroundings?			

Legislation	Best practice
Tactile indicators or colour contrasting signs are required to indicate pathways and the location of facilities.	All steps, changes in direction and level should have both tactile indicators and vivid contrasting colours to ensure the safety of the vision impaired.

Awareness training

	Yes	No	Comments
Has the marae had training around disability awareness?			

Support information

Te Roopu Tiaki Hunga Haua Providers

CCS Disability Action 17 Claudelands Road PO Box 272, Waikato Mail Centre Hamilton 3240 Ph: (07) 853 9761 Fax: (07) 853 9765 Email: waikato@ccsdiabilityaction.org.nz www.ccsdiabilityaction.org.nz	**Community Living Trust** 180 Collingwood Street PO Box 292 Hamilton 3240 Ph: (07) 834 3700 Fax: (07) 834 3701 Email: enquiries@clt.org.nz
Deaf Aotearoa NZ (Waikato Branch) 292 Cambridge Road, Riverlea PO Box 24 023 Hamilton 3253, New Zealand TEXT : 021 540 193 Ph: (07) 856 2064 Fax: (07) 856 2047 www.deaf.org.nz	**Disability Support Link** 76 Rostrevor Street Hamilton Ph: (07) 839 1441 Fax: (07) 839 1225
Gracelands Group Of Services Ph: (07) 871 6410 www.gracelands.org.nz	**Hauraki Māori Trust Board** 41 Belmont Road P.O.Box 33 Paeroa 3640 Free ph: 0508 468 288 www.hauraki.iwi.nz
Head Injury Society (Waikato) Inc. Māori Services Field Officer Ph: (07) 839 1191 Mob: 021 470 889 Fax: (07) 839 5648 Email: whisfieldofficer@gmail.com www.whis.nzl.org	**Interactionz / Tari Whakawhitinga** Community Connector Mob: 027 451 4145 Email: tinihua@interactionz.org.nz www.interactionz.org.nz

Te Kōhao Health Free ph: 0800 4 TEKOHAO Fax: (07) 856 5938. Email: admin@tekohaohealth.co.nz www.tekohaohealth.co.nz	**Te Korowai Hauora O Hauraki** Thames office 210 Richmond St, Thames Ph: (07) 8685375 Fax: (07) 8685389 www.korowai.co.nz We have five sites; Te Aroha, Paeroa, Thames, Coromandel and Whitianga.
The Western Community Centre Ph: (07) 847 4873 46 Hyde Ave, Hamilton admin@wccham.org.nz www.westerncommunity.org.nz	**Rauawaawa Kaumātua Charitable Trust** Monday to Friday 9am to 5pm 50 Colombo St, Frankton, Hamilton Ph: (07) 847 6980 Fax: (07) 847 6981
The Royal New Zealand Foundation of the Blind Aronga / Needs Assessor Free ph: 0800 24 33 33 Ph: (07) 839 2266 Website: www.rnzfb.org.nz	**Ngāti Maniapoto Marae Pact Trust** Maniapoto House Cnr 51 Sheridan & Taupiri Streets Te Kuiti Ph: (07) 878 0028 Puketapu House Miriama Street Taumarunui Ph: (07) 895 9081

Links and references

Barrier Free New Zealand Trust
www.barrierfreenz.org.nz

Building Act 2004
www.legislation.govt.nz

Buildings Regulations 1992
www.legislation.govt.nz

CCS Disability Action
www.ccsdisabilityaction.org.nz

Compliance document for New Zealand building code
www.dbh.govt.nz

Department of Building and Housing Te Tari Kaupapa Whare
www.dbh.govt.nz

New Zealand Standard 4121:2001 Design for Access and Mobility – Buildings and Associated Facilities

Funding links

Waikato-Tainui Te Kauhanganui Incorporated
Tribal Development Unit
451 Old Taupiri Road, Hopuhopu
Private Bag 542, Ngaaruawaahia
0800 TAINUI
www.tainui.co.nz

Hauraki Māori Trust Board
Marae Development
P.O. Box 33
Paeroa
0508 468 288
www.hauraki.iwi.nz

Te Puni Kokiri
info@tpk.govt.nz
www.tpk.govt.nz

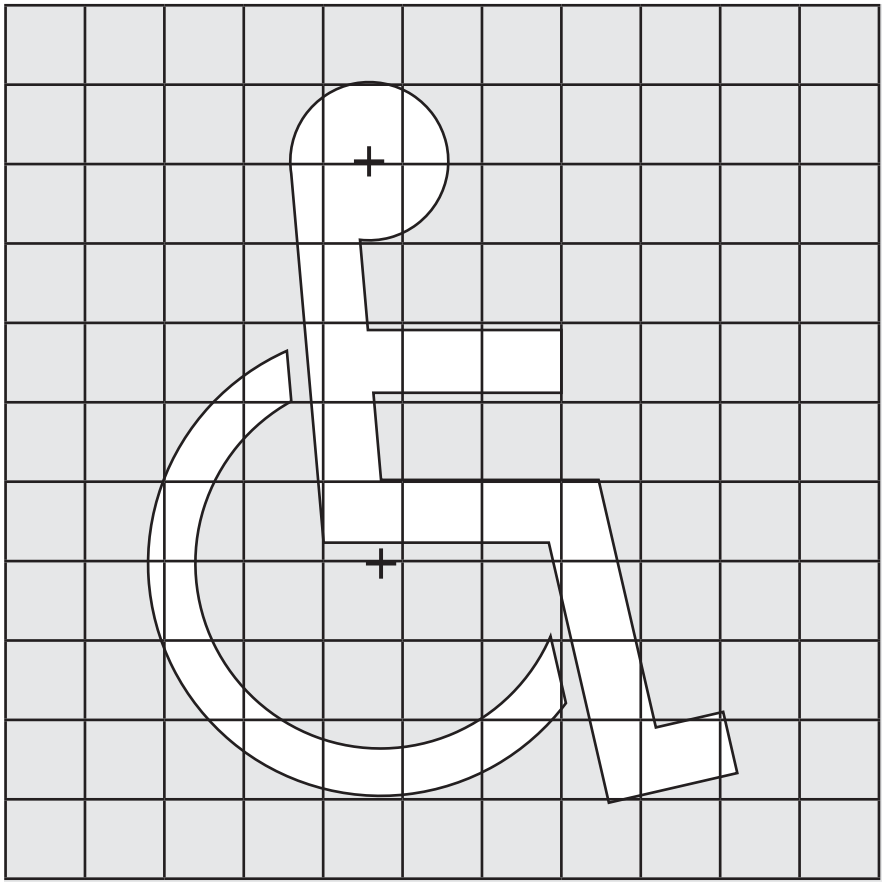
Department of Internal Affairs
Funding Advisor
0800 824 824
www.dia.govt.nz

Trust Waikato
Donations Advisor
0800 436 628
www.trustwaikato.co.nz

ASB Community Trust
Grants Advisor
0800 272 828
www.asbcommunitytrust.org.nz

Appendix one

International symbol for access



Appendix two

Marae layout (Pre-development)

This page can be utilised to draw what the marae, or a particular area on the marae might currently look like.

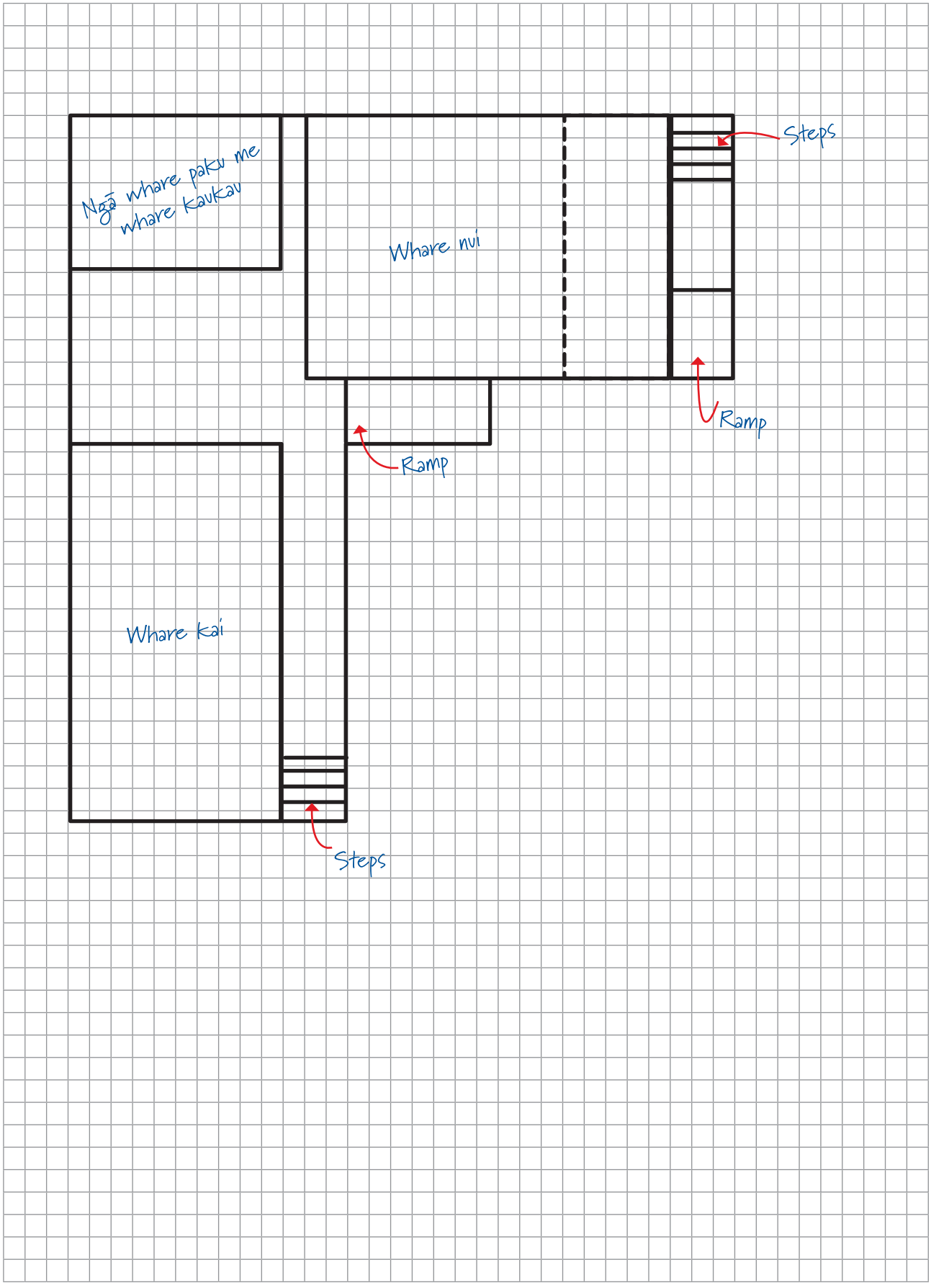
Appendix three

Marae layout (Planning development)

This page can be utilised to draft potential or planned changes for the marae, or a particular area on the marae might currently look like.

Appendix four

Example of utilised layout grid



Appendix five

Example of filled in checklist

Paepae Seating

	Yes	No	Comments
Are disabled people able to participate in proceedings and be seated as part of the audience (NOT separately) as others do?		x	Key area for the marae to consider.
Is the seating on the paepae sheltered?	✓		
Are there places designated for wheelchairs in the seating area of the paepae?		x	No space other than in front of the bench seating.
Is the seating on the paepae user-friendly for disabled people / kaumātua / kuia?	✓		Bench seats slightly low on the right side of the paepae; may need considerations.
Is there an area where a guide dog can be placed?	✓		
Is there an accessible route from the paepae to the whare nui and whare kai?		x	Improvement needed as assistance is required to access the whare nui.

Legislation	Best practice
The law requires that disabled people are seated as other people are and that wheelchair space within fixed seating is a minimum of 1000mm wide x 1500mm long.	This measurement is a minimum allocation. Some wheelchairs are made larger therefore a more adequate space would be 1200mm wide x 1900mm long.
Legislation provides for seating of one disabled person allocated per 250 seats provided.	At least five per cent of the seating area should be reserved for disabled people. The reserved seating should be integrated so that disabled people are not segregated from their whānau and friends.
The accessible route is defined in the New Zealand Building Code as; "an access route usable by people with disabilities. It shall be a continuous route that can be negotiated unaided by a wheelchair user."	An accessible route is a flat level path that can be negotiated by an unassisted user of a wheelchair or walking frame.

Date: 15 December 2010

Completed by: Tamati Richards (Trustee), Michelle Hotene (Stroke victim), Hone Tutama (Project Manager).

Appendix six

Extra checklists

Turanga waka Carpark

	Yes	No	Comments
 Is there a designated (signed) area where disabled people can park or be dropped off?			
Is the car park surface: • stable? • firm? • slip resistant? (A flat surface under all environmental conditions)			
Are there designated accessible parking spaces?			
Is there an accessible route from the parking area to the waharoa, through to the paepae?			

Legislation	Best practice
Buildings and facilities where disabled or impaired people are likely to visit must have car parks on an accessible route.	Car parks should be as close as possible to the main entrance and should provide shelter from the weather.

Paepae Seating

	Yes	No	Comments
Are disabled people able to participate in proceedings and be seated as part of the audience (NOT separately) as others do?			
Is the seating on the paepae sheltered?			
Are there places designated for wheelchairs in the seating area of the paepae?			
Is the seating on the paepae user-friendly for disabled people / kaumātua / kuia?			
Is there an area where a guide dog can be placed?			
Is there an accessible route from the paepae to the whare nui and whare kai?			

Legislation	Best practice
The law requires that disabled people are seated as other people are and that wheelchair space within fixed seating is a minimum of 1000mm wide x 1500mm long.	This measurement is a minimum allocation. Some wheelchairs are made larger therefore a more adequate space would be 1200mm wide x 1900mm long.
Legislation provides for seating of one disabled person allocated per 250 seats provided.	At least five per cent of the seating area should be reserved for disabled people. The reserved seating should be integrated so that disabled people are not segregated from their whānau and friends.
The accessible route is defined in the New Zealand Building Code as; “an access route usable by people with disabilities. It shall be a continuous route that can be negotiated unaided by a wheelchair user.”	An accessible route is a flat level path that can be negotiated by an unassisted user of a wheelchair or walking frame.

Whare nui Meeting house

	Yes	No	Comments
Is the entrance into the building accessible?			
Are there facilities to enable disabled people to be seated, speak and hear as others do?			
Do you have access to bedding that can be raised and lowered?			
Are emergency exits accessible for users of wheelchair and walking frame users?			

Legislation	Best practice
Legislation requires that there be a means of escape from fire or other emergencies for disabled people.	All entrances to the whare nui should serve as emergency exits for disabled people.
Step ramps should be a maximum height of 20mm.	Good building design can eliminate step ramps altogether.
Doorway width should be a minimum of 760mm clear opening width.	But for a public facility such as a marae where large numbers of people gather, 910mm clear opening width would be a good minimum measurement.
Door handles must be able to be used by disabled people. Therefore they should be at a height between 900mm and 1200mm from the floor.	Door handles should be of a lever type and be set at one meter from the ground.

Whare kai Eating house

	Yes	No	Comments
Are aisles wide enough to accommodate wheelchairs?			
Are any hazards clearly marked? I.e. Glass doors.			
Are all spaces in the whare kai wheelchair accessible?			
Is the dining seating inclusive of wheelchair and walking frame users so that they may sit with their whānau?			
Is there a space for whānau in wheelchairs to support in the preparation of kai and other tasks in the kitchen?			

Legislation	Best practice
Legislation says that disabled people must be able to use the facilities for the purposes from which they were provided. New Zealand Standard 4141:2001 recommends a clear space from the underside of the table and kitchen bench to the floor of 675mm and 540mm depth.	The underside of the dining tables should be a minimum of 750mm clear space from the floor to allow wheelchair users to fit their legs under the table. There also needs to be a minimum of 750mm between the floor and the underside of the kitchen bench.
Legislation requires there be a means of escape from fire or other emergencies for disabled people.	All entrances to the whare nui should serve as emergency exits for disabled people.
Step ramps should be a maximum height of 20mm	Good building design can eliminate step ramps altogether.
Doorway width should be a minimum of 760mm clear opening width.	But for a public facility such as a marae where large numbers of people gather, 910mm clear opening width would be a good minimum measurement.
Door handles must be able to be used by disabled people. Therefore they should be at a height between 900mm and 1200mm from the floor.	Door handles should be of a lever type and be set at one meter from the ground.

Ngā whare paku me ngā whare kaukau
Toilets and bathrooms

	Yes	No	Comments
Is there a clear space on the open side of the toilet bowl for a wheelchair to enable a user to transfer to the toilet seat?			
Are the disabled toilet doors able to be opened from the outside if needed in an emergency?			
Can controls be operated with one hand?			
Are facilities inside the toilet compartment able to be used by a wheelchair user?			
Are there hand rails in the toilet and shower?			
Is there a shower seat?			

Legislation	Best practice
A minimum allowable compartment size for a toilet only is 1600mm x 1900mm.	A toilet compartment size is easier to us if 2000mm square.
The shower toilet combo compartment size minimum allowed is 1900mm x 2100mm.	A toilet / shower combo compartment has less maintenance costs and is easier to use if 2500mm.
Toilet compartment doors are required to be a minimum of 760mm 'clear opened width'.	Toilet compartment doors that have a minimum width of 910mm 'clear opened width' are much easier to use and have much less maintenance costs.

General access

Stairs and ramps

	Yes	No	Comments
Do stairs and ramps have handrails?			
Are stairs slip resistant?			
Does the gradient of your ramp allow wheelchair users and elderly easy access?			

Legislation	Best practice
Ramp gradients are required to be a maximum gradient of 1:12.	Ramp gradients of 1:16 or less are safer and much easier for disabled people to use.

Footpaths, doorways and exits

	Yes	No	Comments
Are your footpaths wide enough to accommodate two wheelchairs to pass without one being required to leave the path?			
Are all doorways at least 760mm minimum 'clear open width' with a clear level space immediately before of 1200mm square?			
Are emergency exists accessible and clearly signed?			

Legislation	Best practice
Footpaths are required to be a minimum of 1200mm wide.	If pathways are three meters wide, two wheelchairs can pass without one having to leave the path.
The maximum riser height allowed on a stair is 180mm and the minimum length is 310mm.	Stairs are much easier to use if the riser height is 100mm and the going length is 350mm or more.

Controls

	Yes	No	Comments
Are all controls able to be used by a wheelchair user?			

Legislation	Best practice

Controls on facilities are required to be set between 900mm and 1200mm from the floor.	Controls set at 1000mm from the floor are easy to use by everyone.

Hearing disabilities

	Yes	No	Comments
Have you thought about using a sound amplification system for hearing impaired whānau?			

Legislation	Best practice
Hearing loops are required at meeting rooms and theatres where the audience is likely to be 250 people or more.	Hearing loops allow people with hearing aids to hear and cut out external noise when sound amplification equipment is used. Hearing impaired people benefit when hearing loops are employed in any meeting rooms where more than 25 people gather.

Sight disabilities

	Yes	No	Comments
Are vision-impaired and blind whānau able to walk safely around and through the marae unassisted?			
Are hazards such as steps clearly identifiable from their surroundings?			

Legislation	Best practice
Tactile indicators or colour contrasting signs are required to indicate pathways and the location of facilities.	All steps, changes in direction and level should have both tactile indicators and vivid contrasting colours to ensure the safety of the vision impaired.

Awareness training

	Yes	No	Comments
Has the marae had training around disability awareness?			

Acknowledgements

The Marae Accessibility Project working party would like to express appreciation to the many contributors who have helped in the development of this toolkit.

Alisha Higgins (Head Injury Society)
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Jaemie Whanga (Head Injury Society)
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Louise Were (Western Community Centre)
Maraea Nikora (Population Health, Waikato District Health Board)
Maurice Toon (independent designer)
Ora Kihi (logo artist)
Patricia Nathan (Hauraki Māori Trust Board)
Sandy Pokaia (Community Waikato)
Tamara Miles (Viscom, Waikato District Health Board)
Tame Pokaia (Advisory)
Te Kauri Trustees, committee, building team and whānau
Te Ruka Kiwara (Life Unlimited)

Kevin Churchill offered valued expertise in the area of barrier-free auditing which has been invaluable and educational and is reflected throughout the toolkit.

Te Kauri Marae is considered to be a role model for other marae and we commend Te Kauri Marae for taking the initiative to improve accessibility for their whānau members and wider community.

As a fundamental part of developing the kit we wish to thank our funders / sponsors who have supported us to be able to produce this toolkit.

Working party

HEALTH WAIKATO
CARING FOR YOU
Waikato District Health Board
POPULATION HEALTH

Hauraki

COMMUNITY WAIKATO
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Te Puni Kōkiri
REALISING MĀORI POTENTIAL

Te Whakaaheitanga Marae
Kua wātea te huarahi
Marae Accessibility