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

2 May 2013

AGENDA AND MEETING PAPERS

All information contained in these committee papers is subject to change

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
Jenny McGill	• Employment with Lifelinks working with Ministry of Health contracted providers, including West Coast DHB. • Husband employed by West Coast DHB
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 DHB and West Coast Primary Health Organisation) • Contract for the Café and Catering at Tai Poutini • Daughter employed as nurse for West Coast DHB
Marie Mahuika-Forsyth	• Promoter for Healthy Eating Healthy Action (20 hours per week) • Executive Member of Makaawhio • Member of Tatau Pounamu

Member	Disclosure of Interest
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

DRAFT
MINUTES OF THE COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE held in the Board Room, Corporate Office, Grey Base Hospital on Thursday, 7 March 2013 commencing at 9.00am

PRESENT

Elinor Stratford (Chairperson); Kevin Brown (Deputy Chair); John Ayling; Lynette Beirne; Dr Cheryl Brunton; Marie Mahuika-Forsyth; Jenny McGill; Mary Molloy; Robyn Moore; John Vaile; Peter Ballantyne (ex-officio) and Dr Paul McCormack (ex-officio)

APOLOGIES

There were no apologies

EXECUTIVE SUPPORT

Carolyn Gullery, (General Manager, Planning & Funding); Gary Coghlan (General Manager, Maori Health); Michael Frampton (Programme Director); Ralph La Salle (Planning & Funding); and Kay Jenkins (Minutes).

WELCOME

The Chair welcomed everyone and asked Gary Coghlan, General Manager, Maori Health to lead the Karakia.

1. INTEREST REGISTER

Kevin Brown advised a change to the interest register in respect of his wife's employment.

2. MINUTES OF THE PREVIOUS MEETING

Resolution (3/13)
(Moved: John Vaile; Seconded: Robyn Moore - carried)

"That the minutes of the meeting of the Community and Public Health and Disability Support Advisory Committee held on 24 January 2013 be confirmed as a true and correct record"

3. CARRIED FORWARD/ACTION ITEMS

Discussion took place regarding how the PHO reporting would be delivered going forward. Carolyn Gullery, General Manager, Planning Funding advised that the Alliance is still in its setting up stage. She added that timing for reporting will be addressed in the next while and the quarterly report from the PHO will form part of the overall Alliance report.

The Committee noted the scheduled presentation by the Director of Allied Health for the next meeting.

4. MAORI HEALTH ACTIVITY REPORT

Gary Coghlan, General Manager, Maori Health, presented the Maori Health Update. Some updated information was tabled.

The Committee noted the Maori Health Activity Report, including the positive results around cervical screening.

The General Manager, Maori Health provided the Committee with an update on the Minister, Tariana Turia's visit to the West Coast on Tuesday 5 March 2013. He commented that well over 100 people had attended various Hui held on the day.

The report was noted.

5. PLANNING & FUNDING UPDATE

Carolyn Gullery, General Manager, Planning & Funding presented the Planning & Funding Update which highlighted the key achievements and issues facing the DHB. Discussion took place regarding the following:

Primary Care Workforce
The Committee noted the issues around the DHBs ability to get a stable Primary Care workforce which would allow relationships to develop between GPs and their patients. Discussion took place regarding locum use, recruitment and also the ability to secure the services of long term GPs who have an interest in permanent employment on the West Coast.

Home Based Support
John Ayling declared a potential conflict of interest regarding this topic.
Discussion also took place regarding Home Based Support and noted that the Aged Residential Care on the West Coast, on a per capita basis, is almost twice that of the rest of the South Island. They noted that this is partly due to home based support not being sufficiently targeted to support people to stay in their own homes. They also noted that work will commence right away on a person by person basis to reassess the need for home support currently being provided to ensure this is actually being provided to the right people.

A point was raised regarding recent changes in models of care and it was agreed that over the next few months Planning & Funding would identify these and make them more visible.

Discussion took place regarding Red Cross transport from Buller and the Committee noted that this was not being used a lot. It was noted that a commercial shuttle business has been established for transport 3 days per week between Buller & Greymouth.

Carolyn Gullery introduced Ralph La Salle from Planning & Funding who will be present for the rest of the meeting in her absence.

The report was noted

6. COMMUNITY & PUBLIC HEALTH UPDATE

Jem Pupich, Team Leader, Community & Public Health, presented the Community & Public Health Update. The Committee noted the trial of a fruit and vegetable co-op which had taken place in November/December 2012 which is currently being assessed.

In addition the Committee noted the Community & Public Health quarterly report to the Ministry of Health which was included in the information papers. The comment was made that it was pleasing to see that the feedback from the Ministry had been positive and that Community & Public Health are on track to meet their targets.

The report was noted.

7. BETTER SOONER MORE CONVENIENT (BSMC) AND ALLINACE LEADERSHIP TEAM (ALT) UPDATE

Carolyn Gullery, General Manager, Planning & Funding presented this report. In presenting the report she commented that it demonstrates part of the thinking around how the Alliance Report will look moving into the future. She added that the next Annual Plan process will make it even clearer where this all sits in the overall process.

Discussion took place regarding membership of the Alliance Leadership Team and the Committee noted that whilst the areas of representation have been agreed, individual membership is yet to be determined.

Discussion also took place regarding the flexible funding pool and how this is trying to reflect a different way of looking at resources with the ability to look at the overall funding package.

8. HEALTH TARGETS

Carolyn Gullery, General Manager, Planning & Funding presented this report.

The Committee discussed the Health Targets and some concern was expressed regarding some of these not being achievable on the West Coast. The General Manager, Planning & Funding commented that the way we manage this is that we develop our work plans to ensure we maintain good quality services for the West Coast Community. The Committee noted that this year in particular the Annual Plan guidelines are extraordinarily detailed.

Carolyn Gullery departed at 10.20am

9. GENERAL BUSINESS

- The Committee Chair commented that she is working with management in endeavouring to have a more of a focus on disability issues.

- A query was made regarding the year-end financial result and Michael Frampton, Programme Director, confirmed that the DHB would meet its annual plan commitment of a $3.6m deficit.

INFORMATION ITEMS

- Chair's report to last Board meeting
- Board Agenda 8 February 2013
- CPH&DSAC 2013 Work Plan
- West Coast DHB 2013 Meeting Schedule 2013
- Community & Public Health Six Monthly Report to the Ministry of Health

There being no further business the meeting concluded at 10.30am.

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/ACTION ITEMS AS AT 2 MAY 2013

	DATE RAISED	ACTION	COMMENTARY	STATUS
1.	24 January 2013	**Allied Health Update**	The Director of Allied Health will present to a future meeting	On today's Agenda

PLANNING AND FUNDING UPDATE

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: **Planning and Funding**

DATE: **2 May 2013**

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

1. ORIGIN OF 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's Annual Plan key priority areas.

2. RECOMMENDATION

That the Committee notes the Planning and Funding Update.

3. SUMMARY

✓ **Key Achievements**

- The West Coast has once again achieved the **ED health target**, with 99.8% of people admitted or discharged within six hours during Quarter 3 – well above the target of 95%.
- The West Coast continues to achieve the **cancer treatment health target**, with 100% of people ready for radiotherapy or chemotherapy beginning treatment within four weeks.
- Delivery against the **electives health target** remains on track. For the eight months year-to-date February, 1,054 cases had been delivered – just one case below the year-to-date progress target.
- The strategies put in place to improve **B4 School Check coverage** have proven to be effective. Significant increases in delivery have brought the West Coast to 1% ahead of the year-to-date target as of the end of Quarter 3, though still 5% short of the year-to-date target for the high deprivation population. The service will continue to utilise these effective strategies to increase coverage in the high deprivation group and ensure the West Coast DHB reaches both targets by the end of the year.
- **Newborn hearing screening** uptake increased to 94% in Quarter 3 – 3% more than the previous quarter.
- The number of people accessing **free annual diabetes checks** remains above target for the nine month period to 31 March 2013, with 726 people having had checks, equating to 74% coverage for the year-to-date against our target of 70%. Of those screened, 78% had good management of their diabetes – close to our target of 80%.
- The West Coast has improved performance against the **hospitalised smokers health target**, with 91% of hospitalised smokers offered advice and help to quit – up 2% from the previous quarter. Efforts to further lift our performance against this target continue.

✖ Key Issues & Associated Remedies

- **Immunisation coverage** on the West Coast suffered in Quarter 3 as a result of the high rate of parents choosing to decline immunisation or opt their child off the NIR (16% for both eight-month-olds and two-year-olds). With 78% of eight-month-olds and 82% of two-year-olds fully immunised on time, there were just five eight-month-old children and two two-year-olds overdue for their vaccinations who had not been opted off or declined. The West Coast and Canterbury DHBs are now working together more closely on immunisation. This has proven positive for data management, and our next steps are to improve efforts to reach missed children and children who decline immunisation events as we strive to fully immunise all reachable children.

ⓘ Upcoming Points of Interest

- Work on a new, **restorative homecare model** continues to be on track as part of the Complex Clinical Care Network (CCCN) project, with a variety of activity underway.
- Work continues to roll out **interRAI assessment in aged residential care** (ARC), with 68% of ARC residents now having received an assessment, and plans in place to assess the remaining clients. All new entrants receive an interRAI assessment.
- DHB Specialist Mental Health Services and community NGO providers have developed protocols for working together more effectively to deliver more **integrated mental health care** for consumers. This includes a new cross-agency initiative to provide community-based support for people with alcohol and other drug issues.

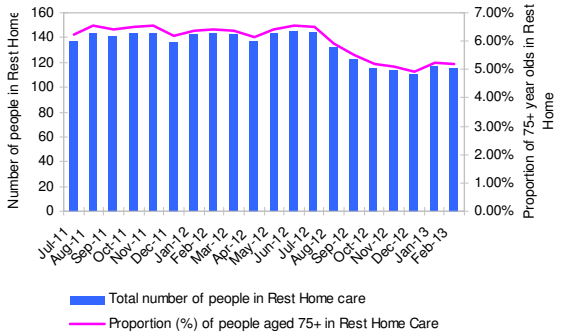
Report prepared by: Planning and Funding Team

Report approved for release by: Carolyn Gullery, General Manager – Planning & Funding

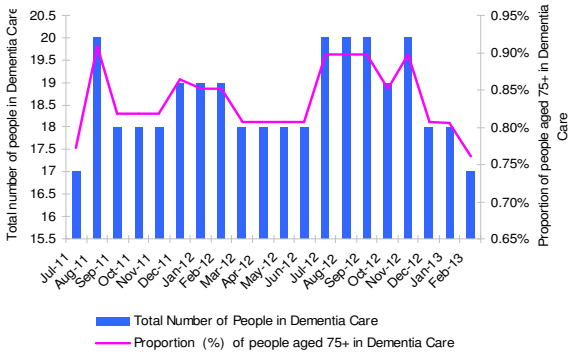
Older Persons' Health

People 65+ Receiving Home-based support vs. in ARC

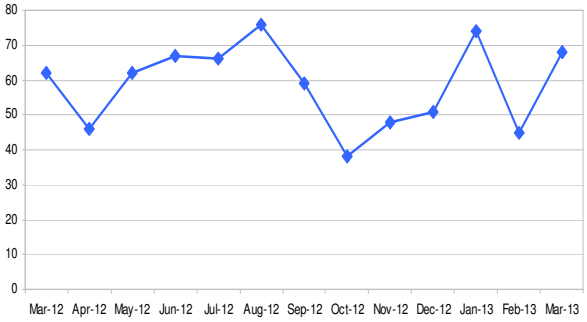
% of people aged 75+ admitted in Rest Home level care



% of people aged 75+ in Specialist Dementia Care



Number of interRAI assessments completed



ACHIEVEMENTS/ISSUES OF NOTE

Maximising independence model for homecare: Work on a new, restorative homecare model continues to be on track as part of the Complex Clinical Care Network (CCCN) project.

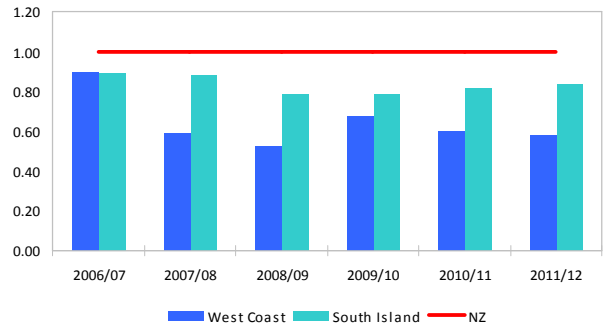
- Transalpine gerontology nursing is now underway, with the Health of Older Persons (HOP) nursing director providing regular support to the Coast. An implementation plan to develop the Gerontology Nurse Specialist (GNS) roles is progressing, with education and awareness for internal and external staff taking place. Dr Michelle Dhanak, geriatrician, and Kate Gibb, HOP Director of Nursing, continue to provide clinical support to the two GNSs based in Westport and Greymouth.
- While Dr Dhanak continues to provide clinical leadership at Interdisciplinary Team (IDT) meetings, the CCCN manager now manages the meetings and is currently ensuring the four IDTs (Westport, Reefton, Hokitika and Greymouth) are consistent with respect to membership and process.
- Current assessor roles will remain unchanged until July 2013 to assist with completing remaining client assessments. Since 28 February, 99 of 308 outstanding reassessments have been completed. At a rate of about 20 per week using 2.6 FTE, these are on track to be completed by July 2013.
- Communications continue with home-based support services and primary care about restorative home-based support services and what this means going forward. Specific face-to-face communications have taken place in South Westland, Westport, Greymouth and Hokitika in March.

InterRAI in rest homes: As at Quarter 3 2012/13, approximately 68% of aged residential care (ARC) residents have now had an interRAI assessment. This number has been taken from Carelink records, as the national interRAI data warehouse is still being set up. An implementation plan is in place to assess the remaining clients. All new entrants receive an InterRAI assessment, which informs their care plans.

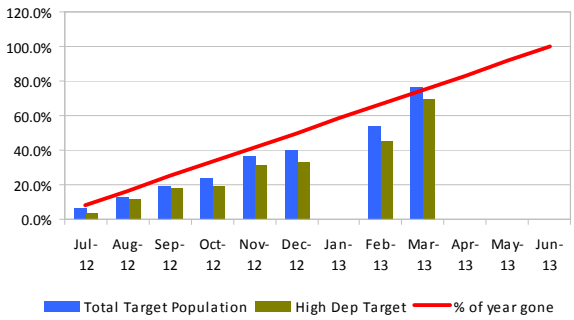
Long-Term Care Facility training on the West Coast began in March, with five trainees completing the course. Three of these trainees were managers of facilities (one Westport facility and two Greymouth facilities), while the other two were registered nurses. They are now progressing well on their case studies. The next training is planned for June 2013, with four staff booked for the five slots available.

Child, Youth & Maternity

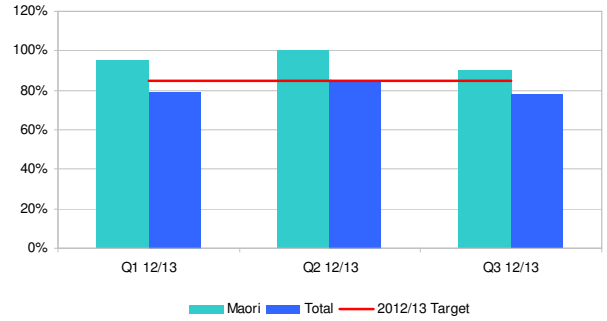
Acute medical discharge rates for children (age 0-14)



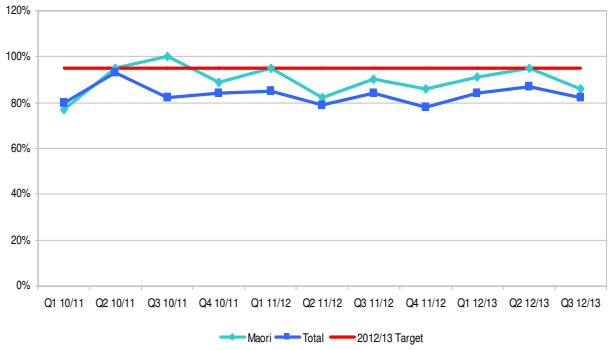
B4 School Check coverage



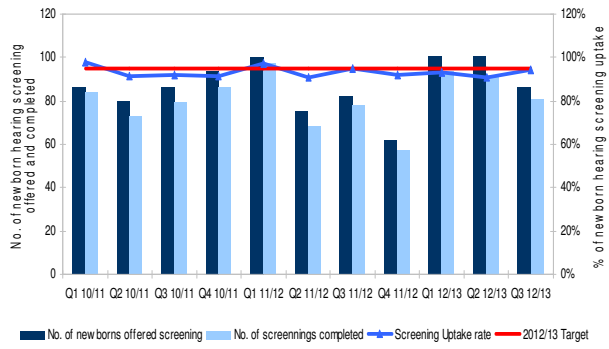
Immunisation HT: Eight-month-olds fully immunised



Two-year-olds fully immunised



Newborn Hearing Screening Uptake



ACHIEVEMENTS/ISSUES OF NOTE

Childhood immunisation:

Eight-month-old immunisation: Quarter 3 saw an overall decrease in the number of children who were fully immunised at 8 months of age, down from 84% in Q2 to 78%, against a national target of 85%. However, the West Coast surpassed the target for Asian (100%), Pacific (100%) and Māori (90%) eight-month-olds. The reason for the low overall immunisation coverage was primarily the high rate of parents choosing to decline immunisation or opt their child off the NIR – in total, 16%. This left just 6% of eight-month-olds, or five children, overdue for immunisation at eight months of age.

Two-year-old immunisation: The West Coast DHB's coverage for Quarter 3 was 82% - a decrease of 5% from the previous quarter. There was better coverage for Māori (87%) and Pacific (100%, though this is only one child). Again, the low overall rate results from the high opt-off and declines of 16%. This left just two children overdue for immunisation at age two.

Work to improve immunisation coverage for both age groups includes:

- The NIR Administrator working closely with the Canterbury DHB NIR team, for support and training

- Timely referral to Outreach Services;
- Collaboration with other WellChild service providers to refer children for immunisation;
- Improving the enrolment process at birth; and
- Improved data management and early identification of overdue and declined children.

There is ongoing collaboration with Canterbury DHB around NIR and ways to identify unvaccinated children. This transalpine collaboration has proven positive for data management, and our next steps are to improve efforts to reach missed children and children who decline immunisation events, as we strive to fully immunise all reachable children.

B4 School Check (B4SC): The West Coast DHB achieved 76% of the total target population by the end of Q3 2012/13 – 1% more than the target as a percentage of the year gone, and an increase of 22% from the end of February 2013.

West Coast achieved 70% of the high deprivation target at the end of Q3 2012/13 – 5% short of the target as a percentage of the year gone. While short of the high deprivation target, this is a 25% increase from the end of February 2013.

The strategies put in place at the end of Q2 2012/13 have proven to be effective, and the service will continue to utilise these strategies to increase coverage in the high deprivation group and ensure the West Coast DHB reaches both targets for the full year.

Newborn Hearing Screening Programme: There were 81 babies offered the newborn hearing screening test in Quarter 3 2012/13, with a 94% uptake rate – 3% more than the previous quarter. Screening continues to be offered in Westport and the Gloriavale Christian Community.

Oral Health: With the recent closing of the Hokitika dental service, the DHB is open to community initiatives with the people of Westland if the community chooses to take the idea further. Oral health services for young people aged up to 18 years of age continue to be provided through the Child and Adolescent Oral Health Service, which operates a dental clinic at Hokitika Primary School.

Mental Health

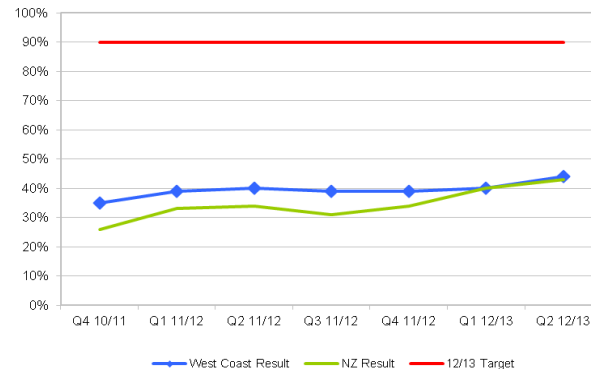
ACHIEVEMENTS/ISSUES OF NOTE

System Planning: DHB Specialist Mental Health Services and community NGO providers met at the end of March to develop protocols for working together more effectively. This included discussion about a new cross-agency initiative that is designed to provide community-based support for people with alcohol and other drug issues.

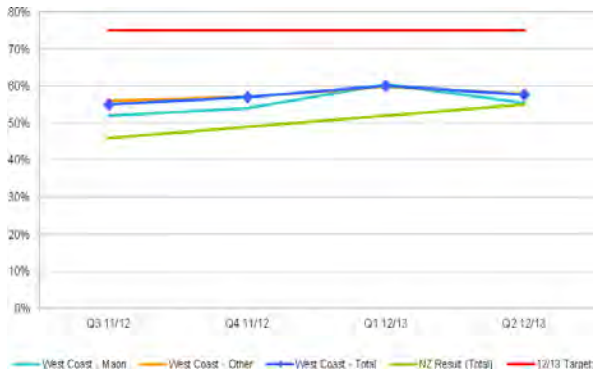
Discussions will continue with sector leaders regarding the best way of providing mental health and addiction services, within the framework set by the Ministry of Health Service Development Plan 2012-2017: 'Rising to the Challenge'.

Primary Care & Long-Term Conditions

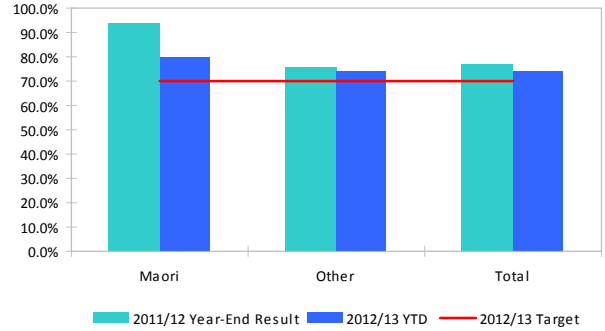
Primary Smokefree Health Target: Smokers attending primary care given advice & help to quit



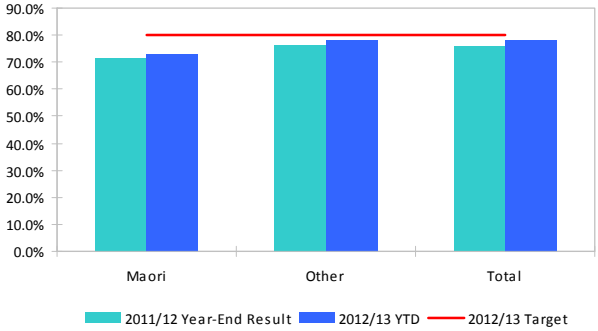
CVD Health Target: % of eligible PHO population having had a CVD risk assessment in the last 5 years



Diabetes Detection: % of people estimated to have diabetes who have had their annual check during the current year



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



ACHIEVEMENTS/ISSUES OF NOTE

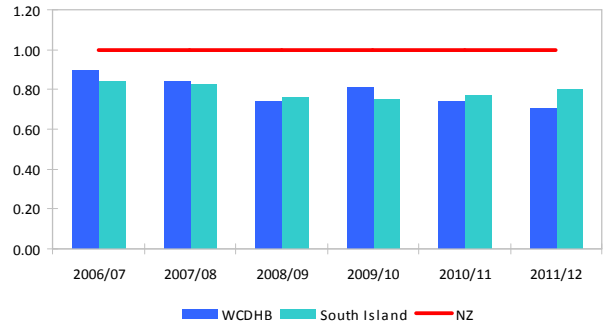
Note: *Data for the CVD and primary care smokefree health targets is only published quarterly. The data set for Quarter 3 was not available in time for this report, but will be provided in the next report.*

Primary care smokefree health target: Activities that focus on improving the accuracy of data capture have continued during Quarter 3. This includes training staff in the use of the new IT tool HealthStat, which can provide more frequent and practice-specific feedback about the ABC health target. A 'Primary Health Target Bulletin' was circulated to all West Coast practices regarding ABC performance, as well as providing clinical guidelines/rationale to practice staff regarding the initiative. Work has continued with four practice teams to support the coding of the Brief Advice component of the 'ABC' and to link patients to local cessation services.

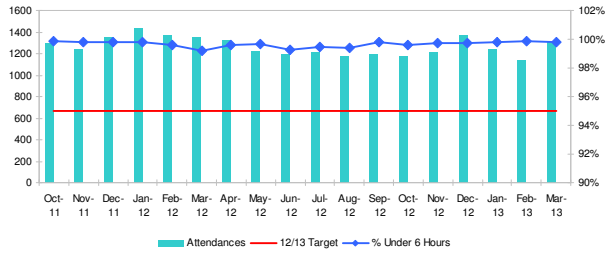
Diabetes care: The number of people accessing free annual diabetes checks remains above target for the nine month period to 31 March 2013, with 726 people having had checks. This equates to 74% of the people expected for the quarterly period, based *pro rata* on the 2012/13 estimates of the West Coast population expected to have diabetes. Of those screened, 78% had good management of their diabetes.

Secondary Care & System Integration

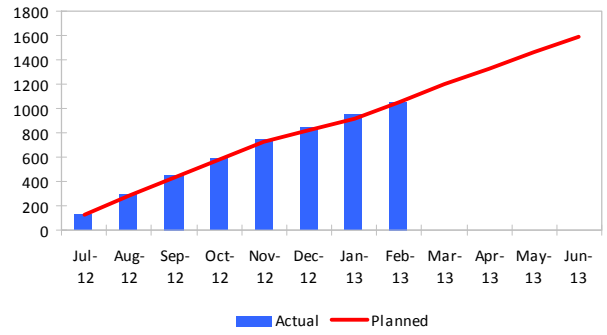
Acute Medical Discharge Rate



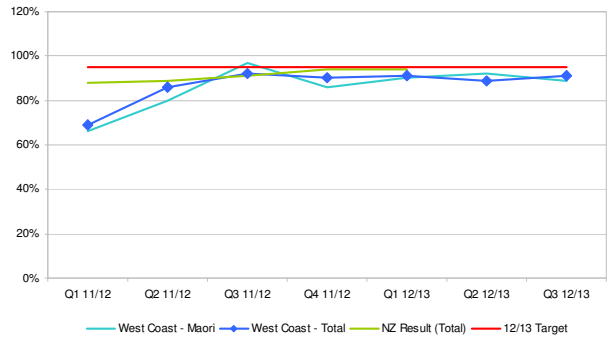
Emergency Department: Attendances & <6 Hours Health Target



Electives Health Target: Elective surgical discharges



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



ACHIEVEMENTS/ISSUES OF NOTE

ED health target: The West Coast has once again achieved the ED health target, with 99.8% of people admitted or discharged within six hours during Quarter 3 – well above the target of 95%. Results for the nine months year-to-date March 2013 show 99.7% of patients were admitted or discharged within 6 hours, and 96.6% within just 4 hours.

The Red Cross transportation service for Buller patients is continuing, in spite of slow uptake in the pilot trial period to the end of February 2013. It is seen to be of value in helping to improve access to specialist services and continues to enjoy the support of its volunteer drivers and coordinators at Buller REAP. West Coast DHB is continuing to work with Red Cross to encourage greater use and uptake of the service in the hope that it can gain a greater degree of longer-term sustainability.

Cancer health target: West Coast DHB continues to achieve the target, with 100% of people ready for radiotherapy or chemotherapy beginning treatment within four weeks for the year-to-date March.

Secondary care smokefree health target: The Quarter 3 result of 91% is an improvement of 2% from the previous quarter. After a disappointing January result of 85%, February (96%) and March (93%) showed pleasing improvement. Work continued with Clinical Nurse Managers to identify 'missed' patients and pinpoint any gaps at ward level, noting the impact of a 'missed' ABC due to small numbers. The Smokefree Services Coordinator also spent time with ward staff to answer questions regarding the process, as well as ensuring a clinical focus remains around the target.

A member of the Ministry of Health Tobacco Control team visited the DHB in March, meeting with management, senior clinical staff and Smokefree staff to discuss progress and the activities in place to improve performance against the target. It was a positive visit, with challenges discussed. Actions from the visit will be incorporated into the health target 'action plan' over the coming quarter.

Electives health target: West Coast DHB remains on track to meet the electives health target. Delivery for the eight months year-to date February was 1,054 cases – just 1 case behind the year-to-date target. This represented 66% of throughput toward the year-end target of 1,592 elective surgical discharges.

P & F Financials for the year to date March 2013

SERVICES	Year to Date Actual	Budget	Variance			2012/13 Annual Budget
	$000	$000	$000	%		$000
Primary Care						
Dental-school and adolescent	302	353	51	14%	✓	470
Maternity	0	17	17	100%	✓	20
Pregnancy & Parent	0	6	6	100%	✓	8
Sexual Health	9	25	16	64%	✓	33
General Medical Subsidy	41	35	-7	-19%	✗	46
Primary Practice Capitation	4,864	4,844	-21	0%	✗	6,458
Primary Health Care Strategy	62	108	46	43%	✓	144
Rural Bonus	718	713	-6	-1%	✗	950
Child and Youth	27	52	25	48%	✓	69
Immunisation	89	27	-62	-227%	✗	96
Maori Service Development	160	415	255	61%	✓	551
Whanua Ora Services	201	82	-119	-144%	✗	110
Palliative Care	111	164	53	32%	✓	214
Chronic Disease	67	153	86	56%	✓	204
Minor Expenses	103	101	-2	-2%	✗	134
	6,754	**7,093**	**339**	**5%**	✓	9,507
Referred Services						
Laboratory	138	206	68	33%	✓	269
Pharmaceuticals	6,050	6,144	94	2%	✓	8,129
	6,188	**6,350**	**162**	**3%**	✓	8,398
Secondary Care						
Inpatients	78	200	122	61%	✓	266
Travel & Accommodation	933	876	-57	-7%	✗	1,168
IDF Payments Personal Health	11,446	11,420	-26	0%	✗	15,226
	12,457	**12,495**	**38**	**0%**	✓	16,660
Primary & Secondary Care Total	**25,399**	**25,937**	**537**	**2%**	✓	**34,565**
Public Health						
Nutrition & Physical Activity	161	145	-16	-11%	✗	194
Public Health Infrastructure	54	55	1	1%	✓	73
Tobacco control	98	102	4	4%	✓	136
Public Health Total	**313**	**302**	**-11**	**-4%**	✗	**403**
Mental Health						
Eating Disorders	23	17	-6	-34%	✗	23
Community MH	479	600	121	20%	✓	773
Mental Health Work force	-4	6	10	163%	✓	8
Day Activity & Rehab	425	431	6	1%	✓	574
Advocacy Consumer	59	130	71	55%	✓	173
Advocacy Family	98	49	-49	-101%	✗	65
Minor Expenses	0	-20	-20		✗	0
Community Residential Beds	1,093	1,119	26	2%	✓	1,493
IDF Payments Mental Health	612	608	-4	0%	✗	811
	2,785	**2,940**	**155**	**5%**	✓	3,920
Older Persons Health						
Information and Advisory	26	23	-3	-11%	✗	30
Needs Assessment	0	0	0		✓	0
Home Based Support	525	503	-22	-4%	✗	671
Caregiver Support	82	87	5	6%	✓	115
Residential Care-Rest Homes	1,809	2,173	364	17%	✓	2,739
Residential Care Loans	-43	-18	25	139%	✓	-24
Residential Care-Community	195	234	39	17%	✓	312
Residential Care-Hospital	3,207	2,874	-333	-12%	✗	3,828
Ageing in place	4	38	34	90%	✓	50
Environmental Support Mobility	56	98	42	43%	✓	132
Day programmes	78	72	-6	-8%	✗	97
Respite Care	87	116	29	25%	✓	154
IDF Payments-DSS	1,071	1,073	2	0%	✓	1,430
	7,097	**7,272**	**175**	**2%**	✓	9,533
Mental Health & OPH Total	**9,882**	**10,212**	**330**	**3%**	✓	**13,453**
Total Expenditure	**35,594**	**36,450**	**857**	**2%**	✓	**48,421**

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

COMMUNITY AND PUBLIC HEALTH UPDATE

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

SOURCE: **Community and Public Health**

DATE: **2 May 2013**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing information about the work of Community and Public Health (West Coast).

2. RECOMMENDATION

That the Committee;

i. notes the Community and Public Health Update

3. SUMMARY

The purpose of this report is to provide the Committee with information and highlights of Community and Public Health's work.

4 APPENDICES

Appendix 1: Community and Public Health Update

Report prepared by: Jem Pupich, West Coast Team Leader, Community and Public Health

Report approved for release by: Dr Cheryl Brunton (Public Health Specialist) and Derek Benfield (Regional Manager, CPH West Coast)

COMMUNITY AND PUBLIC HEALTH (CPH)
May 2013

Drinking Water – the effects of drought

The long period of dry weather this summer has caused problems in quality and quantity of water for at least two West Coast public water supplies.

The capacity of the bores which supply the Greymouth water supply was reduced by the drought and the Grey District Council brought one of its reserve water bores on line to supplement the supply. Unfortunately, this led briefly to saline (salt) contamination of the water resulting in public complaints about its taste and appearance. Pumping from the reserve bore was stopped and water restrictions put in place to manage demand.

In March the bore supplying water to the Inangahua Junction community ran dry and, despite attempts to supplement the supply from a nearby creek, the community ran out of water. CPH provided advice to the community and the Buller District Council (BDC) which arranged for a tank of drinking water to be provided from which residents could fill containers. Fortunately, the school had a storage tank of water which has been sufficient to keep it supplied with drinking water. Recent rains have now increased the level of water in the bore and residents' water is back on. Samples of water have been taken and a boil water notice will remain in force until improvements to the supply are undertaken. The Inangahua Junction community comprises some 30 homes. They have, up to now, run their own water supply through a local Water Board. This is likely to change as the community has recently voted that the BDC take over management of the supply and organise improvements to the supply. It is intended to work towards a Capital Assistance grant application (see below) for the next funding round in 2014 to help fund these improvements.

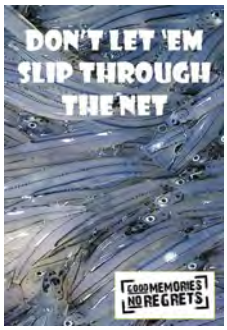
Drinking Water – Ministry of Health Capital Assistance Programme (CAP)

Projects have been completed for Punakaiki and Reefton with commissioning and plant performance to be signed off by CPH shortly. Applications for funding for new water treatment plants at Haast and Karamea have been made with a decision expected around August. Work at Nelson Creek has almost been completed with the water supply standing up well during the recent dry period. The Ahaura community are still working on their water reticulation and road crossings.

Wildfoods Festival

Each year Community and Public Health, Police, Westland District Licensing Inspectors and the Wildfoods Festival organisers plan together to ensure that Festival goers can enjoy themselves without harming themselves or others. Over the years we have been pleased to note that this joint approach is beginning to pay off with less alcohol related harm, including fewer arrests occurring.

Keeping everyone well-hydrated and well-fed were two goals of the Festival this year to help reduce alcohol-related harm. CPH supplied 1000 free bottles of water with safe sex messages on them to festival goers and, after a recommendation from the Police, the Festival organisers ensured that there were more food stalls in the downtown area this year that operated until late at night. As in the past CPH also supplied free condom packs which were available at the Festival, the market, hotels and campsites.



Police and CPH also carried out a Controlled Purchase Operation at the Festival and at downtown off licenses this year with no sales being made to our 16-year-old volunteer. This was an improvement on last year when two stalls at the festival sold to our volunteers and a vast improvement from 2009 when there were nine sales from eleven outlets.

Hotels and licensed premises in Hokitika were also visited on the Saturday evening by CPH staff to monitor their compliance with the Sale of Liquor Act. We observed that they all employed good security and had a range of low- and non-alcoholic drinks available, as well as a variety of food options. Intoxicated patrons were few and mostly well managed.

Last year there were over 60 arrests made over the Wildfoods weekend. This year that number was halved. St Johns reported that their hospital transfers and treatments were also down on last year. CPH has made a number of recommendations to the organising committee for next year and we will remain involved in the planning of the event with the aim of continuing to reduce alcohol-related harm.

Local Alcohol Policies

The Sale & Supply of Alcohol Act 2012 was passed on 18 December 2012. The object of the Act is:

a) that the sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and
b) the harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

The Act allows for Territorial Authorities (TAs) to have a Local Alcohol Policy (LAP). The LAP is a set of decisions made by a TA in consultation with its community about the sale and supply of alcohol in their district. LAPs will give TAs much greater influence over decisions about liquor licensing in their districts. Once in force, a LAP must be considered when licence applications are decided. LAPs may include provisions about:

- Maximum trading hours for the sale of alcohol.
- Number, location & density of premises including proximity to community facilities such as schools, early childhood centres, etc.
- One-way door restrictions that prevent people from entering or re-entering premises after a certain time.
- Conditions that could be imposed on licences or particular kinds of licences.

Councils must consult with the Medical Officer of Health and Police in preparing their draft LAP. West Coast Police and the Medical Officer of Health have encouraged the Buller, Grey and Westland District Councils to develop a joint West Coast LAP. One LAP would provide consistency for licensees, customers and enforcement agencies across the West Coast and demonstrate cooperation between the three Districts. The Medical Officer of Health and the Police will be providing data on the health and social impacts of alcohol on the West Coast to Councils to inform the development of a LAP. This will include data from a community-wide survey of attitudes to alcohol, liquor licensing and alcohol-related harm that CPH is currently conducting. The WCDHB's position statement on alcohol (adopted last year) is also an important document which should help inform Council and public discussions about LAPs and reducing alcohol-related harm.

With local body elections in October 2013, there is a need to move forward with a draft joint West Coast LAP if Councils agree to pursue this. The earliest that the provisional Local Alcohol Policy could be formally adopted would be 18 January 2014. In the absence of a LAP, the default trading hours in the Act would apply which would mean longer opening hours than at present in most parts of the Coast.

ALLIANCE UPDATE

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

SOURCE: **Planning & Funding**
Alliance Leadership Team

DATE: **2 May 2013**

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 the Alliance Update

3. SUMMARY

This report provides an update from the Alliance.

4. APPENDICES

Appendix 1: Alliance Update

Report prepared by: Kim Sinclair-Morris, Planning & Funding
Claire Robertson, Planning and Funding

Report approved for release by: Stella Ward, Allied Health
Carol Atmore, Chief Medical Officer

PP2 BSMC – West Coast DHB Q3 2012/13

Section 1: Delivering on Ministry expectations

Year Three Deliverables

Ministry requirement: *Quarterly reports outlining progress against the key deliverables in the jointly agreed Year Three Implementation Plans, including resolution plans for any areas of slippage against deliverables.*

Progress during Quarter 3 2012-13, for the BSMC workstreams Health of Older People, Buller IFHC and Grey IFHS, Public Health, Pharmacy and Child & Youth is outlined in Sections 2-6.

Flexible Funding Pool

Ministry requirement: *Quarterly reports on the operation and expenditure of the Flexible Funding Pool, including how pool funding has been jointly prioritised to deliver services.*

The Flexible Funding Pool funds are combined with other revenue to deliver a range of PHO programmes, including the Long Term Conditions Management programme and Smoking Cessation. Information on the expenditure of the Flexible Funding Pool is provided in Section 7.

Alliancing & Clinical Leadership

Ministry requirement: *Description of how all necessary clinicians and managers (primary/community and secondary) will be involved ongoing in the process of development, delivery and review.*

Additional members have been recruited into the Alliance Leadership Team to replace membership vacancies and to ensure a full range of perspectives and skill sets from across the West Coast Health system. Three new members have been recruited to provide Maori clinical, senior secondary medical and primary nursing perspectives.

An Alliance Support Group that includes management across DHB, Primary Health Organisation, Planning & Funding, Rata Te Awhina and the Alliance Programme Office has been established to support the West Coast Alliance. The function of this group is to facilitate the implementation of Alliance Leadership Team priorities, allocate resources to alliance activities, provide feedback to workstreams and offer advice to the Alliance Leadership Team.

The various alliance workstreams and Alliance Leadership Team has supported the West Coast DHB Annual Planning process, with particular input into the Integrating the West Coast Health System and Supporting Vulnerable Populations sections of the Service Performance Priorities. These sections provide the high level priorities for each of the alliance workstreams including Grey/Westland Integrated Family Health Services, Buller Integrated Family Health Services, Health of Older People, Child & Youth Health, Pharmacy and Public Health.

Community Pharmacy

Ministry requirement: *Activities to integrate community pharmacy.*

One of the focus areas within the draft Annual Plan 2013/14 Pharmacy section that was developed this quarter is service integration between pharmacy and general practice – pharmacists operating from

general practices or supporting outreach clinics as a way to progress service integration. This service is intended to provide patients and clinicians with greater access to clinical expertise by the pharmacist.

Hospital and community pharmacies continue to work in an integrated manner through activities such as shared intern roles and the compressed pharmacy role. The compressed pharmacy role ensures there is no reliance on locum cover required within pharmacy – decreasing the cost to the health system both for the DHB and for the community pharmacies.

Nursing Services

Ministry requirement: *Activities to expand and integrate nursing services.*

Progress during the quarter on expanding and integrating nursing services have included:

- Transalpine gerontology nursing with the CDHB Health of Older Person's Director providing clinical support to the two Gerontology Nurse Specialists based in Westport and Greymouth.
- Recruitment in Buller for the Kaupapa Maori Nurse District Nursing Positions are currently underway. As per the plan, one additional Rural Nurse Specialist has been employed in Buller.
- The Clinical Nurse Specialists moved from the Community Services department of the Grey Base hospital and our now operating out of the community. This has pulled the nurses together as a clinical team and further integrated them into the community.
- The Director of Nursing met with the Chief Executive and Senior Nurse of Rata Te Awhina Trust and together they have developed a plan to connect the Rata Te Awhina Trust nursing to the Clinical Nurse Specialist team from the DHB. Resources will also be shared such as performance appraisal documentation and support in meeting NCNZ competencies.

Health Needs Analysis

Ministry requirement: *Evidence of health needs analysis of population by localities.*

With integration of the CDHB and WCDHB Planning & Funding teams, the WCDHB is in the process of adopting analytical tools currently being used and developed at CDHB for health needs analysis and risk analysis. The West Coast will retain dedicated analytical support based in Greymouth and will receive additional expertise from Canterbury.

Improved Outcomes

Ministry requirement: *Identification of targeted areas/patient groups for improved outcomes as a result of enhanced primary and community service delivery (with a focus on managing long-term conditions) including:*

a. Identification of and achievement against targets for the number of people that are expected to be appropriately managed in primary/community setting instead of secondary care

At the end of this quarter 2453 patients were enrolled in the Long Term Conditions Management programme, out of the WCPHO's approximately 31,000enrolled patients, this means that 7.9% of the enrolled population is engaged in a structured programme of care for their long term conditions.

b. Identification of and achievement against targets for growth reduction in ED attendance, acute inpatient admissions and bed days

Acute Inpatient Admissions:

- The WCDHB acute length of stay remains second lowest in the country at 3.43 (standardised, year to 31 December 2012).

Acute Readmissions:

- The WCDHB acute readmission rate is the lowest in the country at 7.58 (standardised, year to 31 December 2012).

Reduction in ED Attendance:

- The current rates for ED are indicating a continuing significant decline in Triage Level 5 attendance rate as planned, and achieving a greater reduction overall than the minimum 5% reduction sought. Overall Level 5 attendances are down 15% for the 9 months to 31 March 2013 compared to the same period last financial year – down by 524 attendances to 2899. Level 5 attendances to Grey Base Hospital's Emergency Department are down 15% with 447 fewer presentations while attendances at Buller Accident and Emergency are down by 22% (91 fewer attendances). Only Reefton has gone against this trend – up by 14 attendances this year-to date compared to last. It is still expected that these rates will drop back as winter months impact, but it is anticipated that our 5% per annum reduction will be achieved at year end. To help maintain this, the WCDHB is continuing to undertake steps and strategies outlined in our Annual Plan to help retain the current trend towards overall reduction for the year.

c. Identification of and achievement against a target for the prevention of readmissions for the 75+ population (and any other target populations)

Section 2 outlines the Health of Older People Workstreams Progress.

Our 75+ acute readmission result to 31 December 2012 was 12.13%, achieving our 2012/13 target of 12.91%; it is anticipated that given the appointment of a new complex clinical care manager, as well as confirmed WCDHB geriatrician cover and transalpine gerontology nursing support this quarter, progress will continue to be mad e in this area.

Infrastructure

Ministry requirement: *Identification of and activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model. Progress against the above infrastructure and revenue stream milestones.*

Supporting infrastructure includes the continued development of West Coast-specific HealthPathways and adoption of the appropriate CDHB pathways. The new West Coast HealthPathways Coordinator commenced work this quarter reviewing localised pathways, including those within; child health, haematology, nutrition and ultra-sound.

Managers and clinicians are continuing to work alongside the Partnership Group to develop the Final Business Case for the redevelopment of the Grey Base Hospital. A major focus of clinicians within the model of care working group is to ensure the building is supportive of further enhancement of integrative models of care both within the facility as well as throughout the health system.

The transportation service between Greymouth and Westport is continuing, in spite of a slow uptake of use in the pilot trial period to the end of February 2013. It is seen to be of value to helping improve access to specialist services and continues to enjoy the support of its volunteer drivers and coordinators at Buller REAP. West Coast DHB is continuing to work with Red Cross to encourage greater use and uptake of the service in the hope it can gain a greater degree of longer-term sustainability.

Section 2: Health of Older People Workstream Progress Q3 2012-13

Progress has continued on the development of a restorative homecare model through the Complex Clinical Network project that coordinates care and provides assessment and treatment for people living in the community with complex needs. A detailed work plan has been developed for Health of Older People projects over the next 12 months.

Interdisciplinary Team Meetings: The Inter Disciplinary Team (IDT) meetings are now well established and continue to have strong representation from Allied Health, Primary Care and Home Based Support Services. These take place in Greymouth, Westport, Hokitika and Reefton. All patients referred for aged residential care facilities have had an IDT review and continue to be signed off by the geriatrician in the first instance.

Workforce: WCDHB/CDHB geriatrician cover on the West Coast has been confirmed at 0.6FTE since early March. The Complex Clinical Care Network (CCCN) manager commenced her role in February and is managing the Interdisciplinary Team Meetings (which continue to be lead by the geriatrician). The CCCN manager ensures the four IDT's are consistent with respect to membership and process.

Transalpine Gerontology Nursing: Transalpine gerontology nursing is underway with the CDHB Health of Older Person's Director providing clinical support to the two Gerontology Nurse Specialists based in Westport and Greymouth.

Section 3: Buller Integrated Health Centre Progress Q3 2012-13

Clinical leadership and dedicated project management support have been recruited for the Buller Integrated Family Health Services workstream. During the coming months the Buller workstreams will be re-established to progress the integration of services.

Section 4: Grey Integrated Health Service Progress Q3 2012-13

Much of the focus for quarter three has continued to be on the work being carried out in the Partnership Group process. During May and June 2013 a six week facilitated workshop process will take place to operationalise the alliance priorities for the Grey district. Clinicians, consumers, NGOs and health professionals from across the West Coast health system will be invited to attend a series of three facilitated workshops. The outcome of these workshops will be the development of a two year implementation plan that details the key alliance deliverables for integrating care within the Grey districts and allocates clinical leadership and project support responsibilities. A similar process will be provided across Westland and South Westland.

Section 5: Pharmacy Workstream Progress Q3 2012-13

The draft Annual Plan 2013/14 Pharmacy section was developed with local community and hospital pharmacists through the workstream and an implementation plan is currently being developed. The plan includes the establishment of a pharmacist to general practice service in 2013/14 whereby community pharmacists will operate from general practice on a regular basis to improve team based approaches to the planned and structured management of patients and refocusing the Medicines

Utilisation Review Service as part of a structure approach to managing high needs individuals or whanau.

Section 6: Public Health Workstream Progress Q3 2012-13

The development of the Disease Prevention section of the Annual Plan 2013/14 and the Community & Public Health Action plan has been a focus of the workstream this quarter.

Health Promotion Hui: A Health Promotion Hui was held in February for staff who work in health promotion under the Healthy West Coast organisations (Community & Public Health, Rata te Awhina Trust, WCPHO and WCDHB), 30 participants took part. The objectives of the day included; kotahitanga – working together/sharing/understanding/learning, identifying and enhancing collaboration opportunities for improved public health outcomes in the community.

Smokefree Health Target: During this quarter an action plan was developed to improve performance against the Secondary Smokefree health target, including focusing on senior clinical leadership, reinforcing clinical relevance and focus of the ABC implementation. This resulted in an increase of performance for both February (96%) and March (93%) with an overall quarter result of 91%.

Section 6: Child & Youth Workstream Progress Q3 2012-13

Workstream Development: Due to the high number of priorities and wide scope of the Child, Youth & Maternal Health portfolio, the workstream will provide leadership and an oversight of this work through small working groups that complete projects and report back with progress and developments, for example the Newborn Enrolment Working Group.

Immunisation Health Target: This quarter there has been ongoing collaboration with CDHB around improvement of systems and process to work towards the Minister's Immunisation Health Targets. This includes the work around the National Immunisation Register to identify unvaccinated children and children overdue or pending immunisation, including referrals to outreach immunisation services.

Newborn Enrolment Working Group: This quarter a working group was put together with the aim of developing a process that will ensure a timely coordinated enrolment process from birth with General Practice and Well Child Providers.

Maternal Care and Unborn Wellbeing Group (MCAUW): The MCAUW group was developed in March; it is a multi-disciplinary team, involving key agencies, including Child, Youth & Family, West Coast Family Start, WCDHB maternity services and Well Child/Tamariki Ora Providers. It is aimed at minimizing statutory involvement by identifying, building and reviewing parental capacity through a coordinated response. This is one example of a coordinated, multi-disciplinary approach to protect vulnerable pregnant women and children who are at greatest risk of maltreatment on the West Coast.

Section 7: Flexible Funding Pool

Note: The Flexible Funding Pool funds are combined with other revenue to deliver a range of PHO programmes.

Profit & Loss – West Coast Primary Health Organisation
All Departments 1 July – 31 March 2013

	Clinical Services	Keeping People Healthy	Total
Income			
Services to Increase Access (SIA)	158,992		158,992
Care Plus (C+)	344,038		344,038
Health Promotion (HP)		135,859	135,859
Smoking Cessation	37,499	62,925	100,424
GRx		42,573	42,573
Breastfeeding		54,038	54,038
Diabetes Services	64,855		64,855
Other Clinical Services	46,802		46,802
Other & Sundry Income	57,135	7,654	64,789
Total Income	709,322	303,048	1,012,370
Less Cost of Services	279,059	22,161	301,221
less Operating Expenses	430,263	280,887	711,150
Variance	-	-	-

MAORI HEALTH ACTION PLAN 2013/14

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

TO: **Chair and Members**
Community and Public Health Advisory Committee

SOURCE: **Planning and Funding**

DATE: **2 May 2013**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report accompanies the draft version of the 2013/14 Maori Health Action Plan, which is due to the Ministry of Health for its second submission on 9 May 2013.

2. RECOMMENDATION

That the Committee:

i. Notes the content of the draft Action Plan and provide any feedback on improvements before submission to the Ministry.

3. SUMMARY

All DHBs are required to submit Maori Health Action Plans alongside their Public Health Plans, Annual Plans and Statements of Intent. A national template is provided for the plans with the national priority areas and indicators pre-determined.

There are three submission dates of the Maori Health Action Plan: an initial draft which was submitted in March 2013, a second draft due May and a final Plan due in June.

The initial draft Maori Health Action Plan has been developed with support from Rata Te Awhina Trust, West Coast PHO and the West Coast Alliance Support Group and endorsed by Tatau Pounamu, Executive Management Team (EMT) and the West Coast DHB Board. Their feedback has been incorporated into this draft version. Any feedback provided by this Committee will also be incorporated.

The DHB is expecting feedback from the Ministry of Health's Maori Health Division on the initial draft to incorporate into the second version but as yet this has not been received. We expect that this will arrive before the Committee meeting and the DHB's intended response to the feedback will be discussed with the Committee.

4. DISCUSSION

Like the Annual Plans, the Maori Health Actions Plans focus primarily on how the West Coast DHB will meet national expectations against selected priorities, rather than capturing all activity happening across the system.

In addition to the priorities already identified at a national level, local priorities have been indentified and are included in the Plan. These are areas where there were clear differentials in access or outcomes, where baselines existed in order to determine progress and where there was a particular focus on vulnerable child, young people and populations.

However it should be acknowledge that considerable work is ongoing across the health system that contributes to improving outcomes for Maori – outside of the activity highlighted (summarised) in this Action Plan. This Plan sits alongside the DHB's Annual

Plan and the work plans of the various workstreams under the West Coast Alliance which together present a wider picture of all the activity happening across the West Coast.

The planned activity articulated in the draft Maori Health Action Plan has been pulled from the work plans of Rata Te Awhina Trust, West Coast PHO, the West Coast Alliance Workstreams and other local working groups including: the West Coast Child and Youth Health Advisory Committee, Healthy West Coast, the Local Heart and Respiratory Team and the West Coast Immunisation Advisory Group. It also includes activity under the national Whānau Ora Initiative worked up with He Oranga Pounamu.

The Ministry feedback on the Plan is yet to be received and incorporated.

5. NEXT STEPS

Feedback from the Committee will be incorporated into the second draft Maori Health Action Plan to be submitted 9 May. With receipt of feedback from the Ministry the DHB's intended response will be discussed with the Committee and (time permitting) incorporated into the second draft.

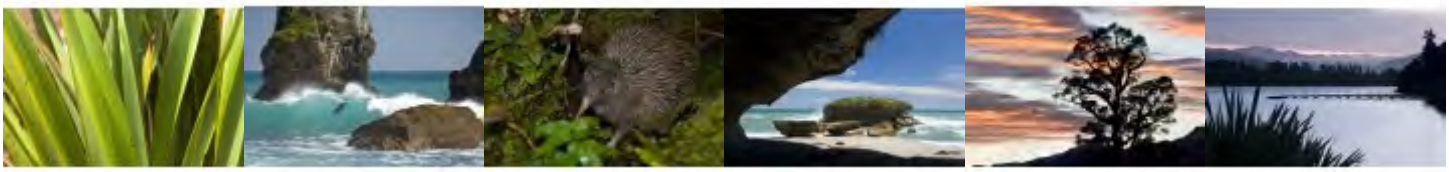
The final Māori Health Action Plan is due in June 2013.

6. APPENDICES

Appendix 1: Draft Maori Health Action Plan 2013/14

Report prepared by: Kylie Parkin, Maori Health Portfolio Manager
Melissa Macfarlane, Team Leader, Accountability

Report approved for release by: Gary Coghlan, GM Maori Health
Carolyn Gullery, GM, Planning and Funding
David Meates, Chief Executive



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

MAORI HEALTH PLAN

2013-14

SUMMARY OF INDICATORS

National Priorities		Indicators		Baseline Maori	Non-Maori	Target
Data Quality	1	Accuracy of ethnicity reporting		To be established		
Access to care	2	% of Maori enrolled in PHOs % of Maori enrolled in clinical programmes		85.4%	94.6%	>95%
	3	ASH rates per 100,000 (year to Sept 2012)	0-74 yr 0-4 yr 45-64 yr	1746 3953 1773	1558 4087 1577	<1,771 <4,397 <1,936
Maternal health	4	Percentage of Maori infants fully and exclusively breastfed	6 weeks 3 months 6 months	75% 54% 28%	77%	
Cardiovascular disease	5	%of Maori who have had their cardiovascular risk assessed within the past five years		42%	70%	90%
	6	Number of tertiary cardiac interventions		Information only		
Cancer	7	Breast screening rate		85.1%	78.6%	>75%
	8	Cervical screening rate		62.4%	82.9%	80%
Smoking	9	% of hospitalised smokers provided with cessation advice		86%	84%	95%
	10	% of smokers seen in primary care and provided with cessation advice		38.8%	39%	90%
Immunisation	11	% of infants fully immunized by eight months of age		New	New	90%
	12	% of the eligible population immunized against seasonal influenza		65.7%		>65%
Local Priorities						
Oral health	13	Pre school dental enrolment rates 5 year old Maori caries free		60% (calendar year) 51% (calendar year)		>77% 65%
Access to services	14	Reduction in hospital readmission rates for Maori		TBC		TBC

CONTENTS

OVERVIEW

This plan describes West Coast District Health Board's (WCDHB) priorities for Maori health for the 2013-2014 year. This plan aligns with the requirements of the New Zealand Public Health and Disability Act (2000) which directs District Health Boards (DHB's) to reduce disparities and improve health outcomes for Maori. The format of this plan and the indicators listed within it follow the guidelines given in the 2013-2014 Operational Policy Framework provided by the Ministry of Health.

Over the coming year we will work closely within an alliance framework to achieve the outcomes described in the Maori Health Plan. The partners within the alliance will consist of the West Coast PHO, Rata Te Awhina Trust working alongside key clinicians and managers within secondary and community services as well as key partners such as Community and Public Health.

Our 2012-2013 Maori plan has laid a solid foundation from which we will continue to build on in 2013-2014. In the past several years real gains have been made in improving Maori health:

- More Maori are enrolled with primary care. 85% of Maori are now enrolled with the West Coast Primary health Organisation – up from 79% in 2009/2010.
- More Maori with diabetes are accessing free annual checks. 94% of Maori with diabetes accessed free annual checks in 2011/2012 – a significant improvement from 53% in 2009/2010
- More Maori with diabetes are better managing their diabetes. 71% of Maori with diabetes who accessed free annual checks have satisfactory or better diabetes management in 2011/2012 – up from 67% in 2009/2010
- More Maori have had their cardiovascular (CVD) risk assessed. 42% of eligible Maori adults have had CVD risk assessment in the last five years in 2011/2012 – up from just 19% in 2009/2010.
- More Maori are being supported to quite smoking. 86% of hospitalised Maori smokers were offered advice and help to quit in 2011/2012 – well up from only 46% in 2009/2010.
- Fewer Maori are going to hospital for preventable illnesses. Avoidable hospitalisation rates for Maori (aged 0-74) have dropped to 1746 per 100,000 in 2011/12 – down from 2102 in 2009/2010.
- Maori Health Provider services have been reconfigured to align more closely to the Ministry's Better, Sooner more Convenient health and Whanau ora strategy including Maori Health positions within Integrated Family Healthcare Centres.

Through work undertaken we have identified the key areas where further investment is required to ensure that we are achieving the targets set and continuing to build on the momentum created in 2012-2013.

We will continue to work alongside our Maori Provider on the West Coast to more closely align services to the Ministry's 6 Health targets and the indicators within the Maori Health Plan and also to integrate some of their services within the Integrated Family Healthcare Centres.

We will continue to focus on improving the capacity and capability of the West Coast health system to provide appropriate, accessible and integrated health services for Māori on the West Coast. This includes improving the responsiveness and effectiveness of mainstream service providers, reorienting and integrating Māori health services and delivering on the national Whānau Ora initiative.

Following the review of mainstream service effectiveness for Māori, our service priorities include child and maternal health, long term conditions, smoking cessation, and oral health. We anticipate that Māori will benefit from the establishment of clear patient pathways and targeted initiatives that are aimed specifically at increasing Māori uptake of services such as immunisation programmes, breastfeeding support, and school-based health services and reducing inequalities. Additionally we will focus on improved discharge pathways to better support patients on discharge from hospital to improve their recovery and reduce readmissions.

Delivery on Whānau Ora and improving access and health outcomes for our population by supporting interconnectedness and the provision of seamless services between providers and sectors will continue to be a priority. We will work alongside providers to support the organisational transformation required for the delivery of

a Whānau Ora Integrated model that is clinically sound, culturally robust and empowers patients while recognising the strengths within Whanau and encourages Whānau to be self-managing.

Performance Reporting

In addition to the alliance group quarterly performance results for the Maori Health Plan indicators will be disseminated to four key audiences.

First, results will be submitted to the Board for review and discussion in the same manner that annual Plan and Health Target results are presented. Second, quarterly performance reports will be reviewed by the Mana Whenua Health Board – Tatau Pounamu. Third, quarterly performance results will be presented at the DHB's executive management meetings and Fourth the DHB's Maori Health Plan performance will be presented in the DHB's Annual Report.

ABBREVIATIONS

ABC	An approach to smoking cessation requiring health staff to ask, give brief advice, and facilitate cessation
AP	Annual Plan
ARF	Acute rheumatic fever
ASH	Ambulatory sensitive hospitilisation
BFHI	Baby friendly hospital initiative
WCDHB	West Coast DHB
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
CVRA	Cardiovascular Risk Assessment
DAR	Diabetes Annual Review
DHB	District Health Board
DMFT	Decayed, Missing or Filled teeth
DNA	Did not attend
ENT	Ear Nose and Throat
GM	General Manager
HbA1c	Glycosylated haemoglobin
IGT	Impaired Glucose Tolerance
IHD	Ischaemic heart disease
ISDR	Indirectly standardised discharge rate
MoH	Ministry of Health
NSU	National Screening Unit
WCPHO	West Coast PHO

Section 1 – West Coast DHB Population: Profile and Health Needs

1. Geographic Distribution

The West Coast DHB has a total population of 32,900[1], of which 10% (3320) identify as Māori – an increase of 5% from the 2006 estimated resident population.

WCDHB comprises three territorial authorities. In the 2006 census, the proportion of the population indicating Maori ethnicity increased across all three territorial local authorities.

District	Buller	Grey	Westland
Maori (no)	804	1098	1014
Maori (%)	8.3%	8.3%	12.1%

2. Health Service Providers

Key health service providers in the DHB include:

- 3 public hospitals within the West Coast DHB
- General Practice – 2 privately owned, 4 DHB owned
- West Coast Primary Health Organisation
- Rata Te Awhina Trust Maori Health Provider
- Multiple local and national non-profit and private health and social providers

3. Iwi within the WCDHB

Poutini Ngai Tahu
Under section 9 of the Te Rūnanga O Ngai Tahu Act 1996 the two runanga who hold such status on the West Coast are Te Rūnaka O Ngati Waewae and Te Rūnanga O Makaawhio.

Te Runanga O Makaawhio
The takiwa (tribal area) of Te Rūnanga o Makaawhio centres on Mahitahi (Bruce Bay) and extends from the south bank of the Pouerua River to Piopiotahi (Milford Sound) and inland to the Main Divide together with a shared interest with Te Rūnanga o Ngati Waewae in the area situated between the north bank of the Pouerua River and the south bank of the Hokitika River.

Te Runanga O Ngati Waewae
The takiwa (tribal area) of Te Rūnanga o Ngāti Waewae centres on Arahura and Hokitika and extends from the north bank of the Hokitika River to Kahuraki and inland to the Main Divide, together with a shared interest with Te Rūnanga o Makaawhio in the area situated between the north bank of the Pouerua River and the south bank of the Hokitika River

Tatau Pounamu Manawhenua Health Group
The West Coast District Health Board has Treaty-based relationships with Te Rūnanga o Ngāti Waewae and Te Rūnanga o Makaawhio, and supports and regularly consults with Tangata Whenua and the Māori community both directly and through Tatau Pounamu, its manawhenua consultive group

4. Age Distribution of the Maori Populaiton

Similar to the national Maori population, West Coast Maori have a younger population age structure. Almost half of West Coast Maori (45% are under twenty years of age, compared to 24% of non-Maori population. In contrast, 9% of Maori on the West Coast are aged 60 years and over compared to 24% of non-Maori in the same age band.

Age Group	0-9	10-19	20-39	40-69	70-79	80+
Maori (%)	23.05	24.79	24.39	25.61	1.75	0.41
Non-Maori (%)	11.47	13.07	22.81	42.43	6.49	3.73

5. Population Growth Projections

[1] Estimated Resident Population at June 2011: Statistics NZ updated November 2011

Over the period 2006-2026, the young (aged 0-14 years) and working age (15-64 years) Maori populations are predicted to increase by 7.0 percent and 18.7 percent respectively. The greatest population increase occurs in the elderly population for Maori (261.5%). This is predicted to lead to an overall increase in the Maori population of 24.5 percent while the non-Maori population is expected to decrease by 2.7 percent.

6. Deprivation Distribution

The West Coast population is relatively deprived overall, as defined by the New Zealand Deprivation Index 2006. West Coast Maori have a similar deprivation profile to the total West Coast population, and this is in contrast to the national picture, in which Maori have a more deprived profile. However, data from the 2006 Census indicate that West Coast Maori have higher levels of deprivation than the total West Coast population on a number of measures including income, education, access to a car and telephone and home ownership.

7. Leading causes of hospitalisations for children 0-4 years by ethnicity, 2007-09

	West Coast DHB		New Zealand	
	Condition	**Rank**		**Rank**
Maori	Respiratory Infections	1	Respiratory Infections	1
	Disorders related to length of gestation and fetal growth	2	*Persons encountering health services in other circumstances	2
	*Persons encountering health services in other circumstances	3	Disorders related to length of gestation and fetal growth	3
	Gastro-oesophageal reflux disease	4	Gastro-oesophageal reflux disease	4
	Dental conditions	5	ENT Infections	5
Non-Maori	Respiratory Infections	1	Persons encountering health services in other circumstances	1
	Persons encountering health services in other circumstances	2	Respiratory infections	2
	Gastro-oesophageal reflux disease	3	Disorders related to length of gestation and fetal growth	3
	Disorders related to length of gestation and fetal growth	4	Gastro-oesophageal reflux disease	4
	Respiratory and cardiovascular disorders specific to the perinatal period	5	ENT infections	5

Note: ENT infections = ear, nose and throat infections

*Persons encountering health services in other circumstances (Z70-Z76). For example, health supervision and care of other healthy infant and child

Leading causes of avoidable hospitalisations, ethnicity, 0-74 years

	West Coast DHB		New Zealand	
	Condition	**Rank**		**Rank**
Maori	Respiratory Infections	1	Respiratory Infections	1
	Dental conditions	2	Dental conditions	2
	Asthma	3	Asthma	3
	ENT infections	4	ENT infections	4
	Diabetes	5	Angina	5
Non-Maori	Respiratory infections	1	Respiratory infections	1
	Gastroenteritis	2	Gastroenteritis	2
	Dental conditions	3	ENT infections	3
	Obstructed hernia	4	Dental conditions	4
	ENT infections	5	Angina	5

All Cause Mortality (Source: New Zealand Health Information Service)

	West Coast		New Zealand	
	Maori	Non-Maori	Maori	Non-Maori
All ages all-cause mortality, 1996-2004, mean annual rate per 100,000	410.0 (334.1-498.0)	236.6 (225.6-248.0)	475.8 (469.6-482.0)	201.3 (200.3-202.3)

Nb: small numbers prevent the calculation of an avoidable mortality rate for West Coast Maori females, and contribute to wide 95% confidence intervals around the rate for West Coast Maori males.

8. Primary Care – PHO Enrolment

Over the past 26 quarters, enrolments in the Pho by Maori and Pacific Island people have grown by 52%. While those by people of all other ethnicities have grown 15%

Enrolled population as at30 June 2012

PHO	WCPHO
Total Enrolled	31,114
Maori	**2869**
Maori (%)	**9.2%**

9. Social Determinants of Health

(Source: Statistics New Zealand 2006 Census data)

WCDHB			New Zealand	
	Maori	Non-Maori	Maori	Non-Maori
Income more than $50,000	4.6%	9.1%	5.9%	12.7%
Income less than $20,000	29.3%	35.2%	27.7%	30.4%
Degree or higher qualification	1.9%	5.3%	4.1%	11.1%
No qualification	23.4%	25.5%	23.0%	17.6%
No access to telephone	20.7%	12.1%	23.3%	10.9%
No access to car	8.0%	4.6%	8.2%	4.7%
Home not owned	39.5%	23.9%	49.0%	29.9%

Section 2 – National Indicators

Health Issue:	**Data Quality**
Indicator 1:	**Accuracy of ethnicity reporting in PHO registers**
Baseline:	
Target:	Less than 10% of enrolled people are identified as 'ethnicity not stated'
Current Actions:	1. WCDHB has provided training for PHOs and primary care providers aimed at increasing the accuracy of ethnicity data 2. WCDHB has promoted use of the MoH's ethnicity data collection protocol in PHO enrolment process 3. PHO Roadshows target accurate data collection

Action Plan:

Outcome:	Accurate population health information		
To help achieve this outcome we will:	Decrease the number of enrolled people with 'ethnicity not stated' on their enrollment Limit misclassification of ethnicity in primary care		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Support the PHO quality control team to deliver training for data collection	75% of practices have completed data collection training	50% complete by Dec 2013 75% by June 2014	WCDHB Maori Health West Coast PHO
Use the MoH ethnicity audit tool to measure progress in accurate ethnicity data collection	Baseline data established Reduction in the number of 'Ethnicity not Stated' in PHO enrollments	Baseline data confirmed by Oct 30 2013	WCDHB Maori Health West Coast PHO

Health Issue:	**Access to care**
Indicator 2:	**Percentage of Maori enrolled in PHOs** **Percentage of Maori enrolled in primary healthcare clinical programmes**
Baseline:	85.4% of West Coast Maori were enrolled with a PHO at 30 June 2011/2012
Target:	95% Maori Pho enrolment rates by 30 June 2014
Current Actions:	1. WCDHB has attained high PHO enrolment rates for Maori compared with national figures and Maori enrolment rates continue to increase at a faster rate than any other ethnicity.

Action Plan:

Outcome:	Improved access to primary care		
To help achieve this outcome we will:	Increase the PHO enrolment rate for Maori		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Implement the newborn PHO enrolment process	All newborns are enrolled with a primary care provider by 6 weeks of age	Process in place by Dec 2013 100% enrollment by June 30 2014	West Coast PHO Child Youth Health Workstream

Maori Provider Kaimahi support Maori to enroll with the PHO	Quarterly reports are provided by the Maori Provider that give evidence of whanau who are supported to enroll with the PHO	Reported on each quarter	Rata Te Awhina Trust
Decrease the number of misclassification of ethnicity	Reducing number of 'ethnicity not stated'	Baseline data confirmed by Oct 2013 June 30 2014	West Coast PHO
Recruitment of specific Maori health positions within Integrated Family Healthcare Care Services	Buller recruitment commenced Grey recruitment commenced Westland recruitment commenced	July 2013 Nov 2013 Nov 2013	Rata Te Awhina Trust West Coast DHB Maori
Maori Provider clients supported to participate in appropriate clinical programmes	Number of Rata Te Awhina Trust clients participating in; - Long Term Conditions Programme - Diabetes Annual Review - CVRA - Cardiac Rehabilitation programmes	Quarterly reports provided by PHO and Rata Te Awhina Trust	Rata Te Awhina Trust West Coast PHO

Health Issue:	**Access to care**
Indicator 3:	**Ambulatory Sensitive Hospitalisations rates per 100,000 for the 0-74, 0-4, and 45-64 age groups**
Baseline:	Age standardized ASH rates (year to June 2012) 0-74 yr age group: 1746 vs 1558 per 100,000 (Maori vs. non-Maori) 0-4 yr age group: 3953 vs 4087per 100,000 (Maori vs. non-Maori) 45-64 yr age group: 1773 vs 1577 per 100,000 (Maori vs. non-Maori)
Target:	0-74 yr age group: <1,771 per 100,000 0-4 yr age group: <4,397 per 100,000 45-64 yr age group: <1,936 per 100,000
Current Actions:	1. Improvement in pre-school dental enrolment rates 2. Maori positions within Integrated Family Health Care Services

Action Plan:

Outcome:	Improved access to primary care Reduced readmission rates
To help achieve this outcome we will:	Reducing the ambulatory sensitive hospitalisation (ASH) rate

Activity/Action	Evidence	Timeframe	Responsibility
Develop and implement an action plan to facilitate improved management of ASH conditions in primary care	Identification of the top five ASH conditions and a plan in place to facilitate improved management of these conditions	Q4 2014	WCDHB Maori health WCPHO WCDHB

			Rata Te Awhina Trust
Develop a collaborative model with the Maori Provider to implement a process for improved management of Long Term Conditions	Reduction in ASH admissions relating to Long Term Conditions	Dec 2013 June 30 2014	West Coast DHB Maori Health West Coast PHO Rata Te Awhina Trust WCDHB Nurse Specialists
Develop a collaborative model with the Maori Provider and the PHO to Improve the interface between primary and secondary care when patients are discharged	Whanau Ora workers and Kaiamahi are notified when Maori discharged from hospital require comprehensive support services	Dec 2013 June 30 2014	WCDHB Maori health Chronic Conditions Nurse Specialist GP Practices

Health Issue:	**Child Health**
Indicator 4:	**Percentage of Maori infants exclusively breastfeeding at 6 weeks, 3 months, and 6 months**
Baseline:	6 weeks – 75% 3 months – 54% 6 months -28%
Target:	6 weeks – >75% 3 months – 57% 6 months – 40%
Current Actions:	1. Breastfeeding health promotion activities continue to be delivered by the West Coast PHO 2. Breastfeeding support has been facilitated through lactation consultants, Tamariki Ora providers, Maori Health Providers, Mum4Mum Peer Supporters and Plunket nurses

Action Plan:

Outcome: **To help achieve this outcome we will:**	Improved health amongst mothers and their babies Increase the number of mothers who have fully and exclusively breastfed their baby to six months		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Continue to provide health promotion activities which support breastfeeding	• Number of mums with Maori babies accessing WCPHO lactation services • Number of mums with Maori babies graduating from the Mum 4 Mums antenatal support group	Six monthly	West Coast PHO Rata Te Awhina Trust Health West Coast Governance Group
Investigate opportunities for the Maori Provider Kaiawhina/Mothers and Pepi service to walk alongside Maori mums from antenatal to postnatal care	Report developed with maternity services on options to establish this service Options for inclusion into contracts explored and made available	Six monthly	West Coast DHB Maori Health West Coast DHB Maternity Services Rata Te Awhina Trust
Continue Maori involvement in Breastfeeding Interest groups	Number of meetings attended by Maori Kaimahi	Six monthly	West Coast DHB Maori Health Rata Te Awhina Trust

	Cardiovascular disease
Indicator 5:	**Cardio vascular risk assessment (CVRA) completion within the past 5 years (percentage of the eligible population)**

Baseline:	42% at June 2012
Target:	90% by June 2014
Current Actions:	1. Heart Respiratory Team responsible for monitoring results for CVD 2. CVRA performance targets incorporated into Maori Provider Service delivery contracts

Action Plan:

Outcome:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will:	Increase the proportion of cardiovascular risk assessments (CVRA) performed in the eligible population		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Work with the PHO to review CVRA rates in general practices	Identification of high and low-performing clinics. Shared strategies to improve rates implemented	Dec 2013 June 2014	West Coast DHB Maori Health West Coast PHO
Training and tools are provided to Maori Provider clinicians to ensure clinical guidelines are met	Rata Te Awhina Trust clinical staff are up-skilled in clinical best practice	Dec 2013 June 2014	West Coast DHB Maori Health West Coast PHO Rata Te Awhina Trust
Hold CVRA clinics for Maori in collaboration with Nurse Specialists, PHO and Maori Provider	6 CVRA clinics held	Quarterly	West Coast DHB Maori Health West Coast PHO Rata Te Awhina Trust WCDHB Nurse Specialists
Delivery of Te Whare Oranga Pai physical activity and healthy eating programme	Number of health plans developed Base line data established	Quarterly reports	
Continued involvement by Maori in the Heart and Respiratory quarterly meetings	Number of meetings attended	Quarterly	Rata Te Awhina Trust West Coast DHB Maori Health
Develop a process for data capture from Maori Provider back to the practices	All screening completed in community settings is feed in to the relevant practice	Meetings held and process decided by December 2013 =- process implemented by June 2014	Rata Te Awhina Trust West Coast DHB Maori Health West Coast PHO GP Practices

Health Issue:	**Cardiovascular disease**
Indicator 6:	**Number of tertiary cardiac interventions (by ethnicity)**
Baseline:	
Target:	
Current Actions:	1. WCDHB will work with the Cardiology team to develop a monitoring framework to measure progress in relation to this indicator throughout the year.

Action Plan:

Outcome:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will:	Monitor the number of tertiary cardiac interventions for Maori and non-Maori in the WCDHB		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**

Develop a framework for capturing data in relation to tertiary cardiac interventions for Maori.	Framework developed and quarterly monitoring reports provided.	June 2014	Planning and Funding WCDHB Maori Health

Health Issue:	**Cancer**
Indicator 7:	**Breast screening rate among the eligible population**
Baseline:	85.1% at 30 June 2012
Target:	75% by June 2014
Current Actions:	1. Maori participation in the Local Cancer Team Meeting 2. Promotion of Breast screen Aotearoa by primary care providers 3. Breast screening attendance data reviewed on a regular basis

Action Plan:

Outcome:	**Reduced cancer mortality and morbidity**		
To help achieve this outcome we will:	Improve breast screening rates		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Work with the regional provider to ensure support services are engaged and co-ordinated effectively	Meetings held and agreed best practice models for breast screening service delivery models developed for the West Coast	Dec 2012 June 2013	West Coast DHB Maori Health Breastscreen Aotearoa Local Cancer Team

Health Issue:	**Cancer**
Indicator 8:	**Cervical screening rate among the eligible population (three year cycle), age 25-69**
Baseline:	59.3% at June 30 2012
Target:	80% by June 2014
Current Actions:	1. 0.4 FTE Maori Cervical Screening Nurse employed by the DHB 2. Collaborative initiatives between the WCDHB, WCPHO and the Maori Provider to better co-ordinate and improve screening rates

Action Plan:

Outcome:	Reduced cancer mortality and morbidity		
To help achieve this outcome we will:	Improve cervical screening rates		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Increased referrals to Maori Cervical Screener through promotion and integration of service in primary care	Monthly reports from the WCDHB including referral from primary care and number of Maori women accessing the service	Quarterly reports Additional reports to Tatau Pounamu as required	West Coast DHB Maori Health West Coast DHB Cervical Screener West Coast PHO
Work with the PHO to highlight mainstream responsiveness to inequalities in cervical screening rates	Inclusion in PHO quality training	June 2014	West Coast DHB Maori Health West Coast PHO
Work with the Maori Provider and the PHO to identify opportunities for	Number of clinics held Number of outreach screening occurred	Quarterly reports	West Coast DHB Maori Health

outreach clinics and screening to occur			West Coast DHB Cervical Screener West Coast PHO
Develop a process to facilitate improved coordination between services Engage key stakeholders in identifying a system approach to improve cervical screening rates for priority women	Process facilitated and embedded in the pathway	Dec 2012 June 30 2013	West Coast DHB Maori Health West Coast DHB Cervical Screening services West Coast PHO

Health Issue:	**Smoking**
Indicator 9:	**Percentage of hospitalised smokers provided with cessation advice**
Baseline:	86% as at June 2012
Target:	95% by June 2014
Current Actions:	1. Maori targets identified within the West Coast Tobacco Control Plan implementation 2. Aukati Kaipaipa programme implemented on the West Coast 3. Monthly reporting is provided for WCDHB by ward and stratified by ethnicity

Action Plan:

Outcome:	Improved respiratory health		
To help achieve this outcome we will:	Increase the proportion of hospitalised smokers who are offered cessation advice		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
ABC training provided to all Maori Kaimahi who interface with hospital services including Kaiawhina, navigators, and Maori provider Kaimahi	100% of Maori Provider staff trained in ABC	June 30 2014	WCDHB Maori Health West Coast PHO Smoking Cessation Co-ordinator
WCDHB has developed standardised systems for smoking cessation advice during discharge planning for current smokers	Discharge planning tools and processes include smoking cessation options	June 30 2014	WCDHB Maori Health West Coast PHO Smoking Cessation Co-ordinator WCDHB WCDHB Smoking Cessation Co-ordinator WCDHB discharge Planning services
Aukati Kai Paipa services are promoted to all wards and a process for referrals developed and implemented	% of Aukati Kai Paipa referral that come from the hospital	Quarterly	WCDHB Community and Public Health Aukati kai paipa
Strategies developed and implemented to support Maori pregnant mothers to become smokefree	Number of pregnant mothers working with smoking cessation services	Quarterly	WCDHB Community and Public Health Aukati kai paipa Rata Te Awhina Trust

Priority:	**Smoking**
Indicator 10:	**Percentage of smokers seen in primary care and provided with cessation advice**
Baseline:	38.8% as at 30 June 2013

Target:	90% by June 30 2014
Current Actions:	1. Implementation of Maori objectives within the West Coast Tobacco Control Plan 2. System improvements in primary care to enable increases in the quantity and quality of coding information for Maori and non-Maori 3. ABC deliverables within Maori Provider contracts 4. Maori Provider training opportunities being delivered by the PHO Smoking Cessation Co-ordinator

Action Plan:

Outcome:	Improved respiratory health		
To help achieve this outcome we will:	Increasing the proportion of smokers in primary care who are offered cessation advice		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Support implementation of ABC training in community settings	Number of primary care health workers trained in ABC	Dec 2013 June 30 2014	WCDHB Maori Health WCPHO Smoking Cessation Co-ordinator
Establish smokefree leaders and champions in each PHO	Number of smokefree champions in primary care and community	Dec 2013 June 30 2014	WCDHB Maori Health WCPHO Smoking Cessation Co-ordinator West Coast Smokefree Coalition
Provide targeted community based cessation support to Maori through the Aukati Kaipaipa cessation programme	Number of Maori supported through Aukati Kai Paipa Regular reports from Community & Public Health on the AKP programme	Quarterly reporting	WCDHB Maori Health Community & Public Health - AKP
Maori Provider clients are provided with smoking cessation advice and referred to the appropriate service	Number of Rata Te Awhina Trust whanau provided with cessation advice Number of Rata Te Awhina Trust whanau referred to cessation services	Quarterly reporting	Rata Te Awhina Trust

Priority:	**Immunisation**
Indicator 11:	Percentage of infants fully immunized by eight months of age
Baseline:	89% as at June 30 2012 (2 year olds fully immunized) new
Target:	95% of Maori 2 year olds fully immunized by 30th June 2014 90% of all eight month olds will be fully vaccinated by 30th June 2014
Current Actions:	1. Outreach Immunisation Services focused on locating and vaccinating hard to reach children and reducing inequalities for Tamariki Maori and children. 2. Immunisation deliverables within Maori Provider contracts

Action Plan:

Outcome:	Improved child health		
To help achieve this outcome we will:	Increase the proportion of Maori children fully immunized by 8 months of age		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Develop and implement systems for	95 % of newborn babies are enrolled on	system developed by	Maori Health WCDHB

seamless handover between maternity, general practice and WCTO services	the NIR at birth	Dec 2013 and embedded into services by June 2014	Child Youth Health work-stream
Ensure timely enrolment of newborns within general practice	100% of newborns are enrolled with a primary care provider by 6 weeks of age	Quarterly reports	Maternity Services Child Youth Health Work-stream
Identify the immunisation status of children in hospital and refer them for immunisation.	Process in place and implemented by June 2014	System developed by Dec 2013 and embedded into services by June 2014	Maori Health WCDHB Child Youth Health work-stream
Focus Outreach Immunisation Services on locating and vaccinating hard to reach children and reducing inequalities for Tamariki Maori and children.	OIS Referrals show ethnicity and are reported on quarterly Three clinics are held in primary settings during 2013/14	Quarterly reporting Clinics held by June2014	Maori Health WCDHB West Coast PHO Outreach Immunisation Rata Te Awhina Trust

Priority:	**Immunisation**
Indicator 12:	**Percentage of the eligible population immunized against seasonal influenza**
Baseline:	65.7% as at 30 June 2012
Target:	>65% by 30th June 2014
Current Actions:	1. Maori Provider collaboration with the PHO in the delivery of outreach clinics for 65+ Seasonal Influenza 2. Immunisation Advisory Group prioritises Maori Immunisation

Action Plan:

Outcome: **To help achieve this outcome we will:**	Reduced communicable disease Increasing the proportion of eligible Maori who have received the seasonal influenza vaccine		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Provide Outreach clinics in a primary setting targeting 65+ seasonal influenza vaccinations	Three outreach clinics held targeting Maori during 2013/14	30 June 2014	WCDHB Maori Health WC PHO Rata Te Awhina Trust
Develop and implement a process to increase opportunistic immunization in secondary care	Process in place and implemented	Process developed by March 2014 and embedded into services by 30 June 2014	WCDHB Maori Health Health of Older People workstream
Ensure 65+ Seasonal influenza is included in Maori provider contracts	Data provided quarterly in Maori Provider contract	Quarterly reports 30 June 2014	WCDHB Maori Health Rata Te Awhina Trust

Section 3 - Local Indicators

Health Issue :	**Oral health**
Indicator 13:	**Pre- school dental enrolment rates** **5 year old Maori caries free**
Baseline:	60% as at 2012 (calendar year) 51% caries free as at 2012 (calendar)
Target:	>77% enrolled 65% caries free
Current Actions:	1. Barriers to care survey being developed 2. Working with pre-school and Te Kohanga Reo to provide education 3. Reviewing information and resources

Action Plan:

Outcome:	**Improved oral health among children**		
To help achieve this outcome we will:	Focus on increasing preschool dental clinic enrolment rates		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
A review on the way all dental services are offered to Maori children and whanau Implement ;barriers to care' survey Based on the survey results develop a plan for change	Results of survey indicates: - issues with enrolment or attendance - opportunities for improvement Plan for change is developed and implementation commenced	Survey completed by January 2014 and changes implemented by June 30 2014	WCDHB Maori Health WCDHB Dental Services
Provide education and information to Maori Provider staff Oral health data included in Maori Provider contracts	100% of Maori provider staff are trained in lift the lip and provided with appropriate resources 85% of Maori Provider Tamariki are enrolled in the dental service	Training and resources delivered by August 2013 Quarterly reports provided	WCDHB Maori Health WCDHB Dental services Rata Te Awhina Trust
Work with the Maori Provider on ways to introduce the level one mobile screening unit in primary care settings	Number of Mobile screening services delivered in Maori settings	Dec 2013 June 30 2014	WCDHB Maori Health WCDHB Dental services Rata Te Awhina Trust
Work with Public Health Nurses to ensure Maori whanau are being provided with oral health information and education	Number of Maori whanau visited by the Public Health Nurses and provided with oral health information and education	Numbers of whanau reported on quarterly	WCDHB Community services

Health Issue:	**Access to services**
Indicator 14:	**Reduction in hospital readmission rates for Maori**
Baseline:	TBA
Target:	TBA
Current Actions:	1. Long Term Conditions programme 2. Maori Provider Whanau ora contract includes deliverables around LTC

Action Plan:

Outcome:	A reduction in the number of Maori readmitted to hospital		
To help achieve this outcome we will:	Focus on discharge planning and rehabilitation processes for Maori Focus on reducing inequalities in readmission rates		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Work with the WCDHB discharge planning team to develop appropriate discharge pathways for Maori Process developed for post discharge care working with the Maori Provider	A pathway is developed for Maori discharges from hospital and embedded in discharge planning services Maori Provider Kaimahi are included in the discharge planning process where appropriate Number of inpatients referred to the Maori Provider for post discharge care	Planning complete by Dec 2013 Embedded into services by June 30 2014	WCDHB Maori Health WCDHB discharge planning WCDHB Social work dept Rata Te Awhina Trust
Comprehensive support services for Maori discharged from the hospital	Participation by Maori Provider services in discharge planning and post discharge support A reduction in readmissions to hospital	June 30 2014	WCDHB Maori Health WCDHB discharge planning WCDHB Social work dept Rata Te Awhina Trust

Health Issue:	Disease prevention by improving nutrition, increasing physical activity and reducing obesity
Indicator 14:	- Number of Maori participating in Te Whare Oranga Pai - Number of Maori Participating in Green Prescription - Number of Maori participating in Appetite for Life
Baseline:	TBA
Target:	Increase number of Maori engaged in nutrition and physical activity programmes
Current Actions:	1. Te Whare Oranga Pai 2. Green Prescription 3. Appetite for Life

Action Plan:

Outcome:	Reduction in the onset of chronic illness		
To help achieve this outcome we will:	Focus on supporting iwi Maori to lead healthier lifestyles		
Activity/Action	**Evidence**	**Timeframe**	**Responsibility**
Actively engage primary care practitioners in obesity prevention and referral to services that support improved nutrition and increased physical activity	Number of referrals to nutrition and physical activity programmes from primary care practitoners • Green prescription • Te Whare Oranga Pai • Appetite for Life	Dec 2013	
Support the sustained growth of the Te Whare Oranga Pai initiative by developing pathways for clinical and professional support	1. Stakeholder relationships created 2. Referral pathways developed	Dec 2013	

Delivering Whanau Ora

Building capacity and capability.	Enhance the capacity and capability of provider collectives through support of the Canterbury DHB funded Maori Development Organisation - He Oranga Pounamu. Continue to support the agreed Maori appointment process across the system (led by He Oranga Pounamu) to enhance the capability of advisory boards and working groups.	Renewal of He Oranga Pounamu service agreement.
Supporting the sector to be outcomes focused.	Identify opportunities for the introduction of Integrated Contracts across government agencies to support the implementation of the Whānau Ora models. Provide advice around outcomes based monitoring and evaluation frameworks that have proved successful in alliance work streams.	At least one meeting held with other government funders by Q1.
Support the Implementation of the Whānau Ora programmes of action.	Support the Whānau Ora collectives to move into Phase 2 of the national programme and develop Whānau Ora models including advice and expertise in the following areas: • Service planning and the provision of information and trend data for analysis; • Analysis of Census 2013 returns, identifying significant population changes that might influence demand; • Development of organisation infrastructure; and • Support for research and professional development within Whānau Ora collectives.	Complete and distribute Maori and Pacific Health Profiles by Q1 Analysis of 2013 Census Maori and Pacific data, and distribution to Whanau Ora collectives by Q2.
Supporting Strategic Change.	Participate in the Whānau Ora Regional Leadership Group. Work with other government agencies at a local and regional level to actively support the implementation of Whānau Ora and improve cross-sector collaboration. Seek opportunities for the WCDHB to become more informed and updated on the national MOH contribution to Whānau Ora and help to share that information across the sector: • Formalise relationships between the Whānau Ora Collectives, DHB and Maori and Pacific Provider Forum. • Engage with Whānau Ora Collectives should there be any high level Maori or Pacific health planning that will result in changes to • Share regular updates on progress received as part of the Whanau Ora Regional Leadership Group. • Support continued engagement with the Maori and Pacific Health Provider Forum to enhance relationships with providers outside of the Whānau Ora Ccollective	Formalisation of relationship between WCDHB and Whanau Ora collectives (include ensuring consistency of regional distribution of information through Te Herenga Hauora and SI General Managers Network) by Q2.

The functions of CPHAC & DSAC, in accordance with their Terms of Reference and the New Zealand Public Health and Disability Act 2000 are:

"With respect to Community and Public Health, is 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.*

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 the Committee's advice must be:

- *to ensure that the services that the West Coast District Health Board provides or funds, along with the policies it adopts, will maximize the overall health gain for the resident population of the West Coast District Health Board; and*

- *to ensure that the kind of disability support services that the West Coast District Health Board provides or funds, along with the policies it adopts, will 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'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 Strategic Plan and the Disability Support Action Plan of the West Coast District Health Board."

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 2 May 2013 commencing at 9.00am

ADMINISTRATION			**9.00am**
	Karakia		
	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** *7 March 2013*		
3.	**Carried Forward/ Action Items**		
REPORTS/PRESENTATIONS			**9.10am**
4.	**Planning & Funding Update**	Carolyn Gullery *General Manager, Planning & Funding*	*9.10am - 9.25am*
5.	**Community and Public Health Update**	Jem Pupich *Team Leader, Community and Public Health*	*9.25am -9.40am*
6.	**Alliance Update**	Carolyn Gullery *General Manager, Planning & Funding*	*9.40am - 10.00am*
7.	**Draft 2013/14 Maori Health Plan**	Carolyn Gullery *General Manager, Planning & Funding* Gary Coghlan *General Manager, Maori Health*	*10.00am – 10.15am*
8.	**Allied Health Presentation**	Stella Ward *Executive Director, Allied Health*	*10.15am – 10.45am*
9.	**General Business**	Elinor Stratford *Chair*	*10.45am - 10.50am*
ESTIMATED FINISH TIME			**10.50am**

INFORMATION ITEMS

- **Board Agenda – 22 March 2013**
- **Chair's Report to last Board meeting**
- **West Coast CPHAC/DSAC Workplan 2013**
- **West Coast DHB 2013 Meeting Schedule**
- **PHO Quarterly Report**

NEXT MEETING

Date of Next Meeting: 6 June 2013 Corporate Office, Board Room at Grey Base Hospital.

AGENDA – PUBLIC

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

WEST COAST DISTRICT HEALTH BOARD MEETING
To be held at St John, Waterwalk Road, Greymouth
Friday 22 March 2013 commencing at 10.00am

KARAKIA			***10.00am***
ADMINISTRATION			***10.05am***
	Apologies		
1.	**Interest Register** *Update Board Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Meeting** ▪ *8 February 2013*		
3.	**Carried Forward/Action List Items** *There are no carried forward/ action items*		
REPORTS			***10.15am***
4.	**Chair's Update – Verbal Update**	Dr Paul McCormack *Chairman*	*10.15am – 10.30am*
5.	**Chief Executive's Update**	Michael Frampton *Programme Director*	*10.30am – 10.45am*
6.	**Clinical Leader's Update**	Dr Carol Atmore *Chief Medical Advisor* Karyn Kelly *Director of Nursing and Midwifery* Stella Ward *Executive Director of Allied Health*	*10.45am – 11.00am*
7.	**Finance Report**	Justine White *General Manager, Finance*	*11.00am – 11.15am*
8	**Health Target Report – Quarter 2**	Carolyn Gullery *General Manager, Planning & Funding*	*11.15am – 11.30am*
9	**Report from Committee Meetings**		
	- CPH&DSAC *7 March 2013*	Elinor Stratford *Chairperson, CPH&DSAC Committee*	*11.30am – 11.40pm*
	- Hospital Advisory Committee *7 March 2013*	Sharon Pugh *Chairperson, Hospital Advisory Committee*	*11.40am – 11.50pm*
	- Tatau Pomanau *7 March 2013*	Elinor Stratford *Board Delegate to Tatau Pounamu*	*11.50am – 12 noon*
10	**Resolution to Exclude the Public**	*Board Secretariat*	*12 noon – 12.05pm*

INFORMATION ITEMS

- Confirmed Minutes
  - CPH&DSAC Meeting – 24 January 2013
  - HAC Meeting – 24 January 2013
  - Tatau Pounamu Meeting – 24 January 2013
- Schedule of Correspondence
- 2013 Meeting Schedule

ESTIMATED FINISH TIME *12.05pm*

NEXT MEETING

Friday 10 May 2013 commencing at 10.00am

COMMUNITY & PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEE MEETING UPDATE - 7 MARCH 2013

TO: **Chair and Members**
West Coast District Health Board

SOURCE: **Chair, Community & Public Health & Disability Support Advisory Committee**

DATE: **22 March 2013**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board as an interim update on the Community & Public Health & Disability Support Advisory Committee (CPH&DSAC) meeting of 8 March 2013 Following confirmation of the minutes of that meeting at the 2 May 2013 meeting, confirmed minutes of the 7 March 2013 meeting will be provided to the Board at its 10 May 2013 meeting.

For the Board's information the functions of CPH&DSAC, in accordance with their Terms of Reference and the New Zealand Public Health and Disability Act 2000:

"*With respect to Community and Public Health, is 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*

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 the Committee's advice must be:
- *to ensure that the services that the West Coast District Health Board provides or funds, along with the policies it adopts, will maximise the overall health gain for the resident population of the West Coast District Health Board, and*
- *to ensure that the kind of disability support services that the West Coast District Health Board provides or funds, along with the policies it adopts, will 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'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 Strategic Plan and the Disability Support Action Plan of the West Coast District Health Board."

2. RECOMMENDATION

That the Board:

i. notes the Community & Public Health & Disability Support Advisory Committee Meeting Update – 7 March 2013.

3. SUMMARY

ITEMS OF INTEREST FOR THE BOARD

- **Maori Health Activity Report**

  The Committee noted the Maori Health Activity Report including the positive results around cervical screening.

  The General Manager, Maori Health provided the Committee with an update on Minister, Tariana Turia's visit to the West Coast on Tuesday 5 March. He commented that well over 100 people had attended various Hui held on the day.

- **Planning & Funding Update**

  The General Manager, Planning & Funding, presented this report. She commented on the issues around the DHBs ability to get a stable Primary Care workforce which would allow relationships to develop between GPs and their patients. Discussion took place regarding locum use, recruitment and also the ability to secure the services of long term GPs who have an interest in permanent employment on the West Coast.

  The Committee discussed Home Based Support and noted that the Aged Residential Care on the West Coast, on a per capita basis, is almost twice that of the rest of the South Island. This is partly due to home based support not being sufficiently targeted to support people to stay in their own homes. They noted that work will commence right away on a person by person basis to reassess the need for home support currently being provided to ensure this is actually being provided to the right people.

- **Community & Public Health Update**

  The Committee noted the trial of a fruit and vegetable co-op which had taken place in November/December 2012. This trial is currently being assessed.

  In noting the Community & Public Health quarterly report to the Ministry of Health, which was included in their information papers, the Committee noted that feedback from the Ministry of Health had been positive and Community & Public Health were on track to meet their targets.

- **BSMC & ALT Update**

  In presenting this report the General Manager, Planning & Funding commented that this report demonstrates part of the thinking around how the Alliance Report will look moving into the future. She added that the next Annual Plan process will make it even clearer where this all sits in the overall process. Discussion took place regarding membership of the Alliance Leadership Team and the Committee noted that whilst the areas of representation have been agreed, individual membership is yet to be determined.

- **Health Targets**

  The Committee discussed the Health Targets and some concern was expressed regarding some of these not being achievable on the West Coast. The General Manager, Planning & Funding commented that the way we manage this is that we develop our work plans to ensure we maintain good quality services for the West Coast Community. The Committee noted that this year in particular the Annual Plan guidelines are extraordinarily detailed.

4. APPENDICES

Appendix 1: Agenda – Community & Public Health & Disability Support Advisory Committee – 7 March 2013.

Report prepared by: Elinor Stratford,
Chair
Community & Public Health & Disability Support Advisory Committee

WORKPLAN FOR CPH&DSAC 2013 – BASED ON WEST COAST DHB PRIORITY PLAN

	24 January	7 March	2 May	6 June	11 July	22 August	10 October	28 November	2014
STANDING ITEMS	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	Karakia Interests Register Confirmation of Minutes Carried Forward Items	
STANDARD REPORTS	Health Target Q1 report Planning & Funding Update Alliance Update	Māori Health Activity Report Planning & Funding Update Community & Public Health Update Alliance Update BSMC Q2	Planning & Funding Update Community & Public Health Update Alliance Update	Maori Health Activity Report Planning & Funding Update Community & Public Health Update Alliance Update BSMC Q3	Health Target Q3 report Planning & Funding Update Community & Public Health Update Alliance Update	Māori Health Activity Report Planning & Funding Update Community & Public Health Update Alliance Update BSMC Q4	Health Target Q4 report Planning & Funding Update Community & Public Health Update Alliance Update	Māori Health Activity Report Planning & Funding Update Community & Public Health Update Alliance Update BSMC Q1	
PRESENTATIONS	As required	As required	Allied Health	As required	As required	As required	As required	As required	
PLANNED ITEMS	Smoke Free Position Statement		2012/13 Draft Maori Health Plan						
GOVERNANCE AND SECRETARIAT	2013 Work Plan							2014 Meeting Dates	
DSAC Reporting	As available	As available	As available	As available	As available	As available	As available	As available	
INFORMATION ITEMS	Latest Board Agenda Chair's Report to Board from last meeting 2013 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan C&PH 6 Monthly report to MoH 2013 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2013 Schedule of Meetings PHO Quarterly Report	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2012/13 Final Annual Plan 2013 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2013 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2013 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan C&PH 6 Monthly report to MoH 2013 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2014 Schedule of Meetings	

WEST COAST DHB –MEETING SCHEDULE FOR 2013

DATE	MEETING	TIME	VENUE
Thursday 24 January 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 24 January 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 24 January 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 24 January 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 8 February 2013	BOARD	10.00am	Board Room, Corporate Office
Thursday 7 March 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 7 March 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 7 March 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 7 March 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 22 March 2013	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 2 May 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 2 May 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 2 May 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 2 May 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 10 May 2013	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 6 June 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 6 June 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 6 June 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 6 June 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 28 June 2013	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 11 July 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 11 July 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 11 July 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 11 July 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 2 August 2013	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 22 August 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 22 August 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 22 August 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 22 August 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 13 September 2013	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 10 October 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 10 October 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 10 October 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 10 October 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 25 October 2013	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 28 November 2013	CPHAC & DSAC	9.00am	Board Room, Corporate Office
Thursday 28 November 2013	HAC	11.00am	Board Room, Corporate Office
Thursday 28 November 2013	QFARC	1.30pm	Board Room, Corporate Office
Thursday 28 November 2013	TATAU POUNAMU	3.30pm	Board Room, Corporate Office
Friday 13 December 2013	BOARD	10.00am	Board Room, Corporate Office

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

Quarterly Report
January to March 2013

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.

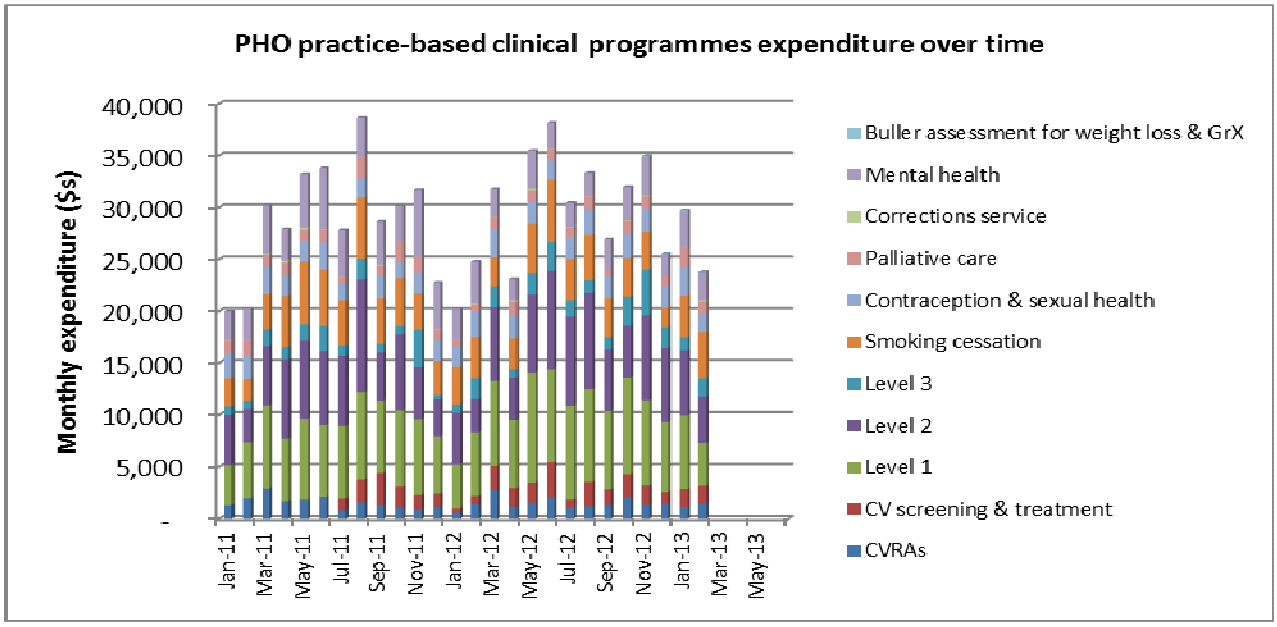
1. Executive summary

Possible new medical centre

A back-to-back agreement was issued for GP, Dr Martin Smith, to set up a new practice in Westport. Dr Smith plans to open the practice from early April 2013 with the enrolment process now underway. This practice will be a non VLCA practice.

Clinical services

Uptake from practices for the PHO's various clinical programmes continues, workforce shortages are having an impact on activity as per this graph:



Keeping people healthy

The foci of health promotion campaigns in the quarter has been:

- January – eating well for the year ahead;
- February – heart month;
- March – seasonal influenza vaccination.

Workforce and rural support

With added support for administration Dr Anna Dyzel is be able to continue to support the coordination of CME on the West Coast. A key area of focus for the CME is to identify a more suitable time to deliver the education that will cater for more participants.

Standing Orders training workshops are planned to begin at the end of April for Reefton Rural Nurse Specialists, with planning for South Westland and Buller to follow. Dr Jane Nugent will be providing the workshop facilitation, support and training along with the PHO Clinical Manager.

Admin road shows

There were no practice administration road shows held this quarter, with one practice visit outstanding (South Westland). This was scheduled for March 2013 but due to staff illness at the practice this will now occur next quarter.

The focus of the road shows has been on quality improvement in several key areas:

- patient eligibility and enrolment;
- ethnicity;
- address recording and geo-coding.

A key theme has been to emphasise the link between the sometimes arcane and arbitrary things administration and reception staff (have to) do and the revenue it brings in to practices.

Strategic relationships

Rata Te Awhina Trust officially co-located their Greymouth staff into the PHO office during January 2013. A mihi whakatau was held on the 29th January followed by a shared morning tea for both organisations.

This is a great opportunity to enable collaborative approaches to improve access to and use of available services by whanau in Te Tai Poutini.

Governance matters (Trustee appointment processes)

The process of nomination and appointment of Trustees positions is up-to-date to 20th March 2013. Necessary processes have been initiated as the beginning of this quarter to fill places for those trustees whose terms expire March 2013. The relevant constituencies affected are the Buller District Council, Maori health provider, practice administration electoral college plus the seconded position in place of a practice nurse.

Staffing, vacancies and succession planning

Helen Reriti commenced her role as Executive Officer as of the 20th February 2013.

Michelle Reihana, youth psychologist, resigned and left at the end of February 2013.

Pauline Ansley, Registered Nurse, has joined the PHO team as Clinical Manager during March 2013. Pauline will be based in Westport, spending two days a week at the PHO offices in Greymouth.

Also joining the PHO team in March was Pam O'Hara, a psychologist, as the mental health manager replacing Bev Barron. Both of these new staff will make up part of the Senior Management Team.

The Medical Director role became vacant in January with Dr Carol Atmore's resignation. Despite requests to West Coast GPs to fill this role there has been no uptake. The possibility is to now canvass further afield and try for non-local GP input for this role.

PHO enrolment internal audit

The PHO is planning to re-run the 'mock audit' it first conducted in 2010. This will be occurring in May 2013.

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

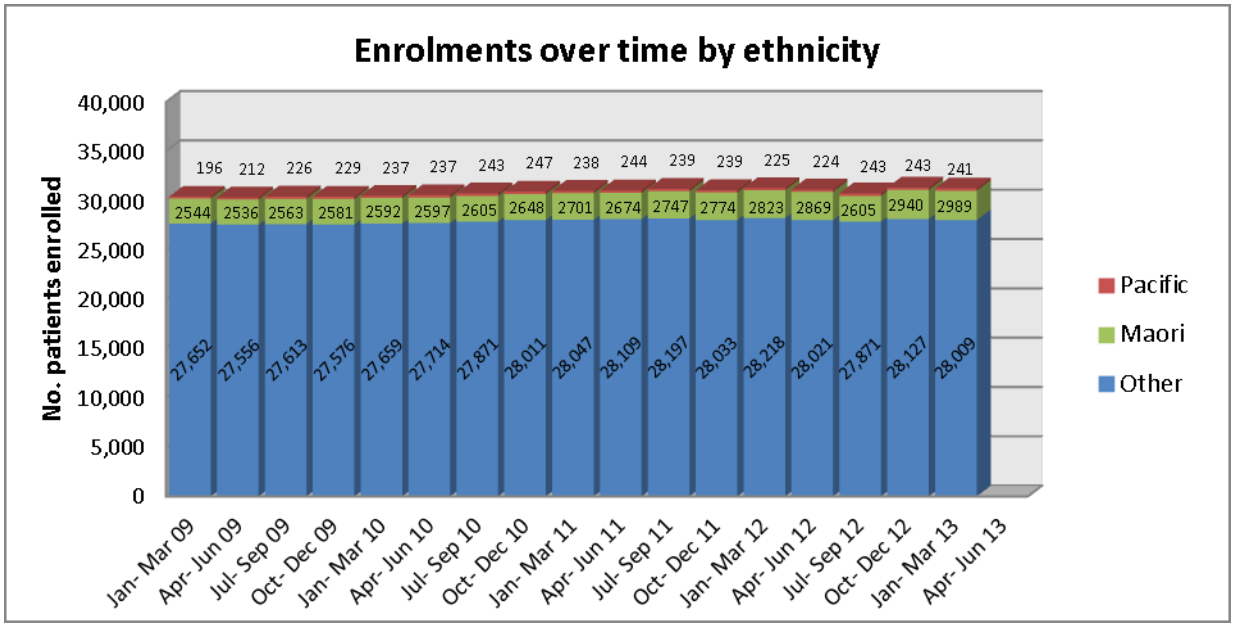
- better engagement with the community, families/whanau and individuals;
- implementing the 'Better, Sooner, More Convenient Primary Care' Business Case;
- adoption of efficient business/service models based on the principles of Alliance Contracting.

3. Financial summary

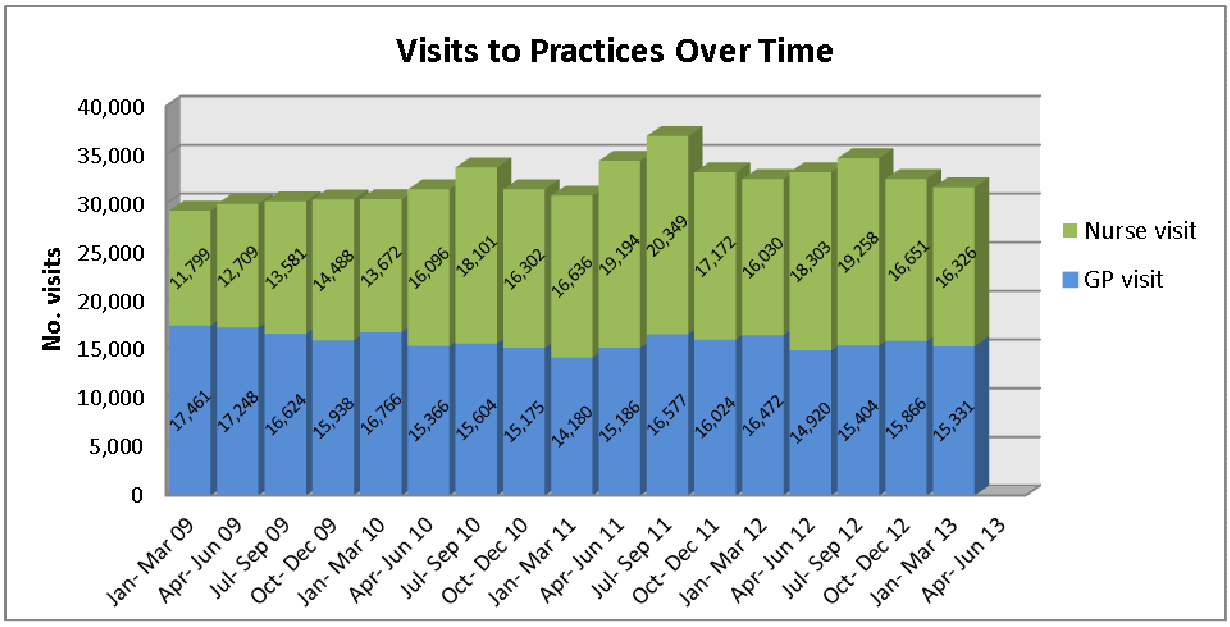
Profit & Loss	
West Coast Primary Health Organisation	
1 July 2012 to 31 March 2013	
	31 Mar 13
Income	
1. Patient care subsidies	3,972,525
2. Clinical services	559,817
3. Mental health	319,416
4. Keeping people healthy	278,966
5. Workforce & rural support	1,009,999
6. Administration	501,832
Total Income	**6,642,555**
Less Cost Of Sales	
1. Patient care subsidies	3,972,525
2. Clinical services	279,059
3. Mental health	25,485
4. Keeping people healthy	22,161
5. Workforce & rural support	913,042
Total Cost Of Sales	**5,212,273**
GROSS PROFIT	**1,430,282**
Other Income	
6. Administration	67,948
Total Other Income	**67,948**
Less Operating Expenses	
Staffing & operations	1,506,109
Transfers to/from reserves	- 71,199
Total Operating Expenses	**1,434,910**
NET PROFIT	**63,320**

4. Subsidising core general practice care

4.1. Demographics of the enrolled population



4.2. Service Utilisation (visits to the practices)

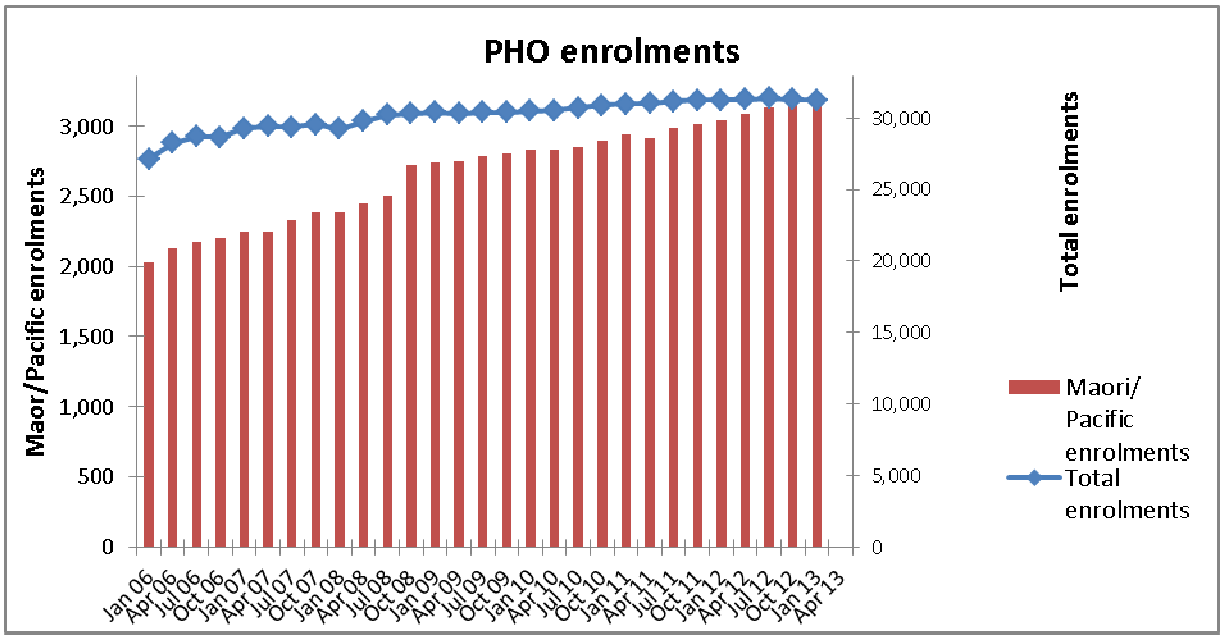


Waiting times to be seen by a medical centre or clinic
March 2013

(in working days)

Scenario	Average	Minimum	Maximum
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)	16	7	28
Waiting time if rings today for routine appointment with a nurse for three monthly review and prescription	7	0	21

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

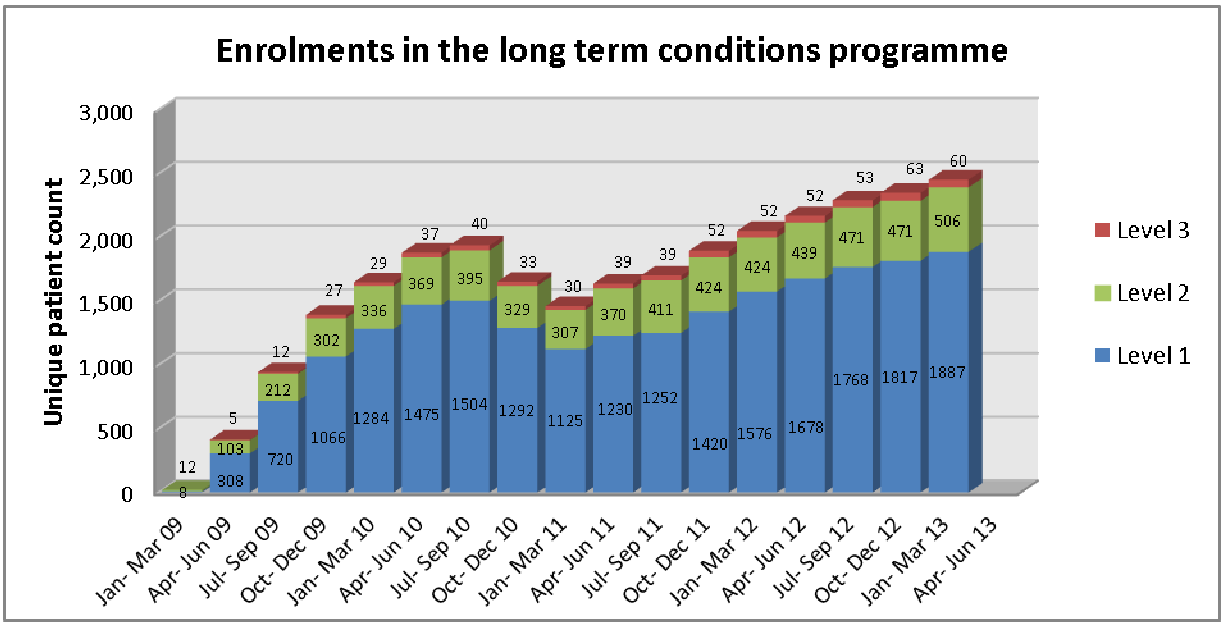
These are the fees patients can expect to be charged at their normal practice during working hours for a normal consultation, if the patient is enrolled with the West Coast PHO. Additional fees may apply to after hours, weekends, long appointments, home visits, procedures and casual patients. The PHO encourages all eligible 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

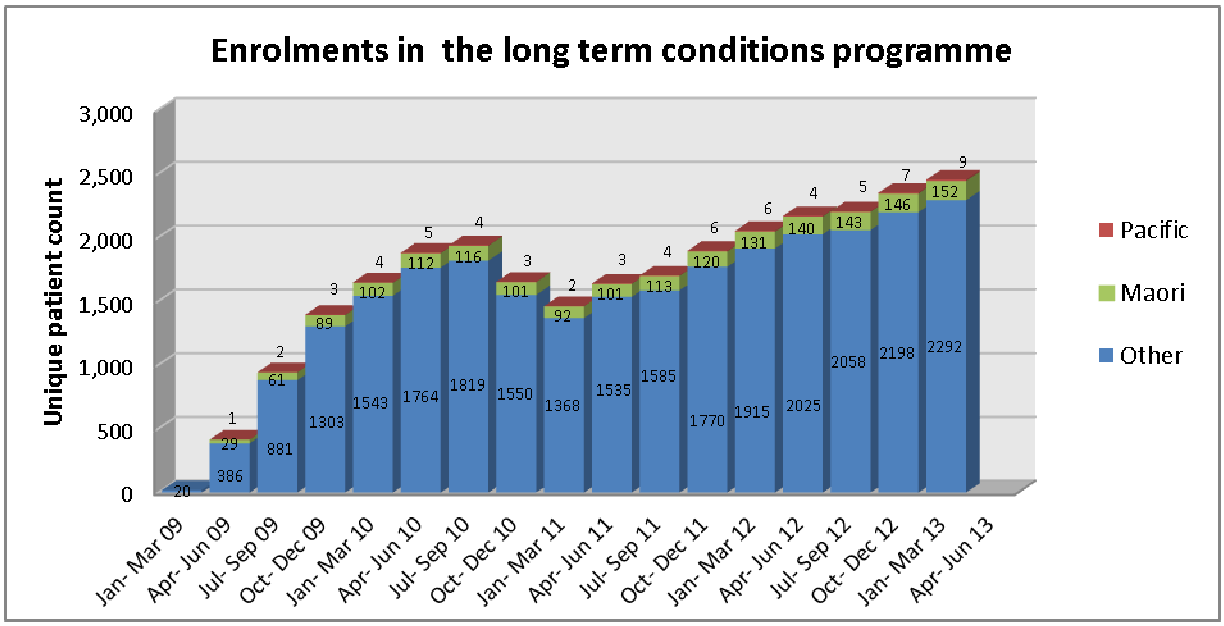
5.1. Long Term Conditions (LTC) programme

On target: *Yes*

1. Outcomes/Outputs



The 2453 patients who are enrolled in the LTC programme, out of the PHO's approximately 31,300 enrolled patients, means that 7.9% of the enrolled population is engaged in a structured programme of care for their long term condition(s).



Maori enrolments make up 6% of all enrolments in the LTC programme to date. For comparison Maori make up 5.3% 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 and places available in the capped 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**

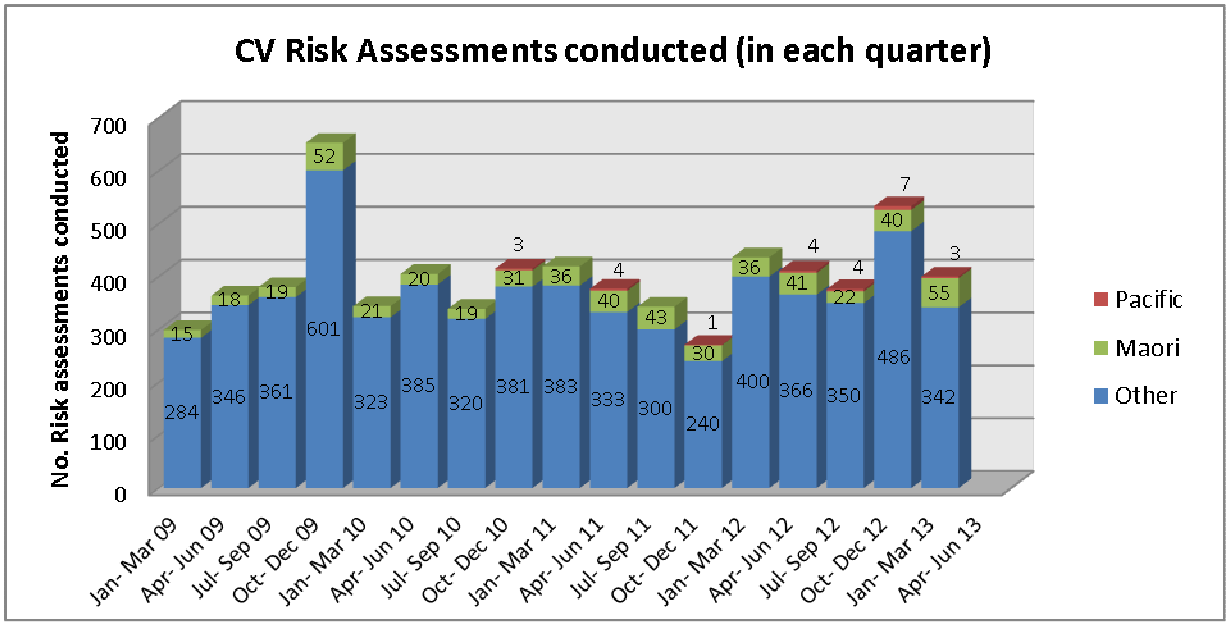
Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

5.2. Cardiovascular risk assessments

On target: Yes

'More heart and diabetes checks', will measure the number of completed Cardiovascular Risk Assessments (CVRA) for all eligible persons within the last five years (which includes a diabetes check). The national goal target will be 90%, to be achieved in steps over three years. The target to reach by 1 July 2013 is 75%.

1. Outcomes/Outputs



A total of 400 cardiovascular risk assessments conducted this quarter. This reduction is partly due to GP and nurse staff shortages across this period. It is also a reflection that we have now screened the 'easy to reach' with the more 'reluctant folk' still to screen.

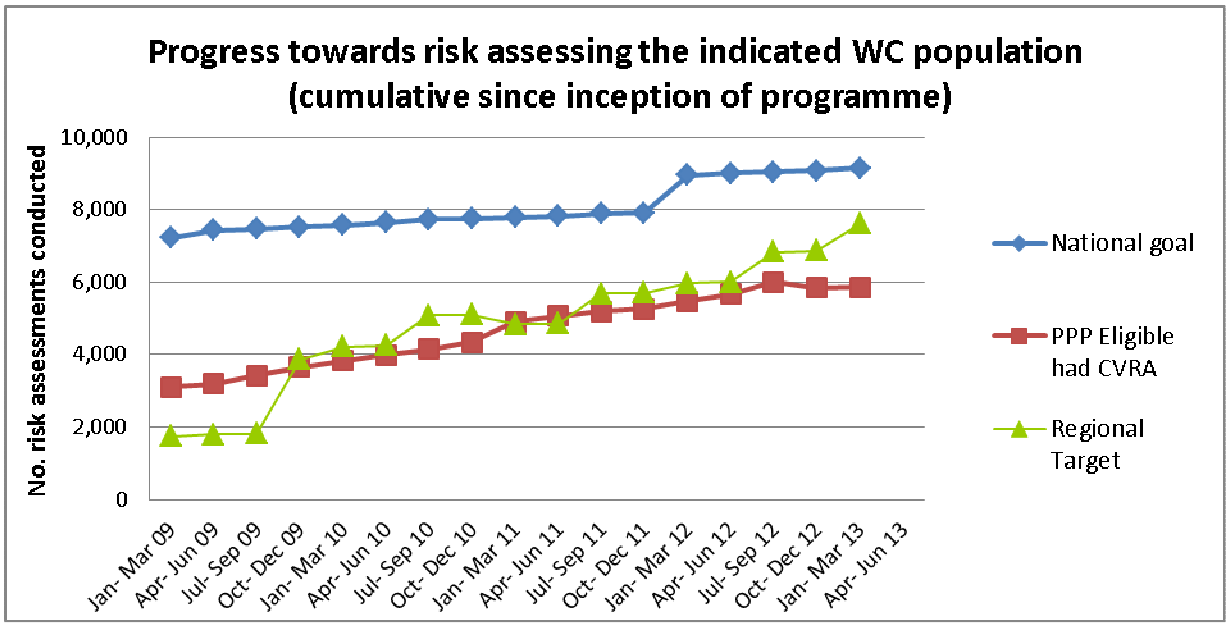
Maori make up 10% of completed CVRAs this quarter. By comparison, Maori make up 7.8% of the eligible cohort for CVRA on the West Coast. (The eligible age range for Maori is male 35-74 years and for female 45-74 years.)

The smoking profile for CVRAs YTD (01/07/12 – 30/06/13) is of Maori screened to date 67% were not smoking compared with other ethnicities screened not smoking 86%.

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 led clinics to have their 5 year cardiovascular risk assessed;
- High Street Medical Centre made direct invitations by letter and follow-up phone calls to 100 identified patients who were still to be screened. 32 CVRAs were completed in February and 33 in March;

- dedicated CVRAs clinics were held for DHB staff run by the two clinical nurse specialists in both Greymouth and Westport with a total of 38 staff screened;
- Utilisation of Healthstat, a Quality Improvement (QI) tool, enables monitoring of practice performance for cardiovascular indicators in relation to the PHO Performance Programme (PPP) for practice QI teams. The Clinical Audit Tool (CAT) will be installed in April 2013 enabling practice teams to identify patients eligible for screening but not yet screened.



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 1st July 2014. The first stage was to achieve 60% by July 2012. The second phase is now to achieve 75% by 1st July 2013 as is depicted in the regional target. As at 30th March 5,868 people who were eligible for their CVRA were completed which is 77% of the regional target of 7,618. This equates to 58% of the 1 July 2014 target of 90%. Of the 5,868 people screened to date 61% (2192) were female and 56% (3676) were male.

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 QI teams;
   - practice teams.

4. **Issues and Risks**

Issues/Risks	Mitigation/Resolution
• Increasing targets for CVRA may become more difficult to achieve as the regular users of health services may have already been assessed.	• To be discussed with practice QI teams.

5.2.1 Treatment for those identified with increased cardiovascular risk

1. **Outcomes/Outputs**
   - Of the 343 Cardiovascular Risk Assessments (CVRAs) completed this quarter (doesn't include patients with known diabetes), 62 (18%) were identified as having >15% risk of having a heart attack or stroke in the next 5 years.

   Comment:
   In previous reports a graph was inserted here showing the percentage of high risk patients followed-up for one year who are on a preventative medication. What was of concern, and required further investigation, was the apparent significant drop in the percentage of people with CVRA>15% being prescribed medication one year after initial detection.
   Following review of the data quality it was found that there are some issues and inaccuracies and until these are resolved a graph will not be available at this stage.

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**

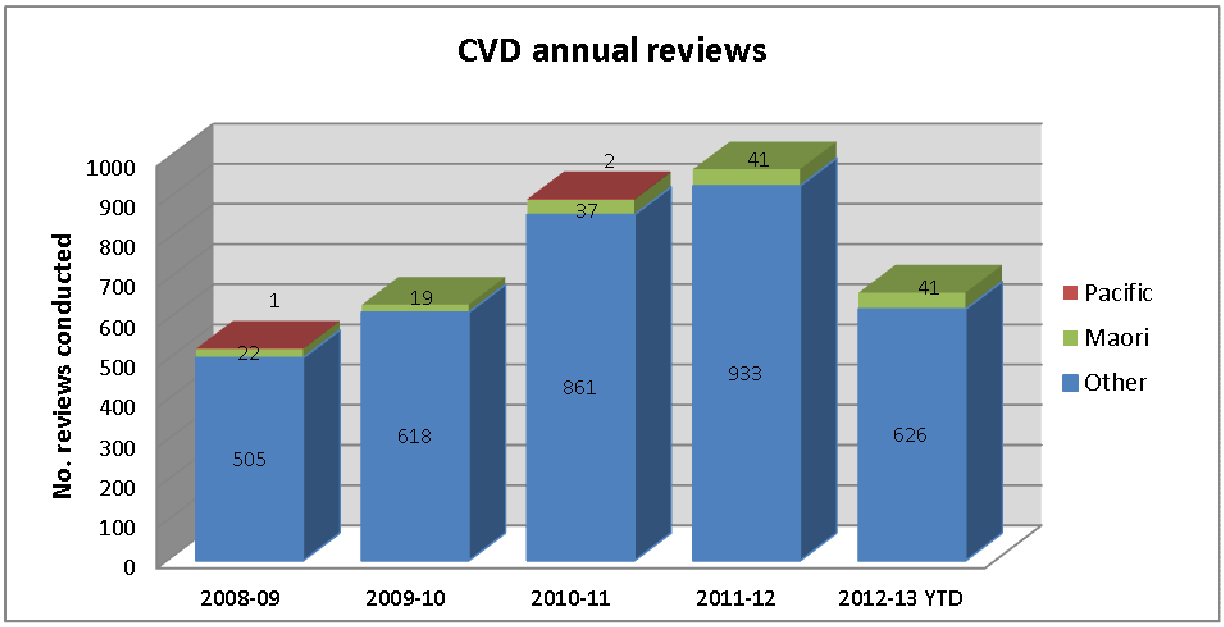
Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

5.3. CVD annual reviews

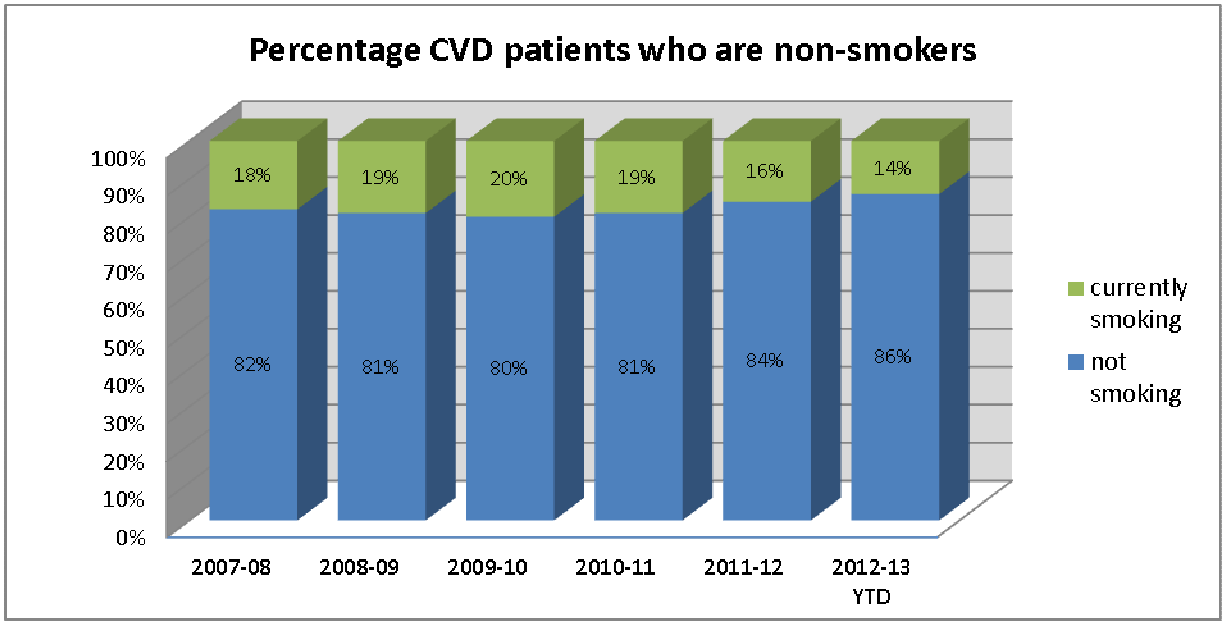
On target: Yes

1. Outcomes/Outputs

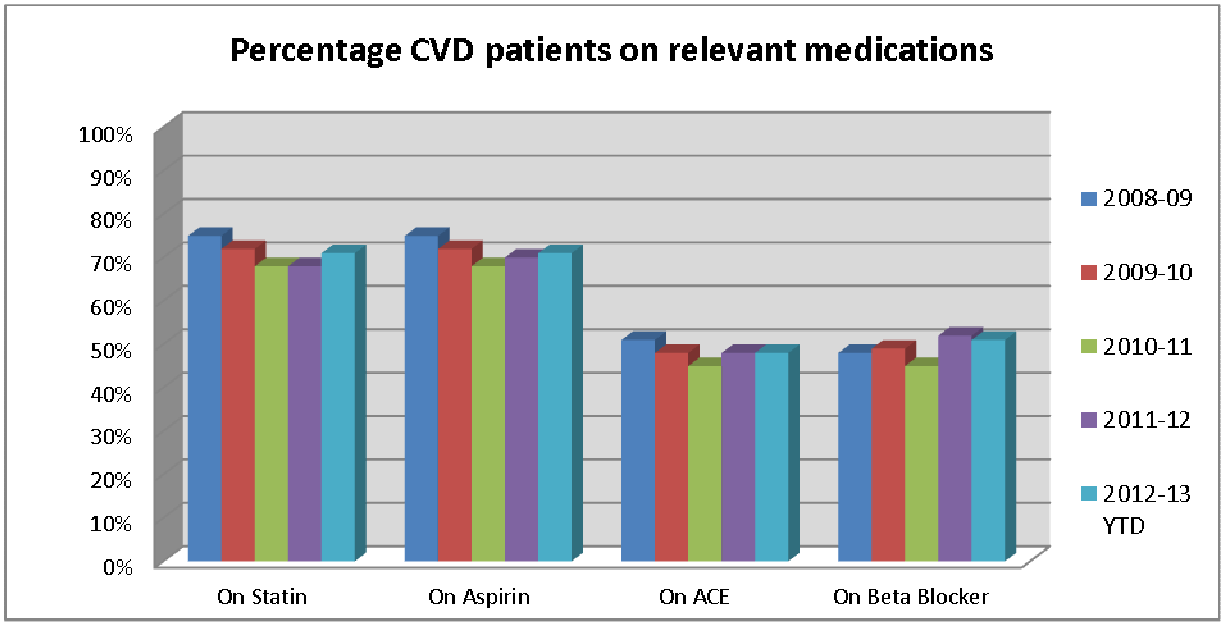
People with identified cardiovascular disease have an annual review of their condition as part of the Long Term Conditions (LTC) management programme.



6.1% of the annual reviews conducted this quarter were for Maori. For comparison Maori make up 5.5% of the enrolment population aged 45+ years – the prime age group of people in the LTC programme.



Of those reviewed YTD 86% of people were not smoking. Of Maori reviewed YTD 85% were not smoking and other ethnicities 85.6% 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.



Pharmacological management for people with established heart disease continues to be pleasing.

2. Key Activities

- nurse led clinics occurring at the majority of practices for CVD annual reviews as part of the LTC programme;
- Utilisation of Healthstat, a Quality Improvement (QI) tool that enables monitoring of practice performance for cardiovascular indicators in relation to the PHO Performance Programme (PPP) for practice QI teams. The Clinical Audit Tool (CAT) will be installed in April 2013 enabling practice teams to identify patients with cardiac disease but not yet enrolled in LTC;
- on-going support from PHO's clinical manager to general 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;
- Cardiac Nurse Specialists
- Heart Respiratory Team (HRT) meetings

4. Issues and Risks

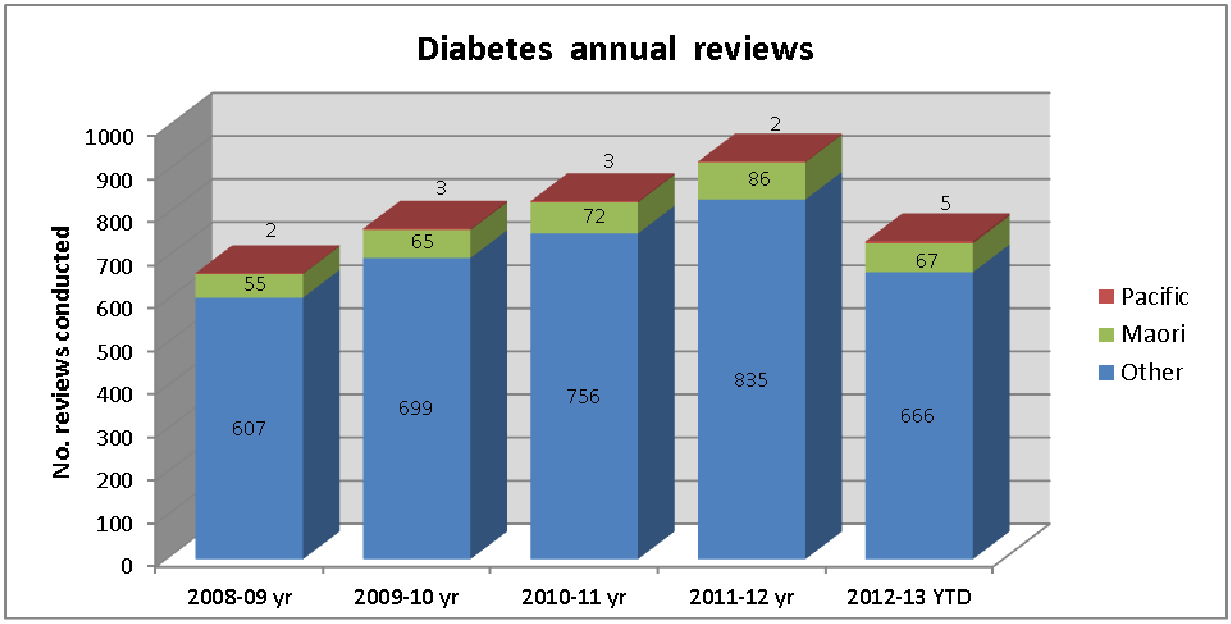
Issues/Risks	Mitigation/Resolution
• Nil	• Nil.

5.4. Diabetes care

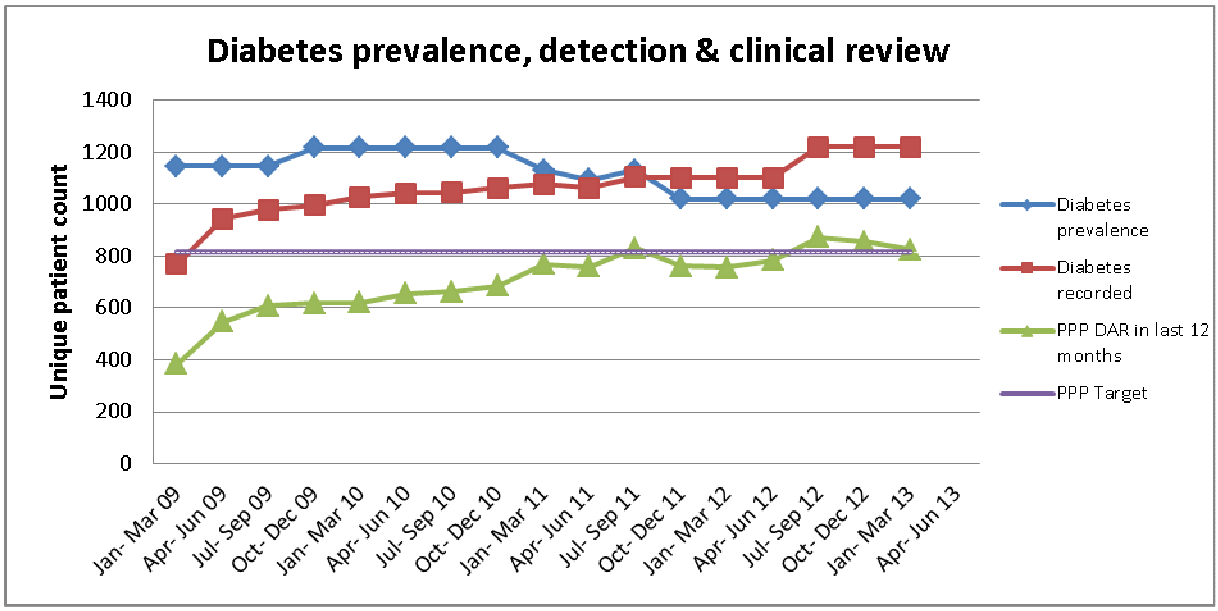
On target: Yes

1. **Outcomes/Outputs**

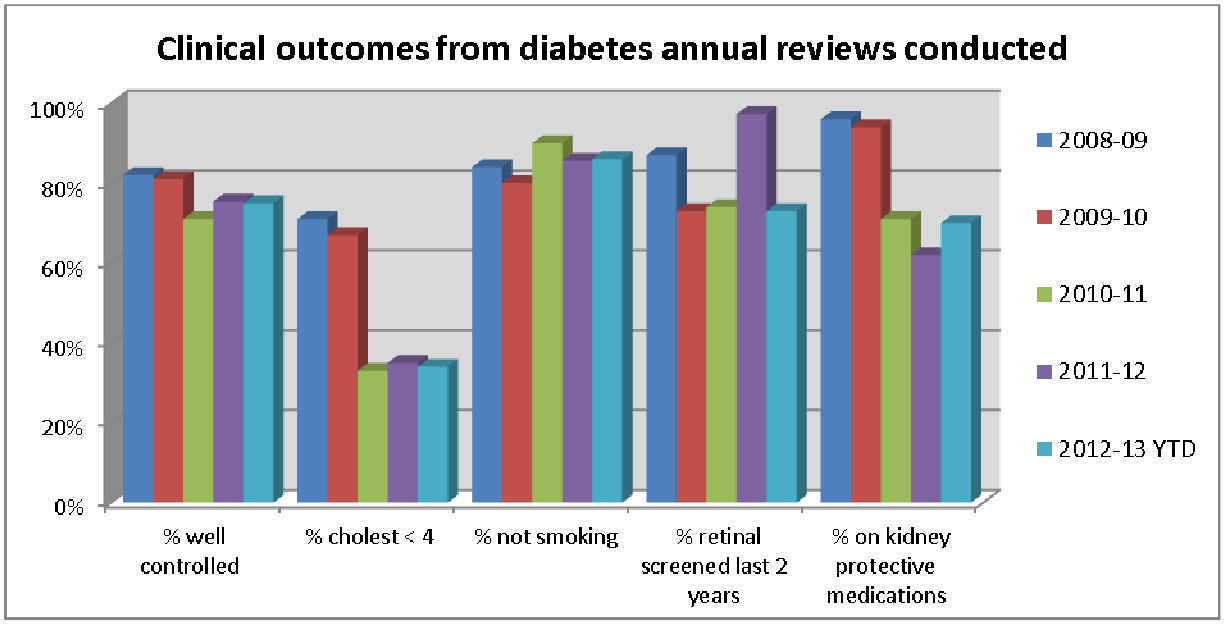
People identified with diabetes have an annual review of their condition as part of the Long Term Conditions (LTC) management programme.



9.0% of the annual reviews conducted YTD were for Maori. For comparison Maori make up 5.5% of the enrolment population aged 45+ years – the prime age group of people in the LTC 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, although it is noted that of those identified with elevated cholesterol (>4), 70% are appropriately medicated on a statin. The decline in retinal screening rates can be attributed to the increase in people with diabetes detected and as yet not had retinal screening completed, and the volume of people to be screened every two years beginning to exceed the capacity of the quarterly scheduled clinics

	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	1	16	0	17	3%	11	65%	6	65%	65%	76%
Pacific	0	2	0	2	0%	2	100%	1	50%	100%	0%
Other	26	135	2	163	25%	119	73%	35	79%	85%	73%
TOTAL	**27**	**153**	**2**	**182**	**27%**	**132**	**73%**	**42**	**77%**	**84%**	**73%**

Numbers in this table are less than the graph depicting diabetes annual reviews as this table looks only at people with diabetes aged 15-79 years (those eligible for the PHO Performance Programme (PPP)) and the graph looks at all people reviewed with diabetes.

2. Key Activities

- a retinal screening week was held in February, 109 people screened, all in Greymouth;
- planning for next retinal screening clinic for 13th – 17th May 2013 and further dates for 2013;
- training was held in March to train current facilitators, Diabetes Nurse Specialists and dietician in the diabetes conversation map model of diabetes self-management education, 5 attendees in total;
- Utilisation of Healthstat, a Quality Improvement (QI) tool that enables monitoring of practice performance for diabetes indicators in relation to the PHO Performance Programme (PPP) for practice QI teams. The Clinical Audit Tool (CAT) will be installed in April 2013 enabling practice teams to identify patients with diabetes but not yet enrolled in the LTC programme.

3. **Networking/Education** (either with Health Sector or Community)
   - diabetes nurse educators at DHB;
   - diabetes course facilitators Buller and Greymouth;
   - Local Diabetes Team meeting 27th February 2013;
   - retinal screening appointments made and confirmation letters sent out;
   - notification to practices of patients retinal screened;
   - planning for first diabetes conversation map diabetes self-management education for people with type 2 diabetes next quarter.

4. **Issues and Risks**

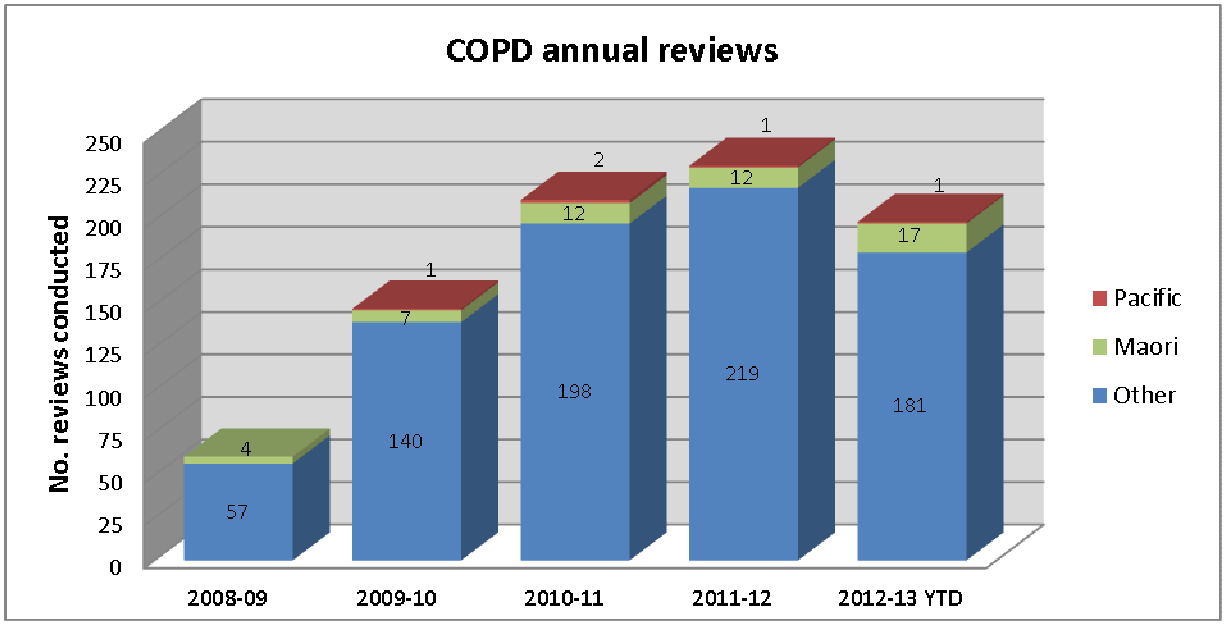
Issues/Risks	**Mitigation/Resolution**
• Numbers for retinal screening now exceeding the capacity of quarterly clinics.	• The potential to add another clinic this year will be explored.

5.5. COPD annual reviews

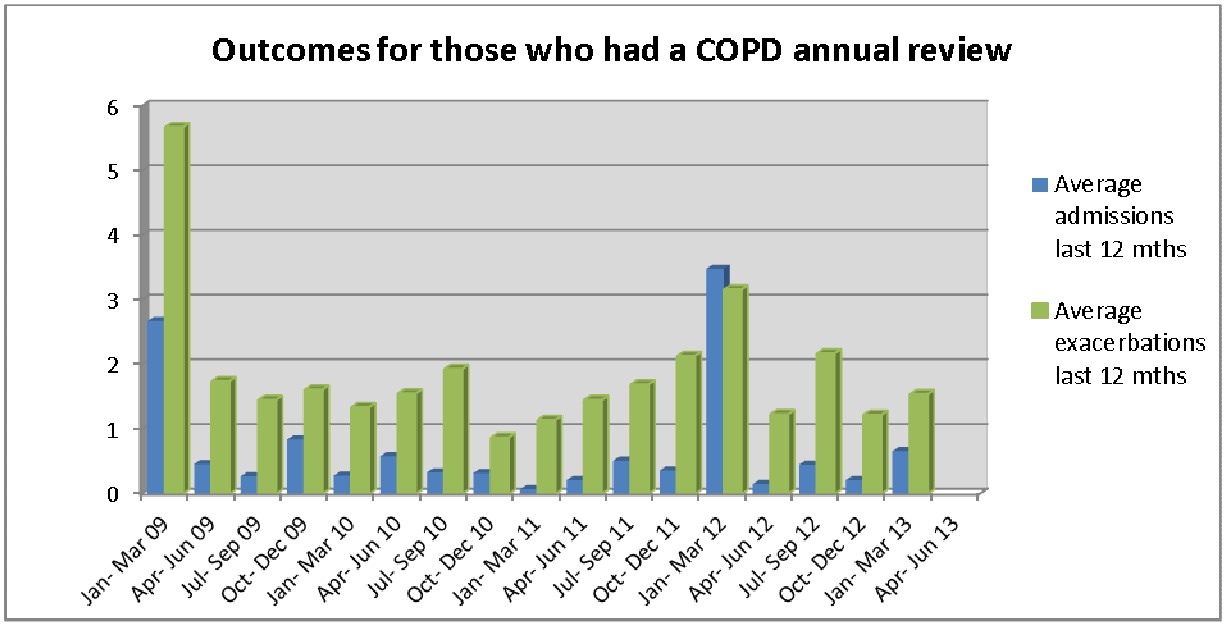
On target: Yes

1. **Outcomes/Outputs**

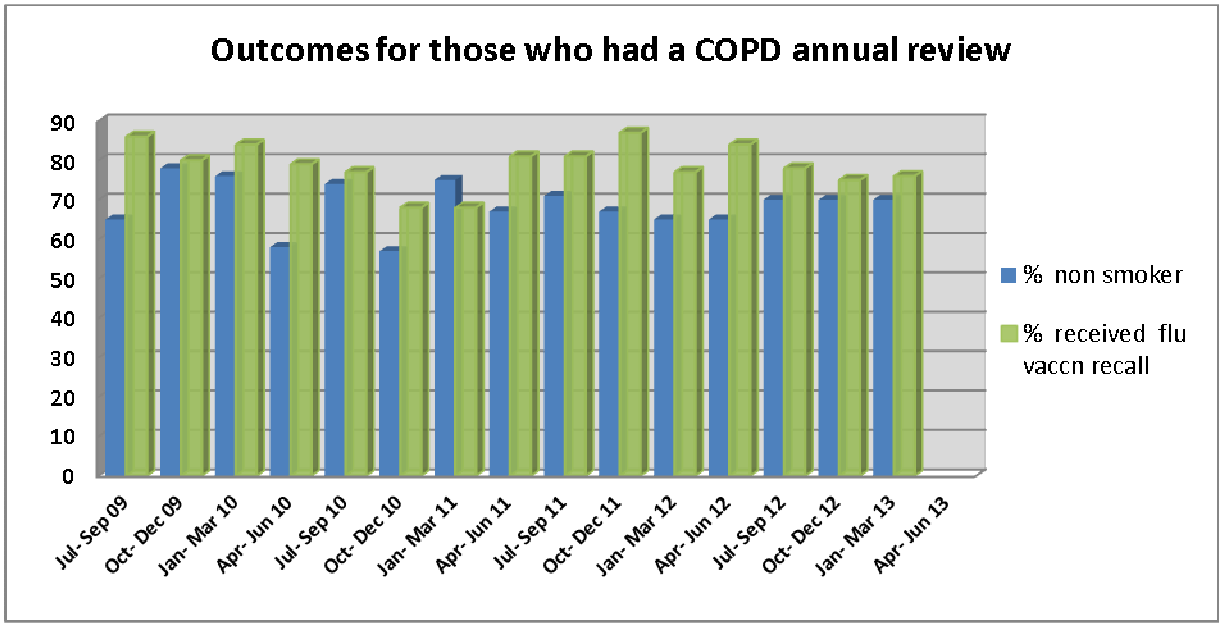
   People identified with COPD have an annual review of their condition as part of the Long Term Conditions (LTC) management programme.



8.5% of reviews conducted year to date have been for Maori. For comparison Maori make up 5.3% of the enrolment population aged 45+ years – the prime age group of people in the LTC programme.



There has been an increase in the average exacerbations and hospital admissions this quarter with both still at an acceptable level.



For those people who had their COPD annual review this quarter, 70% are smokefree and 76% of people have a recall for their annual flu vaccination.

2. Key Activities

- nurse led COPD clinics at practices;
- on-going brief advice and offers of smoking cessation options to all COPD patients who continue to smoke..

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

- practices and pharmacies;
- respiratory nurse specialists;
- 2 day Spirometry training held 8th-9th March in Christchurch with no attendees from the West Coast;
- Heart Respiratory Team meeting held March 2013.

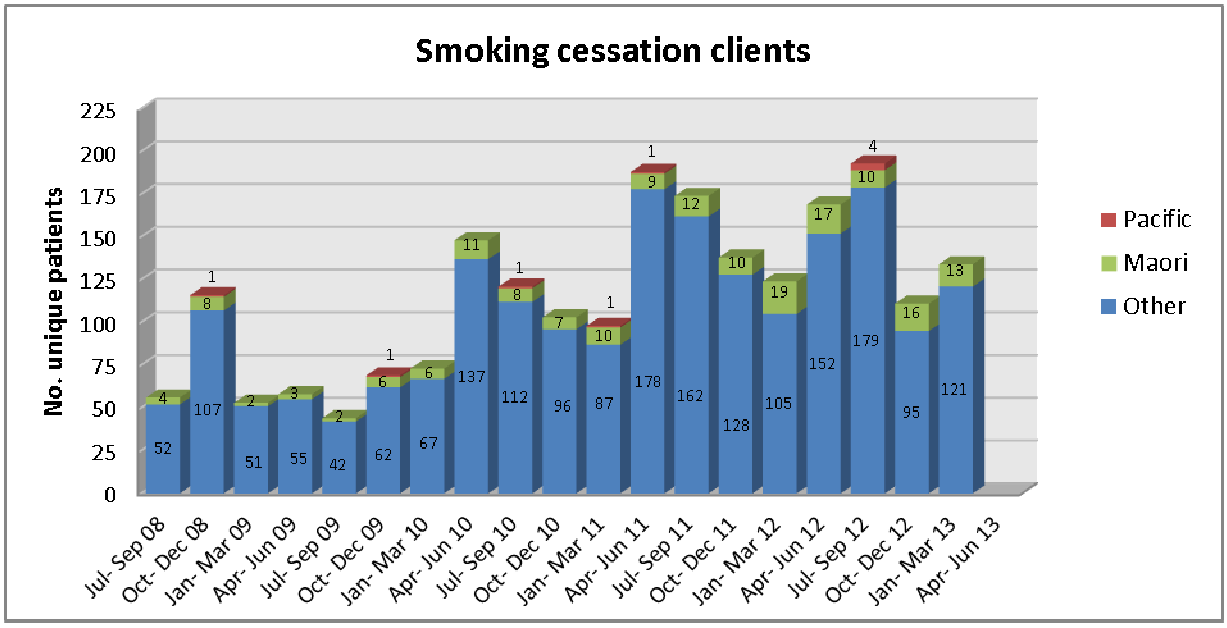
4. Issues and Risks

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

5.6. Smoking cessation

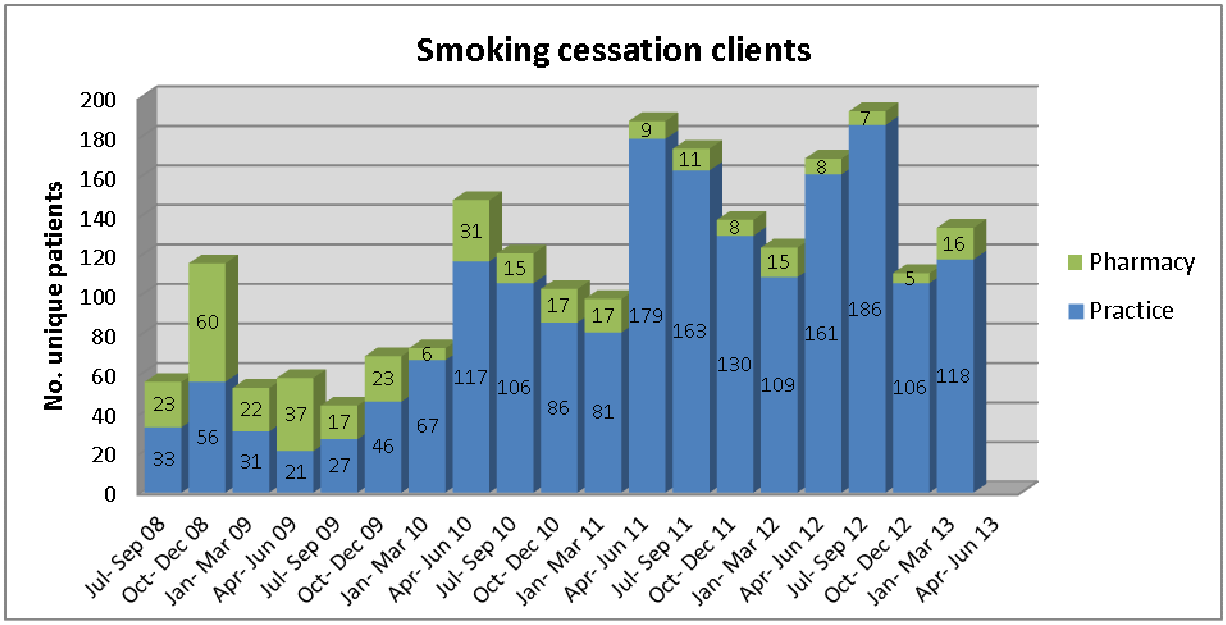
On target: Yes.

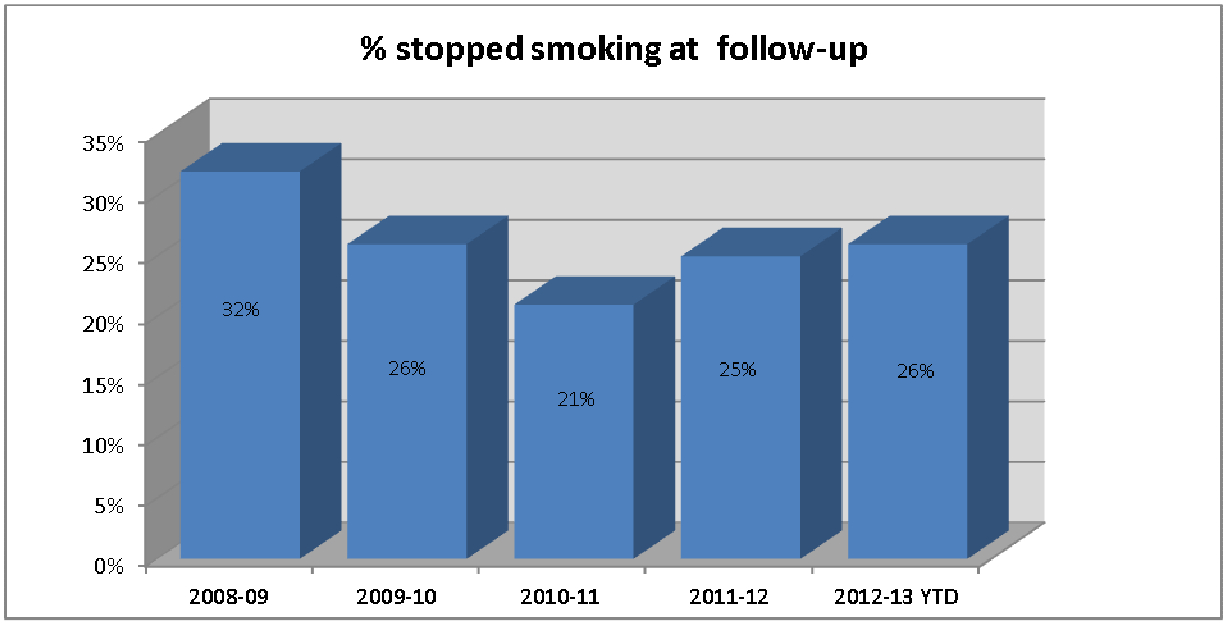
1. Outcomes/Outputs



Enrolments to the Coast Quit programme remain pleasing despite being less than the last three quarters.

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, it is pleasing to see that Maori enrolments made up 14.4% of all enrolments in the Coast Quit programme this quarter.





The above graph shows 26% of the people phoned for their follow-up were still smoke free in the 3-4 month period since commencing the Coast Quit programme (follow-up made during this quarter). This increase is a very encouraging outcome of the programme.

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 2011-12 our quit rates were calculated at 6 months following TQD. Current YTD rates are collated and corrected each quarter at three to four months.

2. Key Activities

Cessation:

- 3-4 month outcome follow-up phone calls and collation of results (26% quit rate for 120 'intention to treat patients; 38% quit rate for 92 actual contacts);
- filling Coast Quit NRT orders from practices and pharmacies.

Primary Care:

- participation in monthly Ministry of Health (MoH) led telephone conferences;
- primary care tobacco health target bulletin sent out to all nurses and doctors in the practices;
- MoH report (and summary) on Pregnancy Smoking Cessation Services sent out to clinicians in the practices;
- liaison with DHB Community Services workforce development co-ordinator;
- support for 'ABC Call-up' project;
- Utilisation of Healthstat, a Quality Improvement (QI) tool that enables monitoring of practice performance for all smoking indicators in relation to the PHO Performance Programme (PPP) for practice QI teams.

Secondary Care:

- meetings with senior nursing and hospital management, and with coders, regarding ABC target results;
- monthly feedback on ABC target results to Clinical Nurse Managers and ward champions – and several meetings;
- short 'in-service' sessions with McBrearty and Morice ward staff;
- patient file audits re documenting the Smokefree ABC intervention;
- fortnightly meetings with Smokefree Services manager;
- liaison with DHB smoking cessation providers;
- participation in monthly MoH-led telephone conferences re secondary targets;
- further distribution of reminder letter for mandatory ABC training for DHB staff;
- revision of current NRT guidelines and preparation of new information and teaching resources for staff and patients in mental health inpatient unit IPU;
- preparing NRT mouth spray guidelines and instructions for use in IPU – discussions with IPU Clinical Nurse Manager and Champion;
- ordering Carbon Monoxide monitor for use in maternity services;
- visit by Dr McRobbie (MoH) re the secondary care tobacco health target;
- preparation of revised mandatory smokefree-ABC training presentation for new DHB staff, and new pamphlet for orientation pack.

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

- West Coast Tobacco-Free Coalition (WCTFC) meeting and follow-up, and liaison with health promotion advisors at C&PH and cancer society;
- meeting with WCTFC mental health sub-group;
- liaison with 3 aged care residential facility managers regarding cessation options for staff and residents;
- steering group meeting and phone conference for Buller REAP Youth Project, and liaison with Buller REAP smokefree youth worker;
- clinical supervision for Aukati Kai Paipa provider (C&PH);
- involvement in smokefree health promotion activities including Waka Ama day at Lake Kaniere;
- review and summary of DiFranza book on nicotine dependence, as a potential educational resource;
- attended powhiri for Dr Cragg (Rata Te Awhina) and mihi whakatau for Kelsey Moore (C&PH);
- study day on smoking cessation and mental health, facilitated by Dr Mark Wallace-Bell with 21 attendees;
- delivered DHB mandatory ABC-Smokefree training session;
- prepared and delivered training session for ABC primary care coding project;
- attended DHB smokefree coordinators' meeting in Wellington;
- attended the National Tobacco Control 2012 Conference in Wellington.

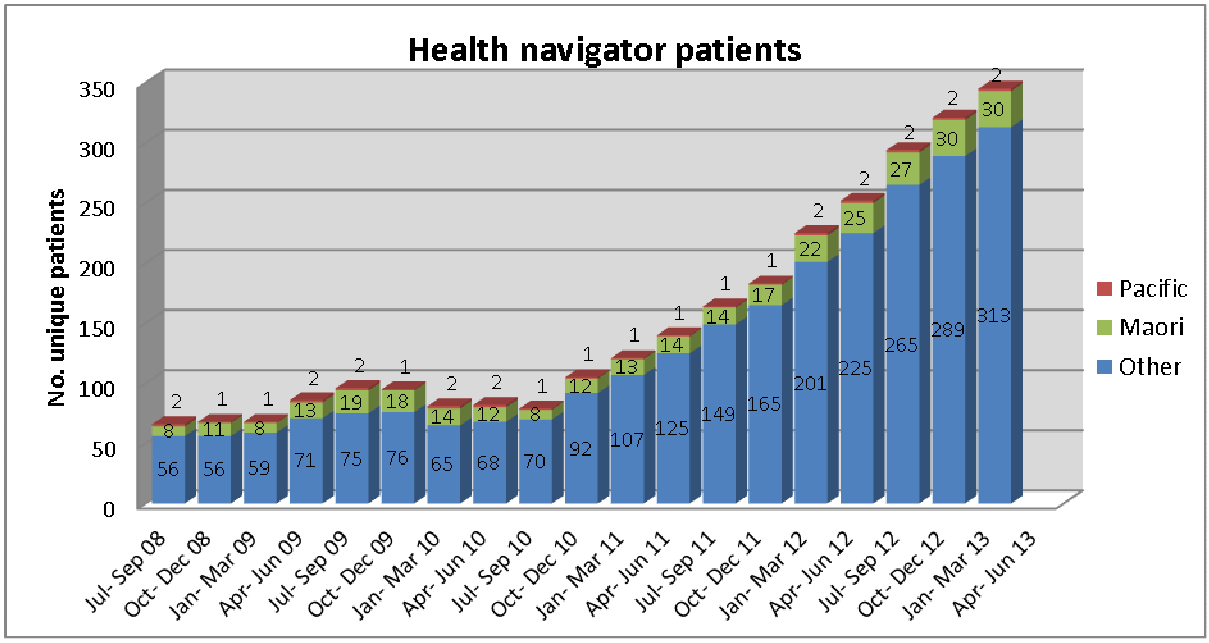
4. **Issues and Risks**

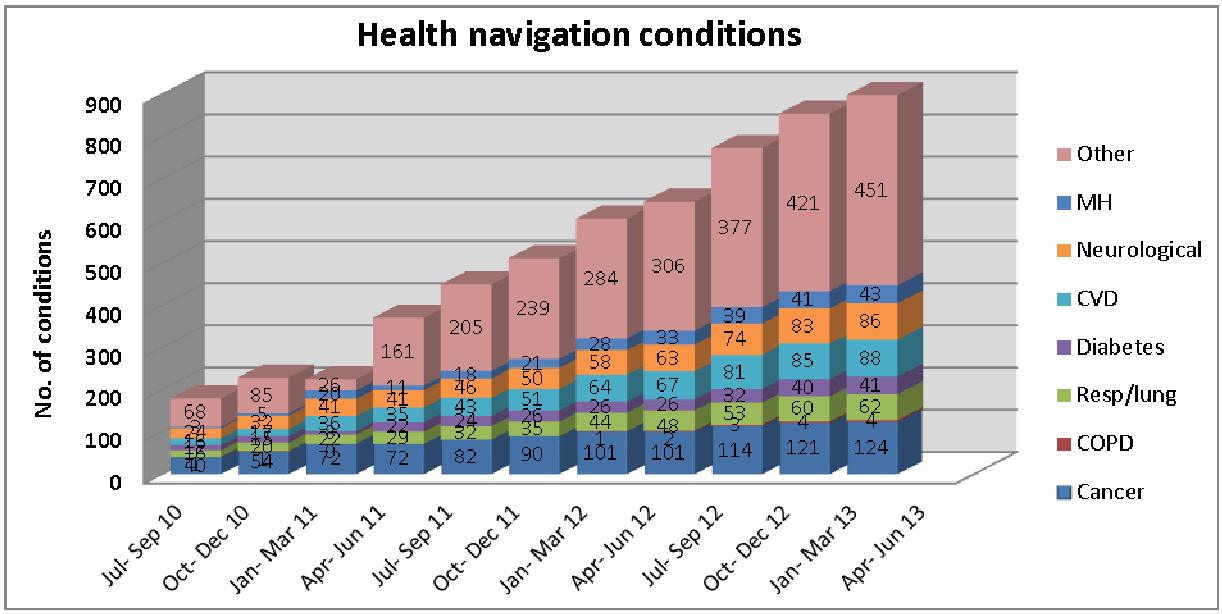
Issues/Risks	**Mitigation/Resolution**
• Nil	• Nil

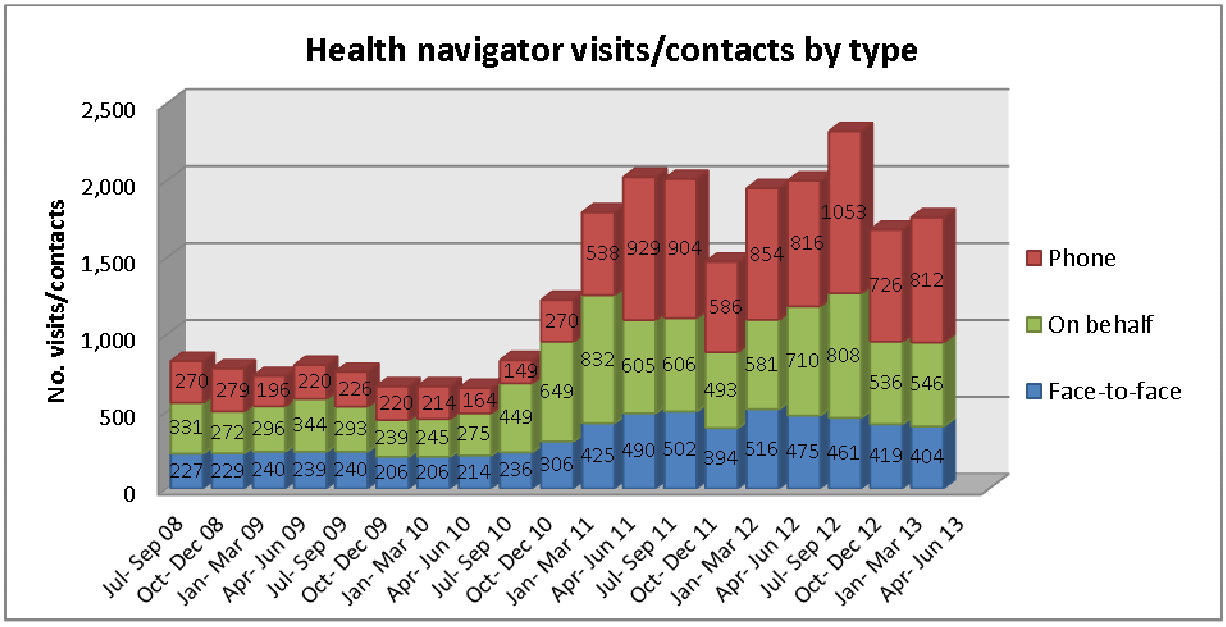
5.7. Health navigator service

On target: Yes, tracking as expected.

1. Outcomes/Outputs







This programme is well utilised by the practices who enrol their patients and appears to be well received by patients which is unsurprising considering the findings of the Health Outcomes International evaluation

2. Key Activities

- provide additional support for Long Term Conditions (LTC) patients and their whanau with complex social needs;
- improve access to health care for these patients;
- support the general practices 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)

- education with optician;
- Maori Suicide Prevention - Webinar (2 sessions);
- Sorotomist presentation;
- WCDHB Consumer Council Meeting (Christchurch);
- Cancer Society Support Manager visited;
- The Hon.Tariana Turia presentation;
- NZ framework for dementia care pathways SI forum – presentation;
- SCN Meeting;
- Cancer Congress Conference – Auckland;
- Royal Foundation for the Blind – expo.

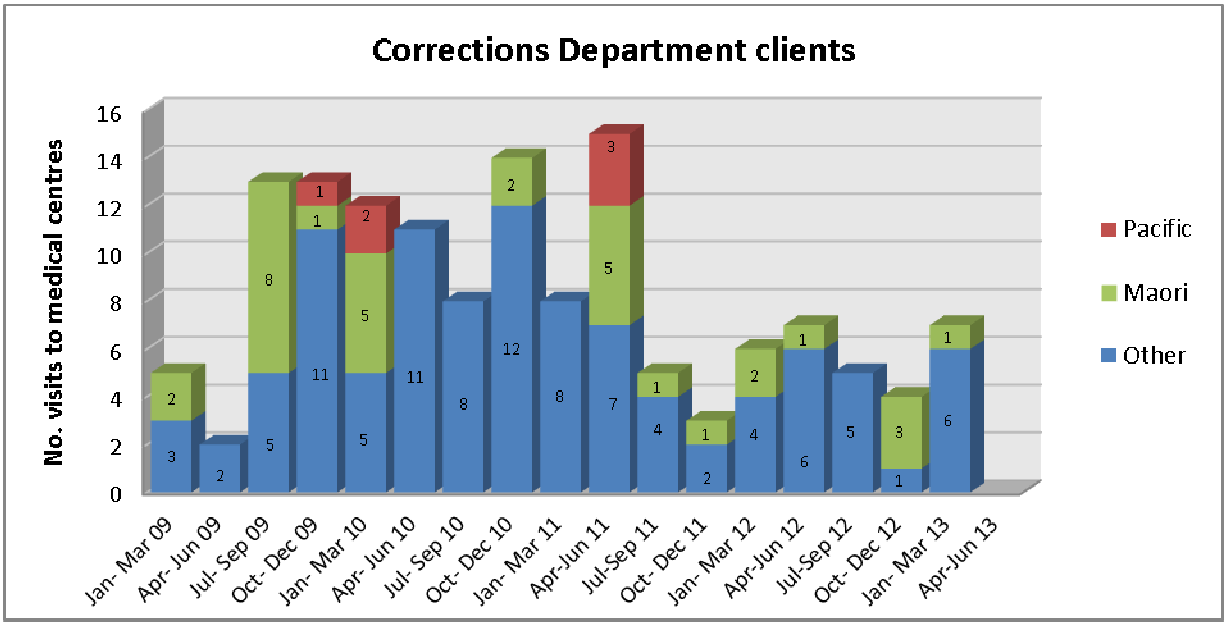
4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• Patient reporting outcome measures suitable to assessment of patient navigation.	• Identify ways to measure outcomes for this programme.

5.8. Health checks for clients of the Corrections Department

On target: Yes

1. **Outcomes/Outputs**



Activity this quarter was the same as the previous year for the corrections programme. 1 of the 7 visits this quarter were for Maori.

2. **Key Activities**
   - vouchers are issued by Community Probation Service staff to clients requiring free general practice services.

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

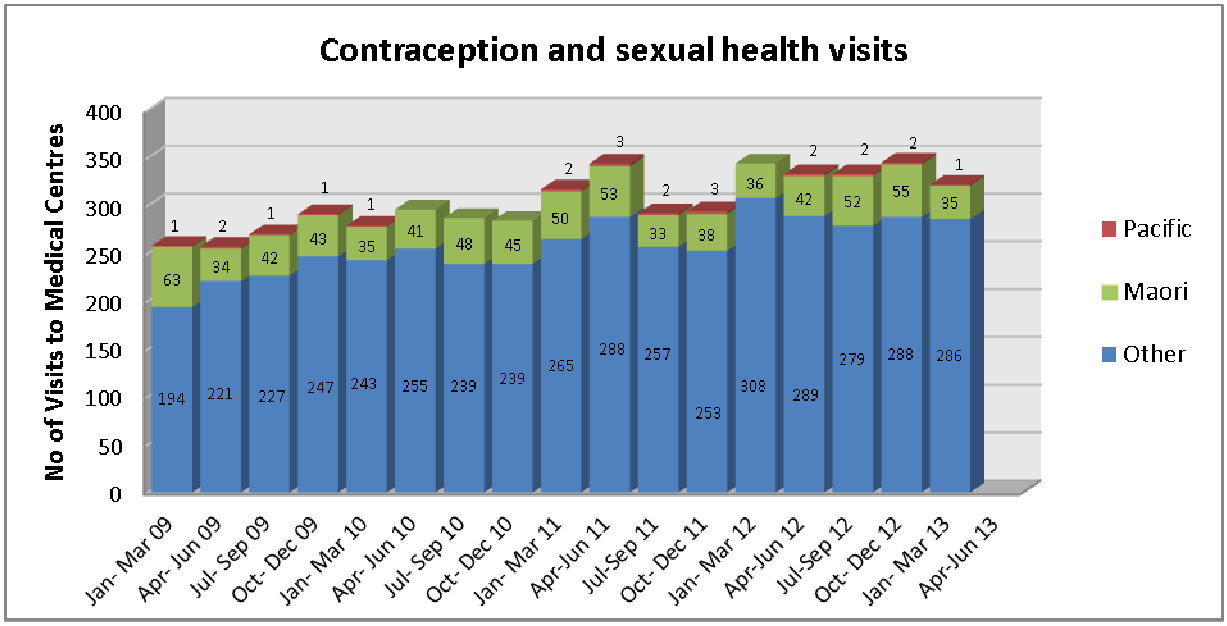
4. **Issues and Risks**

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

5.9. Contraception & sexual health visits

On target: Yes

1. Outcomes/Outputs



11% of all visits made to practices for contraceptive and sexual health consults were for Maori. For comparison, Maori make up 14.6% of the 15-24 year age band likely to be the principal users of this programme.

2. Key Activities

- pharmacy claims: 30 ECP; 82 script fees;
- 3 Jadelle contraception;
- Unfortunately the contraception training update planned for March was cancelled due to low number of registrations.

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

- practice teams;
- pharmacies;
- Clinical Training and Development - Family Planning, Christchurch.

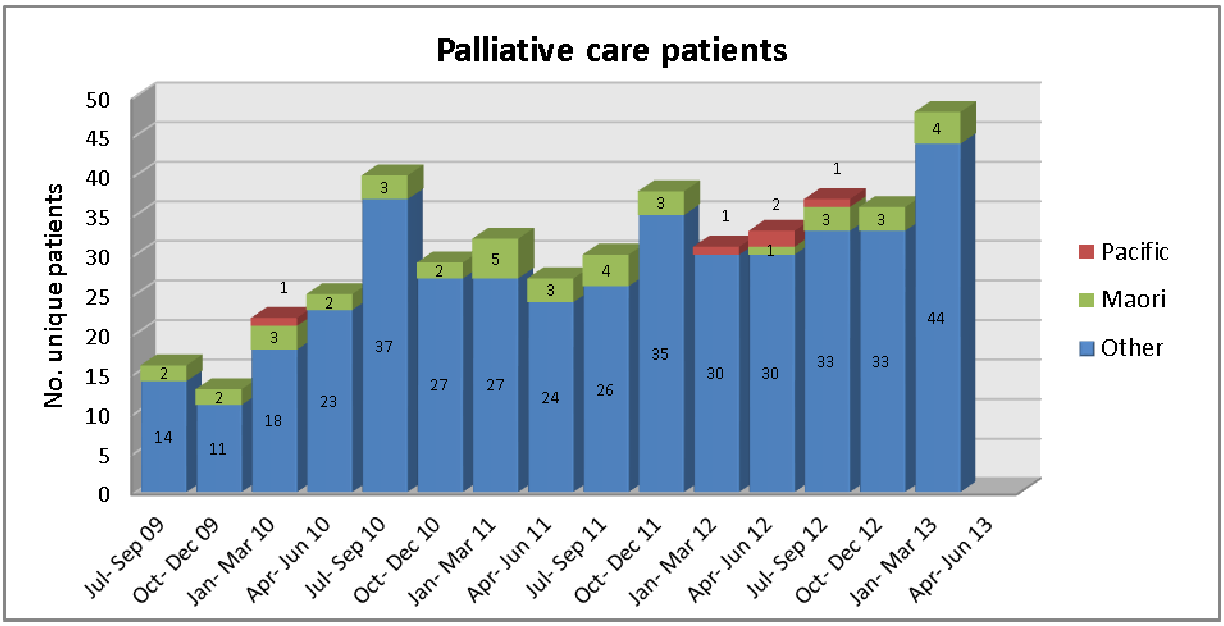
4. Issues and Risks

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

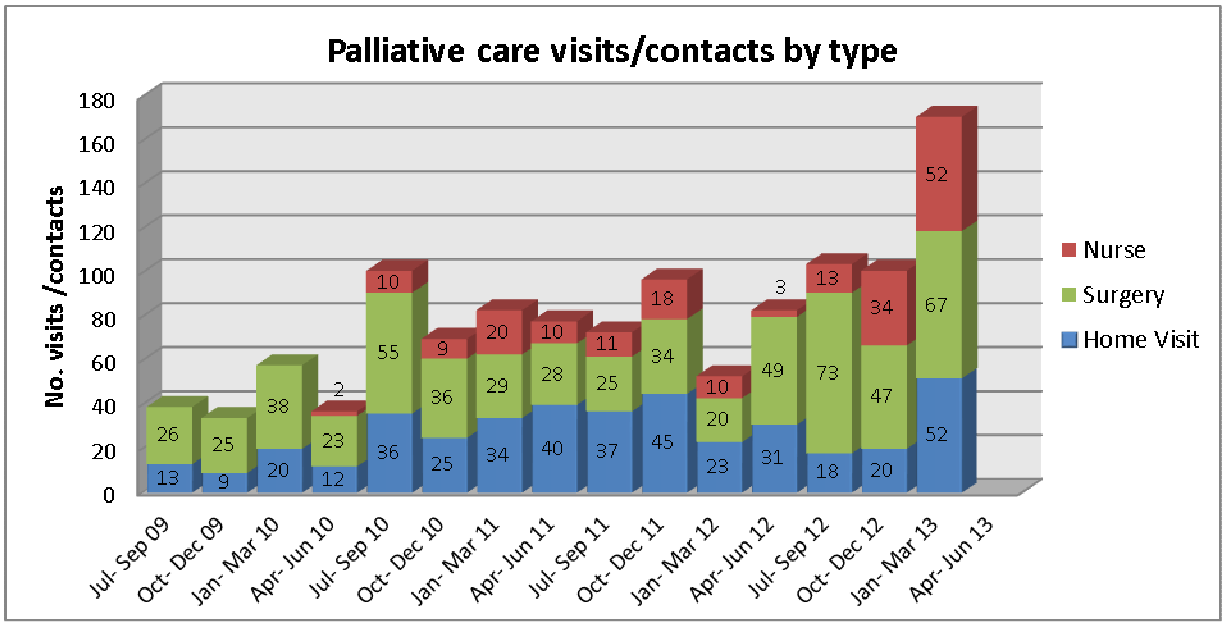
5.10. Palliative care

On target: Yes

1. Outcomes/Outputs



The number of individual patients has increased this quarter.



The practices being able to claim for the palliative care team virtual visits is beneficial not only for the practices but it also improves palliative service delivery to the community.

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

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

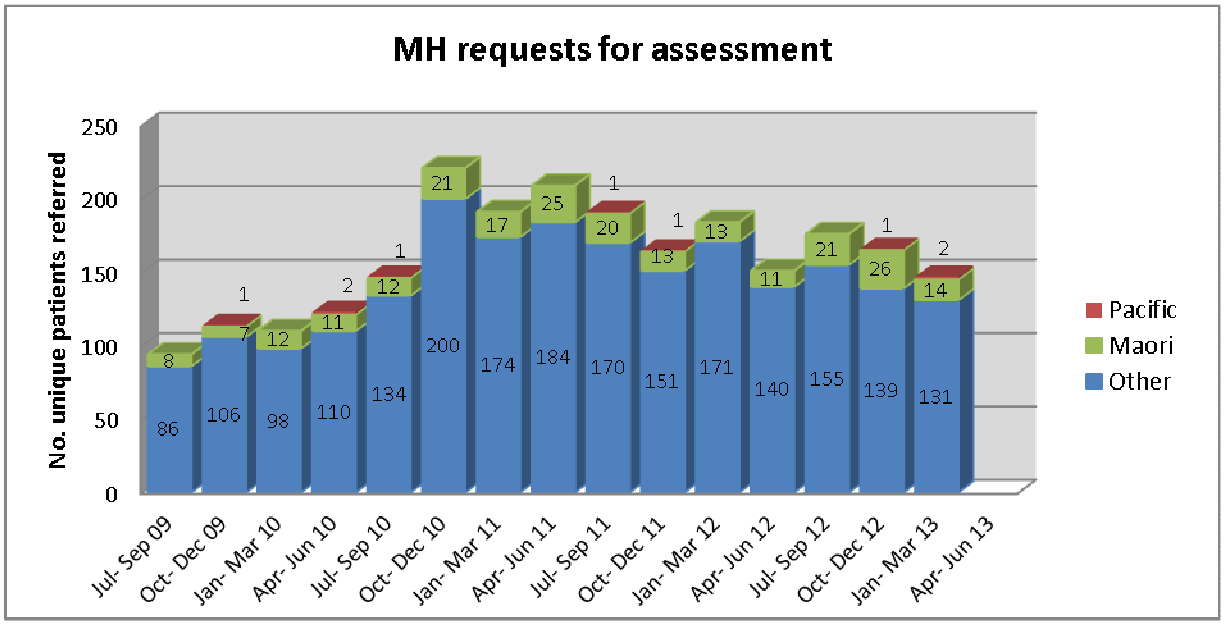
4. **Issues and Risks**

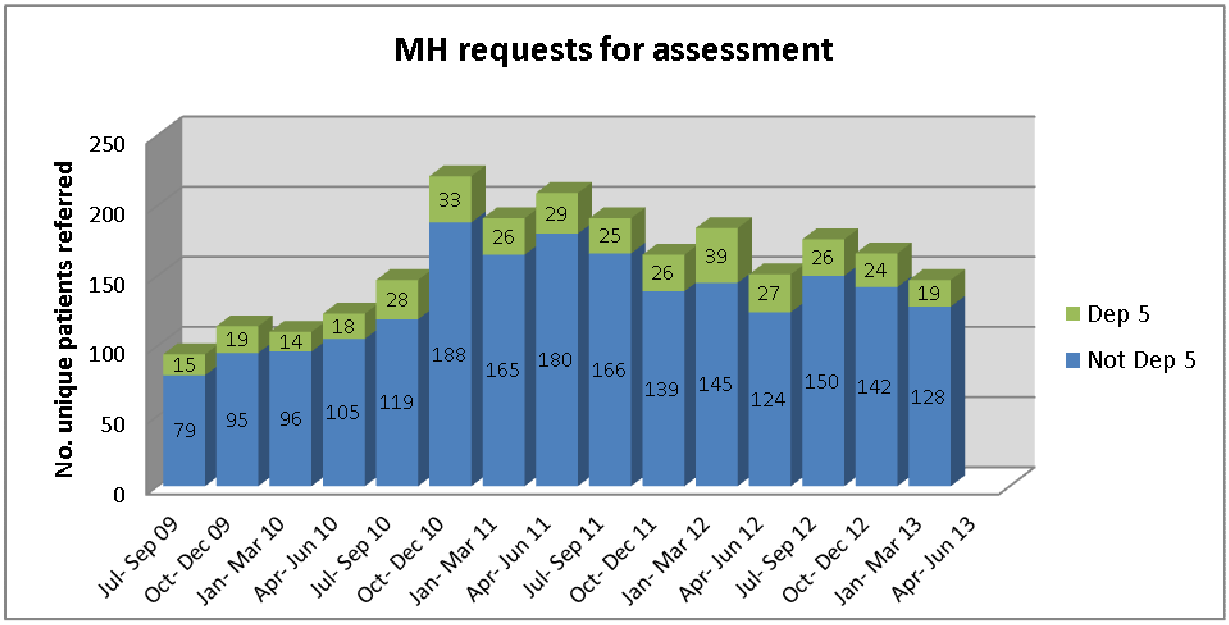
Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

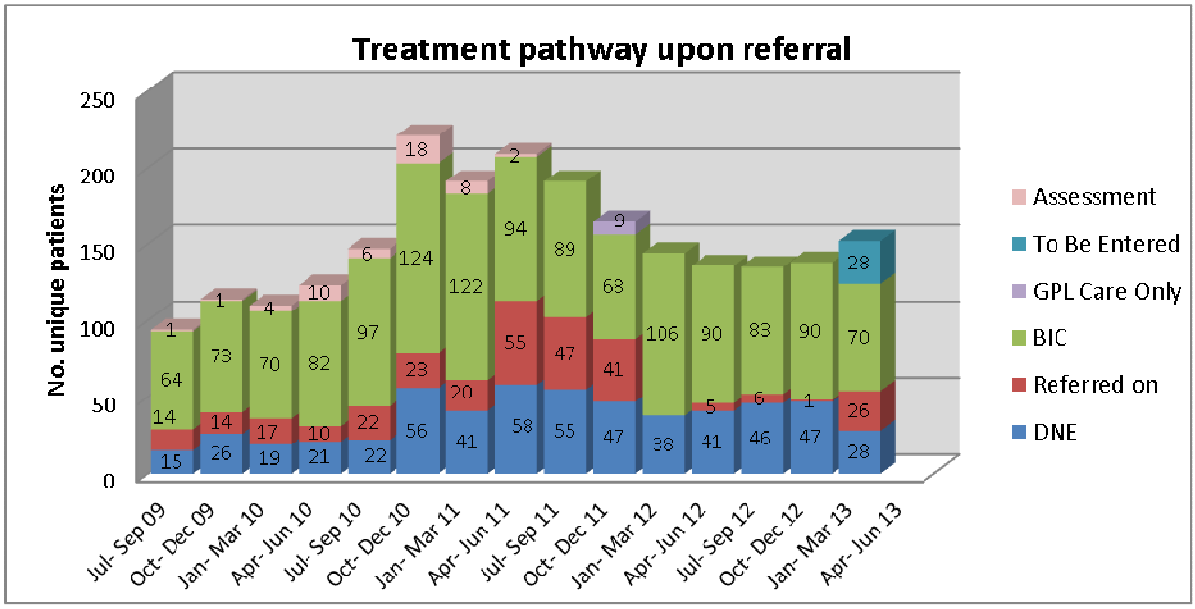
5.11. Mental Health services

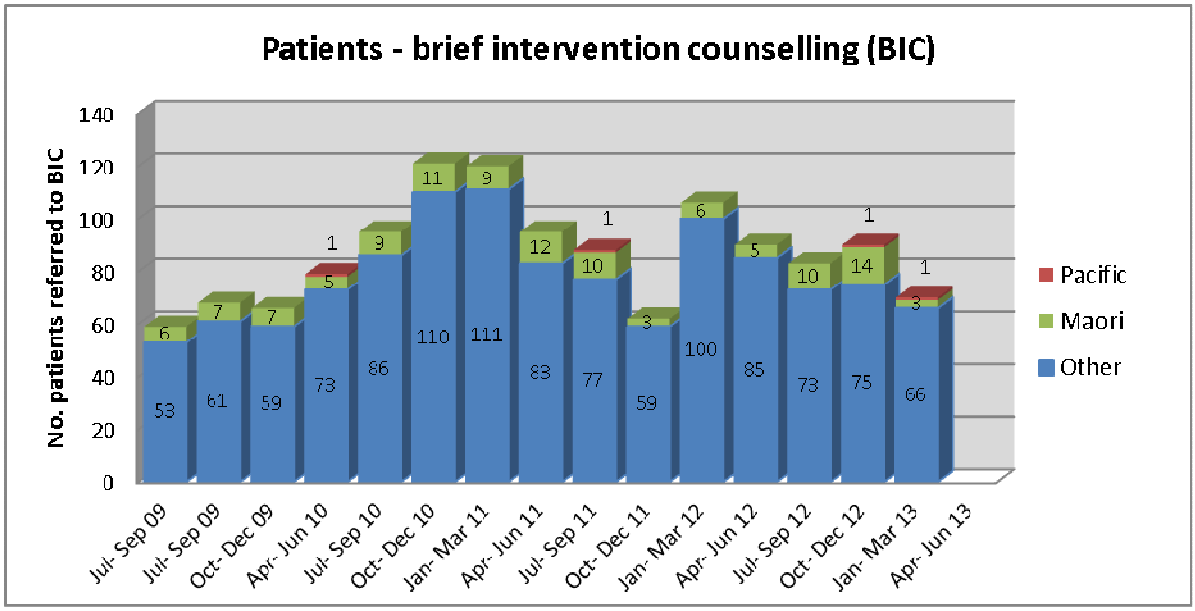
On target: *Yes*

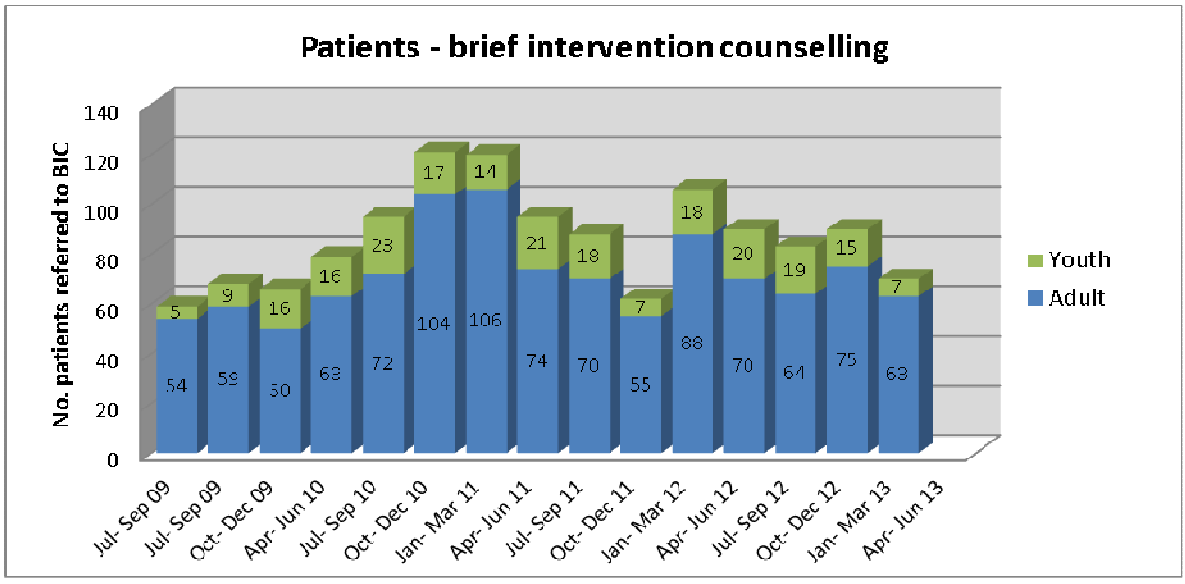
1. Outcomes/Outputs

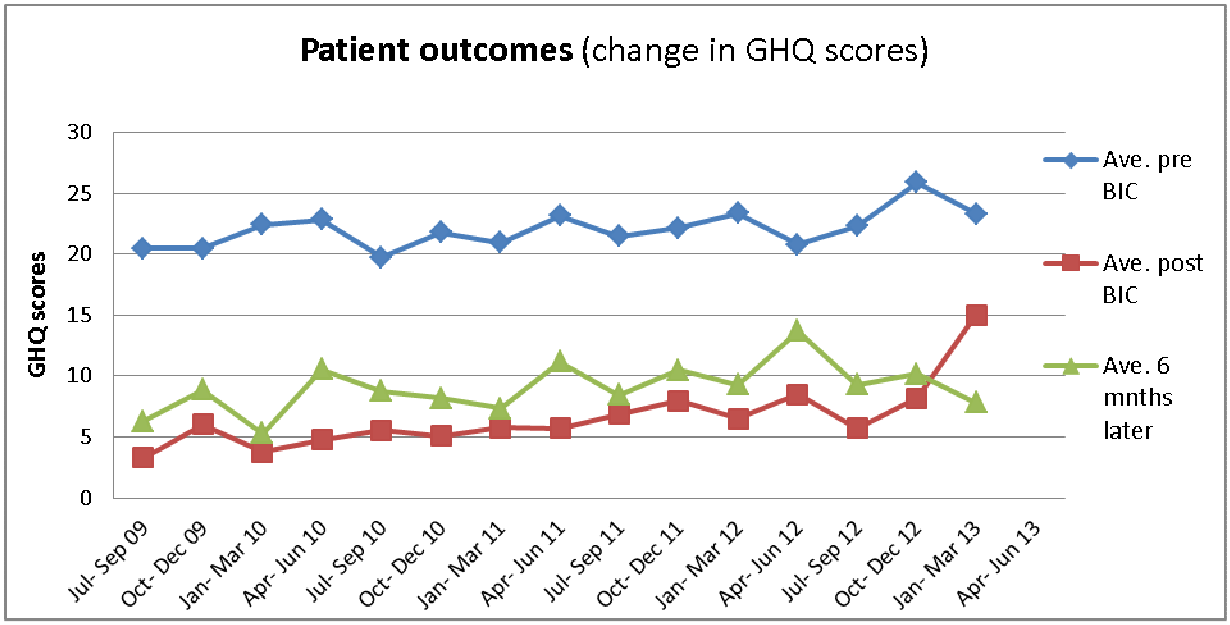





Treatment pathway upon referral
No. unique patients
250
200
150
100
50
0
Assessment
To Be Entered
GPL Care Only
BIC
Referred on
DNE
Jul- Sep 09
Oct- Dec 09
Jan- Mar 10
Apr- Jun 10
Jul- Sep 10
Oct- Dec 10
Jan- Mar 11
Apr- Jun 11
Jul- Sep 11
Oct- Dec 11
Jan- Mar 12
Apr- Jun 12
Jul- Sep 12
Oct- Dec 12
Jan- Mar 13
Apr- Jun 13


Patients - brief intervention counselling (BIC)
No. patients referred to BIC
140
120
100
80
60
40
20
0
Pacific
Maori
Other
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
Jul- Sep 12
Oct- Dec 12
Jan- Mar 13
Apr- Jun 13


Patients - brief intervention counselling
No. patients referred to BIC
140
120
100
80
60
40
20
0
Youth
Adult
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
Jul- Sep 12
Oct- Dec 12
Jan- Mar 13
Apr- Jun 13



The outcomes data indicate that significant changes were made to levels of psychological distress as measured at six months follow-up after the last counselling session. However, a discrepancy in average post BIC scores for this quarter shall be monitored and addressed as necessary.

2. Key Activities

- There were 147 new requests processed this quarter, with 14 (9.5%) of these people identifying as Maori.
- The number of people entering Brief Intervention Counselling this quarter was 70 with 7 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.
- The two team members who joined the service last quarter have continued to establish themselves in their respective positions.
- Two long serving members, the Mental Health Manager/Psychologist and the Psychologist/Youth have left the team and a new Mental Health Manager/ Clinical Psychologist has joined the team.

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

- Networking continues to occur with relevant NGO groups (notably this quarter: support for our elderly clients through Care Link's Enliven programme), as well as attendance at relevant health sector meetings across the West Coast.
- The GP Liaison Nurse continues to meet on a regular basis with secondary mental health personnel, primary practice teams, and others as appropriate. The combined meeting of GP practice, Community Mental Health and PHO GP Liaison nurse is working well with a seamless pathway of care.
- Team members continue to be proactive in taking up training opportunities when they present to extend their knowledge and skills.

4. Issues and Risks

Issues/Risks	Mitigation/Resolution

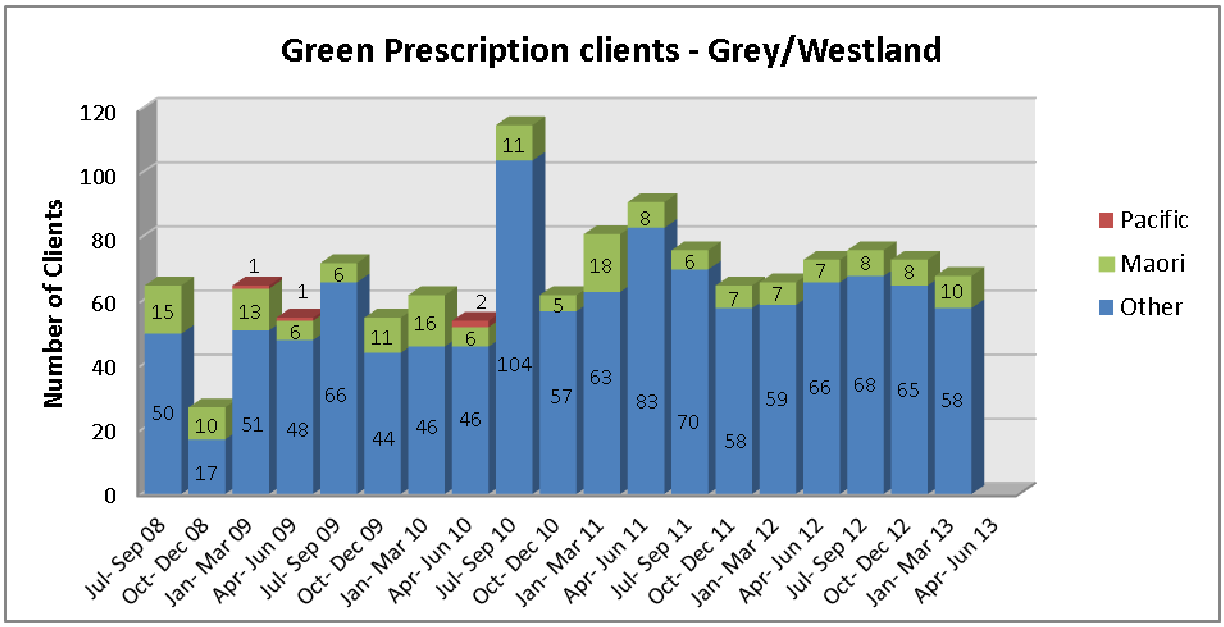
• Nil.	• Nil.

6. Keeping People Healthy

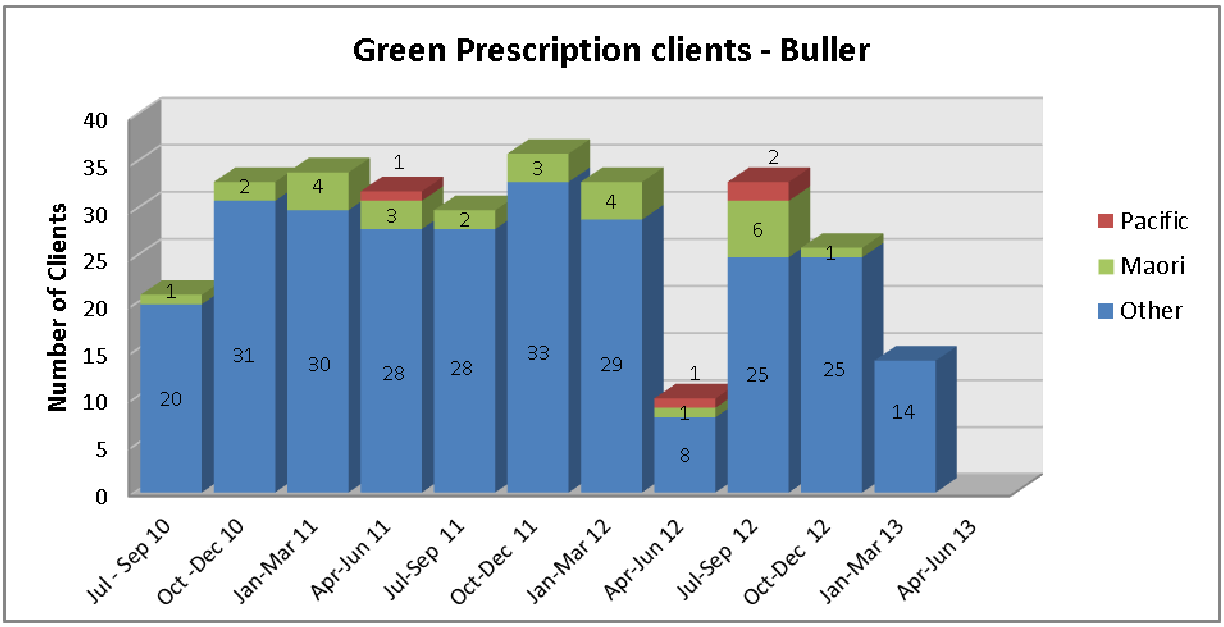
6.1. Green Prescription (GRx)

On target: *Yes*

1. Outcomes/Outputs



Grey/Westland numbers remain steady. 14.7% of referrals were for Maori. Of the quarterly referrals: 75% (51) were female and 25% (17) were male.



Buller GRx recommenced in July 2012. Numbers decreased a little this quarter which is not unexpected for the January holiday period. No referrals for the quarter were for Maori. 4 referrals (28%) were for men.

2. **Key Activities**

- continuation of GRx programme in Reefton every Thursday;
- continuation of GRx gym sessions held Tuesday mornings in Hokitika;
- GRx sessions in the PHO gym every Tuesday afternoon, Wednesday and Friday morning;
- GRx administration includes: initial phone calls, phone reviews, face-to-face consultations, data entry;
- GRx initial consultations held in Greymouth on Monday mornings and Hokitika on a Tuesday;
- two respiratory groups every Friday (10week programmes) plus new gym sessions;
- Te Rununga o Makaawhio exercise group (Te Whare Oranga Pai) every Tuesday for two hours in Hokitika.

Buller:

- Buller GRx programme re-commenced in July, now delivered from the Buller Solid Energy Centre, it still involves group based physical activity aimed at independence to be active after the 12 week programme;
- group gym sessions are being held on two different days and times to suit participants.

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

- monthly Green Prescription newsletter to practice and rural clinics;
- GRx presentation was given to the new staff at PHO orientation day.

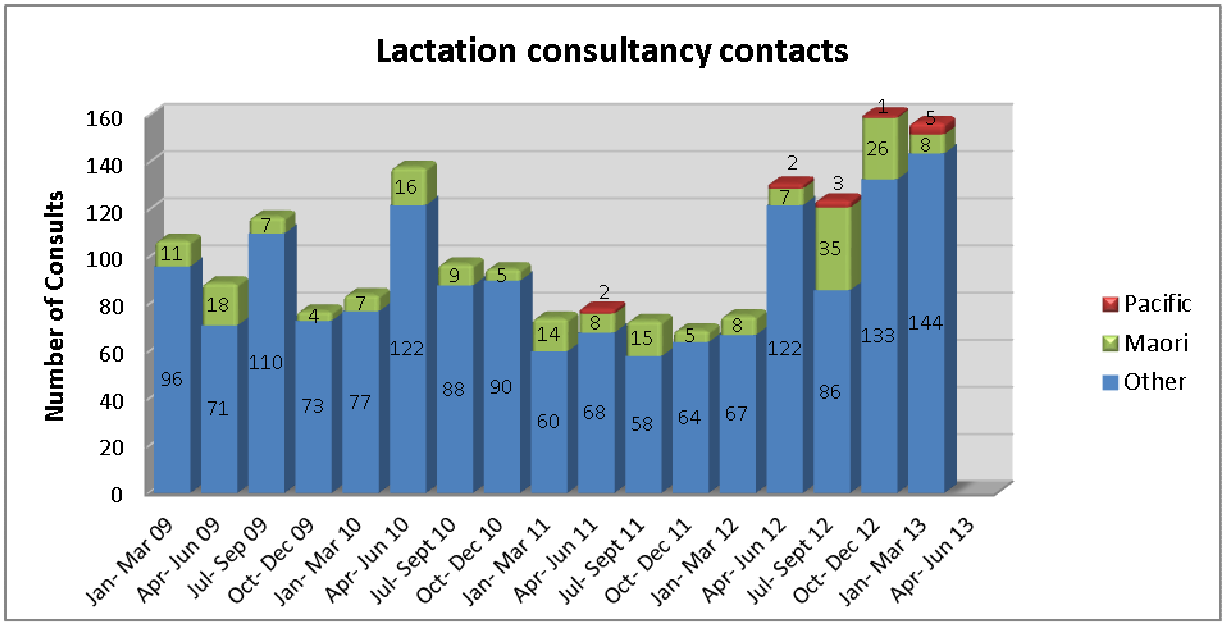
4. **Issues and Risks**

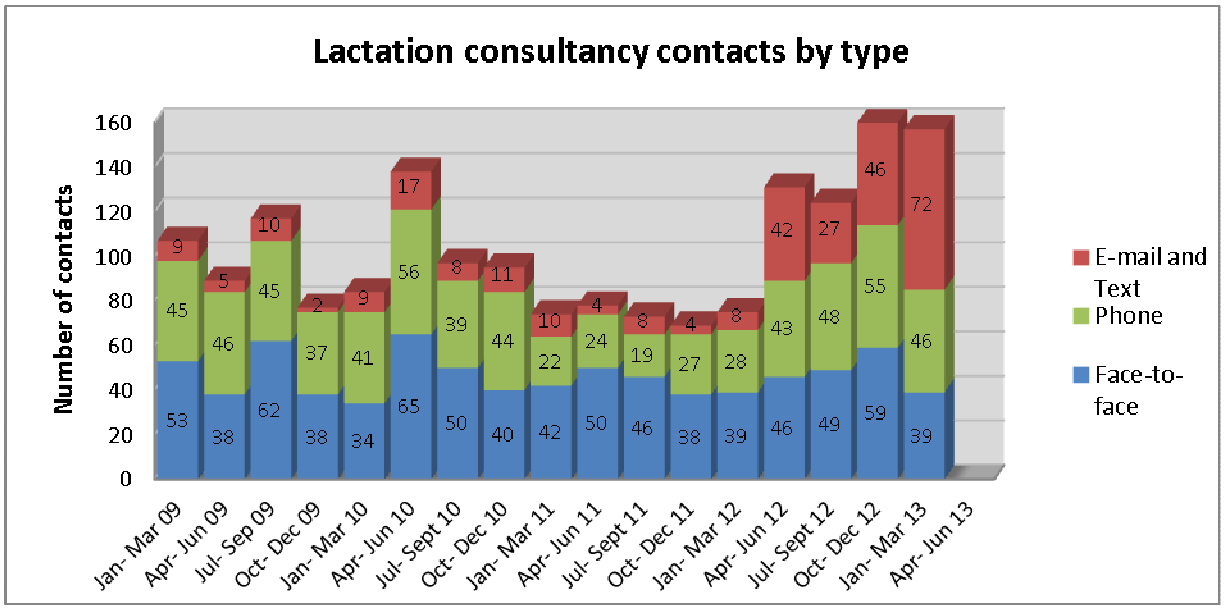
Issues/Risks	**Mitigation/Resolution**
• As at February have met the funded 244 referral number	• Top up from HEHA underspend to 360 referrals.

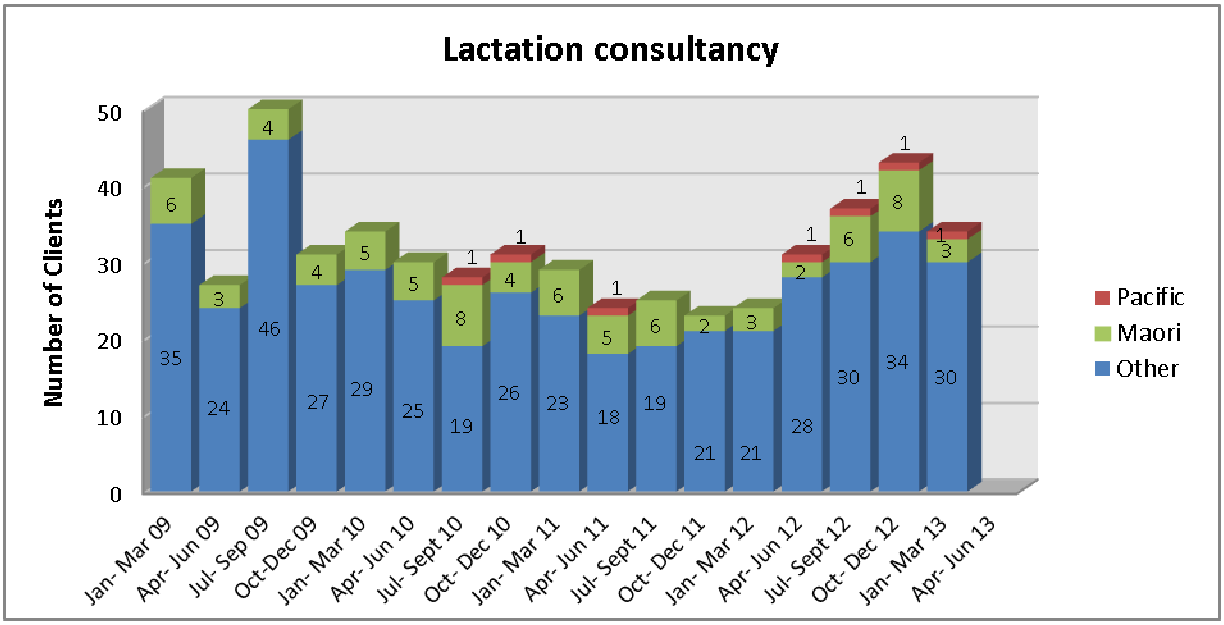
6.2. Breastfeeding Support

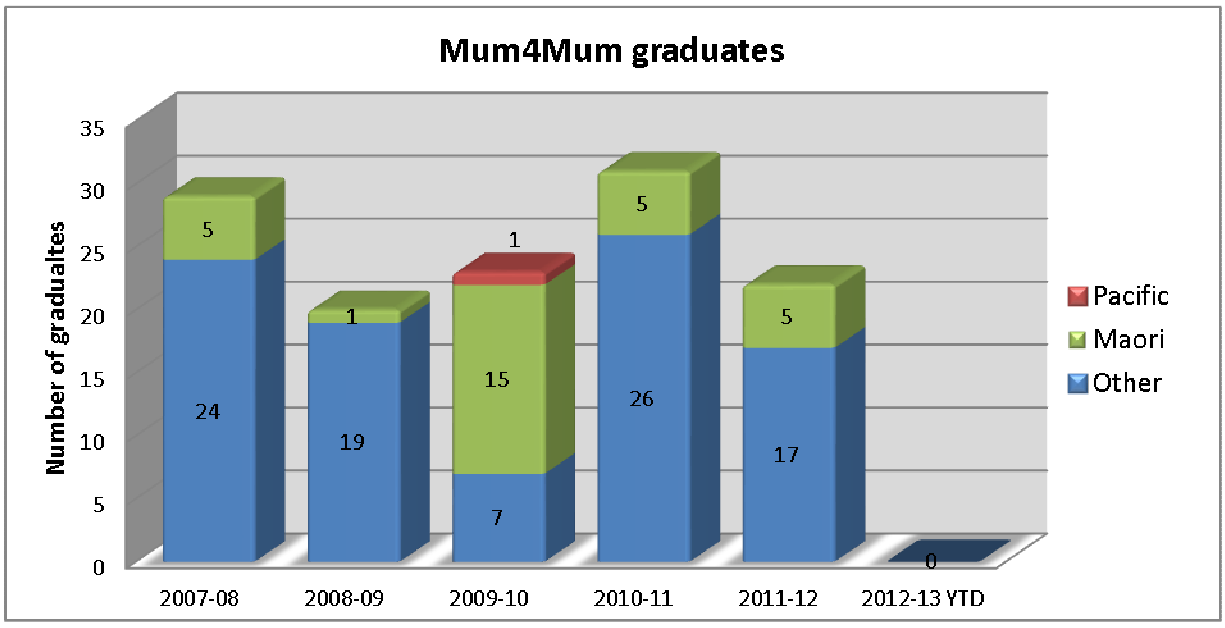
On target: Yes

1. Outcomes/Outputs









2. Key Activities

Lactation consultancy:

- 24 new and 10 return clients, including 3 Maori, 1 Pacific, and 30 other;
- of these 34 new and returned clients, 19 were Deprivation 8-10, 13 rural; 0 were under 20 years of age and 2 were ante-natal women;
- this quarter there were 157 contacts total; including 8 Maori (2 face-to-face, 3 phone, nil e-mail, and at least 3 text), 5 Pacific (2 face-to-face, 1 phone, and at least 2 text) and 144 other (35 face-to-face, 42 phone, 1 e-mail and at least 66 texts);
- referrals were from women themselves, family/friends, Mum4Mums, Midwives, and Well-Child providers;
- referrals were made to Well-Child providers, GP, Midwives and Mum4Mums;

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

Peer Counselling:

- no new graduates this quarter;
- Hokitika training began in February and will finish in April, with four mums due to complete;
- Mum4Mum training to commence in April in Reefton;
- Mum4Mums attend breastfeeding antenatal classes to describe the service they offer and how to access them for support;
- Mum4Mums continue to support many women informally. This support is by example (Mum4Mums breastfeed their own new babies and older children at various community and family gatherings) as well as through conversations and sharing of information with other women they have contact with;
- Mum4Mums reported providing at least 27 people with "formal" breastfeeding support;
- Mum4Mums frequently attend BABES-in-Arms, Plunket and other support groups;
- continuing education Mum4Mum meetings in Westport (2), Reefton (1). Two meetings cancelled in Greymouth and one in Hokitika due to lack of availability of the Mum4Mums to attend;
- 4 newsletters to Mum4Mums;
- BABES in Arms breastfeeding support groups held monthly in Greymouth, Cobden, Hokitika, Reefton and Westport.

Education sessions:

- ante-natal breastfeeding classes as part of DHB series of classes: Greymouth (1), Westport (1);
- participant evaluations from Greymouth antenatal class showed that people were very positive and 'highly likely' to access BABES in Arms, Mum4Mums and PHO Breastfeeding Advocates when they have their baby;
- a breastfeeding education session held with 5th year medical students in Greymouth;
- breastfeeding road show including updates covering support services available and how to access services at Westland Medical, Franz Josef clinic with all South Westland and Buller Medical staff;
- Buller Rural Nurse Team scheduled to receive this education session in April.

3. **Networking/Education** (either with Health Sector or Community)
   - a Breastfeeding Interest Group (BIG) meeting was held in February with representatives from Kawatiri, general practice, Mum4Mums and PHO Breastfeeding Advocates in attendance;
   - on-going contact with others in maternity and Well Child work, including midwives, Plunket and PAFT, Rata Te Awhina Trust, Childbirth Educators, Family Start, and Practice Nurses;
   - attendance at Child and Youth Committee meeting at DHB;
   - Raewyn, in her role as Lactation Consultant acts specifically as a resource person for midwives Coast wide;
   - breastfeeding information and resources were delivered to South Westland practices;
   - 'breastfeeding update' of recent research sent to local midwives and maternity staff;
   - more folders of breastfeeding information provided to McBrearty ward to remain in the rooms for families to read while there;
   - a second printing of the (revised and updated) West Coast Breastfeeding Handbook was distributed;
   - new BABES in Arms promotional material provided to local Plunket services;

- each medical centre was provided with current Mum4Mum and BABES in Arms promotional material to use;
- a breastfeeding education session is included as part of the PHO orientation for new practice staff on the West Coast;
- Regular time spent at 'the Hub' for breastfeeding support groups.
- Nicola has completed 3/10 modules through the Health E-Learning BreastEd series;
- Raewyn attended the NZLCA 2 day conference in Auckland;
-

Mum4Mums and BABES in Arms promoted through:

- Wellchild/Tamariki Ora providers on noticeboards at the clinics and via Plunket nurses;
- maternity Wards – on walls in each room and on the notice boards;
- community notice boards (e.g. Grey District Library, supermarkets, church notice boards);
- West Coast Breastfeeding Handbook;
- West Coast Breastfeeding Facebook page used frequently to promote BABES in Arms.

4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• Mum4Mum training target of 17 not likely to be met in 2012-13. • Difficult engagement with some practice teams to schedule delivery of breastfeeding education to clinicians.	• Is expected to be well exceeded in the 2013-14 year. • Continue to attempt to schedule times to suit practice team clinicians for education.

6.3. Health Promotion Integration

On target: Yes

1. **Outcomes/Outputs**
   - On February 14th 38 WCDHB staff were screened for their 5 year cardiovascular risk (34 Greymouth and 4 Buller) in a clinic run by the cardiac nurse specialists. 3 people were identified with a risk over 15%.
   - During the week of 11-18th February the PHO worked directly with High Street Medical Centre where 100 personalised letters were sent out to targeted patients who were eligible for their cardiovascular risk assessments (CVRAs). 100 follow-up phone calls were made in an effort to invite people in for their screening.
   - On the 12th February a presentation was given to Greymouth Rotary on heart health with an account of the presenter's bypass experience, 20 people attended.
   - 100 flu pamphlets were delivered to a local optometrist for a targeted mail out to their over-65 year old population.

2. **Key Activities**

   Heart Month February:

   This quarter's main objective was to increase awareness of heart disease and increase public uptake of cardiovascular risk assessments. A series of events and media opportunities were developed and at one medical centre included a specific targeted approach, including personal letters and phone calls.

   13th February Bike-a-thon: This was an exercise based challenge. Participants were part of a team who rode their bikes (static and freewheeling) for several hours during the day held in all 3 regions:
   - Greymouth (12 -6 pm): 6 members of the Fat Boys Cycle Club organised with the Greymouth Lifestyle Ambassador, Peter Hines, this was held at Greymouth Aquatic Centre;
   - Westport (7 am – 7 pm): 90 members of the Westport Cycle Club, the Solid Energy Gym and members of the public participated. This was held at the Veledrome, Victoria Park, in Westport;
   - Hokitika (8 am – 8 pm): 40 members of Bodyworx Gym which was held at the gym.

   15th February – Heart walks, Greymouth and Westport:
   - the Cardiac Clubs and DHB Cardiac Nurse Specialists walked from their regular meeting place locations into the centre of their towns. In Westport, the group was joined by the children of St Canices School and in total 65 people walked, with 9 people walking in Greymouth;
   - healthy heart messages were included with messages sent to all schools on the West Coast, and reprinted in school newsletters.

   Influenza Month March:

   To support the intent to increase flu targets a strategy meeting was attended, press releases were sent out, arranged reminder stickers for pharmacies and liaised with Medical Centres and Rural Clinics on their flu clinic dates. In addition 110 flu pamphlets were delivered to a local Optometrist for a targeted mail out to over 65's:
   - Healthy West Coast advert in Messenger – Flu vaccinations;
   - Messenger Ask a professional: Flu Facts;
   - Flu vaccination update and High Street Medical Centre photo in Greymouth Star.

3. **Networking/Education** (either with Health Sector or Community)
   - West Coast Tobacco Free Coalition meeting March 2013;
   - West Coast PHO Smokefree Services Coordinator;
   - Local Diabetes and Heart Respiratory teams;
   - Active West Coast meeting January 2013;
   - EMS meeting (Emergency Management System) – January;
   - Rata Te Awhina Trust joint meeting to share and discuss PHO's 2013 health promotion calendar and activities;
   - Westport Cardiac Club presentation on activities for heart month – January;
   - Westport News – discuss heart month and other media opportunities for PHO –January;
   - attended Health Promotion Hui organised by Healthy West Coast Governance Group – February;
   - influenza strategy meeting – March;
   - Rusty the PHO Health Promotion Dog made appearances at Relay For Life Greymouth in February and Children's Day at Dixon park in Greymouth in March;
   - practices and pharmacies for all promotional activity as above.

4. **Issues and Risks**

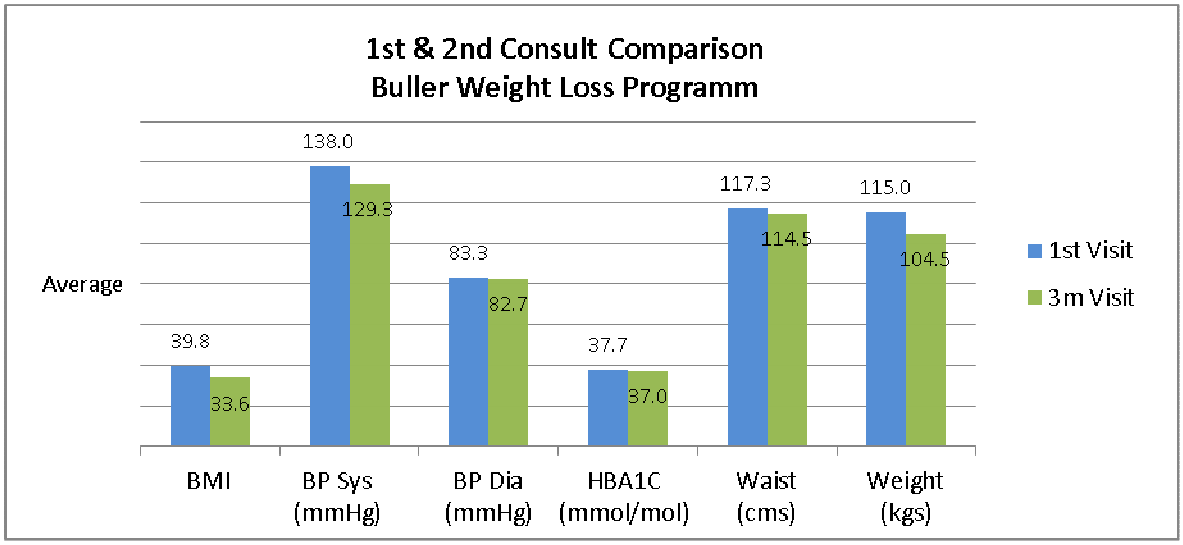
Issues/Risks	**Mitigation/Resolution**
• Nil	• Nil

6.4 Buller Weight Loss Programme Pilot

On target: No - due to nursing staff resource being down due to high staff turn-over recently. This pilot programme, currently only available in Westport, began in July 2012. The overall aim of this programme is to enable people within the enrolled population who are obese (BMI ≥ 30), or overweight and identified at risk of developing diabetes to have access to a supported 12 week programme. The participants are supported to modify their behaviour and environment to assist them to lose weight and prevent the onset of diabetes.

1. Outcomes/Outputs

- 7 referrals to the weight loss programme; 14% Maori, and 86% Other ethnicities;
- 29% male and 71% female participants;
- 12 people have now had their three month follow-up assessments since beginning the programme.



2. Key Activities

- participants all receive individual initial assessments with Life Coach, Cathie Edwards;
- attend 6 group sessions over 12 week period with telephone coaching on alternate weeks;
- participant maintains a food and activity diary and records daily pedometer steps;
- inactive participants may also be in the Buller Green Prescription programme simultaneously, where relevant;
- as from April 2013 this programme will be available from the new Buller practice - Coast Medical.

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

- Buller Health Medical Centre;
- Cathie Edwards programme facilitator;
- Solid Energy Centre gym;
- Number 37, Westport;
- WCDHB dietician services;
- community mental health.

4. Issues and Risks

Issues/Risks	Mitigation/Resolution
• Nurse facilitator at Buller Medical commences maternity leave in December.	• Another RN commencing training this quarter.

7. Workforce and rural support

1. Outcomes/ outputs:

2012/13 National Health Targets for Primary Care

By July 2013, 85% of eight-month olds will have their primary course of immunisation (at 6 weeks, 3 months, and 5 months) on time, increasing to 90% by July 2014 and 95% by December 2014.

This new health target commenced 1 July 2012. Target results are reported using the Childhood Immunisation data from the PHO Performance Programme .

PHO Performance as at 31st December 2012:

- Age Appropriate Vaccinations - 8mth Olds - Total Population 84.09% an increase from 72.28% last quarter
- Age Appropriate Vaccinations - 8mth Olds - High Need 91.3% an increase from 73.33% last quarter

90% of the eligible population will have their cardiovascular risk assessed in the last five years to be achieved in stages by 1st July 2014. The first stage was to achieve 60% by July 2012, and the 75% by July 2013.

This new target commenced 1st January 2012. Target results are reported using the Cardiovascular Risk Assessment data from the PHO Performance Programme.

PHO Performance as at 31st December 2012:

- CVD Risk Assessment - Total Population 57.98% a decrease from 59.81% last quarter
- CVD Risk Assessment - High Need 60.5% an increase from 60.15% lastquarter

90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. Indicator 5 - "the smoking brief advice and cessation suppport" indicator of the PHO Perforamnce Programme is being used for reporting on progress of this target.

PHO Performance as at 31st December 2012:

- Brief Advice and/or Cessation Support/Referral provided to patients seen in last 12 months: Total Population 44.17% an increase from 39.88% last quarter.

- Brief Advice and/or Cessation Support/Referral provided to patients seen in last 12 months: High Need 44.72% an increase from 40.18% last quarter.

PHO Performance Programme PPP

The PHO Performance Programme has been developed by District Health Boards (DHBs), the Ministry of Health and the primary health care sector to support improvements in the health of people enrolled in a PHO. The programme aims to:

- Encourage and reward improved performance by PHOs in line with evidenced-based guidelines.
- Measure and reward progress in reducing health inequalities by including a focus on high need populations.

DHBs contract PHOs to deliver a range of health care services for people when they are unwell, to help people stay healthy and to reach out to groups of people in the community who have poor health or are missing out on primary health care.

The programme has developed a number of performance indicators to measure PHO achievements over a six month period. Some performance indicators measured by the Programme look at services accessed by all PHO-enrolled patients while others look at services specifically accessed by Maori or Pacific Island people or those living in lower socio-economic areas. These patients are referred to as 'high need' patients.

PPP report of funded indicators, to 31st December 2012

Indicator	Programme Goal	PHO achieved in this quarter	Progress compared to previous quarter	Programme indicator achieved	Comment
Flu Vaccine Coverage – Total Population	≥75	54.69	↑	✗	This is not the current flu season, begins March 2013
Flu Vaccine Coverage – High Need	≥75	56.49	↓	✗	This is not the current flu season, begins March 2013
Cervical Cancer Screening Coverage – Total Population	≥75	79.51	↑	✓	A pleasing increase this quarter, reflecting the work undertaken by practice teams
Cervical Cancer Screening Coverage – High Need	≥75	75.34	↑	✓	A pleasing increase this quarter, reflecting the work undertaken by practice teams
Age Appropriated Vaccinations – 2yr olds – Total Population	≥95	87.07	↑	✗	An increase this quarter with 15 children required to reach target

Age Appropriated Vaccinations – 2yr olds – High Need	≥95	90.63		✗	A significant increase this quarter with 3 children required to reach target
Breast Cancer Screening Coverage – High Need	≥70	76.85		✓	A great increase this quarter, target still met
Ischaemic CVD Detection – Total Population	≥90	113.67		✓	Good results continue here
Ischaemic CVD Detection –High Need	≥90	117.97		✓	Good results continue here
CVD Risk Assessment – Total Population	≥75 by 1 July 2013	57.98		✗	A decrease this quarter due to a cohort of patients screened 5 years ago now eligible for re-screening again
CVD Risk Assessment – High Need	≥75 by 1 July 2013	60.50		✗	A small increase this quarter that continues towards the 1 July 13 goal of 75%
Diabetes Detection – Total Population	≥90	109.21		✓	Another increase this quarter, good results continue with this indicator
Diabetes Detection – High Need	≥90	108.75		✓	Another increase this quarter, good results continue with this indicator
Diabetes Detection and Follow Up – Total Population	≥90	83.84		✗	A pleasing increase this quarter
Diabetes Detection and Follow Up – High Need	≥90	80.47		✗	A significant increase this quarter
Smoking Status Ever Recorded - Other	≥90	78.79		✗	Another increase this quarter – 2.5%
Smoking Status Ever Recorded – High Need	≥90	76.59		✗	Another increase this quarter – 1.8%
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 &/or cessation support – Total Population	≥90	44.17		X	A significant increase this quarter reflecting the work undertaken by staff
Brief advice to stop smoking &/or cessation support – High Need	≥90	44.72		X	A significant increase this quarter reflecting the work undertaken by staff

Cornerstone outputs

Submission of the 2012 CME Annual Report to the College in January 2013.

Regular updates are conveyed to relevant staff and practice owners regarding any changes to the cornerstone process or guidelines, as below:

- updated all in one Guide for the CORNERSTONE programme, and we have recently introduced an online registration form;
- invitation to The RNZCGP Annual Quality Symposium 15th and 16th February 2013 at Te Papa, Wellington;
- Buller Medical Services have let their annual accreditation lapse and will incur greater costs once accreditation is maintained in the future.

At the Clinical Governance meeting held February 2013 the same provision will be made to the new Buller practice, who has never undergone accreditation to cover all initial costs (if undertaken within a one year period) as was given to another practice who has yet to undergo accreditation.

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.	There were no professional development activities held this quarter due to the unavailability of a CME coordinator.
Provide annual PHO QI workshop; practice PHO orientation programme; practice management road shows; practice nurse workshops.	The South Westland practice is yet to have the practice administration road show delivered. Updated practice administration folders will be distributed at this time and will be the focus of the training. The first PHO orientation programme commenced for any new staff from practice teams, these will occur every 2nd and 3rd Thursday of every month. Planning is underway for the next QI team study day to be held next quarter.

Enable training in the use of standing orders by funding staff attendance.	Training workshops are planned for Reefton, South Westland and upper Buller for the Rural Nurse Specialists commencing April 2013.
Adapt Canterbury HealthPathways for Coast use and provide educational sessions to implement them, (see HealthPathways plan).	A West Coast HealthPathways coordinator was appointed by Streamliners, Marie West is based at the West Coast PHO offices and commenced in January.
The PHO has an organisational commitment to create an environment where health literacy is not assumed	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.	Healthstat quality improvement tool installed at all Medtech PMS practices.
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).	Ongoing.
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. All practices with MedTech now have software installed for Healthstat, a QI tool for practice teams to directly monitor their PPP data directly from their Medtech systems. A Clinical Audit Tool will be installed in quarter 4, 2013.
Provide PHO Performance Programme incentive payments according to the percentage of targets met by each practice.	These incentive payments are due to be made during June 2013 (annual payment).
Support pharmacists to provide feedback to GPs on cost effective prescribing and reducing prescription errors.	An established process is in place and is on-going.
Develop/adopt a patient survey to measure patient satisfaction with the care they receive at their IFHC	The 2013 survey is scheduled to occur August 2013

3. Issues and Risks

Issues/Risks	Mitigation/Resolution
The CME coordinator was delayed for a quarter whilst the current GP coordinator gained locum support within the practice.	CME will continue from April 2013 as in previous years.