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

22 August 2013

AGENDA
AND
MEETING PAPERS

All information contained in these committee papers is subject to change

AGENDA

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
To be held in the Board Room, Corporate Office, Greymouth Hospital
Thursday 22 August 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**
   11July 2013

3. **Carried Forward/ Action Items**
   (There are no carried forward items)

REPORTS/PRESENTATIONS — 9.10am

4	**Community and Public Health Update**	Jem Pupich *Team Leader, Community and Public Health*	*9.10am - 9.25am*
5.	**Planning & Funding Update**	Carolyn Gullery *General Manager, Planning & Funding*	*9.25am -9.40am*
6.	**Maori Health Activity Update**	Gary Coghlan *General Manager, Maori Health*	*9.40am – 9.55am*
7.	**Alliance Update – Quarterly Report**	Carolyn Gullery *General Manager, Planning & Funding*	*9.55am - 10.10am*
8.	**General Business**	Elinor Stratford *Chair*	*10.35am - 10.50am*

ESTIMATED FINISH TIME — 10.50am

INFORMATION ITEMS

- **Chair's Report to last Board meeting**
- **Board Agenda – 2 August 2013**
- **West Coast CPHAC/DSAC Workplan 2013**
- **West Coast DHB 2013 Meeting Schedule**
- **PHO Quarterly Report**

NEXT MEETING

Date of Next Meeting: 10 October 2013 Corporate Office, Board Room at Grey Base Hospital.

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

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 Representative on Tatau Pounamu • Advisor to MS/Parkinson West Coast
DEPUTY CHAIR Kevin Brown **(Board Member)**	• Councillor, Grey District Council • Trustee, West Coast Electric Power Trust • 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 • Member – DISC Trust
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). • Chair PHO Alliance
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
Mary Molloy	• Director - Molloy Farms South Westland Ltd

Member	Disclosure of Interest
(Board Member)	• Trustee - L.B. & M.E Molloy Family Trust • Spokeswoman - 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 • Consumer Representative on South Island Quality & Safety SLA

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, 11 July 2013 commencing at 9.00am

PRESENT

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

APOLOGIES

An apology for absence was received and accepted from Mary Molloy.

EXECUTIVE SUPPORT

Carolyn Gullery (General Manager, Planning & Funding); and Kay Jenkins (Minutes).

WELCOME

The Chair welcomed everyone and asked Marie Mahuika-Forsyth to lead the Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
John Ayling – add Chair PHO Alliance.
Elinor Stratford – remove Committee Member CARE and Member of Sub Committee Stroke Conference and add Disability Resource Trust , Contractor to wind up organisation.

Declarations of Interest for Items on Today's Agenda
John Ayling declared a possible conflict of interest for Item 7.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. MINUTES OF THE PREVIOUS MEETING

Resolution (7/13)
(Moved: Lynette Bierne; Seconded: Cheryl Brunton - carried)

"That the minutes of the meeting of the Community and Public Health and Disability Support Advisory Committee held on 6 June 2013 be confirmed as a true and correct record subject to the following change: Item 4 – change "until the products are completely banned" to "until new legislation is passed later this year".

3. CARRIED FORWARD/ACTION ITEMS

There were no carried forward items.

4. COMMUNITY & PUBLIC HEALTH UPDATE

Jem Pupich, Team Leader,, Community & Public Health, presented the Community & Public Health Update.

This report from Community & Public Health provided information as follows:

Health Impact and the Public Health Response to Major Job Losses in Small Communities
The West Coast Community & Public Health team were motivated to obtain a literature review on this topic in the wake of the announcement of the closure of Solid Energy's Spring Creek Mine. They were seeking information about what might be expected in terms of health and wellbeing impacts on the local community and any evidence about what public health and community responses might serve to mitigate the adverse impacts.

The Literature Review has recently been completed and the Executive Summary of the review will be provided to Committee members.

Annual Drinking Water Survey
Community & Public Health are about to embark on the Annual Drinking Water Survey for the West Coast. This survey is carried out each year and assesses the microbiological and chemical quality of drinking water supplies serving populations of more the 100 people, and progress towards meeting the requirements of drinking water legislation.

Local Alcohol Policy Development
Community & Public Health have met with the 3 Councils and police to get an understanding of the common ground between the areas. The general feeling is that they would like to develop one document with slight variations of local input.

Alcohol Controlled Purchase Operation (CPO)
A CPO was carried out recently to test the off-licenses in Greymouth regarding their compliance with the legal purchase restriction for alcohol. It was pleasing that the 17 year old volunteer was unable to purchase alcohol at any of these outlets.

The Report was noted.

5. PLANNING & FUNDING UPDATE

Carolyn Gullery, General Manager, Planning & Funding, presented this report which was taken as read.

The Committee noted the achievements in relation to the health targets for the year where the electives target was exceeded and there were no patients waiting longer than 5 months. They also noted that in regard to the HPV vaccination 98% of those who have consented have received this.

The Committee also noted that the DHB is moving into a new funding model where the cost of actual delivery is funded (not CWT).

Discussion took place regarding the training of young people as part of the Complex Clinical Care Network and the Committee noted that specific training is overseen by a Professor of Gerontology from Auckland University.

Discussion also took place regarding District Nursing Services. The Committee noted that this is seen as a key service and the DHB is very fortunate to also have Rural Nurse Specialists.

The report was noted

6. PRIMARY & COMMUNITY SERVICES UPDATE

This report provided an update of activities in the Primary and Community Services area of the DHB.

Discussion took place regarding the partnership with Better Health Limited and some background was provided around how this is working.

The report was noted

7. ALLIANCE UPDATE

Carolyn Gullery, General Manager, Planning & Funding, presented this update which was taken as read.

This report provided an update of progress around DHB owned General Practice Management; the Grey/Westland Integrated Family Health Services; Kaupapa Maori Nurse Appointments; Complex Clinical Care Network and the Alliance Leadership Team Membership.

The Board Chair asked that a presentation to the Board on the Alliance Leadership Team be scheduled to provide some visibility around membership and show this links with the Annual Plan.

The update was noted.

8. DISABILITY RESOURCE CENTRE PRESENTATION

Debbie Webster, General Manager, Queenstown & Southland Disability Resource Centre, spoke to the Committee regarding the provision of resources on the West Coast.

The Centre is a voluntary not-for-profit organisation and provides information to disabled members of the community to enable access to resources they require, to be able to participate in their communities. They also provide adaptive equipment and products to make day to day life easier.

With the closure of the local resource centre it is intended to provided services to the West Coast via a mobile unit.

The Chair thanked Debbie for her presentation.

9. GENERAL BUSINESS

A query was raised regarding an article on the stuff website which stated that West Coasters are more likely to die in road crashes. The Committee asked that management look into this and bring information back to a future meeting.

INFORMATION ITEMS

- Chair's report to last Board meeting
- Board Agenda 28 June 2013
- CPH&DSAC 2013 Work Plan
- West Coast DHB 2013 Meeting Schedule

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

Confirmed as a true and correct record:

_____ _____

Elinor Stratford Date
Chair

COMMUNITY AND PUBLIC HEALTH UPDATE

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

SOURCE: **Community and Public Health**

DATE: **22 August 2013**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing information regarding the work of Community and Public Health on the 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)

REPORT to WCDHB CPHAC/DSAC

COMMUNITY AND PUBLIC HEALTH (CPH)

August 2013

Grey District Council Economic Development Strategy

Since late last year, CPH have been involved with the development of the Grey District Economic Development Strategy (ELDG) which is now waiting for adoption by the Grey District Council. As mentioned in last month's report CPH commissioned a literature review on the impact of job losses in small communities. The literature review, which focussed on the experience of towns in New Zealand who have suffered major job losses, has been summarised and was presented to the Health, Sustainability and Wellbeing section of the ELDG last month. It will also be provided to the wider ELDG group.

Grey High School Careers Expo

CPH provided its inaugural 'Careers in Public Health' display for the Careers Expo held at Greymouth High School on 7 – 8th August. The display focussed on things that affect health, what it takes to work in public health and a photo collage of the public health work carried out locally. YouTube clips called 'Just the Job' showed young people 'shadowing' various public health workers in order to learn about the jobs of a health protection officer, a health promoter, a medical officer of health and others. As a way to get people's attention and to notice the display, a prize draw for a sports bag was on offer. One-hundred thirty people entered the draw and answered the quiz question on the form by finding the answer in the display. The winner was from Hokitika.

Supplies of topical health brochures were also available at the display stand. CPH's Aukati Kaipapa cessation worker was on site to talk with people who smoke and to ask them about quitting. It was supremely gratifying to note that very few amongst the crowds of young people and parents attending the Expo said they smoked. However, amongst those who said they did, two students signed up their parents as a result of their conversation with the Aukati Kaipapa promoter.

Youth Health Action Group

CPH is currently chairing this group of professionals as an offshoot of the Child and Youth Health Committee. The main aim of the group is to update the Youth Health Plan for the West Coast, and raise the profile of youth health. Initial drafts are currently being worked on, with WCDHB Planning and Funding, developing ideas such as:

- How to ensure our current services are youth friendly
- Engaging young people in developing more accessible and appropriate services
- Raising awareness of wellbeing and keeping our young people well
- Improving competencies of health workers to ensure services are youth friendly

PLANNING & FUNDING UPDATE

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

SOURCE: **Planning & Funding**

DATE: **22 August 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

- In Quarter 4, the West Coast has surpassed the **immunisation health target**, with 93% of eight-month-olds fully immunised, including 100% of Māori children. This is a substantial increase on previous quarters.
- The West Coast DHB surpassed the **B4 School Check** target for the total population, achieving 81% coverage in 2012/13.
- The West Coast continues to lead the country in performance against the **ED health target**, with 99.7% of people admitted or discharged within six hours during 2012/13.
- West Coast continues to achieve the **cancer treatment health target**, with 100% of people ready for radiotherapy or chemotherapy beginning treatment within four weeks.
- The **secondary care smokefree health target** was achieved in Quarter 4, with 95% of hospitalised smokers provided with advice and help to quit.
- West Coast DHB met its **electives health target** for the 2012/13 year, delivering 1,686 elective surgical procedures – 94 cases above our target. We also met the electives targets of no-one waiting more than six months for First Specialist Assessment or treatment by the end of June 2013.

✗ Key Issues & Associated Remedies

- Performance against the **heart checks health target** rose marginally to 58% of the eligible population having had a cardiovascular risk assessment in the five years to 30 June 2013. A range of activities are occurring to follow up eligible patients and provide risk assessments, including active recall to nurse-led clinics and targeting of high-needs populations.

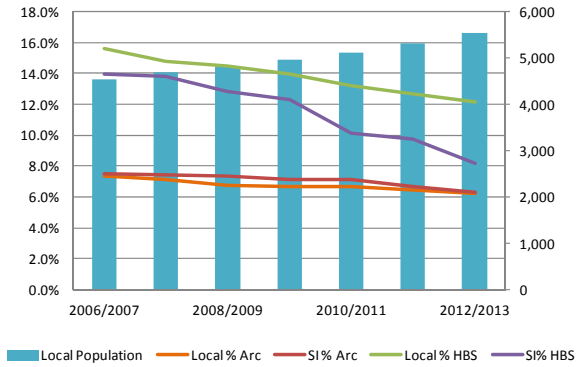
ⓘ Upcoming Points of Interest

- Workshops are underway to support the next steps in implementing a new, **restorative homecare model** as part of the Complex Clinical Care Network (CCCN) project.
- The West Coast **Mental Health Review** is nearing completion, with the panel expected to finalise their report for the General Manager in the coming weeks.

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

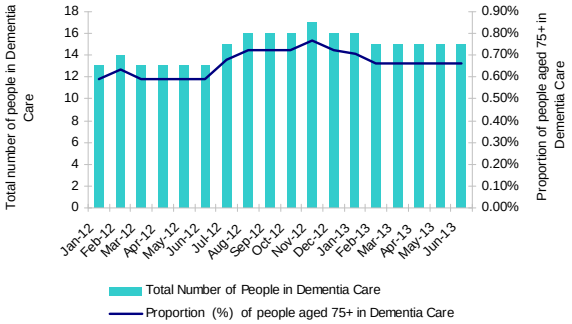
Older Persons' Health

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

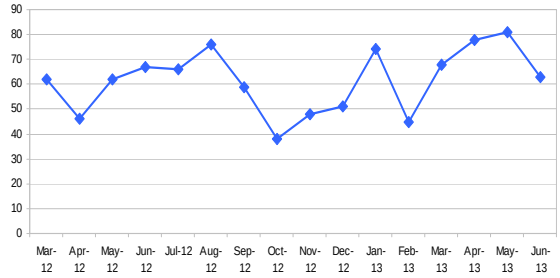


Proportion of people aged 75+ admitted in Rest Home level care

% of people aged 75+ in Specialist Dementia Care



Number of interRAI assessments completed



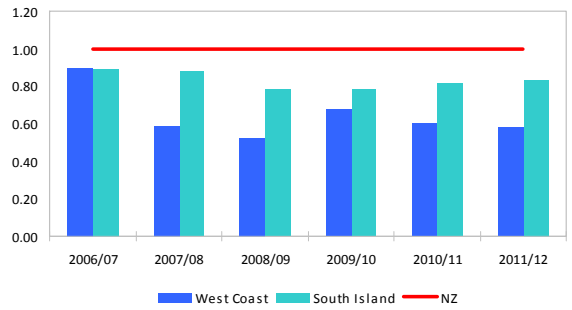
ACHIEVEMENTS / ISSUES OF NOTE

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

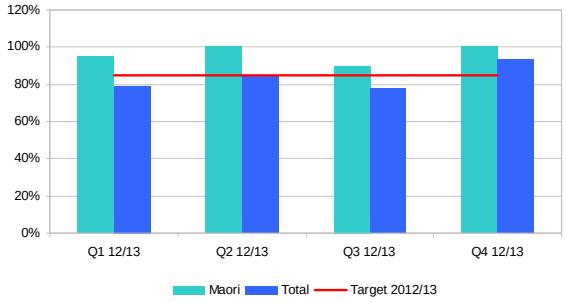
- A workshop in July 2013 provided the CCCN (including WCDHB allied health professional leaders) with a recap on the history of the restorative home support model, an overview of the range of tools that other DHBs have developed or found useful, and examples of the service models from Canterbury and other DHBs. This is intended to assist the key players on the West Coast to think in a more focused way about how they can begin to implement restorative home support.
- A second workshop is planned for 6 August 2013 for a CCCN subgroup to utilise the Community Services Operations Manual developed in Canterbury DHB as an example on which to base the manual for the West Coast.

Child, Youth & Maternity

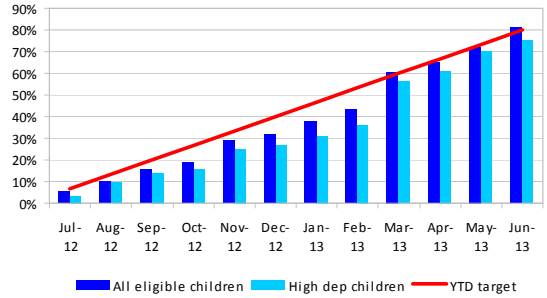
Acute medical discharge rates for children (age 0-14)



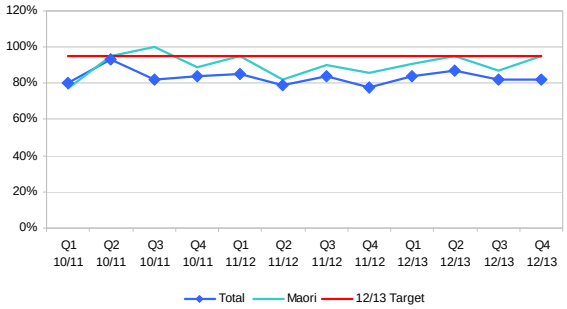
Immunisation HT: Eight-month-olds fully immunised



B4 School Check coverage



Two-year-olds fully immunised



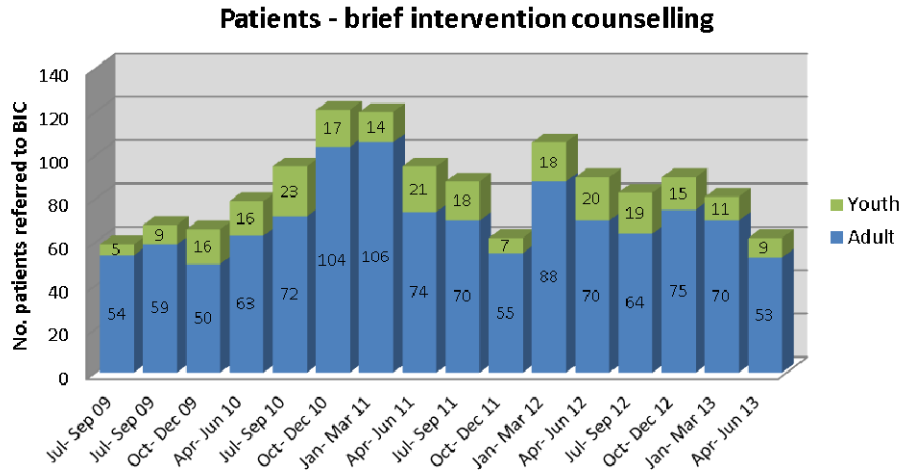
ACHIEVEMENTS / ISSUES OF NOTE

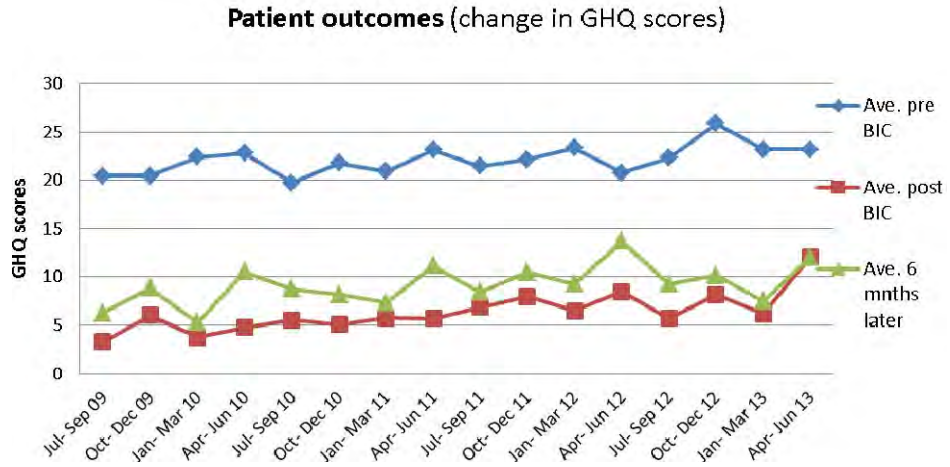
Childhood immunisation: 93% of all eligible eight-month-olds were fully immunised in Quarter 4, including 100% of Māori. This is an excellent result for West Coast DHB and surpasses the national health target of 85%. This substantial improvement has been possible due to much lower rates of opt-offs and declines this quarter (5%, compared to 16% last quarter).

A Position Paper has been drafted for the West Coast that focuses on what interventions could be made to streamline immunisation events and ensure early identification of overdue children. The draft is currently being reviewed by the Chair of the West Coast Immunisation Advisory Group.

B4 School Check: The West Coast DHB achieved the B4SC target for the total population, achieving 81% coverage (against a target of 80%). This result shows the success of collaboration with other WellChild service providers and public health nurses. The target for Quintile 5 (high deprivation) children was missed by just three children, with a result of 75% (against a target of 80%). This was the result of three 'Did Not Attends' (DNAs) – in each case due to illness. The collaborative team of public health nurses, vision/hearing technician, and immunisation outreach is recognised as the most effective way of reaching children on the West Coast.

Mental Health





ACHIEVEMENTS/ISSUES OF NOTE

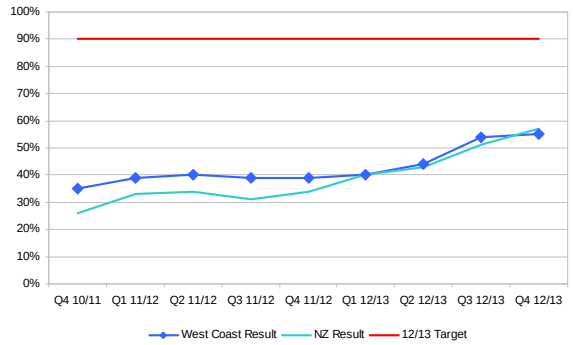
System Planning: The West Coast Mental Health Review is nearing completion, with the panel expected to finalise their report for the General Manager in the coming weeks.

The 'whole of system' approach initiated with a stakeholders meeting late 2012 is continuing, with strengthened cross-agency collaboration that is based on consumer and family need.

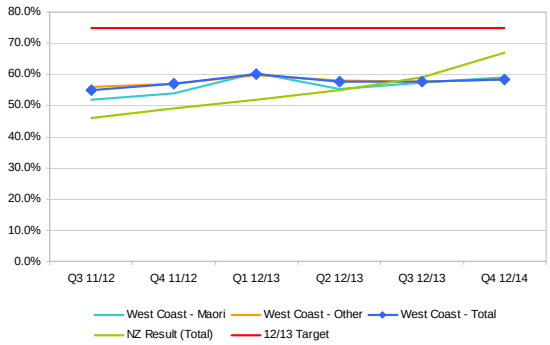
Primary Mental Health Services: Primary mental health services continue to achieve positive outcomes, as demonstrated in the graphs above.

Primary Care & Long-Term Conditions

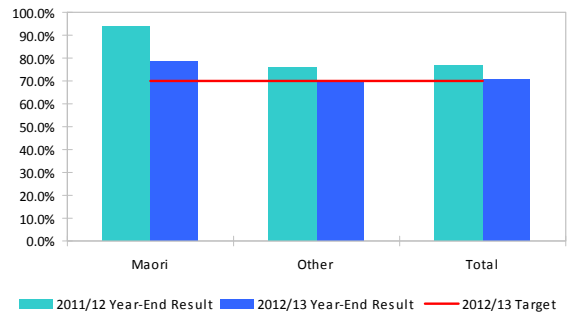
Primary Smokefree Health Target: Smokers attending primary care given advice & help to quit



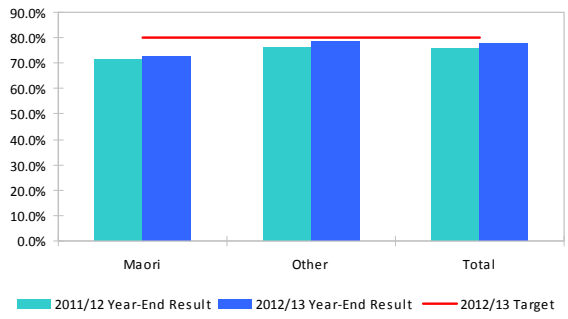
CVD Health Target: % of eligible PHO population having had a CVD risk assessment in the last 5 years



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

Primary care smokefree health target: Preliminary results from MoH show a marginal increase in performance against the primary care smokefree health target this quarter, with 55% of people who smoke attending general practice, offered advice and support to quit. Work is continuing on enabling the Clinical Audit Tool to be installed in the DHB Medtech server configuration; this will support clinicians to improve data capture. The PHO has continued to include coding and data entry training as part of orientation for all new practice staff, along with updates for identified current staff.

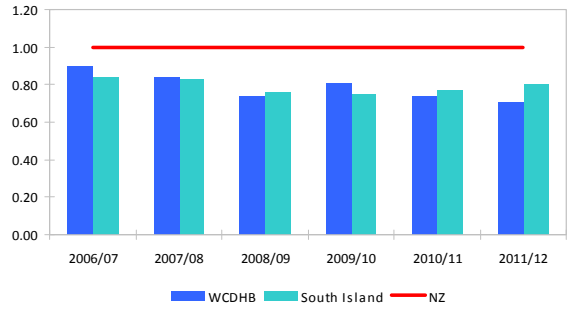
CVD health target: Preliminary results from MoH show a marginal increase in performance against the heart checks health target, with 58% of the eligible enrolled West Coast population having had a cardiovascular risk assessment in the five years to 30 June 2013. The West Coast PHO is working on increasing the rates during this year, and has set a progress target to reach 78% for this measure by December 2013 and to achieve the national target of 90% of eligible people assessed by 30 June 2014. As well as ongoing performance monitoring with a particular focus on high-needs groups, key activities to help improve the rate include: active recall of people due for a cardiovascular risk assessment (CVRA) to nurse-led clinics; collaboration with newly appointed Rata Te Awhina Trust's Kaupapa Māori nurses to better reach high-needs Māori; and a move to non-fasting blood testing to enable people who have never been screened before to be tested on presentation.

Diabetes: The West Coast achieved its 2012/13 target of reaching 70% of people with diabetes having their annual review. Among those who had their review, 78% had satisfactory or better management of their diabetes (as measured by the clinical indicator HBA1c of $\leq$ 8.0%).

Green Prescription: As part of the larger 2013 Diabetes Budget package, the Ministry of Health have indicated an increase in funding for Green Prescription referrals over the coming four years. For the 2013/14 year, this is an increase from 360 to 500 referrals on the West Coast. Green Prescription has been identified as a key component to help slow or prevent the progression of pre-diabetes and diabetes, as well as a way to support the active management for those who already have diabetes.

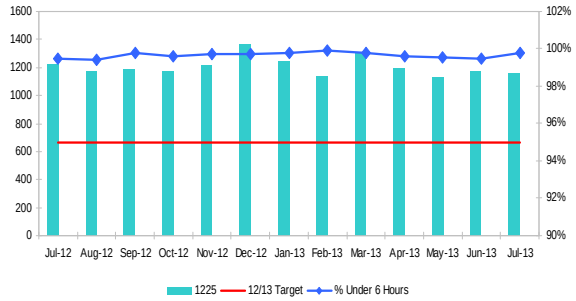
Secondary Care & System Integration

Acute Medical Discharge Rate

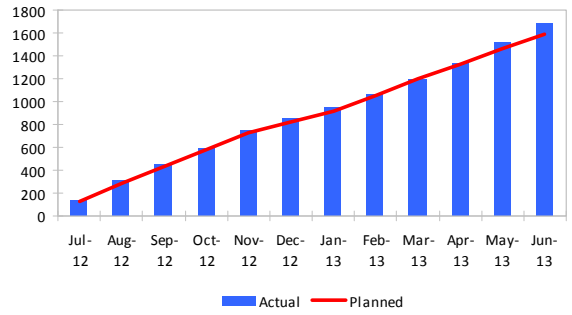


The annual update for this data is not yet available

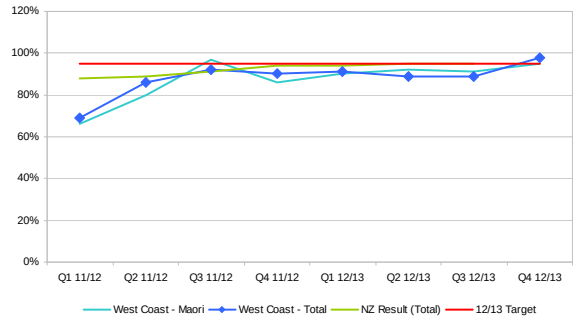
Emergency Department: Attendances & <6 Hours Health Target



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 continues to lead the country in performance against the health target of over 95% of people admitted, discharged or transferred from ED services within 6 hours. Results for the year to 30 June 2013 show that 99.7% of patients were seen, treated and discharged within 6 hours. Furthermore, 96.5% were seen, treated and discharged within just 4 hours.

Cancer health target: The West Coast achieved the cancer treatment health target throughout the 2012/13 financial year, with 100% of people ready for radiotherapy or chemotherapy beginning treatment within four weeks.

Secondary care smokefree health target: West Coast DHB achieved the secondary care smokefree health target for Quarter 4, with 95% of patients who smoke offered advice and support to quit (and 98% of Māori). Smokefree staff are working to maintain a clinical focus around the health target, for example running a Quit Card refresher training, which encourages staff to provide Quit Cards on discharge from hospital to take the idea of 'better help for smokers to quit' further than the initial ABC.

Electives health target: West Coast DHB met the electives health target for 2012/13, delivering a total of 1,686 elective surgical procedures – 94 cases above our target.

ESPI compliance: The West Coast DHB also met the Elective Services Performance Indicator (ESPI) targets of no-one waiting more than six months for an outpatient First Specialist Assessment or for elective treatment, by the end of June 2013. From 1 July 2013, the maximum target waiting times for both these ESPIs has reduced to five months.

Planning and Funding Financials for the Year Ended 30 June 2013

Current Month					SERVICES	Year to Date					2012/13 Annual Budget
Actual	Budget	Variance				Actual	Budget	Variance			
$000	$000	$000	%			$000	$000	$000	%		$000
					Primary Care						
36	39	4	9%	✓	Dental-school and adolescent	410	470	60	13%	✓	470
-2	-7	-5	76%	✗	Maternity	-1	20	21	106%	✓	20
0	0	0		✗	Pregnancy & Parent	0	8	8	99%	✓	8
2	2	0	16%	✓	Sexual Health	11	33	22	67%	✓	33
5	4	-1	-34%	✗	General Medical Subsidy	32	46	14	30%	✓	46
577	538	-39	-7%	✗	Primary Practice Capitation	6,523	6,458	-65	-1%	✗	6,458
3	12	9	72%	✓	Primary Health Care Strategy	82	144	62	43%	✓	144
78	79	1	2%	✓	Rural Bonus	946	950	4	0%	✓	950
-2	6	8	135%	✓	Child and Youth	30	69	39	56%	✓	69
12	9	-4	-31%	✗	Immunisation	190	96	-94	-98%	✗	96
12	44	32	73%	✓	Maori Service Development	206	551	346	63%	✓	551
44	9	-35	-381%	✗	Whanua Ora Services	283	110	-173	-157%	✗	110
31	20	-11	-59%	✗	Palliative Care	156	214	58	27%	✓	214
14	17	3	17%	✓	Chronic Disease	95	204	109	53%	✓	204
9	11	3	23%	✓	Minor Expenses	138	134	-4	-3%	✗	134
820	**783**	**-36**	**-5%**	✗		**9,101**	**9,507**	**406**	**4%**	✓	9,507
					Referred Services						
22	17	-4	-25%	✗	Laboratory	203	269	66	24%	✓	269
868	662	-205	-31%	✗	Pharmaceuticals	7,989	8,129	140	2%	✓	8,129
889	**679**	**-210**	**-32%**	✗		**8,193**	**8,398**	**205**	**3%**	✓	8,398
					Secondary Care						
-17	22	40	179%	✓	Inpatients	72	266	194	73%	✓	266
103	97	-6	-6%	✗	Travel & Accommodation	1,230	1,168	-62	-5%	✗	1,168
608	1,269	661	52%	✓	IDF Payments Personal Health	14,599	15,226	628	4%	✓	15,226
692	**1,388**	**695**	**50%**	✓		**15,900**	**16,660**	**759**	**5%**	✓	16,660
2,402	**2,850**	**449**	**16%**	✓	**Primary & Secondary Care Total**	**33,194**	**34,565**	**1,370**	**4%**	✓	**34,565**
					Public Health						
14	16	2	13%	✓	Nutrition & Physical Activity	219	194	-25	-13%	✗	194
7	6	-1	-15%	✗	Public Health Infrastructure	66	73	7	9%	✓	73
12	11	-1	-6%	✗	Tobacco control	133	136	3	2%	✓	136
36	**34**	**-1**	**-4%**	✗	**Public Health Total**	**421**	**403**	**-19**	**-5%**	✗	**403**
					Mental Health						
0	2	2	100%	✓	Eating Disorders	23	23	0	-1%	✗	23
54	72	19	26%	✓	Community MH	640	773	134	17%	✓	773
0	1	1	0%	✓	Mental Health Work force	-4	8	12	148%	✓	8
49	48	-1	-3%	✗	Day Activity & Rehab	569	574	5	1%	✓	574
11	14	3	22%	✓	Advocacy Consumer	94	173	79	46%	✓	173
10	5	-5	-85%	✗	Advocacy Family	130	65	-65	-99%	✗	65
0	0	0		✓	Minor Expenses	0	0	0		✓	0
123	124	1	1%	✓	Community Residential Beds	1,445	1,493	48	3%	✓	1,493
66	68	2	3%	✓	IDF Payments Mental Health	813	811	-2	1%	✗	811
313	**335**	**22**	**7%**	✓		**3,709**	**3,920**	**211**	**5%**	✓	3,920
					Older Persons Health						
-3	3	6	240%	✓	Information and Advisory	-9.5	30	41	135%	✓	30
0	0	0		✓	Needs Assessment	0.16	0	0		✗	0
141	56	-85	-153%	✗	Home Based Support	788	671	-117	-17%	✗	671
4	9	4	49%	✓	Caregiver Support	101	115	14	12%	✓	115
286	182	-104	-57%	✗	Residential Care-Rest Homes	2,472	2,739	267	10%	✓	2,739
-3	-2	1		✓	Residential Care Loans	-50	-24	26	109%	✓	-24
8	26	18	69%	✓	Residential Care-Community	126	312	186	60%	✓	312
314	313	-1	0%	✗	Residential Care-Hospital	4,203	3,828	-376	-10%	✗	3,828
0	3	3	100%	✓	Ageing in place	7	50	43	87%	✓	50
11	12	1	7%	✓	Environmental Support Mobility	76	132	55	42%	✓	132
13	8	-5	-62%	✗	Day programmes	108	97	-12	-12%	✗	97
4	13	9	70%	✓	Respite Care	102	154	52	34%	✓	154
94	119	25	21%	✓	IDF Payments-DSS	1,403	1,430	27	2%	✓	1,430
869	**742**	**-130**	**-17%**	✗		**9,328**	**9,533**	**205**	**2%**	✓	9,533
1,182	**1,077**	**-108**	**-10%**	✗	**Mental Health & OPH Total**	**13,037**	**13,453**	**417**	**3%**	✓	**13,453**
3,621	**3,963**	**341**	**9%**	✓	**Total Expenditure**	**46,652**	**48,421**	**1,769**	**4%**	✓	**48,421**

MAORI HEALTH REPORT

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

SOURCE: **General Manager Maori Health**

DATE: **13 August 2013**

Report Status – For:	Decision	Noting ☐	Information ☑

1. ORIGIN OF THE REPORT

This report is provided to Community & Public Health & Disability Support Advisory Committee as a regular update.

2. RECOMMENDATION

That the Community & Public Health & Disability Support Advisory Committee:

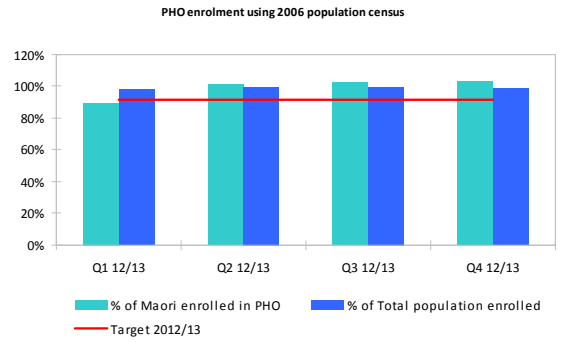
- notes the Maori Health Activity Update.

3. SUMMARY

Maori Health Quarterly Report – Q4, 2012/13

Access to care

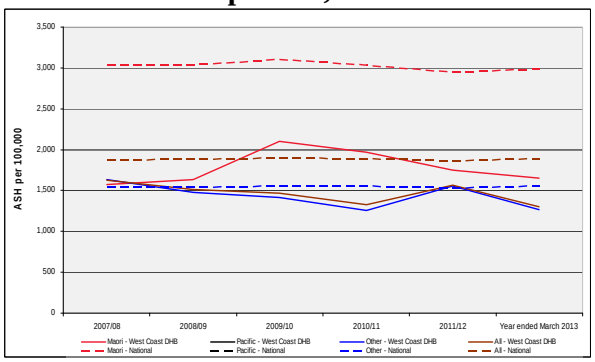
Percentage of Maori enrolled in the PHO



*** 2006 census population was used as the denominator.**

Ambulatory Sensitive Hospitalisation

Ambulatory Sensitive Hospitalisation per 100,000



ACHIEVEMENTS/ISSUES OF NOTE

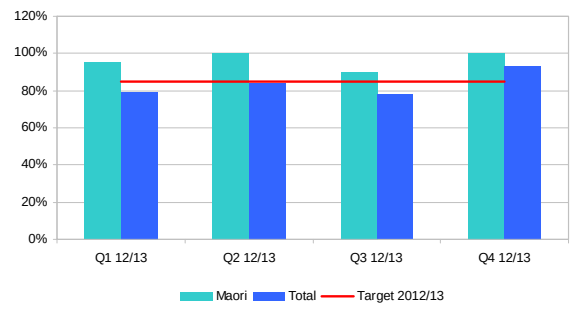
Enrolment in PHO: Using the 2006 population census figures100% of Maori were enrolled with the PHO as at June 30 2013. Please see table below for further breakdown. Enrolments for Maori and Pacific people continue to increase at a faster rate than other ethnicities and have for the first time exceeded that of other ethnicities.

On the 20th June 2013 the Ministry of Health issued a Request for Proposal, to Implement the Primary Care Ethnicity Data Audit Tool'. The West Coast PHO and the DHB have jointly developed the proposal and it will be submitted in August 2013. The Audit tool comprises Systems Compliance and Audit Checklist, Implementation of a staff survey, Data matching quality audit with the findings being collated and reported back to practices to enable a level of benchmarking for quality improvement. Any residual funding from the project will be used for ethnicity data collection education.

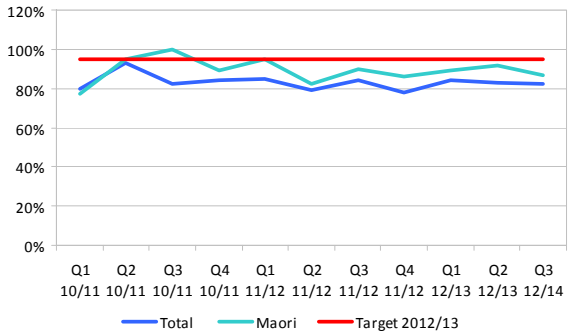
Practice		00-04	May-14	15-24	25-44	45-64	65+	Total
Westland	Maori	89	201	171	209	174	72	916
Buller	Maori	74	121	145	149	134	35	658
Coast Med	Maori	4	5	2	6	12	1	30
Grey Med	Maori	83	114	102	143	123	15	580
High St	Maori	30	61	66	57	57	22	293
Rural Ac	Maori	37	64	61	73	66	8	309
Reefton	Maori	18	43	38	38	35	11	183
South We	Maori	10	18	18	31	25	13	115
	Total	**338**	**608**	**587**	**698**	**612**	**176**	**3019**

Child, Youth and Maternity

NEW Immunisation HT: Eight-month-olds fully immunised



Immunisation: Two-year-olds fully immunised



ACHIEVEMENTS/ISSUES OF NOTE

Eight-month-old immunisation: 100% of Maori babies have been immunised on time at 8 months of age in quarter 4. This equates to 20 babies out of 20.

Two-year-old immunisation: The West Coast DHB's total coverage for Quarter 4 is 82%. - This remains high as was the case in Quarter 3 an indication of the continuous effort of primary care and Outreach Immunisation Services to achieve the highest possible coverage. Coverage for Māori two-year-olds sits at 95% an increase from Q3- so 21 from 22 eligible Maori babies have been immunised for this age milestone. Work to improve immunisation coverage for both eight-month-olds and two-year-olds includes:

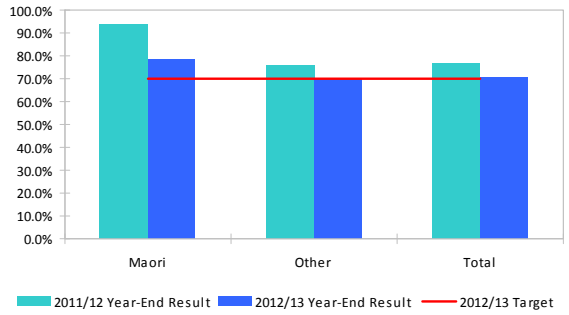
- A process timeline for all practices to use as guidance to ensure timely immunisation by eight months of age;
- NIR Administrator working with a key contact in each practice to identify children due, pending or overdue;
- Timely referral to Outreach Services;
- Collaboration with other Well Child service providers to refer children for immunisation; and
- Improving the enrolment process at birth

Mum4Mum: At the end of Q4, 2012/13, a total of 22 mothers were trained as Mum4Mums of which 22% (5) are Maori. The target for 2012/13 is to have 6 Maori Mum4Mum graduates.

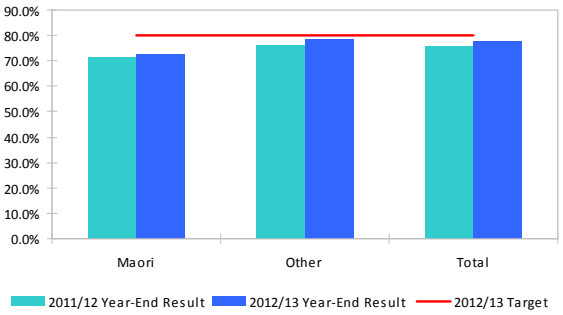
Lactation consultancy contacts and services: For quarter 4, 3 Maori were provided with Lactation support, there were 174 contacts in total, including 45 Maori, 4 Pacific and 125 other ethnicity. Contacts were in homes, maternity ward, phone, Face book, e-mail and text messages about breastfeeding related issues.
The target is to have 25 mothers with Maori babies referred to lactation support and specialist advice consultants in 2012/13 and YTD we have 20 Maori mums who have been referred to the service.

Cardiovascular and Diabetes

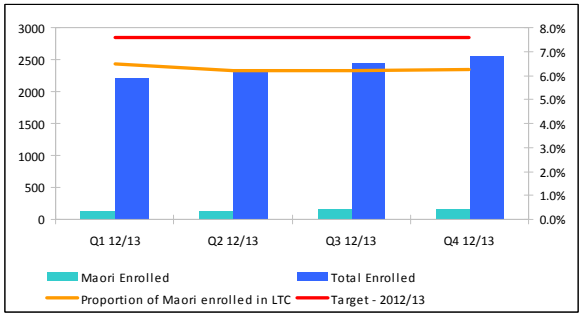
Diabetes Detection: % of people estimated to have diabetes who have had their annual check during the current year



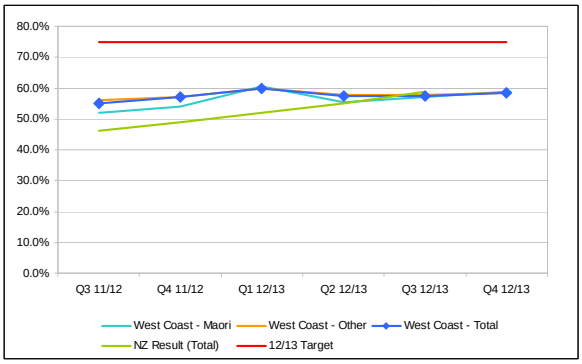
Diabetes Good Management: % of people who have HBA1c levels at or below 8.0 when assessed at their annual check



Number of Maori enrolled in LTC management programme



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



ACHIEVEMENTS/ISSUES OF NOTE

CVD Health Target: Nationally the West Coast DHB sit 6th from 20 DHB's against this target for Maori at 59% with all DHB's sitting more than 20% away from the national target of 90%. The WCDHB, WCPHO and Poutini Waiora are implementing a targeted approach to increase the number of Maori having their cardiovascular risk assessment done. The Clinical Manager of the PHO has been assisting the Kaupapa Maori Nurses to orientate within the practices and facilitate the integration of these positions into the IFHS. The CVRA project has provided a good platform for both the practice nurses and Kaupapa Maori nurses to test how this partnership can practically work. The project involves identifying Maori and Pacific patients who have, for a variety of reasons, not engaged with general practice to get their CVRA - Westland Medical Centre, Grey Medical Centre and Buller Health have the highest numbers of eligible and overdue Maori. Contessa Popata and Fergus Bryant have started working within these practices initially to focus on CVRA. Additionally there is some extra resource from the Ministry to look at strategies for improving this target one idea that we have been discussing is to target the big companies around the West Coast to work in with their representatives to screen those within their workforce who are eligible.

Diabetes care: The number of Maori accessing free annual diabetes reviews is on target for the period to June 2013 with 70% having an annual review and 73% of them achieving good diabetes management for the period to 30 June 2013.

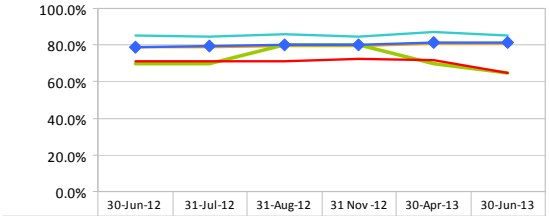
Diabetes: The West Coast achieved its 2012/13 target of reaching 70% of people with diabetes having their annual review. Among those who had their review, 78% had satisfactory or better management of their diabetes (as measured by the clinical indicator HBA1c of $\leq$ 8.0%).

Green Prescription: As part of the larger 2013 Diabetes Budget package, the Ministry of Health have indicated an increase in funding for Green Prescription referrals over the coming four years. For the 2013/14 year, this is an increase from 360 to 500 referrals on the West Coast. Green Prescription has been identified as a key component to help slow or prevent the progression of pre-diabetes and diabetes, as well as a way to support the active management for those who already have diabetes.

Long Term Condition Management (LTC): 159 Maori are enrolled in the Long Term Conditions programme as at June 30 2013 Maori enrolment makes up 6.2% of all enrolment in the LTC programme. For comparison Maori make up 5.3% of the enrolled population at the primary practices aged 45 years and above. The target is 7.6%. We are working closely with the CEO and Clinical Manager of the PHO, and Poutini Waiora to identify those Maori who are enrolled in the programme and link them in to the Kaupapa Maori Nurses and Kaiarataki.

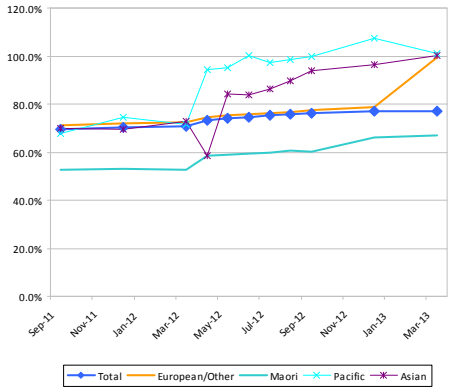
Cancer

Percentage of eligible Maori women (45-69) receiving breast screening examination in the last 24 months ending



	30-Jun-12	31-Jul-12	31-Aug-12	31 Nov -12	30-Apr-13	30-Jun-13
Other	78.6%	79.0%	79.4%	79.5%	80.6%	80.8%
Maori	85.1%	84.7%	85.6%	84.5%	87.1%	85.5%
Pacific	70.0%	70.0%	80.0%	80.0%	70.0%	65.0%
Total	79.1%	79.4%	79.9%	79.9%	81.1%	81.1%
All DHB's	71.2%	71.2%	71.3%	72.3%	72.0%	64.7%

Percentage of eligible Maori women (25-69) receiving cervical screening in the last 3 years ending…



ACHIEVEMENTS/ISSUES OF NOTE

Breast Cancer Screening: Approximately 81% of all eligible women aged 45-69 age-groups on the West Coast have undergone breast screening for the period ending 30th June 2013. The coverage for eligible Maori women (85.5%) is higher compared to other ethnicities on the West Coast.

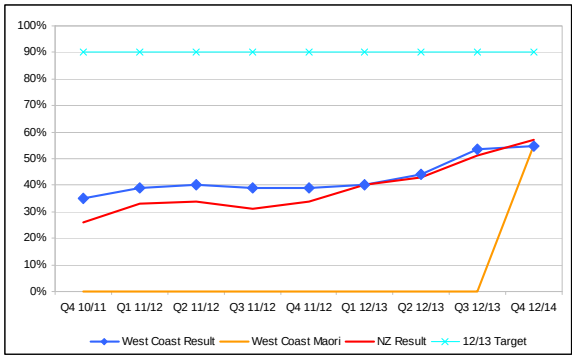
Cervical cancer screening: At the end of March 2013, the three year coverage rate for cervical screening on the West Coast has increased to 77% which is an increase of approximately 4% from the three year period ending 30th June 2012. The coverage rate for Maori eligible women is at 67.1% a significant increase of 14% from 53% in March 2012. We are closely monitoring the Maori cervical screening service and working with the DHB Screening Unit and the practices to ensure the option for the Maori Screener is offered and is being fully utilized by the practices to assist in engaging those hard to reach clients.

Cancer Nurse Cordinator: This role has now been in place for several months and we are working with the Co-ordinator, Andrea Reilly to develop specific objectives for the CNC role when working with Maori. Some of these will be:

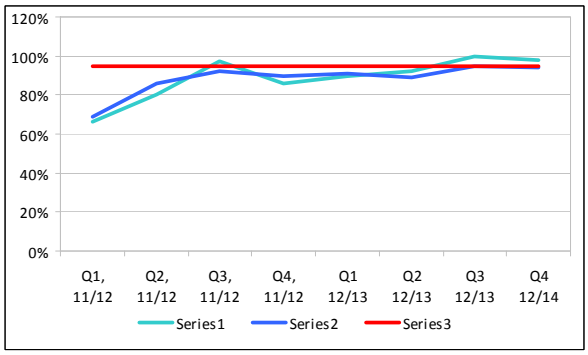
- monitoring Faster Cancer Treatment pathways and providing auditable data to review areas of inequality
- identify Maori patient utilisation of cancer services for cancer diagnosis
- to identify gaps that may occur in existing care pathways and act as a representative of West Coast DHB to incorporate national initiatives into care delivery in a way that solves problems and closes gaps
- to be the referral conduit to ensure Kaupapa Maori Nurses and Kaiawhina services are utilised

Smoking Cessation

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



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



ACHIEVEMENTS/ISSUES OF NOTE

Primary Smokefree Health Target: Preliminary results from MoH show a marginal increase in performance against the primary care smokefree health target this quarter, with 55% of people who smoke attending general practice, offered advice and support to quit. Work is continuing on enabling the Clinical Audit Tool to be installed in the DHB Medtech server configuration; this will support clinicians to improve data capture. The PHO has continued to include coding and data entry training as part of orientation for all new practice staff, along with updates for identified current staff.

	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
West Coast Result	39%	40%	39%	39%	40%	44%	54%	55%
NZ Result	33%	34%	31%	34%	40%	43%	51%	55%
12/13 Target	90%	90%	90%	90%	90%	90%	90%	90%

Secondary Smokefree Health Target: West Coast DHB achieved the secondary care smokefree health target for Quarter 4, with 95% of patients who smoke offered advice and support to quit (and 98% of Māori). Smokefree staff are working to maintain a clinical focus around the health target, for example running a Quit Card refresher training, which encourages staff to provide Quit Cards on discharge from hospital to take the idea of 'better help for smokers to quit' further than the initial ABC

Aukati Kai Paipa: For the period 01 April 2013 to 30 June 2013 the AKP service has had 23 new clients bringing the total number of clients on the programme YTD to 123 with 28% (23) recorded as validated abstinence at 3 months and 36% self validated.

Report prepared by: Kylie Parkin, Maori Health

Report approved for release by: Gary Coghlan, General Manager Maori Health

ALLIANCE UPDATE – QUARTERLY REPORT

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

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

DATE: **22 August 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 – Quarterly Report

3. APPENDICES

Appendix 1: Alliance Quarterly Report

Report prepared by: Alliance Leadership Team
Planning & Funding

Report approved for release by: Stella Ward, Chair, Alliance Leadership Team
Carolyn Gullery, General Manager, Planning & Funding

PP2 BSMC – West Coast DHB Q4 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 4 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.

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.*

An additional member has been recruited onto the Alliance Leadership Team to replace membership vacancies and to provide a primary mental health perspective on the group. The meeting process for ALT has also been refined during this quarter.

The Alliance Support Group continues to meet three-weekly to operationalise ALT priorities, allocate resources and provide advice to workstreams and the Alliance Leadership Team.

Members of the Alliance Leadership Team are actively participating in research on the impact of the Better, Sooner, More Convenient (BSMC) programme on the West Coast. This research will explore what can be learned from the roll-out of the BSMC business case initiatives and how the programme has affected health service provision and integration of services on the West Coast.

Community pharmacy

Ministry requirement: *Activities to integrate community pharmacy.*

Section 5 outlines the Pharmacy workstream's progress to integrate community pharmacy.

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 has included the following.

- Transalpine gerontology nursing continues, with the CDHB HOP Nursing Director providing support to the two Gerontology Nurse Specialists based in Westport and Greymouth.

- Rata te Awhina Trust, in partnership with the West Coast DHB, has successfully recruited into the Kaupapa Māori positions. The Kauapapa Māori Nurses will have a long-term conditions focus and will become part of the Integrated Family Health Services based in Westport, Greymouth and Hokitika. Each of the Kaupapa Māori Nurses is supported by a non-clinical Kaiarataki position.
- Progress has been made towards finding a resource solution for Medtech training so that community-based nursing teams can work out of the 'Heath Care Home' / Primary Practice, working towards the one patient record. This is a key step in enabling full integration of community-based nursing into the primary practice team.

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, 2,552 patients were enrolled in the Long-Term Conditions Management programme, out of the WCPHO's approximately 31,000 enrolled patients. This means that 8.2% 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 has surpassed the target for acute length of stay at 3.25 (standardised, year to 31 March 2013) and has the lowest rate in the country.

Acute Readmissions:

- The WCDHB has surpassed the target for acute readmission rates at 7.64 (standardised, year to 31 March 2013) and has the lowest rate in the country.

ED attendance:

- The WCDHB has achieved a greater reduction in Triage Level 5 attendance than the minimum 5% sought; overall attendances reduced 14% for 2012/13 – down 654 compared to 2011/12.

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

Our 75+ acute readmission result to 31 March 2013 was 11.57%, achieving our 2012/13 target of 12.91%. The West Coast has achieved the lowest rate in the country.

Section 2 outlines the Health of Older People workstream's progress that contributes to the continued improvement in the 'prevention of readmissions for the 75+ population.'

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.*

DHB-owned General Practice Management – An agreement has been reached with Better Health Limited West Coast to support the management of West Coast DHB-owned general practices. This new management agreement provides an opportunity to build viable and vibrant DHB-owned general practices on the West Coast and improve continuity of care for patients through the establishment of a stable clinical workforce in general practice, a heightened focus on the financial sustainability of practices and improved clinical, administration and recruitment systems.

Areas of immediate focus for Better Health include the recruitment of General Practitioners and Practice Managers, training and development of seconded Practice Managers until permanent Practice Managers are recruited, accounting and bookkeeping for the practices (with support from the West Coast DHB finance team) and process documentation and improvement within each of the general practices.

HealthPathways: Supporting infrastructure includes the continued development and localisation of West Coast-specific HealthPathways. The West Coast HealthPathways Coordinator is working alongside clinical teams to localise the 647 Canterbury HealthPathways. At the beginning of July 2013, the review, localisation and updating process has been completed for a total of 243 pathways, including pathways in the allied health, child health, investigations, and medical and surgical service areas. An additional 68 pathways are currently being reviewed. The West Coast HealthPathways Coordinator has visited all general practices throughout the West Coast to support and encourage HealthPathways utilisation. During June 2013, there were a total of 883 visitors to HealthPathways and 6,097 pages viewed. The Alliance Leadership Team has agreed to champion HealthPathways utilisation throughout the West Coast Health System.

Improve Transport Options for Planned (ambulatory) and Unplanned Patient Transport: Through the support of its volunteer drivers and coordinators at Buller REAP, Red Cross are running the Buller Community Minivan service run on an "as demand requires" basis, Monday to Friday, with Saturdays added when required. The West Coast DHB is continuing to work with the Red Cross to explore options to help continue to support the longer-term sustainability of the service.

Negotiations are still continuing with St John as part of a South Island-wide joint DHB approach for the provision of unplanned patient transport services. These discussions are reviewing key points of acute transportation, including proposed scheduling, volumes, costs, and coordination of transfers.

Section 2: Health of Older People Workstream Progress Q4 2012-13

Progress has continued on the development of a restorative homecare model through the Complex Clinical Care Network (CCCN) project that coordinates care and provides assessment and treatment for people living in the community with complex needs.

Practice Visits: Informal 1-1 visits to practices by HOP specialists and/or group CCCN education/consultation sessions with key staff as appropriate at the Reefton and South Westland clinics and practices have been the targeted areas in May. One intended outcome of these sessions is to enable and encourage primary care representation (GP where possible, practice nurse as appropriate) consistently at IDTs, and to raise awareness of encourage utilisation of the HOP specialists.

GNS skill Development/Transalpine Peer Support: Transalpine gerontology nursing continues, with the CDHB HOP Nursing Director providing support to the Coast. The HOP Nursing Director and Planning and Funding continue to work with the Director of Nursing and Associate Director of Nursing North to identify quality improvements in how we support ARC facilities.

The education visits to the practices described above have also been intended to improve the understanding of the roles and therefore utilisation of the two Gerontology Nurse Specialists (GNSs) based in Westport and Greymouth.

Dementia/Cognitive Impairment Services: The Cognitive Impairment pathway has been completed by the working group and is now at sign-off/final feedback stage. A communications plan is being developed, with the launch intended to take place as part of a peer review/education session to GPs and practice nurses.

Communications: Collaborative meetings with home-based support services at management level and staff and stakeholders at operational level in Reefton, Greymouth and South Westland have taken place during the month of May. NGO and consumer involvement in identifying barriers to health information for consumers on the Coast has also taken place to progress a solution towards improving access.

Section 3: Buller Integrated Health Centre Progress Q4 2012-13

The recent focus in Buller has been stabilising general practice. Within Buller Health Medical Centre, two full-time receptionists have recently been appointed, and a Practice Manager has been seconded from Planning & Funding in Greymouth while we work with Better Health to improve the processes and implement change to establish sustainable general practice in Buller.

The Health Research Council (HRC) funded evaluation of the BSMC implementation on the West Coast, focusing on the Buller Business Case, is now at the stage of surveying a sample of health professionals by interview and patients over 65 and those within the long-term conditions pathway by questionnaire.

Section 4: Grey Integrated Health Service Progress Q4 2012-13

A facilitated alliance workshop was held in the Grey district on 16 May to determine the key deliverables for integrating health care in the Grey community (including Reefton) over the next two years. Clinicians, consumers, NGOs and health professionals from across the West Coast health system attended the workshop. From this workshop, a number of short-term priorities related to self-management, general practice services, acute demand and support discharge services and team work were identified. A small group of clinicians and project managers are working to make progress on these priorities.

The Grey Alliance workshop has supported the development the Grey/Westland Integrated Family Health Services 2013-15 workplan that was endorsed by the Alliance Leadership Team on 19 June 2013. This work plan outlines key deliverables that support service integration and improvement priorities identified in the 2013/14 Annual Plan and through the Grey Alliance Workshop (held in May 2013), including:

- The development and implementation of community-based responses for patients at risk of deteriorating health;
- Improving Māori patient and whānau experience of health care and support services across the West Coast;
- The redesign of models of care within DHB-owned general practices that support the health care home approach and 'lean thinking' models;
- The development of Integrated Family Health Centres/Services that support a sustainable and quality health system for the West Coast;
- The development of models of care that support sustainable after-hours services;
- The integration of community nursing across district nursing, long-term conditions nursing with primary care;
- The integration of allied health to a single service that is networked to allied health professionals in the community and primary care;
- The integration of mental health services across primary, community and secondary care;
- Localised *HealthPathways* that enable timely clinical decision-making and seamless transition between services for patients; and
- The development of an integrated model of pharmacy on the West Coast.

The work plan allocates roles and responsibilities for clinical leaders and project managers. Planning is underway for the development of a Grey/Westland workstream to support and facilitate the implementation of the work plan.

Section 5: Pharmacy Workstream Progress Q4 2012-13

In Quarter 4, Planning & Funding and community pharmacists met together twice and progressed the development of the Pharmacist2GP initiative and the Medicines Utilisations Review service. Development of the former has focussed on identifying what pharmacists will do in practices to benefit LTC patients and their practice team. Development of the latter has focussed on identifying how, through aligning with the Medication Management Service in Canterbury, West Coast pharmacies can be supported to offer

substantially more reviews to LTC patients most at need of medication management intervention. This development work is expected to be completed within Quarter 1 2013/14.

Section 6: Public Health Workstream Progress Q4 2012-13

Smokefree Health Targets: For the primary care smokefree health target, activities focused on improving data capture and accuracy, with emphasis on the new IT tool HealthStat, which can provide more frequent, practice-specific feedback about the target. Work against the action plan continued to improve performance against the secondary smokefree health target. Of particular focus in Quarter 4 was reinforcing clinical relevance and focus of the ABC implementation.

Local Alcohol Policy (LAP) Community Consultation: Community & Pubic Health have commissioned an 'Alcohol in the Community Survey' on the West Coast to get a sample of community views to inform the policies and rules on liquor licensing for the West Coast. Healthy West Coast has also asked health workers across the sector to share their views on alcohol as it relates to their work, to sit alongside the statistical data and provide a 'real life' picture of the impacts of alcohol on the West Coast.

Breastfeeding – Mum4Mum Peer Support Programme: The breastfeeding advocates delivered breastfeeding peer support training in Reefton and South Westland (Franz Joseph) this quarter. Given the rurality of South Westland, this is particularly beneficial for the small community. The Mum4Mum programme has been developed to overcome issues associated with rurality and isolation, by giving West Coast mothers the skills to provide one-to-one support and breastfeeding advice to their whānau and community.

Section 6: Child & Youth Workstream Progress Q4 2012-13

Immunisation Health Target: A position paper regarding the West Coast Immunisation Services was developed this quarter. The purpose of this was to analyse the current systems and processes to see what support can be offered towards achieving the national immunisation targets.

Newborn Enrolment Working Group: This quarter a newborn enrolment form was developed by the work group, which included maternity services, WellChild/Tamariki Ora services, NIR services, primary practice and Planning & Funding. The form addresses timely enrolment and referrals to WellChild services and has a coordinated process for all referrals to newborn services.

The Child & Youth Health Compass: Child & Youth workstream members are involved in the Child & Youth Health Compass: Supporting Innovation, Good Practice and Equity. Appropriate clinical leads were 'tagged' to the ten questions, and then engaged with those they feel needed to be involved to answer the question against the criteria provided. Feedback will be sent back to individual DHBs and will include tailored information for Child & Youth services. The Child & Youth workstream will use this process and feedback tool to identify areas of improvement against 'best practice' as identified by the Children's Commission.

COMMUNITY & PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEE MEETING UPDATE 11 JULY 2013

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

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

DATE: **2 August 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 11 July 2013 Following confirmation of the minutes of that meeting at the 22 August 2013 meeting, confirmed minutes of the 11 July 2013 meeting will be provided to the Board at its 13 September 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 – 11 July 2013.

3. SUMMARY

ITEMS OF INTEREST FOR THE BOARD

- **Community & Public Health Update**

  This report from Community & Public Health provided information as follows:

  Health Impact and the Public Health Response to Major Job Losses in Small Communities

  The West Coast Community & Public Health team were motivated to obtain a literature review on this topic in the wake of the announcement of the closure of Solid Energy's Spring Creek Mine. They were seeking information about what might be expected in terms of health and wellbeing impacts on the local community and any evidence about what public health and community responses might serve to mitigate the adverse impacts.

  The Literature Review has recently been completed and the Executive Summary of the review will be provided to Committee members.

  Annual Drinking Water Survey

  Community & Public Health are about to embark on the Annual Drinking Water Survey for the West Coast. This survey is carried out each year and assesses the microbiological and chemical quality of drinking water supplies serving populations of more the 100 people, and progress towards meeting the requirements of drinking water legislation.

  Local Alcohol Policy Development

  Community & Public Health have met with the 3 Councils and police to get an understanding of the common ground between the areas. The general feeling is that they would like to develop one document with slight variations of local input.

  Alcohol Controlled Purchase Operation (CPO)

  A CPO was carried out recently to test the off-licenses in Greymouth regarding their compliance with the legal purchase restriction for alcohol. It was pleasing that the 17 year old volunteer was unable to purchase alcohol at any of these outlets.

- **Planning & Funding Update**

  The Committee noted the achievements in relation to the health targets for the year where the electives target was exceeded and there were no patients waiting longer than 5 months. They also noted that in regard to the HPV vaccination 98% of those who have consented have received this.

  The Committee also noted that the DHB is moving into a new funding model where the cost of actual delivery is funded (not CWD).

  Discussion also took place regarding District Nursing Services. The Committee noted that this is seen as a key service and the DHB is very fortunate to also have Rural Nurse Specialists.

- **Primary & Community Services Update**

  This report provided an update of activities in the Primary and Community Services area of the DHB.

Discussion took place regarding the partnership with Better Health Limited and some background was provided around how this is working.

- **Alliance Update**

  This report provided an update of progress around DHB owned General Practice Management; the Grey/Westland Integrated Family Health Services; Kaupapa Maori Nurse Appointments; Complex Clinical Care Network and the Alliance Leadership Team Membership.

  The Board Chair asked that a presentation to the Board on the Alliance Leadership Team be scheduled to provide some visibility around membership and show this links with the Annual Plan.

- **Disability Resource Centre Presentation**

  Debbie Webster, General Manager, Queenstown & Southland Disability Resource Centre, spoke to the Committee regarding the provision of resources on the West Coast.

  The Centre is a voluntary not-for-profit organisation and provides information to disabled members of the community to enable access to resources they require, to be able to participate in their communities. They also provide adaptive equipment and products to make day to day life easier.

  With the closure of the local resource centre it is intended to provide services to the West Coast via a mobile unit.

4. APPENDICES

Appendix 1: Agenda – Community & Public Health & Disability Support Advisory Committee – 11 July 2013.

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

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 2 August 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** ▪ *28 June 2013*		
3.	**Carried Forward/Action List Items**		
REPORTS			***10.15am***
4.	**Chair's Update – Verbal**	Dr Paul McCormack *Chairman*	*10.15am – 10.25am*
5.	**Chief Executive's Update**	Michael Frampton *Programme Director*	*10.25am – 10.40am*
6.	**Clinical Leader's Report**	Dr Carol Atmore *Chief Medical Officer* Karyn Kelly *Director of Nursing and Midwifery* Stella Ward *Executive Director, Allied Health*	*10.40am – 10.50am*
7.	**Finance Report**	Justine White *General Manager, Finance*	*10.50am – 11.00am*
8	**Presentation & Meeting with Chair of Clinical Board**	Stella Ward *Chair, Clinical Board*	*11.00am – 11.30am*
9.	**Report from Committee Meetings**		
	- CPH&DSAC *6 June 2013*	Elinor Stratford *Chairperson, CPH&DSAC Committee*	*11.30am – 11.40am*
	- Hospital Advisory Committee *6 June 2013*	Sharon Pugh *Chairperson, Hospital Advisory Committee*	*11.40am – 11.50am*
	- Tatau Pomanau *6 June 2013*	Elinor Stratford *Board Delegate to Tatau Pounamu*	*11.50am – 12noon*
10.	**Resolution to Exclude the Public**	*Board Secretariat*	*12noon*

INFORMATION ITEMS

- Confirmed Minutes
  - CPH&DSAC Meeting – 6 June 2013
  - HAC Meeting – 6 June 2013
  - Tatau Pounamu Meeting – 6 June 2013
- 2013 Meeting Schedule

ESTIMATED FINISH TIME *12noon*

NEXT MEETING

Friday 13 September 2013 commencing at 10.00am

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 BSMC Q3	Maori Health Activity Report Planning & Funding Update Community & Public Health Update Alliance Update 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 2013 Schedule of Meetings	Latest Board Agenda Chair's Report to Board from last meeting Committee Work Plan 2013 Schedule of Meetings 2012/13 Final Annual Plan	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
April to June 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.

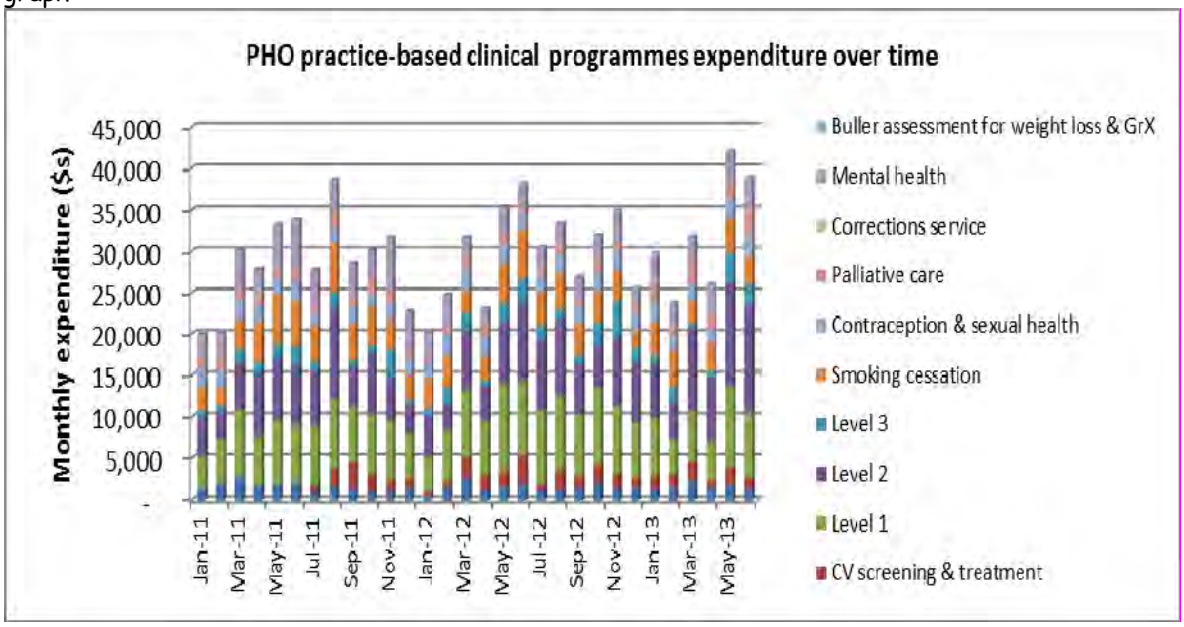
1. Executive summary

New medical centre

Dr Martin Smith opened the new Coast Medical Ltd practice in Westport in April 2013 and has continued to take new enrolments. This practice is a non-VLCA practice.

Clinical services

Uptake from practices for the PHO's various clinical programmes continues. Expenditure for May and June has been the highest yet despite workforce shortages as per activity on this graph:



Keeping people healthy

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

- April – childhood immunisation;
- May – smokefree;
- June – men's health with a special focus on bowel screening awareness.

Workforce and rural support

With added support for administration Dr Anna Dyzel is continuing the coordination of CME on the West Coast. The first session is planned to be delivered at the beginning of July.

The Canterbury District Health Board (CDHB) has made available the opportunity to expand their funded education programme for Canterbury GPs, practice nurses and community pharmacist to the West Coast health professionals. This is a CDHB-funded programme, accredited by the College of GPs, for CME points that provides small group peer to peer education to primary care. The programme is facilitated through Pegasus Health. Work is in

progress to adapt this model for the West Coast primary clinical staff and community pharmacists.

Standing Orders training workshops began in May. To the end of June three sessions have been completed for a combined Reefton, Buller and Moana Rural Nurse Specialists (RNS) group, and one session for the South Westland RNS group, with a further session planned for South Westland in July. Dr Jane Nugent provided the workshop facilitation, support and training along with the PHO clinical manager.

The PHO team has begun preparation for the third GP/Nurse weekend conference. The proposed dates are the 9th and 10th of November 2013. As per last year this will be held in Hokitika. Potential guest speakers are being contacted and practice teams have been notified of dates.

Strategic relationships

The Rata Te Awhina Trust Disease State Management Nurse began working from the PHO office in June; this role will become the Greymouth Kaupapa Maori position from October. The nurse will be working closely with the PHO clinical manager to develop partnerships with the practices 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 that were due March 2013. New Trustees are: Maori Health Provider - Dr Melissa Cragg and the Practice Administration Electoral College - Karin van Kuppevelt. Rosalie Sampson returns for another term as the Buller District Council nominee and John Boyes was seconded for another year as Practice Nurse Electoral College replacement.

Staffing, vacancies and succession planning

Nic Neame began working for the PHO in April in the Administration Support role.

The Medical Director role remains vacant after Dr Carol Atmore resigned. Despite requests to West Coast GPs to fill this role there has been no uptake. The search to fill this role has now moved to Canterbury.

PHO enrolment internal audit

The PHO began the re-run of the 'mock audit' of patient registers during this quarter, with the final practice due to be completed in early July. Reports are due back to practice management in late July, early August.

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

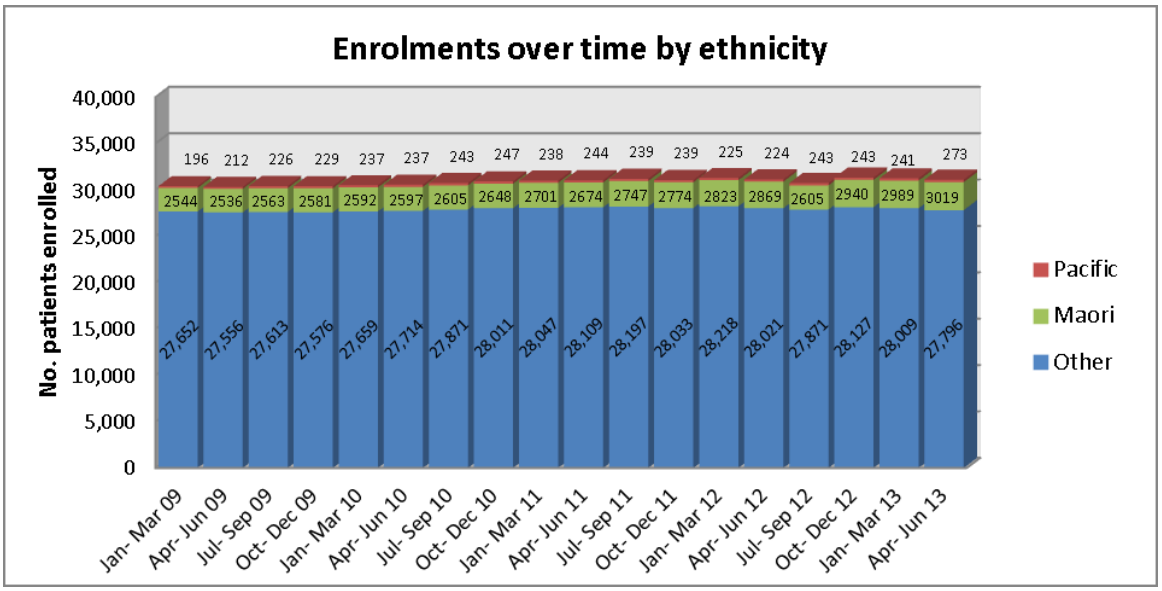
Profit & Loss
West Coast Primary Health Organisation
1 July 2012 to 30 June 2013

		30 Jun 13
Income		
1. Patient care subsidies		5,293,935
2. Clinical services		756,372
3. Mental health		394,275
4. Keeping people healthy		356,889
5. Workforce & rural support		1,199,544
6. Administration		633,694
Total Income		**8,634,708**
Less Cost Of Sales		
1. Patient care subsidies		5,293,935
2. Clinical services		386,898
3. Mental health		36,661
4. Keeping people healthy		28,043
5. Workforce & rural support		1,175,799
Total Cost Of Sales		**6,921,337**
GROSS PROFIT		**1,713,372**
Other Income		
6. Administration		95,011
Total Other Income		**95,011**
Less Operating Expenses		
Staffing & operations		1,943,770
Transfers to/from reserves	-	118,019
Total Operating Expenses		**1,825,751**
NET PROFIT	**-**	**17,368**

NB. This end of year result is provisional and unaudited.

4. Subsidising core general practice care

4.1. Demographics of the enrolled population



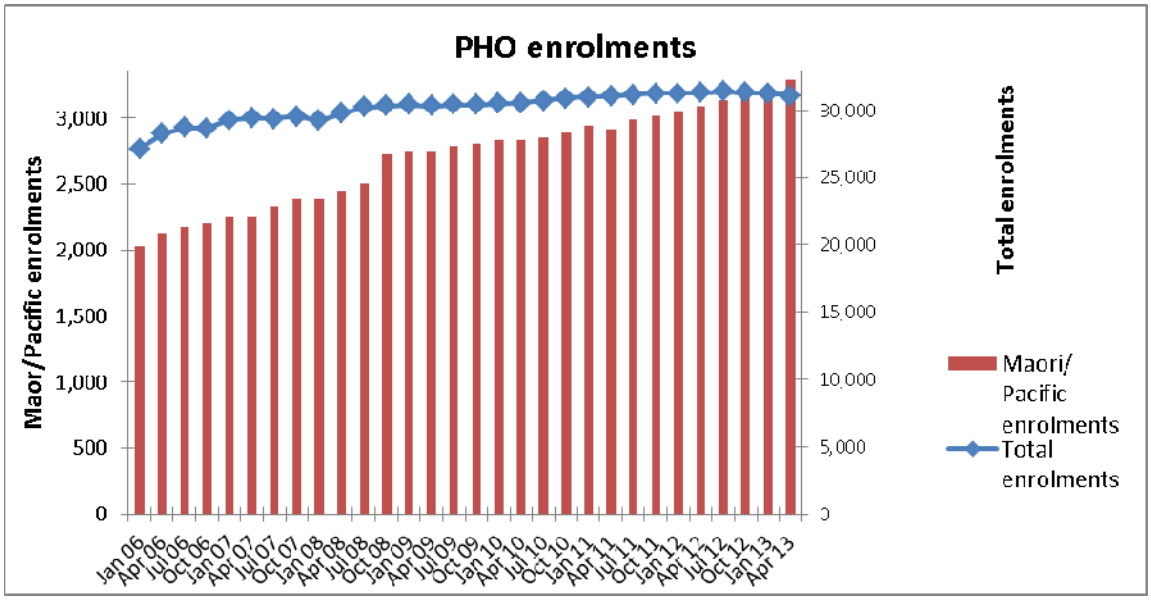
4.2. Service Utilisation (visits to the practices)

Waiting times to be seen by a medical centre or clinic
June 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)	11	4	21
Waiting time if rings today for routine appointment with a nurse for three monthly review and prescription	5	0	12

4.3. Access by Maori



Enrolments of Maori and Pacific people continue to increase at a faster rate than other ethnicities and have for the first time exceeded that of other ethnicities.

4.4. Providers

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

Buller Medical Services (Westport and Karamea)
Coast Medical Ltd (Westport)
Reefton Medical Centre (Reefton)
Greymouth Medical Centre (Greymouth and 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 their fees set to the maximum currently permitted under the Very Low Cost Access (VLCA) scheme. Coast Medical Ltd is a non-VLCA practice thus these fees do not apply.

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
Coast Medical Ltd	$0	$35.00	$45.00	$45.00	$45.00	$45.00

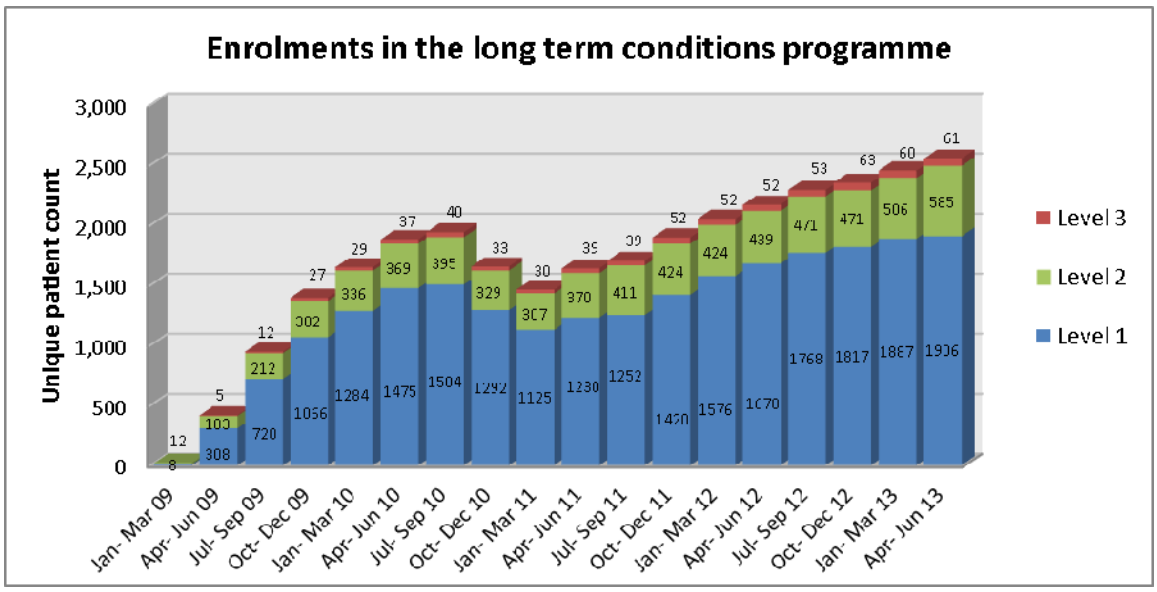
These are the fees patients can expect to be charged at their normal practice during working hours for a normal consultation, if the patient is enrolled with the West Coast PHO. Additional fees may apply to after hours (except under 6s), weekends, long appointments, home visits, procedures and casual 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 enrolled.

5. Clinical Services

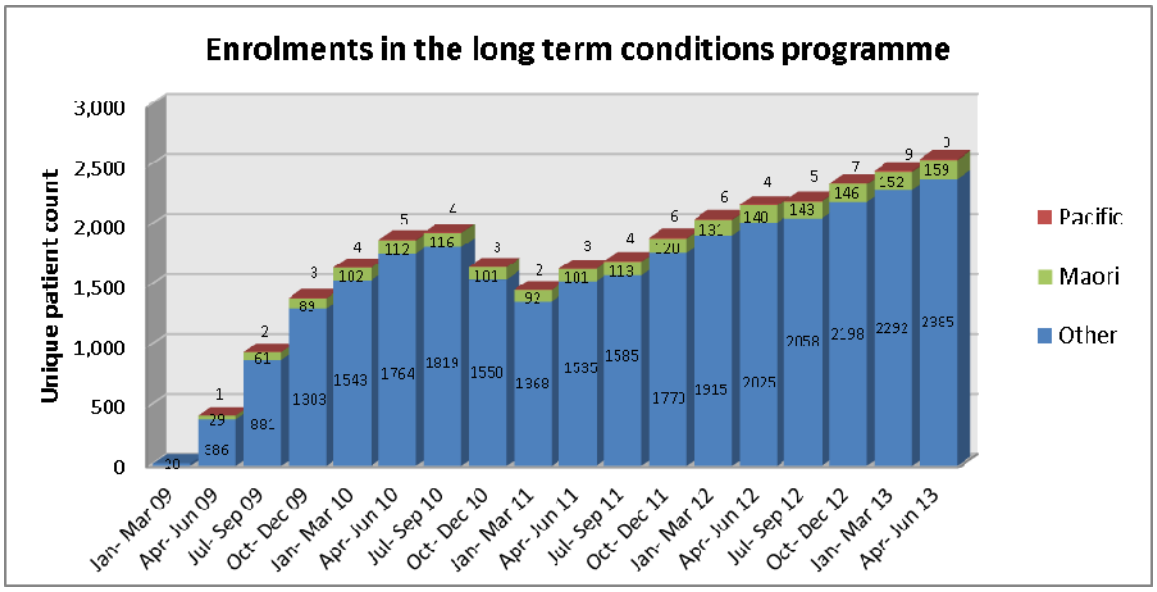
5.1. Long Term Conditions (LTC) programme

On target: *Yes*

1. Outcomes/Outputs



The 2,552 patients who are enrolled in the LTC programme, out of the PHO's 31,088 enrolled patients, means that 8.2% of the enrolled population is engaged in a structured programme of care for their long term condition(s). There is a pleasing increase in the number of level one and two enrolments.



Maori enrolments make up 6.2% of all enrolments in the LTC programme to date. For comparison

Maori make up 5.8% of the enrolment population aged 45+ years – the prime age group of people in the LTC 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;
    - working with practices to identify eligible people and increase enrolments in level two and three.

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**

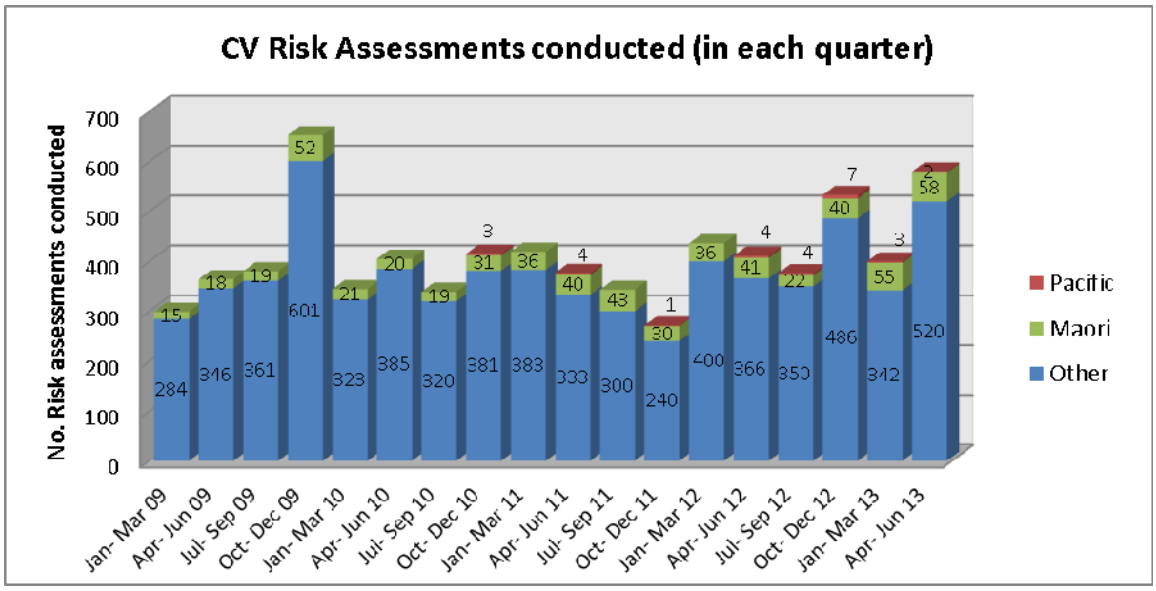
Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

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 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 580 cardiovascular risk assessments conducted this quarter. This is a reflection of the increased focus on risk assessments within general practice. It is still worth noting that we have now screened the 'easy to reach' with the more 'reluctant folk' still to screen.

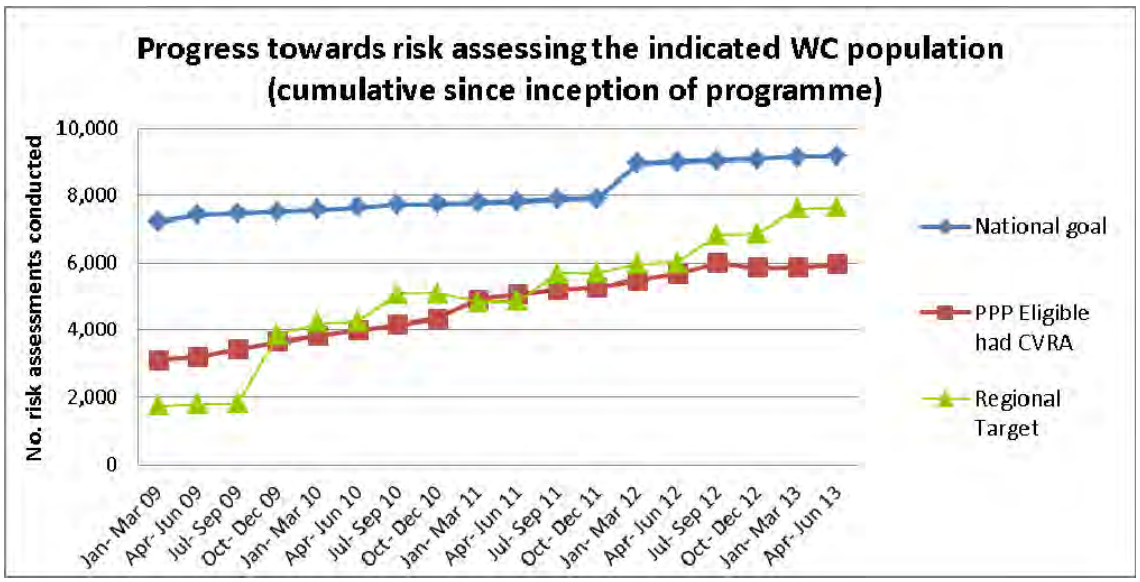
Maori make up 10% of completed CVRAs this quarter. By comparison, Maori make up 8.8% (902) of the eligible cohort for CVRA on the West Coast. (The eligible age range for Maori is male 35-74 years and for female 45-74 years.)

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

2. Key Activities

- on-going support from the PHOs clinical manager to practice nurses/teams to identify eligible patients for screening;
- practice teams are actively inviting eligible people in to nurse led clinics to have their 5 year cardiovascular risk assessed;
- collaboration between newly appointed Rata Te Awhina Trust nurses, the PHO and several practices is occurring to outreach to the high needs Maori population who have not responded to invitations for CVRA screening;
- 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 was to achieve 75% by 1st July 2013 as depicted in the regional target. As at 30th June 5,943 people who were eligible for their CVRA were completed which is 77.8% of the regional target of 7,638. This equates to 64.8% of the 1 July 2014 target of 90%. Of the 5,943 people screened to date 37% (2201) were female and 63% (3742) were male 58.8% (531) were Maori.

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;
   - a Heart Foundation training workshop was held in April on the new CVRA tools and was attended by 5 people including practice nurses, a Rata Te Awhina nurse and PHO staff. These tools were taken back to practice teams for training and use in practices.

4. **Issues and Risks**

Issues/Risks	Mitigation/Resolution
• From 1 July the target for CVRA has increased to 90%.	• Integration of Kaupapa Maori nurses to assist with high need engagement for screening. • Specific nurse led CVRA clinics at practices.

5.2.1 Treatment for those identified with increased cardiovascular risk

1. **Outcomes/Outputs**
   - Of the 336 Cardiovascular Risk Assessments (CVRAs) completed this quarter (doesn't include patients with known diabetes), 65 (19%) 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;
   - all identified high risk people are offered a referral to Green Prescription;
   - optimal pharmacological treatment is commenced;
   - regular follow-up monitoring of cardiovascular risk;
   - those identified with high risk will be given a 'Taking Control' booklet for heart health.

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, held 20th June 2013.

4. **Issues and Risks**

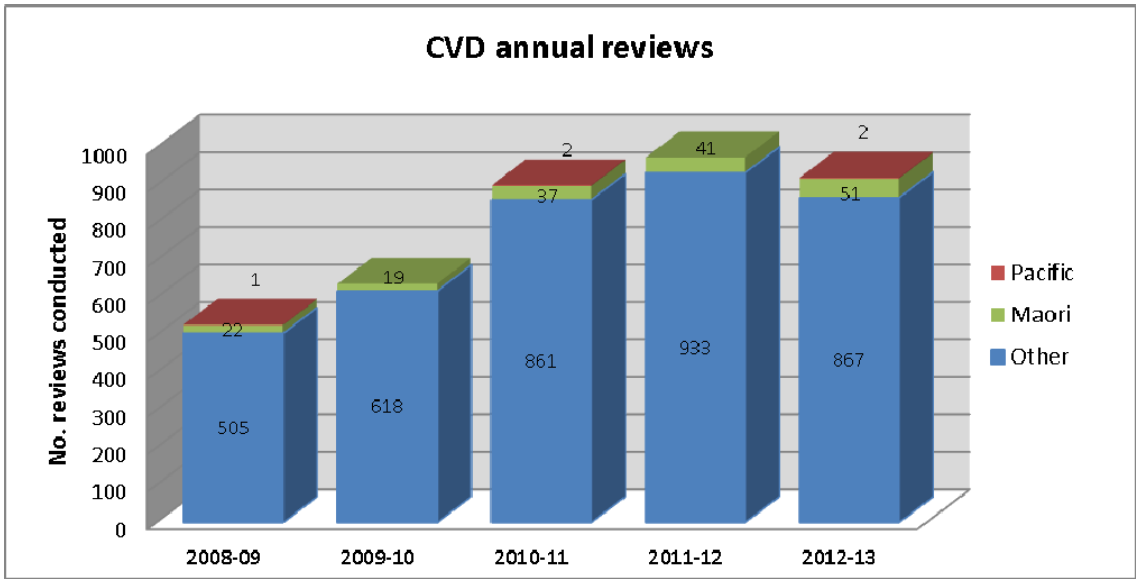
Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

5.3. CVD annual reviews

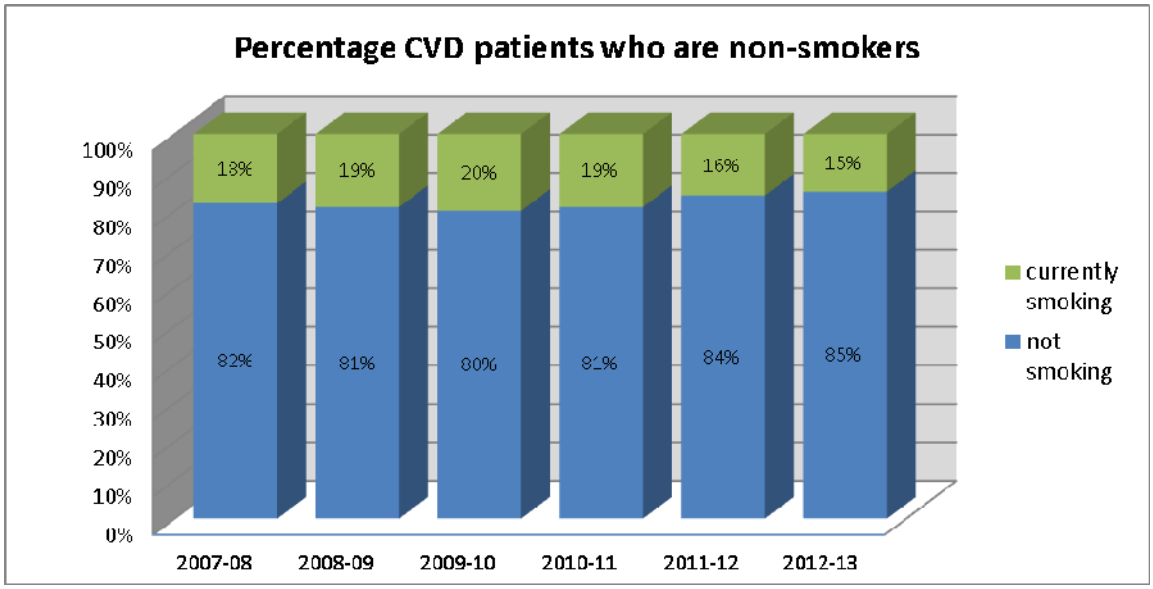
On target: Yes

1. Outcomes/Outputs

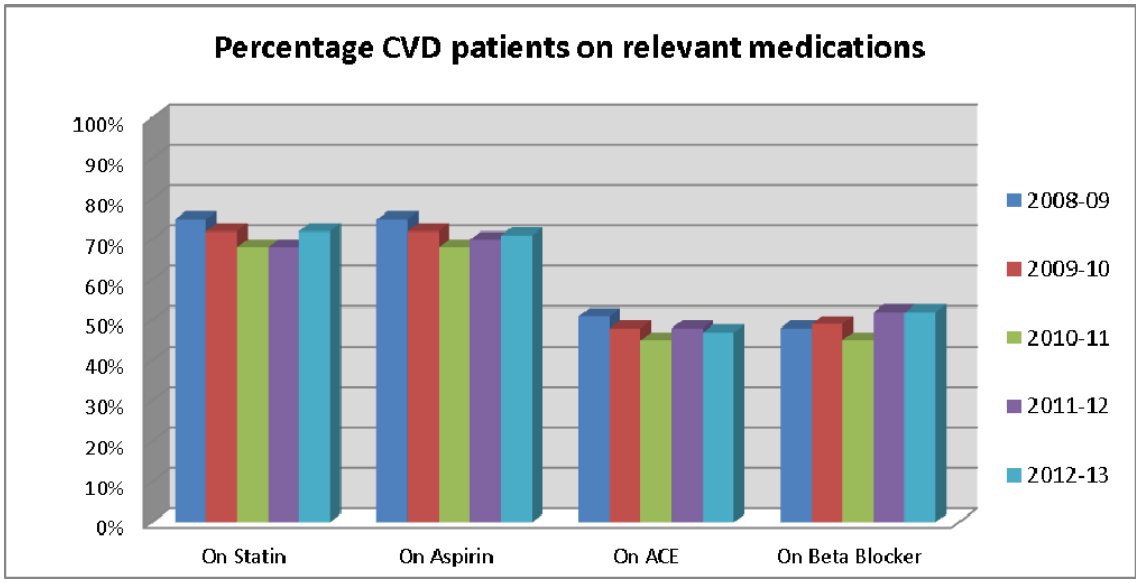
People with identified cardiovascular disease have an annual review of their condition as part of the Long Term Conditions (LTC) management programme.



6% of the annual reviews conducted this quarter were for Maori. For comparison Maori make up 5.8% of the enrolment population aged 45+ years – the prime age group of people in the LTC programme.



Of those reviewed YTD 85% of people were not smoking. Of Maori reviewed YTD 78% were not smoking and other ethnicities 86% 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) installation has been delayed due to IT issues, however a fix is underway. This tool will enable practice teams to identify patients with cardiac disease but not yet enrolled in LTC;
- on-going support from PHOs 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) meeting 20th June 2013;
- collaboration with Rata Te Awhina Trust to integrate services to support Maori identified with CVD;
- WCDHB Maori Health team.

4. Issues and Risks

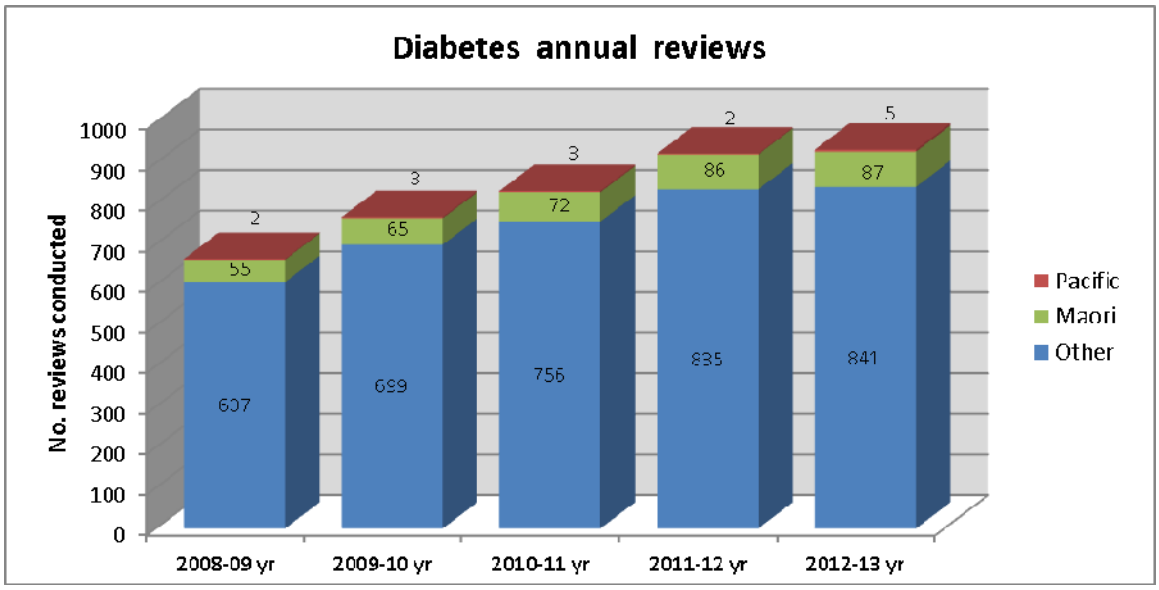
Issues/Risks	Mitigation/Resolution
• Nil	• Nil.

5.4. Diabetes care

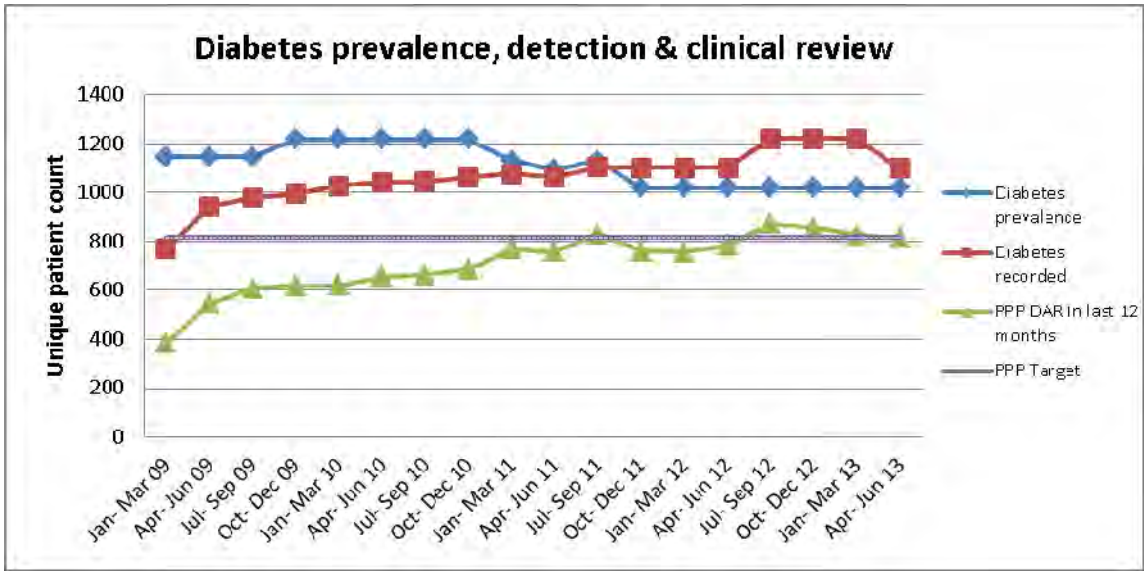
On target: *Yes*

1. Outcomes/Outputs

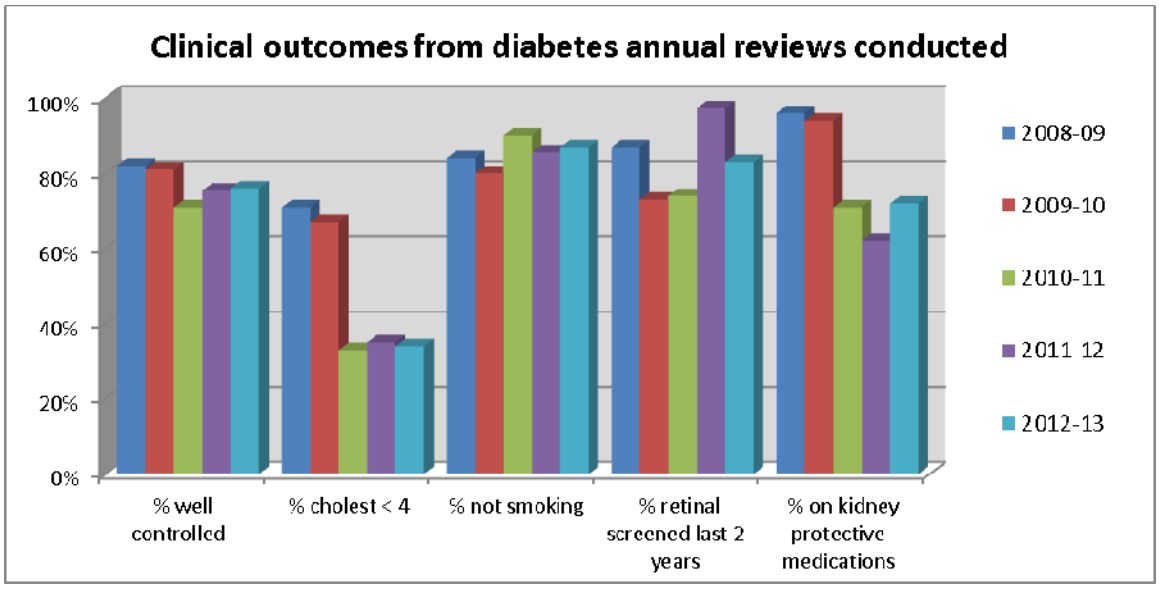
People identified with diabetes have an annual review of their condition as part of the Long Term Conditions (LTC) management programme.



9.3% of the annual reviews conducted YTD were for Maori. For comparison Maori make up 5.8% 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), 73% are appropriately medicated on a statin.

	Type 1	Type 2	Other Diabetes	Total Diabetes	As % Total Annual Reviews	Retinal Exam in Past 2yrs	% had Ret Exams	HbA1c > 8	As % HbA1c <=8	% non-Smokers	% On Statins
Maori	1	19	0	20	10%	17	85%	6	70%	50%	65%
Pacific	0	0	0	0	0%	0	0%	0	0%	0%	0%
Other	16	159	0	175	90%	165	94%	36	79%	84%	70%
TOTAL	17	178	0	195	100%	182	93%	42	78%	81%	70%

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 May; 113 people were screened in Greymouth and Hokitika;
- planning for next retinal screening clinic is 12th to 16th August 2013 in South Westland, Buller and Reefton and further dates for 2013;
- currently re-negotiating another contract with Matthews Eyewear Eyecare as the current one ends 30th June 2013;
- planning is underway to hold the Diabetes Conversation Maps Self-Management sessions for patients, with a first session focus on health eating and being active. Currently the PHO is processing referrals to run the first group session by the end of August;

- 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) installation has been delayed due to IT issues, however a fix is underway. This tool will enable 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 22nd May 2013;
   - retinal screening appointments made and confirmation letters sent out;
   - notification to practices of patients retinal screened;
   - planning for first Diabetes Conversation Map Self-Management education for people with Type 2 diabetes next quarter.

4. **Issues and Risks**

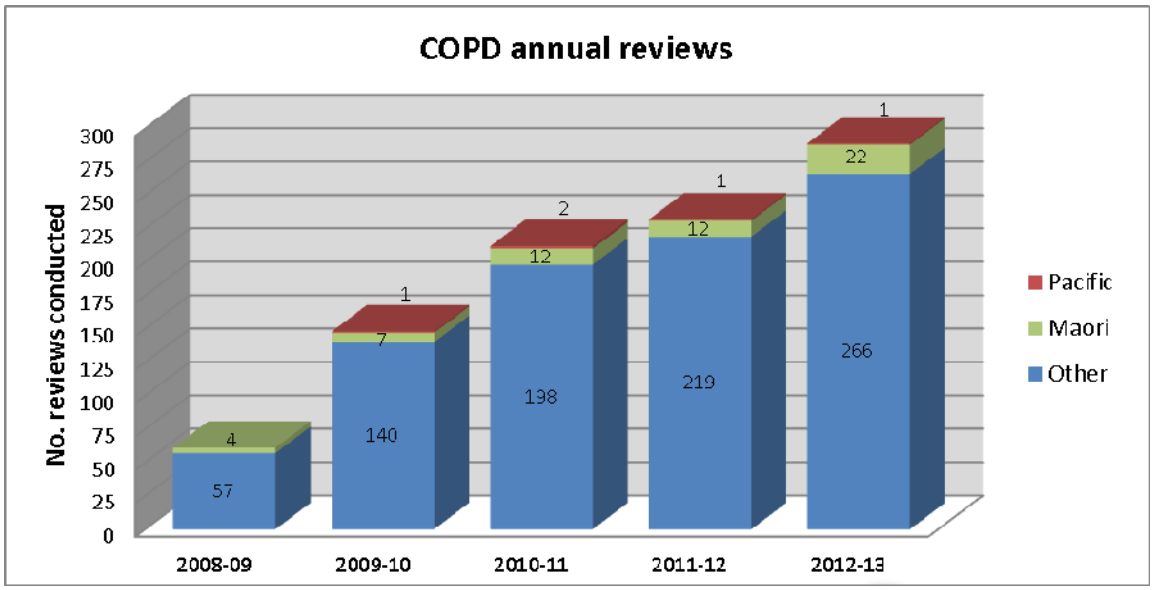
Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

5.5. COPD annual reviews

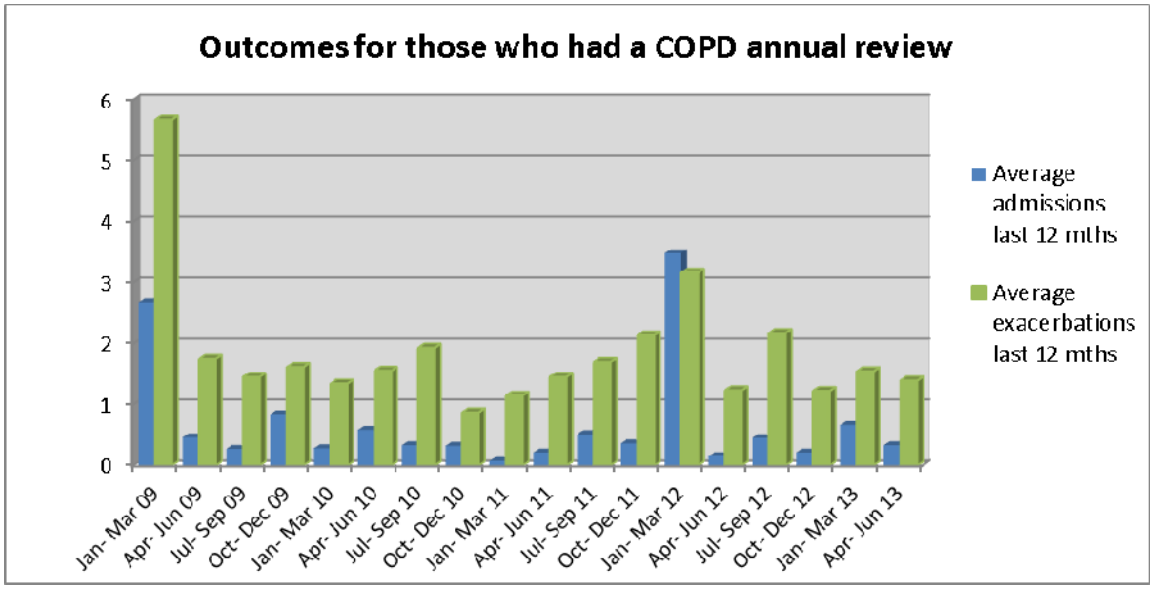
On target: Yes

1. Outcomes/Outputs

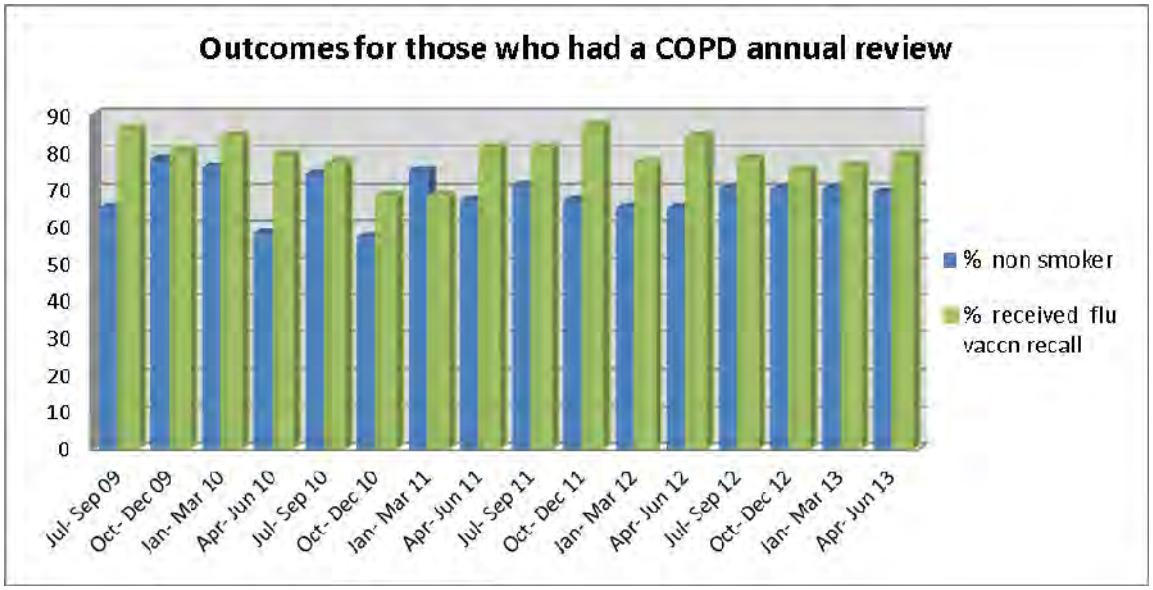
People identified with COPD have an annual review of their condition as part of the Long Term Conditions (LTC) management programme.



7.6% of reviews conducted year to date have been for Maori. For comparison Maori make up 5.8% of the enrolment population aged 45+ years – the prime age group of people in the LTC programme.



There has been a decrease in the average exacerbations and hospital admissions this quarter.



For those people who had their COPD annual review this quarter, 69% are smokefree and 79% 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;
- Heart Respiratory Team meeting held 20th June 2013.

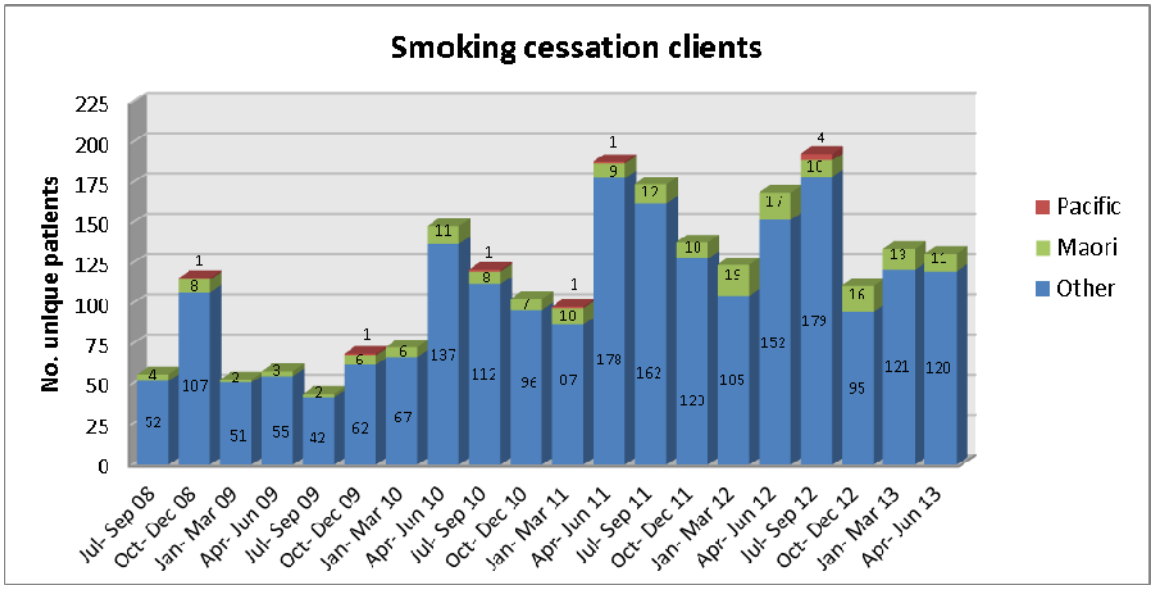
4. Issues and Risks

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

5.6. Smoking cessation

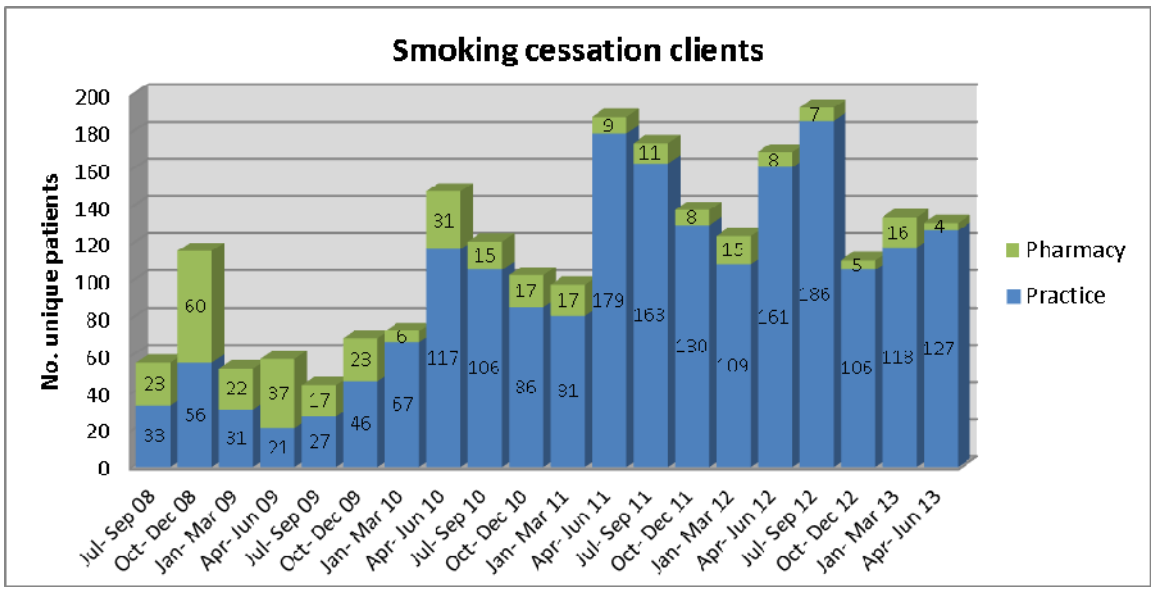
On target: *Yes.*

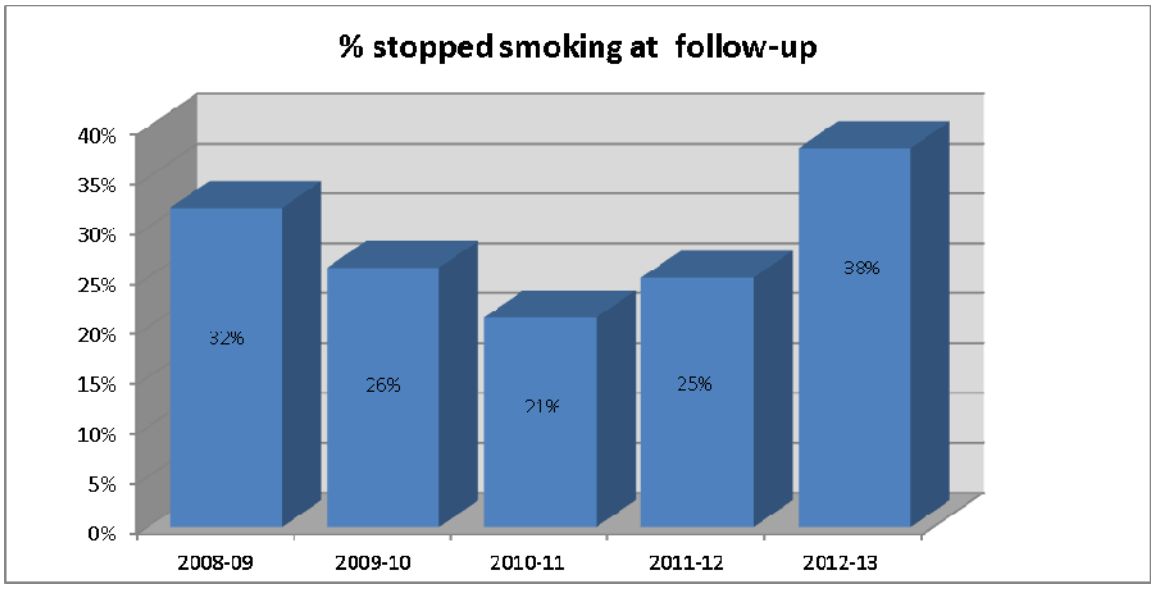
1. Outcomes/Outputs



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). Maori enrolments made up 8.3% of all enrolments in the Coast Quit programme this quarter.





The above graph shows 38% 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 (38% quit rate for 116 'intention to treat' patients; 44% quit rate for 99 contacted clients);
- Coast Quit bulletin prepared and sent to all providers;
- Coast Quit patient hand-out revised;
- filling Coast Quit NRT orders from practices and pharmacies.

Primary Care:

- participation in monthly MoH-led telephone conferences;
- quarterly and monthly Primary Care tobacco health target bulletins sent out to all nurses and doctors in the practices;
- support for 'ABC Call-up' project.

Secondary Care:

- monthly reporting and feedback on ABC target results and NHI report to clinical nurse managers and ward champions;
- consultation with clinical nurse managers, ward champions and DHB smoking cessation counsellors re mandatory smokefree-ABC training;
- patient file checks re documenting the Smokefree ABC intervention;
- commenced file audit for NRT charting;
- fortnightly meetings with HEHA and Smokefree Services manager;

- liaison with DHB smoking cessation providers (Grey and Buller) re revised mandatory training presentation;
- participation in monthly MoH-led telephone conferences;
- discussion with senior mental health staff re smokefree situation in IPU, and preparation of new information resources for staff;
- delivery of CO monitor to McBrearty Ward; preparation of Guidelines; and training for staff;
- Smokefree May displays in Mental Health reception area and ED, Greymouth.

3. **Networking/Education** (either with Health Sector or Community)
   - West Coast Tobacco-Free Coalition meetings and follow-up, and liaison with health promotion advisors at C&PH and Cancer Society;
   - presentation to Rata staff, Hokitika, on smokefree ABC and nicotine dependence;
   - presented Coalition submissions to Buller and Grey District Councils;
   - attended regional smokefree meeting at Springfield;
   - article for "Ask a Professional" column;
   - liaison meeting with local Salvation Army CO;
   - steering-group meetings and phone conference for Buller REAP Youth Project, and preparation of youth-relevant information resources;
   - participation in Smokefree May activities, including table and display at Mitre 10 and The Warehouse (Greymouth), and New World (Hokitika);
   - installing pull-up banners and pamphlet stands in Westport and at Tai Poutini Polytechnic;
   - involvement in Smokefree health promotion activities, including 'Quit Now NRT'/TXT2QUIT poster deliveries, and workplace-targeted 'Quit Now' support packages;
   - clinical supervision sessions for Aukati Kai Paipa provider.

   Training:
   - abridged 'flip-chart' version of DHB mandatory Smokefree-ABC training;
   - Smoking Cessation Practitioner stages 1 and 2 (Heart Foundation 'Quit Card Provider' training), June 18th and 19th: 12 attended;
   - 2 Smokefree ABC sessions for new practice staff orientation (PHO);
   - scheduled DHB mandatory Smokefree ABC training;
   - 'one-off' DHB mandatory Smokefree-ABC training session for ED and Outpatients staff;
   - Quit Card Update (half-day) session for 4 DHB staff, and for new practice nurse;
   - attended Group–Based Therapy training for smoking cessation: a 2-day course in Christchurch, June 24th and 25th.

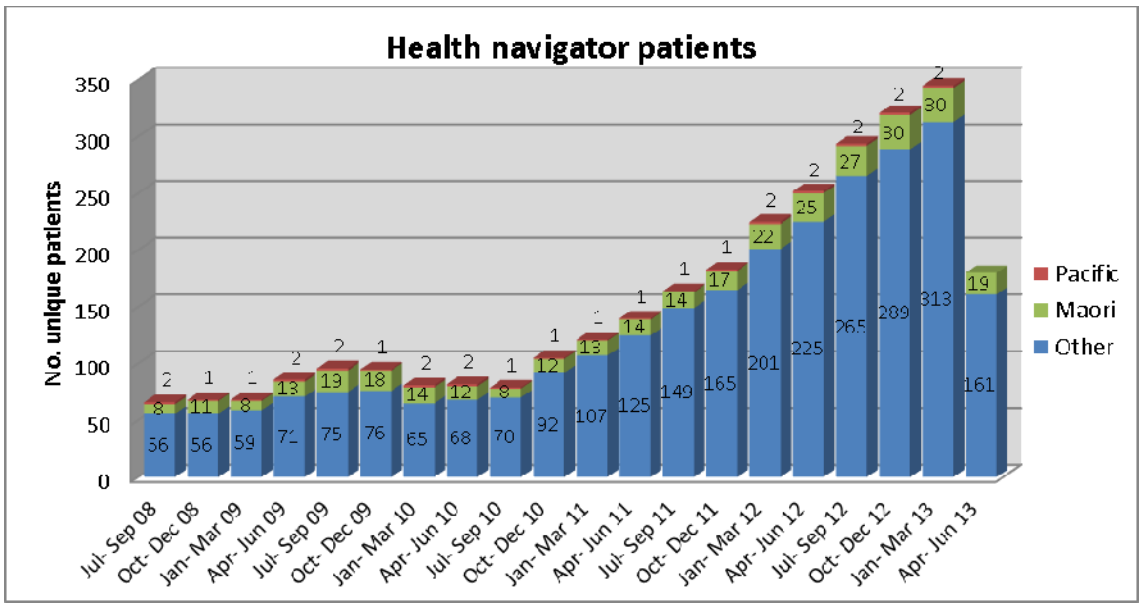
4. **Issues and Risks**

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

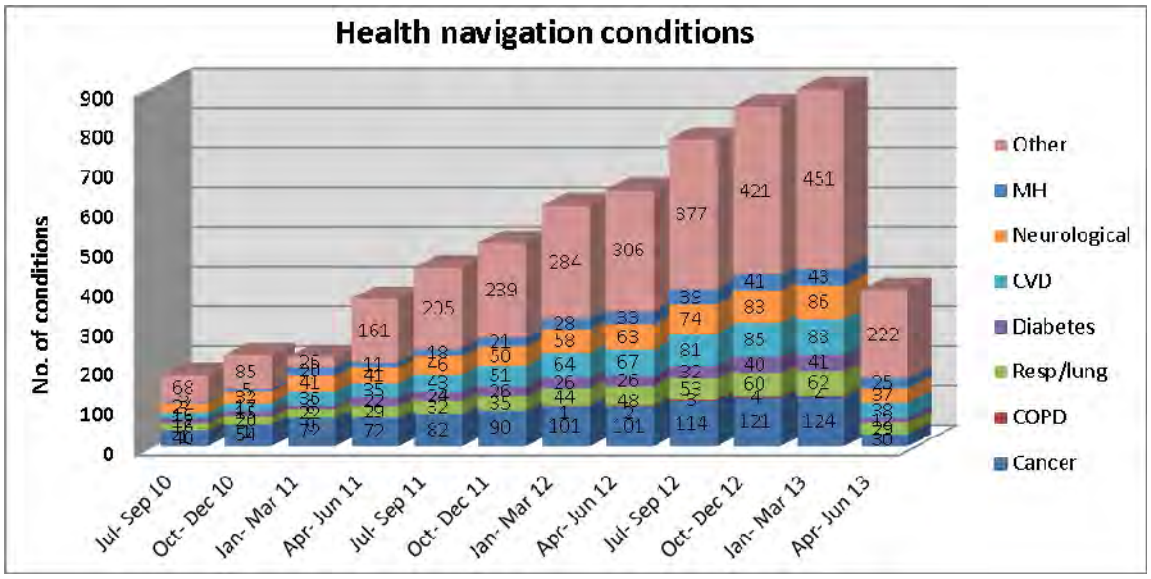
5.7. Health navigator service

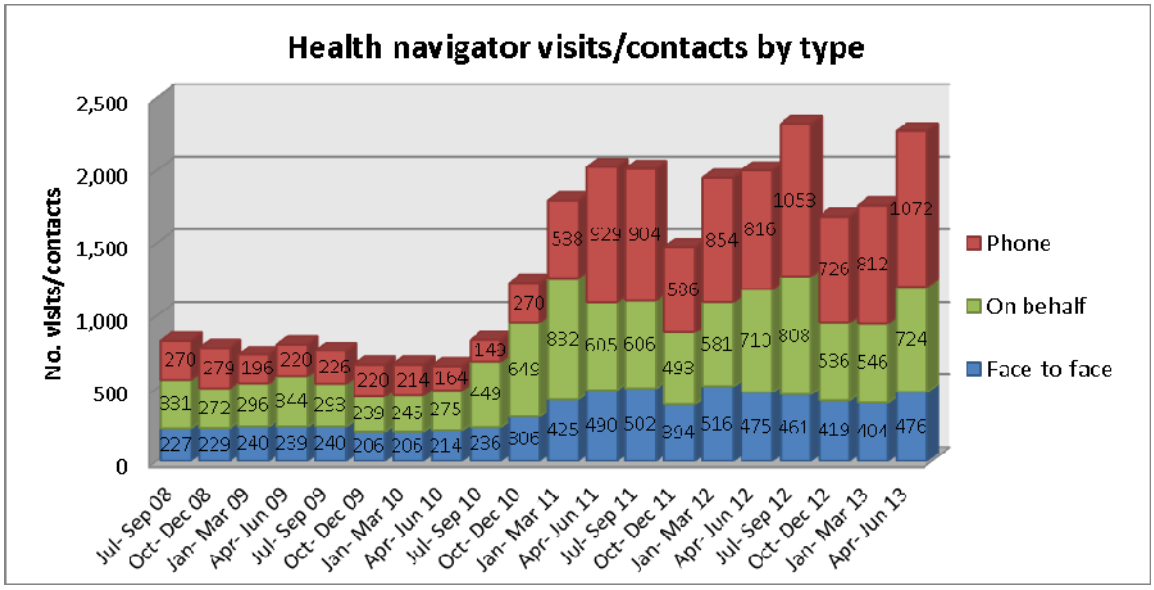
On target: Yes, tracking as expected.

1. Outcomes/Outputs



Data recorded prior to this quarter was as a cumulative result. From this quarter data is recorded to reflect the total number of current clients who access this service, thus the reduction in numbers in these graphs.





Prior to April-June the data set has reflected the total number of clients referred to the service. We are now reporting on the actual number of current clients who access the service within the reported quarter. This will lead to a better understanding of the summary reporting as an example in the previous quarter 26 new people were referred to the service, the Apr-Jun quarter saw 50 new referrals. The visits/contacts by type is unaffected by the change.

Currently we are awaiting publication of a review of this innovative lay-led health navigator service provided by the West Coast Primary Health Organisation in the Australian Health Review, an international health services journal. People may not realise the uniqueness of this West Coast service. Although patient navigation services are relatively common within cancer care, they are less frequently used in other health care sectors, such as primary care.

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 Age Concern;
- Cultural Competency Mauri Ora and Assoc. Introduction training completed (3 Navigators);
- Occupation Therapy HOD visited;
- Te Wananga o Aotearoa Mauri Ora Certificate Level 4 (1 Navigator);

- National Certificate in Maori (Te Waharoa) Level 2 (1 Navigator);
- Southern Cancer Network meeting;
- local Cancer Network meeting;
- WCDHB Local Consumer Council meeting;
- Heartland Service Corrections Department forum;
- elected onto National Cancer Consumer Group (NCCRAG) (1 Navigator);

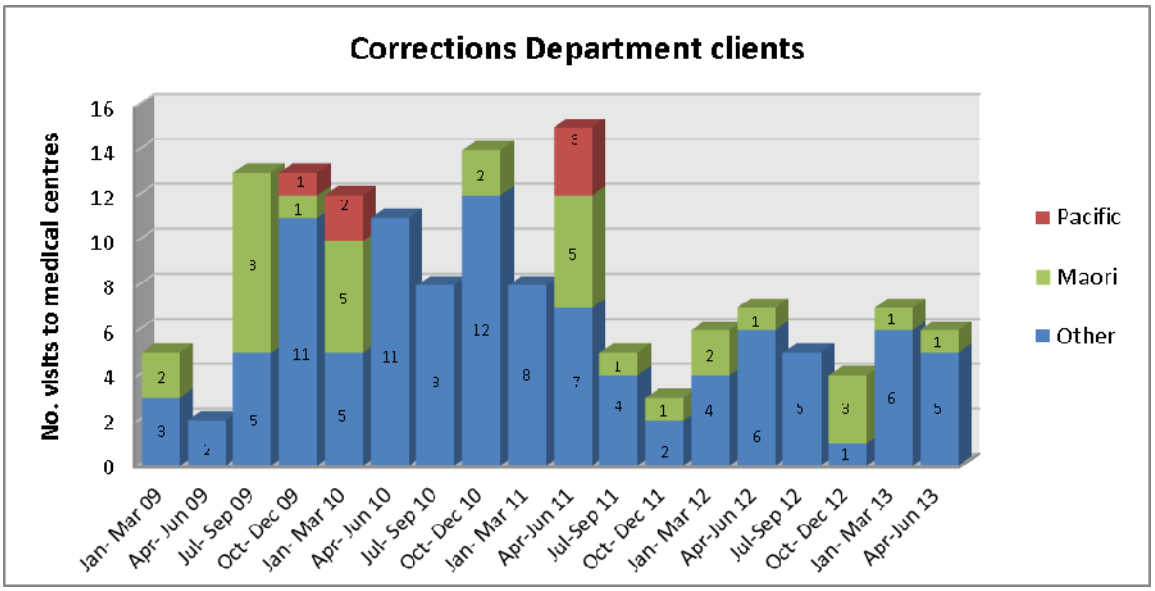
4. Issues and Risks

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 6 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.

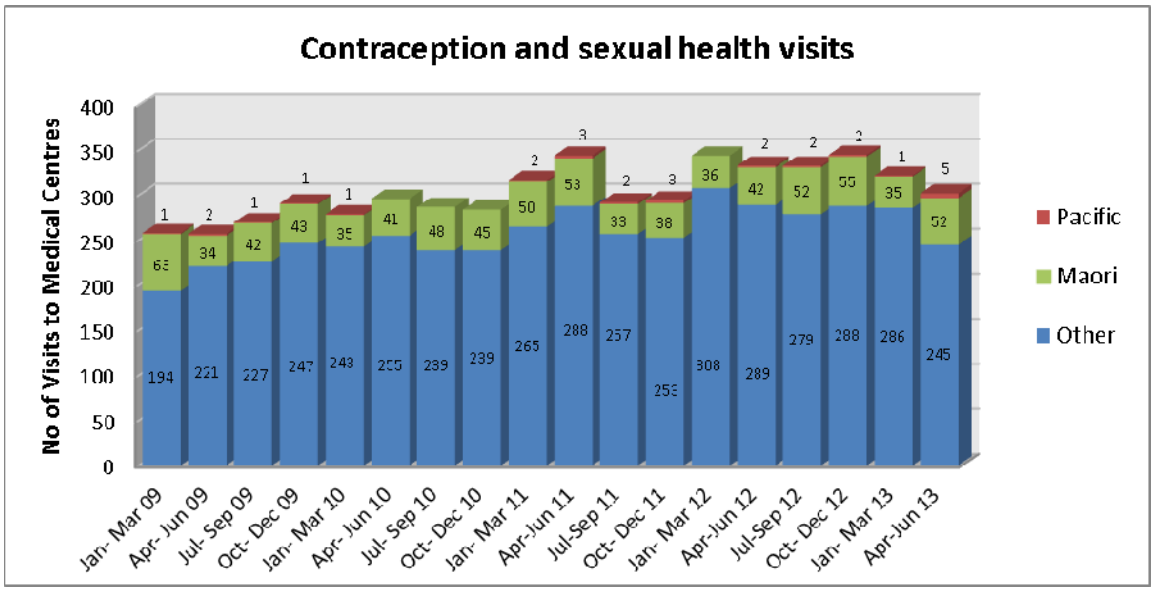
4. **Issues and Risks**

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

5.9. Contraception & sexual health visits

On target: Yes

1. Outcomes/Outputs



17.2% 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: 26 ECP; 87 script fees;
- 1 Jadelle contraception.

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

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

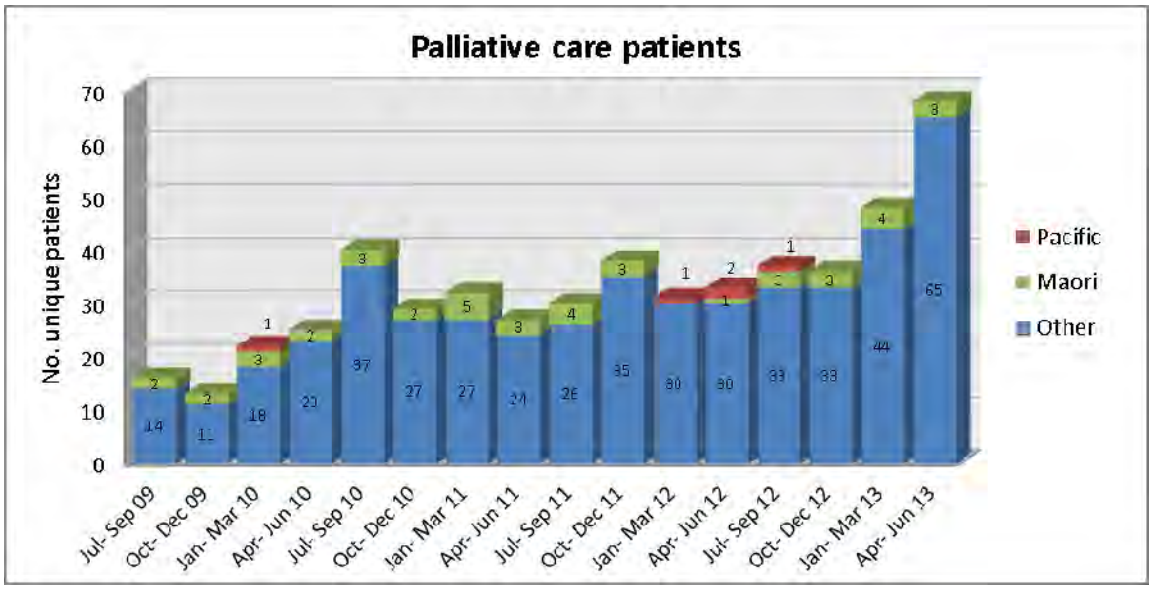
4. Issues and Risks

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

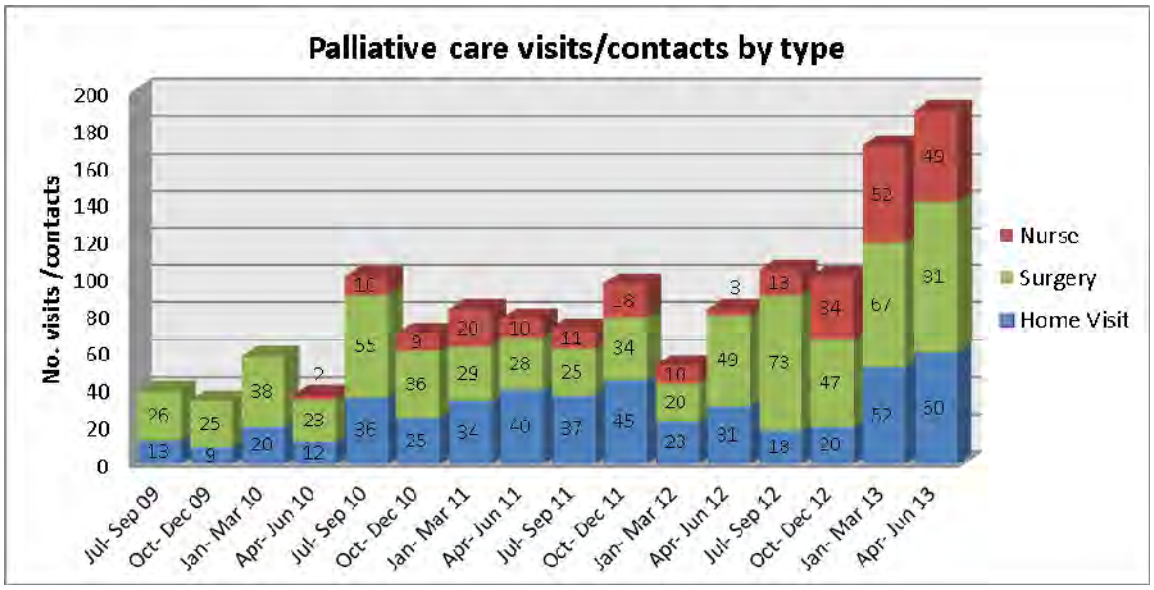
5.10. Palliative care

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)
   - collaborating with Buller West Coast Home Hospice Trust on funding of pharmacy charges not met by PHO.

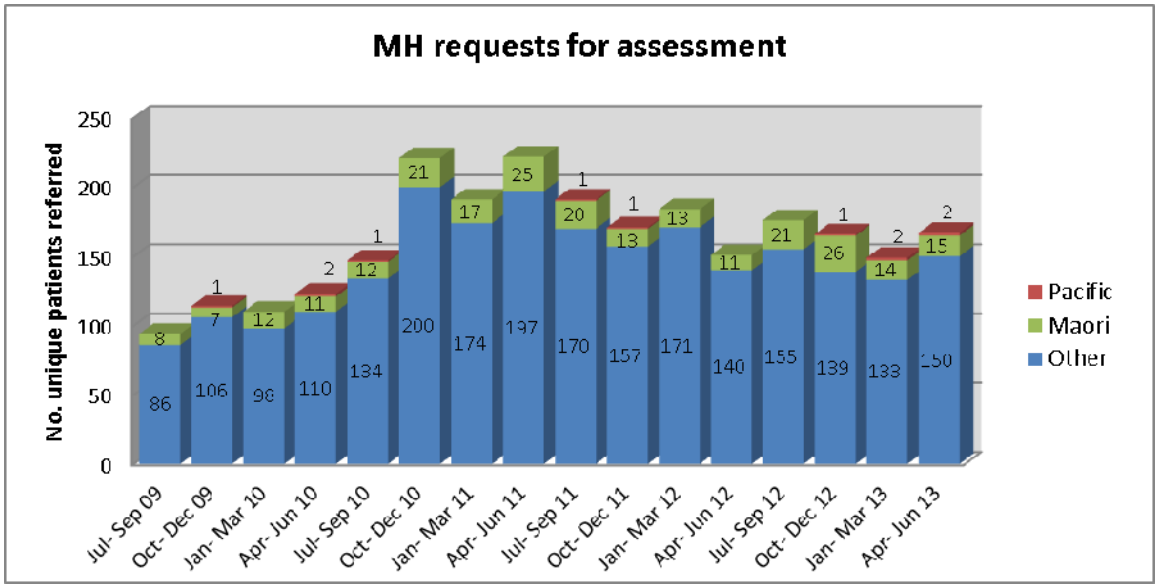
4. **Issues and Risks**

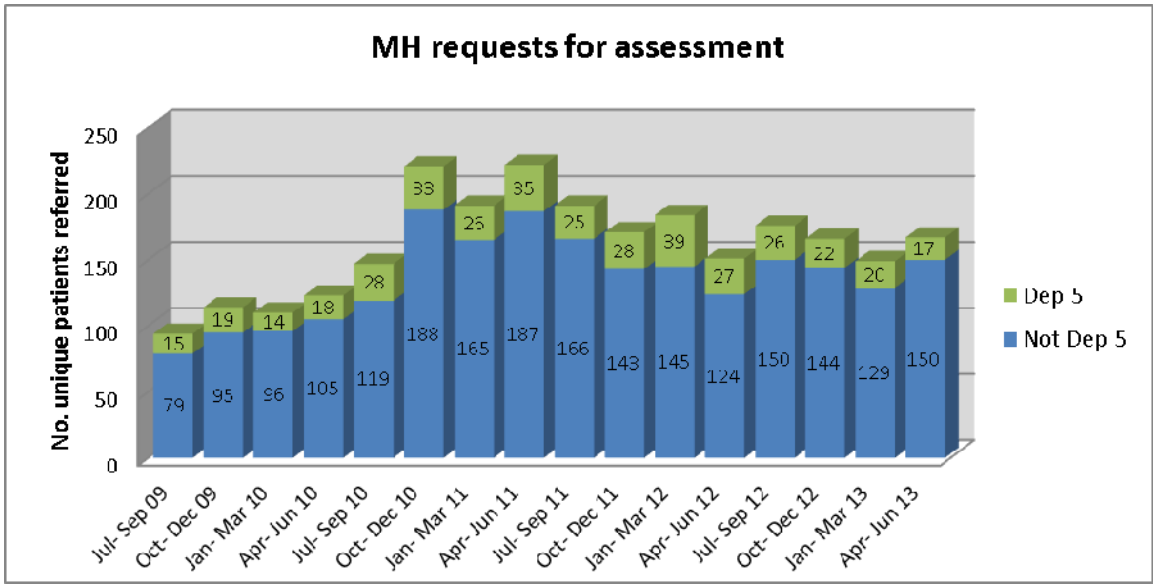
Issues/Risks	**Mitigation/Resolution**
• Nil.	• Nil.

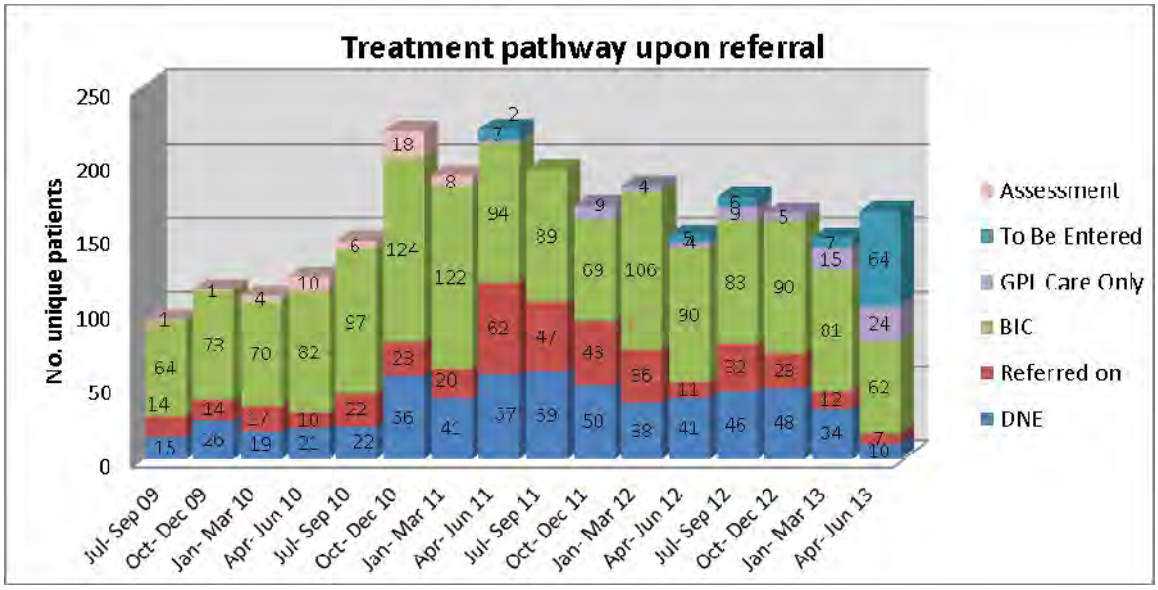
5.11. Mental Health services

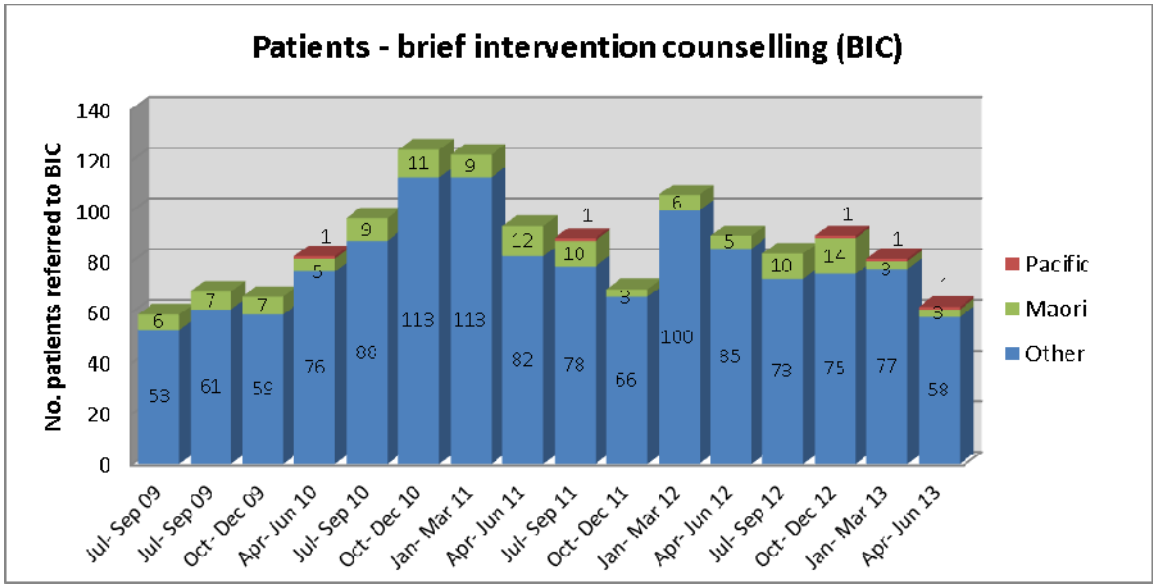
On target: Yes

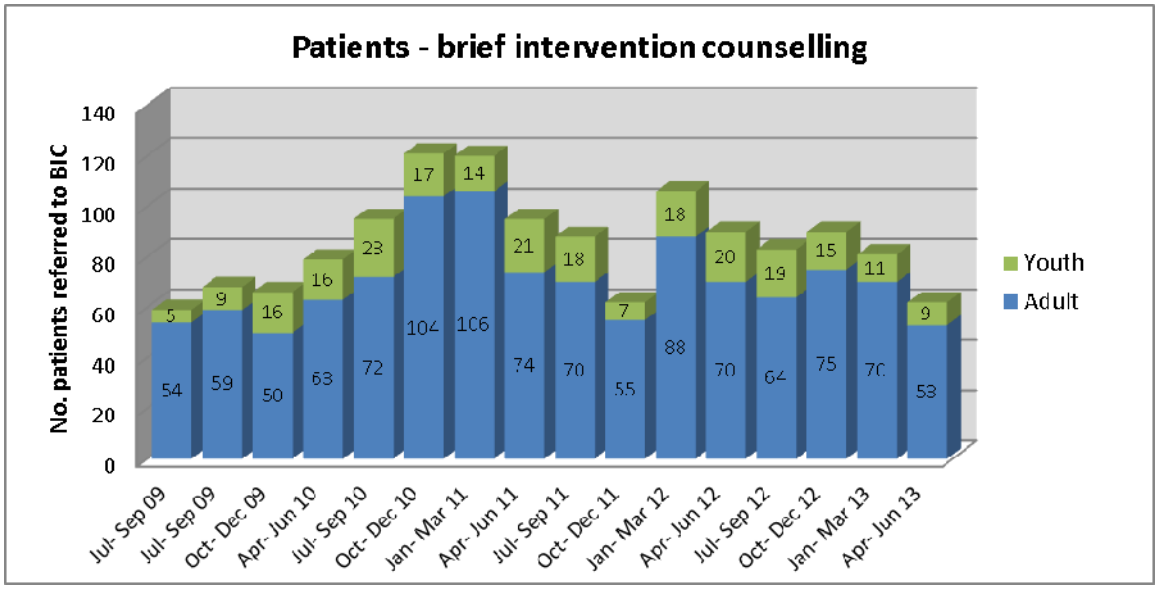
1. Outcomes/Outputs

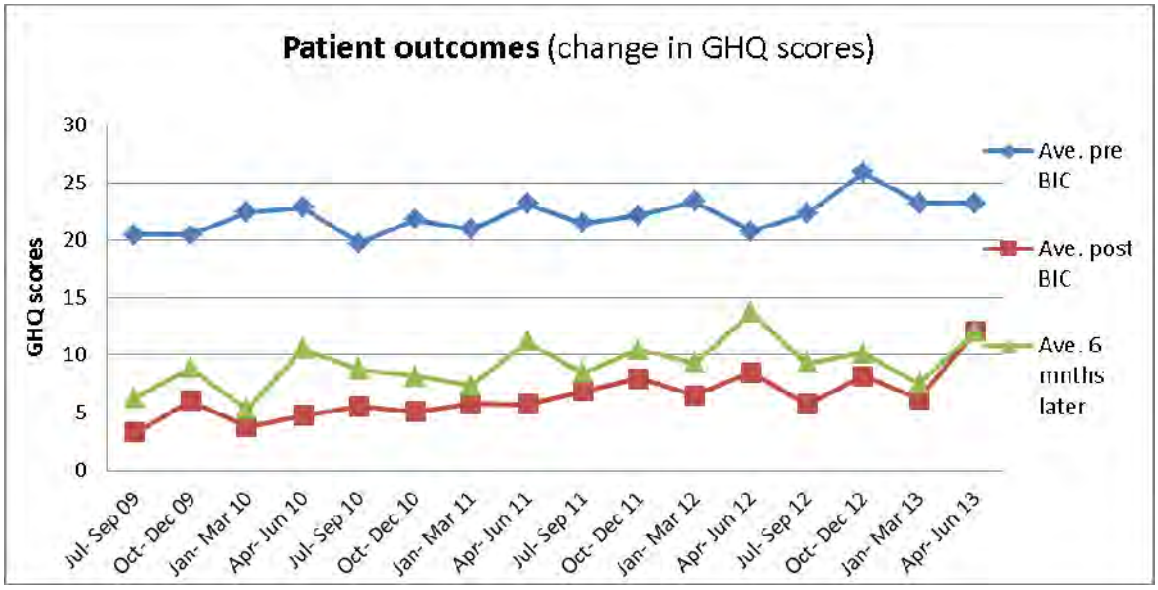





Treatment pathway upon referral
No. unique patients
250
200
150
100
50
0
Assessment
To Be Entered
GPI Care Only
BIC
Referred on
DNE
Jul- Sep 09
Oct- Dec 09
Jan- Mar 10
Apr- Jun 10
Jul- Sep 10
Oct- Dec 10
Jan- Mar 11
Apr- Jun 11
Jul- Sep 11
Oct- Dec 11
Jan- Mar 12
Apr- Jun 12
Jul- Sep 12
Oct- Dec 12
Jan- 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 150 new requests processed this quarter, with 15 (10%) of these people identifying as Maori.
- The number of people entering Brief Intervention Counselling this quarter was 62 with 9 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.
- With the proposed drop to age twelve for youth to enter Brief Intervention Counselling a gap analysis is being undertaken to establish the scope of mental health services being provided currently to this age group. The needs of this group when identified will inform future programme development.

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

- Networking continues to occur with relevant DHB and NGO groups notably this quarter: Rata Te Awhina, DHB Buller GP Liaison Nurse, and Youth Health Action Group. Also team members have attended relevant health sector meetings across the West Coast including Alliance Leadership Team and Mental Health Services review meetings.
- 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. This quarter a team member has completed a Certificate in Hauora and another team member has attended an advanced workshop in co-existing problems for youth.
- All team members continue to attend regular supervision.

4. Issues and Risks

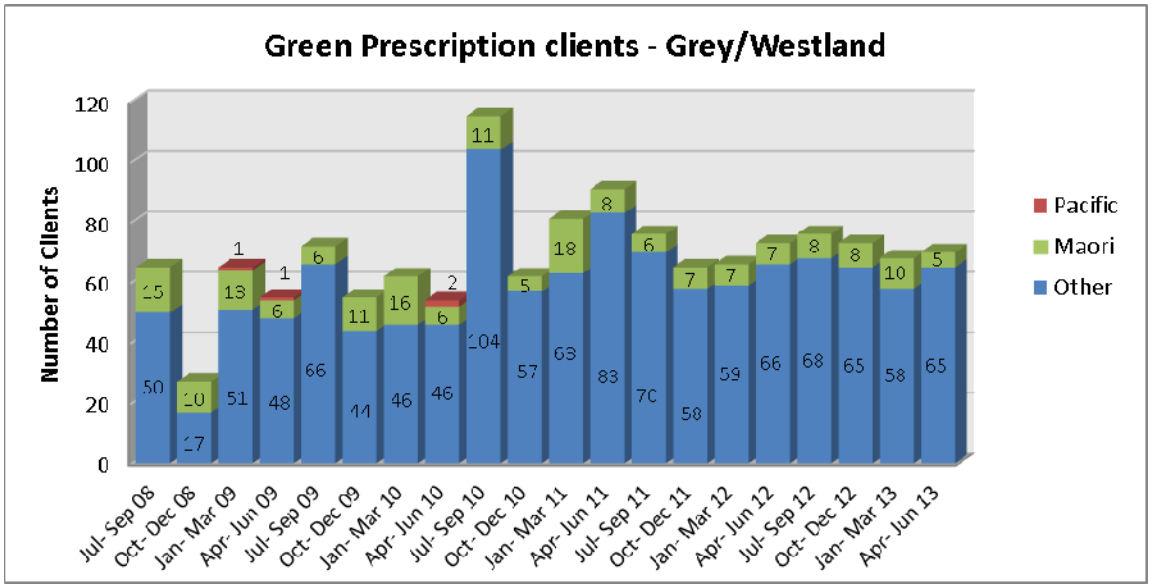
Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

6. Keeping People Healthy

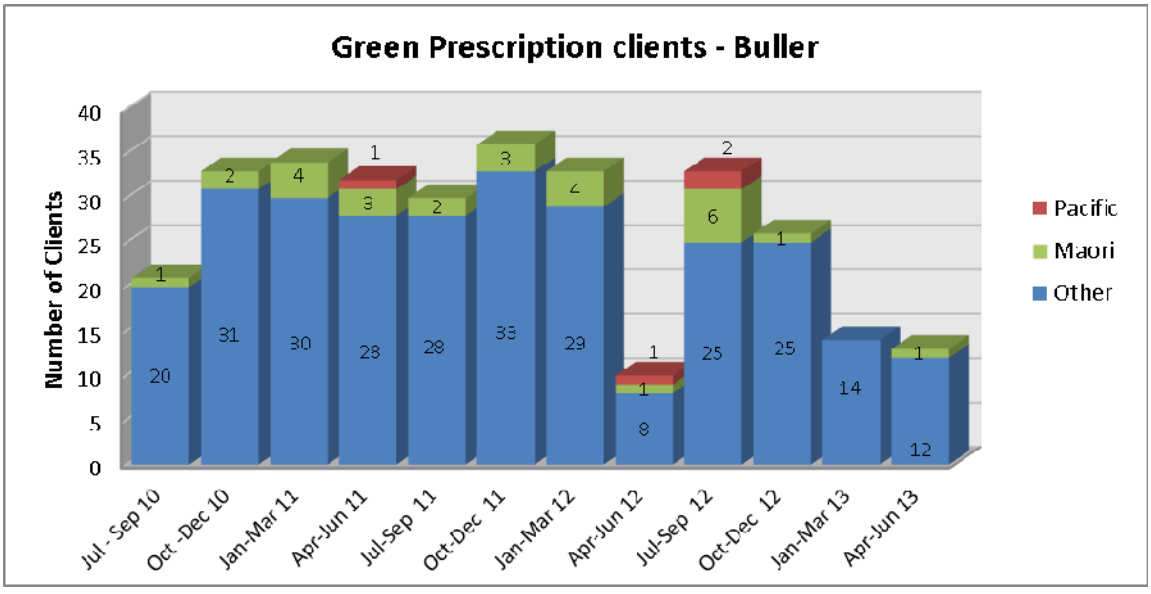
6.1. Green Prescription (GRx)

On target: Yes

1. Outcomes/Outputs



Grey/Westland numbers remain steady. 7.14% (5) referrals were for Maori. Of the quarterly referrals: 78% (55) were female and 21.4% (15) were male.



Buller GRx recommenced in July 2012. Numbers continued to be low this quarter with 13 in total. One referral for the quarter was for Maori. 1 referral was male. There was 1 referral in April, 5 referrals for May, 7 for June.

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;
- Home Builders exercise group 7am Thursday mornings for 12 weeks (09/05/13);
- aquatic sessions every Wednesday at 6pm at Aquatic centre
- Active You Programme started for Nurturing the Future Hub.

Buller:

- Buller GRx programme re-commenced in July 2012, being delivered from the Buller Solid Energy Centre. It involved group based physical activity aimed at independence to be active after the 12 week programme.
- Group gym sessions were being held on two different days and times to suit participants.
- The Buller pilot programme finished at the end of June 2013, with planning underway to continue a Green Rx programme from the Solid Energy Centre.

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

- GRx presentation given monthly to new practice staff at PHO orientation day;
- meeting with Lynette, Aqua session for June "Active You" programme;
- GRx Sport Canterbury Area Manager visit to set up new data base;
- GRx presentation to Health Science group at Polytech;
- GRx presentation and plan Active You programme for the Nurturing the Future Hub.

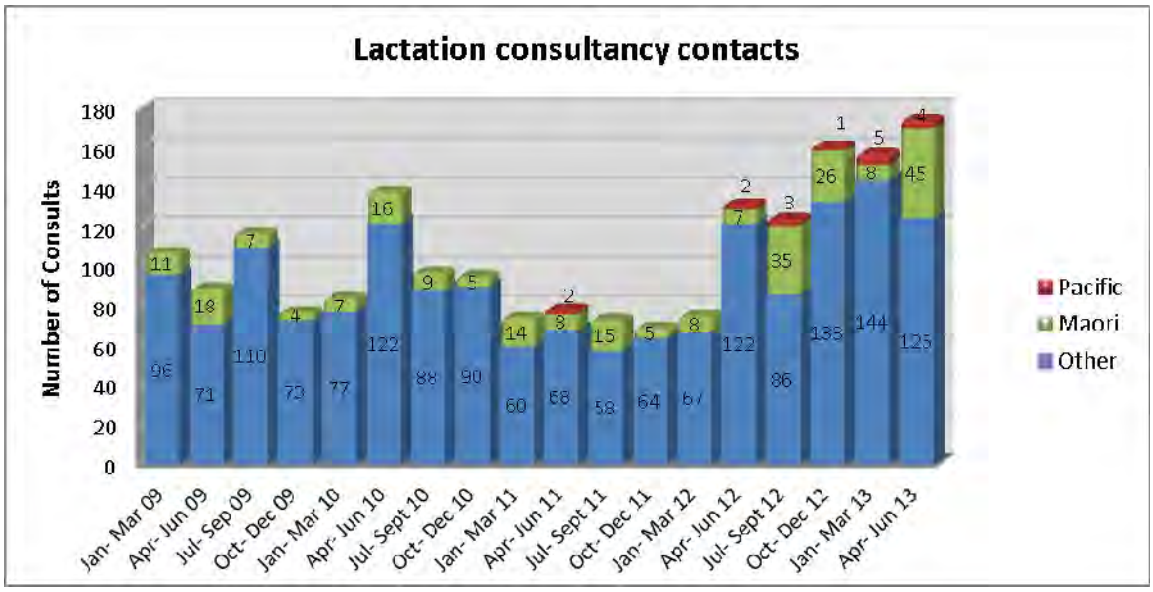
4. Issues and Risks

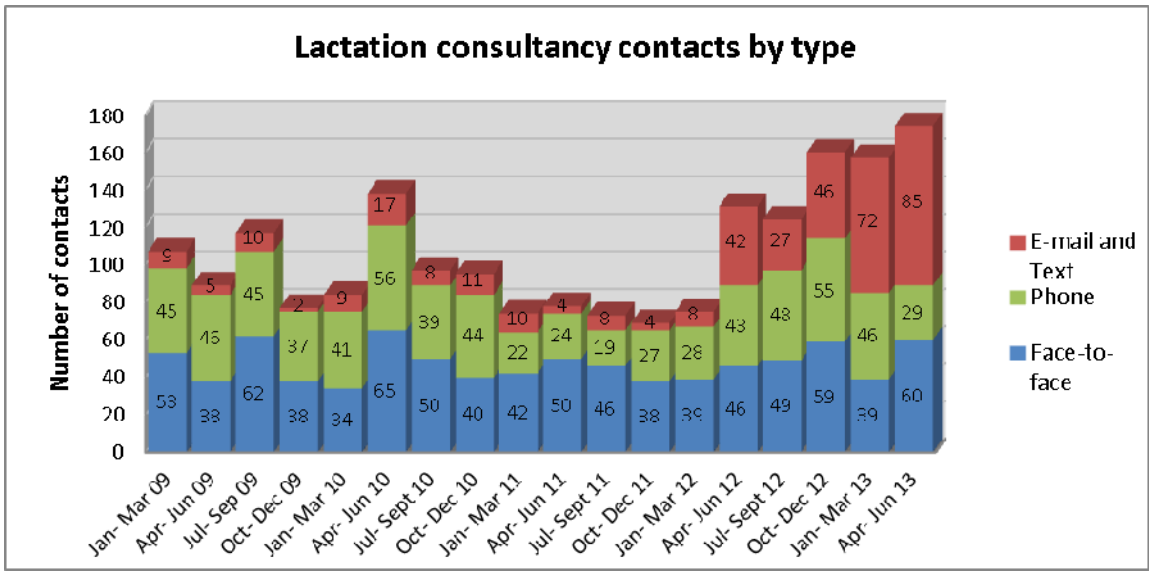
Issues/Risks	Mitigation/Resolution
• Nil.	• Nil.

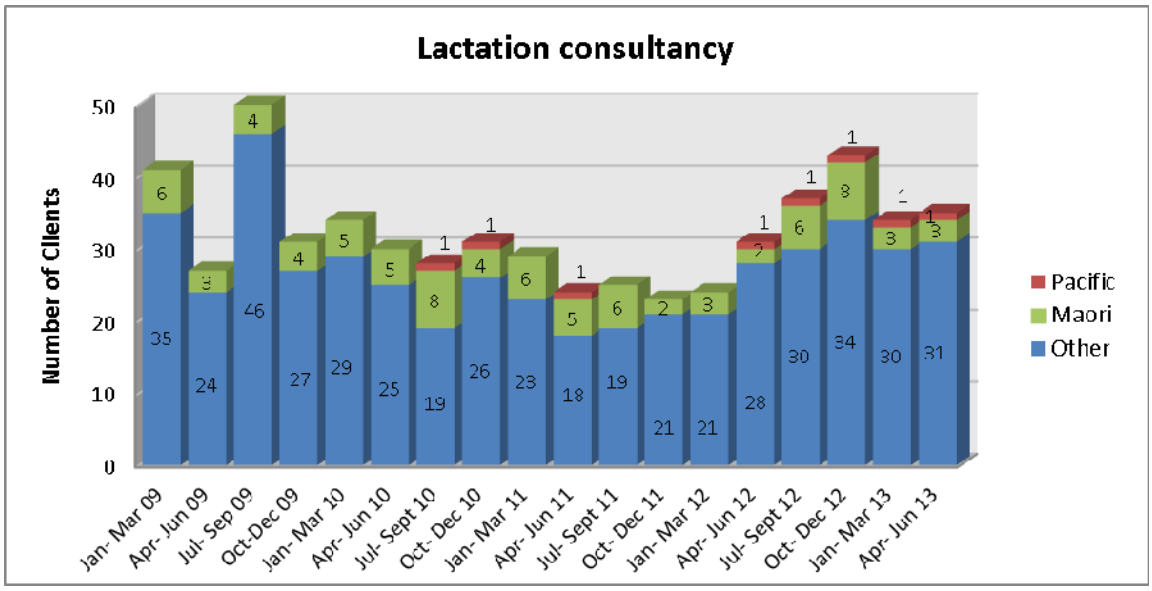
6.2. Breastfeeding Support

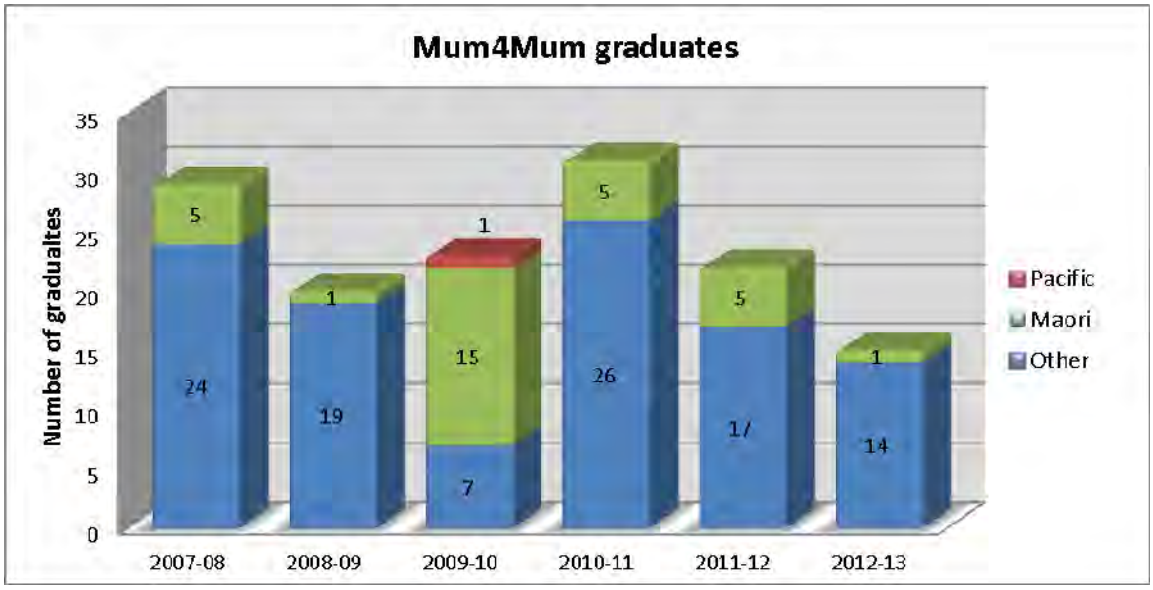
On target: Yes

1. Outcomes/Outputs









2. Key Activities

Lactation consultancy:

- 31 new and 4 returned clients, including 3 Maori, 1 Pacific, and 31 other;
- of these 35 new and returned clients, 16 were Deprivation 8-10, 8 rural; 5 were under 20 years of age and 2 were ante-natal women;
- this quarter there were 174 contacts total; including 45 Maori (12 face-to-face, 14 phone, 0 email, and at least 19 text conversations), 4 Pacific (1 face-to-face, 0 phone, and at least 3 text) and 125 other (47 face-to-face, 15 phone, 4 e-mail and at least 63 text conversations);
- referrals were from women themselves, family/friends, Midwives, Mum4Mums and Well-Child providers,
- referrals were made to GPs, Midwives and Mum4Mums;

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

Peer Counselling:

- Three new graduates in Hokitika. Seven were expected to complete but could not due to unavoidable circumstances;
- Mum4Mum training completed in Reefton with four mums graduating;
- Mum4Mum training completed in Franz Josef with eight mums graduating;
- Mum4Mums attended 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. Some Mum4Mums are play centre supervisors and are committed to providing breastfeeding friendly environments;
- Mum4Mums reported providing at least 16 new people with 'formal' breastfeeding support this quarter;
- Mum4Mums frequently attend BABES-in-Arms, Plunket, play centre and other support groups;
- continuing education Mum4Mum meetings in Westport (2), Reefton (2), Hokitika (1); meeting held in Greymouth with 0 Mum4Mums attending;
- four 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;
- Breastfeeding road show including updates covering support services available and how to access services with Buller Rural Nurse team.

Progress against service plan/contract

- Mum4Mum training target of 17 not met in 2012-2013. The 2011-2012 target of 15 was exceeded at 22 women trained. The target for 2013-2014 is expected to be exceeded.

3. **Networking/Education** (either with Health Sector or Community)
   - Breastfeeding Interest Group meetings held in April and June with representatives from WCDHB, Kawatiri, Mum4Mums, McBrearty, Rata Te Awhina Trust and PHO Breastfeeding Advocates in attendance;
   - on-going contact with others in maternity and Well Child work, including: midwives, Plunket Nurses, Plunket Pepe Co-ordinator and PAFT, Rata Te Awhina Trust, Childbirth Educators, Family Start, Public Health Nurse and Practice Nurses, and other IBCLCs from around NZ;
   - attendance at Child and Youth Committee meeting at DHB;
   - advocate attended the Maternity Quality and Safety Group meeting;

- advocate, in her role as Lactation Consultant acts specifically as a resource person for midwives Coast-wide;
- regular time spent at 'the Hub' for breastfeeding support groups;
- more folders of breastfeeding information provided to McBrearty to remain in the rooms for families to read while there;
- a breastfeeding session was part of the PHO orientations with new practice staff on the West Coast;

Mum4Mums and BABES-in-Arms promoted through:

- Well Child/Tamariki Ora providers on noticeboards at the clinics and via Plunket nurses;
- Maternity Wards – on walls in each room and on the notice boards;
- West Coast Breastfeeding Handbook;
- West Coast Breastfeeding facebook page used frequently to promote BABES-in-Arms;
- Breastfeeding aadvocate has completed 6/10 modules through the Health E-Learning BreastEd series;
- advocate attended 2 x Brainwave Trust presentations in Westport – one on the 1-3 year old brain, and the other on the teenage brain;
- both breastfeeding advocates participated in a webinar: Supporting Employed Mothers with Breastfeeding presented by Cathy Carothers;
- advocate participated in a second webinar: Breastfeeding in Emergencies presented by Karleen Gribble.

4. Issues and Risks

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

6.3. Health Promotion Integration

On target: Yes

1. Outcomes/Outputs

Main outputs this quarter were Health Promotion meetings and visits:

- West Coast Tobacco Free Coalition, 2 meetings this quarter
- Rata Te Awhina Trust – re-brand process support
- Media Interview Technique Workshop
- Practice visits to Ngakawau, Karamea and Coast Medical
- Rusty 'On Retreat' being refurbished – now back

2. Key Activities

Key activities were marketing and media releases-

Influenza – Flu immunisation – (20% increase in early Flu uptake since 2011)
To continue support for, and promote the uptake of flu immunisations press releases were sent out, stickers were produced for pharmacies, and flu resources distributed to Medical Centres. Activities included:

- Ask a Professional – Immunisation story;
- 'Be Flu Strong' Media Release – published in West Coast Messenger;
- flu follow up story – Greymouth Star;
- flu story on 20% increase over 2 years - Greymouth Star;
- 1,000 flu stickers produced for pharmacies to attach to prescription bags;
- flu resources distributed to pharmacies and medical centres.

Smoke-Free May:

- Ask a Professional – smokefree story;
- smokefree resources distributed to pharmacies and medical centres;
- 'manning' of the smoking cessation stand at Mitre 10, 15 people.

Diabetes:

- liaise with Ministry of Health (MoH) regarding diabetes stories; MoH to do follow up story on a local West Coaster.

Men's Health:

- Ask a Professional – Men's Health.

Other:

- media guidelines policy: MT approved, presented to staff at PHO Team Meeting, media sheet;
- Politician's Visit Strategy, visit postponed;
- Feedback competition for youngsters on Facebook;
- orientation presentations;
- media quote regarding new contract for West Coast PHO Chair;
- early planning for annual GPs Conference being held in November;
- discussion and planning for breastfeeding month.

3. **Networking/Education** (either with Health Sector or Community)
Emergency Management System (EMS) meetings:
- involved in a pre-meeting for 'Project Ripahana' as well as attending the event and the post event cold debrief.

CVD Project:
- presentation of prize for February Heart Month to Nora McQuarry, given to one person who had their CV risk assessment completed in February;
- feedback discussion with Cardiac Nurse Specialist on February Heart Month
- CVRA: meeting with Roche to discuss possible purchase of Cobas Machine for CVRA; meeting with Rata Te Awhina and Portfolio Manager Maori Health where attended three meetings to discuss the project for increasing Maori CVRA uptake. Strategy paper was written and circulated;
- attended meetings with practices (Westland Medical, Karamea, Ngakawau clinic) to discuss strategy and engage participation.

4. **Issues and Risks**

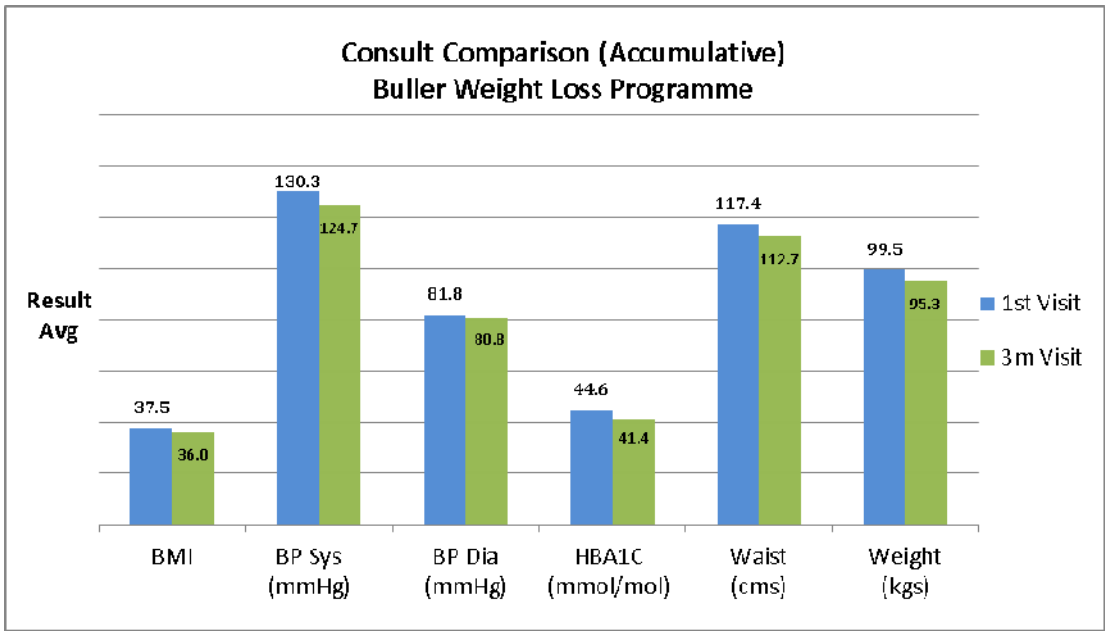
Issues/Risks	**Mitigation/Resolution**
• Nil	• Nil

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

- 13 referrals to the weight loss programme this quarter all Other ethnicity;
- 15% male and 85% female participants;
- 14 people have now had their three month follow-up assessments since beginning the programme;
- 4 people have now had their six month follow-up assessments since the 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;

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
• programme uptake low this quarter • potential cessation of pilot programme beyond 1 July 2013 due to financial prioritisation	• PHO clinical manager support with programme • PHO clinical programme prioritisation process with PHO Clinical governance and Board with recommendations to Alliance Leadership Team early July 2013

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 March 2013:

- Age Appropriate Vaccinations - 8mth Olds - Total Population 72.92% a decrease from 81.54% last quarter;
- Age Appropriate Vaccinations - 8mth Olds - High Need 92.00% an increase from 91.3% 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 March 2013:

- CVD Risk Assessment - Total Population 57.77% similar to 57.98% last quarter
- CVD Risk Assessment - High Need 60.96% a slight increase from 60.05% 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 March 2013:

- Brief Advice and/or Cessation Support/Referral provided to patients seen in last 12 months: Total Population 53.02% another good increase from 44.17% last quarter.
- Brief Advice and/or Cessation Support/Referral provided to patients seen in last 12 months: High Need 53.74% another good increase from 44.72% last quarter.

PHO Performance Programme (PPP)

The PHO Performance Programme (PPP) 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 March 2013

Indicator	Programme Goal	PHO achieved in this quarter	Progress compared to previous quarter	Programme indicator achieved	Comment
Flu Vaccine Coverage – Total Population	≥75	19.45		✗	Current flu season, began March 2013
Flu Vaccine Coverage – High Need	≥75	20.73		✗	Current flu season, began March 2013
Cervical Cancer Screening Coverage – Total Population	≥75	80.22	↑	✓	Continued increase this quarter, reflecting the work undertaken by practice teams
Cervical Cancer Screening Coverage – High Need	≥75	76.33	↑	✓	Continued increase this quarter, reflecting the work undertaken by practice teams

Age Appropriated Vaccinations – 2yr olds – Total Population	≥95	88.78		✗	An increase this quarter with 11 children required to reach target
Age Appropriated Vaccinations – 2yr olds – High Need	≥95	89.29		✗	A decrease (from 90.67%) this quarter with 3 children required to reach target
Age Appropriate Vaccinations - 8mth Olds - High Need	≥85	92.00		✓	Very pleasing results continuing to track above target this quarter, 2 children required to reach target
Age Appropriate Vaccinations - 8mth Olds - Other	≥85	72.92		✗	A decrease this quarter from 81.54 last quarter. 13 children required to reach target
Breast Cancer Screening Coverage – High Need	≥70	74.78		✓	A slight decrease this quarter, target still met
Ischaemic CVD Detection – Total Population	≥90	114.10		✓	Good results continue here
Ischaemic CVD Detection –High Need	≥90	119.87		✓	Good results continue here
CVD Risk Assessment – Total Population	≥75 by 1 July 2013	57.77		✗	Remains steady with the results from the last 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	60.96		✗	Remains steady this quarter
Diabetes Detection – Total Population	≥90	108.81		✓	Remains steady this quarter, good results continue with this indicator
Diabetes Detection – High Need	≥90	108.75		✓	Remains the same as the last quarter, good results continue with this indicator

Diabetes Detection and Follow Up – Total Population	≥90	80.90		✗	A slight decrease this quarter
Diabetes Detection and Follow Up – High Need	≥90	79.46		✗	A very slight decrease this quarter

Cornerstone outputs

No practices underwent any accreditation processes during this quarter.

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

- Draft Foundation Standard for consultation – RNZCGP document for comment sent to all practices.

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.	A CME coordinator has been secured and planning for CME events commenced. Planning to trial Pegasus model of CME for the West Coast, negotiations with Canterbury team underway.
Provide annual PHO QI workshop; practice PHO orientation programme; practice management road shows; practice nurse workshops.	The PHO orientation programme has continued for any new staff from practice teams, occurring 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.	Three training workshops for the Rural Nurse Specialists have been delivered for the combined Reefton, Buller and Moana teams. One workshop has been delivered for the South Westland team with a second one planned for July 2013.
Adapt Canterbury HealthPathways for West Coast use and provide educational sessions to implement them, (see HealthPathways plan).	This process continues.
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. Clinical Audit Tool (CAT) is planned next. Text messaging capability for WCDHB MedTech practices planned for next quarter install.
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. The CAT install was delayed due to IT issues with DHB server, a 'fix' is currently being developed.
Provide PHO Performance Programme incentive payments according to the percentage of targets met by each practice.	These annual incentive payments were made during June 2013.
Support pharmacists to provide feedback to GPs on cost effective prescribing and reducing prescription errors.	The Pharmacy workstream are progressing well towards pharmacist integration into practices across the Coast.
Develop/adopt a patient survey to measure patient satisfaction with the care they receive at their practice or rural clinic.	The 2013 survey is scheduled to occur August 2013

3. Issues and Risks

Issues/Risks	Mitigation/Resolution
Nil.	Nil.