COLLABORATION BETWEEN THE WEST COAST DISTRICT HEALTH BOARD AND THE CANTERBURY DISTRICT HEALTH BOARD

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

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

DATE: **12 June 2009**

HEALTH BOARD COLLABORATION

Executive Summary

1. From a West Coast District Health Board (WCDHB) perspective there is a high degree of innovation and a commitment to collaboration with others, but a need to work with others and to be supported in areas where our capacity or capability is near, or beyond the margins of viability.

2. What is marginally viable in a small system may be quite viable when part of a larger system. The WCDHB seeks to do what it can do safely and sensibly at a local level. Working with Canterbury District Health Board (CDHB) as the largest adjacent DHB in circumstances where it is not safe or sensible to do so locally is an obvious choice under such a criterion.

3. It is self evident that the WCDHB needs to collaborate with others to maintain access to services. With more than 90% of our out of District referrals currently going to Christchurch, adopting CDHB as the principal partner for collaboration is an obvious choice.

4. Such an approach is consistent with all recent government policies and priorities re service provision and planning through regional and inter-district collaborative approaches.

5. From a CDHB perspective the WCDHB's population is also CDHB's population for many services. The WCDHB's population also becomes Canterbury's by default in the event of any service failure or discontinuity, which raises risk for both Boards. The risks are best managed collaboratively. The best risk management for both Boards is collaborative and integrated service design and operation leading to routine interaction that is as smooth and seamless as possible.

6. A degree of inertia has been caused by the scale and complexity of achieving a sustainable future plan for health service delivery to the people of the West Coast. There is a unique opportunity to overcome this through a definite but measured approach to working in collaboration with Canterbury DHB in defined areas.

7. There is immediate advantage in taking this opportunity to pilot some new collaborative initiatives with CDHB without relinquishing the possibility of wider or further collaborative initiatives in the immediate future.

8. A decision to work in closer collaboration with CDHB does not pre-empt the possibility of also working with Nelson Marlborough District Health Board (NMDHB) where there are clear advantages to such an approach.

Purpose

9. The purpose of this paper is to set out the already existing relationship and opportunities for with CDHB so that this is not overlooked when considering the opportunities for closer collaboration with other DHBs (NMDHB)

10. There is an assumption that this paper is being read in conjunction with both the Francis report and with prior knowledge of the specific issues and challenges identified in the Sustainability Project reports.

Background

11. The question of maintaining clinically and financially viable models of service delivery for the West Coast has been the subject of numerous reviews and planning processes over many years.

12. The earlier strategic intent tended to focus on overcoming the challenge of recruiting and retaining a full range of clinical staff and covering the additional cost of this by justifying a case for additional funding over that which the DHB allocated through the standard funding formulas.

13. Over the last three years WCDHB has been through a series of operational reviews and strategic planning processes that has been conceptually different to the many reviews that have taken place before this time.

14. This commenced in 2006 with the development of the Secondary Service Plan as part of the District Strategic Planning process which evolved into Grey Base 2020 and then culminated with the West Coast Sustainability Project undertaken in partnership with the Ministry of health.

15. A fundamentally different principle was adopted for these planning processes and was articulated in a document written by the then CEO (Kevin Hague: ”Redesigning Health Care on the West Coast”) in which he stated the following:

    “It is manifestly obvious that continuing to work in traditional ways and in the ways that we are currently working will not meet these challenges, with the inevitable consequence of widespread system failure and mission failure: the health and independence needs of West Coasters not being met. Therefore fundamental redesign is required, and the West Coast DHB believes it should aim to find the best solutions possible to its challenges.”

    From this came the concept of the “*Burning Platform*”: that doing nothing or attempting to just maintain the status quo was simply not an option for the West Coast.

16. In the three years since this first document was written, a number of the potential risks and dangers highlighted in it have since manifested themselves. It has only been through the significant efforts of both staff and management within the organisation and in many instances, clinical support from CDHB that has enabled us to avoid a significant system failure. This has frequently been at an inordinate cost to the organisation in terms of both financial and human resources.

17. Despite the many challenges, WCDHB has developed a good track record of excellence and innovation in rural service delivery. In particular the models of care for remote rural service delivery, the integration of aspects of primary and secondary service delivery, joint planning on public health and the use of information technology has been widely recognised. Further to this the West Coast has successfully implemented rural immersion development programmes for both Doctors and Nurses and has significant expertise in generalist health service delivery in rural settings.

18. A consistent characteristic of these recent planning processes is that nearly all of the potential solutions identified rely on us having closer collaborative working relationships with our neighbouring districts. Until recently there has been insufficient engagement and support from our neighbouring DHBs for such an approach.

19. While there have always been long standing relationships with CDHB these have tended to be viewed as the fall back position when it has proven difficult to maintain services 'in-District'. As a consequence, the relationship with CDHB has been perceived as variable or unreliable and this has recently led to the WCDHB to look elsewhere for solutions (mainly NMDHB).

Current situation

20. On 4th May 2009, the Chairs of the WCDHB and the CDHB convened a meeting attended by their respective Chief Executives plus other senior clinical and management staff from each District. It was clear to both parties that there was significant enthusiasm and commitment to achieving a greater level of collaboration that both reflects and utilises the skills and knowledge that exist between the Districts to greater advantage for both sides.

21. It was identified that there is in general, and at a Board and Advisory Committee level in particular, a lack of awareness of the degree of both formal and informal collaboration that already exists. The breadth and depth of existing service dependencies and interdependencies, and the weight of existing service flows presents a compelling case for not only maintaining but extending the relationship between the two Districts.

22. The group identified that in addition to the formal agreement with CDHB for the provision of advanced secondary and tertiary services through Inter District Flows (IDFs), there are many other connections and collaborative arrangements in place. There are currently no less than 70 areas across a broad spectrum of both clinical and non-clinical service provision where there is some form of partnership or support arrangement already in place or where there is potential for such an arrangement to be developed (see appendices 1 and 2).

23. The meeting concluded that there was significant benefits for both the WCDHB and the CDHB in cementing the existing arrangements through a more formal agreement or memorandum of understanding as well as exploring the opportunities for extending collaboration in other areas. There are a number of potential strategic benefits and opportunities for both organisations and its stakeholders in taking such an approach. These include

    - Better clinical and financial risk management for both District Health Boards
    - Improved access - right services, right place, right time.
    - Enhanced quality of services.
    - Better clinical outcomes/outcomes for patients/public.
    - Support for clinical quality and improved clinical governance.
    - Improved risk management for clinicians and Boards.
    - Training and development opportunities, for both clinical and non-clinical staff.
    - Opportunities for joint planning and service operation.
    - Better Integration of operational systems, policies, information, etc.
    - Opportunities for incidental or opportunistic efficiencies where practicable.

24. In contrast to previous joint planning discussions, which have led to many ideas but not much action, there is a strong and tangible commitment to achieving a positive outcome within a short time frame.

25. The CDHB and WCDHB have identified several key areas of delivery, which with the appropriate development of new models of care could be implemented on a pilot basis within the next six months.

26. This will not only provide the necessary level of reassurance to both our clinicians and our community but would be a useful pre-requisite to the development of further collaborative arrangements where there is evidence of benefits to be gained. In the first instance the following five areas for piloting a collaboration approach have been identified:

    - Remote support Emergency Department/acute services via telemedicine
    - A collaborative approach on obstetrics and maternity services
    - Shared support for anaesthesiology
    - Exploration of all weather transport for the evacuation and / or retrieval of patients requiring advanced secondary or tertiary level care
    - Examining opportunities for the standardisation of equipment and processes between the two Districts

Cost/benefit analysis

27. It is beyond the scope of this paper to undertake a detailed cost benefit analysis at this stage though such an analysis would need to be part of the scoping process for the pilot initiatives.

28. Regardless of the level of collaboration and support between DHBs there are a number of inherent costs to providing accessible services in dispersed rural communities although a possible early gain from a WCDHB perspective would be a reduction in the current heavy reliance on locum cover (budgeted to cost $7.4m in 2009/2010).

29. Where there is potential significant benefit is in non-financial aspects of improved safety, quality and continuity of clinical and non-clinical services and the potential for shared learning and exchange of ideas between agencies.

30. The main clinical and operational risks for the WCDHB are of key resources shortage leading to service disruption. Best managed by planned support, escalation or fall back arrangements and integrated service design where appropriate.

31. The main risks for CDHB arise with no/short notice service disruption for the WCDHB placing additional unplanned demands on CDHB. This is best managed by agreed support from greater collaboration or, escalation on fall back arrangements and integrated service design where appropriate.

32. In addition, there are opportunities for collective economics and efficiencies in clinical and non clinical support activities.

Conclusions

33. The WCDHB's population also becomes the CDHB's by default in the event of any service failure or discontinuity, which raises risk for both Boards. The risks are best managed collaboratively.

34. The best risk management for both Boards is collaborative and integrated service design and operation leading to routine interaction that is as smooth and seamless as possible.

35. It is therefore in the mutual in the interest of both Boards is to endorse greater collaboration between the organisations, noting the opportunities and benefits of building on the already existing custom and practice between the Districts.

36. Such collaboration between WCDHB and CDHB need not preclude the development of wider collaborative arrangements with either Nelson-Marlborough or through the South Island Health Services Plan.

37. That it is not in the best interest of either DHB to wait for a 'perfect plan' to evolve between all of the interested parties as this will create a real risk of us losing the current impetus and enthusiasm to overcome the inertia of the status quo that exists right now.

Recommendations

38. In order to continue from here and to maintain momentum it is recommended that the Board agrees to the following:

    a. The development of a formal statement of common strategic purpose on collaboration between the WCDHB and CDHB to be brought back for discussion and ratification at the next meeting of the WCDHB.

    b. That the Chief Executives are tasked with developing a joint framework and for further collaboration in the future.

    c. That Senior Clinicians and Management of both DHBs are tasked with developing the terms of reference and a formal project plan for developing and implementing pilot programmes in each of the five areas identified with an end of year (calendar year) timeframe.

CANTERBURY DHB SERVICES TO WEST COAST DHB

MEDICAL – SURGICAL SERVICES	
Tertiary provider under IDF Agreement	
Services	**Comments**
1. General Surgery	Considerable discussion with WCDHB in 2004/5 regarding weekend support for acute cover over there – a proposal formulated - but not confirmed. WCDHB SMOs have been invited to join CME / audit activities.
2. Orthopaedics	CDHB is the tertiary provider of orthopaedics for West Coast. Do not formally provide any services but provide acute cover for the WCDHB when they are not able to do this locally or through NMDHB. Have been involved and will continue so into the future with providing back up to their Surgeons in terms of advice, expertise and supervision within reason (and when practicable). This could mean surgeons visiting CDHB for supervised work etc. CDHB is prepared to look at any arrangement that provides the West Coast community with Orthopaedic services. Privately, Canterbury surgeons manage some of the more complex ACC cases (other ACC cases go to Nelson).
3. Anaesthesia	Provision of Paediatric anaesthetics for operating lists at Greymouth Hospital – approximately 3.5 days pa. Support for WCDHB anaesthetists and Medical Council Registration requirements. Involves anaesthetists working at CDHB for one week supervision and report provided by Clinical Director.
4. Secondary/Tertiary Services Care	Inpatient and outpatients services including attending to GPs' queries across all specialities. **Refer attached** for services provided under IDF. Attending to calls and queries from WC GPs. Telephone assistance, support and advice, clinical management advice to WCDHB clinical staff and arranging for potential transfer of patient requiring tertiary care.
5. Air ambulance/retrieval	Air ambulance/retrieval (Inter-Hospital Transfers)
Outreach Clinics/Services	
Services	**Comments**
6. Respiratory	4-5 Clinics per annum (as required)
7. Neurology	3 clinics per annum
8. Cardiology	6 Clinics per annum Visits have increased up to 12 pa. Patients also comes to Christchurch Hospital for Cardiology and Endoscopy therapeutic and diagnostic procedures
9. Cardiology Technician	Visit up to 6 times per annum
10. Haematology	5-6 Clinics per annum (including Haemostasis patients)
11. Nephrology	4 General Clinics per annum 3 Transplant Clinics per annum
12. Oncology	24 clinics per annum (2 per month)
13. Urology	31 days of clinics or operating sessions pa on a monthly basis. Some patients from WC come to Christchurch Hospital for surgery
14. Vascular	There has been discussion about setting up an outreach clinic (six weekly) but constrained by current resources. Vascular nurses link with community nurses.

WOMEN'S & CHILDREN'S HEALTH	
Tertiary provider under IDF Agreement	
Services	**Comments**
Secondary Care Services	15. Includes amniocentesis and chorionic villus sampling, via our Fetal Medicine Unit, we have been providing complete cover since 2006. 16. Obstetric SMO cover and off site supervision/advice occurring for substantial periods of time in the 07/08, 08/09 years. In 08/09 over 45 women transferred to Christchurch for obstetrics and gynaecology care. The obstetric women received midwifery care via our clinics. Labour and birth support is provided via our core midwives this involves substantial amounts of midwifery resource. St Georges assisted with some planned caesarean sections as CWH was working to capacity. 17. Our Midwifery Clinical Coordinators in Birthing Suite regularly give clinical midwifery advice, particularly after hours. 18. Supervision of incoming overseas SMOs with provision for them to work at CWH for two – three weeks to enable credentialing to occur prior to them commencing on the West Coast, off site supervision thereafter with collegial support via the Clinical Director. 19. Midwifery advice via the Director of Midwifery as required in particular support with the QLP/PDRP coordination and assessment; this also involves our Midwifery Educators. 20. Support to West Coast midwifery staff to complete NZ Midwifery Council education requirements, staff attend some of our educational compulsory days. 21. Gynaecology clinics in Christchurch, all as extras to 2007/08 and will continue possibly until 2010. This includes AGA visits for early pregnancy issues. The CDHB are the sole provider of first and second trimester terminations of pregnancy for WCDHB women. 22. In essence most of the current secondary care as outlined in the MOH service specifications are being provided by the CDHB, with no recognition of this occurring. 23. Engagement and discussions are occurring around future service provision of SMO's as a rotational position. This will include gynaecology clinics on the West Coast and gynaecology surgery.
Outreach Clinics	
Services	**Comments**
Child Health	24. Paediatric on call advice- 24/7. Calls from both WCDHB Nursing staff and SMO's to relevant CDHB clinical staff for advice as well as potential transfer of patient should the condition deemed to be critical and requiring tertiary care. Outreach Nurse support for children with chronic conditions via phone 25. Paediatric Outpatient Clinics- Joint appointment with Paediatric SMO who provides two outpatient clinics monthly and advice via phone- This position is currently filled but not active due to the successful applicant completing his training. Starting date Jan 2010 26. In addition, one SMO undertakes a general clinic every six weeks 27. Paediatric Oncology Services- 24/7 advice and transfer to CCDHB for treatment and outpatient care. 28. Paediatric Surgery on call advice 24/7. Paediatric surgeon work in a private capacity undertakes a list and outpatient clinic every six weeks. 29. Paediatric Neurology on call advice 24/7 and transfer to CCDHB for treatment and outpatient care, as well as outreach nurse support for children on the coast. 30. Neonatal- Provides tertiary and level 2 services for WCDHB. This includes a retrieval service, training of staff to assist with stabilisation of infants pre transfer and outreach nurse support via phone for infants transferred/ discharged home. 31. B4 School Check – telemedicine service

OLDER PERSONS HEALTH

Tertiary provider under IDF Agreement	
Services	**Comments**
32. Bone Clinic	Average of seven clients a month for assessment / treatment
Outreach Clinics	
Services	**Comments**
33. Electro Convulsive Therapy	Average one client per year for treatment which includes inpatient stay of about four weeks
34. Psycho-geriatrician Input	One day per month for consultations
35. Community Dental Service (CDS)	Visits West Coast 3-4 times a year for meetings with dental therapists but not for patient consults. Telephone support re patients as required. Clinical oversight and management support to the service and staff come to CDS for training sessions

REHABILITATION SERVICES	
Tertiary provider under IDF Agreement	
Services	**Comments**
36. Pain Management Clinic	Provides regional Clinical services under the IDF on and as requested basis. Most are ACC and come referred by case managers.
37. Rehabilitation (BIRS)	BIRS take brain injured patients as required- IDF and ACC funding
38. Spinal Services	Services provided in Christchurch – on IDF and ACC basis at Burwood Hospital
Outreach Clinics	
Services	**Comments**
39. Spinal Services	No clinics provided at present. Patients come to Christchurch

MENTAL HEALTH SERVICES	
Tertiary provider under IDF Agreement	
Services	**Comments**
40. ECT Therapy	Hillmorton (AIS) by referral from the West Coast
41. CAF Regional Service contract	Inpatient regional beds for Child and Youth. Consultation/training to the CAMHS team if requested. Daniel Svoboda/Colin Kelly (SMO) is contracted to WCDHB directly part time. There has been a long standing arrangement for our service to provide training and supervision also, however this has not been utilised by the Coast team for some time. As one of the Christchurch CAF Consultants has been directly contracted by the Coast team for some time, this support has not been requested as much as it used to occur in the past. Team members also used to come over to Christchurch to orient to our services.
42. Forensic Regional Service contract	Forensic visits on three monthly basis , more if required , monthly in-service video conf, court liaison training on WCHB delivered recently. Telephone calls We generally visit regions on a three monthly basis and have phone/email contact in between times. In regards to recent contact Dr Jill Buchan and a nurse have visited in September 2008, December 2008, February 2009 and May 2009. These contacts are over a two day period and can include Westport, every second visit, and Greymouth every visit. Dr Buchan has had regular contact with Terry Guilder via phone approximately monthly. This can be around patients visiting Canterbury from the coast or risk management issues.

43. Intellectual Disability Liaison team's contract 44. NGO Regional Services to WCDHB	Covers WCHB but have not had any referrals under IDCC&R act since the new law came in. • AOD supported landlord services – He Waka Tapu • AOD residential services adult and youth – Odyssey House • AOD residential services women – Odyssey AKL • AOD residential services – Nova Trust • AOD residential services – Salvation Army In Primary care the Doctor for sexual abuse has WCDHB cover.
Outreach Clinics	
Services	**Comments**
45. Psychiatrist Visits	SMHS only bills the West Coast for Dr Brinded's and CD services for AOD. Monthly and link in weekly via Telemed as their Clinical Director of AOD as well as being available for any concerns they may have in AOD. Also works there once a month as their weekend locum SMO's attending WCHB are, Stoner (CD,WC,2/10)- CDHB arrangement The following are private arrangement: Buchan (Forensics, regional visits), Boggis (AOD 3/10), Dell ario(AOD,CD 1 W/E 2/52),Foulds and Lacey (share a Locum, 2/10)
46. Director of Area Mental Health Services (DAMHS) Phil Brinded, Director	DAMHS office provides all DAMHS administration for West Coast. We also provide DAO training for the West coast to seen DAOs to three times per year

HOSPITAL SUPPORT AND LABORATORIES	
Services	**Comments**
47. Pathologist	2/10th pathologist time ie access to a pathologist 24/7 for: • enquiries and consultation as well as support • provide the for laboratory pathologist support required to meet IANZ accreditation • Haematologist visits for patient clinics and clinical education • Attendance by a microbiologist for infection control support to lab and hospital infection control nurses regularly.
48. Laboratory Testing Support	Referred testing service for all tests not performed on site at the WCDHB Lab. • Canterbury Health Lab (CHL) provides the logistics (pick up and transport for this service • Scientific, technical and clinical supports are provided for all referred testing as required. • Also supported by the 0800 lab information service operating 24/7. • Access to web-based test database for all test information. • Difficult diagnosis on routine tests performed by WCDHB are referred to CHL for interpretation and reporting.
49. Anatomical Pathology service	As part of the referred testing service CHL provides all the WCDHB anatomical pathology and cytology services and diagnosis. This includes access to pathologists for consultation, education and case review sessions as required.
50. Cytology Service	Full cytology service including both gynae and non-gynae cytology. • Gynae Cytology screening service is provide by a liquid based cytology (LBC) service • LBC is at no charge to patients. • The intention is to supplement this with the benefits of automated screening, which will increase cancer pick up rates, in mid 2009.
51. Laboratory education	To support the laboratory IANZ accreditation CHL provides as part of continuing education to meet MoH requirements for professional development under the Health Practitioner Competency and Assurance (HPCA) Act • access to specialist areas education seminars via teleconference facilities • Also access to laboratory lecture series including overseas speakers lectures (either attendance or videoconference if requested)

52. Laboratory IANZ Accreditation support	Full scientific, technical and clinical support to support the laboratory accreditation including: • Annual place for CHL user group. • Audit and advice from senior scientific staff as required and at a level to support accreditation. • Regular visits to WCDHB by clinical and scientific staff • Inclusion in peer review meetings • Information documentation and support for accreditation needs.
53. Population based disease monitoring (Developing service)	Includes: • provision of data relating to antibiotic susceptibilities resistance and trends. • Access to data warehouse for population data analysis and chronic disease information. • MRSA risk prevalence, monitoring and control strategy. • Test demand trends and management information to promote appropriate utilization and control costs.
54. Lab Information System (Propose, quoted and project scoped)	Ongoing discussions on utilising the CDHB laboratory information system (Delphic) to replace the aging system in place. This would be via Multilab which is also provide to HBDHB, NMDHB and TDHB.

COMMUNITY & PUBLIC HEALTH	
Services	**Comments**
55.	Public health services for WCDHB funded by Ministry of Health are delivered by Community and Public Health, a division of CDHB.

Nursing Support	
Services	**Comments**
56. Oncology	WC Nurses visit once a year for education/chemo support day. On average, we provide telephone advice/support twice a month.
57. NETP	• 4 WCDHB new grads attended study days 18 months to two years ago (12 study days/year). • Training, support and shared resources to Michele Barber in the development implementation of NETP 18 months ago. • Regular meetings and teleconferences 18 months ago.
58. PDRP	• Assessment of six PDRP portfolios to date including teleconference support for interviews • Four days training on site at WCDHB by NC-PDRP over the past 2 years for assessors, resource people and senior nurse managers (mileage/flights and accommodation paid for by WCDHB) • Support and training to Michele Barber re development, implementation and ongoing maintenance of PDRP by NC and PDRP Admin staff • MOU set up and responsibilities for monitoring of adherence to NCNZ standards as CDHB partner programme for PDRP • WCDHB members of PDRP committee, teleconferencing and guidance provided. • Resource sharing, support and training for Angela Bradley and now Karen Kelly •
59. Midwifery Quality Leadership Program	• QLP 6 portfolios assessed including teleconference for interviews • Support and training to Jude Bruce (Midwifery Manager) on assisting her staffs involvement in QLP • Support and training to Michele Barber re development, implementation and ongoing maintenance of QLP • CDHB Midwifery educator support to two WCDHB staff in portfolio preparation • WCDHB members of QLP committee, teleconferencing and guidance provided. • Appeals process management re: QLP portfolio which involved three assessors within the CDHB along with the coordination of a Nelson Marlborough QLP moderator/assessor.
60. PDU	• Sarah Brophy, NE also went to the WCDHB for two days of training re: Nurse Initiated Discharge project (mileage, etc as above paid for by WCDHB)

RURAL FOCUSED HOSPITAL SPECIALIST (POTENTIAL MODEL)

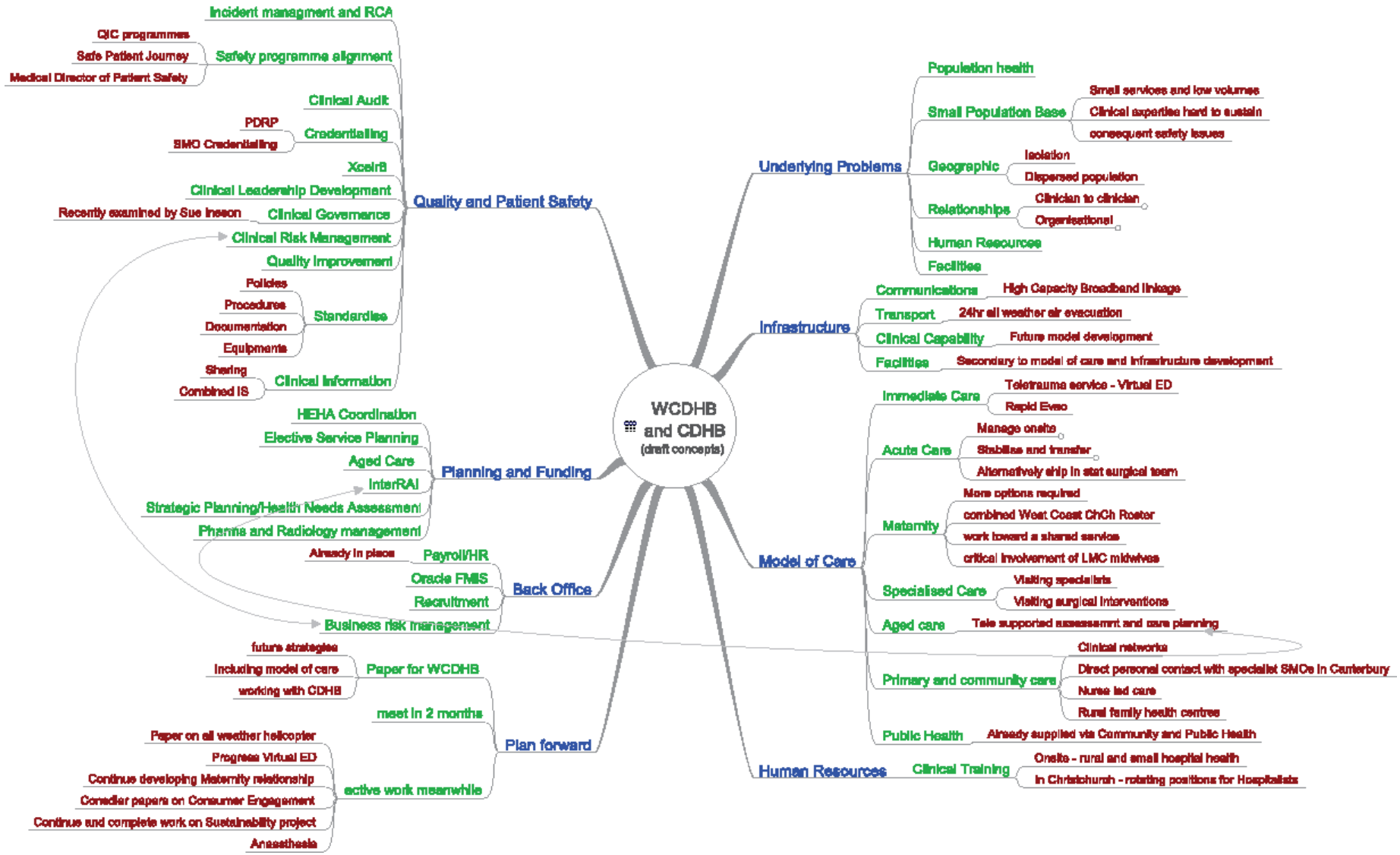
Services	Comments
61. Paediatrics, Ophthalmology, ENT, Nephrology, Neurology (Yet to be discussed in detail)	Martin London, Rural GP and WCDHB Clinical Senior Lecturer in Rural Health has developed a conceptual framwork identifying certain clinical departments who would take on a rural focus through periodic visits to rural practices for consulting, continuing professional development of the clinical staff and assisting in teaching rural immersion students. The consultant from each department would build relationships with the rural practitioners and carry the 'rural bleep' enabling more effective distance support for difficult clinical decision making. At a later stage, when the technology is in place, the support could extend to videoconferencing/video consulting.

HEALTHY EATING – HEALTHY ACTION (HEHA)	
Services	**Comments**
62. CDHB and WCDHB have a collaborative secondment arrangement for the HEHA Manager position. This 1.0 FTE position is shared equally between the DHBs.	This secondment arrangement has been in place since February 2009 and various opportunities for joint planning and programme implementation exists (e.g. Breastfeeding framework, workplace wellness programmes, Cooking Skills to Life Skills Programme implementation, joint training for Community Action Projects).

CLINICAL ENGINEERING SERVICE	
Services	**Comments**
63. Servicing Oxygen Concentrator	Approx 12 Oxygen concentrator repairs per annum
64. Sterile Service Support	Advice on Sterile service delivery, as required

OTHER SERVICES	
Services	**Comments**
65. Payroll	Host system and private applications support. Running Stargarden payroll system. Transition to PsE payroll and HR system planned for later in 2009; Service Level Agreement (SLA) pending. Provide advice re contract configuration and some reporting requirements. All system failures are initially reported to the CDHB payroll team for rectification. Historically the CDHB would manage contract maintenance on the system but WCDHB now manages this eg Updates mainly: PSA Union increases, NZNO Union and bargaining fees increases, etc.
66. Health and Safety (H&S)	A two day review of the WCDHB H&S system was conducted by the CDHB H&S team and as a result of this an SLA has been prepared and is awaiting signature from WCDHB for 12 hours per month H&S support and coaching by CDHB Health and Safety Advisors. A request for assistance with the Occupational Health (OH) function has been made. A plan is underway to scope these requirements for work to commence in June. Possibly, WCDHB would need a 0.5 FTE and some of these tasks would be performed at CDHB as part of our Workforce Shared Service function; with some visits needed to WCDHB in future.
67. Industrial Relations Support and Advice	No formal arrangement in place however we do give support to WCDHB on interpretation and application of collective agreements on an as required basis.
68. Site Redevelopment - Project Management Service	Site Redevelopment Unit in CDHB has acted as the Project Manager on WCDHB's behalf, controlling the design development and supervision of construction of the facility. Eg Dementia Unit project. And will continue to be available to do that.
69. Site redevelopment – lease management service	Site Redevelopment Unit in CDHB manages the lease arrangements for Community Public Health's building at Greymouth.
70. Information System Admin Support	CDHB Information Service Staff on site at West Coast as required.
71. Telecommunication Contracts	CDHB prices implemented for all South Island DHBs.
72. Emergency Care Coordination Team (Air Retrieval,	Ongoing. Coordination by CDHB

Emergency Services)	
73. InterRai for South Island DHBs	Ongoing Information Service project – potentially providing the service to all SI DHBs
74. Support service contracts (potential)	There is significant potential to include the WCDBH into the support service contracts operated through the Division including Food and access to cook chill Cleaning Fleet control and management systems Courier services Travel etc.
75. Supply Chain	Procurement – we previously provided this service to WCDHB in the past (over three years ago) saving WCDHB around $100k We provide telephone assistance & guidance to WCDHB supply dept, eg queries on stock management process, pricing comparison, procurement policy, etc. As required, we negotiate purchasing on behalf of WCDHB, where vol from WCDHB and CDHB can be combined to gain bargaining power.
76. Pandemic Planning – support and training (Potential)	Can provide support in terms of advice or training, with regard to pandemic planning.


WCDHB and CDHB
(draft concepts)
Quality and Patient Safety
Incident management and RCA
Safety programme alignment
QIC programmes
Safe Patient Journey
Medical Director of Patient Safety
Clinical Audit
Credentialling
PDRP
SMO Credentialling
Xcelr8
Clinical Leadership Development
Clinical Governance
Recently examined by Sue Ineson
Clinical Risk Management
Quality Improvement
Standardise
Policies
Procedures
Documentation
Equipments
Clinical Information
Sharing
Combined IS
Planning and Funding
HEHA Coordination
Elective Service Planning
Aged Care
InterRAI
Strategic Planning/Health Needs Assessment
Pharma and Radiology management
Back Office
Already in place
Payroll/HR
Oracle FMIS
Recruitment
Business risk management
Plan forward
Paper for WCDHB
future strategies
including model of care
working with CDHB
meet in 2 months
active work meanwhile
Paper on all weather helicopter
Progress Virtual ED
Continue developing Maternity relationship
Consider papers on Consumer Engagement
Continue and complete work on Sustainability project
Anaesthesia
Underlying Problems
Population health
Small Population Base
Small services and low volumes
Clinical expertise hard to sustain
consequent safety issues
Geographic
Isolation
Dispersed population
Relationships
Clinician to clinician
Organisational
Human Resources
Facilities
Infrastructure
Communications
High Capacity Broadband linkage
Transport
24hr all weather air evacuation
Clinical Capability
Future model development
Facilities
Secondary to model of care and infrastructure development
Model of Care
Immediate Care
Teletrauma service - Virtual ED
Rapid Evac
Acute Care
Manage onsite
Stabilise and transfer
Alternatively ship in stat surgical team
Maternity
More options required
combined West Coast ChCh Roster
work toward a shared service
critical involvement of LMC midwives
Specialised Care
Visiting specialists
Visiting surgical interventions
Aged care
Tele supported assessment and care planning
Primary and community care
Clinical networks
Direct personal contact with specialist SMOs in Canterbury
Nurse led care
Rural family health centres
Public Health
Already supplied via Community and Public Health
Human Resources
Clinical Training
Onsite - rural and small hospital health
In Christchurch - rotating positions for Hospitalists

Author:	**General Manager Planning and Funding – 5 June 2009**