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

ADVISORY COMMITTEE MEETING

27 September 2019

10.30am

St John
Water Walk Road, Greymouth

AGENDA AND MEETING PAPERS

ALL INFORMATION CONTAINED IN THESE COMMITTEE PAPERS IS SUBJECT TO CHANGE

COMMITTEE MEMBERS

WEST COAST DISTRICT HEALTH BOARD

ADVISORY COMMITTEE MEMBERS

Michelle Lomax (Joint Chair)
Elinor Stratford (Joint Chair)
Chris Auchinvole
Jenny Black
Lynnette Beirne
Kevin Brown
Sarah Birchfield
Cheryl Brunton
Paula Cutbush
Helen Gillespie
Chris Lim
Jenny McGill
Chris Mackenzie
Joseph Mason
Edie Moke
Peter Neame
Nigel Ogilvie
Francois Tumahai

EXECUTIVE SUPPORT

David Meates (*Chief Executive)*
Ginny Brailsford (*Team Leader, Planning & Funding)*
Gary Coghlan (*General Manager, Maori Health)*
Mr Pradu Dayaram *(Medical Director, Facilities Development)*
Michael Frampton *(Chief People Officer))*
Carolyn Gullery *(Executive Director, Planning, Funding & Decision Support)*
Brittany Jenkins (*Director of Nursing)*
Dr Cameron Lacey *(Medical Director, Medical Council, Legislative Compliance and National Representation)*
Jacqui Lunday-Johnstone (*Executive Director, Allied Health)*
Dr Vicki Robertson (*Medical Director, Patient Safety and Outcomes)*
Karalyn van Deursen (*Executive Director, Communications)*
Stella Ward *(Chief Digital Officer)*
Philip Wheble (*General Manager, West Coast)*
Justine White (*Executive Director, Finance & Corporate Services)*
Kay Jenkins (*Board Secretary)*

AGENDA

WEST COAST ADVISORY COMMITTEE MEETING
To be held at St John, Water Walk Road Greymouth
Friday 27 September 2019 commencing at 10.30am

ADMINISTRATION — 10.30am

Karakia

Apologies

1. **Interest Register**
   Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.

2. **Minutes of the Previous Meeting**
   - *9 August 2019*

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

DECISION PAPERS — 10.35am

4.	**Environmentally Sustainable Health Care: Position Statement**	Gail MacLauchlan *Community & Public Health*	*10.35am – 10.45am*

PRESENTATIONS — 10.45am

5.	**Maori Health**	Gary Coghlan *General Manager, Maori Health*	*10.45am – 11.30am*

REPORTS — 11.30am

6.	**Community and Public Health Update**	Gail McLauchlan *Regional Manager, Community and Public Health*	*11.30am – 11.40am*
7.	~~**Disability Action Plan Update**~~ *(Deferred until November Meeting)*		
8.	**Alliance Update**	Jenni Stephenson *Programme Manager, West Coast Alliance*	*11.40am – 11.50am*
9.	**Planning & Funding Update**	Carolyn Gullery *Executive Director, Planning & Funding & Decision Support*	*11.50am– 12noon*
10.	**Operational Update**	Philip Wheble *General Manager, West Coast*	*12noon – 12.20pm*

ESTIMATED FINISH TIME — 12.20pm

INFORMATION ITEMS

- **Disability Directorate e-Newsletter**
- **2019 Committee Work Plan – Working Document**
- **West Coast DHB 2019 Meeting Schedule**

NEXT MEETING

Date of Next Meeting: Friday 1 November 2019

KARAKIA

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.

WEST COAST DISTRICT HEALTH BOARD ADVISORY COMMITTEE MEMBERS INTERESTS REGISTER

Name	Interests	Pecuniary (Y/N)	Type of Conflict (Actual / Perceived / Potential)
Elinor Stratford **Joint Chair**	• Clinical Governance Committee, West Coast Primary Health Organisation The West Coast PHO Clinical Governance Committee (CGC) act as an advisory committee to its Board. The CGC's role is to assist the Board with any clinical aspects that relate to its business.	N	Perceived
	• Active West Coast – Committee Member Active West Coast (AWC) is a network of agencies and groups committed to improving the health of West Coasters through the promotion of healthy life styles such as physical activity, nutrition, smoke free, youth and older person's health.	N	Perceived
	• West Coast Sub-branch - Canterbury Neonatal Trust – Chairperson	N	Perceived
	• Canterbury Neonatal Trust – Trustee The primary focus of The Neonatal Trust (Canterbury) is to support families who are going through or have been through a neonatal journey.	N	Perceived
	• Accessible West Coast Coalition Group – Member A group that works together to improve access to all aspects of the community.	N	Perceived
	• Kowhai Project Committee - Chair The Kowhai Project, is a community project and is raising money to provide an inner courtyard for staff, patients and visitors including plantings for the entry and the parking areas at the new Te Nikau, Grey Hospital and Health Centre	N	Perceived
	• MS - Parkinsons New Zealand – West Coast Committee Member MS Parkinsons provides education, information and help people make informed decisions about living with Parkinson's.	N	Perceived
Michelle Lomax **Joint Chair**	• Daughter is a recipient of WCDHB Scholarship	N	
	• Community Law Canterbury - Part-time Advisor on Disability Issues	N	
	• Daughter is part of the Rural Medicine Emerging Programme in Greymouth	N	
	• People's Choice candidate for Christchurch Central Ward Community Board	N	
	• Pharmacy Council – lay member	N	

Chris Auchinvole **Board Member**	• Director Auchinvole & Associates Ltd • Trustee, Westland Wilderness Trust • Justice of the Peace Justices of the Peace carry out important functions in the administration of documentation and justice in New Zealand • Daughter-in-law employed by Otago DHB	N N N N	
Lynnette Beirne	• Patron of the West Coast Stroke Group Incorporated • Daughter employed as nurse for West Coast DHB • Consumer Representative on WCDHB Stroke Coalition Committee • Running a Homestay for DHB Students & Staff • Member, Accessible West Coast Coalition Group • Consumer Representative on West Coast DHB Health of Older Persons Committee	N N N N N N	Perceived Perceived
Sarah Birchfield	• Member, Accessible West Coast Coalition Group • Member West Coast DHB Consumer Council • Member, West Coast DHB Child & Youth Committee • Member, Canterbury/West Coast Action Plan Committee	N N N N	
Jenny Black **Board Chair**	• **Chair, Nelson Marlborough District Health Board** Appointed as Chair for a third term by the Minister of Health. Member of Statutory Committees and Audit Committee. • **Chair, South Island Alliance Board** The South Island Alliance enables the regions five DHBs to work collaboratively to develop more innovative and efficient health services than could be achieved independently. • **Chair, National DHB Chairs** Elected position from the National DHB Chairs. • **West Coast Partnership Group** This is a Partnership Group set up by government to provide governance for the facilities development of the new Grey Hospital & Health Centre and a health facility at Buller. • **Health Promotion Agency (HPA) – Member** The Health Promotion Agency is an evidence-based health promotion organisation, influencing all sectors that contribute to health and wellbeing. Their key role is to lead	Y N N N	Perceived Perceived Perceived

	and support health promotion initiatives to: promote health and wellbeing and encourage healthy lifestyles; prevent disease, illness and injury; enable environments that support health, wellbeing and healthy lifestyles; and reduce personal, social and economic harm.		
Kevin Brown **Board Member**	• West Coast Electric Power Trust - Trustee The West Coast Electric Power Trust was formed in 1992 as a consequence of the passing of the Energy Companies Act 1992. The six Trustees hold the shares of Westpower Ltd and the associated companies on behalf of the electricity consumers of the West Coast. • Diabetes West Coast - Patron and Member • West Coast Juvenile Diabetes Association - Trustee Diabetes West Coast provides services for people with diabetes. • Greymouth Lions Club – Member • Justice of the Peace Justices of the Peace carry out important functions in the administration of documentation and justice in New Zealand • West Coast Rugby League - Hon Vice President West Coast Rugby League is a sporting organisation	N N N N N N	Perceived Perceived Perceived
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	N N N N N N N N	
Paula Cutbush	• Owner and stakeholder of Alfresco Eatery and Accommodation • Daughter involved in Green Prescriptions • Justice of the Peace	N N N	
Helen Gillespie **Board Member**	• Department of Conservation – Employee - Partnerships Manager. My current role with DOC is to lead Healthy Nature Healthy People – an initiative seeking to make a	N	

	positive difference to the lives of all New Zealanders through nature. • Husband works for New Zealand Police – Based in Hokitika and currently working in the Traffic Safety Team • Accessible West Coast Coalition Group - Member - I represent the Department of Conservation in the Coalition Group. The Department, like many other agencies and organisations is seeking to create greater accessibility for people • Kowhai Project Committee – Member - I am a member of this committee in a voluntary capacity and am able to share examples of nature in health settings to support patients, staff and visitors.	N N N	
Chris Lim	• No interests to declare		
Chris Mackenzie **Board Deputy Chair**	• **Development West Coast** – Chief Executive Development West Coast (DWC) was set up as a Charitable Trust in 2001 to manage, invest and distribute income from a fund of $92 million received from the Government. It is governed by a "Deed of Trust" which specifies DWC's Objects - to promote sustainable employment opportunities; and generate sustainable economic benefits for the West Coast, both now and into the future. • **Horizontal Infrastructure Governance Group** – Chair A Memorandum of Understanding was agreed in September 2013 between the Government and the Christchurch City Council to create this group to focus on lessons learned from one of New Zealand's most challenging civil engineering projects: rebuilding the earthquake damaged pipes, roads, bridges and retaining walls in the city of Christchurch 2011 - 2016. • **Mainline Steam Trust** – Trustee Mainline Steam is an organisation devoted to the restoration and operation of historic mainline steam locomotives. • **Christchurch Mayors External Advisory Group** – Member An External Advisory Group set up by Government and the Christchurch City Council to provide independent advice on Christchurch City Council's long-term capital works programme and related spending plans.	N N N N	
Jenny McGill	• Husband employed by West Coast DHB • Peer Support – Mum4Mum • Member, Accessible West Coast Coalition Group	Y N N	
Joseph Mason	• Representative of Te Runanga o Kati Wae Wae Arahura • Employee Community and Public Health, Canterbury DHB	N Y	Perceived

Edie Moke **Board Member**	• South Canterbury DHB – Appointed Board Member; Chair: Disability Support Advisory Committee; Deputy Chair: Maori Health Advisory Committee; and Member: Audit and Assurance Committee • Nga Taonga Sound & Vision - Board Member (elected); Chair: Assurance and Risk Committee; and Member: Property Committee Nga Taonga is the newly merged organisation that includes the following former organisations: The New Zealand Film Archive; Sounds Archives Nga Taonga Korero; Radio NZ Archive; The TVNZ Archive; Maori Television Service Archival footage; and Iwi Radio Sound Archives.	Y N	Perceived
Peter Neame **Board Member**	• White Wreath Action Against Suicide – Board Member and Research Officer White Wreath is a non-denominational, non-political and anti-discriminatory body supporting people who have been directly affected by suicide and those who are affected by mental illness/disorders. • Author and Publisher of "Suicide, Murder, Violence Assessment and Prevention" 2017 and four other books.	N N	Perceived
Nigel Ogilvie **Board Member**	• Westland Medical Centre - Managing Director • Thornton Bruce Investments Ltd - Shareholder/Director • Hokitika Seaview Ltd - Shareholder • Tasman View Ltd - Shareholder, • White Ribbon Ambassador for New Zealand • Sister is employed by Waikato DHB • West Coast PHO - Board Member • Wife is a General Practitioner casually employed with West Coast DHB and full time General Practitioner and Clinical Director at Westland Medical Centre • Wife is Board Member West Coast PHO	Y N N N N N Y Y Y	Actual Perceived Actual Perceived
Francois Tumahai **Board Member**	• Te Runanga o Ngati Waewae – Chair This is one of 18 Ngai Tahu regional Papatipu Rūnanga which exist to uphold the mana of their people over the land, the sea and the natural resources. Te Rūnanga o Ngāti Waewae is based at Arahura a short distance from Hokitika on the West Coast. • Poutini Environmental - Director Poutini Environmental is the authorised body for resource management, cultural impact assessment and resource consent certification. • Arahura Holdings Limited – Chief Executive • West Coast Regional Council Resource Management Committee – Member	N N N	

	Provides a broad direction and framework for managing the West Coast's natural and physical resources under the Resource Management Act 1991.	N	
	• Poutini Waiora Board - Chair Poutini Waiora is a Maori Health and Social Service provider that delivers holistic care to whanau across Te Tai O Poutini.	Y	Actual
	• Development West Coast – Trustee Development West Coast (DWC) was set up as a Charitable Trust in 2001 to manage, invest and distribute income from a fund of $92 million received from the Government. It is governed by a "Deed of Trust" which specifies DWC's Objects - to promote sustainable employment opportunities; and generate sustainable economic benefits for the West Coast, both now and into the future.	N	
	• West Coast Development Holdings Limited – Director	N	
	• Putake West Coast – Director This is a joint venture between Development West Coast and Putake Honey to develop a West Coast wholesale honey business.	N	
	• Ngai Tahu Pounamu – Director Waewae Pounamu is the home of Ngāti Waewae Pounamu carving	N	
	• Westland Wilderness Trust – Chair	N	
	• West Coast Conservation Board – Board Member The West Coast Tai Poutini Conservation Board serves a conservation advisory role, along with offering community perspective on conservation management issues for the West Coast region.	N	
	• New Zealand Institute for Minerals to Materials Research (NZIMMR) – Director	N	
	• Westland District Council – Councillor	N	
	• Tatau Pounamu – Committee Member	Y	Perceived

MINUTES

DRAFT
MINUTES OF THE WEST COAST ADVISORY COMMITTEE
held at St John, Water Walk Road, Greymouth
on Friday 9 August 2019 commencing at 10.30am

PRESENT

Elinor Stratford (Joint Chair – in the Chair); Chris Auchinvole; Lynnette Beirne; Jenny Black; Sarah Birchfield; Kevin Brown; Dr Cheryl Brunton; Paula Cutbush; Helen Gillespie; Chris Lim; Michelle Lomax; Chris Mackenzie; Jenny McGill; Joseph Mason; Edie Moke; Peter Neame; Nigel Ogilvie; and Francois Tumahai.

APOLOGIES

There were no apologies

EXECUTIVE SUPPORT

David Meates (Chief Executive); Philip Wheble (General Manager, West Coast); Pradu Dayaram (Medical Director, Faciities); Brittany Jenkins (Director of Nursing); Mardi Postill (Planning & Funding); Imogen Squires (Communications); Karalyn van Deursen (Executive Director, Communications); and Kay Jenkins (Minutes).

IN ATTENDANCE

Gail McLauchlan, Regional Manager, Community & Public Health – Item 6

Joe Mason opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions or alterations to the Interest Register.

Declarations of Interest for Items on Today's Agenda
There were no interests declared for items on today's agenda.

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

2. MINUTES OF THE PREVIOUS MEETING

Resolution (8/19)
(Moved: Michelle Lomax/Seconded: Jenny McGill - carried)

"That the minutes of the meeting of the West Coast Advisory Committee held on 10 May 2019 be confirmed as a true and correct record with the addition of Peter Neame as an attendee."

3. CARRIED FORWARD/ACTION ITEMS

The Carried Forward/Action Items were noted.

4 PRESENTATION - AGEING WELL ON THE WEST COAST

Mardi Postill, Planning & Funding, provided the Committee with a presentation "Are we Ageing Well on the West Coast?"

The presentation provided information regarding what the data says about this and it was noted that some really great work has been done with more people living in their own homes and this is better than the South Island average. Other data included falls statistics and acute re-admission rates.

It was noted that the Ministry, in 2016, issued the Healthy Ageing Strategy and the presentation showed the desired outcome and enablers of this strategy. An example of one of the outcomes was provided and Ms Postill explained FIRST and Community Bundles and these worked.

The Chair thanked Mardi for her presentation.

5. PRESENTATION – DRINKING WATER UPDATE

Cheryl Brunton, Medical Officer of Health, provided a presentation on Drinking Water.

The Committee noted that a number of disease causing organisms can be contracted through water. Ms Brunton provided an overview of imformation provided previously including: microbial contamination of water; exposure pathways; the burden of water borne disease in New Zealand; the Havelock North outbreak in 2016; protection using multiple barriers; monitoring; compliance and the law.

Ms Brunton provided statistics around West Coast water and recent West Coast drinking water incidents and provided information around regulatory reform of three waters.

The Chair thanked Cheryl for her presentation.

6. COMMUNITY AND PUBLIC HEALTH UPDATE

Gail McLauchlan, Regional Manager, Community & Public Health presented the Community & Public Health update. She provided an updates on activity around: Alcohol; Smokefree; Healthy Public Policy; Drinking Water and the annual drinking water survey currently underway; Nutrition; and physical activity.

The update was noted.

Jenny McGill departed the meeting at 12.10pm

7. ALLIANCE UPDATE

Dr Cheryl Brunton, Acting Chair, Alliance Leadership Team presented this update which was taken as read.

It was noted that at the June meeting the ALT:

- Reviewed the whānau ora model of care that has been successfully tested with a hard to reach group of diabetic patients at Buller Health and have therefore supported the extension of this way of working with more patients;

- Were pleased to review the draft West Coast Maternity Strategy and have agreed to support wider distribution for further community consultation; and
- Comprehensively reviewed the work stream work plans for 2019/20 and requested further work be done on these to reflect the expected priorities.

At last night's meeting the new Chair, Kevin Hague, was welcomed and the ALT approved all the work stream plans apart from one and this will be presented at the next meeting.

The update was noted.

8. OPERATIONAL UPDATE

Philip Wheble, General Manager, West Coast, presented the Operational update.

Mr Wheble's report highlighted the following notable features:

- The format of the report has been slightly changed based on feedback from the Committee. This will continue to be developed, particularly as we progress in our organisational change to show reporting across the three localities.
- The recruitment of Rural Generalist consultants is advancing well. The recruitment team will be promoting the West Coast by attending medical conferences in the coming months and are looking at developing a promotional video.
- A daily briefing at 8:30am has been initiated and includes services across the Coast, ensuring that we remove barriers to patients getting treated promptly and that care is provided in the best location.

Discussion took place regarding the 100% achievement in B4School Checks and it was noted that an number of changes were made that influenced this result.

Discussion also took place regarding outpatient DNAs and there is a continued focus on this.

Mr Wheble spoke regarding ESPI results detailed in the report as follows:

ESPI 2 FSA (First Specialist Assessment)
There were 72 patients waiting over 120 days for their outpatient First Specialist Assessment as at the end of May 2019. Of these, 32 were orthopaedic cases and 28 were plastic surgery cases. The remaining cases were spread among a number of specialties, including general surgery (3), general medicine (2), haematology (2), and neurology (5). Both the West Coast and Canterbury DHB orthopaedic services have faced similar non-compliance issues due to service constraints; however additional sessions have been engaged to progressively provide those current patients with prolonged waiting times with an appointment booking. Patients who were waiting over 120 days on the general medical and general surgical outpatient lists at the end of May have been delayed due to other clinical complications in two instances; while three among them have respectively been given previous appointments within 120 days of initial referral, but then failed to attend. Those with prolonged waits for haematology and neurology were influenced by a quirk of the timing between the visiting specialist clinics rather than any capacity issue; with all having booked to a firm appointment at the next available clinic.

Some patients who are indicated as being over the 120-day target have previously been offered appointments, but not turned up at their clinic appointments; the reasons for which may be quite variable depending on the individual patient and their particular circumstances. They have been left on our waiting lists for re-booking, so as to offer them additional appointment dates to see a Specialist, rather than being simply removed and their referral returned to their primary care referrer.

ESPI 5 (Treatment)

Nineteen patients were waiting over 120 days from FSA to surgical treatment as at the end of May 2019. Additional plastic surgery theatre and outpatient sessions have been delivered to help address the back-log to the service, but the risk remains that this will only help to keep pace with the increased demand rather than reduce or remove it. Outpatient clinic and theatre list mix of the visiting specialists are being reviewed as a possible option to help smooth this out. Wait times on the orthopaedic surgical waiting list continue to reduce with additional visits from Canterbury specialists being undertaken. Patients who were waiting over 120 days for dental surgery at the end of May have since been treated or provided with a firm appointment date for surgery. The dental waiting list still has a new set of patients who are moving into the 120 day wait period for surgery which is likely to see a maximum wait time target breach in this service continue into June and July.

The update was noted.

INFORMATION ITEMS

- Disability Directorate e-Newsletter
- West Coast DHB 2019 Meeting Schedule
- 2019 Committee Work Plan – working Document

There being no further business the meeting concluded at 12.25pm.

Confirmed as a true and correct record:

_____ _____

Elinor Stratford, Joint Chair Date

ENVIRONMENTALLY SUSTAINABLE HEALTH CARE: POSITION STATEMENT

TO: **Chair and Members**
West Coast Advisory Committee

SOURCE: **Community & Public Health**

DATE: **27 September 2019**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The South Island Public Health Partnership has created a Sustainability Position Statement. This Position Statement is being presented to each South Island Board for approval.

2. RECOMMENDATION

That the Committee recommends to the West Coast DHB Board that it:

i. supports the direction of travel of the attached Sustainability Position Statement, noting that the DHB will work towards achieving an environmentally sustainable health system; and
ii. notes that before fully committing to the programme some clarity is required around costs, funding and resourcing.

3. SUMMARY

The purpose of this position statement is to describe the commitment of the West Coast District Health Board to achieving an environmentally sustainable health system and the actions needed to accomplish this. This position statement builds on the South Island District Health Boards' current environmental sustainability commitments and actions and sets out our approach to managing environmental impacts, reporting on our sustainability performance, and delivering environmentally sustainable patient-centred health care services – to 2050.

4. DISCUSSION

The position statement and accompanying actions enable South Island District Health Boards to work both collaboratively and independently to ensure an appropriate focus and response to sustainability.

5. APPENDICES

Appendix 1: Environmentally Sustainable Health Care Position Statement

Report prepared by: South Island Public Health Partnership

Report approved for release by: Evon Currie, General Manager, Community & Public Health

Environmentally Sustainable Health Care: Position Statement

2019

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

SOUTH ISLAND ALLIANCE

Contents

POSITION STATEMENT

Purpose

The purpose of this position statement is to describe the commitment of the XXXX District Health Board to achieving an environmentally sustainable health system and the actions needed to accomplish this. This position statement builds on the South Island District Health Boards' current environmental sustainability commitments and actions and sets out our approach to managing environmental impacts, reporting on our sustainability performance, and delivering environmentally sustainable patient-centred health care services – to 2050.

Definition

The World Health Organization (WHO) defines an environmentally sustainable health system as:

> '*A health system that improves, maintains or restores health, while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and well-being of current and future generations'* (WHO, 2017, p. IV).

Scope

The focus of this position statement and background paper is on human-caused global warming[1] and the resultant global climate change, because human-caused global warming has been identified as *the* most pressing environmental change currently occurring [1-3].

Position

Note: (page numbers) refer to the corresponding sections of the Background Paper

At the 2015 Paris Climate Conference (COP 21), the New Zealand Government affirmed New Zealand's commitment to limiting the increase in global average temperature to well below 2°C above pre-industrial levels (page 10) [4,5]. XXX District Health Board acknowledges New Zealand's commitment to the 2015 Paris agreement and:

1.1. recognises the impending impacts of global climate change on human health as *the* most pressing environmental issue in the immediate future (alongside other aspects of environmental protection such as resource use, waste, and water) (page 10 & 11)

1.2. recognises that significant ill-health effects will result from ongoing unchecked climate change, and other environmental impacts, and as the burden of this harm will likely be carried disproportionately by some population groups, special attention to equity and Treaty of Waitangi issues is required (pages 11–12)

1.3. acknowledges that the health sector has the ability and the responsibility to advocate for public health by communicating the threats and opportunities to the public and policy makers and ensuring that climate change is understood as a central issue for human wellbeing (page 13)

... continued

[1] In this Position Statement, the term *global warming* refers to a gradual increase in average global surface temperature (as one of the consequences of anthropogenic emissions) and the term *climate change* describes the resultant amplification of natural climate variability (i.e., the portion of climatic variability that is attributable to human activities).

1.4. acknowledges that health care systems' contributions to New Zealand's total greenhouse gas emissions are significant, and environmental sustainability within health care involves ensuring the efficient management of all physical, financial, and human resources within the sector, including upstream inputs of goods and services and downstream clinical and non-clinical waste, (pages 14–17) and

1.5. recognises that health systems can benefit directly (e.g., improved efficiency) and indirectly (e.g., via a healthier population) from implementing environmentally sustainable actions as business-as-usual (pages 18–21, & Appendix).

Actions

XXX District Health Board will:

2.1. advocate for health by demonstrating sustainability leadership in the community, and by communicating the threats and opportunities to the public and policy makers to ensure that climate change is understood as a central issue for human wellbeing (page 13)

2.2. develop the system-wide resource capacity and capability to effect change; including the establishment of a South Island network, group, or entity with the means to work collaboratively to develop, embed and promote environmentally sustainable health systems (page 13 & Appendix)

2.3. participate in a regional project to measure the total carbon footprint of the South Island District Health Boards, and identify the main areas that could be improved (emission *hot-spots*). In order to achieve this, the South Island District Health Boards commit to expanding the scope of measurement previously applied under the Carbon Emission Measurement and Reduction Scheme (CEMARS) to include the embedded carbon inherent in procurement, travel, food and catering, and other indirect emissions sources (pages 14–19 & Appendix), and

2.4. develop and implement a local and/or South Island-wide environmental sustainability plan to guide the reduction of the District Health Board's environmental burdens, across the full range of activities, in order to be environmentally sensitive and carbon-neutral by 2050. The plan will include mitigation measures and an adaptation strategy that anticipates service change (pages 19–24).

About this Position Statement

This Statement was developed for the South Island District Health Boards by the Information Team, Community and Public Health, a division of the Canterbury District Health Board, with the guidance of the South Island Public Health Partnership Management Group.

BACKGROUND PAPER

Abstract

The purpose of this Background Paper is to inform the commitment, statements, and actions of the South Island District Health Boards in their efforts to achieve an environmentally sustainable health system. The most rapid environmental change currently occurring, on a global scale, is human-induced global warming and the resultant global climate change [1-3]. Increased emissions of fossil CO_2 since the mid-18th century have amplified the natural greenhouse effect causing the Earth's average surface temperature to rise [1,6,7]. The effects of ongoing global warming and global climate change now threaten to undermine many of the social, economic, and environmental drivers of health and wellbeing that have contributed greatly to human progress [1,3]. Trends in climate change impacts, exposures, and vulnerabilities indicate high levels of risk for the current and future health and wellbeing of all populations in New Zealand [8]. Our failure to reduce emissions and to build adaptive capacity threatens human health and wellbeing and the viability of health infrastructure and services.

Most organisations and businesses still apply a fragmented, reactive approach to climate change mitigation, rather than embedding sustainability as a core principle. However, in the health sector, there are a number of exemplar organisations around the world that have made substantial progress towards sustainable health systems. Many health systems have achieved substantial improvements in resource efficiency in areas such as energy, waste, water, and use of raw materials, along with financial savings, positive environmental impacts, and direct benefits to health.

While some progress has been made, the most recent Intergovernmental Panel on Climate Change report (IPCC, 2018) clearly demonstrates that the increasing rate of global warming is greatly outweighing the scale and urgency of the response, not only in health but across all sectors. The Intergovernmental Panel on Climate Change concludes that *unprecedented* rapid and far-reaching transitions in energy, land use, infrastructure, and industrial systems are required to limit the worst effects of global warming [6]. Within the health sector, substantial investment in sustainable infrastructure and systems will be required to ensure the sustainable, equitable delivery of health services, in the face of increased demand. Future climate-resilient development within health care will require a mix of mitigation and adaptation measures consistent with profound societal and systems transformations [6]. Ambitious mitigation actions are crucial to limiting future warming. Significant adaptation actions will also be needed to manage already inevitable impacts of climate change – by reducing vulnerability and exposure to its harmful effects [6].

This Background Paper provides a brief, practical overview of relevant issues and challenges, and the resultant risks to human health and wellbeing. The Background Paper also outlines current and potential health-sector actions (New Zealand and international) that aim to prevent and/or manage these risks to human health, as well as describing the potential health co-benefits that can accrue from well-designed policies that support climate-resilient development.

Key definitions relevant to this position statement

SUSTAINABILITY

"a dynamic process that guarantees the persistence of natural and human systems in an equitable manner"

Source: The Intergovernmental Panel on Climate Change (IPCC) Working Group II: Impacts, Adaptation and Vulnerability, Annex II, 2014

HEALTH SYSTEM

"all the activities whose primary purpose is to promote, restore or maintain health"

Source: The world health report (2000). Health systems: improving performance. Geneva, World Health Organization, 2000, p.5

HEALTH

"A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"

Source: World Health Organization (1946): Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference; New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

ENVIRONMENTALLY SUSTAINABLE HEALTH SYSTEM

'A health system that improves, maintains or restores health, while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and well-being of current and future generations'

The World Health Organization (2017). Environmentally sustainable health systems: a strategic document WHO Regional Office for Europe (p. IV)

Introduction

Background

Global warming[2] and subsequent global climate change are consequences of anthropogenic emissions, mainly from fossil fuel–based power generation and transport, agriculture, and industry, which increase the heat-retaining capacity of the lower atmosphere[3] [9,10] . Global warming is part of a larger set of human-induced global environmental changes which include land degradation, ocean acidification, depletions of the ozone layer, reduced soil fertility and fresh-water resources, and disruptions to biodiversity stocks and ecosystem functioning [9].

The global scale and economic intensity of contemporary human activity are unprecedented [11,12]. Increasingly, interrelated and widespread environmental impacts are resulting from population growth, intensive economic activities, urbanisation, and consumerism [12-14]. These global changes fundamentally influence patterns of human health and health care activities [7,9,12,15-21]. Human-induced global warming has already caused multiple observed changes in climate systems [2,10,22].

Human activities are estimated to have already caused approximately 1.0°C of global warming above pre-industrial levels (likely range of 0.8°C to 1.2°C) [3,6]. Global warming is likely to reach 1.5°C between 2030 and 2050 if emissions continue to increase at the current rate (BOX 1) [6]. Pathways limiting global warming to 1.5°C will require rapid and far-reaching transitions in energy, land use, urban infrastructure, and industrial systems (including transport and buildings) [6]. Limiting global warming to 1.5°C will also require future large-scale deployment of carbon dioxide removal technologies (CDR) [23] and can only be achieved if global CO_2 emissions start to decline well before 2030 [6]. Without these global actions, the world will exceed its carbon budget and may experience high levels of warming (4- 6^{o}C) by 2100 [6]. Warming in the range of 4–6^{o}C will result in many populated areas of the world being unable to support human health and wellbeing.

BOX 1

Why the 1.5°C threshold?

At the 2015 Paris Climate Conference, 195 nations agreed to curb greenhouse gas emissions sufficiently to limit global warming to "well below" 2 degrees Celsius above pre-industrial levels. However, many nations called for the goal of '*pursuing efforts to limit'* global temperature rise to 1.5°C above pre-industrial levels (the 1.5 degrees target having first been proposed within UN Climate Change documents in 2010, or earlier). Subsequently, the 1.5 degrees target has been adopted as the lower temperature value in climate modelling scenarios. Current modelling highlights stark environmental differences between the two warming targets (i.e., 1.5^{o}C vs. 2^{o}C) [22].

However, the 2018 IPCC's analysis now predicts that the 1.5° C temperature threshold will be exceeded around 2050. The IPCC state that "negative emissions" will be required to bring the temperatures back down after overshooting 1.5° C mid-century. However, the technologies required, such as carbon capture and storage, are not yet commercially viable [6,22].

The scale of future risks to human health and wellbeing generally depend on numerous interactions between specific hazards, exposures, and vulnerability. Climate-related risks for natural and human

[2] In this Background Paper, the term *global warming* refers to a gradual increase in average global surface temperature (as one of the consequences of anthropogenic emissions) and the term *climate change* describes the resultant amplification of natural climate variability.

[3] This list only includes emissions, however, deforestation also increases the net carbon dioxide (CO_2) in the atmosphere by reducing the amount of natural carbon dioxide removal.

systems depend largely on the future magnitude and rate of warming, geographic location, levels of development, and ultimately on the choices and implementation of mitigation and adaptation options [10,22]. The effects of climate change are being felt today, and have been described as representing an 'unacceptably high and potentially catastrophic risk to human health' [2, p.1861] which 'threaten[s] to undermine the past 50 years of gains in public health' [1, p.581].

Climate change in New Zealand

The IPCC [Australasia] report concludes that increased atmospheric warming is 'almost certain' for New Zealand as the 21st century progresses [24]. Projected overall changes for New Zealand have been calculated using a regional climate model developed by the National Institute of Water and Atmospheric Research (NIWA) and the New Zealand Ministry for the Environment [8]. The model estimated that mean temperature will increase for New Zealand (relative to the 1986-2005 period) by 1.6°C by 2110. In New Zealand, annual average temperatures have already risen 0.92°C, over the period 1909 to 2015, and coastal sea levels show an average increase of 1.7 mm per year between 1900 and 2013 [25]. Both temperature and sea level are expected to continue to rise.

These changes in average temperature will have large effects on the likelihood and frequency of future extreme weather events [24] and local and regional differences in the type and extent of the consequences are expected [20]. In New Zealand, populations living in different social, economic, and physical conditions will be affected differently by climate changes. Low-income and remote populations are more vulnerable to physical hazards, undernutrition, infectious diseases, and the health consequences of displacement [18]. The list below summarises the health risks that are related to climate change, by category, sourced from both New Zealand specific and global analyses [1,2,6,8,17,18,20,26,27].

Primary health effects/risks include death, injury, and/or loss of public welfare that may result directly from:

- drought
- heat waves
- wildfire
- wind and storms
- heavy rainfall
- flooding
- landslides
- sea level rise
- coastal inundation
- increased ultraviolet radiation
- decreased air quality.

Secondary health effects/risks that are related to changes in biophysically and ecologically based processes and systems include:

- emerging/re-emerging infectious disease
- changes to infectious-disease vectors
- changes to intermediate-host ecology
- increases in toxin-producing organisms
- increases in antimicrobial resistant bacteria
- health effects related to cancer, cardiovascular disease, stroke and nutritional risk factors
- undernutrition related to disruption of food production and water supply (including access to drinking and irrigation water).

Tertiary health effects/risks include:

- social change and population displacement/migration to New Zealand
- social and economic disruptions (diverse health consequences of livelihood loss)
- child development and life-course/adult health
- mental health and stress-related disorders, and neurological diseases and disorders
- health effects related to food security and safety
- effects on occupational health
- consequences of tension and conflict (domestic and international) owing to climate change-related declines in basic resources
- poverty and disadvantage increased effects of aesthetic and cultural impoverishment.

Towards environmentally sustainable health care

Approaches to environmental sustainability within private and public organisations have evolved significantly over the past 50 years, from a basic compliance approach to an environmental stewardship approach [18,28,29]. During the era of *compliance* (1970s-2000s), most organisations applied a fragmented, often minimal, reactive approach in order to comply with regulations or to deal with emergencies [30]. For the health sector, the *stewardship* approach involves the efficient management of all physical, financial, and human resources, including upstream inputs of goods and services and downstream clinical and non-clinical waste. Current approaches to stewardship (or sustainable development) in health care anticipate change and are based on the relationships between human health, wellbeing, and the environment. The World Health Organization defines an environmentally sustainable health system as a health system that:

> 'improves, maintains or restores health, while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and well-being of current and future generations' [29, p. IV].

Through stewardship, innovation can arise from a recognition of the synergies that exist between health and the environment, and of the need to address modifiable upstream determinants of health. This means a strong focus on actively identifying win–win solutions (co-benefits) whereby environmental sustainability actions reinforce core service delivery. Co-benefits provide an important framework for public health action on climate change [18,28,29,31]. The WHO definition of an environmentally sustainable health system also highlights the focus on social equity (BOX 2), the fair access to resources, and the fair distribution of costs and benefits across and between generations. Financial sustainability, environmental sustainability, and improving the quality of care (including equity) can be framed and operationalised as complementary goals.

BOX 2

Equity

The principle of equity is central to issues of environmental sustainability – recognising that many of the impacts of global warming, and some potential impacts of the mitigation actions required, fall disproportionately on the poor and vulnerable [6,38].

Māori health and equity

Climate change will result in different exposures and degrees of impact for different population groups; depending on geographic location, age, ethnicity, health status, socioeconomic circumstances, and other pre-existing vulnerabilities [32,33]. Māori, Pacific people, the elderly, and low-income groups in New Zealand are at greater risk of many of the adverse health impacts of climate change, compared with the general population [34,35].[4] A disproportionately high number of Māori and Pacific people in New Zealand live in deprived circumstances, and deprivation is a significant driver of poor health outcomes [36-38]. Māori may also experience unique impacts related to indigenous relationships with the environment and/or cultural impoverishment [38].

Exposures related to climate change can be expected to exacerbate pre-established and disproportionate burdens and susceptibilities to disease for Māori, across many health conditions

[4] Many equity issues for Māori may also be experienced by Pacific Peoples living in New Zealand and by low income New Zealanders.

[38]. These effects will act most strongly on the more climate-sensitive conditions, such as water/food/vector-borne diseases, direct injuries due to extreme weather events, respiratory diseases, heat stress, and mental health conditions [1,2,20,39]. Further, reduced agricultural production could lead to higher unemployment, and wide-ranging economic and social impacts, including impacts on income distribution, attitudes and health behaviours, and these impacts may be disproportionately severe for Māori [40]. Overall, climate change will increasingly exert an influence on and through the broader social determinants of health in New Zealand and globally, and progress on adaptation will require the health sector to increasingly engage with the multiple sectors outside health, in areas such as trade, agriculture, employment, and education [41,42].

Advocacy

Attention to the related health effects of climate change, and the necessary responses, is growing both in the media and in academic publications [1]. Contributions from within the health professions are increasingly seen as essential in driving sustained progress on reducing emissions, and realising the local and global health benefits of climate action [1]. The need for advocacy in public health is not new. The 1986 Ottawa Charter [43] has long highlighted advocacy as a fundamental strategy for advancing health as a major resource for social, economic and personal development, and an important dimension of quality of life. Most definitions of public health reinforce that public health is future–orientated and depends on 'the organised efforts of society'[5] [44,45]. The World Health Organization continues to highlight the need for the health sector to 'advocate social change as a means for sustainable improvement of population health' [37, p.175]. Moreover, the principle of moral equality[6] provides strong ethical grounds for the health community in particular, to advocate for climate change action on behalf of current and future generations [45]. Advocacy is required to raise attention and sustain support for climate change actions and this requires the development and implementation of a health sector strategy for high-level strategic communication [1,2,37].

[5] Adapted from the 'Acheson Report', the *Report of the Committee of Inquiry into the Future Development of the Public Health Function*. London, 1988.

[6] The principle that no one individual is intrinsically superior to, or worth more than, another.

Mitigation

Carbon accounting

The first step towards system-wide emission reductions for an organisation is to measure its carbon footprint; or the *total* (direct and indirect) greenhouse gas emissions[7] of the organisation occurring over a given time frame or event. Carbon accounting can produce a detailed breakdown or profile of the relative contributions across the different sources of emissions (called scopes) [46-50]. The emission profile can then be used to inform planning and mitigation actions. There are three defined groupings or Scopes of emissions as set out in the *Greenhouse Gas Protocol*, the internationally adopted guidebook on carbon accounting methods [50]. Table 1 provides an example overview of the greenhouse gas Scopes 1, 2 and 3 as applied to a health system in a developed country (in this example, the NHS England, 2015) [51].

Table 1: Summary of Greenhouse Gas Protocol Scopes 1, 2 and 3, applied to a health care system

Scope	Description	Summary	Contribution[A]
1	Scope 1 emissions are the *direct* emissions emitted from the burning of fossil fuels to generate heat and electricity, on-site.[B] Plus the direct emissions from health-organisation owned vehicles such as fleet and patient transport services, other incinerators or combustion processes, and emissions from chemical production where the equipment is owned and operated by the health-organisation/entity. Scope 1 emissions account for approximately 20% of the total CO_2e emissions in this example.	Direct, by-products of combustion (for heat, power, and transport: on-site.	≈20% 
2	Scope 2 emissions are those *indirect* CO_2e emissions attributable to the generation of electricity off-site[C] that is purchased and consumed on-site. Scope 2 emissions account for approximately 20% of the total CO_2e emissions in this example.	Indirect by-products of electricity generation: off-site.	≈20% 
3	Scope 3 emissions are those *indirect* CO_2e emissions attributable to the production of materials used for buildings and health care infrastructure, the procurement of goods and services used in the delivery of health services, and patient, visitor and staff travel.[D] Scope 3 emissions account for approximately 60% of the total CO_2e emissions in this example.	Indirect, everything else: off-site.	≈60% 

[A] The relative contributions from each scope are likely to be country/organisation/time-specific. A country's electricity generation profile will influence the relative contributions (the table should be considered as an example only).
[B] Direct CO_2 emissions from the combustion of biomass (e.g., in a wood-fired boiler) are reported separately.
[C] Scope 2 emissions physically occur at the power station where electricity is generated.
[D] These emissions occur as a consequence of the activities of a health-organisation, but occur from sources not owned or controlled by the health-organisation (e.g., pharmaceuticals and medical devices; transportation of purchased fuels and other goods; employee business travel, employees commuting, transportation of waste, and emissions generated during the production of electricity that is consumed/lost in a transmission and distribution system).

[7] Climate change is largely attributable to emissions of carbon dioxide (CO_2), hence other greenhouse gasses are equivalised to CO_2's warming potential.

The Scopes 1, 2, and 3 cover three fundamental categories of emissions: emissions generated by the production of heat and electricity (on-site), emissions attributable to the generation of grid electricity (off-site), and 'everything else'. These broad categories can be further broken down into numerous sub-categories, such as heating, lighting, travel to-and-from health care sites by patients and visitors, staff commuting and business travel, and notably, embedded carbon emissions associated with the procurement of goods and services used in health care delivery.

Scope 1 and Scope 2 emissions are relatively easy to identify and quantify as they relate to energy consumption activities that occur within an organisation's operational boundary. These energy-related emissions may account for approximately 40% of a health system's total carbon footprint (depending on a country's electricity generation profile or 'percent renewable' and the influence this has on Scope 1 and Scope 2 emissions). Scope 3 emissions have been shown to account for approximately 60% of a developed country's health system's total CO_2e emissions, based on a number of carbon footprinting studies [46,51-54]. In particular, procured pharmaceuticals, single-use medical devices, and medical equipment typically contribute the most within the Scope 3 category [55], as well as non-medical goods (e.g., food) and building/construction [52]. Health systems also procure substantial volumes of services from external contractors, and these procured services also contribute to Scope 3 emissions. The Appendix extends Table 1 and provides a detailed example of the application of carbon accounting principles to an entire health system. International research in the US, Australia and the UK[8] [46,51,56-59] has shown that it is necessary to pursue carbon reductions across all categories, because no one category has the potential for the scale of savings necessary to meet current global emission targets [47,56].

Applying carbon accounting to prioritisation and decision-making processes

As already outlined, the primary purpose of carbon accounting is to produce an emissions profile that is sufficiently detailed to inform planning and decision-making about future mitigation initiatives. The challenge for decision-makers, in this regard, is to effectively prioritise and implement a complementary selection of mitigation initiatives that together result in the most economically-efficient carbon reductions, taking into account the cradle-to-grave [60] environmental costs of service delivery and other practicalities (BOX 3) [12,31,61,62]. In selecting mitigation initiatives (particularly for energy-emissions), it is necessary to take account of interactions and overlaps between initiatives. Interactions concern situations where the potential carbon savings from one initiative are reduced because another technology or approach has already been implemented.

[8] Sustainable Development Unit NHS carbon footprint publications relating to 2004, 2007, 2010, 2012, and 2015, are available at: http://www.sdu.nhs.uk/corporate-requirements/measuring-carbon-footprint/nhs-carbon-footprint.aspx

In practice, prioritising abatement measures involves simultaneously considering different initiatives that broadly fit within two main approaches: (1) energy generation/efficiency and (2) non-energy emissions. The energy-generation approach typically involves energy infrastructure projects such as converting coal-fuelled boilers to biomass-fuelled boilers (e.g., wood chip) or installing combined-heat-and-power plants in hospital settings (i.e., targeting Scope 1 emissions). The energy efficiency approach focuses on Scope 2 emission reduction projects such as lighting upgrades, insulation, and/or other energy saving initiatives within hospitals and other facilities [48,50]. While fundamentally important, the abatement potential of energy projects is to some extent limited, because their total contribution to a health system's carbon footprint is likely to be less than 30% (see Appendix).

The non-energy initiatives focus on Scope 3 emissions.[9] This broad category of emissions includes all emissions that occur as a consequence of the activities of a health-organisation, but occur from sources not owned or controlled by the health-organisation.

Most health systems in developed countries have yet to start the transition to upstream carbon accounting that substantively includes Scope 3 emissions. To date, most measurement and mitigation projects have been focused on energy-related emissions. However, informative work has been undertaken by the UK National Health Service over the last ten years [47,51,56,57] and by other health systems including the US [58] and more recently Australia [46].

One consistent rule-of-thumb that *has* been demonstrated [12,31,63] is that it is ideal to pursue the most economically-efficient carbon reductions first, to their maximum potential. This principle applies even when upfront capital costs may be relatively high, or when implementation is perceived as difficult, because failing to do so may lead to the overall cost of mitigation and adaptation measures being considerably higher over the longer term [12,31,63]. By applying knowledge of the emission scopes and the best available carbon abatement initiatives, planners and decision-makers can weigh the relevant practical, operational, clinical, and economic factors, alongside current and future projected health burdens, and the cost of any essential social safeguards [64].

BOX 3

Cradle-to-grave analysis of the environmental costs of goods and services

Life Cycle Assessment (LCA) is the 'cradle-to-grave' analysis of the environmental costs associated with a given product or service (covering manufacture, use and disposal) and LCA can be applied to examine the environmental effects of an entire supply chain in health care [60,61]. Impacts are all-inclusive, covering resource consumption, release of greenhouse gases, and generation of solid waste. LCAs use economic input–output carbon accounting methods to provide a comprehensive picture by ensuring that both the direct and indirect effects are captured [67].

[9] Note: Scope 3 is not entirely non-energy because it also includes fuel consumed for staff, patient, and visitor travel, and lifetime emissions from all medical products used by patients in home-care settings.

Procurement emissions: hot-spots, and possible solutions

The hot-spots approach to reducing procurement emissions initially involves identifying those high-carbon aspects of service delivery that are also the most amenable to optimisation. Then, low carbon procurement seeks to work with suppliers, and to procure goods, services, works, and utilities with a reduced carbon footprint, throughout their life cycle. Identifying goods and services that produce high levels of greenhouse gas emissions may also highlight areas where potential cost savings can be made. Low carbon procurement can lead to substantial reductions to the organisation's overall carbon footprint [65] and this is particularly relevant to clinical settings because many of the consumables used, such as pharmaceuticals and anaesthetic gasses, contain particularly high levels of embedded carbon. Low carbon procurement strategies can be applied across all settings, including primary care, hospitals and other facilities, as well as patients' homes [48].

Because detailed information is needed to calculate the environmental impacts of each individual product of service used by a provider, spend-based models and industry averages, using pharmaceutical and medical device guidelines [66], are now available and are often used to calculate an organisation's procurement emissions [47,48,50,65]. For products or services not covered by existing guidelines, a standardised approach to calculating these emissions has been developed, and detailed guidance is available from the *Publicly Available Specification for assessing the life cycle GHG emissions of goods and services* (BOX 4) [67].

BOX 4

The PAS 2050

The PAS 2050 [67] is a publicly available specification providing a method for assessing the life cycle greenhouse gas emissions of goods and services (jointly referred to as "products").

Originally published in 2008, the 2011 revision is now parent to an expanding family of specifications, providing tailored guidance for individual sectors to enable the most effective application of carbon footprinting and supply chain management.

Procurement patterns reflect a health system's decisions about the design of specific care pathways and/or the state of optimisation across existing services [68]. Optimisation strategies can include, for example, investing in prevention early in care pathways, opting for e-solutions that strengthen self-care, and/or delivering care at patients' homes, and all of these approaches can act to influence the size and type of demand for goods and services, and therefore contribute to improved environmental, health, and wellbeing outcomes [68].

Optimisation can initially focus on obvious product substitutions; guided by a substantial body of research that has now identified and short-listed the pharmaceuticals and other procured items that are the most greenhouse intensive. Top-20 lists have been compiled for pharmaceuticals as well as a range of medical items (based on aggregating the ranking for cost, quantity and greenhouse gas estimates). The published lists prioritise items for further investigation and provide a starting point for a systematic approach to reducing procurement emissions. Lower impact product alternatives may be immediately available for full or partial substitution or small changes to a care pathway may enable additional pharmaceutical choices and/or waste reductions [48,49,53]. When lower impact product alternatives are not readily available, working with suppliers to reduce the carbon intensity of the supply chain, via modifications to product specifications, can bring about some of the larger reductions in emissions, over the longer term.

In summary, accounting for and acting on Scope 3 emissions is not without complexity, and there remain significant gaps in the evidence base on procurement, as it relates to health system

sustainability. Further assessments of environmental impacts are needed, both at the level of individual care facilities and at the system level [52]. However, despite these knowledge gaps, a large amount of easily accessible information is now available to inform sustainable procurement planning and action. A useful starting point is to apply cradle-to-grave [69] assessments to a small number of selected business-as-usual care pathways, using product guidelines and product hot-spot lists. Incrementally, this approach can progress to applying environmental and social/ethical criteria to all tendering processes [48,50,67].

Future opportunities within the New Zealand health sector

There is considerable scope to improve environmental sustainability practices within the New Zealand health sector, with large potential for operational cost savings [70-73].[8] However, as yet, there is no legislation, national framework, or mandate to support this work, despite sufficient international expertise [50,67,74]. Nevertheless, noteworthy regional-level work has been undertaken by select District Health Boards via the Carbon Emission Measurement and Reduction Scheme (CEMARS).[10] In these accreditations/assessments, comprehensive data have been collected across Scope 1 and Scope 2 emission inventories to meet or exceed the mandatory reporting standard. However, the reporting standard for Scope 3 emissions allows for considerable discretion, and to date, Scope 3 emissions have not been extensively reported in New Zealand. For example, Table 2 shows the coverage of Scope 3 emissions for Canterbury and Counties Manukau District Health Boards via the CEMARS programme for 2017; compared with the full range of possible Scope 3 items/categories as specified in the Greenhouse Gas Protocol (the international standard with which CEMARS conforms). The table shows that the Scope 3 emissions reported by the two District Health Boards' examples do not include the major categories of pharmaceuticals and medical instruments/devices, commissioned health services from outside system, or food and catering. A standardised and expanded approach to Scope 3 reporting in New Zealand would provide broader, and more in-depth information to guide future health sector emission reduction initiatives [1].

[10] CEMARS® a wholly owned subsidiary of Landcare Research and 100% owned by the New Zealand Government.

Without comprehensive Scope 3 data, service providers lack much of the information needed to be able to understand and effectively manage their future sustainability.

Table 2: Comparison of included Scope 3 emissions for the Canterbury District Health Board CEMARS programme and Counties Manukau CEMARS programme, compared with the full range of Greenhouse Gas Protocol Scope 3 emissions, 2017

The Greenhouse Gas Protocol Scope – 3 emissions*	CEMARS programme	
GHG protocol Scope 3 sources (non-exhaustive) ranked by contribution	Canterbury	Counties Manukau
Pharmaceuticals		
Commissioned health services from outside system		
Medical Instruments/devices		
Food and catering		
Freight transport		
Meter-Dose inhalers		
Air travel - domestic and international		
Transport – private car for work-related transport		
Taxi		
Other staff transport (shuttle bus)		
Staff commuting to and from work		
Construction		
Paper products (office paper)		
Waste products and recycling		
Anaesthetic gases		
Other products		
Other services (e.g. linen services)		
Home use of medical devices (e.g., electricity used to run CPAP machine)		
ITC technologies		
Water and sanitation		

= included = not included

* Scope 3 emissions have been estimated to account for the majority of a health system's total GHG emissions (the balance being energy-related emissions – in one form or another). The exact proportions will differ from country to country based on different energy generation profiles and other factors.

Climate change threats to health also highlight the vital requirement for improved leadership, and population-based planning. Anticipatory action is necessary [75] because the ability to mount responses in any future circumstance might be limited by the degradation of infrastructure and by the economic stressors that climate change brings [15]. Health systems need to maintain a platform for the delivery of clinical services but they also need to provide the foundation for an effective public health response to the many climate-induced threats to health [1,2,15]. Therefore, at national and subnational levels, long-term strategies and investments will continue to be needed to develop the clinical, management, and human capacity of health systems [15].

Whole-of-system planning will be most effective when focused on organisational change – to embed sustainability principles and practices in all policies, operations and technologies, across the health system. As a starting point, planning might be based on WHO best practice guidelines [21]; including a focus on energy efficiency, environmentally sensitive building design, alternative energy generation, transportation (staff, patient and community), and limiting embedded carbon emissions from procured goods and services [49].

Co-benefits

Further opportunities lie in the leveraging of health co-benefits. There is growing recognition that the implementation of low-carbon policies can have substantial near-term health co-benefits through multiple overlapping pathways [31] (see Box 5 for examples). Co-benefits are the positive effects that a carbon reduction policy or measure might have on other objectives. Co-benefits and their related cost savings are often not taken into account in decision making processes[11] [76] but the economic co-benefits of climate change mitigation policies *can* be put forward as a forceful argument for policy makers to take action [76]. Initiatives that effectively leverage co-benefits to reduce greenhouse gas emissions can bring about strong positive welfare effects [31].

Common pathways to health co-benefits include promoting and facilitating low-carbon transport such as walking, cycling, and public transport; which in turn can improve physical activity levels, therefore lowering the incidence of heart disease, cancer, obesity, musculoskeletal disease, Type 2 diabetes, and some mental health conditions. Active transport also reduces air pollution (and hence respiratory disease) and road traffic injuries [77,78]. Electronic health interventions (eHealth) are another group of interventions that can generate important co-benefits. A range of e-health interventions have been shown to reduce carbon emissions *and* improve access to care, reduce demand for care, improve health outcomes, and reduce out-of-pocket expenses through reduced need for patients to travel [79]. Other health benefits can accrue via socioeconomic pathways, for example, the reduction of out-of-pocket health expenses for households can improve the affordability of good nutrition and other health promoting activities [2,31]. Even so, compensatory and/or redistributive measures may be required in some circumstances [40].

Overall, health and equity co-benefits associated with climate change mitigation have the potential to significantly reduce the burdens (costs) on health care systems [1,21,32]. Analyses [80] using data from the Global Burden of Disease Study 2015 [81] show that the health co-benefits of meeting commitments under the Paris Agreement are 'potentially immense', reducing the burden of disease for many of the greatest health challenges today and in the future [1, P.601]. Projected climate change effects will impact human health mainly by exacerbating health problems that already exist (at least until mid-century) [10]. Therefore, mitigation and adaptation mechanisms are likely to be most efficient and cost-effective when they recognise locally relevant scenarios of future change (i.e., continue to work on well-understood historical health problems) and when they seek to exploit co-benefits to maximum effect [10].

[11] Likely because they are not easy to capture and some potential wellbeing impacts and/or cultural value(s) cannot be fully monetarised.

BOX 5

Examples of carbon reduction measures applicable to health systems, the overlapping pathways, and a range of health co-benefits

Adapted from: Frumkin et al. (2008); Iacobucci (2016); Watts, et al. (2015); Younger et al. (2008)

Adaptation

Adaptation in this context means 'adjustment in natural or human systems in response to actual or expected climate stimuli or their effects, which moderates harm or exploits beneficial opportunities' [82, p.1758]. Mitigation will not be sufficient as the need for adaptation is already locked in [6,17]. Therefore, there is a need for the health sector to plan for the inevitable health impacts of climate change in coming decades [22,71]. Adaptation to climate change can reduce existing and near-term risks. However, a number of potential barriers to public health adaptation to climate change have been identified; including, uncertainty about future socioeconomic and climatic conditions as well as a range of financial, institutional, and skills/knowledge gaps within health institutions [83]. These barriers can constrain the recognition of climate change effects and the actions required [83].

Suggested approaches for health sector institutions include; placing a high priority on research aimed at clarifying the potential health impacts of climate change, including scenario-based projections of local-level health impacts, identifying and clarifying the health co-benefits of potential mitigation strategies, and evaluating the cost-effectiveness of potential options [83]. While some of these approaches build on conventional health sector activities, others (for example, local-level scenario-based projections of climate change health impacts) will require health agencies to develop new skills, methods and tools, and broader collaborative relationships within other sectors. These collaborative relationships will become essential as the adaptive capacity of the health sector alone will have a limited impact, partly because the environmental determinants of health are complex and are largely outside the direct influence of the health system [42,64].

There is a strong argument for strengthening public health services' climate change planning and response capability. As one example approach, the US Centers for Disease Control and Prevention (CDC) has proposed a 5-step climate change adaptation framework "Building Resilience Against Climate Effects" (BRACE) to facilitate climate readiness in public health agencies [84]. The BRACE framework steps are:

- forecasting climate impacts and assessing vulnerabilities
- projecting the disease burden
- assessing public health interventions
- developing and implementing a climate and health adaptation plan, and
- evaluating impact and improving the quality of activities [84].

As a further example, Table 3 provides a brief list of potentially relevant climate change actions (selected examples only). These actions build on and extend conventional public health activities. A comprehensive response will involve adapting all of the 'building blocks' broadly common to all health systems, including leadership and governance, health workforce, health information systems, infrastructure, essential medical products and technologies, and service delivery [42]. Within the health sector, substantial investment in sustainable infrastructure and systems will be required to limit the economic and health impacts of climate change and to ensure the sustainable delivery of health services, in the face of increased demand.

Table 3: Examples of climate change adaptation activities relevant to New Zealand health care settings

Secondary prevention *(Adaptation)*

- Tracking of diseases and trends related to climate change.
- Program assessment of various preparedness efforts.
- Research on the local-level health effects of climate change, including innovative techniques such as scenario-based modelling, and research on optimal adaptation strategies.
- Training of health care providers on health aspects of climate change.
- Public health partnerships with industry, other professional groups, and others, to craft and implement solutions.
- Promote written heat response plans to reduce heat-related morbidity and mortality.
- Preparing for and responding to climate change-related public health emergencies, such drought, heat waves, wildfire, wind and storms, heavy rainfall, flooding, landslides, coastal inundation.
- Enforce laws and regulations that protect health and ensure safety (although probably little role for public health).
- Develop a coordinated adaptation plan
- Build capability and capacity in climate change adaptation across public health units/DHBs. Adaptation must be recognised as an essential part of the climate change agenda now (alongside the legislative attention being given to climate change mitigation) because all of New Zealand will be impacted by the changing climate.
- Engage in broader collaboration with other sectors.
- Strengthen all public health programmes.
- Support vulnerable communities.
- Advocacy.

Source: adapted from The Climate Change Adaptation Technical Working Group (2018). Adapting to Climate Change in New Zealand; Frumkin et al. (2008). Climate change: the public health response; and McMichael (2013). Globalization, climate change, and human health [17,31,75].

Conclusion

The health sector is increasingly considering and responding to the health effects of climate change [1]. Future climate-resilient development within health care will require a mix of mitigation and adaptation measures consistent with profound societal and systems transformations [6]. Ambitious mitigation actions are crucial to limiting future warming [6]. Significant adaptation actions will be needed to manage the impacts of climate change over the long term; primarily by reducing vulnerabilities and exposure to its harmful effects. The health system has important roles to play in achieving longer-term sustainable development, including advocacy, building resilience, and enhancing human capacities to adapt, all while paying close attention to equity and wellbeing for all [6].

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Appendix

International example: the National Health Service (England)

Work completed by the National Health Service (NHS) in England provides perhaps the best international example of the development of an environmentally sustainable health system. In response to the (United Kingdom) Climate Change Act 2008 [85][12] the NHS has made significant progress towards environmental sustainability. A dedicated Sustainable Development Unit (SDU) was established to develop and enact an approach to environmental sustainability across the NHS. Two key achievements of the SDU have been the development of (1) a detailed *carbon footprint* which covers the entire NHS, public health and social care sector and (2) a *marginal abatement cost curve* (MACC) that provides an estimate of the potential of all technological greenhouse gas abatement measures, and their relative cost-effectiveness.

The SDU

The Sustainable Development Unit is a government agency with the sole purpose of embedding the principals of sustainable development across the health and social care system in England. The SDU had undertaken extensive work, through carbon accounting, to inform and facilitate a reduction in the NHS's environmental impact. This approach has incentivised models of care that favour prevention, self-care and 'lean' pathways; which in turn have driven low carbon procurement, energy-efficiency, and other environmentally sustainable practices.

The footprint

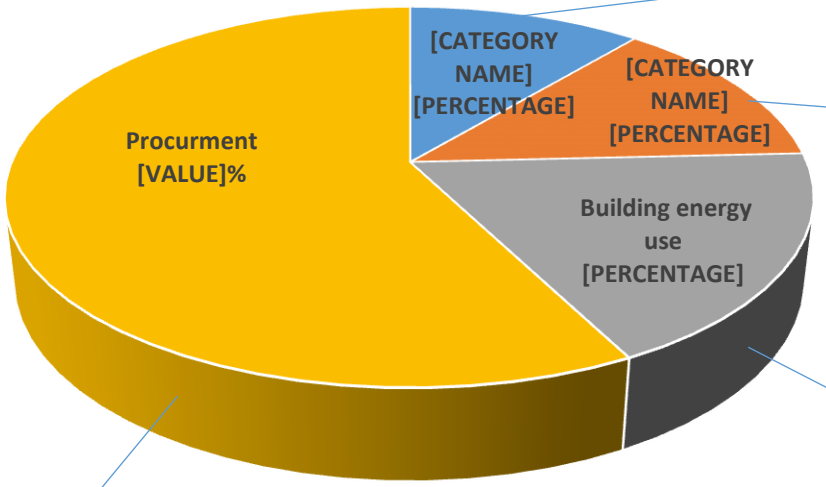
Using the best available carbon accounting methods, a series of updated footprints have been published[13] for 2004, 2007, 2010, 2012, and 2015. The current carbon footprint provides a detailed breakdown of emissions across four broad categories: building energy use and direct emissions, travel, commissioned health and care services from outside the NHS system, and procurement of goods and services. These four main categories are further broken down into 21 sub-categories.

The NHS consumption carbon footprint (Figure 1) clearly shows that the main sources are embedded carbon within procured goods and services, and this category of emissions accounted for approximately 57% of all emissions in 2015. The balance was due to: heating, lighting and providing power for NHS sites (18%); travel to and from NHS sites by patients, visitors, and staff, and business travel (13%); and health services commissioned from outside the NHS (11%) [47]. The NHS's carbon footprint has fallen by 12% between 1990 and 2015, within the context of an 18% increase in inpatient admissions over the same period [57]. The NHS's carbon footprint is predicted to fall by a further 15% by 2020 and 20% by 2050 [47,56].

[12] The Climate Change Act 2008 specifies that the net UK carbon account for all six Kyoto greenhouse gases for the year 2050 is to be at least 80% lower than the 1990 baseline.

[13] Sustainable Development Unit NHS carbon footprint publications, available at: http://www.sdu.nhs.uk/corporate-requirements/measuring-carbon-footprint/nhs-carbon-footprint.aspx

Figure 1: Consumption carbon footprint breakdown by categories for the NHS, in 2015



Commissioned health services		Proportion
Health services		11%

Travel		Proportion
Patient		6%
Visitor		2%
Staff commute		2%
Business		3%
Total travel	Total	13%

Building energy use and direct emissions		Proportion
Electricity		8%
Fossil fuels (Gas, Coal and Oil)		8%
Total building energy	Total	18%

Procurement of goods and services		Proportion
Pharmaceuticals (excluding Meter Dose Inhalers)		11%
Business services		11%
Medical Instruments /equipment		10%
Food and catering		5%
Freight transport		3%
Meter Dose Inhalers		3%
Construction		2%
Manufactured fuels, chemicals and gases		2%
Paper products		2%
Waste products and recycling		2%
Anaesthetic gases		2%
Other manufactured products		2%
Information and communication technologies		2%
Water and sanitation		1%
Total Procurement	Total	57%

Notes

– Metered Dose Inhalers use Hydrofluorocarbons gases as aerosol propellants. The gases used have over 1000 times the impact on global warming compared with the same weight of carbon dioxide gas. The majority of the emissions are released during the 'in use' phase and occur mostly outside health care premises.

– Anaesthetic gases (including Nitrous Oxide) are potent greenhouse gases with between 130 to 2000 times the impact on global warming compared with the same weight of carbon dioxide gas.

Summarised from: Sustainable Development Unit and UK National Health Service data (2016) *Carbon footprint update for the NHS in England 2015*

The Cost Curve

Marginal Abatement Cost (MAC) reflects the cost of one additional unit or ton of pollution that is abated, or not emitted. A marginal abatement cost curve (MACC) is a data visualisation tool that allows the user to compare emission reduction options both in terms of cost-effectiveness and their potential for CO_2 reductions (Figure 2). Marginal abatement cost curves highlight the win-wins where carbon cutting measures can save money and the abatement information also puts into perspective those measures where the investment costs cannot be recouped.

A marginal abatement cost curve can help decision makers to plan and prioritise a number of options into a strategic package of mitigation measures. However, MACCs cannot produce a definitive and generalisable set of initiatives, because local and country-level characteristics vary greatly. In addition, it is necessary to take account of interactions and overlaps between interventions, where the potential carbon savings from one initiative are reduced because another technology has already been installed.

Figure 2: A hypothetical example of a Marginal Abatement Cost Curve (MACC) applied to a health care system (indicative only)

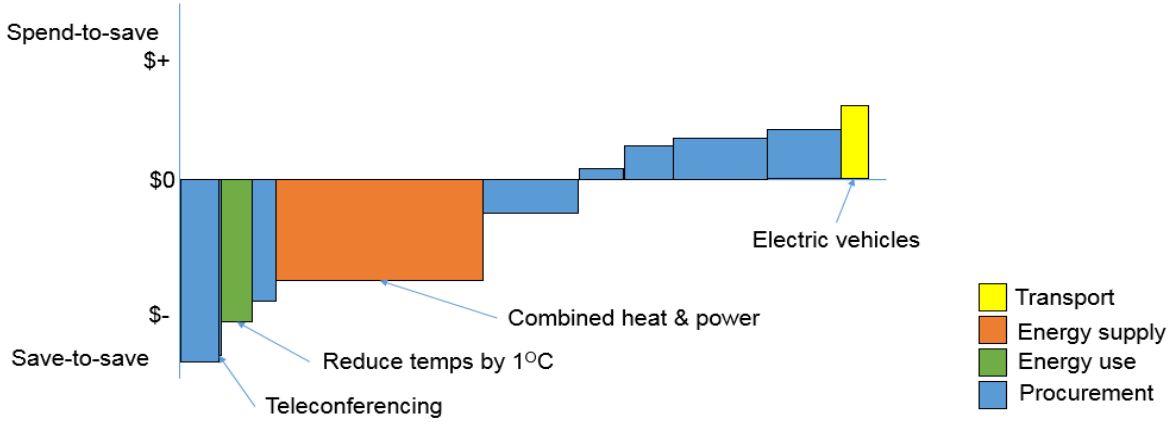


Figure 2 shows a generalised example of a health system's Marginal Abatement Cost Curve (MACC). Each block represents a different technology or intervention. In this example, each technology is colour-coded into four categories: transport, energy supply, energy use and procurement. A block that is projecting downwards indicates that the technology has the potential to generate financial savings (i.e., negative costs indicate a net financial benefit to the health system over the lifecycle of the abatement opportunity) and a block that projects above the zero line indicates that the particular technology is not cost-effective (i.e., positive costs imply that capturing the opportunity would incur incremental costs compared to business-as-usual or 'do nothing'). The relative height or depth of each block represents the degree to which the intervention is cost-saving. The options presented in a MACC are always placed in decreasing order of cost-effectiveness so that the reader can easily identify how options compare with each other on both cost-effectiveness and abatement potential. The horizontal axis (x-axis) shows the annual carbon savings that would result from the full implementation of a particular technology. The cumulative annual savings, shown by the full width of all of the blocks side-by-side on the MACC, gives an indication of the maximum potential for system-wide carbon savings in a particular assessment year. The abatement potential can be compared with the baseline year and/or any future targets set for an organisation.

Source: drawn from the principles and methodology developed by McKinsey & Company and informed by findings from the Marginal Abatement Cost Curve for NHS England (2015).

Marginal abatement cost information can also be displayed in table format. Table 4 shows marginal abatement cost information for the NHS England for 2015 [56]. The table lists a range of energy-efficiency interventions that have been identified as suitable for implementation within health care facilities. The list is presented in descending order of cost-effectiveness (not considering interactions and overlaps between measures). The right-hand column shows the potential CO_2 savings that could be made in one-year if the technology was fully implemented. The table shows that the top-five technologies/interventions are (1) combined-heat-and-power, equal with biomass boiler (2) energy awareness campaigns (3) travel planning (4) lighting controls, and (5) reduce heating by 1 degree Celsius (based on potential CO_2 saving as shown in bold in Table 3). The table also shows that the cost-effectiveness of these examples differs considerably. For example, combined-heat-and-power and biomass boilers offer similar potential CO_2 saving, but combined-heat-and-power is significantly more cost-effective than a biomass boiler conversion (ranked 6th compared with 24th in the example list).

Table 4: List of CO_2 reduction measures related to energy supply and use, not considering interactions and overlaps (non-energy related measures for procurement of pharmaceuticals and medical devices are not shown)

	CO_2 reduction measures (options)	*£/tCO_2	CO_2 savings (tCO_2)
1	Teleconferencing	-2051	6,827
2	Introduce hibernation system for stations	-120	1,255
3	Improve the efficiency of chillers	-110	9,133
4	Voltage optimisation	-110	16,828
5	1 degree C	-110	**32,763**
6	CHP installation	-98	**173,975**
7	Improve lighting controls	-94	**34,286**
8	Variable speed drives	-90	3,083
9	Energy awareness campaign	-89	**90,265**
10	Building management system optimisation	-86	11,521
11	Improve insulation to pipe work, boiler house	-79	10,264
12	Decentralisation of hot water boilers	-77	10,612
13	Improve heating controls	-72	17,219
14	Roof insulation	-71	22,869
15	Improve efficiency of steam or hot water boiler	-71	6,367
16	Wall insulation	-70	24,624
17	Energy efficient lighting	-67	22,290
18	Upgrade garage and workshop heating	-60	214
19	Install high efficiency lighting and controls	-45	3,745
20	Wind turbine	-42	10,722
21	Double insulation window and draught proofing	-27	11,831
22	Improve building insulation levels (U-levels)	-19	951
23	Boiler replacement/optimisation HQ/control	-15	171
24	Biomass boiler	-6	**172,724**
25	Travel planning	1	**81,524**
26	Office electrical equipment improvements	17	15,900
27	Solar hot water	49	0
28	Electric vehicles	49	36,96

* NHS data: presented as published, in British pounds [47]


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


SOUTH ISLAND
ALLIANCE

COMMUNITY AND PUBLIC HEALTH UPDATE

TO: **Chair and Members**
West Coast Advisory Committee

SOURCE: **Community and Public Health**

DATE: **27 September 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is to provide the Committee with information regarding items of interest around Community and Public Health on the West Coast.

2. RECOMMENDATION

That the Advisory Committee:

i notes the Community and Public Health Update

3. APPENDICES

Appendix 1: Community and Public Health Update

Report approved for release by: Dr Cheryl Brunton, Public Health Specialist, Community and Public Health

REPORT to JOINT COMMITTEE
COMMUNITY AND PUBLIC HEALTH (CPH)

September 2019

Health promoting schools – Heritage Apple project

Michael Reynolds from the Food Resiliency Network in Canterbury contacted Tessa Hunter, Health Promoting Schools Facilitator, earlier this year with the offer of 55 heritage apple trees to West Coast schools. This gift came with the kaupapa that these trees would contribute to, or form the beginning of a community orchard in schools. After inviting expressions of interest from all schools on the West Coast, 25 schools from Granity to Haast elected to take part in this project. Community participation has been encouraged, as well as knowledge sharing and learning across generations and raising community awareness of how to enhance food security. From 28th August through to 6th September Michael and Tessa travelled many kilometres delivering the trees, supporting the planting (for which the schools were well prepared), and having conversations with school students, staff and their communities.

Cobden School

Sacred Heart School, Reefton

Haast School

As a flow on project, there is a challenge for students to become 'fruit tree detectives' this summer identifying heritage trees within their communities. They are encouraged to have conversations with community members about the history of gardens/orchards within their communities and how those fruit trees came to be there. Michael Reynolds has committed to revisit next winter and support students in learning how to propagate these trees, although from our journeys it is evident there are many knowledgeable gardeners in communities who may also be able to share their skills. The schools have also chosen to keep in touch on a digital platform sharing diaries of their trees, their gardens and orchards.

Healthy public policy

Since our last report, CPH has compiled and made submissions on behalf of Active West Coast on the following:

- Smoke-free Environments (Prohibiting Smoking in Motor Vehicles Carrying Children) Amendment Bill (also supported submission from West Coast Tobacco Free Coalition)
- Road to Zero: Consultation on the 2020-2030 Road Safety Strategy
- Westland District Council's proposal for Redevelopment of Lazar Park
- Advertising Standards Authority's consultation on the standards for Advertising and Promotion of Alcohol

Nutrition

CPH continues to facilitate the Food Security steering group which met for the third time last month. The group have confirmed their purpose and terms of reference, and at the most recent meeting, were extremely fortunate to have Michael Reynolds from the Food Resiliency Network, Christchurch attend and share his inspiring messages.

CPH has worked alongside Poutini Waiora to support whānau with nutrition and lifestyle, offering two separate nutrition courses in July and August. One, Appetite for Life, was delivered to a group of eighteen adults. The changes experienced were positive and multi-level, including Poutini Waiora staff taking ideas to provide shared healthy kai at their recent hui, participants trying new foods and making new foods at home, and a referral to the PHO dietetic service for one participant. The other programme we supported, Ko Wai Ahau, involved local rangatahi and many different activities. CPH supported this kaupapa by delivering cooking skills sessions as part of the programme which the rangatahi really enjoyed and learnt lots from. Rangatahi fed back, "we didn't realise cooking didn't have to be hard, we learnt team-work, and that home-made burgers (with whole-meal buns) were way nicer than take-away ones".

CPH met with IDEA house, Westport, and provided guidance on their menu for six residents with intellectual disabilities. We have sent extra lunch and snack ideas as requested, and also some sitting and standing physical activity charts from the Green Prescription coordinators. The IDEA staff member was extremely appreciative of a personal visit as they don't have email or much time to talk on the phone.

Our nutrition health promoter talked about Food and Mood at a workshop called "Shining Light on the Dark" on World Suicide Prevention Day. This incorporated the 5 Ways to Wellbeing, easy food tips, and information about nutrition services. The workshop brought together a day of yoga, mindfulness, weaving, and speakers including the Suicide Prevention Coordinator for the West Coast.

Alcohol

An alcohol controlled purchase operation conducted by Police with CPH support at on and off-licence premises in Westport and Mokihinui on 24th August was successful in that no sales of alcohol were made to the underage volunteers.

Smokefree

During August tobacco retailer compliance visits have been conducted by CPH to all tobacco retailers in Hokitika, Westport, Reefton, Greymouth and Grey District. CPH staff have met with the new Wildfoods Festival organising committee for the 2020 event and planning is underway. A smoke and vape free policy was implemented at Wildfoods 2019 and we are pleased this policy will remain in place for the 2020 event. CPH is working with the organising committee to increase awareness of the policy through advertising material and better signage placement.

Oranga Hā/Smoking cessation

In addition to the existing Smokefree pregnancy incentive programme, there is now a new expanded programme for whānau after the baby is born. If parents can stay smokefree for 4 months after their baby is born they receive $50 New World vouchers each month. Even when they'd managed to stay smokefree during pregnancy, many whānau were returning to smoking after their babies were born. This new incentive is proving to be very successful in helping whānau maintain a smokefree environment for their babies.

ALLIANCE UPDATE

TO: **Chair and Members**
West Coast Advisory Committee

SOURCE: **Alliance Leadership Team**

DATE: **27 September 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the progress made by the West Coast Alliance.

2. RECOMMENDATION

That the Committee;

i. Notes the Alliance Update.

3. SUMMARY

Progress of Note:

Alliance Leadership Team (ALT)

At their meeting in August the Alliance Leadership Team (ALT):

- Were very pleased to welcome Kevin Hague into the Chair and thanked Dr Chery Brunton for her time acting in this role.
- Approved the workplans presented by the workstreams with the exception of the Mental Health workstream who will be invited to present a revised plan to the next ALT meeting.
- Reviewed the workstreams' Highlights and Opportunities report which is attached as Appendix 1 to share with the Committee.

4. APPENDIX

Appendix 1: Alliance Workstream Highlights 2018/19

Report prepared by: Jenni Stephenson, Programme Manager, West Coast Alliance

Report approved for release by: Kevin Hague, Chair, Alliance Leadership Team

Alliance Workstream Highlights 2018/19

Mental Health

Highlights

- Community AOD services commenced under The Salvation Army.
- A decision has been reached regarding how to provide crisis response within locality teams across the Coast.
- The Māori Mental Health review has been completed with a subsequent proposal in development.

Opportunities for Improvement

- A number of actions from the 2018/19 plan are being carried forward into 2019/20. Some of these delays have been driven by the late release of the national review recommendations in He Ara Oranga.

Buller

Highlights

- The strong partnership between Poutini Waiora, the PHO and DHB Clinical Nurse Specialists has seen improved the care for Māori with Diabetes. This work will continue next year with the intention to expand the model in to Reefton.

Opportunities for Improvement

- Completion of actions in this workstream was impacted by resource constraints again this year.

Reefton

Highlights

- The workstream focussed on the health issues relating to rural isolation with the aim to simplify health provider registration.

Opportunities for Improvement

- Completion of actions in this workstream was impacted by resource constraints again this year.

Healthy West Coast

Highlights

- Barrytown School has become the only “official” water only school on the West Coast though some other schools have formal or informal policies along those lines.
- The Smokefree Pregnancies Incentive programme has been extended to provide mothers with incentives into the first four months post partum as part of the SUDI prevention programme.
- Initial data extraction from Medtech systems at DHB owned practices show a promising number of adults have had their alcohol consumption documented. This will provide a good basis from which to develop some on-going monitoring.

- The Food Security Steering Group was established late in 2018/19. This group is working to define its scope and Terms of Reference.

Opportunities for Improvement

- Some of the actions were delayed and will need continued focus in 19/20. These include development of the alcohol harm reduction action in relation to teenagers and continued emphasis on integrated nutrition services.

Pharmacy

Highlights

- Coast Medical and High Street Medical have implemented the NZ electronic Prescription Service, offering efficient communication between GPs and pharmacists about scripts, and time-savings.
- All community pharmacies have new service agreements with the DHB which are 'evergreen' and enable both local service commissioning and regular updating through a national annual review.
- A second integrated pharmacist role has been established to work across both hospital and the community. This is intended to improve the availability of pharmacists to contribute to optimising care for complex patients, as well as attracting newly-qualified pharmacists to the region.
- The Pharmacy Services Expert Advisory Group (EAG), including local pharmacist Julie Kilkelly, is continuing to oversee the development of a service model for a Pharmacy Minor Ailments Service.

Opportunities for Improvement

- Pharmacist workforce continues to be in short supply.

Health of Older People

Highlights

- Education and support has been provided for providing end of life care in both Aged Residential Care as well as community providers. The additional support for this through transalpine agreement with Palliative Care service has been appreciated.
- Telehealth for Older People is managed out of the Complex Clinical Care Network, and appointments are being arranged on an as required basis around client capacity and need.
- Advanced Care Plan education has commenced in the community. There are currently have three ACPs entered on Health Connect South with the fourth almost completed and ready for checking.

Opportunities for Improvement

- The Fracture Liaison Service had been on hold pending appointment of a Gerontology Nurse Specialist in Buller and this person started in June 2019. The Service will be commencing in the near future.

Child and Youth

Highlights

- Nelson Marlborough DHB Paediatrician, Nick Baker, presented three "Safe Sleep" workshops (one in Westport and two in Greymouth, daytime and evening) in August. This was part of the programme of activity to raise workforce and community understanding of the modifiable risk factors in Sudden Unexplained Death in Infancy (SUDI).
- Following a successful stakeholder and consumer engagement hui, a draft West Coast Maternity Strategy has been prepared and is currently being shared with communities for feedback and further development.
- The workstream have been involved with both the development of the Child & Youth Wellbeing Strategy and the Well Child Tamariki Ora Service review. These two national programmes will have ongoing impacts for Child & Youth health in the near future and the workstream have represented West Coast and rural health at these forums.

Opportunities for Improvement

- The national focus on Child & Youth wellbeing and Child Poverty reduction support the ongoing need to work across all sectors to address social determinants of health. While the workstream has good cross sector membership, activity continues to be mostly health service focussed.

PLANNING & FUNDING UPDATE

TO: **Chair and Members**
West Coast Advisory Committee

SOURCE: **Planning & Funding**

DATE: **27 September 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The attached report has been prepared to provide the Committee with an update progress against the initiatives, actions and targets highlighted in the DHB's Annual Plan for 2018/19. This report is circulated to operational and management teams and shared with the Ministry of Health.

2. RECOMMENDATION

The Committee:

i. notes the update on progress to the end of quarter four (April - June) 2018/19.

3. SUMMARY

Overall there is good progress across most focus areas. Areas that were off-track were largely related to staff capacity, delays with the hospital build or a change in direction during the year.

Key Points to Note:

- The Whakakatoahi Pilots in the Buller region was re-scoped and linked in with Poutini Waiora to better support Maori with diabetes. The initial evaluation has indicated this has been successful in targeting high risk groups.
- The Healthy West Coast Alliance workstream is leading the development of a cohesive Oral Health Promotion plan that capitalises on opportunistic contacts as well as creating supportive environments.
- A Living Well workshop held Greymouth on 13 April 2019, with a host of smaller targeted group sessions also being delivered. West Coast DHB is engaged in the following regional priority focus areas: improving lung cancer pathways, roll-out of MOSAIQ, and increased use of clinical Multi-Disciplinary Meetings for reviewing individual patient care.
- Performance against national targets was really positive in quarter four. Despite small population number making it difficult to achieve a 100% result: 100% of newborns were enrolled with general practice; 100% of pregnant women were offered brief advice and support to stop smoking; 100% of obese children (identified at their B4 School Check) were referred for support; 100% of people received urgent colonoscopies in under two weeks and 100% received non-urgent colonoscopies in under six weeks; 100% of stroke patients were admitted to an organised stroke service; 100% of 0-19 year olds were seen in addiction services within three weeks; we delivered 100%+ against the elective surgical discharges target; and data for 100% of patients with Acute Coronary Syndrome was entered onto national registers within 30 days. The West Coast was also one of only four DHBs meeting the Shorter Stays in ED performance target in quarter four.

Report prepared by: Sarah Fawthrop, Accountability Coordinator, Planning & Funding

Report approved by: Carolyn Gullery, Executive Director Planning, Funding & Decision Support

West Coast DHB
Annual Plan 2018/19

Delivery against National Priorities & Targets

Photo courtesy of Wendy Elwood

Status Report Quarter 4
April - June 2019

Status Key:

✓	Completed As Planned
↺	Underway (but not yet completed)
×	Delayed / At Risk

Mental Health Services

Population Mental Health Services

NZ Health Strategy link - One Team

Status Report for 2018/19

Performance Reporting Link – PP43

Key Actions from the Annual Plan	Milestones	Status	Comment
Establish a Mental Health Workstream under the West Coast Alliance to oversee the implementation of the new model of care.	Q1: Alliance Mental Health Workstream established.	✓	Workstream established with whole of system membership in place.
Expand enrolment in the Long-term Conditions Management (LTCM) Programme to include people with mental health issues. (EOA)	Q4: 50% of Westport practices enrolling people with mental health issues in the LTCM Programme.	✓	Enrolment in the Buller practice and Coast Medical is ongoing. Rollout of expanded LTCM will commence in Westland from 01 July 2019.
Continue to collaborate with social services, (MSD and Education) through Te Ara Mahi, to support people with mental health issues into employment or further education.	Q4: Increased number of clients supported into employment or education.	✓	There were 6 referrals to Te Ara Mahi vocational services during this period and 30 for the year.
Realign resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based community health model. Implement the new Crisis Response model to provide improved access to crisis services across the age and severity continuum.	Q2: Afterhours crisis response phone service established.	↺	There was an initial delay in this work, to allow the teams to consider the recommendations from the national MH Inquiry. The West Coast's Direction for Change document, supporting implementation of a locality based approach for our mental health services, has since been released (June). Implementation is underway and the after-hours crisis response phone service will be the first focus. Additional resource is also being configured for the inpatient unit.
	Q4: Mental health services integrated into locality bases.	↺	
	Q4: Additional resource in place in the inpatient unit to respond afterhours.	↺	
Review the current provision of Māori Mental Health Services and develop a complementary model that provides improved cultural support for Māori across the continuum. (EOA)	Q1: Stakeholder Hui held.	✓	As above, this work was also delayed to consider the national inquiry recommendations. An engagement Hui was held with a positive participation from across the sector. Feedback was circulated to stakeholders for further input and next steps are now being worked through.
	Q2: Recommendations proposed.	✓	
	Q3: Revised Model Adopted.	↺	
Continue to progress implementation of the national Supporting Parents Healthy Children guidelines and confirm priority actions.	Q2: Implementation Plan agreed.	✓	Action items have been agreed and work is ongoing to finalise reporting requirements.
	Q3: Priority actions identified.	✓	
	Q4: Progress review completed.	✗	
Coordinate the national Mental Health Inquiry Panel visit and provide opportunities for agencies, providers and consumers to be represented and heard by the Panel.	Q1: Publish submission and feedback dates to encourage participation.	✓	Completed in the first quarter of the year.
	Q1: Actively participate and provide feedback to the Panel.	✓	

Key Performance Measures	Result	Comment
>150 Young people (0-19) accessing brief intervention counselling in primary care.	47	
>450 Adults (20+) accessing brief intervention counselling in primary care.	116	
80% of people referred to specialist mental health services are seen within 3 weeks.	84.5%	This result continues to be impacted by those waiting for psychometric testing which is currently provided by an external contractor with limited capacity.
95% of people referred to specialist mental health services are seen within 8 weeks.	93.3%	

Mental Health Improvement Activities

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP7

Key Actions from the Annual Plan	Milestones	Status	Comment
Provide Safe Practice Effective Communication (SPEC) training for inpatient staff. Integrate weekly meetings (with staff and patients) to enable patient participation in decision-making to enhance the environment and safe practices of the unit. Invest in environmental and therapeutic practice changes to support staff to provide a safe therapeutic environment for inpatients. Include cultural expertise in environmental improvements to build cultural awareness amongst staff and improve access to cultural support for consumers and whānau. (EOA)	Q1: 95% of frontline staff receive SPEC de-escalation training.	✓	An Occupational Therapist is currently being recruited to the service.
	Q2: Integrated meetings held weekly.	✓	
	Q3: Additional Occupational Therapy FTE in place to support sensory modulation and meaningful activity for inpatients.	↺	
	Q4: Safe ward concept embedded into everyday practice.	✓	
	Q4: Equity of consumers experiencing seclusion being monitored.	✓	
Commence discharge planning on entry to Mental Health Services, embed the primary nursing model and process for engaging community teams at the earliest opportunity and build patient awareness and participation in transition/wellness planning.	Q1: Transition from inpatient to community services reviewed.	✓	Primary nursing is now embedded with early allocation to Community Mental Health Teams to support the patient journey/pathway. Family involvement in discharge meetings is the current focus.
	Q2: Updated pathway in place.	✓	
	Q3: Patient participation in discharge processes evident.	✓	
Engage staff and patients in the Marama real-time feedback survey to identify opportunities to improve service delivery, particularly for Māori consumers. (EOA)	Q4: 75% of discharged patients complete the Marama survey.	↺	Most feedback has been provided prior to discharge and changes are being implemented to support use of the survey.
	Q4: 75% of discharged Māori patients complete the Marama survey.	↺	

Key Performance Measures	Result	Comment
95% of clients discharged with a transition plan in place (inpatient services)	38.4%	PRIMHD, the Mental Health Quality Team and the Mental Health Team Managers are now required to report monthly to the Clinical Risk Meeting to ensure the target is met by the next quarter.
95% of audited files meet accepted good practice.	53.8%	

Addictions Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP8

Key Actions from the Annual Plan	Milestones	Status	Comment
Realign resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based community health model.	Q1: Additional mental health respite capacity available in Buller.	✓	Respite is now being provided by a local ARC provider, in partnership with Community Mental Health Team, and this is working well.
Implement the new AOD Crisis Response model to provide improved access to crisis services across the age and severity continuum.	Q2: Additional community-based AOD support options identified.	✓	A new service has commenced and is being implemented by the Salvation Army.
Investigate options to increase community-based respite, withdrawal management and recovery support, particularly for Māori. (EOA)	Q4: Increased AOD capacity available.	✓	

Key Performance Measures	Result	Comment
80% of people referred to specialist addiction services are seen within 3 weeks.	64.1%	We anticipate increased community options and the realignment of resources across locality bases will improve wait times going forward.
95% of people referred to specialist addiction services are seen within 8 weeks.	83.5%	

Primary Care Services

Service Access

NZHS Link – Closer to Home

Status Report for 2018/19 | Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with the West Coast PHO to implement the national zero fees policy, extending zero fees for children <13 to zero fees for children <14. (EOA) Work with local Pharmacies to ensure they update systems to align with the national policy. (EOA) Work with the West Coast PHO to implement the national lower fees for Community Services Card holder policy. (EOA) Update the DHB and PHO websites in line with the implementation of zero fees policy, showing details of practices' fee arrangements.	Q2: Proposed new zero fees model communicated and agreed.	✓	All general practices on the West Coast have signed up to the zero fees for children under 14 years and the initiative to provide 'lower cost general practice visits'. Adults with a Community Services Card (CSC) who are enrolled with a general practice pay no more than $18.50 for a standard visit and young people (14 to 17), who have a parent or caregiver with a CSC are charged no more than $12.50.
	Q2/Q3: Implementation of zero fees model for children <14 (both in and out of hours).	✓	
	Q4: PHO/DHB websites updated to reflect changes in fees.	✓	
	Q4: 95% of children <14 have zero fee access to general practice services and prescriptions.	✓	

System Integration

NZHS Link – Closer to Home

Status Report for 2018/19 | Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to invest in the West Coast Alliance as a mechanism for leading service and system improvements. Engage system partners in the Alliance's new Mental Health Workstream to support the implementation of the locality-based mental health service model. Ensure a strong Māori voice and focus on Alliance workstreams. (EOA) Monitor system performance against the national System Level Measures (SLM) to identify areas for improvement and focus.	Q1: New Alliance Chair is appointed to vacant role.	✓	An independent Chairperson has been identified and they will be in place for the first meeting of 19/20. Work to highlight equity through various reports continues with performance results for Māori included wherever this is captured. Narrative relating to activity to address inequity is included at all levels of performance reporting. Work to develop a refreshed dashboard is underway, capturing ideas from other DHBs. Actions in the SLM Improvement Plan have been delivered.
	Q2: Work plan for the Mental Health Workstream endorsed by the Alliance Leadership Team.	✓	
	Q2: Equity reporting dashboard developed.	↺	
	Q4: Delivery of the actions agreed in the SLM Improvement Plan.	✓	
Work through the West Coast Alliance to refresh and refine the SLM Improvement Plan, outlining collective activity to improve performance in 2018/19.	Q1: Implementation of agreed SLM Improvement Plan underway.	✓	The SLM Plan was agreed and approved by the Ministry. It is now being implemented.
	Q1: Quarterly review of progress against the Improvement Plan.	✓	
Continue to develop a rural generalist workforce model to support the transformation of service models on the Coast. Invest in a lead role to support an integrated Dietetic and Nutrition Service, working across DHB, PHO and CPH areas of service delivery. Recruit and develop more nurse practitioners to support care in primary health settings.	Q1: Rural Hospital Medical Specialist (with extended scope in Obstetrics) engaged.	✓	The lead clinician for Nutrition Service continues to be discussed in the context of the DHB's new organisational structure and the services' plans for the coming year. Three Nurse Practitioners are in place; one in unplanned care, one in LTCM and one in Mental Health.
	Q3: Lead clinician engaged to provide oversight to nutrition services.	↺	
	Q4: Three Nurse Practitioners working in primary care.	✓	

CVD and Diabetes Service Improvement

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP20

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with the PHO and general practices to maintain the proportion of the eligible population receiving a CVD and Diabetes Risk Assessment at or above 90%. Engage Poutini Waiora to identify and contact Māori men to lift the Risk Assessment rates for this high-risk population. (EOA)	Q1: Monthly performance reporting by general practice.	✓	The West Coast PHO is actively monitoring results by ethnicity and working with Poutini Waiora to implement key actions to support the uptake of CVD assessment by Māori men as a high-risk group.
	Q1: Monthly performance reporting by ethnicity.	✓	
Work with Health Quality & Safety Commission to further advance the Whakakotahi work plan by trialling evidence-based care pathway improvements in two primary care pilot sites. Target improvements in engagement with Maori as a high risk group. (EOA)	Q1: Two Whakakotahi pilots underway.	✓	The pilot project in the Buller region was re-scoped and linked in with Poutini Waiora to better support Maori with diabetes. The initial evaluation has indicated this has been successful in targeting high risk groups. The Grey Medical Practice in Greymouth is now looking at implementing the pilot trialled in Buller, targeting high risk groups. The second pilot project in Greymouth, focussing on pre-diabetes, was halted as patient data evaluation did not support project continuation.
	Q4: Completion of Phase I of the pilot with assessment of pathway improvements.	✓	
Establish a visiting specialist vascular surgical outpatient service to support diagnosis and treatment for West Coast patients, without the need to travel. (EOA)	Q1: Visiting Specialist Vascular service established.	✓	
Continue to support community-based initiatives to engage and enrol people with diabetes in the primary care LTCM Programme so that people can be supported to make lifestyle changes to help reduce their risk, with a particular focus on Māori as a high needs population group. (EOA)	Q1: Retinal screening expo and clinic in Reefton and Greymouth.	✓	Four week-long Retinal Screening Expo clinics were held this year in Reefton and Greymouth in August 2018, Greymouth and Westport in November 2018, Greymouth and Hokitika in March 2019 and Westport in June 2019.
	Q4: Three pre-diabetes and high risk CVD dietitian clinics delivered.	✓	
	Q4: Three Living Well with Diabetes courses delivered.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
90% of the eligible population had a CVD risk assessment in the last 5 years.	87.3%	86.5%	305 more people needed to have complete their CVDRA to meet the target for the whole population.
90% of eligible Maori men (35-44) have had a CVD risk assessment in the last 5 years.		70.9%	Only 29 more Maori men needed to be reached to meet this target.
90% of the population with diabetes, have had an annual HbA1c test.	81%	81%	To reach the target, another 11 Maori and 77 non-Maori would have needed to have had their annual HbA1c tests in the last year.

Pharmacy Action Plan

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Participate in the national process to develop and implement a new service agreement for integrated community pharmacy services. Offer the new agreements and opportunities to improve integration of local services.	Q2: West Coast pharmacies have new 'evergreen' pharmacy service agreements in place.	✓	All West Coast pharmacies are signed up to the new agreements.
Further develop the Pharmacy Long-Term Conditions Service, to improve access to pharmacist support for people on multiple regular medicines. (EOA) Support more pharmacists to provide medication use reviews (MURs) for people taking many or high-risk medicines. (EOA)	Q3: Two more pharmacists accredited to provide MURs.	✗	This was an ambitious target with limited availability of pharmacists to provide medicines management support for patients via LTC and MUR services. The number of people enrolled in LTC service has fallen and is now at 657.
	Q4: >20 people receive a MUR from their pharmacist.	✗	
	Q4: >900 people are enrolled in the Long-Term Conditions Service.	✗	
Work with the national Expert Advisory Group to develop a Minor Ailments (pharmacy) Initiative to ease access to timely treatment for Community Service Cardholders. (EOA)	Q4: Minor Ailments Initiative developed and put forward for approval.	✗	The Expert Advisory Group is still to complete development of a Minor Ailments service model.

Newborn Enrolment

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – SI18

Key Actions from the Annual Plan	Milestones	Status	Comments
Establish a process to support general practice enrolment as part of the current new-born multi-enrolment process and complete a review of the multi-enrolment form to ensure it is meeting the stakeholder needs. Work with Plunket and Poutini Waiora to develop a Kaupapa Māori Pregnancy & Parenting Education Programme. (EOA) Ensure the Programme emphasises the importance of enrolling with primary care to support engagement with health services. (EOA)	Q2: Process to support general practice enrolment developed.	✓	A proposed model for Kaupapa Māori PPE has been developed. Planning is underway for delivery of the first cohort.
	Q2: Kaupapa Māori PPE Programme developed.	✓	
	Q3: New-born enrolment form review completed.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
85% of new-borns are enrolled with general practice by 3 months of age.	110%	83.3%	15 out of 18 Maori babies were enrolled with a general practice by three months of age on the West Coast for quarter four

Support to Quit Smoking

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Identify smoking patients newly enrolling in the primary care LTCM Programme for mental health concerns, with the goal of offering them stronger support to quit smoking.	Q2: Process for capturing new patients established.	✓	All patients enrolled in the LTCM are asked about their smoking and offered support to quit.
	Q4: Identified patients contacted by Stop Smoking Service.	✓	
Work with the Buller Health Practice to identify Māori smokers and ex-smokers who have not been appropriately screened for COPD. (EOA) Work with Poutini Waiora to engage those patients in spirometry clinics, where screening, smoking cessation advice and other opportunistic referrals can be offered. (EOA)	Q2: Process for capturing Māori smokers and ex-smokers age 35+ established.	✓	The Buller Health team including Respiratory Nurses Specialist along with Poutini Waiora Whānau Ora nurses have proactively invited smokers and ex-smokers to come along with their whānau to undertake spirometry testing and engage in discussions about smoking cessation options and other lifestyle changes.
	Q4: Identified patients and appropriate whānau invited for COPD screening.	✓	
Work with the PHO and Well Child Tamariki Ora providers (collecting smokefree status data) to improve data collection and establish how whānau being offered brief advice and cessation support can be captured.	Q2: Data collection for smokefree household measure in place.	✓	The new data capture system was implemented in early March. It was agreed that the offer of brief advice to whānau through a WCTO visit should be captured in the WCTO notes.
	Q4: Process for ABC data capture in Patient Management System investigated.	✓	

Key Performance Measures	Total Result	Maori Result	Comment
90% of PHO enrolled patients who smoke are offered brief advice/support to quit.	96%	96%	The PHO continues to maintain high rates of smoking status ever recorded for patients (99%).
90% of West Coast households with a newborn have their smokefree status recorded at the first core Well Child check.			Data has not been released by Ministry of Health for this measure

Child Health Services

Maternal Mental Health Services

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP44

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to support the use of free general practice consultations for pregnant women with medical, mental health or social issues that may be exacerbated by pregnancy. (EOA) Promote the maternal mental health service referral pathway using HealthPathways. Review the timeliness of referrals from LMCs to Well Child providers, with a focus on Māori as a population of higher need. (EOA)	Q1: Review of maternal mental health pathway complete.	✓	The DHB continues to support stronger relationships between West Coast LMCs and WCTO providers, in order to support timely referral and handover.
	Q2: Promotion of pathway to increase uptake.	✓	
	Q3: Review of referral timeliness completed and opportunities for improvement identified.	✓	The DHB continues to advocate for improved visibility of all WCTO Core check data in order to support quality improvement actions in this area.
Identify all community-based DHB funded services and initiatives currently in place to support maternal mental health and the number of women being supported.	Q2: Stocktake report completed.	✓	A stocktake has been completed and submitted to the Ministry. Work continues to improve data capture in relation to the Maternal Mental Health Pathway so that referral and access rates to services can be reported and monitored. In 2018/19, 3 women accessed the free primary practice appointments available for women experiencing mental health concerns in pregnancy.
	Q4: Access report provided to the Ministry of Health.	✓	

Child Wellbeing

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP27

Key Actions from the Annual Plan	Milestones	Status	Comments
Work collectively to increase the number of pregnant women (and partners) engaging in the Smokefree Pregnancy Incentives programme. Extend the schedule for incentives to support continued engagement with cessation services beyond birth, to promote a smokefree home environment for babies.	Q1: Pregnancy Incentives programme model reviewed.	✓	The programme continues to track well with good uptake from women. Success stories have not yet been published as women have been reluctant to 'go public' with their story, however overall results of the programme will be shared in the DHB Quality Accounts and one whānau (two sisters and their partners) is working with the DHB on a story for early in the new year.
	Q2: Opportunities to enhance the Programme actioned.	✓	
	Q4: Successes of women who have successfully quit are celebrated.	↺	
Continue to train volunteer peer supporters through the Mum4Mum programme, with a focus on Māori supporters to extend the reach of the service. (EOA) Investigate strategies to link high need populations to a Mum4Mum supporter. (EOA)	Q2: Opportunities to enhance the programme actioned.	✓	Only one new Mum4Mum supporter trained this year has identified as Māori. A further two unfortunately withdrew their commitment prior to commencing training. The team continues to work with key stakeholders to try and identify women who are willing to complete the training course.
	Q4: An increased number of Māori mothers trained as peer supporters.	↺	
Establish a Transalpine Oral Health Service Development Group to support a whole of life approach to good oral health. Promote the Newborn Enrolment Form to support early enrolment of children with the Community Oral Health Service. (EOA) Identify opportunities for health promotion and education for families whose children are hospitalised for dental surgery. (EOA)	Q1: West Coast Development Group membership confirmed.	✓	The Healthy West Coast Alliance workstream is leading the development of a cohesive Oral Health Promotion plan that capitalises on opportunistic contacts as well as creating supportive environments.
	Q1: Childhood Nutrition/Health Promotion role supporting Early Childhood Centres established.	✓	
	Q2: Practice Nurses complete 'Lift the Lip' checks at immunisations.	✓	
	Q2: 'Water Only' policies in place in West Coast schools.	✓	
Continue to invest in the Violence Intervention Programme (VIP) and activity to support a reduction in harm and adverse health outcomes.	Q1: VIP training sessions ongoing.	✓	Audit results were positive 84/100.
	Q4: VIP audit results >70/100.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
95% of children (0-4) are enrolled with Community Dental Services.	101%	90%	There are denominator issues with these ethnicity results, which are based on projected population figures. The 'Other' population enrolment rate was 105%. In total there were 5,089 children enrolled.
90% of enrolled children (0-12) are examined according to plan.	96%	93%	There were 225 children overdue, 60 of those children were Maori.
85% of adolescents (13-17) are accessing DHB-funded oral health services.	75.7%		The DHB was 160 young people short of the target.

Supporting Health in Schools

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP39

Key Actions from the Annual Plan	Milestones	Status	Comments
Support the Health Promoting Schools framework in lower decile and schools with a high proportion of Māori/Pacific students. (EOA) Support the roll out of the 'Water Only in Schools' programme as part of good oral health promotion and an enabler to wellbeing. Undertake a stocktake of all initiatives currently underway to support health in schools. Review the 2018 Greymouth Schools Wellbeing Survey and identify actions for improvement.	Q2: Schools recruited to develop 'Water Only' policy.	✓	Poutini Waiora is now leading work around defining Wellbeing using the WHO model and how to incorporate supports for this into daily school business.
	Q2: School Wellbeing Survey reviewed.	✓	
	Q2: Stocktake report completed.	✓	
	Q3: Service improvement recommendations developed and agreed.	✓	

Immunisation

NZHS Link – One Team

Status Report for 2018/19

Performance Reporting Link – PP21

Key Actions from the Annual Plan	Milestones	Status	Comments
Monitor and evaluate immunisation coverage at DHB, PHO and general practice level, to maintain coverage and identify unvaccinated children. Fill the vacant Māori provider role on the Immunisation Advisory Group to ensure a strong focus on Māori as a priority group. (EOA) Continue with a focus on pregnancy vaccinations and LMCs having immunisation conversations. Share refreshed immunisation process charts and prompts for difficult immunisation conversations. Support general practice to promote the co-delivery model for HPV and Tdap.	Q1: Quarterly review of vaccination and decline rates by ethnicity.	✓	Work is underway on the development of the Difficult Conversations training programme with a programme outline developed and a model for delivery being confirmed for 2019/20.
	Q1: Māori representative on the Immunisation Advisory Group.	✓	
	Q2: Refreshed process chart issued to general practice.	✓	
	Q2: HPV and Tdap Information and education resources issued.	✓	
	Q4: Difficult Conversations training options explored for practice nurses.	↺	

Key Performance Measures	Total Result	Maori Result	Comments
95% of 8-month-olds fully immunised.	75%	85%	Four consenting children were missed this quarter with a high combined opt-off and decline rate of 20.3%.
95% of 2-year-olds fully immunised.	82%	88%	Two consenting children were missed this quarter. The combined opt-off and decline rate was 16.6%.
95% of 5-year-olds fully immunised.	90%	83%	Two consenting children were missed this quarter. The combined opt-off and decline rate was 7.7%

School-Based Health Services (SBHS)

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP25

Key Actions from the Annual Plan	Milestones	Status	Comments
Engage decile 4 schools in the School Based Health Services (SBHS) programme. Undertake a stocktake of all SBHS currently provided in West Coast secondary schools. Work with decile 1-4 schools to identify barriers to participation in routine health assessments with particular focus on Māori children. (EOA) Work with schools and providers to develop an implementation plan for expanding SBHS to all public secondary schools on the West Coast.	Q2: Stocktake report completed.	✓	SBHS are now in place at three of the four decile 1-4 schools and both Alternative Education facilities on the Coast. Work continues to finalise a MoU with the last school. An implementation plan has been provided to MoH, which outlines timeframes, enablers and constraints for full roll out of SBHS to all secondary schools on the West Coast.
	Q2: Barriers to access identified.	✓	
	Q4: Implementation plan completed and provided to MOH.	✓	
	Q4: SBHS in place in all West Coast 1-4 decile schools.	↺	

Key Performance Measures	Total Result	Maori Result	Comments
95% of eligible year nine students received a Routine Health Assessment (including a HEEADSSS assessment) in the last calendar year.	54%	32%	Changes in staffing within the Public Health Nursing team have impacted on service delivery.

Responding to Childhood Obesity

NZHS Link – Value and High Performance

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Engage a community-based dietitian to work alongside Public Health Nurses to provide advice and support to families regarding healthy weight in childhood at their B4 School Check.	Q2: Dietitian attending B4SC clinic days in Greymouth.	✓	A dietitian continues to attend B4 Schools Clinics held in Greymouth to provide information/hand-outs, as well as meeting with families and providing support and advice. The dietitian resource required to cover all B4SC clinics has been identified and work continues with the team to ensure this model is supported whenever possible outside of the Grey district.
	Q4: Resource required to provide support at all clinics identified.	✓	
Provide primary care teams with training and education regarding healthy weight in childhood to support appropriate onward referrals for family/whānau support.	Q2: Training and education needs identified by practices.	✓	
	Q4: Training/education delivered.	✓	
Work with the Ministry of Education to develop an improved process for children with disabilities to access B4 School Checks and discuss healthy weight in childhood with a dietitian. (EOA)	Q1: Process for identifying children with higher needs developed.	✓	
	Q4: Process agreed with Education.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
95% of children identified as obese at their B4 School Check are offered a referral to a health professional for clinical assessment and family-based lifestyle intervention.	100%	100%	Results for the Raising Healthy Kids measure are reflective of local data. Ministry will not be releasing quarter four results. 166 checks were completed during quarter four. 14 children were identified as obese and offered a referral.

Older Person's Health Services

Healthy Ageing

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP23

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with partner organisations through the Health of Older People Workstream and Falls Coalition to enhance and integrate falls and fracture prevention services. Engage local providers to accredit community strength & balance classes, including a number specifically designed and targeted towards older Māori. (EOA) Embed the fracture pathway to ensure people with a fractured Neck-of-Femur (NOF) are referred to the in-home Falls Prevention Service.	Q1: St John representative attending Falls Coalition meetings.	✓	A Maori focussed community exercise class is being held, however the class is not yet accredited and we continue to work with them to achieve this. The NOF pathway work has been delayed due to some wider work being done with ATR within Grey Base hospital. The Fracture Liaison Service will progress very shortly with the appointment of a new staff member.
	Q2: Review and integration of osteoporosis and falls prevention referral pathways complete.	✓	
	Q3: Māori focused community strength & balance class accredited.	↺	
	Q3: NOF pathway embedded.	↺	
	Q4: Virtual Fracture Liaison Service operational.	↺	
Encourage service providers to consider Māori health needs from 50+ to enable older Māori to maintain good health. (EOA) Engage the Māori Needs Assessor to complete InterRAI assessments to ensure an appropriate response for older Māori with complex health issues. (EOA) Employ a Clinical Nurse Specialist to embed and promote the early supported discharge service (FIRST) ensuring the screening and referral of older people to appropriate discharge options.	Q2: InterRAI reporting framework in place and assessment rates tracked by ethnicity.	✓	Recruitment is ongoing for a Maori Clinical Assessor; Poutini Waiora is engaged in the process but as yet this process has not been successful in identifying a candidate. Six clients have completed the FIRST programme since August 2018.
	Q2: CNS appointed to support FIRST.	✓	
	Q3: Baseline established InterRAI assessments per 1,000 population.	✓	
	Q4: Three people admitted to the FIRST service.	✓	
Analyse the 75+ cohort presenting at ED and investigate potential interventions. Analyse the 75+ cohort with repeat acute admissions and investigate potential interventions. (EOA)	Q1: Analysis of ED and repeat acute admissions undertaken.	✓	We have reviewed acute admissions from ED and are in the process of identifying areas where alternative community pathways could be used. The PHO is also identifying all patients who have LTCH conditions and ensuring they have an acute care plan in place
	Q2: Strategies to address repeat cohort presentations and admission identified.	✓	

Key Performance Measures	Result	Comments
720 places available at approved strengths and balance classes.	506	There were 261 attendees at classes in the last quarter.
120 referrals made to the Falls Prevention Service.	105*	This is a preliminary number, the final month is yet to be confirmed.
95% of long-term Home Based Support Services clients have had an InterRAI assessment and have a completed care plan in place.	N/A	During quarter four 81 homecare inteRAI assessments were completed and 43 contact inteRAI assessments.

Improving Systems

Strengthened Delivery of Public Health Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – SI16

Key Actions from the Annual Plan	Milestones	Status	Comments
Implement the planned/ unplanned care model, incorporating a new approach to the provision of after-hours and urgent and emergency care as the DHB transitions to the new Grey Hospital and develops its model of care in Westport. Work with the Ministry to ensure external contracting, reporting and funding mechanisms do not create artificial barriers or restrict development of the new model.	Q2: Communication plan for new planned/unplanned care pathways developed.	↺	Planned and unplanned pathways have been implemented at Grey Medical and we continue to work on improving these and widening the coverage to our community. Delays to the facilities build in Grey will mean some actions around the new model and extended hours won't be implemented until 2019/20.
	Q3: New model allows people to be seen and treated in the right place.	↺	
	Q4: Primary care hours extended to provide greater access to care.	×	
Establish a centralised Hub for the delivery of assessment and coordination services to enhance the integration of services.	Q4: Centralised support service (that includes bookings and community assessments) in place.	↺	A project is underway but further work around this will continue into the next year. Co-location is a key enabler and the new administration facilities that will be completed at the end of the calendar year will enable this to occur.
Realign resources to support implementation of the locality-based services model with three integrated health service spokes in Northern [Buller], Central [Grey] and Southern [Westland].	Q1: Northern integrated health service in place.	✓	The implementation of the locality based services model is now underway for the Central and Southern areas. The Northern area is already in place.
	Q4: Central and Southern integrated health services in place.	↺	
Consider the provision of services currently under hospital management and explore how the DHB might better meet the needs of the population as part of the wider integrated service model.	Q1: Review of OT and Audiology Services completed.	✓	The review of OT has been completed, and a review of the audiology service is now underway. Work is underway to understand capacity for dementia services.
	Q1: Opportunities to provide greater access to residential dementia services explored.	✓	
Invest in the development of a rural generalist workforce model to enable the transformation of models of care and support the sustainability of our system. Design a communications and recruitment strategy that communicates the rural generalist model and attract professionals interested in this way of working.	Q1: Communications and recruitment strategy implemented.	✓	Implementation of the rural education and training cluster is now underway. Obstetrics, General Medicine and Anaesthetics will be the services where we will develop our rural medical generalist approach. Training programmes have been identified to enable this. We have one Rural Generalist with an extended scope in Obstetrics.
	Q4: Rural education and training cluster implemented.	✓	
	Q4: Pathways for development of rural medical generalists identified.	✓	
	Q4: Extended scope roles in place.	✓	

Disability Support Services

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – SI14

Key Actions from the Annual Plan	Milestones	Status	Comments
Form a transalpine West Coast/Canterbury DHB Diversity Training Group to develop a diversity education framework. Engage the Disability Steering Group and Māori and Pacific leads to ensure content is consumer focused and culturally appropriate. (EOA) Engage subject matter experts to develop disability training modules, building on the e-learning work completed in 2017/18. Track uptake and feedback on modules as a means of evaluation.	Q1: Diversity Training Group established.	↺	There have been initial delays with this work but a number of enablers are now in place or underway: the appointment of the Care Starts Here Programme Manager, the initiation of the Diversity Inclusion and Belonging Policy, and the coming together of members from the Disability Steering Group to discuss 'what change looks like'. This provides the basis for a diversity learning framework and there is more clarity on the scope of training linked to the intended behaviour change. This work has been reprioritised for 2019/20.
	Q2: Diversity education framework approved.	×	
	Q2: Development of training modules complete.	×	
	Q3: Disability training modules launched on HealthLearn.	×	
	Q4: Report on uptake of training modules.	×	

Key Performance Measures	Result	Comment
Percentage of staff completing disability training modules.	1,423	This relates to the current online training module available for staff through healthLearn.
Percentage of staff rating content positively.	NA	The currently online module does not include evaluation measures

Shorter Stays in Emergency Departments

NZHS Link – Value and High Performance

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Implement a Short Stay Unit in the new Grey-base Hospital facility, to streamline and support the improved flow and observation of patients.	Q1: Criteria for short stay admission and discharge developed.	✓	This work is underway with short stay criteria developed and workforce projections completed. However, further implementation has been held-up due to ongoing delays with the new Grey Base Hospital build.
	Q2: Workforce requirements and FTE determined.	✓	
	Q3: Recruitment underway.	↺	
	Q4: Unit operational.	↺	
Establish a duty nurse (patient flow manager) manager role, within hours, to assist with patient flow and admission and discharge planning across the wards.	Q1 Role scoped and agreed.	✓	This position has been recruited to with a start date of Q1 19/20. The impact of the role will be reviewed after the position has been in place for a year.
	Q2 Role recruited.	✓	
	Q3 Review of impact and focus.	×	
Map the journey for Maori across the rural health continuum (primary to secondary care) and determine areas of focus to improve earlier engagement. (EOA)	Q3: Journey Mapped.	↺	This action has been delayed due to a change in staff, however meetings have now been set for this project to commence in quarter one 19/20.
	Q4: Opportunities identified and prioritised.	×	

Key Performance Measures	Total Result	Maori Result	Comment
95% of patients are admitted, discharged, or transferred from ED within 6 hours.	98.2%	98.3%	
<20% of patients are admitted from ED short stay unit to inpatient wards.	37%		586 patients were admitted in Q4.
<64% of presentations to Grey Base ED Reduction are triage level 4-5.	54%		The ethnicity breakdown of this measure will be available Q1 19/20
>8/10 average for in-patient survey domain rate your experience of communications.	8.5	NA	Latest result to November 2018.

Cancer Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP30

Key Actions from the Annual Plan	Milestones	Status	Comments
Use data/intelligence systems to monitor the 62-day and 31-day wait time targets and support discussions with specialties missing targets. Undertake breach analysis for patients outside the 62-day target to assess emergent systemic issues that might need corrective action and identify opportunities to reduce process delays. Work with the Southern Cancer Network to support regional initiatives and tumour stream pathway developments that improve equity of access for West Coast patients. (EOA)	Q1: Quarterly monitoring of cancer wait times and analysis of any cases where there are delays.	✓	Monitoring of cancer wait time delays for individual patients is actively undertaken by West Coast DHB's Cancer Nurse Coordinator. The Te Wai Pounamu Maori Leadership Group has endorsed the Southern Cancer Network Equity Assessment Framework for progressive implementation in all work programmes.
	Q2: Improvements identified and implementation underway.	✓	
	Q3: Adopt learnings from the Southern Cancer Network equity assessment framework pilot.	✓	
Engage locally in the regional Te Waipounamu Māori Cancer Pathway Project to support improved outcomes for West Coast Māori. (EOA) Adopt a collective approach to improving cervical and breast screening rates for Māori women.	Q2: Cancer Korero Booklet developed and disseminated.	↺	Publication of the Cancer Korero booklet is underway and it is anticipated this will be completed in Q1 2019/20. The three planned cancer korero hui to promote cancer korero have also been delayed until Q2 19/20. Cultural competency training has been delivered to General Practices in Greymouth and to Poutini Waiora, with further training planned for other areas.
	Q4: Three cancer korero hui held to improve cancer health literacy amongst Māori whānau.	×	
	Q4: Cultural competency training and education package developed and presented to GP practices.	✓	
Incorporate references and links to Kupe (the national prostate cancer decision support tool) into HealthPathways and HealthInfo to support men and their families to understand the risks and benefits of treatment, before having a prostate cancer check.	Q2: Kupe link on HealthPathways to support GPs to have conversations with their patients.	✓	Kupe links have been established.
	Q2: Kupe link on HealthInfo to support patients and their families to make informed decisions.	✓	
Continue to engage with and provide input into community initiatives that support people and their families following, cancer treatment. Engage with the Southern Cancer Network to identify opportunities for the Coast arising from the regional engagement and survivorship initiative pilot.	Q2: Input and support provided to the Cancer Society (Living Well Programme) and Poutini Waiora for delivery of survivorship initiatives.	✓	A Living Well workshop held Greymouth on 13 April 2019, with a host of smaller targeted group sessions also being delivered. West Coast DHB is engaged in the following regional priority focus areas: improving lung cancer pathways, roll-out of MOSAIQ, and increased use of clinical Multi-Disciplinary Meetings for reviewing individual patient care. The DHB's Cancer Nurse Coordinator also sits on the regional Clinical Governance and Operational Leadership Group.
	Q2: Input into regional feedback sessions on end-of-treatment needs.	✓	
	Q4: Review of regional opportunities.	✓	

Key Performance Measures	Total Result	Maori Result	Comment
90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks.	73.7%*	NA	Small numbers are challenging with this result reflecting only five patients who were not seen within the 62 day period. Every non-compliant case individually followed up. Most non-compliant cases are physically, psychologically, or diagnostically challenging. *Note: Ethnicity data is not provided by the MoH and results for Q4 are preliminary.*
85% of patients receive their first cancer treatment (or other management) within 31 days of date of a decision-to-treat.	89.6%*	NA	

Elective Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP45

Key Actions from the Annual Plan	Milestones	Status	Comments
Establish a clinical governance alliance to support a 'One Service' approach to orthopaedics across Canterbury and West Coast DHBs. (EOA) Invest in additional capacity in plastics to improve timely access to treatment. (EOA)	Q2: Transalpine Orthopaedic clinical governance alliance established.	✓	Transalpine Orthopaedic Service in place with joint governance.
	Q2: A Plastics Fellow is in place, as part of the transalpine plastics service.	✓	Several visits by the Plastics Fellow occurred during 2018. We now have regular plastics visits.
Review current booking system processes to identify opportunities to improve the uptake of appointments and access to services. Facilitate cross-system collaboration between booking teams and Poutini Waiora to identify solutions for better engaging with Māori. (EOA) Develop criteria to help identify patients who would be suitable for telehealth clinics, to reduce their need to travel. (EOA) Work with the Ministry to develop consistent rules for counting telehealth events, to ensure activity is appropriately captured.	Q1: DNA service level data used to identify initial areas of focus.	↺	Further data development is required to enable identification of cohorts for the DNA project. This will take place in Q1 2019/20. Electronic delivery of patient appointments is being tested before being fully enabled. Rollout of software-based VC has commenced with telehealth criteria developed and clinics identified and counted via the DHBs patient management system.
	Q2: Electronic delivery of patient appointments enabled.	↺	
	Q3: Business case developed for software-based VC capability.	✓	
	Q4: Telehealth criteria developed.	✓	
	Q4: Process for counting telehealth events in place to recognise activity.	✓	
Engage with Poutini Waiora to established closer links with Māori patients at the pre-presentation and discharge phases to support people to attend appointments. Deliver Tikanga Best Practice training to staff, to support patients to feel culturally comfortable with the care they are given.	Q3: Process in place to offer Māori patient's additional support through their elective patient journey.	↺	Engagement work underway via Tautau Pounamu. Training has not been able to be delivered due to capacity constraints and will resume in again in 2019/20
	Q4: Four Tikanga Best Practice sessions delivered.	✗	

Key Performance Measures	Total Result	Maori Result	Comment
1,916 elective surgeries delivered.	101.3%	NA	The West Coast DHB had provided 1,940 elective surgical discharges to June 2019, slightly higher than anticipated.
100% of people are seen for their First Specialist Assessment within four months (ESPI2).	97%	NA	Results as are at June 2019 and relate to 25 patients who waited outside of timeframes for their FSA and 24 who waited outside of the timeframe for treatment. FSAs have improved from 72 patients waiting outside of timeframes in May and are largely related to plastics patients. Those waiting for treatment included 11 plastics and 8 orthopaedic patients.
100% of people receive treatment within four months of the commitment to treat (ESPI5).	89%	NA	
Average elective length of hospital stay at or below 1.45 days.	1.19	NA	
Outpatient DNAs and maintained at or below 6%.	8.3%	13%	The DNA project has been prioritised for 2019/20.

Service Quality Part I

NZHS Link - Value & High Performance

Status Report for 2018/19			Performance Reporting Link – SI17
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Provide free seasonal flu vaccinations for people at higher risk including Māori over 65 years, pregnant women and people with a recent asthma related hospital admission. (EOA) Engage Poutini Waiora to support practices struggling to reach their target population. (EOA) Undertake analysis of Atlas indicators to identify opportunities to increase influenza vaccinations for target populations, after hospital admission.	Q1: Analysis of Atlas indicators shared to support targeted actions for high need populations.	✓	Key actions identified and highlighted in the DHB's SLM Improvement Plan. Work is underway with practices to remind them of the correct process for messaging NIR re vaccinations given in practice.
	Q2: Difference in coverage reporting between the NIR and general practice patient management system is clarified, to better target those who have not had a flu vaccination.	✓	

Key Performance Measures	**Total Result**	**Maori Result**	**Comment**
75% of the population 65+ have received a free influenza vaccine.	55%	50%	2018 flu season.

Service Quality Part II

NZHS Link - Value & High Performance

Status Report for 2018/19			Performance Reporting Link – SI17
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Work with consumers and staff to co-design and articulate the role of a 'nominated or preferred' contact person. Work with consumers to develop material describing and clarifying the role. Develop an organisational change process, including training and materials for staff who collect patient details, to ensure a patient's nominated or preferred person is identified in the early stages of admission.	Q1: Terminology agreed.	✓	The procedure, patient and family information document has been developed and is being consulted on. This work has been delayed due to staff capacity but has been prioritised for completion in 2019/20.
	Q2: Procedure for contact details collection updated to include nominated contact person.	↺	
	Q3: Organisational change process confirmed and tested.	↺	
	Q4: Change process approved and implemented.	↺	

Key Performance Measures	**Result**	**Comment**
>65% of inpatients felt 'staff included their family/whānau or someone close to them in discussion about their care'.	67%	

Waste Disposal

NZHS Link - Value & High Performance

Status Report for 2018/19			Performance Reporting Link – PP41
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Distribute materials to pharmacies for educating patients about returning unused and expired medicines and used sharps.	Q1: Educational materials distributed to pharmacies.	✓	
Undertake a stocktake on current disposal processes for each category of waste to identify opportunities for improving waste disposal arrangements.	Q2: Stocktake report completed and submitted to the Ministry of Health.	✓	

Climate Change

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP40

Key Actions from the Annual Plan	Milestones	Status	Comments
Link into the Canterbury Sustainability Governance Group (SGG) to support development of a Sustainability Strategy.	Q2: West Coast Sustainability Champions Identified.	✓	A Sustainability Governance Group (SGG) has been established. The transalpine maintenance and commercial managers sits on this group representing the West Coast
	Q2: Links into CDHB Sustainability Governance Group established.	✓	
Establish energy monitoring (using Energypro software) to build up a history of energy use and identify opportunities for improvement.	Q1: Energypro monitoring in place.	✓	The system has been introduced.
Review current inter-hospital truck transport service to identify opportunities to reduce mileage and use of fossil fuels.	Q2: Truck transport review complete and opportunities identified.	✗	Due to capacity constraints this transport review has been delayed until 2019/20. We expect transport kilometres will not reduce this year.
	Q4: Reduction in internal truck transport kilometres by 33%.	✗	
Undertake a stocktake of current initiatives being delivered to mitigate or adapt to the effects of climate change.	Q2: Stocktake of current actions completed.	✓	Stocktake complete and submitted to the Ministry of Health.
With support from Canterbury DHB, seek to introduce the CEMARS and Energy-Mark accreditation programmes.	Q4: CEMARS and Energy-Mark accreditation programmes introduced.	↺	We are working with CDHB to investigate support for improved energy-management systems.

OPERATIONAL UPDATE

TO: **Chair and Members**
West Coast Advisory Committee

SOURCE: **General Manager, West Coast DHB**

DATE: **27 September 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This is a standing report to the West Coast District Health Board Hospital Advisory Committee. It outlines progress in relation to service delivery across the District Health Board's Provider Arm.

2. RECOMMENDATION

That the West Coast Advisory Committee:

i. notes the Operational Update.

3. SUMMARY

This report is intended to:

- provide greater insights into the nature and flow of activity in, and through, the secondary care component of the West Coast health system;
- reflect a patient-centric view of services, being the 'patient journey' through the system; and
- provide greater clarity of, and focus on, key metrics.

The report is broken into six sections: 4.1 - Activity, 4.2 - Workforce Updates, 4.3 - Patient, 4.4 - Health Targets, 4.5 - Quality, 4.6 - Specific Requests [when applicable]. Further changes to graphics and content will occur as well, including the graphic representation of primary care in the acute patient's journey.

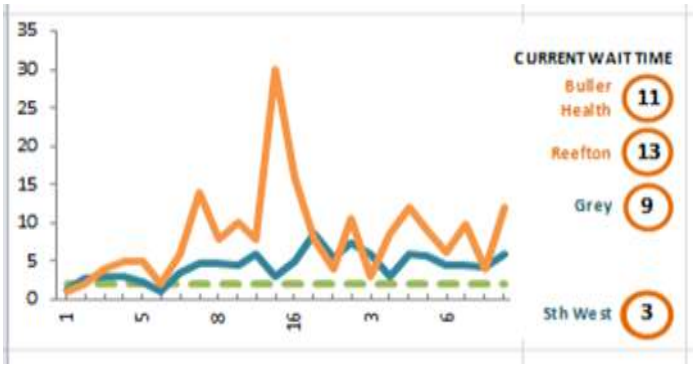
The following are the most notable features of the report:

- Health strategies across the age continuum – as work comes to a completion around the Maternity Health Strategy the teams will be moving to the Child Health Strategy looking at all our services that provide care and support for our children.
- Work is commencing with the Ministry of Health on the implementation of the National Bowel Screening Programme

4. DISCUSSION

4.1 Service Update

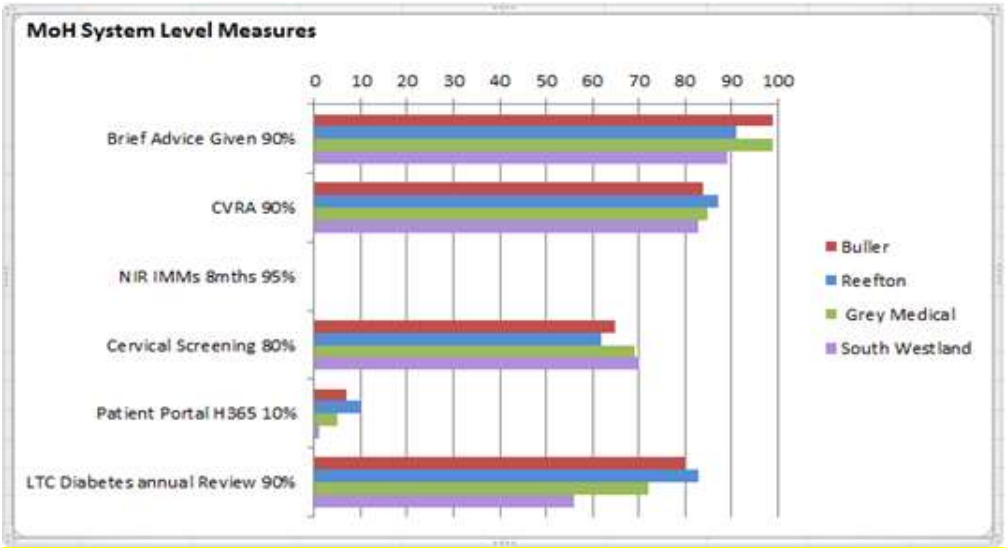
Primary Care & Northern Region Integrated Health Services



Wait times for planned appointments continue to fluctuate over the winter period as the team continues to look to cover gaps with locum general practitioners.

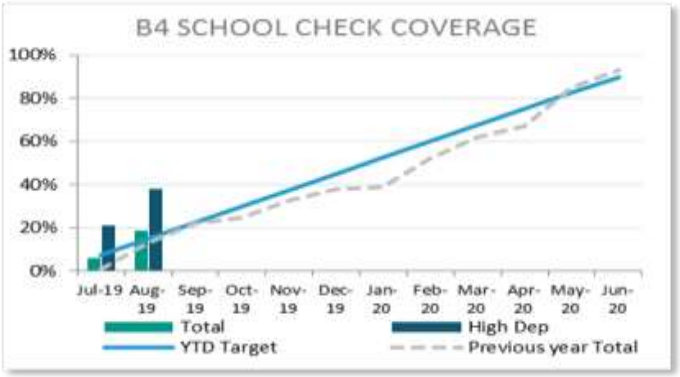
In Westport the decanting of services to Outpatients and Dunsford ward is underway. A Business Impact Analysis is in progress with the Buller team and WCDHB Emergency Planner to support both the decanting process but also supporting longer term preparations for significant events. Formal conversations with the respective services are scheduled with guidance from People & Capability to how best prepare and support staff through the process of relocation.

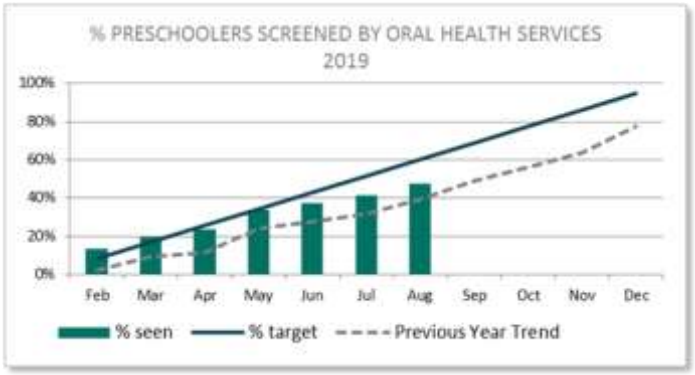
In Greymouth the teams are involved in activities to prepare for the new facility. Key areas of focus are the administration and reception teams where five different teams will be coming together and working as one group to greet and help community members as they interact with our services. Another focus area are looking at opportunities to further improve access to services through extending hours for planned appointments, giving a greater level of convenience to community members who work or find it difficult to attend between work hours.



Community

The B4School service is delivering very positive results as the result of quality improvement. For this time of the year the numbers are ahead of where we need to be to meet target at the end of the financial year. Clinic days scheduled have been cancelled as there are not enough 4 year olds available in some cases. We are on target for High Deprivation as well so it's been a great effort by the team.



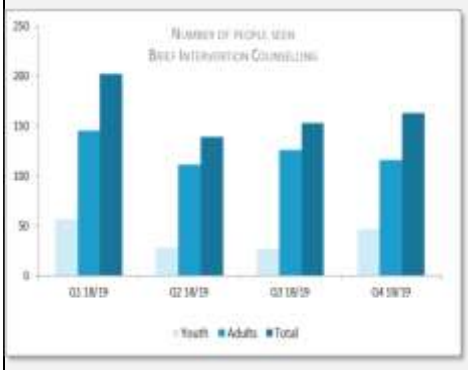


Health strategies across the age continuum

The clinical teams are continuing to work on the Maternity Health Strategy with further engagement with communities and in particular Maori across the Coast, to finalise a strategy that reflects the needs and priorities of our communities. As we come to a completion around this the teams will be moving to the Child Health Strategy that we are starting planning around and will commence engagement in the new year. This will be looking at all our services that provide care and support for our children to identify what is good, what needs improving, where there are gaps but most importantly engaging with our communities once more to understand their priorities and how they want their health services to work for their children.

Mental Health

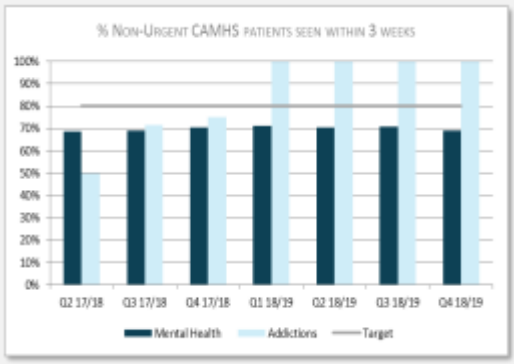
Early Intervention

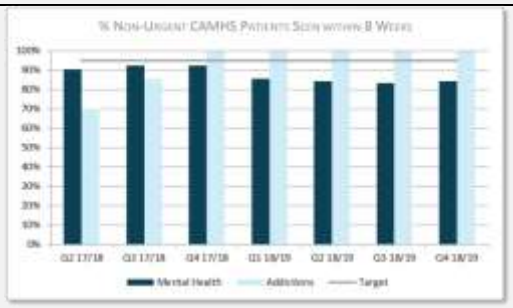


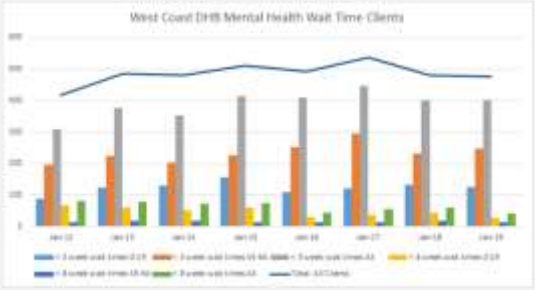
Brief Intervention Counselling delivered by the PHO wait time slightly reduced this quarter compared to last. Of the 70 youth seen this quarter 16% were for Maori. Continued liaison with NGO partners, Schools and ICAMHS is working well.

Community based support for women and their partners in need of additional support before and after the birth of a child continues with free intervention counselling provided for people needing moderate mental health support. The West Coast Maternal Health Pathway was audited and revised. The Pathway puts focus on early support for women requiring MMG support and links these services provided in the community

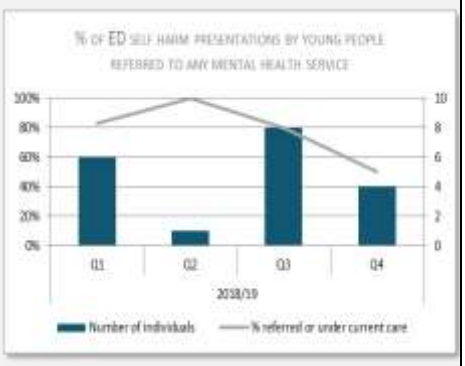
Non-urgent wait times for CAMHS

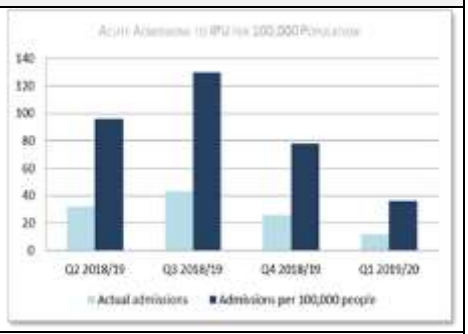




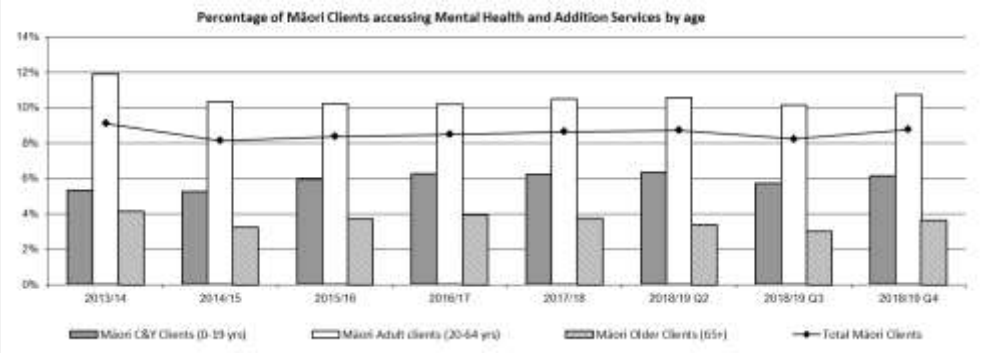


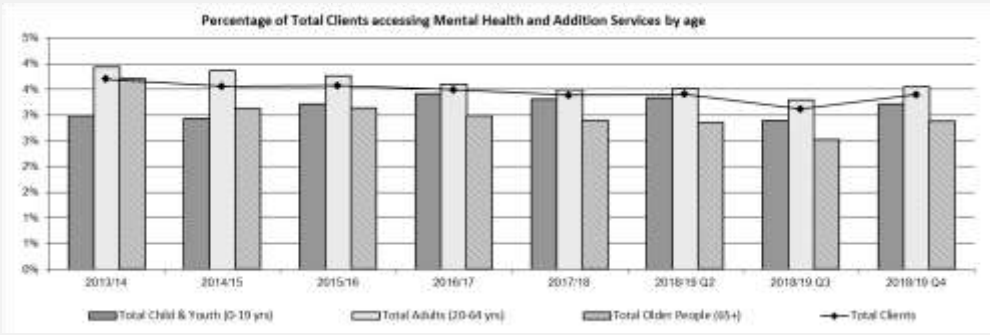
Acute





Access

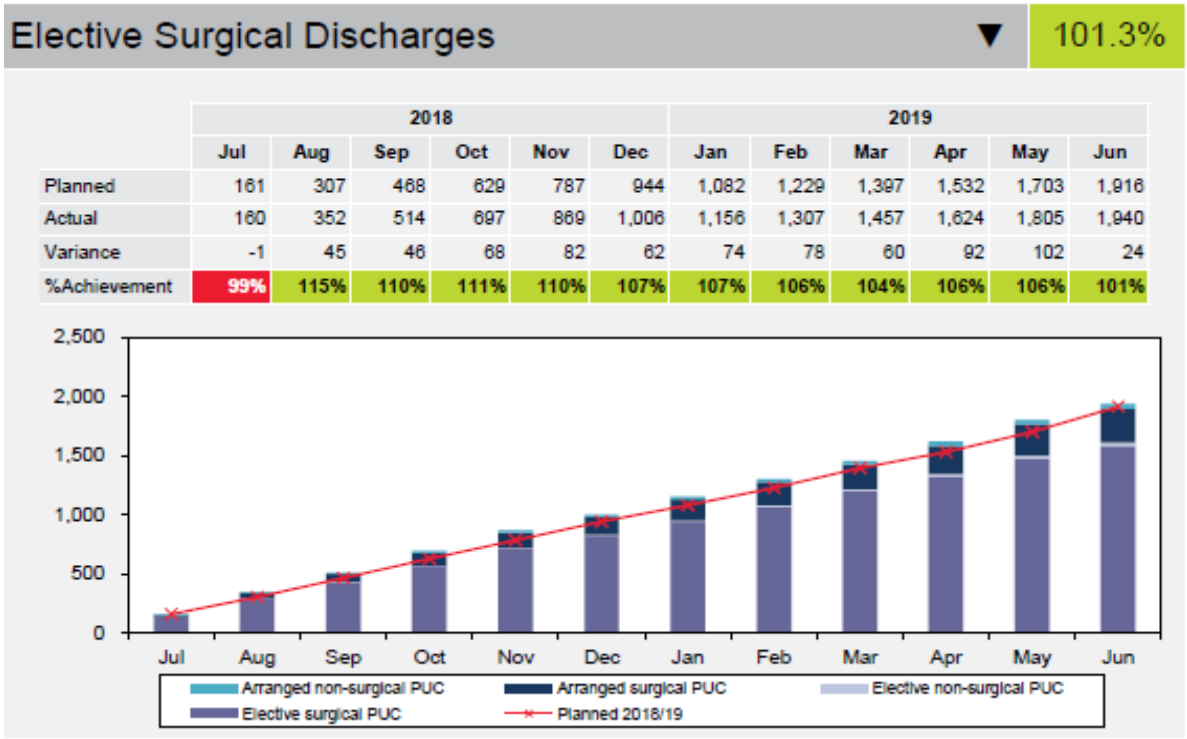




Inpatient and Outpatient

Outpatient Clinic DNA Rates

Month	Total number of patients booked	Number of patients attended clinics	Number of patients did not attend [DNA]	Percentage of patients did not attend [DNA]
August 2018	1621	1500	121	7.46%
September 2018	1566	1437	129	8.24%
October 2018	1637	1485	152	9.29%
November 2018	1644	1522	122	7.42%
December 2018	1155	1061	94	8.14%
January 2019	1507	1371	136	9.02%
February 2019	1544	1428	116	7.51%
March 2019	1555	1443	112	7.20%
April 2019	1488	1338	150	10.08%
May 2019	1730	1583	147	8.50%
June 2019	1375	1259	116	8.44%
July 2019	1515	1367	148	9.77%
August 2019	1664	1511	153	9.19%
13 month rolling totals	**20001**	**18305**	**1696**	**8.48% Average**



West Coast DHB was 24 cases ahead in delivering our target of 1916 elective and arranged discharges for elective surgery for the financial year to 30 June 2019.

West Coast DHB is currently still working with the Ministry of Health to confirm our indicative targets for the new model for Planned Care services for our 2019/20 Annual Plan.

National Bowel Screening Programme - Implementation on the West Coast

West Coast is amongst the last group of DHBs to be staged by the Ministry of Health to "go live" in the programme in 2020-21. Implementation is to be in three phases, with the DHB required to work with the Ministry in each phase to ensure that the required resource and increase in services can be delivered to support implementation. The three phases are as follows:

- Phase One – Information. The DHB is required to provide detailed information to the Ministry to inform the Ministry's business case to Ministers of Finance and Health. Draft information is due in October 2019, and the final Phase One information is due in February 2020.
- Phase Two - Planning. The DHB is required to plan for set up for establishing the service for 'go live'. This is to include various plans for workforce, equity, communications, primary care engagement, governance, leadership, accountability, etc.
- Phase Three – Establishment: The Ministry of Heath will assess our readiness and confirm that we can go live in the programme. Thereafter, the programme will be commenced locally.

Elective Services Patient Indicators [ESPI Compliance]

ESPI 2 FSA (First Specialist Assessment)

There were 23 patients waiting over 120 days for their outpatient First Specialist Assessment as at the end of July 2019 (2.8% of patients waiting). Of these, 16 were plastic surgery cases. The remaining cases were spread among a number of specialties, including 2 waiting over 120 days for ophthalmology, and 1 patient each in gynaecology, urology, general medicine, haematology and respiratory. Patients who were waiting over 120 days in other specialties other than plastic surgery are due to a combination of factors, including clinical complications delaying readiness to attend; some who had been given previous appointments within 120 days of initial referral, but then failed to attend (but not removed from the waiting list); and those for haematology and respiratory due to a quirk of the timing between the visiting specialist clinics rather than any capacity issue.

The previous cases of patients with prolonged waiting times over 120 days for orthopaedic FSA have now been addressed through the provisions of additional specialist clinics.

Some patients who are indicated as being over the 120-day target have previously been offered appointments, but not turned up at their clinic appointments; the reasons for which may be quite variable depending on the individual patient and their particular circumstances. They have been left on our waiting lists for re-booking, so as to offer them additional appointment dates to see a Specialist, rather than being simply removed and their referral returned to their primary care referrer.

ESPI 5 (Treatment)

Thirty patients were waiting over 120 days from FSA to surgical treatment as at the end of July 2019. This included patients in the specialities of plastic surgery (13), orthopaedic (10) dental (5), paediatric surgery (1), and urology (1). Additional plastic surgery theatre and outpatient sessions have been delivered to help address the back-log to the service, but the risk remains that

this will only help to keep pace with the increased demand rather than reduce or remove it in the short to medium term. Outpatient clinic and theatre list mix of the visiting specialists are being reviewed as a possible option to help smooth this out as part of our recovery plans.

Wait times on the orthopaedic surgical waiting list have started to increase again, as more patients have been seen at FSA. This will take time to resolve over forthcoming months as a production plan to manage the list growth is developed.

MoH Planned Care Measurement

Summary of Patient Flow Indicator (ESPI) results

DHB: West Coast

	Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Apr		May		Jun		Jul	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	18 of 18	100.0 %	18 of 18	100.0 %	17 of 17	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %	18 of 18	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	199	17.4%	181	17.1%	215	21.3%	202	20.3%	197	19.1%	178	16.8%	140	15.2%	88	10.1%	67	7.9%	72	9.1%	25	3.0%	23	2.8%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	1	0.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	7	3.0%	9	3.8%	14	5.8%	15	6.8%	18	7.9%	18	8.7%	20	9.3%	20	8.0%	30	11.6%	19	8.1%	24	11.1%	30	11.4%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %	0	100.0 %

Notes:

1. From July 2016 the required timeframe for ESPI 1 is 15 calendar days.
2. From January 2015 the required timeframe for ESPI 2 and ESPI 5 is 4 months.
3. ESPI results do not include non-elective patients, or elective patients awaiting planned, staged or surveillance procedures.
4. Medical specialties are currently included in ESPI 1, ESPI 2 and ESPI 5 but excluded from other ESPIs.
5. ESPIs 4, 6 and 7 have all been retired and are no longer reported.

Please contact the Ministry of Health's Planned Care team if you have any queries about ESPIs (elective.services@health.govt.nz).

ESPI Compliance Levels:

1. DHB Level 'Non-compliant Red' staus for ESPI 1 is temporarily removed so from July 2016 ESPI 1 will be Green if 100%, and Yellow if less than 100%.
2. ESPI 2 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.39%, and Red if 0.4% or higher.
3. ESPI 3 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 4.99%, and Red if 5% or higher.
4. ESPI 5 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.99%, and Red if 1% or higher.
5. ESPI 8 will be Green if 100%, Yellow if between 90% and 99.9%, and Red if less than 90%.

Data Warehouse Refresh Date: 1/09/2019
Report Run Date: 2/09/2019
Data up to: Jul 2019

West Coast DHB national performance measures report

Quarter 4 2018/19 April - June 2019

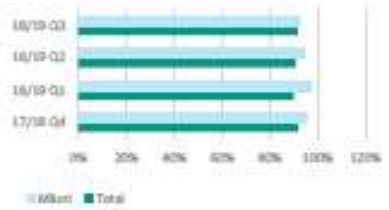
What are the national performance measures?

This report presents current performance against the national performance measures formerly referred to as national health targets.

These measures reflect Canterbury's performance in areas of significant public and government interest and continue to be tracked by the Ministry as part of the DHB's quarterly performance reporting suite. The targets remain in place until the new high-level measures set is released. We will continue to present performance across these priority areas. Three of the measures focus on patient access and three focus on prevention.

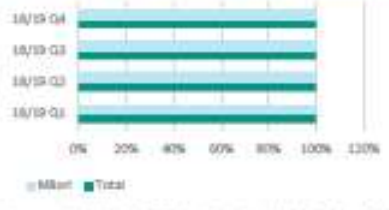
Supplementary indicators

Better help for smokers to quit: secondary smoking



This measures reflects patients in our hospitals, identified as smokers, being offered advice and help to quit smoking.

Better help for smokers to quit: maternity smoking



The Ministry sources this data for DHBs from the national Maternity Data Set. It should be noted that the source of the data only represents around 85% of all pregnancies nationally and the measure is still considered developmental. Results are provided for

Shorter stays in ED — 98%

Patients admitted, discharged or transferred ED within six hours. Target: 90%

The West Coast continues to achieve the national ED target, with 98% of all patients admitted, discharged or transferred from ED within 6 hours during quarter three.

98% of all Māori patients were admitted, discharged or transferred from ED within 6 hours during the same quarter

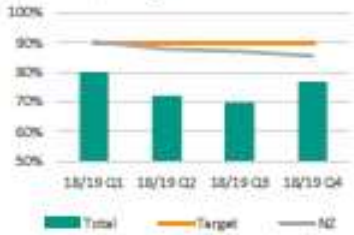
Improved access to elective surgery — 101%

Patients receiving planned surgery
Year-end target: 1,916

The West Coast DHB has provided 1,940 elective surgical discharges at the end of quarter four, achieving the year-end target.

Faster cancer treatment — 73%

Patients getting their first cancer treatment within 62 days. Target: 90%

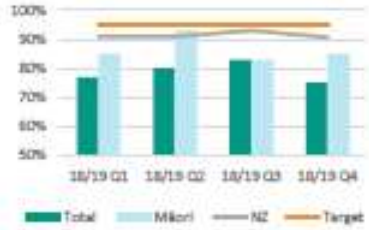


This quarter 73% of patients received treatment on time. Small numbers are challenging with this result reflecting only five patients who were not seen within the 62 day period.

A breach analysis is underway and every non-compliant case individually followed up. Most non-compliant cases are physically, psychologically, or diagnostically challenging.

Increased immunisation — 75%

Eight-month-olds fully immunised



Overall, 75% of all eligible eight-month-olds were fully immunised this quarter.

Small numbers are challenging with this result reflecting only four consenting children who were missed this quarter.

Stronger results were achieved for Māori (85%) and Asian children (100%).

Better help for smokers to quit — 95%

Patients in the community who smoke are offered help to quit. Target: 90%

West Coast health practitioners have reported giving 4,674 smokers cessation advice in the 15 months ending June 2019. This represents 95% of smokers against the 90% target.

96%of Māori and 95% of our Pacific populations were given brief advice to quit smoking.

Raising healthy kids — 100%

Children with obesity referred for support
Target: 95%

During quarter four 166 checks were completed and 14 children were identified as obese and offered a referral.

This result reflect 100% of children exceeding the national average (97%) and target.

4.2 Workforce Update

Enabling our Workforce

- Te Nikau Grey Hospital and Health Centre ground floor workshops are progressing. This is a cross collaborative project involving administrators, nurses and doctors from Grey Medical, Emergency Department, Information Services, Facilities, Outpatients, Booking and Reception teams at this stage. In the last month we have gained Consumer Council representation on the project.
- The Te Nikau room scheduling and utilisation work stream has advanced well and we are confident that the demand on the space available is able to be well managed and coordinated.

Medical

- We have recruited a part time Anaesthetist in the last month and are looking forward to him starting early October. We have had to re-advertise the two full-time vacancies as there were no suitable applicants last round.
- The work to be able to roster Rural Generalist consultants into internal medicine, anaesthesia and obstetric care by the target date of 1 October is taking longer than anticipated as there is significant internal documentation to be completed to ensure all aspects of patient and procedural safety have been addressed. While the target date may not be met the work is progressing steadily and has the added benefit of ensuring our policies and procedures for internal medicine, anaesthesia and obstetrics are up to date.
- The job descriptions for Resident Medical Officers have been updated to support the model of care in the new facility from the start of 2020. We are about to commence the process of agreeing these. This requires negotiating with current House Officers and Unions and could result in difficulties operating in the new hospital if rejected by them.

Nursing

- Overall hospital services occupancy has decreased by 5%. Our day unit however has increased by 3%. To note, from December through to August this year on overage our occupancy has increased by approximately 6%.
- On a positive, nursing has seen a further decrease in sick leave of 19%. Orientation hours have increased this month to 1125. This is an indication that we have been successful with our recruitment. Most vacant areas within the DHB are now fully recruited to with the exception of Maternity.
- One-on-one hours have doubled this month from 340 to 660 hours.
- The day Duty Nurse Manager position has had positive feedback from not only front-line staff but also our outlying areas as the DNM goes to each area and introduces themselves and talk about how their position can help. It is now a month since the introduction of the daily operations meeting and timely for a review in two weeks' time to check it is making a difference.
- The Nurse Director Operations was invited to the high school to talk to year 12 and 13 students regarding health and the opportunities within the services. Nine students have been matched up with managers from all disciplines. They will meet with each manager to discuss their future in health.

Maternity

- Over August and the first two weeks of September, we had 28 births at Grey Hospital and 2 at Kawatiri. From a total of 30 births, 22 were normal vaginal births, 2 instrumental births and 6 births by caesarean section (3 emergency and 3 elective).
- The core midwifery workforce in Greymouth is struggling to get to a full complement. The Clinical Midwifery Manager (CMM) is going on maternity leave in October and a core midwife (1 FTE) was successful in her application for the CMM fixed term position. We are continuously advertising for core midwife positions. A registered nurse with extensive experience in maternity/neonatal care for a 0.8 FTE permanent position is orientating in the ward. We are also aiming to recruit a graduate in 2020.
- We facilitated a maternity skills workshop for registered nurses and enrolled nurses. The 8 attendees gave positive feedback, mentioning that they are now more confident doing casual work in maternity.
- Over August and the first 2 weeks of September our midwifery educator provided Newborn Life Support training in Greymouth and Buller.
- The MEWS (Maternity Early Warning Score) was introduced throughout the hospital and training sessions were facilitated by our midwifery educator, with 60 attendees from various wards.
- Our lactation consultants facilitated a breastfeeding workshop that had 17 attendees from various backgrounds.
- We have started to use the Strep2 education programme – online breastfeeding education. The initiation details have been distributed to the multidisciplinary teams that according to the Baby Friendly Hospital Initiative (BFHI) require breastfeeding education.
- We recently had the local Countdown presentation where we presented our wish list for 2020.

Allied Health

- As reported in previous months, delays in the new build process are creating risk within our radiology service, as a number of imaging technologies reach their end of life. This means that the technology may become less reliable, equipment may no longer be able to be repaired, parts may no longer be available and the levels of radiation emitted may become too high for staff or patient safety. These factors are being monitored regularly.
- Work continues to develop a robust audiology service within the district, that supports our commitment to delivering care as close to home as possible. Challenges include understanding the volumes of activity for the various services that are currently offered and limited regional resource particularly with paediatric audiologists.
- A variety of 'test of change' processes are currently being shaped up to use Allied Health Assistants in new ways within inpatient and community settings, which support our Model of Care and commitment to releasing clinicians to work to the top of scope. This work is supported with the use of the Calderdale Framework for skill sharing and delegation and the Careerforce Levels 3 & 4 training programmes.
- A number of our clinicians are working on quality initiatives currently including improved collaboration for 'non-weight bearing' criteria, aphasia support networks and innovations to reach and support our more remote communities more sustainably.

Recruitment

New Vacancies	12
Total Open Vacancies	40
Appointed Vacancies	28

- Nursing – We have had a successful programme of recruitment recently with a number of new staff into our Medical/Surgical wards as well as new staff into our Mental Health service. Alongside this are some key senior appointments to RNS, Nurse Educator and Nurse Consultant roles.
- Allied Health – We have had a successful month of recruiting with two new appointments into occupational therapy where there has been a significant shortage of staff for a number of months. As well as a successful round of advertising and appointing for intern pharmacists to join us soon.
- Corporate – A small number of vacancies and appointments have occurred in the previous month and application numbers continue to remain high.
- Medical – Challenges continue in GP recruitment with shortages across winter. With the use of new streams of locum attraction this should ease further. Annual recruitment for RMOs is currently happening and a good number of candidates have applied. A strong focus continues in the recruiting of Rural Generalists across the DHB with the appointment of one already. At this stage we are recruiting two full-time and one part-time anaesthetist.

4.3 Patient

Patient Transfers

- The number of tertiary patient transfers from Grey Base and Buller Hospitals remained steady with 46 in July and 48 in August. The majority of transfers in both July and August were for medical and surgical patients, with the principal methods of transportation being via ambulance and pressurised aircraft in both July and August.
- The main reason for the transfers in July and August was for 'Specialty Care not available'.
- For patients transferred from Buller to Grey Base, the numbers remained stable with 29 in July and 30 in August. The majority of the transfers in both July and August were for medical patients. They were transported to Grey Base predominantly via ambulance and helicopter in both July and August.
- Patient transfers from Reefton to Grey Base were low with just 1 in July. The transfer was for a paediatric medical patient and was transported via private vehicle.

4.4 Quality

Hospital Services Incidents recorded in Safety1st for the 8 months to August 2019

GREY / WESTLAND 2019								
Hospital Services	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Behaviour & Safety	16	12	17	18	15	13	16	21
Blood Product	1	0	0	0	0	0	1	0
Drain and Tube	0	0	1	0	0	0	0	1
Employee	16	7	7	4	7	9	8	6
Facilities, Building & Property	0	1	3	1	2	1	0	3
Fall	19	9	15	19	19	18	17	15
Hazard Register	0	0	0	0	0	0	0	0
Infection	1	1	2	1	0	2	0	0
Intravascular Access Device	2	0	1	0	0	0	0	0
Labs / Specimen	2	3	3	3	6	1	4	2
Labour and delivery	1	1	6	4	4	2	1	0
Medication and IV Fluids	7	7	14	12	8	8	13	14
Provision of Care	8	7	11	15	10	4	3	9
Radiology	2	2	1	0	2	0	2	1
Restraint	6	4	10	6	3	2	10	0
Security	2	5	1	3	2	0	5	0
Skin / tissue	2	1	10	4	4	3	5	6
Totals	**85**	**60**	**102**	**90**	**82**	**63**	**85**	**78**

August overall has one of the lowest number of recorded incidents for the year. Behaviour and Safety events are on the rise and this is evidenced by the growing number of verbal abuse events being experienced by staff across all disciplines. Fall numbers are only slightly down on last month. What is very significant is that there were no restraints carried out in August; an early success of focusing on Zero Seclusion and restraints overall.

Report prepared by: Philip Wheble, General Manager West Coast DHB

MINISTRY OF HEALTH
MANATŪ HAUORA

Disability Directorate e-newsletter

September 2019

ISSN 2253-1386

From Toni Atkinson
Group Manager, Disability Support Services

Welcome to our spring edition! I hope you are all looking forward to lighter days and warmer weather.

We are part way through our programme of Community Conversations, where Adri Isbister, our new Deputy Director-General Disability, is visiting regions around Aotearoa to meet disabled people, their family/whānau, carers and our providers. I hope many of you have been able to attend these forums and provided some input into the strategic direction for the Directorate over the next few years.

The Directorate has been going through a time of significant change – and it's not over yet! We have been reorganising ourselves to better meet the needs of the disability community and the Ministry going forward. This has meant a change of roles for many people and you will see some new faces over the coming months as we recruit to full staffing. I want to also acknowledge the people who have left the Directorate over the past few months and wish them well with the next steps of their careers.

We are making progress on our strategic plan and I look forward to this document being finalised by the end of the year. Thank you to everyone who has contributed to the work on setting our future direction – whether it has been through community forums, surveys or contacting us directly with your thoughts about the future.

I hope you enjoy this spring edition of the newsletter.

Contents

Enabling Good Lives

Christchurch

Hannah Perry, Enabling Good Lives Lead, Ministry of Health

Flexible Disability Support

In Christchurch, young people and families connected with EGL have personalised, flexible budgets and choose how they wish to manage them. Most people elect to use a budget 'host', which gives them control of how, when and where they use their budget. Other families find that employing their own staff and keeping track of purchases adds a layer of stress and complication into already busy lives. In response to that, we have a number of Flexible Disability Support (FDS) providers which means that EGL participants still have choice and control over their budgets, but pass over some of the responsibility to the provider.

Families ask the FDS providers to do a number of things differently to what has previously been offered, so they can truly be of service to EGL participants. This includes:

- Providing direct support (eg, a support worker comes and assists the young person to live their life in the community)
- Making purchases on behalf of the person (eg, paying to raise the garden beds to a height where the person is able to reach inside and independently grow vegetables)
- Directly funding a young person and families (eg, ensuring a young person has cash on hand to pay the weekly fee at darts).

These options have meant that people:

- join clubs, courses and groups
- choose their own staff, without the responsibility of rostering, training and management
- go on camps, holidays, tramps and to concerts with their friends
- investigate and make purchases such as technology and e-bikes (and e-trikes!) that ensure they are well connected to their community, able to build and maintain relationships, have fun and keep fit
- lead lives that are centred around who they are as a person, rather than what time works for the taxi company or rostered staff.

The Enabling Good Lives approach is about creating options and building opportunities for disabled people and their families to live great lives in communities that value who they are and what they have to offer. Having service providers that can work flexibly to offer the family what they want means that it is easier for a young person to build a good life for themselves.

Waikato

Kate Cosgriff, Director, Enabling Good Lives Waikato

Collaboration with other key agencies and systems that impact on the lives of disabled people continues to be a focus for the Waikato demonstration. In the past year we have focused on areas where our work intersects with the Waikato District Health Board (DHB), including clinical services and planning.

We are helping the DHB to develop a Tāngata Whaikaha/Disabled Peoples Health Profile. The advocacy of disabled people and families on the DHB's Consumer Consortium resulted in this new initiative. The DHB now has a key strategic intent to radically improve the health outcomes of disabled people. The Profile is an initial step to help the DHB understand the needs and aspirations of disability communities across the Waikato.

In the last quarter, we held a meeting with one of the members of the Health and Disability System Review. This meeting saw a wide-ranging discussion and they were interested to understand how EGL operates and its potential applications.

The demonstration is contributing to the Waikato Plan Regional Housing Initiative Working Group to ensure disability and accessibility are front of mind as the Group begins its strategy work.

Two new EGL videos were completed in the period, with both now up on the website. As well as this, EGL featured in a Radio New Zealand story about the Oliver family. The Olivers had a big vision and built a positive rural flatting situation for their adult son Andrew. The first part of the RNZ story featured Andy's special relationship with Fonterra. The second part focused on his move into his own home and being part of Enabling Good Lives, with one of the connectors interviewed. You can see these stories on Radio New Zealand's website.
https://www.rnz.co.nz/national/programmes/first-up/audio/2018695079/fonterra-fan-andrew-oliver-s-journey-with-disability-to-independent-living

George

George joined EGL at the end of 2016 when he was 18 years old. He has autism and lives with his supportive family. At the time, George experienced bullying at school, spent a lot of time in his room, had no friends, little confidence and needed a lot of encouragement to come out of his shell and connect with others. George's EGL budget originally employed a buddy 7 hours a week to go out and help him try everyday activities and attend a youth group.

Over the last two years George has left school and used his support to try activities and go places typical for young people. As his confidence has grown over the past year, he has focused his budget on getting his licence and finding employment. He now attends a computer training class and recently got his First Aid Certificate. George plans to start flatting within the next year.

A recent email from George's mum indicates the progress George is making as, step by step, he builds his good life as a young adult:

> George is going really well. He has started work experience at the Main Meat Works, 2 weeks ago, Wed-Fri 7am-1.30pm and is loving it. His support worker Michele goes for 8 hours of that time just to check up and ensure all going well with his workmates. We had a big meeting with them and his employment facilitator this week and we are applying for Mainstream. I now no longer need to support George at work, but Michele is still going for 8 hours of his week. It is amazing how it has boosted his confidence, he even went back onto Facebook, declaring on a big first post: 'Hi I am back. I have done great things and I am independent, I have my licence, a car and I now work at Main Meats - Wish me Luck!' We were quite blown away!

Community conversations

Katie Sherriff, Disability Directorate, Ministry of Health

Disability Support Services are travelling to towns around New Zealand to talk about the supports and services you or your whānau may access or provide – and we want you to join us. This is also your opportunity to meet our new Deputy Director-General, Adri Isbister, and hear about her vision for disability support services.

Where will the community conversations be held?

The table below shows when we are coming to your area. The start time is the same for all sessions:

9 am – 12 pm for disability providers

1 pm – 4 pm for disabled people, their whānau and carers.

City/Town	Date	Venue	Room
Wellington	Wednesday 4 September 2019	James Cook Hotel, 147 The Terrace	Chancellor 3
Nelson	Monday 9 September 2019	Honest Lawyer, 1 Point Road, Monaco	Banquet Room
Christchurch	Tuesday 10 September 2019	Sudima Christchurch Airport, 550 Memorial Ave	Avon 2
Dunedin	Wednesday 11 September 2019	Distinction Dunedin Hotel, 6 Liverpool Street	The Exchange Room
Auckland	Wednesday 25 September 2019	Jet Park Airport Hotel and Conference Centre, 63 Westney Road, Mangere	Pukeko Room
Whangarei	Thursday 26 September 2019	Forum North, 7 Rust Ave	Cafler 1 Room
Hamilton	Friday 27 September 2019	Jet Park Hotel Hamilton Airport, 201 Airport Road	Harvard Room
Whanganui	Tuesday 1 October 2019	The Avenue Kingsgate Hotel Wanganui, 379 Victoria Ave	Function Room
Tauranga	Thursday 3 October 2019	Classic Flyers, 8 Jean Batten Drive, Mount Maunganui	Boeing Room
Napier	Friday 4 October 2019	Crown Hotel, Vautier Room, 22A Waghorne Street, Ahuriri	Vautier Room

How to register

It's important that you let us know if you are coming to a community conversation. Please register on our website, or email or call us, at least 10 days before the event, using the details below:

Email: disability@health.govt.nz

Call: 0800 855 066

Visit: the disability conversations page of the Ministry website
www.health.govt.nz/disabilityconversations

When you register, please include the following information:

- the session you're attending (afternoon session for disabled people, whānau and carers)
- the location you're registering for
- the company or organisation you're representing (if applicable)
- if you have any requirements for equipment or interpreters
- if you have any dietary requirements
- anything else that will be useful for us to know.

What will we talk about?

Adri Isbister will share her vision for the future of disability supports and services. We're keen to hear your views and questions, and to hear about the supports and services you or your family and whānau access or provide.

We're grateful to the disabled people, their family and whānau, carers and providers who have shared their stories, experiences and ideas with us so far. We've used what you've told us to develop the first stage of a strategy, and we want to know if we're heading in the right direction.

Can you help us share this information?

We would appreciate if you could share this information with your networks.

You can:

- share this information on social media – contact us for some images you can share
- put up posters in your community spaces – contact us for posters
- tell your whānau, friends and community.

Don't forget to register!

Funded Family Care

Stuart Parkinson, Disability Policy, Ministry of Health

In July 2019, the Prime Minister and Minister Genter announced that we're making changes to Funded Family Care in 2020.

The term Funded Family Care has covers both the Ministry of Health's Disability Support Services policy and District Health Boards' Paid Family Care policies. The upcoming changes apply to both.

These changes include:

- Repeal of Part 4A of the New Zealand Public Health and Disability Act 2000
- Eligibility for Funded Family Care to change to allow spouses and partners to provide Funded Family Care to people with high or very high support needs, and children and young people under the age of 18 with high or very high needs to receive Funded Family Care from resident parents or family members (who are over 18)

- Removing the requirement for an employment relationship between a disabled person and their family member under the Ministry of Health's Funded Family Care policy
- Raise pay rates for funded family carers under the Ministry of Health's Funded Family Care policy to be consistent with the rates received by care and support workers.

These changes to Funded Family Care will make it fairer for family carers and those being cared for, including improved support and paying carers appropriately.

Right now, we're working through the details of these changes so that we can provide advice to Ministers about what these may look like and how we can implement them across New Zealand in a way that is equitable and sustainable.

To help us prepare advice for Ministers that takes our communities' voices and experiences into consideration, we'll be undertaking targeted engagement in the next two months. This will also enhance our understanding of the impact that potential policy options may have on carers, disabled people and their whānau.

We will keep you updated as this work develops, including how we're seeking feedback from people, via our website.

You can also see more information about these changes, including what feedback we've already received, on the Ministry of Health website. **health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/funded-family-care**

Pay equity update

Contract Support Team, Ministry of Health

The contract support team would like to extend their sincere appreciation to those who have provided their Workforce Data Collection Surveys. Thank you for your cooperation, involvement and timely submissions. We really appreciate the effort it has taken to provide this data.

We would also like to take this opportunity to remind providers about the importance of the development of a well trained workforce for the sector and the clients they serve. The Care and Support Workers (Pay Equity) Settlement Act 2017 states that an employer must take all reasonably practical steps to ensure eligible workers are able to attain qualifications within the prescribed framework set out in the Act. The Ministry of Health and the District Health Boards jointly agreed their accountability to ensure workers have access to training and education opportunities, but providers have the responsibility to meet their obligations. How employers provide opportunities for workers is not specified.

There is understandably great interest from the sector in being informed of the results for the data provided. With approximately 90 percent of providers sharing information that covers roughly 50,000 workers, the Ministry continues to validate and analyse the information and plans to release high level analysis of the data by October 2019. We will share more information around the publication of our findings in the coming weeks.

Child development services

Noreen MacMahon, Project Lead, Disability Support Services, Ministry of Health

In Budget 2019, the Government allocated an additional $35 million ($8.75 million per annum) over four years for Child Development Services (CDS). These services support children with disabilities to maximise their potential and support greater independence.

Demand for CDS has increased, so the additional budget will see more children access the supports they need to help achieve their potential. The Ministry also supports CDS to work in a regional and integrated way with other services supporting disabled children, such as specialist communication services, equipment services and Ministry of Education early intervention services.

We've met with CDS providers to help them work in an integrated and consistent way regionally and nationally. Our approach aligns with System Transformation, Enabling Good Lives vision and principles and the Good Start in Life work.

The Ministry held four workshops with CDS providers in Christchurch, Wellington, Rotorua and Auckland throughout August. The workshops aimed to support providers to complete regional implementation plans that outline the approach in each region. This includes increasing the number of FTEs each region requires to reduce waiting lists, deliver more integrated services and shift towards an agreed model of care so that children and their families receive seamless services wherever they live in New Zealand.

We will review the implementation plans in September and will keep you updated as this work progresses.

All smiles at the end of the first Northern Regional workshop for CDS.

Preventing the spread of measles

A DSS-funded Community Residential Support Services provider in the Auckland region informed us this week that one of their clients has contracted measles. This is a good time to encourage you to follow the Ministry's advice on preventing the spread of measles.

- Measles is circulating in New Zealand, particularly in the Auckland region. More cases are likely, and people are encouraged to be vigilant of the symptoms of measles.
- Measles is highly contagious, affects children and adults and can be life-threatening.
- Immunisation is the best way to protect against getting measles. Two doses of the MMR vaccine give 99 percent protection against the virus. In New Zealand the MMR vaccine is offered free at 15 months and at 4 years of age. The MMR vaccine is also free for those under 50 years who have not had 2 documented doses.

We encourage people to get immunised, particularly:

- children and young people who have never been vaccinated
- people born from 1969 who have not had two documented doses.

Measles used to be very common, so those over 50 years old are considered immune and don't need the measles immunisations. Some people can't get immunised (for example, pregnant women and people with low immunity, such as those receiving cancer treatment).

What should I do?

- Please ensure that people younger than 50 years old have been vaccinated, or support them to get both doses of the vaccination.
- Make sure you follow the advice on what to do to minimise the spread of measles if you come into contact with someone with measles.

For more information see the measles page the Ministry of Health website.
health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/measles

For up to date information about measles in Auckland, and useful information on what symptoms to look out for, how to best protect yourself and others, as well as what actions to take if you've been in contact with someone with measles see the Auckland Regional Public Health measles page on their website. **https://www.arphs.health.nz/public-health-topics/disease-and-illness/measles/**

Thank you for your attention to this.

Recent publications

Medication Guidelines for the Home and Community Support Services (HCSS) Sector

In May this year, the Ministry of Health published guidelines to support HCSS providers to provide safe medication support for people at home.

The Guidelines were developed by a working group made up of HCSS providers and representatives from the health and disability sector. The Guidelines are a resource to support the implementation of safe medication practices according to the Home and Community Support Sector Standard that all DSS funded HCSS providers are required to comply with. You can find a copy of the Guidelines on the Ministry's website. **health.govt.nz/publication/medication-guidelines-home-and-community-support-services-sector**

Information Sharing Guidance

The guidance document, *Information Sharing Guidance for Health Professionals, from 1 July 2019*, is now available for download on the Ministry of Health website.

The guidance is to assist the health workforce to understand and respond to new changes. It complements the guidance on sharing information safely and supporting resources published by Oranga Tamariki and the Ministry of Justice. **health.govt.nz/publication/information-sharing-guidance-health-professionals-1-july-2019**

Cancer Action Plan

On 1 September 2019, the Right Honourable Prime Minister Jacinda Ardern and Honourable Minister of Health Dr David Clark released the Ministry of Health's *Cancer Action Plan 2019–2029* which outlines actions that will make a real difference to New Zealanders.

Modernising our approach to cancer care and improving survival rates is a long-term challenge. As kaitiaki of the health and disability system we aspire to achieving equity and sustainable services to all New Zealanders.

In January 2019, the Minister announced at the Cancer Care at a Crossroads Conference the development of a new cancer action plan with the bold goal of achieving equity of outcomes as a priority.

It's important that we know whether this is right or not, so that we can roll out a plan that delivers equitable care.

You can have your say about the Cancer Action Plan from 1 September to 13 October 2019.

See the *Cancer Action Plan 2019–2029* on our website.
health.govt.nz/publication/new-zealand-cancer-action-plan-2019-2029

Have your say: **https://consult.health.govt.nz/cancer-services/cancer-action-plan**

Looking for information about disability in New Zealand? Find it on Firstport!

Have you visited the national disability information website Firstport yet? If not, make time today to check it out!

Replacing the old WEKA site, Firstport has fast become a trusted resource for those searching for information on things like:

- disability funding streams and how to apply
- support available around education, transport, employment, housing and vehicle modifications and more
- how to find local Disability Information Centres and support services
- guides and articles on disability equipment and assistive technology
- latest news and events related to disability
- real life stories and videos.

Firstport has had over 50,000 visitors since it launched. It aims to be a welcoming, easy to use presence in a busy online world and is completely accessible. Users can use colour contrast, keyboard navigation, adjust text size and block animations.

'If you work with disabled people and their whānau, Firstport is a great resource to signpost them to.' says Rhi Galpin, Communications and Marketing Specialist for Firstport. 'You could also explore the site with them and help them find the most effective next steps for their needs.'

Firstport is keen to make sure the look and feel of the site resonates with its target audience. In last year's 'Life through a Lens' photography competition, people sent in photos of how they view life with a disability. Entries now feature on the site, along with the personal stories behind the images. 'In My Own Words' shares real life stories of disability through videos and articles. Julie Woods shared her story of going progressively blind following a diagnosis of Stargardt disease at 18. Her video has had over 22,000 views and has been shared almost 100 times.

The team find information from a range of sources and are keen to receive ideas for content to add to Firstport. They're currently working with a professional advisor to create guides on common questions and will focus on topics that are often searched for online, or that Disability Information Centre staff get asked regularly.

Firstport also has an active presence on Facebook with over 2000 followers. You can link up with them online at **@FirstportNZ**. If you've got ideas or feedback for the site, then contact the team at **comms@firstport.co.nz**

Check out the Firstport website today at **http://www.firstport.co.nz**

Murray Penman

Amanda Bleckmann, Manager Family and Community Support, Disability Support Services

Sadly, our colleague Murray Penman has decided to leave us! While I am so sorry to see Murray go, I'm personally delighted to let you know that Murray has been offered and accepted a role as General Manager, Vision West, one of our HCSS/IF Host providers.

Murray with his family and collegues at his farewell.

Murray has been instrumental in the development of IF, expanding IF participants from 200 in 2008 to almost 6000 as a result of the Ministry's response to the Select Committee Inquiry. Murray worked tirelessly as we travelled around the country, providing training to all the IF Hosts and NASCs. Murray helped in getting Child Development Services budget bid and in highlighting the need for the CDS Stocktake back in 2011.

Murray's been our DSS go to person on all things related to service improvement and self-direction, from Enhanced IF, CICL, flexibility disability supports, EGL Christchurch and EGL Waikato, FDS on Waiheke Island and now the System Transformation prototype. He has updated the purchasing guidelines, written the verification guidelines and co-presented with me at the Self Direction conference. Murray has provided a wealth of knowledge in a range of other areas across DSS.

For those of you who don't know, Murray has worked at the Ministry for 17 years – and during that time, he also got married, has had five children and kept up all his other extracurricular activities such as playing in bands and orchestras.

Murray's last day at the Ministry was Friday 6 September 2019 and we hand him over to Vision West on Monday 9 September 2019.

We know you will join us in congratulating Murray and wishing him every success in his new role.

Provider stories/Innovative practices

Cheryll Graham, Disability Support Services, Ministry of Health

If you provide DSS funded services and you want others to know how your service makes a difference to people with a disability, please tell us about it.

DSS will be publishing a supplement in our December newsletter showcasing providers' innovative practices to mark the International Day of Persons with Disabilities on 3 December 2019.

Here's what we are looking for:

- a story or article in a word document of up to 300 words, saying what you are doing and how it makes a difference
- we'd particularly like to hear about how you help people understand choices so they can make their own decisions (supporting a person's decision making)
- a photograph (high resolution please) if appropriate
- confirmation that you have formal permission from your organisation and from the person or people to use the story and photograph
- please get your submission to us by Friday, 20 September 2019, addressed to **susan.fernandes@health.govt.nz**

Articles may be edited before they are published.

Articles for publication will be selected by a review team. We can't guarantee that we will include your article or story.

We will email a copy of the newsletter to you at the time of publication and will also post it on the Ministry of Health website.

Thank you and we look forward to hearing about the great work underway in the sector!

Contact Disability Support Services

Email: disability@health.govt.nz

Phone: 0800 DSD MOH (0800 373 664)

Web: www.health.govt.nz/disability

To be added to or removed from the email list for this newsletter, please email **disability@health.govt.nz**

DRAFT 2019 WORKPLAN FOR WEST COAST ADVISORY COMMITTEE (*WORKING DOCUMENT)*

	15 February	29 March	10 May	28 June	9 August	27 September	1 November
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
REPORTS FOR RECOMMENDATIN TO THE BOARD		Accessible West Coast 2019/20 Draft West Coast Public Health Plan		West Coast Maternity Strategy		Environmentally Sustainable Health Care: Position Statement	
REPORTS	Community & Public Health Update Planning & Funding Update Alliance Update Maori Health Update Operational Update Committee Work Plan	Community & Public Health Update Alliance Update Operational Update	Community & Public Health Update Planning & Funding Update Alliance Update Operational Update	Community & Public Health Update Alliance Update Operational Update Maori Health Update	Community & Public Health Update Alliance Update Operational Update	Community & Public Health Update Planning & Funding Update Alliance Update Operational Update	Community & Public Health Update Planning & Funding Update Alliance Update Maori Health Update Operational Update
PRESENTATIONS	Oral Health	Facilities Visit	Mental Health	Child & Youth Wellbeing	Ageing Well on the West Coast Drinking Water Update	Maori Health	Service Integration
DISABILITY REPORTING	Disability Support Services Newsletter	~~Disability Action Plan Update~~ (Deferred)	Disability Action Plan Update Disability Support Services Newsletter		Disability Support Services Newsletter	Disability Action Plan Update	Disability Support Services Newsletter
INFORMATION ITEMS	2019 Schedule of Meetings	Committee Work Plan 2019 Schedule of Meetings Revised Terms of Reference	Committee Work Plan 2019 Schedule of Meetings	Committee Work Plan 2019 Schedule of Meetings	Committee Work Plan 2019 Schedule of Meetings	Committee Work Plan 2019 Schedule of Meetings	Committee Work Plan 2020 Proposed Schedule of Meetings (to be approved by incoming Board)

WEST COAST DHB – MEETING SCHEDULE

FEBRUARY – DECEMBER 2019

DATE	MEETING	TIME	VENUE
Thursday 7 February 2019	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 15 February 2019	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 15 February 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Friday 29 March 2019	Advisory Committee Meeting	11.30am	St John, Water Walk Rd, Greymouth
Friday 29 March 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 2 May 2019 (in place of ANZAC Day)	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 10 May 2019	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 10 May 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Tuesday 18 June 2019	Special QFARC Teleconference	2.30pm	Boardroom, Corporate Office
Friday 28 June 2019	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 28 June 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 25 July 2019	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 9 August 2019	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 9 August 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Friday 27 September 2019	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 27 September 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 24 October 2019	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 1 November 2019	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 1 November 2019	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 28 November 2019	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 13 December 2019	BOARD MEETING	10.00am	St John, Water Walk Rd, Greymouth

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