West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

9 MARCH 2012

AGENDA
AND
MEETING PAPERS

ALL INFORMATION CONTAINED IN THESE MEETING PAPERS IS SUBJECT TO CHANGE

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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.

BOARD MEMBERS' DISCLOSURES OF INTERESTS

Member	Disclosure of Interest
Dr Paul McCormack Chair	• Consultant, Ministry of Health, Better, Sooner More Convenient Implementation • General Practitioner Member, Pegasus Health • Advisor, Mauri Ora Associates
Peter Ballantyne Deputy Chair	• Appointed Board Member, Canterbury District Health Board • Chair; Quality, Finance, Audit and Risk Committee, Canterbury District Health Board • Retired partner now in a consultancy role, Deloitte • Council Member, University of Canterbury • Trust Board Member, Bishop Julius Hall of Residence • Spouse, Canterbury District Health Board employee (Ophthalmology Department) • Niece, Juliette Reese, Administrative Assistant West Coast District Health Board
Kevin Brown	• Councillor, Grey District Council • Trustee, West Coast Electric Power Trust • Wife is a Pharmacy Assistant at Grey Base Hospital • Member of CCS • Co Patron and Member of West Coast Diabetes • Trustee, West Coast Juvenile Diabetes Association
Warren Gilbertson	• Chief Operational Officer, Development West Coast • Member, Regional Transport Committee • Director, Development West Coast Subsidiary Companies
Helen Gillespie	• Chair, St Mary's Primary School, Hokitika, Board of Trustees • Peer Support Counsellor, Mum 4 Mum • Employee, DOC
Sharon Pugh	• Shareholder, New River Bluegums Bed & Breakfast
Elinor Stratford	• Clinical Governance Committee, West Coast Primary Health Organisation • Manager, Disability Resource Service West Coast • Committee member, Active West Coast • Chairperson, West Coast Sub-branch-Canterbury Neonatal Trust • Deputy Chair of Victim Support, Greymouth • Committee Member, Abbeyfield Greymouth Incorporated • Trustee, Canterbury Neonatal Trust
John Vaile	• Director, Vaile Hardware Ltd
Susan Wallace	• Tumuaki, Te Runanga o Makaawhio • Member, Te Runanga o Makaawhio

	• Member, Te Runanga o Ngati Wae Wae • Director, Kati Mahaki ki Makaawhio Ltd • Mother is an employee of West Coast District Health Board • Father member of Hospital Advisory Committee • Father Chair of Tatau Pounamu • Father employee of West Coast District Health Board • Vice Chair, Ngā Mātā Waka o Te Tai o Poutini • Secretary and Treasurer of Te Aiorangi Maori Women's Welfare League • Director, Kōhatu Makaawhio Ltd • Appointed member of Canterbury District Health Board • Secretary of Te Runanga o Makaawhio • Chair, Rata Te Awhina Trust • Area Representative-Te Waipounamu Maori Womens' Welfare League
Mary Molloy	• Spokesperson for Farmers Against 1080 • Director, Molloy Farms South Westland Ltd • Trustee, L.B. & M.E. Molloy Family Trust • Executive Member, Wildlands Biodiversity Management Group Inc. • Deputy Chair of the West Coast Community Trust
Doug Truman	• Deputy Mayor, Grey District Council • Director Truman Ltd • Owner/Operator Paper Plus, Greymouth

DRAFT MINUTES OF THE WEST COAST DISTRICT HEALTH BOARD MEETING HELD ON FRIDAY 27 JANUARY 2012 COMMENCING AT 10.04 AM AT ST JOHN, WATERWALK ROAD, GREYMOUTH

PRESENT Peter Ballantyne, Acting Board Chair
Sharon Pugh
Elinor Stratford
Mary Molloy
Doug Truman
Kevin Brown
Warren Gilbertson
John Vaile
Helen Gillespie
Susan Wallace

IN ATTENDANCE David Meates, Chief Executive – West Coast and Canterbury District Health Boards
Hecta Williams, General Manager
Colin Weeks, Chief Financial Manager
Wayne Turp, General Manager Planning and Funding
Gary Coghlan, General Manager Maori Health
Stella Ward, Executive Director of Allied Health
Bryan Jamieson, Communication Officer
Susan Fitzmaurice, Assistant to CEO (CDHB)
Karyn Kelly, Director of Nursing and Midwifery
Dr Carol Atmore, Chief Medical Advisor
Gaylene Mahauariki, Minute Secretary

APOLOGIES Dr Paul McCormack

KARAKIA The meeting began with a Karakia.

1. WELCOME AND KARAKIA

The Acting Board Chair welcomed Board members, members of the management team and other attendees to the meeting.

Susan Wallace led the Karakia.

2. DISCLOSURES OF INTERESTS

- Peter Ballantyne

Amended: Councillor, University of Canterbury

- Helen Gillespie

Amended: Employee, DOC
Removed: Volunteer Facilitator Babes in Arms
Removed: Casual Employee, OPUS

- Susan Wallace

Amended: Chair, Rata Te Awhina Trust

- Warren Gilbertson

Declared a potential conflict of interest with his role as Chief Operational Officer, Development West Coast and possible discussions regarding investment opportunities in the Buller Integrated Family Health Centre.

3. MINUTES OF THE PREVIOUS BOARD MEETING HELD FRIDAY, 2 DECEMBER 2011

Resolution 1/12

Moved: Peter Ballantyne **Seconded: Kevin Brown**

Motion:
"THAT the Minutes of the West Coast District Health Board meeting held Friday, 2 December 2011 be adopted as a true and accurate record."

Carried.

4. MATTERS ARISING

Item 1: Patient Transport
A report will be provided at a future Board meeting.

Item 2: General Practices
Work is continuing in this area. Updates will be provided regularly to the Board.

5. MATTERS REFERRED TO ADVISORY COMMITTEES FOR CONSIDERATION

None.

6. ACTING BOARD CHAIR'S REPORT

The Acting Board Chair spoke to his Report and advised that he had attended the District Health Boards Chairs' Meeting on 5 December 2012 in Wellington.

Matters discussed had included the progress and relationship with Health Benefits Limited and the need to achieve a positive relationship which would enable the advancement of shared services at an appropriate level taking account of the work being carried out by the South and North Island region. At present there was a degree of tension between the District Health Boards and Health Benefits Limited and a process was agreed to advance the Indicative Business Cases.

Discussion had been held on Regionalisation and the positive progress being made by the South Island Alliance of District Health Boards, clinical leadership, DHB Planning and the need for prescribed templates to be concise. Capital planning and the limited current capital funds available to the sector.

The Chairs met with the Minister of Health who emphasised the present and revised health targets going forward and his expectation that these be achieved.

The Acting Board Chair advised he will be attending the South Island Alliance Board Meeting on 30 January 2012 in Christchurch.

Advisory Committee Appointments

Resolution 2/12

Moved: Susan Wallace **Seconded: Warren Gilbertson**

Motion:

"That the Board member appointees to the West Coast District Health Board Advisory Committees being the Quality, Finance, Audit and Risk Committee, the Hospital Advisory Committee and the Community and Public Health Advisory Committee and Disability Support Advisory Committee as at the 31 December 2011 be reappointed for a term expiring 30 April 2012 subject to the individual members confirming their availability;

AND

That the Chairs and Deputy Chairs of those Committees be reappointed for a term expiring 30 April 2012 subject to the individual members confirming their availability."

Carried.

It was noted all Board members present confirmed their availability.

Resolution 3/12

Moved: Peter Ballantyne **Seconded: Doug Truman**

Motion:

"THAT the West Coast District Health receive the Acting Board Chair's Report."

Carried.

7. BOARD AND CHAIR'S CORRESPONDENCE

Resolution 4/12

Moved: Kevin Brown **Seconded: Sharon Pugh**

Motion:

"THAT the inwards correspondence is received and the outward correspondence is approved."

Carried.

8. CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive took his Report as read and gave an additional verbal update. The following points were noted:

Greymouth Regional Health Centre

- Work has commenced on the Greymouth Regional Health Centre Indicative Business Case.
- Request for Proposal Development is in progress to source required external support.

Buller Integrated Family Health Centre

- Buller – Appointed a Project Manager

8.1 Clinical Leaders Report

The Chief Medical Advisor tabled the Clinical Leaders Report. The Report is attached as Appendix One to these minutes.

Discussion was had around developing a new 'Vision Statement' for the West Coast DHB. Board members were in agreement to support this initiative.

Resolution 5/12

Moved: Peter Ballantyne **Seconded: Elinor Stratford**

Motion:
"THAT the West Coast District Health Board receives the Chief Executive's Report and notes the Clinical Leaders Report."

Carried.

9. FINANCE REPORT

The Chief Financial Officer spoke to the Finance Report.

The consolidated result for the month of December 2011 is a deficit of $50k, which is $23k better than budget ($73k deficit).

Areas of concern were outsourced clinical services, clinical supplies and locum costs. This is being worked through.

Resolution 6/12

Moved: Elinor Stratford **Seconded: Warren Gilbertson**
Motion:
"THAT the West Coast District Health Board receive the Financial Report for December 2011."

Carried.

The Board broke for morning tea at 10.42 am and reconvened at 10.55 am.

10. IN COMMITTEE

Resolution 7/12

Moved: Warren Gilbertson **Seconded: Susan Wallace**

Motion:
"THAT members of the public now be excluded from the meeting pursuant to Clause 32a, Schedule 3 of the New Zealand Public Health and Disability Act, so that the meeting may discuss the following matters:

- **In Committee Minutes of meeting held 2 December 2012**
- **In Committee Matters Arising from the minutes of 2 December 2012**
- **In Committee Correspondence**
- **In Committee Chief Executive's Report**
- **In Committee Funding Envelope 2012/13**
- **In Committee Buller Integrated Family Health Centre**

On the grounds that public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under section 9 of the Official Information Act 1982."

Carried.

11. NEXT MEETING

The next meeting will be held on 9 March 2012 at St John, Waterwalk Road, Greymouth.

The Board spent 2 hours and 19 minutes in In Committee.

There being no further business to discuss the meeting concluded at 1.53 pm.

_____ _____

Signed **Date**

CLINICAL LEADERS REPORT

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

FROM: **Carol Atmore, Chief Medical Advisor**
Karyn Kelly, Director of Nursing and Midwifery
Stella Ward, Executive Director of Allied Health (WCDHB and CDHB)

DATE: **27 January 2012**

ACHIEVING EFFECTIVE CLINICAL LEADERSHIP

With the move from a District Strategic Plan to an Annual Plan framework, our previous organisational vision statement has not been included. Participants in recent Xcelr[8] courses have noted that the organisation doesn't have a clear vision statement that people know and own. As part of the annual planning process, we would like to work with our executive management colleagues and our staff to develop a clear vision statement that people can embrace, and relate their ongoing work back to.

A two day workshop in December involved 67 senior doctors, nurses, allied health professionals and managers from both sides of the Alps. The focus of the day was improving the collaboration between Canterbury and West Coast Clinicians and Managers with the primary aim of developing the appropriate model of care for Grey region's health services in the future. This work is looking at primary, community and hospital level services as a whole, with support from Canterbury and further work is planned to progress the collaboration and finalise the future model of care in February 2012.

NURSING AND MIDWIFERY

The focus for nursing and Midwifery in 2012 will be its ongoing professional development to ensure the workforce is well prepared to meet the requirements of the model of care going forward, and clinical need. The development of existing expanded roles and the potential for future expanded roles will be a priority alongside the focus on the importance of maintaining the generalist skill-set for nurses.

MEDICINE

Ongoing efforts continue to recruit senior doctors, both into hospital and general practice vacancies, in collaboration with the Canterbury DHB Recruitment team.

Focus is continuing on improving the structure and processes of the West Coast DHB owned primary practices to work to a common vision within a business model that is sustainable.

The Rural Learning Centre (RLC) facility is receiving a makeover ready for the new academic year. A coordinator for the RLC has been appointed. This role is key to supporting the Academic Director in driving the inter-professional learning goals of the Centre. Four fifth year rural immersion medical students are with us for their academic year in 2012. The new facility will greatly enhance their learning experience with us.

Share for Care', an electronic way of sharing key summary health information from General Practice records to other health providers in the health system went live in December 2011.

ALLIED HEALTH, TECHNICAL & SCIENTIFIC

Collaboration with Canterbury continues with a number of allied health staff receiving remote clinical supervision from Canterbury clinicians.

Work continues on developing and implementing components of integrated care across the West Coast Health system. The focus is on the transition of care between hospital and community clinicians which is a core component of the Buller model of care and is being co-led by allied health and nursing. Included in the work plan is the revamp of systems and processes to support seamless care coordination as part of a patient's journey.

The role of an 'advanced practitioner' for physiotherapy in orthopaedics has been signed off and the development of a position description and recruitment plan is underway. This will improve the wait times for pre and post surgery review.

A review of patient transport assistance provided by Canterbury and the West Coast is underway and led by social work with the aim of providing more consistency and clarity for patients and families who need to travel to Canterbury for care.

Work continues on the implementation of the medication safety actions from the Health Quality and Safety Commission and includes ongoing roll out of the national medication chart; medicines reconciliation and e-pharmacy.

Work continues on the implementation of the recommendations of the external reviews for Social work and Occupational therapy with recruitment for two clinical manager roles underway; updating of policies and procedures and clinical audit.

Report of Progress against Annual Plan 2011-12
(progress reported in italics)

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident?*
Strong clinical governance in the planning and delivery of services across the West Coast DHB	Develop an integrated whole of system clinical governance framework for the West Coast. ▪ *Work continues with the establishment of an 'interim clinical board' with representation from across the health system to agree clinical governance; patient safety and quality systems priorities for 2012. The first meeting was held in December.*	A documented clinical governance framework for the West Coast Health system will be in place by December 2011. Staff survey results indicate improved participation in decision making; clinical leadership and clinical quality initiatives.
Provision of clinical leadership across nursing, allied health and medical staff	Strengthen senior clinical contribution into the West Coast DHB and Advisory committees. ▪ Strengthen clinical inputs into the planning of future services provision across the West Coast Health system ▪ *Work continues with regular participation from all disciplines in the various workstreams underway for future care delivery for the West Coast* ▪ *A facilitated workshop was well attended by clinicians from the WCDHB and CDHB in December*	Regular attendance and reporting from Clinical Leaders group to Board and Advisory Committee meetings. Future health service models of care are developed by the doctors, nurses and allied health professionals who provide the service.
Increased professional development opportunities for clinical staff to increase staff retention	Develop the West Coast as a Rural Learning Centre. ▪ *The South Island Regional Training Hub Progress Report for nursing has been completed with 100% of new graduate nurses and post graduate trainees to complete comprehensive career plans from 2012. Innovative clinical posts/placements have been identified across the region with a focus for the West Coast on Nurse Practitioner development for Primary Care and Aged Care. Regional workforce planning includes strengthening the rural workforce, replacing the ageing workforce, increasing the Maori and Pacific workforce and further development of advanced practice roles such as Clinical Nurse Specialists. Clinical Leadership development is also prioritised across the region. This activity for nursing will be coordinated through the Rural Learning Centre.* ▪ *The Regional priorities have been agreed for Allied Health, Technical and Scientific professions and have been included in the Regional Training Hub progress report – the leadership of remote and rural services will be led by the WCDHB Rural Learning Centre.* ▪ *The Clinical Leaders met with the Director of the RLC to progress the development of the Centre and proposed activities moving into 2012.*	Rural learning centre meets its work plan. Number of professional development workshops/ sessions provided. Increased staff retention. Workforce plan developed that will outline actions to retain and attract clinical staff and report against these – reduced staff turnover and reduced time to recruit into vacancies.

	Facilitate increased opportunities for the professional development of clinical staff. ▪ *HWNZ funded Nursing Post Graduate education has been finalised for 2012 with 21 nurses receiving funding for clinical PG papers. A regional approach will see the redistribution of under spending in any areas to other DHB's for PG nursing where there is an increase in demand. This will facilitate the regional approach to nursing workforce development.* Work with Human Resources and Primary Care recruitment and retention coordinator to focus on activities that enhance recruitment and retention. ▪ *The 6 new graduate nurses, 4 Midwifery first Year of Practice Midwives, and 2 Nursing Entry to Specialty Practice (Mental Health) nurses are due to commence the first week of February.* ▪ *One Rural General Practice Registrar has started their GPEP 1 year at the Rural Academic Practice* ▪ *Another Rural Hospital Medicine and Rural General Practice combined fellowship Registrar is continuing their GPEP 2/registrar training on the West Coast*	

RECOMMENDATION

That the West Coast District Health Board note this report for their information.

Authors:	**Chief Medical Officer,** **Director of Nursing and Midwifery, and** **Executive Director of Allied Health (WCDHB and CDHB) – 18 January 2012**

MATTERS ARISING FROM WEST COAST DISTRICT HEALTH BOARD MEETINGS

Item No.	Board Meeting Date	Action Item	Action Responsibility	Reporting Status	Agenda Item Ref
1.	14 July 2010	The Board Chair requested a report from the Chief Executive around the Patient Transport issue within the region and out of the region and asked that details are provided around the relationship with the current provider and the long-term plan of transport for patients on the West Coast.	Chief Executive	Due to the complexity of the issues i.e. rapid evacuation and road transport etc, a report will be presented to a future meeting.	6
2.	27 August 2010	That the West Coast District Health Board review the present ownership of the General Practices with the intent of identifying options that are clinically and financially sustainable.	Chief Executive	Work Ongoing. Updates will be provided regularly to the Board.	16

MATTERS REFERRED TO ADVISORY COMMITTEES FOR CONSIDERATION

Item No.	Board Meeting Date	Action Item	Committee	Reporting Status	Agenda Item Ref
None.					

ACTING BOARD CHAIR'S REPORT

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

FROM: **Peter Ballantyne, Acting Board Chair**

DATE: **9 March 2012**

The Acting Board Chair will give a verbal update.

Author:	**Peter Ballantyne, Acting Board Chair – 29 February 2012**

BOARD AND CHAIR'S CORRESPONDENCE FOR JANUARY AND FEBRUARY 2012

OUTWARDS AND INWARDS CORRESPONDENCE

Date	Sender	Addressee	Details	Response Date	Response Details
26 January 2012	Hon Tony Ryall Minister of Health	Acting Board Chair	Letter of Expectations for District Health Boards and their subsidiary entities for the 2012/13 year.		
3 February 2012	Hon Tony Ryall Minister of Health	Acting Board Chair	Expectations around improved access to services 2012/13 and beyond.		
10 February 2012	Hon Tony Ryall Minister of Health	Acting Board Chair	Annual Report Requirements – Schedule of Board and Committee Meeting Attendance.		
15 February 2012	Hon Tony Ryall Minister of Health	Acting Board Chair	Improving Waiting Times for Diagnostics.		
24 February 2012	Professor Mike Ardagh Shorter Stays in ED Target Champion Ministry of Health	Board Chair	Achievement of Shorter Stays in Emergency Departments Target.		
27 February 2012	Kevin Woods, Director General of Health Ministry of Health	Board Chair	Health Target Results for Quarter Two 2011/12.		

RECOMMENDATION

That the inwards correspondence is received and the outwards correspondence is approved.

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

Board ✓
EMT ✓

26 JAN 2012

WEST COAST DISTRICT HEALTH BOARD
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Mr Peter Ballantyne
Acting Chair
West Coast District Health Board
Grey Base Hospital
PO Box 387
GREYMOUTH 7840

Dear Peter

Letter of Expectations for District Health Boards and their subsidiary entities for the 2012/13 year

Delivering **better, sooner, more convenient care** and lifting health outcomes for patients within constrained funding increases is the Government's key expectation for the public health service in the 2012/13 financial year.

Thank you for the contribution you and your staff have made to improving the New Zealand public health service. The Government greatly appreciates the work of District Health Board (DHB) staff in providing more service for patients in these difficult economic times.

While internationally a number of countries are making significant cuts to health spending, the re-elected National-led Government will continue to increase its investment in Health, but within a necessarily tighter financial framework.

The Government is determined to return to surplus in 2014/15. The public health service can contribute by lifting productivity, and keeping to budget. All DHBs should establish specific plans to improve financial performance year-on-year. The supply of equity and debt will continue to be constrained, so Boards will need to prioritise capital more closely and fund from internal resources.

Integrated Care

International evidence shows that integrating primary care with other parts of the health service is vital to better management of long-term conditions, an ageing population and patients in general. This is achieved through better coordinated health and social services and the development of care pathways designed and supported by community and hospital clinicians.

DHBs must focus more strongly on service integration particularly with primary care; ensuring the scope of activity is broadened and the pace significantly stepped up. Areas include integrated family health centres, primary care direct-referral to diagnostics, and clinical pathway development involving community and hospital clinicians.

The Annual Plan Guidance provides clear expectations on the need and scope for change. We expect your Board's Annual Plan will show how integration between community and hospital services will be used to drive delivery and improve performance in three priority areas: unplanned and urgent care, long-term conditions, and wrap around services for older people.

Your DHB will also work with local primary care networks and the Ministry of Health (the Ministry) to provide zero fee after hours GP visits for children under six, as outlined in the Government's election policy. Over the next year the Ministry will be looking at further integration of child and maternity services. Expectations from the Prime Minister's Youth Mental Health Project will also be advised to you.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Shorter Waiting Times

The Government's election policy included ambitious plans to further shorten waiting times in a number of key areas including surgery, diagnostics and cancer care. Specific expectations in this significant area will be covered in a separate letter shortly.

Health Targets

Some changes to the national health targets have already been advised. Your DHB is expected to include specific plans for achieving these priority targets in your Annual Plan. This will include joint plans with primary care networks in your district for at least the smoking, cardiovascular disease (CVD) and immunisation targets.

Health of Older People

Our population continues to age and pose new challenges. DHBs are expected to engage with primary/community care to develop integrated services for older people that support their continued safe, independent living at home, particularly after a hospital discharge. Your DHB will also work with the Ministry to implement the Government's commitments relating to dedicated stroke units and dementia.

Regional Integration

Greater integration between regional DHBs is important for both financial and clinical reasons. We expect DHBs to make significant progress in implementing their Regional Service Plans, and delivering on regional workforce, IT and capital objectives that have been set. We will be monitoring execution against the various dashboards used by the National Health Board (NHB).

We need to see further improvements in efficiency and containing costs. Boards will need to support and advance the work of Health Benefits Ltd, Health Workforce NZ and the Health Quality and Safety Commission.

Significant productivity gains will need to be made across services and organisations, particularly hospitals. This will include making smarter use of your workforce and increasing integration with primary care and services for older people.

Strong clinical leadership remains pivotal to your on-going success.

All DHBs are expected to work co-operatively with the Ministry on implementing the Government's election commitments.

Finally, as agents of the Crown, you must assure yourselves that you have in place the appropriate clinical and executive leadership needed to deliver the Government's objectives. The performance of Chief Executives must be monitored against these expectations and I will be interested to see how they are reflected in your annual performance agreement with your Chief Executive.

Thank you for your work in the past, and I look forward to working with you to deliver more and better access to services in the future. Please share this letter with your local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

To: Board ✓
cc: EMT ✓

WEST COAST DISTRICT HEALTH BOARD
RECEIVED 4.20 -
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Actioned sent By 8/2/12

3 FEB 2012

Mr Peter Ballantyne
Acting Chair
West Coast DHB
PO Box 387
GREYMOUTH 7840

Dear Peter

Expectations around improved access to services 2012/2013 and beyond

The Government has made commitments to New Zealanders to deliver even faster access to elective surgery, diagnostic tests, chemotherapy treatment and youth drug and alcohol services.

I would like to thank you, and your colleague DHBs, for your achievements so far in delivering 60,000 additional elective surgeries since 2008, and for ensuring all cancer patients ready for radiation treatment are receiving it within the world gold standard of four weeks.

Now, it is time to set some new goals. There are outlined in the Government's manifesto. Some significant changes will be needed to meet these commitments and your Board will need to work closely with clinicians, primary care and the Ministry of Health to put them in place.

Faster access to elective surgery

DHBs will need to continue delivering, on average, at least 4,000 extra operations each year, as outlined in the *Improved Access to Elective Surgery Health Target.*

We have already advised you of our expectation that no patient should wait longer than 6 months to receive a First Specialist Appointment, or elective surgery, by 1 July 2012.

The Ministry of Health is working closely with you to reduce the waiting list over six months to zero, and I encourage you to share best practice with your colleagues, or seek ideas on how to improve service, depending on your own individual progress.

Productivity and efficiency gains may need to be made to meet these targets, as well as changes to processes and systems currently in place.

This expectation will shift to a maximum of five months in 2013, and a maximum of four months by the end of 2014.

I want to reiterate to you that in meeting this requirement access for patients will not be reduced for example, by lifting thresholds or removing patients from waiting lists.

Improved access to diagnostic tests

Patients can face long waits to get the tests they need before treatment can begin. Some can wait up to 6 months before they see a specialist, and then wait many more months for a CT scan or MRI.

This ultimately means a delay in diagnosis and treatment, and can affect health outcomes.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

There is currently no national reporting or monitoring of waiting times for diagnostic tests.

The Ministry of Health is working with key clinical groups to set maximum waiting times for Coronary Angiography, Colonoscopy, MRI and CT scans.

Along with establishing maximum wait times the first stage is to collect, measure and monitor how long patients are waiting. Your DHB will need to co-operate with the Ministry in establishing the reporting and monitoring system.

Delivering shorter waiting times for diagnostic tests is an important to ensuring patients are treated faster, and DHBs provide the right services at the right time.

Some District Health Boards have made significant progress in reducing waiting times by increasing the ability of GPs to refer patients directly for these tests.

Not only does a direct referral from a GP mean a patient can be diagnosed faster, it also delivers efficiency and productivity gains to hospitals – making smarter use of a specialists' time, allowing them to treat more people, sooner.

Cancer treatment

I wrote to you a few weeks ago outlining changes we have made to the "*Shorter waits for Cancer Treatment*" target. This is an important part of our commitment to deliver faster services to patients.

Building on achievements in radiation therapy, we are adding medical oncology (chemotherapy) to the target from the middle of 2012. This means all patients needing either radiation or chemotherapy treatment, should begin that treatment within the world gold standard of four weeks.

Shorter waits for child and youth drug and alcohol treatment

Many young people and their families are waiting too long to access specialised addiction services.

As part of the Drivers of Crime package, the Government is investing an additional $2 million to provide youth, alcohol or other drug services and associated workforce development and service evaluation.

Our expectation is that 80% of young people are seen by an AOD health professional within 3 weeks. Urgent cases should be seen even faster. This is likely to be the basis of a future national health target.

International evidence has shown the benefits faster treatment makes to young people and their families, and your Board should make this commitment a priority in your mental health and youth services.

I look forward to working with you to deliver these improved services to New Zealanders.

Yours sincerely

Tony Ryall

Hon Tony Ryall
Minister of Health

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

10 FEB 2012

Mr Peter Ballantyne
Acting Chair
West Coast District Health Board
PO Box 387
GREYMOUTH 7840

Dear Peter

Annual Report Requirements – Schedule of Board and Committee Meeting Attendance

In the interest of transparency and keeping the public informed, I ask that all District Health Boards (DHBs) include a schedule of board and committee meeting attendance in their annual reports. I am aware that some DHBs already report on meeting attendance. All schedules are to include attendance of both elected and appointed board members, as well as members appointed by the board to committees. The schedule is also to include the total number of meetings members were required to attend against their performance. This requirement will be added to the Operational Policy Framework.

My expectations around board and committee meeting attendance were clearly outlined in my letter of appointment to each board member. Members are to demonstrate their commitment to the board by attending all board meetings and all meetings of board committees to which they belong, in the absence of exceptional circumstances. In your role as Chair, you are expected to take an active role in addressing any attendance issues with members of your DHB board.

Should you have any queries concerning this requirement, please contact the Ministry of Health's Manager of Governance & Crown Entities, David Pannett, at david_pannett@moh.govt.nz

Yours sincerely

Hon Tony Ryall
Minister of Health

cc Mr David Meates, CEO West Coast District Health Board

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Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

Peter B. ✓

February 15, 2012

Mr Peter Ballantyne
Acting Chair
West Coast DHB
PO Box 387
GREYMOUTH 7840

Dear Peter

IMPROVING WAITING TIMES FOR DIAGNOSTICS

I recently advised you of the Government's expectations for improved access to services, including diagnostic tests. I now am writing with additional information about the direction being taken, and seek your commitment to ensuring your District Health Board engages on this important priority service.

As you are aware diagnostics are a vital step in the pathway for patients to access appropriate treatment, and have improved health outcomes. We cannot achieve streamlined delivery of service without timely and appropriate access to diagnostic services. Yet there is only limited information on how long people wait for most diagnostic tests or procedures.

We currently have a maximum waiting time for first specialist assessment of six months, and then a six months maximum for those patients booked for surgery. In between these two maximas is an unmeasured period of time of waiting for diagnostic tests. By improving and monitoring this period of time, the next government may be in a position to give a waiting time guarantee from GP to surgery.

I recently asked the Ministry of Health to develop an initiative to improve access to diagnostics, including better reporting and information. A summary of the Ministry's proposed initiative is attached. Details have also been provided to your Chief Executive for their feedback.

You will see that the initial focus is to introduce a developmental performance measure to capture waiting time information for four diagnostic modalities:

a. elective coronary angiography (angiogram)
b. colonoscopy
c. magnetic resonance imaging (MRI)
d. computed tomography (CT)

These modalities were chosen because they underpin other Government priorities including patients receiving faster access to cardiac and bowel cancer services. The Ministry has worked with a range of clinical groups to identify waiting time standards for these tests. The waiting time

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standards aren't specific accountability goals yet, as we want to spend the next year getting the data collection and measuring right. Then we will move onto stronger performance monitoring of these waiting times. The Ministry suggests achievement by June 2015 will be possible.

This is an area where there is significant opportunity to improve patient outcomes, and I encourage you to give this your full attention.

Yours sincerely

Hon Tony Ryall
Minister of Health

MINISTRY OF HEALTH
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24 February 2012

Dr Paul McCormack (ext)
Chair
West Coast District Health Board
Grey Base Hospital
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Dear Paul

Achievement of the Shorter Stays in Emergency Departments (ED) target remains a top priority for the Government. This is because reducing length of stay and associated overcrowding in EDs impacts directly on better outcomes for patients, including lives saved.

Research recently published in the Medical Journal of Australia found:

- the introduction of the (4-hour) ED length of stay target in Western Australia in 2010/11 led to a reversal in overcrowding in three tertiary hospital EDs, coinciding with a significant fall in the overall mortality rate

- no reduction in adjusted mortality rates in three secondary hospitals where the improvement in overcrowding was minimal.

You can find an abstract to the research on the link below.
http://www.mja.com.au/public/issues/196_02_060212/gee11159_fm.html

I urge you to read this because it provides evidence to support our work.

District Health Boards are making good progress in improving acute patient flow and resolving ED overcrowding, but face common challenges. It is important that good initiatives and successes in overcoming these challenges are shared.

The Ministry Shorter Stays team has published the attached New Zealand Medical Journal article, which documents the top 10 challenges being faced by DHBs and discusses how DHBs are addressing them.

We are also organising a national ED Forum to be held on 26 and 27 March 2012. I hope all DHBs will take the opportunity to attend and develop common approaches to achieving the Shorter Stays in ED target.

Yours sincerely

Prof Mike Ardagh
Shorter Stays in ED Target Champion

Attachments: New Zealand Medical Journal article *Improving acute patient flow and resolving emergency department overcrowding in New Zealand hospitals—the major challenges and the promising initiatives*

THE NEW ZEALAND MEDICAL JOURNAL
Journal of the New Zealand Medical Association

Improving acute patient flow and resolving emergency department overcrowding in New Zealand hospitals—the major challenges and the promising initiatives

Mike Ardagh, Gary Tonkin, Clare Possenniskie

Abstract

Aim To determine the most common challenges to improving acute patient flow and resolving emergency department (ED) overcrowding in New Zealand hospitals, and to share some of the promising initiatives that have been implemented in response to them.

Methods To facilitate progress towards achievement of the Shorter Stays in Emergency Departments Health Target (the Target), the authors visited every District Health Board (DHB) in New Zealand. These visits followed a standardised visit format and subsequent to each visit a report was produced that noted the observed challenges, initiatives and successes in relation to the DHB's pursuit of the Target. Using these reports, the significant challenges and the promising initiatives across all of the DHBs were collated.

Results Access to hospital beds, access to diagnostic tests and inpatient team delays were the most common challenges, followed by increased demand for ED services, ED facility deficiencies, ED staff deficiencies, delay to discharge of inpatients, difficulty engaging hospital clinical staff in changes, difficulty accessing aged care beds, and problems at nights and weekends. Promising initiatives were noted in relation to each of these.

Conclusions To improve acute care, resolve ED overcrowding and achieve the Target we need a comprehensive, whole of system approach and some significant changes to the way we use our physical and human resources. To address common challenges we need to share our experiences and expertise.

When hospitals fail to cope with demands for acute care one manifestation is overcrowding of the emergency department (ED). ED overcrowding is associated with a number of adverse consequences, including patient deaths.[1–6]

In response to concerns about ED overcrowding[7] and pressure for more focus on acute care (including the recommendations of the Working Group for Achieving Quality in Emergency Departments[8]), on 1 July 2009 'Shorter Stays in Emergency Departments' (the Target) became one of six national Health Targets in New Zealand. The Target is defined as '95% of patients will be admitted, discharged or transferred from an emergency department within 6 hours'.

At the time of this study New Zealand had 21 District Health Boards (DHBs) which plan, manage, provide and purchase health services for the population of their district.[9] Administered by these DHBs are 28 hospitals with EDs of appropriate role delineation (level three and above[10]) to be subject to the Target.

A small team was formed in the Ministry (the three authors) to facilitate and lead progress towards the Target. As part of this, a priority activity for the team during the first year was to visit each DHB to gain an understanding of their specific challenges and successes in relation to the Target. In addition, the team reviewed documentation from each DHB including a 'Delivery Plan for achieving Shorter Stays in ED'. The delivery plans were intended to be comprehensive, prioritised, 'whole of system' plans detailing the DHB's challenges and how they intended to overcome them.[11]

The visits and associated information from DHBs provided a unique national overview of the challenges facing DHBs in their pursuit of better acute care, the resolution of ED overcrowding, and consequent achievement of the Target. The aim of this study was to collate the 10 most common challenges and discuss how DHBs are addressing them.

Methods

All DHBs were visited between 1 July 2009 and 1 July 2010. The visits were attended by the National Clinical Director of ED Services (MA) and one or both of the two other members of the Shorter Stays in ED team (GT and/or CP). The visits took a standardised format which included an initial meeting with senior clinicians and managers to discuss the purpose of the visit and general issues related to the Target. This was followed by meetings with ED staff (doctors, nurses and others), staff responsible for hospital bed management and patient flow clinical staff from in-patient specialities and primary care representatives in some instances, to discuss their perspectives of the challenges and the successful initiatives.

Tours of the ED and in-patient facilities enhanced understanding of local issues, and the visit concluded with a final meeting with senior clinicians and managers to discuss the visitors' impressions and to verify their accuracy. Following the visit a standardised report was constructed with sections describing general conclusions, structure and leadership, specific project components, (for example, 'pre-load', 'contractility' and 'after-load'[11]), specific initiatives at the DHB (for example, Medical Assessment and Planning Unit, acute care pathways, and so on), and finishing with recommendations and agreed actions. These sections recorded both the challenges to achieve the Target and the promising initiatives.

The reports were sent to the DHBs for review and feedback prior to finalising.

The reports of the 21 DHB visits were reviewed by the National Clinical Director of ED Services (MA) and challenges were recorded as present for a DHB whenever they were noted in the report as being significant.

The data was recorded for all DHBs and subcategorised by the seven smallest, seven medium sized, and seven largest DHBs. The size of the DHB was determined by the number of ED presentations in quarter four of 2009/10 (1 April–30 June 2010).

A general list of promising initiatives was constructed based on initiatives already demonstrating success, or initiatives promising to be successful because of experience of similar initiatives elsewhere, and/or initiatives focused on good analysis of the causes and contributors to the challenges (i.e. good 'diagnostics', particularly including 'lean thinking' methodologies).

Results

The top 10 challenges are presented in Table 1.

Table 1. The top 10 challenges

	Challenge	All DHBs (21)	Small DHBs (7)	Medium DHBs (7)	Large DHBs (7)
1=	Access to hospital beds	15	4	4	7
	No bed	11	3	3	5
	No bed and delays in bed ordering/transfer	4	1	1	2
1=	Access to diagnostic tests	15	5	5	5
	CT scanning	9	3	3	3
	Other	6	2	2	2
1=	Inpatient team delays	15	3	6	6
	Delay to registrar attending ED to see patient	7		2	5
	Delay to registrar attending ED and delay to registrar decision-making	8	3	4	1
4	Increased demand for ED services	14	5	3	6
	Increased 'minor' patients	8	4	2	2
5=	ED facility deficiencies	12	3	4	5
	Too small	3	1	1	1
	Poor layout	4	1	1	2
	Both too small and poor layout	5	1	2	2
5=	ED staff deficiencies	12	5	2	5
	SMOs	5	2	1	2
	RMOs	1			1
	Both SMOs and RMOs	4	2	1	1
	Nurses	2	1		1
7	Delays to discharge of inpatients	11	1	4	6
8	Difficulty engaging hospital clinical staff in changes	8	2	2	4
9	Difficulty accessing aged care beds	7	4	1	2
10	Nights and weekends	7	1	3	3

Of the 15 DHBs which noted access to hospital beds as a barrier, all 15 recorded delays because there was 'no available bed' and four DHBs also noted delays getting the patient into a bed even when available. Occasionally 'no available bed' meant 'no suitable bed available', for example if the patient needed isolation in a single room because of an infectious illness.

Lower in the table is 'delay to discharge of inpatients' noted by 11 DHBs, and 'difficulty accessing aged care beds' noted by seven DHBs. Both of these might be considered related to 'access to hospital bed'. If considered together this grouping is alone in first place as the greatest challenge for DHBs.

Access to diagnostic tests were mostly due to delayed access to computed tomography (CT) scanning (nine DHBs) with six DHBs noting delays to other tests, mostly ultrasound scanning. Access to plain radiology and blood and other laboratory tests were not considered significant in causing delays.

Inpatient team delays were noted by 15 DHBs, all of which noted a delay to the registrar coming to the ED and eight also noted a delay to registrar decision-making once there.

Close behind the top three challenges was increased demand for ED services, noted by 14 DHBs, with eight of these noting an increase in 'minor' patients.

ED facility deficiencies (too small and/or poor layout) and ED staff deficiencies (particularly medical staff deficiencies) were next on the list of barriers, with difficulty engaging hospital clinical staff in changes, and problems at night and weekends completing the top 10.

The nature of recording the challenges and the small numbers in the subgroups precludes an analysis of statistical significance, but some challenges showed a trend of relationship to DHB size. While no challenge was peculiar to DHBs of a particular size, access to hospital beds, inpatient team delays, ED facility deficiencies, delay to discharge of inpatients, difficulty engaging hospital clinical staff in changes, and problems at night and weekends seemed to be more common the larger the DHB.

Table 2 presents generalised descriptions of the more promising initiatives witnessed during the DHB visits. These are discussed further in the discussion section below.

Table 2. Promising initiatives

Special beds	Creation of ED observation units and inpatient assessment units so that patients with a particular need, for example further observation or treatment by ED staff to achieve discharge or 'work up' by inpatient teams, have that need fulfilled in a space well suited to that purpose.
Hospital Operations Planning	Dedicated and sophisticated daily hospital operations planning to enhance the use of the human and physical resource, and to improve patient flow between the ED and inpatient wards.
Discharge planning	Good discharge planning, beginning early with multidisciplinary input and as a particular focus of daily activities to reduce unnecessary patient waits and free hospital capacity.
Access to imaging	Guidelines and pathways for accessing imaging and a responsive service for the provision of both images and expert interpretation.
Responsive acute secondary services	Separation of acute and elective medical roster conflicts so that the availability of inpatient specialties is adequate to enable the hospital to provide a responsive acute service.
Pathways for acute patients	Pathways or agreements so that patients with common and relatively straightforward presentations, for example fractured neck of femur, can be transferred to the ward without having to wait in the ED for an inpatient registrar assessment.
Acute demand mitigation	Analysis of the drivers of increased demand for acute services and interventions to mitigate this demand.
Enhanced ED layout	Layout of EDs to enhance function, including 'streaming' of patients and good 'command and control'.
Enhanced ED senior staffing	A greater senior staff presence to enhance decision-making and overview of department activities.
Engagement of staff	Engagement of all staff by 'marketing' changes with an appropriate whole of system and patient focused emphasis.

Discussion

This study is unique, providing a comprehensive national overview of the challenges facing our hospitals in the pursuit of improved acute care. However, the nature of the methodology can mean the findings are indicative only. They were the insightful opinions of those spoken to during the DHB visits, although these were usually based

on significant analysis of patient flow and performance. Most DHBs shared charts, graphs and documents supporting the opinions expressed, although the evidence base for them cannot be assured.

Those spoken to during the visits were broadly representative of the acute care system but indisputably with a bias towards staff associated with the ED. Management staff and those responsible for bed management were well represented, and ward based nursing staff generally had good input. Inpatient medical staff, general practitioners and resident medical officers were usually under-represented.

In addition, the challenges presented were ranked according to how many DHBs saw them as being important and not how relatively large an issue they were. Hence, a challenge ranked lower by this methodology might be more significant because of the number of patients it affects or the extent of the delay it causes.

The results are a stimulus for discussion and in particular, for exploration of appropriate ways to address these challenges. To this end, the remainder of this discussion will briefly recount the authors' experience of initiatives seen during the visits. More detail and further opportunity for sharing are to be found on the Health Improvement and Innovation Resource Centre (HIIRC) website which has a section on the Target.[12]

Of particular note is that most of the top 10 challenges, including the top three, relate to issues in the patient journey outside the control of the ED, reinforcing the understanding that improving acute care, resolving ED overcrowding and achieving the Target requires effort across the whole of the patient pathway. This finding reinforces the need for a whole of system structure, with clear leadership and responsibilities, and with a comprehensive (so important things are not missed out), and prioritised (so the most important things are addressed first), plan for progressing improvements in acute care.[11]

Access to hospital beds, particularly when combined with delay to discharge of inpatients and the related subset barrier of difficulty accessing aged care beds, is the biggest challenge nationally. Discussion in relation to this issue included consideration of an optimal occupancy of hospitals. There is some evidence that hospital occupancy of around 85% allows optimal flow.[13] Debate about measuring occupancy, (which beds should be counted, whether beds without a nurse are counted, at what time of the day should occupancy be measured, and so on), and concerns that extra capacity, if acquired, would soon be filled, have distracted from the key understanding—that there needs to be some spare capacity, existing or readily mobilised, so that patients can move to the right bed when ready to go.

DHBs have created capacity by investing in additional capacity or by freeing up existing capacity, or a combination of the two. A number of DHBs have examined their bed stock and have redistributed beds among speciality groups and/or have increased capacity. Many have invested in beds with a specific function, for example inpatient assessment and planning or ED observation, thereby enhancing bed stock but also (ideally) enhancing the efficiency of use of the beds. Guidance on the use of ED observation and inpatient assessment units is available.[14]

Hospital bed management in New Zealand is variable. Many DHBs are using predictive demand tools and attempting to match capacity to demand as a

consequence. A number of DHBs have 'overcapacity' or 'gridlock' plans intended to mobilise capacity or minimise the risk to patients when the hospital is over occupied. Most DHBs have enhanced daily operational bed management through holding daily meetings, while some are developing sophisticated operations facilities based on precedents in other industries, such as airlines, with promising early anecdotal results.

Many DHBs have introduced programmes such as 'Releasing Time to Care: The Productive Ward', which include modules enhancing discharge planning including the use of 'journey boards' and multidisciplinary team meetings. Some DHBs are advancing criteria based discharge, some have dedicated a nursing resource to discharging patients, and some are using regular 'rapid rounds' with a focus on enhancing decision-making. DHBs reported mixed results from the use of discharge/transit lounges.

Good discharge planning that begins early with multidisciplinary input and as a particular focus of daily activities was considered important to reduce unnecessary patient delays and free hospital capacity.

Difficult access to aged care beds prevents the discharge of some patients. Capacity shortages in aged care facilities, and a lack of cohesion between the hospital and aged care facilities, were two common contributors noted. Some DHBs also described behaviours, such as a reluctance to receive patients in aged care facilities at any time other than early on a weekday, as also being contributory. Good access to aged care facilities was considered to be an important component of a 'whole of system' response.

Access to diagnostic tests, and particularly CT scanning, is next on the list. Some DHBs are constructing mutually agreed guidelines which describe when CT scans and other tests are warranted for particular patient groups. The Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Radiologists are soon to publish agreed guidelines for imaging in acute care. These guidelines should be very influential for practice in New Zealand. In addition, some DHBs have embarked on significant process improvement initiatives within their Radiology Departments to enhance access to acute imaging and the rapid provision of expert reports on images.

Guidelines and pathways for accessing imaging, and a responsive service for the provision of both images and expert interpretation, were considered to be important initiatives for removing unnecessary delays in this part of the patient journey.

'Inpatient team delays' was one of the top three barriers and mostly referred to a delay in the inpatient registrar attending the ED. In the majority of DHBs, with most patient groups, a patient could not be transferred to a bed, or have a bed organised in anticipation, until the inpatient registrar had given approval to do so. This practice persisted even if a senior ED doctor had determined that admission was required and the registrar giving approval to admit was considerably more junior. Frequently an additional step of 'clerking' the patient by the inpatient house officer was interposed between the ED referral to the inpatient team and the registrar approval to admit.

Some commentators thought these steps were unnecessary and caused long and uncomfortable waits for patients, ED overcrowding, and conflict when busy inpatient registrars were 'hassled' by ED staff to see their patients. Many thought the additional

assessment in the ED seldom added value to patient care. However, others were of the view that the practice needs to continue for reasons of safety (an incompletely 'packaged' patient might deteriorate on the wards where there are neither the doctors nor the facilities required to rescue them), convenience (it is usually harder to assess a patient and get diagnostic tests performed on a general ward), and appropriateness (the patient might end up under the wrong team).

While the traditional practice of inpatient registrar assessment in the ED is causing delays, some were concerned the Target could encourage a swing to the other extreme —all patients will be transferred to the ward without inpatient registrar assessment in the ED when the clock ticks past a certain time.

A 'middle ground' was generally thought to be best for patients. For a large proportion of patients, although not all, if the right things are done in the ED by the right people they can be safely, conveniently and appropriately transferred to the ward without an assessment in the ED by the inpatient team. There they can wait in relative comfort and quiet, with dedicated nursing oversight, and without contributing to ED overcrowding and all the harms that ensue. However, other patients who will benefit from staying in the ED for reasons of clinical safety, or because that is the best place for them to have further diagnostic workup, should stay in the ED until these needs are met, regardless of their length of stay.

For General Medical patients, the use of Medical Assessment and Planning Units (MAPUs) allows a space for the registrar assessment of the patient which is well suited to this purpose (much more so than an ED corridor, or a general ward in the middle of the night), and which is equipped to address issues of safety and convenience.

It was noted that delays for inpatient registrar attendance in the ED were common among the surgical specialities, mostly because the registrars were busy elsewhere. Registrars were sometimes engaged in elective theatre lists or outpatient clinics while also being rostered to attend ED if required. Many DHBs are responding to this by separating acute and elective commitments, either with dedicated elective surgery centres or by separating acute and elective rosters, thereby enhancing the provision of a responsive service for acute surgery and its subspecialties.

Pathways for patients with fractured neck of femur are almost ubiquitous in our DHBs, allowing movement of the patient to the ward without orthopaedic registrar review in the ED once an agreed set of interventions has occurred. Some DHBs have produced pathways with similar objectives for other patient groups. It was considered that there is great potential for pathways of this type to apply to a large number of patient groups, from finger flexor tendon lacerations to pneumonia with a particular severity score.

The production of pathways has the additional benefits of standardising diagnostic test ordering (as discussed above), enhancing decision-making particularly among junior medical staff, providing clinical information based on evidence and accepted practice, and reducing conflict over patient referrals by stating an institutional agreement. While such pathways will need to be locally relevant, there is great opportunity to share efforts and learnings through existing relationships and the HIIRC website.

Close behind the top three challenges is increased demand for ED services, which many DHBs claimed was hiding progress made in other areas. Despite 14 DHBs raising this concern many had done little or no analysis of ED attenders to attempt to ascertain the drivers of increased demand, and only a few had instituted initiatives to mitigate demand. Initiatives included enhanced allied health intervention to prevent admissions, greater access to diagnostics in the community and management of conditions such as cellulitis and deep venous thrombosis in the home.

ED facility deficiencies (too small and/or poor layout) and ED staff deficiencies (particularly medical staff deficiencies) are among the top 10 challenges.

The experience of EDs around New Zealand suggests that increased size alone is not the solution to ED overcrowding. Although greater capacity is often justified, it needs to be designed to match an appropriate model of care. In particular, it was considered beneficial to have a layout which allows 'streaming' of patients (triaging them to an area that suits their needs), and 'command and control' including good oversight and responsibility for all patients so that they are kept safe, but also to understand and advocate for their needs including facilitating progress through the stages of care.

Often good command and control was achieved by giving staff responsibility for an area of the ED, ensuring clear lines of communication when concerned about patients, and having nursing and medical leadership on a shift with explicit responsibility for oversight of patient flow and distribution of the human resource in response to fluctuating demand in different areas of the ED. With clarity of the functional layout of the department, and the 'command and control' relationships and responsibilities of staff on a shift defined, the required number and type of staff becomes dictated by the needs of a roster to achieve this.

Many DHBs have increased senior staffing of the ED to enhance the quality and safety of clinical care in the ED and to enhance ED decision-making.

Difficulty engaging hospital clinical staff in changes was a common concern and was largely seen to be a consequence of the perceived ED-centric nature of the Target. Smaller DHBs seemed to engage staff more easily, but a few of the larger DHBs (one very successfully) have 'marketed' the work in a way which promotes the whole of system brief, the intention to enhance the quality of patient care, and the responsibility of all staff to contribute.

Finally, problems at night and weekends completes the top 10. This category included a number of the problems already discussed, which are more pronounced at night and weekends, for example, fewer and more junior staff, delayed decision-making, fewer inpatient registrars on site further delaying inpatient assessment, and poorer access to diagnostics.

Weekend shifts are typically busy in EDs, but hospitals usually have skeletal staffing and reduced access to services. Continuing acute admissions over the weekend, combined with significantly fewer discharges, meant that many of our hospitals started the week with little or no bed capacity. Mondays are typically one of the ED's busiest days with a high admission rate due to the case mix mobilised after the weekend. It was considered that hospital flow could be greatly improved if activities over the weekend were increased to a level similar to that provided during weekdays.

Although bed availability was not a specific night time concern, transfer to the ward at night was delayed by all the other challenges, and by concern that patients were less safe in the wards at night. At the start of the day shift a number of EDs often have a large accumulation of patients remaining from the night shift. All EDs have an influx of patients starting between 10am and midday and continuing into late afternoon or evening. If this influx is superimposed on a full ED, and particularly if discharges on the wards are not occurring until late in the day to free up beds for new patients, the ED will suffer severe overcrowding.

At least one DHB had addressed this by rostering senior doctors over the night shift, while others were using observation beds to accommodate patients who might go home in the morning (particularly the elderly after falls).

While it was considered inappropriate to have the same access to all services at nights, (demand is less, a daytime service needs to be maintained and many non-urgent interventions are less safely performed at night), it was apparent that our hospitals need to augment acute services at night. An elderly patient spending the night on a hard stretcher, in a bright and noisy ED, scantily clad in public view, simply because the ward does not take admissions at night, or there is no orthopaedic registrar on site, or a CT scan cannot be accessed, or there is insufficient medical seniority to make a decision, is poor care.

Consequent to their limitations, the top 10 challenges presented should not be considered the definitive top 10 in terms of content or ranking. However, the list is based on a significant consensus of many people involved in acute care, informed by experience and local analysis, and representing small, medium and large hospitals from the length and breadth of New Zealand. Hence, they should not be ignored.

Progress towards addressing some of them is excellent in places, but piecemeal nationally, but with a general consensus that significant momentum had been gained since the institution of the Target. It is hoped that this paper will encourage consideration and discussion of the challenges to improving acute care, and the sharing of thoughts and solutions in various forums.

Competing interests: None.

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27 February 2012

Mr David Meates
Chief Executive Officer
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Dear David

I am writing to share the health target results for quarter two 2011/12.

National progress
Nationally, the results for quarter two are excellent. Once again I am pleased to advise that all District Health Boards (DHBs) achieved the Shorter waits for cancer treatment target. The national target for Improved access to elective surgery was also achieved again this quarter, and the Shorter stays in emergency departments target performance has reached its highest ever position.

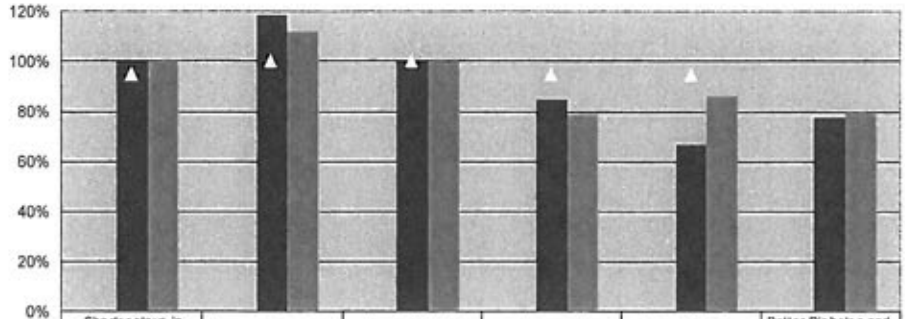
There has been good progress in the Better help for smokers to quit target and positive improvement in the Increased immunisation target.

As you are aware, this is the last time the existing Better diabetes and cardiovascular services target will be reported. On 1 January 2012, the CVD and diabetes target changed to 'More heart and diabetes checks'.

We are now all collectively working to achieve the new 'More heart and diabetes checks' target goal of 90 percent of eligible people to have their CVD risk assessments completed within the last five years by 2014. Achieving this goal will be challenging, but I look forward to good early progress being reported next quarter.

DHB specific progress
Despite the very pleasing national results this quarter, there remains variation at an individual DHB level. In relation to your own DHB, the following table provides information on your progress during the first two quarters of the year.

West Coast health targets quarter two 2011/12 results



	Shorter stays in Emergency Departments	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment	Increased Immunisation	Better Help for Smokers to Quit	Better Diabetes and Cardiovascular Services
Ranking quarter two 2011/12	1	4	1	20	15	4
Quarter one 2011/12	99.8%	118.8%	100.0%	84.8%	66.7%	77.8%
Quarter two 2011/12	99.9%	112.0%	100.0%	78.5%	85.8%	79.4%
National goal	95.0%	100.0%	100.0%	95.0%	95.0%	

The Ministry's Target Champions continue to visit DHBs, and work closely with the sector to share good practice and support improved performance. The following feedback is provided by the champions on your results for quarter two.

Mike Ardagh, Target Champion, Shorter stays in emergency departments

Congratulations to West Coast DHB on your continued achievement of the Shorter stays in emergency departments health target. West Coast has consistently been the top performer in this target, which is a commendable performance. It is important to recognise that the target is a surrogate for quality, so I expect that you (and all other DHBs) are looking at other acute care/ED quality measures to ensure that a quality services is being delivered.

Clare Perry, Target Champion, Improved access to elective surgery

West Coast DHB has continued to perform strongly this quarter, and has achieved its quarter two health target – Improved access to elective surgery. At the end of quarter two 945 people have been provided with elective surgery, which is 12 percent ahead of plan. This is an excellent result - well done.

John Childs, Target Champion, Shorter waits for cancer treatment

West Coast DHB has achieved the four week Shorter waits for cancer treatment health target for quarter two. This is excellent sustained performance against the target. The DHB is encouraged to maintain this performance over 2011/12 in close collaboration with your regional oncology centre.

Pat Tuohy, Target Champion, Increased immunisation

West Coast DHB's total coverage dropped from 85 percent in quarter one to 79 percent this quarter. Māori coverage also dropped this quarter from 95 percent in quarter one to 82 percent in quarter two.

West Coast DHB's combined opt-off/decline rate increased this quarter to 18.7 percent compared to 14.4 percent in quarter one. The Ministry asks that the DHB provide an update about ongoing activities to engage with the

community about disease outbreaks and measures being taken to address the decline rate in the quarter three report. It will be important that the DHB and PHOs identify practices which have a high decline and opt-off rate and continue paediatric liaison with these practices to ensure their approach is evidence based and meets the needs of their population. We suggest the DHB continue to provide education and support to parents, especially antenatally.

The Ministry suggests that all DHBs continue to review the list of children unimmunised at eighteen months by PHO and practice and update records from the Ministry's quarterly 'reaching every child' report to ensure practice, address and PHO enrolment details are correct. This will ensure that all children due for immunisation are recalled by their practice and/or referred to outreach in a timely fashion.

Karen Evison, Acting Target Champion, Better help for smokers to quit
The DHB has achieved a substantial increase in providing advice to hospitalised smokers this quarter, and a small increase towards the target for primary care. More attention is needed in this area.

It is very encouraging to see the increase to 85.8 percent in quarter two for provision of advice to hospitalised smokers. I will be interested to hear about the impacts of the strategies you have described to be undertaken in the next quarter as further significant improvement is needed to meet the 95 percent target.

The DHB has achieved 40.3 percent for provision of advice in general practices, a good result when compared with the national range this quarter. A concentrated effort will be needed by the DHB to work with their PHO, allocating sufficient resources in quarters two and three. Initiatives supporting hospital performance could be applied in general practice.

Brandon Orr-Walker, Target Champion, Better diabetes and cardiovascular services
For the final report on the Better diabetes and cardiovascular services health target, West Coast DHB continues to make improvement in its overall performance achieving 79 percent in quarter two 2011/12. This is an increase of 2 percent on last quarter. The DHB ranking increased to fourth place, from sixth in quarter one. Your CVD risk assessment result for the quarter was 79 percent, 1 percent higher than last quarter. Diabetes free annual checks were again significantly above target by 18 percent at 88 percent, and 1 percent higher than last quarter. Diabetes management, at 72 percent, was 3 percent higher than last quarter, although still below target. You continue to make excellent progress with diabetes checks, particularly for Māori. I look forward to seeing this follow through into improved diabetes management over the next six months.

The Ministry will publish target results in five national newspapers, the New Zealand Herald, Waikato Times, The Dominion Post, The Christchurch Press, and the Otago Daily Times on Tuesday, 28 February 2012. As occurs each quarter, a package of

supporting information has been sent to DHB General Managers Planning and Funding, and to Communication Managers.

Changes to the health target set for 2012/13
As I have previously advised, the Minister of Health has recently confirmed the revised target set for 2012/13. With the exception of the Shorter stays in emergency departments target, all targets have been revised to a greater or lesser extent. Of particular note, medical oncology is being added to the cancer waiting time target and the immunisation target is changing to 95 percent of eight month olds completing their scheduled vaccinations by the end of 2014.

I look forward to seeing concrete and measurable actions that support delivery of the revised targets in your 2012/13 draft Annual Plans due with the Ministry in March.

Yours sincerely

Kevin Woods
Director-General of Health

cc: Dr Paul McCormack, Chair, West Coast District Health Board

CHIEF EXECUTIVE'S REPORT

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

FROM: **David Meates, Chief Executive**

DATE: **9 March 2012**

SUMMARY

The year to date financial result is $3,474k which is a negative variance to budget of $222k. This result, while not deteriorating further since last month still remains behind plan. A range of service improvement initiatives have been actioned to address the variance to plan.

The fifth annual release of serious and sentinel events for all District Health Boards (DHBs) covering the period 1 July 2010 and 30 June 2011 occurred in February. The Health Quality and Safety Commission noted that that was variance across DHBs in reporting serious and sentinel events and also noted that their focus was working with DHBs to reduce preventable harm including falls prevention, medication safety, reduction of infections and implementation of WHO Safe Surgery Checklist. West Coast reported five serious or sentinel events for this period.

Grey Integrated Family Health Centre (IFHC) and regional hospital planning activity is on track with the recent appointment of Sapere to develop the indicative and final business cases for the reconfigured facility at Greymouth based on a collaborative trans-Alpine clinical service model and on integrated family health services being provided from that facility. Workshops are being held weekly involving clinicians from West Coast and Canterbury confirming the trans Alpine models prior to development of the business cases.

Buller IFHC implementation also continues on track with patient pathways being confirmed building to further discussions next month with architects to confirm facility design.

It was pleasing to note progress has been made in achieving our Health Targets in particular better help for smokers to quit, improved access to elective surgery, better diabetes and cardiovascular services. The DHB's performance slightly deteriorated in reaching the target for immunisation for two year olds. However the DHB remains on target with the six hour waiting target in ED

Budget preparation- clinical and management staff are working with the Finance team to prepare a draft budget for submission to the Ministry of Health on 2 March 2012. The DHB remains committed to an ongoing pathway towards living within its available funding.

Focus continues to be placed on production planning to ensure the effective use of resources in the delivery of elective services as the DHB continues to deliver on the Minister's expectations.

FINANCIAL AND OPERATIONAL PERFORMANCE OVERVIEW

Financial Overview for the period ending 31 January 2012

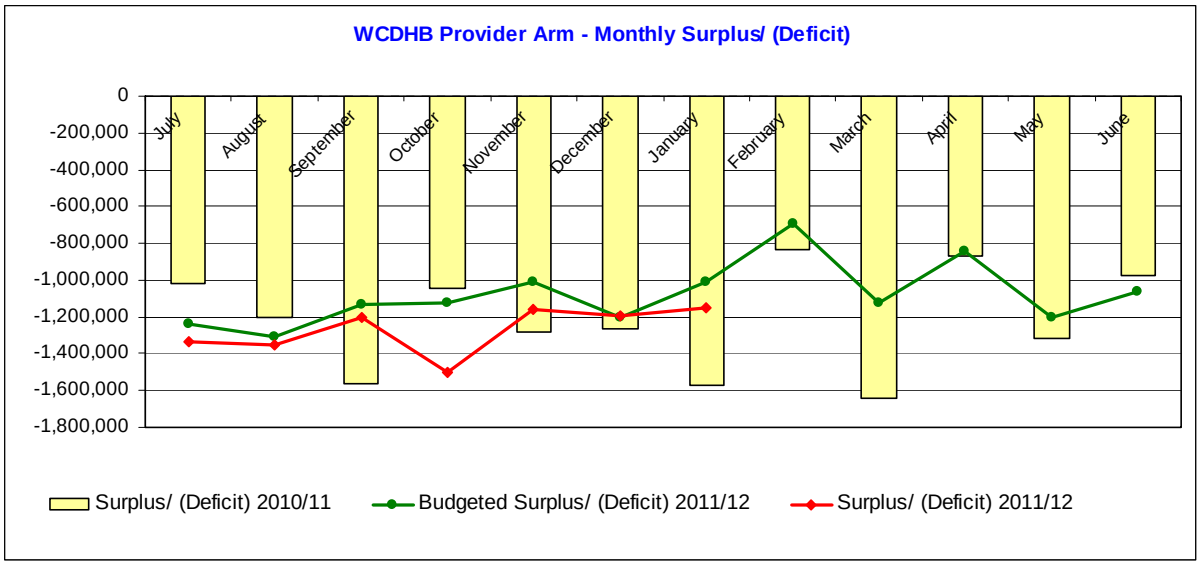
	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,117	6,358	(241)	√	44,129	43,697	432	√
Governance & Administration	208	212	(4)	√	1,496	1,485	11	√
Funds & Internal Eliminations	4,370	4,392	(22)	√	30,904	31,153	(249)	×
	10,695	10,962	(267)	√	76,529	76,335	194	√
EXPENSES								
Provider								
Personnel	4,482	4,492	10	√	30,436	30,751	315	√
Outsourced Services	864	831	(33)	×	7,972	6,484	(1,488)	×
Clinical Supplies	540	599	59	√	4,627	4,202	(425)	×
Infrastructure	870	903	33	√	6,592	6,433	(159)	×
	6,756	6,825	69	√	49,627	47,870	(1,757)	×
Governance & Administration	168	212	44	√	1,347	1,486	139	√
Funds & Internal Eliminations	3,533	3,708	175	√	25,478	26,375	897	√
Total Operating Expenditure	10,457	10,745	288	√	76,452	75,731	(721)	×
Deficit before Interest, Depn & Cap Charge	(238)	(217)	21	√	(77)	(604)	(527)	×
Interest, Depreciation & Capital Charge	550	551	1	√	3,551	3,856	305	√
Net deficit	**312**	**333**	**21**	√	**3,474**	**3,252**	**(222)**	×

The consolidated result for the five months ending 31 January 2012 is a deficit of $3,474k, this being $222k unfavourable to budget. The main drivers of the unfavourable variance were higher than budgeted outsourced services costs and clinical supply costs.

DHB PROVIDER ARM SUMMARY

Operational and Financial Performance Overview

Provider Arm
Financial Performance



For the seven months ending 31 January 2012 the operating result after interest and depreciation for the Provider Arm is a deficit of $9,049k, this resulting in an unfavourable variance of $1,020k. The main drivers of the unfavourable variance are outsourced clinical service costs and clinical supplies. Measures have been implemented to address the mix between outsourced clinical services and personnel costs to bring the combined spend to within budget.

West Coast DHB Hospital Activity - January 2012 - (Including all patients regardless of Domicile)

		MONTH				YEAR TO DATE			
		January 2012	January 2011	Variance	Variance %	January 2012	January 2011	Variance	Variance %
Total Discharges	Buller	70	70	0	0.0%	510	535	-25	-4.7%
	Reefton	2	2	0	0.0%	24	25	-1	-4.0%
	Grey	374	410	-36	-8.8%	3052	2840	212	7.5%
Occupied Bed Days	Buller	601	653	-52	-8.0%	4282	4545	-263	-5.8%
	Reefton	164	181	-17	-9.4%	1400	1406	-6	-0.4%
	Grey	2018	2157	-139	-6.4%	14908	14500	408	2.8%
ED Attendances - all facilities		1433	1370	63	4.6%	9221	9006	215	2.4%
Outpatient Attendances *		1217	1191	26	2.2%	9645	8976	669	7.5%
Deliveries (Buller Health and Grey Base Hospital		36	30	6	20.0%	183	160	23	14.4%

* Specialist medical, surgical and obstetric services only. Excludes ACC outpatient volumes

	CURRENT YEAR TO DATE - 2011/2012				PREVIOUS YEAR TO DATE - 2010/2011			
	Actual to 31 January 2012	Budget to 31 January 2012	Variance	Variance %	Actual to 31 January 2011	Budget to 31 January 2011	Variance	Variance %
Surgical Acute CWD	580.4	635.15	-54.75	-8.6%	631.15	547.97	83.18	15.2%
Surgical Elective CWD	902.45	798.51	103.94	13.0%	691.7	855.18	-163.48	-19.1%
TOTAL Surgical CWDs	1482.85	1433.66	49.19	3.4%	1322.85	1403.16	-80.31	-5.7%
Medical CWDs	790.68	769.64	21.04	2.7%	763.67	709.39	54.28	7.7%
Surgical FSA	2205	2358	-153	-6.5%	2155	2384	-229	-9.6%
Medical FSA	978	946	32	3.4%	839	942	-103	-10.9%

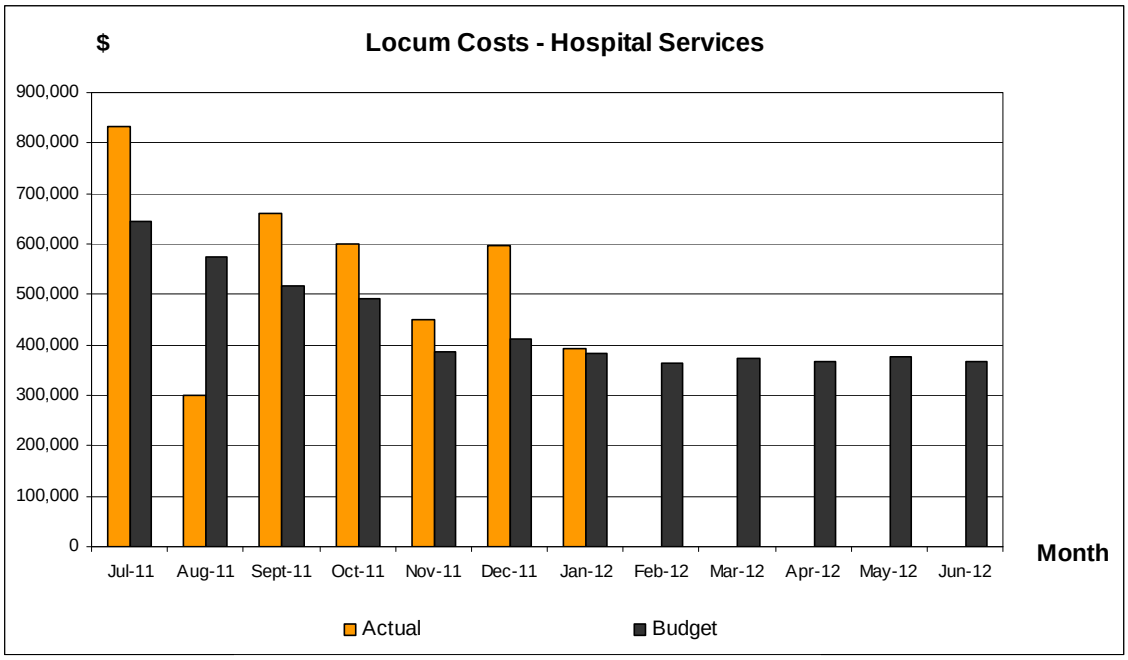
PROVIDER ARM SERVICES

Medical Personnel – Locums

Efforts have been focused on reducing locum spend. This is resulting in;

- Costs tracking down to budget albeit slower than necessary
- Reduced duplication/coverage by locums particularly at weekends. Several locum contracts with contracted dates for 2011 ended which has enabled management of costs to be improved. As a result the January spend was close to budget
- Permanent general surgeon appointment from mid December means this service is fully staffed

With permanent appointments taking longer than planned the challenge over the coming five months will be to contain spending close to the remaining (lower) monthly budget. The two "expensive" services are orthopaedics and obstetrics/gynaecology. There is a strong O&G applicant interest and a new model of care for orthopaedics is being worked through with Canterbury DHB clinicians.



Initiatives for Recruiting

Canterbury DHB Centralised Recruitment Service has now formally taken responsibility for recruitment across West Coast DHB as from January. This will support West Coast DHB recruitment efforts by:

- Having access to a wider range of applicants interested in positions in New Zealand and the West Coast
- Providing a focused professional service to support the applicants and West Coast DHB services
- Shortening of the recruitment timeline

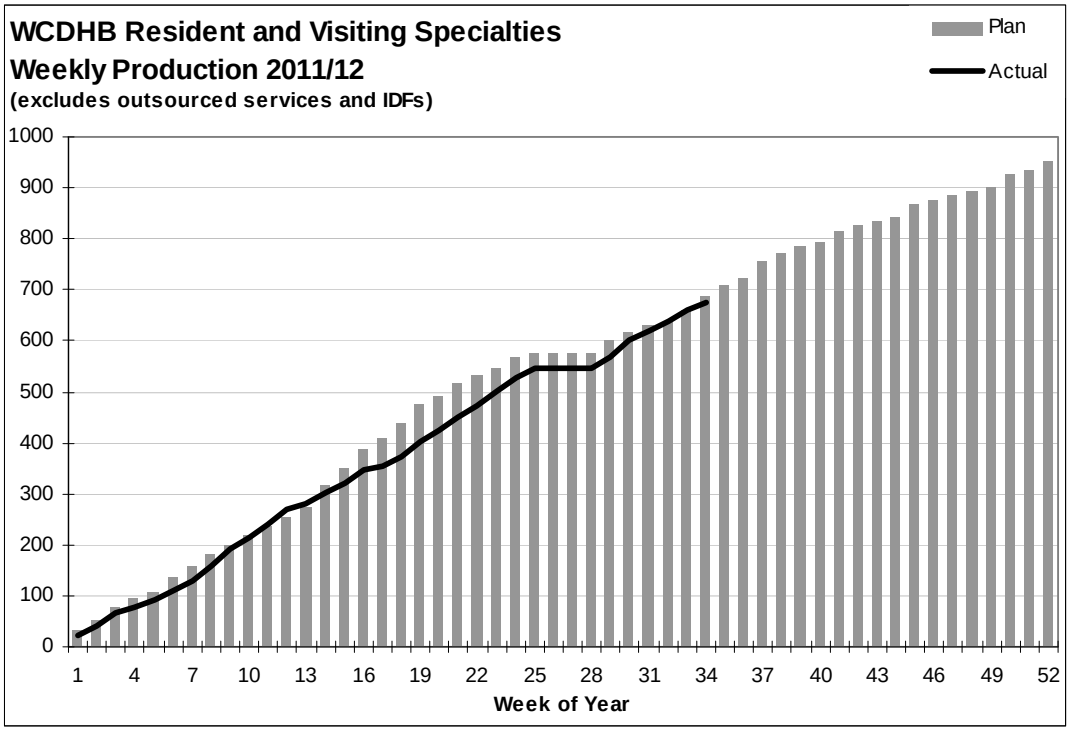
Production Planning / Electives

The Ministry of Health releases reports on DHB performance to the elective surgical discharge health target four to six weeks retrospectively. The report for December 2011 is the current official MoH result available to DHBs. At 31 December 2011 the West Coast DHB is 101 discharges ahead of plan. These 101 discharges have been delivered via IDFs (discharges produced by other DHBs on our behalf).

The West Coast DHB plans production at Grey Base Hospital only for specialties where procedures will be provided at Grey Hospital or by providers contracted privately to deliver services off the West Coast.

At 26 February 2012 Grey Base Hospital is 10 discharges behind the internal production plan. Specialties with clinicians resident on the West Coast are all producing to acceptable levels against plan, however specialties relying on visiting consultants are all behind plan. Underproduction in visiting specialties is attributed to scheduling issues such as changes to visiting dates since the last revision of the production plan. It is expected that all surgical discharges planned for delivery by visiting specialties this financial year will be produced to target over the coming months. Current underproduction in visiting specialties is largely being offset by overproduction in Gynaecology, which ahead of plan year to date.

Grey Hospital Elective Surgical Discharges					
	2011/12 Total Discharges Required	**Planned Discharges YTD**	**Actual Discharges YTD**	**Variance to Plan**	**Remaining Discharges to be Delivered 2011/12**
Resident Specialties	719	532	560	28	159
Visiting Specialties	231	154	116	-38	115
Total	**950**	**686**	**676**	**-10**	**274**



PROVIDER ARM SERVICES - COMMUNITY, PRIMARY AND MENTAL HEALTH SERVICES SUMMARY

South Westland
Management with the support of Tom Love from Sapere is working at present with the South Westland practice team to understand and implement the strategies needed to deliver a cost effective service in this area

Emergency planning is underway with the assistance of John Coleman SI Emergency Planner Primary Health

Home Based Support Services
The business case for the purchase of Caduceus a software programme used to manage administration and staffing for home based support services has been approved. Home Based services have a high number of administrative transactions with large numbers of part time staff needing to be managed and linked with large numbers of clients receiving elements of home based care, with wages paid and invoicing for care provided. This programme gives the tools to be able to more accurately and effectively manage the service.

Increasingly HBSS and district nursing services are working together to provide clinical input into support services provided to individual clients

Request For Proposal for the provision of ACC funded support services has been issued and we have joined a SI Alliance to provide a joint application

Quality Community Services
The DHB Incident Review System is being rolled out to community services

Carelink
A trainer has been appointed for the 'Walking In Another's Shoes dementia education programme.

Carelink is currently working on the roll out of the restorative model with the introduction of packages of care as the basis of the funding method for support services. Via inter Rai, the packages will be able to be reviewed on a regular basis to ensure funding is being allocated appropriately. Training for staff is occurring in this first quarter of the year.

A review is about to commence of Carelink and West Coast HBSS providers by John Baird to determine the fit with the current planning for improving aged care services and identify any necessary changes to ensure seamless management of access to and provision of support services to older people.

Reefton Health
A new General Practitioner (GP) has commenced at Reefton Health on a six month contract. At this stage there are no prospects in sight to replace the GP at the completion of her contract.

Nursing staffing numbers across Reefton Health are stable at present.

A recent meeting has been held with St John rural support officer to discuss concerns over lack of volunteers for the ambulance service and the impact this has on availability of ambulance services. The Clinical Services Manager Reefton is also the Associate Director of Nursing at Buller Health and has been spending significant time on the Buller IFHC Implementation Project. This work will be useful to base the review of models of care for Reefton on.

Buller Health
Continue to seek further permanent GP appointments and utilise locums in the meantime to ensure the after hours and hospital cover is maintained.

The Buller health implementation team supported by Michael Odea as Project Manager is working through the implementation of the Buller Health plan. The focus at present is on developing pathways of care through integrated Buller Health services and understanding the impact of these pathways on facility design and on the resources needed, within the constraints of the available funding.

Greymouth Primary Practices
With a current vacancy for a practice manager the opportunity is being taken to review the position and bring in a manager with a high level of experience and skill in managing and turning around practices This year we are focusing on the reduction and eventual elimination of the planned deficit incurred by DHB owned primary practices and this will require focus and a sense of urgency in ensuring that available funds for health services on the West Coast are spent as effectively and efficiently as possible.

INFORMATION TECHNOLOGY

Telehealth

The proof of concept mobile clinical cart wireless network is enabled in the paediatric ward and remaining teething issues resolved. The further roll out and final commitment to the solution is waiting on Canterbury DHB confirming they will be going with same solution, they are expected to make this decision within four weeks time.

The business case on replacing the Cisco Health Presence system has been completed and approved. Installation of a new Telehealth room is already underway within the Outpatients Eye Room. The new system is expected to be up and running by mid March. As part of the Business Case a surplus unit is being relocated to St Johns.

The Southern Cancer Network MDM procurement process is getting close to announcing the successful vendor. This DHB has highlighted the requirement for compatibility with its existing systems to be a must in any implementation.

Server Infrastructure Upgrade

The project to replace a number of aged computer servers is progressing, with the 3rd stage completed. There is some tidy up work to complete as part of this stage. The final stage of the project is the migration to using a new Citrix platform. This is expected to take until June to be fully deployed.

Laboratory Information Systems Replacement (CHL Delphi) Update

The Laboratory Information System (LIS) business case refresh has been completed, however a decision has been made to delay the implementation of this system to coincide with the Concerto project. This resolves some clinical workflow issues. The business case costs will need to be updated to reflect the new implementation date before being able to be submitted. Regular meetings with the Christchurch Health Laboratories team is taking place to finalise the business case. It is expected this will be finalised by end of March.

Clinical Information System Business Case

The Business Case for the new clinical information system hosted by Canterbury DHB and using Orion's Concerto product has been approved. The kick off meeting was held on the 4 October. Several workshops have been completed both at West Coast DHB and in Canterbury DHB. The implementation planning study was completed and signed off prior to Christmas. Contractual negotiations have been completed with the contract being signed on the 24 February. Detailed project planning is now starting.

Due to the Mental Health solution being scoped as a regional solution, there has been involvement sought from other South Island DHB's. As the complexity (and cost) for the Mental Health solution has been considerably more than what was anticipated by Orion, a financial contribution is also being sort from the South Island DHB's, this will also provide a commitment regionally to the solution. A proposal for this was sent to the South Island IT Alliance to seek their endorsement, in turn they have asked endorsement from the South Island Mental Health alliance. This was received in writing on the 24 February. The South Island IT alliance will raise with the question around funding to the CEOs once written endorsement is received from the MH Alliance. Go live for the new system is provisionally end of August 2012. This clinical information system will enable a single patient portal to clinical information housed within West Coast DHB, South Canterbury DHB, Canterbury DHB and ultimately all South Island DHBs.

Industrial Action

There has been several instances of industrial action occurring by members of the collective for IT. To date there has been no significant impact on services that the IT department provides the rest of the organisation due to these periods of industrial action. A collective has been agreed between parties resolving the likehood of more industrial action occurring for the time being.

HUMAN RESOURCES

Recruitment
Recruitment is continuing for the following key positions - O&G SMO, Physician, Anesthetists, and Emergency Physician at the Grey Hospital. Interviews are also in progress for GPs for the Buller clinic with active interest being shown in GP roles for the Grey Medical Practice.

A meeting to discuss options with Pegasus Health for GP support on the Coast is being arranged.

Industrial Relations
Managed Bargaining – All unions involved in this process are in the process have either settled or are in the process of ratification.

ASMS MECA – Planning is underway to implement the outcomes of bargaining by the end of February.

APEX IT – Settlement has now been reached in this long standing dispute.

RDA – RMOs – Bargaining will commence shortly for this group at a national level.

Employee Engagement
The results of the employee engagement survey is showing that employees feel their work is very important to them, they have significant autonomy to do their job, they are prepared to 'go the extra mile' and that they are comfortable raising concerns about patient safety. The areas of focus going forward will be in relation to leadership, rewards and recognition, performance goals and expectations, developmental opportunities and systems and processes. There will now be a series of focus groups and information sessions for staff commencing in early March prior to the leadership team determining the key areas for focus.

Learning and Development
The strategy has now been approved by EMT for implementation and is attached as Appendix One to this Report for Board members information.

HEALTH SYSTEM OVERVIEW
PLANNING AND FUNDING UPDATE

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

Jan-12						Year to Date						2011/12	2010/11	
Actual	Budget	Variance			SERVICES	Actual	Budget	Variance				Annual Budget	Actual Result	Change (actual 10/11 to budget 11/12)
$000	$000	$000	%			$000	$000	$000	%			$000	$000	%
					Referred Services									
32	43	11	26%	√	Laboratory	245	286	41	14%	√		486	511	5%
591	634	43	7%	√	Pharmaceuticals	4,764	4,871	107	2%	√		8,473	7,705	-10%
623	**677**	**54**	**9%**	√		**5,009**	**5,156**	**147**	**3%**	√		8,959	8,216	-9%
					Secondary Care									
1	20	19	95%	√	Inpatients	26	137	111	81%	√		237	38	-523%
126	150	24	16%	√	Travel & Accommodation	715	811	96	12%	√		1,391	1,189	-17%
1,285	1,285	0	0%	√	IDF Payments Personal Health	8,968	8,992	24	0%	√		15,414	15,606	1%
1,412	**1,455**	**43**	**3%**	√		**9,709**	**9,940**	**231**	**2%**	√		17,042	16,833	-1%
					Primary Care									
16	5	-11	-214%	×	Dental-school and adolescent	220	271	51	19%	√		467	399	-17%
0	2	2	100%	√	Maternity	0	15	15	100%	√		26	0	
0	1	1	100%	√	Pregnancy & Parent	0	4	4	100%	√		8	0	
0	3	3	100%	√	Sexual Health	8	20	12	59%	√		33	13	-152%
0	0	0		√	General Medical Subsidy	18	3	-15	-543%	×		5	76	94%
526	523	-3	-1%	×	Primary Practice Capitation	3,777	3,660	-117	-3%	×		6,275	6,135	-2%
7	7	0	0%	√	Primary Health Care Strategy	51	48	-3	-6%	×		83	251	67%
77	77	0	0%	√	Rural Bonus	540	541	1	0%	√		928	970	4%
12	13	1	10%	√	Child and Youth	90	94	4	4%	√		162	162	0%
5	3	-2	-67%	×	Immunisation	38	39	1	3%	√		96	154	38%
14	14	0	4%	√	Maori Service Development	97	95	-3	-3%	×		162	165	2%
18	31	13	42%	√	Whanua Ora Services	126	218	92	42%	√		373	215	-74%
10	13	3	24%	√	Palliative Care	37	92	55	60%	√		157	110	-43%
12	15	3	21%	√	Chronic Disease	77	159	82	51%	√		286	3	-9440%
11	11	0	2%	√	Minor Expenses	77	78	1	2%	√		134	206	35%
708	**718**	**10**	**1%**	√		**5,156**	**5,337**	**181**	**3%**	√		9,195	8,859	-4%
					Mental Health									
0	1	1	100%	√	Eating Disorders	0	7	7	100%	√		12	23	48%
51	50	-1	-2%	×	Community MH	350	351	1	0%	√		601	538	-12%
1	1	0	0%	√	Mental Health Work force	7	5	-2	-43%	×		8	15	44%
47	47	0	0%	√	Day Activity & Rehab	334	332	-2	-1%	×		569	518	-10%
10	10	0	0%	√	Advocacy Consumer	64	71	7	10%	√		122	120	-2%
6	5	-1	-13%	×	Advocacy Family	46	37	-9	-24%	×		64	71	10%
0	5	5	100%	√	Minor Expenses	0	36	36	100%	√		61	0	
102	118	16	13%	√	Community Residential Beds	711	823	112	14%	√		1,411	1,261	-12%
66	66	0	0%	√	IDF Payments Mental Health	462	464	2	0%	√		796	813	2%
283	**303**	**20**	**7%**	√		**1,974**	**2,126**	**152**	**7%**	√		3,644	3,359	-8%
					Public Health									
0	29	29	100%	√	Nutrition & Physical Activity	140	200	60	30%	√		342	328	-4%
0	7	7	100%	√	Public Health Infrastructure	75	48	-27	-55%	×		83	82	-1%
0	0	0		√	Social Environments	0	0	0		√		0	-15	100%
6	6	0	-7%	√	Tobacco control	18	39	21	54%	√		68	58	-17%
6	**42**	**36**	**86%**	√		**233**	**287**	**54**	**19%**	√		493	453	-9%
					Older Persons Health									
5	0	-5		×	Information and Advisory	22	0	-22		×		0	0	
0	0	0		√	Needs Assessment	29	0	-29		×		0	0	
59	53	-6	-10%	×	Home Based Support	326	357	31	9%	√		595	708	16%
15	10	-6	-58%	×	Caregiver Support	79	67	-13	-19%	×		114	130	12%
245	173	-72	-42%	×	Residential Care-Rest Homes	1,664	1,199	-465	-39%	×		2,030	2,344	13%
-4	0	4		√	Residential Care Loans	-33	0	33		√		0	-113	100%
13	10	-3	-27%	×	Residential Care-Community	83	71	-12	-16%	×		122	48	-155%
321	396	75	19%	√	Residential Care-Hospital	2,114	2,734	620	23%	√		4,622	3,949	-17%
0	5	5	100%	√	Ageing in place	12	38	26	68%	√		65	12	-440%
-21	7	28	396%	√	Environmental Support Mobility	22	50	28	56%	√		85	28	-204%
11	6	-5	-77%	×	Day programmes	76	43	-33	-75%	×		74	75	1%
16	12	-4	-33%	×	Respite Care	116	83	-33	-39%	×		143	118	-21%
108	108	0	0%	√	IDF Payments-DSS	756	758	2	0%	√		1,300	1,060	-23%
768	**780**	**12**	**2%**	√		**5,266**	**5,399**	**133**	**2%**	√		9,151	8,359	-9%
3,800	**3,974**	**175**	**4%**	√		**27,347**	**28,245**	**897**	**3%**	√		**48,483**	**46,079**	**-5%**

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

PLANNING AND FUNDING OVERVIEW

Community laboratory / referred services

Medlab South has notified its intention to discontinue the provision of services for community referred laboratory testing with effect from the 1 April 2012. The West Coast DHB Hospital Laboratory has confirmed that it has the capability and capacity to provide testing services for both hospital and community refereed services in future. A process of engagement with primary health and other community based referrers is underway to determine how best to ensure service continuity of service beyond April 2012.

Healthy Eating Healthy Action

There is uncertainty over the Government's intention on the funding of Healthy Eating Healthy Action beyond the 2011/2012 financial year. HEHA activity on the West Coast has achieved some significant successes in contributing towards improved health outcomes for people leaving within the district. It is also deeply embedded and aligned with integrated health care and improved clinical outcomes through Better Sooner More Convenient service delivery. Confirmation on future direction for HEHA is being sought from the Ministry of Health.

COMMUNITY AND PUBLIC HEALTH (CPH)

Pertussis (Whooping Cough)

The Coast-wide pertussis outbreak that began in May 2011 continues. While the outbreak was initially centred in and around Hokitika, the incidence of pertussis in Westland has now returned to endemic (non-outbreak) levels. However, the incidence of pertussis in the Grey and Buller districts remains high, though it has begun to decline. Nelson, Marlborough and Canterbury are continuing to experience high rates of pertussis so we expect there to continue to be some transmission into the Coast from the north as well as between districts on the Coast.

Between 1 May 2011 and 17 February 2012 428 notifications of suspected pertussis have been received by Community & Public Health's West Coast Office. Of these notifications 256 are either confirmed or probable cases. Four cases have so far been hospitalised for complications of the disease, all adults. Pertussis outbreaks usually have high rates of disease in the most vulnerable group, children under the age of one year, and this is the case everywhere else in New Zealand except the West Coast where disease rates remain comparatively low in this age group. It is possible that the targeted pertussis booster immunisation strategy that was funded by the West Coast District Health Board last year to help limit spread of the disease to children under one year old has contributed to this.

Community & Public Health West Coast will continue to monitor notifications and operate an outbreak response structure until the outbreak is over. Information about pertussis has been distributed widely and media updates will continue to be issued to promote the importance of on-time vaccination of infants to protect them from pertussis.

Promoting Smokefree Environments

In our last report we noted with pleasure that the Buller and Westland District councils had adopted Smokefree policies for their parks and grounds. We are pleased to be able to advise that as a result of a joint submission from members of the West Coast Tobacco Free Coalition, the Grey District Council has also now adopted Smokefree policies for their parks and grounds. This means that all the Coast's council-controlled parks and grounds are now Smokefree and is a significant milestone.

Capital Assistance Programme (CAP) Subsidies for Drinking Water Supplies

Community and Public Health's Drinking Water Technical Assistance Programme (TAP) facilitator has been on the West Coast working with local water suppliers to help them apply for CAP funding to upgrade their water supplies. There are three communities applying for funding assistance in this round; Westport, Nelson Creek and Stillwater.

Submission on Green Paper for Vulnerable Children

Community and Public Health West Coast have made a submission on the "Green Paper for Vulnerable Children."

Two main concepts underly this submission:

- All children are vulnerable, and
- Children are taonga & their status in our society needs to be raised

Our submission agreed that every child deserves to thrive, belong and achieve, and that all children should be afforded the best opportunities this country has to offer in order to succeed and reach their full potential. The maxim that it takes a village to raise a child is often quoted; however, our message is that it takes a nation to raise its children. Our submission emphasised the need to consider an approach to the wellbeing of children that takes account of the wider social, physical and economic determinants of health. We also stressed the importance of intersectoral approaches and the need for agencies, families and whanau to work together to ensure that every child is loved, protected, supported and inspired.

MAORI HEALTH

Te Whare Oranga Pai

A negotiation brief for HEHA Maori Community Action funding has been put to the Planning and funding Team to begin the implementation of the next phase of Te Whare Oranga Pai project.

An Advisory committee with two members from each of the local Runaka was established to work alongside the DHB HEHA team to progress the planning for the expansion of this initiative to the next stage aiming to broaden the scope through:

- Increased co-ordination through the appointment of a Project Manager
- Improved facilities through the establishment of a multi purpose Oranga Pai Facility
- Improved facilitation -linking and building partnerships with other health focused services
- Long-term sustainability of the project through marketing and the development of comprehensive promotional material

A primary objective of this project is

- To create a culturally appropriate Whanau Ora environment where Maori want to come to (overall ethos of the project) and
- that Maori identify and implement their own priorities and solutions that relate to improving nutrition, increasing physical activity and reducing obesity

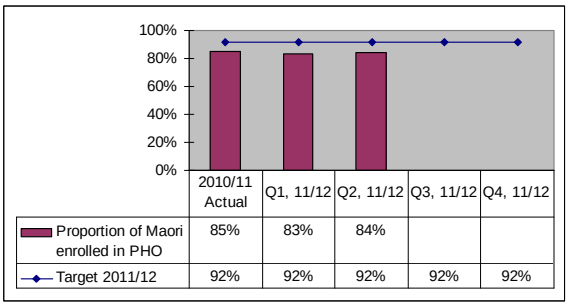
Opportunity to collaborate with the Primary Health Organisation Weight Management programme are currently being scoped and this is looking very promising. The HEHA team will continue to work very closely with the group and Project Manager to add capacity and provide any mentoring or advice required.

Integrated Contracting

Planning and Funding and Maori Health have had several meetings with Ministry of Social Development with the aim of participating in an Integrated Contracting arrangement with the Maori Provider and several of their key funders. A meeting is scheduled for the 13 April with all funders to start working towards a 'Shared Outcomes' agreement using Results Based Accountability as the foundation

Increase Maori enrolment in Primary Care

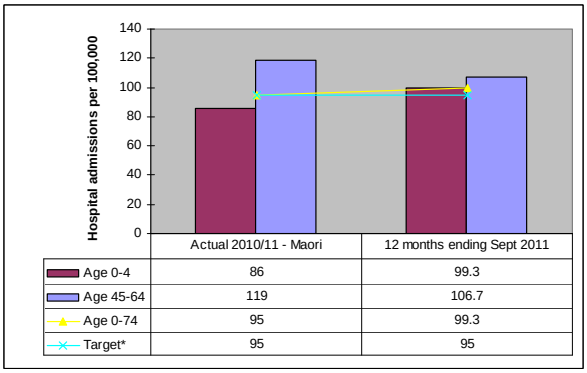
Percentage of Maori enrolled in the PHO



	2010/11 Actual	Q1, 11/12	Q2, 11/12	Q3, 11/12	Q4, 11/12
Proportion of Maori enrolled in PHO	85%	83%	84%		
Target 2011/12	92%	92%	92%	92%	92%

Reduce preventable hospital admissions

Reduction in preventable hospital admissions for Maori per 100,000 by age for the 12 months ending Sept 2011



	Actual 2010/11 - Maori	12 months ending Sept 2011
Age 0-4	86	99.3
Age 45-64	119	106.7
Age 0-74	95	99.3
Target*	95	95

*** Target: <95 per 100,000.**

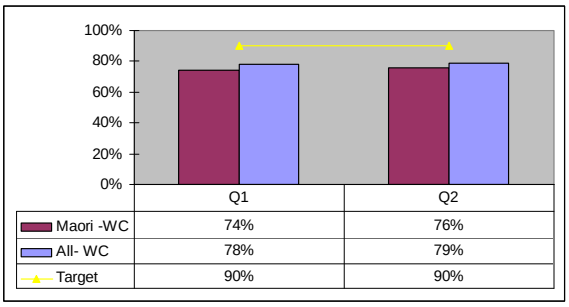
ACHIEVEMENTS/ISSUES OF NOTE

Enrolment in PHO: 1% more Maori enrolled in PHO in Q2, 2011/12 compared to Q1, 11/12. There is still under enrolment of Maori in West Coast PHO (WCPHO), however, the enrolment for Q2, 11/12 is nearly equivalent to the actual Maori enrolment in WCPHO in 2010/11. Note these figures are based on 2011 Statistics New Zealand projections, previous reports showing enrolment coverage above 90% were based on 2006 actual census figures.

Preventable Hospital Admissions: The rate for Maori admitted in hospital for preventable conditions is slightly higher than the target but not statistically significant. Among the 0-74 age group, West Coast Maori compared favourably in two of the top 5 national conditions in the 12 months to 30 September 2011 for their population grouping. Hospitalisation rates for West Coast Maori during this period were 60.9 for cellulitis (9 patients); 55.5 for angina. In the other 3 of the top national conditions however, West Coast Maori fared poorly with rates of 123.4 for dental conditions (15 patients); 118.5 for pneumonia (10 patients); and 126.2 (14 patients) for asthma.

Chronic diseases – Cardiovascular diseases (CVD)

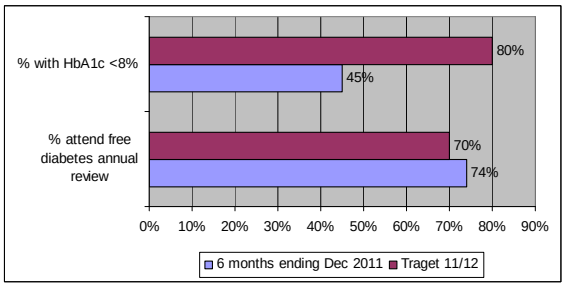
Percentage of Maori who have their CVD risk assessed within the past 5 years



	Q1	Q2
Maori -WC	74%	76%
All- WC	78%	79%
Target	90%	90%

Chronic diseases - Diabetes

Percentage of Maori who attend their diabetes annual review and have HbA1c level <8%



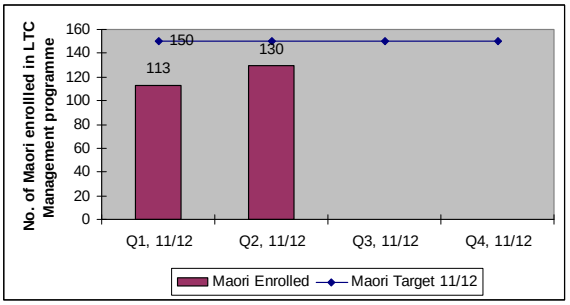
ACHIEVEMENTS/ISSUES OF NOTE

CVD Risk Assessment: 2% more eligible Maori have their cardiovascular risk assessed in the last 5 years for the period ending Q2, 2011/12 compared to the 5 year period ending Q1, 2011/12. However, this rate is 14% lower than the target of 90% for 2011/12.

Diabetes: More Maori are attending their free diabetes annual review – 70% in Q2, 2011/12, with 45% having a HbA1c level of less or equal to 8%. 55% of Maori receiving their diabetes annual review in Q2 had poor diabetes management.
Note – brief explanation of HbA1c: HbA1c is the term/indicator used in relation to diabetes. HbA1c occurs when haemoglobin joins with glucose in the blood. Haemoglobin molecules make up the red blood cells in the blood stream. When glucose sticks to these molecules it forms a Hb1Ac molecule. The more glucose found on the blood, the more haemoglobin will be present. For non-diabetic person, the normal or usual reading for HbA1c is 4-5.9%; a level of less or equal to 8% is a good indicator for good diabetes management; above 8% can be deemed poor diabetes management.

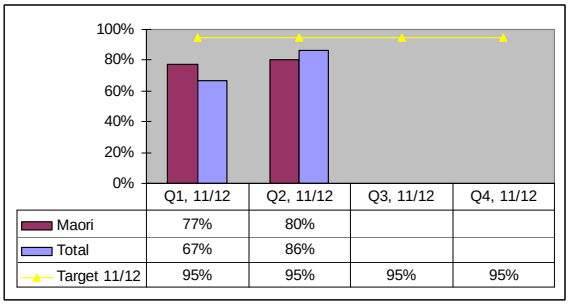
Long-term condition management

Number of Maori enrolled in LTC management programme



Smoking cessation – secondary care.

Maori hospitalised smokers provided with advice and help to quit



	Q1, 11/12	Q2, 11/12	Q3, 11/12	Q4, 11/12
Maori	77%	80%		
Total	67%	86%		
Target 11/12	95%	95%	95%	95%

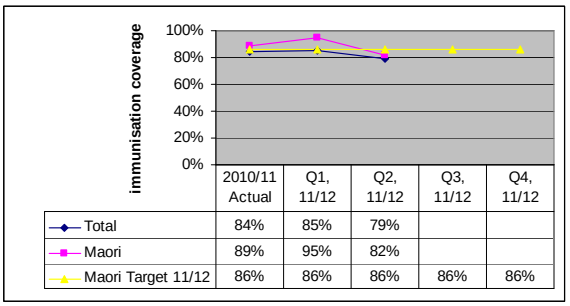
ACHIEVEMENTS/ISSUES OF NOTE

Enrolment in LTC management programme: The number of Maori enrolled in the long term conditions management programme increased by 17 in Q2 2011/12. An increase of 15% on enrolment in Q1, 11/12.

Improving and reaching the ABC Health Target in secondary care will continue to be a priority for all the WCDHB moving foward. Improvements over the last quarter for total (86%) and Maori (80%) in the health target have resulted from identifying three focus areas being addresssed to ensure that a sustainable implementation of the ABC initiative is achieved. The areas are; consistency in leadership and endorsement from senior staff, improved visiability of the ABC initiative at the ward level including improved communication, positive messaging and champions and lastly addressing training gaps. These three areas will continue to be a priority for smokefree staff with a particular focus in the next quarter on working with unit managers to address training gaps that exist with smokefree training.

Increase immunisation

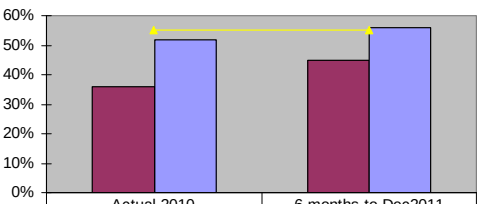
Percentage of Maori 2 year olds fully immunised



	2010/11 Actual	Q1, 11/12	Q2, 11/12	Q3, 11/12	Q4, 11/12
Total	84%	85%	79%		
Maori	89%	95%	82%		
Maori Target 11/12	86%	86%	86%	86%	86%

Oral health

Percentage of 5 year olds dental caries free



	Actual 2010	6 months to Dec2011
Maori 5 y.o	36%	45%
All 5 y.o	52%	56%
Traget -	55%	55%

ACHIEVEMENTS/ISSUES OF NOTE

Immunisation: The immunisation coverage for tamariki Maori turning 2 years in the 3 months ending Q2, 2011/12 is at 79%. Due to the small number of Maori 2 year olds the rate can fluctuate easily therefore, it is advisable to look at the 12 months period of coverage for tamariki Maori; the immunisation coverage rate for 2 year old tamariki Maori for the 12 months ending Q2, 2011/12 is 87% - 1% above the target for Maori for 2011/12.
Dental Caries: This data should be for 2011 calendar/school year 2011.

Support Maori workforce development

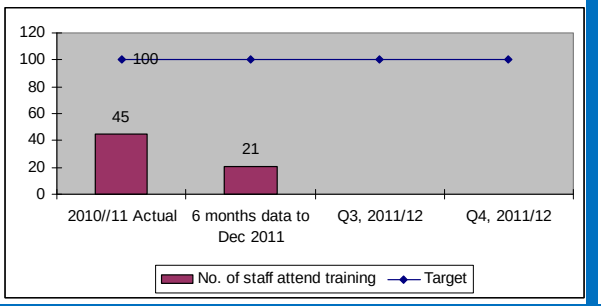
Number of WC Maori enrolled in the Kia ora Hauora programme 11

Percentage of scholarship recipient in 2011/12 identifying as Maori 4 from 17 (23.5%)

ACHIEVEMENTS/ISSUES OF NOTE

Improve the effectiveness and responsiveness of mainstream services

Number of DHB staff who completed Te Pikorua and Tikanga Best Practice training

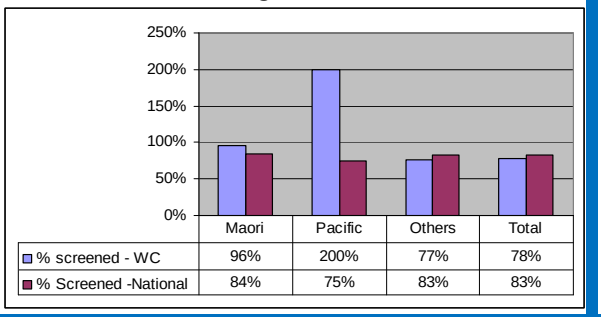


Treaty of Waitangi Training – 30 people attended. Figures for staff orientation will be included in the next report

ACHIEVEMENTS/ISSUES OF NOTE

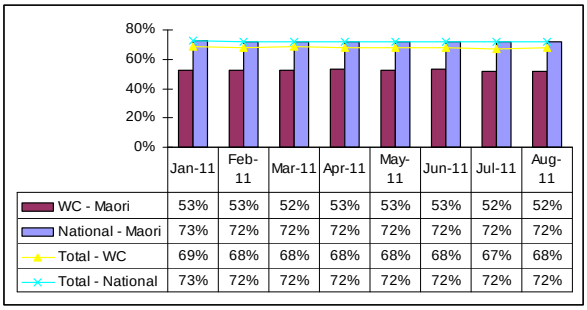
CANCER

Percentage of eligible Maori women receiving breast screening examination



	Maori	Pacific	Others	Total
% screened - WC	96%	200%	77%	78%
% Screened -National	84%	75%	83%	83%

Percentage of eligible Maori women receiving cervical screening in the last 3 years ending…



	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11
WC - Maori	53%	53%	52%	53%	53%	53%	52%	52%
National - Maori	73%	72%	72%	72%	72%	72%	72%	72%
Total - WC	69%	68%	68%	68%	68%	68%	67%	68%
Total - National	73%	72%	72%	72%	72%	72%	72%	72%

ACHIEVEMENTS/ISSUES OF NOTE

Breast Screening: Maori women aged 45-69 have a high rate of breast screening in the 2 years ending Q2 2011/12. Small numbers of Maori women in this age group may cause fluctuations in coverage rates that may be explained by a small number of women and this figure should be interpreted with caution.
Cervical Screening: Maori women aged 20-69 have a lower rate of cervical screening uptake compared to Maori nationally and other eligible women on the West Coast.
The National Cervical Screening (NSCP) target for 3-year coverage has been changed from 75% to 80%, beginning July 2011. The West Coast DHB has developed a NSCP WCDHB Strategic Plan 2011-12 in line with regional strategies and initiatives to increase the coverage rate of priority women to the required 3 yearly coverage rate of 80%, The Strategic Plan aims to continue collaboration with stakeholders and communities to implement the Regional NSCP Strategic Plan that best meets the unique needs of all eligible women on the West Coast

BULLER INTEGRATED FAMILY HEALTH CENTRE IMPLEMENTATION REPORT

The Buller Implementation Service Level Alliance (BSLA) has initiated the priority workstreams. 18 workstreams have been identified for the Q3 and Q4 period as essential. Workflow for facility design, IT resourcing and establishment of Inter-organisational local Clinical Governance are the highest priority areas.

Development of detailed workflows: Seven models of care were chosen to workshop to develop detailed information to inform the architectural design of the facility. These workstreams naturally lead to the development of care pathways which can be further developed and added to "Health Pathways" and then implemented in the current facility model.

IT Implementation: The BSLA in discussion with IT Dept. have determined the resourcing for IT implementation needs increased flexibility and the role of IT project manager is being rescoped to functional needs to resourced separately. Functions identified as being required are;

- Business Analyst – development of reporting requirements by department area to establish in a common PMS system
- System Architect – design of the framework and platform for delivery in an interim basis and well as determine needs for further integration
- Implementation – physical install, test and support
- Training and education – Initial and ongoing support of staff in each location

In addition increasing "Manage my Health" enrolments is essential for Buller if an integrated function is to occur.

Clinical Governance: The lack of local clinical governance at a level to support the range of developing clinical models is seen as a barrier to change. It is also seen as a development opportunity for local clinical leadership. This is identified as a priority to resolve while ensuring collaboration and linkage with regional clinical governance structures.

The BLSA has made a series of schedule changes to the priority tasks based on resourcing and critical path. Project Sponsor approved these and ALT has been informed

There is continued on-going anxiety over the pending site location decision, with a communication plan in development with a continued focus on "how we work together". A staff forum was held following the previous board decision.

Review of activity against Key Goals.

Month	Key Implementation Goals	comments
January	• Draft detailed implementation plan for approval by ALT • Finalise Communication plan for approval by ALT • Pathway workstreams (7) are initiated • IT Project Manager role finalised and advertised	• Implementation plan reviewed and amended to reflect resourcing and priorities. • Communication plan is a working strategy with comms team. Internal communications initiated with staff forum and newsletter • Six work streams initiated. Tele-medicine not initiated • Role rescoped to functional resourcing rather than FTE resourcing
February	• Pathways work streams completed • Facility redesign process initiated • IT Project Manager Appointed • Launch workshop for staff completed • Feedback pathways for staff active • Project reporting format implemented • Project change methodology is approved • Local clinical governance group initiated.	• Incomplete. Six streams are underway. Initiated discussions with Streamliners for health pathway development • Completion of the work streams is a determinant of this task. Scheduled for April • Recommendation paper finalised. Possible vendors and internal resource identified • Staff forum held post Board meeting. Soft launch through workstreams • Underway and active. Web, hardcopy and email feedback established • Completed. Templates developed and in use for workstreams. Consolidated plan for Q3/4 • In development. Defined roles for sponsor and exec management members of BSLA. • Incomplete. Prioritised.

Task	task description	Lead	Start	Finish	Comments
1.2	Buller Health clinical staff develops detailed workflow to inform detailed facility design.	**BIT**	**Q3 11**	**Q4 11**	Critical path task and underway. Determinant for number of other tasks
1.3	Develop a single patient access service & direct calls away from reception	**JR**	**Q4 11**	**Q4 11**	revised start to end of workflow outputs
1.7	Partner with Rata te Awhina and implement Maori health Kaiawhina/support/ nursing roles.	**BS**	**Q3 11**	**Q4 11**	Underway. Rata visiting Implementation team in Feb
3.1	Business case for nurse practitioner role Barbara has started this work	**BS**	**Q3 11**	**Q4 11**	Initiated to schedule
4.1	Extend Medtech to Westport pharmacy (It Manager supported)	**MOD**	**Q3 11**	**Q4 11**	In planning
4.3	Include pharmacist in clinical governance group start work now e.g. Address script errors	**PC**	**Q3 11**	**Q3 11**	Underway
5.1	Implement Medtech for all ambulatory urgent care consults	WT	Q3 11	Q4 11	is this dependant on 5.2 and 1.2.4 and same as 9.1
5.2	Shift interim weekend clinics to current outpatient area systems place	**JR**	**Q4 11**	**Q 4 11**	Moved to Q4 11. dependant on output of workflow workstreams
5.3	Redesign interim day time workflow to integrate urgent care pathways, align copayments	**JR**	**Q3 11**	**Q 4 11**	dependant on 1.2.4 and 5.1
6.1	Recruit additional nursing FTE to expand enrolment in level 1 services for LTC	**BS**	**Q3 11**	**Q4 11**	In planning
7.1	Appoint local coordinator role	**EN**	**Q2 11**	**Q3 12**	completed with recruitment through PHO and revision of team roles
7.2	Develop common stepped care pathway – inc assessment tools, outcome measurement, etc, - including AOD. – engage Streamliners for Patient Pathway mapping – scope work to be done	**EN**	**Q3 11**	**Q4 11**	revised to start at end of workflow outputs
8.5	Developing links to Aged Residential Care, including a shared clinical patient record	**PC**	**Q3 11**	**Q4 11**	In planning, partial dependant on workflow
9.0	Appoint IS project manager to support IFHC IS developments	**WT**	**Q3 11**	**Q4 11**	Critical path task and underway. scope changed to IT resourcing vs. role
9.4	Extend Medtech to District nursing staff as sole PMS & provide training, & laptops (q1)	**MOD**	**Q 3 11**	**Q4 11**	In planning
9.6	Roll out Manage my Health, including web portal that enables web based appointments, e-consults, telehealth consults and self care advice	**MOD**	**Q3 11**	**Q4 11**	Workstream to have all clinical encounters enrol Buller patients in development
11.0	Develop Local Sector Wide Clinical Governance Group	**PC**	**Q3 11**	**Q4 11**	Critical path for consultative development of other tasks. In development
12.1	Develop rural IFHC service specification and outcomes based contract	**WT**	**Q3 11**	**Q4 11**	Portion of work undertaken by PHO. CDHB doing work as well. In planning
13.1	DHB approval in principle for Buller IFHC, & decision on single vs. split site Question for the Board & MOH	WT	Q2 11	Q3 11	Complete. board confirmed one site greenfield build
13.2	Discussions MOH & third party developers re capital options Question for the Board & MOH	**WT**	**Q2 11**		Initiated
13.5	Complete more detailed facility plans for preferred site Question for the Board	**WT**	**Q2 11**		requires output of 1.2
13.6	Consultation with affected staff/unions (as required) – defined process –	**WT**	**Q3 11**		Not initiated
13.7	To DHB board for final decision	**WT**	**Q3 11**		delayed 6 weeks 9 march

Grey Integrated Family Health Service & Regional Hospital Services Workstream

The work to develop the model of care for the Grey Integrated Family Health Centre or Service (IFHC/S) is intimately linked with the Grey Regional Hospital redesign work. Work is underway to define the components of Primary Care, Community services, Mental Health, Health of Older People and Hospital level services for the Grey Region and the wider West Coast (for services that are provided not solely for the Grey region, such as hospital level services). Much of the work will be built upon the original BSMC business case, to review its currency and adapt and extend as required.

These pieces will be brought together to describe an integrated model of care. The Grey IFHC/S model will be melded with the Coast wide hospital level service provision model. A whole system wide reference group will then review the integrated model of care to ensure that it is indeed integrated and sustainable. This draft model of care will be presented to the next Board meeting for approval.

Key to the success of this model of care development is finding the right balance between developing parts of the system in more detail, and keeping a 'whole of system' (i.e. not siloed) approach. It is also important to involve the whole of West Coast, providers and community, in the discussions, as the regional hospital services affect the whole region.

The business case for the Integrated Family Health Centre (IFHC), and for the Regional Hospital are separate (due to different funding channels) but linked. Sapere Research Group is assisting us in developing these business cases. The draft indicative business case for the Grey Regional Hospital and the Grey IFHC business case will be completed by 30 June 2012 for submission to the Capital Investment Committee.

Health of Older People Service Level Alliance

The Health of Older People Service Level Alliance (HOPSLA) was formed in November 2011 and presented an initial proposed model of care to West Coast DHB in November. A small clinical project group has been working on a more detailed proposal based on this model, for implementation by July 2012. These proposed changes were tested and refined at a clinical workshop on Monday 20 February, and will be further refined by consumer focus group meeting on 21 February. The model will also be informed by an external review of West Coast DHB homecare, assessment and case management services which will be completed by the middle of March, after which a detailed implementation plan will be prepared.

QUALITY

Quality Roles
Two significant quality roles signalled in the 2011 Quality Review have now been filled – Quality and Patient Safety Manger (Rachelle Hunt) and Quality Coordinator Hospital Services (Vicki Piner). With both roles filled internally it now becomes a priority to fill the vacancies left so that robust quality processes are maintained in the services they leave.

Certification
Auditors from Verification NZ have confirmed their surveillance visit from 21-23 March 2012, although details of timetabling and focus have yet to be confirmed. From reports submitted, and feedback received it is likely that the focus will be on viewing evidence on progress we have reported. In particular this includes restraint in non mental health areas, treatment planning and discharge planning, and systems for booking surgery. In addition, there remains a significant amount of unfinished work, however with the quality positions now filled, it is expected that progress will pick up over the next few months. Areas still needing attention include the facilities maintenance system and resourcing, document control systems, and systems for recording training, annual practicing certificates, and pre-employment verification of qualifications.

Serious and Sentinel Events
The Health Quality Safety Commission (HQSC) released the annual report on Serious and Sentinel Events for the 2010-2011 year, on 20 February 2012. The report offers high level numbers of incidents across all DHBs, and a link to on on-line breakdown of events for each DHB, including a brief synopsis, and summary of the investigation recommendations for each. In effect the report seeks to provide both transparency with the public for events that have occurred, and reassurance that quality improvements occur as a result of tragic events. The West Coast DHB has recorded five events, however one was later found to not meet reporting criteria, but was too late for printing changes. Recommendations being implemented from these incidents include:

- guidelines for transfer of maternity care, including communication and guidance as to when a midwife escort is appropriate
- changes to orientation for new medical staff
- best evidence guidelines specific to the West Coast DHB on electronic fetal monitoring and the management of twin labour and delivery
- training for multidisciplinary team to improve management of obstetric emergencies
- consideration to transferring women with multiple pregnancies to a tertiary centre at an appropriate gestational age.
- guidelines to assist staff discuss and clarify the involvement of family when visiting, and the need to notify staff of departure. .
- falls risk assessments consistently carried out and reviewed during admission

Locally, a more streamlined system for managing the reporting and investigation of serious incidents is being implemented, and while further fine-tuning is still needed, particularly around communication and feedback loops, improvements are already being realised. Significantly, intentional and open feedback to those affected by events (patients, families and staff) is beginning to occur and further improvements will see this occurring in a more consistent and timely fashion.

Future Priorities:

The guiding principle of the Quality Review is a more intentional focus on systems that ensure greater patient safety, and to that end the breath of work ahead needs to be prioritised. Initial priority will be given to

- streamlining an effective complaints system
- the certification surveillance visit in March
- bringing together a more cohesive quality team to better utilise expertise and resource in a coordinated way
- the roll out of the incident reporting and review system to Community Services, Buller and Reefton,
- developing effective links with the quality team in Canterbury DHB
- developing a workable quality framework for West Coast DHB, aligned with Canterbury DHB, and inclusive of effective and defined reporting requirements

RISK MANAGEMENT

Introduction
Management has continued to develop an improved risk management strategy, with the support of Deloitte

Policy Documentation
West Coast DHB has a Risk Management policy which was due for review in 2009. This policy was referred to the Quality, Finance, Audit and Risk Committee (QFARC) for review and was confirmed subject to ensuring there were no conflicts with Canterbury DHB risk management policy.

Reporting and review of key risks
An Executive Risk Management Committee has now been established.

As part of its functions it will review each of the prioritised 14 top risks and provide a description and identify the mitigations/controls in place for each.

The Committee will review the 14 risks on a rolling timetable and report to QFARC at every meeting on two risks thus providing for each individual risk to be reviewed by QFARC at least once a year .

Deloitte will support the Risk Management Committee in ensuring risk identification and mitigation strategies are robust.

COMMUNICATIONS

Building trust and confidence in the health sector on the West Coast via strategic communications.

- A planning session was held with the PHO and some GMs – which produced a 12 month tactical implementation plan (aligned to the Strategic Communications Plan) with KPIs and key areas of responsibilities.

Grey Integrated Family Health Centre / Hospital redevelopment

- Clinicians and senior staff from both boards met in Christchurch for a workshop to look at how the Canterbury DHB can support the West Coast DHB to provide health services on the Coast. Changes are needed in the way both DHBs work together in order to continue providing a high standard of healthcare services to the West Coast community.
  A key outcome from the workshop was a commitment to a Transalpine approach to how we provide health services. Developing this understanding is critical to our future model of health care delivery.
  The workshop also recognised that good patient pathways are required so West Coasters who require healthcare can get it as close as possible to where they live.

- Our plan is to take the expo information 'on the road' to other areas on the Coast.

- Communications will evolve as the project continues.

Buller Integrated Family Health Centre

- Board members will be visiting the Buller Health and O'Conor Trust sites to inform their decisions regarding the preferred site for the Buller IFHC.

Proactive media relations

- Smokefree coordinator story picked up by media.

- Story on Buller telephone system change released together with an advertisement explaining the system. There were some technical issues which delayed its implementation resulting in an advisory release to the local media. .

- Story on sensory modulation.

- Update on the Buller IFHC decision from the Board meeting released.

- Making Our Hospitals Safer - the Serious and Sentinel events report from the Health Quality and Safety Commission.

- Quarter two results of the West Coast DHB performance against the Government Health targets released.

Other projects

- Work on updating the West Coast DHB website and intranet continues as one of the communications tactics outlined in the strategic communications plan. Some collaboration with the Canterbury DHB may be possible as they also look at refreshing their website and intranet.

- *Report to the Community* - This newsletter goes out under the Healthy West Coast banner. The next issue will be distributed as an insert to the West Coast Messenger on 7 March. Copies are also sent to a wide range of opinion leaders and influentials.

- *ASK NOW* – Is an internal update that answers questions from staff and provides a forum for discussion on particular issues. The next update will accompany pay-slips in early March.

RECOMMENDATION

That the West Coast District Health Board receives the Chief Executive's report.

Author:	**David Meates, Chief Executive – 2 March 2012**

investing in your Development

CDHB Learning and Development Strategy

Vision: *Learning and Development shall partner at every level of the organisation to add value to processes, experiences or needs that are common to all staff.*

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Supporting and partnering learning providers in the Canterbury Health System. *Allowing our staff to experience best quality learning from the best practice experts.*

*A **Shared Management and Leadership Curriculum** that fosters consistent standards of performance; avoids duplication and aligns with professional pathways.*

***Streamlined records of learning outcomes and impact on work practice**. Training records that support individual career goals; help managers develop their staff and evaluate our training spend.*

*The **Blended delivery of programmes** allowing for flexibility across time and location and standardising learner experience. Programme delivery that is the best match for content.*

How does the strategy work for the CDHB and our staff?

*Increased **visibility of potential learning experiences**, allowing managers and staff to make informed choices about the learning they access.*

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

investing in your Development

Canterbury District Health Board
Te Poari Hauora ō Waitaha

One of the key ways to improve Patient outcomes is to support staff learning

Shared Curriculum

Complete
- Tertiary Partnership
- Joint appointment for curriculum development

Current
- Pilot underway for Front line management programme

Next Step
- Pilot Evaluation
- Curriculum Development

Blended Delivery

Complete
- Delivery platform identified
- Moodle site built

Current
- Moodle pilot - Nov 2011 to May 2012

Next Step
- Course Catalogue structure and link to training records

Streamlined Records

Complete
- Learner Managment System comparisons
- Touchpoints identified with other CDHB systems

Current
- LMS identification

Next Step
- Implement and link to wider systems

Partnering Providers

Complete
- Particip8
- PEWS pilot
- Prompt Review
- NIC and Preceptor 1-3 support

Current
- IV assessment online for PDU

Next Step
- Building elearning capacity

Visibility of potential learning

Complete
- Partner with Information Services
- Structure designed for training portal

Current
- Collate provider information
- Design pages

Next Step
- Author training portal information and L&D intranet

Workplace learning is be 70% on the job, 20% coaching or mentoring and 10% formal

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

CLINICAL LEADERS REPORT

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

FROM: **Carol Atmore, Chief Medical Officer**
Karyn Kelly, Director of Nursing and Midwifery
Stella Ward, Executive Director of Allied Health (WCDHB and CDHB)

DATE: **9 March 2012**

ACHIEVING EFFECTIVE CLINICAL LEADERSHIP

The successful first meeting of the revised Alliance Leadership Team for the Better Sooner More Convenient work implementation was held recently. The more clinically focused leadership team focused on the core workstreams of Health of Older People, the implementation of the Buller Integrated Family Health Centre, and the development of the Grey Integrated Family Health Centre, aligned with the Regional Hospital redevelopment.

A second workshop was held in Christchurch in early February to further discuss how Canterbury and West Coast health services can be better aligned to provide reliable, high quality sustainable health services for the people of the West Coast. Over 50 senior doctors, nurses, allied health professionals and managers from both sides of the Alps were at the day. This work is continuing through a smaller working group. This work will combine with the primary and community services, and mental health services work to define the future model of care for Grey regional health services to present in draft to the April Board meeting. Community input into this process will be sought in parallel during mid-March.

NURSING AND MIDWIFERY

Nursing forums are being held to ensure Greymouth based nurses across the health sector are fully informed of Better Sooner More Convenient, the proposed redevelopment of the Grey Base hospital building and the developing model of care. A whole of team approach is being encouraged and enabled in the development and articulation of the nursing component of the model of care for the Greymouth workstream. Principles such as integration, being patient focussed, ensuring a seamless patient journey, best practice, innovation, sustainability, lean thinking and efficient use of the whole health care team are being prioritised. Clear links with the ongoing Buller workstream are also being identified with learnings and principles informing the Greymouth project.

Supporting this is the identification of the required demographic of skills and roles required, and the ongoing workforce development plan to ensure a fit for purpose nursing workforce across the region.

MEDICINE

Ongoing efforts continue to recruit general practitioners and senior hospital doctors, in collaboration with the Canterbury DHB Recruitment team, with some successes.

Focus is continuing on improving the structure and processes of the West Coast DHB owned primary practices to work to a common vision within a business model that is sustainable.

The Rural Learning Centre (RLC) facility was blessed and opened on 21 March. Our four fifth year rural immersion medical students have joined us for their academic year in 2012. The new facility will greatly enhance their learning experience with us.

ALLIED HEALTH, TECHNICAL & SCIENTIFIC

Collaboration with Canterbury continues in the development of processes and care pathways as part of the initial development of the 'Transalpine' models of care.

Allied Health staff have been participating in the various meetings looking at the 'redesign' and 'realignment' of models of care for Buller IFHC; Grey hospital and community services and the Health of Older People. Core elements of this include one allied health team providing services locality based; a philosophy of maximising independence and developing the tools to support active workload management such as capacity planning; process improvement and clinical leadership.

Work continues on developing and implementing components of integrated care across the West Coast Health system. The focus is on the transition of care between hospital and community clinicians which is a core component of the Buller model of care and is being co-led by allied health and nursing. Included in the work plan is the revamp of systems and processes to support seamless care coordination as part of a patient's journey.

Work continues on the implementation of the recommendations of the external reviews for Social work and Occupational therapy with recruitment for two clinical manager roles underway; updating of policies and procedures and clinical audit.

Report of Progress against Annual Plan 2011-12
(progress reported in italics)

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident?*
Strong clinical governance in the planning and delivery of services across the West Coast DHB	Develop an integrated whole of system clinical governance framework for the West Coast. ▪ *The Interim Clinical Governance Group have agreed TOR and a process for membership with the aim to have the first meeting of the Clinical Board occurring in April.* ▪ *TOR attached for the Boards information*	A documented clinical governance framework for the West Coast Health system will be in place by December 2011. Staff survey results indicate improved participation in decision making; clinical leadership and clinical quality initiatives.
Provision of clinical leadership across nursing, allied health and medical staff	Strengthen senior clinical contribution into the West Coast DHB and Advisory committees. ▪ Strengthen clinical inputs into the planning of future services provision across the West Coast Health system ▪ *Work continues with regular participation from all disciplines in the various workstreams underway for future care delivery for the West Coast* ▪ *Two facilitated workshop were well attended by clinicians from the WCDHB and CDHB in December and February* ▪ *Ongoing work is developing the models of care for future services*	Regular attendance and reporting from Clinical Leaders group to Board and Advisory Committee meetings. Future health service models of care are developed by the doctors, nurses and allied health professionals who provide the service.

Increased professional development opportunities for clinical staff to increase staff retention	Develop the West Coast as a Rural Learning Centre. ▪ The Regional priorities have been agreed for Allied Health, Technical and Scientific professions and have been included in the Regional Training Hub progress report – the leadership of remote and rural services will be led by the WCDHB Rural Learning Centre. ▪ The Clinical Leaders met with the Director of the RLC to progress the development of the Centre and proposed activities moving into 2012. ▪ *The official opening of the RLC with a Powhiri and Blessing was held on February 21st. The Powhiri also welcomed new staff to the West Coast. The interdisciplinary learning concept will be led by the RLC and faculty members/support team.* Facilitate increased opportunities for the professional development of clinical staff. ▪ *HWNZ funded Nursing Post Graduate education has been finalised for 2012 with 21 nurses receiving funding for clinical PG papers, semester one is underway.* Work with Human Resources to focus on activities that enhance recruitment and retention. ▪ *The 6 new graduate nurses, 4 Midwifery first Year of Practice Midwives, and 2 Nursing Entry to Specialty Practice have now started in their respective practice areas.* ▪ *One Rural General Practice Registrar has started their GPEP 1 year at the Rural Academic Practice* ▪ *Another Rural Hospital Medicine and Rural General Practice combined fellowship Registrar is continuing their GPEP 2/registrar training on the West Coast*	Rural learning centre meets its work plan. Number of professional development workshops/ sessions provided. Increased staff retention. Workforce plan developed that will outline actions to retain and attract clinical staff and report against these – reduced staff turnover and reduced time to recruit into vacancies.

RECOMMENDATION

That the West Coast District Health Board receives the Clinical Leaders' Report for their information.

Authors:	**Chief Medical Officer,** **Director of Nursing and Midwifery, and** **Executive Director of Allied Health (WCDHB and CDHB) – 1 March 2012**

HEALTH TARGETS

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

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

DATE: **9 March 2012**

BRIEFING POINTS FROM TARGET CHAMPIONS FOR QUARTER TWO 2011/12 HEALTH TARGET RESULTS – FEBRUARY 2012

Overall results
The quarter two 2011/12 health target results show excellent performance improvement in most areas with two of the national health targets being achieved (cancer wait times and elective surgery), and four of the targets showing improvements compared with last quarter (ED, immunisation, tobacco and CVD diabetes).

In the **Shorter waits for cancer treatment** target, nationally 100 percent of patients, who were ready for treatment, received their radiation treatment within four weeks of their first specialist radiation oncology assessment.

Quarter two results for the **Improved access to elective surgery** target show the national target has been achieved with 75,907 elective surgical discharges provided, against a target of 73,114 discharges. This is 2,793 (4 percent) more than planned.

The **Shorter stays in emergency departments** target performance has reached its highest ever result of 92 percent, a 2.3 percent performance increase compared with quarter one 2011/12. This result continues the trend of improved quarter two performance after a slight quarter one drop due to winter seasonal factors. Of the 238,203 patient presentations to emergency departments this quarter, 219,614 were admitted, discharged or transferred within six hours.

In the **Increased immunisation** target, national immunisation coverage increased from 90.8 in quarter one 2011/12, to 91.6 percent against a target of 95 percent for total population. Of the 16,610 children eligible to be immunised this quarter, 15,222 were fully immunised by two years old.

There has been good progress in the **Better help for smokers to quit target** which has reached 89.3 percent this quarter compared with 88.1 percent in quarter one 2011/12. Over 34,900 hospitalised smokers have been identified in quarter two and 31,168 have received brief advice.

In the final report on the **Better diabetes and cardiovascular services** health target, results increased slightly this quarter to 74 percent, 1 percent higher than quarter one 2011/12.

Health target results for quarter two 2011/12 compared with quarter one 2011/12

Target Area	National goal	Quarter one 2011/12	Quarter two 2011/12
Shorter stays in emergency departments	95%	89.9%	92.2%
Improved access to elective surgery	100%	103.4%	103.8%
Shorter waits for cancer treatment	100%	100.0%	100.0%
Increased immunisation	95%	90.8%	91.6%
Better help for smokers to quit	95%	88.1%	89.3%
Better diabetes and cardiovascular services	N/A[1]	73.3%	74.3%

Individualised performance-focused letters will be sent to all DHB CEOs, copied to DHB Chairs, from the Director-General of Health. The letters will contain specific feedback from each Target Champion about each DHB's quarter two 2011/12 health target performance. Target Champions will also be contacting poorer performing DHBs in each target area.

The table of DHBs' performance for publication in newspapers and newsletters has a column to describe the change in performance between quarter one 2011/12 and quarter two 2011/12. Upward and downward triangles indicate where progress has increased or decreased and the dash '-' indicates no change. As in previous quarter, changes up to and including 1 percent have not been displayed in the newspaper table as improvements or decreases in performance. Changes of 1.01 percent or more are displayed as upward or downward facing triangles.

Detailed data on the quarter two results will be available on the Ministry's website from Tuesday 28 February 2012. This includes an interactive excel spreadsheet where detailed results are available by target area, including by ethnicity for some targets, and / or by DHB. Refer to www.moh.govt.nz/healthtargets

The purpose of the briefing points from Target Champions is to provide additional background information to support DHBs disseminating the target results to local communities. This information is not developed to be published in full.

Please note the Ministry plans to publish the quarter two results on 28 February 2012. In some of the past quarters, the Minister has released the results a day early.

New health targets for 2012/13

The Minister has now confirmed the final set of health targets for 2012/13. Technical definitions for each of the targets are available on the Nationwide Service Framework Library website at the Nationwide Service Framework Library website www.nsfl.health.govt.nz.

Health target results

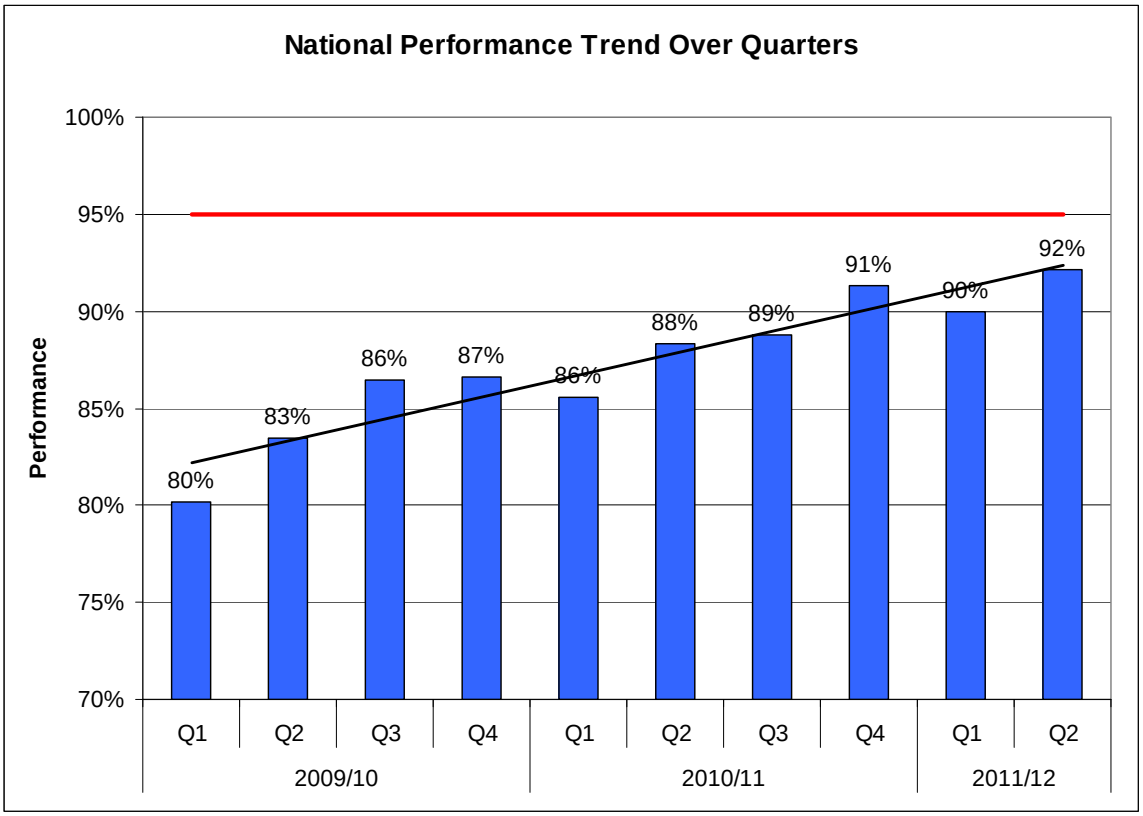
1. Shorter stays in emergency departments

National performance in the Shorter stays in ED health target improved to 92 percent this quarter. This is an increase of 2.3 percent on quarter one of 2011/12 and is the highest national performance achieved since the target was introduced. Of the 238,203 patient presentations to emergency departments this quarter, 219,614 were admitted, discharged or transferred within six hours.

[1] Performance against the Better diabetes and cardiovascular services health target is an average of three target indicators and there is no overall national goal.

DHB performance
Nine DHBs achieved the target this quarter, up from six last quarter. This includes Hawke's Bay DHB achieving the target for the first time, while Auckland and South Canterbury DHBs re-achieved the target after falling below 95 percent last quarter. Canterbury, Counties Manukau, Nelson Marlborough, Tairawhiti, Wairarapa and West Coast DHBs all maintained their achievement of the target from last quarter.

The performance achieved this quarter is consistent with the trend described previously whereby quarter one performance is lower than the prior quarter due to winter demands. This is illustrated in the graph below. Performance then improves with a positive 'straight line' trend.



Capital & Coast DHB's improvement of 8.5 percent is the largest recorded for this quarter. Although Capital & Coast remains the poorest performing DHB, at 82 percent for quarter two, this is very positive progress and the DHB is on track to achieve a progress target of 90 percent in quarter three.
Hawke's Bay DHB achieved the 95 percent target for the first time this quarter. The DHB has been achieving above 90 percent since quarter four of 2009/10, but has found the final few percent to reach 95 percent difficult to achieve.

After falling below the 95 percent target for the first time last quarter, South Canterbury DHB re-achieved the target this quarter with a performance of 97 percent. Auckland DHB also re-achieved the target this quarter, with both the Adult and Children's EDs individually achieving 95 percent.

Lakes and Northland DHBs have emerged as DHBs falling behind this quarter.

2. Improved access to elective surgery

Quarter two results for the elective surgery target show the national target has been achieved with 75,907 elective surgical discharges provided, against a target of 73,114 discharges. This is 2,793 (4 percent) more than planned.

DHB performance
All DHBs are within 5 percent of plan and seventeen DHBs have achieved their target.

Ten DHBs (Northland, Counties Manukau, Lakes, Bay of Plenty, Taranaki, Hawke's Bay, Mid Central, Whanganui, Hutt and West Coast) have actual delivery more than 5 percent over their planned level.

Tairawhiti is currently the only DHB that is more than 2 percent behind plan, at 95 percent. However their delivery is anticipated to lift for the remainder of the year.

The National Health Board has been working closely with all DHBs in quarter two to maintain momentum in delivery and to ensure there is a continued focus on reducing the number of patients waiting over six months for first specialist assessments or treatment.

3. Shorter waits for cancer treatment radiotherapy

Nationally 100 percent of patients, who were ready for treatment, received their radiation treatment within four weeks of their first specialist radiation oncology assessment.

DHB performance
Southern DHB was an outstanding performer this quarter. During quarter two 2011/12, the DHB experienced an influx of pre-Christmas referrals. To ensure that all patients were treated within the four week maximum, the cancer centre staff worked extended hours and weekend shifts over the Christmas and New Year holiday period.

The remaining five cancer centre DHBs – Auckland, Waikato, MidCentral, Capital & Coast, and Canterbury all achieved the four week target for all patients who were ready for treatment.

There were no poor performing DHBs with respect to the Shorter waits for cancer treatment health target.

The Ministry continues to intensively monitor all cancer centre DHBs against the four week health target through weekly reporting of:

- performance against the four week target
- factors influencing treatment delivery capacity
- use of delay code categories.

From 1 July 2012 there will be a combined radiation treatment and chemotherapy target in place. Detailed expectations and definitions of the combined target are available on the Nationwide Service Framework Library website www.nsfl.health.govt.nz.

4. Increased immunisation

National immunisation coverage increased from 90.8 percent in quarter one 2011/12 to 91.6 in quarter two 2011/12, against a target of 95 percent for total population. Of the 16,610 children eligible to be immunised this quarter, 15,222 were fully immunised by two years old.

Ethnicity coverage in quarter two was: NZ European 92.7 percent; Māori 90.3 percent; Pacific 94.2 percent and Asian 95.6 percent.

The overall opt off and decline rate dropped to 4.7 percent this quarter. The Ministry will continue to work with the DHBs with low opt-off and decline rates to ensure immunisation services are delivered to all eligible children within their DHBs and to support the achievement of the national 95 percent target.

DHB performance

Nearly half the DHBs were outstanding performers this quarter, achieving total coverage rates between 93 and 95 percent in their regions: Waitemata (93 percent), Capital & Coast (93 percent), Lakes (93 percent), Hutt Valley (94 percent), Southern (94 percent), Hawke's Bay (94 percent), Wairarapa (94 percent) and South Canterbury (95 percent).

South Canterbury DHB achieved 95 percent for each month in quarter two, reaching all eligible children in the cohort.

Lakes DHB has worked collaboratively with local PHOs to improve coverage.

Nelson Marlborough DHB increased coverage by 5 percentage points this quarter, increasing coverage from 86 percent in quarter one to 91 percent in quarter two.

The following DHBs achieved 90 percent or greater coverage for Māori children: Waitemata (90 percent), Auckland (90 percent), Waikato (91 percent), South Canterbury (91 percent) Taranaki (91 percent), MidCentral (93 percent), Hutt Valley (93 percent), Lakes (94 percent), Capital & Coast (94 percent), Nelson Marlborough (94 percent), Canterbury (94 percent), Hawke's Bay (94 percent), Southern (95 percent) and Wairarapa (95 percent).

The following DHBs achieved 90 percent or greater coverage for Pacific children:

Hutt Valley (91 percent), Auckland (93 percent), Counties Manukau (95 percent), Waikato (96 percent), Canterbury (96 percent) and Waitemata (97 percent).

5. Better help for smokers to quit

There has been good progress in the Better help for smokers to quit hospital target with the national result increasing from 88.1 percent in quarter one to 89.3 percent of smokers being offered help and advice to quit nationally in quarter two 2011/12. Over 34,900 hospitalised smokers have been identified in quarter two and 31,168 have received brief advice.

Six DHBs achieved or exceeded the 95 percent target in quarter two, up from five DHBs in quarter one. Twelve DHBs achieved results of over 90 percent.

In primary care, the preliminary quarter two national result was 32.9 percent. This is a steady increase (4.6 percent) from the preliminary quarter one result (28.3 percent) and a slight increase from the verified quarter one result of 32.7 percent. Over 127,000 patients who smoked received brief advice in general practice over the last 12 months to 31 December 2011 (compared with 97,000 patients for the 12 months to 30 September 2011).

DHB performance

Hospital target

Lakes DHB has achieved 100 percent for the last two quarters. They have analysed critical success factors, and have implemented multi-faceted, system-wide actions.

Hutt Valley, at 96.8 percent, is up almost 6 percent from quarter one. Waitemata (96.1 percent) and Whanganui (95.5 percent) achieved similar results to their quarter one performance.

The most improved DHB is West Coast, where performance was lifted from 66.7 percent in the previous quarter to 85.8 percent for quarter two.

Primary care target

In general practice, outstanding performers were Whanganui, who achieved 100 percent, and Waitemata, who achieved 73.6 percent and is well on the way to meeting the primary care goal of 90 percent.

The biggest increases were made by Northland DHB, increasing from 47.5 percent to 57.0 percent, and Wairarapa DHB, increasing from 16.5 percent to 28.2 percent.

The primary care quarter two data is preliminary at this stage and there will be a degree of inaccuracy until the data is verified as part of the standard verification PHO Performance Programme process.

6. Better diabetes and cardiovascular services

This is the last quarter that the Better diabetes and cardiovascular services health target will be publicly reported in the national table of DHB performance published in newspapers. Results for the new 'More heart and diabetes checks' target will be published for the first time in May 2012.

In quarter two 2011/12 national composite performance in the Better diabetes and cardiovascular services health target increased slightly to 74 percent, 1 percent higher than quarter one 2011/12.

Last quarter the Better diabetes and cardiovascular services result was 70 percent. Due to data corrections the quarter one result has been revised from 70 percent to 73 percent. This explains why the quarter two result of 74 percent only shows a slight improvement of 1 percent.

DHB performance
Most DHBs have the same or better composite results this quarter when compared to the previous quarter. Lakes, Tairawhiti, Taranaki, and Waitemata DHBs have results more than 1 percent lower than quarter one 2011/12.

The target for the CVD risk assessment indicator is 90 percent which no DHBs have achieved. However, eight DHBs achieved more than 80 percent in this indicator, with the national average being 79 percent (3 percent higher than last quarter).

For diabetes free annual checks nine of 19 DHBs achieved their local targets, and three of 19 DHBs succeeded with their diabetes management. Due to earthquake related factors, Canterbury DHB has not set targets for diabetes so is excluded from this count.

CVD Risk Assessment
Results in the CVD risk assessment indicator show a general increase across the DHBs for the number of CVD-related lab tests as outlined above.

From quarter three 2011/12, the new health target 'More heart and diabetes checks' will be reported using the CVD risk assessment numbers sourced from the PHO Performance Programme.

Diabetes Free Annual Checks
Based on the number of diabetes free annual checks delivered in quarter two 2011/12, nationally 72 percent of people with diabetes received their free annual checks. This is the same as last quarter. Nine DHBs achieved their DHB-specific targets and six DHBs were within 5 percent.

Diabetes Management
Nationally, of those who have received their diabetes free annual check during quarter two 2011/12, 72 percent had satisfactory or better diabetes management. This is the same result as quarter one 2011/12. However, only three DHBs have achieved their DHB-specific targets, with a further nine DHBs within 5 percent of their targets.

What are the overall quarter two 2011/12 health target results?

The quarter two 2011/12 health target results show excellent performance improvement in most areas with two of the national health targets being achieved (Shorter waits for cancer treatment and Improved access to elective surgery), and four of the targets showing improvements compared with last quarter (Shorter stays in emergency departments, Increased immunisation, Better help for smokers to quit and Better diabetes and cardiovascular services).

How did each health target perform?

Shorter stays in emergency departments
The Shorter stays in emergency departments target performance has reached its highest ever result of 92 percent, a 2.3 percent performance increase compared with quarter one 2011/12. This result continues the trend of improved quarter two performance after a slight quarter one drop due to winter seasonal factors. Of the 238,203 patient presentations to emergency departments this quarter, 219,614 were admitted, discharged or transferred within six hours.

Improved access to elective surgery
Quarter two results for the Improved access to elective surgery target show the national target has been achieved with 75,907 elective surgical discharges provided, against a target of 73,114 discharges. This is 2,793 (4 percent) more than planned.

Shorter waits for cancer treatment radiotherapy
In the Shorter waits for cancer treatment target, nationally 100 percent of patients, who were ready for treatment, received their radiation treatment within four weeks of their first specialist radiation oncology assessment.

Increased immunisation
In the Increased immunisation target, national immunisation coverage increased from 90.8 in quarter one 2011/12, to 91.6 percent against a target of 95 percent for total population. Of the 16,610 children eligible to be immunised in quarter two, 15, 222 children were fully immunised by two years old. This result includes children who turned two years between 1 October and 31 December 2011 and who were fully immunised.

Better help for smokers to quit
There has been good progress in the Better help for smokers to quit target which has reached 89.3 percent this quarter compared with 88.1 percent in quarter one 2011/12. Over 34,900 hospitalised smokers have been identified in quarter two and 31,168 have received brief advice.

Better diabetes and cardiovascular services
In the final report on the Better diabetes and cardiovascular services health target, national composite performance increased slightly this quarter to 74 percent, 1 percent higher than quarter one 2011/12.

Last quarter the Better diabetes and cardiovascular services result was 70 percent. Due to data corrections the quarter one result has been revised from 70 percent to 73 percent. This explains why the quarter two result of 74 percent only shows a slight improvement of 1 percent.

This is the last time the CVD diabetes target will be reported in this form. From quarter three, the new target is ‘More heart and diabetes checks’.

Where can I find out more information on how my DHB is performing?
More specific information on each of the health targets can be found on the Ministry of Health's website at http://www.moh.govt.nz/moh.nsf/indexmh/healthtargets-reporting

RECOMMENDATION

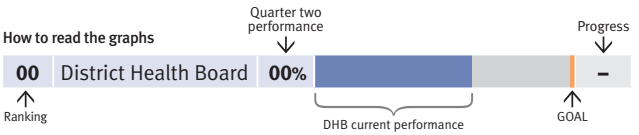
That the West Coast District Health Board receives the Health Targets Report.

Author:	**Wayne Turp, General Manager – Planning And Funding 1 March 2012**

Your District Health Board

2011/12 QUARTER TWO RESULTS

How to read the graphs



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

MINISTRY OF HEALTH
MANATŪ HAUORA

Shorter stays in Emergency Departments

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

		Quarter two performance	Change from previous quarter
1	West Coast	100%	–
2	Nelson Marlborough	97%	–
3	South Canterbury	97%	▲
4	Counties Manukau	97%	–
5	Tairawhiti	96%	▲
6	Auckland	95%	▲
7	Canterbury	95%	–
8	Wairarapa	95%	▼
9	Hawke's Bay	95%	▲
10	Whanganui	94%	▲
11	Hutt Valley	93%	▲
12	Waitemata	92%	–
13	Bay of Plenty	91%	▲
14	Taranaki	91%	▲
15	Waikato	89%	▲
16	MidCentral	89%	▲
17	Southern	88%	▲
18	Lakes	88%	–
19	Northland	87%	▲
20	Capital & Coast	82%	▲
	All DHBs	92%	▲

95%

Improved access to Elective Surgery

Improved access to elective surgery

The target is an increase in the volume of elective surgery by an average of 4,000 discharges per year.

* *DHBs planned to deliver 73,114 discharges year to date, and have delivered 2,793 more.*

		Quarter two performance	Progress against plan (discharges)
1	Lakes	119%	▲
2	Whanganui	115%	▲
3	Northland	113%	▲
4	West Coast	112%	▲
5	Taranaki	111%	▲
6	Counties Manukau	108%	▲
7	MidCentral	107%	▲
8	Hawke's Bay	107%	▲
9	Hutt Valley	105%	▲
10	Bay of Plenty	105%	▲
11	Wairarapa	103%	▲
12	Southern	101%	▲
13	South Canterbury	101%	▲
14	Waitemata	101%	▲
15	Canterbury	101%	▲
16	Auckland	100%	▲
17	Waikato	100%	▼
18	Capital & Coast	99%	▼
19	Nelson Marlborough	98%	▼
20	Tairawhiti	95%	▼
	All DHBs	104%	▲

100%

Shorter waits for Cancer Treatment

Shorter waits for cancer treatment

The target is everyone needing radiation treatment will have this within four weeks. Six regional oncology centres provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

		Quarter two performance	Change from previous quarter
1	Northland	100%	–
1	Waitemata	100%	–
1	Auckland	100%	–
1	Counties Manukau	100%	–
1	Waikato	100%	–
1	Lakes	100%	–
1	Bay of Plenty	100%	–
1	Tairawhiti	100%	–
1	Hawke's Bay	100%	–
1	Taranaki	100%	–
1	MidCentral	100%	–
1	Whanganui	100%	–
1	Capital & Coast	100%	–
1	Hutt Valley	100%	–
1	Wairarapa	100%	–
1	Nelson Marlborough	100%	–
1	West Coast	100%	–
1	Canterbury	100%	–
1	South Canterbury	100%	–
1	Southern	100%	–
	All DHBs	100%	–

100%

Increased Immunisation

Increased Immunisation

The national immunisation target is 95 percent of two year olds will be fully immunised by July 2012.

This quarterly progress result includes children who turned two years between October and December 2011 and who were fully immunised at that stage.

		Quarter two performance	Change from previous quarter
1	South Canterbury	95%	▲
2	Wairarapa	94%	▲
3	Hawke's Bay	94%	–
4	Southern	94%	–
5	Hutt Valley	94%	▲
6	Lakes	93%	▲
7	Capital & Coast	93%	–
8	Waitemata	93%	–
9	Auckland	92%	▲
10	Canterbury	92%	–
11	MidCentral	92%	▼
12	Counties Manukau	91%	▲
13	Nelson Marlborough	91%	▲
14	Whanganui	91%	–
15	Taranaki	91%	▲
16	Bay of Plenty	91%	▲
17	Tairawhiti	90%	–
18	Waikato	90%	–
19	Northland	82%	–
20	West Coast	79%	▼
	All DHBs	92%	–

95%

Better help for Smokers to Quit

Better help for smokers to quit

The target is that 95 percent of hospitalised smokers will be provided with advice and help to quit by July 2012. The data covers patients presenting to Emergency Departments, day stay and other hospital based interventions.

		Quarter two performance	Change from previous quarter
1	Lakes	100%	–
2	South Canterbury	97%	–
3	Hutt Valley	97%	▲
4	Nelson Marlborough	96%	▲
5	Waitemata	96%	–
6	Whanganui	95%	–
7	Capital & Coast	94%	–
8	Bay of Plenty	93%	▲
9	Counties Manukau	92%	▲
10	Hawke's Bay	92%	–
11	MidCentral	91%	▲
12	Taranaki	90%	▼
13	Southern	88%	▲
14	Tairawhiti	87%	▼
15	West Coast	86%	▲
16	Northland	85%	▼
17	Auckland	84%	▲
18	Waikato	81%	–
19	Canterbury	79%	▲
20	Wairarapa	66%	▼
	All DHBs	89%	▲

95%

This is the last time the CVD diabetes target will be reported in this form. From quarter three, the new target is **'More heart and diabetes checks'**.

Better Diabetes and Cardiovascular Services

Better diabetes and cardiovascular services

This graph represents the average progress made by a DHB towards three target indicators:

(a) 90 percent of the eligible adult population will have had their cardiovascular disease risk assessed in the last five years;

(b) an increased percent of people with diabetes will attend free annual checks;

(c) an increased percent of people with diabetes will have satisfactory or better diabetes management.

* *Due to data corrections, the quarter one All DHBs result has been revised from 70 percent to 73 percent.*

		Quarter two performance	Change from previous quarter
1	Whanganui	81%	▼
2	Capital & Coast	80%	–
3	Taranaki	80%	▼
4	West Coast	79%	▲
5	Hutt Valley	78%	–
6	Southern	78%	–
7	MidCentral	77%	▲
8	Bay of Plenty	77%	–
9	Nelson Marlborough	76%	▲
10	Hawke's Bay	76%	▲
11	Wairarapa	75%	▲
12	Waikato	74%	–
13	Northland	73%	–
14	Counties Manukau	73%	–
15	Waitemata	73%	▼
16	Auckland	72%	–
17	South Canterbury	72%	▲
18	Lakes	70%	▼
19	Canterbury	70%	–
20	Tairawhiti	65%	▼
	All DHBs	74%	▲

This information should be read in conjunction with the details on the website **www.moh.govt.nz/healthtargets**

New Zealand Government

Breast Screening Programme DHB Report as at June 2011
West Coast DHB

BSA 24-month or 2 year coverage is the number of BSA screened women aged 50-69 years during the 24-month period as a proportion of all eligible women in New Zealand aged 50-69 years as derived from the 2006 Census population projections for that screening period.

Table 1: BSA Coverage of West Coast DHB Māori women aged 50-69 years for the 24 months ending June 2011

	Eligible Māori Population*	Number of Māori women screened	Coverage of Māori Population
West Coast DHB	250	175	70.0%

**Population projection data based on the 2006 Census produced by Statistics New Zealand according to assumptions specified by the Ministry of Health .*

Figure 1: BSA Coverage of Māori women aged 50-69 years by DHB for the 24 months ending June 2011

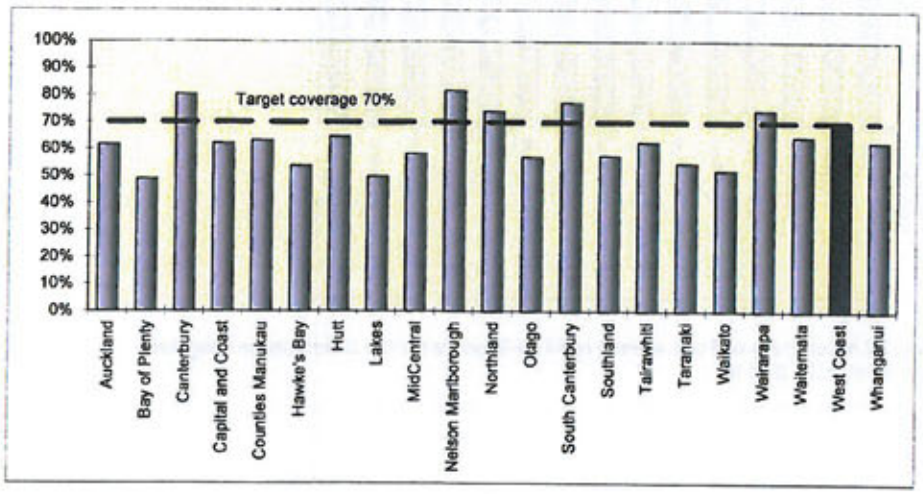


Table 2: BSA Coverage of West Coast DHB Pacific women aged 50-69 years for the 24 months ending June 2011

	Eligible Pacific Population*	Number of Pacific women screened	Coverage of Pacific Population
West Coast DHB	10	9	90.0%

**Population projection data based on the 2006 Census produced by Statistics New Zealand according to assumptions specified by the Ministry of Health .*

Figure 2: BSA Coverage of Pacific women aged 50-69 years by DHB for the 24 months ending June 2011

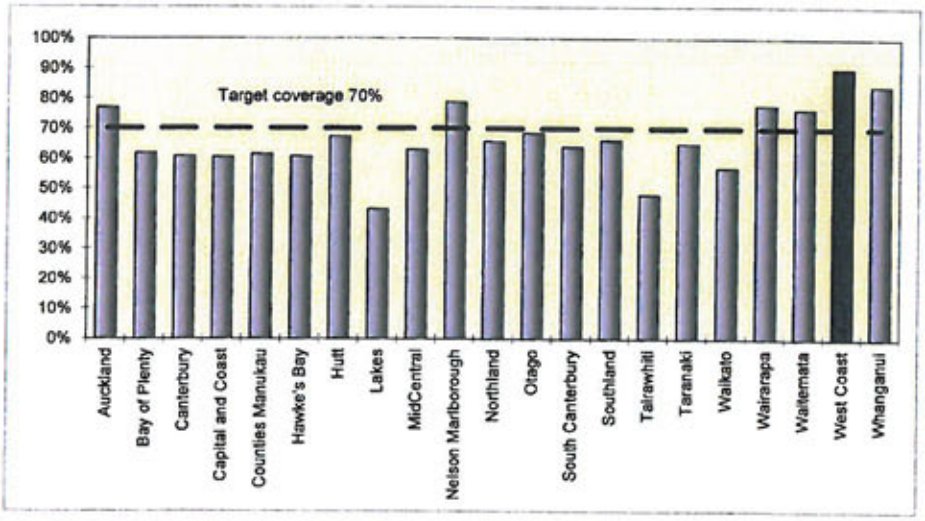


Table 3: BSA Coverage of West Coast DHB of Total women aged 50-69 years for the 24 months ending June 2011

	Total Eligible Population*	Total Number of women screened	Coverage of Total Population
West Coast DHB	4,135	2,916	70.5%

**Population projection data based on the 2006 Census produced by Statistics New Zealand according to assumptions specified by the Ministry of Health .*

Figure 3: BSA Coverage of Total women aged 50-69 years by DHB for the 24 months ending June 2011

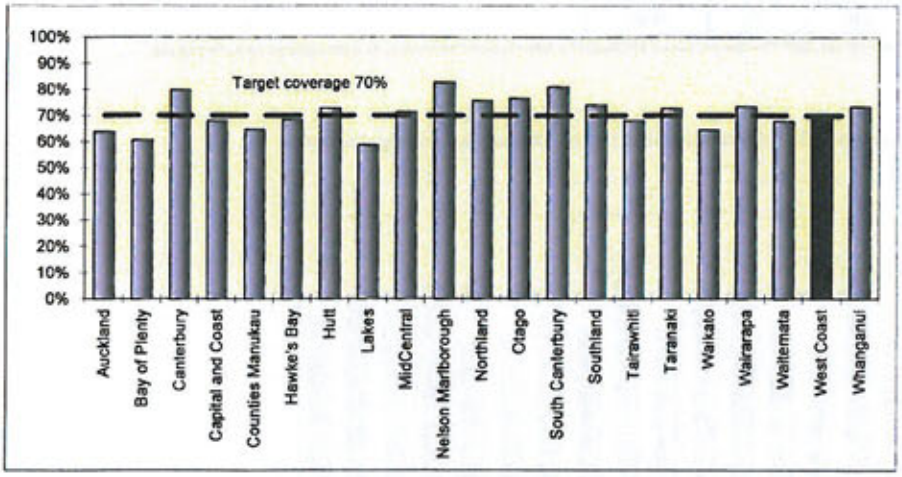


Figure 4: West Coast DHB and National BSA Coverage of Total women aged 50-69 years for the 24 months ending June 2008, 2009, 2010 & 2011 and December 2008, 2009 & 2010

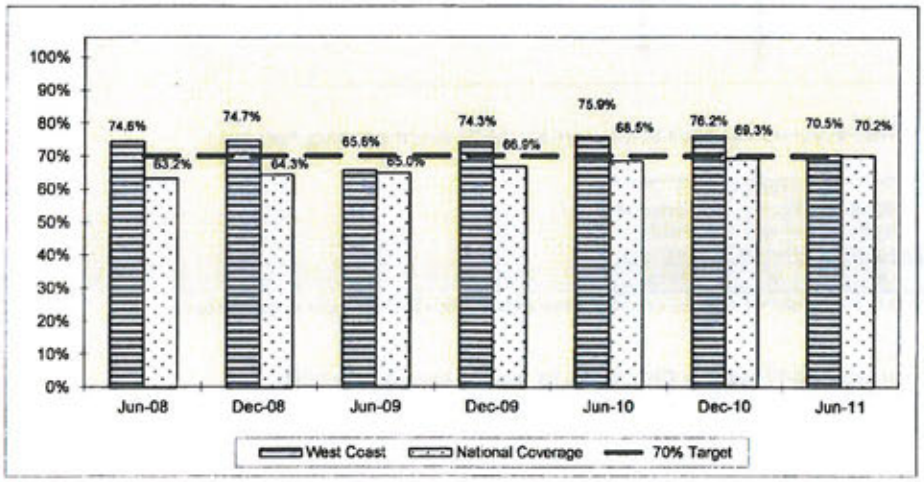


Figure 5: West Coast DHB BSA Coverage of women aged 50-69 years by ethnicity for the 24 months ending June 2008, 2009, 2010 & 2011 and December 2008, 2009 & 2010

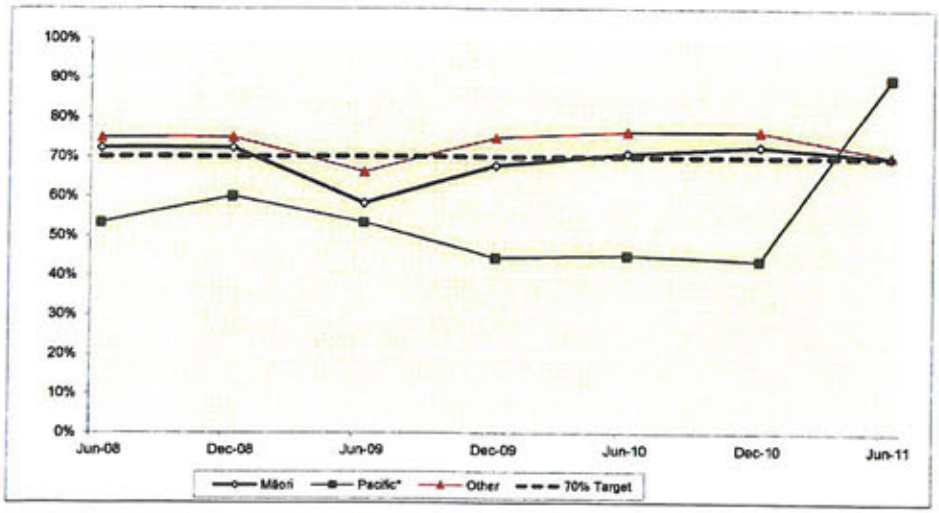


Table 4: West Coast DHB BSA Coverage of women aged 50-69 years by ethnicity for the 24 months ending June 2008, 2009, 2010 & 2011 and December 2008, 2009 & 2010

24 months ending	Māori*	Pacific*	Other	Total
Jun-08	72.3%	53.3%	74.8%	74.6%
Dec-08	72.3%	60.0%	74.9%	74.7%
Jun-09	58.2%	53.3%	66.1%	65.6%
Dec-09	67.8%	44.4%	74.8%	74.3%
Jun-10	70.8%	45.0%	76.3%	75.9%
Dec-10	72.7%	43.8%	76.5%	76.2%
Jun-11	70.0%	90.0%	70.3%	70.5%

Please note the Māori and Pacific populations for West Coast DHB are small and therefore small changes in the number of BSA screens of Māori and Pacific women can cause wide fluctuation in coverage and therefore caution should be taken in comparing coverage trends overtime for Māori and Pacific women.

FINANCE REPORT
JANUARY 2012

Financial Overview for the period ending 31 January 2012

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,117	6,358	(241)	√	44,129	43,697	432	√
Governance & Administration	208	212	(4)	√	1,496	1,485	11	√
Funds & Internal Eliminations	4,370	4,392	(22)	√	30,904	31,153	(249)	×
	10,695	10,962	(267)	√	76,529	76,335	194	√
EXPENSES								
Provider								
Personnel	4,482	4,492	10	√	30,436	30,751	315	√
Outsourced Services	864	831	(33)	×	7,972	6,484	(1,488)	×
Clinical Supplies	540	599	59	√	4,627	4,202	(425)	×
Infrastructure	870	903	33	√	6,592	6,433	(159)	×
	6,756	6,825	69	√	49,627	47,870	(1,757)	×
Governance & Administration	168	212	44	√	1,347	1,486	139	√
Funds & Internal Eliminations	3,533	3,708	175	√	25,478	26,375	897	√
Total Operating Expenditure	10,457	10,745	288	√	76,452	75,731	(721)	×
Deficit before Interest, Depn & Cap Charge	(238)	(217)	21	√	(77)	(604)	(527)	×
Interest, Depreciation & Capital Charge	550	551	1	√	3,551	3,856	305	√
Net deficit	**312**	**333**	**21**	√	**3,474**	**3,252**	**(222)**	×

ORIGIN OF REPORT

This is a regular report and standing agenda item providing an update on the latest financial results and other relevant financial matters of the Board of the West Coast District Health Board.

CONSOLIDATED RESULTS

The consolidated result for the month of January 2012 is deficit of $312k, which is $21k better than budget ($333k deficit).

RESULTS FOR EACH ARM

Year to Date to January 2012

West Coast District Health Board Arm	Actual	Budget	Variance	Comment
	$000	$000	$000	
Provider Arm surplus / (deficit)	(9,049)	(8,029)	(1,020)	Unfavourable
Funder Arm surplus / (deficit)	5,426	4,778	648	Favourable
Governance Arm surplus / (deficit)	149	(1)	150	Favourable
Consolidated result surplus / (deficit)	**(3,474)**	**(3,252)**	**222**	**Unfavourable**

COMMENTARY ON VARIANCES

The following table reconciles the consolidated actual year to date results to the consolidated year to date budget, highlighting variances. The table is followed by an explanation of material variances.

Arm	Nature	Variance	$000
	Revenue		
Provider:	Other Ministry of Health revenue	√	44
Provider:	Internal funding	√	285
Provider:	Other government	√	102
Funder:	Revenue	√	36
	Expenses		
Provider:	Personnel Costs	√	315
Provider:	Outsourced services – Locum costs	x	(1,096)
Provider:	Outsourced services – clinical services	x	(553)
Provider:	Outsourced services – non clinical	√	161
Governance:	Outsourced services – non clinical	√	104
Provider:	Clinical supplies: pharmaceuticals	x	(30)
Provider:	Clinical supplies: Implants & Prostheses	x	(225)
Provider:	Clinical supplies: air ambulance	x	(94)
Provider:	Clinical supplies: other offsetting items	x	(76)
Provider:	Facilities: Repairs and maintenance	x	(21)
Provider:	Facilities: Utilities	x	(92)
Provider:	Professional fees and expenses : Insurance	x	(59)
Provider:	Transport	x	(65)
Provider:	Infrastructure and non clinical: Other offsetting items.	√	78
Funder:	Funder Arm; expenditure	√	613
Provider:	Capital charge credit (2011 financial year)	√	259
DHB	Other offsetting items	√	92
	Year to date variance to budget		**(222)**

REVENUE

Consolidated revenue of $76,529k is $194k better than budget ($76,335k) .
Significant variances to budget are explained the separate arms below.

Provider Arm
Provider Arm revenue year to date is a positive variance of $432k. This is explained by:

- Internal revenue – Funder Arm to Provider Arm is $285k better than budget (eliminated on consolidation along with the Funder cost). This includes elective volumes revenue which was budgeted as an external cost in the Funder Arm, age related care and claims for pharmaceuticals.
- Revenue received from ACC is $111k better than budget (age related rehabilitation, treatment and assessment and elective contract work).

Governance and Administration
A donation of $31k was received in December 2011 from the Fresh Future Trust for neonatal and child health.

EXPENSES

Consolidated
Consolidated expenditure of 80,003k is $416k more than budget ($79,587k).

Provider

- Personnel costs are $30,436k; $315k better than budget ($30,751k).
- Medical Personnel costs are $370k better than budget. This is a combination of Senior Medical Officers (including General Practitioners) being $463k better than budget and Registered Medical Officers being $98k greater than budget, the main reasons can be summarised as follows:
  - Vacancies across hospital and primary services, resulting in a compensating unfavourable variance under outsourced services costs.
  - Registered Medical Officers are $98k more than budget. This is partially due to unbudgeted allowances for extra duties across RMO services and will continue for the remainder of the year.
  - Other personnel costs are $39k more than budget; recruitment costs (including placement fees) are $22k more than budget.

- Nursing Personnel costs are $483k more than budget.
  - This variance includes a one off restructuring cost incurred in October 2011.
  - The nursing costs for age related residential and hospital level care in Buller are over budget due to the increased acuity of the patients resident.
  - Budgeted nursing efficiencies have not been realised to date and this is being investigated with the objective of bringing the nursing costs back into line by improved rostering and a managed annual leave programme.

- Allied Health Personnel costs are $414k better than budget.
  - This is due to a number of vacancies across the service. Recent appointments to key allied health positions have been made, which will result in improved service delivery but the favourable financial variance will not continue to the same extent over the remaining months of the year.

- Outsourced services costs are $7,972k; $1,488k more than budget ($6,484k).

- Outsourced Senior Medical Costs (locums) are $4,961k; $1,049k more than budget.
  - This is due to vacancies reflected above under personnel costs and cover for planned and unplanned staff leave.
- Outsourced clinical services are $2,508, $555k more than budget.
  - This is largely due to ophthalmology and orthopaedic volumes being outsourced. This is being addressed with the objective of reducing the overspend over the year as part of this will be a timing difference of when the volumes were planned and delivered. The production plan will be adjusted to take account of delivered volumes.
  - Laboratory services are $154k more than budget; $29k of this relates to tests for pertussis.

Clinical Supplies
Overall treatment related costs are $425k more than budget, with volumes to date for most specialities being greater than budget.

- Implant and prostheses are $564k, an unfavourable variance of $225k. This is due to a combination of factors, including the timing and mix of cases delivered (volume of orthopaedic cases delivered to date) and budget being set at a lower than actual price for certain implants. This is being addressed via the production plan which will claw back some of the unfavourable variance by year end.

- Clinical supplies and consumables are $98k over budget. Included in this variance are the blood costs for a single high cost patient ($100k).
- Other clinical and client costs are $849k; an unfavourable variance of $50k. This relates to air transfers of patients ($93k more than budget) which is demand driven.

Infrastructure and non Clinical Cost

- Overall infrastructure and non clinical cost are $6,592k, $159k over budget. Within this variance are the following specific variances:
    - Facility costs are $1,524k, $141k over budget. Utility costs are $92k more than budget; these costs will continue to be over budget as prices have increased since the budget was set.
    - Travel and Transport costs are $614k, $65k over budget. This mainly relates to staff travel and accommodation costs ($25k more than budget), lease costs ($28k more than budget – this is reducing as leases expire).
    - Professional fees and expenses are $76k more than budget to date. The cost of insurance premiums (excluding motor vehicle) is $59k more than budgeted. This cost will continue to be over budget for the rest of the year.

Interest, Depreciation & Capital Charge

- Capital charge expense is $305k better than budget. A credit of $259k relating to the previous financial year was received in December 2011.

Funder Arm

The District Health Board's result for services funded with external providers for the month of January 2012 was $175k (4%) better than budget and year to date payments are $897k (3%) better than budget.

Referred Services

- Community pharmaceuticals are $107k less than budget (actual cost to date has not followed the way the budget has been phased).
- Laboratory services are $41k less than budget – these costs include internal payments to the Provider arm for blood costs of an individual patient ($100k to date).

Secondary Care

Secondary Care services are $231k less than budget.

- Travel and accommodation paid under the National Travel Assistance (NTA) scheme being $96k less than budget to date. Claims for NTA are not always received on a timely basis and payments to date may reflect this, with a catch up in future months.

Primary Care

- Whanau Ora service costs are $92k less than budget. Maori health services have been under review and a new contract has been negotiated which will see actual costs for the second half of the year closer to budget.
- Capitation payments are $117k more than budget to date; this largely relates to payments for Careplus, Very Low Cost Access and PHO performance payments – as funding for these is non devolved this cost will be covered by Ministry of Health revenue.

Older Persons Health

Overall expenditure (residential and non residential) is less than budget year to date. These costs are mainly demand driven with prior approval required to access (via Carelink and Home Based Support services). Funding for these services has also been made more flexible with contracts for home and community based care which enable people to remain in the community and delay entry to residential care.

STATEMENT OF FINANCIAL POSITION

- Cash and Short Term Investments
  As at 31 January 2012 the Board had $3.8m in cash and short term investments. This is $1.3m better than budget and mainly due to the timing of capital projects.

- Non Current Assets
  - Property, Plant and equipment including work in progress is $4.6m less than budget. This is due mainly to the revaluation of the Land and Buildings as at 30 June 2011 being brought into account and the timing of capital expenditure.

- Crown Equity
  - Crown Equity is $2.432m lower than budget; this is due to the revaluation referred to under the non current assets.

RECOMMENDATION

That the Board of the West Coast District Health Board receive the Financial Report for the period ending 31 January 2012.

Author:	**Chief Financial Officer - 23 February 2012**

Attachments

1: Financial Results for the period ending 31 January 2012.

2: Funder Arm payments to external providers.

3: Provider Arm Performance Graphs.

West Coast District Health Board
Statement of comprehensive income
For period ending 31 January 2012

in thousands of New Zealand dollars

	Monthly Reporting					Year to Date					Full Year 2011/12	Prior Year
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance	Prior Year	Budget	2010/11
Operating Revenue												
Crown and Government sourced	10,241	10,518	(277)	(2.6%)	10,325	73,705	73,533	172	0.2%	71,150	126,247	124,287
Inter DHB Revenue	3	11	(8)	(71.7%)	10	26	74	(48)	(65.0%)	72	127	110
Patient Related Revenue	266	265	1	0.4%	236	1,697	1,727	(30)	(1.7%)	1,642	2,965	2,828
Other Revenue	185	169	16	9.7%	150	1,101	1,001	100	10.0%	1,086	1,718	1,792
Total Operating Revenue	10,695	10,962	(267)	(2.4%)	10,721	76,529	76,335	194	0.3%	73,950	131,057	129,017
Operating Expenditure												
Employee benefit costs	4,568	4,583	15	0.3%	4,414	31,067	31,384	317	1.0%	30,758	53,396	52,704
Outsourced Clinical Services	816	756	(60)	(8.0%)	1,440	7,610	5,961	(1,649)	(27.7%)	7,559	9,667	13,301
Treatment Related Costs	540	599	59	9.9%	554	4,627	4,202	(425)	(10.1%)	4,085	7,292	7,707
External Providers	2,341	2,516	175	7.0%	2,300	17,161	18,032	871	4.8%	16,625	30,974	28,453
Net Inter District Flows	1,302	1,302	0	0.0%	1,291	9,087	9,115	28	0.3%	9,353	15,625	15,893
Outsourced Services - non clinical	86	129	43	33.1%	97	635	900	265	29.4%	689	1,508	1,245
Infrastructure Costs and Non Clinical Supplies	804	860	56	6.5%	850	6,265	6,135	(130)	(2.1%)	6,141	10,479	10,514
Total Operating Expenditure	10,457	10,744	287	2.7%	10,946	76,452	75,729	(723)	(1.0%)	75,210	128,941	129,817
Result before Interest, Depn & Cap Charge	238	218	20	(9.3%)	(225)	77	606	(529)	87.3%	(1,260)	2,116	(800)
Interest, Depreciation & Capital Charge												
Interest Expense	62	61	(1)	(1.3%)	63	430	428	(2)	(0.4%)	465	735	775
Depreciation	405	400	(5)	(1.3%)	392	2,797	2,800	3	0.1%	2,701	4,801	4,578
Capital Charge Expenditure	83	90	7	7.8%	71	324	630	306	48.6%	369	1,080	690
Total Interest, Depreciation & Capital Charge	550	551	1	0.2%	526	3,551	3,858	307	8.0%	3,535	6,617	6,043
Net Surplus/(deficit)	(312)	(333)	21	6.4%	(751)	(3,474)	(3,252)	(222)	(6.8%)	(4,795)	(4,500)	(6,843)
Other comprehensive income												
Gain/(losses) on revaluation of property												(2,578)
Total comprehensive income	(312)	(333)	21	6.4%	(751)	(3,474)	(3,252)	(222)	(6.8%)	(4,795)	(4,500)	(9,421)

West Coast District Health Board
Statement of financial position
As at 31 January 2012

in thousands of New Zealand dollars

	Actual	Budget	Variance	%Variance	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	31,735	35,442	(3,707)	(10.5%)	35,832
Intangible assets	774	1,055	(281)	(26.6%)	977
Work in Progress	21	600	(579)	(96.5%)	254
Other investments	2	2	0	0.00%	2
Total non-current assets	32,532	37,098	(4,566)	(12.3%)	37,065
Current assets					
Cash and cash equivalents	3,816	2,426	1,390	57.3%	1,272
Other investments	56	55	1	1.8%	55
Inventories	907	746	161	21.6%	745
Debtors and other receivables	3,923	3,303	620	18.8%	3,669
Assets classified as held for sale	136	246	(110)	(44.7%)	246
Total current assets	8,838	6,776	2,062	30.4%	5,987
Total assets	**41,370**	**43,875**	**(2,505)**	18.1%	**43,052**
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	11,195	12,445	(1,250)	(10.0%)	12,695
Employee entitlements and benefits	3,129	3,259	(130)	(4.0%)	3,198
Total non-current liabilities	14,324	15,704	(1,380)	(8.8%)	15,893
Current liabilities					
Interest-bearing loans and borrowings	1,500	250	1,250	500.0%	250
Creditors and other payables	8,854	8,708	146	1.7%	8,871
Employee entitlements and benefits	7,649	7,738	(89)	(1.2%)	7,226
Total current liabilities	18,003	16,696	1,307	7.8%	16,347
Total liabilities	32,327	32,400	(73)	(0.2%)	32,240
Equity					
Crown equity	61,753	61,741	12	0.0%	54,609
Other reserves	21,310	23,888	(2,578)	(10.8%)	23,888
Retained earnings/(losses)	(74,059)	(74,193)	134	(0.2%)	(68,537)
Trust funds	39	39	0	0.00%	39
Total equity	9,043	11,475	(2,432)	(21.2%)	9,999
Total equity and liabilities	**41,370**	**43,875**	**(2,505)**	**(5.7%)**	**42,239**

West Coast District Health Board
Statement of cash flows
For period ending 31 January 2012

in thousands of New Zealand dollars

	Monthly Reporting					Year to Date					2011/12	2010/11
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance	Prior Year	Budget	Actual
Cash flows from operating activities												
Cash receipts from Ministry of Health, patients and other revenue	10,474	345	10129	2933.7%	(434)	78,028	79,215	(1,187)	(1.5%)	74,836	134,640	129,181
Cash paid to employees	(4,344)	(4,583)	239	(5.2%)	(4,344)	(31,087)	(31,386)	299	(1.0%)	(30,262)	(53,394)	(52,322)
Cash paid to suppliers	(2,736)	(2,943)	207	(7.0%)	(3,281)	(19,882)	(16,996)	(2,886)	17.0%	(18,937)	(28,747)	(32,143)
Cash paid to external providers	(2,341)	(2,516)	175	(7.0%)	(2,300)	(17,134)	(18,031)	897	(5.0%)	(16,630)	(30,974)	(28,206)
Cash paid to other District Health Boards	(1,459)	(1,459)	0	(0.0%)	(1,436)	(10,186)	(10,214)	28	(0.3%)	(10,632)	(17,509)	(17,880)
Cash generated from operations	(406)	(11,156)	10750	(96.4%)	(11,795)	(261)	2588	(2,849)	(110.1%)	(1,625)	4,015	(1,370)
Interest paid	(56)	0	(56)	#DIV/0!	0	(372)	0	(372)	#DIV/0!	0	(698)	(814)
Capital charge paid	259	0	259	#DIV/0!	0	(339)	(549)	210	(0)	(562)	(1,089)	(723)
Net cash flows from operating activities	(203)	(11,156)	10953	(98.2%)	(11,795)	(972)	2039	(3,011)	(147.7%)	(2,187)	2,228	(2,907)
Cash flows from investing activities												
Interest received	24	17	7	43.7%	21	197	118	79	67.1%	717	201	820
(Increase) / Decrease in investments	0	0	0		1,500	3,500	0	3500		1,587	0	(1,913)
Acquisition of property, plant and equipment	(44)	(469)	425	(90.6%)	(181)	(1,820)	(2,424)	604	(24.9%)	(2,388)	(4,250)	(3,148)
Acquisition of intangible assets	0	(25)	25	(100.0%)	0	(11)	(100)	89	(89.0%)	0		
Net cash flows from investing activities	(20)	(477)	457	(95.8%)	1340	1,866	(2,406)	4272	(177.5%)	(84)	(4,049)	(4,241)
Cash flows from financing activities												
Proceeds from equity injections	0	0	0		0	0	0	0		0	4,500	7,212
Repayment of equity	0	0	0		0	0	0	0		0	(68)	(68)
Cash generated from equity transactions	0	0	0		0			0			4,432	7,144
Repayment of borrowings	0	0	0		0	0	0	0		0	(250)	(250)
Net cash flows from financing activities	0	0	0		0	0	0	0			-250	-250
Net increase in cash and cash equivalents	(223)	(11,633)	11410	(98.1%)	(10,455)	894	(367)	1,261	(343.6%)	(2,271)	2,361	(254)
Cash and cash equivalents at beginning of period	4,039	14,061	(10,022)	(71.3%)	10914	2,922	3,125	(203)	(6.5%)	3176	3,125	3,176
Cash and cash equivalents at end of year	3,816	2,427	1389	57.2%	459	3,816	2,758	1,058	38.4%	905	5,486	2,922

West Coast District Health Board
Provider Operating Statement for period ending 31 January 2012
in thousands of New Zealand dollars

	Monthly Reporting					Year to Date					Full Year 2011/12	Prior Year
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance	Prior Year	Budget	2010/11
Income												
Internal revenue-Funder to Provider	5,125	5,205	(80)	(1.5%)	5,117	36,719	36,434	285	0.8%	35,657	62,459	63,504
Ministry of Health side contracts	115	144	(29)	(20.1%)	127	1,051	1,007	44	4.3%	1,092	1,727	1,835
Other Goverment	445	584	(139)	(23.8%)	586	3,690	3,588	102	2.8%	3,712	6,010	6,183
InterProvider Revenue (Other DHBs)	3	11	(8)	(71.7%)	10	26	74	(48)	(65.0%)	72	127	110
Patient and consumer sourced	266	265	1	0.4%	236	1,697	1,727	(30)	(1.7%)	1,642	2,965	2,828
Other income	163	149	14	9.1%	132	946	867	79	9.1%	878	1,488	1,461
Total income	**6,117**	**6,358**	**(241)**	(3.8%)	**6,208**	**44,129**	**43,697**	**432**	1.0%	**43,053**	**74,776**	**75,921**
Expenditure												
Employee benefit costs												
Medical Personnel	859	968	109	11.3%	882	5,923	6,293	370	5.9%	6,167	10,823	10,512
Nursing Personnel	2,137	1,986	(151)	(7.6%)	2,102	14,271	13,788	(483)	(3.5%)	13,786	23,405	23,784
Allied Health Personnel	738	801	63	7.8%	684	5,138	5,552	414	7.5%	5,117	9,426	8,768
Support Personnel	185	170	(15)	(9.1%)	170	1,266	1,176	(90)	(7.7%)	1,218	1,996	2,086
Management/Administration Personnel	563	567	4	0.8%	494	3,838	3,941	103	2.6%	3,851	6,655	6,494
	4,482	**4,492**	**10**	**0.2%**	**4,332**	**30,436**	**30,751**	**315**	**1.0%**	**30,139**	**52,304**	**51,644**
Outsourced Services												
Contracted Locum Services	556	477	(79)	(16.6%)	1,136	5,104	4,008	(1,096)	(27.4%)	5,475	6,283	9296
Outsourced Clinical Services	260	279	19	6.8%	304	2,506	1,953	(553)	(28.3%)	2,084	3,348	4005
Outsourced Services - non clinical	48	75	27	35.8%	51	362	523	161	30.8%	353	898	724
	864	**831**	**(33)**	**(4.0%)**	**1,491**	**7,972**	**6,484**	**(1,488)**	**(23.0%)**	**7,912**	**10,528**	**14,025**
Treatment Related Costs												
Disposables, Diagnostic & Other Clinical Supplies	115	112	(3)	(3.0%)	108	880	782	(98)	(12.5%)	771	1,343	1,337
Instruments & Equipment	141	146	5	3.4%	159	1,064	1,022	(42)	(4.1%)	989	1,754	1,896
Patient Appliances	33	31	(2)	(6.5%)	18	197	217	20	9.2%	204	370	367
Implants and Prostheses	37	49	12	23.7%	49	564	340	(225)	(66.1%)	353	583	1,007
Pharmaceuticals	147	147	0	0.00	163	1,073	1,043	(30)	(2.9%)	1,058	1,800	1,895
Other Clinical & Client Costs	67	115	48	41.7%	57	849	799	(50)	(6.3%)	709	1,442	1,204
	540	**599**	**59**	**9.9%**	**554**	**4,627**	**4,202**	**(425)**	**(10.1%)**	**4,084**	**7,292**	**7,706**
Infrastructure Costs and Non Clinical Supplies												
Hotel Services, Laundry & Cleaning	307	298	(9)	(3.0%)	302	2,140	2,089	(51)	(2.5%)	2,100	3,575	3586
Facilities	178	189	11	6.0%	163	1,524	1,383	(141)	(10.2%)	1,480	2,375	2666
Transport	62	70	8	11.2%	89	614	549	(65)	(11.8%)	712	898	1036
IT Systems & Telecommunications	118	120	2	1.3%	120	774	837	63	7.5%	735	1,435	1321
Professional Fees & Expenses	29	22	(7)	(32.4%)	14	229	153	(76)	(49.4%)	128	263	285
Other Operating Expenses	66	95	29	30.2%	97	541	651	110	16.8%	554	1,129	935
Internal allocation to Governanance Arm	110	110	0	0.2%	82	770	772	2	0.2%	574	1,323	984
	870	**903**	**33**	**3.7%**	**867**	**6,592**	**6,433**	**(159)**	**(2.5%)**	**6,283**	**10,998**	**10,813**
Total Operating Expenditure	**6,756**	**6,825**	**69**	**1.0%**	**7,244**	**49,627**	**47,870**	**(1,757)**	**(3.7%)**	**48,418**	**81,122**	**84,188**
Deficit before Interest, Depn & Cap Charge	**(639)**	**(467)**	**172**	**(36.8%)**	**(1,036)**	**(5,498)**	**(4,173)**	**1,325**	**(31.7%)**	**(5,365)**	**(6,347)**	**(8,267)**
Interest, Depreciation & Capital Charge												
Interest Expense	62	61	(1)	(1.3%)	63	430	428	(2)	(0.4%)	465	735	775
Depreciation	405	400	(5)	(1.4%)	392	2,797	2,797	0	0.0%	2,698	4,797	4578
Capital Charge Expenditure	83	90	7	7.8%	71	324	630	306	48.6%	369	1,080	690
Total Interest, Depreciation & Capital Charge	**550**	**551**	**1**	**0.1%**	**526**	**3,551**	**3,856**	**305**	**7.9%**	**3,532**	**6,612**	**6,043**
Net deficit	**(1,189)**	**(1,018)**	**171**	**(16.8%)**	**(1,562)**	**(9,049)**	**(8,029)**	**1,020**	**(12.7%)**	**(8,897)**	**(12,959)**	**(14,310)**

West Coast District Health Board

Funder Operating Statement for the period ending 31 January 2012

in thousands of New Zealand dollars

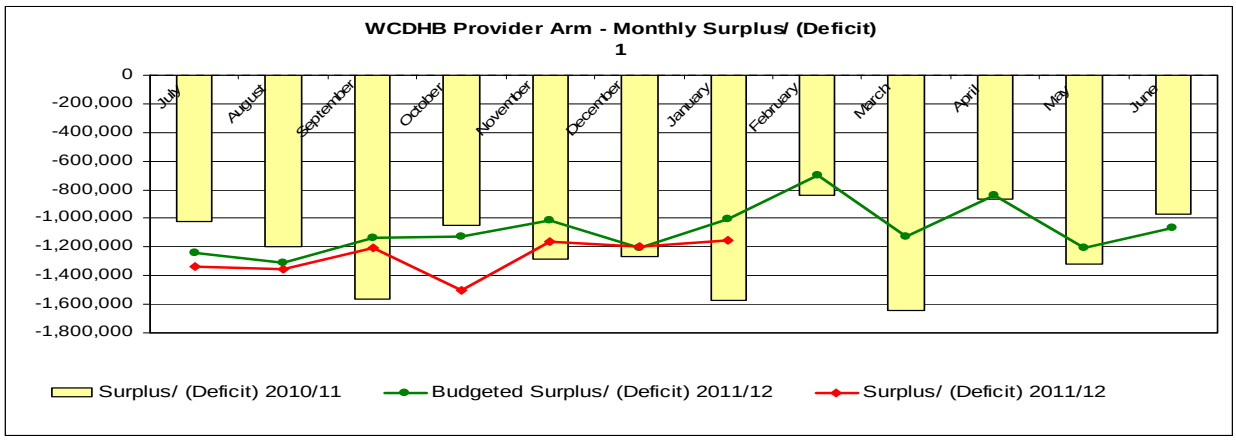
	Monthly Reporting					Year to Date					Full Year 2011/12	Prior Year
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance	Prior Year	Budget	2010/11
Income												
PBF Vote Health-funding package (excluding Mental Health)	8,410	8,453	(43)	(0.5%)	8,154	59,739	59,578	161	0.3%	57,590	97,905	101,801
PBF Vote Health-Mental Health Ring fence	1,157	1,157	0	0,00	1,120	8,099	8,099	0	0,00	7,840	13,884	13,440
MOH-funding side contracts	114	180	(66)	(36.7%)	338	1,126	1,261	(135)	(10.7%)	916	6,721	1,028
Inter District Flow's	157	157	0	0,00	145	1,099	1,099	0	0,00	927	1,884	1,635
Other income	22	15	7	46.7%	18	115	105	10	9.5%	136	180	216
Total income	**9,860**	**9,962**	**(102)**	**(1.0%)**	**9,775**	**70,178**	**70,141**	**36**	**0.1%**	**67,409**	**120,574**	**118,120**
Expenditure												
Personal Health	6,295	6,418	123	1.9%	6,282	45,323	45,411	88	0.2%	44,526	78,016	78,436
Mental Health	1,138	1,157	19	1.6%	1,100	7,948	8,099	151	1.9%	7,640	13,884	12,995
Disability Support	1,424	1,466	42	2.9%	1,337	10,061	10,193	132	1.3%	9,514	17,370	16,542
Public Health	26	84	58	69.1%	92	441	589	148	25.2%	589	1,011	1,009
Maori Health	42	55	13	23.8%	42	293	386	93	24.0%	293	661	503
Governance	98	98	(0)	(0.2%)	98	686	686	(0)	(0.1%)	686	1,174	1,176
Total expenses	**9,023**	**9,278**	**255**	**2.7%**	**8,951**	**64,752**	**65,365**	**613**	**0.9%**	**63,248**	**112,116**	**110,661**
Net Surplus	**837**	**684**	**153**	**22.4%**	**824**	**5,426**	**4,778**	**648**	**13.6%**	**4,161**	**8,458**	**7,459**

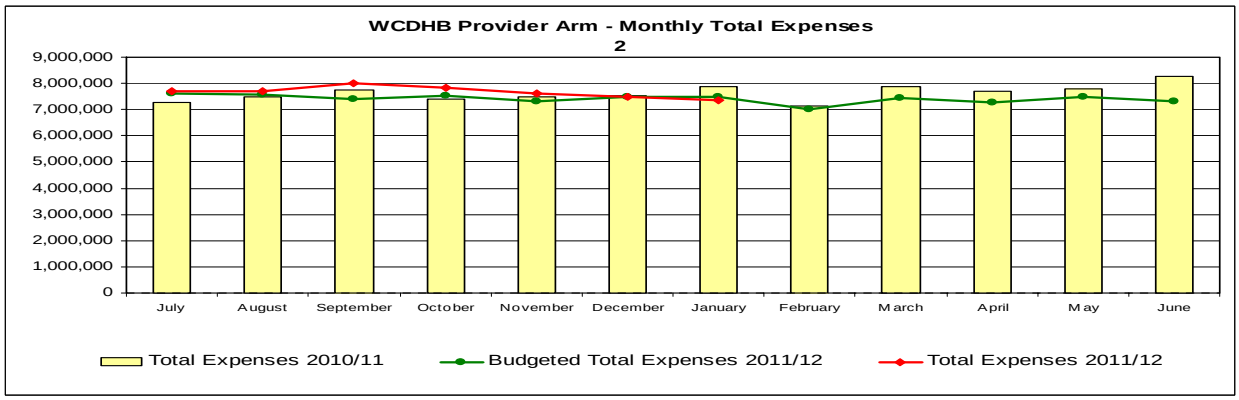
West Coast District Health Board

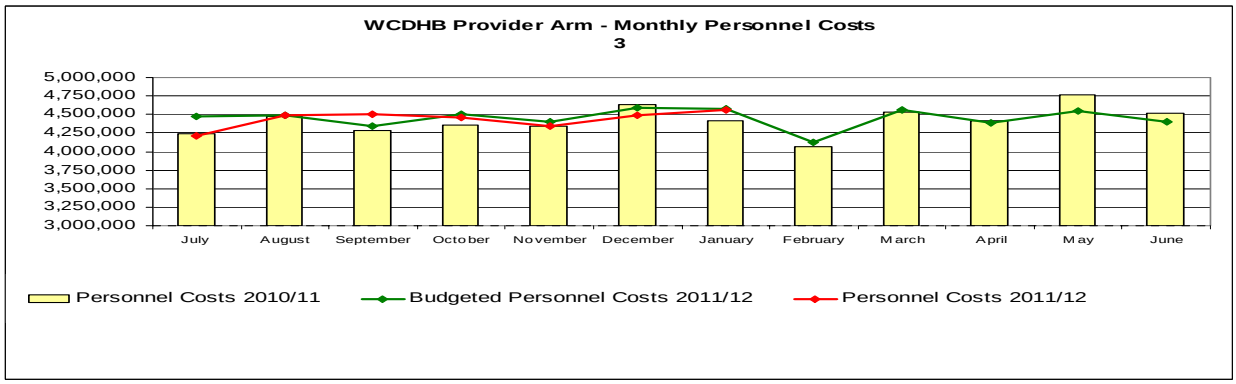
Governance Operating Statement for the period ending 31 January 2012

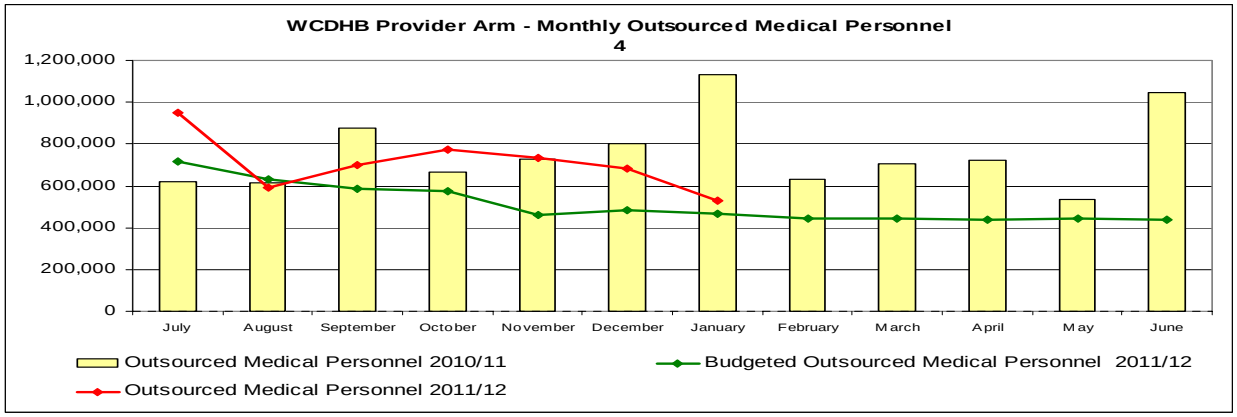
in thousands of New Zealand dollars

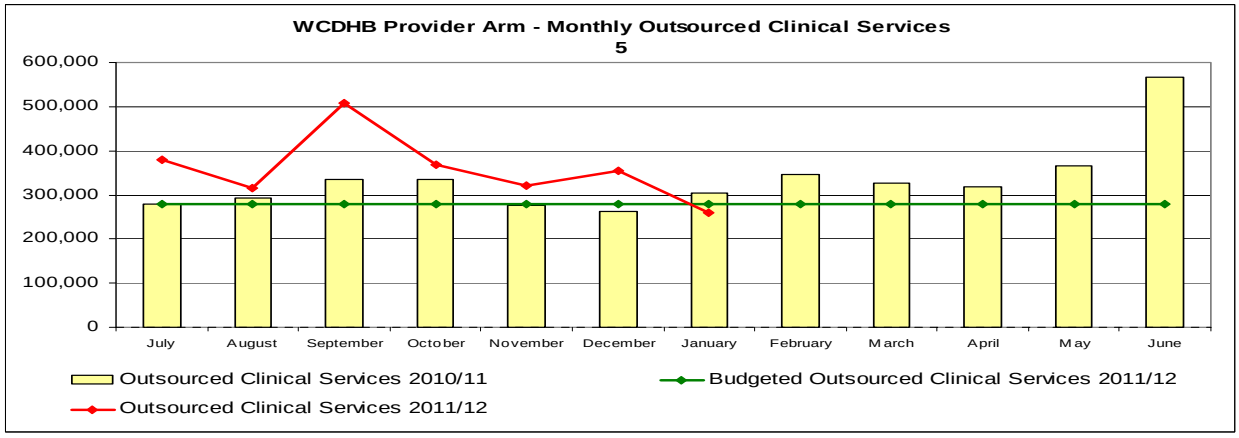
	Monthly Reporting					Year to Date					Full Year 2011/12	Prior Year
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance	Prior Year	Budget	2010/11
Income												
Internal Revenue	98	98	0	0.2%	98	686	685	1	0.2%	686	1,174	1,176
Other income	0	4	(4)	(100.0%)	0	40	29	11	36.1%	72	50	115
Internal allocation from Provider Arm	110	110	(0)	(0.2%)	82	770	771	(1)	(0.2%)	574	1,323	984
Total income	**208**	**212**	**(4)**	**(2.0%)**	**180**	**1,496**	**1,485**	**11**	**0.7%**	**1,332**	**2,547**	**2,275**
Expenditure												
Employee benefit costs	86	91	5	5.4%	82	631	636	5	0.8%	619	1,091	1,060
Outsourced services	38	54	16	29.4%	46	273	377	104	27.5%	336	646	521
Other operating expenses	25	44	19	43.5%	42	277	310	33	10.6%	219	531	373
Democracy	19	23	4	18.5%	19	166	163	(3)	(1.8%)	207	280	315
Total expenses	168	212	44	20.9%	189	1,347	1,486	139	9.4%	1,381	2,548	2,269
Net Surplus / (Deficit)	**40**	**0**	**40**		**(9)**	**149**	**(1)**	**150**		**(49)**	**(0)**	**6**

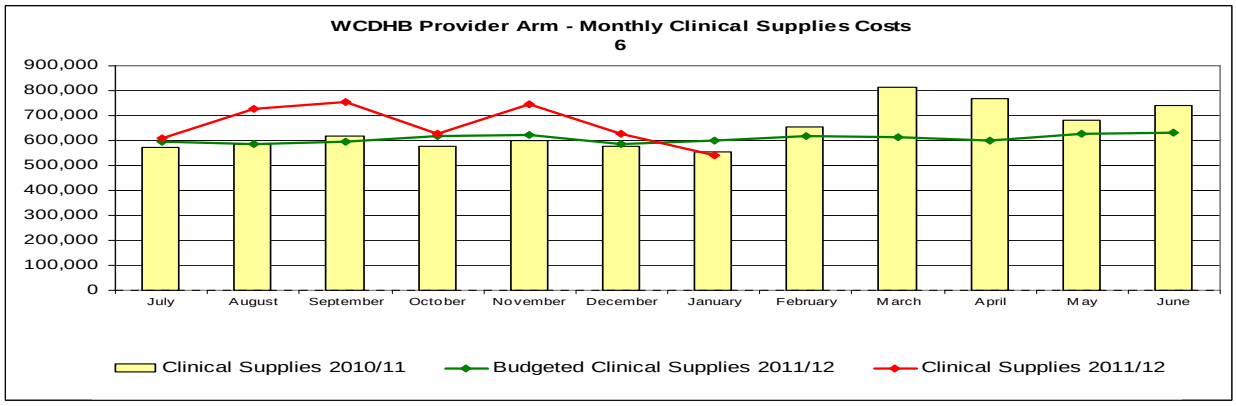

WCDHB Provider Arm - Monthly Surplus/ (Deficit)
1
0
-200,000
-400,000
-600,000
-800,000
-1,000,000
-1,200,000
-1,400,000
-1,600,000
-1,800,000
July
August
September
October
November
December
January
February
March
April
May
June
Surplus/ (Deficit) 2010/11
Budgeted Surplus/ (Deficit) 2011/12
Surplus/ (Deficit) 2011/12

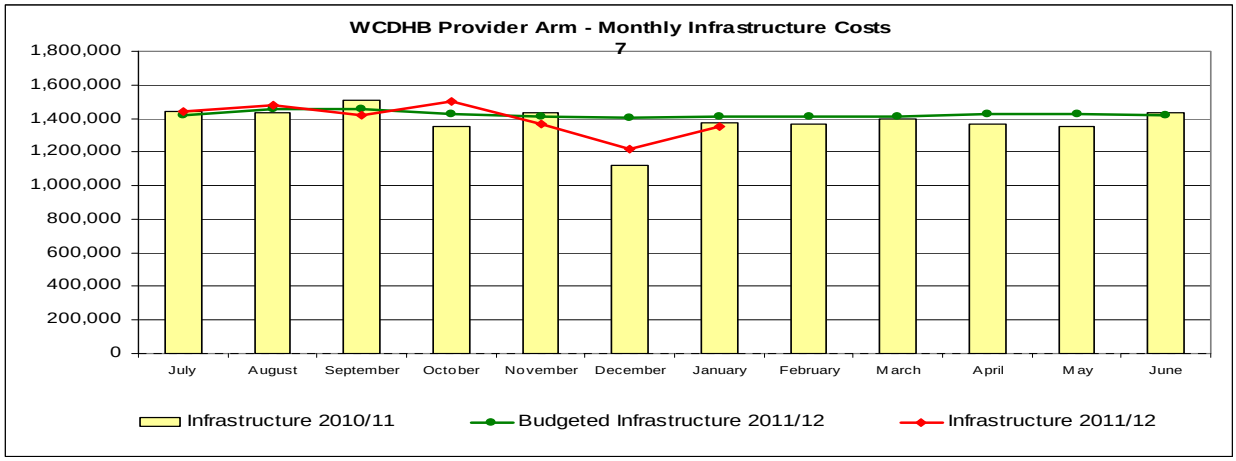

WCDHB Provider Arm - Monthly Total Expenses
2
9,000,000
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0
July
August
September
October
November
December
January
February
March
April
May
June
Total Expenses 2010/11
Budgeted Total Expenses 2011/12
Total Expenses 2011/12


WCDHB Provider Arm - Monthly Personnel Costs
3
5,000,000
4,750,000
4,500,000
4,250,000
4,000,000
3,750,000
3,500,000
3,250,000
3,000,000
July
August
September
October
November
December
January
February
March
April
May
June
Personnel Costs 2010/11
Budgeted Personnel Costs 2011/12
Personnel Costs 2011/12


WCDHB Provider Arm - Monthly Outsourced Medical Personnel
4
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
July
August
September
October
November
December
January
February
March
April
May
June
Outsourced Medical Personnel 2010/11
Budgeted Outsourced Medical Personnel 2011/12
Outsourced Medical Personnel 2011/12


WCDHB Provider Arm - Monthly Outsourced Clinical Services
5
600,000
500,000
400,000
300,000
200,000
100,000
0
July
August
September
October
November
December
January
February
March
April
May
June
Outsourced Clinical Services 2010/11
Budgeted Outsourced Clinical Services 2011/12
Outsourced Clinical Services 2011/12


WCDHB Provider Arm - Monthly Clinical Supplies Costs
6
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
July
August
September
October
November
December
January
February
March
April
May
June
Clinical Supplies 2010/11
Budgeted Clinical Supplies 2011/12
Clinical Supplies 2011/12


WCDHB Provider Arm - Monthly Infrastructure Costs
7
1,800,000
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
July
August
September
October
November
December
January
February
March
April
May
June
Infrastructure 2010/11
Budgeted Infrastructure 2011/12
Infrastructure 2011/12

REPORTS FROM BOARD ADVISORY COMMITTEES

Reports and minutes have been received from the following West Coast District Health Board Advisory Committees and Groups:

- Hospital Advisory Committee
- Community and Public Health Advisory Committee and Disability Support Advisory Committee
- Tatau Pounamu Manawhenua Advisory Group

RECOMMENDATION

That the West Coast District Health Board receives the West Coast District Health Board Advisory Committee Reports.

DRAFT MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING HELD THURSDAY 23 FEBRUARY 2012 AT 11.05AM IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH

PRESENT
Warren Gilbertson, Chair
Sharon Pugh, Deputy Chair
Paula Cutbush
Doug Truman
Gail Howard
Barbara Holland

IN ATTENDANCE
Peter Ballantyne, Board Deputy Chair
Hecta Williams, General Manager
Colin Weeks, Chief Financial Manager
Carol Atmore, Chief Medical Officer
Garth Bateup, Acting General Manager Hospital Services
Karyn Kelly, Director of Nursing and Midwifery
Sandra Gibbens, Minute Secretary
Mary Molloy
Meredith Woodsford (from 11.30am), Recruitment Team Leader, Canterbury District Health Board

APOLOGIES
Dr Paul McCormack, Board Chair
Richard Wallace

Karakia – All

1. WELCOME, APOLOGIES AND AGENDA

- The Chair welcomed everyone to the meeting. Apologies were accepted from Dr Paul McCormack and Richard Wallace.
- Meredith Woodsford, Recruitment Team Leader, Canterbury District Health Board, will be presenting at approximately 11.30am regarding the recruitment programme.

Moved: Warren Gilbertson **Seconded: Peter Ballantyne**

Motion:
"THAT the apologies be accepted."

Carried.

2. DISCLOSURES OF INTERESTS

There were no amendments to the disclosures of interest.

3. MINUTES OF THE PREVIOUS HOSPITAL ADVISORY COMMITTEE MEETING HELD 17 NOVEMBER 2011

- Page 6 – In committee - full name of the mover to be used.
- Page 7 – General Business - the second paragraph regarding the Emergency Room is to be rephrased.

Moved: Warren Gilbertson **Seconded: Sharon Pugh**

Motion:
"THAT the minutes of the Hospital Advisory Committee meeting held 17 November 2011 be adopted as a true and accurate record subject to the above amendments."

Carried.

Hospital Advisory Committee Chair's Report to the Board
The Hospital Advisory Committee Chair spoke to his report:

- A number of the points in the report have been raised and discussed with the Board.
- The Chair emphasised that there are three key focus areas for the Hospital Advisory Committee to monitor on the agenda, these being:
  - Monitoring of locums
  - Rostering
  - Production planning

4. MATTERS ARISING

Item 1: Information to be provided about whether all health practitioners support the 'Better Help for Smokers to Quit' target
Discussed. A report is provided in the management report, and new targets are noted. The figures will continue to be closely monitored. To be taken off matters arising.

Item 2: A classification of complaints graph is requested to be provided specifically for hospital services
On hold.

Item 3: The 'Shorter stays in Emergency Departments' target to be placed on the Recovery Plan for Clinical Services
It is noted that the number of presentations are still high, particularly for triage four and five. To remain on matters arising for future reporting.

Item 4: Communication strategies with the public to be considered regarding clinic cancellations and Did Not Attends (DNAs)

Action Point: The Chair is to follow up with the Communication Officer as to information that is being prepared to go out to the public.

Item 5: Clinical Leaders are to be encouraged to discuss the reporting format of the Clinical Leaders Report with the Board Chair
Completed. The same report is now going to all advisory committees. To be taken off matters arising.

Item 6: Work on communication regarding what people could reasonably expect, and what can be delivered, with regards to transportation home following discharge
A group has been established to look at solutions for transporting patients between areas, i.e. transportation to Westport upon discharge from Grey Base Hospital. It was noted that the provision of transport will need to be arranged outside of the West Coast DHB's jurisdiction, however assistance will be provided to help progress initiatives.

Action Point: The Chair is to follow up with the Communication Officer as to information to go out to the public.

Item 7: A presentation on the Xcelr8 and Collabor8 programmes to be provided to the Committee during 2012
The Chair and the Acting General Manager Hospital Services will organise a presentation on the Xcelr8 and Collabor8 programmes for a future meeting. To be taken off matters arising.

Item 8: Request to provide information as to the difference between the outsourced services costs and clinical supplies costs
The requested information is provided as an addition to the commentary in the Finance Section (6.2) of the Agenda.

Item 9: Request to present updates on the West Coast DHB Provider Arm graphs at each Hospital Advisory Committee meeting
The requested graphs are provided as an addition to the commentary in the Finance Section (6.2) of the Agenda.

Matters arising were taken as read and actioned.

5. CORRESPONDENCE

Incoming

- **Annual Report Requirements**
  A letter regarding Annual Report Requirements was received from Hon Tony Ryall, Minister of Health.

Moved: Warren Gilbertson **Seconded: Sharon Pugh**

Motion:
"THAT the inwards correspondence is approved."

Carried.

6. WORK PLAN

Work Plan – there are no anticipated changes to the Work Plan at present.

6.1 Health Targets

- **Shorter Stays in Emergency Departments**

Action Point: The Acting General Manager Hospital Services is to investigate the higher figure of patients waiting over six hours in the Emergency Department in Buller.

- **Improved Access to Elective Services**
  The West Coast DHB is currently ahead in elective surgical discharges and the target is expected to be achieved.

- **Shorter Waits for Cancer Treatment**
  The Hospital Advisory Committee was advised that Canterbury DHB is going to be short of Radiation Therapists soon. Recruitment is commencing.

- **Better Help for Smokers to Quit**
  The statistics were discussed as the target is not being attained at present. Varying results are being achieved throughout different areas. The Smokefree Coordinator is active and improvements are anticipated. The Hospital Advisory Committee will monitor the 1st Quarter results for 2012 for progress.

6.2 MONITOR PERFORMANCE OF THE PROVIDER ARM

Human Resources

- **Recruitment/Vacancies**
  The Acting General Manager Hospital Services introduced Meredith Woodsford, Recruitment Team Leader, Canterbury DHB to the Hospital Advisory Committee.

  Ms Woodsford has been presenting the upcoming roll-out of the new Recruitment Programme to the West Coast and Canterbury DHBs. Positive feedback has been received from the staff presentations, and the Committee were provided with the hand-out 'Your Transalpine Recruitment Service', through which they were led. The new programme will provide specialist recruitment expertise, a strategic approach, improved time to fill vacancies, improved reporting and most importantly, an improvement in the experience for all involved.

  Action Point: The General Manager to discuss Recruitment/Vacancy reporting requirements with the Chief Executive.

  The Chair thanked Ms Woodsford for her informative and encouraging presentation.

- The Acting General Manager Hospital Services emphasised the importance of the orientation of new staff. The new Quality team Co-ordinator will lead the process of improving this area.

Management Team Report
The Acting General Manager Hospital Services spoke to the report:

Operational Items

- **Medical Personnel – Locums**
  There is much work in progress on bringing the costs of locums down, however it was acknowledged that it will be difficult to achieve this. The new recruitment process for permanent staff will be helpful.
- **Medical Staff Recruitment**
  Recruitment of medical staff is not progressing as quickly as anticipated, particularly in Anaesthetics. Screening and interviews are currently taking place for Obstetrics and Gynaecology. General Surgery is fully staffed.

The Acting General Manager Hospital Services reiterated the importance of ensuring that new permanent staff are the 'right fit' for the West Coast DHB, and the new recruitment processes will support this. Overseas applicants shortlisted will be brought to the West Coast for a 'final' interview.

- **Production Planning / Electives**
  The West Coast DHB is ahead on electives at present, and there has been a huge improvement on the way things are being done. There has been an improvement in clinician engagement, and meetings are being held with each of the clinical specialties to look at what is needed to be achieved by the end of the year for their targets. Being ahead on orthopaedics, it is necessary to look at managing joints for the rest of the financial year.

  A communication plan is being developed to increase awareness in the community regarding the importance of lowering the number of 'Did Not Attends' at clinics and for surgery.

- **Inpatient Inter-District Flow (IDF) Cost and Volume Over-run**
  Inter-District Flow costs are well ahead of budget. Some of the cases were high-cost interventions, and also patients requiring treatment at Canterbury, Wellington, and Dunedin. This will continue to be monitored.

- **Outsourced Services**
  Work is progressing on reviewing the ophthalmology services that the West Coast DHB receives, particularly focussing on costs.

- **Industrial Relations**
  The Chief Financial Manager advised the Committee that the national Multi-Employer Collective Agreements (MECAs) are greater than the funding increases that the West Coast DHB receives. Budgets therefore need to be set on the previous increase. There are a number of Individual Employment Agreements (IEAs) on the West Coast, and the Board has recently approved a job evaluation process of these. This will have some consequences as to the finances.

  It was noted that the APEX and West Coast DHB Information Technology were ratified in the last week.

Caseweights

- Elective surgery is tracking relatively well against target, although we do note that the cost of over-production will be reflected in the financial results.

Finance Report

The Chief Financial Manager spoke to the Finance Report for January 2012:

The West Coast DHB recorded a consolidated deficit of $312k, which is $21k better than budget ($333k deficit) for the month of January 2012. Unfavourable variance has reduced since the previous report which was October 2011. Looking at the January 2012 result, theatres closed, therefore dropping clinical costs and allowing staff to take leave.

- **Inter-district Flows**
  It was noted that the next four–five months will be a challenge as to locum and inter-district flow costs. On top of the figures provided there is another $600k increase in deficit due to inter-district flows, and the forecast has been adjusted accordingly. It is particularly difficult to forecast forward in this area.

The Chief Financial Manager provided the following graphs showing the Provider Arm results as at January 2012:

- WCDHB Provider Arm – Monthly Surplus/(Deficit) – planned reduction in costs in the second six months.
- WCDHB Provider Arm – Monthly Total Expenses – from September 2011 to now there has been management of costs and it is intended to carry this through.
- WCDHB Provider Arm – Monthly Personnel Costs
- WCDHB Provider Arm – Monthly Outsourced Medical Personnel – is reducing, and the budget is dropping also.
- WCDHB Provider Arm – Monthly Outsourced Clinical Services
- WCDHB Provider Arm – Monthly Clinical Supplies Costs
- WCDHB Provider Arm – Monthly Infrastructure Costs

- **Capital Expenditure**
  There are two major I.T. projects being progressed:
  - Concerto, which is the Clinical Information System (CIS) replacing the existing West Coast DHB CIS (Healthviews), enabling the regional clinical view, has a project team and should go live July/August 2012.
  - A scoping project is underway, the IBA Financial System onto Oracle is being closely associated with Canterbury DHB who are upgrading. When this is completed the same version will be taken and West Coast DHB plan to go live on 1 July 2012. This will allow the West Coast DHB to also link in with Canterbury DHB Stores.

- It was acknowledged that overspending has been a culture within the West Coast DHB, however this is changing, with new models of care being developed, collaboration, new challenges and work towards improving the DHB's situation. Improvements need to start to be seen in the fourth quarter.

Moved: Warren Gilbertson **Seconded: Barbara Holland**

Motion:
"THAT the Hospital Advisory Committee receive the Finance Report."

Carried.

Outpatient Department Cancellations

The graphs and results were discussed by the Committee.

Clinical Leaders Report

The Director of Nursing and Midwifery spoke to the report:

- The Clinical Leaders anticipate finalisation of the Future Model of Care by the end of March 2012. Discussions are taking place and issues are being addressed.
- Share of Care – a communication strategy is being worked upon to encourage people to sign up, and also encourage the practitioners themselves to sign up patients. It was clarified that you do have to sign up to the scheme, it is not an automatic registration.
- The opening of the Rural Learning Centre with a Powhiri resulted in positive feedback on this event.
- Staff Survey results – a brief update only has been received to date. Approximately 450 people responded and upon receipt of the final results a series of presentations to the departments and professional groups will be forthcoming. Strategies and steps will then be developed for improvements. Management emphasise that they

do to wish to engage more with staff and for people to know that they are being listened to.

Action Point: The General Manager to provide a summary of the Staff Survey results to the Hospital Advisory Committee upon receipt.

6.3 INVESTIGATIONS / SCOPING

Monitoring Inter District Flows - Patient Transfers

This report is looking positive with regards to no patients needing to be transferred in October/November/December 2011 for the reason of 'Service not available at Grey Base'.

Moved: Warren Gilbertson **Seconded: Sharon Pugh**

Motion:

"THAT the Hospital Advisory Committee receive the Information Reports."

Carried.

7. KEY ISSUES / ITEMS OF INTEREST TO REPORT TO THE BOARD

- Meeting targets for the next few months will be challenging and is being addressed
- Clinical Leaders report – 'Share of Care' to be monitored in terms of update
- Staff survey to be made available upon receipt
- 'Did Not Attends' – discussion to be held with Communication Officer promoting awareness

8. IN COMMITTEE

Moved: Doug Truman **Seconded: Gail Howard**

Motion:

"That members of the public now be excluded from the meeting pursuant to Clause 32a, Schedule 3 of the New Zealand Public Health and Disability Act, so that the meeting may discuss the following matters:

- **2012/13 Annual Plan and Statement of Intent**

On the grounds that public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under section 9 of the Official Information Act 1982."

Carried.

The Hospital Advisory Committee moved into In Committee at 1.12pm.

There were no in committee resolutions.

The Hospital Advisory Committee moved out of In Committee at 1.16pm

9. GENERAL BUSINESS

Action Point: The Board Deputy Chair to discuss the dates for the Induction for new advisory committee members with the Board Secretary.

10. NEXT MEETING

The next meeting will be held on Thursday, 12 April 2012 in the Boardroom, Corporate Office, Grey Base Hospital.

The Hospital Advisory Committee spent four minutes in In Committee

There being no further business to discuss the meeting concluded at 1.20pm.

MATTERS ARISING FROM HOSPITAL ADVISORY COMMITTEE MEETINGS

Item No.	Meeting Date	Action Item	Action Responsibility	Reporting Status	Agenda Item Ref.
1	18 August 2011 23 February 2012	A classification of complaints graph is requested to be provided specifically for hospital services. Graph provided 30 September 2011 meeting. On hold.	Quality Co-ordinator		
2	30 September 2011 23 February 2012	The 'Shorter stays in Emergency Departments' target to be placed on the Recovery Plan for Clinical Services in order to address the high number of presentations. To remain on matters arising for future reporting.	Acting General Manager Hospital Services		
3	30 September 2011 23 February 2012	Communication strategies with the public to be considered regarding clinic cancellations and Did Not Attends (DNAs). The Chair to follow up with the Communication Officer as to information that is being prepared to go out to the public.	Hospital Advisory Committee Chair		
4	30 September 2011 23 February 2012	Work on communication regarding what people could reasonably expect, and look at what can be delivered, with regards to transportation home following discharge. The Chair to follow up with the Communication Officer as to information to go out to the public.	Hospital Advisory Committee Chair		
5	23 February 2012	Shorter Stays in Emergency Departments – the higher number of patients waiting over six hours in the Emergency Department in Buller to be investigated.	Acting General Manager Hospital Services		
6	23 February 2012	Recruitment/Vacancy reporting to Advisory Committees to be discussed with the Chief Executive.	General Manager		
7	23 February 2012	A summary of the Staff Survey results to be provided to the Hospital Advisory Committee upon receipt.	General Manager		
8	23 February 2012	The dates for the Induction for new advisory committee members to be discussed with the Board Secretary.	Board Deputy Chair		

Item No.	Meeting Date	Action Item	Action Responsibility	Reporting Status	Agenda Item Ref.
ITEMS REFERRED FROM THE BOARD					

HOSPITAL ADVISORY COMMITTEE WORKPLAN

Objective	Responsibility	End Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
To receive a report on relevant section for Hospital Advisory Committee							
1. Annual Plan	General Manager Planning and Funding	Ongoing	Quarterly		√		West Coast District Health Board 2011/12 Annual Plan now signed off by Ministers.
2. District Health Board Hospital Benchmark Information	Acting General Manager Hospital Services	Ongoing	Quarterly				As available.
Provide input into							
1. South Island Health Services Plan	Acting General Manager Hospital Services and General Manager Planning and Funding		Annually		√		South Island Regional Health Services Plan approved.
2. South Island Elective Services Plan	Acting General Manager Hospital Services		Annually		√		The South Island Elective Services Plan is part of the South Island Regional Health Services Plan.
3. South Island Regional Strategic Plan	General Manager Planning and Funding		Annually		√		District Strategic plan has been replaced by Regional Strategic Plan 2010/11 on plus an annual output plan instead of the District Annual Plan.
4. Next Year Annual Plan and Statement of Intent	General Manager Planning and Funding		Annually			√	Annual Plan and Statement of Intent for 2010/11 now submitted to Minister of Health.
5. Facilities Redevelopment Plan	Acting General Manager Hospital Services	Ongoing	As required		√		
6. Health Information Strategy	Acting General Manager Hospital Services		Semi-Annual		√		National Health I.T. Plan for review and discussion.
7. Annual Report	Chief Financial Manager / Acting General Manager Hospital Services / General Manager Planning and Funding		Annually			√	Final copy to be provided when auditors complete.
8. Provision of advice to the Board on how to reduce the deficit	Chief Financial Manager / Acting General Manager Hospital Services / General Manager Planning and Funding	Ongoing	Six weekly		√		Project – GP Business Model.
To monitor							
1. Financial performance	Chief Financial Manager	Ongoing	Six weekly		√		Regular Finance Reports.

Objective	Responsibility	End Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
2. Health Targets	Acting General Manager Hospital Services	Ongoing	Quarterly weekly		√		Report included in papers.
3. Provider performance to contract	Acting General Manager Hospital Services	Ongoing	Six weekly		√		Included in operational indicators.
4. Elective Services Patient Flow Indicators (ESPI)	Acting General Manager Hospital Services	Ongoing	Six weekly		√		Report included in papers.
5. CDHB Collaboration - Monitor key deliverables / milestone dates	Acting General Manager Hospital Services	Ongoing	Six weekly		√		Report included in papers.
6. Workforce Development	Human Resources Manager	Ongoing	Quarterly		√		Included in management reports.
7. Implementation of Clinical Governance Action Plan - Monitor key deliverables / milestone dates Framework	Chief Executive	Ongoing	Quarterly		√		Report provided from the Clinical Advisory Group.
8. Clinical Governance - Reporting on Outcomes Achieved	Clinical Leadership Team	Ongoing	Quarterly	√			Report provided from the Clinical Leadership Team.
9. Outpatient Department Cancellation Report	Acting General Manager Hospital Services	Ongoing	Six Weekly		√		Report included in papers.
10. South Island Health Services Plan	Acting General Manager Hospital Services / General Manager Planning and Funding		Quarterly				

DRAFT MINUTES OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 22 FEBRUARY 2012 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH, COMMENCING AT 9.00 AM

PRESENT	Kevin Brown, Deputy Chair Peter Ballantyne, (ex officio) Barbara Holland Dr Cheryl Brunton John Vaile Lynette Beirne Marie Mahuika-Forsyth Mary Molloy Patricia Nolan Robyn Moore
IN ATTENDANCE	Wayne Turp, General Manager Planning and Funding Dr Carol Atmore, Chief Medical Advisor Yolandé Oelofse (minute secretary) Anthony Cooke, Chief Executive, PHO
APOLOGIES	Dr Paul McCormack, Board's Chair (ex officio) Elinor Stratford, Chair John Ayling Gary Coghlan, General Manager Maori Health

1. APOLOGIES, WELCOME & KARAKIA

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

Apologies were received on behalf of Elinor Stratford, Dr Paul McCormack, John Ayling and Gary Coghlan.

Moved: John Vaile **Seconded: Dr Cheryl Brunton**

Motion:
"THAT the apologies be noted"

Carried.

2. STANDING ORDERS

The Chair waived standing orders noting reinstatement if required.

3. DISCLOSURES OF INTEREST

Barbara Holland	Insert: Member – Breastscreen Aotearoa Advisory Group
Mary Molloy	Remove: Trustee – West Coast Community Trust

4. MINUTES OF THE PREVIOUS COMBINED COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 17 NOVEMBER 2011

Corrections to minutes:

Item 4	Minutes: typo's
	Page 2 Item 4: environ should read environment impact.
	Page 3 first line: 40 has should read have
	Page 3 Action Point: be place should be placed
	Page 3 Item 2 Advance should read Advanced
	Page 3 item 8: we loose should read lose and disadvantage should read disadvantaged.
	Page 4 second paragraph: been should read being
	Page 4 third paragraph: Excelr should read Xcelr8
	Page 4 fifth paragraph: and or should read and/or
	Page 5 item 9: rage should read range and been should read being
Item 8	Page 4, Recruitment and retention of staff: Maori project re retention and recruitment, its actually generic and not Maori specific.
Item 8	second paragraph: community based referrers should read reference
	fourth paragraph: people leaving should read living.
	Author of this report should have read Wayne Turp, General Manager Planning and Funding.

Moved: Kevin Brown **Seconded: Peter Ballantyne**

MOTION:
"THAT the Minutes of the Combined Community and Public Health and Disability Support Advisory Committee meeting held 17 November 2011 with amendments as noted be accepted as a true and accurate record"

Carried.

5. MATTERS ARISING

Item 1	The schedule to come through for April's meeting.
Item 2	Dr Carol Atmore will endeavour to provide more information at the April's meeting.
Item 3 and 4	To delete as action is complete.

6. CORRESPONDENCE

The correspondence has been taken as read.

The Chair will send a reply through to Peter Burton from The Nelson Marlborough District Health Board regarding Sign Language Interpreters

Moved: Lynette Beirne **Seconded: Mary Molloy**

Motion:
"THAT the Committee receives the correspondence"

Carried.

7. CHAIRS REPORT

The Chair's report has been taken as read.

Moved: Kevin Brown **Seconded: Mary Molloy**

Motion:
"THAT the Committee receives the Chairs report"

Carried.

8. ORGANISATIONAL LEADERSHIP REPORT

The Chair's report has been taken as read.

Granger House: An update was provided for by the General Manager of Planning and Funding.

In response to concern of the quality of clinical and leadership management; two new positions have been appointed and the Management of Granger house meets bi-monthly with the DON of West Coast District Health Board. A twelve month certificate to practice has been issued. This is due for renewal at the end of the financial year. The service is improving and delivery is currently satisfactory. Positive feedback has been received from patients at Granger House that there is an improvement. Monitoring of progress against required service improvement is ongoing.

Community laboratory / referred services: The GM P&F advised the committee that only a small proportion of referred services is made via Medlab South. As to the future financial impact of the hospital laboratory picking up these services, it was explained that as the hospital laboratory had capacity to pick this up largely within its existing resources it was beneficial to the DHB overall. In moving to a single provider it is important that all services receive an effective and efficient service and that our community's needs and health interests are held uppermost.

CVD Screening:

- A question was raised regarding the policy, is it only restricted for women and why are the men excluded. It was noted that the policy on screening applies to the entire population. The GM said he would check to see what arrangements are made for CVD screening for the population of the Coast as a whole.

Action: The General Manager of Planning and Funding to clarify the policy and the gender aspect thereof and to report back to the Committee.

That the Committee receives the Organisational Leadership report.

Moved: John Vaile **Seconded: Barbara Holland**

Carried.

Clinical Leadership:
The Clinical Leadership's report has been taken as read.

BSMC primary care: A workshop on the Health of Older People recently took place with positive feedback and outcomes. The team is currently continuing to develop a model of care for Grey regarding primary services, this will service the whole of the West Coast. The team is working towards meeting the timeline for the end of March in having the model of care developed. The Rural Learning Centre building was opened on Tuesday.

- A question was asked regarding the paediatric nurse/trainee, if they had commenced work on the Coast? A person has been trained in CDHB and will be based in Christchurch and travel to the Coast on a regular basis.

- Reference was made to the CPHAC and DSAC minutes of 17 November 2011: Progress with the Grey Health Trust suggested by Mayor Kokshoorn and whether this has taken place? The Chief Medical Officer had met with Tony Kokshoorn and mentioned that although other issues have taken precedence over the last year it is still on list of things to do.

A Grey IFHC steering group with a sub group has been established. The group is currently working on areas of effective business practice and models. They will meet in early March to discuss this further in detail.

Primary Practice review: Practices have received the practice management report and are each working towards practice management and efficiency.

- In response to the long term expectations for practice ownership it was explained that there is no active plan to change ownership of DHB owned practices but that the Board has an open mind to alternative models should they prove to be more effective in providing good patient care.

It was moved that the Committee receives the Clinical Leadership report.

Moved: Dr Cheryl Brunton **Seconded: Barbara Holland**

Carried.

Community and Public Health (C&PH):
The C&PH's report has been taken as read.

Smokefree public: The Grey council has announced that in future it would encourage people not to smoke in all public spaces. The committee applauded this decision by the District Council.

Whooping cough: Pertussis outbreak is over in the Westland district no cases has been received for the past ten weeks. Rate of Pertussis is epidemic nationally. This year we are the second highest district with Pertussis outbreak. The rate is on a decline and we are currently monitoring the incubation period of beginning of the new school term. A discussion took place on short term residents on the Coast for whom the cost of vaccinations is a deterrent to them getting immunised.

That the Committee receives the C&PH report.

Moved: Dr Cheryl Brunton **Seconded: Patricia Nolan**

Carried.

BSMC progress report:
The BSMC's report has been taken as read.

Points of interest:

- An Alliance Leadership Team (ALT) report will be submitted to the Committee in the future. The ALT meets on a six weekly basis.

- WCPHO funds: There has been some media interest regarding the availability of WCPHO funding to contribute towards the implementation of BSMC. The General Manager Planning and Funding reassured the Committee that the PHO has indicated that it has lees reserve funding than originally anticipated. This has required a review of funding priorities regarding the future implementation of BSMC but this has been resolved to the satisfaction of the DHB.

THAT the Committee receives the BSMC report.

Moved: John Vaile **Seconded: Mary Molloy**

Carried.

PHO:

The PHO's report has been taken as read. Areas of interest raised by the committee included:

- Take up of 'Shared Care' and the process for opting on or off of this system. The Chief Medical Advisor explained that patient privacy is absolutely maintained according to the patients' wishes and access without consent would only occur in cases of extreme emergency.

- The funding of Correction Service access; This is a small program whereby vouchers are issued by community probation service staff to clients requiring free general practice service, this voucher entitles them to a free health check.

- Green Prescription: this is largely access to a physical activity programmes determined on health grounds. Referrals for inactive patients are referred by their General Practitioner.

- Keeping people healthy: access by young people; the numbers are very small on the West Coast, this is a referral basis done by the General practice. It was noted that the General practice are doing referrals to the gym which is fantastic.

- Cardiovascular risk: A challenge and concern is that CV risk patients should be assessed every five years. The WCPHO is currently looking at running clinics outside the medical practices and will involve the General Practice's running clinics and possibly look at major employers to get involved; these would all lead to acute intervention.

- Feedback from Maori community to ascertain their view about the quality of patient care for Maori - has this being actioned? Not at this stage. A generic patient satisfaction survey to measure patient satisfaction with the care they received at their IFHC has been sent to each practice.

Moved: Peter Ballantyne **Seconded: John Vaile**

Motion:
"THAT the Committee receives the PHO report"

Carried

9. GENERAL BUSINESS

A concern was raised by the Deputy Chair regarding the time of receiving the Agenda. A review of the courier services is currently undertaken by the WCDHB.

Action: The General Manager Planning and Funding to find solutions and to bring back to the April Meeting.

Community Services currently raised the issue of access to the building is difficult. This would need to work through the proper company process by raising a Capex. The Deputy Chair mentioned that this has been raised previously, and that WCDHB should take this into consideration when the new building facility is built.

Action: **The General Manager Planning and Funding to address.**

10. INFORMATION PAPERS

For information only.

11. OTHER BUSINESS

There are no items to be referred to the Board:

The Community and Public Health Advisory and Disability Support Advisory Committee moved into In Committee at 10:20am

Moved: Marie Mahuika-Forsyth **Seconded: John Vaile**

Motion:
"THAT the Committee moves into In-Committee section"

Carried.

The Community and Public Health Advisory and Disability Support Advisory Committee spent 10 minutes in In Committee

The Community and Public Health Advisory and Disability Support Advisory Committee moved out of In Committee at 10:30am

Moved: John Vaile **Seconded: Lynette Beirne**

Motion:
"THAT the Committee moves out In-Committee section and back into the public section"

Carried.

Patient Advocacy: The need for patient advocacy was raised previously. This has not yet been addressed about the adequacy of support for patients and families in remote rural areas. How to ensure that patients had the necessary support and guidance when receiving medical care. We possibly need to address education and/or training in this area. It was agreed that this would be brought back to the Committee in a form of a workshop which will be held directly after CPHAC and DSAC meeting. A general discussion considering ideas on how to solve such problems. To invite staff involved in such areas to present and discuss what potential gaps there are within the system.

Action: Wayne Turp, Manger of Planning and Funding to arrange workshop directly after a meeting.

Meeting closed at 10:40am

11.1 NEXT MEETING

The next meeting will be held on Thursday, 12 April at 9am in the Boardroom, Corporate Office, West Coast District Health Board, Greymouth.

Apologies were received for April's meeting from Patricia Nolan and Dr Carol Atmore.

DRAFT MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY GROUP MEETING HELD ON THURSDAY 23 FEBRUARY 2012 AT CORPORATE OFFICE, GREY HOSPITAL, 3.40 PM

PRESENT	Ben Hutana (Deputy Chair)	Te Rūnanga O Ngāti Waewae
	Marie Mahuika-Forsyth	Te Rūnanga O Makaawhio
	Francois Tumahai	Te Rūnanga O Ngāti Waewae
	Sharon Marsh	Nga Maata Waka O Kawatiri
	Wayne Secker	Nga Maata Waka O Māwhera
IN ATTENDANCE	Hecta Williams	General Manager, West Coast DHB
	Gary Coghlan	General Manager Māori Health, West Coast DHB
	Wayne Turp	General Manager Planning and Funding West Coast DHB
	Claire Robertson	HEHA and Smokefree Services Manager West Coast DHB
	Peter Ballantyne	Acting Board Chair, West Coast DHB
MINUTE TAKER	Linda Atkins	Administration Assistant, CEO Office
APOLOGIES:	Richard Wallace (Chair)	Te Rūnanga O Makaawhio
	Elinor Stratford	West Coast District Health Board Representative on Tatau Pounamu
	Dr Paul McCormack	West Coast DHB Chair

WELCOME

The Deputy Chair welcomed everyone to the meeting.

1. AGENDA / APOLOGIES

Item 14 (2012 Meeting Schedule) needs to be revised and finalised today.

Apologies

▪ Richard Wallace	Te Rūnanga O Makaawhio
▪ Elinor Stratford	West Coast District Health Board Representative on Tatau Pounamu
▪ Dr Paul McCormack	West Coast DHB Chair

Apologies accepted
Moved: Wayne Secker **Seconded: Francois Tumahai**

2. 2012 MEETING SCHEDULE

The Advisory Group discussed the timetable in Section 14 which was an out of date schedule, dates and locations are to be arranged for 2012. These were decided as follows:

- Wednesday 11 April at the Arahura Marae, Hokitika, from 1 pm to 3 pm.
- Thursday 24 May in the Boardroom, Corporate Office, Greymouth, 3.30 – 5.30 pm.
- Wednesday 11 July at the Westport Motor Hotel, 27 Palmerston Street, Westport, 1 – 3 pm.
- Thursday 23 August, in the Boardroom, Corporate Office, Greymouth, 3.30 – 5.30 pm.
- Thursday 11 October in the Boardroom, Corporate Office, Greymouth, 3.30 – 5.30 pm.
- Thursday 22 November in the Boardroom, Corporate Office, Greymouth, 3.30 – 5.30 pm.

The Advisory Group agreed that the next meeting at the Te Tauraka Waka a Maui Marae in Bruce Bay South Westland would be held in 2013.

Moved: Marie Mahuika-Forsyth **Seconded: Francois Tumahai**

Carried

3. DISCLOSURES OF INTERESTS

The following amendments are to be made:

Delete
Ben Hutana
Deputy Chair Te Runanga O Ngati Waewae

Add
Ben Hutana
Member of the Rata Te Awhina Trust Board

Add
Francois Tumahai:
Member of Rata Te Awhina Trust Board

4. MINUTES OF THE LAST MEETING – 30 NOVEMBER 2011

No changes were made to the minutes.

Moved: Marie Mahuika-Forsyth **Seconded: Wayne Secker**

Motion
THAT the Minutes of the Tatau Pounamu Manawhenua Advisory Group meeting held 30 NOVEMBER 2011 be adopted as a true and accurate record.

Carried.

5. MATTERS ARISING FROM THE LAST MEETING

Kia Ora Hauora Programme:
A member asked about the West Coast Maori participants in the Kia Ora Hauora programme, (see Section 7 Maori Health Plan Quarter Two Progress Report).
There are eleven Maori students enrolled in the programme on the West Coast, and Maori received four of the seventeen scholarships in 2011-12, being 23.5% of the total. Most are employed by the West Coast District Health Board (DHB). The General Manager Maori Health commented that Maori are progressing well, and there are four Kia Ora Hauora regional hubs, with one in the south island. The overall goal is to encourage Maori into the health and disability workforce via education.

West Coast Home Insulation Programme
The HEHA and Smoke free Services Manager confirmed she met with Francois Tumahai in December 2011, and gave an update to the Advisory Group. Francois has been working to identify Hokitika whanau who would benefit from home insulation as part of the Warm up the West Coast Project, and he has taken information to these families, they will then send the forms to Ngati Waewae, then the forms will come to the HEHA and Smoke free Services Manager. The process involves sending the information to local contractors to check, then assess, then if the two criteria (applicants must have a Community Services card, and the home must have been built before 2000) are met they can start the insulation.

Francois explained his programme has a list of seventy applicants; some houses have already been done, including seven kaumatua. Some applicants do not fit the criteria, so there are thirty left to process. Mostly people from Ngati Wae Wae have been assisted to date.

The HEHA and Smoke free Services Manager explained (as per the information in her update tabled in the meeting, Appendix One) in the last eighteen months the programme has received 183 applications coast-wide, 153 have been passed on to insulation companies to be assessed and checked. The Energy Efficiency and Conservation Authority (EECA) only provide this service for private tenants, not Housing New Zealand tenants. So far 76 homes on the west coast have been insulated, and the current aim is to insulate 40-50 homes per month in order to get them done before winter. A total of 11% or 17/153 of the applications were from Maori, and they plan next to target schools and early childhood centres via newsletters, and asking school principles to identify high needs people, also B4 School Check packs can include this information. The West Coast has been allocated a total of 500 homes to insulate, so cost is not important in this project.

It was noted that the EECA also have a general subsidy for insulation, anyone can call them and request a free assessment from them.

Term of Chairperson

Moved: Francois Tumahai **Seconded: Marie Mahuika-Forsyth**

Motion
That the Advisory Group agrees to implement Item 8 in the minutes:
"In keeping with the Terms of Reference it is time to alternate the Tatau Pounamu Chair position to a representative of Te Runanga O Ngati Waewae".

Carried.

Richard Wallace is to be acknowledged by committee members at the next meeting.

It was noted that Ben Hutana was reappointed to Tatau Pounamu last Sunday, by Ngati Waewae Runanga. The position was re-advertised, and he applied and was successful. Francois Tumahai nominated Ben to be Chair, he accepted, and Marie Mahuika-Forsyth seconded the nomination.

Whare Oranga Pai (Living Well Centre Concept.
Marie Mahuika -Forsyth
Marie updated the meeting. Last week she met with Kylie Parkin, Maori Health HEHA and Claire Robertson, HEHA and Smoke free Services Manager, and they presented the negotiation brief for this centre to Planning and Funding at the DHB. They have a draft job description for a project manager, and can apply for $30,000 funding from Te Hotu Manawa. Both Runanga have given verbal support for this project and it is progressing well. Marie is looking at the old St Johns building as a possible venue in Hokitika, and is to meet with the owners to discuss the concept.

It was noted that the sustainability of this project is identified as a risk as future HEHA funding is not clear, so other funding avenues will be a key factor.

6. MAORI HEALTH REPORT TO TATAU POUNAMU

Gary Coghlan, General Manager Maori Health

This report was taken as read.

Rata Te Awhina Trust Organisational Review
Review has been undertaken.

Rata Te Awhina
Two new Maori health positions under Rata Te Awhina will be advertised soon in Buller - Kaupapa Maori nurse and Kaiarataki Maori Health Worker.

The General Manager Planning and Funding explained that preparation for the new positions is underway, and they will involve working under new alliance approach with Rata and Buller Health, which will also require a change in the model of service delivery at Buller Health. This is a new opportunity to integrate systems and will be an important learning process for the DHB.

He said the Board has agreed that a single site for all services (primary, secondary and aged care) will be used, but this site is yet to be chosen. The Board will visit Buller in March and determine the most suitable site. A member noted that the building of the Buller Integrated Family Health Centre site has generated high interest in local organisations Ngai Tahu, and local Runanga.

7. REVIEW OF SERVICES TO MAORI PROJECT

The General Manager Maori Health noted he has met with Neil Woodham, his team is undertaking a review of services to Maori. There is strong support from clinicians towards the objectives of this project.

Waka Ama
A name correction was noted (Tauwhare).
Refer to Section 6 Review of Services to Maori Project.
The General Manager Maori Health thanked the Planning and Funding department for their assistance.

Aukati Kai Paipa /Maori Smoking Cessation
The new person Joe Mason is now on board and is doing a good job.

8. REVIEW OF SERVICES TO MAORI PROJECT

Gary Coghlan, General Manager Maori Health

Covered above.

9. HEHA/SMOKEFREE UPDATE

Claire Robertson – HEHA and Smoke free Services Manager

The HEHA and Smoke free Services Manager tabled her update (Appendix One) and spoke to her report. Key factors were:

a. The West Coast has the highest rate of smoking in New Zealand.
b. 43% of Maori on the West Coast smoke.
c. The Smoke free position at Community and Public Health has been filled (Joe Mason).
d. Buller has a new 0.8 FTE youth focused smoking cessation position for two years at Buller/REAP.
e. HEHA is waiting to hear the future of funding; the contract ends 30 June 2012.
f. Breastfeeding: local information is required for West Coast families; this is being developed for release in March 2012 with a Breastfeeding workshop.

10. MAORI HEALTH PLAN QUARTER TWO PROGRESS REPORT

Gary Coghlan, General Manager Maori Health

It was noted some information is not currently available (see last page Indicators).

Overall progress is being made but more work is required to encourage Maori to enrol in the West Coast PHO. This is one of the key roles for Kaiarataki to assist Maori to enrol in the PHO, and Maori nurses to work with the Maori community.

- Oral Health: there is a need for a stronger coordinated approach to improve the oral health of young Maori on the West Coast as the results are not good. The Group discussed issues such as the cost of milk, the use of (cheaper) cordials, and the lack of fluoridation in the local water supply. If done, this would improve oral health; Research indicates fluoridation helps oral health. Other factors are poor diet, lack of hygiene, and lack of education on this issue. Other Maori health areas covered included:
- Cardiovascular Disease Risk: needs improving.
- Long Term Conditions.
- Maori Smoking Rates.
- Maori Workforce Development:
- Cervical screening: West Coast Maori women's statistics are 20% lower than the national figure for Maori women.

A member asked if there would be more regular reporting against the Maori Health Plan, and wanted Tatau Pounamu to be more involved in achieving the health targets discussed for Maori. There was quite a discussion regarding strategies such as early prevention, and working closer with whanau. It was noted HEHA seems to be making a difference and it is important to keep driving these messages, and to make them fun for people. For example, the current television advertisements for cervical and breast screening are helping, as women must feel comfortable to go along to the clinics.

11. ANNUAL PLAN PROCESS

Wayne Turp, General Manager Planning and Funding

The General Manager West Coast DHB spoke on this topic and tabled the Minister of Health's 'Letter of Expectations for District Health Boards and their subsidiary entities for the 2012/13 year' (Appendix Two), and the Minister of Health's letter 'Expectations around improved access to services 2012/2013 and beyond' (Appendix Three). Both letters demand faster access to services, with reduced waiting times for elective surgery, and the DHB must meet these health targets.

The West Coast has problems with waiting for child and youth services, as there are fewer resources, and also problems with immunisation as people choose not to immunise their children, so the health target results are low. The Smokers Provided with Help to Quit target of 90% is not being met in hospital or primary as it is only at 40% currently, so there is a lot of work to be done in this area. The Acting Chair of the West Coast DHB pointed out the Minister does not accept this situation and demands that the outcome is achieved.

The Annual Plan is to acknowledge the Maori Health Plan, both are to be aligned, and the General Manager Planning and Funding will confer with the General Manager Maori Health to discuss this as the Annual Plan is to be submitted in the next two months.

Correction to be made: the wording 'Maata Waka' needs to be removed from the Annual Plan as it no longer exists.

12. WORKING WITH IWI FORUMS IN TE WAIPOUNAMU

Gary Coghlan, General Manager Maori Health

The letter from Joe Puketapu Chair of Iwi Health Board Nelson Marlborough DHB requires a response from Tatau Pounamu.

Action: The Chair and General Manager Maori Health are to meet to write this letter.

13. MEMORNADUM OF UNDERSTANDIN AND TERMS OF REFERENCE

To be covered at the next meeting.

14. CARRY OVER ITEMS FOR THE NEXT MEETING

Memorandum of Understanding and Terms of Reference.
Marie Mahuika-Forsyth noted this has just been reviewed and signed off in 2011.

Annual Plan.

15. CORRESPONDENCE

Letter to Pauline Southorn:
This was discussed, and included in the meeting papers for information. The response from the Acting Chair of West Coast DHB addressed the writer's concern regarding process, and Maata Waka representation on the Tatau Pounamu Advisory Group.

Further discussion regarding the Terms of Reference and representation can be discussed at the next Tatau Pounamu meeting.

A member stated if there were any further amendments to the Terms of Reference, these will need to be discussed with both Runanga on the West Coast.

Letter from Joe Puketapu:
Response to be written (as in 11 above).

Letter from Susan Wallace regarding Te Runanga o Makaawhio Representation:
Noted.

Moved: Ben Hutana **Seconded: Francois Tumahai**

Motion
That the Inwards and outwards correspondence is accepted.

Carried

16. GENERAL BUSINESS:

West Coast PHO Quarterly Report - October to December 2011 - Tabled (Appendix Four)
Maori health data is clearer to understand.

Manawhenua Hui in Christchurch 23 February 2012
Maori on mana whanau health committees throughout the South Island had been invited to a meeting at Ngai Tahu regarding Maori health issues; it seems no invitation was sent to the West Coast.

Action: General Manager Maori Health and the Chair to follow up.

Deputy Chair of Tatau Pounamu:
Marie Mahuika-Forsyth Deputy Chair.

The Chair thanked the Tatau Pounamu meeting members and attendees, and finished with karakia.

The meeting finished at 5.55 pm

Signed _____ **Date** _____

appendix 1 : Tabled 23/2/12 CR

TATAU POUNAMU – MAORI HEALTH ADVISORY COMMITTEE UPDATE

TITLE	WARM UP WEST COAST – HEHA & SMOKEFREE UPDATE
PREPARED BY	Claire Robertson
DATE	23 February 2012

Warm Up West Coast

The Insulation Company have been insulating 25-30 homes per month; they are looking to increase this to 35-40 homes per month. Healthy West Coast continues to prioritise households with children under 2 years, someone over 65 years and those with a housing related health problem such as a respiratory illness.
The Warm Up West Coast Coordinator met with Francois Tumahai in December 2011 to discuss working alongside a similar project, led by Francois currently happening in Hokitika.

The next step for the project is to send information and referral packs to all schools and Early Childhood Centres for families within their communities. Warm Up West Coast Flyers will also be added to the Before School Checks packs.

Data - *All data below is as of 17 February 2012*

1. Applications Received

	Number
Applications received by Healthy West Coast	183
Applications forwarded to The Insulation Company	153
Applications to be processed	15
Number of applicants declined *	15
Number of homes insulated	76

* 14/15 applicants did not have a current Community Services Card, 1 applicant was a Housing New Zealand tenant.

2. Ethnicity

Ethnicity	**No. of applications forwarded to The Insulation Company (/153)**	**Percentage**
Maori	17	11%
NZ European	131	85%
Other	4	3%
Unknown	1	0.7%

Smokefree

Positions Filled

Aukati Kaipaipa

Joe Mason has commenced employment with Community & Public Health in January as the new Aukati Kaipaipa provider for the West Coast.

Buller Youth Project

The West Coast Tobacco Free Coalition project aims to reduce smoking prevalence in youth by providing a youth focused smoking cessation service in the Buller district. The 0.8 FTE position is being piloted for two years and will be based at BullerREAP. Berdie Milner had been providing support in this process after coordinating a similar project in Hornby in her previous role. The position has been filled and employment commenced with BullerREAP this month.

ABC – Secondary Care

	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11	Q1 11/12	Q2 11/12
Maori	67%	83%	90%	100%	66%	80%
Total	59%	72%	88%	83%	69%	86%
2011/12 Target	95%	95%	95%	95%	95%	95%

The percentage of smokers given support to quit increased to 86% for Quarter 2 2011/12 (October 86%, November 88% & December 83%).

Prevalence of Smoking (based on discharges from secondary services)

2011/2012	Maori	Total
Quarter 1	29% (31/108)	17% (279/1651)
Quarter 2	29% (25/86)	16% (245/1539)

Maori Cessation Enrolments (July-December 2011)

- DHB secondary services – 10% Maori (15/152)
- Coast Quit – 8% Maori (22/290)
- Aukati Kaipaipa – Jem to provide % Maori – 63 referrals during this time

Maori Health Planning & Review of Services - Smoking Cessation

Smokefree staff involved in Smoking Cessation provision on the West Coast took part in the Maori Health Planning & Review of Services on the 9th February. This was attended by Anne McDonald (DHB Cessation provider – Grey Hospital, John Caygill – Smokefree Services Coordinator, Jem Pupich – Team Leader C&PH and Claire Robertson – HEHA & Smokefree Service Development Manager).

HEHA

WCDHB are yet to hear about the future of HEHA funding with the contract ending 30 June 2012. MOH have indicated the information will be released by the end of February 2012.

Breastfeeding

Booklet Development

The Breastfeeding Interest Group (B.I.G) identified the need for a local breastfeeding resource to provide West Coast families with clear, consistent and local information regarding breastfeeding. To eliminate multiple resources the handbook has also been developed to be used from conception through to end of breastfeeding. All feedback on the final draft from health professionals and West Coast families was received by 31 December 2011 and it is hoped the resource will be finalised for release this quarter in conjunction with a Breastfeeding workshop that is taking place in March.

Maori Community Action

Oranga Pai

Marie Mahuika-Forsyth presented the Whare Oranga pai Concept to Tatau Pounamu at the previous meeting held on 30 November 2011.

Project planning is continuing and a joint committee including two representatives from each Runanga is working with the HEHA Maori Co-ordinator HEHA Manager and P & F Analyst to develop and oversee the next stage of the Oranga Pai project. Sustainability of the project has been identified as a risk with the uncertainty of HEHA funding in the future other funding options need to be investigated.

23/2/12 Tabled

To: Board Appendix 2
cc: EMT.

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

3 FEB 2012

Mr Peter Ballantyne
Acting Chair
West Coast DHB
PO Box 387
GREYMOUTH 7840

Dear Peter

Expectations around improved access to services 2012/2013 and beyond

The Government has made commitments to New Zealanders to deliver even faster access to elective surgery, diagnostic tests, chemotherapy treatment and youth drug and alcohol services.

I would like to thank you, and your colleague DHBs, for your achievements so far in delivering 60,000 additional elective surgeries since 2008, and for ensuring all cancer patients ready for radiation treatment are receiving it within the world gold standard of four weeks.

Now, it is time to set some new goals. There are outlined in the Government's manifesto. Some significant changes will be needed to meet these commitments and your Board will need to work closely with clinicians, primary care and the Ministry of Health to put them in place.

Faster access to elective surgery

DHBs will need to continue delivering, on average, at least 4,000 extra operations each year, as outlined in the *Improved Access to Elective Surgery Health Target.*

We have already advised you of our expectation that no patient should wait longer than 6 months to receive a First Specialist Appointment, or elective surgery, by 1 July 2012.

The Ministry of Health is working closely with you to reduce the waiting list over six months to zero, and I encourage you to share best practice with your colleagues, or seek ideas on how to improve service, depending on your own individual progress.

Productivity and efficiency gains may need to be made to meet these targets, as well as changes to processes and systems currently in place.

This expectation will shift to a maximum of five months in 2013, and a maximum of four months by the end of 2014.

I want to reiterate to you that in meeting this requirement access for patients will not be reduced for example, by lifting thresholds or removing patients from waiting lists.

Improved access to diagnostic tests

Patients can face long waits to get the tests they need before treatment can begin. Some can wait up to 6 months before they see a specialist, and then wait many more months for a CT scan or MRI.

This ultimately means a delay in diagnosis and treatment, and can affect health outcomes.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

There is currently no national reporting or monitoring of waiting times for diagnostic tests.

The Ministry of Health is working with key clinical groups to set maximum waiting times for Coronary Angiography, Colonoscopy, MRI and CT scans.

Along with establishing maximum wait times the first stage is to collect, measure and monitor how long patients are waiting. Your DHB will need to co-operate with the Ministry in establishing the reporting and monitoring system.

Delivering shorter waiting times for diagnostic tests is an important to ensuring patients are treated faster, and DHBs provide the right services at the right time.

Some District Health Boards have made significant progress in reducing waiting times by increasing the ability of GPs to refer patients directly for these tests.

Not only does a direct referral from a GP mean a patient can be diagnosed faster, it also delivers efficiency and productivity gains to hospitals – making smarter use of a specialists' time, allowing them to treat more people, sooner.

Cancer treatment

I wrote to you a few weeks ago outlining changes we have made to the "*Shorter waits for Cancer Treatment*" target. This is an important part of our commitment to deliver faster services to patients.

Building on achievements in radiation therapy, we are adding medical oncology (chemotherapy) to the target from the middle of 2012. This means all patients needing either radiation or chemotherapy treatment, should begin that treatment within the world gold standard of four weeks.

Shorter waits for child and youth drug and alcohol treatment

Many young people and their families are waiting too long to access specialised addiction services.

As part of the Drivers of Crime package, the Government is investing an additional $2 million to provide youth, alcohol or other drug services and associated workforce development and service evaluation.

Our expectation is that 80% of young people are seen by an AOD health professional within 3 weeks. Urgent cases should be seen even faster. This is likely to be the basis of a future national health target.

International evidence has shown the benefits faster treatment makes to young people and their families, and your Board should make this commitment a priority in your mental health and youth services.

I look forward to working with you to deliver these improved services to New Zealanders.

Yours sincerely

Tony Ryall

Hon Tony Ryall
Minister of Health

Appendix 3
Tabled 23/2/12

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

26 JAN 2012

Mr Peter Ballantyne
Acting Chair
West Coast District Health Board
Grey Base Hospital
PO Box 387
GREYMOUTH 7840

Dear Peter

Letter of Expectations for District Health Boards and their subsidiary entities for the 2012/13 year

Delivering **better, sooner, more convenient care** and lifting health outcomes for patients within constrained funding increases is the Government's key expectation for the public health service in the 2012/13 financial year.

Thank you for the contribution you and your staff have made to improving the New Zealand public health service. The Government greatly appreciates the work of District Health Board (DHB) staff in providing more service for patients in these difficult economic times.

While internationally a number of countries are making significant cuts to health spending, the re-elected National-led Government will continue to increase its investment in Health, but within a necessarily tighter financial framework.

The Government is determined to return to surplus in 2014/15. The public health service can contribute by lifting productivity, and keeping to budget. All DHBs should establish specific plans to improve financial performance year-on-year. The supply of equity and debt will continue to be constrained, so Boards will need to prioritise capital more closely and fund from internal resources.

Integrated Care

International evidence shows that integrating primary care with other parts of the health service is vital to better management of long-term conditions, an ageing population and patients in general. This is achieved through better coordinated health and social services and the development of care pathways designed and supported by community and hospital clinicians.

DHBs must focus more strongly on service integration particularly with primary care; ensuring the scope of activity is broadened and the pace significantly stepped up. Areas include integrated family health centres, primary care direct-referral to diagnostics, and clinical pathway development involving community and hospital clinicians.

The Annual Plan Guidance provides clear expectations on the need and scope for change. We expect your Board's Annual Plan will show how integration between community and hospital services will be used to drive delivery and improve performance in three priority areas: unplanned and urgent care, long-term conditions, and wrap around services for older people.

Your DHB will also work with local primary care networks and the Ministry of Health (the Ministry) to provide zero fee after hours GP visits for children under six, as outlined in the Government's election policy. Over the next year the Ministry will be looking at further integration of child and maternity services. Expectations from the Prime Minister's Youth Mental Health Project will also be advised to you.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Shorter Waiting Times

The Government's election policy included ambitious plans to further shorten waiting times in a number of key areas including surgery, diagnostics and cancer care. Specific expectations in this significant area will be covered in a separate letter shortly.

Health Targets

Some changes to the national health targets have already been advised. Your DHB is expected to include specific plans for achieving these priority targets in your Annual Plan. This will include joint plans with primary care networks in your district for at least the smoking, cardiovascular disease (CVD) and immunisation targets.

Health of Older People

Our population continues to age and pose new challenges. DHBs are expected to engage with primary/community care to develop integrated services for older people that support their continued safe, independent living at home, particularly after a hospital discharge. Your DHB will also work with the Ministry to implement the Government's commitments relating to dedicated stroke units and dementia.

Regional Integration

Greater integration between regional DHBs is important for both financial and clinical reasons. We expect DHBs to make significant progress in implementing their Regional Service Plans, and delivering on regional workforce, IT and capital objectives that have been set. We will be monitoring execution against the various dashboards used by the National Health Board (NHB).

We need to see further improvements in efficiency and containing costs. Boards will need to support and advance the work of Health Benefits Ltd, Health Workforce NZ and the Health Quality and Safety Commission.

Significant productivity gains will need to be made across services and organisations, particularly hospitals. This will include making smarter use of your workforce and increasing integration with primary care and services for older people.

Strong clinical leadership remains pivotal to your on-going success.

All DHBs are expected to work co-operatively with the Ministry on implementing the Government's election commitments.

Finally, as agents of the Crown, you must assure yourselves that you have in place the appropriate clinical and executive leadership needed to deliver the Government's objectives. The performance of Chief Executives must be monitored against these expectations and I will be interested to see how they are reflected in your annual performance agreement with your Chief Executive.

Thank you for your work in the past, and I look forward to working with you to deliver more and better access to services in the future. Please share this letter with your local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

INFORMATION PAPERS

WEST COAST DISTRICT HEALTH BOARD ADVISORY COMMITTEE MEMBERS TERMS OF APPOINTMENT

AUDIT, RISK AND FINANCE COMMITTEE

Member	Date of Appointment	Length of Term	Expiry Date
Helen Gillespie Chair	27 January 2012	Three Months	30 April 2012
Peter Ballantyne Deputy Chair	27 January 2012	Three Months	30 April 2012
Susan Wallace	27 January 2012	Three Months	30 April 2012
Rex Williams	6 May 2011	1 Year	6 May 2012
Dr Paul McCormack	28 July 2011	Until advised by the West Coast District Health Board	

HOSPITAL ADVISORY COMMITTEE

Member	Date of Appointment	Length of Term	Expiry Date
Warren Gilbertson Chair	27 January 2012	Three Months	30 April 2012
Sharon Pugh Deputy Chair	27 January 2012	Three Months	30 April 2012
Doug Truman	27 January 2012	Three Months	30 April 2012
Barbara Holland	25 June 2003 (Re-appointed 30 June 2006 & 12 June 2009)	3 Years	30 June 2012
Richard Wallace	25 July 2005	Until advised by Te Runanga o Makaawhio	
Gail Howard	6 May 2011	3 Years	6 May 2014
Paula Cutbush	6 May 2011	3 Years	6 May 2014

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE

Member	Date of Appointment	Length of Term	Expiry Date
Elinor Stratford Chair	27 January 2012	Three Months	30 April 2012
Kevin Brown Deputy Chair	27 January 2012	Three Months	30 April 2012
John Vaile	27 January 2012	Three Months	30 April 2012
Mary Molloy	27 January 2012	Three Months	30 April 2012
Barbara Holland	Co-opted September 2004 Appointed 4 March 2005 (Re-appointed 1 October 2007 & 30 June 2009)	3 Years	30 June 2012
Cheryl Brunton	1 February 2005 (Re–appointed 3 November 2006 & 13 June 2008)	Whilst remaining as the Medical Officer of the Health for the West Coast DHB	
Marie Mahuika-Forsyth	20 April 2009	Until advised by Te Runanga o Makaawhio	
Patricia Nolan	18 July 2005 (Re-appointed 18 July 2006 & 19 July 2008 & 28 July 2011)	1 Year	28 July 2012
Lynette Beirne	24 March 2011	3 Years	24 March 2014
John Ayling	24 March 2011	3 Years	24 March 2014
Robyn Moore	3 June 2011	3 Years	3 June 2014

WEST COAST DISTRICT HEALTH BOARD AND ADVISORY COMMITTEE SCHEDULE
JANUARY TO DECEMBER 2012

DATE	MEETING	TIME	VENUE
~~Friday 27 January 2012~~	~~BOARD~~	~~10.00 AM~~	~~St Johns Waterwalk Rd Greymouth~~
~~Thursday 23 February 2012~~	~~CPHAC/DSAC~~	~~9.00 AM~~	~~Boardroom, Corporate Office~~
~~Thursday 23 February 2012~~	~~HAC~~	~~11.00 AM~~	~~Boardroom, Corporate Office~~
~~Thursday 23 February 2012~~	~~QFARC~~	~~1.30 PM~~	~~Boardroom, Corporate Office~~
~~Thursday 23 February 2012~~	~~TATAU POUNAMU~~	~~3.30 PM~~	~~Boardroom, Corporate Office~~
Friday 9 March 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Wednesday 11 April 2012	TATAU POUNAMU	1.00 pm	Arahura Marae, Hokitika
Thursday 12 April 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 12 April 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 12 April 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Friday 20 April 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 24 May 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 24 May 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 24 May 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 24 May 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 8 June 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Wednesday 11 July 2012	TATAU POUNAMU	1.00 pm	Westport Motor Hotel, Westport
Thursday 12 July 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 12 July 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 12 July 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Friday 20 July 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 23 August 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 23 August 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 23 August 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 23 August 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 7 September 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 11 October 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 11 October 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 11 October 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 11 October 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 19 October 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth
Thursday 22 November 2012	CPHAC/DSAC	9.00 AM	Boardroom, Corporate Office
Thursday 22 November 2012	HAC	11.00 AM	Boardroom, Corporate Office
Thursday 22 November 2012	QFARC	1.30 PM	Boardroom, Corporate Office
Thursday 22 November 2012	TATAU POUNAMU	3.30 PM	Boardroom, Corporate Office
Friday 7 December 2012	BOARD	10.00 AM	St Johns Waterwalk Rd Greymouth