West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Friday 8 June 2012

ST JOHN
WATERWALK ROAD
GREYMOUTH

ALL INFORMATION CONTAINED IN THESE MEETING PAPERS IS SUBJECT TO CHANGE

KARAKIA

E Te Atua i runga rawa kia tau te rangimarie, te aroha, ki a matou i tenei wa
Manaaki mai, awhina mai, ki te mahitahi matou, i roto, i te wairua o kotahitanga, mo nga tangata e noho ana, i roto i tenei rohe o Te Tai Poutini mai i Karamea tae noa atu ki Awarua.

That which is above all else let your peace and love descend on us at this time so that we may work together in the spirit of oneness on behalf of the people of the West Coast.

WEST COAST DISTRICT HEALTH BOARD MEMBERS INTEREST REGISTER

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

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, Coordinator/Administrator Medical Training Programmes, 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 • 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 20 APRIL 2012 COMMENCING AT 10.06 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
Helen Gillespie

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
Bryan Jamieson, Communication Officer
Karyn Kelly, Director of Nursing and Midwifery
Garth Bateup, Acting General Manager Hospital Services
Gaylene Mahauariki, Minute Secretary
Susan Fitzmaurice, Executive Assistant to Chief Executive
Kay Jenkins, Executive Assistant, Canterbury District Health Board

APOLOGIES

Dr Paul McCormack
Dr Carol Atmore, Chief Medical Officer
Stella Ward, Director of Allied Health, West Coast and Canterbury District Health Board
Mary Molloy (leaving early 12.50 pm)

1. WELCOME AND KARAKIA

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

The General Manager of Maori Health led the Karakia.

2. DISCLOSURES OF INTERESTS

- Elinor Stratford

Removed: Manager, Disability Resource Service West Coast

3. APOLOGIES

Resolution 36/12

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

Motion:
"THAT the apologies be accepted."

Carried.

4. MINUTES OF THE PREVIOUS BOARD MEETING HELD FRIDAY, 9 MARCH 2012

Resolution 37/12

Moved: Elinor Stratford **Seconded: Doug Truman**

Motion:
"THAT the Minutes of the West Coast District Health Board meeting held Friday, 9 March 2012 be adopted as a true and accurate record."

Carried.

5. 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.

6. MATTERS REFERRED TO ADVISORY COMMITTEES FOR CONSIDERATION

None.

7. ACTING BOARD CHAIR'S REPORT

The Acting Board Chair spoke to his Report and gave a brief verbal update on the Joint Chairs meeting held in Wellington on 17 April 2012.

Mr Kevin Woods, Director General of Health addressed the meeting.

An Induction was held in Corporate Office on 20 April 2012 for new Advisory Committee Members.

The Board advised that the West Coast District Health Board and the Canterbury District Health Board will give a joint presentation to the Health Select Committee on 2 May 2012 in Wellington.

Resolution 38/12

Moved: Doug Truman **Seconded: Elinor Stratford**

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 30 April 2012 be reappointed for a term expiring 31 January 2014 subject to the individual members confirming their availability.

Further

That the Chairs and Deputy Chairs of those Committees be reappointed for a term expiring 31 January 2014 subject to the individual members confirming their availability."

Carried."

Resolution 39/12

Moved: Peter Ballantyne **Seconded: Susan Wallace**

Motion:

"That the West Coast District Health Board appoints Rex Williams for a further term of one year to the 6 May 2013 as a member of the Quality, Finance, Audit and Risk Committee."

Carried.

Resolution 40/12

Moved: Doug Truman **Seconded: Susan Wallace**

Motion:

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

Carried.

8. REPORTS FROM ADVISORY COMMITTEES

9.1 Hospital Advisory Committee

The Chair tabled his Report and minutes that are attached as Appendix One to these minutes.

9.2 Community and Public Health and Disability Support Advisory Committees

The Chair tabled his Report and minutes that are attached as Appendix Two to these minutes.

9.3 Tatau Pounamu Manawhenua Advisory Group

The General Manager Maori Health tabled the Tatau Pounamu Manawhenua Advisory Group Minutes that are attached as Appendix Three to these minutes.

Resolution 41/12

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

Motion:
"THAT the West Coast District Health Board receives the West Coast District Health Board Hospital Advisory Committee Reports."

Carried.

10. BOARD AND CHAIR'S CORRESPONDENCE

Resolution 42/12

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

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

Carried.

11. CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive took his Report as read and gave an additional verbal update.

The Chief Executive responded to the recent speculation in the media in regards to the future health services on the West Coast. The Chief Executive advised a number of the headlines had been misleading and the Board have been more open and transparent than just about any other DHB about the challenges it faced.

The Chief Executive advised that the complaint received by the media from a former Grey Base Hospital Doctor, whose complaints about accidental patient deaths are being investigated by the Health and Disability Commissioner, did not have a practising certificate.

It was noted that the recent leaks to the media had been distressing to a number of specialist nurses and junior doctors who were really talented and gifted professionals.

It was noted the Board will continue to be positive and proactive with the media.

Resolution 43/12

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

Motion:
"That this Board endorses the present direction of travel of the West Coast DHB and fully supports the actions of the Chief Executive, management and clinical team."

Carried.

Resolution 44/12

Moved: Elinor Stratford **Seconded: Susan Wallace**

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

Carried.

10.1 Clinical Leaders Report

The Director of Nursing and Midwifery spoke to the Clinical Leaders' Report.

Resolution 45/12

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

Motion:
"THAT the West Coast District Health Board notes the Clinical Leaders' Report."

Carried.

11. FINANCE REPORT

The Chief Financial Officer spoke to the Finance Report and took the Report as read.

The consolidated result for the month of February 2012 is a deficit of $470k, which is $461k worse than budget ($9k deficit).

The following points were noted:

- The March figures are an improvement on Februarys.
- The forecast of $5.1M is still on track.
- The Inter District Flows (IDFs) which at the end of November were $600k has reduced by half to just under $300k.

Resolution 46/12

Moved: John Vaile **Seconded: Helen Gillespie**

Motion:
"THAT the West Coast District Health Board receive the Financial Report for February 2011."

Carried.

12. INFORMATION PAPERS

The Acting Board Chair advised a number of Advisory Committee Members terms were to expire. The Acting Board Chair advised he would leave it to the Chairs of the Advisory Committees to manage the appointment process.

13. IN COMMITTEE

Resolution 47/12

Moved: Susan Wallace **Seconded: Doug Truman**

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 9 March 2012**
- **In Committee Matters Arising from the minutes of 9 March 2012**
- **In Committee Correspondence**
- **In Committee Chief Executive's Report**
- **In Committee Contracts**
- **In Committee Grey 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.

14. NEXT MEETING

The next meeting will be held on 8 June 2012 at St John, Waterwalk Road, Greymouth.

The Board spent 1 hour and 54 minutes in In Committee.

There being no further business to discuss the meeting concluded at 2.00 pm.

_____ _____

Signed **Date**

BOARD AND CHAIR'S CORRESPONDENCE FOR JUNE 2012 BOARD MEETING

OUTWARDS AND INWARDS CORRESPONDENCE

Copies of the correspondence are contained in the information items at the back of the agenda.

Date	Sender	Addressee	Details	Response Date	Response Details
13 April 2012	Prof Des Gorman Executive Chair Health Workforce NZ	Board Chair	Health Workforce NZ Funding for 2012/13 – Postgraduate Medical Training		
18 April 2012	Peter Ballantyne Acting Chair West Coast DHB	Minister of Health Minister of Finance	Request for Equity – Deficit Support for the 2011/12 year		
26 April 2012	Lyn Provost Controller and Auditor General	Board Chair	Keeping Fraud at Bay – Sector Results		
30 April 2012	Hon Tony Ryall Minister of Health	Board Chair	Orthopaedic Services		
10 May 2012	Jackie Edmond Chief Executive Family Planning	Board Chair	Information Letter		
22 May 2012	Hon Tony Ryall Minister of Health	Board Chair	Approval of Application for Equity		
28 May 2012	Kevin Woods Director General of Health	Chief Executive cc to Board Chair	Health Targets		
29 May 2012	Hon Tony Ryall Minister of Health	Board Chair	Service Provision for Older People		

CHIEF EXECUTIVE'S UPDATE

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

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

SOURCE: **Chief Executive**

DATE: **8 June 2012**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

This report is a regular report and standing agenda item, providing the latest update and overview of key organisational activities and progress from the Chief Executive to the Board of the West Coast DHB.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

3. FINANCIAL AND OPERATIONAL PERFORMANCE OVERVIEW

The consolidated West Coast DHB financial result for the month of April 2012 was a deficit of $428k which was $50k unfavourable against the budgeted deficit of $378k. The year to date result was a deficit of $4,494k which is $731k unfavourable against the budgeted deficit of $3,763k.

The breakdown of the result for the month is as follows:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.062	-	0.062	0.341	-	0.341
Funder	0.646	0.470	0.176	7.748	6.933	0.815
DHB Provider	(1.136)	(0.848)	(0.288)	(12.583)	(10.696)	(1.887)
West Coast DHB Group Result	**(0.428)**	**(0.378)**	**(0.05)**	**(4.494)**	**(3.763)**	**(0.731)**

Planning & Funding

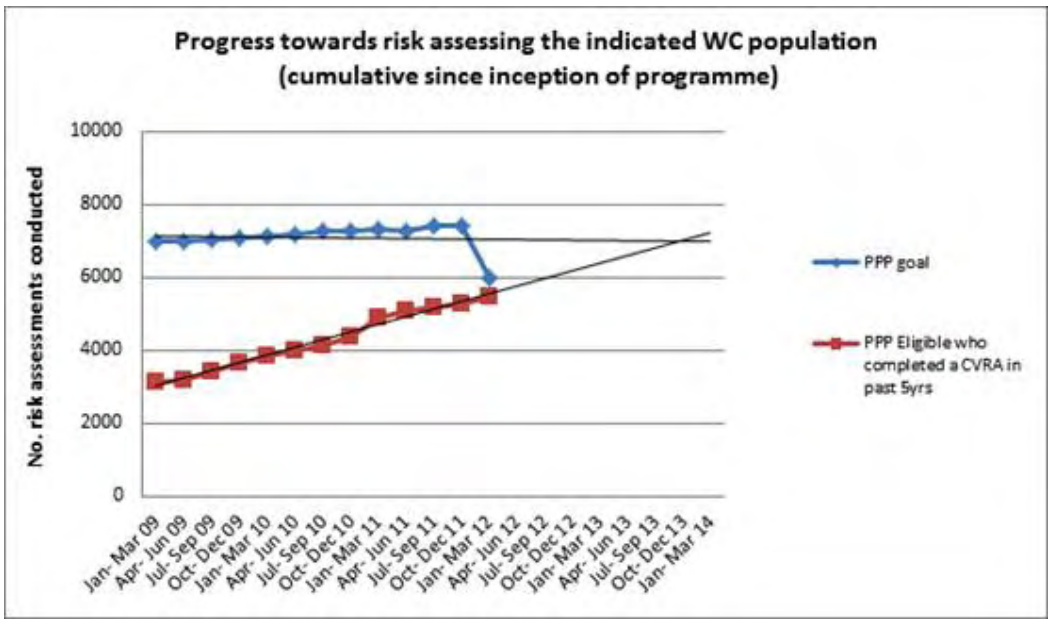
Key Achievements

- *Annual Plan and Statement of Intent*
  - The QFARC Committee reviewed the proposed final Annual Plan and Statement of Intent and approved its submission to the Ministry of Health on Friday 18 May. It is anticipated that the plan submitted will achieve all of the Government's health targets. It also commits the WCDHB to achieve the elimination of all operating deficits and to operate on a break-even from 2014/15 on. The final phase of the submission and approval process is for the Ministry of Health to make it recommendation for sign-off by the Minister of Health on 18th June. The plan will be published and distributed to the community once it has been approved by the Minister.
- *Community Laboratory / Referred Services*
  - The transfer of community referred laboratory testing from Medlab South to the DHB Hospital laboratory has been completed satisfactorily. The hospital laboratory has been

able to provide the additional testing services at only a marginal increase in its operating costs. This reduction in over capacity and duplication means a reduction in the cost of service delivery across the system as whole. Primary health services that previously used Medlab South laboratories have indicated their satisfaction with the services now being delivered by the hospital laboratory.

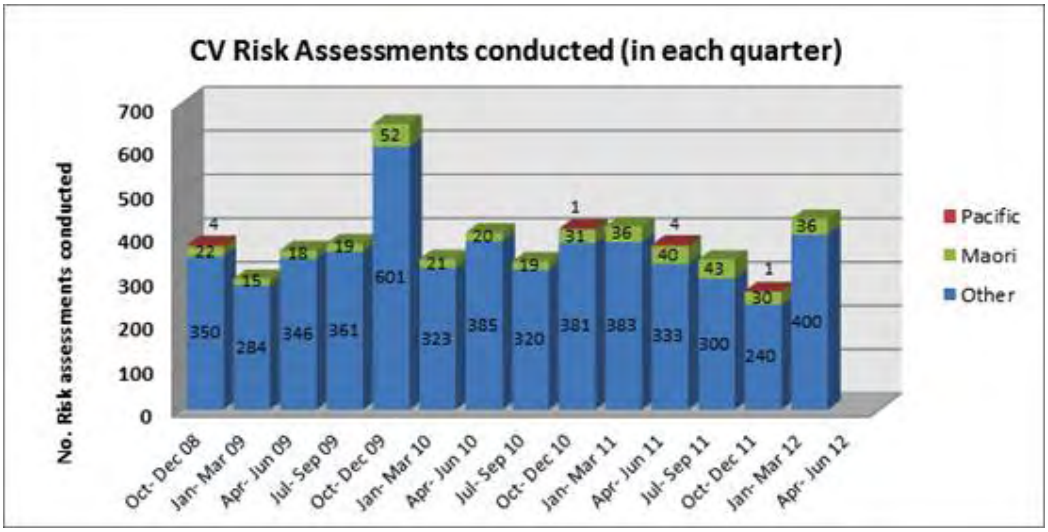
- *Expression of Interest in the Development of Integrated Health Care Facilities in Westport*
  - The Expression of Interest process for the Buller IFHC has been completed with five parties stating an interest variously in the financing, design, construction and maintenance of a new health centre planned for Westport. A formal engagement with interested parties now needs to occur to ensure that any future agreement or partnership with investors is conducive to the plan for clinically and financially sustainable service delivery to the Buller community.
- *Warm Up West Coast*
  - Warm Up West Coast is progressing on schedule with its home insulation programme. The original plan was to insulate up to 500 homes over a two year period. In the six months since the programme has started there have been 218 homes approved for insulation with 129 completed. During this reporting period there was a media release regarding the Warm Up West Coast project highlighting the health advantages of an insulated home during winter. A participant advocated for the project, in particular recommending the project for families with children that suffer from a respiratory illness such as asthma. There will be an evaluation of the outcome for those who have had their homes insulated after 12 and 24 months.
- *More Heart And Diabetes Checks: Part One: Background – Long Term Conditions Programme (LTC Programme)*
  - The West Coast DHB has in place a Long-Term Conditions Management (LTC) Strategy that overarches our strategies of leading for outcomes for improved patient self-management, clinical management and best practice principles for all long term conditions across primary and secondary services, with a primary focus on diabetes, cardiovascular disease, chronic respiratory disease and stroke; and intimately linked in with CVD risk assessment and smoking cessation programmes.
  - As at 31 March 2012, there were 2052 patients who are enrolled in the LTC programme, (out of the West Coast PHO's approximately 31,000 enrolled patients). This represents 6.6% of the enrolled population who are engaged in a structured programme of care for their long term condition(s). Maori enrolments make up 6.3% of all enrolments in the LTC programme to date. For comparison, Maori make up 5.1% of the enrolment population aged 45+ years – the prime age group of people in the Long Term Conditions programme. The number in the programme is up from 1896 at the end of December 2011; and up from 1462 as at 31 January last year.
  - Key LTC activities during the January – March 2012 Quarter:
    - Enrolments this quarter have increased across all levels of care;
    - Health Navigators continue with their support to practice teams with level 2 and 3 patients;
    - Quarterly reports to practices regarding enrolments, places available and capped numbers for levels 2 and 3;
    - Clinical Manager visited Franz Josef for the South Westland full-team meeting and Buller Health Medical Centre in February 2012;
    - input/attendance at the aged care Health of the Older Person workshop held in February 2012 as part of the Better, Sooner, More Convenient (BSMC) workstream and models of care development and implementation..
    - Health Navigators visiting relevant practices to action all referrals.

- *More Heart And Diabetes Checks: Part Two: Cardiovascular risk assessments (CVRAs)*
  - From 1 January 2012, there has been a change to the national health target for cardiovascular disease and diabetes. The revised health target, 'More heart and diabetes checks', measures the number of completed cardiovascular risk assessments for all eligible persons within the last five years (which includes a diabetes check). The national goal target is 90% of the eligible population will have had their cardiovascular risk assessed in the last five years - to be achieved in steps over three years. Our goal this year is to reach 60% by 1 July 2012 as part of that progress. It is noted that there is still a way to go, but that the West Coast PHO is working to improve this rate through its 3-tiered LTC programme and concentrating on undertaking CVRAs. Progress to date is reflected in the table below:



CVRAs Outcomes/Output during the January – March 2012 Quarter

- There has been marked increase in activity this quarter compared to last. Maori make up 8.2% of completed CVRAs this quarter. By comparison, Maori make up 7.8% of the eligible cohort for CVRA on the West Coast. (The eligible age range for Maori is male 35-74 years and for female 45-74 years.



- The smoking profile for CVRAs during the financial YTD (1.7.11 - 31.3.12) showed that of Maori screened to date 62.6% were not smoking, compared with other ethnicities screened not smoking 82%.

Key Activities

- On-going support from Clinical Manager to Practice Nurses/teams to identify eligible patients for screening;
- Practice teams received a current list identifying all eligible people who still have not had their 5 year cardiovascular risk assessed
- Networking/Education (either with Health Sector or Community), via:
  - PHO Clinical Governance Committee;
  - Quarterly progress reports to practice teams and articles of interest sent to practice nurses;
  - Practice teams.

Key Issues & Associated Remedies

Upcoming Points of Interest

- Planning is underway to provide Gateway Assessments (comprehensive health and social support assessments) for children and youth who come to the attention of Child Youth and Family Services. Dr. John Garret (Joint WC-CDHB Consultant Paediatrician) is leading this process with a view to having the services in place by July 2012.
- The provision of free after hours primary care for children under the age of six is in development with the intent of providing access to all children on the West Coast from the beginning of July2012.
- Planning is underway to reinstate the development of an integrated model of service delivery between all mental health service providers as part of Better Sooner More Convenient health care services for the West Coast.
- A Consumer Council has been recently established to ensure the views of consumers are heard, and influence the planning and design of services. Reports will be provided to the Board from this Council.
- A change management group is being established to support staff with advising and coordinating good process as we move through the stages of changing the ways we deliver care. This will include engaging with staff and their unions.

Hospital Services

Key Achievements

- *Medical Staff Recruitment*
  - Recent placements include two permanent Anaesthetists (signed contracts, one started April) and one permanent O&G Consultant (has signed).
  - Once applicants have been through the initial screening process and identified as suitable, they are being brought over for a face to face interview and visit to the area. Upcoming interviews/visits:
    - O&G Consultant – arrives week beginning 18 June 2012; Emergency Physician – arrives week beginning 4 June 2012. A General Physician is also looking likely to visit within next two months, pending referee feedback.
    - Psychiatrist – this is proving one of the more challenging vacancies to source applicants for, however in last week a suitable candidate has been identified and discussions are progressing. We will be in competition with other District Health Boards for this candidate.
  - Jo Goodhew, Associate Minister of Health, accompanied by National list MP, Chris Auchinvole visited Grey Base Hospital. The opportunity was taken to explain the concepts of the Rural Academic Practice, Rural Learning Centre; where the Minister

participated in a videoconference education programme, across six locations, and also the mobile Telehealth unit. The Minister also participated in a discussion with nurses at Grey Hospital and via the videolink with Reefton nurses.

- The official launch of the mobile Telehealth unit from Parfitt Ward and the paediatric library at Christchurch Hospital was held on Thursday, 3 May 2012. With the Grey District Mayor, Board members and staff present this was an opportunity for the DHB to express its appreciation to everyone involved in bringing this state-of-the-art technology to the West Coast. The main contribution was the funding by the Countdown Kids Hospital Appeal but a number of others had key roles:
  - Countdown Kids Hospital Appeal
  - Countdown Greymouth
  - Countdown Westport
  - Polycom
  - Vivid Solutions
  - Asnet Technologies
  - Gen-i
  - Aruba networks
  - West Coast DHB / Canterbury DHB Telehealth Initiative led by Assoc. Prof. Michael Sullivan
  - Medical and nursing staff of West Coast DHB and Canterbury DHB paediatric and maternity departments, particularly Dr John Garrett, CNM Dot O'Connor and Maternity Co-ordinator Jude Bruce
  - West Coast DHB IT Department

Key Issues & Associated Remedies

- Due to less capacity for First Specialist Appointments (FSA's) particularly in Orthopaedics, as we transition to the new service patients in Orthopaedics were getting close to the maximum wait times. This has been resolved by engaging the Canterbury DHB Orthopaedic GP Liaison who has reviewed all outstanding referrals and patients have either been booked, seen or a plan for management by GP's is to occur. This will ensure WCDHB is ESPI compliance as at 30 June.
- Processes are being put in place so that clinical teams have the relevant information to enable them to plan and manage patient flow to meet elective targets, ESPI compliance, health targets and WCDHB volumes. A position description has been developed encompassing these responsibilities into the Clinical Leaders role for each speciality. The clinical teams are also being involved in production planning for the first time. This approach is now appropriate as permanent staff replace locums within each speciality.

Upcoming Points of Interest

- Xcelr8 Cohort 3 commenced in May.
- An SMO "Engagement Day" is scheduled for late June. The day for SMO's will also include key CDHB staff that link with WCDHB services.

Community & Mental Health Services

Key Achievements

- The Dementia Education programme 'Walking in Another's Shoes' for residential care facility staff has commenced.
- The Carelink team is moving to a case management model with assessors attached to each primary practice and drawing their caseload from that practice. This will provide better linkages between assessors, clients and their primary practice.
- An experienced practice manager is now working with 2 DHB owned practices and expects that improvement in systems and financial performance will quickly be achieved.
- The annual Mental Health Consumer Satisfaction Survey is currently underway.

- Buller is progressing well with the continuing implementation of the Buller Health Services Plan with staff engaged and participating well in a number of projects designed to maximise an efficient pathway through care for patients now and when the new facility is built.

Key Issues & Associated Remedies

- There are a number of GP vacancies across the Coast at present with resignations recently received from Reefton and South Westland. The recruitment team from Christchurch is working hard to employ effective strategies to find GPs from overseas. We are working with Pegasus Health and Rural Canterbury PHO to develop a common strategy to source and employ locum GPs across both regions.

Upcoming Points of Interest

- The new software management programme for Home Based Support services- Caduceus- is close to being implemented and will provide significant improvement in the efficiency of this service

4. INFORMATION TECHNOLOGY

Telehealth

- The proof of concept mobile clinical cart wireless network is enabled in the Paediatric Ward. CDHB has confirmed commitment to the same vendor, which WCDHB has now also committed. Rollout to the remaining areas in this business case has commenced with the remaining equipment delivered and cabling being completed to Maternity, with ED and Outpatients to be completed.
- St Johns has been contacted with setting up a wireless link to them to enable the new Telehealth unit to be installed there. Visual sighting has confirmed line of sight.

Server Infrastructure Upgrade

- WCDHB is upgrading the Citrix and Desktop platform in use to a more modern and better supported environment. This will be the same version CDHB uses within their environment. A business case has been presented to the Capex Committee and approved for this work to be carried out.

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. The Project Manger used by WCDHB to project manage the Concerto project is also being used for this project as the two pieces of work are closely related.

Clinical Information System Business Case

- The business case for the new clinical information system hosted by CDHB and using Orion's Concerto product has been approved. This clinical information system will enable a single patient portal to clinical information housed within WCDHB, SCDHB, CDHB and ultimately all South Island DHB's.
- The implementation planning study was completed and signed off prior to Christmas. Contractual negotiations have been completed with the contract being signed on the 24th February. Significant work is being carried out by CDHB, WCDHB and Orion to delivery this project as quickly as possible.

- Detailed planning sessions between CDHB, WCDHB and Orion have provided a committed go live of 20/10/2012. This date will be raised with the project Steering group for approval before publishing.

Clinical Information System Business Case - Mental Health Component

- 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 sought from the South Island DHB's, this will also provide a commitment regionally to the solution. A proposal for this has been approved by the South Island IT Alliance and Mental Health Alliance, with the South Island CEO's approving PBF based funding.
- The Mental Health contract addendum has been signed on 30th April 2012, and three workshops have been scheduled for June for the detailed planning.

Patient Portal Roll Out

- The Manage My Health patient portal business case has been approved. This will allow patients to access their primary care electronic medical record from an internet connection anywhere in the world. The system also has the capability to self book into a general practice, and email a doctor directly should these features be enabled. A project team has been assembled with 3 initial project meetings occurring. Discussions are occurring to determine the most suitable practice to implement as a pilot.

Home Based Care System

- The business case to implement the Caduceus home based care system has been approved. Contract negotiations are underway and have been completed. Discussion on how the project will be resourced is occurring between CDHB and WCDHB with a collaborative model being selected as the way to implement this solution.

Provation

- The Clinical Quality Improvement Team identified the lack of an endoscopy reporting system as an important quality issue. A business case is being prepared for the implementation of the system, hosted by CDHB for WCDHB. Regionally, all DHBs are in various stages of implementing a Provation solution.

e-Board Papers

- Plans are underway to deliver Board papers electronically to iPads.

5. HUMAN RESOURCES

Employee Relations

- Initiation of bargaining received from APEX for the IT workers. Negotiations are continuing with the EPMU for Support Services. HR support for the current number of change management projects is being resourced and will be based on the Coast.

Health, Safety and Employee Wellness

- The Safe Handling programme has been discussed at EMT and HOD meetings and will be implemented. An identified programme team on the West Coast will facilitate this programme. Preparation is underway for the ACC Workplace Safety Management Programme (WSMP) audit in June. Education and information sessions on bullying and harassment in the workplace are being arranged for September and will be available for all staff.

Employee Engagement Survey

- A facilitated session will be undertaken in the next month with EMT to finalise the WCDHB wide priorities as a result of the survey, working parties will then be formed to address the key issues.

Recruitment/Retention

- Recruitment activity remains constant with a number of offers for key roles including Psychiatry, O&G, and Emergency SMOs confirmed. We do have some concerns at the increase in recent GP resignations that have created additional GP vacancies. An integrated and targeted campaign is now underway to address the retention of this workforce as well as future attraction of GP's. The look and feel of the new careers website has now been completed and we are working with local specialists to populate the content. Integration of the recruitment technology with CDHB is currently a high priority and will remain so for the next 6-8 weeks.

6. MAORI HEALTH

Consultation with the Maori community in the Buller in relation to Maori health within the Integrated Family Health System occurred over two hui in April and May. The Maori Health Manager worked in collaboration with Canterbury DHB with Lisa Tumahai, Service and Portfolio Manager Maori and Pacific Health and Michael O'Dea, Primary Care Planning and Funding using the Appreciative Inquiry method for community engagement.

The Maori community in the Buller is now fully invested in assisting in shaping the future direction of health services for Maori in the Buller. Some key themes to emerge from these hui are as follows:

- Need to build local capacity and capability
- Need to develop clinical capability for long term conditions
- Non clinical roles required to navigate health system
- Working as part of the Buller health team
- Local Maori commnuity input was seen as being important in terms of future developments

The second draft version of the Maori Health Plan has been finished and has been sent to the Ministry and also to a number of people for their feedback. In addition several meetings are planned regarding working with other services to deliver on the Plan's objectives.

7. COMMUNITY & PUBLIC HEALTH

Smokefree

Smokefree May aims to encourage people to remain or become Smokefree. Thursday 31 May was World Smokefree Day and this year's theme is Quit Now – It's about Whanau.

The New Zealand Government has committed to a Smokefree Aotearoa by 2025. This means that by 2025 less than 5% of people will smoke, compared with the estimated 21% of NZers aged 15+ years who smoked in 2008.

West Coast initiatives for Smokefree May & World Smokefree Day are:

- A Smokefree display with the theme of 'Quit Now – it's about whanau' has been spending time at various locations on the West Coast including the Community Mental Health Unit at Greymouth Hospital, the Solid Energy Recreation Centre in Westport, Hokitika New

World, reception at Greymouth Hospital and the National Bank in Greymouth. On the 30th and 31st of May, the Smokefree display will be at The Warehouse in Greymouth. Members of the West Coast Tobacco Free Coalition will be on hand to talk with people about smoking, quitting and Smokefree issues. Feedback on the display from members of the public has been very positive so far with increased awareness of cessation options. Several people have also accessed cessation services to support them to become Smokefree.

- Community & Public Health and the West Coast Tobacco Free Coalition have made submissions to the Long Term Plans of the three West Coast District Councils on Smokefree issues.

Sexual Health

A poster presentation about Community and Public Health's "Good Memories, No Regrets" campaign promoting safe sex and safe drinking has been accepted for presentation at the Public Health Association of Aotearoa/New Zealand's national conference in September.

Work by Community and Public Health's health promoters prior to this year's Grey High School ball raising awareness about alcohol and sex, including radio interviews and messages in the school magazine has contributed to a good outcome. For the first time ever, local Sexual Health and Family Planning Clinics did not have to provide the emergency contraceptive pill (ECP) to anyone on the Monday after the school ball. Local pharmacists also did not see the usual post-ball peak in requests for ECP. While this may be due to a number of factors, it is still a very positive outcome in terms of youth sexual health.

Submissions to local councils on long-term plans and waste assessments

As indicated in our last report, Community and Public Health has been working on submissions on all four West Coast Councils' Long Term Plans. Our submissions highlight the important role that local authorities have in influencing the wider determinants of health, such as the provision of infrastructure for water supply and sewage disposal, supportive environments for physical activity and recreation (including Smoke free public places), local alcohol policies and community emergency preparedness, amongst others. These submissions have now been made and staff members are preparing to speak in support of these at the LTP hearings. These submissions are available to Board members who wish to read them.

The Medical Officer of Health has provided feedback on the draft waste assessments conducted by the Buller and Grey District Councils (as required by the Waste Minimisation Act 2008). Westland District Council's draft waste assessment has now been received and feedback will be provided next month.

Pertussis (Whooping Cough)

The West Coast community-wide outbreak of pertussis continues. While case numbers had been declining over the last few months, there has been a recent increase in incidence. Since the beginning of May 2012 there have been 22 notifications, of which 12 are confirmed or probable cases, and 10 are still under investigation. Sixteen of these notifications have been from the Buller District, with the majority being from Reefton. Community and Public Health continues to follow up these cases with the help of the WCDHB's public health nurses and rural nurse specialists. We also promote the WCDHB's targeted booster vaccination programme and on time vaccination against pertussis for infants.

South Island District Health Boards' Alcohol Position Statement

The South Island District Health Boards' Public Health work stream has developed a draft alcohol position statement (and a background paper providing more detail of the evidence for the policy positions advocated in the position statement). The aim of project is to have South Island DHBs adopt a common, consistent position on alcohol and alcohol-related harm which is evidence-based. This is particularly important in the light of the Alcohol Reform Bill which is shortly to be considered again by Parliament.

This draft position statement was presented to this month's CPHAC/DSAC by Community and Public Health for endorsement and recommendation to the Board.

8. COMMUNICATIONS

Key Achievements

- A perspective/opinion piece was published in local media on changes in the West Coast Health System.
- A comprehensive media response discussing the services and the way forward for West Coast orthopaedic services was prepared and distributed.
- Material and plans are being developed to enable wider communication of the Model of Care that is being developed as an integral part of the changes to the heath system in Greymouth.
- Proactive media releases were issued on the Warm-up West Coast home insulation scheme; two stories along with photos were prepared for launch of telehealth unit and a media release to celebrate International Nurses' Day and this year's theme "Closing the Gap: from evidence to action" was issued. A media release was also issued to coincide with World Smokefree day, highlighting the fact that daily smoking rates have dropped dramatically among Year 10 students.
- The mobile telehealth technology purchased with funding from Countdown Kids was launched with a ceremony on Thursday 3 May. Acting Chair Peter Ballantyne, Countdown Kids Chair Ruth Krippner and liaison paediatrician Dr John Garrett joined the ceremony via video conference. A media release was prepared on the launch and received coverage in key papers.
- The launch included a demonstration of the technology and some case studies of how this technology has already made a difference were presented. Acknowledgement of everyone involved in bringing this project to fruition was made.
- The West Coast Clinical Board was launched and had its inaugural meeting on May 8 2012.
- Chief Executive David Meates presented a forum to DHB staff covering a number of the points that were made in the presentation to the Parliamentary Select Committee on Health.

Key issues and associated remedies

- There was some debate in the media regarding the public - private funding anticipated for the Buller Integrated Family Health Centre facility. Ongoing open discussion about this will serve to increase public awareness and understanding.

Upcoming points of interest

- Work on updating the West Coast DHB website and intranet continues. We are exploring ways of collaborating with the CDHB as they are also revamping their website and intranet.
- The winter edition of the Report to the Community is currently being prepared and will be published on 13 June.

Report prepared by: David Meates, Chief Executive

CLINICAL LEADERS UPDATE

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

SOURCE: **Clinical Leaders**

DATE: **8 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board as a regular update.

2. RECOMMENDATION

That the Board:
i. notes the Clinical Leaders Update

3. SUMMARY

Ongoing work to develop the model of care for sustainable health services for the West Coast continues. This is feeding in to the draft indicative business case for Grey Hospital redesign and a Grey Integrated Family Health Service.

Leadership in quality and clinical governance continues, including the West Coast Health System Clinical Board, the West Coast PHO, the BSMC Alliance Leadership Team, the hospital Continuous Quality Improvement Team, and the South Island Regional Training Hub

Medical
Ongoing efforts continue to recruit general practitioners and senior hospital doctors, in collaboration with the Canterbury DHB Recruitment team. Permanent appointments within the hospital show the fruit of this work.

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

Ongoing meetings with health professionals about the future model of care for West Coast health services continue, both locally and with Canterbury health professionals.

The document attached as Appendix 1 'Creating a sustainable health care service' outlines the key aspects of the proposed model of care.

Nursing & Midwifery
Greymouth hosted the 34th NZNO National Enrolled Nurse Section Annual Conference and AGM on 23 - 25 May 2012.

Feedback received was very positive with heartfelt congratulations to Bernie Morgan and John Morel for organising a high quality event. Presentation content included clinical topics such as strokes, blast

burns and diabetes, all delivered by local clinicians. Strategic enrolled nursing issues were presented and discussed including potential future roles for enrolled nurses in the developing model of care on the West Coast, with best utilisation of their new scope of practice. A total of 37 West Coast enrolled nurses have transitioned and will not only be more versatile within the system but will also contribute to the future development of this valuable group within the nursing workforce, growing the new generation of nurses completing the Diploma of Enrolled Nursing.

A review of the prioritisation strategy and approval process for nursing and midwifery education spending will commence over the next month. Education planning is tied to individual, clinical area, service and then organisational requirements. We need to ensure that appropriate education spend occurs to get the best value from the budget available. The project will be West Coast wide and be linked to the overarching education plan and workforce plan. A firm and transparent process will be put in place to support decision making for nurses, midwives, line managers and service managers when considering and approving training options.

Allied Health, Technical and Scientific

We had several staff attend the national Allied Health Technical and Scientific Conference in Christchurch where the key themes of resilience; transition; transformation and innovation were of great interest. Key note speakers shared thinking about the Telehealth service working between Canterbury and the West Coast as well as workforce innovation and how clinical information systems can support new models of care.

Social Work services continue to have had significant vacancies and external support has been provided by Canterbury. There is a short term contract in place for leadership locally and a new recruitment plan in development. There are also vacancies in Physiotherapy but we have had a high level of interest in the roles which is a new result for the discipline.

The Allied Health model of care document is referenced as part of the three workstreams looking at new care delivery across the Coast – Buller; Grey and Health of Older People. There have been first level discussions with the hospital and community pharmacists on how they can work differently to support these new models of care.
Work continues on the collaboration with Canterbury – particularly in the area of Telehealth with the concept of RUSFUS being explored for allied health. Work continues on the Allied Health leadership framework implementation.

There are several staff members from technical and scientific professions on the current xcerl8 programme.

4. APPENDICES

Appendix 1:	Creating a Sustainable Health Care Service
Report prepared by:	Carol Atmore, Chief Medical Officer Karyn Kelly, Director of Nursing & Midwifery Stella Ward, Executive Director, Allied Health

THE WEST COAST HEALTH SYSTEM

– supporting you to be well

Creating a Sustainable Health Care Service

Healthy West Coast
Te Hauora o Tatou – The Health of Us All

West Coast Primary Health

Community & Public Health West Coast
a division of Canterbury District Health Board

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

WHY DO WE NEED TO CHANGE?

For many years we have signalled that health services on the West Coast face serious challenges. Over the past 12 months we have consulted with our community, staff, health practitioners and allied services about a range of initiatives and changes that once implemented or approved will improve access to health services. We are now developing a proposal to change how we provide health services on the Coast.

At the heart of the proposed changes is a commitment from the West Coast District Health Board, the West Coast Primary Health Organisation and other health professionals, practitioners and organisations to ensure people living on the Coast have access to the kind of services that will enable them to be able to stay well in their own community. Delivering the right services is the most important decision we have ahead of us to ensure we provide sustainable healthcare on the Coast.

Already important steps have been taken towards achieving a more sustainable future for health services on the West Coast. These include improving clinical information systems, preparing to build a new integrated health facility at Buller, and setting in place new cooperative arrangements between specialist services in Greymouth and Christchurch. Clinician and community input into these initiatives have been very valuable.

Underpinning the changes in service delivery is our vision called ‘the future model of care’. It sets out an approach for how services can be delivered on the Coast in a financially viable and clinically sustainable way. A model of care gives direction to what, where and by whom services will be delivered.

Under the proposed future model of care people will have access to a wide range of services on the Coast, as long as the service provided is clinically and financially viable. Services will cover the range of preventative, planned, urgent and emergency care, delivered across community and hospital settings. Our vision is to provide a people centred, integrated single health system that is viable in the long term.

WHAT ARE THE KEY CHANGES PROPOSED?

Healthy Environment & Lifestyles

Working together to support:

- The reorientation of health services to ensure emphasis on prevention and health promotion.
- The creation of health-promoting environments, such as through advocating for bicycle paths, ensuring there are smoke free workplaces and clean drinking water, and following up on communicable diseases
- The development of healthy public policy, for example writing submissions to local, regional and central government plans about health issues
- Community action by working alongside citizens on issues such as town development strategies
- The development of personal skills, such as through the provision of cooking/life skills class

Health Care Home

- Integrated Family Health Care Service
- Teams of nurses and doctors, with pharmacists and other community based health professionals
- New ways of working with wider team
- Email and telephone consults as well as face-to-face
- Links with ambulance, ED, hospital
- Reduced waiting times.

Single Point of Entry for Complex Care

- All complex care is managed together
- Multidisciplinary team to do assessment
- Better outcomes for people and whanau
- Referral and assessment from any setting, including hospital, the community and home.

Transalpine Health Service

- Local and visiting hospital level services for the Coast
- Most services on the Coast, some services off Coast
- Strong links with Canterbury DHB clinical and organisational staff
- Support for Coast based staff in sustainable teams.

Integrated Information Systems

- Services and staff working closer together
- Timely sharing of accurate information among members of the health care team
- People have control over who has access to their health information
- People are not repeatedly asked for the same information.

Transport

- Better transport options for health care:
- Within the Coast, supporting local solutions.

Health Professionals

- Strong core with generalist skills supported by specialists
- Stronger linkages within the health system on the West Coast
- Stronger linkages with Canterbury
- Training our future workforce locally.

Settings

- Grey Hospital
  - Flexible care within ward and other places
  - Bringing acute care into one hub within the hospital
  - Improved seismic performance
  - Reliable infrastructure
- Integrated family health service location
  - opportunity to bring primary and community care, and hospital care together to improve the patient journey.

The future model of care is about change; some services may be provided differently by different people, and some new services may be introduced. Our goal is to ensure our precious health funding is used in the best possible way to provide wide-ranging services. We want to enable people to stay well, and to seek health care expertise in their own environment as much as possible. The future model of care takes into account what workforce will be needed to deliver services and what settings these services will be delivered in.

Alongside the proposed model of care sits the opportunity to re-develop Grey Base Hospital. After consultation with the community, staff and other health professionals, we are preparing a business case to obtain funding from the government to re-develop the core of Grey Base Hospital, and determine the location and facility options for a Greymouth based Integrated Family Health Service (IFHS). This 'indicative business case' will be sent to the National Health Board's Capital Investment Committee in July seeking approval to develop a 'detailed business case'. If they agree, this 'detailed business case' will be prepared in the second half of this year. If that gets the green light early next year, we will be able to refurbish and rebuild parts of Grey Base facilities.

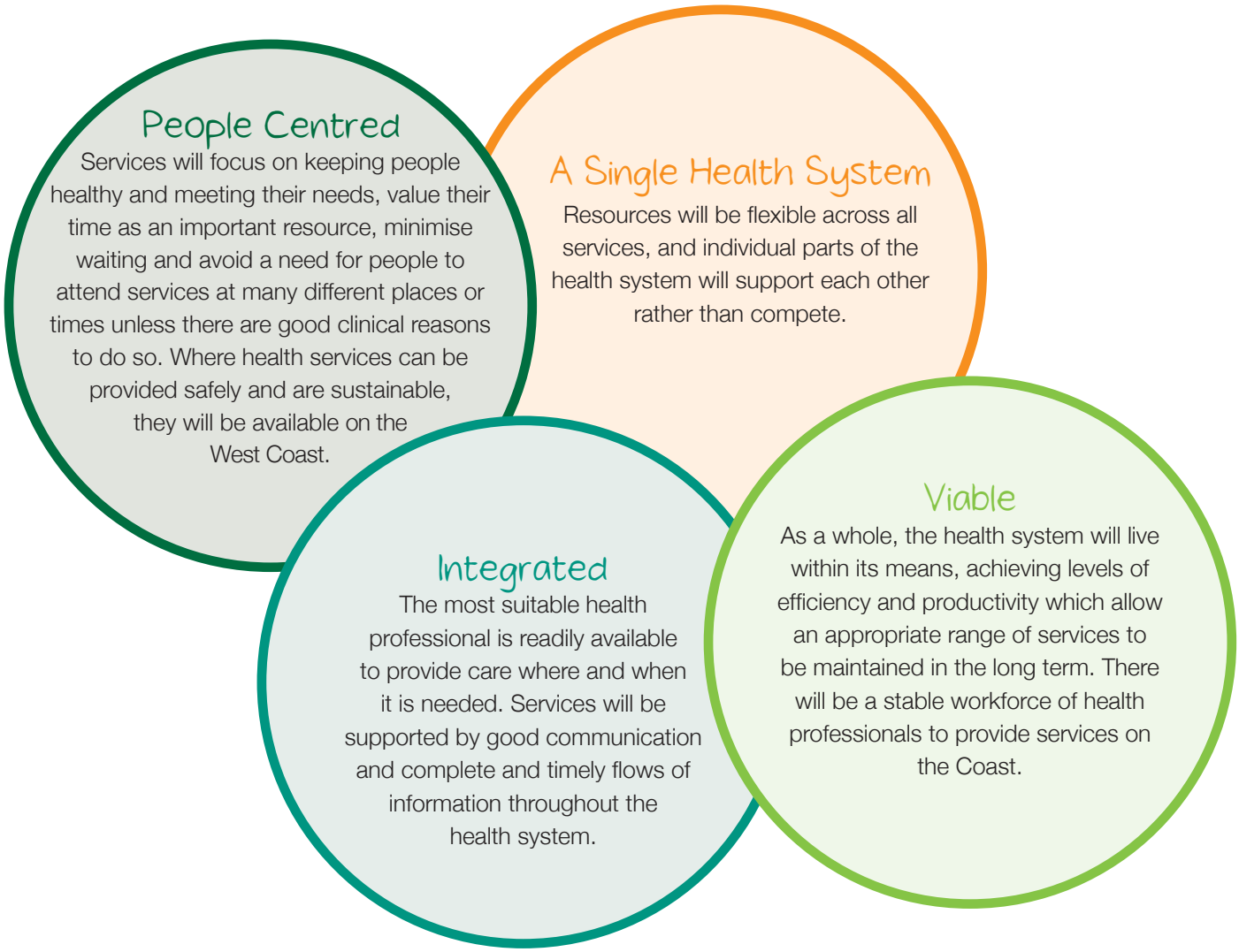
It is important to note that even if the proposed Grey Base Hospital redevelopment does not receive government funding, many of the changes proposed under the model of care will still take place.

Our overall goal is to support Coasters to be well.

WHAT ARE THE SERIOUS CHALLENGES FACING OUR HEALTH SERVICES?

- Achieving clinical sustainability. Services are not always provided in the most appropriate community or hospital setting, services can be isolated and inflexible.
- Creating a sustainable workforce. Recruitment and retention has been difficult, leading to high use of locums and temporary staff which makes it difficult to maintain continuity and consistency of care. It is also very expensive and not a good use of our limited health dollar.
- Joining up fragmented systems. Service configurations are inefficient, there is poor integration between primary (general practice) and secondary care (hospital).
- Developing fit for purpose facilities. Hospital facilities in their current configuration limit improvements to care, are expensive to maintain, and not compliant with modern seismic standards. Some primary and community care facilities are not adequately sized or located for the services provided from them.
- Achieving financial sustainability. Even allowing for our geographic spread and high health need, the West Coast DHB uses more than its fair share of available health funding compared to other communities in New Zealand.

UNDER THE PROPOSED MODEL OF CARE FUTURE HEALTH SERVICES ON THE WEST COAST WILL BE:



BACKGROUND INFORMATION

Over the past 12 months the community at various public meetings across the Coast was asked:

The information from these meetings has guided the thinking in developing the proposed future model of care.

To access the community presentations and videos from key West Coast health professionals please visit http://www.westcoastdhb.org.nz

FINANCE REPORT

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

SOURCE: **Chief Financial Manager**

DATE: **8 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE 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.

2. RECOMMENDATION

That the Board:

i. notes the financial results for the period ended 30 April 2012.

3. DISCUSSION

Financial Overview for the period ending 30 April 2012

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,257	6,321	(64)	×	63,147	62,456	691	√
Governance & Administration	231	212	19	√	2,143	2,122	21	√
Funds & Internal Eliminations	4,314	4,284	30	√	44,076	44,534	(458)	×
	10,802	10,817	(15)	×	109,366	109,112	254	√
EXPENSES								
Provider								
Personnel	4,582	4,294	(288)	×	43,960	43,540	(420)	×
Outsourced Services	885	805	(80)	×	10,632	8,910	(1,722)	×
Clinical Supplies	627	600	(27)	×	6,552	6,034	(518)	×
Infrastructure	889	921	32	√	9,529	9,157	(372)	×
	6,983	6,620	(363)	×	70,673	67,641	(3,032)	×
Governance & Administration	169	212	43	√	1,802	2,123	321	√
Funds & Internal Eliminations	3,668	3,812	144	√	36,328	37,602	1,274	√
Total Operating Expenditure	10,820	10,645	(175)	√	108,803	107,365	(1,438)	×
Deficit before Interest, Depn & Cap Charge	18	(172)	(190)	×	(563)	(1,747)	(1,184)	×
Interest, Depreciation & Capital Charge	410	551	141	√	5,057	5,510	453	√
Net deficit	**428**	**378**	**(50)**	×	**4,494**	**3,763**	**(731)**	×

Consolidated Result

The consolidated result for the month of April 2012 is deficit of $428k, which is $50k unfavourable against the budgeted deficit of $378k.

Results for Each Arm

Year to Date to April 2012

West Coast District Health Board Arm	Actual	Budget	Variance	Comment
	$000	$000	$000	
Provider Arm surplus / (deficit)	(12,583)	(10,696)	(1,887)	Unfavourable
Funder Arm surplus / (deficit)	7,748	6,933	815	Favourable
Governance Arm surplus / (deficit)	341	0	341	Favourable
Consolidated result surplus / (deficit)	**(4,494)**	**(3,763)**	**731**	**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		
Consolidated	Crown and other government sourced	√	86
Provider:	Patient sourced	√	44
Consolidated	Other Income	√	124
	Expenses		
Provider:	Personnel Costs	x	(420)
Provider:	Outsourced services – Locum costs	x	(1,566)
Provider:	Outsourced services – clinical services	x	(457)
Consolidated	Outsourced services – non clinical	√	561
Provider:	Clinical supplies: pharmaceuticals	x	(128)
Provider:	Clinical supplies: Implants & Prostheses	x	(300)
Provider:	Clinical supplies: Disposable, diagnostic and equipment	x	(169)
Provider:	Clinical supplies: other offsetting items	√	79
Provider:	Facilities: Repairs and maintenance	x	(103)
Provider:	Professional fees and expenses : Insurance	x	(89)
Provider:	Transport	x	(117)
Funder:	Expenditure to external providers /NGOs	√	1,270
Provider:	Capital charge credit (2011 financial year) and expense	√	410
DHB	Other offsetting items	√	44
	Year to date variance to budget	x	**(731)**

Revenue

Consolidated revenue of $109,366k is $254k favourable against a budgeted $109,112k. Material variances to budget are explained in the narrative for the separate arms below.

Provider Arm

Provider Arm revenue year to date is a positive variance of $691k. This is explained by:

- Internal revenue – Funder Arm to Provider Arm is $365k favourable against 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, pharmaceutical and laboratory claims.

- Revenue received from ACC is $155k favourable against budget (age related rehabilitation, treatment and assessment and elective contract work) and funding from the West Coast Primary Health Organisation to the West Coast District Health Board primary practices is $86k favourable against budget to date.

Expenses

Consolidated

Consolidated expenditure of $113,860k is $985k more than budget ($112,875k).

Provider Arm

Personnel costs are $43,960k; $420k worse than budget ($43,540k).

- Medical Personnel costs are $113k better than budget. This is a combination of Senior Medical Officers (including General Practitioners) being $388k better than budget and Resident Medical Officers being $229k 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.
  - Resident Medical Officers (RMOs) are $229k more than budget. This is partially due to unbudgeted allowances for extra duties across RMO services and greater FTE than was budgeted. This will continue for the remainder of the year.

- Nursing Personnel costs are $899k more than budget.
  - This variance includes a one off restructuring cost incurred in October 2011. Overtime and penal time are over budget and this partly due to the way the budget was set and phasing.

- Allied Health Personnel costs are $465k better than budget.
  - This is due to a number of vacancies across the service. Recent appointments have been made, which will result in improved service delivery but the favourable financial variance will not continue to the same extent in over the remainder of the year.

Outsourced Services

Outsourced services costs are $10,632k; $1,722kk more than budget ($8,910k).

- Outsourced Medical Costs (included in locums) are $6,939k, $1,566k more than budget. The West Coast District Health Board is undergoing a significant change from the heavy reliance on locums to a much more sustainable long term service configuration. This is based on a new emerging service framework being developed with Canterbury District Health Board. Given the long established reliance on the use of locums on the West Coast, changes to their use have been complex to untangle i.e. long term contractual commitments, and have delayed the necessary changes which has resulted in locums being used to cover for vacancies and staff leaves. Recent permanent appointments will alleviate the situation going forward.

- Outsourced clinical services are $3,247, $457k more than budget.
  - This is largely due to ophthalmology services and orthopaedic volumes being outsourced. This is being addressed, with a reduction in the level of overspending over the last few months. Ophthalmology costs were slightly over budget for the month of April 2012 and outsourced orthopaedic costs were less than budget.

Clinical Supplies

Overall treatment related costs are $518k more than budget, with volumes to date for most specialities being greater than budget.

- Implant and prostheses are $785k, an unfavourable variance of $300k. 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.

- Pharmaceuticals are $1,617k, an unfavourable variance of $128k which largely relates to oncology treatments and staff vaccinations for pertussis.

Infrastructure and non Clinical Cost

Overall infrastructure and non clinical cost are $9,529k, $372k over budget. Within this variance are the following specific variances:

- Facility costs are $2,178k, $207k over budget.

    - Utility costs are $45k more than budget; these costs will continue to be over budget as prices have increased since the budget was set. Maintenance and repairs are $103k more than budget and due to necessary maintenance.

    - Travel and Transport costs are $875k, $117k over budget. This relates to staff travel and accommodation costs being over budget and increased costs to run and maintaining the motor vehicle fleet.

    - Professional fees and expenses are $136k more than budget to date. The cost of insurance premiums (excluding motor vehicle) is $89k 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 $410k better than budget. A credit of $259k relating to the previous financial year was received in December 2011 and monthly cost is less than budget.

Funder Arm external payments

The West Coast District Health Board's result for services funded with external providers for the month of April 2012 was $146k better than budget and year to date payments are $1,274 (3%) better than budget.

- **Referred Services**
  Community pharmaceuticals are $354k less than budget (actual cost to date has not followed the way the budget has been phased) and laboratory services are $80k less than budget – payments for blood products to private hospitals and tests via Medlab.

- **Secondary Care Services**
  Secondary Care services are $361k less than budget, with travel and accommodation paid under the National Travel Assistance (NTA) scheme being $210k 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.

- **Older Persons Health**
  Overall expenditure (residential and non residential) is less than budget year to date ($120k or 2% less). 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 (as seen in some of the variances to budget) 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 30 April 2012 the Board had $4m in cash and short term investments.

- **Non Current Assets**
  Property, plant and equipment including work in progress is $4.9m 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 $3.941m lower than budget; this is due to the revaluation referred to under the non current assets and deficit support of $1m in the budget for February, but not received. The deficit support is planned to be received in May 2012.

4. APPENDICES

Appendix 1:	Financial Results for the period ending 30 April 2012
Appendix 2:	Funder Arm payments to external providers
Appendix 3:	Provider Arm Performance Graphs

Report prepared by: Colin Weeks, Chief Financial Manager

Report approved for release by: Hecta Williams, General Manager

West Coast District Health Board
Statement of comprehensive income
For period ending 30 April 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	10,381	10,410	(29)	(0.3%)	10,797	105,187	105,044	143	0.1%	102,272	126,247	124,287
Inter DHB Revenue	3	11	(8)	(71.7%)	6	49	106	(57)	(53.8%)	104	127	110
Patient Related Revenue	228	246	(18)	(7.3%)	210	2,526	2,482	44	1.8%	2,331	2,965	2,828
Other Revenue	190	151	39	26.2%	121	1,604	1,480	124	8.4%	1,486	1,718	1,792
Total Operating Revenue	10,802	10,817	(15)	(0.1%)	11,134	109,366	109,112	254	0.2%	106,193	131,057	129,017
Operating Expenditure												
Employee benefit costs	4,655	4,385	(270)	(6.2%)	4,417	44,855	44,447	(408)	(0.9%)	43,766	53,396	52,704
Outsourced Clinical Services	885	730	(155)	(21.3%)	1,082	10,186	8,163	(2,023)	(24.8%)	10,682	9,667	13,301
Treatment Related Costs	627	600	(27)	(4.5%)	768	6,552	6,033	(519)	(8.6%)	6,323	7,292	7,707
External Providers	2,476	2,622	146	5.6%	2,493	24,411	25,681	1,270	4.9%	23,306	30,974	28,453
Net Inter District Flows	1,302	1,302	0	0.0%	1,291	13,016	13,021	5	0.0%	13,426	15,625	15,893
Outsourced Services - non clinical	25	129	104	80.6%	73	724	1,285	561	43.7%	932	1,508	1,245
Infrastructure Costs and Non Clinical Supplies	850	878	28	3.2%	850	9,059	8,734	(325)	(3.7%)	8,718	10,479	10,514
Total Operating Expenditure	10,820	10,645	(175)	(1.6%)	10,974	108,803	107,365	(1,438)	(1.3%)	107,153	128,941	129,817
Result before Interest, Depn & Cap Charge	(18)	172	(190)	110.5%	160	563	1,747	(1,184)	67.8%	(960)	2,116	(800)
Interest, Depreciation & Capital Charge												
Interest Expense	60	61	1	2.0%	61	610	612	2	0.3%	647	735	775
Depreciation	350	400	50	12.5%	394	3,957	3,998	41	1.0%	3,891	4,801	4,578
Capital Charge Expenditure	0	90	90	100.0%	60	490	900	410	45.6%	562	1,080	690
Total Interest, Depreciation & Capital Charge	410	551	141	25.6%	515	5,057	5,510	453	8.2%	5,100	6,617	6,043
Net Surplus/(deficit)	(428)	(378)	(50)	(13.1%)	(355)	(4,494)	(3,763)	(731)	(19.4%)	(6,060)	(4,500)	(6,843)
Other comprehensive income												
Gain/(losses) on revaluation of property												(2,578)
Total comprehensive income	(428)	(378)	(50)	(13.1%)	(355)	(4,494)	(3,763)	(731)	(19.4%)	(6,060)	(4,500)	(9,421)

West Coast District Health Board
Statement of financial position
As at 30 April 2012

in thousands of New Zealand dollars

	Actual	Budget	Variance	%Variance	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	30,837	35,094	(4,257)	(12.1%)	35,348
Intangible assets	893	1,030	(137)	(13.3%)	902
Work in Progress	379	850	(471)	(55.4%)	483
Other investments	2	2	0	0.00%	2
Total non-current assets	32,111	36,976	(4,865)	(13.2%)	36,735
Current assets					
Cash and cash equivalents	3,942	3,310	632	19.1%	2,156
Other investments	56	55	1	1.8%	55
Inventories	899	746	153	20.5%	750
Debtors and other receivables	4,092	3,303	789	23.9%	3,600
Assets classified as held for sale	136	246	(110)	(44.7%)	246
Total current assets	9,125	7,660	1,465	19.1%	6,807
Total assets	**41,236**	**44,636**	**(3,400)**	6.0%	**43,542**
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	11,195	12,445	(1,250)	(10.0%)	12,695
Employee entitlements and benefits	3,221	3,259	(38)	(1.2%)	3,288
Total non-current liabilities	14,416	15,704	(1,288)	(8.2%)	15,983
Current liabilities					
Interest-bearing loans and borrowings	1,500	250	1,250	500.0%	250
Creditors and other payables	9,303	8,980	323	3.6%	9,617
Employee entitlements and benefits	7,994	7,738	256	3.3%	7,958
Total current liabilities	18,797	16,968	1,829	10.8%	17,825
Total liabilities	33,213	32,672	541	1.7%	33,808
Equity					
Crown equity	61,753	62,741	(988)	(1.6%)	54,609
Other reserves	21,310	23,888	(2,578)	(10.8%)	23,888
Retained earnings/(losses)	(75,079)	(74,704)	(375)	0.5%	(69,802)
Trust funds	39	39	0	0.00%	39
Total equity	8,023	11,964	(3,941)	(32.9%)	8,734
Total equity and liabilities	**41,236**	**44,636**	**(3,400)**	**(7.6%)**	**42,542**

West Coast District Health Board
Statement of cash flows
For period ending 30 April 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	10,369	10,957	(588)	(5.4%)	10,726	110,913	112,412	(1,499)	(1.3%)	107,308	134,640	129,181
Cash paid to employees	(4,492)	(4,385)	(107)	2.4%	(4,022)	(44,572)	(44,448)	(124)	0.3%	(42,761)	(53,394)	(52,322)
Cash paid to suppliers	(1,126)	(2,335)	1209	(51.8%)	(3,055)	(26,597)	(24,013)	(2,584)	10.8%	(26,573)	(28,747)	(32,143)
Cash paid to external providers	(2,476)	(2,623)	147	(5.6%)	(2,493)	(24,407)	(25,680)	1273	(5.0%)	(23,311)	(30,974)	(28,206)
Cash paid to other District Health Boards	(1,459)	(1,459)	0	(0.0%)	(1,436)	(14,563)	(14,591)	28	(0.2%)	(15,140)	(17,509)	(17,880)
Cash generated from operations	816	155	660	427.3%	(280)	774	3680	(2,906)	(79.0%)	(477)	4,015	(1,370)
Interest paid	(186)	(180)	(6)	3.2%	(180)	(559)	(512)	(47)	9.2%	(180)	(698)	(814)
Capital charge paid	0	0	0	0.00	(11)	(339)	(549)	210	(0)	(573)	(1,089)	(723)
Net cash flows from operating activities	630	(26)	656	(2556.2%)	(471)	(124)	2618	(2,742)	(104.7%)	(1,230)	2,228	(2,907)
Cash flows from investing activities												
Interest received	21	17	4	25.7%	15	263	168	95	56.5%	779	201	820
(Increase) / Decrease in investments	0	0	0		0	3,500	0	3500		1,587	0	(1,913)
Acquisition of property, plant and equipment	(239)	(229)	(10)	4.3%	7	(2,608)	(3,452)	844	(24.4%)	(2,710)	(4,250)	(3,148)
Acquisition of intangible assets	0	(25)	25	(100.0%)	0	(11)	(150)	139	(92.7%)	0		
Net cash flows from investing activities	(218)	(237)	19	(8.2%)	22	1,144	(3,433)	4577	(133.3%)	(344)	(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		1000	0	1000	(1,000)		1000	(68)	(68)
Cash generated from equity transactions	0	0	0		1000		1000	(1,000)			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	412	(263)	675	(256.6%)	551	1,020	186	834	449.1%	(1,574)	2,361	(254)
Cash and cash equivalents at beginning of period	3,530	3,573	(43)	(1.2%)	1605	2,922	3,125	(203)	(6.5%)	3176	3,125	3,176
Cash and cash equivalents at end of year	3,942	3,310	632	19.1%	2156	3,942	3,311	631	19.1%	1,602	5,486	2,922

West Coast District Health Board

Provider Operating Statement for period ending 30 April 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	5,197	5,205	(8)	(0.1%)	5,646	52,413	52,048	365	0.7%	51,709	62,459	63,504
Ministry of Health side contracts	142	144	(2)	(1.4%)	127	1,449	1,439	10	0.7%	1,491	1,727	1,835
Other Goverment	540	584	(44)	(7.5%)	642	5,348	5,094	254	5.0%	5,294	6,010	6,183
InterProvider Revenue (Other DHBs)	3	11	(8)	(71.7%)	6	49	106	(57)	(53.8%)	104	127	110
Patient and consumer sourced	228	246	(18)	(7.3%)	210	2,526	2,482	44	1.8%	2,331	2,965	2,828
Other income	147	131	16	11.9%	106	1,362	1,287	75	5.8%	1,227	1,488	1,461
Total income	**6,257**	**6,321**	**(64)**	(1.0%)	**6,737**	**63,147**	**62,456**	**691**	1.1%	**62,156**	**74,776**	**75,921**
Expenditure												
Employee benefit costs												
Medical Personnel	963	900	(63)	(7.0%)	957	8,878	8,991	113	1.3%	8,859	10,823	10,512
Nursing Personnel	2,094	1,912	(182)	(9.5%)	1,945	20,385	19,486	(899)	(4.6%)	19,543	23,405	23,784
Allied Health Personnel	747	775	28	3.6%	750	7,386	7,851	465	5.9%	7,326	9,426	8,768
Support Personnel	174	164	(10)	(6.1%)	166	1,809	1,662	(147)	(8.8%)	1,739	1,996	2,086
Management/Administration Personnel	604	543	(61)	(11.3%)	511	5,502	5,549	47	0.8%	5,416	6,655	6,494
	4,582	**4,294**	**(288)**	**(6.7%)**	**4,329**	**43,960**	**43,540**	**(420)**	**(1.0%)**	**42,883**	**52,304**	**51,644**
Outsourced Services												
Contracted Locum Services	543	451	(92)	(20.5%)	764	6,939	5,373	(1,566)	(29.1%)	7,607	6,283	9296
Outsourced Clinical Services	342	279	(63)	(22.6%)	318	3,247	2,790	(457)	(16.4%)	3,075	3,348	4005
Outsourced Services - non clinical	0	75	75	100.0%	45	446	747	301	40.3%	477	898	724
	885	**805**	**(80)**	**(10.0%)**	**1,127**	**10,632**	**8,910**	**(1,722)**	**(19.3%)**	**11,159**	**10,528**	**14,025**
Treatment Related Costs												
Disposables, Diagnostic & Other Clinical Supplies	138	113	(25)	(22.4%)	130	1,196	1,118	(78)	(7.0%)	1,146	1,343	1,337
Instruments & Equipment	170	146	(24)	(16.4%)	183	1,553	1,462	(91)	(6.2%)	1,553	1,754	1,896
Patient Appliances	28	31	3	9.7%	30	274	310	36	11.6%	294	370	367
Implants and Prostheses	57	49	(9)	(17.5%)	125	785	485	(300)	(61.9%)	772	583	1,007
Pharmaceuticals	158	150	(8)	(5.3%)	172	1,617	1,489	(128)	(8.6%)	1,534	1,800	1,895
Other Clinical & Client Costs	76	112	36	32.1%	128	1,127	1,170	43	3.7%	1,023	1,442	1,204
	627	**600**	**(27)**	**(4.5%)**	**768**	**6,552**	**6,034**	**(518)**	**(8.6%)**	**6,322**	**7,292**	**7,706**
Infrastructure Costs and Non Clinical Supplies												
Hotel Services, Laundry & Cleaning	321	298	(23)	(7.7%)	306	3,079	2,982	(97)	(3.2%)	3,025	3,575	3586
Facilities	197	207	10	5.0%	207	2,178	1,971	(207)	(10.5%)	2,122	2,375	2666
Transport	76	70	(6)	(8.9%)	75	875	758	(117)	(15.4%)	949	898	1036
IT Systems & Telecommunications	103	120	17	13.9%	88	1,159	1,196	37	3.1%	1,051	1,435	1321
Professional Fees & Expenses	53	22	(31)	(142.0%)	77	355	219	(136)	(62.1%)	237	263	285
Other Operating Expenses	29	95	66	69.3%	56	783	928	145	15.6%	754	1,129	935
Internal allocation to Governanance Arm	110	110	0	0.2%	82	1,100	1,103	3	0.2%	820	1,323	984
	889	**921**	**32**	**3.5%**	**891**	**9,529**	**9,157**	**(372)**	**(4.1%)**	**8,958**	**10,998**	**10,813**
Total Operating Expenditure	**6,983**	**6,620**	**(363)**	**(5.5%)**	**7,115**	**70,673**	**67,641**	**(3,032)**	**(4.5%)**	**69,322**	**81,122**	**84,188**
Deficit before Interest, Depn & Cap Charge	**(726)**	**(299)**	**427**	**(142.6%)**	**(378)**	**(7,526)**	**(5,185)**	**2,341**	**(45.1%)**	**(7,166)**	**(6,347)**	**(8,267)**
Interest, Depreciation & Capital Charge												
Interest Expense	60	61	1	2.0%	61	610	612	2	0.3%	647	735	775
Depreciation	350	400	50	12.4%	394	3,957	3,999	42	1.1%	3,888	4,797	4578
Capital Charge Expenditure	0	90	90	100.0%	60	490	900	410	45.6%	562	1,080	690
Total Interest, Depreciation & Capital Charge	**410**	**551**	**141**	**25.6%**	**515**	**5,057**	**5,511**	**454**	**8.2%**	**5,097**	**6,612**	**6,043**
Net deficit	**(1,136)**	**(850)**	**286**	**(33.6%)**	**(893)**	**(12,583)**	**(10,696)**	**1,887**	**(17.6%)**	**(12,263)**	**(12,959)**	**(14,310)**

West Coast District Health Board

Funder Operating Statement for the period ending 30 April 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)	8,233	8,345	(112)	(1.3%)	8,883	85,266	85,140	126	0.1%	83,296	97,905	101,801
PBF Vote Health-Mental Health Ring fence	1,157	1,157	0	0,00	1,120	11,570	11,570	0	0,00	11,200	13,884	13,440
MOH-funding side contracts	309	180	129	71.6%	25	1,553	1,801	(248)	(13.8%)	991	6,721	1,028
Inter District Flow's	157	157	0	0,00	145	1,570	1,570	0	0,00	1,362	1,884	1,635
Other income	20	15	5	33.3%	14	179	150	29	19.3%	179	180	216
Total income	**9,876**	**9,854**	**22**	**0.2%**	**10,187**	**100,138**	**100,231**	**(94)**	**(0.1%)**	**97,028**	**120,574**	**118,120**
Expenditure												
Personal Health	6,458	6,557	99	1.5%	6,955	64,638	64,886	248	0.4%	64,176	78,016	78,436
Mental Health	1,140	1,157	17	1.5%	1,049	11,393	11,570	177	1.5%	10,872	13,884	12,995
Disability Support	1,423	1,433	10	0.7%	1,389	14,282	14,470	188	1.3%	13,480	17,370	16,542
Public Health	56	84	28	33.5%	140	665	842	177	21.0%	856	1,011	1,009
Maori Health	55	55	0	0.2%	42	432	551	119	21.6%	419	661	503
Governance	98	98	(0)	(0.2%)	98	980	978	(2)	(0.2%)	980	1,174	1,176
Total expenses	**9,230**	**9,384**	**154**	**1.6%**	**9,673**	**92,390**	**93,297**	**907**	**1.0%**	**90,783**	**112,116**	**110,661**
Net Surplus	**646**	**470**	**176**	**37.5%**	**514**	**7,748**	**6,933**	**815**	**11.7%**	**6,245**	**8,458**	**7,459**

West Coast District Health Board
Governance Operating Statement for the period ending 30 April 2012

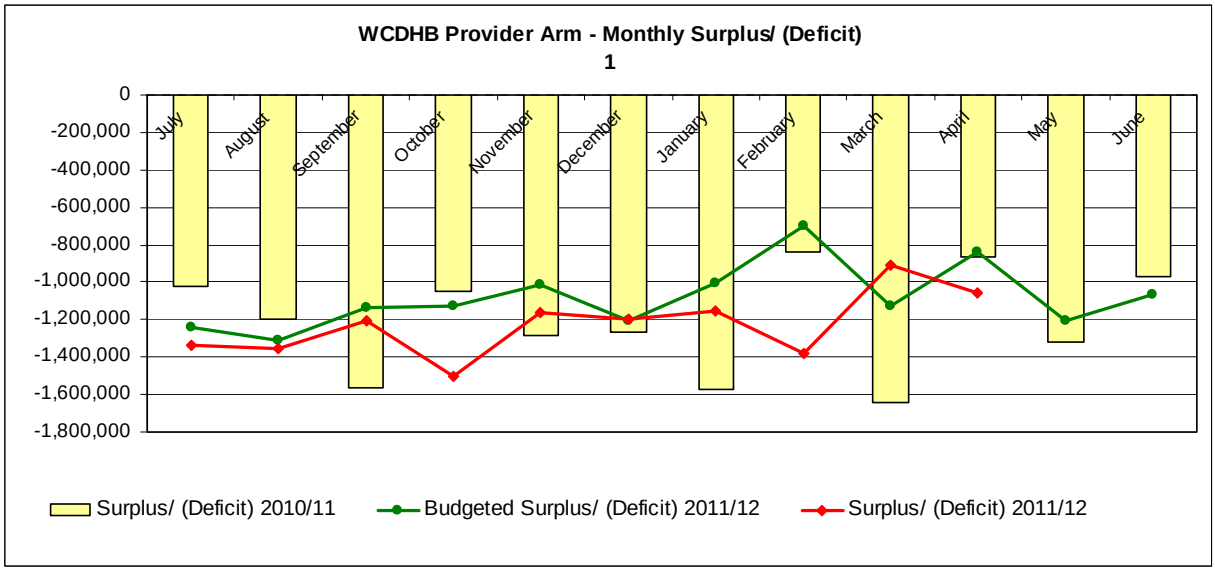
in thousands of New Zealand dollars

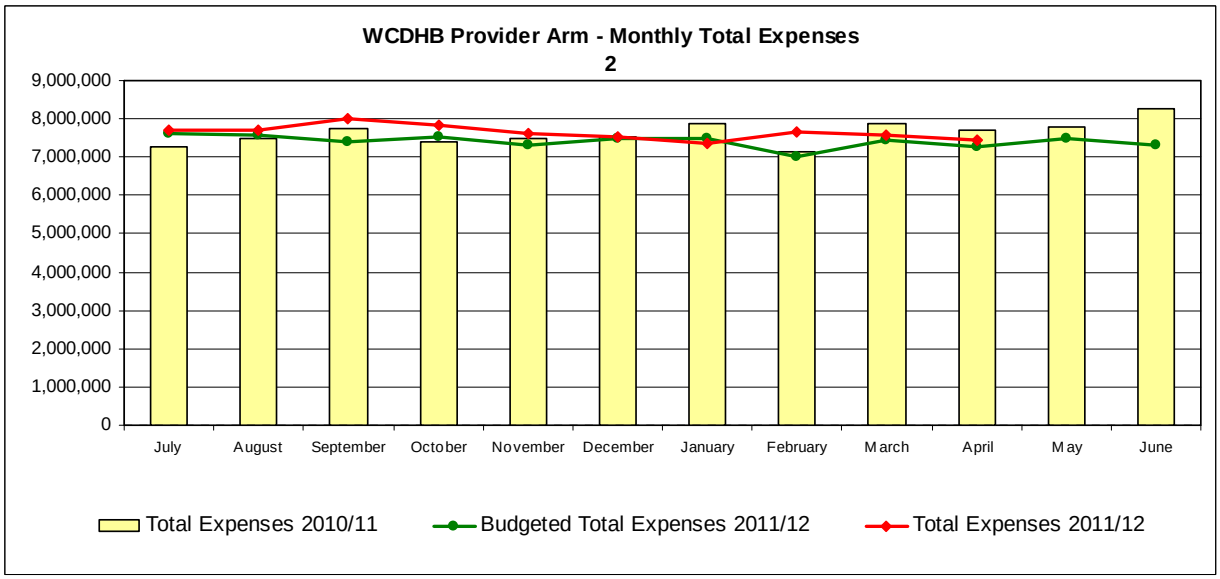
	Monthly Reporting					Year to Date					Full Year 2011/12	Prior Year
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance	Prior Year	Budget	2010/11
Income												
Internal Revenue	98	98	0	0.2%	98	980	978	2	0.2%	980	1,174	1,176
Other income	23	4	19	447.6%	1	63	42	21	50.0%	80	50	115
Internal allocation from Provider Arm	110	110	(0)	(0.2%)	82	1,100	1,102	(2)	(0.2%)	820	1,323	984
Total income	**231**	**212**	**19**	**8.9%**	**181**	**2,143**	**2,122**	**21**	**1.0%**	**1,880**	**2,547**	**2,275**
Expenditure												
Employee benefit costs	73	91	18	19.7%	88	895	909	14	1.5%	883	1,091	1,060
Outsourced services	25	54	29	53.5%	28	278	538	260	48.3%	455	646	521
Other operating expenses	40	44	4	9.6%	18	385	443	58	13.0%	305	531	373
Democracy	31	23	(8)	(33.0%)	21	244	233	(11)	(4.7%)	269	280	315
Total expenses	169	212	43	20.4%	155	1,802	2,123	321	15.1%	1,912	2,548	2,269
Net Surplus / (Deficit)	**62**	**0**	**62**		**26**	**341**	**0**	**341**		**(32)**	**(0)**	**6**

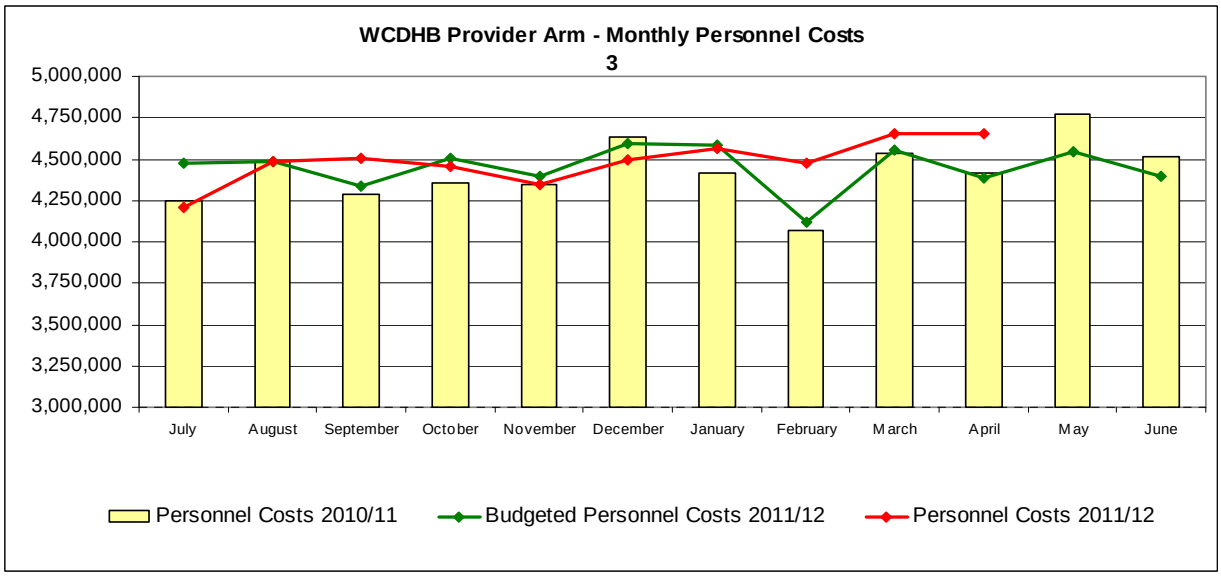
WEST COAST DISTRICT HEALTH BOARD
FUNDER ARM - PAYMENTS TO EXTERNAL PROVIDERS
as at 30 April 2012

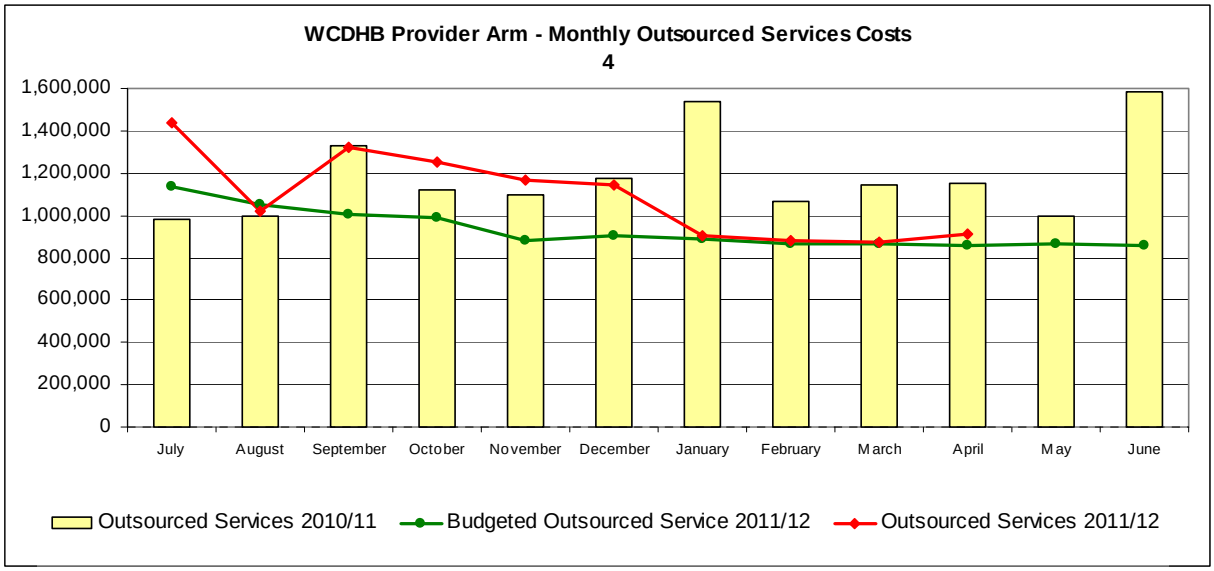
Apr-12						Year to Date						2011/12	2010/11	
Actual	Budget	Variance			SERVICES	Actual	Budget	Variance			Annual Budget	Actual Result	Change (actual 10/11 to budget 11/12)
$000	$000	$000	%			$000	$000	$000	%		$000	$000	%
					Referred Services								
21	40	19	48%	√	Laboratory	324	404	80	20%	√	486	511	5%
611	764	153	20%	√	Pharmaceuticals	6,592	6,946	354	5%	√	8,473	7,705	-10%
632	**803**	**172**	**22%**	√		**6,916**	**7,349**	**433**	**6%**	√	8,959	8,216	-9%
					Secondary Care								
7	20	13	64%	√	Inpatients	44	196	152	78%	√	237	38	-523%
96	116	20	17%	√	Travel & Accommodation	949	1,159	210	18%	√	1,391	1,189	-17%
1,285	1,285	0	0%	√	IDF Payments Personal Health	12,846	12,845	-1	0%	√	15,414	15,606	1%
1,388	**1,421**	**33**	**2%**	√		**13,839**	**14,200**	**361**	**3%**	√	17,042	16,833	-1%
					Primary Care								
11	41	30	73%	√	Dental-school and adolescent	278	378	100	26%	√	467	399	-17%
0	2	2	100%	√	Maternity	0	22	22	100%	√	26	0	
0	1	1	100%	√	Pregnancy & Parent	0	6	6	100%	√	8	0	
0	3	3	100%	√	Sexual Health	8	28	20	71%	√	33	13	-152%
2	0	-2		×	General Medical Subsidy	23	4	-19	-475%	×	5	76	94%
526	523	-3	-1%	×	Primary Practice Capitation	5,355	5,229	-126	-2%	×	6,275	6,135	-2%
13	7	-6	-87%	×	Primary Health Care Strategy	84	69	-15	-22%	×	83	251	67%
77	77	0	0%	√	Rural Bonus	771	773	2	0%	√	928	970	4%
38	13	-25	-184%	×	Child and Youth	155	134	-21	-16%	×	162	162	0%
44	14	-30	-214%	×	Immunisation	116	66	-50	-76%	×	96	154	38%
27	14	-13	-93%	×	Maori Service Development	152	135	-17	-13%	×	162	165	2%
18	31	13	42%	√	Whanua Ora Services	180	312	132	42%	√	373	215	-74%
51	13	-38	-289%	×	Palliative Care	164	131	-33	-25%	×	157	110	-43%
15	15	0	1%	√	Chronic Disease	108	255	147	58%	√	286	3	-9440%
11	11	0	2%	√	Minor Expenses	110	112	2	2%	√	134	206	35%
833	**765**	**-68**	**-9%**	√		**7,504**	**7,654**	**150**	**2%**	√	9,195	8,859	-4%
					Mental Health								
0	1	1	100%	×	Eating Disorders	22	10	-12	-120%	×	12	23	48%
53	50	-3	-6%	×	Community MH	507	501	-6	-1%	×	601	538	-12%
1	1	0	0%	√	Mental Health Work force	10	7	-3	-43%	×	8	15	44%
48	47	-1	-2%	×	Day Activity & Rehab	476	474	-2	0%	×	569	518	-10%
10	10	0	0%	√	Advocacy Consumer	102	102	0	0%	√	122	120	-2%
5	5	0	6%	√	Advocacy Family	55	53	-2	-4%	×	64	71	10%
0	5	5	100%	√	Minor Expenses	0	51	51	100%	√	61	0	
104	118	14	12%	√	Community Residential Beds	1,026	1,176	150	13%	√	1,411	1,261	-12%
66	66	0	0%	√	IDF Payments Mental Health	660	663	3	0%	√	796	813	2%
287	**303**	**16**	**5%**	√		**2,858**	**3,037**	**179**	**6%**	√	3,644	3,359	-8%
					Public Health								
24	29	5	16%	√	Nutrition & Physical Activity	184	285	101	35%	√	342	328	-4%
0	7	7	100%	√	Public Health Infrastructure	75	69	-6	-9%	×	83	82	-1%
0	0	0		√	Social Environments	0	0	0		√	0	-15	100%
12	6	-6	-114%	×	Tobacco control	120	56	-64	-114%	×	68	58	-17%
36	**42**	**6**	**14%**	√		**379**	**410**	**31**	**8%**	√	493	453	-9%
					Older Persons Health								
0	0	0		×	Information and Advisory	27	0	-27		×	0	0	
0	0	0		√	Needs Assessment	33	0	-33		×	0	0	
49	47	-2	-3%	×	Home Based Support	491	494	3	1%	√	595	708	16%
1	10	9	89%	√	Caregiver Support	96	95	-1	-1%	×	114	130	12%
299	164	-135	-82%	×	Residential Care-Rest Homes	2,395	1,692	-703	-42%	×	2,030	2,344	13%
-2	0	2		√	Residential Care Loans	-39	0	39		√	0	-113	100%
13	10	-3	-27%	×	Residential Care-Community	121	102	-19	-19%	×	122	48	-155%
268	378	110	29%	√	Residential Care-Hospital	2,983	3,849	866	23%	√	4,622	3,949	-17%
0	5	5	100%	√	Ageing in place	13	54	41	76%	√	65	12	-440%
7	7	0	1%	√	Environmental Support Mobility	43	71	28	39%	√	85	28	-204%
9	6	-3	-45%	×	Day programmes	104	62	-42	-68%	×	74	75	1%
7	12	5	42%	√	Respite Care	154	119	-35	-29%	×	143	118	-21%
108	108	0	0%	√	IDF Payments-DSS	1,080	1,083	3	0%	√	1,300	1,060	-23%
759	**747**	**-12**	**-2%**	√		**7,501**	**7,621**	**120**	**2%**	√	9,151	8,359	-9%
3,935	**4,080**	**146**	**4%**	√		**38,997**	**40,271**	**1,274**	**3%**	√	**48,483**	**46,079**	**-5%**

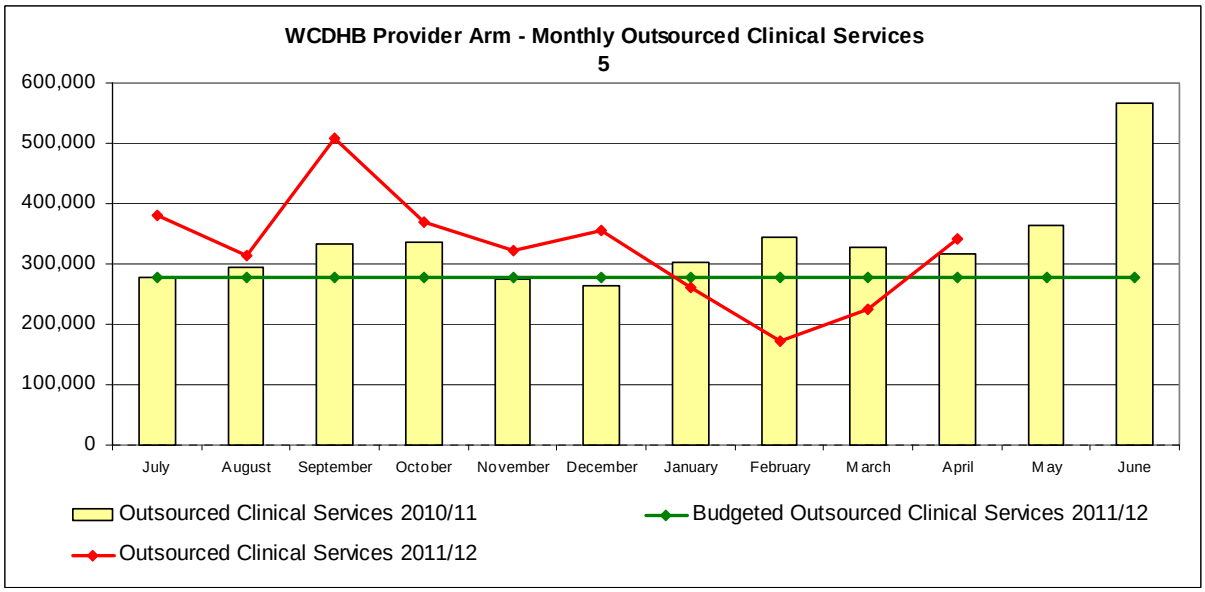
please note that payments made to WCDHB via Healthpac are excluded from the above figures

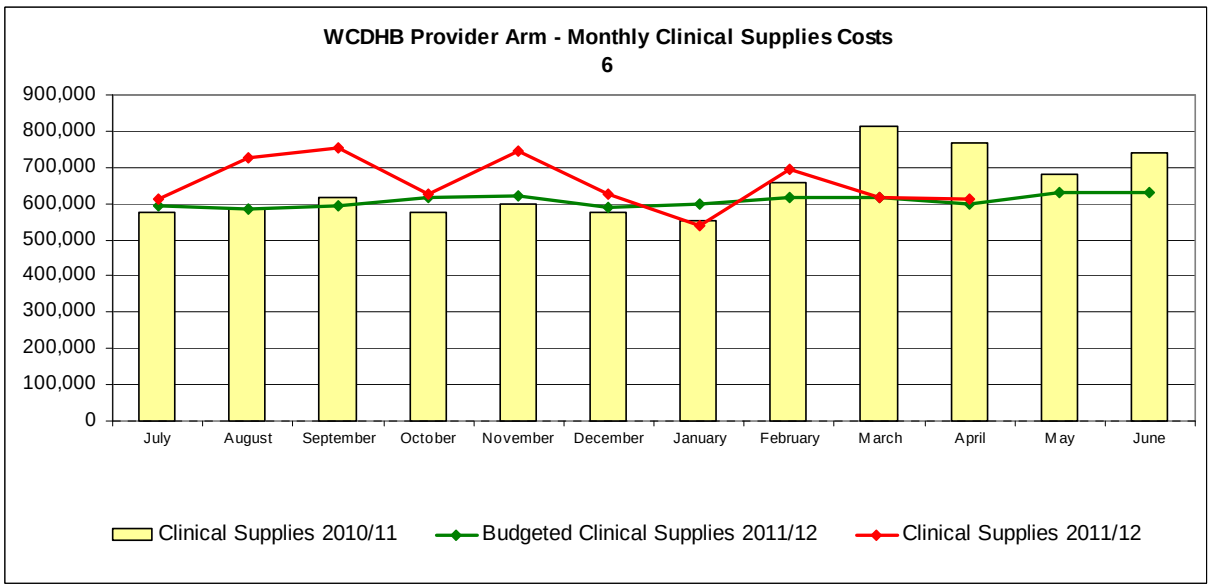

WCDHB Provider Arm - Monthly Surplus/ (Deficit)
1
0
-200,000
-400,000
-600,000
-800,000
-1,000,000
-1,200,000
-1,400,000
-1,600,000
-1,800,000
July
August
September
October
November
December
January
February
March
April
May
June
Surplus/ (Deficit) 2010/11
Budgeted Surplus/ (Deficit) 2011/12
Surplus/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

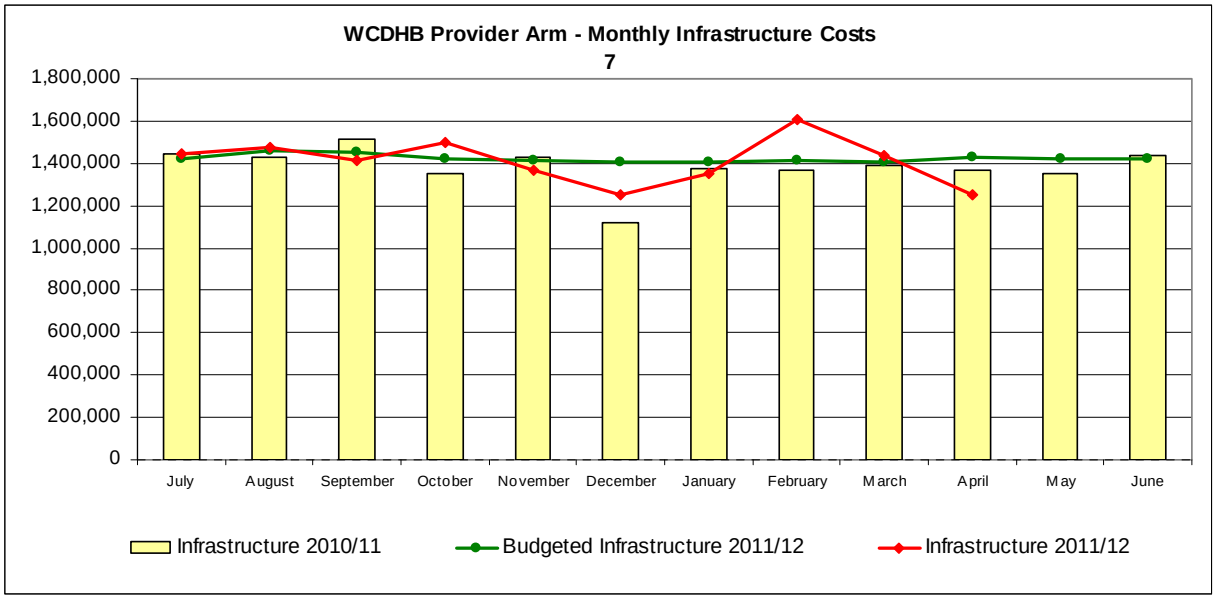

WCDHB Provider Arm - Monthly Total Expenses
2
9,000,000
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0
July
August
September
October
November
December
January
February
March
April
May
June
Total Expenses 2010/11
Budgeted Total Expenses 2011/12
Total Expenses 2011/12


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 Services Costs
4
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
Outsourced Services 2010/11
Budgeted Outsourced Service 2011/12
Outsourced Services 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

HEALTH TARGET RESULTS – QUARTER 3

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

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

SOURCE: **Planning & Funding**

DATE: **8 June 2012**

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

1. ORIGIN OF THE REPORT

The purpose of this report is to present the Board with the national Health Target results for Quarter 3 (January – March 2012). These results are published each quarter in newspapers and online on the Ministry and DHB websites.

2. RECOMMENDATION

That the Board:
i. notes the Quarter 3 Health Target results

3. SUMMARY

As these results have just been released more detail will be provided at the meeting.

4. APPENDICES

Appendix 1	National Results
Appendix 2	West Coast Results
Appendix 3	Ministry of Health Briefing Points

Report prepared by: Wayne Turp, General Manager, Planning & Funding

How is my DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2011/12 QUARTER THREE (JANUARY–MARCH) RESULTS www.health.govt.nz/healthtargets

Shorter stays in Emergency Departments

		Quarter three performance	95%	Change from previous quarter
1	West Coast	99%		–
2	South Canterbury	98%		▲
3	Whanganui	98%		▲
4	Nelson Marlborough	97%		–
5	Counties Manukau	97%		–
6	Tairawhiti	96%		–
7	Waitemata	96%		▲
8	Wairarapa	96%		▲
9	Canterbury	95%		–
10	Hawke's Bay	95%		–
11	Auckland	95%		–
12	Hutt Valley	93%		–
13	Bay of Plenty	92%		–
14	Northland	92%		▲
15	Waikato	92%		▲
16	MidCentral	92%		▲
17	Taranaki	90%		–
18	Lakes	89%		▲
19	Southern	89%		–
20	Capital & Coast	87%		▲
	All DHBs	93%		▲
			95%	

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.

Improved access to Elective Surgery

		Quarter three performance	100%	Progress against plan (discharges)
1	Lakes	121%		▲
2	Taranaki	121%		▲
3	Counties Manukau	111%		▲
4	Whanganui	111%		▲
5	Northland	111%		▲
6	West Coast	107%		▲
7	Hawke's Bay	106%		▲
8	MidCentral	105%		▲
9	Waitemata	105%		▲
10	Bay of Plenty	105%		▲
11	South Canterbury	104%		▲
12	Southern	103%		▲
13	Waikato	101%		▲
14	Canterbury	101%		▲
15	Wairarapa	101%		▲
16	Nelson Marlborough	100%		▲
17	Hutt Valley	100%		▲
18	Auckland	99%		▼
19	Tairawhiti	99%		▼
20	Capital & Coast	98%		▼
	All DHBs	105%		▲
			100%	

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 106,783 discharges year to date, and have delivered 5,011 more.*

Shorter waits for Cancer Treatment

		Quarter three performance	100%	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%	

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy. Six regional oncology centres provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

Increased Immunisation

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

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 January and March 2012 and who were fully immunised at that stage.

Better help for Smokers to Quit

		Quarter three performance	95%	Change from previous quarter
1	Lakes	100%		–
2	South Canterbury	97%		–
3	Whanganui	97%		▲
4	Waitemata	97%		–
5	Capital & Coast	96%		▲
6	Hutt Valley	95%		▼
7	Nelson Marlborough	94%		▼
8	Counties Manukau	94%		▲
9	Hawke's Bay	93%		▲
10	MidCentral	93%		▲
11	West Coast	92%		▲
12	Taranaki	91%		–
13	Auckland	90%		▲
14	Bay of Plenty	88%		▼
15	Waikato	88%		▲
16	Southern	87%		–
17	Canterbury	86%		▲
18	Northland	86%		▲
19	Tairawhiti	86%		▼
20	Wairarapa	72%		▲
	All DHBs	91%		▲
			95%	

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.

This is the first time the new target is being reported. The results are provisional while we confirm the data.

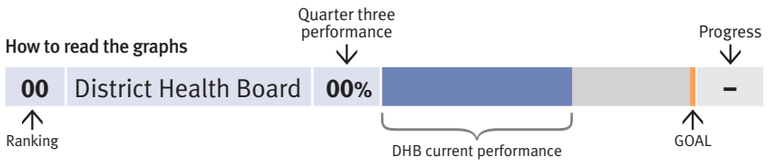
More Heart and Diabetes Checks

		Quarter three provisional performance	60%	Change from previous quarter
1	Wairarapa	66%		NA
2	Whanganui	59%		NA
3	Bay of Plenty	59%		NA
4	Waitemata	56%		NA
5	West Coast	55%		NA
6	Taranaki	55%		NA
7	Northland	54%		NA
8	Lakes	53%		NA
9	Waikato	51%		NA
10	Hawke's Bay	51%		NA
11	Counties Manukau	50%		NA
12	Capital & Coast	50%		NA
13	Nelson Marlborough	50%		NA
14	Tairawhiti	45%		NA
15	Southern	43%		NA
16	Auckland	42%		NA
17	MidCentral	39%		NA
18	South Canterbury	36%		NA
19	Hutt Valley	28%		NA
20	Canterbury	18%		NA
	All DHBs	46%		NA
			60%	

More heart and diabetes checks

The target is that, by July 2012, 60 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. This target will increase in stages each year to 90 percent by July 2014. Because this is a new health target, no comparison can be made between the results this quarter and data from the previous quarter. Results for the diabetes indicators from the previous CVD/Diabetes target can be found on www.health.govt.nz/healthtargets

How to read the graphs

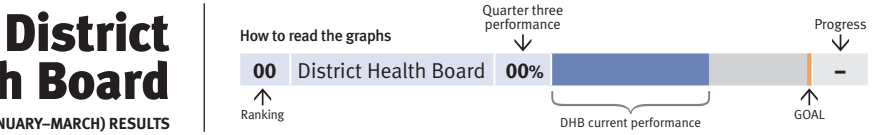


This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

New Zealand Government

My District Health Board

2011/12 QUARTER THREE (JANUARY–MARCH) RESULTS



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 three performance	Change from previous quarter
1	West Coast	99%	–
2	South Canterbury	98%	▲
3	Whanganui	98%	▲
4	Nelson Marlborough	97%	–
5	Counties Manukau	97%	–
6	Tairawhiti	96%	–
7	Waitemata	96%	▲
8	Wairarapa	96%	▲
9	Canterbury	95%	–
10	Hawke's Bay	95%	–
11	Auckland	95%	–
12	Hutt Valley	93%	–
13	Bay of Plenty	92%	–
14	Northland	92%	▲
15	Waikato	92%	▲
16	MidCentral	92%	▲
17	Taranaki	90%	–
18	Lakes	89%	▲
19	Southern	89%	–
20	Capital & Coast	87%	▲
	All DHBs	93%	▲

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 106,783 discharges year to date, and have delivered 5,011 more.*

		Quarter three performance	Progress against plan (discharges)
1	Lakes	121%	▲
2	Taranaki	121%	▲
3	Counties Manukau	111%	▲
4	Whanganui	111%	▲
5	Northland	111%	▲
6	West Coast	107%	▲
7	Hawke's Bay	106%	▲
8	MidCentral	105%	▲
9	Waitemata	105%	▲
10	Bay of Plenty	105%	▲
11	South Canterbury	104%	▲
12	Southern	103%	▲
13	Waikato	101%	▲
14	Canterbury	101%	▲
15	Wairarapa	101%	▲
16	Nelson Marlborough	100%	▲
17	Hutt Valley	100%	▲
18	Auckland	99%	▼
19	Tairawhiti	99%	▼
20	Capital & Coast	98%	▼
	All DHBs	105%	▲

100%

Shorter waits for Cancer Treatment

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy. Six regional oncology centres provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

		Quarter three 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 January and March 2012 and who were fully immunised at that stage.

		Quarter three performance	Change from previous quarter
1	Wairarapa	97%	▲
2	Hawke's Bay	96%	▲
3	MidCentral	96%	▲
4	Lakes	95%	▲
5	Southern	95%	–
6	South Canterbury	93%	▼
7	Waitemata	93%	–
8	Counties Manukau	93%	▲
9	Canterbury	93%	–
10	Hutt Valley	93%	▼
11	Auckland	92%	–
12	Capital & Coast	92%	–
13	Tairawhiti	91%	–
14	Waikato	91%	–
15	Bay of Plenty	90%	–
16	Whanganui	89%	▼
17	Taranaki	89%	▼
18	Northland	87%	▲
19	Nelson Marlborough	85%	▼
20	West Coast	84%	▲
	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 three performance	Change from previous quarter
1	Lakes	100%	–
2	South Canterbury	97%	–
3	Whanganui	97%	▲
4	Waitemata	97%	–
5	Capital & Coast	96%	▲
6	Hutt Valley	95%	▼
7	Nelson Marlborough	94%	▼
8	Counties Manukau	94%	▲
9	Hawke's Bay	93%	▲
10	MidCentral	93%	▲
11	West Coast	92%	▲
12	Taranaki	91%	–
13	Auckland	90%	▲
14	Bay of Plenty	88%	▼
15	Waikato	88%	▲
16	Southern	87%	–
17	Canterbury	86%	▲
18	Northland	86%	▲
19	Tairawhiti	86%	▼
20	Wairarapa	72%	▲
	All DHBs	91%	▲

95%

This is the first time the new target is being reported. The results are provisional while we confirm the data.

More Heart and Diabetes Checks

More heart and diabetes checks

The target is that, by July 2012, 60 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. This target will increase in stages each year to 90 percent by July 2014. Because this is a new health target, no comparison can be made between the results this quarter and data from the previous quarter. Results for the diabetes indicators from the previous CVD/Diabetes target can be found on www.health.govt.nz/healthtargets

		Quarter three provisional performance	Change from previous quarter
1	Wairarapa	66%	NA
2	Whanganui	59%	NA
3	Bay of Plenty	59%	NA
4	Waitemata	56%	NA
5	West Coast	55%	NA
6	Taranaki	55%	NA
7	Northland	54%	NA
8	Lakes	53%	NA
9	Waikato	51%	NA
10	Hawke's Bay	51%	NA
11	Counties Manukau	50%	NA
12	Capital & Coast	50%	NA
13	Nelson Marlborough	50%	NA
14	Tairawhiti	45%	NA
15	Southern	43%	NA
16	Auckland	42%	NA
17	MidCentral	39%	NA
18	South Canterbury	36%	NA
19	Hutt Valley	28%	NA
20	Canterbury	18%	NA
	All DHBs	46%	NA

60%

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

New Zealand Government

Briefing Points from Target Champions for Quarter Three 2011/12 Health Target Results – May 2012

Overall results

The quarter three 2011/12 health target results show positive performance improvement. Two of the targets have been achieved and three are within 4 percent of reaching the national goal. This is the first time results for the new target more heart and diabetes checks are being reported.

All DHBs achieved 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.

The national target for **Improved access to elective surgery** was also achieved again this quarter, with 111,794 elective surgical discharges provided, against a target of 106,783 discharges. This is 5,011 (5 percent) more than planned.

Results for the **Shorter stays in emergency departments** target are again the highest since the target was introduced, with a national result of 93 percent, a 1.3 percent performance increase compared with quarter two 2011/12. Of the 247,799 patient presentations to emergency departments this quarter, 231,651 were admitted, discharged or transferred within six hours.

National immunisation coverage increased from 91.6 percent in quarter two 2011/12, to 92.2 percent against a target of 95 percent for the total population in the **Increased immunisation** health target. Of the 16,184 children eligible to be immunised in quarter three, 14,926 children were fully immunised by two years old. This result includes children who turned two years between 1 January and 31 March 2012 and who were fully immunised at that stage.

Most DHBs have improved their performance in quarter three for the **Better help for smokers to quit** hospital target. The national result increased from 89.3 percent in quarter two to 91.3 percent of smokers being offered help and advice to quit nationally in quarter three 2011/12. The number of hospitalised smokers identified this quarter was 34,308 and 31,339 have received brief advice.

The national result for the new **More heart and diabetes checks** target is 46 percent against a target of 60 percent by 30 June 2012. Due to issues with data collection processes, results are being published as provisional this quarter.

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

Target Area	National goal	Quarter two 2011/12	Quarter three 2011/12
Shorter stays in emergency departments	95%	92.2%	93.5%
Improved access to elective surgery	100%	103.8%	104.7%
Shorter waits for cancer treatment	100%	100.0%	100.0%
Increased immunisation	95%	91.6%	92.2%
Better help for smokers to quit	95%	89.3%	91.3%
More heart and diabetes checks	60%	N/A	46.0%

Regular health target performance-focused letters sent all DHB CEOs will contain specific feedback from each Target Champion about each DHB's quarter three 2011/12 health target performance.

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.

Web information
Detailed data on the quarter three results will be available on the Ministry's website from Tuesday 29 May 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.health.govt.nz/healthtargets

This quarter, the web information has been adjusted to include a time series of national performance against each target in place of the previous graph displaying relative performance.

Graphs of regional performance against the health targets are also included on the Ministry's website. These are provided for DHBs' information only, as performance against the targets is not currently managed on a regional basis.

Please note the Ministry plans to publish the quarter three results on 29 May 2012. In some of the past quarters, the Minister has released the results a day early.

New health targets for 2012/13

From 1 July 2012 there will be changes to three of the current health targets.

Shorter waits for cancer treatment

Chemotherapy wait times are being added to the cancer health target. The combined target is Shorter waits for cancer treatment: Radiotherapy and chemotherapy, defined by: Everyone needing radiation or chemotherapy treatment will have this within four weeks.

The Shorter waits for cancer treatment health target will be publicly reported as one figure in newspapers and performance against both targets will individually be reported on the health targets website.

Increased immunisation

From 1 July the two year old immunisation target will change to immunisation coverage of eight month olds. The target will commence with 85 percent of all children eight months of age fully immunised July 2013, 90 percent by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of patients who smoke and are seen by a health practitioner in primary care or public hospitals, are offered brief advice and support to quit smoking. From 1 July, within the target a specialised identified group will include progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

Health target results

1. Shorter stays in emergency departments

National performance in the Shorter stays in ED health target improved to 93 percent this quarter (93.48 percent). This is an increase of 1.3 percent on quarter two of 2011/12 and is the highest national performance achieved since the target was introduced.

Of the 247,799 patient presentations to emergency departments this quarter, 231,651 were admitted, discharged or transferred within six hours.

DHB performance
More than half of the DHBs are now achieving the target. Eleven DHBs achieved the target for quarter three, up from nine last quarter and six in quarter one 2011/12. Waitemata and Whanganui are the new DHBs to achieve the target compared to last quarter. They improved by 3.8 percent and 3.6 percent respectively to achieve the target, with Whanganui achieving a very impressive 98 percent for quarter three.

The DHBs maintaining their target achievement since last quarter are Auckland, Canterbury, Counties Manukau, Hawke's Bay, Nelson Marlborough, South Canterbury, Tairawhiti, Wairarapa and West Coast DHBs.

Capital & Coast DHB achieved the largest increase in performance this quarter of 5.1 percent. While it remains the poorest performing DHB, with 87 percent for the quarter, this is the second consecutive quarter the DHB has made the largest improvement and its performance has improved by 13 percent since quarter one 2011/12.

Northland DHB improved by 4.7 percent to 92 percent. Whanganui DHB improved by 3.6 percent, to achieve 98 percent for quarter three.

The four poorest performing DHBs are Lakes, Taranaki, Southern and Capital & Coast DHBs.

2. Improved access to elective surgery

Quarter three results for the elective surgery target show the national target has been achieved with 111,794 elective surgical discharges provided, against a target of 106,783 discharges. This is 5,011 (5 percent) more than planned.

DHB performance
All DHBs are within 2 percent of plan. Seventeen DHBs have achieved their target year to date.

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

There were no poor performers this quarter.

The National Health Board has been working closely with all DHBs in quarter three 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
During quarter three 2011/12, all DHBs continued to achieve the Shorter waits for cancer treatment health target. The staff in the cancer centre DHBs (Auckland, Waikato, MidCentral, Capital & Coast, Canterbury and Southern) have worked overtime when required to maintain achievement of the cancer health target. The willingness of staff to agree to overtime indicates the continued commitment of the cancer centre DHBs to achieve the target.

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.

4. Increased immunisation

National immunisation coverage increased from 91.6 percent in quarter two 2011/12, to 92.2 percent against a target of 95 percent for the total population. Of the 16,184 children eligible to be immunised in quarter three, 14,926 children were fully immunised by two years old. This result includes children who turned two years between 1 January and 31 March 2012 and who were fully immunised.

Ethnicity coverage in quarter three was: NZ European 93 percent; Māori 91 percent; Pacific 96 percent and Asian 96 percent.

Of the 16,184 children eligible to be immunised in quarter three, 14,926 children were fully immunised by two years old. This result includes children who turned two years between 1 January and 31 March 2012 and who were fully immunised.

In quarter three, the average national, combined opt-off and decline rate was 5.1 percent, 0.5 percent higher than quarter two. Ten DHBs reported combined opt-off and decline rates above the national average.

The Ministry will continue to recommend DHBs review the opt-off and decline rates, and ensure immunisation services are delivered to all eligible children within their DHBs. The opt-off decline rate has reduced where DHBs revisit families who had previously been recorded as decline.

DHB performance
The following DHBs were outstanding performers this quarter, achieving the national health target with total coverage rates of 95 percent and over: Hawke's Bay (96 percent),

Lakes (95 percent), MidCentral (96 percent), Southern (95 percent) and Wairarapa (97 percent).

The following DHBs achieved coverage between 92 to 94 percent: Auckland (92 percent), Canterbury (93 percent), Capital & Coast (92 percent), Counties Manukau (93 percent), Hutt Valley (93 percent), South Canterbury (93 percent) and Waitemata (93 percent).

West Coast DHB increased coverage from 79 percent in quarter two to 84 percent in quarter three.

The poor performers this quarter were Nelson Marlborough, Taranaki and Northland DHBs.

The immunisation target will shift in focus from 1 July to children at eight months of age. In order to reach the current 95 percent target for two year olds, it is important that all DHBs get coverage as high as possible during quarter four. The Ministry is the actively supporting the final effort needed by DHBs and immunisation service providers to achieve and then maintain 95 percent of coverage after 30 June 2012.

5. Better help for smokers to quit

Most DHBs have improved their performance in quarter three for the Better help for smokers to quit hospital target. The national result increased from 89.3 percent in quarter two to 91.3 percent of smokers being offered help and advice to quit nationally in quarter three 2011/12. The number of hospitalised smokers identified this quarter was 34,308 and 31,339 have received brief advice.

DHB performance
The following DHBs were outstanding performers: Lakes at 100 percent has achieved this result now for three consecutive quarters; South Canterbury at 96.9 percent sustained a similar result to quarter two (97 percent); Whanganui at 96.8 percent with a slight increase from quarter two (95 percent); Waitemata at 96.8 percent with a slight increase from quarter two (96 percent); Capital & Coast at 95.7 percent showing an increase from quarter two (94 percent) and Hutt Valley at 95.5 percent with a slight decrease from quarter two (97 percent).

In addition to strong leadership and commitment across hospital staff for the target, a key factor for success is timely feedback to staff about the target results. This action contributes to maintaining staff momentum to achieve the target.

The most improved DHB is Canterbury, where performance was lifted from 78.9 percent in the last quarter to 86.3 percent for quarter three.

Poor performers this quarter included Wairarapa, Tairawhiti and Northland DHBs.

Primary care target
Based on provisional data, performance for the primary care Better help for smokers to quit target has decreased slightly in quarter three. The national results decreased from 33.7 percent in quarter two to 31.1 percent of smokers being offered help and advice to quit nationally in quarter three 2011/12 against a target of 90 percent.

Whanganui DHB has been able to maintain their performance at 100 percent for three quarters now. Nelson Marlborough DHB is next highest performer, currently at 48.9 percent.

After initial data challenges, South Canterbury is the most improved area with an increase of 13.2 percent compared to verified data for quarter two. Wairarapa increased their performance by 8.8 percent this quarter; Capital & Coast by 8.0 percent and MidCentral by 6.9 percent.

The primary care tobacco target data is sourced from the PHO Performance Programme. Results are provisional this quarter as there are issues with the way this is currently being mapped to individual DHBs.

A recent change in the PHO software system LINKTECH also affected some PHO data. As a consequence there was a substantial drop in reported results in Auckland, Northland and Waitemata this quarter.

6. More heart and diabetes checks

This is the first quarter that the new target, More heart and diabetes checks, has been formally reported. This target measures the proportion of enrolled people in the PHOs within the eligible population who have had a cardiovascular disease (CVD) risk assessment recorded within the last five years. Data for this target is sourced from the PHO Performance Programme and PHO enrolment registers.

The target goal is 90 percent to be achieved by June 2014, with phased targets of 60 percent by 30 June 2012, then 75 percent by 30 June 2013, and 90 percent by 30 June 2014.

The provisional national quarter three results for the new More heart and diabetes check target is 46 percent against a target of 60 percent by 30 June 2012.

Because this is a new health target, no comparison can be made between the results this quarter and data from the previous quarter. Results for the diabetes indicators from the previous CVD/Diabetes target can be found on www.health.govt.nz/healthtargets

There remain some issues with data collection processes as we transition into the new target, primarily concerning the way the PHO data is collated and mapped to provide a DHB result. Consequently the results are acknowledged as provisional.

DHB performance
Provisional results show Wairarapa DHB as the highest performer and achieving 66 percent, followed by Whanganui and Bay of Plenty DHBs, both on 59 percent. Waitemata is next with 55 percent and West Coast and Taranaki DHBs are both at 55 percent, with seven other DHBs reaching 50 – 54 percent.

The poor performers were Canterbury, Hutt Valley and South Canterbury DHBs.

ALCOHOL POSITION STATEMENT

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

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

DATE: **8 June 2012**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board to seek its endorsement of a position statement on Alcohol. The position statement was recommended for endorsement by the Community & Public Health & Disability Support Advisory Committee at its meeting on 24 May 2012.

2. RECOMMENDATION

That the Board:

i. Endorses the position statement on Alcohol as recommended by the Community & Public Health & Disability Support Advisory Committee.

3. SUMMARY

As noted by the Community & Public Health & Disability Support Advisory Committee this position statement is consistent with the position statements of Nelson Marlborough, South Canterbury, Canterbury & Southern District Health Boards.

In endorsing the position statement the West Coast District Health Board acknowledges the wide range of alcohol-related harm that is experienced by people within the West Coast District. It also recognises that alcohol is a major risk factor for numerous health conditions, injuries and social problems and costs the health sector significant money, time and resources.

4. APPENDICES

Appendix 1: Alcohol Position Statement Report to the Community & Public Health & Disability Support Advisory Committee

Report prepared by: Hecta Williams, General Manager

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

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

SOURCE: **Dr Cheryl Brunton, CDHB**

DATE: **24 MAY 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

March 2012

West Coast District Health Board

POSITION STATEMENT ON ALCOHOL

This position statement is consistent with the position statements of Nelson Marlborough, South Canterbury, Canterbury, and Southern District Health Boards[1] and should be read in conjunction with the evidence-based background paper on alcohol.[2] Both documents have been developed collaboratively by the South Island Public Health Units and represent the South Island DHBs working together to address alcohol-related harm.

The West Coast District Health Board acknowledges the wide range of alcohol-related harm that is experienced by people within the West Coast district and that the burden of this harm is carried disproportionately by some population groups. It recognises that alcohol use is a major risk factor for numerous health conditions, injuries and social problems. Additionally, alcohol-related harm costs the health sector significant money, time and resources.

WEST COAST DHB POSITION:

The West Coast District Health Board will reduce the alcohol-related harm experienced by people within the West Coast district by developing an Alcohol Harm Reduction Strategy. This strategy will set out the actions West Coast District Health Board will undertake to reduce alcohol-related harm, including a communication plan.

The West Coast District Health Board will identify and record alcohol-related presentations within the West Coast district in a consistent manner.

The West Coast District Health Board will support and assist Territorial Authorities to develop local alcohol plans that seek to reduce alcohol-related harm by providing information on alcohol-related presentations to emergency departments, and other information pertaining to the burden of alcohol. It will provide further evidence-based advice to assist with these plans.

EVIDENCE BASED SOLUTIONS:

The West Coast District Health Board will advocate for the following evidence-based solutions to reduce the alcohol-related harm experienced by New Zealanders[3]:

[1] Individual DHBs: delete own DHB from this list as appropriate.
[2] A summary of evidence from the paper is attached as an appendix. Full references are in the background paper.
[3] These recommendations align with the CDHB's Submission to The Law Commission's Issues Paper on the Reform of New Zealand's Liquor Laws (2009), and with those contained in a recent Commentary from the Injury Prevention Research Unit: Kypri, K., Maclennan, B., Langley, J.D., and Connor, J.L. 2011. 'The *Alcohol Reform Bill*: More

Raise alcohol prices

- Increase levels of excise tax on alcohol by at least 50%
- Adjust excise tax so that alcohol products taxed directly on level of ethanol
- Use revenue from increase in excise tax to reduce harm amongst high-risk consumers
- Set minimum retail price for alcohol (per alcohol unit)

Raise the alcohol purchase age

- Restore alcohol purchase age to 20 years for both on-licences and off-licences
- Ensure enforcement of minimum purchase age
- Additionally, make it an offence for an adult other than a parent/guardian to supply alcohol to a child; and require parents/guardians who supply alcohol to their child to supervise the consumption of that alcohol

Reduce alcohol accessibility

- Restrict on-licences from selling alcohol after 2am
- Restrict off-licences to selling alcohol between 8am and 10pm
- Restrict convenience stores / dairies from selling alcohol
- Tighten law on granting of liquor licences – provide further grounds to refuse licences (e.g. detrimental social impact to community)
- Tighten restrictions on numbers of outlets in a given area

Reduce marketing and advertising of alcohol

- Ban alcohol sponsorship of sporting and cultural events
- Ban advertising of alcohol from television and cinema
- Advertising of alcohol to convey only basic information about the product
- Put health warning labels on alcohol products
- Ensure alcoholic beverages are labelled with ingredient and nutritional information
- Prohibit marketing of alcohol to youth

Reduce legal blood-alcohol limits for drivers

- Lower the legal blood alcohol (BAC) limit from 80mg/100ml blood to 50mg/100ml blood

tinkering than reform in response to the New Zealand public's demand for better laws'. *Drug and Alcohol Review* 30, 428-433.

APPENDIX: Summary of Evidence

Alcohol Related Harm:

Alcohol use is a major risk factor for numerous health conditions, injuries and social problems, causing approximately 4% of deaths worldwide and (in 2000) 3.9% of all deaths in New Zealand. Much acute harm results from intoxication and includes: road traffic injuries and fatalities, burns, falls, drowning, poisoning, foetal alcohol spectrum disorder, assault, self-inflicted injury, suicide and homicide.

Biological effects of alcohol
Alcohol affects the brain. It alters the mood and impairs memory and psychomotor function. People who consume alcohol are less inhibited and therefore more likely to take risks and behave aggressively, leading to motor vehicle accidents and other injuries. Alcohol use is linked to a wide range of major diseases, including: heart disease, cancer, psychiatric and neurological conditions, gastrointestinal disease, and birth defects including foetal alcohol syndrome. It also contributes to diabetes, sleep disorders, and infectious diseases such as pneumonia and tuberculosis.

Unborn children and adolescents are particularly vulnerable to the effects of alcohol. Unborn children exposed to alcohol are at high risk of problems with memory, language, attention, learning, visuo-spatial ability, fine and gross motor skills, and social and adaptive functioning. Adolescent brains are still developing and therefore vulnerable to alcohol toxicity, addictive problems and psychiatric disorders.

Alcohol-related harm
Alcohol contributes to crime in New Zealand. Nearly half of all homicides in New Zealand between 1999 and 2008 involved alcohol. A third of all offenders in the year 2007/08 had consumed alcohol. Drink driving causes substantial harm - 27% of drivers in all fatal crashes between 2007 and 2009 were reported as having consumed alcohol.

Social harm results from alcohol: reportedly 12.2% of adults experienced harmful effects on friendships, social life, home life, work/study/employment opportunities, financial position, and legal problems or difficulty learning from their own drinking in the past year.

The economic cost of alcohol-related harm in New Zealand is significant. Harmful alcohol use in 2005/06 alone cost New Zealand an estimated $4,794 million of diverted resources and lost welfare.

Alcohol-related harm and population groups
Alcohol-related harm is experienced variably throughout the population. Men have a higher rate of alcohol-related mortality than women and Māori have a higher rate than non-Māori. Evidence clearly demonstrates that Māori suffer disproportionately from a wide range of alcohol-related harms compared to non-Māori. New Zealanders with lower socioeconomic status also bear a disproportionate burden of alcohol-related harm. Children are particularly vulnerable to alcohol-related harm caused by the drinking of other people and can suffer from increased susceptibility to child abuse, neglect and witnessing family violence if caregivers have an alcohol problem.

Cost of alcohol-related harm to the health sector
Alcohol-related harm in New Zealand costs the health sector significant money, time and resources. Intoxicated patients also impact negatively on staff and other patients. An estimated 35% of injury-based emergency department presentations are alcohol-related. From 1 November 2010 to 29 October 2011 892 patients were seen in Dunedin Hospital Emergency Department for alcohol-related presentations. The average length of stay for these patients was 4.5 hours, with an average cost to Southern District Health Board of $1,000 per person.

NZ Drinking Pattern:

Alcohol is widely available in NZ
Alcohol is easily accessible from a wide variety of outlets and to anyone over the age of 18. It can be purchased 24 hours a day, 7 days a week and on most days of the year. Alcohol can be consumed either on the premises (on-licences) in bars, restaurants, cafes, hotels, pubs and individual clubs or at special functions; or off the premises (off-licences) when purchased from liquor stores, supermarkets, grocery stores or dairies. Alcohol is more widely available now than in the past: in 2010 the number of places which held liquor licences was 14,424; this has increased from 6,295 in 1990. It is inexpensive: reportedly, in 2010, 3 litres of cask wine could be purchased (on special) for as little as $16.99.

Drinking patterns in NZ
According to recent surveys, most New Zealanders (85%) drink at least some alcohol. At least two-thirds of those surveyed in 2007/08 drank once a week. Of people surveyed, nearly two-thirds of all people drank to excess at least once a year and one in ten did so at least once a week. Harmful drinking is more common amongst Māori, Pacific and young people. New Zealanders tolerate excess drinking – less than half surveyed agreed that "It is never O.K. to get drunk" and over one quarter agreed that it is "O.K. to get drunk as long as it's not everyday". A third of those surveyed started drinking at around the age of 14.

How the current law impacts upon these drinking patterns
The Sale of Liquor Act (1989) has liberalised the sale of alcohol, allowing it to be sold widely, including from supermarkets and over a 24 hour period. Since 1999 (with an amendment to the Act), the purchase age has dropped to 18 (from 20 years), beer has become available in supermarkets and alcohol can be purchased on Sundays. District Licensing Authorities (DLAs) in each local area grant and renew licenses and stipulate opening times. Licensing Inspectors check that premises within their area comply with regulations (e.g. not selling to those who are already intoxicated). The Resource Management Act (1991) legislates how local communities manage the use of land, which requires that a District Plan be put into place and complied with. The Local Government Amendment Act 2001 allows local authorities to impose liquor bans, banning alcohol in public places at certain times. The Land Transport Amendment Act (2011) has lowered the blood alcohol concentration (BAC) limit for drivers under 20 years to zero. The limit for drivers over 20 years is 80mg per 100ml blood.

Evidence Based Strategies to Reduce Harm:

Raise prices
Evidence shows that when alcohol prices go up, consumption goes down. One of the best ways to influence the consumption of alcohol is through pricing. Alcohol prices are subject to excise tax, which in New Zealand is set at a particular rate depending on which band of alcohol strength the product falls into (e.g. alcoholic beverages between 9-14% alcohol are taxed at 10%). Currently excise tax rates are lower than that of other countries; they are also not adjusted for inflation. In

New Zealand there is often a price differential between on and off-licences, which encourages 'pre-loading' (loading up on cheap alcohol before frequenting on-licences).

Raise the purchase age

Research shows that the legal purchase age affects how much youth drink. A lower purchase age has been associated with increased harm (including traffic crashes). In order for a higher purchase age to be effective, it needs to be combined with adequate enforcement. A higher purchase age acknowledges that the effect of alcohol and its harms is much greater on the adolescent brain as it is still developing.

Reduce alcohol accessibility

It is scientifically and economically effective to restrict the physical availability of alcohol in order to reduce harm. Limiting the physical availability of alcohol can be achieved through limiting the hours and days of sale, and controlling outlet density. Currently alcohol is too easily purchased and facilitates pre-loading. There are often too many alcohol outlets within an area – high densities of alcohol outlets have been shown to be associated with increased harm, including traffic crashes.

Reduce marketing and advertising

Advertising of alcohol has increased in many countries over recent decades, including New Zealand. Prior to the 1980s alcohol advertising in New Zealand was mostly non-existent, due to legislation controlling the advertising of alcohol – now alcohol advertising is left to the self-regulation of the industry. Since 1992, advertising of alcohol has been allowed on both television and radio – albeit at restricted times (9pm-6am) for television. Since 1987 alcohol companies have been allowed to sponsor sports and advertise corporately. Alcohol advertisements often sell the image that drinking is attractive, glamorous and fun; and these messages are particularly appealing to young people. Alcohol advertising not only leads to greater consumption of alcohol, but also colours people's perceptions of the drinking habits of others.

Reduce legal blood alcohol limits for drivers

With increasing levels of alcohol in the blood, driving performance declines. Currently (as of 2011), there is zero tolerance for drivers under 20 years with any alcohol at all in their blood. Drivers over 20 are legally entitled to drive after drinking with no more than 80mg per 100ml of alcohol in the blood. In 2009 in New Zealand, 138 deaths resulted from traffic accidents where alcohol (and/or drug use) was a contributing factor. Research has shown that the risk of traffic crashes goes up proportionate to the level of alcohol in the blood: the risk doubles for those with 0.05% BAC compared to those with none; there is ten times the risk for those with 0.08% BAC; and one hundred times the risk for those with 0.15% BAC or higher.

BACKGROUND PAPER

of Supporting Evidence to the South Island District Health Boards'

POSITION STATEMENT on ALCOHOL

Prepared by:

Willow MacDonald, Public Health South, Southern DHB

Sarah Colhoun and Susan Bidwell, Community and Public Health, Canterbury DHB

Executive summary

- This background paper provides supporting evidence to the accompanying Position Statement. It outlines the current legislation and regulations relating to alcohol in New Zealand, followed by the effects of alcohol on personal health, the social and economic harms related to alcohol, and approaches to reduce alcohol-related harm.
- The quantity of alcohol available for consumption, the number and variety of locations where alcohol is sold in both on- and off-licensed premises, and the relatively cheap price mean that alcohol is widely available in New Zealand. Additionally, there are almost no restrictions on the hours of the day or days of the year on which alcohol may be sold.
- The main piece of legislation controlling alcohol in New Zealand is the Sale of Liquor Act (1989) and its subsequent amendments. The Act regulates the conditions under which alcohol may be bought and sold and the minimum purchase age. It also sets out penalties for breaching those conditions.
- Advertising of alcohol is controlled by the Broadcasting Act (1993), and restrictions on driving after drinking alcohol are dealt with in the Land Transport Act (1998) and its amendments. The Resource Management Act (1991) and the Local Government Act (2001) also have provisions that allow local government bodies to determine where alcohol is bought and sold in their district.
- The Alcohol Law Reform Bill currently before Parliament aims to reduce the access to alcohol by limiting the range of outlets that may sell alcohol, controlling the density of alcohol outlets, reducing the alcohol content of some drinks and tightening up on marketing. The Bill also proposes raising the purchase age for off licensed premises and higher penalties for some liquor-related offences .
- Most New Zealanders drink at least some alcohol, and many drink more than the recommended amount. Recent surveys that have examined the drinking habits of New Zealanders have found that young people (including underage drinkers) are particularly likely to drink excessively. The surveys also established that there was a general tolerance of drunkenness among those surveyed.
- The effects of alcohol on health are well documented. Alcohol impairs cognitive and motor function, decreases inhibitions and so increases risk-taking behaviour, accidents and other injuries. Exposure to alcohol in the critical developmental period before birth and again during adolescence is particularly damaging, potentially causing life-long behavioural and cognitive consequences.
- Certain individuals and families are particularly susceptible to problems with alcohol. While genetic components are known to be responsible, at least in part, their interaction with easy access to alcohol and low social constraints are also likely to play a part, along with factors such as stress, adverse life experiences and gender roles.
- Major categories of disease are causally linked to heavy alcohol drinking including neuropsychiatric, gastrointestinal, and cardiovascular conditions and a range of cancers. Alcohol is a contributing or exacerbating factor for a wide range of other conditions such as depression, diabetes, sleep disorders, infectious diseases and inflammatory conditions, and injuries from burns, falls and fractures.
- Although light to moderate drinking has been associated with a decreased risk of coronary disease in healthy older adults, heavy drinking as well as occasional binge drinking at any age has the opposite effect. Moreover, alcohol is contraindicated for many other conditions, including other cardiovascular diseases.
- Intoxication with alcohol is the main cause of alcohol-related harm in New Zealand society, leading to risk-taking behaviour, road traffic and other accidents, injuries from falls and drowning, assaults, self-inflicted injury, and acute alcohol poisoning.
- There are social costs from the use and abuse of alcohol, to drinkers themselves, to others they come into contact with, and to the whole of New Zealand society. Costs range from avoidable morbidity and mortality, hospital presentations, aggression and violence, and

crime, to harmful effects on family relationships, friendships and social life, schooling, study and employment opportunities, and financial problems.

- Alcohol-related harm is not evenly distributed in the New Zealand population. New Zealanders with low socioeconomic status suffer disproportionately compared to those who are better off. Similarly, the burden of alcohol-related harm varies by ethnicity and is higher for the Māori and Pacific populations.
- Children whose caregivers abuse alcohol are more likely to suffer from abuse and neglect, and to be exposed to family violence. They also have an increased risk of injury from vehicle and other accidents and non-accidental injury. Additionally, increased exposure to alcohol at an early age makes it more likely that children will have alcohol problems themselves later on.
- Alcohol-related harm has a significant economic impact including the cost of injuries, adverse effects on work and study productivity, vandalism, and loss of trade because of public safety concerns.
- Approaches that combine reducing the availability of alcohol and modifying the drinking environment along with restrictions on advertising and sponsorship and increased enforcement of drink-driving counter-measures have been shown to be successful in reducing alcohol-related harm. Community-wide approaches to discourage heavy drinking and encourage alcohol-free events and entertainment also have a positive influence.
- The Position Paper on Alcohol for which this background paper provides the supporting evidence is a proposed joint statement by the five South Island District Health Boards, indicating their concern about the extent of alcohol-related harm in New Zealand and the need for action to reduce it.

Table of Contents

Section One: Introduction and overview of alcohol in New Zealand

This background paper has been developed to provide supporting evidence to the accompanying Position Statement on Alcohol. It is set out in four sections: Section One describes how alcohol is used in New Zealand and gives an overview of existing and proposed legislation. Section Two covers the personal health effects of alcohol in terms of its effect on the brain and its contribution to a range of diseases. Section Three outlines the social and economic harms caused by alcohol. Section Four presents the approaches that have been shown to be effective in reducing alcohol-related harm.

The paper was written collaboratively by staff from Community & Public Health and Public Health South. It was internally peer reviewed and then circulated for feedback to a wide range of people in the South Island DHB networks and beyond.

Searches of the international databases Medline and Science Citation Index were conducted in October 2011 to gather evidence for the effects of alcohol on all aspects of health and disease, and the social harm created by alcohol.

A wide ranging search of other electronic information was undertaken to identify information on the status of alcohol in New Zealand and to locate international and New Zealand examples of measures taken or suggested to reduce alcohol related harm. Major sources included:

- Policy and position statements from New Zealand District Health Boards
- The Canterbury District Health Board submission to the Law Commission review of all aspects of the law on the sale and supply of liquor
- Publications from the Ministry of Health, Statistics New Zealand, Ministry of Transport, the New Zealand Police, and the Ministry of Social Development.
- The report of Law Commission *Alcohol in Our Lives: Curbing the Harm* (Law Commission 2010)
- University research groups, particularly the University of Otago Injury Prevention Research Unit
- The Alcoholic Liquor Advisory Council
- Alcohol Health Watch.
- Considerable use was also made of the two editions of the work by Babor et al (2003 & 2010) in the publication *Alcohol: No Ordinary Commodity. Research and Public Policy.*

References to other relevant sources that were cited in the works investigated were also followed up for further information.

Alcoholic beverages contain the substance ethanol (pure alcohol), which is produced when yeast ferments carbohydrates or sugars in food (ALAC 2011). Alcoholic beverages usually contain between 2.5% and 55% alcohol, ranging from light beer to brandy, rum and whisky. The latest alcoholic products available are ready-to-drink beverages (RTDs), also known as alcopops. These have been available in New Zealand since 1995, and usually range in alcohol content from 4 to 7%. In New Zealand, beverages need to contain at least 1.15% alcohol to be defined as liquor (or alcohol). The Sale of Liquor Act (1989) defines liquor as “any fermented, distilled, or spirituous liquor (including spirits, wine, ale, beer, porter, honeymead, stout, cider, and perry) that is found on analysis to contain 1.15% or more alcohol by volume”.

Alcoholic beverages are measured in terms of ‘standard drinks’, defined as 10 grams of pure alcohol. Beverages with the highest pure alcohol content require the least volume to comprise one standard drink. Spirits with 40% alcohol content in a 30ml glass, wine with 13% alcohol content in

a 100 ml glass, RTDs with 5% alcohol content in a 275ml bottle, or beer with an alcohol content of 4% in a 330 ml can are all examples of standard drinks.

Availability of alcohol

Alcohol is widely available in New Zealand. Statistics New Zealand figures (2011) show that in 2010, 474 million litres of alcoholic beverage were available for consumption, of which the pure alcohol content was 33 million litres (Statistics New Zealand 2011). This meant that on average, each New Zealander aged 15 years and over had available 9.6 litres of pure alcohol to consume.[4] In the same year the amount of pure alcohol available increased 5.5% from the previous year with the sharpest increase being a 20% increase in the amount of spirits. The amount of wine available also increased by 7.7%. The most widely available alcoholic beverage in 2010 by volume was beer (299 million litres available), followed by wine (103 million litres) and spirits (13 million litres).

New Zealanders surveyed for a Ministry of Health report on alcohol use in 2007/08 (MoH 2009) most commonly consumed wine (62.3% of those aged 16-64 years) and beer (60.6%). A large number also reported drinking spirits, liqueurs or mixed cocktails (46.5%), while a smaller number said they consumed RTDs (22.2%), and fewer still drank sherry, port or vermouth (6.7%) or cider (5.4%).

Currently in New Zealand, anyone who is over the age of 18 may purchase alcohol to drink. Those who are under 18 years of age may drink on licensed premises only if the alcohol has been purchased by a legal parent or guardian, and if they remain in a supervised or unrestricted area of the premises. In order to purchase alcohol, people may need to supply photographic identification as proof of age. In New Zealand there is no minimum drinking age (Wellington City Council undated).

New Zealanders can purchase alcohol from a variety of locations, defined by the type of licences which apply to the sale of alcohol. 'On-licences', including bars, restaurants, hotels, and cafes, sell alcohol on the premises for consumption on the premises. 'Off-licences' sell alcohol for consumption off the premises and include bottle-stores, supermarkets, and convenience stores and dairies. Club licences enable the operators to sell alcohol for consumption on the premises to members of the club or to their invited guests. Special licences allow alcohol to be sold at special events. (Christchurch City Council 2011).

The number of places to drink in New Zealand has increased since 1989 when the Sale of Liquor Act lifted restrictions on liquor licensing, meaning more and more places have been able to sell alcohol. In 1990, the number of places which held liquor licences was 6295; by 2010 this number was 14, 424 (Law Commission 2010).

The density of alcohol outlets has been found to be associated with alcohol-related harm in both international and national research. A New Zealand study by Connor et al. (2011) noted that "more than 50 research papers have been published since the early 1990s finding associations between the spatial density of alcohol outlets and levels of harm" (p. 841). The same study showed that the number of licensed premises within 1km of home was associated with the level of self-reported harm and that the number of off-licences was associated with binge drinking.

[4] Figures on the amount actually consumed were sought during the writing of this paper but do not appear to be readily available.

As well as the wide variety and number of locations where alcohol is available, New Zealanders can purchase alcohol at any time and almost all days of the year (ALAC undated). Since 1989, 24 hour liquor licences have become available, meaning that bars, supermarkets and convenience stores may supply alcohol throughout the day and night. Since 1999 (with an amendment to the Sale of Liquor Act), New Zealanders have been able to purchase alcohol on Sundays. In 2004, hours of sale were extended to include Easter Sunday for wineries. On public holidays the sale of alcohol may be restricted, depending on the type of premises. Pubs and off-licences may not sell alcohol on Christmas Day, Good Friday, Easter Sunday or before 1pm on Anzac Day. (ALAC undated)

Alcohol is available at relatively cheap prices in New Zealand. There are no minimum prices for alcohol – price is determined by the industry. The average price of alcohol has increased over the last 10 years, but by comparison, so has the price of milk. The average prices for alcohol in 2010 were as follows: 1 litre whisky $42.94; 3 litre cask white wine $21.80; 1 dozen bottles beer $19.50; and glass of beer (licensed premises) $4.95 (Gunesekara and Wilson 2010). These prices represent increases of 18.8%, 26.5%, 16.2% and 35.1% respectively over the ten year period since 1999. In comparison, the price of milk has increased by 22.8%. Although the price of alcohol has increased, it has become more affordable, in comparison with average hourly earnings. For example, results of this study compare differences in "the minutes taken to earn sufficient alcohol to reach the legal blood alcohol limit" from 1999 to 2010. In 1999 it would have taken a worker 16.4 minutes to earn enough money to get intoxicated by drinking whisky, while in 2009 it would only have taken 13.2 minutes. Prices of alcohol can be subject to wide variation; the same study found that 3 litres of cask wine could be bought for as little as $16.99 (Gunesekara and Wilson 2010). A more recent study (Sloane et al. 2011) compared discounted alcohol prices to that of discounted non-alcoholic beverages. The average lowest price per standard drink was: $0.61 for cask wine; $1.17 for cider; 0.69 for RTDs; $0.33 for Coca Cola; $0.35 for apple juice; $1.39 for grape juice; and $0.42 for milk. The difference in price between cask wine and grape juice, both made from the same product, was noted by the authors.

Alcohol prices in New Zealand are subject to excise tax (ie a tax on specific goods sold or produced for sale, paid by the producer or seller to the government). Alcohol is taxed either by its ethanol content within a range or by beverage volume. For example, beverages with an alcohol content of between 9-14% are taxed at 10%. In 2009, tax rates were 10% of the retail price for beer, 15% for wine, and 38% for spirits (Alcohol Healthwatch undated).

Current legislation

New Zealand's current main piece of legislation regarding alcohol is the Sale of Liquor Act (1989). Under this Act, the sale of alcohol is able to be determined by the market, rather than by 'need' (Maclennan 2010, p.48). Alcohol sales are no longer monopolised by a few providers, but are driven by "free-market ideology" (Maclennan 2010, p.48). The Sale of Liquor Act lifted restrictions on hours and places of sale, allowing 24 hour licenses and supermarkets to sell wine. The Act aimed to allow communities greater control of liquor licensing, with most of the responsibility for liquor licensing going to local government. It also introduced the concept of host responsibility, which means, for example, that licensed premises are required to have food and non-alcoholic beverages available to purchase. The Act aimed to "promote moderate drinking and reduce alcohol-related harm through host responsibility" (Maclennan 2010, p.48). The Act had several amendments in 1999 which lowered the purchase age from 20 to 18 years; allowed licensed premises to sell alcohol on Sundays; and enabled supermarkets and grocery stores to sell beer as well as wine.

Effectively, the Sale of Liquor Act made it easier to sell alcohol, by lifting restrictions. Its aims were "… to establish a reasonable system of control over the sale and supply of liquor to the public

with the aim of contributing to the reduction of liquor abuse, so far as that can be achieved by legislative means [and] to set out the provisions relating to on-license, off-licenses, club licenses and special licenses; define the powers of the Licensing Authority, District Licensing Agencies; outline offences and enforcement provisions" (National Drug Policy New Zealand 2010). The Sale of Liquor Act introduced District Licensing Authorities (DLAs), in each local area, with powers to grant and renew liquor licenses in their area and stipulate hours of trade (Maclennan 2010, p.60). Each DLA has licensing inspectors who monitor how the licensed premises are run (for example, not selling alcohol to those under the age of 18 or serving alcohol to intoxicated customers).

New Zealand law imposes penalties on those who breach the regulations around the sale of alcohol. Those who try to purchase alcohol before they are legally of age (i.e. under 18 years) can receive a $200 fine. If they are unsupervised on licensed premises they may incur a $2000 fine, and if they are apprehended drinking or possessing alcohol in a public place they may be fined $300. Those who try to use someone else's ID to purchase alcohol may be charged with fraud and receive heavy penalties if convicted (New Zealand Drug Foundation undated).

There are also penalties for those who attempt to supply alcohol to minors (under 18 year-olds). Those who purchase alcohol for supply to under 18 year-olds can receive a fine of up to $2000. On licensed premises, managers and staff can be fined heavily (separate fines for each) for selling or supplying alcohol to those who are underage
(a fine of up to $10,000 for the manager, up to $2000 for a staff member, and a suspended licence for the licensee). For the sale or supply of alcohol to an intoxicated person the licensee may be fined up to $10,000.

Apart from the Sale of Liquor Act (1989), there are two other pieces of legislation relevant to the way alcohol is supplied and controlled. Under the Resource Management Act (1991), local government bodies have the power to determine the location of new licensed premises, and under the Local Government Act (2001) they have the power to introduce bylaws and enforce them with penalties of up to $20,000.

Driving

In New Zealand the law sets the limits for the amount of alcohol a person can drink while driving measured by Blood Alcohol Content (BAC). Drivers under 20 years of age have a zero BAC limit (lowered in 2011 from 0.03 milligrams per 100 millilitres of blood). This means that after even one drink a young person can be charged with drink driving. Fines and demerit points are the penalties for a blood alcohol level of less than 150 micrograms per litre of breath and less than 30 milligrams per 100 millilitres of blood. For higher blood alcohol content, disqualification, demerit points, fines and imprisonment are all available as penalties (New Zealand Transport Agency 2011). Penalties for drivers 20 years and over who attempt to drive with a BAC in excess of the permitted levels include up to three months in prison, and/or a fine of up to $4500, and loss of licence for six months or more for a first or second offence. Penalties increase for repeat offenders. For those who kill or injure someone while driving under the influence of alcohol, penalties are higher - up to five years' imprisonment and/or a fine of up to $20,000.

Advertising

Currently legislation around the advertising of alcohol is controlled by the Broadcasting Act (1993), which allows for the self-regulation of alcohol advertising by the alcohol industry. Within the advertising industry itself, the Advertising Standards Authority is responsible for alcohol

advertising codes (Maclennan 2010, p.49). Prior to the 1980s no advertising of alcohol at all was allowed through any media. By 1981, off-licenses were allowed to advertise on television and radio. In 1987, alcohol companies were allowed to sponsor sports and advertise corporately. In 1992 advertising of alcohol products was allowed on broadcast media between 9pm-6am on television and anytime on radio (Maclennan 2010, p.49).

Alcohol Reform Bill

In 2008 the Government commissioned the Law Commission to review legislation around alcohol in New Zealand. After an extensive review, the Law Commission produced the report, "Alcohol in our Lives, Curbing the Harm" (Law Commission 2010). The Government responded to this with the Alcohol Law Reform Bill.

The Alcohol Law Reform Bill was first introduced in November 2010. It has had two readings so far and is currently (as at November 2011) before Parliament. It has received more than 5000 submissions. The then Minister of Justice, Simon Power, stated that the Bill called for a "safe and responsible drinking culture" and aimed to "reduce excessive drinking, improve the operation of the alcohol licensing system (including community input on licensing), support the responsible sale, supply and safe consumption of alcohol…and make licenses harder to get and easier to lose".[5]

The Alcohol Reform Bill responds to the Law Commission report by picking up "126 of the 153 recommendations in the Law Commission report" (Nick Smith, Second Reading, Parliament 2011). According to the Minister of Justice, for the "first time in 20 years Parliament aims to restrict, rather than relax, our liquor laws" (Simon Power, Second Reading, 2011).

The Bill aims to reduce the accessibility of alcohol by limiting the maximum national trading hours: 8am-4am for on-licenses, clubs and special licenses; 7am-11pm for off-licenses. It also targets off-licenses, including convenience stores and dairies, which would no longer be able to sell alcohol. Supermarkets would only be able to display alcohol in one non-prominent area. The Bill would instigate a split purchase age: the off-license purchase age would increase to 20, while on-licenses would stay at 18. The Bill would also make the supply of alcohol to minors without parental or guardian consent an offence, and would put greater emphasis on host responsibility. It aims to give communities greater control about the use of alcohol in their own area, giving them the responsibility to make decisions about the location of alcohol outlets in their area, along with controlling the density of alcohol outlets and opening hours. It would aim to limit the alcohol content of RTDs to 5%, and by law "particularly dangerous alcohol products would be able to be banned." The new law would also create tighter limits on alcohol marketing. There would be a higher penalty for breaching the liquor ban and an investigation of minimum prices. While these measures go some way towards implementing the recommendations of the Law Commission report, they have not been considered strong enough by many. Kypri et al (2011), for example, described them as "tinkering" rather than reform.

NZ drinking pattern

Most New Zealanders drink at least some alcohol. Eight in ten of the New Zealanders aged between 16-64 (85.2%) who were surveyed in the 2007/08 New Zealand Alcohol and Drug Use Survey had had an alcoholic drink in the past year (MoH 2009). In the same survey, nearly two-

[5] See http://www.parliament.nz/en-NZ/PB/Legislation/Bills/8/2/7/00DBHOH_BILL10439_1-Alcohol-Reform-Bill.htm for documents and media releases relating to this Bill and from which the statements in this and the following two paragraphs are taken.

thirds (61%) drank alcohol at least once a week. A smaller proportion (7%) drank alcohol daily – equating to 152, 900 adults in the New Zealand population. Men were more likely than women to drink more often, with 6.3% of men drinking daily compared to 4.3% of women (MoH 2009).

In New Zealand, the current legal purchase age for alcohol is 18 years, however, surveys show that many New Zealanders start drinking at a younger age. In 2007/08, for those surveyed aged between 16-64, the median age for first trying alcohol was 16 years. Almost one third of New Zealanders (31.9%) had first tried alcohol at age 14 or younger (MoH 2009).

Many New Zealanders also drink more than the recommended amount per drinking occasion (more than 6 standard drinks for males and more than 4 standard drinks for females). In 2007/08, nearly two-thirds (61.6%) of drinkers exceeded the recommended amount at least once during the year. This is most common for young drinkers: for those in the 18-24 year age-group, 80% had consumed more than the recommended amount at least once in the last year (MoH 2009). Almost half of those surveyed (44.3%) had first consumed a large amount of alcohol when they were aged between 15 and 17 years; 13.9% had consumed a large amount of alcohol at least once when aged 14 years or younger. Maori and Pacific groups were also more likely to drink large amounts: 76.6% of Maori and 76.5% of Pacific drinkers had exceeded the recommended amount at least once in the last year. Almost one in ten (9.4%) New Zealanders who drank more than the recommended amount did so one or two times a week in the past year. In addition, 3.2% consumed a large amount three or more times a week. The majority of New Zealanders surveyed (76.7%) had consumed a large amount of alcohol at least once during their lifetime (MoH 2009).

Another nationally representative survey that sampled 628 young people aged between 12 and 17 years and 659 adults aged 18 years and over found that New Zealanders tolerate drunkenness (ALAC 2005). A quarter (27%) of those surveyed agreed that "It's OK to get drunk as long as it's not every day". One third of people (34%) disagreed that "It's never OK to get drunk" while less than half of people (47%) agreed with this statement. Nearly one in ten drinkers (9%) "drink to get drunk". Drunkenness was more prevalent amongst young people. Nearly half (47 %) of those between 12 and 17 years agreed that "It's OK to get drunk as long as it's not every day". Within the same age group, 14% said they "drink to get drunk". The survey had a margin of error of ±4.3% for the youth sample and ± 5.5% for the adult sample (both at the 95% confidence level) and results were weighted in terms of ethnicity, age and gender.[6]

Section Two: The effects of alcohol on health

The hazardous and harmful use of alcohol contributes to death, disease and injury to the drinker and to others through the dangerous actions of intoxicated people, or the impact of drinking on foetal and child development. The most recent World Health Organisation report on alcohol (2011), categorised it as the world's third largest risk factor for disease and disability, a causal factor in 60 types of disease and injuries and a component cause in 200 others. The WHO report noted that almost 4% of all deaths worldwide can be attributed to alcohol, more than the deaths caused by HIV/AIDS, violence or tuberculosis. New Zealand researchers have suggested that ethanol shares the same characteristics as other substances that are classified as drugs of high risk to public health and it should be scheduled accordingly (Sellman et al 2009). This section provides an overview of the health effects of alcohol drawn from international journal literature, including recent meta-analyses.

Alcohol and the brain

[6] The methodology of this study is described

Alcohol acts on specific targets in the brain and triggers a variety of neurotransmitter systems that lead to acute behavioural effects (Field et al. 2010). Alcohol impairs cognitive and psychomotor function, affects mood, and causes feelings of intoxication, and impairments in memory, attention and planning. It decreases inhibitions and so increases sexual risk taking, aggressive behaviour and risk of motor vehicle accidents and other injuries.

The prefrontal cortex, the hippocampus, the cerebellum, the white matter and glial cells of the brain are particularly susceptible to the effects of alcohol. Alcohol also acts on neurotransmitters, and signalling pathways resulting in neural impairments and cognitive and behavioural dysfunction. Some mechanisms are common to both the developing and the adult brain, while others affect developmental stages before birth and during adolescence.

Mechanisms and signalling pathways that affect reinforcement and reward are involved in the initiation and maintenance of alcohol drinking behaviour. The biological mechanisms that link impulsivity and inhibitory control over alcohol are as yet poorly understood (Field et al. 2010; Lejuez et al. 2010). The impairment of control results in diminished ability to focus on and persist with tasks, a tendency to act on the spur of the moment, poor future planning, inability to delay gratification, and diminished ability to regulate emotion (Lejuez et al. 2010). Additionally, the impairment of inhibitory control is associated with increased alcohol seeking behaviour.

Genetic and environmental influences on drinking behaviour

The linkage and association of alcohol dependence with particular chromosomes and genes has been the subject of much research. The US National Institute on Alcohol Abuse and Alcoholism, for example, has been funding the Collaborative Studies on Genetics of Alcoholism (COGA) since 1989. The goal of these studies is to identify the specific genes which underlie the vulnerability of some individuals to having problems with alcohol.[7] However, while the initiation and maintenance of problem drinking behaviour can be attributed at least in part to genetic mechanisms, environmental factors are also important, and the two interact in a complex way (Campbell & Oei 2010; Young-Wolff et al. 2011). Twin and adoption studies where genetic and environmental factors can be controlled have established that there is a variance in interfamilial alcohol problems; certain children do not develop alcohol use disorders in spite of having a family history of them, while others with no family history may do so (Campbell & Oei 2010). A wide range of environmental factors that may interact with a genetic predisposition have been investigated. Social learning cognitions that form expectancies and memories around alcohol in childhood are believed to play a critical part by some researchers (Oei & Morawska 2004), while other studies have looked at factors such as gender roles, stress, adverse life experiences, wider societal influence, and the age of drinking onset (Harden et al. 2008; Pitkanen et al. 2008; Winstanley et al. 2008; Latendresse et al. 2010). Low social constraints and easy access to alcohol are believed to be particularly influential at younger ages (Kendler et al. 2011).

Effect of alcohol on foetal development

The developing brain is particularly vulnerable to alcohol. Alcohol affects the developing central nervous system, leading to a range of physical, learning, and behavioural deficits including growth deficiencies, cranio-facial abnormalities, and intellectual disabilities (Alfonso-Loeches & Guerri 2011). Heavy pre-natal exposure to alcohol has been associated with deficits in memory, language, attention, learning, visuo-spatial abilities, fine and gross motor skills, and social and adaptive functioning. Exposed children are more likely to be rated as hyperactive, disruptive, impulsive or

[7] See http://pubs.niaaa.nih.gov/publications/arh26-3/214-218.htm

delinquent than non-exposed children and have difficulties with social mixing and aggression, anxiety disorders, and suicidal ideation throughout their lives (Hellemans et al. 2010) .

MRI studies in children affected by prenatal alcohol exposure have found structural alterations to the shape, volume and surface area of the overall brain and particular brain regions, as well as reduced white matter and increased grey matter densities in corresponding areas (Guerri et al. 2009). The specific brain structures affected are strongly influenced by the timing of alcohol exposure, with the most damaging period being early in pregnancy and up until week 20. Binge drinking appears to have a more damaging effect than chronic exposure to lower levels of alcohol (Alfonso-Loeches & Guerri 2011). The genetic make up of the mother and foetus also has an influence. If either or both have the aldehyde dehydrogenase enzyme, which provides more efficient alcohol metabolism at higher blood concentration levels, there is some measure of protection (McCarver et al. 1997).

Effect of alcohol on adolescents

The adolescent brain is still maturing, undergoing important structural and functional changes particularly in the pre-frontal cortex (Witt 2010). It is particularly vulnerable to alcohol toxicity, alcohol and substance use problems and psychiatric disorders. The area most affected by alcohol is that associated with cognitive flexibility, self-regulation, inhibitory control, and judgement of risk and reward. These brain circuits develop relatively late in adolescence and may explain the tendency of adolescents to impulsiveness and to disregard the consequences of their behaviour, both of which also increase the risk of substance abuse. Heavy drinking at this age can have a negative impact on brain structure and functions that cause short and long term cognitive and behavioural consequences (Maldonado-Devincci et al. 2010; Alfonso Loeches & Guerri 2011; Witt 2010). MRI studies of adolescents with alcohol use disorders have established that they had smaller brain volumes in the prefrontal cortex compared with control subjects (De Bellis et al. 2005). There also appear to be gender differences in how vulnerable the different areas of the adolescent brain are to alcohol, with females being more at risk than males, although the mechanisms whereby this occurs are not yet fully understood (Caldwell et al. 2005; Guerri & Pascual 2010; Alfonso Loeches & Guerri 2011) .

Adolescent binge drinking is associated with cognitive deficits, poor academic achievement, and attention and memory disorders. Adolescent drinkers are susceptible to the immediate consequences of alcohol use, including blackouts, hangovers, and alcohol poisoning and are at elevated risk of neurodegeneration (particularly in regions of the brain responsible for learning and memory), impairments in functional brain activity, and neurocognitive deficits. Drinking in early adolescence may modify brain maturation processes in certain areas that result in a worsened ability in problem solving, verbal and non-verbal retrieval, visuo-spatial skills, and working memory. Heavy episodic or binge drinking impairs study habits and erodes the development of transitional skills to adulthood (Ziegler et al. 2005).

Another important long-lasting consequence of alcohol use during adolescence is the higher risk of developing alcohol abuse and dependence in adulthood. Adolescents who begin to use alcohol before the age of fifteen are four times more likely to develop alcohol dependence at some stage of their lives compared with those who start at the age of twenty or later (De Wit et al. 2000). It is not clear whether starting to drink at an early age has a causative relationship with alcoholism or whether it suggests a predisposition because of personality characteristics, genetic background, and environmental factors (Alfonso Loeches & Guerri 2011; Kendler et al. 2011).

Alcohol and older people

While there is evidence for some benefits of moderate consumption of alcohol in healthy adults, there is considerable risk associated with even moderate intake in older people. Alcohol in older age has a wide range of negative associations (Heuberger 2009). Physiological changes with ageing mean that older people have poorer balance, are frailer and more at risk of falls. They are more likely to be taking prescribed or over-the-counter medications that interact with alcohol, or to have existing diseases which contraindicate drinking alcohol. Older people often have poor appetites and alcohol displaces important nutrients which would help to maintain health. In conjunction with ageing and poor diet, alcohol has also been associated with dental and oral disorders such as impaired salivary flow, periodontitis, and poor chewing function, which further deplete nutritional status. Older people are at greater risk for gastrointestinal disease and cancer, and are more likely to suffer from bereavement, to be depressed, or socially isolated, all of which may precipitate heavy drinking. Moreover, "excessive intake" in an older person may be equivalent to an amount that would be considered moderate in someone younger. However, wide differences in individual medical status and life history modify the extent that these factors apply to any particular individual.

Longitudinal studies have suggested that light to moderate alcohol consumption may have a protective effect against age-related pre-dementia, Alzheimer's disease or vascular origin dementia, though findings from research have been inconsistent (Panza et al. 2009). On the other hand, there is no evidence to show that light drinking is a risk factor for these conditions, but neither is there any evidence of a specific beneficial level.

Alcohol and disease

The ethanol in alcoholic drinks is oxidised in the liver to acetaldehyde, and further detoxified to acetate. Variants in genetic make up result in differences in the ability of individuals to process acetaldehyde, leading to a varied genetic susceptibility to alcohol exposure. Major categories of disease are causally linked to alcohol, particularly heavy drinking. These diseases include neuropsychiatric, gastrointestinal, and cardiovascular conditions, a range of cancers, foetal alcohol syndrome and pre-birth complications (WHO 2011). Alcohol is also a contributory cause to a wide range of other conditions including major depression, anxiety, diabetes, sleep disorders, infectious diseases such as pneumonia and tuberculosis, and injuries from burns, falls, and fractures (Carrao et al. 2004). Among conditions which are exacerbated by alcohol are inflammatory conditions such as psoriasis (Farkas & Kemeny 2010) and there is a relationship between heavy drinking and epileptic seizures (Samokhvalov et al. 2010). Alcohol, especially beer, increases the risk of gout (Singh et al. 2011) and contributes to the risk of obesity as it is a passive form of energy consumption adding to the energy consumed as food (Yeomans 2010). Chronic heavy drinking can also irreversibly compromise bone quality and increase the risk of osteoporosis in later life (Sampson 2002).

The harmful use of alcohol is a particularly important risk factor for men. The World Health Organisation (2011) classes alcohol as the leading risk factor for death in males ages 15–59, mainly due to injuries, violence and cardiovascular diseases. Globally, 6.2% of all male deaths are attributable to alcohol, compared to 1.1% of female deaths. Men also have far greater rates of total disease burden attributed to alcohol than women – 7.4% for men compared to 1.4% for women. Men outnumber women four to one in weekly episodes of heavy drinking and have much lower rates of abstinence. Lower socioeconomic status and educational levels are also associated with a greater risk of alcohol-related death, disease and injury – and are social determinants that are greater for men (WHO 2011).

Cancers

Alcohol consumption is strongly associated with cancers of the head and neck, (the oral cavity, pharynx, larynx, and oesophagus) as well as the respiratory and digestive tract. Daily consumption of around 50g of alcohol increases the risk for these cancers by two to three times, compared with the risk in non-drinkers. Acetaldehyde produced from alcohol by microbes in the normal gastrointestinal tract or salivary glands is a local and topical carcinogen that affects the human gut (Salaspuro 2003; Chen et al. 2009; Oze et al. 2011; Ogden 2005). The relationship is dose dependent, so that damage increases with heavier drinking. There is uncertainty about the existence of a threshold (a number of drinks per day) below which alcohol may not cause any damage but it is likely that any threshold varies depending on ethnicity, gender, age, and the existence of other conditions. Some ethnic groups, for example Japanese, have a genetic inability to detoxify acetaldehyde (aldehyde dehydrogenase deficiency). These populations have a greatly increased risk of alcohol-related GI tract cancers compared to populations where most people have a fully active enzyme (Baan et al. 2007; Salaspuro 2003).

Alcohol and tobacco have a synergistic effect greater than either of them alone so that heavy smokers and drinkers have a greatly increased risk of upper aero-digestive tract cancers. Acetaldehyde is also present in high concentrations in cigarette smoke, hence the increased exposure to acetaldehyde from both smoking and drinking (Ansary-Moghaddam et al. 2009; Altieri et al. 2005; Ogden 2005). It has been suggested that this exponentially greater effect may be due to the direct contact of solvent action on the tissues of the body, that enhances the effects of tobacco (Altieri et al. 2005).

There is good evidence from several systematic reviews that heavy alcohol intake moderately increases the risk of breast cancer (Weir et al. 2007; Baan et al. 2007; Collaborative Group on Hormonal Factors in Breast Cancer 2002). One systematic review (Carrao et al. 2004) observed a 7.1% increase in the risk of breast cancer for each additional 10g per day intake of alcohol compared to non-drinkers. The estimated risk ratio at 25g alcohol per day was 1.25, at 50g/day was 1.55 and at 100g per day was 2.41.

Similar results have been reported from the pooled analysis of studies of the effect of alcohol on colorectal cancer, with evidence of an increased relative risk of about 1.4 for colorectal cancer with regular consumption of 50g alcohol per day compared to non-drinkers (Baan et al. 2007).

Diseases of the liver and pancreas

Liver cirrhosis is characterised by the replacement of normal tissue with fibrous tissue and the loss of functional liver cells. It leads to permanent scarring of the liver that blocks blood flow and prevents normal metabolic and regulatory processes. The causal impact of heavy drinking on liver disease and on cirrhosis in particular has been known for several hundred years, and has been confirmed by recent studies (Corrao et al. 1999; Corrao et al. 2004). A meta-analysis by Rehm et al. (2010) that further investigated the dose-response relationship found that more than two drinks a day for women and more than three drinks a day for men were significantly associated with higher risk, and the risk increased with increasing volumes of alcohol consumed. This meta-analysis also suggested that for people with any signs of liver disease (even when not related to alcohol), only abstinence from alcohol could be considered safe. Moreover, there were likely to be interactions between alcohol and drugs that are used to treat liver problems (Rehm et al. 2010, p. 442).

There is a link between alcohol consumption and pancreatitis – both in its acute and chronic forms. Alcohol has numerous deleterious effects on the pancreas including direct toxicity to pancreatic

cells as well as changes of production and flow of pancreatic juice which result in mechanical obstruction of pancreatic ducts, fibrosis, and toxicity to other organ systems from the by-products of ethanol metabolism. A meta-analysis (Irving et al. 2009) of studies that had addressed the relationship between alcohol and pancreatitis found that there was evidence supporting a threshold effect (at four drinks daily) and an exponential dose-response relationship above that threshold between average volume of alcohol consumed and the risk of pancreatitis.

Cardiovascular disease

There is a complex relationship between cardiovascular disease and drinking of alcohol. Moderate consumption (one drink/15g alcohol per day for women or two drinks/30g alcohol for men) has been associated with a decreased risk for coronary heart disease in observational studies of diverse populations (Rimm et al. 1999). Brien et al. (2011) confirmed this protective effect based on a meta-analysis of interventional studies[8] that measured circulating blood levels of biomarkers linked to the risk of coronary heart disease. They concluded that there was "…compelling indirect evidence in support of a causal protective effect of alcohol" (p. 13).

This protective effect on coronary disease is often referred to as the "J-shaped curve" whereby moderate consumption of alcohol in healthy people is beneficial but excessive or binge drinking is quite the opposite (Costanzo et al. 2010). However, even occasional excessive consumption appears to wipe out any protective effect on the heart even if overall consumption is generally moderate or light (Roerecke & Rehm 2010). In contrast, alcohol consumption has detrimental effects on other cardiovascular diseases regardless of drinking pattern (WHO 2011). It is associated with sudden cardiac death, although the effect is complex and the mechanisms are not completely understood. For people with cardiomyopathy or arrhythmias, avoiding alcohol altogether is the most favourable option for reducing risk (George & Figueredo 2010). Alcohol also increases blood pressure, and increases morbidity and mortality from stroke independently from smoking (WHO 2011). Binge drinking is a significant risk factor for stroke especially in people with hypertension (Hillbom et al. 2011). Alcohol is also not recommended for young people, pregnant women, those at risk of alcoholism, or anyone whose activity calls for concentration, skill or coordination (Roerecke & Rehm 2010).

Depression

A meta-analysis of the associations between alcohol use disorder and major depression (Boden & Fergusson 2011) found that the presence of either disorder doubled the risk of the other. The association could not be accounted for fully by common factors that influence both conditions and the disorders appeared to be linked in a causal manner, with the most plausible association being that alcohol use disorder increases the risk of major depression, rather than vice versa. Potential mechanisms include neurophysical and metabolic changes linked to exposure to alcohol but further research is needed to clarify the exact nature of the linkage. Alcohol is also associated with suicidality in both adolescents and adults (O'Connell & Lawlor 2005; Galaif et al. 2007).

[8] The studies included in this meta-analysis administered controlled amounts of alcohol to participants and measured the effect on various biomarkers (for example circulating blood levels of HDL cholesterol, fibrinogen etc), compared to a period of no use of alcohol.

Infectious diseases

A recent meta-analysis (Samokhvalov et al. 2010) showed a strong and consistent relationship between alcohol and the risk of community acquired pneumonia. A relative risk of 8.22(95% CI 4.85-13.95) was found after adjusting for age, sex, smoking and other confounding factors such as comorbidities. Additionally, there was a clear dose-response relationship with increasing consumption giving a greater risk. Mechanisms involved include detrimental immunological effects of alcohol, and diminished oropharyngeal tone resulting in increased risk of aspiration and suppression of coughing. Heavy drinking also predisposes people to liver damage, nutritional deficiency, and poor personal hygiene which may result in immunity being further impaired. The same factors are likely to be involved in the elevated risk of tuberculosis in heavy drinkers (Lonnroth et al. 2008).

Type 2 diabetes

A dual relationship exists between alcohol consumption and type 2 diabetes. Light to moderate drinking may be beneficial while heavy drinking is detrimental. A recent meta-analysis (Baliunas et al. 2009) found that there was a U shaped relationship between average alcohol consumption and risk of diabetes in both men and women, although the biological mechanism for this is not clear. However, the risk of alcohol consumption on other diseases and health outcomes at even moderate levels may outweigh any positive benefits of alcohol consumption for diabetes.

Section Three: Alcohol-related harm

Alcohol use causes approximately 4% of deaths worldwide and 4.5% of the global burden of disease. This is not only because of the deleterious effect of alcohol on the drinker's health but because of the social problems caused by alcohol to the drinker and others. This places alcohol beside tobacco as a leading preventable cause of death and disability (World Health Organisation, 2011; Babor et al., 2010). Intoxication is the main cause of alcohol-related harm in New Zealand society 'because it can lead to risk-taking behaviour, accidents and injuries, violence, and acute alcohol poisoning' (World Health Organisation, 2007). Binge drinking sessions in particular are associated with acute health consequences including: road traffic injuries, falls, drowning, poisoning, assault, self-inflicted injury, and foetal alcohol spectrum disorder (Kypri et al. 2003). This section of the background paper addresses the wide range of alcohol-related harm experienced in New Zealand, including mortality, hospital presentations, crime, and social and economic costs. The ways that alcohol-related harm negatively impacts on children, Māori and people with low socioeconomic status are also explored.

Mortality

Research by Connor et al. (2004) estimated that 3.9% of all deaths in New Zealand in 2000 were attributable to alcohol consumption (approximately 1040 deaths). This study calculated that some deaths from coronary disease would have been prevented by light to moderate drinking of alcohol. However, these were almost entirely among older people, while those attributed to alcohol occurred before middle age with injury being a major contributor. The authors estimated that 17,200 years of life were lost but only 5,300 years of life gained, a net loss of almost 12,000 years of life due to alcohol in one year in New Zealand (Connor et al 2004, p.3) The study also noted that alcohol-related mortality is experienced unequally throughout the population, with men having four to five times the rate of alcohol attributable years of life lost compared to women. Māori men and women

were also found to have higher mortality and rates of years of life lost than non-Māori of the same age (Connor et al. 2004).

Hospital presentations

Research on presentations to an Auckland Emergency Department indicated that 35% of injury-based emergency department presentations were alcohol-related (Humphrey et al. 2003). The New Zealand Alcohol and Drug Use Survey found that 4.7% of adults (aged 16-64 years) had experienced an injury in the past year due to their alcohol use. Men (7.2%) were found to be significantly more likely than women (5.1%) to have experienced an injury in the past year due to their alcohol use (Ministry of Health, 2009).

Data collected from Dunedin Hospital Emergency Department for the period 1 November 2010 to 29 October 2011, identified 892 patients who were seen with alcohol-related presentations. This is considered an underestimate and does not include the victims of others' drinking. Of these 892 cases, 65% (582) were seen on a Friday, Saturday or Sunday. Over half the cases, 55% (492), were seen between 9pm and 6am, a time when staffing and other hospital resources are at their lowest. The length of stay in the Emergency Department was over four hours for 62% (560) of these presentations. The average length of stay for uncomplicated intoxicated patients was 4.5 hours with an average cost to the tax payer of $1000.

Alcohol-related presentations to Emergency Departments throughout New Zealand impact negatively upon staff. A recent study of Wellington Regional Hospital Emergency Department found that a large proportion of *all* Emergency Department staff regularly experienced aggressive and abusive behaviour from intoxicated patients. A large proportion of Emergency Department nurses and ambulance staff also reported experiencing physical assault from intoxicated patients (Gunasekara, et al. 2011). Intoxicated patients presenting to Emergency Departments were reported to negatively impact the quality of care for other patients, for example other patients frequently reported feeling threatened, which could contribute to the stress of their conditions (Gunasekara et al., 2011).

An investigation of the wholly alcohol-attributable hospital admissions for the period 1986 to 2006 indicates the majority of these admissions were for mental and behavioural disorders due to alcohol use. Admissions for mental and behavioural disorders were highest in the 35 to 44 year age group, but occurred in relatively large numbers for all age groups. The largest relative and absolute increase in wholly alcohol-attributable hospital admissions was in the 15 to 19 years age group, which increased by 126% over this period. This is arguably a result of the lowering of the purchase age of alcohol in 1999 (Law Commission 2010).

Traffic crashes

It is well established that alcohol consumption degrades driving performance and negatively impacts driving behaviour. Numerous studies also illustrate that the risk of being involved in a vehicle accident increases as a driver's blood alcohol level increases (Ministry of Transport, 2010). Driver consumption of alcohol causes significant harm in New Zealand through death, injury, and the associated social costs (Ministry of Transport, 2010).

> In 2009 driver alcohol and or drug use was a contributing factor in 113 fatal traffic crashes, 420 serious injury crashes and 1,107 minor injury crashes. These crashes resulted in 138 deaths, 576 serious injuries and 1,743 minor injuries. The total social cost of crashes involving alcohol or drugs

was about $890 million; that is nearly a quarter of the social cost associated with all injury crashes. (Ministry of Transport, 2010).

Twenty seven percent of drivers in all fatal crashes between 2007 and 2009 were reported as having consumed alcohol. Alcohol and drugs were a contributing factor in almost 21% of all serious injury crashes and 13% of minor injury crashes in New Zealand between 2007 and 2009 (Ministry of Transport, 2010).

The harm associated with alcohol-related traffic crashes is often experienced by those other than the alcohol impaired driver, for instance 40% of alcohol-related traffic crash injury is experienced by those other than the alcohol impaired driver (Connor & Casswell, 2009).

For every 100 alcohol or drug-impaired drivers or riders killed in road crashes, 56 of their passengers and 26 sober road users die with them (Ministry of Transport, 2010).

Crime

Alcohol intoxication is associated with violence and aggression:

…a causal link between alcohol intoxication and aggression has been supported by epidemiological and experimental research, as well as by research indicating specific biological mechanisms linking alcohol to aggressive behaviour. Experimental studies suggest a causal relationship between alcohol and aggression…although this relationship is clearly moderated by gender and personality as well as by situational and cultural factors (Babor et al., 2010, p.46).

New Zealand Police's 2009 *National Alcohol Assessment* clearly demonstrates the significant contribution of alcohol to crime in New Zealand. Of all recorded offences in the year 2007/08:

- At least 31% of offences were committed where the offender had consumed alcohol prior to committing the offence
- At least one third of violence offences occurred where the offender had consumed alcohol prior to committing the offence

The number of alleged offenders identified as having consumed alcohol prior to offending increased from 27% in 2005/06 to 32% in 2007/08 (New Zealand Police, 2009).

Alcohol consumption has been identified as a factor in homicides in New Zealand. Either a suspect or victim was found to have been under the influence of alcohol in 49.5% of the 489 homicides recorded between 1999 and 2008 (New Zealand Police, 2009). A Ministry of Social Development investigation of 141 family violence-related homicides found that alcohol and or drug abuse was a factor in approximately two thirds of the couple-related homicides, and was common as both a factor in perpetrator's backgrounds and as a factor at the time of the event (Ministry of Social Development, 2009).

Alcohol and or drug abuse also featured strongly in child homicides, causing researchers to conclude that:

…children are at highest risk of death from maltreatment in their first year of life and when they live with young unemployed parents or caregivers who abuse alcohol and drugs (Ministry of Social Development, 2009).

District Court Judges have also commented on the impact of alcohol use and abuse on the justice system, estimating that up to 80% of defendants coming before the criminal courts have alcohol or

other drug use abuse or dependency issues, and that alcohol is the drug of choice in three-quarters of these cases (Law Commission, 2009).

Social costs

New Zealanders experience a range of social harms due to their own, or other people's alcohol use and abuse. The New Zealand 2007/08 Alcohol and Drug Use Survey found that one in eight adults[9] (12.2%) had experienced harmful effects from their own drinking in the past year. These included harmful effects on friendships or social life, home life, work/study/employment opportunities, financial position, and legal problems or difficulty learning (Ministry of Health, 2009). These harms were not distributed evenly throughout the population. Men (9.8%) were more likely than women (6.1%) to be affected, and men living in the highest deprivation area (NZDep2006 quintile 5) (12.9%) being more likely than men living in the least deprived area (NZDep2006 quintile 1) (5.3%) to report that they had experienced harmful effects on friendships and social life due to their own drinking (Ministry of Health, 2009).

New Zealanders with lower socioeconomic status bear a disproportionate burden of alcohol-related harm. People living in more socioeconomically deprived neighbourhoods are generally more likely than people living in less deprived areas to have experienced :

- harmful effects in the last year due to their own alcohol use
- harmful effects on their home life in the past year due to someone else's alcohol use
- assault (physical and/or sexual) in the past 12 months due to someone else's use of alcohol or drugs (Ministry of Health, 2009).

Research also shows that many New Zealanders experience harm caused by someone else's drinking. In the 2007/8 New Zealand Alcohol and Drug Use Survey one in six adults (18.1%) had experienced harmful effects on their friendships/social life, home life or financial position due to someone else's drinking. Significantly more women (22.8%) than men (17.0%) had experienced such harm from someone else's drinking (Ministry of Health, 2009).

Recent New Zealand research (Casswell et al., 2011a) found a significant association between a person's exposure to a heavy drinker and reduced personal wellbeing and poorer health status. Over 28% of the study sample reported having one or more heavy drinkers in their lives. This research indicates that a large proportion of New Zealanders report harm from the drinking of others. This includes a wide range of harms, such as being physically hurt, emotionally hurt and neglected, and lower work productivity. A large proportion reported at least one adverse event that was attributed to the drinking of a stranger (Casswell et al., 2011b). An Australian national study that surveyed a randomly selected sample of 2,649 adults (Laslett et al) found that 70% of them reported experiencing nuisance, fear, or abuse from strangers' drinking and 30% reported negative effects from someone close to them, whether family, friends, or co-workers.

Heavy drinking makes a significant contribution to workplace absenteeism, impaired work performance, lack of productivity, and low morale both when consumed within or outside of normal work hours (Bacharach et al 2010; Spicer et al 2003; Frone 2006; Bery et al 2007). A study of 2,805 employed adults in the United States, for example, found that 15% reported consuming alcohol before work, during the work day, working under the influence, or working with a hangover (Frone 2006). Data from an Australian national survey showed that high risk drinking occurred at least occasionally in 44% of workers (Bery et al 2007). Other studies have found drinking, hangovers, and a workplace culture that condones high alcohol use are significant contributors to arguments with supervisors and co-workers, falling asleep on the job, harassment of female

[9] Included adults aged 16-64 (Ministry of Health, 2009).

employees, and medical problems and injuries (Ames et al 1997; Bacharach et al 2007; Bery et al 2007).

Children and young people

There are numerous concerns about the impact of alcohol on children and young people's wellbeing. Aside from the effects of alcohol on foetal development already discussed above, children may suffer from:

- increased susceptibility to child abuse and neglect if caregivers have an alcohol problem
- increased likelihood of exposure to family violence
- increased risk of injury from other persons under the influence of alcohol, ie. vehicle accidents, accidental and non-accidental injury, and
- increased risk of early exposure to alcohol themselves (Law Commission, 2010, Girling et al., 2006).

Children are particularly vulnerable to harms caused by others' drinking. Research about people with a heavy drinker in their lives found that 17% of respondents with children under 18 years old indicated their children had been negatively affected by someone else's drinking in the last 12 months. This included being verbally abused and witnessing violence (Casswell et al., 2011b).

As earlier stated, caregivers with alcohol problems featured strongly in a review of child homicides in New Zealand (Ministry of Social Development, 2009). Another review, looking at the deaths of children between 2005 to 2007[10] found that alcohol was a significant contributing factor in a range of child deaths. Alcohol was found to be involved in 31% of the 158 deaths of children due to vehicle crash injuries.[11] Alcohol was also involved in 19.1% of the 199 child deaths due to drowning, assault, poisoning, suffocation or falls (Child and Youth Mortality Review Committee, 2009).
Infants and younger children (under 15 years of age) had significantly fewer deaths involving alcohol (2.2% of 92 deaths) compared to young people (15 to 24 years of age) (32.1% of 265 deaths) (Child and Youth Mortality Review Committee, 2009).

Alcohol contributes to child deaths differently, depending on age. For infants and young children, alcohol impacts the quality of care giving, contributes to family violence and leads to under-supervision of vulnerable infants and children. In contrast there is a dramatic increase in death rates from injury for those 15 years and older, which is largely related to adolescent risk-taking behaviour which alcohol consumption contributes to (Child and Youth Mortality Review Committee, 2009).

Early exposure to alcohol (consumption on multiple occasions before 15 years of age) is linked to a range of poor adult outcomes, including substance dependence, criminal conviction, herpes infections and failure to achieve educational qualifications (Law Commission, 2010, p.89).

The negative impact of alcohol on adolescents was also identified by the New Zealand Alcohol and Drug Use Survey, which found that a quarter (23.0%) of people aged 16 to 17 years had experienced harmful effects on their friendships or social life in the past year due to someone else's drinking, and one in five (18.8%) had experienced injuries in the past year due to their own alcohol use (Ministry of Health, 2009).

[10] This review focussed on motor vehicle deaths during 2007 and deaths other than motor vehicle (specifically drowning, assault, suffocation, poisoning and falls) from 2005 to 2007 (Child and Youth Mortality Review Committee, 2009).
[11] This included 16 as drivers, 17 as passengers and 14 as pedestrians (Child and Youth Mortality Review Committee, 2009).

Foetal exposure to alcohol during gestation can cause Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder (FASD), which in turn, are associated with a range of adverse life experiences, including disrupted schooling experiences, trouble with the law, confinement (in jail, prison, or a psychiatric or alcohol/drug inpatient settings), inappropriate sexual behaviours, and drug and alcohol problems (Streissguth, et al., 2004).

Māori

Evidence clearly demonstrates that Māori suffer disproportionately from a wide range of alcohol-related harms compared to non-Māori. This is shown by:

- Māori being more likely to die from alcohol-related causes (Māori have 4.2 times the alcohol related mortality of non-Māori and double the rate of years of life lost due to alcohol) (Connor et al., 2005)
- Māori men being significantly more likely to experience harmful effects on financial position, work, study or employment, experience injuries or having legal problems due to alcohol use (Ministry of Health, 2009)
- Māori women being twice as likely to experience harmful effects on home life, social life or financial position, experience injuries or legal problems due to alcohol use (Ministry of Health, 2009)
- Māori women being four times more likely than non-Māori women to have been assaulted by someone who had consumed alcohol (Ministry of Health, 2009)
- Māori being more likely to be apprehended by police for an offence that involved alcohol (New Zealand Police, 2009).

Economic costs and benefits

Alcohol-related harm in New Zealand has a significant economic cost, including the cost of injury, adverse effects on businesses and employment issues. Harmful alcohol use in 2005/06 alone cost New Zealand an estimated $4,794 million of diverted resources and lost welfare. Injuries from harmful alcohol use in 2005/06 cost an estimated $1.592 billion in New Zealand (Slack et al., 2009).

Businesses have reported various day-to-day adverse effects of alcohol including vandalism, environmental hazards that need to be cleaned up (eg. urine, vomit, broken glass) and loss of trade due to public safety concerns (Law Commission, 2010).

Alcohol has a negative impact on work and study productivity, with the Alcohol and Drug Use Survey finding that:

- 3.2% of adults reported harmful effects to their work, study or employment opportunities as a result of alcohol use in the last year
- An estimated 5.6% of respondents reported having one day off school or work in the last 12 months as a result of alcohol use
- Nearly one in ten adults worked while feeling under the influence of alcohol (Ministry of Health, 2009).

Alcohol does have a number of economic benefits to society in terms of creating employment and export earnings. According to the National Business Review (Swann 2009), in 2009 the wine industry alone was worth $1.5 billion to New Zealand's gross domestic product, and was the 11th largest export, representing 2.2% of total goods exported. The same article noted that the wine industry provided 16,568 full time jobs and contributed to tourism, with over 200,000 visitors annually to vineyards and related events. These tourists also on average stayed longer and spent more than other tourists. The export of spirits and liqueurs has also increased in recent years, with a

contribution of $52.6 million to the economy in the year 2010-2011 (National Business Review 2011).

Section Four: Reducing alcohol-related harm

As outlined in the previous sections, there is strong evidence that New Zealanders' lives are affected by alcohol in numerous ways ranging from preventable mortality, and morbidity, to the effects of violence and lost productivity. It has been argued that this harm has resulted from an increasingly liberalised environment for the sale of alcohol, and societal attitudes which encourage excessive drinking. This section looks at measures that have been shown to be effective in reducing alcohol-related harm. Much of it draws on the work by Babor et al (2010) *Alcohol: no ordinary commodity* which documents the reasons why effective alcohol policies need to take account of the physical, social and economic environments in which people live rather than merely concentrating on the health effects alone.

Increasing taxation

Increasing alcohol taxes has been shown to be highly effective in reducing alcohol consumption and therefore alcohol related harm. Moreover it is not expensive to implement. Evidence shows that when prices go up, alcohol consumption goes down (Babor et al 2010; Ministry of Justice 2007).

Currently, New Zealand's excise tax rate is lower than other nations. The tax on beer in New Zealand for example (10%), is much lower than that in Australia (24%) (Casswell and Maxwell 2005). New Zealand also has an excise tax policy that groups alcoholic beverages into 'bands' – for instance, alcoholic beverages with an alcohol content between 9-14 % are taxed at the rate of 10% (Alcohol Healthwatch undated). This means that manufacturers have an incentive to create higher-alcohol content drinks in order to get the best tax advantage. Instead, the excise tax could be based directly on the level of ethanol in the product.

Alcohol prices are subject to the economic theory of supply and demand. That is, when there is an increased supply and high demand for alcohol, or when there is a constant supply but decreased demand, prices go down. Thus, "deliberate changes in prices will affect the supply and demand relationship" (Babor et al. 2010, p.110). Therefore a strategy for government is to increase excise taxes on alcohol (and increase revenue), leading to increased alcohol prices which in turn leads to decreased alcohol consumption. Other factors affecting alcohol prices (apart from excise tax) include differences in price between on-premise and off-premise outlets and the geographical distance and transport needed to access supplies of alcohol.

There has been a worldwide trend towards reduced alcohol prices since 1950. One reason for this is that excise taxes are set at a fixed amount, and are not adjusted for inflation. Unless legislation sets a new tax level, in line with inflation, excise taxes on alcohol do not reflect the value of the local currency.

Alcohol price changes may particularly affect youth and heavy drinkers. Studies have shown that young people drink less when beer prices go up (Coate and Grossman 1988). Babor et al. (2010, p. 121) draw attention to a number of studies that have shown higher beer taxes have significantly reduced both the frequency of youth drinking and the probability of heavy drinking, with heavy drinkers being more affected by price increases than occasional drinkers (Laixuthai and Chaloupka 1993). These studies also noted a reduction in violence in association with higher alcohol prices. Higher prices may also result in changes in health outcomes. In the U.S. between 1960 and 1975, when liquor taxes (and prices) went up, cirrhosis mortality went down (Cook 1981).

Reducing the purchase age

Changes to the minimum purchase age have been shown to substantially affect youth drinking. For example, in the 1970s and 1980s in the United States, the minimum alcohol purchase age fluctuated greatly. One study showed that when the minimum purchase age was increased to 21 it led to reduced alcohol use among young Americans and a decrease in traffic crashes (O'Malley and Wagenaar 1991). Other studies in the U.S. have shown that the effectiveness of limiting supply to youth is dependent upon enforcement – otherwise young people are still able to access alcohol (Wagenaar and Wolfson 1994).

Reducing availability

Reducing the physical availability of alcohol is a strategy that is effective yet relatively inexpensive to implement. The cost of restricting alcohol availability is low relative to the health consequences of drinking. The main methods of reducing the availability of alcohol are through restricting hours and days of sales, and controlling the number, location, and type of retail premises. Regulations can be imposed such as government ownership of alcohol outlets, outlet location and limiting 'bunching' (e.g. minimum distance between outlets), limiting the number of outlets, restricting hours and days of sale, and restricting the density of retail outlets (Babor et al. 2010). Studies have shown that changing the hours and days of sale has "significant impacts on the volume of alcohol consumed and the rates of alcohol- related problems" (Babor et al. 2010, p.136). Restricting sales of alcohol from off-licence premises is most likely to affect those who do not keep a supply of alcohol.

Another factor influencing the availability of alcohol is the location and density of liquor outlets. Governments can impose laws limiting the location of alcohol outlets, and these can be enforced at local and national level. For example, zoning laws may impose restrictions on the location of outlets nears schools and churches. Density of outlets can be regulated by declaring a minimum distance between them, or by limiting the number of outlets in an area, or both. The 'bunching' of bars and restaurants, is considered to give rise to alcohol-related problems. Traffic crashes in particular are more likely to occur in high-density alcohol outlet areas. Changing the number of outlets in an area can therefore influence consumption of alcohol and alcohol-related problems (Babor et al. 2010, p.131).

Further restrictions can be put in place concerning how alcohol is sold at on-premise and off-premise locations. There is likely to be more control over sales from on-premises than off-premises. With on-premise sales there is room to influence a variety of factors around the sale of alcohol including specifying drink sizes, non-discounted drink promotions, and responsible and trained service.

Government ownership of alcohol outlets has been shown to reduce the number of outlets, limit the hours of sale, and remove the profit motive. There is evidence that off-premise monopoly systems limit alcohol consumption and alcohol-related problems; and conversely, that the elimination of government off-premise monopolies can increase alcohol consumption. For example, Swedish alcohol consumption increased when beer became available in grocery stores between 1965 and 1977.

It is possible to further restrict the physical availability of alcohol through regulating who may sell alcohol. Those who sell alcohol are required to hold a license to do so. It is common to check the credentials of those who seek licenses, for example, excluding those with a criminal history. The Law Commission report recommended tightening up regulations on who may obtain a liquor

licence – they must be a "suitable person" and declared that there were "serious problems" with laws relating to off-licences, particularly the number of small liquor outlets (p.14). The report recommended prohibiting service stations and takeaway food stores from selling alcohol and that spirits and RTDs should only be available from specialist alcohol outlets (Law Commission Report Summary, p.14).

Modifying the drinking context

Efforts to reduce alcohol harm can be focused on the environments where alcohol is bought and consumed. It has been shown that aspects of the bar environment such as serving practices that promote intoxication, aggressive bar staff and the inability to manage problem behaviour make alcohol-related problems worse (Babor et al. 2010, p.149). Approaches to modifying the drinking context include responsible beverage service training and in-house policies for licensed premises, enhanced enforcement of sanctions for breaching the regulations relating to the sales of alcohol, the legal liability of servers, managers and owners of licensed premises, voluntary codes of practice, interventions for managing aggression and other problem behaviour, reducing environmental precipitants of aggression, and community mobilization approaches (Babor et al. 2010, p.149-162). Limiting the strength of alcoholic beverages; and promotion of alcohol-free activities are also likely to have an influence.

Restricting marketing, promotion and sponsorship

Advertising of alcohol has increased in many countries over recent decades, and studies have shown it to have detrimental effects. Increasingly, countries have left the regulation of alcohol promotion to the self-regulation of the industry. Research shows that alcohol advertising can have a detrimental effect on young people, exposing them early to the messages that alcohol is attractive, glamorous and fun. If these messages permeate the environment at a young age they may set drinking patterns in later life. Effectively, alcohol advertising leads to greater consumption of alcohol (Babor et al. 2010, p.188-189). A further effect of alcohol advertising is to colour how people perceive the drinking habits of others, thus normalising drinking behaviour. Since the early 1990s, sponsorship of sports and cultural events has become common, particularly those that appeal to young people. These events combine marketing messages on products, giveaways, and grounds signage and associate them with good times and with drinking the sponsors product. McCreanor et al (2008), draw attention to the Export Gold campaign in 2004 that used as its slogan "The best weekend you'll never remember" in a competition aimed at young people, describing it as "…the synergistic, cumulative effects of environmental exposure of young people to alcohol marketing [which] creates and maintains expectations and norms for practices of drinking to intoxication." (p. 944)

Legislation may attempt to partially restrict alcohol advertising, for example by banning the advertising of spirits, or restricting hours of advertising to particular times on television. Research into the effect of such legislation has been inconclusive to date, largely because of methodological difficulties and limited experience internationally of countries that have implemented comprehensive restrictions. Babor et al (2010), however, concluded that the "…most probable scenario, based on the theoretical and empirical evidence available, is the extensive restriction of marketing would have an impact" (p. 188).

Drink-driving counter-measures

Alcohol greatly impairs how well a person can drive. As levels of alcohol in the blood go up, driving performance declines. Research has shown that judgement and reaction times are impaired at a BAB of 0.05% and substantially diminished at 0.10% (Davis et al 2003 cited in Babor et al 2010, p. 166). Impairment risk goes up exponentially with increasing amounts of alcohol: at a BAC of 0.08% the relative risk of any crash involvement is 2.7 and at a BAC of 0.15% the relative risk is 22.1 (Babor et al 2010, p. 166). Various measures can be instigated to counter this, one of which is to set maximum Blood Alcohol Concentration (BAC) levels (see Section One). Enforcement includes random breath-testing to check these levels, and penalties for those who exceed the drink-driving BAC limits. Further restrictions may also be placed on younger or inexperienced drivers, for example, reducing the legal BAC level to 0 for drivers under 20, as has just been done in New Zealand in 2011.

Acting to reduce alcohol-related harm

There is increasing concern about the misuse of alcohol in New Zealand society and the need to take action to reduce the harm it causes.

In their report on curbing the harm from alcohol, the Law Commission Report (2009) proposed an 'Alcohol Harm Reduction Act' which would:

> … encourage responsible attitudes to the promotion, sale, supply and consumption of alcohol; contribute to the minimisation of crime, disorder and other social harms; delay the onset of young people drinking alcohol; protect and improve public health; promote public safety and reduce public nuisance; and reduce the impact of the harmful use of alcohol on the Police and public health resources.

In order to reduce alcohol-related harm, the Commission recommended:

> …restricting the times alcohol can be sold; restricting the places alcohol can be sold; preventing a growing proliferation of alcohol outlets; increasing the purchase age for alcohol; expanding the grounds upon which a liquor licence can be declined; providing for more local input into liquor licensing decisions; reorganising and upgrading the efforts of local authorities in relation to alcohol decisions; providing for local alcohol policies to be decided by councils; financing liquor licensing, monitoring and compliance through licence fees, not a combination of fees and ratepayer contributions; tightening the law about off-licences; and improving regulation of special licences" (Law Commission Report Summary, p.13).

The South Island District Health Boards are gravely concerned about the effect that misuse of alcohol has, either directly or indirectly, on the health and wellbeing of all New Zealanders and particularly the disproportionate effect that it has on the most vulnerable members of society. In their role as leaders responsible for promoting and protecting the health of their constituents the Boards are publishing a joint Position Statement which indicates that concern and sets out a number of recommendations for actions that can and should be taken to address the harm created by alcohol.

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COMMUNITY & PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEE MEETING UPDATE – 24 MAY

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

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

DATE: **8 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board as an interim update on the Community & Public Health & Disability Support Advisory Committee (CPH&DSAC) meeting of 24 May 2012. Following confirmation of the minutes of that meeting at the 12 July 2012 meeting, full minutes of the 24 May 2012 meeting will be provided to the Board at its 20 July 2012 meeting.

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

"*With respect to Community and Public Health, is to provide advice and recommendations to the Board of the West Coast District Health Board on:*
- *the health needs of the resident population of the West Coast District Health Board; and*
- *any factors that the Committee believes may adversely affect the health status of the resident population, and*
- *the priorities for the use of the health funding available*

With respect to Disability Support, are to provide advice and recommendations to the Board of the West Coast District Health Board on:
- *the disability support needs of the resident population of the West Coast District Health Board, and*
- *the priorities for the use of the disability support funding provided.*"

The aim of the Committee's advice must be:
- *to ensure that the services that the West Coast District Health Board provides or funds, along with the policies it adopts, will maximise the overall health gain for the resident population of the West Coast District Health Board, and*
- *to ensure that the kind of disability support services that the West Coast District Health Board provides or funds, along with the policies it adopts, will promote the inclusion and participation in society, and maximise the independence, of people with disabilities within the resident population of the West Coast District Health Board."*

The Committee's advice to the Board must be consistent with the priorities identified in the New Zealand Health Strategy, the New Zealand Disability Strategy and with the Strategic Plan and the Disability Support Action Plan of the West Coast District Health Board."

2. RECOMMENDATION

That the Board:

i. notes the Community & Public Health & Disability Support Advisory Committee Meeting Update – 4 May 2012; and

ii. notes that a recommendation from the Committee to the Board regarding the adoption of the position statement on alcohol is included in the agenda of this meeting.

3. SUMMARY

ITEMS OF INTEREST FOR THE BOARD

- Appointments have been made to the Consumer Council and the first meeting has been held.
- Discussion re the West Coast DHB Policy for identifying/reporting of violence against men and children and whether this is documented at ED.
- Community and Public Health report re the Position Statement on Alcohol was discussed.
- A workshop was held at Kahurangi following the meeting re Quality and Patient Safety management and what would be relevant for reporting to CPHAC/DSAC. Further information to be brought back to a follow on workshop prior to a decision being made.

4. APPENDICES

Appendix 1: Agenda – Community & Public Health & Disability Support Advisory Committee – 24 May 2012.

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

AGENDA

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

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
To be held in the Board Room at Corporate Office, Grey Base Hospital, High Street, Greymouth
Thursday 24 May 2012 commencing at 9.00am

ADMINISTRATION			**9.00am**
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Meeting & Matters Arising** ▪ *12 April 2012*		
REPORTS/PRESENTATIONS			**9.10am**
3.	**Chairs Report** *(CPHAC & DSAC)*	Elinor Stratford *Chair*	*9.10am-9.20am*
4.	**Workplan** *(CPHAC & DSAC)*	Elinor Stratford *Chair*	*9.20am-9.30am*
5.	**Organisational Leadership Report** *(WCDHB)*	Wayne Turp *General Manager, Planning & Funding*	*9.30am-9.40am*
6.	**Clinical Leadership Report** *(WCDHB)*	Dr Carol Atmore *Chief Medical Officer, WCDHB*	*9.40am-9.50am*
7.	**Better Sooner More Convenient and Alliance Leadership Team Report** *(WCDHB)*	Wayne Turp *General Manager, Planning & Funding*	*9.50am-10.00am*
8.	**Primary Health Organisation Quarterly Report** *(PHO)*	Anthony Cooke *Director PHO*	*10.00am-10.10am*
9.	**Quality and Patient Safety Report (**a workshop will take place directly after this meeting – 11:15 at Kahurangi**)** *(WCDHB)*	Rachel Hunt, *Quality and Patient Safety Manager*	*10.10am-10.20am*
10.	**General Business**		
	Items to be reported back to Board	Elinor Stratford *Chair*	*10.20am-10.25am*
	Primary Practices: *(WCDHB)*	Hecta Williams *General Manager*	*10.25am-10.30am*
	Finance: *(WCDHB)*	Colin Weeks *Chief Financial Manager*	*10.30am-10.35am*
	South Island District Health Board "Position Statement on Alcohol" *(CPHAC & DSAC)*	Dr Cheryl Brunton *CDHB*	*10.35am-10.40am*
IN-COMMITTEE SECTION			*10.40am -10.45am*
ESTIMATED FINISH TIME			**10.45am**

11. INFORMATION ITEMS

Community and Public Health and Disability Support Advisory Committee Terms of appointment

Community and Public Health and Disability Support Advisory Committee Schedule

Community and Public Health and Disability Support Advisory Committee Terms of Reference

NEXT MEETING

Date of Next Meeting: 12 July 2012 commencing at 9.00am

HOSPITAL ADVISORY COMMITTEE MEETING UPDATE – 24 MAY 2012

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

SOURCE: **Chair, Hospital Advisory Committee**

DATE: **8 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board as an interim update on the Hospital Advisory Committee (HAC) meeting of 24 May 2012. Following confirmation of the minutes of that meeting at the 12 July 2012 HAC meeting, full minutes of the 24 May 2012 meeting will be provided to the Board at its 20 July 2012 meeting.

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

"- monitor the financial and operational performance of the hospital and specialist services of the West Coast DHB; and
- *assess strategic issues relating to the provision of hospital and specialist services by the West Coast DHB; and*
- *give the Board advice and recommendations on that monitoring and that assessment.*

The Hospital Advisory Committee's advice to the Board must be consistent with the priorities identified in the New Zealand Health Strategy and with the Strategic Plan of the West Coast DHB."

2. RECOMMENDATION

That the Board:

i. notes the Hospital Advisory Committee Meeting Update – 24 May 2012.

3. SUMMARY

Detailed below is a summary of the HAC meeting on 28 July 2011. Minutes of the meeting will be available once confirmed by the next HAC meeting on 1 September 2011. Papers presented to the Committee meeting are available on the West Coast DHB website. A copy of the agenda for this meeting is attached as Appendix 1.

ADVICE TO THE BOARD

The Committee noted the following key points which it wished to draw to the attention of the Board:

- Positive progress
  - Practical implementation of XCELR8 projects and benefits which are occurring – transfer of acute cardiac patients.
  - Recruitment of clinical specialists - indication that recruitment strategy is working along with a renewed emphasis on initiatives to ensure retention of key staff.

- Ongoing Monitoring
  - Financial position – ability of the West Coast DHB to meet the year end target remains challenging.

- Caseweights – overproduction in orthopaedics is under current review.
- Elective Services Patient Flow Indicators (ESPIs) – new processes established by the Central Booking Unit along with better engagement with clinicians are key to improvement in this area.
- Outpatient Department Cancellations – ongoing improvements to communication initiatives for patients need to remain a priority.

- Follow-up
  - Staff Survey Results – key findings to be reviewed by the Hospital Advisory Committee on availability.
  - Exit Interviews – standing quarterly item needs to be included highlighting whether any trends (positive/negative) are emerging.

4. APPENDICES

Appendix 1: Agenda - Hospital Advisory Committee – 24 May 2012.

Report prepared by: Warren Gilbertson, Chair, Hospital Advisory Committee

AGENDA

FOR THE WEST COAST DHB HOSPITAL ADVISORY COMMITTEE MEETING 24 MAY 2012 FROM 11.00 AM TO 1.00 PM

Karakia

1. Welcome and Apologies
2. Disclosure of Committee members' interests
3. Minutes of the last meeting 12 April 2012

   Feedback from report to the Board
4. Matters Arising / Action and Responsibility
5. Correspondence
6. Work Plan

6.1 Health Targets

6.2 Monitor performance of the Provider arm

- 11.30am - Presentation – Xcelr8 Project
- Management Team Report
- Operational Indicators – Caseweights
- Financial Report
- Elective Services Patient Flow Indicators
- Outpatient Department Cancellations
- Clinical Leaders Report and Terms of Reference

6.3 Investigations / Scoping

- Monitoring Inter District Flows – Patient Transfers

7. Items to be reported back to Board

TATAU POUNAMU ADVISORY GROUP MEETING UPDATE – 24 MAY 2012

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

SOURCE: **General Manager, Maori Health**

DATE: **8 June 2012**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to the West Coast DHB Board as an interim update on the Tatau Pounamu Advisory Group meeting of 24 May 2012. Following confirmation of the minutes of that meeting at the 11 July 2012 Tatau Pounamu Advisory Group meeting, full minutes of the 24 May 2012 meeting will be provided to the Board at its 20 July 2012 meeting.

For the Board's information the following is the role and aims of the Tatau Pounamu Advisory Group, as stated in the Memorandum of Understanding:

"Role
"To give advice on:
- *the needs and any factors that the committee believe may advance and improve the health status of Maori, also advise on adverse factors of the resident Maori population of Te Tai o Poutini, and:*
- *priorities for use of the health funding provided."*

Aims
- *To provide advice that will maximise the overall health gain for the resident Maori population of Te Tai o Poutini through:*
  - *all service interventions the West Coast District Health Board has provided or funded or could provide or fund for that population; and.*
  - *all policies the West Coast District Health Board has adopted or could adopt for the resident Maori population of Te Tai o Poutini"*

2. RECOMMENDATION

That the Board:
i. notes the Tatau Pounamu Advisory Group Meeting Update – 24 May 2012.

3. SUMMARY

Detailed below is a summary of the Tatau Pounamu meeting on 24 May 2012. A copy of the agenda for this meeting is attached as Appendix 1.

ITEMS OF INTEREST FOR THE BOARD

The Group noted the following key points:

- **Maori Health Plan – 2012-2013**
  The first draft has been sent to the Ministry of Health and the final Maori Health Plan is due to the Ministry of Health on 1 June 2012.

- **Maori Health Review**
  The Consultants at present are drafting a report along with it's recommendations, this will be due out within the next few weeks.

- **Rata Te Awhina Trust**
  The General Managers of Maori Health and Planning and Funding met with the Rata Te Awhina Trust Board on 9 May 2012. The General Manager Maori Health has also met with Rata Te Awhina Trust staff on 24 and 28 May 2012 to discuss and further develop the draft Maori Health Plan.

- **Buller Health Hui May**
  This was a follow-up hui with the Maori community from the April hui. There was a very good turn out. A plan of action has now been drafted as a consequence of these discussions. .

4. APPENDICES

Appendix 1: Agenda – Tatau Pounamu Advisory Group Meeting – 24 May 2012.

Report prepared by: Gary Coghlan, General Manager, Maori Health

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

AGENDA

TATAU POUNAMU MANAWHENUA ADVISORY GROUP HUI TO BE HELD 24 MAY 2012 AT BOARD ROOM, CORPORATE OFFICE, GREY BASE HOSPITAL, HIGH STREET, GREYMOUTH STARTING AT 3.30PM

ITEM	KARAKIA / WELCOME	WHO
1	Agenda & Apologies	
2	Disclosures of Interests	
3	Minutes for the meeting held Wednesday, 11 April 2012	
4	Matters Arising from the last meeting	
	MEETING ITEMS	
5	Maori Health Report	GM Maori Health
6	Review of Services - Maori Health Project	GM Maori Health
7	Maori Health Plan 2012-2013 draft	GM Maori Health
8	Buller Health Hui - 16th April and 17 May 2012	GM Maori Health
9	HEHA/Smokefree Update	HEHA and Smokefree Services Manager
10	West Coast PHO – Maori/Pacific Enrolments	
	GENERAL BUSINESS	
11	Correspondence	
12	2012 Meeting Schedule	

RESOLUTION TO EXCLUDE THE PUBLIC

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

SOURCE: **Board Secretariat**

DATE: **8 June 2012**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The following agenda items for the meeting are to be held with the public excluded. This section contains items for discussion that require the public to be excluded for the reasons set out below. The New Zealand Public Health and Disability Act 2000 (the "Act"), Schedule 3, Clause 32 and 33, and the West Coast DHB Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATION

That the Board:

i resolve that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and the information items contained in the report.

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the New Zealand Public Health and Disability Act 2000 (the "Act) in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting of 20 April 2012	For the reasons set out in the previous Board agenda.	
2.	Grey Base Hospital Draft Indicative Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
3	West Coast Integrated Health Services – Model of Care	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4	DHB Primary Practice Autonomy	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Chief Executive and Chair - Update on Emerging Issues	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	s9(2)(j) S9(2)(a)
6.	Clinical Leaders Update	Protect the privacy of natural persons To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)

7.	Buller IFHC – Facilities Development	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8	Collective Insurance Renewal	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9	HBL Collective Banking Agreement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10	HBL Draft Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11	Risk Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons	s9(2)(j) S9(2)(a)
12.	Advisory Committee – Public Excluded Updates	For the reasons given in the Committee agendas	S9(2)(a)

iii notes that this resolution is made in reliance on the New Zealand Public Health and Disability Act 2000 (the "Act"), Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982";

3. SUMMARY

The New Zealand Public Health and Disability Act 2000 (the "Act"), Schedule 3, Clause 32 provides:

"A Board may by resolution exclude the public from the whole or any part of any meeting of the Board on the grounds that:

(a) the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6,7, or 9 (except section 9(2)(g)(i) of the Official Information Act 1982".

In addition Clauses (b) (c) (d) (e) of Clause 32 provide further grounds on which a Board may exclude members of the public from a meeting, which are not considered relevant in this instance.

Clause 33 of the Act also further provides:

"(1) Every resolution to exclude the public from any meeting of a Board must state:

(a) the general subject of each matter to be considered while the public is excluded; and

(b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on Clause 32(a) the particular interest or interests protected by section 6 or 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and

(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32)

(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution must be available to any member of the public who is present and from part of the minutes of the Board".

Approved for release by: General Manager

ATTENDANCE

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

WEST COAST DISTRICT HEALTH BOARD MEMBERS

Paul McCormack (Chair – (on Leave of Absence))
Peter Ballantyne (Acting Chair)
Kevin Brown
Warren Gilbertson
Helen Gillespie
Mary Molloy
Sharon Pugh
Elinor Stratford
Doug Truman
John Vaile
Susan Wallace

Executive Support

David Meates *(Chief Executive)*
Hecta Williams *(General Manager)*
Dr Carol Atmore (*Chief Medical Advisor)*
Garth Bateup *(Acting General Manager, Hospital Services)*
Gary Coghlan *(General Manager, Maori Health))*
Brian Jamieson *(Communication Officer)*
Karyn Kelly *(Director of Nursing & Midwifery)*
Wayne Turp (*General Manager, Planning and Funding)*
Stella Ward *(Executive Director, Allied Health)*
Colin Weeks *(Chief Financial Manager)*
Kay Jenkins (*Minutes)*

Item 10
Jem Pupich, Community & Public Health

AGENDA – PUBLIC

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

WEST COAST DISTRICT HEALTH BOARD MEETING
To be held at St John, Waterwalk Road, Greymouth
Friday 8 June 2012 commencing at 10.00am

KARAKIA			***10.00am***
ADMINISTRATION			***10.05am***
	Apologies		
1.	**Interest Register** *Update Board Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Meeting** ▪ *20 April 2012*		
3.	**Carried Forward/Action List Items**		
REPORTS			***10.15am***
4.	**Acting Chair's Update – Oral Report** *- Correspondence List*	Peter Ballantyne *Acting Chairman*	*10.15am – 10.30am*
5.	**Chief Executive's Update**	David Meates *Chief Executive*	*10.30am – 10.50am*
6.	**Clinical Leader's Report**	Dr Carol Atmore *Chief Medical Advisor* Karyn Kelly *Director of Nursing and Midwifery* Stella Ward *Executive Director of Allied Health*	*10.50am – 11.00am*
7.	**Clinical Governance** - Presentation	Stella Ward *Executive Director, Allied Health*	*11.00am – 11.20am*
8.	**Finance Report**	Colin Weeks *Chief Financial Manager*	*11.20am – 11.35am*
9.	**Health Targets** - Q3 Results	Wayne Turp *General Manager, Planning & Funding*	*11.35am – 11.45am*
10.	**Alcohol Position Statement**	Jem Pupich *Community & Public Health*	*11.45am – 12noon*
11.	**Report from Committee Meetings**		
	- CPH&DSAC *- 24 May 2012*	Elinor Stratford *Chairperson, CPH&DSAC Committee*	*12noon - 12.10pm*
	- Hospital Advisory Committee *- 24 May 2012*	Warren Gilbertson *Chairperson, Hospital Advisory Committee*	*12.10pm -12.20pm*
	- Tatau Pounamu *- 24 May 2012*	Gary Gouglan *General Manager, Maori Health*	*12.20pm - 12.30pm*

12 **Resolution to Exclude the Public** *Board Secretariat* *12.30pm – 12.30pm*

INFORMATION ITEMS

- Copies of Correspondence
- Confirmed Minutes
  - CPH&DSAC Meeting – 12 April 2012
  - HAC Meeting – 12 April 2012
  - Tatau Pounamu Meeting – 11 April 2012

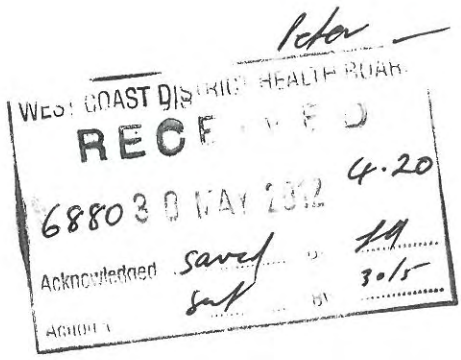
ESTIMATED FINISH TIME ***12.30pm***

NEXT MEETING

Friday 20 July 2012 commencing at 10.00am

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises



29 MAY 2012

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

Dear Peter

Service Provision for Older People

The Government is committed to enabling older people to live in their own homes for as long as it is safe and appropriate for them to do so. This includes supporting informal carers in their vital role through the provision of suitable and timely respite care. I expect older people and their carers to be able to access quality respite care services that maintain and build on their wellbeing. Please treat this as a priority within the health of older people area.

In April 2011, District Health Boards (DHBs) were informed that I had decided to allow greater flexibility in the way the 2010 increased allocation of respite care funding was used to provide respite care for older people. In return for flexibility, I expected DHBs to improve their planning and increase the provision of respite care.

Ministers have asked the Ministry of Health to ensure you report back on your agreed respite care plan and your provision of respite care services for 2011/12. We anticipate all DHBs will deliver the respite care services they agreed to, and look forward to receiving feedback from the Ministry of Health about the success of the increased funding.

The Government is also committed to ensuring that people with dementia receive quality services and live as good a life as possible – whether they live at home or in residential care. This Government sees dementia as a priority area, which has been reflected in the 2012 Budget.

As you have already been advised, Budget 2012 delivers an extra $10 million, from baseline funding released from pharmaceutical savings, to look after people living with dementia, which includes $7.5 million for increasing the price paid for residential dementia services.

The remaining $2.5 million has been allocated for the development of dementia care pathways, which you have agreed to develop in your 2012/13 annual plan. We expect this funding will improve dementia services, in particular, development of local dementia pathways for diagnosis, treatment and support within primary and community care.

Thank you for the work you are doing in these fiscally constrained times.

Yours sincerely

Hon Tony Ryall
Minister of Health

cc Hon Jo Goodhew, Associate Minister of Health
Mr David Meates, CEO, West Coast DHB

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

POSITIVE SEXUAL HEALTH
Family Planning

10 May, 2012

Peter B ✓

WEST COAST DISTRICT HEALTH BOARD
RECEIVED
6872 14 MAY 2012 4.20
Acknowledged saved By ll
Actioned sent By 30/5

Dr P McCormack
West Coast District Health Board
PO Box 387
Greymouth 7840

National Office
Level 6
203 - 209 Willis Street
PO Box 11515
WELLINGTON 6142

T: (04) 384 4349
F: (04) 382 8356
familyplanning.org.nz

Charities # CC11104

Dear Paul

Like many, I have watched with bewilderment as sexual and reproductive health – in particular women's access to contraception, emergency contraception and safe, timely abortion services – have all come under attack during the opening months of the United States presidential campaign.

It would be easy to feel a little smug on this side of the Pacific and to imagine that New Zealand has resolved the issues currently being debated in the United States. Although the tenor of the debate in New Zealand is more low key, the issues – ensuring costs don't prevent people, especially young people, from accessing services, maintaining and improving access to abortion services, and ensuring young people (wherever they go to school) are receiving comprehensive sexuality education – remain the same.

This week, attention has focussed on a decision by the Government to offer free long-acting reversible contraceptives to beneficiaries aged 16 to 18. Family Planning did a significant amount of media commentary on this issue and reiterated our commitment to all women being able to choose the contraceptive that is best for them and their stage of life. We also expressed the hope that the Governments programme could, and should, be extended to include all women. In this issue of Forum we call out some of the old myths about one of these long-acting reversible contraceptives, the IUD which are a highly effective contraception for most women, including young women and women who haven't had children.

Abortion access is an ongoing issue for New Zealand women. Many people are unaware that the grounds for an abortion in New Zealand sit within the Crimes Act and that women must navigate a slow and difficult process to access an abortion – particularly women who live outside the main centres. In addition, Early Medical Abortion services are only available in six New Zealand centres denying many women access to abortion choice. Expect to hear more from us on abortion issues throughout this year and beyond.

… continued over the page

Anti-choice and "family" groups continue to attack sexuality education in New Zealand. Such was the level of debate on this issue towards the end of last year that we've dedicated a portion of this issue to debunking some of the myths around this issue. It may feel that you've read much of this before – we certainly feel like we've said it all time and time again! That said, we believe young New Zealanders have the right to quality information and quality services to help them make the best choices for themselves.

People like you can help us make a difference – to protect the services and access we have and to advocate for improved services in the future. Become a member of Family Planning or "like" us on Facebook – with your moral and financial support we can continue to advocate for positive sexual health for all. Check out the "support us" tab of our website www.familyplanning.org.nz or email us on funding@familyplanning.org.nz for more information.

I know you will find much of interest in the newsletter.

Kind regards

Jackie Edmond
Chief Executive

MINISTRY OF HEALTH
MANATŪ HAUORA

Peter B ✓

No.1 The Terrace
PO Box 5013
Wellington 6145
New Zealand
T+64 4 496 2000

28 May 2012

Mr David Meates
Chief Executive
West Coast District Health Board
PO Box 387
GREYMOUTH 7840

Dear David

As a sector we can be very pleased with the continuing progress we are making to deliver on the health targets.

Generally results for quarter three are positive, however we will need to continue to focus our efforts to ensure we deliver on some challenging year end goals. In particular I would like to reinforce the need for all DHBs to achieve an immunisation coverage rate for two year olds that is as high as possible, so that collectively we reach our goal of 95 percent coverage in quarter four.

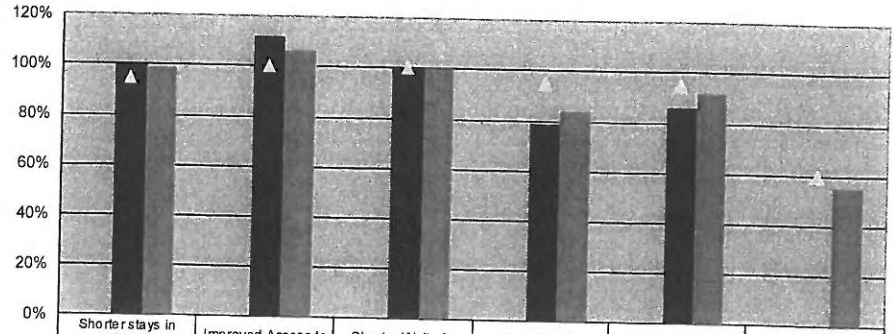
National progress
Once again I am very pleased to advise that this quarter all District Health Boards (DHBs) achieved the Shorter waits for cancer treatment target. The national target for Improved access to elective surgery was also achieved again this quarter, with 111,794 elective surgical discharges provided, against a target of 106,783 discharges.

Results for the Shorter stays in emergency departments target are again the highest since the target was introduced, with a national result of 93 percent. Nationally we have achieved 92 percent immunisation coverage for two year olds and our 95 percent goal is within reach. Most DHBs have improved their performance in quarter three for both the hospital and primary care Better help for smokers to quit targets.

The national result for the new More heart and diabetes checks target is 46 percent. Due to issues with data collection processes, results are being published as provisional this quarter.

DHB specific progress
In relation to your own DHB, the following table provides information on your progress during the year to date.

West Coast health targets quarter three 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	More heart and diabetes checks
Ranking quarter three 2011/12	1	6	1	20	11	5
Quarter two 2011/12	99.9%	112.0%	100.0%	78.5%	85.8%	
Quarter three 2011/12	99.4%	106.7%	100.0%	84.2%	92.1%	55.0%
National goal	95.0%	100.0%	100.0%	95.0%	95.0%	60.0%

The following feedback is provided by the Ministry's Target Champions on your results for quarter three.

Mike Ardagh, Target Champion, Shorter stays in emergency departments

Congratulations to West Coast DHB for continuing to achieve the Shorter stays in ED health target. Well done and I look forward to seeing a continuation of target achievement through the winter months.

Clare Perry, Target Champion, Improved access to elective surgery

West Coast DHB has continued to perform strongly, and has achieved its quarter three health target – Improved access to elective surgery. At the end of quarter three 1309 people have been provided with elective surgery, which is 7 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 three. This is excellent sustained performance against the target. The DHB is encouraged to maintain this performance for the remainder of 2011/12 in close collaboration with your regional oncology centre.

Pat Tuohy, Target Champion, Increased immunisation

Thank you for your on-going support for the immunisation health target, 95 percent of all two-year-olds are fully immunised by 30 June 2012. As of 31 March 2012 (quarter three) total national coverage was 92.2 percent and the national coverage for both Pacific and Asian two-year-old children was 96 percent.

West Coast DHB achieved 84 percent total coverage and 100 percent coverage for the Asian population. We look forward to seeing an increase in total coverage.

The Ministry suggests that all DHBs continue to review monthly the list of children unimmunised at 18 months by PHO and practice to ensure these children are recalled in a timely fashion by their practice and referred to outreach with sufficient time to be fully immunised before they turn two years of age.

The Ministry recognises the considerable efforts made by the sector to increase immunisation coverage over the past three years. We have identified additional one-off funding for DHBs and immunisation service providers to increase coverage and support the final effort needed to achieve and maintain the immunisation health target. The funding is also to support planning for implementation of the new eight month old target. Your General Manager Planning and Funding will be able to give you more details.

Karen Evison, Acting Target Champion, Better help for smokers to quit

West Coast DHB is now not far from achieving the target for providing advice to hospitalised smokers. Performance for the primary care target dropped slightly and more attention is needed in this area.

Well done, the DHB increased its results for hospitalised smokers by 6.4 percent and is at 92.1 percent for quarter three. The DHB is making good progress in the areas of staff training in ABC and increasing management and clinical leadership. Close monitoring and feedback to staff so that missed opportunities with patients can be rectified will be an important action that helps in achieving the target by June 2012.

The DHB has achieved 38.5 percent (based on provisional data) for provision of advice in general practices, which is a slight decline from last quarter. A concentrated effort will be needed by the DHB to work with your PHO, allocating sufficient resources in quarter four. Initiatives supporting hospital performance could be applied in general practice.

Brandon Orr-Walker, Target Champion, More heart and diabetes checks

This is the first time the new target More heart and diabetes checks results are being reported. There remain some issues with data collection processes as we transition into the new target, primarily concerning the way the PHO data is collated and mapped to provide a DHB result.

Your DHB is not far off reaching the 60 percent target. I look forward to seeing your quarter four results.

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, 29 May 2012. As occurs each quarter, a package of

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

Now that we are well into quarter four of the 2011/12 year, it is timely to look ahead to 2012/13. We have some changes in focus with regard to the cancer, immunisation and tobacco targets that we will need to work together to deliver, while building on our current achievements for emergency departments, electives and CVD diabetes.

I look forward to continuing to work together to achieve our collective target goals.

Yours sincerely

Kevin Woods
Director-General of Health

cc: Peter Ballantyne, Acting Chair, West Coast District Health Board

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

SF PB ✓ CW HW EMT ✓

22 MAY 2012

Mr Peter Ballantyne
Acting Chair
West Coast District Health Board
P O Box 387
GREYMOUTH

Dear Mr Ballantyne

Application for Equity – West Coast District Health Board (DHB)

I refer to your equity request for $4.5M in the 2011/12 year.

I am pleased to advise that approval has been given to provide West Coast District Health Board (DHB) with equity support of $4.5M. The payments will be released immediately by the National Health Board.

In granting this approval I remind West Coast DHB of its obligation to manage within the allocated funding but note that the DHB has forecast a full year deficit result of $5.1M, which is $0.6M unfavourable to the planned deficit in your 2011/12 Annual Plan.

I expect the Board to plan to achieve a breakeven position and for this to be addressed in the 2012/13 annual planning process, to minimise the need for deficit support in 2012/13 and 2013/14 financial years.

The purpose of the deficit support is to enable West Coast DHB to restore financial liquidity.

Yours sincerely

Tony Ryall

Hon Tony Ryall
Minister of Health

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

Office of Hon Tony Ryall

Minister of Health
Minister of State Owned Enterprises

6820

4.20
1.51
1.39.1
8.10

PB, SF sent to EMT ✓

saved

30 APR 2012

Mr Peter Ballantyne
Acting Chair
West Coast District Health Board
pballantyne@deloitte.co.nz

Ref. 12000066

Dear Mr ~~Ballantyne~~ Peter

Thank you for your email of 22 March 2012 about the orthopaedic service at West Coast District Health Board (DHB).

As you will appreciate, it is important that a high quality and sustainable service is provided to the DHB's population, with proposed changes to the orthopaedic service to be made based on sound clinical advice. On 3 April 2012, I responded to Dr Charles Mixter and Dr Lasantha Martinus to inform them the National Health Board (NHB) is looking into the matters they have raised, and that they may wish to raise their concerns directly with the Chief Executive of West Coast DHB.

Please ensure you continue to keep me closely informed, through the NHB, as work on your new service model progresses.

Yours sincerely

Hon Tony Ryall
Minister of Health

Thankyou for the work you & your executive team are doing

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

CONTROLLER AND AUDITOR-GENERAL
Tumuaki o te Mana Arotake

100 Molesworth Street, Thorndon 6011
PO Box 3928, Wellington 6140, New Zealand
Telephone: +64 4 917 1500
Facsimile: +64 4 917 1509

Email: lyn.provost@oag.govt.nz
Website: www.oag.govt.nz www.auditnz.govt.nz

Lyn Provost

Peter B

26th April 2012

Mr Paul McCormack
Chairperson
West Coast District Health Board
PO Box 387
Greymouth 7805

Dear Mr McCormack

CLEANEST PUBLIC SECTOR IN THE WORLD: KEEPING FRAUD AT BAY – SECTOR RESULTS

In November last year, I released the results of our survey of almost 1500 people working in the public sector about their perceptions of fraud.

Attached are the specific results from the survey for your sector. I hope you will find the information useful for discussing current risks and prevention practices with those interested and involved in fraud prevention in your organisation.

Your auditor would be happy to have an opportunity to discuss the survey results with you or those most appropriate in your organisation.

If you are interested in the survey results for other types of entities, please check our website (www.oag.govt.nz/2012). We will be adding further results as they become available.

Quickly informing your auditor about fraud incidents

To help maintain our awareness of risks and ways of preventing fraud, please take the simple step of informing your auditor quickly when you deal with a fraud incident.

They will give us the details so we can help identify any fraud risk factors for your sector, but the information we share will be high-level and anonymous.

I hope you will find these results useful and look forward to your support in working to protect the public purse.

Yours sincerely

L Provost

Lyn Provost
Controller and Auditor-General

CONTROLLER AND AUDITOR-GENERAL
Tumuaki o te Mana Arotake

Served 6.20

Summary of our fraud survey results for district health boards

Cleanest public sector in the world: Keeping fraud at bay

When should you contact your auditor?

You should contact your auditor as soon as you suspect a fraud. You'll need to provide information about:

- the nature of the fraud;
- whether it's suspected or proven;
- when it happened;
- the name and position of the perpetrator (if you know);
- how the fraud was discovered;
- whether any prevention controls failed; and
- what action managers have taken so far.

What happens with the information that you give to your auditor?

For all instances of fraud or suspected fraud, your auditor will tell us straight away that there might be a fraud. They give us the details so we can identify any risk factors.

We use the information to give auditors some direction to help them assess the risk of fraud within each public entity.

In the future, we'll use the information to provide more timely information to you and to auditors about fraud incidents in your type of entity.

Office of the Auditor-General
Private Box 3928, Wellington

Telephone: (04) 917 1500
Facsimile: (04) 917 1549

Email: reports@oag.govt.nz
www.oag.govt.nz

Fraud: Frequently asked questions

2012

What is fraud?

Fraud is dishonest activity that causes a financial loss to someone. It includes stealing money or other property, could be carried out by employees or people outside an organisation, and involves deception (either before or after the activity).

Corruption is slightly different. Corruption is the abuse of power for private gain (for example, seeking or receiving gifts or other benefits to carry out an official duty, or to not carry out an official duty). The difference between fraud and corruption is not well understood, so to keep things simple we just use the term "fraud".

What lets fraud happen?

Fraud can happen when people have:

- opportunity (when there are no fraud controls, or ineffective controls, or they can override controls);
- attitude (some people have an attitude, character, or set of values that allow them to knowingly and intentionally commit a dishonest act); and
- incentive (people might find themselves in circumstances that motivate them to commit fraud).

How can managers prevent fraud?

An effective managerial approach to preventing fraud should focus on:

- prevention – controls designed to reduce the risk of fraud;
- detection – controls designed to uncover fraud when it occurs; and
- response – policies and processes to help put matters right after a fraud.

Managers need to have a complete set of controls and policies , make it easy for staff to safely raise any concerns, keep levels of awareness high, and consider (for every incident) reporting fraud to the relevant authorities. Although trusting staff is important, trust is not a control.

How can fraud be detected?

Fraud is often detected by:

- internal control systems (such as financial delegations, reviews, and separating duties that could enable fraud);
- internal tip-off (which is why it's so important to have an environment that encourages staff to come forward if they suspect fraud, and to have a "protected disclosures" policy);
- internal audit functions (including regular reviews of internal controls and checks of high-risk areas like cash and inventory).

What should you do if you suspect fraud?

Dealing with fraud can be difficult. It's important to handle fraud appropriately, to set or keep a culture of "zero tolerance". Your entity's approach to reporting fraud is often an effective deterrent for those who might consider committing fraud.

If you believe your entity has been defrauded, it's important to consider whether to refer the matter to the appropriate enforcement agency (the Police, Commerce Commission, Serious Fraud Office, or Financial Markets Authority). The authorities can help you with the best way to proceed and ensure that you have (or get) enough evidence for any prosecution.

The Auditor-General expects public sector entities to consider reporting fraud to an appropriate authority (usually the Police).

You should also tell your auditor as soon as possible about any alleged, suspected, or actual fraud incidents that required management action. If the full details aren't yet available, you should update your auditor as the details become known.

If you believe that the incident is significant, you should consider reporting it to the Serious Fraud Office.

What is the role of the audit?

Auditors are not responsible for preventing fraud. The governing body and managers are responsible for maintaining systems to prevent and detect fraud. The auditor's primary role is to express an independent opinion on the financial statements and (where appropriate) non-financial information. Occasionally, an auditor might discover a fraud in the course of their work.

When should your auditor talk to you about fraud?

Your auditors should ask you about actual and suspected fraud as part of every audit. They do this for their assessment about the risk of fraud having an effect on the entity's financial statements and (where appropriate) non-financial information.

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

Corporate Office

Telephone 03 768 0499
Fax 03 768 2791

18 April 2012

Minister of Health and Minister of Finance
Ministry of Health
PO Box 5013
WELLINGTON

Hon Tony Ryall and Hon Bill English

Re.: Request for Equity -Deficit Support for the 2011/12 year

The West Coast DHB is hereby applying for deficit support of $4.5m based on the approved Annual Plan (AP) for the 2011/12 year.

The deficit support (additional equity) is required to maintain the appropriate levels of liquidity to maintain operations and not to use funding set aside for capital projects.

Financial Performance for 2011/12
The West Coast DHB has revised its financial performance forecast from the approved budgeted deficit of $4.5m to a forecast deficit result of $5.1m for the year ending 30 June 2012.

The West Coast DHB is undergoing a significant change from the heavy reliance on locums to a much more sustainable long service configuration. This is based on a new emerging service framework being developed with CDHB. Given the long established reliance on the use of locums on the West Coast, changes to their use have been complex to untangle i.e. long term contractual commitments, and have delayed the necessary changes. This along with the impact of the earthquakes in Canterbury has resulted in an increased deficit ($600k)

Overview of previous funding of deficits
For the 2005/06 financial year the West Coast DHB was close to a "break-even" point with a deficit of $157k. Since this date the West Coast DHB has incurred annual deficits which the West Coast DHB has in part funded from cash reserves held.
These reserves have now been depleted and it is now necessary to fund the deficit via an equity injection.

Funding of prior year deficits:

- The 2006/07 deficit ($2.4m) was funded internally without requesting deficit support.
- The 2007/08 deficit ($6.3m) was funded internally. An equity application ($4.6m) was requested and not accepted by the Ministry of Health as the cash position at that time did not require additional funds.
- The 2008/09 deficit ($7.7m) was funded by internal resources and by receiving deficit support ($3.0m).
- The 2009/10 deficit ($7.7m) was funded by internal resources and by receiving deficit support ($6.1m).
- The 2010/11 deficit ($7.1m) was funded by receiving deficit support ($7.2m).

Capital Projects
The West Coast DHB is operating within the capital budget, and has two major capital projects in progress that are of significant strategic importance, namely the implementation of Concerto patient system and Oracle financial management system. It is important that the funds reserved for capital expenditure are used for this purpose.

Current Cash situation

Cash flow projection for the year ending 30 June 2012
Annexure 1: Cash Flow projection to 30 June 2012.

Based on the cash flow projection the deficit applied for is required before 31 May 2012.

The cash flow projection has been prepared on the following basis:
(1) The equity support applied for above has not been included in the cash flow projection.
(2) WCDHB maintains "early payment status".
(3) WCDHB has at all times the ability to repay the amount of the early payment. This will be in the form of confirmed undrawn working capital facilities (one month's total planned Crown revenue for the Provider Arm).
(4) The cash flow projection has been based on the forecast result of a $5.1m deficit.
(5) The West Coast DHB is able to meet its short term cash commitments.

Board Resolution
At the 02 December 2011 Board meeting of the West Coast District Health Board, a resolution was passed authorising the Acting Board Chair of the Board to apply to the Minister of Health and Minister of Finance for an Equity Injection - Deficit Support up to $4,500,000.00.

Thank you for considering this request.

Yours sincerely

Peter Ballantyne
Acting West Coast District Health Board Chair

cc: Lyn Richardson
John Hazeldene

MINISTRY OF HEALTH
MANATŪ HAUORA

1 The Terrace
PO Box 5013
Wellington
New Zealand
Phone 04 496 2000

Peter ✓

13 April 2012

Paul McCormack
Chairperson West Coast District Health Board
Grey Base Hospital
PO Box 387
Greymouth 7840

Dear Paul

Health Workforce New Zealand Funding for 2012/13 – Postgraduate Medical Training

I write to advise you of some changes to the funding of postgraduate medical education by Health Workforce New Zealand (HWNZ) for the 2012/13 year. I have taken this step in view of the significant changes in the approach from previous years and the need for your DHB to respond accordingly by the end of May. The allocation method has been determined after wide health sector engagement and, for the first time, is transparent and inclusive, accountable and, to some degree, contestable.

The final HWNZ 2012/13 budget will be known shortly and in this context we have agreed to allocate the same proportion of the total budget to postgraduate medical education as we did in 2011/12 (66%).

A number of medical disciplines previously excluded from funding will be included this year, and first year general practice trainees will be employed and not remunerated by way of a non-taxable bursary as in the past. Details regarding changes to the GP training have been sent to CEOs previously.

As alluded to above, there are new requirements for DHBs regarding postgraduate medical training in 2012/13. To allow for review, follow-up negotiations and contracting prior to 2012/13, every DHB will need to supply HWNZ with a relevant district whole-of -health-workforce plan by the end of May, 2012. This plan has to 'support' your DHB's annual plan, and the relevant regional service plan and be consistent with trainee information already provided to HWNZ. It should also list all medical training specialties and associated training numbers and not only those trainees funded by HWNZ.

As you can see from the enclosed document, approval of the whole-of -health-workforce plan for your DHB will result in an initial allocation of 70% of the funding (by FTE). A further 30% will be available half way through the year (20% against performance on such criteria as career planning) or through a contestable process to facilitate those medical disciplines we have identified as needing additional support (10%). Further detail is attached.

Over the next few weeks, HWNZ will host meetings in each of the four regions to discuss the change in approach and to help ensure your plan meets our requirements. If you would like further clarification on any of the above, or have specific questions in relation to your DHB, please contact Ms Brenda Wraight, Director of the HWNZ Business Unit on Brenda_wraight@moh.govt.nz or 04 4962398.

Thank you for the work that your Board is doing to support the development of New Zealand's future health workforce.

Yours sincerely

Professor Des Gorman BSc MBChB MD (Auckland) PhD (Sydney)
Executive Chairman of Health Workforce New Zealand

Cc: CEO

MINUTES OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 12 APRIL 2012 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH, COMMENCING AT 9.00 AM

PRESENT	Elinor Stratford, Chair Kevin Brown, Deputy Chair Peter Ballantyne, (ex officio) Barbara Holland Dr Cheryl Brunton John Ayling John Vaile Lynnette Beirne Marie Mahuika-Forsyth Mary Molloy Robyn Moore
IN ATTENDANCE	Wayne Turp, General Manager Planning and Funding Yolandé Oelofse (minute secretary) Gary Coghlan, General Manager Maori Health Karyn Kelly – Director of Nursing and Midwifery Bryan Jamieson – Community Liaison Officer
APOLOGIES	Dr Paul McCormack, Board's Chair (ex officio) Dr Carol Atmore, Chief Medical Advisor Patricia Nolan

1. APOLOGIES, WELCOME & KARAKIA

The 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 Dr Paul McCormack, Dr Carol Atmore and Patricia Nolan,

Moved: John Vaile **Seconded: Lynnette Beirne**

Motion:
"THAT the apologies be noted"

Carried.

2. STANDING ORDERS

The Chair waived standing orders noting reinstatement if required.

3. DISCLOSURES OF INTEREST

Lynette Beirne - Daughter is now employed as a nurse at the WCDHB.

4. MINUTES OF THE PREVIOUS COMBINED COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD ON 23 FEBRUARY 2012

Corrections to minutes:
Page 4: CVD Screening: The comment that was made at the last meeting was about Family Violence screening and why this was only undertaken for women?

Granger House query was referred to Quality Finance Audit and Risk Committee.

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

MOTION:
"THAT the Minutes of the Combined Community and Public Health and Disability Support Advisory Committee meeting held 23 February 2012 with amendments as noted be accepted as a true and accurate record"

Carried.

5. MATTERS ARISING

Item 1 Disability services: apologies received that due to other commitments there has been no report, the General Manager Planning and Funding will undertake to bring this back at the next meeting.
Item 2 Advance Directives are on the Agenda for Clinical Board. Work has commenced and feedback will be brought back to the May meeting.
Item 3 The General Manager Planning and Funding gave a brief outline of the guidelines for CVD Screening. It has been identified that the various practices would need more information on this service. Re the issue raised at the last meeting about apparent gender specificity of screening for family violence: The General Manager Planning and Funding indicated that this is not gender specific and that any males or females presenting with injuries should be screened for family violence.
Item 4 Facilities Audit.
Item 5 To remove this item
Item 6 A discussion will be taking place directly after this meeting.

6. CORRESPONDENCE

The correspondence has been received.
Motion:
"THAT the Committee notes the correspondence received"

7. CHAIRS REPORT

The Chair's report has been taken as read.

Two Board members and Advisory members had attended training recently.

Items of interest:
The Transalpine model of care is hoping to reduce the number of people travelling from the coast to Canterbury.

IT improvement around a regional clinical information system will help share records with other DHBs who are participating.

Moved: John Ayling **Seconded: Lynnette Beirne**

Motion:
"THAT the Committee receives the Chairs report"

Carried.

8. WORKPLAN

A concern was raised regarding the contents of the Workplan and that the content is more internally focussed on a monitoring role for operation of the DHB. It was discussed that perhaps the Committee should have a broader role reporting for the whole of the community. It was agreed that the current Workplan be reviewed and be re-aligned to the Annual Plan which is due in June/July this year.

Action: The Chair and General Manager of Planning and Funding to address the current Workplan and arrange a workshop to incorporate the changes of the Annual Plan once the Annual Plan has been signed off by the Ministry.

9. REPORTS

9.1 Organisational Leadership Report:

The Organisational Leadership's report has been taken as read.

Item 4 Matters Arising: The facility audit was carried out three years ago by the Facilities manager. The WCDHB is aware of the current accessibility issues. The plans for the IFHC are currently underway and subject to approval should be built within 3-4 years.

The Quarterly reports will only be available at the May meeting.

The Draft Annual Plan and Maori Health Plan have been submitted to the Ministry and we are yet to receive the recommendations from the Ministry. We still have an opportunity to provide additional information to both plans. The PHO and C&PH work through a similar process for their plans and all three agencies work collaboratively together in development of the Annual Plan.

A concern was raised about the relatively low figures for the Warm Up West Coast program. The Committee was reassured that the contractors have undertaken additional staff with the intention to insulate 20-30 homes per month; they are endeavouring to address this before Winter. With regard to monitoring and evaluation there will be a voluntary self evaluation conducted with those who have had their home insulated next year. A self evaluation program is underway.

Page 3 – Funder Arm Payments Report Item Tobacco control is noted. A question was raised if there was a budget for alcohol harm reduction? This is not specified as a line item but there are a number of initiatives which are implicit and in place. The Ministry funds C&PH directly for alcohol harm reduction and regulatory activities under the Sale of Liquor

Act. There is room for further work on alcohol harm reduction to be considered by the WCDHB in addition to this.

That the Organisational Leadership report be received.

9.2 Clinical Leadership Team's Report:

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

The Committee received details on the newly established Clinical Governance group. An Invitation will be sent out shortly regarding the launch.

A discussion took place around the role of the Clinical Board. The Director of Nursing and Midwifery said that the purpose of the Clinical Board is to be an overarching governance group to work with the existing groups that are responsible for quality throughout the Health sector.

A question was asked regarding Maori representation and if that was included in the Consumer representative nominations. The answer was no, they are to be different representatives. The nominations for Maori Representation are currently underway and the three Consumer representatives' nominations were undertaken by the District Mayors.

That the Clinical Leadership report be received.

9.3 Finance Report:

The Finance report has been taken as read.

A Committee member would like the reporting framework improved and suggested that we address the issues around variances and trends. A discussion took place around the reporting requirements and the need for relevant information regarding items of concern that the Committee should be made aware of. The Board gives a clear direction as to what is required and the General Manager of Planning and Funding would like a clear direction from the Committee as to their requirements. More detailed reports are presented and discussed at QFARC.

Action: The Chair, General Manager Planning and Funding and the Chief Financial Manager to review the reporting composition and relevance requirements.

That the Finance report be received.

9.4 BSMC and ALT Report:

The BSMC and ALT reports have been taken as read.

A concern was raised around the lack of communication within the community regarding the development of the Buller Health Centre. It was requested that more communication and feedback to the community be disseminated. The Committee was reassured that a variety of communications strategies are in place.

Action:

- **To provide the Communication strategy at the next meeting.**
- **A Board member commented on an article that was published regarding the Hospital Health Services on Tuesday 10th April 2012. Concern was raised regarding the correctness of the article and in particular in relation to the elected Board members. To refer to Board for discussion and recommendations.**

Moved: Kevin Brown **Second: Peter Ballantyne**

Motion:
"That the published article be referred to the Board for discussion and recommendations"

Carried.

9.5 Quality and Patient Safety Report:
The Quality and Patient Safety Reporting template was received.
A workshop to be scheduled directly after the May meeting to identify what is required.

That the Quality and Patient Safety Report be noted.

10. GENERAL BUSINESS

To note that the Committee is assessing information and detail within the financial report relevant to CPHAC and DSAC Committee. We need to ensure that there is no overlapping of reporting to the various Committees.

11. INFORMATION PAPERS

The information papers were noted as read.

Terms of Appointment to be reviewed.

Action: Terms of Appointment to be updated.

12. OTHER BUSINESS

The community meeting in Franz Josef was not well advertised. There is an urgent need to address how to notify those in the rural areas of any such meetings and future presentations.

Action: Future planned meetings or presentation details to be sent through to the Community Liaison Officer.

Primary Practices: The verbal update from the General Manager of Community and Primary Health to be deferred to May's meeting.

Apologies from John Ayling and Cheryl Brunton noted for the next meeting.

Recommendations to be referred to the Board:

- In relation to the article published regarding Hospital health services on Tuesday 10th April concerns were raised regarding the correctness of the article and in particular in relation to elected Board members.

- Regarding the Facilities: A concern was raised regarding the facilities accessibility and wish to make recommendation that the Board ensure design brief includes access audit.

Meeting closed at 10:40am

NEXT MEETING

The next meeting will be held on Thursday, 24 May 2012 at 9am in the Boardroom, Corporate Office, West Coast District Health Board, Greymouth.

A Quality and Patient Safety workshop to take place directly after this meeting to discuss the requirements of the report.

_____ _____

CHAIR DATE

MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING HELD THURSDAY 12 APRIL 2012 AT 11.05AM IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH

PRESENT Sharon Pugh, Deputy Chair
Warren Gilbertson, Chair (from 11:13am via phone)
Barbara Holland
Gail Howard
Paula Cutbush
Doug Truman
Richard Wallace

IN ATTENDANCE Peter Ballantyne, Board Deputy Chair
Mary Molloy, Board Member (from 12:40 pm)
Colin Weeks, Chief Financial Manager
Garth Bateup, Acting General Manager Hospital Services
Karyn Kelly, Director of Nursing and Midwifery
Bryan Jamieson, Community Liaison Officer
Silvie Sasková, Minute Secretary

APOLOGIES Dr Paul McCormack, Board Chair

Karakia – Richard Wallace

1. WELCOME, APOLOGIES AND AGENDA

The Deputy Chair chaired the meeting. The attendees were welcomed to the meeting, and apologies were accepted from Dr Paul McCormack.

Moved: Sharon Pugh **Seconded: Barbara Holland**

Motion:
"THAT the apologies be accepted."

Carried.

2. DISCLOSURES OF INTERESTS

Richard Wallace
Add: Member of the National Asthma Foundation Maori Reference Group

3. MINUTES OF THE PREVIOUS HOSPITAL ADVISORY COMMITTEE MEETING HELD 23 FEBRUARY 2012

Page 5 – Production Planning / Electives – the last sentence of the first paragraph to be reworded to "Being ahead on orthopaedics, it is necessary to look at managing joint repairs for the rest of the financial year."

Moved: Gail Howard **Seconded: Paula Cutbush**

Motion:
"THAT the minutes of the Hospital Advisory Committee meeting held 23 February 2012 be adopted as a true and accurate record subject to the above amendment."

Carried.

Hospital Advisory Committee Chair's Report to the Board
There have been no comments to the report.

4. MATTERS ARISING

Item 1: A classification of complaints graph is requested to be provided specifically for hospital services
On hold. The graph has been received. The West Coast DHB now has new quality monitoring staff who are developing a quality work plan. The plan will include more detailed information on quality initiatives.

Item 2: The 'Shorter stays in Emergency Departments' target to be placed on the Recovery Plan for Clinical Services
To remain on matters arising for future reporting. Nothing to report at this point. Monitoring is ongoing.

Item 3: Communication strategies with the public to be considered regarding clinic cancellations and Did Not Attends (DNAs)
A media release concerning Did Not Attends has gone out. Completed.

Item 4: Work on communication regarding what people could reasonably expect, and what can be delivered, with regards to transportation home following discharge
Work in progress. The West Coast DHB is currently in discussion with a number of organisations.

Item 5: Shorter Stays in Emergency Departments – the higher number of patients waiting over six hours in the Emergency Department in Buller to be investigated
Included in the Management report section 6.2. It was remarked that some people in Buller, in order to see their favourite medical practitioner, present to the Emergency Department when the clinicians are on duty, rather then attend the general practice.

Action Point: Director of Nursing & Midwifery to gather data.

Item 6: Recruitment / Vacancy reporting to Advisory Committees to be discussed with the Chief Executive
No report is included in the current papers. West Coast DHB staff are working with the Canterbury DHB team on reporting for both DHBs.

Item 7: A summary of the Staff Survey results to be provided to the Hospital Advisory Committee upon receipt
The report has not been released yet, but there is a series of information forums coming up. The report is to be included in the next papers.

Item 8: The dates for the Induction for new advisory committee members to be discussed with the Board Secretary
The Induction took place and was considered worthwhile. As there has been interest from the Board members, the slides are also going to be distributed to them. Completed.

Matters arising were taken as read and actioned.

5. CORRESPONDENCE

There was no correspondence inwards or outwards for February / March 2012.

6. WORK PLAN

There are no anticipated changes to the Work Plan at present.
It was confirmed that the dates in the section 4 "Next Year Annual Plan and Statement of Intent" are correct, and that the documents for 2011/12 are under way.

6.1 HEALTH TARGETS

- **Shorter Stays in Emergency Departments**
  There have been good results in achieving this target.

- **Improved Access to Elective Services**
  The West Coast DHB is currently ahead on outsourced services and slightly behind on in house services. The progress is closely monitored. The number of surgical discharges is at a reasonable level.

- **Better Help for Smokers to Quit**
  The results for February 2012 were good, 96%. However, the number tends to fluctuate. The good results are likely to be the outcome of the initiatives of the new staff member, and the proactive effort throughout the hospital. Clinical Nurse Managers are key in driving the effort. With acute cases smoking cessation cannot be addressed on admission, but nurses need to go back to the patient and follow up.

  Smoking data is not available for staff, but colleagues are encouraged to do smoking cessation and there is peer pressure on staff who smoke.

- **Production Planning**
  As many visiting specialists only come to the West Coast a few times a year, there are patients who have exceeded the target waiting times. A lot of work is being done on production planning to reduce waiting times. For example, some visiting specialists are supported by nurse specialists based on the West Coast who are monitoring long waits and acuity. The Manager of Allied Health and Support Services is working together with one of the orthopaedic surgeons on resolving the issues in orthopaedics. There are some strategies in place, for instance five appointments have been set aside in every clinic for compliance, and some patients will be seen by the clinical nurse specialists rather then being placed initially on waiting lists.

  Waiting times compliance needs to be achieved by 30 June 2012.

  It was noted that the target length of time is going to be reduced from six to four months, and that balance is required between clinical acuity and waiting time compliance.

More work also needs to be done on refocusing the Central Booking Unit and their processes. The new Central Booking Manager is starting on 30 April 2012, and will be working alongside an analyst to implement the necessary changes. With a number of visiting specialists now considering using Telemedicine, there should be improved use of the available technology.

6.2 MONITOR PERFORMANCE OF THE PROVIDER ARM

Management Team Report
The Acting General Manager Hospital Services and the Director of Nursing and Midwifery spoke to the report.

Operational Items

- **Medical Personnel – Locums**
  The cost for February and March 2012 was higher than expected. The locum budget was phased heavily in the first six months of the year, but appointing new permanent staff is taking longer than anticipated.

  Since Marion and Anders Johnson have finished, the West Coast DHB is presently fully reliant on locums for anaesthetics.

  There are also a number of locums providing cover for obstetrics and gynaecology, and orthopaedics.

- **Medical Staff Recruitment – Progress (Hospital Services)**
  There is one anaesthetist starting at the end of April 2012, after spending two weeks at Canterbury DHB to fulfil the requirement of New Zealand Medical Council. The second anaesthetist signed his contract yesterday and it is anticipated that another one will be signing soon. At the moment the West Coast DHB is continuing with the South African practice, while seeking a fourth permanent appointment.

  An interview process in is progress for an obstetrics and gynaecology consultant, and recruiting is ongoing for a second consultant.

  As a continued recruitment effort the West Coast DHB is about to advertise in overseas adventure and sport magazines. However, there are still strong enquiries coming though without the DHB soliciting them. It is difficult to establish a timeframe for filling up the permanent positions. As a common practice the West Coast DHB brings the consultants and their spouses into the country before appointing them. This allows both sides to meet and enables the consultants to familiarise themselves with the environment.

- **Orthopaedic Pathway**
  The West Coast DHB is working closely with the Canterbury DHB on developing a plan around the orthopaedic cover on the West Coast in the future.

  Clinical services in the future will require full Emergency Department staffing. Currently there are three permanent Emergency Department positions, but the budget allows for five. It will also be considered whether there is a need for a rural hospital specialist to provide night cover as opposed to the current situation where a House Surgeon is on call.

Discussions with the Senior Medical Officers are ongoing, and the whole model of care implementation is going to the Board on 20 April 2012. The Minister is well aware of the proposal.

The numbers of presentations during weekends and night will be closely monitored.

Action Point: Information about the numbers of any serious orthopaedic cases that are already sent to Christchurch to be provided at the next meeting.

The on site cover for obstetrics and gynaecology will continue to be 24/7, including after hours and weekends.

The recent article in the local newspaper reporting on the proposed hospital changes was discussed.

(Richard Wallace left the room at 11:28am.)

The West Coast DHB is dedicated to maintaining safe services, with the aim for safe sustainability. It must present a clear vision and eliminate misinformation about the future plan.

(Richard Wallace entered the room at 11:54am.)

- **Patient transfers to Christchurch**
  The correct mode of transport for patients needs to be monitored. It is a clinical decision whether an air transfer is required. While the initiative was developed for cardiac patient as an Xcelr8 project, it will now be also applied on other cases/specialities.

- **Staffing**
  The preferred applicant has just accepted the position of Clinical Manager Occupational Therapy.

- **Shorter Stays in Emergency Departments**
  It was pointed out that this section provides information to Item 5 of the Matters Arising.

- **Share for Care**
  With only two percent of patients opting in, it was queried whether the trained staff are asking all the patients who present to medical centres. Any new enrolments are asked the question, but the problem is with the existing enrolments.

- **Carelink**
  A proposal of the review process for home care will be presented to the Executive Management Team next week.

- **Industrial relations**
  The negotiations with APEX and West Coast DHB Information Technology have concluded with the settlement has been reached.

  Negotiations with the Resident Medical Officers are coming up.

Caseweights

- The first sentence should be “This report includes base service level agreement and additional electives initiative volumes.”
- By the end of February 2012 there was under production in acute surgery and over production in elective services, especially orthopaedics. The elective cases are viewed in cases (discharges) rather then caseweights, and caseweights will need to be reviewed.
- The Minister instructed the DHBs not to go below the national intervention rates. The recommended number of cases for orthopaedics is 90, and it is up to the West Coast DHB to consider whether more cases need to be done. As part of the new orthopaedic pathway, patients’ need for surgery is assessed by a physiotherapist. The care provided by the Physiotherapy Department is linked in with the orthopaedic surgery performed each week.

Finance Report

The Chief Financial Manager spoke to the Finance Report for February 2012 and presented the graphs for the Provider Arm results:

- At the end of February 2012 the year to date variance was $682 000.
- The budget did not include the extra day of the leap year (29 February), which had a large impact on the personnel costs recorded in Graph 3.
- Graph 5 shows that the outsourced clinical services were down in February 2012. This drop was due to service adjustments between the West Coast DHB and Canterbury DHB. After a high number of orthopaedic surgeries at the beginning of the year, there was a reduction in February 2012.
- Graph 7 includes patient travel which is cost sensitive, as a small number can result in a big difference. Negotiations are currently in progress with the outside providers of patient travel. There has been an increase in the cost of orthopaedic implants.
- The West Coast DHB is still working on achieving the forecast deficit. A lot of work has been done within the hospital services: for example, some appointments are being deferred, and travel declined, unless approved by the Acting General Manager Hospital Services. In Buller they are now carefully examining the expenditure in aged care.

(Mary Molloy entered the room at 12:40pm.)

Outpatient Department Cancellations

The graphs and results were discussed by the committee. Attention needs to be paid to leave planning to eliminate cancellations. Flight cancellations include an instance when a flight that had four clinicians on board was cancelled for other reasons than weather. Only two of these clinicians chose to travel over on the shuttle with the other two clinics being cancelled. There are no notifications of any new flight schedule changes.

Clinical Leaders Report

The Director of Nursing and Midwifery responded to questions. It was noted that the report reflected progress against the Annual Plan 2011/12 and that there has been positive feedback on the trans-alpine meeting.

The Terms of Reference of the West Coast Health System Clinical Board were briefly discussed. The members of the board consist of the most appropriate staff, without the board being too large. It is anticipated that the initiative will evolve when the Clinical Board starts acting. The board will be directly accountable to the Chief Executive for advice.

6.3 INVESTIGATIONS / SCOPING

Monitoring Inter District Flows - Patient Transfers
The report includes information for three months, ending with January 2012. There was a high number of cardiology transfers after Christmas 2011, and January 2012 was a busy month for transfers from Buller Hospital to Greymouth.

7. INFORMATION PAPERS

The Terms of Reference for the Hospital Advisory Committee demonstrate that the committee has a clear purpose and is heading in the right direction.

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

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

Carried.

8. IN COMMITTEE

Moved: Sharon Pugh **Seconded: Peter Ballantyne**

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 12:52pm.

There were no In Committee resolutions.

The Hospital Advisory Committee moved out of In Committee at 12:53pm.

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

- A lot of work is currently being done on production planning to achieve the balance between clinical acuity and waiting times.
- The new Central Booking Unit Manager is starting on 30 April 2012. The manager will be working alongside an analyst on the refocusing of the unit and defining the processes.
- Locum cost for February and March 2012 was higher then planned as appointing new permanent staff is taking longer than anticipated. At the moment the West Coast DHB fully relies on locums in anaesthetics, and there is also a large number of locums used in the obstetrics and gynaecology.

- There are positive results in recruitment for anaesthetics. An interview process for an obstetrics and gynaecology consultant is in progress.
- Patient transfers in all areas are now being closely monitored. It is a clinical decision whether a helicopter transfer is required or if another mode of transport can be used.
- Relative to the Provider Arm all practical steps have been taken to contain expenditure while ensuring the safety and quality of the service.

The report to the Board is to be sent to be tabled at the Board meeting next week, on Friday 20 April 2012.

10. GENERAL BUSINESS

The members of the committee would like to express their appreciation for the services provided by Sandra Gibbens as their Minute Secretary, and wish her all the best for the future.

11. NEXT MEETING

The next meeting will be held on Thursday 24 May 2012 in the Boardroom, Corporate Office, Grey Base Hospital.

The Hospital Advisory Committee spent one minute in In Committee

There being no further business to discuss the meeting concluded at 1pm.

_____ _____

Signed **Date**

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY GROUP MEETING HELD ON WEDNESDAY 11 APRIL 2012 AT ARAHURA MARAE, 3 PM

PRESENT	Ben Hutana (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
	Richard Wallace	Te Rūnanga O Makaawhio
	Elinor Stratford	West Coast District Health Board Representative on Tatau Pounamu
IN ATTENDANCE	Gary Coghlan	General Manager Māori Health, West Coast DHB
	Claire Robertson	HEHA and Smokefree Services Manager West Coast DHB
MINUTE TAKER	Rachel Passuello	Administration Support
APOLOGIES:	Hecta Williams	General Manager, West Coast DHB
	Wayne Turp	General Manager Planning and Funding West Coast DHB
	Peter Ballantyne	Acting Board Chair, West Coast DHB

WELCOME

The Chair welcomed everyone to the meeting and opened with karakia.

1. AGENDA / APOLOGIES

Apologies

- Hecta Williams — General Manager, West Coast DHB
- Wayne Turp — General Manager, Planning and Funding
- Peter Ballantyne — Acting Board Chair, West Coast DHB

Apologies accepted

Moved: Francois Tumahai **Second: Elinor Stratford**

2. DISCLOSURES OF INTERESTS

Elinor Stratford: remove ‘Manager, Disability Services Resource Service West Coast’, as she is no longer the Manager.

3. MINUTES OF THE LAST MEETING – 23 FEBRUARY 2012

Page 6 – Memorandum of Understanding and Terms of Reference there was a spelling error

Moved: Marie Mahuika -Forsyth Seconded: Francois Tumahai

Motion
THAT the Minutes of the Tatau Pounamu Manawhenua Advisory Group meeting held 23 FEBRUARY 2012 be adopted as a true and accurate record [subject to any changes or amendments above].

Carried.

MEETING SCHEDULE
The meeting dates were set prior to Christmas. A member mentioned at least one meeting needs to be held at the Te Runanga O Makaawhio office.

ANNUAL PLAN PROCESS
It was noted that the reference to "Maata Waka' in this section was not correct so the suggestion was made that the wording needed to be changed.

GENERAL BUSINESS
Manawhenua Hui Christchurch 23 February 2012
'Mana whanau' should read 'Mana Whenua'.
It was mentioned that the invitation to the 'Manawhenua Hui in Christchurch on the 23 February 2012' has been received but the chair and deputy chair of Tatau Pounamu could not go as the Tatau Pounamu hui was on this same day. Ngai Tahu were made aware of this It was suggested that Ngai Tahu need to have their hui on a different date and time and that Ngai Tahu should already be aware when the Tatau Pounamu hui is on.

4. MATTERS ARISING FROM THE LAST MEETING

WEST COAST HOME INSULATION PROJECT
The reporting status of this is now complete and can now come off matters arising.

WORKING WITH IWI FORUMS IN TE WAIPOUNAMU Blenheim – 19 MARCH 2012
This hui went ahead but no managers from within the Ngai Tahu rohe attended although the Kaiwhakahaere for Ngai Tahu and the Deputy Kaiwhakahaere for Ngai Tahu did attend.

Moved: Marie Mahuika-Forsyth Seconded: Francois Tumahai

5. MAORI HEALTH REPORT TO TATAU POUNAMU

Gary Coghlan, General Manager Maori Health
This report was taken as read.

Te Whare Oranga Pai
There was some discussion regarding the membership of the committee set up to support this project. Membership is comprised of two people from each Runanga

Maori Health Data and Feedback – Q2 Progress Report Graphs

The General Manager (GM) Maori Health spoke commented that the information in the graphs shows a slight update from the last report, with no significant changes.

- It was noted on some occasions, particularly when numbers are small that percentages can be confusing, and this can impact on how information is understood.
- A member asked why the number of staff who had completed Te Pikorua and Treaty of Waitangi training was included in the report. The GM responded because it was a requirement from the Ministry of Health to know the numbers of staff undertaking this training, and it is part of the Annual Plan and the Maori Health Plan. More information could be included, for example staff undertaking Tikanga Best Practice Training, Ka Awatea for home support workers, Orientation for new staff (which includes a section on Maori health), and training for providers outside the DHB.
- Mainstream responsiveness was very important in terms of giving people working in the Health and Disability sector an opportunity to understand Maori health issues.
- There were some questions regarding breast screening and Immunisation statistics for Maori, particularly if the targets are achievable.
- It was suggested that where possible, the actual numbers could be added in with the percentages.

6. REVIEW OF SERVICES TO MAORI PROJECT

Gary Coghlan, General Manager Maori Health

An update was given by the GM Maori health. Neil Woodhams and Associates have been contracted to undertake a short term planning project to influence clinical service changes to improve Maori health outcomes on the West Coast. The project will focus on reviewing the responsiveness and effectiveness of services specifically delivered to Maori and mainstream services in areas related directly to the Maori Health Plan. This includes maternal health, cardiovascular disease, diabetes, cancer, smoking, immunisation and oral health. Currently a draft report is being written.

7. MAORI HEALTH PLAN 2012-2013 DRAFT

Gary Coghlan, General Manager Maori Health

A member asked why there is a requirement for a yearly plan. The GM Maori Health explained this is a Ministry of Health requirement. The draft Plan had been sent to the Ministry Of Health and we are awaiting feedback. Some feedback from members included having a stronger focus on Maori mental health, obesity and nutrition for Maori, rangatahi and Tamariki (child and youth health). Overall the feedback was positive; however there are still areas to work on. The next step is to meet with Maori communities to discuss the plan and other issues relating to Maori health. There have been two hui recently and another one is set for Buller on the 16 April 2012.

8. MAORI CONSULTATION – MULTIPLE SCLEROSIS

Gary Coghlan, General Manager Maori Health

A request has been made by Dr Deborah Mason, a Consultant Neurologist Christchurch Public Hospital, for consultation with Maori for her study on the incidence of Multiple Sclerosis in New Zealand. Tatau Pounamu is very supportive of this work, however the incidence of Multiple Sclerosis for Maori on the Coast is low.

Action – The Chair to draft a letter of support.

9. BULLER MAORI HEALTH HUI – 16 APRIL 2012

Gary Coghlan, General Manager Maori Health

The hui is on the 16 April 2012, and a number of Tatau Pounamu members will be attending.

10. HEHA/SMOKEFREE UPDATE

Claire Robertson – HEHA and Smokefree Services Manager

The HEHA and Smoke free Services Manager gave an update. Key factors were:

- Follow up from the last Smoke free report regarding Maori access to smoke free services on the West Coast, Coast Quit: 8% and DHB cessation services: 10%
- Smokefree: Three core services were provided – secondary, Coastquit and the Community and Public Health – Aukati Kai Paipa.
- The quit rate for Maori using Coast Quit 3-6 months after their quit date was 22%, compared to a total of 19.5% for total population. These success rates are substantially higher than those attempting to quit with no support. It is important to point out that the numbers being referred to here are low and the key data is the access rates to the above services, as with smoking cessation it is the number of quit attempts that is important.
- There has been an increase in the - Better Support for Smokers to Quit Health Target results in Quarter 3 with 86% (90% Maori) in January and 96% (92% Maori) in February. For 2012/2013 the health target remaining the same; 90% of smokers within primary care will be provided advice and support to quit and 95% within secondary care.
- In addition there is a target of progress towards 90% of pregnant women who identify as smokers at confirmation of pregnancy are provided advice and support to quit by the GP or Midwife. The Maori Smokefree Roopu could play a pivotal role in getting progress within this high needs area - smoking and pregnancy, particularly Maori women on the West Coast.
- The ASH Year 10 Survey Results 2011 were released in March 2012. The group with the best improvement from the previous years being Maori with 14-15 females nationally dropping from 16.3% to 11.3%.
- The West Coast specific results, although not broken down by ethnicity, show significant improvement compared to previous years' ASH results.
- The West Coast Tobacco Free Coalition have appointed Ellie Ngatai to Buller Reap as the Smokefree Youth Co Ordinator, as part of the Buller Youth Project.
- A member asked if Tatau Pounamu were interested in being updated on the work of the Smokefree Youth Coordinator as she reports to the West Coast Tobacco Smokefree Coalition. It was agreed by the group it would be good to be informed on the progress Ellie is making in this new project, as part of the HEHA & Smokefree reports prepared by Claire.

11. MAORI MENTAL HEALTH

There was an open and robust conversation regarding whether it would be better for the Maori community if the Maori Mental Health DHB team sat within a Maori health provider. The members supported Maori mental health being more closely situated within the community. It was felt that the timing had to be right for this to occur.

12. CORRESPONDENCE

Richard Wallace has received an invitation to be on a National Asthma committee and would like support from Tatau Pounamu to fill this position.

Action: A letter is to be drafted from the Chair of Tatau Pounamu supporting Richard Wallace to be on this committee.

Moved: Marie Mahuika-Forsyth **Seconded: Sharon Marsh**

Motion
That the Inwards and outwards correspondence is accepted.

Carried

13. 2012 MEETING SCHEDULE

This is to be put on matters arising for the next meeting.

Meeting finished at 5.20 pm

Signed _____ **Date** _____