West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Friday 4 April 2014
10.00am

St John
Waterwalk Road
GREYMOUTH

ALL INFORMATION CONTAINED IN THESE MEETING PAPERS IS SUBJECT TO CHANGE

WEST COAST DISTRICT HEALTH BOARD MEMBERS

Paul McCormack (Chair)
Peter Ballantyne (Deputy Chair)
Kevin Brown
Helen Gillespie
Michelle Lomax
Peter Neame
Sharon Pugh
Elinor Stratford
Joseph Thomas
John Vaile
Susan Wallace

Executive Support

David Meates (*Chief Executive)*
Michael Frampton (*Programme Director)*
Dr Carol Atmore (*Chief Medical Officer)*
Karyn Bousfield *(Director of Nursing & Midwifery)*
Gary Coghlan *(General Manager, Maori Health)*
Kathleen Gavigan *(General Manager, Buller)*
Carolyn Gullery *(General Manager, Planning & Funding)*
Mark Newsome *(General Manager, Grey & Westland)*
Stella Ward *(Executive Director, Allied Health)*
Karalyn van Deursen *(Strategic Communications Manager)*
Justine White *(General Manager, Finance)*
Kay Jenkins (*Minutes)*

AGENDA – PUBLIC

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

WEST COAST DISTRICT HEALTH BOARD MEETING
To be held St John, Waterwalk Road, Greymouth
Friday 4 April 2014 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** ▪ *21 February 2014*		
3.	**Carried Forward/Action List Items**		
REPORTS			***10.15am***
4.	**Acting Chair's Update (Verbal Update)**	Peter Ballantyne *Acting Chairman*	*10.15am – 10.25am*
5.	**Chief Executive's Update**	David Meates *Chief Executive*	*10.25am – 10.40am*
6.	**Clinical Leader's Update**	Karyn Bousfield *Director of Nursing and Midwifery*	*10.40am – 10.50am*
7.	**Finance Report**	David Green *Acting General Manager, Finance*	*10.50am – 11.00am*
8.	**Draft 2014-15 Public Health Plan**	Jem Pupich *Team Leader, Community & Public Health*	*11.00am – 11.15am*
9.	**Maternity Review – Update on Progress Against Recommendations**	Mark Newsome *General Manager, Grey/Westland* Karen Bousfield *Director of Nursing & Midwifery*	*11.15am – 11.30am*
10.	**Maori Health Quarterly Update**	Gary Coghlan *General Manager, Maori Health*	*11.30am – 11.40am*
11.	**Health Target Report – Quarter 2**	Greg Hamilton *Actg General Manager, Planning & Funding*	*11.40am – 11.50am*
12.	**Tatau Pounamu Terms of Reference**	David Meates *Chief Executive*	*11.50am – 12noon*

13. **Report from Committee Meetings**

- CPH&DSAC *20 March 2014*	Elinor Stratford *Chair, CPH&DSAC Committee*	*12noon – 12.10pm*
- Hospital Advisory Committee *20 March 2014*	Sharon Pugh *Chair, Hospital Advisory Committee*	*12.10pm – 12.20pm*
- Tatau Pounamu Advisory Group *Next Meeting 10 April 2014*	*Report at next Board Meeting*	

14. **Resolution to Exclude the Public** — *Board Secretariat* — *12.20pm*

INFORMATION ITEMS

- 2014 Meeting Schedule

ESTIMATED FINISH TIME ***12.20pm***

NEXT MEETING

Friday 9 May 2014

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 INTERESTS REGISTER

	Disclosure of Interest
Dr Paul McCormack **Chair**	• General Practitioner Member, Pegasus Health
Peter Ballantyne **Deputy Chair**	• Member, Quality, Finance, Audit and Risk Committee, Canterbury DHB • Retired partner, Deloitte • Member of Council, University of Canterbury • Trust Board Member, Bishop Julius Hall of Residence • Spouse, Canterbury DHB 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 works part time at CAMHS • Patron and Member of West Coast Diabetes • Trustee, West Coast Juvenile Diabetes Association
Helen Gillespie	• Peer Support Counsellor, Mum 4 Mum • Employee, DOC
Michelle Lomax	• Kawatiri Action Group – Past Member • Autism New Zealand – Member • West Coast Community Trust – Trustee • Buller High School Board of Trustees – Trustee • St John Youth Leader
Peter Neame	• No Conflicts of Intrest
Sharon Pugh	• Shareholder, New River Bluegums Bed & Breakfast • Chair, Greymouth Business & Promotions Association
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, Grey/Westland district • Committee Member, Abbeyfield Greymouth Incorporated • Trustee, Canterbury Neonatal Trust • Advisor MS/Parkinson West Coast • Disability Resource Trust - contracted to wind up this Organisation • Trustee, Disability Resource Centre, Queenstown/West Coast • Elected Member, Arthritis New Zealand, Southern Regional Liaison Group

Joseph Thomas	• New Zealand Institute of Management Inc – Chief Executive • The Canterbury Community Trust – Trustee • Canterbury Direct Investments Limited – Director • The Canterbury Community Trust Charities Limited – Director • Canterbury Trust House Limited – Director • Ngati Mutunga o Wahrekauri Asset Holding Company Limited – Chair • Motuhara Fisheries Limited – Director • Management South Limited – Director • Ngati Mutunga o Wharekauri Iwi Trust – Trustee • New Zealand Institute of Management Inc – Member (Associate Fellow) • New Zealand Institute of Chartered Accountants – C A, Member
John Vaile	• Director, Vaile Hardware Ltd • Member of Community Patrols New Zealand
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 • Member of Tatau Pounamu • Father employee of West Coast District Health Board • Director, Kōhatu Makaawhio Ltd • Appointed member of Canterbury District Health Board • Chair, Poutini Waiora • Area Representative-Te Waipounamu Maori Womens' Welfare League

MINUTES

MINUTES OF THE WEST COAST DISTRICT HEALTH BOARD MEETING
held at St John, Waterwalk Road, Greymouth
on Friday 21 February 2014 commencing at 10.00am

BOARD MEMBERS

Dr Paul McCormack (Chair); Peter Ballantyne (Deputy Chair); Kevin Brown; Helen Gillespie; Michelle Lomax; Peter Neame; Sharon Pugh; Elinor Stratford; Joseph Thomas; John Vaile; and Susan Wallace.

APOLOGIES

There were no apologies.

EXECUTIVE SUPPORT

David Meates (Chief Executive)(from 11.05am); Michael Frampton (Programme Director); Dr Carol Atmore (Chief Medical Officer); Gary Coghlan (General Manager, Maori Health); Kathleen Gavigan (General Manager, Buller); Mark Newsome (General Manager, Grey/Westland Justine White (General Manager, Finance) (from 11.05am); and Kay Jenkins (Minutes).

Susan Wallace led the Karakia. She expressed the Board's condolences to the family of Marian van der Goes who passed away earlier in the Month. Marian was the Chair of the West Coast DHB from 1999 – 2001.

The Chair advised that due to cancellation of flights from Christchurch the Chief Executive and General Manager, Finance would join the meeting later in the morning.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Michelle Lomax advised that she is a "past" member of the Kawateri Action Group.
Peter Ballantyne advised that "in consultancy role" should be deleted from his Deloitte interest.
Joseph Thomas advised that he is now a "Trustee" of The Canterbury Community Trust and not "Deputy Chair"
Kevin Brown advised that he is no longer a member of CCS.

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest regarding items on today's agenda

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

2. CONFIRMATION OF MINUTES OF THE PREVIOUS MEETINGS

Resolution (1/14)
(Moved Sharon Pugh/seconded Helen Gillespie - carried):

"That the minutes of the Meeting of the West Coast District Health Board held in the Board Room, Corporate Office, Grey Base Hospital, Greymouth on Friday 13 December 2013 be confirmed as a true and correct record subject to an alteration in Item 4, Resolution 50/13 - delete "Acting" and page 3, Item 5, bullet point 4 Model of Care – amend to read "Mr Frampton expanded on the agreed Model of Care which described how we deliver care to the West Coast Community".

3. CARRIED FORWARD/ACTION LIST ITEMS

There were no carried forward items.

4. CHAIR'S UPDATE

Partnership Group
The Chair advised that both he and Peter Ballantyne (as Deputy Chair) were now part of the Facilities Partnership Group. They have been involved in 2 teleconferences so far this year and the next face to face meeting of the Group is scheduled for 12 March 2014. He added that he is confident that over the next short period of time there will be a proposal that will deliver the desired model of care on the West Coast.

Discussion took place regarding the Partnership Group process and the Chair asked the Deputy Chair to describe the process and Group membership for the benefit of new members of the Board.

South Island Alliance
The Chair commented that the South Island Alliance is working in the way that it should. The next meeting of this is scheduled for 31 March 2014.

Tatau Pounamu Terms of Reference
The Chair advised that that Tatau Pounamu have spent some time looking at how they work and the revised Terms of Reference proposed by Tatau Pounamu have been referred to management for comment and will come to the next Board meeting.

Resolution (2/14)
(Moved Joseph Thomas/seconded Susan Wallace – carried)

That the Board:
i. notes the Chair's verbal update.

The meeting moved to item 6

6. CLINICAL LEADERS REPORT

Dr Carol Atmore, Chief Medical Officer; spoke to this report, which was taken as read.

Dr Atmore commented that the three headings in the report are the three pieces of work that they are focussed on at the moment.

Facilities
She commented that this has been the largest time commitment for the Clinical Leaders and is happy to report excellent engagement from the clinical teams including open mindedness and good suggestions.

Workforce
She commented that a lot of work is taking place around developing our workforce to align with the new models of care. She added that it is great to see the additional funding from Health Workforce New Zealand to support a larger number of nurses completing postgraduate qualifications.

Quality and Safety
She commented that a lot of work is taking place in this area. There is a further focus on the falls programme and also the DHB is producing its first set of Quality Accounts this year and copies will be provided to Board members when available.

Resolution (3/14)
(Moved Helen Gillespie/seconded Elinor Stratford – carried)
That the Board:
ii. notes the Clinical Advisor's updates.

The meeting moved to item 8

8. NOTICE OF MOTION

The Chair spoke regarding the standing orders around revoking or altering resolutions of the Board and advised that he was happy to be relaxed regarding the standing orders to allow discussions to take place providing there is a seconder for the motions.

Motion 1: That birthing facilities be reinstated at Buller Hospital.
Seconder: Michelle Lomax (pro-forma to open up for discussion)

Board member, Peter Neame, spoke to his notice of motion and commented that the general public are concerned about reducing services.

Michael Frampton, Programme Director, provided the meeting with the background around the safety issues which led to the current status. He advised that since that time the DHB have been in discussions with the Kawateri Action Group and College of Midwives to ascertain if services could be sustainably and safely provided. We are currently working to produce a plan going forward and also looking at how other rural areas deliver this service.

Dr Carol Atmore, Chief Medical Officer, commented that the proposed new Buller facility does provide for birthing and the driver for how these services are being provided are around safety and these issues are being worked through but are proving challenging to solve.

Michael Frampton provided background regarding the Maternity Review recommendations. He advised that a decision has been taken to appoint a contractor (midwife) which will give capacity to develop a work programme which will be put in place over the next 12 – 18 months.

A request was made for an update against the review recommendations to be provided to the next meeting.

The motion was lost with Peter Neame and Michele Lomas asking that their votes for the motion be recorded.

Motion 2: That the Greymouth Laundry be reopened.
The motion lapsed due to there being no seconder.

The meeting moved to item 10.

10. COMMITTEE MEMBERSHIP

The Chair spoke to this paper. He advised that it was intended to review this membership after 12 months.

Joseph Thomas commented that he would prefer to be a member of the QFARC Committee and asked that this be considered when membership was reviewed.

Resolution (4/14)
(Moved Susan Wallace/seconded Helen Gillespie – carried)
That the Board:

i. Confirms the appointment of Board members to the Quality, Finance Audit and Risk Committee, Hospital Advisory Committee, and the combined Community and Public Health Advisory & Disability Support Advisory Committee as per the schedule attached as Appendix 1; and
ii. Confirms the appointment of Chair's and Deputy Chair's to the Committees as shown in Appendix 1; and
iii. Confirms that the term of Committee appointments for Board members is for a three year term until the end of February 2017 (while they remain members of the Board) with a review to take place after the first year; and
iv. Notes that a further report will come to the Board regarding the external/community membership of the Quality, Finance Audit and Risk Committee, Hospital Advisory Committee, Community and Public Heath and Disability Advisory Committee and Disability Support Advisory Committee; and
v. Approves the rollover of the current external members of the Board's Committees (including the Retention of Warren Gilbertson on the QFARC Committee) until the 27 June 2014 Board meeting, to enable a review to be carried out, noting that appointments can be concluded earlier if necessary.
vi. Notes that the Terms of Reference (TOR) for all Committees will be reviewed in 2014 and submitted to the Board for approval in due course.

David Meates & Justine White joined the meeting at 11.05am

5. CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented this report which was taken as read.

He highlighted the following:

- The direction of travel in terms of moving to clinical and financial sustainability and the ongoing journey of getting longer term solutions in place.
- The significant amount of work that has taken place on the Grey Hospital site due to earthquake repairs.
- The significant issues around the boiler house and chimney stacks which will need to be stepped through carefully.
- The appointment of the new General Manager, Grey/Westland, Mark Newsome, which is an important part of the journey.
- The West Coast is one of the few DHBs nationally sitting ahead in wait times and Michael and the team here have worked very hard to achieve this.
- A lot of work over the last three years has been committed to living within our means and the important element underpinning this is the culture change which is really important for building long term sustainable services.

Discussion took place regarding consultation in Buller and the Chief Executive commented that whilst consultation with Buller has been extensive there has been a delay due to a number of process issues being worked through by the Partnership Group. He added that the framework has not changed from the original consultation.

Discussion also took place regarding the discharge of West Coast patients from hospital in

Christchurch with some issues being experienced. The Chief Executive assured the Board that these incidents are being looked into with Social Workers looking at a range of options as to how these are dealt with. This is one of the reasons that a broader plan is required around transport options. The Board noted that there is an ongoing piece of work being undertaken to continue to improve the journey of West Coast patients. The Chief Executive added that Canterbury provides services for thousands of patients across the whole South Island and where acute treatment is concluded in Canterbury this is an ongoing challenge as it is not appropriate to keep people in hospital once treatment is concluded however there is an obligation to ensure discharges into the community are appropriate. The Board will be kept up to date with progress in this area.

A query was made regarding transport policy and whether this had recently changed. The Programme Director advised that there had not been any change in policy and that there are national rules around this that we have to comply with whereby patients travel and then claim back and there is also a voucher system. He added that it was unfortunate that there had been conflicting reports in the local newspaper that had added to the confusion around this.

Discharges from Grey Hospital of Buller residents was also raised. The Chief Executive commented that we need to be clear that the responsibility for transport to and from health facilities is the responsibility of the individual however we are trying to choose to work with people to achieve the best outcomes. He reiterated that is it not generally appropriate to keep people in hospital because they do not have transport.

Discussion took place regarding communications and the Chief Executive commented that the clarity of messages and communication has come a long way. He added that there is a strategy around communicating into the community with the "grass roots" plan and every opportunity is being taken in this area.

Resolution (5/14)
(Moved Sharon Pugh/seconded Michelle Lomax – carried)

That the Board:
i. notes the Chief Executive's update.

7. FINANCE REPORT

Justine White, General Manager, Finance, spoke to the Finance Report for December 2013 which was taken as read. The report advised that the consolidated West Coast DHB financial result for the month of December 2013 was a deficit of $0.027m, which was $0.025m unfavourable against the budgeted deficit of $0.002m. The year to date position is now $0.035m unfavourable.

The Board noted that we are still seeing the same themes although December and January have seen quite high locum costs due to annual leave over the Christmas period. It was also noted that the DHB is on track to achieve the $1.1m deficit for the current year and break even for next year.

A query was made regarding locums being allowed for in budgets and it was confirmed that this is the case.

Resolution (6/14)
(Moved Elinor Stratford/seconded Joseph Thomas – carried)
That the Board:
i. Notes the financial result for the period ended 31 December 2013

9. HBL –SHARED BANKING AND TREASURY SERVICES AUTHORISED SIGNATORIES

Justine White, General Manager, Finance, spoke to this report**.**

Justine provided an overview of the HBL banking process.

Resolution (7/14)
(Moved Elinor Stratford/seconded Joseph Thomas – carried)
That the Board:

i. approves the changes to the authorised signatories for the Health Benefits Limited Master Services Agreement as detailed in Appendix 1.

11. REPORTS FROM COMMITTEE MEETINGS

Elinor Stratford, Board representative on the Tatau Pounamu Advisory Group provided an update from the meeting held on 20 February 2014. It was noted that Tatau Pounamu have reviewed the Terms of Reference which are attached to the Memorandum of Understanding between Tatau Pounamu and the DHB. The Terms of Reference will come to the next Board meeting for discussion.

The first draft of the Maori Health Plan is almost completed and this will go out for feedback shortly.

The update was noted.

12. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (8/14)
(Moved Paul McCormack/seconded Michelle Lomax – carried)

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 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 13 December 2013	For the reasons set out in the previous Board agenda.	
2.	Chief Executive and Chair – Verbal 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)

3.	Clinical Leaders Verbal 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)
4.	Risk Mitigation Strategy Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
5.	South Island Patient Information Care System	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
6.	Advisory Committee – Public Excluded Updates	For the reasons given in the Committee agendas	

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";

There being no further business the public open section of the meeting closed at 12.10pm.

The Public Excluded section of the meeting commenced at 12.15pm and concluded at 1.10pm.

_____ _____

Paul McCormack, Chair Date

CHIEF EXECUTIVE'S UPDATE

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

SOURCE: **Chief Executive**

DATE: **04 April 2014**

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.

Its format is organised around the key organisational priorities that drive the Board and Executive Management Team's [EMT] work programmes. Its content is focused on reporting recent performance, together with current and upcoming activity.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

	DELIVERING COMPREHENSIVE STABLE AND SAFE SERVICES IN THE COMMUNITY

A: Reinvigorate the West Coast Alliance

- **Alliance Leadership Team** – The Alliance Leadership Team [ALT] last met on 26 February. This meeting was an opportunity for ALT to review draft workplans from each of the workstreams for the coming annual planning year and provide feedback.
- **Alliance Support** – A framework for reporting is currently under discussion with the Alliance Support Group [ASG] to provide greater visibility about priorities, progress and performance to the ALT, the Executive Management Team and the Board, and to support decision-making. The ASG is supporting workstreams in the finalisation of their workplans, facilitating consistent outcome descriptors, providing guidance and ensuring the rationalisation of activities across workstreams.

B: Build Primary and Community Capacity and Capability

Primary

- Performance in relation to Primary Health Organisation [PHO] targets continues to improve with the increased capacity at Buller Medical Service. Significantly, waiting time is down to one day at the most for an appointment, complaints have reduced and staff morale is good. Waiting times are also reducing across all other practices and we are now within the target

times of two days for routine appointments and one day for urgent appointments.

- A full time permanent GP for Reefton commences employment in May, and recruitment continues for a second GP. These positions will also work at the Rural Academic General Practice [RAGP] at Grey Hospital and share the Monday - Friday GP role in Reefton. The practice manager for Reefton has resigned and a plan is in place to recruit for this role; in the interim a Better Health practice manager is currently in place.
- Two Better Health GP locums have been recruited to provide locum cover for the Coast.
- While we have a full complement of [permanent and contract] GPs across the Coast, we continue to have vacancies for *permanent* GPs, with one GP considering a permanent contract at this time. Work continues between Better Health and the DHB to strengthen recruitment processes.

Community

- Good progress is being made with filling vacancies in the areas of emergency/acute and aged care at **Buller Health Services**. It is pleasing to see an excellent pool of applicants for some positions and a number of young nurses choosing to take up career opportunities in the Buller region. Recruitment of a physiotherapist is proving difficult, engendering a rethink about how to attract suitable applicants. The joint district nursing and home based support registered nurse position has been filled and it is expected that an appointment will be made to the district nursing vacancy in the near future, bringing the team up to full establishment.

- **Reefton Health** hospital is now fully staffed and recruitment is underway for more casual on-call staff. The hospital wing has one vacancy for residential care, with 11 beds currently occupied. Future workforce development continues, with a CPIT year three student in Reefton from 28 April to 6 June for clinical experience in rural community nursing. The Nursing Entry to Practice RN has also commenced in Reefton. The Rural Nurse Specialists [RNS] from Moana and North spent a day in Murchison on 12 March as part of joint training with the Nelson Marlborough DHB on managing mass casualty incidents in remote/rural areas. This multi-agency training included presentations from clinical experts, with St John ambulance staff delivering a presentation, along with John Coleman from the South Island PHO Alliance. Training for Caregivers through CareerForce will start early April.

- Mobile Health Solutions [MHS] visited Westport on 18 March for their annual training session which was open to all staff. MHS is a privately owned company that works in partnership with the Ministry of Health, District Health Boards and other health providers to deliver low risk elective day surgery via a surgical bus to rural New Zealanders.

- **Greymouth and South Westland:** The first planning meeting for the development of an *Acute Demand Model* took place this month. This model will be an integrated model aimed at keeping people well and in their own homes, reducing the need for hospital admission and supporting early discharge from hospital. This model will sit beside the *Complex Clinical Care Network* and will involve district nursing, clinical nurse specialists, primary care teams and home based support. Principles will be similar to the *Community Rehabilitation Enablement & Support Team* [CREST] model developed in Canterbury, but with elements specific to the rural nature of the West Coast and different resourcing. The CREST model began as a community-based supported discharge team to facilitate earlier discharge from hospital to appropriate home-based rehabilitation services. It has since been extended to accept referrals

directly from general practice, providing older people referred this way with care and support to be rehabilitated in their own homes so as to avoid hospital admission altogether.

- Increased tourism in South Westland has meant an increase in demand for the RNS team and South Westland practice over the summer months. Staffing levels for Greymouth and South Westland community nursing and RNS's remain at capacity with no vacancies. The increased demand has been managed well by the team.

C: Implement the Maori Health Plan

Maori Health Plan 2014/2015

- The first draft of the Maori Health Plan was sent to the Ministry of Health on 14 March. The plan is a work in progress and, once the initial round of feedback is received back from the Ministry, the first draft will be distributed to Tatau Pounamu and other key groups to ensure sufficient time for constructive feedback to be incorporated before the second draft is due at the Ministry.

Suicide Prevention - Te Waka Hourua

- The General Manager of Maori Health has met with the Kaihautu for Poutini Waiora and the Operations Manager for Mental Health to investigate the possibility of applying for funding from the Wakahauora Fund. Wakahauora is a national suicide prevention programme for Maori and Pacific communities and is a partnership between national Maori health organisations - Te Rau Matatini and national pacific non-governance organisation, Le Va. This application for funding would come from Poutini Waiora. The $2 million Wakahauora Fund has been established to support Maori and Pacific families, whanau, hapu iwi and community groups to design and implement suicide prevention initiatives for their own communities.

- The Fund provides a clear focus for suicide prevention in Maori whanau, hapu, iwi and Pacific families and communities. The programme invites Maori and Pacific communities to build capacity, to prevent suicide and to respond safely and effectively when and if suicide occurs. The programme also seeks to build leadership and knowledge through education, training and resources that are relevant and effective among Maori and Pacific whanau, families and communities.

Violence Intervention Programme

- The Whanau Ora workstream within the Violence Intervention Programme [VIP] continues to meet. Feedback from staff at the VIP core training identified the need for a culturally specific referral tool and identified a pathway to follow for whanau who may be struggling with family violence. The Whanau Ora workgroup will utilise the Whanau Ora tool in the implementation of appropriate resource for staff.

Kia ora Hauora

- This is a Ministry of Health [MOH] funded national programme aimed at increasing Maori Health Workforce numbers. Registrations nationally are 4136 and 575 for the South Island.
- Planned Activity for West Coast
    - MoH Hauora Maori Scholarship Workshop

- Health Careers Roadshow – Greymouth High, Buller High, John Paul High
- West Coast Careers Expo
- Grey Hospital Work Placement Programme

South Island Whanau Ora Commissioning Agency

- Te Putahitanga o Te Waipounamu will be the Whanau Ora Commissioning Agency for the South Island. Te Putahitanga o Te Waipounamu is a partnership of nine South Island iwi who have a strong history of working with their whanau in Te Waipounamu.

- Te Putahitanga o Te Waipounamu will identify the aspirations of whanau and families and invest in new or existing programmes it expects will best deliver progress towards Whanau Ora outcomes in areas such as health, education, and economic development. Essentially this new initiative empowers iwi to look after themselves and prioritise funding.

- The following nine iwi of the South Island comprise the Shareholder Council of Te Putahitanga o Te Waipounamu:
  - Te Runanga o Ngai Tahu
  - Ngati Apa Ki Te Ra To Trust
  - Te Runanga a Rangitane o Wairau
  - Ngati Koata Trust
  - Ngati Tama Manawhenua Ki Te Tau Ihu Trust
  - Te Runanga o Toa Rangatira Incorporated
  - Te Atiawa Manawhenua Ki Te Tau Ihu
  - Te Runanga o Ngati Kuia Charitable Trust
  - Ngati Rarua Iwi Trust

Healthy West Coast Governance

- At the February meeting of the Healthy West Coast Workstream, a decision was made to prioritise Maori across all smoking cessation programmes and delivery of the ABC initiative. The required action to make this happen will be discussed at the next meeting and will make up the Workplan.

Tatau Pounamu Ki Te Tai O Poutini – Manawhenua Advisory Group Buller Region

- The Tatau Pounamu Advisory Group has advertised for a Maori Community Representative in the Buller Region. This is to replace the recent resignation of Sharon Marsh.

	DELIVERING MODERN FIT FOR PURPOSE FACILITIES

A: Facilities Report

Grey Hospital

- The works for the cable replacement and switchboard installation is now complete. This has removed considerable risk from this site. Work is progressing on the boiler surveys. One is now completed, and the next one is underway and it will be completed prior to winter.

Buller Hospital

- Business as usual with the Building Warrant of Fitness now in place.

General

- The new Site Maintenance Manager [Craig Shaw] is now in post and is working through an induction process.

Areas of Focus

- The structural defects on the boilerhouse and chimney stack still present a risk for anyone entering the building and for the site should there be an incident that caused damage. The issue here is around entry to the boilerhouse as, at the moment, the building is 9% of IL3 and has been identified as earthquake prone. The chimney stack in particular needs to come down as a high priority and Site Redevelopment is currently working on this project. A safety plan has been agreed regarding the necessary boiler survey work and this is now well underway.
- Focus is also on improving the WCDHB site maintenance department performance around service delivery, energy performance and aligning the policies and procedures with those used at the Canterbury DHB [CDHB].
- Time will need to be spent in formulating a viable asset management plan, taking on board the intention of the facilities master planning for the West Coast sites when this is available.
- The CDHB Energy Manager is now actively involved in obtaining energy related information in order that we can run this through our existing monitoring and targeting database. He is also developing energy related target KPI's for each site. The energy data is now being entered into the monitoring and targeting database.
- We are also aligning contracts for service where possible as contracts come out of agreement, to ensure one overall system is in place for both DHBs, and participating in the SI Alliance workstream opportunities.
- Input into the proposed new facilities development is gearing up and we expect this will be an area we need to focus on carefully in the forthcoming months.
- Following on from last years all of government tender for electricity, the WCDHB will take advantage of the Genesis pricing; it is however likely that this will be via a letter of intent until the next tender period which is later this year.

B: Facilities Case Update

- A positive and productive meeting was held with the government-appointed West Coast Hospital Redevelopment Partnership Group this month. The Partnership Group members were impressed with the results of the intensive clinical engagement over the past month, following on from the work carried out in October and November last year.

- A revamped business case, entitled the Implementation Business Case [IBC], has been recently completed and was the subject of discussion at the meeting. It is the result of extensive clinical engagement. Over the last month more than 50 hours of workshops involving more than 70 clinicians and staff from the West Coast DHB, the West Coast PHO, general practice teams, community pharmacy, Poutini Waiora, the Canterbury DHB and service contractors were held with the Design Team.
- The IBC covers the redevelopment plans for both Greymouth Hospital and Integrated Family Health Centre, and an Integrated Family Health Centre in Westport. It is also worth noting that the Functional Brief development is a part of the facilities design process, which will continue over the coming months as we move into preliminary design and detailed design.
- We can all be really proud that the final outcome of our new facilities will be able to deliver our Model of Care which has been developed by West Coast DHB clinicians, with input from their Canterbury colleagues. Over the coming weeks the IBC will be reviewed by Government officials from Treasury and the Ministry of Health.
- The Design Team has been working very hard to finalise the outputs from the last round of consultation. Over the next week, the staff who participated in the workstreams will receive an updated Schedule of Accommodation, the updated Functional Relationship Diagrams, the updated Functional Brief and the minutes from the workstream meetings. Once the workstream leaders receive the Functional Brief, there is opportunity to provide further input that the Design Team will incorporate into the final Functional Brief document.
- The actual detail is still very much evolving and there will be opportunity for staff and the community to provide feedback.

	RECONFIGURING SECONDARY AND TRANSALPINE SERVICES

A: Hospital Services [including Secondary Mental Health Services]

Elective Services Performance Indicators [ESPI] Compliance

- ESPI 2 – Two patients non-compliant, one in urology the other in ophthalmology. This means that we will be yellow.
- ESPI 5 – Compliant in all specialties. This means that we will be green.
- Month of March – No compliance issues are anticipated at this stage.
- The West Coast continues to be a leader in compliance against the reduced four month wait times for ESPI 2 and ESPI 5, with more than 70% of our services delivering to this new target [which is in effect from the end of 2014].

Mental Health Services

Update on Suicide Prevention Strategy

- Work continues by West Coast health providers to address the increased number of suicides in the region in the past year. The Governance and Action Groups continue to meet to deliver on the work programme that they have agreed, and further updates on this work will be provided to future board meetings.

National Mental Health KPI Project

- Since 2011, the Adult Mental Health and Addiction Sector has participated in a national Key Performance Indicator framework with the intention of improving the outcomes for people who use mental health and addiction services. The indicators cover the following aspects of care delivery;
    - Total HoNOS Inpatient scores [A nationally collected clinical outcome measurement tool providing information about the effectiveness of inpatient treatment]
    - 28 day acute readmission rate
    - Average length of inpatient stay
    - The number of community treatment days per service user
    - Pre admission community care - i.e. the amount of care provided to a client in their own community prior to an admission
    - Post discharge community care - measures the level of support provided post discharge to prevent readmission
    - Level of non-government service investment
    - Total staff turn over
    - Sick leave usage
- Benchmarks have been established which the West Coast DHB regularly achieves.
- Two supplementary indicators have recently been chosen for a national focus as a measure of productivity ;
    - KPI 33 - Percentage of contact time with direct client participation - recommended target 80 - 90 % [West Coast DHB currently averages 90% over a three year period]
    - KPI 34 - Community service - user related time - includes face to face contact, consult liaison, care coordination, documentation etc - recommended target is 35-40% [West Coast DHB average 28% over a three year period]
- We are currently working on an action plan to identify how we will improve our performance in these particular two indicators. One of the key tasks in this action plan will be to ensure that the system provided to record/report activity by clinicians is fast, user friendly and accurately reflects the work that is being undertaken.

	**DEVELOPING TRANSPORT AND TELEMEDICINE SERVICES**

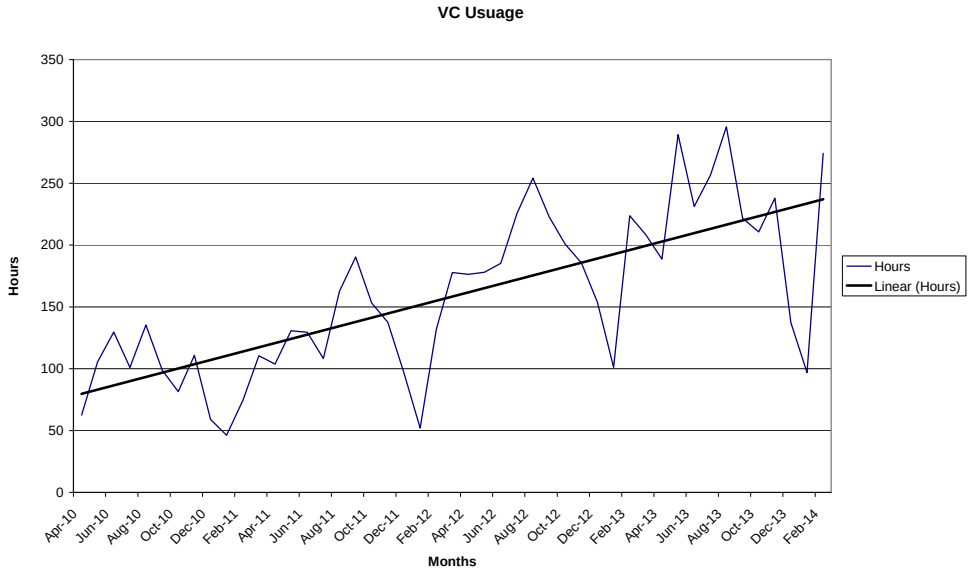
A: Improve Transport Options for Planned [Ambulatory] and Unplanned Patient Transport, Within and Beyond the West Coast

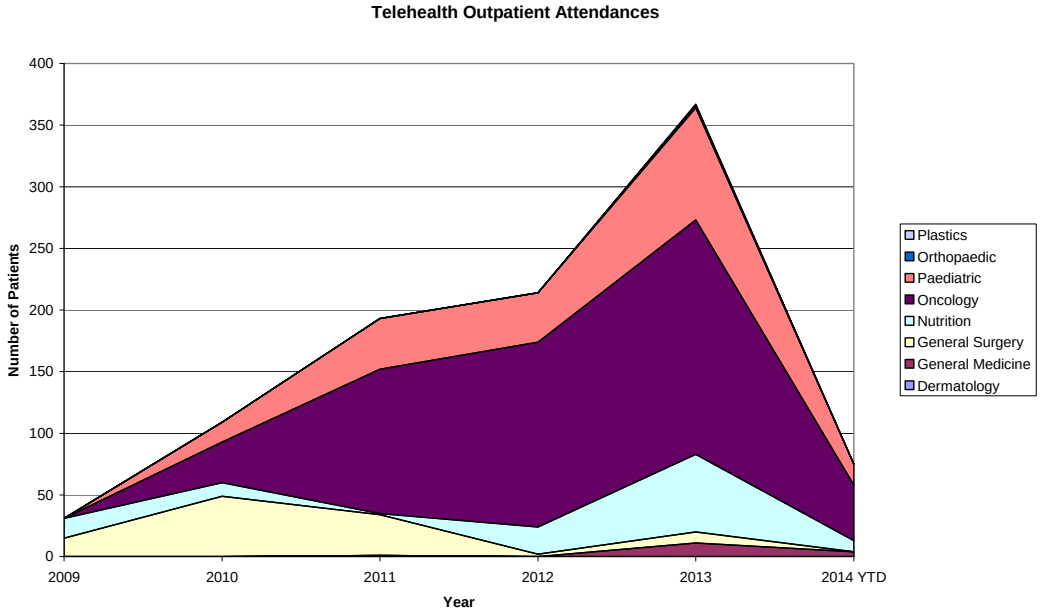
- The voluntary Red Cross Buller Community Transport service continues to run on a regular basis, and is slowly growing in patronage. It is proving an invaluable service to those without a vehicle or ability to drive, and those unable to get family or friends to take them to appointments.
- Short-listing of potential suppliers of chartered flights between Greymouth and Christchurch has been undertaken, with technical clarification of proposals and service configuration options now being considered. This service is designed to support patient and staff transport within the Transalpine framework.
- Negotiations are still continuing with St John as part of a South Island wide joint DHB

approach for the provision of unplanned patient transport services.

B: Champion the Expanded use of Telemedicine Technology

- WCDHB has expanded its videoconferencing capacity considerably within the last several years. See below graph for monthly usage details.
- Several new specialities are beginning to run Telehealth Clinics, including Plastics, General Surgery and Orthopaedics.
- The Telehealth procedure which describes in detail how Telehealth sessions should be run and scheduled, including the type of patients suitable for Telehealth as well as some sample letters informing a patient has been booked for a Telehealth clinic, has now been finalised and published on the intranet and internet websites. The procedure is being promoted with the relevant clinicians who use telehealth.





INTEGRATING THE WEST COAST HEALTH SYSTEM

A: Implement the Complex Clinical Care Network [CCCN]

- The new restorative case mix model of care is currently being piloted with providers. This will enable the CCCN to test the case mix criteria to ensure that it fits the West Coast population needs to enable services in the right place at the right time.
- Continuation of regular training sessions have proved invaluable for the teams and has allowed complex clients to receive a more comprehensive assessment and care to enable them to be more functionally independent in their own home.
- The Rehab Response model, based on the Canterbury CREST model, is being finalised and a planned pilot is scheduled for quarter four.

B: Establish an Integrated Family Health Service [IFHS] in the Buller Community

- Following the appointment of long standing vacancies as well as reviewing rostering practices, Buller Medical General Practice is now fully staffed, resulting in average patient waiting times reducing significantly.

C: Establish an Integrated Family Health Service [IFHS] in the Grey/Westland Community

- The workstream has arranged for key clinical and non-clinical staff to visit exemplar sites in Christchurch and Hamilton, where the *Health Care Home* concept is in various stages of development and implementation. A framework has been drafted to ensure the underlying processes, which can be developed for the West Coast System, are captured and shared appropriately. Attendees will be representatives from both clinical and non-clinical groups from different localities across the Coast with the aim of capturing the different perspectives of each group.

D: Develop an Integrated Model of Pharmacy on the West Coast

- The workstream is progressing discussions around integrating the work of community and hospital pharmacies including looking at technology and shared workforce solutions.

BUILDING CAPACITY TO TRANSFORM THE SYSTEM

A: Live Within our Financial Means

- The consolidated result for the month ending 28 February 2014 was a surplus of $0.345m, which was $0.013m unfavourable against the budgeted surplus of $0.358m. The year to date position is now $0.069m unfavourable.

	Monthly Reporting			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
	$'000	$'000	$'000	$'000	$'000	$'000
Governance Arm	0	(1)	1	0	(10)	10
Funder Arm	470	(5)	475	737	(394)	1,131
Provider Arm	(125)	364	(489)	(1,546)	(336)	(1,210)
Consolidated Result	345	358	(13)	(809)	(740)	(69)

B: Implement Employee Engagement and Performance Management Processes

Employee Health and Wellness

- Information on EAP and Workplace Support has been updated on the website.
- Information sheets on sleep and shift work has also been developed and is available for staff.
- The Influenza Vaccination Programme is underway.
- Work related injuries remain static with the main injury causation being patient/manual handling, slips and falls and physical assaults. The common injuries remain as body stress and strain to lower back and shoulders.
- Greymouth and Westport hospitals have been HSNO audited and corrective actions are underway.

Recruitment

- Current active vacancies are at 42, with activity evenly spread across all professional groups. We have seen an increase in nursing vacancies [up to 17 from 8 in the last reporting period]. Nursing roles are challenging to fill, but progress is being made. Sourcing of applications for medical roles is slow due to the nature of the positions, but we are seeing positive interest in current vacancies, with job offers extended to an Anaesthetist, General Surgeon, and GP; and a face to face visit scheduled with an O&G Specialist who has been interviewed and deemed suitable.

iPerform

- We currently have data for 500 employees and are in the process of loading this into iPerform. The rollout plan is being finalised. It is the intention to roll this product out in May.

Employee Relations

- Negotiations with APEX representing IT workers is now completed and in the process of sign off.
- We are entering into a period of increased activity in the negotiation of employment agreements at both a national and local level. Initiation of bargaining has been received from the EPMU representing trades staff following the breakdown of negotiations at a national level with combined unions. Initiation has also been received from the PSA representing allied health and technical employees. Negotiations which have been underway for some months continue with the PSA representing clerical workers.

C: Effective Clinical Information Systems

eSign Off

- The eSign off business case has been approved. This will allow electronic sign-off by clinicians of hospital-ordered pathology and radiology tests. The steering group for this project has been formed and planning for implementation is in progress with Christchurch Health Laboratories.

Windows XP replacement

- All DHBs need to have replaced or provided risk mitigation strategies for any Windows XP desktop in their organisation by April 2014. IT currently has this as one of its highest priorities and is in the process of building the replacement equipment/software to achieve this. Progress to date is 98 of the 161 devices have been replaced. All laptops will be completed by the 6 April deadline. There will be a handful of complex or legacy systems which will not be completed by this date. These will be isolated from accessing the internet.

Performance Issues

- Computer systems have, in more recent times, struggled to maintain pace with demand, primarily due to the growth in the number of users, and more complicated systems requiring greater computing resources. The new system based on Windows 2008R2 is currently being rolled out with approximately half of the organisation on the new system. Almost all staff will be on the new system within the next few weeks. As part of this change, Office 2003 will be replaced with Office 2010 once everyone is on the new system. This change, along with the desktop/laptop replacement, is a significant undertaking and fundamentally renews the computer systems for all staff within the DHB.

IT Strategic plan

- A draft IT strategic plan is in circulation with various clinical and management groups. This outlines the roadmap for IT changes and improvements over the next two years. It is expected that this will be finalised within the next few weeks.

IT Infrastructure replacement

- An investment in upgrading some systems at the end of their life has been approved. This includes replacement of UPS power systems in the Greymouth server room, replacement of firewall, move to a new mail system, replacements of some legacy computer terminals and improvements to the Medtech32 system to increase stability. This programme of work will be carried out over the next several months.

D: Effective Two-way Communication and Stakeholder Engagement Activity Supporting Health System Transformation

Recruitment of a Senior Communications Advisor

- This month interviews took place for a full-time Senior Communications Advisor based in Greymouth. This role will report to the Strategic Communications Manager, who is based at the Canterbury DHB.

Implementing a Grassroots Strategy

- The grassroots strategy is an important way for the DHB to communicate directly with community organisations across the Coast. This strategy will continue this year and will be very important as we seek to engage with the community on the facilities redevelopment project.
- Last month a meeting was held with the Reefton community to discuss their concerns about the makeup of health services in Reefton. More than 60 people attended the meeting. Key points from the meeting include that the DHB:
    - Is committed to engaging with the community about the makeup of its health services.
    - Is implementing a comprehensive plan for ensuring safe and consistent health services are delivered on the Coast in a sustainable way, while still meeting the needs of particular communities.
    - Will commence a community engagement programme with the Reefton community in the middle of the year. The meeting was told that to provide long-term viable health service solutions for Reefton, the DHB must first finalise the facilities redevelopment for Grey Base Hospital and Buller.
- Upcoming grassroots meetings include:
    - Buller, Hokitika and Karamea [meetings to be organised]
- All the people who have attended the internal grassroots meetings and those organisations that have had presentations from the DHB are now receiving the CE Update.

Other External Communications

- **Quality Accounts** - The first set of West Coast Quality Accounts has been produced by the West Coast DHB. This is an initiative set by the Health Quality & Safety Commission. Quality Accounts are designed to give prominence to the reporting of quality of care, alongside the traditional reporting of financial performance. The Health Quality & Safety Commission views the Quality Accounts as a great opportunity for DHBs to engage with their public and communicate the ways in which quality is at the centre of DHB's services. Copies of the Quality Accounts have been sent to a large number of West Coast stakeholders.
- A review of all the Quality Accounts prepared by DHBs said that the West Coast's Quality Accounts demonstrated the breadth of activities related to quality and safety that the organisation is undertaking. They also commented that the publication was well-written and used language that was easy to understand.
- **Report to the Community** - Preparation for the winter issue of *Report to the Community* has begun and will be distributed to West Coasters via The Messenger in May.

Internal Communications

- The Internal Communications Advisory Panel continues to meet and these meetings are providing the communications team with valuable 'grassroots' information which is shaping current internal communications initiatives.
- Internal grassroots staff meetings are being organised for:
    - South Westland
    - Buller
    - Hokitika
- The weekly CE Update continues to be a strategic document, giving staff and other

stakeholders first hand information about initiatives and change occurring across the West Coast health system. The CE Update is also sent to local media and a large influential and community organisations database.

Proactive Media Relations

- Sharing proactive positive stories with the media continues, with West Coast and other media reporting the stories. This is a valuable way for the community to learn about the positive initiatives going on across the health sector on the Coast.
- Proactive stories released to the media and reported this month include:
    - **Progress made on WCDHB Facilities Development** – story updating the community about the progress of the Facilities Development project.
    - **DHB commits to engagement with the Reefton community** – story updating the community on the outcomes of the community meeting held in Reefton.
    - **West Coast DHB continues to improve on national health targets** – story highlighting the WCDHB's success in meeting the national health targets.

Reactive Media Relations

- Some of the issues commented on this month included comments on:
    - Bed numbers in the proposed Buller IFHC.
    - Further maternity questions.
    - Questions relating to the facilities redevelopment.

	PROMOTING HEALTHY ENVIRONMENTS AND LIFESTYLES

Key Achievements/Issues of Note

Wildfoods Festival

- Community and Public Health [CPH] carried out alcohol monitoring at this year's festival along with Police, the Westland District Council liquor licensing inspector, security and festival organisers. CPH also monitored licensed premises in Hokitika and the local campsites on Saturday evening. In addition, the Police and CPH conducted an alcohol controlled purchase operation [see below]. This year's festival had a very positive atmosphere and more than 8,000 people attended. Our assessment of the event is that it was well run and that festival liquor outlets were taking their responsibilities under the Sale and Supply of Alcohol Act 2012 seriously. All had measures in place to check for intoxication and under age patrons. There were few problems with disorderly behaviour or people requiring treatment for intoxication at the event itself, though incidents of both occurred later in the evening in and around the town. Downtown licensed premises were generally well run and we saw no major issues during our evening monitoring. We did observe a large number of intoxicated people at the campsites. Campers can bring their own alcohol and situations like this are not regulated by the Sale and Supply of Alcohol Act 2012. The number of arrests for alcohol-related offending over the festival weekend was down on last year, but data on ambulance treatment and transfers in relation to the festival weekend is not yet available.

Tobacco and Alcohol Controlled Purchase Operations [CPOs]

- Earlier this year CPH conducted two tobacco CPOs. Six outlets in the Grey District were visited with no sales resulting. Fifteen outlets in the Buller District were also visited and one sale occurred. An infringement notice has been issued for this sale. Two alcohol CPOs have been carried out in the Westland District: one associated with the Wildfoods Festival and the other in the Westland district earlier in the year. At the Wildfoods Festival all liquor outlets at the event and downtown were tested and we are pleased to say that no sales were made. One sale was made in the earlier Westland CPO. These premises will now be dealt with through the new District Licensing Committee process. The Police have indicated that they would like to increase the number of controlled purchase operations, and CPH will work in partnership with them to do this.

Results of the Annual Report on Drinking Water Quality 2012-13

- The Annual Report on Drinking Water Quality [Annual Survey] for the period 1 July 2012 to 31 June 2013 has just been released by the Ministry of Health. Overall compliance of the water supplies on the West Coast is significantly less than the national average, apart from the bacteriological compliance results for the Grey District.
    - In the Buller District, no supplies provided drinking water meeting all the requirements of the standards.
    - In the Grey District, no supplies provided drinking water meeting all the requirements of the standards.
    - In Westland District only two drinking water supplies; Hari Hari and Ross, met all the requirements of the standards.
- Of concern is the on-going protozoal non-compliance in several water supplies that have had recent water treatment upgrade works which included treatment to meet protozoal compliance. In most cases, these have received Ministry of Health Capital Assistance Programme funding to do so. These include the Reefton, Punakaiki and Blackball water supplies. Over the last annual survey year these new plant installations either had treatment or monitoring faults meaning full protozoal compliance was not able to be verified.

Appetite for Life

- CPH is currently running the fourth Appetite for Life [AFL] course for this reporting period. These courses have been offered in Greymouth, Hokitika and Westport. There has been a steady flow of referrals from local medical centres, Poutini Waiora and West Coast PHO programmes such as Green Prescription. CPH assisted in training a second facilitator for the programme in Westport so that in future AFL can run independently of CPH.

	DELIVERING HEALTH TARGETS AND SERVICE DEVELOPMENT PRIORITIES
	The West Coast DHB continues to achieve the **Shorter Stays in Emergency Department Health Target**, with **99.8%** of people admitted or discharged within six hours during the 2013/14 year to 28 February 2014 – well above the target of 95%.
	West Coast DHB is on track to meeting the **Electives Health Target**, delivering **921 confirmed elective discharges** for the year to date to 31 January. The West Coast DHB target to deliver 1,592 elective procedures remains unchanged for 2013/14.
	The West Coast continues to achieve the **Shorter Waits for Cancer Treatment Health Target**, with **100%** of people ready for radiotherapy or chemotherapy beginning treatment within four weeks.
	The West Coast DHB did not achieve the **Increased Immunisation Health Target** for Quarter 2 2013/14. This target increased from 85% in the 2012/13 year to 90% in the 2013/14 year. The West Coast DHB achieved **84%** fully immunised eight-month-olds, with 94% NZ European and 88% Maori children fully vaccinated. This quarter also had a 3.1% increased opt-off and declines rate at 11.9%. Only four children were overdue for the quarter, one of which was vaccinated after the milestone age.
	In January 2014, West Coast DHB staff provided **94%** of hospitalised smokers with smoking cessation advice and support – missing the targeted 95% for the **Secondary Care Better Help for Smokers to Quit Health Target** by just five patients. This is a promising increase from the disappointing 86% result for Quarter 2. The **Primary Care Smokers Better Help to Quit Health Target** continues to show steady improvement with a 2% increase against the previous quarter, but is still well under the 90% target at **59.9%.** Actions previously reported continue, and training in Buller and Reefton has taken place for the upcoming TXT2Remind project. This project in particular is expected to feed through into next quarter's results.

	Provisional performance against the **More Heart and Diabetes Checks Health Target** has shown an increase of 2.4% in the December quarter, with **66.4%** of the eligible enrolled West Coast population now having had a cardiovascular risk assessment in the last five years [not meeting the December progress target of 78%]. Rates for West Coast Maori are slightly lower than our overall total population, at 61%. WCDHB continues to work on increasing the rates during the year and meet the 90% target by 1 July 2014. This includes integration of Kaupapa Maori nurses, implementing specific nurse led CVRA clinics at practices and providing extra nursing resources for CVRAs. Additional funding received from the Ministry of Health to help support further uptake of More Heart and Diabetes checks has resulted in a contract being concluded with the West Coast PHO and an after-hours clinic already being delivered in Reefton. Further recruitment of nurses to work at dedicated general practices after-hours clinics, marae, work places and other venues continues.

Report prepared by: David Meates, Chief Executive

CLINICAL LEADERS UPDATE

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

SOURCE: **Clinical Leaders**

DATE: **4 April 2014**

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. DISCUSSION

Facilities Planning
Significant progress has been made on developing facilities solutions for Grey and Buller that will enable the agreed model of care to be provided going forward. The level of clinical engagement in recent weeks has been heartening.

After the conclusion of the Design team workshops and the submission to the Partnership Group Clinical teams have been focused on how to begin to shape how we bring to life the new ways of working we have articulated in the models of care and facilities business case. This work is also reflected in the Alliance Leadership Team and workstreams of the Alliance.

Workforce
The Nursing Workforce Stream of the South Island Alliance continues to progress work around a sustainable nursing workforce. The West Coast will be showcasing two nurses as part of this project, with a focus on encouraging people to consider nursing as a career, and the importance of valuing the older more experienced nurse. It is recognised that in order to build capacity in the nursing workforce to meet the predicted future demand, we need this two pronged approach of more nurses trained and keeping older nurses employed.

Work began on the implementation of the Dedicated Education Unit (DEU) framework for supporting nursing students while on clinical placement. The DEU optimises clinical learning for students in a supportive environment and broadens each student learning experience. This is a move away from the current preceptorship model of learning where students work with one mentor only. The West Coast DHB Director of Nursing and Midwifry is now a member of the Canterbury and West Coast DEU Governance Group thus facilitating a transalpine approach. The Medical/Surgical clinical area will be the first DEU operational, commencing August 11, with at view to introduce a DEU into the Mental Health service at a later date.

A new and innovative recruitment campaign has been developed that will be accessible on social media sites. This will include video snapshots of local clinicians show-casing why working at the West Coast

DHB is a great option, alongside an introduction to the West Coast as a place to live and work. To demonstrate the potential for social media in recruitment activity, the recruitment team linked into the MetService website while cyclone Luci was approaching. During this time there 157,000 hits on the website and of that 650 clicked on the link to the WCHB recruitment site.

Discussions continue to advance a transalpine approach to how we provide hospital level health services to our community, both at transalpine clinical leaders level, and in individual services.

The Allied Health Leadership framework implementation plan is underway with recruitment for an Associate Director of Allied Health. Allied Health roles are featured as part of the new recruitment campaign with a focus on working across an integrated health system, which has seen more collaboration occurring between various employers within the West Coast health system.

There has been significant work by the Social Work teams from Canterbury and West Coast on how to support travel assistance as part of the transalpine model of care.

Quality and Safety

The Resuscitation Service Leader has commenced a significant programme of work that includes developing a Resuscitation Committee and completing an audit of all resuscitation equipment across services from Haast to Karamea. The aim is to ensure standardisation, improve the quality of education and maintain high clinical standards.

An audit programme has commenced at Grey Base Hospital with a focus on clinical documentation. The focus of this work is measuring the completion and quality of documentation related to falls risk identification and associated care planning, smoking cessation, fluid balance charts and Post Anaesthetic Care Unit (PACU) documentation. This is an important component of quality assurance with feedback going to nursing staff to ensure documentation compliance and associated quality of clinical care. A new tool is also currently being trialled "My Care Plan". This tool is available at the patients' bedside and provides a snapshot of the key components of the patient care plan specifically falls risk, pressure ulcer risk, nutrition and estimated discharge day. The purpose of this tool is to ensure that all who provide care to the patient has ready access to important information at the point of care.

4. CONCLUSION

The Clinical Leaders will continue to work across a range of activities to promote a sustainable West Coast health care service.

Report prepared by: Carol Atmore, Chief Medical Officer
Karyn Kelly, Director of Nursing & Midwifery
Stella Ward, Executive Director, Allied Health

FINANCE REPORT

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

SOURCE: **General Manager, Finance**

DATE: **4 April 2014**

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, a more detailed report is presented and received by the Quality, Finance, Audit and Risk Committee (QFARC) prior to this report being prepared.

2. RECOMMENDATION

That the Board:

i. notes the financial results for the period ended 28 February 2014.

3. DISCUSSION

Overview of February 2014 Financial Result

The financial information in this report represents a summary and update of the financial statements forwarded to the Ministry of Health and presented to and reviewed by QFARC. The consolidated West Coast DHB financial result for the month of February 2014 was a surplus of $0.345m, which was $0.013m unfavourable against the budgeted surplus of $0.358m. The year to date position is now $0.069m unfavourable. The breakdown of February's result is as follows.

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,831	6,874	(43)	×	54,606	54,999	(393)	×
Governance & Administration	166	147	19	√	1,284	1,254	30	√
Funds & Internal Eliminations	4,425	4,390	35	√	35,304	35,035	269	√
	11,422	11,411	11	√	91,194	91,288	(94)	×
EXPENSES								
Provider								
Personnel	4,419	4,127	(292)	×	35,506	34,640	(866)	×
Outsourced Services	514	192	(322)	×	4,268	2,650	(1,618)	×
Clinical Supplies	498	734	236	√	5,116	6,280	1,164	√
Infrastructure	1,050	911	(139)	×	7,619	7,397	(222)	×
	6,481	5,964	(517)	×	52,509	50,967	(1,542)	×
Governance & Administration	166	148	(18)	×	1,284	1,264	(20)	×
Funds & Internal Eliminations	3,955	4,395	440	√	34,567	35,429	862	√
Total Operating Expenditure	10,602	10,507	(95)	×	88,360	87,660	(700)	×
Surplus / (Deficit) before Interest, Depn & Cap Charge	820	904	(84)	×	2,834	3,628	(794)	×
Interest, Depreciation & Capital Charge	475	546	71	√	3,643	4,368	725	√
Net surplus/(deficit)	**345**	**358**	**(13)**	×	**(809)**	**(740)**	**(69)**	×

4. APPENDICES

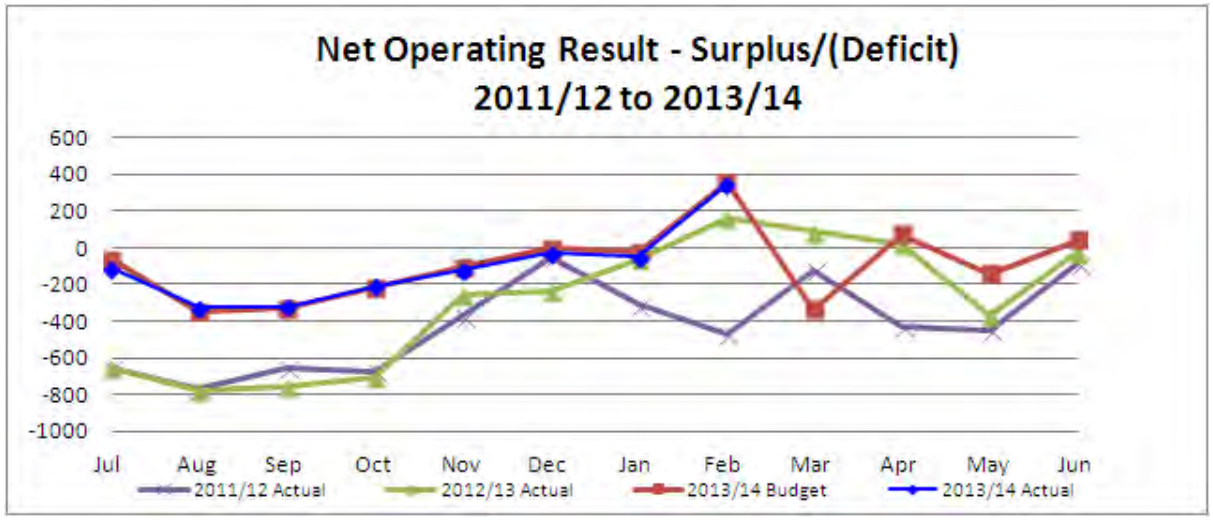
Appendix 1:	Financial Results for the period ending 28 February 2014
Appendix 2:	Statement of Financial Performance – February 2014
Appendix 3:	Statement of Financial Position – February 2014
Appendix 4:	Cashflow – February 2014

Report prepared by: Justine White, General Manager: Finance

APPENDIX 1: **FINANCIAL RESULT**

FINANCIAL PERFORMANCE OVERVIEW – YTD FEBRUARY 2014

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Surplus/(Deficit)	345	358	(13)	-4%	✗	(809)	(740)	(69)	9%	✗

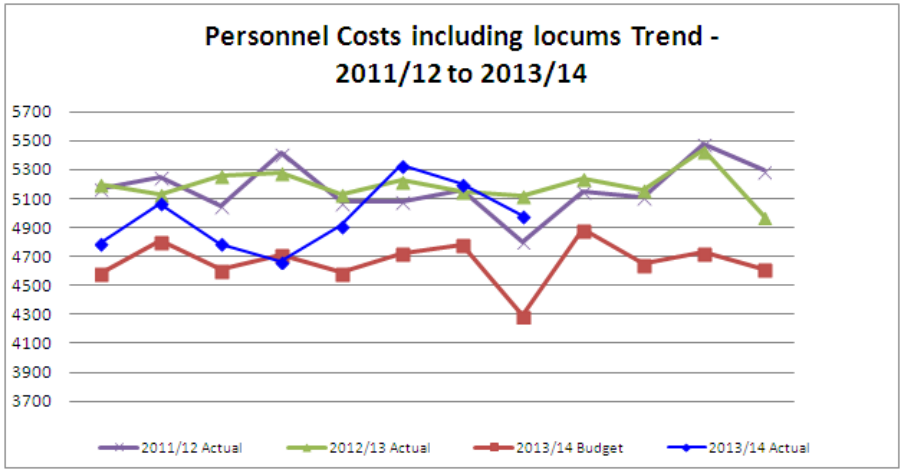


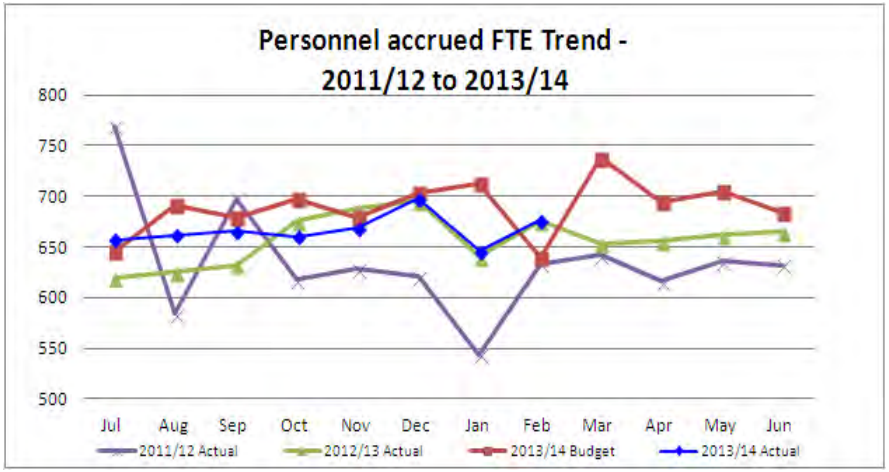
We have submitted an Annual Plan with a net deficit of $1.1m, which is entirely consistent with the previously outlined reduced deficit track and is also consistent with the Detailed Business Case as compiled for the draft Facilities Development Plan.

KEY RISKS AND ISSUES

Although currently tracking on target, the achievement of the annual plan will continue to require a significant level of oversight and management in order to be achieved, we are confident that the forecast year end result will be on track with our annual plan.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

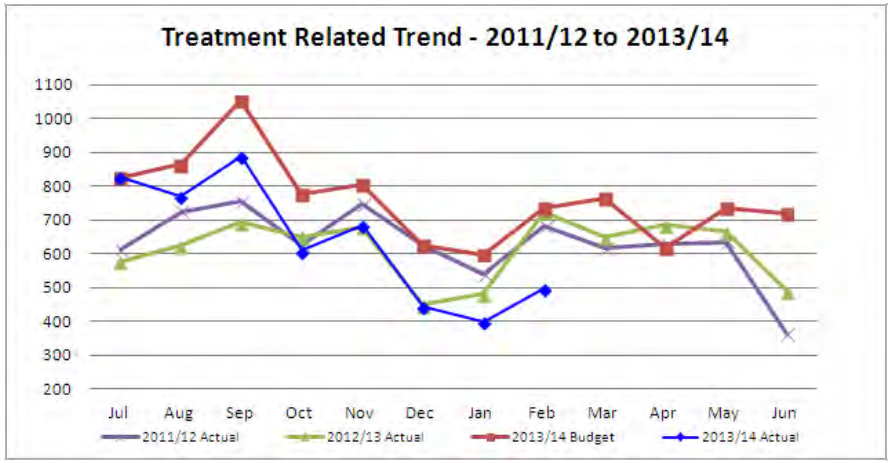


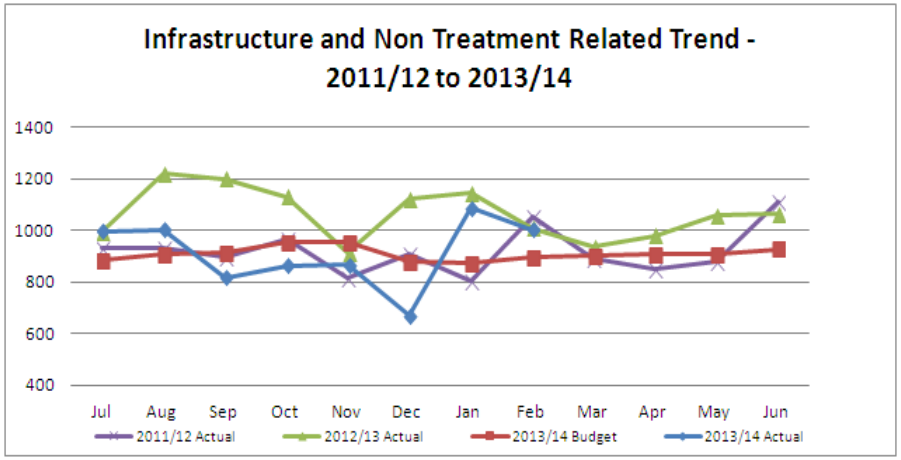


KEY RISKS AND ISSUES

Although better use of stabilised rosters and leave planning is in the process of being embedded within the business, the results are slower to transpire than originally anticipated. This is further exacerbated by some recent turnover which has required more reliance on short term placements, which are more expensive than permanent staff. The results are that the costs are tracking ahead of budget from a YTD perspective.

TREATMENT & NON TREATMENT RELATED COSTS

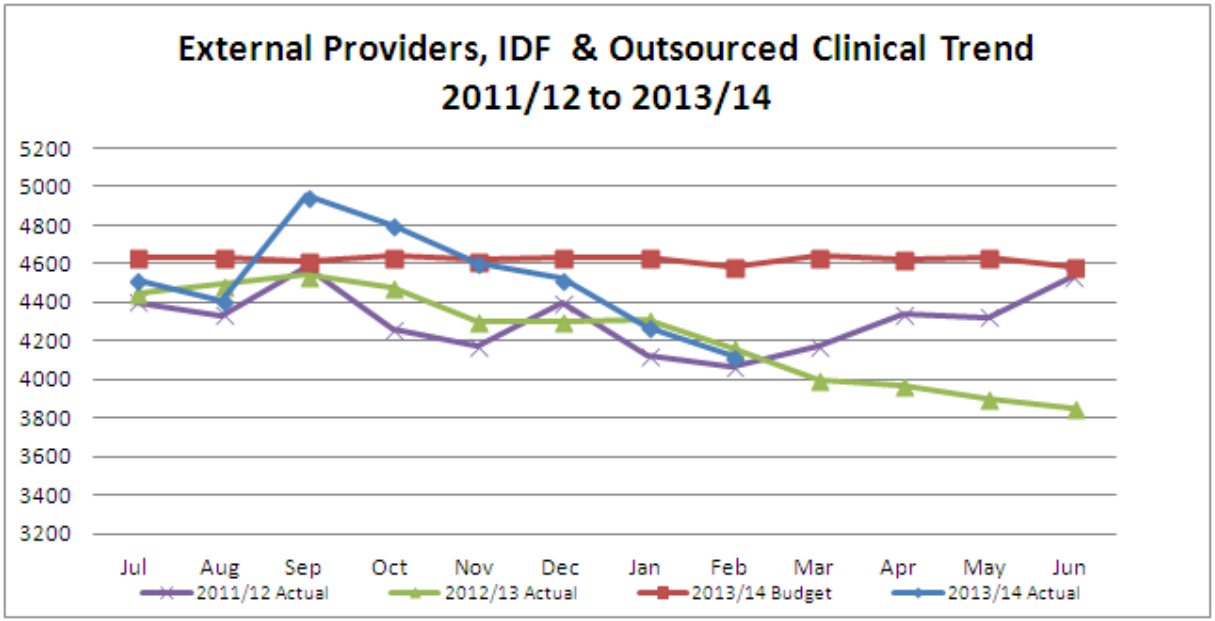




KEY RISKS AND ISSUES

Albeit with cyclical patterns these costs tend to be managed to predictions, key oversight should enable us to meet budget throughout the year.

EXTERNAL PROVIDER COSTS



KEY RISKS AND ISSUES

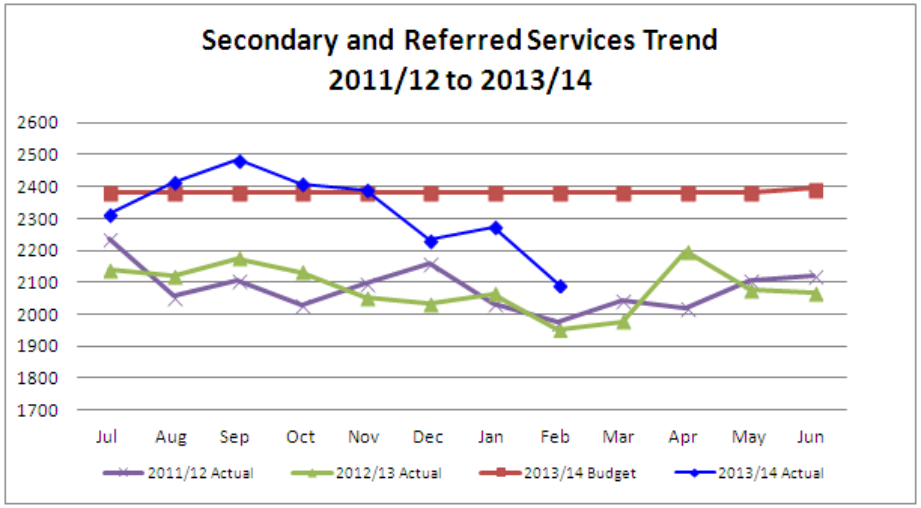
Capacity constraints within the system require continued monitoring of trends and demand for services.

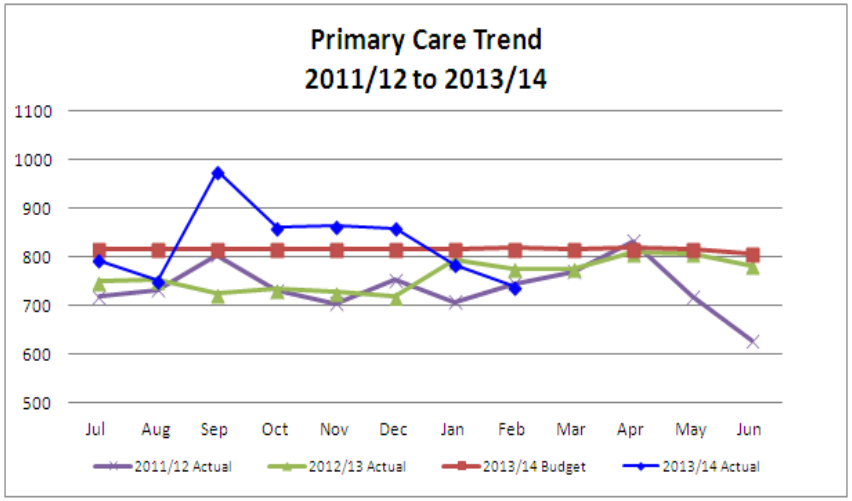
Planning and Funding Division

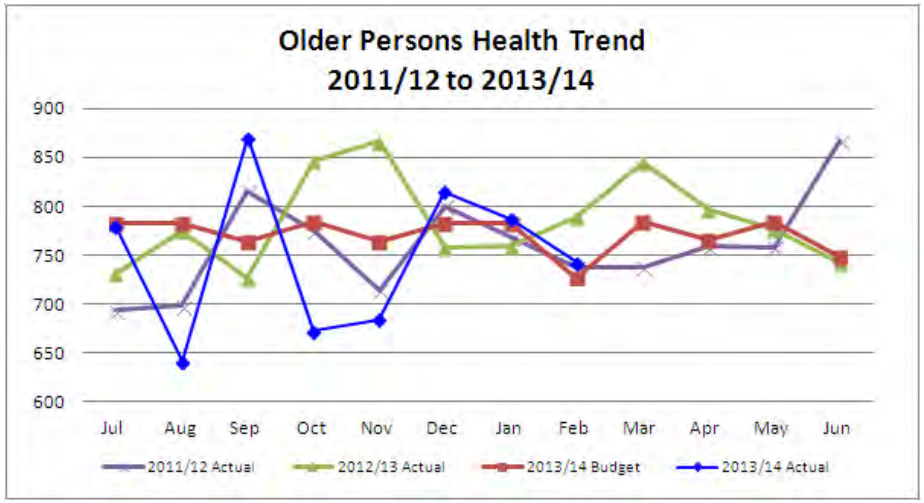
Month ended Feb 2014

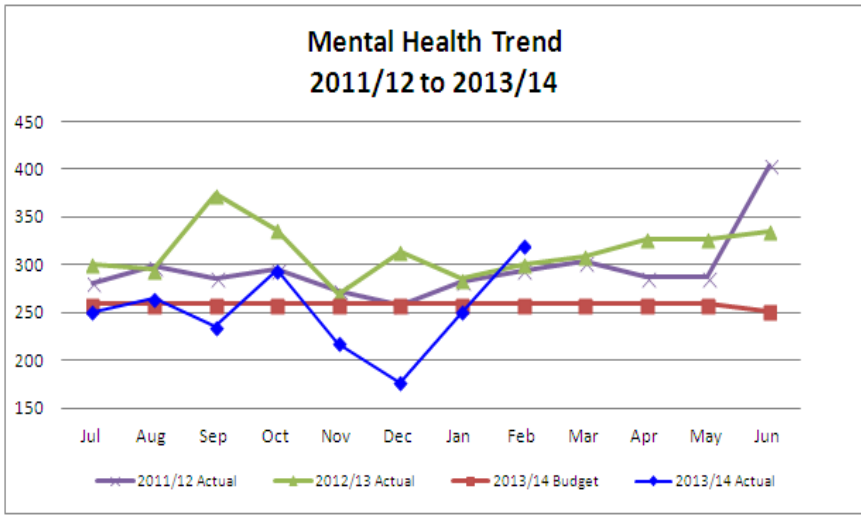
Current Month					SERVICES	Year to Date					2013/14 Annual Budget
Actual	Budget	Variance				Actual	Budget	Variance			
$000	$000	$000	%			$000	$000	$000	%		$000
					Primary Care						
24	43	19	44%	✓	Dental-school and adolescent	253	344	91	26%	✓	512
0	3	3	100%	✓	Maternity	0	22	22	100%	✓	28
81	84	3	4%	✓	PHO non-Capitated Services & Combine	708	672	-36	-5%	✗	1,013
560	579	19	3%	✓	Primary Practice Capitation	4,674	4,624	-50	-1%	✗	6,930
4	5	2	30%	✓	Child and Youth	22	40	18	44%	✓	55
2	4	2	52%	✓	Immunisation	27	32	5	17%	✓	53
4	12	8	69%	✓	Maori Service Development	66	96	30	31%	✓	148
42	45	3	7%	✓	Whanua Ora Services	401	360	-41	-11%	✗	536
6	17	11	67%	✓	Palliative Care	109	136	27	20%	✓	215
7	8	1	10%	✓	Chronic Disease	59	64	5	8%	✓	87
9	18	9	48%	✓	Other Primary	348	144	-204	-142%	✗	215
738	**818**	**80**	**10%**	✓		**6,667**	**6,534**	**-133**	**-2%**	✗	9,792
					Referred Services						
-162	56	218	389%	✓	Laboratory	-8	448	456	102%	✓	675
659	687	28	4%	✓	Pharmaceuticals	5,508	5,496	-12	0%	✗	8,238
497	**743**	**246**	**36%**	✓		**5,500**	**5,944**	**444**	**8%**	✓	8,913
					Secondary Care						
96	96	0	0%	✓	Inpatients	768	768	0	0%	✓	1,161
71	66	-5	-8%	✗	Radiology services	755	528	-227	-43%	✗	795
65	112	47	42%	✓	Travel & Accommodation	664	896	232	26%	✓	1,344
1,364	1,366	2	0%	✓	IDF Payments Personal Health	10,934	10,928	-6	0%	✗	16,396
1,596	**1,640**	**44**	**3%**	✓		**13,121**	**13,120**	**-1**	**0%**	✗	19,696
2,831	**3,201**	**370**	**12%**	✓	**Primary & Secondary Care Total**	**25,288**	**25,598**	**310**	**1%**	✓	**38,401**
					Public Health						
26	11	-15	-139%	✗	Nutrition & Physical Activity	185	88	-97	-110%	✗	126
0	6	6	100%	✓	Public Health Infrastructure	0	48	48	100%	✓	73
11	12	1	5%	✓	Tobacco control	103	96	-7	-8%	✗	137
-17	0	17		✓	Screening programmes	0	0	0		✗	6
20	**29**	**9**	**30%**	✓	**Public Health Total**	**288**	**232**	**-56**	**-24%**	✗	**342**
					Mental Health						
61	47	-14	-30%	✗	Day Activity & Rehab	419	376	-43	-12%	✗	569
22	11	-11	-97%	✗	Advocacy Family	155	88	-67	-76%	✗	132
109	15	-94	-624%	✗	Other Mental Health	310	120	-190	-158%	✗	168
62	117	55	47%	✓	Community Residential Beds	769	936	167	18%	✓	1,408
69	69	0	2%	✓	IDF Payments Mental Health	549	552	3	2%	✓	823
321	**259**	**-62**	**-24%**	✗		**2,201**	**2,072**	**-129**	**-6%**	✗	3,100
					Older Persons Health						
60	56	-4	-7%	✗	Home Based Support	512	448	-64	-14%	✗	665
13	9	-4	-41%	✗	Caregiver Support	49	72	23	32%	✓	111
239	214	-26	-12%	✗	Residential Care-Rest Homes	1,863	1,674	-189	-11%	✗	2,520
0	-2	-2	100%	✗	Residential Care Loans-Rest Homes	-6	-16	-10	-63%	✗	-25
0	-2	-2	100%	✗	Residential Care Loans-Hospital Level	-7	-16	-9	-56%	✗	-26
9	26	17	64%	✓	Residential Care-Community	83	208	125	60%	✓	314
302	372	70	19%	✓	Residential Care-Hospital	2,603	2,914	311	11%	✓	4,371
0	0	0		✓	Ageing in place	-3	0	3		✓	0
9	8	-1	-6%	✗	Day programmes	74	64	-10	-16%	✗	96
17	8	-9	-105%	✗	Respite Care	76	64	-12	-18%	✗	99
3	4	1	36%	✓	Community Health	13	32	19	58%	✓	42
92	91	-1	-2%	✗	IDF Payments-DSS	739	728	-11	-2%	✗	1,089
743	**783**	**40**	**5%**	✓		**5,997**	**6,172**	**175**	**3%**	✓	9,255
1,064	**1,042**	**-22**	**-2%**	✗	**Mental Health & OPH Total**	**8,198**	**8,244**	**46**	**1%**	✓	**12,355**
3,915	**4,272**	**357**	**8%**	✓	**Total Expenditure**	**33,774**	**34,074**	**300**	**1%**	✓	**51,098**

EXTERNAL PROVIDER COSTS









FINANCIAL POSITION

	Month Actual $'000	Month Budget $'000	Month Variance $'000			Annual Budget $'000
Equity	9,343	11,388	(2,045)	-18%	✗	12,060
Cash	9,194	6,543	2,651	41%	✓	7,809

KEY RISKS AND ISSUES

The cash on hand position reflects that the funding to rectify the seismic strengthening has been received.

APPENDIX 2: STATEMENT OF FINANCIAL PERFORMANCE

Statement of comprehensive income

For period ending 28 February 2014

in thousands of New Zealand dollars

	Morthly Reporting				Year to Date				Full Year 2013/14	Prior Year
	Actual	Budget	Variance	%Variance	Actual	Budget	Variance	%Variance	Budget	Actual
Operating Revenue										
Crown and Government sourced	10,981	10,930	51	0.5%	87,311	87,440	(129)	(0.1%)	131,156	128,940
Inter DHB Revenue	0	3	(3)	(100.0%)	20	24	(4)	(16.7%)	36	36
Inter District Flows Revenue	135	134	1	0.7%	1,075	1,072	3	0.3%	1,622	1,656
Patient Related Revenue	240	281	(41)	(14.6%)	1,953	2,248	(295)	(13.1%)	3,371	3,112
Other Revenue	66	63	3	4.8%	835	504	331	65.6%	759	1,088
Total Operating Revenue	11,422	11,411	11	0.1%	91,194	91,288	(94)	(0.1%)	136,944	134,833
Operating Expenditure										
Personnel costs	4,470	4,174	(296)	(7.1%)	35,887	35,031	(856)	(2.4%)	53,310	55,688
Outsourced Services	431	108	(323)	(299.1%)	3,489	1,978	(1,511)	(76.4%)	2,532	9,120
Treatment Related Costs	490	734	236	32.2%	5,116	6,280	1,164	18.5%	9,114	7,369
External Providers	2,544	2,946	402	13.6%	23,241	23,915	674	2.8%	35,866	29,843
Inter District Flows Expense	1,523	1,526	3	0.2%	12,222	12,208	(14)	(0.1%)	18,308	16,675
Outsourced Services - non clinical	133	123	(10)	(8.1%)	1,098	984	(114)	(11.6%)	1,460	1,445
Infrastructure and Non treatment related costs	1,249	896	(353)	(39.4%)	9,152	7,264	(1,888)	(26.0%)	10,915	12,787
Total Operating Expenditure	10,848	10,507	(341)	(3.2%)	90,205	87,660	(2,545)	(2.9%)	131,505	132,927
Result before Interest, Depn & Cap Charge	574	904	(330)	36.5%	989	3,628	(2,639)	72.7%	5,439	1,907
Interest, Depreciation & Capital Charge										
Interest Expense	57	54	(3)	(5.6%)	460	432	(28)	(6.5%)	642	650
Depreciation	104	424	320	75.5%	803	3,392	2,589	76.3%	5,085	4,156
Capital Charge Expenditure	68	68	0	0.0	535	544	9	1.7%	812	677
Total Interest, Depreciation & Capital Charge	229	546	317	58.1%	1,798	4,368	2,570	58.8%	6,539	5,482
Net Surplus/(deficit)	345	358	(13)	3.7%	(809)	(740)	(69)	(9.3%)	(1,100)	(3,576)
Other comprehensive income										
Gain/(losses) on revaluation of property										
Total comprehensive income	345	358	(13)	3.7%	(809)	(740)	(69)	(9.3%)	(1,100)	(3,576)

APPENDIX 3: **STATEMENT OF FINANCIAL POSITION**

Statement of financial position

As at 28 February 2014

in thousands of New Zealand dollars

	Actual	Budget	Variance	%Variance	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	24,897	29,709	(4,812)	(16.2%)	28,321
Intangible assets	537	1,162	(625)	(53.8%)	917
Work in Progress	3,930	528	3,402	644.3%	513
Other investments	121	2	119	5950.0%	2
Total non-current assets	29,485	31,401	(1,916)	(6.1%)	29,753
Current assets					
Cash and cash equivalents	9,194	6,543	2,651	40.5%	6,881
Patient and restricted funds	60	58	2	3.4%	58
Inventories	1,009	1,040	(31)	(3.0%)	1,044
Debtors and other receivables	1,651	4,614	(2,963)	(64.2%)	4,411
Assets classified as held for sale	136	136	0	0.00%	136
Total current assets	12,050	12,391	(341)	(2.8%)	12,530
Total assets	**41,535**	**43,792**	**(2,257)**	(8.9%)	**42,283**
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	14,195	12,195	2,000	16.4%	12,195
Employee entitlements and benefits	3,131	3,461	(330)	(9.5%)	3,152
Total non-current liabilities	17,326	15,656	1,670	10.7%	15,347
Current liabilities					
Interest-bearing loans and borrowings	250	250	0	0.00%	250
Creditors and other payables	6,689	8,374	(1,685)	(20.1%)	8,959
Employee entitlements and benefits	7,927	8,124	(197)	(2.4%)	8,190
Total current liabilities	14,866	16,748	(1,882)	(11.2%)	17,399
Total liabilities	32,192	32,404	(212)	(0.7%)	32,746
Equity					
Crown equity	69,729	71,729	(2,000)	(2.8%)	66,197
Other reserves	19,569	19,569	0	0.00%	19,569
Retained earnings/(losses)	(79,994)	(79,949)	(45)	0.1%	(76,268)
Trust funds	39	39	0	0.00%	39
Total equity	9,343	11,388	(2,045)	(18.0%)	9,537
Total equity and liabilities	**41,535**	**43,792**	**(2,257)**	**(5.2%)**	**42,283**

APPENDIX 4: CASHFLOW

Statement of cash flows

For period ending 28 February 2014

in thousands of New Zealand dollars

	Monthly Reporting				Year to Date				2013/14	2012/13
	Actual	Budget	Variance	%Variance	Actual	Budget	Variance	%Variance	Budget	Actual
Cash flows from operating activities										
Cash receipts from Ministry of Health, patients and other revenue	11,356	11,391	(35)	(0.3%)	91,098	91,128	(30)	(0.0%)	136,704	135,453
Cash paid to employees	(5,777)	(4,295)	(1,482)	34.5%	(40,813)	(37,066)	(3,800)	10.3%	(55,948)	(55,710)
Cash paid to suppliers	(938)	(1,740)	802	(46.1%)	(11,498)	(14,424)	2926	(20.3%)	(21,335)	(31,744)
Cash paid to external providers	(2,679)	(2,946)	267	(9.1%)	(24,316)	(23,915)	(401)	1.7%	(35,866)	(31,499)
Cash paid to other District Health Boards	(1,388)	(1,526)	138	(9.0%)	(11,147)	(12,208)	1061	(8.7%)	(18,308)	(15,019)
Cash generated from operations	574	884	(310)	(35.1%)	3324	3515	(244)	(6.9%)	5,247	1,480
Interest paid	(57)	(54)	(3)	5.6%	(460)	(432)	(28)	6.5%	(642)	(648)
Capital charge paid	(68)	(68)	0	0.00	(679)	(544)	1223	(224.8%)	(812)	(677)
Net cash flows from operating activities	449	762	(313)	(41.1%)	2185	2539	951	37.5%	3,793	155
Cash flows from investing activities										
Interest received	41	20	21	105.0%	406	160	246	153.8%	240	229
(Increase) / Decrease in investments	0	0	0		0	0	0		0	0
Acquisition of property, plant and equipment	(29)	(258)	229	(88.8%)	(1,506)	(2,064)	558	(27.0%)	(3,300)	(3,436)
Acquisition of intangible assets	0	(17)	17	(100.0%)	5	(136)	141	(103.7%)	0	(1,706)
Net cash flows from investing activities	12	(255)	267	(104.7%)	(1,095)	(2,040)	945	(46.3%)	(3,060)	(4,913)
Cash flows from financing activities										
Proceeds from equity injections	0	0	0		0	0	0		0	3,600
Repayment of equity	0	0	0		(68)	0	(68)		0	(68)
Cash generated from equity transactions	0	0	0		(68)	0	(68)		0	3,532
Borrowings raised	0	0	0		2000	0	2000		0	0
Repayment of borrowings	0	0	0		0	0	0		0	0
Payment of finance lease liabilities										
Net cash flows from financing activities	0	0	0		1932	0	1932		0	3,532
Net increase in cash and cash equivalents	461	507	(46)	(9.1%)	3,022	499	3828	767.1%	1,765	(1,226)
Cash and cash equivalents at beginning of period	8,733	6,036	2697	44.7%	6,172	6,044	128	2.1%	6,044	7,398
Cash and cash equivalents at end of year	9,194	6,543	2,651	40.5%	9,194	6,543	3956	60.5%	7,809	6,172

DRAFT WEST COAST DHB PUBLIC HEALTH PLAN 2014-15

TO: **Chair and Members**
West Coast DHB Board

SOURCE: **Community and Public Health**

DATE: **4 April 2014**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper seeks Board endorsement of the draft Public Health Annual Plan 2014-15 which is due to the Ministry of Health as a final draft by 26 May 2014.

2. RECOMMENDATION

That the Board, as recommended by the Community and Public Health and Disability Support Advisory Committee:

i endorse the draft West Coast DHB Public Health Plan, 2014-15.

3. SUMMARY

The draft West Coast DHB Public Health Plan 2014-15 is prepared as a basis of the Community and Public Health (C&PH) contract with the Ministry of Health. While primarily focused on the work of Community & Public Health, the scope of the Plan includes other relevant West Coast DHB funded activities. The Plan is structured around five core public health functions agreed by the Public Health Clinical Network. The Plan was endorsed by the West Coast DHB Community and Public Health and Disability Support Advisory Committee on 20 March 2014. Some small revisions have been made in response to Committee feedback.

4. DISCUSSION

This draft West Coast DHB Public Health Plan 2014-15 has been prepared by Community and Public Health, with contributions from the West Coast PHO and the West Coast DHB Planning and Funding Division.

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The Plan is based on a template developed in 2012 by the South Island Public Health Services. The short-term outcomes and outcome indicators in the Plan are shared across the South Island. Other content is specific to each DHB.

The Plan covers relevant West Coast DHB funded activities, in addition to those delivered by CPH, and as such also includes the West Coast PHO and divisions of the West Coast DHB in the responsibilities column.

The Plan has two functions:

1. as an appendix to the West Coast DHB Annual Plan 2014-15, as the West Coast DHB Public Health Plan 2014-15; and
2. as the basis of the Community and Public Health contract with the Ministry of Health.

6. APPENDICES

Appendix 1:	Draft WCDHB Public Health Plan 2014-15
Report prepared by:	Annabel Begg, Public Health Specialist, Community and Public Health
Report approved for release by:	Evon Currie, General Manager, Community and Public Health

THE WEST COAST HEALTH SYSTEM
– supporting you to be well

Draft 24th March 2014

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

CONTENTS

1. WEST COAST DISTRICT HEALTH BOARD'S PUBLIC HEALTH PLAN FOR 2014–15

- West Coast DHB Vision: An integrated health system that is clinically sustainable and financially viable and wraps care around the patient to help them stay well.
- West Coast DHB Values:

  Manaakitanga – caring for others

  Whakapapa – identity

  Integrity

  Respect

  Accountability

  Valuing people

  Whanaungatanga – family and relationships.
- This plan accompanies the West Coast DHB Annual Plan 2014-15 [and has been endorsed by the Board of the West Coast DHB-*this content pending Board review*].
- It describes public health services provided or funded by the WCDHB and its Public Health Unit, Community and Public Health.
- It describes key relationships with other agencies.
- The plan is based on a South Island planning template utilising the Core Public Health Functions framework (as agreed in the South Island Public Health Partnership plan).

a. Our Public Health Service

Community and Public Health (a division of the Canterbury DHB) provides public health services throughout the West Coast DHB region, as well as within Canterbury and South Canterbury. Public health services on the West Coast are also provided through the Planning and Funding Division of the West Coast DHB and by the West Coast Primary Health Organisation. The plan focuses on the work of Community and Public Health, and also includes activities of Planning and Funding and the West Coast Primary Health Organisation, but does not cover non-DHB funded public health providers, such as non-government organisations, Maori and Pacific providers

The West Coast District Health Board serves a population of 32,150 people (up by 2.6% from 31,330 at the 2006 Census), spread over a large area from Karamea in the north to Jackson's Bay in the south (and Otira in the east) - as such, it has the most sparse population of the 20 DHBs in New Zealand. The population is spread across three Territorial Local Authorities (TLAs): Buller, Grey and Westland Districts.

- The West Coast population is slightly older than the rest of New Zealand, with a higher proportion of people aged over 65 (16.1% in 2013, which is up from 13.8% in 2006). This differs for the Māori population (more than one in ten West Coasters are Māori), which is younger overall. At the time of the 2006 Census, the West Coast population was more socioeconomically deprived than the total New Zealand population. For example, those in the most deprived groups (NZDep deciles 6 – 10) made up 61% of the West Coast population, compared with less than 50% of the total New Zealand population.[1]
- The work of this plan is guided by the following public health principles:
  a. focusing on the health of **communities** rather than individuals
  b. influencing **health determinants**
  c. prioritising improvements in **Māori health**
  d. reducing **health disparities**
  e. basing practice on the best available **evidence**
  f. building effective **partnerships** across the health sector and other sectors
  g. remaining **responsive** to new and emerging health threats.

[1] CPH Region NZDep2006 data by ethnic group. NZDep for the 2013 Census is not yet available.

b. Our Key Priorities

- West Coast DHB critical success factors as specified for 2014-15, are:

  Integrate fragmented health services

  Reduce overreliance on secondary care

  Connect the system

  Assure patient safety

  Build a sustainable workforce

  Meet community expectations

  Meet the Minister's expectations.

- The five South Island DHBs have identified four strategic outcomes. The first of these outcomes is that: "People are healthier and take greater responsibility for their own health". The focus therefore is on "The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing".[2]

  The vision for the future of the West Coast health system is of an integrated system that wraps care around the patient to support people to stay safe and well in their own homes and communities wherever possible.

c. Alignment with National and Regional Strategic Health Priorities

- This plan aligns with national and regional priorities and includes activities that support strategic health initiatives.
- The plan is aligned with and sits alongside the West Coast DHB Annual Plan and Statement of Intent 2014-15 and the WCDHB Māori Health Plan 2014-15. The plan contents reflect Government, Ministry of Health and WCDHB priorities. Community and Public Health activities are carried out under the public health service specifications as agreed by the Ministry of Health.
- The NZ Public Health and Disability Act lays out the responsibilities that DHBs have in ensuring Māori health gain as well as Māori participation in health services and decision making. The West Coast DHB works in partnership with Māori to reduce inequalities and improve the health status of Māori.
- The South Island Public Health Partnership is a collaboration of the three South Island Public Health Units (PHUs) – Nelson Marlborough (NMDHB), Community and Public Health (CPH) and Public Health South (Southern DHB). The partnership aims to facilitate the three PHUs working together – collaborating on leadership and sharing planning, resources and strategic work.
- Community and Public Health has statutory responsibilities under the Health Act 1956 that are conducted by Medical Officers of Health (MOsH), Health Protection Officers, and those acting under delegation from the MOH.
- Reporting against this plan will meet the requirements of the Ministry of Health reporting schedule and ISE (Information Supporting the Estimates of Appropriation) reporting as outlined in the planning and reporting package for 2014-15.

d. A Renewed Focus

- The five core public health functions agreed by the Public Health Clinical Network[3] and included in the draft revised Ministry of Health Tier One Public Health Service Specifications are:

  1. Health assessment and surveillance
  2. Public health capacity development
  3. Health promotion
  4. Health protection
  5. Preventive interventions.

- This plan groups public health initiatives according to their primary public health function. However, the core public health functions are interconnected; core functions are rarely delivered individually. Effective public health service delivery generally combines strategies from several core functions to achieve public health outcomes in one or more public health issue or setting.
- The appendix outlines how public health strategies from a range of core functions are combined across the West Coast DHB to address priority health issues, and specifies targets for that work.

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[2] West Coast DHB Annual Plan 2012-13, p. 14

[3] Available at http://www.cph.co.nz/Files/CorePHFunctionsNZ.pdf

2. KEY RELATIONSHIPS

The Public Health work of the WCDHB involves partnership with many health and non-health agencies. Some key partners of Community and Public Health are listed below. Formal agreements are noted in parentheses.

Local authorities:
West Coast Regional Council
Buller District Council
Grey District Council
Westland District Council
District Licensing Agencies

Government agencies:
Alcohol Regulatory and Licensing Authority
Department of Conservation
Department of Internal Affairs
Environmental Protection Authority
Environmental Science and Research
Health Promotion Agency
Liquor Licensing Authority
Ministry of Business, Innovation and Employment
Ministry of Education
Ministry for the Environment
Ministry of Health
New Zealand Fire Service
New Zealand Police

Māori /Iwi agencies:
Te Runanga o Ngati Waewae
Te Runanga o Maakaawhio
Poutini Waiora

Educational institutions:
Education Facilities and Settings
Tai Poutini Polytechnic

West Coast DHB:
Infection Control Nurse Specialist, Grey Hospital
Falls Prevention Coalition
Grey Hospital Infection Control Committee
Immunisation Coordinator
Immunisation Advisory Group
Public Health Nurses
Rural Nurse Specialists
Clinical Board
CPHAC/DSAC
Child and Youth Health Committee

Non-government organisations/networks:

Action on Smoking and Health (ASH)
Active West Coast
Buller and Westland Sports Trusts
Buller Reap
Buller Interagency Forum
Cancer Society
Education West Coast
Family Planning Association
Heart Foundation
Healthy West Coast Governance Group (Terms of Reference, joint work plan)
Laboratories
Liaison on Alcohol and Drugs
Medical Centres
Mental Health Foundation
New Coasters
Smokefree South Island
Sport Canterbury West Coast
Te Rito network
West Coast DHB Consumer Council
West Coast Tobacco Free Coalition
West Coast Primary Health Organisation
West Coast Youth Workers Collective
West Reap

3. HEALTH ASSESSMENT AND SURVEILLANCE

a. Strategies

- **Monitoring, analysing and reporting** on population health status, health determinants, disease distribution, and threats to health, with a particular focus on health disparities and the health of Māori.
- Detecting and investigating **disease clusters and outbreaks** (both communicable and non-communicable).

b. Outcomes and Activities table

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
Health assessment	Robust population health information available for planning health and community services	Availability of information for planning	Monitor, analyse and report on key health determinants, including: alcohol related harm smoking status (e.g. from ASH Year 10 data and 2014 Census and WCPHO reports).	CPH, P&F WCDHB and WCPHO	Number and accessibility of reports. Formal/informal feedback
			Develop health status reports and health needs analyses for specific populations as required.	CPH	Number and accessibility of reports.
			Develop disease-specific reports for conditions of concern, eg Pertussis.	CPH	Number and accessibility of reports.
			Contribute to related work of partner organisations, eg	CPH, WCPHO and WCDHB	Quality of working relationship No of meetings and records of

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			WCPHO and WCDHB through the Healthy West Coast Workstream.		meetings and outcomes (including joint planning processes and sharing of population health information).
	Improved public understanding of health determinants	Availability of information to public	Disseminate information in existing and dedicated reports (eg WCDHB Quality Accounts, WCDHB website, WCDHB Community Report, print, broadcast and social media).	CPH, WCDHB Communications Team and WCPHO	Number and nature of media reports.
Surveillance	Prompt identification and analysis of emerging disease trends, clusters and outbreaks	Timeliness and effectiveness of reports for identifying trends and outbreaks of concern	Review, analyse and report on communicable diseases data, including via web applications and written reports (eg Public Health Information Quarterly, weekly reports on notifiable diseases and influenza –May to September).	CPH	Number and accessibility of reports. Formal/informal feedback
			Produce disease-specific reports for communicable diseases of concern, eg Pertussis, other diseases causing outbreaks	CPH	Number and accessibility of reports. Formal/informal feedback
			Review, analyse and report on other disease data (eg alcohol-related harm, and diseases relevant to West Coast context).	CPH, P&F WCDHB	Number and accessibility of reports. Formal/informal feedback
			Contribute to the development of a SI Rheumatic fever register.	CPH, SI Partnership	Record of progress.

4. PUBLIC HEALTH CAPACITY DEVELOPMENT

a. Strategies

- Developing and maintaining public health **information systems**.
- Developing **partnerships** with iwi, hapü, whānau and Māori to improve Māori health.
- Developing partnerships with Pacific leaders and communities to improve Pacific health
- Developing **human resources** to ensure public health staff with the necessary competencies are available to carry out core public health functions.
- Conducting **research, evaluation and economic analysis** to support public health innovation and to evaluate the effectiveness of public health policies and programmes.
- **Planning, managing, and providing expert advice** on public health programmes across the full range of providers, including PHOs, Planning and Funding, Councils and NGOs.
- **Quality management** for public health, including monitoring and performance assessment.

b. Outcomes and Activities table

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
Public health information systems	Public health information accessible to public health, partner organisations and the public	Availability and accessibility of public health information	Review and maintain public health information systems (common file structure; databases; intranet, extranet and public websites, including Healthscape, SIPHAN, Health Pathways, HIIRC, NIR; Community Health Information).	CPH, P&F WCDHB and WCPHO	Level of utilisation Completeness and currency of information
			Contribute to development and implementation of national, regional and local public health	CPH, WCPHO and WCDHB	Nature and effectiveness of systems, including degree of

	Short Term Outcomes (the results that we're working towards)	Short Term Outcome Indicators (how we'll monitor progress towards the results)	Activities (what we'll do to get the result)	Responsibilities (who will do it and when)	Performance measures (key measures of quantity or quality of activities)
			information systems, including West Coast STI Surveillance System.		integration.
Partnerships with iwi, hapü, whānau and Māori	Effective partnerships with iwi, hapü, whānau and Māori	Joint processes and initiatives	Take a whānau ora approach to working with local iwi, hapü, whānau and Māori around -health information and analysis -proposals and policies with health implications -health determinants and outcomes. Implement CPH Māori Health Plan.	CPH CPH (Māori Health Sub-Group)	No. of initiatives supported. Formal/informal feedback. Progress against plan.
Partnerships with Pacific and other ethnic leaders and communities	Effective partnerships with Pacific and other ethnic communities	Joint processes and initiatives	Work with local Pacific and other ethnic leaders and communities around -health information and analysis -proposals and policies with health implications -health determinants and outcomes. Contribute to WCDHB ethnic specific plans as appropriate.	CPH CPH, P&F WCDHB and WCPHO	No. of initiatives supported. Formal/informal feedback. Progress towards plan development/implementation.
Human resources	A highly skilled public health workforce	Workforce Development Plans Record of training opportunities (Training calendar)	Implement the CPH Workforce Development Plan, including promoting a focus on specific competencies and contributing to SI workforce development	CPH, SI Partnership	Training participation and feedback (for public health, other health sector and non-health staff).

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			and national networks. Explore/facilitate training for CPH staff in the Treaty, inequalities, Health in All Policies, Te Reo, Hauora Māori, and undergraduate and postgraduate study in public health as appropriate to staff development needs.	CPH	Formal/informal feedback. Extent of training recorded and evaluated.
Research, evaluation, economic analysis	Information available on priority public health issues and effectiveness of public health interventions	Research / evaluation reports and publications	Support public health research and evaluation, eg research into impacts of mine closures with a particular focus on improving Māori health and reducing health disparities. Media releases about items of interest including Year 10 ASH data, alcohol trends, etc. Pursue conference presentations and peer-reviewed publication where appropriate.	CPH CPH CPH	Number and accessibility of reports. Formal/informal feedback Number and impact of media reports. Number and impact of presentations and publications.
Planning and advising on public health programmes	Population health interventions are based on best available evidence and advice	Planning advice / reports	Develop reports and advice for health and non-health organisations to support robust public health interventions, with a focus on improving Māori health and reducing health disparities, including evidence reviews, needs assessments, GIS analysis.	CPH, P&F WCDHB and WCPHO, SI Partnership	Number and accessibility of reports. Formal/informal feedback Extent and impact of

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			Contribute to national, regional and local public health infrastructure and supports, including Public Health Association, Health Promotion Forum, South Island Public Health Partnership, National Public Health Clinical Network, National Health Promoting Schools Group, New Zealand College of Public Health Medicine, Healthy West Coast Workstream, PASHANZ, West Coast Tobacco Free Coalition, Active West Coast, WCDHB Child & Youth Health Workstream and West Coast Immunisation Advisory Group.	CPH	contribution.
Quality management	A continuous improvement culture and robust quality systems for all public health work	Quality improvement plan and reports Accreditation results	Develop, implement and maintain the quality improvement plans including Internal Audit Plan and provision of information, training and support to staff. Present annual quality report to CPH Divisional Leadership Team (DLT). Contribute to the WCDHB organisation-wide quality programme. Maintain IANZ accreditation of	CPH CPH CPH	Plans approved and progress reported , eg review of policies and procedures Progress against improvements and recommendation log. Progress towards quality programme.

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			drinking water unit.	CPH/SIDWAU	Accreditation maintained.
	Effective regional delivery of public health core functions	Reports of South Island Public Health Partnership	Contribute to management and work groups as per *South Island Public Health Partnership Plan 2012-15:* SI Public Health Analysts Network SI Alcohol Workgroup SI Workforce Development Plan Issues-specific work groups e.g. Sustainability, Tobacco, Communicable diseases protocols Management group	CPH	Progress against plans Partnership evaluation

5. HEALTH PROMOTION

a. Strategies

- Developing public and private sector **policies** beyond the health sector that will improve health, improve Māori health and reduce disparities.
- Creating physical, social and cultural **environments** supportive of health.
- Strengthening **communities' capacity** to address health issues of importance to them, and to mutually support their members in improving their health.
- Supporting **people to develop skills** that enable them to make healthy life choices and manage minor and chronic conditions for themselves and their families.
- Working in **partnership with other parts of the health sector** to support health promotion, prevention of disease, disability, injury, and rational use of health resources

b. Outcomes and Activities table

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
Policy	Policies and practices within and beyond the health sector that will improve health, improve Māori health, and reduce disparities	New and reviewed strategies, plans and policies reflect health priorities	Develop and make available resources to support health impact assessment (HIA) and a "health in all policies" (HiAP) approach Support health and non-health sector staff with appropriate tools and customised advice to support a HiAP approach, eg the IRPG (Integrated Recovery Planning Guide), Te Pae Mahutonga, HPSTED etc. Ensure these tools are available to all partner agencies and support	CPH (Policy) CPH (Policy)	Record of contributions and their impact. Record of contributions and their impact.

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			their implementation.		
			Support settings (workplaces, sports clubs, schools) to develop policies which support health.	CPH	Training opportunities, participation, and feedback
			Engage with and co-ordinate efforts of key external agencies, including local iwi, to identify and support HiAP opportunities, including relevant Ministry of Education initiatives, housing, community resilience & wellbeing in response to mine closures.	CPH	Record of contributions. Formal/informal feedback
			Develop joint work plans with a range of stakeholders.	CPH	Formal/ informal feedback, including evaluation of joint work plans.
			Support and coordinate development of WCDHB and regional position statements and submissions on public health issues.	CPH, SI Partnership (Population Health Information)	Number and impact of position statements and submissions
Social environments, media	Communities educated and aware of health issues and healthy choices and behaviours	Communications Plan, record of campaigns and information delivered	Develop and implement CPH public health communications plan.	CPH	Progress against plan.
			Deliver relevant and timely public health information and campaigns (including World Smokefree Day, Mental Health Awareness Week, National Heart Week. Matariki, Waitangi Day	CPH, WCDHB ,WCPHO and Poutini Waiora	No .and type of public health messaging distributed. Evaluation of reach and impact of individual campaigns.

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			and Ask the Professional columns in the Messenger)		
Education settings	ECECs, schools and tertiary settings that support healthy choices and behaviours	Education settings evaluation reports	Develop and support health promoting schools initiatives reflecting national strategic direction and guided by the draft service specification 2013/14.	CPH, WCDHB PHNs	Number of Schools engaged and with action plans developed.
			Support school initiatives that meet health and wellbeing needs identified by the school such as promoting student voice, healthy lifestyles and environments, emotional and mental wellbeing, improved attendance, hygiene, and whanau engagement	CPH	Number of schools engaged in the stages of HPS inquiry Information entered into National HPS Database as required.
			Work with young people to encourage healthy choices e.g. Smokefree, promoting oral health and alternatives to alcohol.	CPH, WCDHB Oral Health Service	Number of completed evaluations using the template set out in the National HPS framework.
			Support schools with information about alcohol and sexual health especially prior to the school balls being held.	CPH	Electronic and hard copy distribution of HPS magazine Uptake of health messages in school newsletters.
			Continue to develop the Good Memories No Regrets campaign, raising awareness of safe sex and safe drinking.	CPH	Record of presentations. Outcomes entered into Healthscape.

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
Workplaces	Workplaces that support healthy choices and behaviours	Workplace initiatives and evaluation reports	Work with priority workplaces to develop health promoting workplaces. Work with workplaces to encourage smoking cessation among staff.	CPH CPH and WCPHO	No. of workplaces engaged. Outcomes of workplaces initiatives. Number of referrals. Number of quit attempts.
Marae and Other Māori Settings	Marae and other Māori settings that support healthy choices and behaviours	Marae other Māori settings' initiatives and evaluation reports	Work in a whānau ora approach with Māori in settings to support healthy choices and make healthy lifestyle changes. Settings include: Kohanga Reo, Marae and Poutini Waiora.	CPH	No. of Māori settings worked with. No. of initiatives supported and evaluated ie: Appetite for Life, Auahi Kore, alcohol harm reduction.
Other community settings	Other community settings that support healthy choices and behaviours	Setting initiatives and evaluation reports	Work with event organisers and other community groups to develop health promoting settings e.g. Waitangi Day, Relay for Life, Waka Ama Festival, Kapa Haka festival. Support active transport through advocacy and membership on the WC Regional Transport Committee, West Coast Road Safety Committee. Support initiatives such as Bikewise, bike to work day and walk to work day. Identify ways of working with early childhood centres to promote Smokefree lifestyles.	CPH, WCDHB, WCPHO and Poutini Waiora CPH, WCDHB CPH, WCDHB and WCPHO	No of events supported Evaluation findings. Meetings attended and opportunities of change recorded. No of initiatives recorded and evaluated.

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
Community capacity	Communities able to address health issues of importance to them	Changes achieved by community partnerships	Support communities to address priority issues, including community engagement initiatives and development of sound health promotion projects, eg community resilience & wellbeing in response to mine closures, supporting delivery of the Prime Minister's Youth Mental Health initiative. Encourage community members to participate in submission-making process.	CPH, WCDHB and WCPHO CPH	Record of new networks established or linked into. No of initiatives supported and evaluated. No of groups engaged. No of submissions made.
Individual skills	People with skills to enable healthy choices and behaviours	ABC coverage in primary and secondary care. Smoking quit rates Evaluation of other initiatives	Maintain ABC coverage in primary and secondary care including quit card, hospital cessation service and Coast Quit. Deliver Aukati Kai Paipa as per the MoH contract. Develop and deliver other lifestyle intervention support (eg Appetite for Life, Green Prescription, fall prevention programmes, breastfeeding support, cooking programmes). Support mental wellbeing initiatives. Support delivery of the Prime Minister's Youth	WCDHB, WCPHO and CPH CPH CPH, WCDHB, WCPHO and Poutini Waiora CPH, WCPHO (Primary Mental Health Team) and other WCDHB Teams/Services (e.g. Oral Health,	Sustained quit attempt rates MoH targets met. AKP contract specifications met. Numbers of interventions made and evaluated. Number of participants Community linkages engaged with – e.g. Homebuilders, Salvation Army. Level of access to services Awareness of Five Ways to

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			Mental Health initiative. Deliver safe sexual health training and resources to priority groups.	Mental Health) CPH, Family Planning, WCDHB	Wellbeing No. training sessions delivered
Healthcare settings	Hospitals and community healthcare settings that support healthy choices and behaviours	Healthcare initiatives and evaluation reports	Work with hospital and community healthcare providers to develop health promoting settings (eg promoting active transport, Smokefree and healthy food availability).	CPH, WCPHO and WCDHB	No of initiatives supported recorded and evaluated.

6. HEALTH PROTECTION

a. Strategies

- Developing and reviewing public health laws and regulations[4].
- Supporting, monitoring and enforcing compliance with legislation.
- Identifying, assessing, and reducing communicable disease risks, including management of people with communicable diseases and their contacts.
- Identifying, assessing and reducing environmental health risks, including biosecurity, air, food and water quality, sewage and waste disposal, and hazardous substances.
- Preparing for and responding to public health emergencies, including natural disasters, hazardous substances emergencies, bioterrorism, disease outbreaks and pandemics.

b. Outcomes and Activities table

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
Communicable disease control	Reduced incidence of notifiable diseases Reduced incidence of influenza	Notifiable diseases and influenza rates and trends Outbreak rates and trends	Investigate cases and contacts as per protocols and Communicable Disease Control Manual 2012, including timely identification and investigation of notifiable diseases and outbreaks. Quality data entry in EpiSurv in a timely manner.	CPH, WCDHB (PHNs, RNSs and Infection Control Service) CPH	Disease rates (as compared with previous years). Data quality as outlined in the ESR Annual Data Quality Report. Statistics as outlined in the ESR

[4] Public health legislation covers a wide variety of issues, including communicable disease control, border health protection, food quality and safety, occupational health, air and drinking water quality, sewerage, drainage, waste disposal, hazardous substances control, control of alcohol, tobacco and other drugs, injury prevention, health information, screening programmes, and control of medicines, vaccines and health practitioners.

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			Investigate outbreaks as outlined in the Outbreak Response Procedure and ESR guidelines Contribute to the development of shared South Island protocols. Provide public information and advice, including promoting immunisation and hand hygiene and condom distribution. Work with priority settings and communities to increase immunisation and improve infection control. Provide vaccinator and programme authorisations as per Medicines Regulations Contribute to development and implementation of SI Rheumatic Fever Prevention Plan (reported through SI Public Health Partnership via CD protocols group).	CPH, WCDHB (PHNs, RNSs and Infection Control Service) CPH CPH, WCDHB Infection Control Committee, WCDHB Immunisation Advisory Group CPH CPH SI Partnership (Communicable Disease Protocols Group)	Annual Data Quality Report and Annual Outbreak Report. Outbreaks controlled Progress against Outbreak Debrief Report action points. Number and impact of shared protocols. Number of media releases and promotional opportunities undertaken Records of (intra WCDHB and interagency) meetings attended/settings worked with. Impact of contribution as evidenced by meeting minutes. Documented numbers of authorised vaccinator & programme applications and approvals. Progress against Plan.
Drinking water quality	Improved water quality and protection measures in community drinking water supplies	% of minor, medium and large community supplies complying with DWS % of minor, medium and	Support local authorities to maintain catchment protection Review and prioritise all community supplies and work	CPH/SIDWAU CPH	Record of interactions with suppliers concerning their legislative obligations (in SIDWAU filing system).

	Short Term Outcomes (the results that we're working towards)	Short Term Outcome Indicators (how we'll monitor progress towards the results)	Activities (what we'll do to get the result)	Responsibilities (who will do it and when)	Performance measures (key measures of quantity or quality of activities)
		large community supplies with approved and implemented Water Safety Plans.	with prioritised communities and TLAs and regional bodies to improve water quality. Carry out functions and duties of a DWA as defined under the Health Act. Undertake Annual Survey Ensure water carriers are registered. Respond to high-risk transgressions.	CPH CPH CPH CPH	DWA activities completed within legislative time frames Annual survey data delivered by required date. Record of registration Record of responses and outcomes
Sewage	Less disease caused by human contact with sewage	Sewage-related outbreaks Environmental contamination events	Work with councils to promote and ensure safe sewage disposal. Work with councils to manage risks of unplanned contamination events. Liaise with councils to provide public advice on safe sewage disposal, sewage overflows, and waterways contamination.	CPH CPH CPH	Record of external meetings attended and agreed actions. Record of contribution. Record of contribution.
Recreational water	Less disease caused by contamination of beach, river and lake water	Waterborne disease outbreaks Beach and river water gradings	Agree recreational water protocols with councils annually and monitor implementation. Work with councils to provide public information and advice, including health warnings and	CPH CPH	Agreed protocol in place Number of media releases produced in relation to RW including micro quality and algal

	Short Term Outcomes (the results that we're working towards)	Short Term Outcome Indicators (how we'll monitor progress towards the results)	Activities (what we'll do to get the result)	Responsibilities (who will do it and when)	Performance measures (key measures of quantity or quality of activities)
			media releases.		bloom events.
Housing	Less disease caused by inadequate housing	Housing quality improvements	Work with national, local and community organisations to ensure warm and dry housing, especially for vulnerable groups (including identification and referral of vulnerable households).	CPH, WCDHB P&F and WCPHO	Actions and/or outcomes from key housing stakeholder meetings/interactions reflect public health input.
Resource management	Regional and local council resource management practices and decisions reflect health priorities	Evaluation of council decisions, implementation and enforcement Air quality monitoring results	Work with councils to ensure health issues are identified and considered in RMA processes. Assess and submit on consent applications. Work with stakeholders to identify and address potential health issues	CPH CPH CPH	Number of applications assessed (scoped) Number of submissions made. Number of hearings where evidence presented. Number of decisions reviewed. Record of external meetings attended and agreed actions. Record of formal advice given.
Hazardous substances	Public protected from exposure to hazardous substances	Reports of public exposure	Work with councils and other agencies to reduce public exposure to hazardous substances, including responding to hazardous substance emergencies and complaints. Conduct investigations where required. Provide public information and advice.	CPH CPH	Record of external (including HSTLC) meetings attended and agreed actions. Record of formal advice given. Number and outcome of investigations. Record of advice given, including

	Short Term Outcomes (the results that we're working towards)	Short Term Outcome Indicators (how we'll monitor progress towards the results)	Activities (what we'll do to get the result)	Responsibilities (who will do it and when)	Performance measures (key measures of quantity or quality of activities)
			Process applications for application of vertebrate toxic agents under HSNO legislation. Conduct field audits of VTA activity where appropriate.	CPH CPH CPH	website utilisation. Number of VTA applications processed. Number and outcome of audits.
Early childhood education centres	Health hazards reduced in ECECs	Compliance with ECC Regulations, including infection control and lead exposure	Visit, assess and provide advice to ECECs. Work with councils to ensure appropriate placement of new ECECs.	CPH CPH	Number of ECECs assessed in terms of meeting requirements of ECC 1998/ 2008 Regulations. Number of meetings held with MoE and TAs.
Emergency preparedness	WC districts prepared for emergencies impacting on public health	Effective emergency responses as required	Develop and maintain emergency plans. Deliver CIMS in Health training to new staff and refresher training to established personnel. Participate in Public Health exercise with Public Health South and Nelson/Marlborough Public Health. Contribute to the development of an integrated South Island Public Health Business Continuity Plan.	CPH, WCDHB, WCPHO CPH CPH CPH	Emergency plans are current. Record of training. Performance against exercise performance measures. Progress towards plan completion, implementation.
Sustainability	Greater understanding of and action on sustainability	Evidence of increased awareness and development of sustainable	Raise awareness regarding sustainability and climate disruption, including both	CPH	Evidence of activity to improve understanding of sustainability and to promote sustainable

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
		approaches within our DHBs and partner organisations.	adaptation and mitigation strategies.		practices
Tobacco	Reduced tobacco sales, especially to minors Reduced exposure to second-hand smoke	Retailer display compliance at inspection. Retailer compliance during controlled purchase operations. Number and nature of workplace complaints.	Respond to public complaints. Complete education visit/compliance check prior to CPO/complaint. Inspect retailers and licensed premises for compliance in response to complaints. Conduct controlled purchase operations. Provide public and retailer information and advice	CPH CPH CPH CPH CPH	% complaints responded to within 5 days. % of retailers inspected. % of licensed premises inspected. Number of CPOs conducted. CPO compliance. Record of advice, information given.
Alcohol	Less alcohol-related harm	ED presentations Police data (violence, road traffic crashes) Retailer compliance during controlled purchase operations	Set up ED alcohol data collection system. Monitor licensed premises. Inquire into all on- , off-, club, and special licence applications and provide Medical Officer of Health reports to DLC where necessary. Conduct controlled purchase operations. Contribute to training of Duty Managers	WCDHB, CPH CPH CPH CPH CPH	Progress towards establishing system. Number of licensed premises monitored. Number of licence applications processed and percentage processed within 15 working days. Number of CPOs conducted. Number of premises visited during CPO. CPO compliance. Record of contribution.

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
			Work with Police and DLC to support community alcohol initiatives, eg alcohol accords. Support councils' implementation of Local Alcohol Policies (LAP's). Work with event organisers, eg for Wildfoods Festival, to encourage development of Event Management Plans. Work with SI Public Health Partnership to facilitate the development of DHB Alcohol Harm Reduction Strategies with associated outcomes frameworks and indicators.	CPH CPH CPH CPH, SI Partnership (Alcohol Workstream)	Record of meetings attended and agreed actions. Health impacts of Local Alcohol Policies. Record of meetings, number of plans in place. Progress against workplan.
Other psychoactive substances	Improved compliance with Psychoactive Substances Act 2013	Retailer compliance during controlled purchase operations	Work with police and other agencies to undertake regulatory activities in line with the Psychoactive Substances Act 2013 and Regulations	CPH	Number of licensed retail premises assessed for compliance. Number of premises visited during Controlled Purchase Operations. CPO compliance
Other	Public protected from other health hazards	Evidence of harm to public	Undertake other regulatory health protection work using a risk-based approach, including six-monthly inspections of solaria as per May 2012 request.	CPH	Record of external meetings attended and agreed actions. Record of formal advice given. Number of documents reviewed. Number of decisions reviewed.

7. PREVENTIVE INTERVENTIONS

a. Strategies

- Developing, implementing and managing **primary prevention programmes** (targeting whole populations or groups of well people at risk of disease: eg immunisation programmes).
- Developing, implementing and managing population-based **secondary prevention programmes** (screening and early detection of disease: eg. cancer screening).

b. Outcomes and Activities table

	Short Term Outcomes (the results that we're working towards)	**Short Term Outcome Indicators** (how we'll monitor progress towards the results)	**Activities** (what we'll do to get the result)	**Responsibilities** (who will do it and when)	**Performance measures** (key measures of quantity or quality of activities)
Immunisation	Increased immunisation coverage, especially for priority groups	Immunisation rates	Immunisation coordination - work strategically to improve immunisation coverage especially for tamariki and rangatahi. Immunisation promotion eg Pertussis vaccination among frontline healthcare workers, immunisation within ECECs and schools. Immunisation delivery.	CPH, WCDHB (P&F, PHNs, RNSs, WCDHB Immunisation Advisory Group) and WCPHO CPH, WCDHB (Communications Team, PHNs and Outreach Co-ordinator) and WCPHO WCPHO, WCDHB (Outreach Co-ordinator, PHNs, RNSs)	Record of initiatives. Formal/informal feedback. Record of promotion initiatives and outcomes. Record of delivery initiatives and outcomes.
Lifestyle interventions	Systematic identification of and response to risk factors	Completeness of practice and hospital information on smoking, alcohol intake, and physical activity	Work with the Maternity Quality and Safety Programme to enhance coverage and effectiveness of Smokefree ABC interventions with pregnant	WCDHB,WCPHO,CPH	Record of progress

	Short Term Outcomes (the results that we're working towards)	Short Term Outcome Indicators (how we'll monitor progress towards the results)	Activities (what we'll do to get the result)	Responsibilities (who will do it and when)	Performance measures (key measures of quantity or quality of activities)
			women who smoke. Implement the ABC Smoking Cessation Strategy in primary care and the community. Meet the smokefree health target. Meet PPP smoking targets, including smoking status documentation and delivery of brief advice and cessation support to smokers. Deliver Coast Quit smoking cessation initiatives.	WCDHB,WCPHO,CPH WCPHO,WCDHB WCPHO,WCDHB WCPHO	Number of practices provided with ABC training. Health Target Quarterly Report PPP Quarterly Reports. Quarterly report to WCDHB Smokefree manager, including enrolments in cessation programmes.
Screening and early detection	Early detection of cancer	Coverage rates for cervical and breast cancer screening	Participate in Cervical Screening Strategic and Working Groups to develop regional strategies to increase uptake. Maintain current levels of uptake of breast screening through a planned approach.	WCPHO, WCDHB WCPHO, WCDHB	Record of strategies and outcomes. Record of strategies and outcomes.
	Early detection of diabetes and cardiovascular disease	Coverage of diabetes and CVD screening programmes	Promote CVD risk assessments and diabetes screening in primary care settings and the community to increase uptake.	WCPHO,WCDHB	Quarterly report on utilisation. Numbers, age group, ethnicity and conditions identified.

8. GLOSSARY/DEFINITIONS

ABC – Ask; Brief Advice; Cessation support. A memory aid approach to smoking cessation for health practitioners.

ACC – Accident Compensation Corporation

AHMC –Alcohol Harm Minimisation Co-ordinator

AKP - Aukati Kai Paipa – A face to face smoking cessation service, offered to Māori and their whānau.

ASH – Action on Smoking and Health – A charity working to eliminate death and disease caused by tobacco.

CIMS – Coordinated Incident Management System – The managed response to incidents within New Zealand amongst multiple agencies.

CPH – Community and Public Health

CPO – Controlled Purchase Operation

CSNZ – Cancer Society New Zealand

CVD – Cardiovascular Disease

DLC – District Licensing Committee

DWA - Drinking Water Assessment

DWS – Drinking Water Standards

ECC – Early Childcare Centre

ECEC – Early Childhood Education Centre

ED – Emergency Department

EpiSurv – National notifiable disease surveillance database.

ESR – Environmental Science and Research

GIS – Geographical Information Systems

Healthscape – The CPH database which records information about CPH activities, and relationships with other organisations.

Healthy West Coast Governance Group –a tripartite alliance of CPH, the WCDHB and WCPHO for joint planning and delivery of health promotion.

HIA – Health Impact Assessment – A systematic procedure to judge what potential (and sometimes unintended) effects a policy, plan, programme or project will have on a population and how those effects will be spread across that population.

HiAP – Health in All Policies

HIIRC – Health Improvement and Innovation Resource Centre. An online resource providing health information.

HPS – Health Promoting Schools

HPSTED – Health Promotion and Sustainability Through Environmental Design

HSNO – Hazardous Substances and New Organisms

HSTLC - Hazardous Substances Technical Liaison Committee

IANZ – International Accreditation New Zealand

IHR - International Health Regulations

IRPG – Integrated Recovery Planning Guide

ISLA – Immunisation Service Level Alliance

MOH – Medical Officer of Health

MoU – Memorandum of Understanding

NGO – Non Government Organisation

NIR – National Immunisation Register

PASHANZ – Promoters Advocating Sexual Health in Aotearoa New Zealand

PEGS - (Preparation, Education, Giving Up and Staying Smokefree) A smoking cessation programme promoted through Primary Care.

PHN – Public Health Nurse

PHO – Primary Health Organisation

PHRMP – Public Health Risk Management Plan

P & F – Planning and Funding

PPP – PHO Performance Programme

Pratique – The license given to a ship to enter a port which states that it is free from contagious disease.

Quality Accounts – Reports provided by health providers on the quality of their services, presented in a similar way to financial accounts showing how an organisation has used its money.

RMA – Resource Management Act

RNSs – Rural Nurse Specialists

RW – Recreational Water

SIDWAU – South Island Drinking Water Assessment Unit

SIPHP - South Island Public Health Partnership

SIPHAN – South Island Public Health Analyst Network

SMG – Strategic Management Group

STI – Sexually Transmitted Infection

Te Pae Mahutonga – A model for Māori Health Promotion. Te Pae Mahutonga is the Māori name given to the constellation of the Southern Cross: four stars with two stars as pointers.

TLA – Territorial Local Authority

VTA – Vertebrate Toxic Agent

WCPHO – West Coast Public Health Organisation

WCDHB – West Coast District Health Board

9. APPENDIX

West Coast Prevention/Early Detection and Intervention Targets 2014-2015

	Community		**Primary Care**		**Secondary Care**	
Tobacco						
Goal Increase the number of successful quit attempts and reduce smoking prevalence amongst the West Coast population. *To reduce the major risk factor of long-term conditions and inequalities in health outcomes, particularly for Māori and Pacific people, who have disproportionately higher smoking rates.*	Three CPOs carried out and appropriate enforcement action taken as necessary.	**CPH**	90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit.	**WCPHO** **WCDHB**	95% of hospitalised smokers will be provided with advice and help to quit.	**WCPHO** **WCDHB**
	Increase in the number of year 10 students who have never smoked (base 69%)	**CPH**	4 ABC training sessions are delivered in primary care.	**WCPHO** **WCDHB**	Progress is made towards providing 90% of women who identify as smokers at the time of confirmation of pregnancy advice and support to quit.	**WCPHO** **WCDHB** **CPH**
	≥100 people enrol with the Aukati Kai paipa smoking cessation programme.	**CPH**	>500 people enrol with the Coast Quit smoking cessation programme	**WCPHO**		
Alcohol						
Goal Reduce the harm caused by alcohol. *To reduce a major risk factor of harm and*	≥3 monitoring visits per year to high-risk premises	**CPH**				
	95% of duty managers trained complete the Host Responsibility	**CPH**				

	Community		Primary Care		Secondary Care	
long term conditions	course.					
	Programmes to reduce the harm caused by alcohol are identified in the hospital and community health settings.					**WCDHB** **WCPHO** **CPH**
Nutrition and Physical Activity						
Goal Empower people and communities to take positive action to improve health & wellbeing. *To support healthy eating and physical activity and reduce the risk factors of long-term conditions.*	≥5 community nutrition courses delivered	**CPH**	≥500 Green Prescription referrals (base 274) 74% of infants are fully or exclusively breastfed at 6 weeks and 40% at 6 months. ≥17 Mum-4-Mum Breastfeeding Peer support counselors trained	**WCPHO** **WCPHO** **WCDHB** **WCPHO**	≥100 lactation support and specialist advice consults in the community. 96% of mothers are breastfeeding on hospital discharge.	**WCDHB** **WCDHB**
Immunisation and Vaccine-Preventable Disease						
Government expectation 95% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by December 2014.	Provide public information and advice, including promoting immunisation and hand hygiene.	**CPH**	95% of all West Coast children fully immunised at eight months by December 2014.	**WCPHO** **WCDHB**	Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date.	**WCDHB**
	Work with priority settings and communities to increase immunisation and improve infection control	**CPH**	95% of all West Coast children fully immunised at aged two.	**WCPHO** **WCDHB**		
	All cases and contacts of vaccine preventable disease investigated	**CPH**	90% of newborns enrolled with a GP or Well Child Tamariki Ora	**WCPHO**		

	Community		Primary Care		Secondary Care	
Goal Decreased number of cases of vaccine-preventable diseases in the community.	per protocols All outbreaks of vaccine preventable disease investigated and control measures instituted as outlined in the Outbreak Response Procedure and ESR Guidelines.	**CPH**	provider by 6 weeks of age.	**WCDHB**		

MATERNITY REVIEW – UPDATE ON PROGRESS

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

SOURCE: **Programme Director**

DATE: **4 April 2014**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

At the West Coast DHB Board meeting on 21 February 2014, a request was made for a report to be provided in relation to progress made to date against recommendations from the maternity review.

Following. Attached as Appendix 1, is a document summarising the recommendations arising from the review as publically released. The traffic light report, attached as Appendix 2, reports on the status of work in relation to the recommendations, with associated narrative comment.

2. RECOMMENDATION

That the Board;

i. Notes the report of progress against recommendations from the maternity review.

3. APPENDICES

Appendix 1: Maternity Review Summary
Appendix 2: Traffic Light Report on Progress

Report prepared by: Karen Bousfield, Director of Nursing and Midwifery
Mark Newsome, General Manager Grey | Westland

Report approved by: Michael Frampton, Programme Director

West Coast DHB Maternity Review: Summary Report

30 September 2013

REVIEW TEAM MEMBERS

Dr Clare Doocey, Paediatrician, Canterbury District Health Board [Review Lead]

Dr Keith Allenby, Obstetrician and Gynaecologist, Counties Manukau District Health Board

Anne Atkins, Clinical Midwifery Manager, West Coast District Health Board

Dr Lesa Freeman, Maternity Quality & Safety Programme Co-ordinator for Canterbury District Health Board and West Coast District Health Board

Dr Vicki Robertson, Obstetrician and Gynaecologist, West Coast District Health Board

ABSTRACT

To provide the West Coast District Health Board with a report on the current safety of the West Coast maternity services in the context of the rural environment in which they are provided.

To provide any recommendations for service improvement that will improve the safety and quality of maternity care provided to the West Coast community.

1. Executive Summary

This report makes significant tangible recommendations for improvements in the quality, safety and sustainability of the West Coast's maternity services.

It is essential that this report is not condemned to the paper pile and that the recommendations are endorsed and implemented by the Chief Executive and the Executive Management Team. We strongly urge that a significant proportion of the report recommendations are duplicated as the recommendations needed to be part of the Maternity Safety and Quality Program and included in the 2013/14 priorities and deliverables due to be submitted to the Ministry of Health in June 2013.

The review group find that it is essential to maintain Greymouth Hospital with a secondary obstetric service for exactly the same reasons that make maintaining such a service challenging; geographical isolation, recruitment and retention difficulties, and transport difficulties as a result of terrain and weather. Not having a secondary service would in our view jeopardise the lives of mothers and babies on the West Coast. The model of care developed to deliver this requirement needs to drive the decision-making process surrounding facility development with special emphasis on the collocation of maternity, paediatrics and theatres. Maintaining the secondary obstetric service also ensures the need for anaesthetics and therefore maintains that support for other services.

We recommend that the Kawatiri primary birthing unit Buller Hospital discontinue being a place where planned deliveries can occur but becomes a site for antenatal care and inpatient postnatal care with provision for emergency delivery if needed in extenuating circumstances. The IFHCs should be being specifically designed around this model of care.

Funding for midwifery should be through the Section 88 of the New Zealand Public Health and Disability Act Maternity Notice [Section 88] and caseloading midwifery funded by the WCDHB should cease. However, a key component of these recommendations is the support for self-employed LMCs for education, leave

planning and ensuring a full caseload to ensure practice viability is maintained for these key practitioners.

Currently the workforce of SMOs in obstetrics and gynaecology is as stable as it has been for many years but it is clear that the service remains vulnerable. There needs to be a one in three roster [reducing to one in two with leave] as a minimum. It was outside our scope and expertise to develop further the approach to recruitment and retention of this workforce but we recommend that a significant piece of work be undertaken looking at recruitment and retention for small isolated DHBs. This work should involve the ASMS, NZMC and RANZCOG with workshops involving senior medical staff from both Christchurch and the West Coast with their respective management teams, but lead by the Human Resources team that now works across both DHBs.

We are pleased to report that there do not appear to be recurring themes in either the incidents or root cause analysis [RCA] investigations. The increase in frequency of such events seems to be a positive manifestation of an evolving culture change with regard to the reporting and investigating of incidents and adverse outcomes. However, the processes, timelines and monitoring of the implementation of recommendations leave considerable room for improvement and we have made a number of recommendations pertaining to this.

From interviews with staff it is clear that a significant culture change is required from all parties. We urge that all tiers of the WCDHB embrace a culture of respect, openness and relationship building that allows reciprocity of leadership that allows effective leadership that fosters trust and team working. The actions of individuals need to endorse and embrace the stated ideology, visions and values of the service.

The clinical teams including midwifery, obstetrics and quality need to be aligned carefully with appropriate reporting lines and accountability. It is therefore recommended that the Director of Midwifery and the Clinical Director Obstetrics & Gynaecology roles should be across both DHBs with a transalpine model. Both of these roles will require the incumbent to be readily visible and specifically allocated time at both sites. An integration of the two services with fully shared and developed

guidelines, policies, credentialling and performance appraisal needs to occur with dedicated time spent at each site by those clinical heads.

This will require face-to-face work from senior management, effectively conducting a complete change management process. The changes required will result in a shift from a prolonged period of poorly co-ordinated, often reactionary change based on crises without clear communication strategies to one of open, honest communication. This will need to be built upon carefully considered continuous improvements based on optimising the patient care experience for families of the West Coast.

2. Purpose of Review

Over the last two years, there have been a number of serious and sentinel events involving maternity services provided on the West Coast. There has also been a Health and Disability Commissioner investigation, incident reports and patient complaints about the service provided.

These incidents taken as a group have raised a range of concerns regarding the safety of the maternity services provided to the West Coast community. It is unclear whether these are an unfortunate cluster of isolated cases, or whether there are systemic issues in the way that maternity services are provided to the West Coast community.

Purpose

The purpose of the review is to:

- provide the West Coast District Health Board with a report on the current safety of the West Coast maternity services in the context of the rural environment in which they are provided, and
- provide any recommendations for service improvement that will improve the safety and quality of maternity care provided to the West Coast community.

Elements of the Review

The components of the review are to:

- Review the cases above, and any associated recommendations;
- Understand the key issues involved in the cases in progress;
- Review existing guidelines, protocols and systems for birthing planning and care delivery, both antenatally and intrapartum, and transfer protocols and transfer timeliness within the West Coast and between West Coast and Canterbury;
- Assess the impact of staffing issues [numbers, locum use and skill mix] on service delivery;
- Provide observations on the findings of their review;
- Recommend actions for service delivery change that will improve the safety and quality of the maternity services provided for the West Coast community.

3. Background

Geography and Rurality

The West Coast DHB covers a geographical area 600km in length [the distance from Auckland to Wellington] and about 30-40 km in width. This is 10% of the land area of New Zealand with a population density of about 1/10th the national average. Due to limited public transport the majority of transport is by private car.

Only 64 percent of West Coast residents live within 60 minutes by road from secondary hospital services. Only two percent of the population are within 180 minutes by road from the nearest tertiary hospital at Christchurch. For logistical reasons it takes about four hours to effect ambulance transfer from Westport to Greymouth. The winding nature of roads means ambulances are slower than private cars. Helicopter transfers from centres along the West Coast to Greymouth Hospital originate in Greymouth. Fixed wing air transfer from Greymouth to Christchurch takes [from decision to arrival time in Christchurch] approximately four hours. Delays often occur due to either weather conditions or staffing constraints [midwifery or air ambulance]. From 2005, to 2007 some 13.7% of requested air ambulance transfers were unable to be completed. Inclement weather was the cause of 71% of these.

Helicopter transfers from centres along the West Coast to Greymouth Base Hospital originate in Greymouth. This requires travel firstly to collect the woman and baby and then the return flight.

Section 88 defines regions based on their rurality. All areas on the West Coast are classified as either rural, semi-rural or remote rural and attract additional fees for the necessary midwifery travel time.

Population Demographics

West Coast DHB serves a population of 31,000 people, 7500 people live in Greymouth, 4000 in Westport, 1000 in Reefton and 3000 in Hokitika and 1000 in Reefton. There are multiple smaller population centres scattered along the Coast from Karamea in the north to Haast in the south.

The West Coast DHB has an older than national average age and funding for this is reflected in the population based funding formula. A 2013 estimate of the female population on the West Coast is 16,235 of which 6,910 are of child-bearing age [15 to 49 years]. There is a lower proportion of Māori [10%] compared to the national average and almost no Pacific Island people. The West Coast has proportionally more people in the more deprived section of the population than the national average.

Gloriavale Christian Community

Gloriavale Christian Community is situated in Haupari approximately one hour's drive from Greymouth and has a population of 500 with approximately 25-30 births per annum. This number will continue to increase. There is currently one qualified midwife within the community and another community member in her second year of midwifery training who will graduate late in 2014.

4 – Key Recommendations | Findings:

Key Recommendations | Findings:

- **It is essential to maintain Greymouth Hospital with a secondary obstetric service for exactly the same reasons that maintaining such a service is challenging; geographical isolation, recruitment and retention difficulties [removal of secondary service would impact upon recruitment of LMC workforce], and transport difficulties as a result of terrain and weather**

  - Planned births no longer occur at Buller Hospital due to low numbers of births, risks associated with intrapartum transfer when transport not rapidly available and unavailability of midwives for the majority of births outside the locality
  - A primary maternity service [antenatal, postnatal and emergency delivery] in Westport is essential due to isolation
  - Models of care for maternity services should help determine the design of the new IFHC facilities and hospital facilities at Grey Base Hospital
  - The model of care for primary maternity must engage GPs working alongside midwives in providing antenatal care based in the IFHCs
  - The arrangements for inpatient care in Kawatiri Maternity Unit in Buller must be urgently reviewed to ensure they are safe. Women must be attended on site 24/7 by a midwife when an inpatient
  - Buller Hospital clinical leaders must ensure closer collaboration between all disciplines including joint education and simulation training
  - The WCDHB need to reimburse LMCs who provide inpatient care when patients are resident in Kawatiri Maternity Unit in Buller using a similar model to Golden Bay

- **The issues of transport need to be addressed**

  - Development of an elective transfer policy for specific conditions [eg severe pre eclampsia or twins]
  - The current emergency in utero transfer policy needs clarification and refining

- The Neonatal transfer policy needs reviewing and updating
- Agreement reached that CDHB facilitates and are responsible for transfers [either to Christchurch or another facility]
- Consider that acceptance of a neonate or mother needing transfer is guaranteed in Christchurch because irrespective of the bed status the risk to mother and baby is less at Christchurch [or in another tertiary unit] than remain on the West Coast. i.e Christchurch becomes responsible for making appropriate arrangements for care
- Clear guidelines need to be developed, documented, and widely distributed to assist staff in managing the transport / transfer process within the DHB and DHB to DHB ensuring timely, appropriate and safe care for all women and babies transferred
- Work with CDHB Birthing Suite Transport Coordinator to ensure CDHB staff have a clear understanding of the environment West Coast staff practice in [currently underway]
- Ensure all staff who may be called upon in an emergency undergo STABLE and PROMPT training to enable them to provide best possible care whilst a retrieval is pending
- Clinical contingencies should be developed to cover options when weather conditions interfere with the above agreed plans
- Develop information material for women to ensure they understand the transfer/ transport processes on the West Coast
- Bedside fFn testing be introduced

Work is required in conjunction with St John ambulance service to:

- Establish a workable policy regarding transfer from Buller which addresses issues of patient safety. This must include addressing the perverse situation of a possible cardiac event being higher priority than an actual maternity event
- Ensure the ability of St John's to provide a timely service whilst dependent on volunteers to provide that service

- This work should be seen as a key priority for both WCDHB and CDHB and needs to tie in with the existing work being conducted to address these issues

- **CDHB and WCDHB department of Obstetrics and Gynaecology be unified with shared management and accountability lines and appropriate protected dedicated time to enable quality and service development activities**

- **A full departmental and individual credentialing process should occur**

- **A specific piece of work needs to be commissioned by WCDHB and CDHB specifically charged with looking at solving the problems of recruitment and retention for isolated DHBs and the O&G staff. This work needs to involve the SMO body at both DHBs, the NZMC, the ASMS, RANZCOG and consideration be given as to whether HWNZ be involved**

- **WCDHB should commit to a community based primary midwifery model claiming from the Section 88 of the New Zealand Health and Disability Act 2000 maternity notice and make changes to the current model so this occurs**

- **A single Director of Midwifery role should be established with professional responsibility for both the WCDHB & CDHB midwifery services with sufficient focus on and understanding of the particular needs of the West Coast. This position needs to have a regular visible presence on the West Coast**

- **Design and develop a maternity service quality plan that supports the delivery of safe clinical outcomes for the West Coast community and is consistent with the New Zealand Maternity Standards**

- **Implement the Shared Maternity Record of Care [SMRoC] as per the National Maternity Clinical Information System and Shared Maternity Record of Care Business Case [2012]**

✓ Complete | Underway & on schedule | Ongoing work behind schedule | Yet to commence and/or over timeframe | ☐ Yet to commence

Status		Recommendation	Progress
Maternity Services on the West Coast			
IMMEDIATE	✓	It is essential to maintain Greymouth Hospital with a secondary obstetric service for exactly the same reasons that maintaining such a service is challenging; geographical isolation, recruitment and retention difficulties [removal of secondary service would impact upon recruitment of LMC workforce], and transport difficulties as a result of terrain and weather.	▪ *A secondary obstetric service continues at Grey Base Hospital.*
6 MONTHS	✓	Planned births no longer occur at Buller Hospital due to; low numbers of births, risks associated with intrapartum transfer when transport is not rapidly available; and unavailability of midwives for the majority of births outside the locality.	▪ *Planned birthing is not currently occurring at Buller Hospital.*
6 MONTHS	✓	A primary maternity service [antenatal, postnatal and emergency delivery] in Westport is essential due to isolation.	▪ *Antenatal, postnatal and emergency birthing is currently available in Westport.*
2 YEARS *Due June 2015*		Models of care for maternity services should help determine the design of the new IFHC and hospital facilities at Grey Base Hospital.	▪ *Model of care [MOC] development is underway alongside facilities concept planning for Grey and Buller. Full engagement of clinical teams, professional bodies and community representatives will contribute to MOC development.* ▪ *A workgroup has been formed to develop an agreed work plan for the Buller component of the MOC.*
2 YEARS *Due June 2015*		The model of care for primary maternity must engage GPs working alongside midwives in providing antenatal care based in the IFHCs.	▪ *GPs in Buller are part of the workgroup formed to develop an agreed work plan for the Buller component of the MOC.*
IMMEDIATE	✓	The arrangements for inpatient care in Buller Health must be urgently reviewed to ensure they are safe. Women must be attended on site 24/7 by a midwife when an inpatient.	▪ *Staffing arrangements for Buller now provide 24/7 cover for emergency birthing through a combination of midwife and RN care, with a midwife on call 24/7.*
2 YEARS *Due June 2015*		Buller Health clinical leaders must ensure closer collaboration between all disciplines including joint education and simulation training.	▪ *Meetings between all health professionals continue to take place regarding emergency obstetric care.* ▪ *Buller staff are now included in all education conducted on the West Coast.*

✓ Complete | Underway & on schedule | Ongoing work behind schedule | Yet to commence and/or over timeframe | Yet to commence

Status		Recommendation	Progress
2 YEARS *Due June 2015*	✓	The WCDHB needs to reimburse LMCs who provide inpatient care while patients are in the Kawatiri Maternity Unit in Buller—using a similar model to Golden Bay.	▪ *WCDHB has an agreement to reimburse the self-employed midwives for travel to Greymouth for the births of their patients.*
Transport & Patient Transfers			
1 YEAR *Due June 2014*		Development of an elective transfer policy for specific conditions [eg severe pre eclampsia or twins].	▪ *On track to be available in April 2014.*
6 MONTHS *Due Dec 2013*		The current *Emergency In Utero Transfer Policy* needs clarification and refining.	▪ *The CDHB 'In-Utero Transfer Between Hospitals' policy has been reviewed, with a focus on the WCDHB. The updated policy specifically acknowledges WCDHB's isolation and accordingly addresses these needs.* ▪ *The working group that reviewed the policy has simplified the process steps and developed a flow chart to aid arranging in-utero transport.* ▪ *Many groups were involved in the policy review including; QC Maternity, MQSP Co-ordinator, CDHB & WCDHB Charge Midwife Managers, and our neonatal unit, with the final draft distributed to the Department of Obstetrics and Gynaecology, Senior Medical Officers and St John Ambulance Services for further consultation.* ▪ *This policy is now ready for approval, and is anticipated to be released in May 2014. [It is for this reason that we have classified this recommendation amber.]* ▪ *An implementation plan will be made closer to release which will include education of staff and communicating the policy to internal and external stakeholders.* ▪ *Beyond the approval of this policy, we will be auditing the policy every six months; conducting a survey on communication and collaborative working when transferring women and babies; and providing education sessions with the relevant staff.*
6 MONTHS *Due Dec 2013*		The *Neonatal Transfer Policy* needs reviewing and updating.	▪ *This policy has been reviewed and is now ready for approval. [It is for this reason that we have classified this recommendation amber.]*
6 MONTHS *Due Dec 2013*		Agreement reached with CDHB to determine the process for facilitation and responsibility of timely transfers.	▪ *Ongoing work closely linked with the development of associated policies and procedures. With the approval of the polices above, this work can then be enabled.*

✓ Complete | Underway & on schedule | Ongoing work behind schedule | Yet to commence and/or over timeframe | ☐ Yet to commence

Status		Recommendation	Progress
6 MONTHS *Due Dec 2013*		Clear guidelines need to be developed, documented, and widely distributed to assist staff in managing the transport / transfer process within the DHB and DHB to DHB—ensuring timely, appropriate and safe care for all women and babies transferred.	▪ *See 'The current Emergency In Utero Transfer Policy needs clarification and refining' [above].*
ONGOING		Work with CDHB Birthing Suite Transport Coordinator to ensure CDHB staff have a clear understanding of the environment West Coast staff practice in.	▪ *Since July 2013, the Birthing Suite Coordinator has been contacted by midwives from Grey Base or Buller hospital for transfers. Increased communication in relation to transfers has resulted, with additional work still required.*
ONGOING		Ensure all staff who may be called upon in an emergency undergo ***STABLE*** and ***PROMPT*** training to enable them to provide best possible care whilst a retrieval is pending.	▪ *Training is occurring and continues to ensure all staff will have the required skill. Training is available both on the West Coast and in Canterbury.*
6 MONTHS *Due Dec 2013*		Clinical contingencies should be developed to cover options when weather conditions interfere with the above agreed plans.	▪ *Clinical contingencies are in place when weather conditions prohibit the usual transfer of mothers and babies. Formal documentation of these contingencies remains to be completed, and for this reason this recommendation is classified red* ▪ *Ongoing education is provided to all staff in relation to transfer of mothers and their babies.*
1 YEAR *Due June 2014*		Develop information material for women to ensure they understand the transfer/ transport processes on the West Coast.	▪ *In progress. 2 x flight midwives are working with a West Coast Quality Coordinator and Social Worker to develop an information resource that reflects the revised 'In-utero Between Hospitals' transfer policy.*
6 MONTHS *Due Dec 2013*	✓	Bedside fFn testing be introduced	▪ *New equipment and associated processes has changed the focus of this recommendation by providing an alternate solution appropriate to the West Coast. This is now in place.*
6 MONTHS *Due Dec 2013*		Establish a workable policy for transfer from Buller which addresses issues of patient safety. This must include addressing the perverse situation of a possible cardiac event being higher priority than an actual maternity event.	▪ *Work is ongoing and closely linked to the South Island wide investigation across all DHB's to develop more robust and workable patient transfer systems.* ▪ *Further information will be provided at the 04 April board meeting in relation to the range of work underway*
6 MONTHS *Due Dec 2013*		Ensure the ability of St John's to provide a timely service whilst dependent on volunteers to provide this.	

✓ Complete | Underway & on schedule | Ongoing work behind schedule | Yet to commence and/or over timeframe | Yet to commence

Status		Recommendation	Progress
Workforce			
1 YEAR *Due June 2014*		CDHB and WCDHB Department of Obstetrics and Gynaecology are working towards becoming a Transalpine service with shared management and accountability lines and appropriate protected dedicated time to enable quality and service development activities.	▪ *Planning for this work is occurring. Notwithstanding, this is a complex piece of work involving many Transalpine clinicians and managers and is unlikely to be complete within the year.*
1 YEAR *Due June 2014*		A full departmental and individual credentialing process should occur.	▪ *This process is being developed and is expected to be implemented by the end of 2014.*
1 YEAR *Due June 2014*		A specific piece of work needs to be commissioned by WCDHB and CDHB to find ways to solve the problems of recruitment and retention for isolated DHBs and the O&G staff. This work needs to involve the SMO body at both DHBs, the NZMC, the ASMS, RANZCOG and consideration be given as to whether HWNZ be involved.	▪ *An ongoing focus on stabilising the clinical workforce on the Coast continues as a priority across all services. This includes a comprehensive reconsideration of the 'employment value proposition' for SMOs to come to the Coast.* ▪ *It is expected that through joint appointments between the Coast and Canterbury, clarity about the future of facilities and a Transalpine Department of O&G, longstanding recruitment challenges can be better confronted and resolved.*
1 YEAR *Due June 2014*		Commit to a community based primary midwifery model, claiming from Section 88 of the New Zealand Health and Disability Act 2000 maternity notice, and make changes to the current model so this occurs.	▪ *This work is underway as part of the MOC development across the West Coast.*
1 YEAR *Due June 2014*		A review of the roles of a potential Transalpine Director of Midwifery and the current WCDHB Director of Nursing and Midwifery be undertaken to develop a workable model.	▪ *This work is underway. A close working relationship between the CDHB Director of Midwifery and the West Coast DHB Director of Nursing and Midwifery exists, and options for a potentially workable model for greater collaboration are being discussed. This activity is linked to a single Transalpine Department of O&G and it is unlikely that the review will be complete within the year.*
6 MONTHS	✓	Design and develop a maternity service quality plan that supports the delivery of safe clinical outcomes for the West Coast community and is consistent with the New Zealand Maternity Standards.	▪ *Maternity Service Quality Programme is in place.* ▪ *Maternity Quality and Safety Group is working on a workplan.*
ONGOING		Implement the Shared Maternity Record of Care [SMRoC] as per the National Maternity Clinical Information System and Shared Maternity Record of Care Business Case [2012].	▪ *Work is in progress.* ▪ *CDHB and WCDHB are waiting for national implementation of the agreed IT solution*

MAORI HEALTH PLAN UPDATE

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

SOURCE: **General Manager, Maori Health**

DATE: **4 April 2014**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

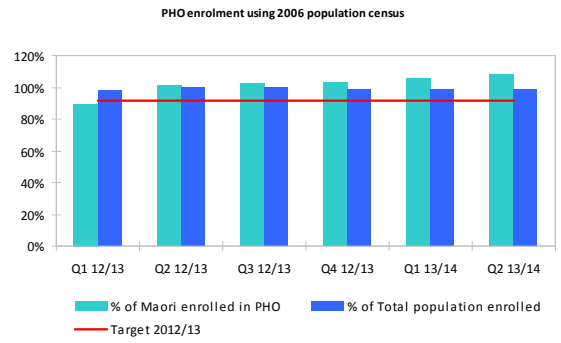
That the Board:
i notes the Maori Health Plan Update.

3. SUMMARY

Maori Health Quarterly Report – Q2, 2013/14

Access to care

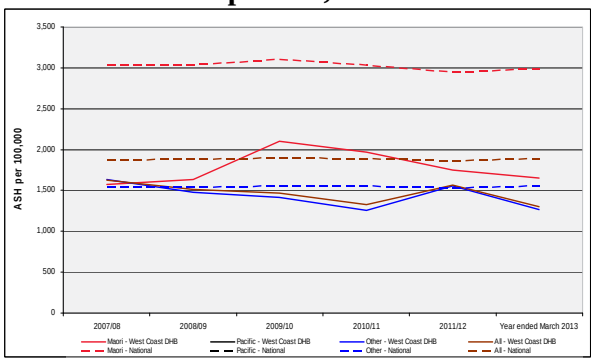
Percentage of Maori enrolled in the PHO



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

Ambulatory Sensitive Hospitalisation

Ambulatory Sensitive Hospitalisation per 100,000



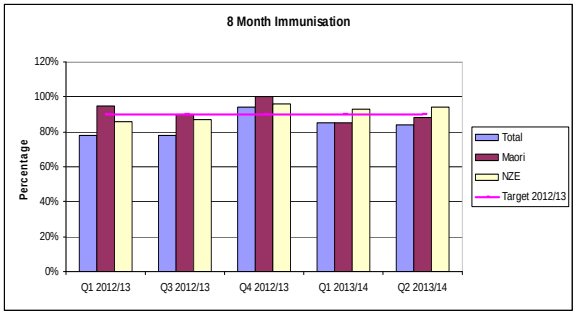
ACHIEVEMENTS/ISSUES OF NOTE

Enrolment in PHO: Using the 2006 population census figures 93% of Maori were enrolled with the PHO as at December 30 2013. Enrolments for Maori and Pacific people continue to increase at a faster rate than other ethnicities and exceed that of other ethnicities.

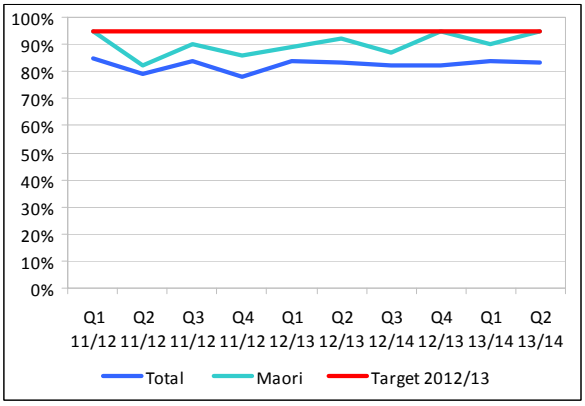
On the 20th June 2013 the Ministry of Health issued a Request for Proposal, to Implement the Primary Care Ethnicity Data Audit Tool'. The West Coast PHO and the DHB have jointly developed the proposal and it was submitted in August. The Audit tool comprises Systems Compliance and Audit Checklist, Implementation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

Child, Youth and Maternity

NEW Immunisation HT: Eight-month-olds fully immunised



Immunisation: Two-year-olds fully immunised



Eight-month-old immunisation: 88% of Maori babies have been immunised on time at 8 months of age in quarter 2. This equates to 23 babies out of 26.

Two-year-old immunisation: The West Coast DHB's total coverage for Quarter 2 is 83% of babies being immunised by 8 months of age. – This remains high as was the case in Quarter 4 an indication of the continuous effort of primary care and Outreach Immunisation Services to achieve the highest possible coverage. Coverage for Māori two-year-olds sits at 95% so 18 from 19 eligible Maori babies have been immunised for this age milestone. Work to improve immunisation coverage for both eight-month-olds and two-year-olds includes:

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

Breastfeeding: Breastfeeding results for the 12/13 year were released by the MoH during this reporting period. It is important to note that unfortunately the DHB is unable to present a full picture of breastfeeding results this year and it is Plunket services only. Poutini Waiora and the WCDHB also provide WCTO services, but due to national data issues with Plunket data the three data sources cannot be accurately combined as they have been in the previous years.

WCDHB 2012/13 results (Plunket data only):

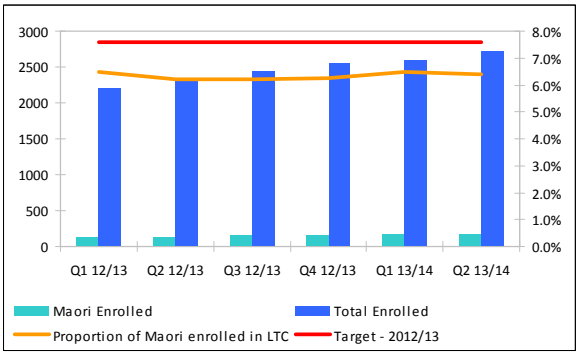
	Target	Maori	Total
6 weeks	74%	70%	61%
6 months	40%	15%	22%

Breastfeeding Support: Mum 4 Mums – Peer Counselling for this quarter has seen a marked increase in the number of Maori Mums being trained and graduating with 4 Maori Mums in the Buller. We are still looking to increase the number of Maori mums being involved in this initiative.

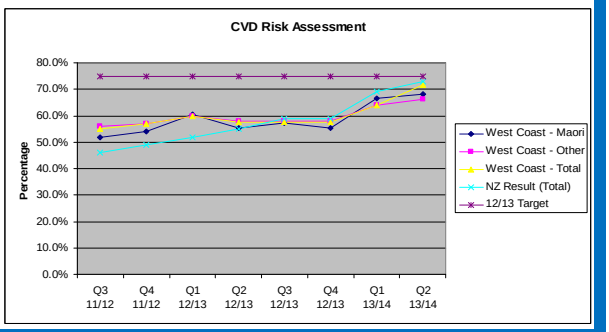
Newborn Enrolment: The Newborn enrolment form will now include a section where new Mums can consent to being contacted by a Lactation Consultant within a week of birth. The lactation consultant will then be able to determine whether support is required or not. This service can be provided in the home or clinic.

Long Term Conditions

Number of Maori enrolled in LTC management programme



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



ACHIEVEMENTS/ISSUES OF NOTE

More Heart & Diabetes Checks:

MoH is providing additional funding over four years (2013/14 = $57,052 and decreasing annually) to support the achievement of the national Health Target *More Heart & Diabetes Checks* in Primary Care
A delivery plan on how to implement the *More Heart & Diabetes* service funding is being developed by the PHO alongside their clinical governance group. The delivery plan will be reviewed with secondary care and tabled with the ALT.

Activities discussed include; additional registered nurses FTE to carry out screening and after hours screening clinics at general practice. Increasing integration and collaboration with Kaupapa Maori Nurses.

CVD Health Target: Performance against this health target has shown an increase from 58% in the June quarter to 71.8% of the eligible enrolled West Coast population now having had a cardiovascular risk assessment in the five years to 30 December 2013. Quarter 2 rates for West Coast Māori show 68.1% having had their CVD risk assessments undertaken which is an increase from 66% last quarter. Collaboration with Poutin Waiora , the PHO and several practices is enabling better outreach to high-need Māori, including an awareness campaign (which began during Quarter 1) and a tailored package of care from Poutini Waiora through its Kaupapa Māori Nurses and its Kaiarataki (non-clinical Māori Health Navigators). Greymouth Medical Centre and Poutini Waiora began working together in Quarter 4 2012/13 to provide support and health care for Māori and Pacific people with long-term conditions, with the Kaupapa nurse working within the practice and 'out-reaching' directly to practice patients. This pilot model expanded to Hokitika during Quarter 1 and is working well.

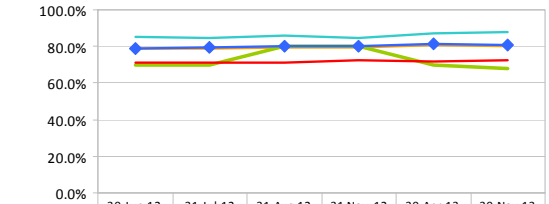
Practice teams continue to actively identify and invite eligible people to nurse-led clinics to have their cardiovascular risk assessed, with a special focus on high-need people who haven't been screened.

Green Prescription: Quarter 2 has seen a steady increase in Maori referrals in to the Green Prescription programme with 13% (10) in the Grey/Westland district and 26% (6) in the Buller district. The major group of conditions this quarter is people with elevated body mass index (BMI), followed by depression/anxiety and cardiovascular disease.

Long Term Condition Management (LTC): 159 Maori are enrolled in the Long Term Conditions programme as at Dec 30 2013. Year to date Maori enrolment makes up 6.4% of all enrolment in the LTC programme. The target is 7.6%. For comparison Maori make up 5.3% of the enrolled population at the primary practices aged 45 years and above. This means that from the 2717 enrolments on the LTC programme 174 are Maori and 8 are Pacific. We are working closely with the CEO and Clinical Manager of the PHO, and Poutini Waiora to identify those Maori who are enrolled in the programme and link them in to the Kaupapa Maori Nurses and Kaiarataki and also to identify any Maori who should be enrolled in the programme but aren't.

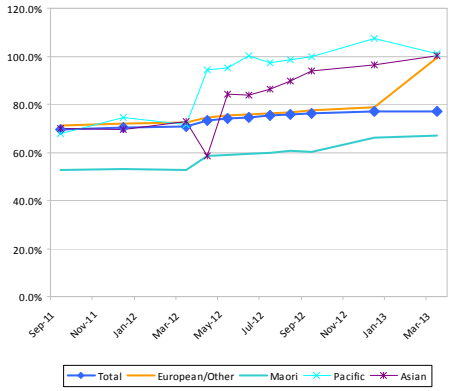
Cancer

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



	30-Jun-12	31-Jul-12	31-Aug-12	31 Nov -12	30-Apr-13	30-Nov-13
Other	78.6%	79.0%	79.4%	79.5%	80.6%	80.2%
Maori	85.1%	84.7%	85.6%	84.5%	87.1%	88.0%
Pacific	70.0%	70.0%	80.0%	80.0%	70.0%	68.2%
Total	79.1%	79.4%	79.9%	79.9%	81.1%	80.7%
All DHB's	71.2%	71.2%	71.3%	72.3%	72.0%	72.4%

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



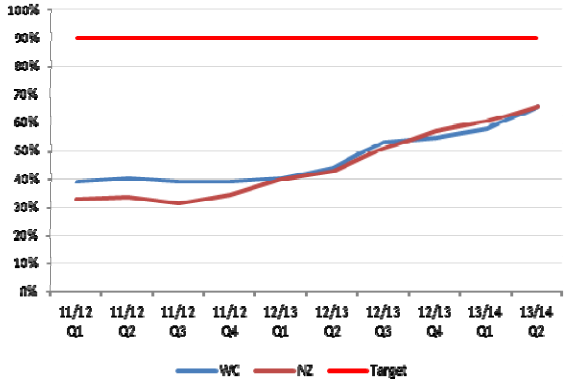
ACHIEVEMENTS/ISSUES OF NOTE

Breast Cancer Screening: Approximately 81% of all eligible women aged 45-69 age-groups on the West Coast have undergone breast screening for the period ending 30th November 2013. The coverage for eligible Maori women (88%) is higher compared to all other ethnicities on the West Coast. The National Maori Health Plan Indicators report shows that the West Coast DHB is 2nd from 20 DHB's for this Indicator.

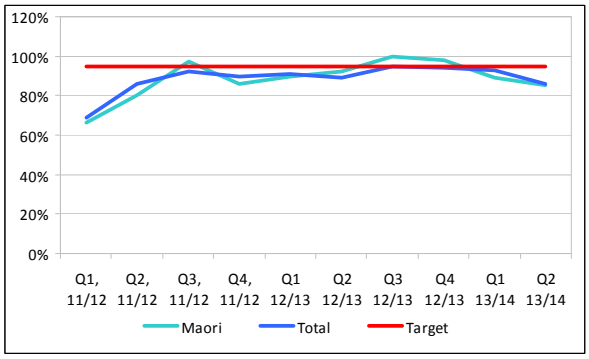
Cervical cancer screening: At the end of Dec 2013, the preliminary three year coverage result for cervical screening on the West Coast non-Maori was 78%. The coverage rate for eligible Maori women is at 71% an increase from last quarter and a sustained increase from June 2012. The process for cervical screening is being embedded into the practices with overdue priority lists regularly being forwarded through to the Maori cervical screening. Additionally to this the Maori cervical screener is working very closely with Poutini Waiora to locate those hardest to reach and holding community clinics.

Smoking Cessation

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



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



ACHIEVEMENTS/ISSUES OF NOTE

Primary Smokefree Health Target: Results for Quarter 2 2013/14 show the target has increased by 2% to reach 60% with 58% of Maori smokers who have attended general practice offered advice and support to quit. There is a comprehensive plan in place to improve this target. The majority of Poutini Waiora kaimahi are trained to give brief cessation advice and are aware of the pathways for referral.

Secondary Smokefree Health Target: The secondary target of 95% was not achieved this quarter with 86% of the total population being offered advice and 85% of Maori in the hospital being offered brief advice. More work is occurring with senior hospital management to ensure greater progress is achieved against this target.

Aukati Kai Paipa: For the period December 2013 the AKP service is working with 85 clients, 47 who identify as Maori with 20% validated abstinence rate at 3 months. The Aukati Kai Paipa cessation adviser is working more closely with Poutini Waiora which is resulting in increased referrals to the service.

Report prepared by: Kylie Parkin, Maori Health

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

HEALTH TARGET REPORT – QUARTER 2

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: **4 April 2014**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to present the Board with the West Coast DHB's progress against the national health targets for Quarter 2 (October-December 2013). The attached report (Appendix 1) provides a detailed account of the results and the work underway for each health target.

DHB performance against the health targets is published each quarter in newspapers and on the Ministry and DHB websites. The Quarter 2 health target league table is attached as Appendix 2.

2. RECOMMENDATION

That the Board notes the West Coast's performance against the health targets.

3. SUMMARY

The West Coast has performed well in Quarter 2. It has:

- Achieved the **ED health target**, with 99.8% of people admitted or discharged within six hours. The West Coast is a leader the country in performance against this health target.
- Achieved the **faster cancer treatment health target**, with 100% of patients ready for radiation therapy or chemotherapy beginning treatment within 4 weeks of their specialist assessment.

Health target performance has been weaker, but still positive, in the following areas:

- Performance against the **elective surgery health target** saw a minor decrease against the target for the quarter - that is expected to be made up for by quarter 4. A two-week shut down and issues with visiting specialists are most likely responsible for being 17 patients shy of this target.
- For the **immunisation health target**, 84% of all eight-month-olds were fully immunised in Quarter 2 (the national target changed in quarter 1, increasing from 85% to 90%). While this is a decrease on last quarter, op-off's and declines have risen by 3%. Only three children remain overdue. An implementation plan for recommendations made by the Alliance Leadership Team on the West Coast has been approved.
- The West Coast DHB did not meet the **hospitalised smokers health target**, with 86.2% of hospitalised smokers having received advice and help to quit – 31 smokers were missed. The systems and processes are in place for the target to be achieved however challenges do exist including the level of staff attendance at ABC Smokefree training. Meetings with senior hospital management will be ongoing until progress against the target is again achieved and sustained.

- General practices' performance against the **primary care smokers health target** continues to show modest increases, up 1.9% on the previous quarter, with 59.9% of smokers attending primary care receiving advice and help to quit. Activities continue to focus on improving data capture, feedback and training.
- Performance against the **heart checks health target** has had a 2.4% increase this quarter to 66.4% of the eligible enrolled West Coast population having had a cardiovascular risk assessment in the last five years. A range of activities are occurring to increase this and remove the barriers preventing assessments taking place, such as after-hours clinics in a variety of locations.

4. APPENDICES

Appendix 1:	Health Target Report – Quarter 2
Appendix 2:	Ministry Health Target League Table – Quarter 2

Report prepared by:	Planning and Funding
Report approved by:	Carolyn Gullery, GM Planning & Funding

National Health Targets Performance Summary

Quarter 2 2013/2014 *(October-December 2013)*

Target Overview

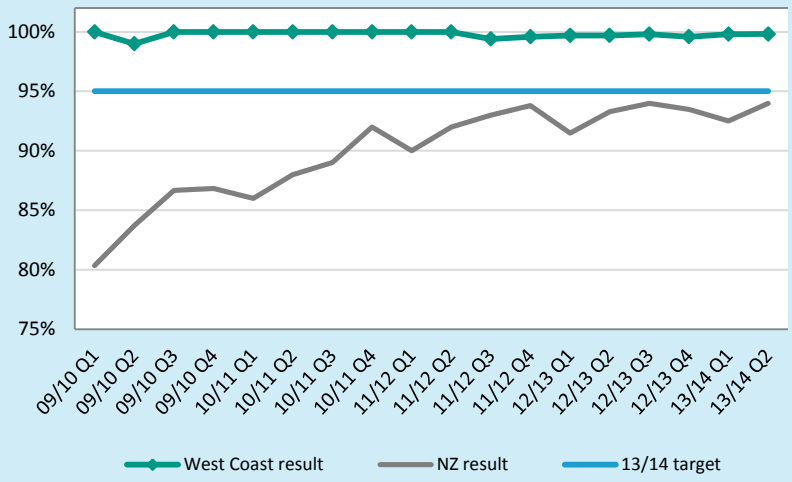
Target	Q3 *12/13*	Q4 *12/13*	Q1 *13/14*	Q2 *13/14*	Target	Status	Pg
Shorter Stays in ED Patients admitted, discharged or transferred from an ED within 6 hours	99.8%	99.6%	99.8%	99.8%	95%	✓	2
Improved Access to Elective Surgery West Coast's volume of elective surgery	1,173 YTD	1,686	434 YTD	795 YTD	812 YTD	✗	2
Shorter Waits for Cancer Treatment People needing cancer radiation therapy or chemotherapy having it within four weeks	100%	100%	100%	100%	100%	✓	3
Increased Immunisation Eight-month-olds fully immunised	78%	93%	85%	84%	90%	✗	5
Better Help for Smokers to Quit **Hospitalised** smokers receiving help and advice to quit	91%	95%	93%	86.2%	95%	✗	3
Better Help for Smokers to Quit Smokers attending **primary care** receive help and advice to quit	53%	55%	58%	59.9%	90%	✗	4
More Heart and Diabetes Checks Eligible enrolled adult population having had a CV risk assessment in the last 5 years	58%	58%	64%	66.4%	90%	✗	6

Shorter Stays in Emergency Departments

Target: *95% of patients are to be admitted, discharged or transferred from an ED within 6 hours*

✔

Figure 1: Percentage of patients who were admitted, discharged or transferred from ED within six hours



The West Coast continues to achieve impressive results against the ED health target, with **99.8%** of patients admitted, discharged or transferred from ED within 6 hours during Quarter 2.

Improved Access to Elective Surgery

Target: *1,592 elective surgeries in 2013/14*

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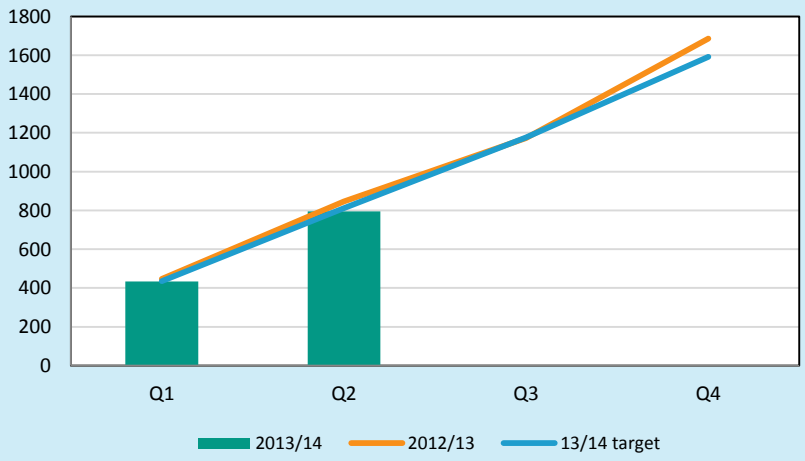
Figure 2: Elective surgical discharges delivered by the West Coast DHB[1]



795 elective surgical cases were delivered to Coasters in Quarter 2 2013/14, representing **97.9%** of our year-to-date target delivery. Being only 17 patients shy of meeting the targeted 812 this quarter, we have no doubt that this shortfall will be made up for by the end of Quarter 4.

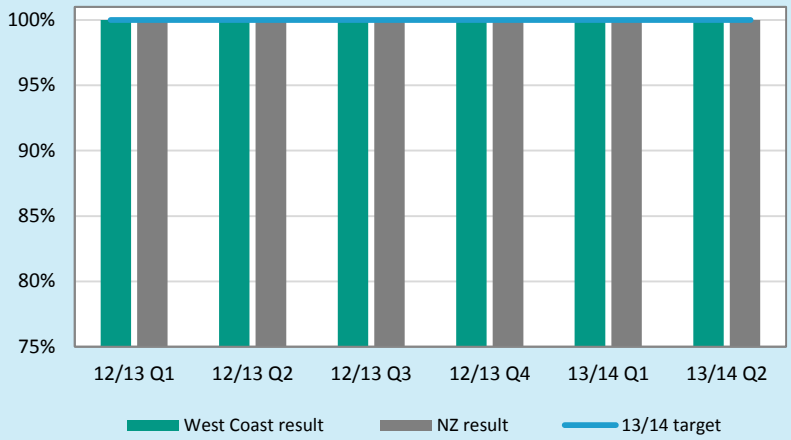
A two week shutdown at Christmas and issues with visiting specialists during December are most likely responsible for our decline this quarter.

[1] *Excludes cardiology and dental procedures. Progress is graphed cumulatively.*

Shorter Waits for Cancer Treatment

Target: *100% of people needing radiation or chemotherapy receive it within four weeks*

Figure 3: Percentage of West Coasters needing radiation or chemotherapy treatment who received it within four weeks[2]



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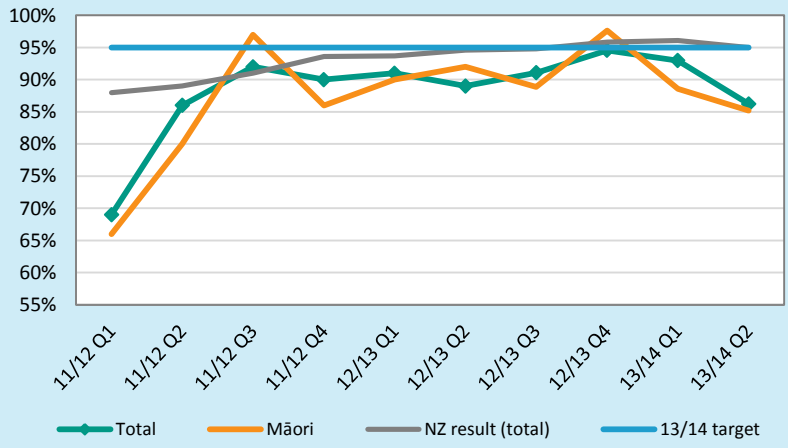
In Quarter 2 2013/14, **100%** of patients met the 4 week target for both radiation therapy and chemotherapy.

Better Help for Smokers to Quit: *Secondary*

Target: *90% of smokers attending primary care receive advice to quit*

Figure 4: Percentage of West Coasters needing radiation or chemotherapy treatment who received it within four weeks



✘

In Quarter 2, West Coast DHB staff provided **86.2%** of hospitalised smokers with smoking cessation advice and support – 31 patients shy of meeting the targeted 95%.

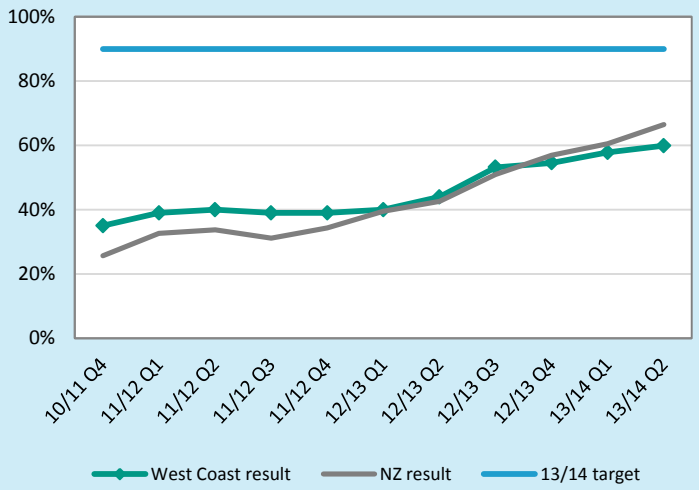
The systems and processes are in place for the target to be achieved by June 2014; however, challenges do exist including the level of staff attendance at ABC Smokefree training which can impede full understanding of the ABC procedures as a national health target and a significant clinical intervention. Meetings with senior hospital management will need to be ongoing until progress against the target is again achieved and sustained.

[2] *This measure does not include instances in which a patient chooses to wait for treatment or there are clinical reasons for delay.*

Better Help for Smokers to Quit: *Primary*

Target: 90% of smokers attending primary care receive advice to quit

Figure 5: Percentage of smokers expected to attend primary care who were offered advice and help to quit smoking[3]



West Coast general practices have reported giving 2,693 smokers cessation advice in the 12 months ending December 2013, representing **59.9%** of smokers expected to attend general practice during the period. A 2% increase against the previous quarter but still well under the target.

A key barrier to achieving this target is data capture and coding of conversations taking place. Monthly coding and data entry training has been implemented at the PHO as part of standard orientation for all new practice staff in an effort to increase data capture. Smoking assessment tools that prompt staff where required should also increase data capture, and their implementation continues to be progressed. The use of advanced forms on MedTech 'smoking assessment' tool supports and reminds staff to capture the correct data and prompts the 'brief advice' if required. Practice-specific feedback is circulated monthly to all staff within general practice, through a 'Primary Health Target Bulletin,' alongside clinical relevant messaging regarding the health target or quarterly Coast Quit outcomes to create a clear link between ABC intervention and patients quitting smoking.

During this quarter the Smokefree Services Coordinator (SSC) further analysed individual practice performance. This identified one practice in particular that required extra support to improve their coding of B&C[4]. This support was provided by the SSC and should result in improved results for this practice for Quarter 3.

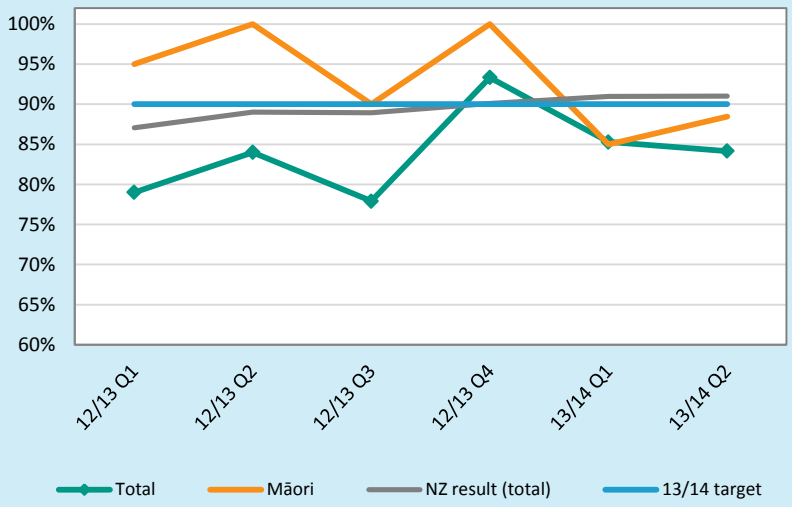
Along with existing and previously reported actions, during this quarter the 'Supporting the Primary Care Health Targets' Action Plan was updated and approved by the MoH. This identifies opportunities for better integration between the two primary care health targets. Key actions include driving and supporting senior and clinical leadership within primary practices, including the reinvigoration of Quality Improvement Teams and identifying Quality Improvement Primary Health Targets Champions. Work is already underway against this plan and will continue through to July 2014.

[3] *Data for this measure is supplied by the Ministry on a quarterly basis from the PHO Performance Programme (PPP).*
[4] *The 'B & C' refer to the latter part of the The ABC Strategy for Smoking Cessation involves Asking if a patient smokes, offering Brief advice to quit and referring them to Cessation support*

Increased Immunisation

Target: 90% of eight-month-olds are fully immunised

Figure 6: Percentage of West Coaster eight-month-olds who were fully immunised



The West Coast has not achieved the revised national health target this quarter, vaccinating 84% of eligible children. This represents NZ European (94%), Maori (88%) and 100% of Pacific and Asian children.

Opt-off[5] (9.9%) and declines (2%) continue to be a challenge for the West Coast. 11.9% of children this quarter could not be immunised due to parent's choice (a noteworthy increase from last quarter of 3.1%). Of those that were able to be immunised, there were only four children missed. Of these, one was vaccinated after milestone age and the other three remain overdue.

An implementation plan for recommendations made by the Alliance Leadership Team on the West Coast has been approved. Recommendations include data management; increased focus on outreach, linking with B4 School Checks process; DHB promotions and communications plan—linking with the Canterbury DHB Immunise for Life programme (with a West Coast theme); Seasonal Influenza Programme; working on leadership and engagement of Service Level Alliances and the West Coast Immunisation Advisory Group; and strengthening clinical and administration linkages between Canterbury and the West Coast.

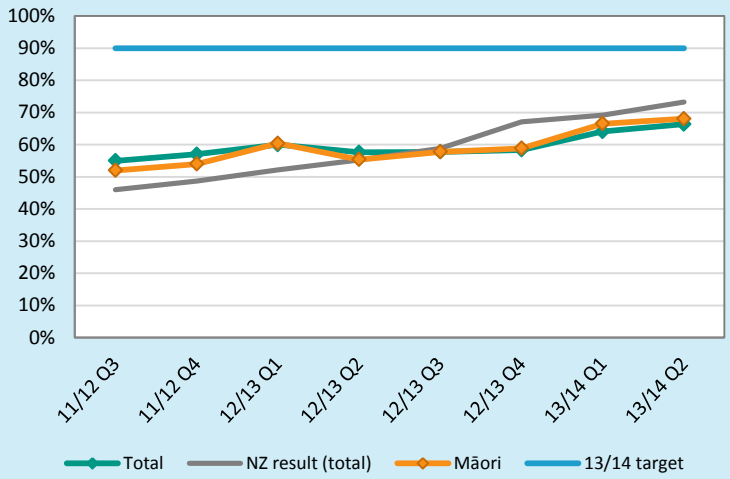
Work is now underway on this with the aim to get a better understanding of immunisation provision and improve immunisation rates.

[5] *Children's parents can decide (typically at the child's birth) to opt their child off the NIR. These children continue to be counted in the cohort for the DHB of birth, but there is no way to determine or record if they have later been vaccinated, declined or moved out of the DHB area.*

More Heart and Diabetes Checks

Target: 90% of the eligible enrolled population have had a CVD risk assessment in the last five years

Figure 7: Percentage of the eligible enrolled West Coast population having had a CVD risk assessment in the last 5 years[6]



Data for the five years to 31st December 2013 shows that West Coast general practices have continued to increase coverage, with 66.4% of the eligible enrolled West Coast population having had a cardiovascular risk assessment (CVRA) – up from 64% in Quarter 1.

A lot of positive work was undertaken this Quarter to improve performance, and while the results demonstrate an increase of 2.4% on the previous quarter's result, we have not met our 78% progress target as intended.

WCDHB continues to work on increasing the rates during the year and meet the 90% target by 1st July 2014. This includes integration of Kaupapa Maori nurses, implementing specific nurse led CVRA clinics at practices and providing extra nursing resources for CVRAs.

Additional funding received from the Ministry of Health to support further uptake of More Heart and Diabetes checks has resulted in an after-hours clinic delivered in Reefton. Further recruitment of nurses to work at dedicated general practices after-hours clinics, marae, work places and other venues continues.

To meet the 90% target we are focussed on delivering the Primary Care Health Target Action Plan to support a more integrated approach to both primary care health targets, which was signed off by the Ministry in December 2013.

Actions in the coming quarter to address performance and reach the target include:

- Integrating Kaupapa Maori nurses to assist with high need engagement for screening;
- Implementing specific nurse led CVRA clinics at practices;
- Screening for CVD patients for CVRA;
- Providing extra nursing resources for CVRAs; and
- Introducing after-hours clinics to provide additional CVRAs for people not easily able to access general practice during working hours.

[6] *Data for this measure is supplied by the Ministry on a quarterly basis from the PHO Performance Programme (PPP).*

How is My DHB performing?

2013/14 QUARTER TWO (OCTOBER–DECEMBER) RESULTS

www.health.govt.nz/healthtargets

MINISTRY OF HEALTH
MANATŪ HAUORA

Shorter stays in Emergency Departments

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

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 two performance (%)	100%	Progress against plan (discharges)
1	Lakes	120		▲
2	Northland	116		▲
3	Counties Manukau	114		▲
4	Waikato	113		▲
5	Hutt Valley	109		▲
6	Taranaki	107		▲
7	Bay of Plenty	106		▲
8	Waitemata	103		▲
9	MidCentral	102		▲
10	Whanganui	102		▲
11	Wairarapa	102		▲
12	Canterbury	102		▲
13	South Canterbury	101		▲
14	Southern	101		▲
15	Tairawhiti	100		▼
16	Auckland	100		▼
17	Capital & Coast	98		▼
18	West Coast	98		▼
19	Hawke's Bay	98		▼
20	Nelson Marlborough	92		▼
	All DHBs	105		▲

Improved access to elective surgery

The target is an increase in the volume of elective surgery by at least 4000 discharges per year. DHBs planned to deliver 76,231 discharges for the year to date, and have delivered 3554 more.

Shorter waits for Cancer Treatment

		Quarter two 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		–

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy. Six regional cancer centre DHBs provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin. Medical oncology services are provided by the majority of DHBs.

Increased Immunisation

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

Increased immunisation

The national immunisation target is 90 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2014 and 95 percent by December 2014. This quarterly progress result includes children who turned eight-months between October and December 2013 and who were fully immunised at that stage.

Better help for Smokers to Quit

		Change from previous quarter	95%	Hospitals
▼				90
–				99
–				95
▼				90
–				99
▼				93
▼				89
▼				97
▼				93
▼				95
▼				95
▲				97
–				96
–				97
–				96
▼				86
–				96
–				98
▲				97
–				95
–				95

		Quarter two performance (%)	Primary care	90%	Change from previous quarter
1	Wairarapa	97			–
2	South Canterbury	86			▲
3	Whanganui	82			▲
4	MidCentral	81			▲
5	Hawke's Bay	80			–
6	Nelson Marlborough	78			▲
7	Bay of Plenty	77			▲
8	Northland	77			–
9	Capital & Coast	74			▲
10	Taranaki	71			▲
11	Counties Manukau	69			▲
12	Waikato	68			▲
13	Southern	64			▲
14	Hutt Valley	63			–
15	Auckland	60			▲
16	West Coast	60			▲
17	Tairawhiti	59			▲
18	Waitemata	55			▲
19	Lakes	55			▼
20	Canterbury	49			▲
	All DHBs	66			▲

Better help for smokers to quit

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.

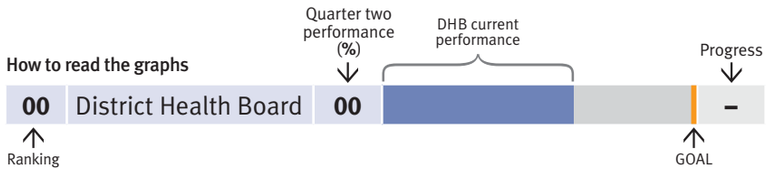
More Heart and Diabetes Checks

		Quarter two performance (%)	90%	Change from previous quarter
1	Wairarapa	84		▲
2	Auckland	83		▲
3	Counties Manukau	83		▲
4	MidCentral	82		▲
5	Capital & Coast	80		▲
6	Taranaki	80		▲
7	Bay of Plenty	80		▲
8	Northland	80		▲
9	Waikato	77		▲
10	Waitemata	76		▲
11	Tairawhiti	75		▲
12	Lakes	74		▲
13	Hawke's Bay	74		–
14	Whanganui	73		▼
15	South Canterbury	72		▲
16	West Coast	66		▲
17	Nelson Marlborough	64		▲
18	Southern	64		–
19	Hutt Valley	62		▲
20	Canterbury	45		▲
	All DHBs	73		▲

More heart and diabetes checks

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved by July 2014.

How to read the graphs



Health target results are sourced from individual DHB reports, national collections systems and information provided by primary care organisations.

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

New Zealand Government

TATAU POUNAMU ADVISORY GROUP/WEST COAST DHB TERMS OF REFERENCE

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

SOURCE: **Tatau Pounamu Advisory Group**

DATE: **4 April 2014**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The Tatau Pounamu Advisory Group have referred to the District Health Board a suggested revised Terms of Reference which forms part of the Memorandum of Understanding between themselves and the DHB and sets out the processes by which the organisations work together.

2. RECOMMENDATION

That the Board;

i. agrees to the revised Terms of Reference as detailed in the attached Appendices.

3. SUMMARY

Te Runanga o Ngai Waewae and Te Runanga o Makaawhio who together comprise Poutini Ngai Tahu and are represented in their relationship with the West Coast DHB by the Tatau Pounamu Advisory Group, have a Memorandum of Understanding with the West Coast DHB.

This Memorandum of Understanding recognises the special relationship and obligations upon the West Coast DHB in exercising its Treaty Partnership with Poutini Ngai Tahu.

The Terms of Reference presented to the Board today are attached as an Appendix to the Memorandum of Understanding and set out the process for all parties working together.

The Memorandum of Understanding allows for parties to amend this agreement at any time.

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4. APPENDICES

Appendix 1: Schedule of Changes
Appendix 2: Existing Terms of Reference
Appendix 3: Proposed Terms of Reference with Tracked Changes

Report prepared by: Board Secretariat

APPENDIX 1

The following amendments have been made to the Terms of Reference:

- References to Maata Waka has been replaced with Iwi throughout the Terms of Reference
- Clause 3 Functions of Tatau Pounamu Manawhenua Advisory has been replaced with Role of Tatau Pounamu Manawhenua Advisory
- Clauses 3.1 – 3.31 have been deleted and replaced with roles and responsibility clauses 6.1 – 6.2.2 from the Memorandum of Understanding
- Clause 4.1 Membership – Sentence added "The total membership of Tatau Pounamu shall be six (6) and the composition shall be determined as follows:"
- Amend Clause 4.1.2 – Reference to In addition, Nga Maata Waka people will select 2 representatives (2) from Tai Poutini communities (Total 6) and amend to an additional clause "4.1.3 – In addition, Tatau Pounamu will select 2 Maori community representatives (2) from Tai Poutini Communities and one member of the West Coast DHB Board shall be appointed by the West Coast DHB to attend Tatau Pounamu Advisory Group meetings.
- Clause 4.1.3 becomes 4.1.4 and has been amended to read as follows: Elected members not resident in Te Tai o Poutini costs associated with attending meetings may be met by their nominating bodies.
- Clause 4.1.4 becomes 4.1.5 and has the word "No" removed and now reads "Alternatives or proxy voting will be allowed for Committee members.
- Clause 4.1.5 becomes 4.1.6
- Add an additional clause 4.1.7 to read "A quorum shall consist of not less than one member from each of the Papatipu Runanga".
- Clause 5 Term of Office – add "Membership is determined as in Clause 4".
- Amend clause 5.1 from "Members of this committee will remain in office for the period specified in the notice of appointment and, not exceeding 6 years or until such time as to now read "Members of this committee will remain in office for the period of three years or until such time as:"
- Amend clause 5.2.1 remove "Nga Maata Waka" and replace with "in the case of the Maori community representatives to Tatau Pounamu". Clause now reads "Tatau Pounamu and its members are accountable to the respective bodies who appointed them i.e. Papatipu Runanga, in the case of the Maori community representatives to Tatau Pounamu".
- Amend clause 5.2.2 remove "Papatipu Runanga Chair and Nga Maata Waka Chair and replace with Tatau Pounamu Chair" Remove "review" "the" and amend sentence. Clause now reads The Tatau Pounamu Chair will ensure that performance reviews are conducted of the Tatau Pounamu members, annually or sooner if the Chair and appointing committee deems it necessary".
- Amend clause 5.3.1 add "Tatau Pounamu will on occasion go in committee for discussion of a sensitive nature. These meetings will only be open to members and invitees" Clause 5.3.1 now reads "West Coast District Health Board members and members of the public will be welcome to attend meetings. Tatau Pounamu will on occasion go in committee for discussion of a sensitive nature."
- Amend clause 9.1.6 remove No and add silent. Clause now reads Cell phones will be on silent during Tatau Pounamu hui.

TATAU POUNAMU KI TE TAI O POUTINI
Manawhenua Advisory Group

TATAU POUNAMU
Terms of Reference

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1. MISSION STATEMENT

1.1 Whakapiki ake te hauora Māori ki te Tai o Poutini

This mission statement is reflective of the belief that:

1.1.1 Good health and wellness outcomes for Māori will be advanced through the West Coast District Health Board working with Iwi/Maata Waka community.

1.1.2 Individuals will want to maximise their own health, wellbeing and independence.

1.1.3 Promoting health and preventing illness or injury is an essential investment.

1.1.4 People's fundamental rights and responsibilities should be the focus of all services.

1.1.5 Tatau Pounamu Manawhenua Advisory Group (Tatau Pounamu) will have significant involvement in planning processes, which will help make better and more informed planning decisions.

1.1.6 Open decision making will contribute to Iwi/Maata Waka community confidence.

1.1.7 Improved access to services should be fair and based on need

1.1.8 Improved co-ordination and integration of health providers and services will improve outcomes and contribute to reducing inequalities.

1.1.9 The spirit of all relationships should be collaborative and co-operative.

1.1.10 Working intersectorally (e.g. local government, education, employment and housing) is necessary to achieve improved health outcomes.

1.1.11 Good information will improve decision-making.

1.1.12 Iwi / Maata Waka community throughout the region have a right to an efficient and effectively performing committee.

2. MISSION AND OBJECTIVES

2.1 Tatau Pounamu will focus on:

2.1.1 Strategic planning of service initiatives that positively impact on Māori for the region.

2.1.2 Specific cultural policy development for West Coast District Health Board.

2.1.3 Provision of Māori cultural guidance and support to West Coast District Health Board.

3. FUNCTIONS OF TATAU POUNAMU MANAWHENUA ADVISORY GROUP

3.1 The role of Tatau Pounamu is to give advice on

3.1.1 The needs and any factors that the committee believe may advance and improve the health status of Māori, also advise on adverse factors of the resident Māori population of Te Tai o Poutini, and:

3.1.2 Priorities for use of the health funding provided.

3.2 The aim of this committee

3.2.1 Provides advice that will maximise the overall health gain for the resident Māori population of Te Tai o Poutini through:

3.2.2 All service interventions the West Coast District Health Board has provided or funded or could provide or fund for that population.

3.2.3 All policies the West Coast District Health Board has adopted or could adopt for the resident Māori population of Te Tai o Poutini

3.3 The advice of this committee

3.3.1 Should aim to where possible to be consistent with the New Zealand Public Health and Disability Act 2000 and He Korowai Oranga.

4. COMPOSITION OF TATAU POUNAMU

4.1 Membership

4.1.1 Tatau Pounamu is the recognised manawhenua advisory group regarding Māori health for Te Tai o Poutini

4.1.2 Each Papatipu Rūnanga of Tai Poutini, that being Te Rūnanga O Ngati Waewae and Te Rūnanga O Makaawhio will select 2 representatives each from respective hapu (4). In addition Nga Maata Waka people will select 2 representatives (2) from Tai Poutini communities. (Total 6).

4.1.3 Elected members must reside in Te Tai o Poutini unless the nominating bodies are prepared to pay costs associated with attending meetings

4.1.4 No alternatives or proxy voting will be allowed for Committee members.

4.1.5 Committee members will be provided with a copy of the New Zealand Public Health and Disability Act 2000 Whakatataka, He Korowai Oranga, and West Coast District Health Board Māori Health Plan.

4.2 Chairperson

4.2.1 The Chairperson is appointed by a vote from the Committee and will remain in this position until such time as:

4.2.2 The Chairperson ceases to be a member of the Committee; or

4.2.3 The Chairperson is removed from the chair by a consensus vote within Tatau Pounamu

4.2.4 The Chairperson is responsible for the efficient functioning of the Committee and sets the agenda for meetings.

4.2.5 The Chairperson must ensure that all Committee members are enabled and encouraged to play a full role in the activities of the Committee and have adequate opportunities to express their views.

4.2.6 The Chairperson is also responsible for ensuring that all Committee members receive timely information to enable them to be effective Members.

4.2.7 The Chairperson is also the link between Committee members and the General Manager, Māori Health of the West Coast District Health Board.

4.3 Co-opted Membership

4.3.1 Tatau Pounamu may co-opt additional members to the Tatau Pounamu from time to time, for specific Kaupapa for specific periods and purposes as it deems necessary to assist the Committee.

4.4 Sub Committees

4.4.1 Tatau Pounamu may form sub committees from time to time, from within its members and co-opt experts in the specified fields for specified periods and purposes as it deems necessary to assist the Committee.

5. TERM OF OFFICE

5.1 Members of this committee will remain in office for the period specified in the notice of appointment and, not exceeding 6 years or until such time as:

5.1.1 A member resigns from the committee.

5.1.2 A member is removed from the committee either by its members or the appointing body

5.2 Accountability

5.2.1 Tatau Pounamu and its members are accountable to the respective bodies who appointed them i.e. Papatipu Rūnanga, Nga Maata Waka.

5.2.2 The Papatipu Rūnanga Chair and Nga Maata Waka Chair will review the performance of the Tatau Pounamu members, annually or sooner if the Chair and appointing committee deems it necessary.

5.3 Attendance at Committee Meetings

5.3.1 West Coast District Health Board members and members of the public will be welcome to attend meetings.

5.4 Management Reporting

5.4.1 The West Coast District Health Board management will be responsible for providing information / reporting on issues requested by Tatau Pounamu to the West Coast District Health Board.

5.5 Administrative Support

5.5.1 The Māori Health Unit and chair of Tatau pounamu will be responsible for the co-ordination and facilitation of Committee meetings.

5.5.2 The Māori Health Unit will ensure adequate administrative support for Tatau Pounamu.

5.5.3 Internal secretarial, legal, financial, analytical and administrative staff will also support Tatau Pounamu.

6. ANNUAL WORKPLAN

6.1 Tatau Pounamu will develop an annual work plan that outlines planned activity for the year:

The annual work plan will be monitored at committee meetings and a report written against the set objectives bi-annually and annually. Key elements are:

6.1.1 Communication strategy – reciprocal reporting to statutory committees, primary health organisation and back to appointing bodies.

6.1.2 Prioritise Māori strategies/projects

6.1.3 Monitor Māori health gains

6.1.4 Joint Board / Manawhenua Advisory Group meetings scheduled

6.1.5 Budget management

6.1.6 Leadership and succession planning

7. COLLECTIVE RESPONSIBILITY

7.1 Members recognise that at times there may be tension between the concepts of collective accountability of Tatau Pounamu and individual accountability to Iwi/Maata Waka.

Members agree to support and abide by the following principles:

7.1.1 Members may clearly express their Iwi views at Tatau Pounamu hui and endeavour to achieve a particular decision and course of action. However, members accept that once a decision has been formally reached by Tatau Pounamu, this decision is binding.

7.1.2 It is inappropriate for a member to undermine a decision of Tatau Pounamu once made, or to engage in any action or public debate, which might frustrate its implementation.

7.1.3 Individual members will not attempt to re-litigate previous decisions at subsequent Hui, unless a majority of members agree to re-open the korero.

7.1.4 Members' personal actions should not bring Tatau Pounamu into disrepute or cause a loss of confidence in the activities and decisions of Tatau Pounamu.

8. TATAU POUNAMU AGENDAS

8.1 Requests for Items to be placed on Tatau Pounamu Agendas

8.1.1 Members with a request for an item to be placed on the Agenda must notify the minute secretary no later than 48 hours prior to the hui. Personal agenda items; members must seek the support of its appointing body prior to it being placed on the agenda.

8.1.2 No new items will be accepted on the agenda, but placed on the agenda for the next scheduled meeting.

8.1.3 It is accepted that at times certain kaupapa will command priority. In these instances Tatau Pounamu will exercise its' own discretion and proceed accordingly.

8.1.4 The Agenda will be structured to ensure that decision papers have priority with information papers included under a separate section.

9. BEHAVIOUR AND ATTENDANCE

9.1 Behaviour and Attendance at Hui

9.1.1 Members undertake to have read and familiarise themselves with the minutes of the previous Hui.

9.1.2 Members will only make a point if it has not already been raised and is relevant to the kaupapa.

9.1.3 Members will not interrupt each other or talk while another member is speaking.

9.1.4 Issues will be raised in an objective manner-no personal reference or innuendo will be made to persons associated with the matter being raised.

9.1.5 Members will endeavour to achieve closure on one point before another point is raised.

9.1.6 No cell phones will be on during Tatau Pounamu hui.

9.1.7 Members, the Chair and the General Manager of Māori Health will endeavour to clarify questions, issues, and requests before taking actions or responding.

9.1.8 Will not use their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducements and which could compromise the Mana of Tatau Pounamu.

9.1.9 Will exercise care and judgement in accepting any gifts, and advise the Chair and/or the Tatau Pounamu of any offer received.

9.1.10 Non-attendance at three (3) consecutive hui without extenuating circumstances is deemed unacceptable resulting in notification to the Chair of their Iwi/ appointing body of their unavailability along with a request for consideration for a replacement.

9.1.11 All members will assist the Chair to uphold the behaviour protocols agreed to by Tatau Pounamu.

10. CONFLICT OF INTEREST

10.1 The New Zealand Public Health and Disability Act 2000

sets out the definition and procedure for disclosure of member's interests:

10.1.1 A member who is 'interested in a transaction' of the West Coast District Health Board must, as soon as practicable, disclose the nature of the interest to Tatau Pounamu.

10.1.2 The member must not take part in any deliberation or decision of Tatau Pounamu relating to the transaction.

10.1.3 The disclosure must be recorded in the minutes and entered in a separate interest's register.

10.1.4 Recognise that where an interest is declared (or where considered that there is a clear "perception of interest") the normal practice is for the member concerned to leave the room. Tatau Pounamu can, however, exercise it's discretion in allowing the member to remain. In such circumstances the member may have speaking rights but would not participate in any decision.

11. PUBLIC STATEMENTS

11.1 Communications from the committee with the public and the media will be subject to the following principles:

11.1.1 Only the chairperson or delegated spokesperson may speak on behalf of Tatau Pounamu.

11.1.2 If a dissenting member is approached by the media for comment after a hui the member is bound by the general decision, but may expand on an issue or point raised personally by the member at that particular hui.

11.1.3 The focus is to remain on the issue and not personalised in any way that is critical of employees or other members of Tatau Pounamu.

11.1.4 Members will advise Tatau Pounamu if they are contacted by or intend to speak to the media.

11.2 Should an opinion be sought from the media members should:

11.2.1 Make clear the capacity in which they are speaking; i.e. personal views and not those of Tatau Pounamu.

12. TRAINING

12.1 Members are required where possible:

12.1.1 To be familiar with the obligations and duties of a member of Advisory Committees and avail themselves of opportunities for training in areas deemed appropriate. This may include courses and or training provided by West Coast District Health Board.

13. REVIEW

13.1 Tatau Pounamu may review these terms of reference at any time.

SIGNED ON BEHALF OF
THEIR RESPECTIVE ORGANISATIONS

Name .....

Designation/Title..... Date .....

For Tatau Pounamu

Name .....

Designation/Title..... Date .....

For West Coast District Health Board

Witnessed by..... Date .....

Name .....

TATAU POUNAMU
Terms of Reference

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1. Mission Statement

1.1 "Whakapiki ake te hauora Māori ki te Tai o Poutini."

This mission statement is reflective of the belief that:

1.1.1 Good health and wellness outcomes for Māori will be advanced through the West Coast District Health Board working with Iwi/Maori community.

1.1.2 Individuals will want to maximise their own health, wellbeing and independence.

1.1.3 Promoting health and preventing illness or injury is an essential investment.

1.1.4 People's fundamental rights and responsibilities should be the focus of all services.

1.1.5 Tatau Pounamu Manawhenua Advisory Group (Tatau Pounamu) will have significant involvement in planning processes, which will help make better and more informed planning decisions.

1.1.6 Open decision making will contribute to Iwi/Maori community confidence.

1.1.7 Improved access to services should be fair and based on need

1.1.8 Improved co-ordination and integration of health providers and services will improve outcomes and contribute to reducing inequalities.

1.1.9 The spirit of all relationships should be collaborative and co-operative.

1.1.10 Working intersectorally (e.g. local government, education, employment and housing) is necessary to achieve improved health outcomes.

1.1.11 Good information will improve decision-making.

1.1.12 Iwi/Maori community throughout the region have a right to an efficient and effectively performing committee.

2. Mission and Objectives

2.1 Tatau Pounamu will focus on:

2.1.1 Strategic planning of service initiatives that positively impact on Māori for the region.

2.1.2 Specific cultural policy development for West Coast District Health Board.

2.1.3 Provision of Māori cultural guidance and support to West Coast District Health Board.

3. Role of Tatau Pounamu Manawhenua Advisory Group

3.1 The role of Tatau Pounamu is to give advice on:

3.1.1 The West Coast District Health Board and Tatau Pounamu will work together on activities associated with the planning of health services for Māori in Te Tai Poutini rohe.

3.2 The West Coast District Health Board and Tatau Pounamu will take responsibility for the activities listed below:

3.2.1 The West Coast District Health Board will:

a) Involve Tatau Pounamu in matters relating to the strategic development and planning and funding of Māori health initiatives in the Te Tai Poutini rohe;

b) Establish and maintain processes to enable Maori to participate in, and contribute to strategies for Maori health improvement

c) Continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori

d) Include Tatau Pounamu in decision making process that may have an impact on Poutini Ngāi Tahu; and

e) Feedback information to Tatau Pounamu on matters which may impact on the health of Māori in Te Tai Poutini rohe.

3.2.2 Tatau Pounamu will:

a) Involve West Coast District Health Board in matters relating to the development and planning of Māori health and disability;

b) Feedback information to Ngā Rūnanga o Poutini Ngāi Tahu as required;

c) Advise West Coast District Health Board on matters which may impact on the health of Māori in Te Tai Poutini rohe;

d) Assist West Coast District Health Board to acquire appropriate advice on the correct processes to be used so as to meet Poutini Ngāi Tahu kawa (custom/protocol) and tikanga (rules of conduct).

4. Composition of Tatau Pounamu

4.1 Membership

The total membership of Tatau Pounamu shall be six (6) and the composition shall be determined as follows:

4.1.1 Tatau Pounamu is the recognised manawhenua advisory group regarding Māori health for Te Tai o Poutini

4.1.2 Each Papatipu Rūnanga of Tai Poutini, that being Te Rūnanga O Ngati Waewae and Te Rūnanga O Makaawhio will select 2 representatives each from respective hapu (4).

4.1.3. In addition Tatau Pounamu will select 2 Māori community representatives (2) from Tai Poutini communities and one member of the West Coast DHB Board shall be appointed by West Coast DHB to attend Tatau Pounamu Advisory Group meetings

4.1.4 ~~Elected members must reside in Te Tai o Poutini unless the nominating bodies are prepared to pay costa associated with attending meetings~~ Elected members not resident in Te Tai o Poutini costs may be met by their nominating bodies.

4.1.5 ~~No~~ alternatives or proxy voting will be allowed for Committee members.

4.1.6 Committee members will be provided with a copy of the New Zealand Public Health and Disability Act 2000 Whakatataka, He Korowai Oranga, and West Coast District Health Board Māori Health Plan.

4.1.7 A quorum shall consist of not less than 4 members and must include at least 1 member from each of the Poutini Papatipu Rununga ~~A quorum shall consist of not less than one member from each of the Papatipu Runanga.~~

4.2 Chairperson

4.2.1 The appointed Chairperson MUST be from one of the Poutini Ngai Tahu Runanga and rotate between Runanga every 3 years and will remain in this position until such time as:

4.2.2 The Chairperson ceases to be a member of the Committee; or

4.2.3 The Chairperson is removed from the chair by a consensus vote within Tatau Pounamu

4.2.4 The Chairperson is responsible for the efficient functioning of the Committee and sets the agenda for meetings.

4.2.5 The Chairperson must ensure that all Committee members are enabled and encouraged to play a full role in the activities of the Committee and have adequate opportunities to express their views.

4.2.6 The Chairperson is responsible for ensuring that all Committee members receive timely information to enable them to be effective Members.

4.2.7 The Chairperson is also the link between Committee members and the General Manager, Māori Health of the West Coast District Health Board.

4.3 Co-opted Membership

4.3.1 Tatau Pounamu may co-opt additional members to the Tatau Pounamu from time to time, for specific Kaupapa for specific periods and purposes as it deems necessary to assist the Committee.

4.4 Sub Committees

4.4.1 Tatau Pounamu may form sub committees from time to time, from within its members and co-opt experts in the specified fields for specified periods and purposes as it deems necessary to assist the Committee.

5. Term of Office

Membership is determined as in Clause 4.

5.1 Members of this Committee will remain in office for the period of three years or until such time as:

5.1.1 A member resigns from the committee.

5.1.2 A member is removed from the committee either by its members or the appointing body

5.2 Accountability

5.2.1 Tatau Pounamu and its members are accountable to the respective bodies who appointed them i.e. Papatipu Rūnanga, in the case of the Māori community representatives to Tatau Pounamu.

5.2.2 The Tatau Pounamu Chair will ensure that performance reviews are conducted of the Tatau Pounamu members, annually or sooner if the Chair and appointing committee deems it necessary.

5.3 Attendance at Committee Meetings

5.3.1 West Coast District Health Board members and members of the public will be welcome to attend meetings. Tatau Pounamu will on occasion go in committee for discussion of a sensitive nature. These meetings will only be open to members and invitees.

5.4 Management Reporting

5.4.1 The West Coast District Health Board management will be responsible for providing information / reporting on issues requested by Tatau Pounamu to the West Coast District Health Board.

5.5 Administrative Support

5.5.1 The Māori Health Unit and chair of Tatau pounamu will be responsible for the co-ordination and facilitation of Committee meetings.

5.5.2 The Māori Health Unit will ensure adequate administrative support for Tatau Pounamu.

5.5.3 Internal secretarial, legal, financial, analytical and administrative staff will also support Tatau Pounamu.

6. Annual Workplan

6.1 Tatau Pounamu will develop an annual work plan that outlines planned activity for the year.

The annual work plan will be monitored at committee meetings and a report written against the set objectives bi-annually and annually. Key elements are:

6.1.1 Communication strategy – reciprocal reporting to statutory committees, primary health organisation and back to appointing bodies.

6.1.2 Prioritise Māori strategies/projects

6.1.3 Monitor Māori health gains

6.1.4 Joint Board / Manawhenua Advisory Group meetings scheduled

6.1.5 Budget management

6.1.6 Leadership and succession planning

6.1.7 Monitor Implementation of Maori Health strategies

7. Collective Responsibility

7.1 Members recognise that at times there may be tension between the concepts of collective accountability of Tatau Pounamu and individual accountability to Iwi/Maori.

Members agree to support and abide by the following principles:

7.1.1 Members may clearly express their Iwi views at Tatau Pounamu hui and endeavour to achieve a particular decision and course of action. However,

members accept that once a decision has been formally reached by Tatau Pounamu, this decision is binding.

7.1.2 It is inappropriate for a member to undermine a decision of Tatau Pounamu once made, or to engage in any action or public debate, which might frustrate its implementation.

7.1.3 Individual members will not attempt to re-litigate previous decisions at subsequent Hui, unless a majority of members agree to re-open the korero.

7.1.4 Members' personal actions should not bring Tatau Pounamu into disrepute or cause a loss of confidence in the activities and decisions of Tatau Pounamu.

8. Tatau Pounamu Agendas

8.1 Requests for Items to be placed on Tatau Pounamu Agendas

8.1.1 Members with a request for an item to be placed on the Agenda must notify the minute secretary no later than 48 hours prior to the hui. Personal agenda items; members must seek the support of its appointing body prior to it being placed on the agenda.

8.1.2 No new items will be accepted on the agenda, but placed on the agenda for the next scheduled meeting.

8.1.3 It is accepted that at times certain kaupapa will command priority. In these instances Tatau Pounamu will exercise its' own discretion and proceed accordingly.

8.1.4 The Agenda will be structured to ensure that decision papers have priority with information papers included under a separate section.

9. Behaviour and Attendance

9.1 Behaviour and Attendance at Hui

9.1.1 Members undertake to have read and familiarise themselves with the minutes of the previous Hui.

9.1.2 Members will only make a point if it has not already been raised and is relevant to the kaupapa.

9.1.3 Members will not interrupt each other or talk while another member is speaking.

9.1.4 Issues will be raised in an objective manner -no personal reference or innuendo will be made to persons associated with the matter being raised.

9.1.5 Members will endeavour to achieve closure on one point before another point is raised.

9.1.6 ~~No~~ Cell phones will be on silent during Tatau Pounamu hui.

9.1.7 Members, the Chair and the General Manager of Māori Health will endeavour to clarify questions, issues, and requests before taking actions or responding.

9.1.8 Will not use their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducements and which could compromise the Mana of Tatau Pounamu.

9.1.9 Will exercise care and judgement in accepting any gifts, and advise the Chair and/or the Tatau Pounamu of any offer received.

9.1.10 Non-attendance at three (3) consecutive hui without extenuating circumstances is deemed unacceptable resulting in notification to the Chair of their Iwi/ appointing body of their unavailability along with a request for consideration for a replacement.

9.1.11 All members will assist the Chair to uphold the behaviour protocols agreed to by Tatau Pounamu.

10. Conflict of Interest

10.1 The New Zealand Public Health and Disability Act 2000 sets out the definition and procedure for disclosure of member's interests:

10.1.1 A member who is 'interested in a transaction' of the West Coast District Health Board must, as soon as practicable, disclose the nature of the interest to Tatau Pounamu.

10.1.2 The member must not take part in any deliberation or decision of Tatau Pounamu relating to the transaction.

10.1.3 The disclosure must be recorded in the minutes and entered in a separate interest's register.

10.1.4 Recognise that where an interest is declared (or where considered that there is a clear "perception of interest") the normal practice is for the member concerned to leave the room. Tatau Pounamu can, however, exercise it's discretion in allowing the member to remain. In such circumstances the member may have speaking rights but would not participate in any decision.

11. Public Statements

11.1 Communications from the committee with the public and the media will be subject to the following principles:

11.1.1 Only the Chairperson or delegated spokesperson may speak on behalf of Tatau Pounamu.

11.1.2 If a dissenting member is approached by the media for comment after a hui the member is bound by the general decision, but may expand on an issue or point raised personally by the member at that particular hui.

11.1.3 The focus is to remain on the issue and not personalised in any way that is critical of employees or other members of Tatau Pounamu.

11.1.4 Members will advise Tatau Pounamu if they are contacted by or intend to speak to the media.

11.2 Should an opinion be sought from the media members should:

11.2.1 Make clear the capacity in which they are speaking; i.e. personal views and not those of Tatau Pounamu.

12. Training

12.1 Members are required where possible:

12.1.1 To be familiar with the obligations and duties of a member of Advisory Committees and avail themselves of opportunities for training in areas deemed appropriate. This may include courses and or training provided by West Coast District Health Board.

13. Review

13.1 Tatau Pounamu may review these Terms of Reference at any time.

SIGNED ON BEHALF OF

THEIR RESPECTIVE ORGANISATIONS

Name: .....

Chairperson:.....

For Tatau Pounamu

Date: .....

Name: .....

Chief Executive Officer: .....

For West Coast District Health Board

Date: .....

Witnessed by: .....

Name: .....

Date: .....

COMMUNITY & PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEE MEETING UPDATE 20 MARCH 2014

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

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

DATE: **4 April 2014**

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 20 March 2014. Following confirmation of the minutes of the 20 March 2014 meeting at the 1 May CPH&DSAC Meeting, confirmed minutes will be provided to the Board at its 9 May 2014 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 – 20 March 2014.

3. SUMMARY

ITEMS OF INTEREST FOR THE BOARD

- **Community & Public Health Update**.
  This report provided the Committee with updates on: The Wildfoods Festival; Tobacco and Alcohol Controlled Purchase Operations; Drinking Water (results of the Annual Report on Drinking Water Quality 2012-13); Capital Assistance Programme Applications for West Coast Drinking Water Supplies; and Appetite for Life

  Discussion took place regarding water quality and the Committee noted that there are currently a lot of "boil water" notices in place. It was also noted this is a long and ongoing problem even though a fair amount of funding has been provided. Discussion also took place regarding there only being one more round of the government subsidy scheme in this area. It was noted that this funding is for the capital expense and does not cover any maintenance. The Medical Officer of Health advised that this is not just a West Coast problem but a national problem and we are needing to look at alternative ways that drinking water can be improved including improving people's ability to treat their own water.

- **Draft Community & Public Health Plan 2014-15**
  The Committee discussed this plan and suggested changes have been included in the draft presented to the Board today.

- **Planning & Funding Update**
  This report provided the Committee with an update on progress made on the Minister of Health's health and disability priorities and the West Coast DHBs Annual Plan key priority areas.

  Key Achievements
  - The West Coast continues to perform well above the 95% ED health target; results for the year to 28 February 2014 show that 99.8% of patients were admitted, discharged or transferred within 6 hours - and 96.8% within just 4 hours.
  - The West Coast has continued to achieve the cancer treatment health target throughout the first seven months of the 2013/14 financial year, with 100% of people ready for radiotherapy or chemotherapy beginning treatment within four weeks.
  - At the end of Quarter 2, the West Coast DHB B4 School Checks has exceeded the year-to-date target of 50% for both the high deprivation group (59%) and for total checks (51%).
  - The West Coast PHO exceeded the year-to-date target for completion of annual diabetes reviews, with 529 people with diabetes having had an annual review by 31 December (104% of year-to-date target). Māori results for the period was 106% of year-to-date target, with 53 checks having been completed. The year-end target is 70% for all population groups.

  Key Issues & Associated Remedies
  - 84% of eight-month-olds were fully immunised in Quarter 2– missing the new immunisation health target of 90% by just four children. With an 11.9% opt-offs or declines rate, this target continues to be challenging to meet. An implementation plan has been approved and work has commenced.

- Secondary care smokefree health target**:** It was disappointing that the West Coast DHB again did not reach the secondary care smokefree health target of 95%, with a result of 86% for Quarter 2. An action plan is in place and a January result of 94% is promising.

Upcoming Points of Interest

- Complex Clinical Care Network's pilot plan to support case mix 8 clients (those that show potential for short term rehab) is about to be rolled out to a limited number of clients.
- The Canterbury West Coast Well Child Network will focus on three indicators: increasing the number of children receiving all Well Child Tamariki Ora checks within their first year; increasing the number of mothers who are smokefree at two weeks postnatal and; increasing the number of children identified as at risk through the "Lift the Lip" program (oral health screening) with these children then being referred to specialist services.
- Mental Health integration across primary, community (NGO) and DHB services is continuing to progress with a similar peer support programme that ran weekly for eight weeks in 2013 being planned for Buller.

- **Maori Health Plan Update**
  This quarterly report is included in today's Board papers.

- **Health Target Report – Quarter 2**
  This report is also included in today's Board papers

- **Alliance Update**
  This report provided an update of progress made around the West Coast Alliance

  The report also provided the Committee with information on the Alliance Leadership Team; Annual Planning; Complex Clinical Care Network; Buller Integrated Family Health Service; Grey/Westland Integrated Family Health Service; Pharmacy; Healthy West Coast; and Child and Youth Workstream.

- **Committee Work Plan**
  The Committee discussed the draft work plan and noted this is a working document and will be updated each month and included in the information section of future meetings

- **General Business**
  Discussion took place regarding the Patient Journey and what part of this can be reported to this Committee. A Presentation on the complex Clinical Care Network will be added to the work plan as a starting point for this.

4. APPENDICES

Appendix 1: Agenda – Community & Public Health & Disability Support Advisory Committee – 20 March 2014

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

AGENDA

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
To be held in the Board Room, Corporate Office, Greymouth Hospital
Thursday 20 March 2014 commencing at 9.00am

ADMINISTRATION			**9.00am**
	Karakia		
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Meeting & Matters Arising** *28 November 2013.*		
3.	**Carried Forward/ Action Items**		
REPORTS/PRESENTATIONS			**9.10am**
4	**Community and Public Health Update**	Jem Pupich *Team Leader, Community and Public Health*	*9.10am - 9.25am*
5.	**Draft Community & Public Health Plan 2014-15**	Cheryl Brunton *Community & Public Health*	*9.25am – 9.40am*
6.	**Planning & Funding Update**	Ralph La Salle *Planning & Funding*	*9.40am – 9.55am*
7.	**Maori Health Plan Update**	Gary Coghlan *General Manager, Maori Health*	*9.55am – 10.05am*
8.	**Health Target Report – Q2**	Ralph La Salle *Planning & Funding*	*10.05am – 10.15am*
9.	**Quarterly Performance Summary Q1**	Ralph La Salle *Planning & Funding*	*10.15am – 10.25am*
10.	**Alliance Update**	Ralph La Salle *Planning & Funding*	*10.25am – 10.35am*
11.	**Draft 2014 Committee Work Plan**	Elinor Stratford *Chair*	*10.35am – 10.45am*
12.	**General Business** **- Patient Journey**	Elinor Stratford *Chair*	*10.45am – 10.55am*
ESTIMATED FINISH TIME			**10.55am**

INFORMATION ITEMS

- **Board Agenda – 13 December 2013**
- **Chair's Report to last Board meeting**
- **Health Target Report Q1 and Appendices (*as provided to the Board on 13 December 2013)***
- **West Coast DHB 2014 Meeting Schedule**

NEXT MEETING

Date of Next Meeting: Thursday 1 May 2014

HOSPITAL ADVISORY COMMITTEE MEETING UPDATE 20 MARCH 2014

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

SOURCE: **Chair, Hospital Advisory Committee**

DATE: **4 April 2014**

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 20 March 2014. Following confirmation of the minutes of the 20 March 2014 meeting at the 1 May 2014 HAC meeting, full minutes of the meeting will be provided to the Board at its 9 May 2014 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 – 20 March 2014.

3. SUMMARY

Detailed below is a summary of the Hospital Advisory Committee meeting held on 20 March 2014. 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.

MANAGEMENT REPORT

Michael Frampton, Programme Director, presented this report. He highlighted the following most notable features:

- Consistent performance continues in most health target areas;
- Allied Health proposal for change decision document released;
- ESPI compliance has remained during the period for both ESPI 2 and ESPI 5; and
- Recruitment for key positions continues.

The Committee discussed in detail the graphics summarising the Elective Patient Journey (provided for the information of Board members in the last Committee Chair's report) and also the Acute Patient Journey. These continue to be updated and improved and the Allied Health and Diagnostic Journey's will be added when they are able to be populated.

The Committee noted the excellent work being undertaken to achieve the Health Targets and commended staff for their efforts in this area.

The DHB still remains CLAB (Central Line Associated Bacterium) free. As at 3 March 2014 this has now been the case for 587 days.

Discussion took place regarding complaint trends. Mr Frampton advised that detailed information in relation to Clinical Incidents and any trends emerging from complaints are monitored by QFARC. Notwithstanding this, he advised that future HAC reports will contain information relating to any broad trends emerging from patient complaints relating to hospital services.

FINANCE REPORT

The Committee noted that financial trends remain the same as in previous months.

Management advised that the high level of cash to hand is due to a definite strategy around "business as usual" capital spending as we await the outcomes of the facilities development Business Case.

CLINICAL LEADERS UPDATE

Karyn Bousfield, Director of Nursing & Midwifery, presented this report which was provided to the Board at their last meeting.

A query was made regarding whether management could foresee any difficulties in filling vacancies. Ms Bousfield commented that from a nursing perspective only the usuall challenges were being experienced. Mr Frampton advised that the stabilisation of the Clinical Workforce, both in Primary Care and Hospital level services remains a top priority for the organisation. He specifically noted the more recent success within the General Practitioner workforce, evidenced by wait times for GP appointments being down to 2 days across most of the West Coast. He also commented on ongoing challenges in the Allied Health space. The Committee noted that clarity about facilities would be important for providing the kind of certainty that can only assist ongoing recruitment endeavours.

COMMITTEE WORK PLAN

The Committee discussed the draft work plan and noted this is a working document and will be updated each month and included in the information section of future meetings.

Members were asked to make any suggestions for further items to the Chair for consideration.

4. APPENDICES

Appendix 1: Agenda - Hospital Advisory Committee – 20 March 2014.

Report prepared by: Sharon Pugh Chair, Hospital Advisory Committee

AGENDA

WEST COAST DHB HOSPITAL ADVISORY COMMITTEE MEETING
To be held in the Board Room at Corporate Office, Grey Base Hospital, Greymouth
Thursday 20 March 2014 commencing at 11.00am

ADMINISTRATION			11.00am
	Karakia		
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Meeting** *28 November 2013*		
3.	**Carried Forward/Action Items**		

REPORTS/PRESENTATIONS			11.10am
4.	**Management Report**	Michael Frampton *General Manager, Hospital Services*	*11.10am - 11.30am*
5.	**Finance Report**	Justine White *General Manager, Finance*	*11.30am - 11.45am*
6.	**Clinical Leaders Report**	Karyn Bousfield *Director of Nursing & Midwifery*	*11.45am – 12noon*
7.	**2014 Committee Work Plan**	Sharon Pugh *Chair*	*12noon – 12.15pm*
8.	**General Business**	Sharon Pugh *Chair*	*12.15pm – 12.30pm*

ESTIMATED FINISH TIME	12.30pm

INFORMATION ITEMS

- **Chair's Report to last Board meeting**
- **Board Agenda – 21 February 2014**
- **West Coast DHB 2014 Meeting Schedule**

NEXT MEETING:

Date of Next Meeting: 1 May 2014
Corporate Office, Board Room at Grey Base Hospital.

RESOLUTION TO EXCLUDE THE PUBLIC

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

SOURCE: **Board Secretariat**

DATE: **4 April 2014**

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 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 21 February 2014	For the reasons set out in the previous Board agenda.	
2.	Chief Executive and Chair – Verbal 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)
3.	Clinical Leaders Verbal 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)
4.	Risk Mitigation Strategy Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
5.	Draft Annual Plan	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
6.	Draft South Island Health Services Plan	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)

7.	Mental Health Services Review	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)
8.	Resolution to Support Implementation Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
9.	Advisory Committee – Public Excluded Updates	For the reasons given in the Committee agendas	

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".

Report Prepared by: Board Secretariat

WEST COAST DHB – MEETING SCHEDULE

FEBRUARY – DECEMBER 2014

DATE	MEETING	TIME	VENUE
Thursday 20 February 2014	TATAU POUNAMU	2.00PM	Board Room, DHB Corporate Office
Friday 21 February 2014	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 20 March 2014	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 20 March 2014	HAC	11.00am	Boardroom, Corporate Office
Thursday 20 March 2014	QFARC	1.30pm	Boardroom, Corporate Office
Thursday 10 April 2014	TATAU POUNAMU	3.00pm	Poutini Waiora
Friday 4 April 2014	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 1 May 2014	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 1 May 2014	HAC	11.00am	Boardroom, Corporate Office
Thursday 1 May 2014	QFARC	1.30pm	Boardroom, Corporate Office
Thursday 1 May 2014	TATAU POUNAMU	3.00pm	Board Room, DHB Corporate Office
Friday 9 May 2014	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 12 June 2014	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 12 June 2014	HAC	11.00am	Boardroom, Corporate Office
Thursday 12 June 2014	QFARC	1.30pm	Boardroom, Corporate Office
Friday 27 June 2014	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 24 July 2014	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 24 July 2014	HAC	11.00am	Boardroom, Corporate Office
Thursday 24 July 2014	QFARC	1.30pm	Boardroom, Corporate Office
Thursday 24 July 2014	TATAU POUNAMU	2.00pm	Kahurangi Room, Grey Hospital
Friday 8 August 2014	BOARD	10.00am	West Coast Regional Council
Thursday 11 September 2014	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 11 September 2014	HAC	11.00am	Boardroom, Corporate Office
Thursday 11 September 2014	QFARC	1.30pm	Boardroom, Corporate Office
Friday 26 September 2014	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth
Thursday 23 October 2014	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 23 October 2014	HAC	11.00am	Boardroom, Corporate Office
Thursday 23 October 2014	QFARC	1.30pm	Boardroom, Corporate Office
Thursday 23 October 2014	TATAU POUNAMU	3.00pm	Board Room, DHB Corporate Office
Friday 31 October 2014	BOARD	10.00am	West Coast Regional Council
Thursday 27 November 2014	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 27 November 2014	HAC	11.00am	Boardroom, Corporate Office
Thursday 27 November 2014	QFARC	1.30pm	Boardroom, Corporate Office
Thursday 4 December 2014	TATAU POUNAMU	3.00pm	Board Room, DHB Corporate Office
Friday 12 December 2014	BOARD	10.00am	St Johns, Waterwalk Rd, Greymouth

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