West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Friday 26 September 2014
10.15am

St John
Waterwalk Road
GREYMOUTH

ALL INFORMATION CONTAINED IN THESE MEETING PAPERS IS SUBJECT TO CHANGE

WEST COAST DISTRICT HEALTH BOARD MEMBERS

Peter Ballantyne (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)*
Justine White *(General Manager, Finance)*
Lee Harris *(Senior Communications Advisor)*
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 at St John, Waterwalk Road, Greymouth
On Friday 26 September 2014 commencing at 10.15am

KARAKIA			***10.15am***
ADMINISTRATION			***10.20am***
	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** ▪ *8 August 2014*		
3.	**Carried Forward/Action List Items**		
REPORTS			***10.25am***
4.	**Chair's Update** **(Verbal Update)**	Peter Ballantyne *Chairman*	*10.25am - 10.35am*
5.	**Chief Executive's Update**	David Meates *Chief Executive*	*10.35am - 10.50am*
6.	**Clinical Leader's Update**	Dr Carol Atmore *Chief Medical Officer* Karyn Bousfield *Director of Nursing and Midwifery*	*10.50am - 11.00am*
7.	**Finance Report**	Justine White *General Manager, Finance*	*11.00am - 11.10am*
8.	**Maternity Review Update**	Mark Newsome *General Manager, Grey/Westland*	*11.10am - 11.25am*
9.	**2015 Schedule of Meetings**	Peter Ballantyne *Chairman*	*11.25am - 11.35am*
10.	**Health Target Report – Quarter 4**	Phil Wheble *Team Leader, Planning & Funding*	*11.35am - 11.45am*
11.	**Governance Responsibilities** **Health & Safety**	Greg Brogden *Senior Corporate Solicitor*	*11.45am – 12noon*
12.	**Report from Committee Meetings**		
	- CPH&DSAC *11 September 2014*	Elinor Stratford *Chair, CPH&DSAC Committee*	*12noon – 12.10pm*
	- Hospital Advisory Committee *11 September 2014*	Sharon Pugh *Chair, Hospital Advisory Committee*	*12.10pm – 12.20pm*
	- Tatau Pounamu Advisory Group *11 September 2014*	Elinor Stratford *Board Representative to Tatau Pounamu*	*12.20pm – 12.30pm*

13. **Resolution to Exclude the Public** *Board Secretariat* *12.30pm*

INFORMATION ITEMS

- 2014 Meeting Schedule

ESTIMATED FINISH TIME ***12.30pm***

NEXT MEETING

Friday 31 October 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

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

	Disclosure of Interest
Peter Ballantyne **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 • Temporary Acting Chair, Brackenridge Estate Limited
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 – Joint Chair • St John Youth Leader
Peter Neame	• President, Multiple Sclerosis Society, West Coast
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 • Trustee, Disability Resource Centre, Queenstown/West Coast • Elected Member, Arthritis New Zealand, Southern Regional Liaison Group
Sharon Pugh	• Shareholder, New River Bluegums Bed & Breakfast • Chair, Greymouth Business & Promotions Association

Joseph Thomas	• Chief Executive, Development West Coast • Ngati Mutunga o Wahrekauri Asset Holding Company Limited – Chair • Motuhara Fisheries Limited – Director • Management South Limited – Director • Ngati Mutunga o Wharekauri Iwi Trust – Trustee & Member • 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 the West Coast Regional Council, 388 Main South Road, Greymouth
on Friday 8 August 2014 commencing at 10.15am

BOARD MEMBERS

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

APOLOGIES

An apology for lateness was received and accepted from Susan Wallace (11.50am).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Michael Frampton (Programme Director); Dr Carol Atmore (Chief Medical Officer); Gary Coghlan (General Manager, Maori Health); Mark Newsome (General Manager, Grey/Westland); Stella Ward (Executive Director, Allied Health); Philip Wheble (Team Leader, Planning & Funding); Justine White (General Manager, Finance): and Kay Jenkins (Minutes).

Gary Coghlan led the Karakia.

1. INTEREST REGISTER

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

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest for 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 (34/14)
(Moved Elinor Stratford/seconded Helen Gillespie - carried):

"That the minutes of the Meeting of the West Coast District Health Board held at St John, Waterwalk Road, Greymouth on Friday 27 June 2014 be confirmed as a true and correct record.

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward items were noted.

4. CHAIR'S UPDATE

The Chair provided updates to the Board on the South Island Alliance Meeting held on 28 July 2014; and the Partnership Group Teleconference, 7 August 2014. He also advised that there is to be a National Chair's Strategy Meeting in Wellington on 13 August.

In regard to the filling of the vacant position on the Board it was noted that this will not take place until after the elections.

Resolution (35/14)
(Moved Peter Neame/seconded Michelle Lomax – carried)

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

5. CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented his report which was taken as read. He commented on the commitment of the DHB to "Live Within Our Means" and added one of the Board's commitments for the year was to ensure that this was achieved.

The Chief Executive also commented on the following:

- Access to Primary Care is also a priority and there was a deliberate strategy to improve this.
- Community Engagement – This is an ongoing process and further interactions will continue to take place in addition to the formal consultation processes.
- Buller IFHC – it has been agreed to engage with the community around this and the first of these meetings has already taken place.
- Reefton – a date has been confirmed and a media statement will be released today. It is important that the DHB works with the Community to achieve the best and most appropriate services.
- Facilities – A process is being worked through for an EOI for partners in the Buller project with a 3 week timeframe.

  The Chief Executive commented on the importance of some of the remedial action, particularly on the Grey Hospital site that has stood up to a number of tests and we can turn the power supply off with confidence that the backup system will work.

Discussion took place regarding norovirus and the reasons for restricted access and the disciplines and processes around this.

Discussion also took place regarding the writing off of debts for services provided.

Resolution (36/14)
(Moved John Vaile/seconded Sharon Pugh– carried)
That the Board:
i. notes the Chief Executive's update

6. CLINICAL LEADERS REPORT

Dr Carol Atmore, Chief Medical Officer, and Stella Ward, Executive Director, Allied Health presented this report which was taken as read.

They highlighted the following points:

- The Nursing Staffing Model which is work around changing the way we staff our hospital with the key part of this being getting ready for our new facilities.

- Rural Learning Centre – there is a lot of hard work taking place in this area and we are expanding our Rural Hospital Medicine Registrar positions for 2015.
- Over 50 staff have been trained in advanced resuscitation over the last 12 months with 37 staff undertaking the "train the trainer" course.
- The Chief Medical Officer presented to a Rural Health conference in Dunedin last month promoting the West Coast and encouraging people to come and work here.
- Allied Health has a focus on recruitment and a workshop was recently held in Christchurch which produced a number of ideas to be progressed.
- Community Pharmacy has been a concept which has taken a while to get going but is now making a difference and is part of the work stream for the Alliance.

A query was made regarding how new staff are orientated to understand what need to happen in the new facilities. The Board noted that there is a defined process around this also ensuring that new people who are coming here understand our integrated system.

Resolution (37/14)
(Moved Helen Gillespie/seconded Elinor Stratford – carried)
That the Board:
i. notes the Clinical Advisor's updates.

7. FINANCE REPORT

Justine White, General Manager, Finance, spoke to the Finance Report for June 2014 which was taken as read. The report advised that the consolidated West Coast District Health Board financial result for the month of June 2014 was a surplus of $0.043m, which was $0.002m unfavourable against the budgeted surplus of $0.045m. The year-end position is a deficit of $1.087m which is $0.013m favourable against budget. The Board noted that this is a provisional result which is currently being audited.

The Board congratulated management on the result achieved and asked that this be passed onto staff. They also acknowledged the collaboration with Canterbury.

Resolution (38/14)
(Moved Michelle Lomax/seconded Sharon Pugh – carried)
That the Board:
i. Notes the financial result for the period ended 30 June 2014

8. PRESENTATION – THE YEAR IN REVIEW AND THE YEAR AHEAD

Michael Frampton, Programme Director provided a presentation to the Board entitled "The Year in Review and the Year Ahead.

Susan Wallace joined the meeting at 11.50am

The Chair thanked Mr Frampton for his presentation.

9. MAORI HEALTH PLAN UPDATE

Gary Coghlan, General Manager, Maori Health, presented this report which was taken as read. He commented that good progress is being made.

Resolution (39/14)
(Moved Joseph Thomas/seconded Sharon Pugh – carried)
That the Board:
i. Notes the Maori Health Plan Update

10. REPORTS FROM COMMITTEE MEETINGS

a) Elinor Stratford, Chair, Community & Public Health and Disability Support Advisory Committee provided an update from the Committee meeting held on 24 July 2014.

The update was noted

b) Sharon Pugh, Chair, Hospital Advisory Committee, provided an update from the Committee meeting held on 24 July 2014.

She mentioned in particular: the launch of the Maternity website; physiotherapy issues; the good news of a new GP in Reefton; DNA trends; and the Committees disappointment on the slow progress around transport issues.

The update was noted.

c) Elinor Stratford provided a verbal update on the Tatau Pounamu Advisory Group meeting held on 24 July 2014.

The update was noted.

12. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (40/14)
(Moved John Vaile/seconded Helen Gillespie – 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, 7, 8, 9, 10 & 11 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 27 June 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.	Delegations for Annual Accounts	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
6.	Audit Arrangements Letter – Year Ended 30 June 2014.	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
7.	Maternity Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
8.	All of Government Printing Contract	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
9.	Committee Membership	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)
10.	HBL – National Infrastructure Platform Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
11.	Advisory Committee – Public Excluded Updates	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)

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 12.20pm.

The Public Excluded section of the meeting commenced at 12.20pm and concluded at 3.00pm with a break for lunch between 1.15pm and 1.50pm.

_____ _____

Peter Ballantyne, Chair Date

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

WEST COAST DISTRICT HEALTH BOARD
CARRIED FORWARD/ACTION ITEMS AS AT 26 SEPTEMBER 2014

	DATE RAISED	ACTION	COMMENTARY	STATUS
1	21 February 2014	Maternity Review update.	Progress against review recommendations to be provided to the Board at alternate meetings. First Update provided on 27 June 2014.	Further update at today's meeting.
2.	4 April 2014	Telemedicine	Topic for Presentation when time allows.	Presentation when time allows.

CHIEF EXECUTIVE'S UPDATE

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

SOURCE: **Chief Executive**

DATE: **26 September 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 has been reorganised around the key organisational priorities that drive the Board and Executive Management Team's work programmes. Its content has been refocused 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

- **Mental Health Workstream:** The workstream continues to meet regularly while still in the early stages of setting priorities for the rest of this year. The current principal focus of the workstream is the development of a mental health service model for Buller that can be provided within an Integrated Family Health Service context. More broadly, the workstream is responsible for implementing the great majority of outcomes from the review of mental health services.
- **Rural Service Level Alliance:** The Rural Service Level Alliance has now been established with the Terms of Reference approved by the Alliance Leadership Team and the first meeting conducted on 6 August. The Rural SLA is now reviewing the funding model for rural practices, with implementation expected 1 January 2015. This will move funding from nationally decided criteria for rural funding to locally agreed distribution to better meet West Coast needs.

B: Build Primary and Community Capacity and Capability

Primary

- **General**
  - **Practice Management**: All Practice Managers will have completed *Collabor8* [lean thinking and leadership] training by the end of October. Monthly meetings continue to provide in-house training for the Practice Managers. The need for a clinical lead at Buller Medical remains key to the success of the management team and discussions continue to progress this.
  - **GP Recruitment:** Three GPs have been appointed for a mid-October start, two being fulltime at Buller Medical on 12 and 6 month contracts respectively, and a part-time GP at Greymouth Medical for 6 months. Two GPs have been offered contracts for South Westland in 2015. Waiting times for routine GP appointments remain routinely under two working days at all sites except Buller Health.
  - **Financial:** Work continues to develop a pragmatic solution to debt management.
  - **Documentation:** The integration of *GPdocs* as part of the wider WCDHB Policy and Procedure system continues.
- **South Westland Area Practice:** The roving Rural Nurse Specialist [RNS] position has been filled by a nurse who has a rural background in Australia and is working toward becoming a Nurse Practitioner. The South Westland RNS group is now fully staffed.
- **Rural Academic and Greymouth Medical:** Weekly meetings have been initiated between the Emergency Department [ED], Rural Academic General Practice and Greymouth Medical Centre in order to both understand the reasons for ED presentation and to strive to improve outcomes for this group of patients. A two week collection of activity data has been undertaken aimed at getting a greater understanding of work flows. This is crucial in unlocking efficiencies and in preparation for the move into an IFHC. In addition, one of the nurses is attending every multi-disciplinary team [MDT] meeting of the Complex Clinical Care Network; this supports the evolving model of care within the IFHC. The practices are also involved in the *Enhance Recovery After Surgery* [ERAS] project in regard to orthopaedic procedures [fractured neck of femur, hip and knee replacements]. The nurses are also working to improve PHO target results. Planning is underway for a patient newsletter for each season.
- **Reefton Health:**
  - The Practice Manager position remains vacant. The Practice Receptionist has resigned due to relocating and advertising has commenced.
  - Engagement with the staff, residents, relatives and the community commenced on 21 August. Stakeholder groups are currently being formed and will examine the future of health services for Reefton. The meetings held to date have received positive feedback.
  - The Nurse Entry to Practice [NETP] has finished her 6 months in the District

Nursing service; she is now in the general practice for the second 6 months of her placement.

- The review of the Clinical Services Manager position description and title has been completed. The title has changed to Reefton Nurse Manager.

Community-Based Services

- **Home Based Support Services [HBSS]:** Further work is occurring with Careerforce to explore development opportunities for our caregiving staff. Work is occurring with Reefton in an effort to standardise the Meals on Wheels service to Reefton clients. After hours service provision management has been strengthened to ensure continuity of care for clients in the event of staff illness, and to provide service for clients who are discharged over weekends.
- **Clinical Nurse Specialists [CNS]:** MedTech training is underway to help improve integration of services between the CNS group and the practices, which also includes High Street Medical Centre. The chemotherapy service is experiencing increasing volumes and is moving to three days per week on some weeks. Factors driving this increased demand include the availability of a wider range of chemotherapy agents that can be delivered on the Coast, as opposed to having to travel to a tertiary centre, and the fact that the Oncology Service is offering a larger range of chemotherapy agents to patients who are palliative with a view to improving pain control, and improving quality of life.
- **District Nursing [DN]:** A review of the requirement for on-call and the arrangements around that is occurring with a focus on palliative care and clients being able to remain at home. In regard to our evolving Model of Care becoming more community focused, there will be an increasing need for DN involvement in the home after hours. The evolution of the model of care and keeping people independent and well at home will require innovative thinking and planning as the input from District Nurses increases.
- **Public Health Nursing [PHN]:** Our PHN team is now at full strength with the appointment to the existing vacancy.
  - *School Based Health Services [SBHS]:* The MOU is being reviewed for year 9, decile 3 schools [Buller and Reefton]. The numbers and impact of offering all year 9 students a comprehensive assessment and referral service is also being investigated. The South Westland Area School is being supported and service provided by the Hokitika PHN.
  - *B4 School Checks [B4SC]:* The first meeting of the Clinical Advisory Group has been held. Terms of Reference have been set including a meeting schedule. This group is a local initiative which emerged from the West Coast Alliance Child and Youth Workstream plan. The principal aim is to implement quality initiatives to enhance the delivery and outcomes from the service. The service has been in operation since 2007 and it was felt that a formal Clinical Advisory Group was needed to ensure a consistent direction for the B4SC programme.
  - *Neo-Natal Outreach:* This is a WCDHB initiative in consultation with and support from the CDHB Neonatal service and Dr John Garrett. It is developing well.

- *Well Child:* One of our PHN staff has commenced her Well Child [Plunket] training through Whitireia Polytechnic. Work is underway with Planning and Funding to review how we continue to provide this service within the guidelines with a small cohort of staff.

- **Moana Rural Nurse Specialist [RNS]:** This is the largest geographical area for RNS service provision with boundaries at Stillwater, Gloriavale, Arthurs Pass and the Taramakau Settlement. They have just recently taken delivery of one of the new DHB Suzuki all-wheel drive vehicles which is a vast improvement for them especially with the distances and the types of terrain that they cover. One of the nurses is presenting at the NZ Nurses Organisation conference later this month on "Rural Nursing Pushing the Boundaries".

C: Implement the Maori Health Plan

- **DNA Project:** The objective of this work is to increase outpatient clinic attendance rates to 95% for Maori and non-Maori. An implementation plan has been developed led by Acting Nurse Manager Clinical Services, Maori Health, Manager of Central Booking Unit and the Emergency Department Manager. The purpose is to reduce the number of DNA for the whole population on the West Coast with a special focus on Maori. Patient non-attendance at outpatient clinics is a significant problem resulting in a waste of resources and patients forgoing medical care which they require. Although the overall 'Did Not Attend' or DNA rate at the West Coast DHB has reduced over recent years, there is certainly scope for improvement, and the DNA rates of Maori is about twice that of non-Maori. It is well documented that Maori have poorer health outcomes with significantly higher mortality and morbidity rates than non-Maori.

- **Rangatahi Work Placement – West Coast DHB 17-19 September 2014:** A rangatahi/youth work placement programme is being organised in September by the Maori health team with assistance from Mokowhiti consultancy. Kia Ora Hauora is a Ministry of Health funded initiative which is led by Tumu Whakarae - General Managers of Maori Health. This is the first time the work placement programme has been offered on the Tai Poutini and is a fantastic opportunity for our rangatahi. It is available to year 12/13 students who have expressed an interest in health as a career. Work is occurring with secondary schools and Tai Poutini Polytechnic. There has been great interest in the programme which will offer up to twelve placements. The students will receive presentations and visit the following services both within the hospital setting and in the community; Maternity, Social work, Laboratory, Paediatrics, PHO, CPH Westland Medical Centre, Poutini Waiora, Physio and Occupational Therapy.

West Coast Health Alliance – Workstream workplans

- **Child and Youth Workstream:** Pregnancy and Parenting Education plan with a special focus on improving attendance of Maori, Pacific and younger women has been finalised. There is now a lot of scope to revisit the way in which parenting programmes are delivered for Maori. The Breastfeeding Implementation Plan has now been developed and finalised.

- **Healthy West Coast - Maori Smoking Cessation:** Progress has been made within the plan in the following areas:

- Stoptober: the first stop smoking month in NZ will begin in October
- Joe Mason has been working with practices to phone Maori who have not been offered brief cessation advice
- WERO challenge: the aim is to have several teams ready to go for the March round
- Approached Kaihautu at Poutini Waiora to identify a potential champion within the organisation for cessation, also to identify potential clients for Stoptober and to increase the number of Kaimahi who are trained in ABC [smoking cessation brief advice]
- Incentivisation project has been approved to try to increase the number of pregnant Mums who continue to smoke during pregnancy

- **Te Whare Oranga Pai:** An implementation plan will be developed and approved by Healthy West Coast for Te Whare Oranga Pai to enable a service specification to be developed and a contract offered. This is one-off funding aimed at providing intensive support for Maori who are at risk of poor health outcomes due to inactivity and poor nutrition.
- **Poutini Waiora:** The Organisational restructure for Poutini Waiora with recruitment and reorientation of several positions is well underway. The Kaihautu has been working with the DHB senior nurses to develop a formal clinical support agreement for the Kaupapa Maori Nurses and to identify opportunities that will ensure that levels of clinical proficiency are maintained. In addition, the intention is to develop a more inclusive and supportive structure for the Kaupapa Maori nurses.
- **Treaty of Waitangi and Maori Health workshop:** The Maori health team ran a full day Treaty of Waitangi and Health Inequalities workshop this month. There was a total of eighteen staff with the majority being clinicians from many different services within the hospital. The morning focused on the Treaty of Waitangi from a health context and in the afternoon we shifted focus to health inequity and the use of Inequality Assessment tools. We broke into working groups with each group identifying a service relevant to them and then applying a condensed version of the Health Equity Assessment Tool [HEAT]. Feedback has been positive particularly with the focus group session providing a practical context. This training is a key way to improve mainstream awareness and the workshop offers a practical way for participants to consider health equity and awareness of inequality within their jobs.

	DELIVERING MODERN FIT FOR PURPOSE FACILITIES

A: Facilities Report

- **Current Activity includes:**
  - Business as usual at all sites with emphasis on working through infrastructure issues and liaising with design teams for the new developments. This week saw the start of the Grey Hospital Redevelopment consultation work streams and Facilities Maintenance are very pleased to be having an input.

- The roofing membrane on the McBrearty Block, Wards 3 & 4 and the Community Services building all need repairs due to lack of adhesion to the substrate and breaking up of the membrane. This work is expected to commence shortly.

- The WCDHB incinerator requires refractory maintenance in the very near future and a scheduled outage will be required to perform this work. This incinerator is key for the Hospitals waste management and has discharge consent until 2035 with the repairs estimated at $15k.

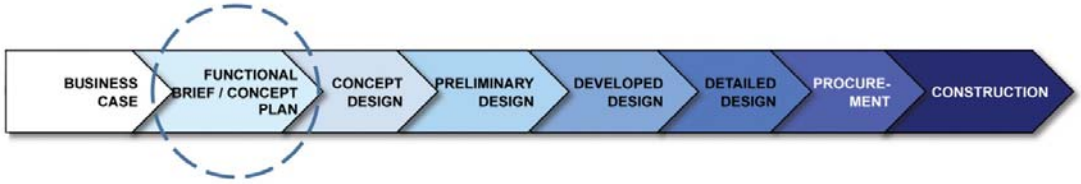
- Community Services/Mental Health Building developed a significant leak in its Sprinkler System but there was very little water damage due to the swift actions of local staff. The Insurers and the fire service were notified of the fault and system was drained and repaired within 24hrs.

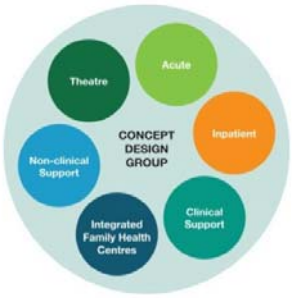
- The SCADA Computer which controls the steam boiler failed and had to be replaced without any impact on the operational safety of the plant.

- The Tender Submissions for Fire Monitoring for a joint CDHB/WCDHB contract is being evaluated at the moment and work is ongoing to align the other service contracts where possible.

- 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 are currently working on this project.

B: Facilities Case Update





- Work has now commenced with the Partnership Group and NHB and in relation to the next steps in the design processes for both Grey and Buller.
- Health planner, architect, QS and project management contractors have now been appointed for the next stages in the Grey design process, and the first round of clinical engagement workshops were held on 11 / 12 September.
- In relation to Buller, we are currently evaluating responses to the Expression of Interest process for Buller facilities development. In the meantime, the Buller IFHS workstream continues to focus on bringing to life service improvements that will be further enabled by the new IFHC facility.

A: Hospital Services includes Secondary Mental Health Services

Hospital Services

- **Nursing**
  - Recruitment continues to be positive with a high standard of applicants.
  - Continue to recruit for a Clinical Nurse Educator.
  - The *Dedicated Education Unit* [DEU] was formally opened and is working well. Nursing students have integrated well into the workforce and are enjoying the relationships they are building with the teams within Grey Hospital.
  - Background planning and preparation has begun in preparing the nursing workforce for different ways of working as we work toward a new facility.
  - New graduates have now moved into new areas and are progressing well.
- **Quality**
  - The Clinical Nurse Managers [CNM] are concentrating on quality activities, such as ward based resources, and are taking an active lead in auditing and reminding staff of their documentation responsibilities.
  - *MEWS* and *PEWS* [Modified Early Warning Score and Paediatric Early Warning Score] and ISBAR [a standardised communication tool – Identity, Situation, Background, Assessment, Request/Recommendation] teaching sessions are underway for all general staff at Grey Hospital, with Buller and Reefton to be included. Feedback from these sessions is positive.
  - The *Shorter Stays Quality Framework Initiative* for the Emergency Department has been implemented. This is a Ministry of Health quality requirement. There have been some challenges in collecting the required data that needs to be reported on, but work continues to embed this.
  - Concentration on documentation standardisation continues throughout the hospital, with improvement noted.
  - Planning for the Christmas/New Year period [19 December to 11 January] has been finalised. This will allow some staff to take well deserved breaks, excess annual leave to be used, and a more efficient use of resources over this traditionally quiet period for planned activity.
  - Train the trainers has now been completed and nurses are moving out to their workplaces training those staff who need CPR training. Core training continues with good numbers going through, with planning underway so that the SMO group can be included.
  - The Trendcare update is being implemented this month. The falls risk

component will be utilised within the tool as it has been successful in a number of other DHBs. As well as an excellent data capture and reporting tool, the falls risk will help populate the care plans which will release additional time for nursing.

- Work on five key priorities for improving the performance of our health system continues as we look to bring to life our vision of a safe, sustainable, integrated and viable health care system. Progress on these priorities is as follows:

  ✓ **Making most efficient use of our resources:** Implementation of a plan to reduce the number of Do Not Attend [DNA] patients for specialist assessment and surgery has started and a team is progressing on the implementation plan for improved discharge planning.

  ✓ **Ensure we are delivering our services in the right ways:** A team is exploring opportunities to bring care currently delivered in Canterbury that could be delivered on the Coast. Currently this is focused around ENT surgery which has previously been delivered on the Coast.

  ✓ **Building the capacity of primary care:** Work continues to build primary care into a solid foundation for delivering care on the Coast, improving access and continuity of care for people on the Coast.

  ✓ **Accelerating preparations for working differently in new facilities:** We now know that we will have new facilities in Grey and Westport and preparation is underway to develop how we will work in those new facilities and start working in this way now.

  ✓ **Continue innovations across nursing, medical and allied health professionals:** Looking at how we can continue the innovation across our workforce, exploring how we might work differently in the new facilities.

- **Maternity Services**

  - Good progress continues to be made in the implementation of the maternity review recommendations.

  - Proposals for change for the community midwifery service in Grey are being consulted on. This proposes disestablishing the DHB employed case-loading midwives, and moving to a self-employed LMC model with support from the DHB. The proposal for change for Buller has been finalised.

  - A Midwifery Educator position has been appointed on a fixed term contract.

Mental Health Services

- **Evaluation of the Mental Health Primary Liaison role in Buller Medical Centre:** In May 2013 a Registered Mental Health Nurse was employed by the Mental Health Service, but was located in the Buller Medical Centre as part of the new way of working within an integrated model. The purpose of having this nurse embedded within the practice was to contribute to the provision of accessible mental health services for the Buller region. Ten months after this role was established a review has been undertaken on the effectiveness of this role, with

outcomes that included a reduction in the referrals to the Specialist Community Mental Health team and the PHO Brief Intervention team.

- Buller Medical Centre staff were extremely positive in their feedback when surveyed for their perception of the usefulness of this new role as it provided support to the wider practice team in the management of emerging and existing mental health and addiction problems.
- The embedding of a mental health specialist nurse within the practice team has worked extremely well and provides a model for this role to be established in other Integrated Family Health Services throughout the Coast.
- **The Mental Health workstream**: The workstream has met fortnightly since 1 July 2014 to drive the implementation of recommendations from the 2013 review. Initial actions focussed on establishing the workstream, its connections with stakeholders and strengthening relationships with CDHB. Now the emphasis is on development of a locality based model for providing mental health and addiction services in Buller within the wider context of the IFHS. This involves finding a means of providing most services [including crisis resolution and respite] locally in partnership with other health, social services and the wider community. This will reduce wait times for services provided from Greymouth, create more opportunity for early intervention and create alternatives to inpatient admissions.
- Members of the workstream are meeting with Buller Health workers, other agencies, service users and families to seek input into the planning process. This work will result in a model that will be a basis for other communities with variation according to local needs.

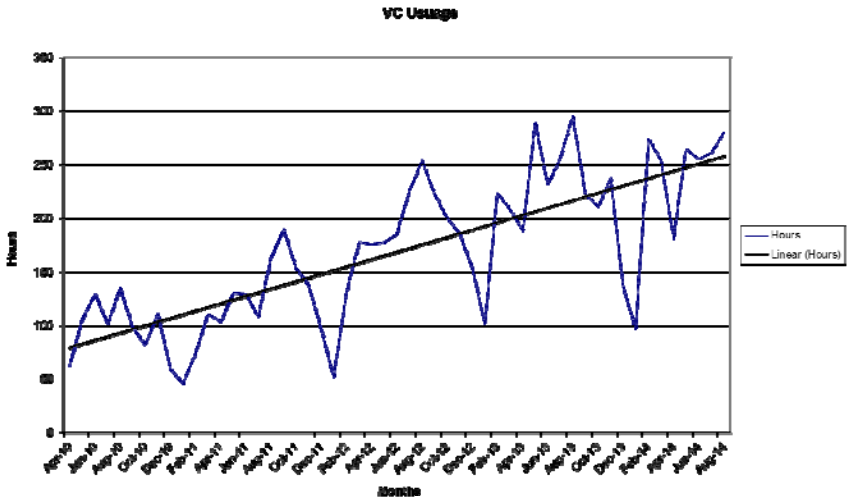
	**DEVELOPING TRANSPORT AND TELEMEDICINE SERVICES**

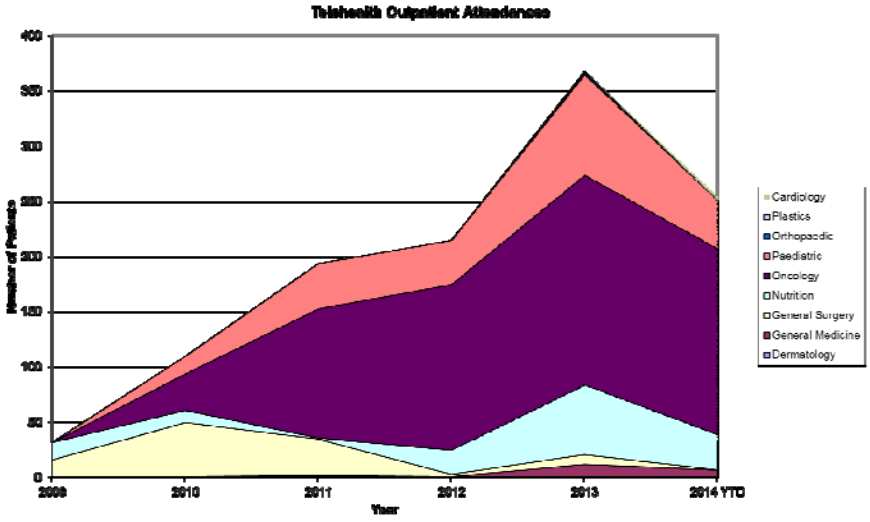
A: Improve Transport Options for Planned [Ambulatory] and Unplanned Patient Transport, Within and Beyond the West Coast

- Negotiations are coming to completion with St John as part of a South Island-wide joint DHB approach for the provision and pricing of non-acute ambulance transport services for inter-hospital patient transfer. The model that will be used for the West Coast has been finalised and only a few issues in other regions need to be addressed prior to completion. The next meeting of the group is scheduled for mid-September.
- During the 2013-14 financial year, 308 people used the Red Cross Buller Community Transport service between Westport and Greymouth.

B: Champion the Expanded use of Telemedicine Technology

- WCDHB has expanded its video conferencing capacity considerably within the last several years; see below graph for monthly usage details.





INTEGRATING THE WEST COAST HEALTH SYSTEM

A: Implement the Complex Clinical Care Network [CCCN]

- Work continues on the *Rapid Rehab* model and how it interlinks with Acute Demand and Primary Care. The next phase is bringing together a working party to ensure that we have the appropriate skills to deliver the model of care.
- The Buller Community Stakeholder Group had its first meeting on 24 August with over 30 people attending. The key focus of this meeting was to agree the Terms of Reference, discuss what works well and the perceived challenges for older person's health in the Buller Community. A second meeting was held on 4 September with discussions focused around community based options for older person's health. The next public meeting will be held on 16 September which will include feedback from the Buller Community Stakeholder Group meetings.

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

- The Buller IFHS workstream is focusing on:
  - Systems that ensure people presenting to the Buller IFHS without an appointment access the right care in a timely way.
  - An implementation plan for the new model of care proposed for community mental health services in Buller.
  - Improving case coordination and discharge planning.
- In addition the Buller IFHS planning group is identifying aspects of the IFHS concept plan that need further consideration prior to the detailed design phase of the building project.

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

- The process of undertaking risk profiling and stratification of the West Coast population has begun. Community engagement has begun in Reefton to understand how services can be best delivered to that community in the future.
- Clinical Nurse Specialists across the Coast now have access to the Primary Care MedTech system allowing for easier communication with the Health Care Home.
- Greymouth General Practices have begun the process of tracking and analysing practice activity by completing a two-week survey of patient and telephone activity types. This will help inform decisions around possible shared resources in the IFHC.
- A practice trialling allocated time for doctor triage has, as a result, adopted this process. Their learnings will be shared with the workstream for consideration of possible adoption in other practices.
- The preferred option for an electronic patient portal [online access to appointment booking and repeat prescription ordering] has been decided with implementation due by end of Quarter 2. The preferred option for an electronically shared-care-pathway visible across the system has also been identified and implementation set for end of Quarter 4.

	BUILDING CAPACITY TO TRANSFORM THE SYSTEM

A: Live Within our Financial Means

- The consolidated West Coast District Health Board financial result for the month of July 2014 was a deficit of $0.163m, which was $0.158m unfavourable against the budgeted deficit of $0.005m.

	Monthly Reporting			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
	$'000	$'000	$'000	$'000	$'000	$'000
Governance Arm	0	0	0	0	0	0
Funder Arm	658	51	607	658	51	607
Provider Arm	(821)	(56)	(765)	(821)	(56)	(765)
Consolidated Result	(163)	(5)	(158)	(163)	(5)	(158)

B: Implement Employee Engagement and Performance Management Processes

- An options paper has been prepared for the 2014 employee engagement survey and will be presented to EMT in September.
- The majority of IEA employees now have access to the online performance management tool. Maternity are preparing to migrate from their current manual process to the online tool during September/October and are highly engaged in this.

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 kick off for the project has now occurred. The steering group is meeting regularly and includes clinicians from both WCDHB and CDHB. Go live is tentatively planned for the end of year.
- **eSCRV:** The electronic Shared Care Record View [eSCRV] project has kicked off with initial planning with the Pegasus Health team occurring mid-September. This project will radically improve the integration between primary and secondary services by facilitating seamless access to patient information between both primary and secondary systems with appropriate security and robust auditing. Go live is tentatively planned for end of year.
- **Windows XP replacement:** All DHBs need to have replaced or provided risk mitigation strategies for any Windows XP desktops in their organisation by April 2014. IT has 9 remaining desktops to do with all laptops being completed, down from 161 units originally. The remaining desktops are more complex machines but are prevented from accessing the internet as a risk mitigation. The 9 remaining desktops are being worked through as quickly as possible.
- **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 and remote access system, move to a new mail system, replacements of some legacy computer terminals and improvements to the Medtech32 system to increase stability. Medtech performance improvements have now being implemented. A new printer contract with the same provider CDHB uses has been approved. Planning is underway for a full printer replacement before the end of year.

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

Implementing a Grassroots Strategy

- The grassroots strategy is an important way for the DHB to communicate directly with community organisations across the Coast. Programme Director Michael Frampton has presented at recent meetings with Grey Power in Buller and Lions in Greymouth. Further Buller, Hokitika and Karamea meetings are being organised, including Buller Rotary in September and Buller REAP in October, plus Greymouth Grey Power in the next couple of months.
- A community meeting in Reefton last month began the engagement over the future of Reefton health services.
- A full communications and engagement strategy has been developed to support a series of 'community conversations' in Buller on Older Persons' Health. The first community meeting fronted by David Meates, Chief Executive attracted around 60 people and included a lively discussion about health services. Mr Meates and Programme Director Michael Frampton spoke to staff prior to the meeting, and also met the Buller District Council that day to discuss the project.

Other External Communications

- The spring issue of *Report to the Community* – the West Coast health system's community update – is now underway with a plan to distribute in October.
- The new Maternity Services web page was launched at the end of June on the WCDHB website.
- The senior communications advisor met with the South Island communications manager and engagement manager for Housing New Zealand. We discussed improving relationships to encourage better outcomes for our shared customers/patients. At some stage over the next few months a visit to the West Coast is envisaged by the CE of Housing NZ, which will include discussions with DHB staff about our interactions with people in need of social housing.
- Working with the Mental Health Awareness Week group [involves multiple providers and users], assisting with communications.
- Part of a project team looking at the redevelopment of the WCDHB website. Updating the website will greatly assist us in ensuring the community has an easily accessible and user-friendly place to get correct information.

Internal Communications

- The Internal Communications Advisory Panel provides the communications team with valuable 'grass roots' information and are able to champion key messages within the organisation. The panel met recently and discussed objectives and Terms of Reference; set up a group to assist with reviewing content of our current website in anticipation of transferring to a new website.
- A small team are working on improving the content, look and feel of the internal staff intranet pages.
- Staff are regularly contributing to the CE Update which is produced every two/three weeks.

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:
  - Reefton community invited to discuss health services
  - West Coasters encouraged to get vaccinated
  - WCDHB health targets improve
  - New E-Incident Management Project Kicks into Action! [South Island Alliance media release]
  - Vulnerable urged to get flu shots
  - Countdown Kids hospital appeal
  - West Coast leads Australasia in system fight against infections

Reactive Media Relations

- Issues commented on this month included responses to questions around:
  - Facilities redevelopment – Grey and Buller
  - Influenza
  - Health of Older Persons in Buller
  - Midwifery services
  - Fluoride in the water
  - 1080
  - GP/staffing in Buller

Engagement with Key Influencers

- As well as formal speaking engagements, we will also be looking for opportunities for the Programme Director and Coast-based General Managers in particular, to meet with local leaders throughout the Coast. These are opportunities to share important information about the West Coast Health System.

	PROMOTING HEALTHY ENVIRONMENTS AND LIFESTYLES

Key Achievements/Issues of Note

- **Drinking Water Subsidies:** Four West Coast communities were successful in obtaining Ministry of Health funding from the recent 2013/14 round of drinking-water subsidies. No West Coast applications were declined.

Applicant name	Water supply name	Project cost	Approved funding
Buller District Council	Karamea	$1,686,310	$1,433,364
Grey District Council	Kaiata	$1,144,973	$973,227
Buller District Council	Inangahua	$222,740	$189,329
Buller District Council	Waimangaroa	$473,692	$402,639

- Due to the poor condition of many West Coast community water supplies this is a very pleasing outcome. Community and Public Health will be working closely with Councils as these projects are implemented.
- **Alcohol Policies in Schools:** The Medical Officer of Health has made presentations to the Principals' Association and Education West Coast about alcohol-related issues. The topics discussed included alcohol policies, special licences, whether alcohol has a place at school fundraising events, the provisions of the Gambling Act relating to alcohol, and the changes to legislation around supply of alcohol to under 18 year olds. CPH will assist schools wanting to develop alcohol policies.
- **Mental Health Awareness Week:** "Keep Learning" is the theme for this year's Mental Health Awareness Week [6-12 October]. There will be opportunities across the West Coast for people to try out new activities and keep learning. Activities confirmed to date include Tai Chi, yoga, knitting and crochet. People are being encouraged to share their talents and skills with others to support everyone's wellbeing.
- **Stoptober:** The West Coast Tobacco Free Coalition is supporting Stoptober, the 31 day stop smoking challenge being held around New Zealand during October. Advertising and events are focussed on getting people who smoke to sign up to quit by 1st October. People are being encouraged to sign up at www.stoptobernz.co.nz. The key message is for people to get support to help them stop smoking. On the West Coast we will be promoting Stoptober in the streets of Greymouth and Hokitika in September. There will also be stop smoking support groups running in Greymouth and Westport.

DELIVERING HEALTH TARGETS AND SERVICE DEVELOPMENT PRIORITIES

Target	Q1 *13/14*	Q2 *13/14*	Q3 ***13/14***	Q4 ***13/14***	Target	Current Status	Progress
Shorter Stays in ED Patients admitted, discharged or transferred from an ED within 6 hours	99.8%	99.8%	99.6%	99.6%	95%	✓	The West Coast DHB continues to achieve impressive results against the **Shorter Stays in ED Health Target**, with **99.6%** of patients admitted, discharged or transferred from ED within six hours during Quarter 4. Data for the 12 month period 2013/14 financial year shows 96.6% were admitted, discharged or transferred within just four hours.
Improved Access to Elective Surgery West Coast's volume of elective surgery	434 YTD	795 YTD	1,182 YTD	1,695	1,592	✓	The West Coast DHB is pleased to have surpassed our year-end **Improved Access to Elective Surgery Health Target** of 1592 by 6.5%, having delivered **1,695 discharges** in the twelve months to 30th June 2014.
Shorter Waits for Cancer Treatment People needing cancer radiation therapy or chemotherapy having it within four weeks	100%	100%	100%	100%	100%	✓	The West Coast DHB has achieved the **Shorter Waits for Cancer Treatment Health Target** for the 2013/14 financial year, with **100%** of people ready for radiotherapy or chemotherapy beginning treatment within four weeks.
Increased Immunisation Eight-month-olds fully immunised	85%	84%	89%	81%	90%	✗	Although only vaccinating 81% of our eligible children for **the Increased Immunisation Health Target** we vaccinated 99% of consenting children. High opt-off and declines [18.4%], continue to be challenging in meeting this target.
Better Help for Smokers to Quit **Hospitalised** smokers receiving help and advice to quit	93%	86.2%	92.5%	95%	95%	✓	During Quarter 4, West Coast DHB staff provided **95%** of hospitalised smokers with smoking cessation advice and support –meeting the **Secondary Care Better Help for Smokers to Quit Health Target**. It is pleasing to see Quarter 3's upward trend continue. Work continues to increase consistency of results.
Better Help for Smokers to Quit Smokers attending **primary** care receive help and advice to quit	58%	59.9%	55.4%	61.9%	90%	✗	While we are still 28% off target and ranked last out of all DHBs against the **Primary Care Smokers Better Help to Quit Health Target**, we had a pleasing 6.5% increase this quarter that represents our best result yet. Actions previously reported continue, with monthly practice by practice reporting expected to provide visibility for which practices need most support.
More Heart and Diabetes Checks Eligible enrolled adult population having had a CVD risk assessment in the last 5 years[5]	64%	66.4%	69.6%	76.6%	90%	✗	Performance against the **More Heart and Diabetes Checks Health Target** continues to steadily increase with 76.6% of the eligible enrolled West Coast population having had a cardiovascular risk assessment in the last five years. While this is an encouraging 7% increase, West Coast DHB is still below the national average, ranked 19th out of 20 DHBs. Work continues to meet target.

Report prepared by: David Meates, Chief Executive

CLINICAL LEADERS UPDATE

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

SOURCE: **Clinical Leaders**

DATE: **26 September 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

Workforce
Transalpine health service development will be the focus of a workshop between Canterbury and West Coast clinicians in early October, with a view to charting the course for service development over the next 2 or 3 years.

The commencement of the Maternity Educator has enabled a significant amount of midwifery education to be achieved over the last three months, including team training for Buller services, epidural certification and smoking cessation promotion.

Two new graduate nurses have commenced, these are the first mid-year intake we have been able to support and are part of the ongoing plan for a sustainable workforce and growing our own.

Quality and Safety
A recent workshop involving the Quality team and senior leadership of WCDHB, to identify areas of greater collaboration to improve patient safety and quality in the services we provide.

Patient Safety Walkarounds are commencing shortly, where senior clinical leaders and managers visit clinical areas to focus on patient safety activities at the 'coal face'.

Facilities Planning
The first round of the next phase of planning for the new Grey Hospital and Integrated Family Health Centre commenced mid September, with good representation from clinical teams in the workstreams. This planning work will last into the first half of next year, and clinician involvement in this process is paramount to the design of a successful facility for our future health services.

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 Bousfield, Director of Nursing & Midwifery

FINANCE REPORT

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

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

SOURCE: **General Manager, Finance**

DATE: **26 September 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 31 July 2014.

3. DISCUSSION

Overview of July 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 District Health Board financial result for the month of July 2014 was a deficit of $0.163m, which was $0.158m unfavourable against the budgeted deficit of $0.005m. The breakdown of July's result is as follows.

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,889	6,957	(68)	×	6,889	6,957	(68)	×
Governance & Administration	187	188	(1)	×	187	188	(1)	×
Funds & Internal Eliminations	4,786	4,536	250	√	4,786	4,536	250	√
	11,862	11,681	181	√	11,862	11,681	181	√
EXPENSES								
Provider								
Personnel	4,391	4,541	150	√	4,391	4,541	150	√
Outsourced Services	878	481	(397)	×	878	481	(397)	×
Clinical Supplies	747	612	(135)	×	747	612	(135)	×
Infrastructure	1,162	842	(320)	×	1,162	842	(320)	×
	7,178	6,476	(702)	×	7,178	6,476	(702)	×
Governance & Administration	187	188	1	√	187	188	1	√
Funds & Internal Eliminations	4,128	4,485	357	√	4,128	4,485	357	√
Total Operating Expenditure	11,493	11,149	(344)	×	11,493	11,149	(344)	×
Surplus / (Deficit) before Interest, Depn & Cap Charge	369	532	(163)	×	369	532	(163)	×
Interest, Depreciation & Capital Charge	532	537	5	√	532	537	5	√
Net surplus/(deficit)	**(163)**	**(5)**	**(158)**	×	**(163)**	**(5)**	**(158)**	×

4. APPENDICES

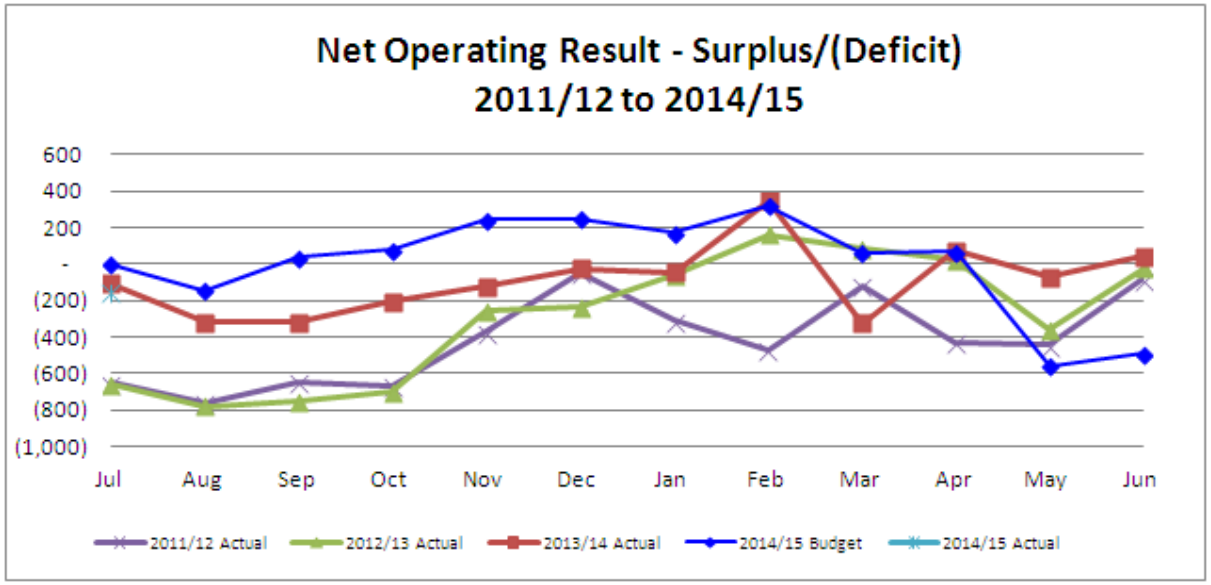
Appendix 1:	Financial Results for the period ending 31 July 2014
Appendix 2:	Statement of Financial Performance – July 2014
Appendix 3:	Statement of Financial Position – July 2014
Appendix 4:	Cashflow – July 2014

Report prepared by: Justine White, General Manager: Finance

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – JULY 2014

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	(163)	(5)	(158)	3160% ✗	(163)	(5)	(158)	3160% ✗

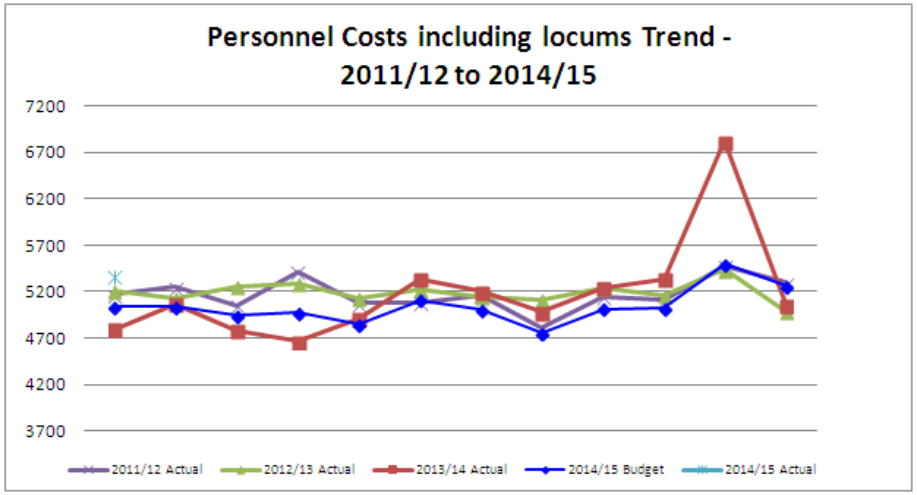


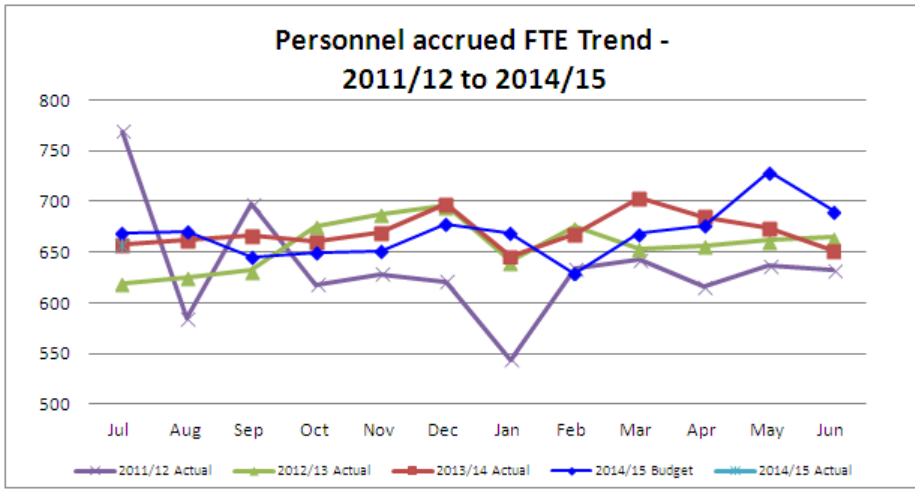
We have submitted an Annual Plan with a breakeven position.

KEY RISKS AND ISSUES

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

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

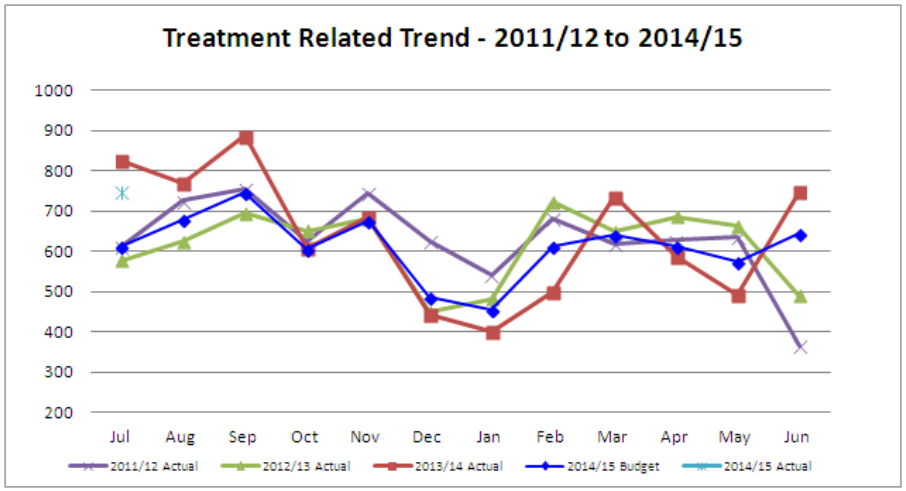


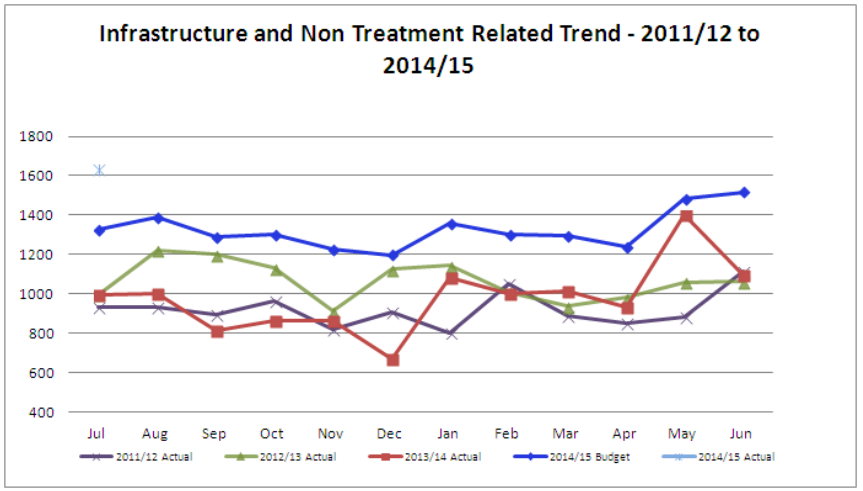


KEY RISKS AND ISSUES

Although better use of stabilised rosters and leave planning is in the process of being embedded within the business, the results have been slower to transpire than originally anticipated. This is further exacerbated by unexpected turnover which has required more reliance on short term placements, which are more expensive than permanent staff.

TREATMENT & NON TREATMENT RELATED COSTS

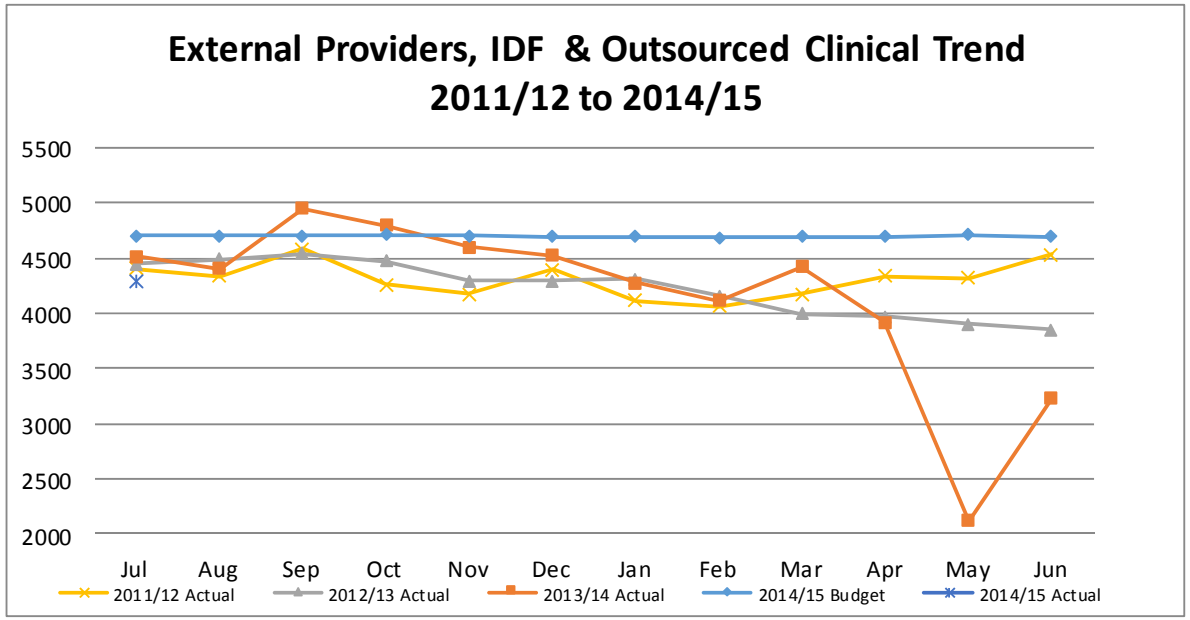




KEY RISKS AND ISSUES

Treatment related costs tend to be managed within predicted levels; we are continuing to refine contract management practices to generate savings in these areas.

EXTERNAL PROVIDER COSTS



KEY RISKS AND ISSUES

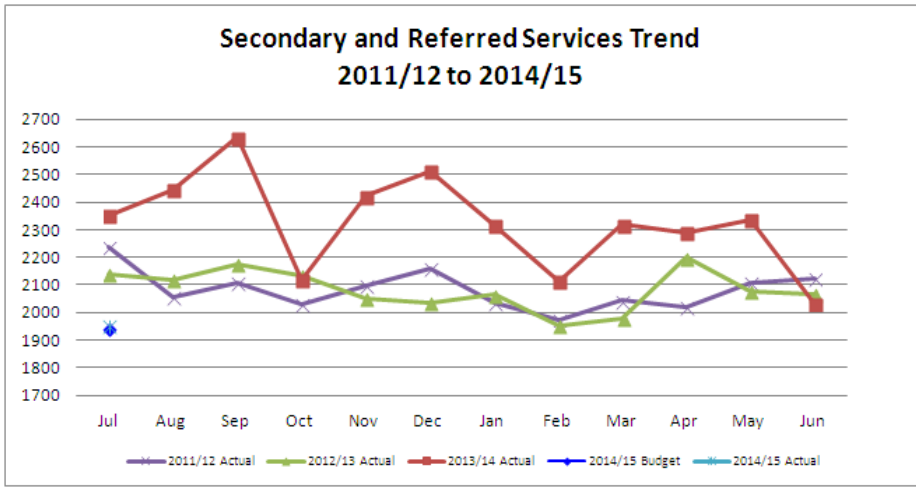
Capacity constraints within the system require continued monitoring of trends and demand for services.

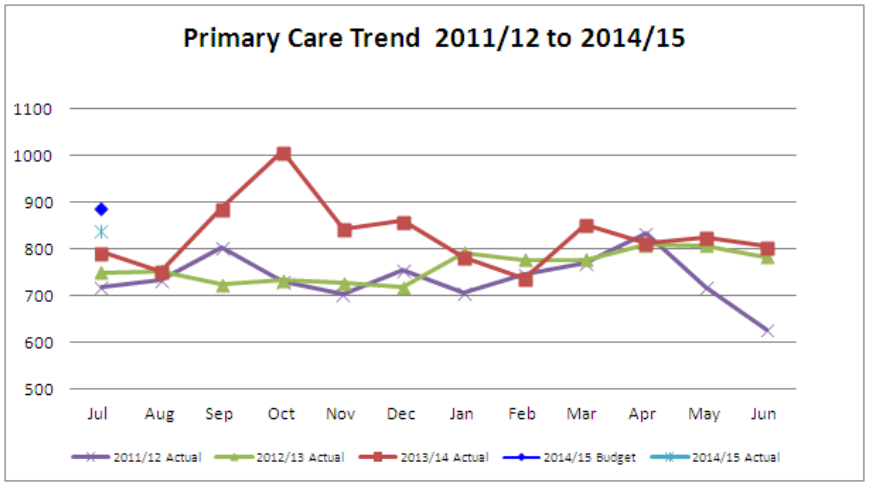
Funder Arm - Payments to External Providers

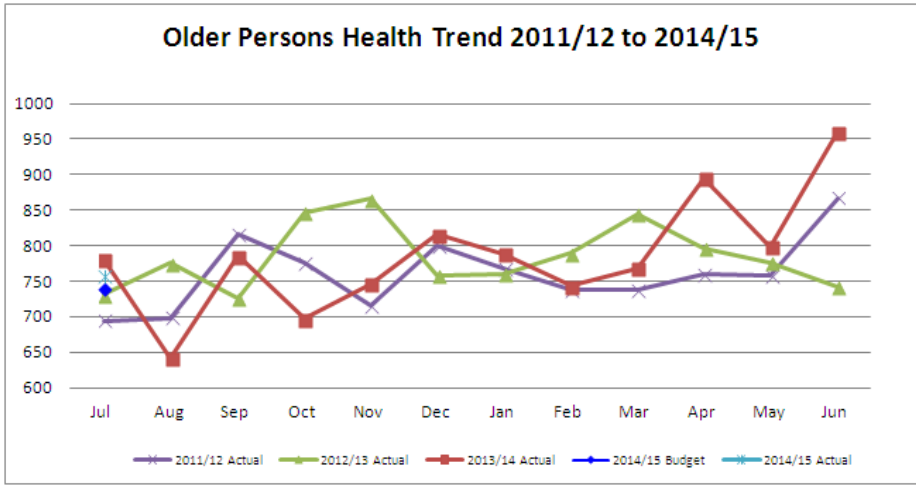
Month ended July 2014

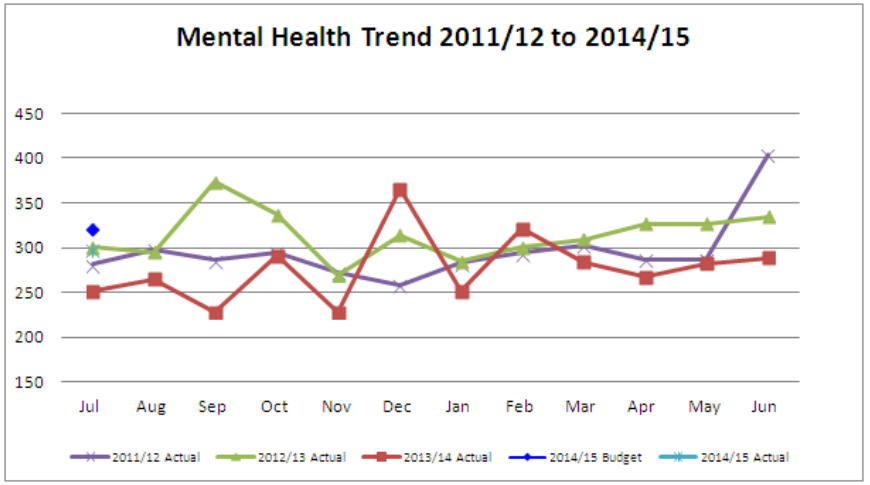
Current Month					SERVICES	Year to Date					2014/15 Annual Budget
Actual $000	Budget $000	Variance $000	%			Actual $000	Budget $000	Variance $000	%		$000
					Primary Care						
37	36	0	-1%	✗	Dental-school and adolescent	37	36	0	-1%	✗	434
	2	2	100%	✓	Maternity	0	2	2	100%	✓	20
	1	1	100%	✓	Pregnancy & Parent	0	1	1	100%	✓	8
	3	3	100%	✓	Sexual Health	0	3	3	100%	✓	33
2	3	1	48%	✓	General Medical Subsidy	2	3	1	48%	✓	36
495	522	26	5%	✓	Primary Practice Capitation	495	522	26	5%	✓	6,258
91	91	0	0%	✓	Primary Health Care Strategy	91	91	0	0%	✓	1,093
79	80	1	1%	✓	Rural Bonus	79	80	1	1%	✓	963
4	5	1	11%	✓	Child and Youth	4	5	1	11%	✓	59
4	8	3	42%	✓	Immunisation	4	8	3	42%	✓	153
5	5	0	1%	✓	Maori Service Development	5	5	0	1%	✓	58
52	53	1	1%	✓	Whanua Ora Services	52	53	1	1%	✓	634
15	18	4	19%	✓	Palliative Care	15	18	4	19%	✓	218
	0	0		✓	Community Based Allied Health	0	0	0		✓	0
7	9	2	19%	✓	Chronic Disease	7	9	2	19%	✓	106
47	54	7	13%	✓	Minor Expenses	47	54	7	13%	✓	647
839	**888**	**50**	**6%**	✓		**839**	**888**	**50**	**6%**	✓	10,722
					Referred Services						
24	24	-1	-3%	✗	Laboratory	24	24	-1	-3%	✗	283
651	658	7	1%	✓	Pharmaceuticals	651	658	7	1%	✓	7,961
676	**682**	**6**	**1%**	✓		**676**	**682**	**6**	**1%**	✓	8,244
					Secondary Care						
230	202	-28	-14%	✗	Inpatients	230	202	-28	-14%	✗	2,420
112	101	-11	-11%	✗	Radiolgy services	112	101	-11	-11%	✗	1,212
87	115	28	25%	✓	Travel & Accommodation	87	115	28	25%	✓	1,380
1,520	1,520	0	0%	✓	IDF Payments Personal Health	1,520	1,520	0	0%	✓	18,242
1,948	**1,938**	**-10**	**-1%**	✗		**1,948**	**1,938**	**-10**	**-1%**	✗	23,254
3,463	**3,508**	**45**	**1%**	✓	**Primary & Secondary Care Total**	**3,463**	**3,508**	**45**	**1%**	✓	**42,220**
					Public Health						
14	25	11	44%	✓	Nutrition & Physical Activity	14	25	11	44%	✓	298
6	7	1	17%	✓	Public Health Infrastructure	6	7	1	17%	✓	88
12	5	-7	-140%	✗	Tobacco control	12	5	-7	-140%	✗	58
-2	0	2		✓	Screening programmes	-2	0	2		✓	0
30	**37**	**7**	**19%**	✓	**Public Health Total**	**30**	**37**	**7**	**19%**	✓	**445**
					Mental Health						
7	7	0	1%	✓	Dual Diagnosis A&D	7	7	0	1%	✓	86
	2	2	100%	✓	Eating Disorders	0	2	2	100%	✓	23
20	20	0	1%	✓	Child & Youth Mental Health Services	20	20	0	1%	✓	243
5	5	0	1%	✓	Mental Health Work force	5	5	0	1%	✓	61
61	61	1	1%	✓	Day Activity & Rehab	61	61	1	1%	✓	735
11	11	0	1%	✓	Advocacy Consumer	11	11	0	1%	✓	130
81	82	1	1%	✓	Other Home Based Residential Support	81	82	1	1%	✓	982
11	11	0	1%	✓	Advocacy Family	11	11	0	1%	✓	134
10	29	19	66%	✓	Community Residential Beds	10	29	19	66%	✓	345
0	0	0	100%	✓	Minor Expenses	0	0	0	100%	✓	1
92	92	0	0%	✗	IDF Payments Mental Health	92	92	0	0%	✗	1,100
297	**320**	**23**	**7%**	✓		**297**	**320**	**23**	**7%**	✓	3,839
					Older Persons Health						
	0	0	100%	✓	Information and Advisory	0	0	0	100%	✓	1
	0	0		✓	Needs Assessment	0	0	0		✓	0
60	67	7	11%	✓	Home Based Support	60	67	7	11%	✓	784
8	9	1	16%	✓	Caregiver Support	8	9	1	16%	✓	107
260	216	-45	-21%	✗	Residential Care-Rest Homes	260	216	-45	-21%	✗	2,538
4	10	6	55%	✓	Residential Care-Community	4	10	6	55%	✓	120
344	349	5	2%	✓	Residential Care-Hospital	344	349	5	2%	✓	4,114
0	0	0		✗	Ageing in place	0	0	0		✗	0
9	10	1	7%	✓	Day programmes	9	10	1	7%	✓	118
11	18	7	38%	✓	Respite Care	11	18	7	38%	✓	220
1	1	0	1%	✓	Community Health	1	1	0	1%	✓	15
	0	0	100%	✓	Minor Disability Support Expenditure	0	0	0	100%	✓	3
58	58	0	0%	✗	IDF Payments-DSS	58	58	0	0%	✗	698
756	**739**	**-20**	**-3%**	✗		**756**	**739**	**-18**	**-2%**	✗	8,720
1,053	**1,058**	**4**	**0%**	✓	**Mental Health & OPH Total**	**1,053**	**1,058**	**6**	**1%**	✓	**12,559**
4,545	**4,603**	**58**	**1%**	✓	**Total Expenditure**	**4,545**	**4,603**	**58**	**1%**	✓	**55,223**

EXTERNAL PROVIDER COSTS









FINANCIAL POSITION

	Month Actual $'000	Month Budget $'000	Month Variance $'000			Annual Budget $'000
Equity	8,834	10,079	(1,245)	-12%	✗	72,537
Cash	5,041	5,521	(480)	-9%	✗	10,037

KEY RISKS AND ISSUES

APPENDIX 2: STATEMENT OF FINANCIAL PERFORMANCE

Statement of comprehensive income

For period ending 31 July 2014

in thousands of New Zealand dollars

	Monthly 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	11,431	11,209	222	2.0%	11,431	11,209	222	2.0%	134,509	131,279
Inter DHB Revenue	3	3	0	0.0	3	3	0	0.0	34	20
Inter District Flows Revenue	130	129	1	0.8%	130	129	1	0.8%	1,551	1,615
Patient Related Revenue	227	230	(3)	(1.3%)	227	230	(3)	(1.3%)	2,760	2,880
Other Revenue	71	110	(39)	(35.5%)	71	110	(39)	(35.5%)	1,323	1,237
Total Operating Revenue	11,862	11,681	181	1.5%	11,862	11,681	181	1.5%	140,177	137,031
Operating Expenditure										
Personnel costs	4,479	4,635	156	3.4%	4,479	4,635	156	3.4%	55,613	55,477
Outsourced Services	794	377	(417)	(110.6%)	794	377	(417)	(110.6%)	4,520	6,373
Treatment Related Costs	747	612	(135)	(22.1%)	747	612	(135)	(22.1%)	7,342	7,727
External Providers	2,876	2,934	58	2.0%	2,876	2,934	58	2.0%	34,757	34,383
Inter District Flows Expense	1,370	1,670	300	18.0%	1,370	1,670	300	18.0%	20,465	14,486
Outsourced Services - non clinical	130	129	(1)	(0.8%)	130	129	(1)	(0.8%)	1,548	1,608
Infrastructure and Non treatment related costs	1,097	792	(305)	(38.5%)	1,097	792	(305)	(38.5%)	9,491	12,225
Total Operating Expenditure	11,493	11,149	(344)	(3.1%)	11,493	11,149	(344)	(3.1%)	133,736	132,279
Result before Interest, Depn & Cap Charge	369	532	(163)	30.6%	369	532	(163)	30.6%	6,441	4,752
Interest, Depreciation & Capital Charge										
Interest Expense	66	114	48	42.1%	66	114	48	42.1%	1,364	713
Depreciation	398	327	(71)	(21.7%)	398	327	(71)	(21.7%)	3,937	4,373
Capital Charge Expenditure	68	96	28	29.2%	68	96	28	29.2%	1,140	753
Total Interest, Depreciation & Capital Charge	532	537	5	0.9%	532	537	5	0.9%	6,441	5,839
Net Surplus/(deficit)	(163)	(5)	(158)	(3160.0%)	(163)	(5)	(158)	(3160.0%)	0	(1,087)
Other comprehensive income										
Gain/(losses) on revaluation of property										
Total comprehensive income	(163)	(5)	(158)	(3160.0%)	(163)	(5)	(158)	(3160.0%)	0	(1,087)

APPENDIX 3: STATEMENT OF FINANCIAL POSITION

Statement of financial position

As at 31 July 2014

in thousands of New Zealand dollars

	Actual	Budget	Variance	%Variance	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	26,846	24,862	1,984	8.0%	26,996
Intangible assets	1,474	1,596	(122)	(7.6%)	1,517
Work in Progress	141	6,010	(5,869)	(97.7%)	74
Other investments	307	245	62	25.3%	227
Total non-current assets	28,768	32,713	(3,945)	(12.1%)	28,814
Current assets					
Cash and cash equivalents	5,041	5,521	(480)	(8.7%)	7,483
Patient and restricted funds	79	60	19	31.7%	79
Inventories	994	1,100	(106)	(9.6%)	1,010
Debtors and other receivables	6,818	4,218	2,600	61.6%	7,686
Assets classified as held for sale	136	136	0	0.0%	136
Total current assets	13,068	11,035	2,033	18.4%	16,394
Total assets	**41,836**	**43,748**	**(1,912)**	6.4%	**45,208**
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	10,695	10,695	0	0.0%	10,695
Employee entitlements and benefits	2,661	2,895	(234)	(8.1%)	2,636
Total non-current liabilities	13,356	13,590	(234)	(1.7%)	13,331
Current liabilities					
Interest-bearing loans and borrowings	3,750	3,750	0	0.0%	3,750
Creditors and other payables	7,073	7,548	(475)	(6.3%)	9,927
Employee entitlements and benefits	8,823	8,781	42	0.5%	9,203
Total current liabilities	19,646	20,079	(433)	(2.2%)	22,880
Total liabilities	33,002	33,669	(667)	(2.0%)	36,211
Equity					
Crown equity	69,661	70,761	(1,100)	(1.6%)	69,661
Other reserves	19,569	19,569	0	0.0%	19,569
Retained earnings/(losses)	(80,435)	(80,290)	(145)	0.2%	(80,272)
Trust funds	39	39	0	0.0%	39
Total equity	8,834	10,079	(1,245)	(12.4%)	8,997
Total equity and liabilities	**41,836**	**43,748**	**(1,912)**	**(4.4%)**	**45,208**

APPENDIX 4: CASHFLOW

Statement of cash flows

For period ending 31 July 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	13,753	11,632	2121	18.2%	13,753	11,632	2121	18.2%	139,589	131,187
Cash paid to employees	(5,667)	(5,043)	(624)	12.4%	(5,667)	(5,043)	(624)	12.4%	(60,505)	(61,481)
Cash paid to suppliers	(5,850)	(1,502)	(4,348)	289.5%	(5,850)	(1,502)	(4,348)	289.5%	(18,009)	(21,406)
Cash paid to external providers	(3,074)	(2,934)	(140)	4.8%	(3,074)	(2,934)	(140)	4.8%	(35,182)	(35,998)
Cash paid to other District Health Boards	(1,240)	(1,670)	430	(25.7%)	(1,240)	(1,670)	430	(25.7%)	(20,040)	(12,871)
Cash generated from operations	(2,078)	483	(2,561)	(530.2%)	(2,078)	483	(2,561)	(530.2%)	5,853	2,431
Interest paid	(66)	(114)	48	(42.1%)	(66)	(114)	48	(42.1%)	(1,364)	(781)
Capital charge paid	(68)	(96)	28	(29.2%)	(68)	(96)	28	(29.2%)	(1,140)	(897)
Net cash flows from operating activities	(2,212)	273	(2,485)	(910.3%)	(2,212)	273	(2,485)	(910.3%)	3,349	753
Cash flows from investing activities										
Interest received	43	49	(6)	(12.2%)	43	49	(6)	(12.2%)	588	608
(Increase) / Decrease in investments	0	(80)	80		0	(80)	80		(402)	0
Acquisition of property, plant and equipment	(273)	(4,062)	3789	(93.3%)	(273)	(4,062)	3789	(93.3%)	(48,740)	(1,987)
Acquisition of intangible assets	0	0	0	0.0	0	0	0	0.0	0	5
Net cash flows from investing activities	(230)	(4,093)	3863	(94.4%)	(230)	(4,093)	3,863	(94.4%)	(48,554)	(1,374)
Cash flows from financing activities										
Proceeds from equity injections	0	0	0		0	0	0		18,000	0
Repayment of equity	0	0	0		0	0	0		(68)	(68)
Cash generated from equity transactions	0	0	0		0	0	0		17,932	(68)
Borrowings raised	0	0	0		0	0	0		28,000	2,000
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		0	0	0		45,932	1,932
Net increase in cash and cash equivalents	(2,442)	(3,820)	1378	(36.1%)	(2,442)	(3,820)	1378	(36.1%)	727	1,311
Cash and cash equivalents at beginning of period	7,483	9,341	(1,858)	(19.9%)	7,483	9,341	(1,858)	(19.9%)	9,341	6,172
Cash and cash equivalents at end of year	5,041	5,521	(480)	(8.7%)	5,041	5,521	(480)	(8.7%)	10,068	7,483

MATERNITY REVIEW – UPDATE ON PROGRESS

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

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

SOURCE: **Programme Director**

DATE: **26 September 2014**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

At the West Coast DHB Board meeting on 27 June 2014, an update on progress to date against recommendations from the maternity review was provided. The Board noted progress and requested that quarterly updates be provided.

Attached as Appendix 1, is an updated report 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: Traffic Light Report on Progress

Report prepared by: Mark Newsome, General Manager Grey/Westland

✓ 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 a secondary obstetric service at Grey Base Hospital 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.	▪ *An Expression of Interest (EOI) has been placed on the GETS government tenders site. This EOI is seeking interested provider(s) for 24/7 facility coverage and emergency cover for Kawatiri. Significant work has been completed to address intrapartum transfer guidelines, neonatal retrieval guidelines and multi-disciplinary education. Work has also been completed with St. John to improve intrapartum transfer with a move to using the Emergency ambulance service rather than the DHB to DHB patient transfer service.*
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. Full engagement of clinical teams, professional bodies and community representatives will continue to contribute to the MOC development.* ▪ *The Buller workgroup formed to develop a MOC for Buller continues its work.*
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.	▪ *MDT workshop planned for Buller late in 2014.* ▪ *The recommendation to develop and fund a system of primary care referrals between GPs and midwives has been implemented Sept. 2014.*
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.	▪ *The staffing arrangement for Buller has been agreed with 24/7 cover. This includes a combination of Midwife and RN care, with a Midwife on call 24/7.* ▪ *Additional education has been organized for he Foote ward nursing staff for normal birth, neonatal resuscitation and obstetric emergencies.*

✓ 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*		Buller Health clinical leaders must ensure closer collaboration between all disciplines including joint education and simulation training.	▪ *MDT has been organised for Buller Health and WCDHB maternity service. This recommendation can be further strengthened to become business as usual once a clear direction for Kawatiri unit is cemented.* ▪ *A maternity services educator has been appointed for WCDHB.*
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 Buller Midwives for travel to Greymouth for births of their women.* ▪ *A model of facility cover for Buller is being sought through an EOI process on the GETS site to ensure a safe, sustainable service is provided.*
Transport & Patient Transfers			
1 YEAR *Due June 2014*		Development of an elective transfer policy for specific conditions [e.g. severe pre eclampsia or twins].	▪ *This is close to completion and has been added to the MQSP WCDHB operations group plan.*
6 MONTHS *Due Dec 2013*	✓	The current *Emergency In Utero Transfer Policy* needs clarification and refining.	▪ *Completed*
6 MONTHS *Due Dec 2013*	✓	The *Neonatal Transfer Policy* needs reviewing and updating.	▪ *Completed*
6 MONTHS *Due Dec 2013*	✓	Agreement reached with CDHB to determine the process for facilitation and responsibility of timely transfers.	▪ *Completed*
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.	▪ *Completed*
ONGOING	✓	Work with CDHB Birthing Suite Transport Coordinator to ensure CDHB staff have a clear understanding of the environment West Coast staff practice in.	▪ *This recommendation has become embedded as senior staff are aware of the environment West Coast DHB staff are working in.*

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

Status		Recommendation	Progress
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 retrieval is pending.	▪ *Training is occurring and continues to ensure all staff will have the required skills. Training is available both on the West Coast and in Canterbury.* ▪ *A WCDHB educator has been appointed and can embed these training sessions to occur on an annual basis.*
6 MONTHS *Due Dec 2013*		Clinical contingencies should be developed to cover options when weather conditions interfere with the above agreed plans.	▪ *A policy is currently being developed and this has been added to the MQSP operational plan.*
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*		FFN be introduced	▪ *FFN testing currently occurs at WCDHB. Parto-sure, the point of care test has not been approved for use at CDHB.*
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.	▪ *Transfer policy has moved maternity transfers to the EAS arm of St. John to expedite transfer by ambulance.*
6 MONTHS *Due Dec 2013*		Ensure the ability of St John's to provide a timely service whilst dependent on volunteers to provide this.	▪ *Ongoing and also closely linked to the South Island work underway with all DHB's investigating a more robust and workable patient transfer system. Move to EAS arm of St. John has also progressed this recommendation.*
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.	▪ *Work on a transalpine approach to service delivery is progressing.*
1 YEAR *Due June 2014*		A full departmental and individual credentialing process should occur.	▪ *Process for Credentialing currently being developed and to be implemented by end of 2014*

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

Status		Recommendation	Progress
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.	▪ *To link in with National Initiatives.*
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.	▪ *A consultation process around the proposal for change is underway for Greymouth is underway and feedback for this closes on Oct. 6th.*
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.*
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.	▪ *MQSP operations group have developed a maternity service quality plan.*
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].	▪ *Implementation of this system is significantly delayed nationally with no pilot successfully implemented to date.* ▪ *A meeting is taking place in Canterbury to discuss the project. A request for WCDHB to dovetail with the CDHB project has been made.*

SCHEDULE OF MEETINGS - 2015

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

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

SOURCE: **Board Secretariat**

DATE: **26 September 2014**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to seek the Board's confirmation and approval to a schedule of meetings for the Board and its Committees, both statutory and non-statutory, for the 2015 calendar year as required by the NZ Health and Public Disability Act 2000.

2. RECOMMENDATION

That the Board:

i. Adopts the schedule of meetings attached as Appendix 1 for 2015; and
ii. Confirms the delegation of authority to the Chief Executive, in consultation with the Chair of the Board and/or relevant Committee Chairperson, to alter the date, time or venue of a meeting, or cancel a meeting, should circumstances require this.

3. SUMMARY

The suggested meeting dates for 2015 are based on the same cycle of meetings as adopted by the Board December 2013 meeting.

Background

If a DHB does not adopt an annual schedule of meetings then, in terms of the New Zealand Public Health and Disability Act 2000 (the Act) and in accordance with Standing Orders (Clause 1.14.1), members are instead required to be given written notice of the time and place of each individual meeting, not less than ten working days before each meeting.

The adoption of a meeting schedule allows for more orderly planning for the forthcoming year for the Board, Committees and staff. The proposed schedule also serves as advice to members that the meetings set out on the schedule are to be held.

2015 Meeting Schedule

The suggested meeting dates for 2015 contained in Appendix 1 are based on the current cycle of meetings with Committee meetings on Thursdays and Board meetings on Fridays.

The proposed meeting cycle would apply to meetings of the Board, the Hospital Advisory Committee, Quality, Finance, Audit and Risk Committee and the Community and Public Health and Disability Support Advisory Committee.

In situations where additional meetings of the Board and its Committees are required, these will, in terms of the Act, be treated as special meetings. Notice of these meetings will be given to members in each case prior to the meeting. In addition, where workshops are required, which are not part of the regular meeting cycle, notice of these meetings will also be given to members prior to the workshop.

On rare occasions it may be necessary to alter the date, time or venue of a meeting or to cancel a meeting. It is recommended that the authority to do this be delegated to the Chief Executive in consultation with the Chair of the Board or the Committee Chairperson.

The proposed meeting schedule takes account of public holidays with meetings rescheduled as appropriate to avoid clashes and also Canterbury DHB meetings.

Meetings of the Board and its Statutory Committees will be publicly notified in accordance with Section 16 of Schedule 3 of the New Zealand Health and Disability Act 2000.

The proposed 2015 meeting schedule will be provided to all Committee meetings for the information of members.

4. APPENDICES

Appendix 1:	2015 Proposed Schedule of Meetings

Report prepared by:	Board Secretariat

DRAFT

WEST COAST DHB – MEETING SCHEDULE

JANUARY – DECEMBER 2015

DATE	MEETING	TIME	VENUE
Thursday 29 January 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 29 January 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 29 January 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 13 February 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 12 March 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 12 March 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 12 March 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 27 March 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 23 April 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 23 April 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 23 April 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 8 May 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 4 June 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 4 June 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 4 June 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 26 June 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 23 July 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 23 July 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 23 July 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 7 August 2015	BOARD	10.15am	St Johns Waterwalk Rd, Greymouth
Thursday 10 September 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 10 September 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 10 September 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 25 September 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 22 October 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 22 October 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 22 October 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 6 November 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth
Thursday 3 December 2015	CPHAC & DSAC	9.00am	Boardroom, Corporate Office
Thursday 3 December 2015	HAC	11.00am	Boardroom, Corporate Office
Thursday 3 December 2015	QFARC	1.30pm	Boardroom, Corporate Office
Friday 11 December 2015	BOARD	10.15am	St John, Waterwalk Rd, Greymouth

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

DRAFT

HEALTH TARGET REPORT QUARTER 4

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: **26 September 2014**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to present the committee with West Coast's progress against the national health targets for Quarter 4 (April-June 2014). The attached report 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 4 health target league table is attached as an Appendix.

2. RECOMMENDATION

That the Community and Public Health & Disability Support Advisory Committee:

i. notes the West Coast's performance against the health targets.

3. SUMMARY

In Quarter 4, the West Coast has:

- Achieved the **ED health target**, with 99.6% of people admitted or discharged within six hours. The West Coast is a leader in the country with consistent performance against this health target.
- Achieved the access to **elective surgery health target**, delivering 1,695 elective surgical cases against our 1,176 year-to-date 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.
- Achieved the **better help for smokers to quit (secondary) health target**, with 95% of hospitalised smokers receiving help and advice to quit.

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

- Although experiencing a decrease in results against the **increased immunisation health target**—vaccinating 81% of eight-month-olds this quarter, 99% of consenting children were immunised. High opt-off and declines (18.4%) continue to be challenging in meeting this target.
- Performance against the **more heart and diabetes checks health target** continues to steadily increase with 76.6% of the eligible enrolled West Coast population having had a cardiovascular risk assessment in the last five years. While this is an encouraging 7% increase, West Coast DHB is still below the national average, ranked 19th out of 20 DHBs.
- While we are still 28% off target and ranked last out of all DHBs against the **primary care better help for smokers to quit health target**, this is a pleasing 6.5% increase this quarter and our best result yet.

6. APPENDICES

Appendix 1:	Q4 1314 WC Health Target Report
Appendix 2:	Q4 1314 WC Health Ministry League Table

Report prepared by:	Libby Doran, Planning & Funding
Report approved by:	Carolyn Gullery, General Manager, Planning & Funding

National Health Targets Performance Summary

Quarter 4 2013/2014 *(April-June 2014)*

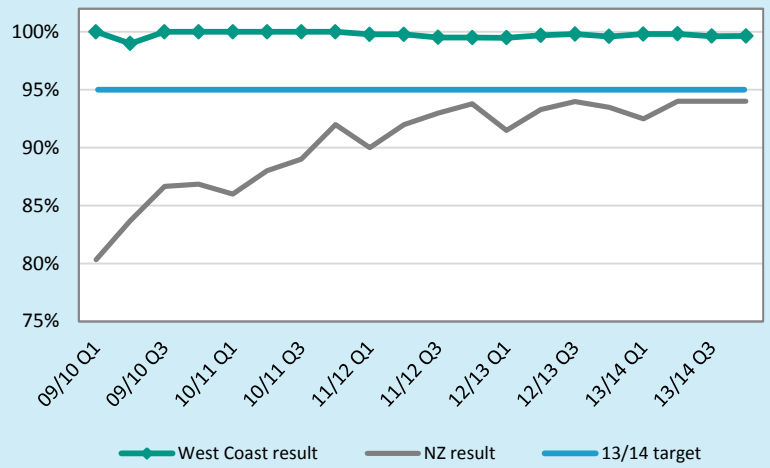
Target Overview

Target	Q1 *13/14*	Q2 *13/14*	Q3 *13/14*	Q4 *13/14*	Target	Status	Pg
Shorter Stays in ED Patients admitted, discharged or transferred from an ED within 6 hours	99.8%	99.8%	99.6%	99.6%	95%	✓	2
Improved Access to Elective Surgery West Coast's volume of elective surgery	434 YTD	795 YTD	1,182 YTD	1,695	1,592	✓	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	85%	84%	89%	81%	90%	✗	3
Better Help for Smokers to Quit **Hospitalised** smokers receiving help and advice to quit	93%	86.2%	92.5%	94.6%	95%	✓	4
Better Help for Smokers to Quit Smokers attending **primary care** receive help and advice to quit	58%	59.9%	55.4%	61.9%	90%	✗	4
More Heart and Diabetes Checks Eligible enrolled adult population having had a CV risk assessment in the last 5 years	64%	66.4%	69.6%	76.6%	90%	✗	5

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



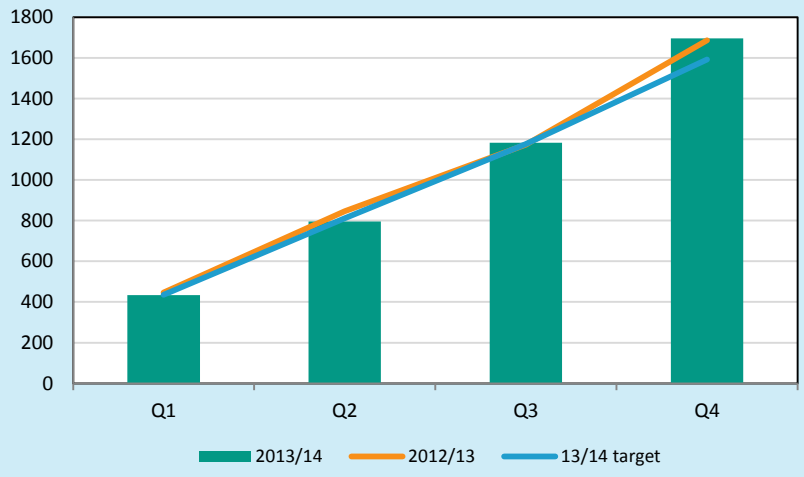
✔

The West Coast continues to achieve impressive results against the ED health target, with **99.6%** of patients admitted, discharged or transferred from ED within 6 hours during Quarter 4.

Improved Access to Elective Surgery

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

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



✔

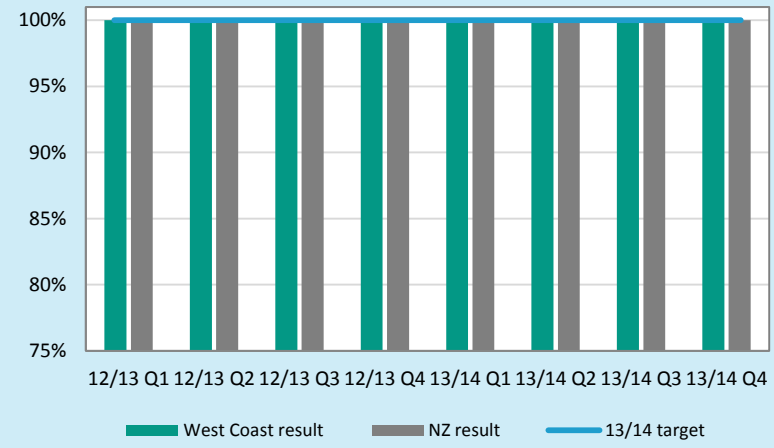
1,695 elective surgical cases were delivered to Coasters during 2013/14, representing **106.5%** of our year-end target delivery. We are pleased to have exceeded our target by 103 discharges.

[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]



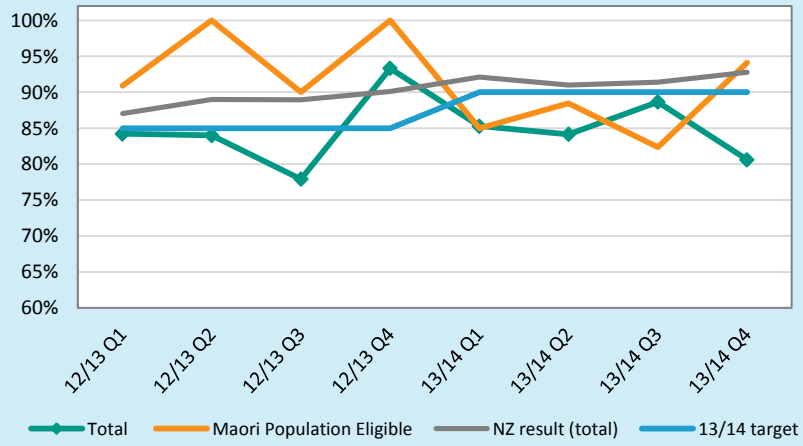
✓

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

Increased Immunisation

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

Figure 4: Percentage of West Coast eight-month-olds who were fully immunised



✗

Although we have not met the 8-month-old immunisation target this quarter, we have vaccinated 99% of consenting children. **81%** of all 8 month olds were fully immunised during the quarter, with only one child missing the milestone age. This child is now fully vaccinated.

Strong results were achieved for Pacific and Asian at 100% and NZ European and Maori performance both at 94%.

Opt-off[3] (15.3%) and declines (3.1%) made the target impossible to reach this quarter with a combined total of 18.4%. We continue to focus vaccinating 100% of reachable children.

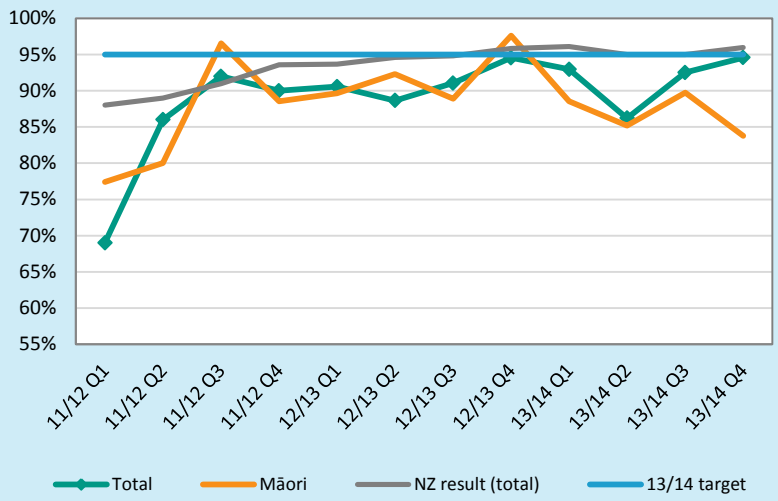
[2] This measure does not include instances in which a patient chooses to wait for treatment or there are clinical reasons for delay.

[3] 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.

Better Help for Smokers to Quit: *Secondary*

Target: 95% of smokers attending secondary care receive advice to quit

Figure 5: Percentage of smokers in West Coast DHB hospitals who were offered advice and help to quit smoking



✓

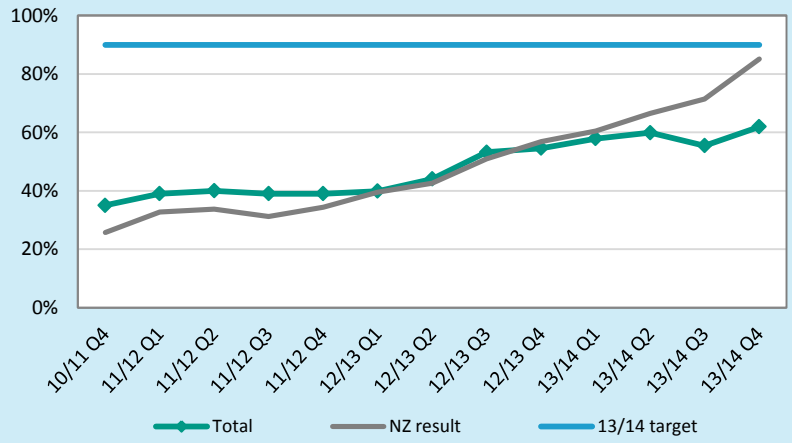
In Quarter 4, West Coast DHB staff provided **94.6%** of hospitalised smokers with smoking cessation advice and support –just meeting the 95% target.

While it is pleasing to meet the target following varied results during the year, work continues to increase consistency of performance during 2014/15.

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[4]



✗

West Coast general practices have reported giving **2,875** smokers cessation advice in the 12 months ending June 2014, representing 61.9% of smokers expected to attend general practice during the period. While this is a pleasing 6.5% increase on last quarter, we are still 28% off target and ranked last out of all DHBs in performance against this target.

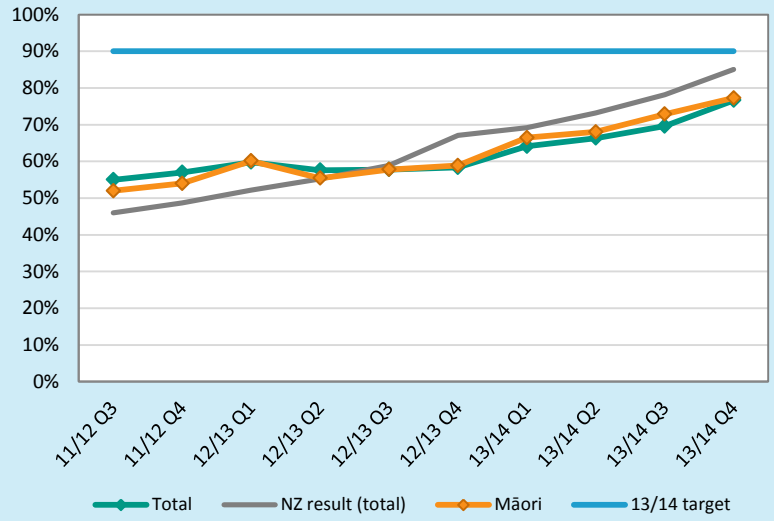
While previously reported actions continue, plans looking forward to the 14/15 year include the trial of IT tools such as the Appointment Scanner and Dashboard. These tools cannot be implemented until necessary upgrades have been made to local Medtech systems (planned for August 2014).

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

More Heart & 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[5]



Data for the five years to 30th June 2014 shows that West Coast general practices have continued to increase coverage, with **76.6%** of the eligible enrolled West Coast population having had a cardiovascular risk assessment (CVDRA)—a 7% increase.

While it is pleasing to have increased in performance throughout the year, we still have not met the target and rank 19th out of the 20 DHBs in performance against this target.

Continuing work includes; integration of Kaupapa Maori nurses; implementing specific nurse led CVDRA clinics at practices and our PHO having dedicated resource to commence capturing CVDRAs in absentia and increased coding of patients with a >20% risk of CVD.

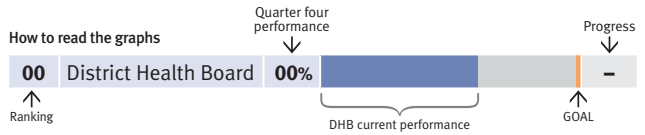
Progress on implementing the Primary Care Health Target Action Plan to support a more integrated approach to both primary care health targets continues, with progress monitored by the Healthy West Coast Alliance Workstream.

Following install delays, TXT2Remind was activated in Buller as a first step in implementation. Reefton practice has commenced the patient consent process as part of the next phase of its roll-out.

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

My District Health Board

2013/14 QUARTER FOUR (APRIL–JUNE) RESULTS



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

MINISTRY OF HEALTH
MANATŪ HAUORA

Shorter stays in Emergency Departments

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

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

95%

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 152,287 discharges for the 2013/14 year, and have delivered 9646 more.

		Quarter four performance (%)	Progress against plan (discharges)
1	Northland	125	▲
2	Lakes	114	▲
3	Taranaki	113	▲
4	Counties Manukau	112	▲
5	Waikato	111	▲
6	MidCentral	109	▲
7	West Coast	106	▲
8	Bay of Plenty	106	▲
9	Whanganui	106	▲
10	Southern	106	▲
11	Hutt Valley	106	▲
12	Tairawhiti	105	▲
13	Hawke's Bay	104	▲
14	South Canterbury	104	▲
15	Wairarapa	104	▲
16	Nelson Marlborough	103	▲
17	Waitemata	102	▲
18	Capital & Coast	101	▲
19	Auckland	101	▲
20	Canterbury	101	▲
	All DHBs	106	▲

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.

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

100%

Increased Immunisation

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 April and June 2014 and who were fully immunised at that stage.

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

90%

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.

* Waitemata DHB's result is 101 percent as, in addition to offering advice in primary care settings, they contacted patients who had not recently attended their general practice to offer them brief advice and support to quit smoking.

Change from previous quarter	Hospitals		Quarter four performance (%)	Primary care	Change from previous quarter
–	97	1	Waitemata*	101	▲
–	97	2	Auckland	100	▲
–	96	3	Counties Manukau	99	▲
▼	94	4	Wairarapa	98	▲
▲	99	5	South Canterbury	97	▲
▼	94	6	Northland	97	▲
▲	93	7	Bay of Plenty	88	▲
–	96	8	Taranaki	84	▲
▲	97	9	Tairawhiti	84	▲
–	96	10	Waikato	84	▲
–	93	11	MidCentral	81	–
–	99	12	Lakes	78	▲
–	98	13	Hawke's Bay	77	▲
▲	97	14	Whanganui	76	▼
–	95	15	Canterbury	75	▲
▲	96	16	Nelson Marlborough	75	–
▲	92	17	Capital & Coast	72	▼
–	95	18	Southern	71	▲
–	96	19	Hutt Valley	71	▲
▲	95	20	West Coast	62	▲
–	96		All DHBs	86	▲

95% 90%

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.

		Quarter four performance (%)	Change from previous quarter
1	Auckland	92	▲
2	Counties Manukau	91	▲
3	Whanganui	91	▲
4	Northland	90	▲
5	Waitemata	89	▲
6	Wairarapa	88	▲
7	Lakes	88	▲
8	Taranaki	88	▲
9	MidCentral	87	▲
10	Bay of Plenty	87	▲
11	Tairawhiti	86	▲
12	Capital & Coast	85	▲
13	Waikato	85	▲
14	Hawke's Bay	84	▲
15	South Canterbury	81	▲
16	Hutt Valley	81	▲
17	Nelson Marlborough	78	▲
18	Southern	78	▲
19	West Coast	77	▲
20	Canterbury	66	▲
	All DHBs	84	▲

90%

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

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

New Zealand Government

GOVERNANCE RESPONSIBILITIES HEALTH AND SAFETY

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

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

SOURCE: **Corporate Legal**

DATE: **26 September 2014**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

Following the Independent Taskforce on Workplace Health and Safety Report (the *Taskforce*) (attached as Appendix 1), the Government announced a package of reforms, which are the most significant change to our workplace health and safety system in the last 20 years. The purpose of this report is to inform the Board on these changes and seek Board endorsement of recommendations as to a future direction as detailed below.

2. RECOMMENDATION

That the Board:

i. Notes the detail contained in this report and appendices;
ii. Agrees that the following recommendations be adopted:
   a. Ensure that the West Coast DHB has a comprehensive Health and Safety Management Plan (the Plan), which is fit for purpose and reviewed regularly. The plan should be based on the guidelines set out in this paper;
   b. As part of that review, health and safety should be a standing agenda item at each Board meeting.
   c. Provide adequate resources for the plan to be implemented (if there are aspects that require implementation).
   d. Obtain independent advice on the effectiveness of the plan.
   e. Board members and management should receive education, via a seminar, by a suitably qualified organisation about governance responsibilities in relation to the new health and safety regime.

3. SUMMARY

The purpose of this paper is to provide the Board with an update on the New Zealand Workplace Health and Safety reforms and their implications for Employers and Directors together with an overview of actions being undertaken by management to support a smooth implementation.

4. DISCUSSION

Guidelines

The Ministry of Business, Innovation & Employment (*MBIE*), together with the Institute of Directors, has released Good Governance Practice Guidelines for Managing Health and Safety Risks (the *Guidelines*) (attached appendix 2). The Guidelines reflect the recommendations of both the Taskforce and of the Pike River Royal Commission. The Guidelines are a practical tool to assist Directors/Boards to meet their health and safety obligations, which is summarised as "exercising due diligence". The Guidelines set out clear and concise recommendations for adoption as best practice. They also reflect the need to improve New Zealand's workplace health and safety, through leadership and obligations from Directors/Boards.

The Guidelines are neither a statutory document nor a policy statement, but will be taken into account by MBIE and the Courts in any health and safety enforcement action against Directors or Officers of an organisation.

Legislation

The Government will be replacing the Health and Safety in Employment Act (*HSE*) with a new Health and Safety at Work Act. Even before the new law comes into effect, the Government has established a new agency for health and safety – Worksafe New Zealand, which started operating in December 2013.

The new legislation is expected to come into effect in April 2015. Key changes will include:

- A move from a hazards based system to a broader risks based analysis.
- Positive duties on Directors and Officers to understand organisational health and safety risks, and ensure the need that the organisation implements appropriate processes.
- Significant penalties for both the organisation and its Officers.
- A stronger framework for employee participation.

An overview of anticipated changes by way of a comparative table is attached (appendix 3)

Relevance to Earthquake Prone Buildings and Demolition/Construction

The new health and safety regime will have direct relevance to decision making around earthquake prone buildings, and also the systems and processes in place for the demolition of buildings and construction of new buildings. Both West Coast and Canterbury DHBs have in place a matrix for decision making on earthquake prone buildings. It is important that the significant work already done around that matrix continues, and that decisions are:

- Guided by expert advice.
- The rationale for the decision clearly documented.
- The Board has appropriate knowledge of the process so that it can confirm, or question the process.

There have been recent examples of asbestos being found in buildings, where this was not expected, either for the building as a whole or in a particular part of the building. This has highlighted matters including:

- The adequacy of our asbestos register.
- Staff training in recognising asbestos material.
- Who has responsibility for responding and managing the process when asbestos is located.

Under the new health and safety regime, there will be an expectation that Boards and Directors have assurance that appropriate systems and processes in place.

Conclusion

In anticipation of the pending legislation the following work is being undertaken by management, via a working group that has been established.

1. Governance framework and structure to be developed for approval by EMT
2. In parallel a stocktake is being undertaken organisationally to identify risks, to agree gaps that need to be addressed, develop plans to address gaps and risks, and to have a timeline for addressing these that will be reviewed regularly.

3. As the proposed legislation is based on the Australian experience knowledge and experience is being sourced from the Australian health sector to inform future recommendations to the Board.

6. APPENDICES

Appendix 1:	Independent Taskforce Report on Health and Safety
Appendix 2:	The Ministry of Business, Innovation & Employment (*MBIE*) and the Institute of Directors, Good Governance Practice Guidelines for Managing Health and Safety Risks
Appendix 3:	Comparison H&S in Employment Act 1992, and Proposed H&S at Work Legislation 2015

Report prepared by: Human Resources
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Independent Taskforce
on Workplace Health and Safety

THE REPORT OF THE INDEPENDENT TASKFORCE ON

WORKPLACE HEALTH & SAFETY

HE KOROWAI WHAKARURUHAU

EXECUTIVE REPORT

APRIL 2013

He Korowai Whakaruruhau

A protective cloak

He Whakatauki

"He korowai āta raranga
He korowai whakaruruhau,
Mō tātou katoa"
"A carefully woven cloak, is a protective cloak for us all."

Cover image acknowledgment:

The Taskforce gratefully acknowledges weaver Robin Hill for the use of her korowai or protective cloak on the front cover.

"This korowai is made of pheasant feathers, both male and female birds, which speaks to me of the inclusion of all people. The taniko (woven border) is designed with a family in mind. The marriage of two people and their respective families join to make one pattern. Although people belong together in society we are all individuals so there are individual bundles of feathers throughout the korowai body." *Robin Hill*

Further copies

The Independent Taskforce on Workplace Health and Safety report is divided into three parts:

1. Workplace Health and Safety Executive Report
2. Workplace Health and Safety Report
3. Workplace Health and Safety Working Papers

Each of the above reports and papers can be found at: www.hstaskforce.govt.nz

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DISCLAIMER

Contents


HARD HAT AREA

Introduction

The Independent Taskforce on Workplace Health and Safety was established by the Minister of Labour in June 2012 to assess whether the workplace health and safety system in New Zealand is fit for purpose, and to recommend practical strategies for reducing the rate of workplace fatalities and serious injuries by 2020.

The Taskforce's report is in three parts: this Executive Report, the Main Report, and a set of working papers. The Executive Report summarises the Main Report, which is the culmination of our extensive consultation with stakeholders and experts, and of research and analysis we commissioned on specific health and safety topics. The working papers are published online only.

We recommend an integrated package of measures which represent the first steps necessary to bring about the substantial changes we believe are necessary for healthy and safe workplaces in New Zealand. These are our collective views and we all fully endorse the findings and recommendations.

The recommendations are structured to support the Government's role in influencing the health and safety system. The Government can pull on three broad levers to influence the attitudes, understandings and behaviours of employers, workers and others in the system – Accountability levers, Motivating levers and Knowledge levers.

The Taskforce has formed a clear vision of workplace health and safety in 2023 and of the prerequisites to make this a reality. We call for an urgent, sustainable step-change in harm prevention activity and a dramatic improvement in outcomes to the point where this country's workplace health and safety performance is recognised as among the best in the world in 10 years' time. This vision reflects our findings on the performance and weaknesses of the current system, and the invaluable input of many stakeholders and experts over the past 10 months.

The Taskforce is strongly of the view that all injuries and deaths in New Zealand workplaces are preventable, and any such death is unacceptable. We lack comprehensive and reliable intelligence on the extent and causes of ill-health, injury and fatality. What is certain is that the number of people dying each year in New Zealand workplaces is a shameful tragedy.

We believe that far more resource must go into preventing ill-health, injury and death – and that the returns will come in greater quality of life for New Zealanders, higher productivity, and reduced medical and other costs.

We feel privileged to have been involved in such important work. We thank the hundreds of submitters in our consultation process, and many others who gave their time, expertise and personal life experiences to inform the Taskforce's work. It is our sincerest wish that our work contributes to fewer deaths and injuries in New Zealand workplaces from now on.

ROB JAGER

PAULA ROSE QSO

PAUL MACKAY

DR BILL ROSENBERG

MAVIS MULLINS MNZM

MIKE COSMAN

Recommendations

Accountability levers

The Taskforce recommends that the Government:

1. establish a new workplace health and safety agency with a clear identity and brand, and statutorily defined functions, including:
    a. it should be a Crown agent
    b. the new agency should be constituted on a tripartite basis, including an independent chair and members reflecting the interests of workers, unions, employers and iwi, as well as other parties interested in the workplace health and safety system
    c. the new agency should have primary responsibility for workplace harm prevention, including strategy and implementation
2. enact a new workplace health and safety Act based on the Australian Model Law ('Model Law'), including:
    a. the scope of the new Act should include acute, chronic and catastrophic harm
    b. an Object based on the Object in the Model Law
    c. duties should extend to all relationships between those in control of workplaces and those who are affected through adopting the Australian approach of persons conducting a business or undertaking (PCBUs)
    d. duties should extend to all those in governance roles through adopting the Australian approach of giving a due diligence obligation to officers of PCBUs
    e. replacing the current 'all practicable steps' test with the Australian 'reasonably practicable' test
3. strengthen the legal framework for worker participation, including through providing (based on the Model Law):
    a. specific obligations for employers to support worker participation
    b. expanded powers and responsibilities for worker health and safety representatives
    c. stronger protections for workers who raise workplace health and safety matters
4. ensure that the following actions occur to support effective worker participation:
    a. the new agency should include in regulations, approved codes of practice (ACoPs) and guidance material more specific requirements for how worker participation is expected to occur
    b. the new agency should provide increased support for worker participation, including increased support for:
        i. worker health and safety representatives
        ii. workers who raise workplace health and safety matters, including either confidentially or anonymously
        iii. unions' existing rights of entry
5. ensure a much stronger alignment and co-ordination of workplace health and safety activities through:
    a. regulation of the use of hazardous substances in the workplace that are currently under the Hazardous

Substances and New Organisms Act 1996 (HSNO Act) (although enforced by the Ministry of Business, Innovation and Employment (MBIE)) moving to the new workplace health and safety legislation. This will make it easier for the new agency to provide guidance, co-ordinate and enforce the law, and reduce complexity and uncertainty for businesses

b. a partnership between the new agency and Accident Compensation Corporation (ACC) to oversee funding arrangements for the delivery of workplace injury prevention activities

6. revise the workplace health and safety activities of transport regulatory agencies (Civil Aviation Authority (CAA), Maritime New Zealand (MNZ), New Zealand Police and NZ Transport Agency (NZTA)) to ensure that they:

   a. are led by the new agency through service-level agreements for specific health and safety services

   b. are strategically and operationally co-ordinated through a cross-agency oversight group to ensure:

      i. effective targeting that takes a risk-based approach

      ii. common capabilities and warranting

      iii. the alignment of compliance strategies

      iv. effective co-ordination when dealing with accidents

      v. stronger operational co-ordination while allowing for specialist expertise

7. significantly strengthen the regulation of occupational health by:

   a. giving the new agency accountability and responsibility for leading strategic and operational occupational health activities in New Zealand

   b. establishing an occupational health unit within the new agency

8. strengthen the regulatory regime for managing the risks of major hazard facilities by:

   a. mapping the risk landscape around potential catastrophic failure

   b. developing criteria and prioritising types of major hazard facility for inclusion in the major hazards regulatory framework

   c. ensuring that robust regulatory requirements apply to all priority facilities

   d. building capacity in the new agency to provide rigorous regulatory oversight and ensure compliance with the new regulatory framework.

Motivating levers

The Taskforce recommends that the Government:

9. provide strong leadership and act as an exemplar of good health and safety practice, demonstrated by:

   a. developing a comprehensive and targeted public health and safety awareness programme to change behaviours, norms, culture and tolerance of poor practice. This programme should be linked to a compliance strategy and specific compliance activity

   b. ensuring that excellent health and safety outcomes are achieved by

its own agencies (e.g. ministries, departments, Crown entities, state-owned enterprises (SOEs))

c. government procurement policies and practices that drive high standards of health and safety practice through the supply chain

d. introducing an assessment of workplace health and safety impacts to all preliminary impact and risk assessments (PIRAs)

10. implement measures that:

a. reward businesses for better health and safety performance through a levy regime that:

i. more meaningfully differentiates based on risk, good and poor performance

ii. is based on lead and lag indicators

iii. is aligned to a business health and safety rating scheme

b. reflects the costs of regulatory activity inherent to the industry (e.g. major hazards)

11. implement measures that increase the costs of poor health and safety performance, including:

i. extending the existing manslaughter offence to corporations and revising the corporate liability framework that applies to all offences (including manslaughter)

ii. stronger penalties and cost recovery

iii. visible and effective compliance activity

Knowledge levers

The Taskforce recommends that the Government:

12. ensure that the new agency implements a comprehensive set of regulations, ACoPs and guidance material that clarifies expectations of PCBUs, workers and other participants in the system:

a. Significant resourcing should be dedicated to this function of the new agency in the short term. The new agency should publish a timetable for the development and review of regulations, ACoPs and guidance material, and must ensure that these processes are undertaken on a tripartite basis. The new agency must consider what support is required for tripartite participation in the standard-setting process, including training and potentially funding for participation.

b. The new agency must ensure that its information and support services are delivered effectively to hard-to-reach population groups and should consider establishing advocacy or advice services (potentially on a trial basis) to support this.

13. improve the quality and availability of data and information on workplace injury and occupational health performance by establishing a sector-leading research, evaluation and monitoring function within the new agency:

a. with the mandate to influence and direct the collection of occupational health and workplace injury administrative data across government regulatory, compensation and health agencies and to collate and integrate this data for research purposes

b. to commission and undertake research, monitoring and evaluation programmes, including the development of minimum datasets for workplace injuries and occupational illnesses and a system-wide suite of lead and lag performance indicators, to inform evidence-based regulatory and business practice

c. to publish and disseminate findings, including through annual reporting on system-wide performance measures, and to make monitoring data available to partner agencies and key stakeholders in appropriate formats

14. require that the new agency lead the development and implementation of a workforce development strategy to identify and address capacity and capability gaps within the new agency as well as the workforce more generally, so that the workplace health and safety system functions effectively. Priority components for the new agency for inclusion in the workforce development strategy are:
    a. developing specific workforce development plans for the new agency's staff generally and occupational health staff specifically
    b. information-gathering to inform the strategy's content
    c. leadership from the new agency for the establishment of a health and safety professionals alliance (HaSPA), and the development of a pathway to the occupational regulation (registration) of health and safety professionals
    d. a comprehensive embedding of workplace health and safety into the education and training system at all levels to support up-skilling of the workforce generally
15. ensure that the new agency's compliance activity is focused on harm prevention, with far greater emphasis placed on root-cause analyses in investigations. To support this, the Government should:
    a. require that the new agency develop ACoPs or guidance material on how employers and PCBUs can implement no-blame, no-fault or even-handed culture models of managing workplace health and safety matters, and how to undertake root-cause analysis
    b. require that all investigations by the regulators examine the root causes of incidents, and that the regulators undertake more systemic reviews of root causes across groups of incidents
    c. extend the role and function of TAIC to allow it to undertake root-cause investigations of a broader range of workplace health and safety incidents.

Inquiry process

The Taskforce and its Secretariat gathered and analysed information from a wide range of sources during a 10-month inquiry process. We consulted with stakeholders in three phases. The first involved consulting expert reference groups to help identify and frame the issues pertaining to New Zealand's health and safety system prior to the release of a public consultation document, *Safer Workplaces,* in September 2012. In phase two, 429 written submissions were received and 500 people attended 28 public meetings (including open forums, hui, fono, workplace visits and business network meetings). The third phase involved synthesising the Taskforce's thinking around key issues and opportunities, and sharing a high-level discussion document with a range of stakeholders for feedback. Around 100 people attended a two-day February 2013 conference.

The Taskforce met with the following government agencies to discuss their roles in the health and safety regulatory and injury prevention systems: ACC, CAA, the Environmental Protection Authority (EPA), MNZ, the Ministry for the Environment (MfE), MBIE, the New Zealand Police Commercial Vehicles Inspection Unit, NZTA and the Transport Accident Investigation Commission (TAIC). The Taskforce also met with the New Zealand Council of Trade Unions and other interested parties in the judiciary and business sector.

To support its decision-making and to fill gaps in knowledge, the Taskforce commissioned research into health and safety culture change. This research identified and reviewed examples of successful national culture change programmes to identify common themes and success factors. The Taskforce also commissioned other research on international injury and fatality rate comparisons, and on the operation of health and safety systems in 11 firms varying in size, nature of industry and organisational form. Case studies were developed to assess workplace capacity and capability for effective health and safety systems.

When the Taskforce was established, the best available data on New Zealand's workplace injury, health and fatality rates were Statistics New Zealand's Serious Injury Outcome Indicators (SIOIs). These showed that on average there were 102 fatal work-related deaths a year between 2008 and 2010, and New Zealand had a workplace fatality rate of around four deaths per 100,000 workers a year. On the basis of international comparisons using historical SIOIs and data from other jurisdictions, New Zealand was identified as having a high rate of deaths compared with many Organisation for Economic Co-operation and Development (OECD) countries.

The Taskforce was struck by how little knowledge there is on how health and safety headline numbers are derived and how unreliable they are. In *Safer Workplaces*, we reported that there is no comprehensive or reliable data set for monitoring workplace fatal injury rates in New Zealand.

In November 2012, Statistics New Zealand issued an official caution: "We have discovered some quality concerns with the work-related indicators and are working to fix them… We recommend that no further use is made of the data on work-related injury… until our review is complete." We understand that Statistics New Zealand will soon release modified work-related fatal and non-fatal SIOIs.

The Taskforce is left with a profound unease about the quality of data in New Zealand. We are deeply concerned that we do not have a clear, reliable picture of New Zealand's performance. Accordingly, we believe that data improvements, vital to advancing our understanding and targeting of issues and to monitoring and evaluating outcomes accurately, need to be addressed as a priority.

Key findings

Poor performance

The Taskforce is deeply concerned about New Zealand's workplace health and safety performance. While we acknowledge that there are problems with the data, the fact is that a lot of bad things happen to people at work in this country. Each year, around 1 in 10 workers are harmed, with about 200,000 claims being made by people to ACC for costs associated with work-related injuries and illnesses. Of these, about 90 percent are medical fee expense claims, often involving only one or two visits to a health professional. The remainder are more substantive entitlement claims, reflecting a more serious degree of harm, for which compensation and support beyond medical fees are required. These include payments for rehabilitation, weekly compensation and accidental death benefits. Approximately 26,000 workplace-related entitlement claims were approved by ACC for people being harmed at work in 2010. Workplace injuries and diseases inflict an enormous emotional toll on the people affected, and significant economic costs on New Zealand. In 2010, the costs were most reliably estimated at $3.5 billion a year (almost two percent of GDP).

Five industries – manufacturing, construction, agriculture, forestry and fishing – account for more than half of all workplace injury entitlement claims and have the highest entitlement claim rates (as high as 32 per 1,000 full-time-equivalent employees in the agriculture, forestry and fishing industries).

Some groups of workers are also particularly vulnerable to injury and harm. Work-related injury claims, occupational disease data and fatality figures show that Māori workers, Pacific workers and workers of other ethnicities are more likely to be seriously injured at work. Other vulnerable groups include males, youth, older people, the self-employed and workers with low literacy and numeracy skills. There is a lethal nexus between high-risk population groups and high-risk industries.

Occupational illnesses have significantly worse human and financial impacts than harm incidents. These illnesses arise from a broad range of poorly-managed hazards in the workplace, resulting in gradual impairment or chronic harm conditions such as cancers and musculoskeletal disorders, and acute harms related to hazardous substance exposures.

New Zealand does not collect reliable data on occupational illnesses and diseases, due partly to the difficulties in measurement and attribution arising from long latency periods and conditions that can have multiple causes. In 2011, it was estimated that occupational illness cases result in 500-800 premature deaths a year. The majority of premature deaths are from work-related diseases due to occupational cancer, from exposure to hazardous substances such as asbestos and arsenic, and diseases of the respiratory system and ischaemic heart disease. Mental and nervous system disorders, diseases of the digestive and genito-urinary system, and toxic poisoning are also prevalent.

New Zealand has another particular issue in the potential for catastrophic harm as a result of ineffective oversight of major hazard facilities. The latter include extractive operations such as mining, and major chemical storage and processing facilities. The catastrophic consequences of inadequate management of such facilities were brought into stark relief by the 2010 Pike River mine tragedy.

Weaknesses in the system

The Taskforce has found that there is no single critical factor behind this poor performance. Instead, we see significant weaknesses across the full range of workplace health and safety system components, coupled with the absence of a single strong element or set of elements to drive major improvements or to raise expectations. The fundamental issue is systemic.

It is our view that weaknesses across the system stem from fundamental failure to implement properly the Robens health and safety model in New Zealand: this model, originating from the UK, informed the thinking behind New Zealand's Health and Safety in Employment Act 1992 (HSE Act).

The HSE Act replaced a plethora of highly prescriptive, sector-specific acts which had grown in an ad hoc manner, and in the early 1990s were seen as too complex and overly-reliant on external inspection. The single new Act, by introducing performance-based standards (i.e. duties to do what is 'reasonably practicable' to achieve safe outcomes), provided comprehensive and standardised coverage of most places of work and hazards at work, whilst giving greater flexibility to workplaces for meeting their obligations. Regrettably, it also removed prescription where prescription was warranted, e.g. mining.

Ultimately, New Zealand implemented a much lighter version of the Robens model, and much later, than other countries. This light implementation reflected a range of New Zealand-specific factors during the late 1980s and 1990s, notably resource constraints (including public sector staff cuts), changing attitudes towards the roles of government and business (including an ethos of business self-regulation), and liberalisation of the labour market with weakened union representation.

The Taskforce has identified the following issues with components of the health and safety system.

1. ***Confusing regulation:*** The system currently fails to make clear expectations of regulated entities and duty holders, and the regulator does not make compliance easy for the vast majority who want to comply. Sanctions for those who intentionally, or through neglect, break the law are not adequate. The framework is confusing with multiple pieces of legislation, blending hazard- and risk-management specifications, falling across overlapping and ambiguous jurisdictional boundaries. There is a lack of coordination between agencies and gaps in coverage.

2. ***A weak regulator:*** Despite efforts in specific areas, and the integrity and dedication of many staff, the primary regulator has failed to deliver on core responsibilities under the Robens model. Overall, it has failed to provide the system with sufficient certainty on how duty holders and regulated entities should comply. The regulator lacks capacity and capabilities, and it has failed to collaborate with other agencies on effective harm prevention.

3. ***Poor worker engagement:*** Worker engagement in health and safety is generally ineffective and often virtually absent. New Zealand falls well short of the strength of worker representative legislation and levels of engagement operating in comparable jurisdictions.

4. ***Inadequate leadership:*** There is little leadership being shown by a large number of people and organisations who have influence in the workplace. The issues include a lack of capability among managers generally, New Zealand's shortage of large private sector employers who could become exemplars, and defensive attitudes in some industry bodies.

5. ***Capacity and capability shortcomings:*** These shortcomings exist among workers, managers, health and safety practitioners, business leaders and the regulator. The shortcomings include insufficient knowledge of workplace health and safety risks and specific hazards, and insufficient knowledge of workplace health and safety regulatory requirements, including of rights and obligations.

6. ***Inadequate Incentives:*** New Zealand lacks the positive incentives and deterrents needed to drive compliance with minimum health and safety standards or to foster behaviours that lead to continual improvement. The low likelihood of inspector visits, and of prosecution or other action, creates an uneven playing field and effectively rewards non-compliance. The regulators' resources are not applied optimally, penalties are far too low and the tools available are limited.

7. ***Poor data and measurement:*** New Zealand has poor information and intelligence on health and safety risk concentrations, causes of workplace injuries and illnesses, and the effectiveness of interventions to improve health and safety outcomes. We do not know the full extent of the issues or what to target. Reviewers and committees have reported on the issues before, but their recommendations have been largely ignored.

8. ***Risk tolerant culture:*** Our national culture includes a high level of tolerance for risk, and negative perceptions of health and safety. Kiwi stoicism, deference to authority, laid-back complacency and suspicion of red tape all affect behaviour from the boardroom to the shop floor. If recognition and support for health and safety are low or intermittent, workplaces are liable to develop, accept and defend low standards, dangerous practices and inadequate systems.

9. ***Hidden occupational health:*** New Zealand's estimated 500-800 premature deaths year from occupation ill-health receive little government, media or business attention. Inadequate data systems and research mean the scale and nature of the issues are largely unknown – and the system is unresponsive to new and emerging risks. Activity is fragmented across multiple regulators, disciplines and sectors with no effective co-ordination or leadership.

10. ***Major hazard facilities:*** Some major hazard facilities have insufficient oversight. The current framework focuses on certain industries (e.g. offshore petroleum, mining, geothermal energy) but other facilities with comparable dangers are not subject to the same degree of oversight and regulation. This reflects the gaps in knowledge about major hazards, and the fact that the risk landscape in New Zealand is not understood.

11. ***Particular challenges to SMEs:*** Challenges arise for SMEs from the generally less formal management style of smaller businesses, their resource constraints, limited access to external advice and support, and lack of systems fit for health and safety purposes. The current regulator has provided insufficient, relevant advice to SMEs who are particularly dependent on it.

12. ***Particular at-risk populations:*** Some groups experience disproportionate levels of workplace-related poor health and injury. Low literacy and poor communication skills are, in themselves, risk factors especially in workplaces that are inherently more risky. This presents a particular challenge to policy-makers and regulators, as a one-size-fits-all response to population-specific outcomes, without a careful analysis of all underlying causes, may result in poorly targeted and ill-conceived interventions.

Taskforce vision

The Taskforce seeks an urgent, sustainable step-change in harm prevention activity and a dramatic improvement in outcomes, to the point where New Zealand's workplace health and safety performance is recognised as among the best in the world in 10 years' time.

A number of critical changes and improvements, reflecting dual priorities around acute workplace injury and chronic health conditions, coupled with a seismic shift in attitude, will be needed across the health and safety system to create a robust, efficient and effective system.

At the very least, as required by the Government, the package of practical measures recommended in this report needs to result in *at least* a 25 percent reduction in the rate of fatalities and serious workplace injuries by 2020. We are confident that this modest target can and will be met, but only if the full package of recommendations is implemented in its entirety.

By 2023, if not earlier, the Taskforce wants New Zealand to be one of the best places in the world to go to work and to come home at the end of the day, every day, safe and sound.

To turn our vision into reality, we need all of the elements in place for a new, high-functioning system.

Prerequisites for a high-functioning system

We need a new, stand-alone, well-resourced health and safety agency that is effective in its enforcement and its provision of advice, but this on its own will not be sufficient to ensure the level of change needed across the system. There needs to be a broad-based approach involving change on a number of fronts to help workplaces do the right thing yet hold outliers to account for evading their responsibilities. We need better law, a stronger regulatory toolkit, a lift in leadership, greater commitment and participation from everyone in the workplace, more robust research and data, more effective incentives, and information and guidance material that are fit for purpose. We also require working New Zealanders to shift their mind-sets and lift their game.

Following are our prerequisites for a high-functioning workplace health and safety regulatory system.

1. ***Good, workable law:*** Our vision is that the law makes clear to duty holders (those who create and/or are in the best position to manage risks to workplace health and safety) what their legal duties are and holds them to account for undertaking those duties. The law is comprehensive in its coverage to ensure there are no gaps. The law increases certainty by clarifying compliance requirements and the legal consequences of non-compliance.

2. ***An effective primary regulatory agency:*** Our vision is that the new agency has both the mandate and the resources to be a visible and effective best-practice regulator so that all participants in our nation's health and safety system know how to perform well, and are motivated and able to do so. The new agency requires a defined set of statutory functions, powers and accountability mechanisms for its activities. The new agency engages well with key stakeholders and has a commitment to effective tripartism in developing guidance and support to help all parties to comply with their duties under the law, and to deter non-compliance.

3. ***Strong, visible leadership:*** Our vision is that all people and organisations able to influence what happens in workplaces 'step up' to provide demonstrable leadership

for better workplace health and safety outcomes. Leadership comes from the bottom up, and from the top down – from the Cabinet room and the boardroom to workers on the front line. At a day-to-day level, the chief executive and senior management team lead the way but are held to account by those above (the board) and below (workers) for their responsiveness to concerns and risks. Leadership is vital to creating a workplace culture in which health and safety automatically comes first.

4. ***A robust level of capacity and capability:*** Our vision is that safety is an integral part of everybody's personal and workplace values. Our education system (from school to the vocational and tertiary sectors) supports the development of higher levels of awareness of health and safety risks, rights and obligations, and how to manage risk safely. Different users have access to comprehensive, high-quality guidance and standards that are fit for purpose. Research helps us to monitor and enhance our understanding of workplace health and safety risks, and to improve responses to those risks. There is also easy access to quality specialist advisers, when required.

5. ***Tripartism throughout the system:*** Our vision is that tripartism is inculcated throughout the workplace health and safety system. Tripartism involves the government regulator, employers and unions working together to improve workplace health and safety outcomes. The UK has shown respect for tripartism for 40 years. Tripartism is also the dominant model in Australia. The Royal Commission on the Pike River Coal Mine Tragedy ('Royal Commission') found that a key reason for the Department of Labour (DoL) being an ineffective regulatory body was that it had "no shared responsibility at governance level, including the absence of an active tripartite body". Tripartism needs to be reflected in engagements between the Government and peak representatives of employers and workers, and in the governance of the regulators. Similarly, the implementation of the Robens model needs to be done on a tripartite basis, with representatives of employers and workers actively engaged in the development of regulations, ACoPs and guidance material.

6. ***Genuine and effective worker participation:*** Our vision is that worker participation is a valued part of the workplace health and safety system, and management is interested in and open and responsive to workers' health and safety concerns. 'Active worker participation' means that workers: are involved in developing, implementing and monitoring their workplaces' health and safety systems; can participate through a range of representation mechanisms, including unions; have the training, support and knowledge to enable them to participate without fear of possible repercussions; and can hold employers to account for their responsibilities.

7. ***Incentives that are effective levers for good practice:*** Our vision is for a mix of positive incentives ('carrots') and deterrents ('sticks') to encourage better workplace health and safety outcomes. The carrots include risk- and performance-rated levies, and procurement policies that require good practice to act as levers for proactive behaviour. The sticks include significant financial and legal penalties and sanctions for poor performance. Importantly, the incentive regime is designed to overcome any potentially perverse effects, e.g. non-reporting or suppression of ACC claims to avoid the consequences of higher rates of harm.


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8. ***High-quality data:*** Our vision is that there is a robust, comprehensive and integrated workplace injury and disease data-collection, monitoring and reporting system. An effective data-collection and management system ensures the timely identification of signals and trends among the working population, and across types of work and workplace. Much better intelligence on health and safety risk concentrations, the causes of workplace injuries and illnesses, and the effectiveness of interventions will go a long way to informing the new agency's work, improving health and safety outcomes, and providing benchmarks to firms to understand their own performance in relation to that of others.

9. ***Occupational health is taken seriously:*** Our vision is that occupational health is front and centre of New Zealand's health and safety system. Strong government leadership sets ambitious targets and drives a programme of change to improve occupational health outcomes significantly. There are greater capabilities and awareness across government and business, in the health system and among the public to support the effective control of workplace exposures that cause high rates of occupational ill-health. In short, chronic harm prevention is treated with the same priority and commitment as acute harm prevention.

10. ***SMEs have easy access to useful information:*** Our vision is that health and safety information and advice are accessible and tailored to SMEs, which are the predominant business type in New Zealand. This information may be provided by the new workplace health and safety agency, by other businesses in their industries or with which they do business, and through trusted intermediaries such as accountants and industry associations. Regardless of source, it allows owners, managers and workers in SMEs to address workplace health and safety in a way that is fit for purpose and proportionate to the inherent risks in their workplaces.

11. ***High-risk population groups are targeted effectively:*** Our vision is that the new agency targets its activities towards the high-risk population groups that are overrepresented in injury, illness and fatality rates. These groups include workers in high-risk industries and occupations, males, older and younger workers, Māori, Pacific and other ethnic groups, recent migrants, people in casual and contract work and new on the job, and the self-employed. Further, there are targeted actions to changing unacceptable workplace health and safety practices and improving outcomes, e.g. literacy, language and communication skills training targeted to higher-risk workers with literacy skill gaps in firms in high-risk industries.

12. ***Major hazards are effectively regulated:*** Our vision is that there is a comprehensive and systemic framework for managing workplace health and safety risks in major hazard facilities. This framework is future focused, and involves mapping major hazard facilities and prioritising them by risk. It also involves scanning the New Zealand and international environments to identify new and emerging potentially catastrophic risks, and responding appropriately to the implications of major incidents and international changes to major-hazard-facility regulation. In particular, the regulatory approach to major hazard chemical storage and processing facilities is updated. The general public has confidence that risks in major hazard facilities are managed appropriately.

13. ***A national culture that is more risk aware:*** Our vision is for our national culture to be intolerant of preventable harms and to have a positive view of health and safety. New Zealanders have a high awareness of potential risks at work and are proactive in managing them. This involves New Zealanders being engaged in the campaign to improve workplace health and safety outcomes. It requires everyone to understand the key issues and be committed to solving them together. Ultimately, New Zealanders have a low tolerance for risky, unsafe and unhealthy work, and are personally proactive about good health and safety practice.

Levers for change

The following sections are structured to reflect the nature of the Government's role in influencing the workplace health and safety system. The Government has three broad levers it can pull to influence behaviour by workers, PCBUs and other participants in workplaces.

- ***Accountability levers:*** The Government can create accountabilities and set expectations through legislation, regulations or ACoPs, empowering state agencies by providing them with the mandate and function to ensure compliance with legal requirements, and empowering individuals.
- ***Motivating levers:*** The Government can encourage behaviours. This involves providing positive incentives to encourage or reward desirable behaviours, and negative incentives to discourage or sanction undesirable behaviours.
- ***Knowledge levers:*** The Government can influence behaviours. This involves providing information to influence people's choices about how they behave, and ensuring that people have the knowledge, capacity and capabilities to make decisions. It also involves ensuring there is adequate research and evaluation that reinforces system participants' learning.

Accountability levers

An effective workplace health and safety system requires that those who create risks, those who are best placed to manage those risks, and those who should be protected from harm are absolutely clear about their obligations and rights. The Taskforce proposes a set of accountability mechanisms that will strengthen and clarify these rights and obligations in a new workplace health and safety law.

New agency

We believe the system requires a well-resourced regulatory agency with a clear mandate to bring about change and an ability to do so. This new agency must be able to detect and penalise those who break the law, and to inform, guide and direct as appropriate. Consistent with the recommendation of the Royal Commission, the Taskforce considers that the regulator should be a Crown agent with statutory independence. Its governance board should be constituted on a tripartite basis, with members representing the Government, workers, business and iwi.

The Taskforce recommends that, consistent with modern regulatory practice, the agency's wide range of functions should be specified in the new legislation. The functions should include monitoring the health and safety system to ensure it remains fit for purpose, providing rules, ACoPs and guidance to provide certainty, promoting and supporting education and advice, and monitoring and enforcing standards to ensure compliance.

The new agency should have a clear leadership role to remove current confusion over regulatory responsibilities and inadequate collaboration between agencies. The Taskforce recommends it should also be accountable for all workplace harm prevention, including advice to the Minister of Labour on strategy setting. The new agency should actively work with other agencies, industries, unions, sectors and communities to engage the whole system in harm-prevention efforts.

We recommend that some of the regulation of hazardous substances that relate to use in the workplace transfer to the new Act, and that injury prevention activities be delivered through a partnership between the new agency and ACC. Through a partnership arrangement and defined methodology, ACC's funding for workplace injury prevention activities would move to the new agency, which would lead the delivery of workplace injury prevention activities.

The Taskforce has noted a distinct lack of co-ordination and confused jurisdictions between health and safety regulatory agencies. The Taskforce recommends that the new agency take a leadership role on health and safety regulation through service-level agreements with other health and safety agencies for specific health and safety services to improve clarity of role and co-ordination of service delivery.

The Taskforce also believes that the new agency should work with Victim Support and other similar bodies to identify best practice for providing information, and emotional and practical support, to victims of workplace deaths and serious injuries and their families, and to embed this into its practice.

New law

The Taskforce proposes a new Act to replace the HSE Act 1992, with this legislation to include the functions, duties and powers of the regulatory agency. We recommend that the scope of the new Act extend to acute, chronic and catastrophic harm. We also recommend that the new Act be based on the Australian Model Law and associated regulations, while having regard to distinctive New Zealand conditions, as they are the most recent articulation of the Robens approach available to us. In developing the Model Law, Australia has been through an extensive modernisation process, drawing on both Australian and international experience. We have the opportunity to capitalise on that work.

The Taskforce recommends that the law has an Object with more positive language in relation to what is to be achieved. The current Object in the HSE Act is to *promote* the prevention of harm to all persons at work. The new Object should be to *secure* the health and safety of workers and workplaces. It should state clearly that "workers and other persons" will be protected "through the elimination or minimisation of risks arising from work". The new Object should include a principle to inform duty holders and regulators on the level of health and safety being sought. The principle is that "workers should be given the *highest level of protection* against harm to their health, safety and welfare from hazards and risks arising from work [or from specified types of substance or plant] as is reasonably practicable".

The Taskforce believes that the underlying foundation of the regulatory framework should be the allocation of duties to those who are in the best position to control workplace health and safety risks to keep them as low as is reasonably practicable. The duties should provide for the *coverage* necessary to ensure that those people who can prevent workplace harm have an explicit obligation to do so; and assign the *appropriate duties* to the appropriate duty holders to ensure that their actions are directed at preventing the most workplace harm. Coverage should extend to all upstream participants in the supply chain, including designers, manufacturers, importers and suppliers of plant, substances and structures, and commissioners of plant and structures.

The new Act should adopt the concept of a PCBU as in the Model Law. This covers all relationships between those in control and those who are affected, recognising that the traditional employer-employee relationship is only one arrangement. The Taskforce also recommends that those in governance roles assume a due diligence duty to be held by directors and people (e.g. chief executives) who participate in decision-making. We believe strongly that directors' duties in relation to workplace health and safety should be as strong as other fiduciary duties.

The Taskforce considers that the current 'all practicable steps' test should be changed to the Model Law "reasonably practicable" test to improve certainty, clarify that risk-based decision-making is required, and create a presumption in favour of health and safety. The Taskforce believes that the regulatory framework should be made explicitly risk based.

Worker participation

The value of worker participation in workplace health and safety is acknowledged through conventions by international organisations (e.g. International Labour Organisation) and through research into actual outcomes. The Taskforce's consultation process confirmed that New Zealand worker participation in this area is not effective. Improved engagement with workers is necessary, along with a major 'mind-shift' in New Zealand society and in workplaces. This 'mind-shift' needs not only to lead to more opportunities for worker participation but also to set an expectation that everyone in the workplace is

responsible for workplace health and safety. It is important that each workplace is able to adopt the approach to worker participation appropriate to its circumstances. Research has confirmed that current worker participation arrangements are varied.

The Taskforce recommends that the Government strengthen the legal framework, including through providing stronger obligations on PCBUs to support worker participation, expanded powers and responsibilities for worker health and safety representatives, and stronger protections for workers who raise workplace health and safety matters. We propose that the new agency develops regulations, ACoPs and guidance material on how worker participation should operate. Furthermore, there should be specific obligations on PCBUs to support worker participation. In addition to existing responsibilities set out in the HSE Act 1992, we recommend that PCBUs have explicit legal responsibilities to: consult workers affected by health and safety matters; have issue-resolution procedures in place for health and safety issues that might arise; identify workplace-specific health and safety matters in employment agreements; and identify workplace-specific health and safety issues in staff induction processes.

The new agency should provide increased support for workplace health and safety representatives, unions exercising existing rights of entry, and workplace engagement between its inspectors and workers and their representatives. There should also be better mechanisms for protecting workers who raise health and safety issues.

Occupational health

Occupational health issues, such as chronic harm resulting from the use of hazardous substances and the effects of fatigue and hours of work, can be a hidden feature of workplace health and safety. This is because the risks and/or effects may not be obvious until some time after the events that led to them. The Taskforce considers that occupational health activities should be given the same priority and attention as occupational safety activities. It is clear that these have not been a public or political priority for many years. We recommend that the new agency have responsibility for leading strategic and operational occupational health activities, with the agency having a unit dedicated to this area of risk. This unit's functions could include developing a New Zealand occupational health strategy, facilitating research and evaluation, and leading occupational health communication and social media campaigns.

As a matter of urgency, the new agency needs to improve intelligence on occupational health in New Zealand. It needs to build an occupational health, serious harm dataset and facilitate the development of whole-of-life databases. For this, we consider it needs a strong mandate to collect health-monitoring and exposure-monitoring data. The Taskforce recommends that the new agency be given the authority to direct the collection of occupational health data from government agencies. It should also have the powers to require an employer or a medical provider to provide to it anonymised health-monitoring information on request.

Major hazard facilities

New Zealand has many facilities with a potential for catastrophic failure leading to significant harm to people, property and the environment. A number are not currently covered by specific regulations or proactive regulatory activities. Currently, specific regulations beyond the HSE Act 1992 apply to, for example, mining, pipelines and petroleum and geothermal activities, and are enforced by the current regulator's High Hazards Unit. The Taskforce recommends strengthening the regulatory regime to cover all major hazard facilities and adopting international best practice.

The new agency should begin by mapping the risk landscape and developing regulatory criteria. Prioritisation for inclusion in the expanded regulatory framework should depend on the extent to which the risks are effectively covered off by existing regulations, and the nature of the jurisdictional boundaries operating between the new agency and other regulators (e.g. Police, Fire Service, local authorities).

The Taskforce considers that the costs of regulating major hazard facilities should be separated out and more directly recovered from the operators of these major hazard facilities. We consider that mechanisms such as differentiated levies and direct charging for services are

appropriate to reflect the disproportionate costs of providing regulatory oversight of major hazard facilities.

Motivating levers

Some participants in the workplace health and safety system will respond positively to better information on the issues and what can be done to improve performance. They will also respond positively to leadership, human stories of the costs of poor health and safety, and what their peers are doing to improve performance. Other participants are more likely to be motivated by self-interest. They will act if convinced better workplace health and safety will reduce their costs or create more business opportunities. Regrettably, others will only respond positively if they are compelled to do so. They calculate the likelihood of getting caught for having poor health and safety practices and the costs to them if they are caught. If they think they can get away with poor practices, they will. The Taskforce proposes a set of motivating levers that address the characteristics of these different groups.

Leadership

The system requires leadership from all participants but first and foremost from the Government. The Taskforce recommends that the Government should become an exemplar of good workplace health and safety practice by: undertaking a comprehensive and targeted national public awareness programme to change behaviours, norms, culture and tolerance of poor practice; ensuring that excellent health and safety outcomes are achieved through its own agencies; strengthening workplace health and safety requirements in government procurement policies and practices; and introducing workplace health and safety impacts to all preliminary impact and risk assessments (PIRAs). Active and visible participation by business and community leaders, as demonstrated by exemplar health and safety practices in their respective organisations, is also required if a truly national focus on improving health and safety is to be achieved.

New Zealand's poor health and safety outcomes are exacerbated by social attitudes that tend to underplay both risks and consequences. We need widespread support from the public to achieve significant and enduring improvements. Building public support should involve highly visible campaigns and partnerships with industries and communities, including iwi and other significant groups. The result should maximise voluntary compliance so that the new agency's activities can be focused on where they are needed most.

The Taskforce recommends that government agencies put their own houses in order as exemplars of workplace health and safety practice. This needs to be a first priority if the Government wants the rest of the nation's workplaces to lift their performance. The best approach is to set explicit expectations of government agency chief executives for the health and safety performance of their agencies. Government procurement policies requiring sound workplace health and safety practices are another effective means of driving up standards in the economy. The Government can leverage better outcomes through its purchasing clout particularly in construction and other services where it is a major customer for many New Zealand suppliers. The Taskforce has a firm view that the public sector must demonstrate leadership in procurement practice, and should be subject to ongoing reviews in this matter by the State Services Commission or other monitoring agencies.

Incentives

Incentives to encourage workplaces to do the right thing, and deter them from doing the wrong thing, are essential. Positive incentives need to be strong, visible and worth the effort of both the Government providing them and the businesses pursuing them. It is far better for workplaces to be stimulated to take voluntary steps than for a regulator to enforce action. Deterrents should provide certainty that poor performance will be punished.

The Government should introduce a business health and safety rating scheme with value to both the businesses involved and the people who depend on its ratings when making decisions on employment, investment, procurement and regulatory inspection. The scheme should be voluntary. The Taskforce considers that significant design work is required by MBIE, ACC and the new agency, rather than basing the scheme on existing performance measures (including the ACC levy discount schemes). At the same time,

the Taskforce considers that there is greater potential to use ACC levies to incentivise good performance by introducing a greater differential between good and poor performers.

We recommend that MBIE, ACC and the new agency be jointly mandated to provide advice to the Government on how the rating system can be used to better incentivise good performance. Specifically, the Taskforce considers that stronger lead and lag indicators need to be developed and tested. Poorly performing and higher risk employers should be subject to much higher levy loadings. Careful consideration needs to be given as to whether smaller employers are included in such a regime.

The new agency's research, monitoring and evaluation function will, over time, lead to improved data on health and safety outcomes, and on preventative and resilience factors – and this will enable benchmarking between firms, and across industries and regions. Benchmarks will need to be relevant if they are to serve as guides and motivators for firm and industry improvement.

Penalties

The Taskforce looked closely at Canadian, UK and Australian experience in this area, and we do not propose introducing a new law on corporate manslaughter in New Zealand because other jurisdictions have had very limited success in establishing an effective approach to the offence.

The Taskforce recommends extending the existing manslaughter offence to corporations and revising the corporate liability framework that applies to all offences (including manslaughter). This would be the most effective way to maximise the denunciatory and deterrent effect of the criminal law in influencing the behaviour of corporations. The recommended revision to existing law would need to address two issues. First, it would need to allow the attribution of criminal liability to a corporation as a result of the acts and omissions of a greater range of officers and employees within that corporation, provided they are acting within the scope of their authority. Second, it would need to provide that liability could be attributed to a corporation if two or more individuals of the required seniority within the company engaged in conduct that, if it had been the conduct of only one of them, would have made them personally liable for the offence. This would allow conduct and states of mind to be aggregated for the purposes of attributing corporate liability in a way not permitted under current New Zealand law.

The Taskforce recommends that the maximum penalty ceiling for offences be raised so they are comparable with Australian levels, with a graduated penalty range. At present in New Zealand, offences likely to cause serious harm incur fines of up to $500,000 or imprisonment for up to two years, or both. These are lower than provided for in the Model Law. Under the Model Law, reckless conduct offences by individuals incur penalties of up to $600,000 or five years' imprisonment, or both, and by a body corporate up to $3 million.

The Taskforce considers that the Government should introduce a hierarchy of offences and corresponding penalties of the same or a similar nature to those described in the Model Law. The offences should have three levels: *reckless conduct* where a person who has a health and safety duty without reasonable excuse engages in conduct that exposes an individual (to whom that duty is owed) to a risk of death or serious injury or illness, and the person is reckless as to the risk; *failure exposing to serious risk* where a person fails to comply with their health and safety duty, and the failure exposes an individual to a risk of death or serious injury or illness; and *failure* where a person fails to comply with their health and safety duty. The Taskforce recommends that consideration also be given to including a further category of serious offending with higher maximum penalties that would apply where death results.

The Taskforce considers that judges should be able to make adverse publicity orders after convictions for workplace health and safety breaches. Avoiding the risk of reputational damage caused by publicity about any poor performance or negligence can also incentivise employers to maintain good workplace health and safety systems. Likewise, the Taskforce believes the new agency should be able to make public information on their enforcement actions once the appeal period has expired.

Enforcement

Sustained or repeated poor performance on health and safety is often not due to deliberate non-compliance. Businesses may want to perform well but find it challenging because of competition pressures that favour poor health and safety performers. This might apply particularly to small businesses. To motivate compliance and create a level playing field, the new agency and the other regulators need an enhanced toolkit of effective sanctions, deterrents and remedies for ensuring responses are proportionate to the breaches.

The tools should include enforceable undertakings which are agreements reached between a PCBU and an inspector to put right an alleged breach to a required standard in a specified timeframe. Such an agreement avoids costly prosecution but can be enforced later, if need be, through a compliance order in the District Court. The Taskforce also sees greater potential for enforcement through: civil procedures under the Criminal Proceeds (Recovery) Act 2009 in relation to ill-gotten financial benefits from non-compliance; improved prosecutorial processes generally; the use of infringement notices (with increased penalties) without the current requirement for prior warning; and the use of compliance or restoration orders to address the deficiencies of improvement notices, which resolve the causes but not the consequences of the failure.

An essential feature of a fair regulatory system is transparency. The new agency and other regulators need to ensure their strategies, plans, policies and activities are published and accessible, including their enforcement policies and targeted sectors. By helping system participants to understand where harm-prevention priorities are within the system, the participants are able to focus their attention appropriately.

Knowledge levers

An effective workplace health and safety system requires all participants to have high levels of knowledge about health and safety, and reinforces the value of that knowledge. Participants need to understand their obligations and rights, and how to achieve good outcomes. That knowledge needs to be supported by authoritative data, research and evaluation about what works and what does not. At present, we don't know what the issues are and what to target. The Taskforce proposes knowledge levers that will redress the lack of certainty left by current gaps in information and guidance for duty holders and regulated entities. Knowledge levers should also provide participants with the necessary capacity and capabilities to improve health and safety outcomes. In addition, by learning from past incidents, they will be better able to focus on preventing harm in the future.

Greater certainty

The Taskforce is concerned that low levels of general awareness of health and safety limit the ability of business owners, directors, managers and workers to engage for improved outcomes. New Zealand's poor outcomes are exacerbated by a high tolerance of risk and negative perceptions of health and safety in New Zealand. For system-wide improvements, participants need to recognise poor health and safety practices when they encounter them. Business owners, directors and managers need to know their responsibilities and how they can meet them. Workers need to know how they can ensure their own safety, health and wellbeing.

We recommend that the new agency implement a comprehensive set of regulations, ACoPs and guidance material, giving greater certainty to PCBUs, workers and other participants in the system on the expectations of them. The best available material from Australia can be adopted and adapted to speed up these developments. The Taskforce considers that all firms as a matter of best practice should have a fit-for-purpose health and safety management system. There should also be regulation-making powers that provide for mandatory health and safety systems such as in high-risk areas. Regulations, ACoPs and guidance material will assist in the development of firm-specific health and safety management systems, including the obtaining of competent advice from health and safety practitioners. ACoPs and guidance are also needed to promote worker participation, to address occupational health issues and for major hazard facilities. We note concerns about the current capacity and capabilities of managers and supervisors. The new agency should develop ACoPs and

guidance material for them, these becoming more specific in relation to managers' duties in a high-risk context.

The changing nature of work arrangements and reduced union membership mean a growing number of workers are hard to organise and reach on health and safety matters. The Taskforce understands that existing government agency contact centres, websites, publicity campaigns and inspection services do not meet public expectations. We recommend that the new agency ensures its information and support services are effectively delivered to hard-to-reach groups including through possibly establishing regional support centres, and that advocacy or advice services be considered.

Information quality

New Zealand has incomplete and poorly integrated intelligence on workplace health and safety risk concentrations, the causes of workplace injuries and illnesses, and the prevalence of good preventive practice. Occupational health data is particularly poor. As a consequence, industry bodies, businesses, unions and workers have inadequate information and are unable to compare their prevention-management performance meaningfully against that of their peers, reducing their ability to make improvements. The Taskforce recommends a leading health and safety research, evaluation and monitoring function be established within the new agency to direct the collection of relevant data across government agencies, commission and undertake research, monitoring and evaluation programmes, and to publish and disseminate findings. The latter will include annual reporting on system-wide performance measures. The Taskforce intends this single-focus workplace health and safety research, evaluation and monitoring function to lead a fundamental shift in the comprehensiveness and quality of workplace health and safety data captured, analysed and reported.

Workforce development strategy

The Taskforce recommends that the new agency lead the development and implementation of a workforce development strategy for people working in health and safety New Zealand-wide, including its own staff. We also recommend that a health and safety professionals alliance (HaSPA) network be established by the end of 2014, drawing on Australian experience in this area. Longer term, the Taskforce sees some form of occupational regulation or a register of practitioners as being feasible as capacity and capability build in New Zealand.

In relation to the education system, the Taskforce recommends that health and safety learning is embedded in the nation's education and training systems. Health and safety standards should be embedded in all academic and vocational training at levels 1-6 of the New Zealand Qualifications Framework (NZQF), and made mandatory in trade certification. Together with education agencies and other standards-setters, the new agency needs to define roles and responsibilities for generic health and safety unit standards under the NZQF. It should also collaborate with professional registration bodies to ensure health and safety capabilities are part of university-level qualifications, professional standards and general management training.

The Taskforce is concerned that too often the response to workplace health and safety incidents is to seek and blame an immediate cause or responsible person, not to analyse root causes. As a consequence, the health and safety system does not learn adequately from incidents. A no-blame approach in workplaces would encourage greater co-operation from those who contribute to failures and more opportunity to fix problems for the future. We also recommend that the new agency's compliance activity is focused on harm prevention, with far greater emphasis placed on root-cause analysis in investigations. This will better enable knowledge levers to prevent future harm by ensuring the lessons of the past are understood and acted upon.


SNOOP
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Cost-benefit analysis

The Taskforce's terms of reference required that we identify the net and gross fiscal and economic costs and benefits of our recommendations and, if applicable, how they should be financed. This section addresses this requirement.

In developing this section, we drew on:

- modelling by Ernst & Young of some of the costs of our recommendations
- advice from the New Zealand Institute of Economic Research on the broader costs and benefits of our recommendations.

Modelling the costs of our recommendations

The Taskforce commissioned Ernst & Young to provide advice on some of the costs of our recommendations. This work built upon work that Ernst & Young was undertaking for MBIE on the costs of a workplace health and safety agency. Both of these estimates are based on a steady-state costing. We consider that these steady-state costs are appropriate estimates of the costs of the new agency once it has scaled up to implement our recommendations fully.

The methodology for this work is reflected in the diagram below:

For the purposes of the cost-benefit analysis, the relevant incremental costs are identified by boxes B and C.

Summary of costs of our recommendations

We have been advised by MBIE that the level of funding currently available for the existing functions of the workplace health and safety regulator within MBIE is $53.675 million for 2013/2014, rising to $53.975 million for 2014/15 and out-years (excluding the costs of energy-safety functions).

Ernst & Young estimates of the steady-state costs of the new agency is that it would require funding of approximately $100 million per annum to fully implement our recommendations, including the costs of having a stand-alone workplace health and safety agency. This would involve additional funding of approximately $32 million per annum, when offsetting transfers of funding are taken into account.

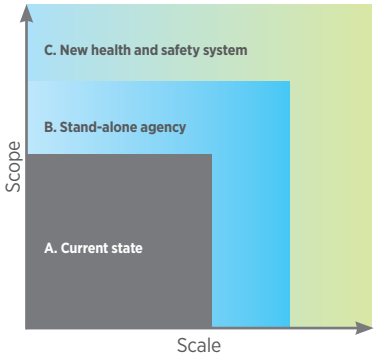
For the purposes of assessing the overall incremental costs of our recommendations, we have made a number of assumptions about the timing for reaching this steady-state level of costs, which are reflected in the annual total costs in Table 1 on the following page.

FIGURE 1: COSTS OF GROWTH IN SCALE AND SCOPE ENVISAGED BY TASKFORCE

C. New Zealand health and safety system: costs of additional scale and scope for stand-alone workplace health and safety agency under Taskforce recommendations

B. Stand-alone agency: costs of stand-alone workplace health and safety agency

A. Current state: costs of existing functions of workplace health and safety regulator within MBIE



The above increases in funding make no explicit allowances for cost pressures, such as the impacts of inflation and labour market cost pressures. The new agency would need to make a case for additional funding for these cost pressures through the normal appropriations processes. The Taskforce considers that funding will need to be monitored carefully over time to ensure that it remains adequate. Account should also be taken of the fact that the Health and Safety in Employment levy revenue received by the Crown will increase in line with growth in leviable earnings.

While the above figures are presented as annual funding allocations, we are also concerned that this model of funding is not appropriate for the new agency. We recommend that the Government consider providing the new agency with a three-year rolling appropriation. This would provide the new agency with greater certainty and stability of funding. For more analysis on the costs and the subsequent benefits to New Zealand, see the Main Report.

TABLE 1: Annual increases in funding for the new agency

	2013/14	2014/15	2015/16	2016/17	2017/18
A: current costs	$53.675m	$53.975m	$53.975m	$53.975m	$53.975m
B: stand-alone agency and **C:** additional scale and scope	$33.870m	$40.524m	$44.709m	$46.422m	$46.422m
Total costs	**$87.555m**	**$94.499m**	**$98.684m**	**$100.397m**	**$100.397m**
Net costs	**$19.970m**	**$26.624m**	**$30.809m**	**$32.522m**	**$32.522m**

Ministry of Business, Innovation & Employment

Institute of Directors IN NEW ZEALAND (INC)

Good Governance Practices Guideline for Managing Health and Safety Risks

"The board and directors are best placed to ensure that the company effectively manages health and safety. They should provide the necessary leadership and are responsible for the major decisions that must influence health and safety: the strategic direction, securing and allocating resources and ensuring the company has appropriate people, systems and equipment."

Royal Commission on the Pike River Coal Mine Tragedy

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May, 2013

This guideline was developed by the Institute of Directors in New Zealand (IoD) and the Ministry of Business, Innovation and Employment (MBIE) as a result of the key findings and recommendations laid out in the final report of the Royal Commission on the Pike River Coal Mine Tragedy. The development of the guideline was assisted by the New Zealand Council of Trade Unions (NZCTU), Business Leaders' Health and Safety Forum, Employers and Manufacturers Association (EMA), New Zealand Institute of Management (NZIM) and Business New Zealand.

Contents

Introduction

The governance of an organisation is a framework of interlocking values, principles and practices. Through this framework boards of directors exercise governing authority and make decisions in order to achieve the organisation's purpose and goals. They also ensure that the organisation operates with high standards of ethical behaviour, abiding by all laws and regulations.

It is important to distinguish between the governance and management of an organisation. The focus of directors should be on determining the organisation's purpose, developing an effective governance culture, holding management to account and ensuring effective compliance[1]. Directors work with management to develop the organisation's strategy and business plans which are then implemented by management.

Health and safety governance is as important as any other aspect of governance. It is a fundamental part of an organisation's overall risk management function which is a key responsibility of directors. Failure to manage health and safety risk effectively has both human and business costs. The price of failure can be the damaged lives of workers, their families and friends as well as direct financial costs, damaged reputations and the risk of legal prosecution.

It is important to remember that an organisation's duty to provide a safe and healthy work environment extends further than its employees. Legislation in New Zealand extends that duty to all those who could be affected by the activities of the organisation such as contractors, visitors and customers.

Organisations that learn to manage health and safety well, learn that the capability that drives success in this area is the same capability that drives success in other areas of the business. Organisations with a good health and safety culture and reputation are valued by workers, investors and stakeholders.

Because of their position in the organisation directors have a unique opportunity and an obligation to make a difference by providing leadership in this critical area of governance. It is also important to ensure that when an organisation achieves success that it is celebrated.

> "Leadership is about what I say, what I do, and what I measure"
>
> Business Leaders' Health and Safety Forum

1 The Four Pillars of Governance Best Practice; Institute of Directors in New Zealand (inc.), Wellington, 2012.

Health and safety should be part of everyday business, it makes good business sense.

PURPOSE AND SCOPE OF THIS GUIDELINE

The purpose of this guideline is to provide advice on health and safety governance and to:

1. Demonstrate how directors can influence health and safety performance
2. Provide a framework for how directors can lead, plan, review and improve health and safety
3. Assist directors to identify whether their health and safety management systems are of a standard and quality that is effective in minimising risk
4. Encourage directors to create strong, objective lines of reporting and communication to and from the board.

The principles discussed in this guideline apply to all members of governing bodies including directors, trustees and councillors of organisations of all types and sizes (including voluntary organisations). It is however, intended to have particular application to directors of medium to large sized organisations (20 or more employees). A separate guideline is available for directors of smaller organisations.[2 3]

This guidance is neither a policy statement nor a statutory document. While a court may take the document into account, there is no compulsion for it to do so. The document does however refer at times to relevant New Zealand legislation and to specific provisions within legislation. Where the word 'must' is used in the document to specify a requirement, this is intended to convey a legal requirement. Where the document intends a good practice imperative, rather than a legal one, the word 'should' is used.

This guideline was developed by the Institute of Directors in New Zealand (IoD) and the Ministry of Business, Innovation and Employment (MBIE) as a result of the key findings and recommendations laid out in the final report of the Royal Commission on the Pike River Coal Mine Tragedy. The development of the guideline was assisted by the New Zealand Council of Trade Unions (NZCTU), Business Leaders' Health and Safety Forum, Employers and Manufacturers Association (EMA), New Zealand Institute of Management (NZIM) and Business New Zealand.

2 This document does not provide industry-specific advice. It is recommended that you seek such advice as a regular part of best practice. Ideally, you will have somebody with industry knowledge on your board who can provide this advice.

3 This document can be used by any organisation regardless of the number of workers. However, SMEs and NGOs often have different needs which may not be specifically addressed in this document.

Why Effective Governance is Important

THE NEED TO IMPROVE

We know that many New Zealand organisations can and should improve their health and safety record. Each week one to two New Zealanders are killed while at work. In addition, there are an estimated 600 to 900 deaths each year from occupational diseases such as asbestosis. The financial cost is estimated to be $3.5 billion or more each year. When looking at our performance in comparison to other developed countries we have much room for improvement.

The statistics do not begin to describe the impact on those who have been harmed, their families, friends and colleagues. The need to address this human cost is in itself sufficient reason to improve our record of harm prevention.

THE BENEFITS OF GOOD HEALTH AND SAFETY

A positive and robust health and safety culture that begins at the board table and spreads throughout the organisation adds significant value, including:

- enhanced standing among potential workers, customers, suppliers, partners and investors as a result of a good reputation for a commitment to health and safety
- workers participating positively in other aspects of the organisation. A good organisational culture spreads wider than health and safety
- decreased worker absence and turnover. Engaged workers are more productive workers
- reduced business costs, for example a reduction in ACC levies as a result of improved health and safety performance and outcomes
- potentially increased economic returns. A report from the International Social Security Association found a return on prevention ratio of 2.2.[4]

The Pike River mine case provides a sobering example of how ineffective governance can contribute to catastrophic results.

CASE STUDY – PIKE RIVER COAL MINE TRAGEDY

An explosion at the Pike River mine on 19 November 2010 caused the deaths of 29 men.

In its final report into the tragedy the Royal Commission reached the following conclusions about corporate governance at the mine:

- **the board's focus on meeting production targets set the tone** for executive managers and their subordinates
- **the board needed to satisfy itself that executive managers were ensuring workers were being protected**. The board needed to have a company-wide risk framework and to keep its eye firmly on health and safety risks. It should have ensured that good risk assessment processes were operating throughout the company
- **an alert board would have ensured that these things had been done and done properly**. It would have familiarised itself with good health and safety management systems. It would have regularly commissioned independent audits and advice. **It would have held management strictly and continuously to account**
- **the Chairman's general attitude was that things were under control unless told otherwise**. This was not in accordance with good governance responsibilities. Coupled with the approach taken by executive managers this attitude exposed the workers to health and safety risks.

4 The Return on Prevention: Calculating the costs and benefits of investments in occupational safety and health in companies; International Social Security Association (ISSA), Geneva, 2011.

Essential Principles of Health and Safety Governance

LEADERSHIP

It is the role of directors to provide leadership and policy that sets the direction for health and safety management. Directors create and demand expectations and exercise due diligence in holding management strictly and continuously to account for meeting them. Directors should:

- ensure there is an active commitment and consistent behaviour from the board that is aligned with the organisation's values, goals and beliefs. This will encourage a positive workplace culture
- ensure leadership is 'informed leadership'. Directors need to be aware of the organisation's hazards and risks. They should have an understanding of hazard control methods and systems so that they can identify whether their organisation's systems are of the required standard. They should understand how to 'measure' health and safety performance so they can understand whether systems are being implemented effectively. Directors should be prepared to seek advice from industry and health and safety experts as required
- set an example and engage with managers and workers, this could include visiting work sites. This provides leadership and improves their knowledge of health and safety matters.

WORKER PARTICIPATION

Worker participation is an important part of health and safety risk management not only because it is a legal requirement but because it has proven to be highly effective. Research has shown that worker participation (and trade union participation) leads to better health and safety outcomes[5]. At the most fundamental level workers should be encouraged to contribute to continuous improvement by raising issues, generating ideas, and participating in system development, implementation, monitoring and review either directly or through their representatives.

Directors should set the overall tone for participation by holding management to account to ensure workers are involved. Questions as simple as "what are our workers saying about this issue?" or "how do our workers feel about it?" can bring a new dimension to the discussion.

> "The main conclusion that emerges from our findings overall is that worker representation and consultation in the UK have a significant role to play in improving health and safety at work. They have the potential to raise health and safety awareness amongst both workers and managers, effect improvement in arrangements for managing health and safety, improve the practical implementation of these arrangements, and contribute to improved health and safety performance. Most importantly they represent means by which workers' voices can be heard and acted upon to the benefit of those that experience the risks of the production process."
>
> David Walters et al (2005)

5 The role and effectiveness of safety representatives in influencing workplace health and safety, Walters, D.R. Theo Nichols, Judith Connor, Ali C. Tasiran and Surhan Cam, (2005), HSE Research Report 363, Sudbury, HSE Books.

LEGISLATIVE COMPLIANCE

An organisation's officers and directors must always comply with relevant laws and regulations and they must ensure their organisation's compliance. This requires that directors keep informed and up-to-date with legislative changes.

The overarching legislation that governs health and safety practice in New Zealand is the Health and Safety in Employment Act 1992 (HSE Act). This is supported by other key legislation such as the Accident Compensation Act 2001 and the Hazardous Substances and New Organisms Act 1996 (HSNO). The HSE Act also has a number of regulations and approved codes of practice. A summary of the HSE Act titled A Guide to the Health and Safety in Employment Act 1992 is available from MBIE.

Under the HSE Act the primary responsibility is placed on the employer who has a general duty to provide a safe and healthy work environment. The duty extends to all persons who may be affected by the activities of the organisation including, employees, contractors, public, visitors and customers and to the organisation's activities as a supplier to other organisations.

Directors can be held personally liable for an organisation's failure to comply with the HSE Act if they are held to have "..directed, authorised, assented to, acquiesced in, or participated in,.."[6] a failure to comply.

A case study on Icepak Coolstores is included in this section and provides an example of a situation where a director was prosecuted.

CASE STUDY – Icepak Coolstores

A director of Icepak Coolstores Ltd was convicted and fined $30,000 after pleading guilty to a charge of breaching health and safety regulations. The specific charge was that **he acquiesced in the failure of the company to take all practicable steps** to ensure the safety of its employees while at work. This followed the coolstore explosion and fire at Tamahere near Hamilton in April 2008. The explosion killed a firefighter and left seven other firefighters with serious injuries.

Icepak Coolstores had installed a propane-based refrigeration system which they were aware was unique as an industrial operation of this kind and had never been adapted to use a highly flammable, explosive substance. The Fire Service had not been made aware of the presence of the explosive material nor were there any warning signs indicating its presence. The Crown claimed that directors had ignored a number of 'red flags' which should have alerted them to the risk such as propane gas regularly leaking, site gas detectors that needed replacing and several sources of ignition such as forklifts and switchboards.

The term 'acquiescence' is not defined in the Act and there was no discussion during the case regarding the meaning as the director had entered a guilty plea. The Department of Labour's position was that acquiescence meant the director was aware of the circumstances of the offending (not necessarily aware that there was an offence committed, just aware of the circumstances), was in a position to do something about it (the fact they were working directors of the business assisted with this) and didn't do anything about it.

6 Health and Safety in Employment Act 1992, Section 56 (1).

The requirements for directors may be expressed as exercising 'due diligence'. While this concept is not currently used in legislation in New Zealand it is now defined in Australian legislation in the Model Work Health and Safety Act (WHS Act). Section 27 of the WHS Act requires officers to take reasonable steps to:

a) acquire and update their knowledge of health and safety matters

b) understand the operations being carried out by the person conducting the business or undertaking in which they are employed, and the hazards and risks associated with the operations

c) ensure that the person conducting the business or undertaking has, and uses, appropriate resources and processes to eliminate or minimise health and safety risks arising from work being done

d) ensure that the person conducting the business or undertaking has appropriate processes in place to receive and respond promptly to information regarding incidents, hazards and risks

e) ensure that the person conducting the business or undertaking has, and uses, processes for complying with duties or obligations under the WHS Act.[7]

Boards and directors should aspire to move beyond compliance to 'best practice' – an approach that has shown results superior to those achieved by other means and that is used as a benchmark.

7 Guidance for officers in exercising due diligence; Comcare (Australian Government).

The Role of Directors in the Governance of Health and Safety

The role of directors is outlined in the following pages in terms of four key elements:

1. Policy and Planning
2. Deliver
3. Monitor
4. Review

The discussion of each element begins with a table that outlines director and management responsibilities. At the end of each section you will find a series of diagnostic questions and director actions. The diagnostic questions are designed to be used by directors as a tool to determine whether the organisation's practices are consistent with the board's beliefs, values, goals and approved systems. They can also be used as a basis for identifying areas that could be improved. The actions for directors are divided into two categories – baseline actions and recommended practice. Baseline actions are a suggested minimum requirement while recommended practice reflects taking the next step towards best practice.

> Directors should never turn a blind eye to health and safety information. If they become aware everything is not as it should be they need to take decisive action.

1 Policy and Planning

DIRECTOR RESPONSIBILITIES

- To determine the board's charter and structure for leading health and safety.
- To determine high level health and safety strategy and policy, including providing a statement of vision, beliefs and policy.
- To hold management to account for implementing strategy.
- To specify targets that will enable them to track the organisation's performance in implementing board strategy and policy.
- To manage the health and safety performance of the CEO, including specifying expectations and providing feedback.

MANAGER RESPONSIBILITIES

- To determine and implement business and action plans to give effect to board strategy.
- To determine targets that will enable them to track their own performance.
- To implement performance management processes for workers that specify health and safety expectations, and provide feedback on performance.

BOARD CHARTER AND STRUCTURE

The board should have its own charter setting out its role in leading health and safety in the organisation as well as the role of individual directors. The board may consider delegating a lead role in health and safety to an individual (if you have someone on the board with the necessary expertise) or a committee. Where specialist expertise is required consideration should be given to the engagement of an expert advisor. However, it must always be remembered that while tasks can be delegated, overall responsibility cannot be.

HEALTH AND SAFETY POLICY (VISIONS AND BELIEFS)

A health and safety policy (also known as a vision and beliefs statement) will be the formal mode of communication that demonstrates the board's commitment to, and beliefs about the management of health and safety. An example from the Todd Corporation is included in this section. As a positive statement about values, beliefs and commitments it represents a long-term view that will set the tone for how they, and others in the organisation, will behave. These policies will be most robust where management and workers are involved in the preparation and 'reality testing'. However, they should ultimately be approved and 'owned' by the board. These policies should reflect the organisation's responsibility to provide a safe and healthy work environment not just for its workers but for contractors, visitors, customers and anyone who may be affected by the organisation's activities.

SETTING TARGETS

Directors should set targets for the organisation that will provide direction, focus and clarity of expectation. They should:

- be measurable
- be challenging but realistic
- contain a mix of lead and lag indicators, ensuring a greater weighting on lead indicators which focus on prevention.

A good discussion of the use of indicators is included in the publication How Health and Safety Makes Good Business Sense – A Summary of Research Findings which is available on the MBIE website.

RELATIONSHIP WITH FINANCIAL TARGETS

It is important that directors send a clear message to management and the wider organisation that health and safety and financial targets are complementary. It is important that directors ensure their organisation does not have a culture where financial targets are prioritised at the expense of health and safety.

ZERO HARM

'Zero harm' is often used as an aspirational target. Before applying this target, consider the strength of your organisation's risk and reporting culture. If it is a weak one, there may be a risk of cover-ups and non-reporting. Always remember, the key is to know what is happening in your organisation so that the board can make the right decisions.

MANAGEMENT STRUCTURE AND PERFORMANCE

The board should ensure that there is an effective linkage between their health and safety goals and the actions and priorities of senior management. The board achieves this linkage through the CEO. Managers allocate health and safety responsibilities and accountabilities throughout the organisation, with details included in role descriptions and performance management processes. It is also good practice for knowledge and commitment to health and safety to be assessed during the recruitment of senior managers.

Lead indicators measure activities designed to prevent harm and manage and reduce risk, whereas lag indicators measure performance results. Care should be taken with the use of lag indicators because of their potential to encourage perverse outcomes such as the non-reporting of incidents, 'near misses' and injuries.

DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to determine whether they are effectively meeting their responsibilities and accountabilities. They can also be useful in determining whether the organisation's practices are consistent with the board's strategies, beliefs, values, goals and approved systems.

1. How do you ensure that the targets you establish for your organisation are aligned with your health and safety strategies and goals in both the long and short-term, are challenging but realistic, and have no unintended perverse consequences?
2. How is your board structured to deliver its commitment to health and safety and where and how is this structure described?
3. What are the key health and safety responsibilities and accountabilities of operating managers and how are these different from support staff?
4. How do you ensure that the CEO understands and meets the board's expectations with regard to health and safety management?
5. What process do you use to assess the CEO's health and safety performance? How does this process recognise good and bad performance?
6. What processes are in place for ensuring that managers clearly understand their health and safety responsibilities and are held accountable for carrying them out?
7. How are the organisation's workers involved in the establishment of your organisation's vision, beliefs and policy?

CASE STUDY – PROGRESSIVE ENTERPRISES

With 18,500 workers across almost 200 locations and 135 million people visiting their stores each year, Progressive Enterprises has a diverse and significant risk profile. While they believed they were putting safety first it was not being reflected in their performance with an LTIFR of over 20. In 2009 they started thinking more deeply about what safety actually meant and started to really engage workers.

In a drive to build credibility and engage workers the Countdown to Zero programme was launched. As part of the programme additional equipment was purchased to reduce specific risks such as injuries from deli slicers. The investment was not small with that upgrade alone costing over $4000 per machine.

Recognising they weren't preparing workers appropriately to deliver the desired safety performance, a significant amount was invested in training. This was very well received by workers. A recent course saw every single band saw operator come along on their day off, not because they had to but because they wanted to.

Changing the culture was fundamental to the process. Implementing measures of performance that meant something to workers and ensuring that all incidents were reported was vital. The organisation now has a culture where the first thought is not blame but how to support the affected person followed by what can we learn and how do we share that.

The investment Progressive has made in health and safety has delivered results – the LTIFR is now under 5 and the financial cost of injuries at work has halved since 2009. It has also had a real impact on staff attitudes and beliefs with over 95% of staff strongly agreeing that safety is important to the organisation.[8]

8 Our countdown to zero injuries; Dave Chambers - Managing Director Progressive Enterprises: www.zeroharm.org

ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
Organisational Beliefs, Vision, Policy	
Develop, approve and publish a safety vision and beliefs statement that will express the organisation's commitment to health and safety.	Consider involving workers and their representatives in the development of a vision and beliefs statement. This will help to ensure that it is 'owned' by the whole organisation.
Targets	
Establish targets for tracking the organisation's effectiveness in implementing the board's health and safety strategy and goals.	Include both lead and lag indicators in targets and ensure they do not create perverse incentives.
Board Policy, Structure, Process	
Decide how to structure the board so that health and safety has appropriate focus and expertise.	Consider nominating a non-executive director as a health and safety 'champion', or a committee that can focus on this key area.
Determine a board charter that will describe the board's own role and that of individual directors in leading health and safety in the organisation.	Ensure the board charter describes detailed structures and processes to be used to plan, deliver, monitor and review leadership of health and safety.
Management Structure and Performance	
Provide the CEO with a role description that includes health and safety responsibilities and accountabilities.	
Ensure that management operates with a structure that appropriately recognises the respective health and safety responsibilities and accountabilities of operating and support staff.	
Apply a performance review process to the CEO role and ensure that a similar process applies to other management.	Ensure that performance review and reward systems do not encourage cover–ups and other unwanted behaviours that are inconsistent with the board's beliefs and values.

EXAMPLE OF POLICY STATEMENT

Health and Safety Policy

TODD CORPORATION

Our Health & Safety Vision:

"We will all have a safe workplace"

We believe that:

- No business objective will take priority over health and safety
- All incidents are preventable
- Whilst management have ultimate accountability, we all have responsibility for health and safety
- All personnel have the responsibility to stop any job they believe is unsafe or cannot be continued in a safe manner

To achieve this we will:

- Maintain and continually improve our Health, Safety and Environmental Management System
- Proactively identify hazards and unsafe behaviours and take all steps to manage these to as low as reasonably practicable
- Set targets for improvement and measure, appraise and report on our performance
- Assess and recognise the health and safety performance of employees and contractors
- Consult and actively promote participation with employees and contractors to ensure they have the training, skills, knowledge and resources to maintain a healthy and safe workplace
- Accurately report and learn from our incidents
- Support the safe and early return to work of injured employees
- Design, construct, operate and maintain our assets so that they safeguard people and property
- Require our contractors to demonstrate the same commitment to achieving excellence in health and safety performance
- Comply with relevant legislation, regulations, codes of practice and industry standards

Jon Young

Group Chief Executive Officer
Todd Corporation Limited

2 Deliver

DIRECTOR RESPONSIBILITIES

- To lay down a clear expectation for the organisation to have a fit-for-purpose health and safety management system.
- To exercise due diligence to ensure that the system is fit for purpose, being effectively implemented, regularly reviewed and continuously improved.
- To be sufficiently informed about the generic requirements for a modern, 'best practice' health and safety management system and about their organisation and its hazards to know whether its system is fit-for-purpose, and being effectively implemented.
- To ensure sufficient resources are available for the development, implementation and maintenance of the system.

MANAGER RESPONSIBILITIES

- To lead the implementation of health and safety management systems and programmes.
- To identify resource requirements for the development, implementation and maintenance of the health and safety system, obtain approval for their provision, and secure and allocate resources accordingly.
- To allocate responsibilities and accountabilities to managers and workers for implementation of the system and its components.
- To monitor the effectiveness of the system and implement continuous improvements.

HEALTH AND SAFETY MANAGEMENT SYSTEM

Organisations should have a fit-for-purpose health and safety management system that is integrated with other management systems. The size, sophistication and detail of the system will reflect the organisation's risk profile, with high hazard organisations requiring more substantial systems.

Merely having a good system will not achieve good health and safety. Systems need to be implemented with rigor and consistency. Directors should hold management to account for effective implementation.

The main aim of a health and safety management system is effective hazard and risk management. This is the process by which hazards that have the potential to cause harm are identified and controls to eliminate, isolate or minimise the risk of harm are implemented. Harm refers to illness, injury or both. It also includes physical or mental harm caused by work-related stress.

Risk assessment requires a judgement about the probability of an incident happening and the potential seriousness if it does happen. Attention needs to be paid to the full spectrum including those incidents that are more likely to occur but with less serious consequences, and those incidents that are less likely to occur, but with catastrophic consequences when they do.

Guidelines on the requirements for an effective health and safety management system are described in Standards AS/NZS 4801:2001 and AS/NZS 4804:2001. Futher guidance to safety management practices and injury manangement can also be obtained from ACC (www.acc.co.nz):

- ACC442 ACC Workplace Safety Management Practices Audit Standards (aligned with the Australia/ New Zealand Standards for Occupational Health and Safety Management Systems (AS:NZS 4801:2001)
- ACC2465 ACC Partnership Programme Injury Management Practices Audit Standards

KEY ASPECTS OF A HEALTH AND SAFETY MANAGEMENT SYSTEM

Hazard and risk management

Organisations must identify all actual and potential hazards and implement controls for those assessed as significant. During organisational change, risk assessments should be undertaken so that the full health and safety impact of the changes can be understood and managed.

Incident management

Organisations should have well-defined processes for reporting and investigating incidents to identify root causes. The aim of incident management is to identify and implement remedial actions to prevent the incident happening again.

Emergency management

Organisations should develop plans for managing potential emergencies that may arise in the workplace. These plans should be communicated to all persons working on site. Plans should be regularly tested by simulation.

Injury management

Organisations should have processes for ensuring that injured persons are properly cared for. In the case of serious injuries and fatalities this care should extend also to families and work mates.

Participation

Under the Act organisations with more than 30 employees, or when requested by an employee or a union, must develop and agree a participation agreement.

Continuous improvement

The need to continuously improve the health and safety management system is a fundamental requirement. Directors should hold management to account for doing this. Guidance on continuous improvement can be found in AS/NZS 4801 and 4804. Continous improvement also includes the audit and review process.

Two areas that overlay the system are resources and leadership. The organisation must be provided with the resources required for it to operate safely. This includes people, plant and equipment, systems and budget. Leadership should be shown at all levels throughout the organisation. Management must define its commitment to health and safety, establish objectives, targets and plans for giving effect to this commitment, and lead the organisation in their achievement.

DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to determine whether they are effectively meeting their responsibilities and accountabilities.

1. How do you know that the organisation's health and safety management system is fit for purpose and represents best practice?
2. What systems are in place to ensure that hazards and risks are identified, assessed and effectively managed?
3. Have you thought about potential incidents that are less likely to occur, but with catastrophic consequences if they do?
4. Where there is significant organisational change that has implications for health and safety how do you ensure that this is reported to the board?
5. How good is the organisation's emergency management plan and state of readiness that will ensure an effective response to any potential emergency? When was it last tested?
6. How does the organisation ensure that it has the right people with the right skills and motivation managing health and safety?
7. How does the organisation ensure that all plant and equipment used on site meets an acceptable standard?
8. How does the organisation ensure that contractors have satisfactory health and safety standards?
9. How does the organisation ensure that the goods and services it supplies to other organisations meet satisfactory health and safety standards?
10. Does the organisation have an adequate budget for its health and safety programme?

"We insist that safety is our number one priority. Above all else, we value human life and expect that our port colleagues will go home to loved ones at the end of their shift in the same condition they entered the port gate."

Mark Cairns, Port of Tauranga

ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
Health and Safety Management Systems	
Ensure that management develops, implements, audits and regularly reviews and updates an effective health and safety management system consistent with accepted standards.	Undertake training to ensure a good understanding of the requirements of the health and safety management system and particularly of hazard and risk management practices.
Review management reports on reviews and audits of systems and control plans.	Commission periodic external audits and reviews of the system. Ensure that workers and representatives participate in audits and system reviews.
Become personally aware of your organisation's hazards and control systems. Review risk registers.	Ensure you have a detailed knowledge of your organisation's hazards and control systems. This should be refreshed regularly including through engagement with managers and workers which may include site visits.
Ensure that hazards are identified by management and that control plans are in place for their effective management.	Periodically (at least every two years) obtain/review independent advice on the adequacy of hazard control plans and the effectiveness of their implementation.
Ensure that management implements procedures for the selection of contractors and monitoring their activities so that you are assured of their health and safety.	Ensure that management insists on contractors having health and safety standards that match your organisations.
Resources – People	
Ensure that management have staffed the organisation with sufficient personnel with the right skill mix, supported by specialists as required to operate the business safely.	Ensure that the organisation has effective processes in place for recruitment, training and direction of managers so that they are skilled and motivated to reinforce a positive health and safety culture and ensure the health and safety of their people and teams.

Ensure management implements a system of worker participation that enables workers and their representatives to participate in decision-making, implementation and monitoring of their workplace health and safety management systems.	Ensure that the organisation implements a 'just culture' whereby there is an atmosphere of trust in which people are encouraged to provide safety-related information, without fear of retribution or blame for honest mistakes but are still held accountable for wilful violations and gross negligence.
Encourage a culture where reporting of events is expected and followed up.	Monitor the overall workplace health and safety culture using survey techniques.
Resources – Plant and Equipment	
Ensure that plant and equipment is provided by management that is fit for purpose, well maintained and supported by training and safe operating procedures.	Ensure well established and documented standards for plant and equipment that are used at procurement and during on-going operation and maintenance. Plant and equipment are not allowed on site if it does not meet this standard. This also applies to equipment used by contractors.
Resources – Systems	
Ensure that management provides systems that will support the effective management of health and safety.	Ensure management provides computer based systems for capturing data on health and safety incidents, analysis and reporting. Good systems will also assist with the tracking of action plans following incidents and audits etc and will assist to ensure their timely completion. The health and safety management system will be documented and available for all to read. Information from it will be regularly communicated to workers.
Resources – Budget	
Provide sufficient funds for the effective implementation and maintenance of the health and safety management system and for improvement programmes.	Ensure there is a policy of dealing with health and safety on the basis of need rather than budget limits.

3 Monitor

DIRECTOR RESPONSIBILITIES

- To monitor the health and safety performance of the organisation.
- To outline clear expectations on what should be reported to the board and in what timeframes.
- To review reports to determine whether intervention is required to achieve, or support organisational improvements.
- To make themselves familiar with processes such as audit, risk assessment, incident investigation, sufficient to enable them to properly evaluate the information before them.
- To seek independent expert advice when required to gain the required degree of assurance.

MANAGER RESPONSIBILITIES

- To give effect to board direction by implementing a health and safety management system using the 'plan, do, check, act' cycle.
- To provide the board with reports on health and safety management system implementation, and performance as required.
- To implement further actions following board review of reports.
- To ensure root cause investigations are carried out using independent investigators in the case of serious incidents.

The implementation of long-term goals and strategy through business planning is the responsibility of management. However, the board needs to ensure, through appropriate monitoring, that these strategies are being effectively implemented.

Directors must never turn a blind eye to undesirable information. They should, instead, always seek out complete and accurate information that will enable them to know whether the organisation is meeting all of its health and safety obligations and goals. Directors must always act decisively whenever that information suggests that it is not.

ROUTINE REPORTS TO BOARD

The following information should be on the board's agenda and reviewed on a regular basis:

- data on all incidents, including near misses and occupational illness. Effective monitoring of these statistics can alert the board to underlying problems before any serious incidents occur
- data on absence rates due to sickness that can be indicators of issues such as stress and fatigue
- data on trends including routine exposure to risks that are potentially harmful to health such as high noise levels, toxic chemicals and bullying
- progress with the implementation of formal improvement plans
- actions in place aimed at preventing harm, such as training, and maintenance programmes
- the health and safety performance and actions of contractors
- reports on internal and external audits, and system reviews.

Directors should be alert to the possibility that there is reluctance to report such information and should satisfy themselves that any such obstacles have been eliminated.

INCIDENTS

Incident investigations should identify root causes and put in place measures to prevent the incident happening again. Investigations should not be about apportioning blame. When looking for root causes there should be consideration of human factors that can contribute to incidents and the possibility of systemic failure such as culture, workload or lack of training.

Directors should review serious incident reports and be satisfied with the integrity of the process, and that the incident investigation has correctly identified root causes, and that an effective action plan has been put in place to address the issues identified. Directors should require further reports covering the completion of actions so that they can be satisfied that the implementation of actions arising from incidents is both effective and timely.

DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to verify that the information they receive is appropriate, accurate and comprehensive.

1. Are you asking the right questions? Do you determine what information you receive or does management?
2. How do you know that the information you are receiving is supported by a strong and honest reporting culture?
3. How does your organisation's performance compare with other comparable organisations and how do you know?
4. Does the organisation have the capability to carry out 'root cause' investigations, or know where to get it?
5. How do you know that actions identified in incident investigations are effectively implemented?
6. How much of the information that you receive is also shared with workers?
7. Are you receiving sufficient information about health as well as safety?

CASE STUDY – COCA-COLA AMATIL NZ

Following a worsening trend in workplace accidents in 2010, it implemented a five-step reform of health and safety measures. The five steps were clear and uncomplicated:

1. Set measurable goals relating to what they wished to achieve with its health and safety reform
2. Use robust and fit-for-purpose health and safety (including hazard) management systems and ensure they are fully integrated into the company
3. Change the culture (including improvement of the reporting culture)
4. Introduce practical programmes (such as stretching before manual labour)
5. Visible leadership – one of the key actions undertaken by the managing director responsible for health and safety was to join the health and safety leadership forum. Another more simple action was to sit in on health and safety committee meetings.

In the year following implementation of the health and safety measures there was a marked increase in reported injuries, but the severity of the injuries had declined. There were 155 near hits reported in November 2011. This indicated a substantial uptake of values by workers at the company and a change in attitudes toward health and safety along with the overall reporting culture. It also indicated that the systems put in place were working. In 2011, the company saw a 90% decrease in ACC costs and in the first quarter of 2012, had zero lost time injuries.

ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
Specify clear requirements regarding reporting and timeframes for significant events in the board's charter.	
Ensure that in the case of serious incidents management have sought external input or review to provide independence and avoid potential vested interests.	
Review serious incidents, including serious non-compliance and near misses and be personally satisfied with the adequacy of management actions in response.	Directors should receive basic training in incident investigation methodology sufficient to ensure that they are able to distinguish between adequate and inadequate investigations. In the case of serious health and safety incidents, obtain independent advice on the adequacy of the investigation and remedial actions.
Ensure that improvement goals are developed annually by management and that regular progress reports are received by the board.	Separate organisations and work sites will have their own business goals. Visible tracking of goals by directors will demonstrate commitment and leadership and encourage commitment from line management to take these goals seriously. For example a site manager may be invited to a board meeting to report on progress with an annual improvement plan or this may be the subject of discussion during a site visit.
Specify clear requirements for the regular reporting of health and safety performance results, and review these reports at meetings for indications of trends, system breakdowns and improvement needs.	Ensure you have a sound understanding of, and focus on, hazards that would have a significant impact on the business. Ensure reports allow tracking of both lag and lead indicators. Directors should satisfy themselves that there are no obstacles to free and frank reporting. Boards should develop their own reports on health and safety performance for shareholders and other stakeholders. Health and safety performance should be included in external reports.

4 Review

DIRECTOR RESPONSIBILITIES

- To ensure the board conducts a periodic (eg annual) formal review of health and safety to determine the effectiveness of the system and whether any changes are required.
- To ensure the board considers whether an external review is required for an independent opinion.

MANAGER RESPONSIBILITIES

- To organise regular audits and reviews of the health and safety management system (internal and external) and its implementation.
- To take remedial actions as required arising from any audit or review.
- To report to the board on the outcomes of audits and reviews.
- To assist the board with the formal health and safety review by providing information and other input as required.

The board should conduct a formal review of health and safety performance on a periodic basis. This enables the board to establish whether their health and safety principles have been embedded in the organisation's culture. Similarly the review will consider whether the policy and system are being effectively implemented and whether they are still fit for purpose.

AUDITS AND SYSTEM REVIEWS

Audits and system reviews arranged by management will inform the board's formal review. Directors should ensure that reviews are undertaken on a regular basis. The objective of an audit is to assess the quality of system implementation and the objective of a system review is to assess whether the system is fit-for-purpose and representative of best practice.

It is normal for audits and system reviews to recommend actions for improvement. Directors should ensure that these recommendations are properly considered by management and where agreed, implemented.

It is desirable that an internal audit or review team comprises a cross section of managers and worker representatives so that a range of perspectives, knowledge and skill is brought to the table. This approach also supports the message that health and safety is everybody's responsibility. Directors should consider if the appropriate people were involved in the review or audit.

It is good practice for the organisation to periodically seek independent and objective assurance from an external audit and/or system review. An external opinion can bring a fresh pair of eyes and new ways of thinking. Involving worker representatives in the selection of external auditors and reviewers is good practice that will help ensure the required objectivity.

FORMAL REVIEW OUTCOMES

The formal review will identify strengths and weaknesses in the system and its implementation.

It is just as important that good performance is recognised and celebrated as it is that opportunities for improvement are identified.

Improvement action plans arising from the formal review should be tracked by directors at regular board meetings.

DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to verify that they are conducting adequate formal reviews of health and safety.

1. What do you do to ensure an appropriate and thorough board level review of health and safety?
2. What information do you use for the review and who do you involve?
3. How do you ensure that your review uses best practice as a benchmark?
4. How do you ensure that workers contribute to this review?
5. How do you ensure maximum independence and objectivity of reviews and audits?
6. How do you recognise and celebrate success?
7. How do you ensure that actions identified in the review are communicated and effectively implemented?

CASE STUDY – HOLCIM NEW ZEALAND

In the mid-90s Holcim New Zealand's safety record was poor. With a LTIFR of 43.8 there was significant room for improvement. While a series of short-term measures saw improvements it wasn't until 2003 when the organisation sought outside help that things really started to change. External audits highlighted there was much more to do than expected and it was clear a change would require a lot of energy and drive. Holcim committed to putting in that effort and put in place the following measures:

- management and the board committed to demonstrating visible safety leadership
  - safety is a key agenda item at board meetings
  - a safety council was created which meets each month to set policy and direction and review progress
  - all of the management team are actively involved in health and safety – they each must spend two half days a year working on-site
  - all managers must attend a four-day safety leadership programme
- adopted a philosophy of 'zero harm, safety first'
- each division has health and safety staff
- the safety manager reports direct to the CEO
- focus on the development of useful lead indicators
- significant effort on developing a safety culture among staff; staff engagement surveys now reflect the effort put into safety
- development of a contractor management programme including a pre-selection process, inductions and specific Holcim site training.

These measures have had a significant impact on Holcim's health and safety performance, the organisation now has an LTIFR of below 3. The focus has shifted significantly with 500 employees completing nearly 6600 safety tours (audits) in 2011. Health and safety is now owned by all Holcim employees in their drive for 'zero harm, safety first'. [9]

9 Safety – one of the toughest leadership challenges; Jeremy Smith - Managing Director Holcim New Zealand: www.zeroharm.org

ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
Specify arrangements for the formal review of health and safety in the board's charter including frequency, who is involved and how, what input is required etc.	Provide opportunities for worker representatives and workers with relevant skills and knowledge to participate in internal audits and reviews and in the selection of external auditors and reviewers.
Ensure that input to the formal review includes audits (internal and external), system reviews, performance results, significant incidents, organisational changes and benchmark data.	Periodically commission a culture survey to assist the review.
As an outcome from the review determine an action plan and track progress.	

Conclusion

As a director, managing your organisation's health and safety risk is just as important as managing financial and reputational risk and it should receive the same focus.

Boards are responsible for determining high level health and safety strategy and policy which managers are required to implement. This strategy and policy must take into consideration all those affected by the organisation's activities, not just workers. Board responsibility however, does not stop with the issuing of strategy and policy as they should also ensure that it is implemented effectively. They do this by holding management to account through processes of policy and planning, delivery, monitoring and review. This includes recognising when the organisation is doing well and celebrating success. Through these processes the board should ensure that they have created an environment in which a commitment to health and safety is part of everyday business. Having a positive health and safety culture and an integrated, embedded and effective health and safety management system in which managers and workers take individual ownership will have significant benefits for the organisation.

> Unless the board is aware of a serious issue, they cannot address it. Information is key. Ensure your management team is telling you all you need to know and don't leave anything to chance. Remember – if it seems too good to be true, it probably is.

Director Health and Safety Checklist

- How do the board and all directors demonstrate their commitment to health and safety?
- How do you involve the organisation's workers in health and safety? Do they feel able to express any concerns?
- How do you ensure that your organisation's health and safety targets are challenging, realistic and aren't creating unintended consequences?
- What data is the board receiving on health and safety? Is this sufficient?
- How do you ensure all staff are competent and adequately trained in their health and safety responsibilities and accountabilities?
- Does the organisation have sufficient resources (people, equipment, systems and budget) for its health and safety programme?
- Does the organisation have a schedule of audits and reviews to ensure the health and safety management system is fit for purpose?
- How do you ensure that actions identified in incident reports, audits and reviews are communicated and effectively implemented?
- How do you ensure that the organisation's risks are assessed and appropriate mitigation measures put in place?
- How connected are you to what happens at the organisation's work sites? What measures are in place to inform you?
- Does the organisation have policies and processes in place to ensure contractors used by the organisation have satisfactory health and safety standards?
- How does your organisation's performance compare with other comparable organisations and how do you know?
- How do you recognise and celebrate success?

Resources

KEY LEGISLATION

All available online at www.legislation.govt.nz

- Health and Safety in Employment Act 1992
- Accident Compensation Act 2001
- Hazardous Substances and New Organisms Act 1996

A wide range of regulations and codes of practice can be found on the MBIE website www.mbie.govt.nz.

STANDARDS

All available from Standards New Zealand online at www.standards.co.nz

- AS/NZS 4801:2001 – Occupational Health and Safety Management Systems - Specification with guidance for use
- AS/NZS 4804:2001 – Occupational health and safety management system - General guidelines on principles, systems and supporting techniques
- AS/NZS ISO 31000:2009 – Risk management - Principles and guidelines

PUBLICATIONS AND WEBSITES

- Ministry of Business, Innovation and Employment – www.mbie.govt.nz
  - A Guide to the Health and Safety in Employment Act 1992
  - Taking All Practicable Steps
  - How Health and Safety Makes Good Business Sense
  - A range of health and safety factsheets on topics such as serious harm, taking all practicable steps and employee participation systems are available online at www.osh.govt.nz/order/catalogue/factsheets.shtml#hse
  - A series of health and safety publications can be found at www.osh.govt.nz/order/catalogue/hse-publications.shtml
- ACC – www.acc.govt.nz/publications
  - Measuring your capabilities in Workplace Safety Management - ACC Workplace Safety Management Practices Audit Standards (ACC442)

- Guidance for Officers in Exercising Due Diligence – www.comcare.gov.au/__data/assets/pdf file/0020/102566/Guidance_for_officers_in_exercising_due_diligence.pdf)
- Institute of Directors in New Zealand www.iod.org.nz
- The Four Pillars of Governance Best Practice (Available from the Institute of Directors in New Zealand)
- Leading Health and Safety at Work, Leadership actions for directors and board members www.hse.gov.uk/pubns/indg417.pdf
- World Class CEO Safety Leadership Assessment (Business Leaders' Health and Safety Forum) www.zeroharm.org.nz/leadership/leadership-assessment/
- The return on prevention: Calculating the costs and benefits of investments in occupational safety and health in companies, International Social Security Association Research Report – www.issa.int/content/download/152234/3046913/file/2-Return-on-prevention.pdf

Glossary

All practicable steps	A key concept in the HSE Act that relates to a requirement to take all steps that a reasonable, prudent person would take in the same situation. For a full definition or explanation of "all practicable steps", refer to the HSE Act and/or the Department of Labour fact sheet, both of which are referenced in the following resource list.
Best practice	A method or technique that in like circumstances has consistently shown superior results in comparison to results achieved using other means – used as a benchmark.
Harm	Illness, injury or both. This includes physical or mental harm caused by work-related stress.
Hazard	Is defined in the HSE Act as an activity, arrangement, circumstance, event, occurrence, phenomenon, process, situation, or substance (whether arising or caused within or outside a place of work) that is an actual or potential cause or source of harm; and includes: • a situation where a person's behaviour may be an actual or potential cause or source of harm to the person or another person; and • without limitation, a situation described above resulting from physical or mental fatigue, drugs, alcohol, traumatic shock, or another temporary condition that affects a person's behaviour.
Lost time injury frequency rate (LTIFR)	Number of reported injuries that resulted in at least one day being lost from work after the day of the injury or illness per million hours worked.
Near miss	A situation or incident where harm might have occurred.
Organisational culture	Collective set of values and beliefs held and exercised within an organisation or workplace.

Serious harm	Is defined in the HSE Act as: • any of the following conditions that amount to or result in: permanent loss of bodily function, or temporary severe loss of bodily function: respiratory disease, noise-induced hearing loss, neurological disease, cancer, dermatological disease, communicable disease, musculoskeletal disease, illness caused by exposure to infected material, decompression sickness, poisoning, vision impairment, chemical or hot-metal burn of eye, penetrating wound of eye, bone fracture, laceration, crushing • amputation of body part • burns requiring referral to a specialist registered medical practitioner or specialist outpatient clinic • loss of consciousness from lack of oxygen • loss of consciousness, or acute illness requiring treatment by a registered medical practitioner, from absorption, inhalation or ingestion of any substance • any harm that causes the person harmed to be hospitalised for a period of 48 hours or more commencing within seven days of the harm's occurrence.
Significant hazard	Is defined in the HSE Act as a hazard that is an actual or potential cause or source of: a) serious harm; or b) harm (being harm that is more than trivial) the severity of whose effects on any person depend (entirely or among other things) on the extent or frequency of the person's exposure to the hazard; or c) harm that does not usually occur, or usually is not easily detectable, until a significant time after exposure to the hazard.
Workers	Employees of the organisation, its contractors and its subcontractors.
Zero harm	An expression used by many organisations to describe an aspirational target of no harm of any sort to workers.

All definitions that relate to legislation are correct as at 30 April 2013.

DOL 12371 MAY 2013

Comparison

Health and Safety in Employment Act 1992
&
Proposed Health and Safety at Work Legislation 2015

<table>
<tr><th>Health and Safety in Employment Act 1992</th><th colspan="3">Health and Safety at Work 2015</th></tr>
<tr><td>Applies to employers, employees and contractors</td><td colspan="3">Applies to previous PLUS volunteer and non-profit organisations</td></tr>
<tr><td>Under-resourced and few inspectors – approximately 30 nationally</td><td colspan="3">Very structured inspection system raising to 200+ inspectors</td></tr>
<tr><td rowspan="2">Fines depended upon culpability:
▪ Low level – up to $50,000 fine
▪ Medium level – up to $100,000 fine
▪ High level – up to $175,000 fine
Reparations also possible to put right damage done</td><td>Maximum Tiered Penalties</td><td>Individual</td><td>Body Corporate</td></tr>
<tr><td>Cat 1 Reckless Conduct
Cat 2 Exposing to serious risk
Cat 3 Failure in H&S duty</td><td>$600,000 and/or 5 Years prison
$300,000
$100,000</td><td>$3 million
$1.5 million
$500,000</td></tr>
<tr><td></td><td colspan="3">Insurance against these fines is not possible; insurance can cover reparations
Cat 1 fines are reserved for “officers”… An “officer” is a person that makes or participates in decisions that affect a substantial part of the business</td></tr>
<tr><td>Employers and Employees must be able to demonstrate that they have taken “Reasonable Care”</td><td colspan="3">Must pass ALL six “Due Diligence” tests:
▪ must have up to date knowledge,
▪ must have an in-depth understanding of the nature of hazards and risks in the organisation;
▪ must provide appropriate resources – not just lip-service,
▪ must monitor incidents, hazards and risks AND take appropriate action
▪ must have H&S compliance
▪ must check that resources and processes are being followed</td></tr>
<tr><td>“Serious Harm” reports unlikely to receive substantial follow-up unless very major injury</td><td colspan="3">Serious Harm incidents likely to result in companies being “invited” to complete an 8 page “Duty Holder Review” detailing a full investigation and root cause correction. 5-10% of Duty Holder Reviews will be audited later to ensure that correction implementation was successful</td></tr>
<tr><td>The term “worker” was restricted to employee</td><td colspan="3">Now “worker” includes trainees, volunteers, sub-contractors, outworkers and students on work experience</td></tr>
<tr><td>Contractor induction required</td><td colspan="3">Contractor and Sub-contractors must be solicited as if “workers” to ensure that they have the opportunity to improve the principal’s system</td></tr>
<tr><td>Board of directors can rely on the reports of senior managers</td><td colspan="3">Directors must now be personally sure that H&S is well managed – visiting the workplace, observing and interviewing staff</td></tr>
</table>

Source – Training in Supply Limited 2014

COMMUNITY & PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEE MEETING UPDATE 11 SEPTEMBER 2014

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

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

DATE: **26 September 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 11 September 2014.

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 –11 September 2014.

3. SUMMARY

ITEMS OF INTEREST FOR THE BOARD

a) Community & Public Health Update.

This report provided the Committee with updates on:

Drinking Water Subsidies

The Committee noted that four West Coast communities were successful in obtaining Ministry of Health funding from the recent 2013/14 round of drinking-water subsidies. No West Coast applications were declined. Details are:

Applicant	Water Supply Name	Total Project Cost	Approved Funding
Buller District Council	Karamea	$1,686,310	$1,433,364
Grey District Council	Kaiata	$1,144,973	$973,227
Buller District Council	Inangahua	$222,740	$189,329
Buller District Council	Waimangaroa	$473,692	$402,639

This is very good news for the Karamea community as this project will construct a new reticulated water supply using the new water source they developed last year. The Kaiata project will create a new reticulation zone of the Greymouth water supply to serve the residential properties in Kaiata. The Inangahua and Waimangaroa supplies have also been approved but will have to meet conditions around funding.

Due to the poor condition of many West Coast community water supplies this is a very pleasing outcome and Community and Public Health will be working closely with Councils as these projects are implemented.

Alcohol Policies in Schools

CPH staff, including the Medical Officer of Health, have made presentations to the Principals' Association and Education West Coast about alcohol-related issues. The topics discussed have included alcohol policies, special licences, whether alcohol has a place at school fundraising events, the provisions of the Gambling Act relating to alcohol, and the changes to legislation around supply of alcohol to under 18 year olds. Each presentation has stimulated lively discussion and CPH staff have offered assistance to schools wanting to develop alcohol policies if they do not already have these.

Alcohol Controlled Purchase Operations (CPOs)

Two licensed premises that sold alcohol to 15 & 16 year old volunteers in Franz Josef and Fox Glacier in April have accepted a 24 hour suspension of their trade at a date to be decided by the Alcohol Regulatory and Licensing Authority. These CPOs are carried out monthly by Police with the assistance of Community & Public Health and it is always disappointing when a sale is made when all that is required to avoid it is for sellers to ask for proof of age.

Promoting Healthy Nutrition and Physical Activity

Community & Public Health continue to support community events around Healthy Nutrition and Physical Activity.

Stoptober

This a 31 day stop smoking challenge being held around New Zealand during October. On the West Coast this will be promoted in the streets of Greymouth and Hokitika in September. There will also be stop smoking support group running throughout the West Coast.

The report was noted.

b) 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 as follows:

Key Achievements

- The West Coast continues to perform well above the **ED health target**; with 99.7% of patients admitted, discharged or transferred within 6 hours, and 95.3% within 4 hours.
- The West Coast continues to achieve the **Shorter Waits for Cancer Treatment health target** during July with 100% of people ready for radiotherapy or chemotherapy beginning treatment within four weeks.
- During Quarter 4 West Coast DHB staff provided 95% of hospitalised smokers with smoking cessation advice and support –meeting the Secondary Care Better Help for Smokers to Quit Health Target. Work continues to increase consistency of results.

Key Issues & Associated Remedies

- While we are still 28% off target and ranked last out of all DHBs against the **primary care smokers better help to quit health target**, we had a pleasing 6.5% increase this quarter that represents our best result yet. Actions previously reported continue, with monthly practice by practice reporting expected to provide visibility for which practices need most support.

Upcoming Points of Interest

- The **B4 Schools Check Clinical Advisory Group** has formed and met for the first time in August. This group will provide guidance on clinical issues, including access and referral patterns and processes related to the programme.
- **Community Engagement Mental Health**
  The recently formed Mental Health Workstream is developing a model for service provision in Buller within the context of IFHS. Community engagement meetings are planned for the coming weeks.

Discussion took place regarding the B4 School Checks target and the Committee noted that management have a focus on the data around this result and the possible issue around the number of 4 year olds available to check.

Discussion also took place regarding immunisation and it was noted that in addition to people opting not to receive immunisations there are also people who opt for this not to be recorded.

The report was noted.

c) Alliance Update

This report provided an update of progress made around the West Coast Alliance including:

- Mental Health Workstream
- Complex Clinical Care Network
- Grey/Westland and Buller Integrated Family Health Services
- Healthy West Coast
- Child and Youth Workstream and
- Pharmacy

The Committee noted that management are working through some new reporting for the Alliance around work streams.

The report was noted.

d) Clinical Leaders Update

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

e) Maori Health Plan Update

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

f) Health Target Report Quarter 4

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

4. APPENDICES

Appendix 1: Agenda – Community & Public Health & Disability Support Advisory Committee – 11 September 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 11 September 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** *24 July 2014*		
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.	**Planning & Funding Update**	Phil Wheble *Team Leader, Planning & Funding*	*9.25am - 9.40am*
6.	**Alliance Update**	Phil Wheble *Team Leader, Planning & Funding*	*9.40am - 9.55am*
7.	**Maori Health Plan Update**	Gary Coghlan *General Manager Maori Health*	*9.55am - 10.10am*
8.	**Health Target Q4 Update**	Phil Wheble *Team Leader, Planning & Funding*	*10.10am - 10.25am*
9.	**General Business**	Elinor Stratford Chair	*10.25am - 10.30am*
ESTIMATED FINISH TIME			**10.30am**

INFORMATION ITEMS

- **Board Agenda – 8 August 2014**
- **Chair's Report to last Board meeting**
- **Work Plan 2014**
- **West Coast DHB 2014 Meeting Schedule**

NEXT MEETING

Date of Next Meeting: Thursday 23 October 2014

HOSPITAL ADVISORY COMMITTEE MEETING UPDATE 11 SEPTEMBER 2014

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

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

SOURCE: **Chair, Hospital Advisory Committee**

DATE: **26 September 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 11 September 2014.

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 – 11 September 2014.

3. SUMMARY

Detailed below is a summary of the Hospital Advisory Committee meeting held on 11 September 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.

CARRIED FORWARD ITEMS

Management will be in a position to report back on patient transport, both locally and regionally at the next meeting.

MANAGEMENT REPORT

Mark Newsome, General Manager, Grey/Westland presented this report.

Mr Newsome advised that the Facilities Development detailed design process commenced today and the consultants are all here on the ground over the next few days. A schedule is being developed for them to be here for 2-3 days each fortnight. The Committee noted that management have been very firm regarding Clinical involvement and participation and the consultants are now well aware of the lead in time required to ensure continued Clinical involvement.

Peter Ballantyne, Board Chair, provided the Committee with an overview from the Partnership Group perspective.

The Management Report was taken as read and Mr Newsome highlighted the following points:

- DNAs – there is a group looking at the West Coast DHB DNA rates which are above the national average. The group now has an implementation plan and will focus on the areas with the highest DNA rate. In addition some simple processes will be put in place initially and these will be reviewed in 3 months time.

- ED Attendances – the Ministry of Health have set a new framework to report on for ED Attendances. These are required to be reported on quarterly and the West Coast is doing its best to report on these however due to the nature of the operation of our ED this is not always possible. Management do believe however that this could be a positive thing as it will highlight some of the areas that need some additional focus.

- Some planning has been undertaken around Christmas and New Year arrangements. Most elective procedures will cease between 19 December and 11 January, Hannan Ward will be closed and the number beds will be reduced in both Barclay and Morice Wards, however there will be the ability to open beds if the need arises. Management are also beginning planning in the Mental Health area. The Committee noted that these arrangements have been based on solid data and have not been decided in isolation and also that as well as allowing staff to have a break it will assist with Annual Leave management.

- The Committee noted that the provision of Allied Health Services remains a challenge, particularly in physiotherapy. The re-advertising of the associate Director of Allied Health role has commenced and an interim arrangement has been put in place meantime to continue to provide leadership to the Allied Health Group.

- In regard to Industrial Relations, the PSA issued strike notices in support of bargaining for three Multi Employer Collective Agreements (MECAs). These were withdrawn after continued negotiations with DHBs and settlements for all agreements were reached via mediation. These three settlements are now being presented to members for ratification. The Committee noted that there is a national contingency planning structure in place for industrial action notifications.

- There were a number of patient transfers during June and July and management will embark on an audit of these to ensure appropriateness.

Discussion took place regarding the patient journey flow charts and referrals back to GPs.

Discussion also took place regarding complaint responses and whether the DHB is meeting timings around this. The Committee noted that a lot of work has been undertaken in this area to ensure that we have a proper process in place and that the quality of the responses is of a high standard. We continue to improve in this area.

A query was made regarding maternity services and Mr Newsome provided the Committee with an outline of the current services provided and the current proposal that is out for consultation.

The report was noted

FINANCE REPORT

Mark Newsome, General Manager, Grey/Westland, presented the Finance Report for the month ending July 2014. The consolidated financial result for the month of July 2014 (and year to date) was a deficit of $0.163m which was $0.158m unfavourable against the budgeted deficit of $0.005m.

Discussion took place regarding the infrastructure and non treatment related trends and the Committee noted that some storm costs are still being seen. Maintenance costs are high and will remain high as we nurse the building through to the provision of the new facilities.

The Committee noted the challenges around getting medical staff to the West Coast (Air NZ flights etc) and also the on-going challenges around the use of Locums which are a significant part of the costs.

Discussion took place regarding accrued annual leave and the Committee noted the fine balance required to ensure staff have a break and also manage the annual leave risk to the organisation. It was also noted that this can be constrained by some of the collective agreements in place.

The report was noted.

CLINICAL LEADERS UPDATE

Dr Carol Atmore, Chief Medical Officer, presented this report which was provided to the Board at their last meeting. The Committee noted the work being undertaken around Rural Learning Centre Development. The DHB is expanding its Rural Hospital Medicine Registrar positions for 2015 and have a record number of General practitioner Registrars for 2015 on the West Coast

4. APPENDICES

Appendix 1: Agenda - Hospital Advisory Committee – 11 September 2014.

Report prepared by: Sharon Pugh Chair, Hospital Advisory Committee

AGENDA

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

WEST COAST DHB HOSPITAL ADVISORY COMMITTEE MEETING
To be held in the Board Room at Corporate Office, Grey Base Hospital, Greymouth
Thursday 11 September 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**
   24 July 2014

3. **Carried Forward/Action Items**

REPORTS/PRESENTATIONS — 11.10am

4.	**Management Report**	Mark Newsome *General Manager Grey | Westland*	*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.	**General Business**	Sharon Pugh *Chair*	*12noon – 12.15pm*

ESTIMATED FINISH TIME — 12.15pm

INFORMATION ITEMS

- **Chair's Report to last Board meeting**
- **Board Agenda – 08 August 2014**
- **2014 HAC Work Plan (Working Document)**
- **West Coast DHB 2014 Meeting Schedule**

NEXT MEETING:

Date of Next Meeting: 23 October 2014
Corporate Office, Board Room at Grey Base Hospital.

TATAU POUNAMU COMMITTEE MEETING UPDATE – 11 SEPT 2014

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

SOURCE: **Chair, Tatau Pounamu**

DATE: **26 September 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 Tatau Pounamu meeting on the 11 September 2014.

For the Board's information the functions of Tatau Pounamu, in accordance with their Terms of Reference is to give advice on:

i. 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.

2. RECOMMENDATION

That the Board

i. notes the Tatau Pounamu Manawhenua Advisory Group update - 11 September 2014.

3. SUMMARY

Detailed below is a summary of the Tatau Pounamu meeting held on 11 September 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.

KEY POINTS FOR THE BOARD

The Committee would like the following points noted by the Board.

Appointment of Maori to Committees and Boards

Tatau Pounamu has an expectation through the MOU to provide appropriate Maori representation to various committees and boards. This is a function that Tatau Pounamu is fully committed to and has developed an appointments policy that will set out the process for the appointment of Maori to these boards and committees.

At our previous Tatau Pounamu meeting it was advised that new appointments needed to be made to the Hospital Advisory Committee (HAC) and the Community Public Health Advisory Committee (CPHAC). The following Rununga appointments have been made:

- **Hospital Advisory Committee (HAC) –** Richard Wallace *(reappointment for further term)*
- **Community Public Health and Disability Support Advisory Committee**

(CPH&DSAC) – Joseph Mason

- **Alliance Leadership Team & Mental Health Workstream**
  Internal advertising has occurred to find a Maori representation for the Alliance Leadership Team and Maori Mental Health Workstream. There has been some verbal interest but nothing has been formally submitted. It was agreed today that due to the significance of these groups to advertise externally in the Grey, Buller and Hokitika newspapers.

Whanau Ora

Tatau Pounamu are currently undertaking work to revise transformational health strategy documents such as the Better Sooner More Convenient and the IFHS business cases with a particular focus on aligning key principles within these documents using the Iwi led Whanau ora Commissioning Agency model as a guide. The intention is for the Board to develop a consistent set of principles to be adopted by the DHB around Whanau ora.

Memorandum of Understanding

Tatau Pounamu's Memorandum of Understanding is due for renewal. Tatau Pounamu would like to request a Board representative to work alongside them at their regular Tatau Pounamu meetings to begin the revision of the document. The Terms of Reference will also be included as part of this review.

4. APPENDICES

Appendix 1:	Agenda – Tatau Pounamu 11September 2014
Appendix 2:	Appointments Policy

Report prepared by: Lisa Tumahi, Chair, Tatau Pounamu Advisory Group

TATAU POUNAMU MANAWHENUA ADVISORY COMMITTEE AGENDA

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

TATAU POUNAMU ADVISORY GROUP MEETING
To be held at West Coast DHB - Kahurangi Room – Mental Health
Thursday 11 September 2014 @ 3.00 pm

KARAKIA

ADMINISTRATION

Apologies

1. **Interest Register**
   Update Interest Register and Declaration of Interest on items to be covered during the meeting.
2. **Confirmation of the Minutes of the Previous Meeting**
   26 July 2014
3. **Carried Forward/Action List Items**
4. **Discussion Items**

- Whanau Ora – Defining its context within DHB/Annual Plan
- Draft Appointments Policy Update
- Maori Representative Appointment Updates
- Mark Newsome General Manager Grey/Westland (Acting for Michael Frampton) 3.45pm

REPORTS

5.	**Chairs Update – Verbal Report**	Chair
6.	**GM Maori Health Report**	General Manager Maori Health
7.	**Memorandum of Understanding Review**	General Manager, Maori Health
8.	**Workstream/Alliance Update**	Jenny Stephenson, Planning & Funding

INFORMATION ITEMS

- West Coast Alliance Presentation
- Media articles
- Tatau Pounamu Meeting Schedule

Information items (hard copies will be distributed on day)

ESTIMATED FINISH TIME 5.00pm

NEXT MEETING

APPENDIX 2

Draft APPOINTMENT POLICY FOR MĀORI REPRESENTATIVES TO Operational Health Committees

1. INTRODUCTION

This draft policy sets out an objective and transparent process for identifying and appointing appropriately skilled and experienced representatives for Māori to West Coast operational health committees.

These appointments will be made on the basis of merit and the Appointment Panel, Tatau Pounamu, will follow governance best practice.

2 POLICY CONTEXT

The WCDHB Board (WCDHB) is responsible for all public hospital and health care provision across primary, secondary and community services in the West Coast region. Committees across these sectors are responsible for strategic planning through to responsive best practice that meets the needs of patients and the community. The participation of credible, competent Maori representation on these committees is necessary to ensure the Māori community voice is present.

The Māori Community want to ensure that Māori Representatives have the support of the Māori community whom they represent, in conjunction with having the skills, knowledge and experience necessary to positively influence Māori health outcomes.

2.1 DEFINITIONS

WCDHB Operational Committees" include a range of committee and not limited to, reference groups, working groups, service development initiatives etc. in which WCDHB has oversight.

"Key Māori Stakeholders" are representative of the Māori community and includes but is not limited to:

- Iwi - Te Runanga o Ngati Wae Wae and Te Runanga o Makaawhio
- All Maori communities of Te Tai Poutini

"Appointment Panel" **is Tatau Pounamu which** is the recognised manawhenua advisory group regarding Māori health for Te Tai o Poutini. The membership is each Papatipu Runanga of Tai Poutini, that being Te Runanga O Ngati Waewae and Te Runanga O Makaawhio and elected Māori community representatives

"Māori Representatives" are applicants *(Māori whakapapa desirable but not a pre-requisite)* that are able to demonstrate understanding of Tikanga Māori, Māori health issues and the health system.

APPOINTMENT POLICY FOR MĀORI REPRESENTATIVES

3 POLICY OBJECTIVE

The objective of this policy is to ensure Māori Representatives had the support of the Mana Whenua and the Māori community whom they represent, in conjunction with having the skills, knowledge and experience necessary to positively influence Māori health outcomes on WCDHB Operational Committees and associated working groups ie ALT workstreams, to which they are appointed to.

The appointment policy formalises the appointment process to secure appropriate representation on the WCDHB operational health committees.

4 POLICY STATEMENT

4.1 Selection and Appointment of 'Māori Representatives' to WCDHB Operational Committees

4.1.1 Tatau Pounamu, hereafter called the Appointment Panel, shall be convened to appoint Māori Representatives.

4.1.2 Where an Appointment Panel is responsible for appointing a 'Māori Representative', and has not delegated that responsibility to any other body, nominations for candidates to be appointed as 'Māori Representative(s)' to a WCDHB Operational Committee and associated working groups will be received via email and/or post at the West Coast DHB, Maori Health Department as the current secretariat provider.

4.1.3 An Appointment Panel will consider matters including the skills, knowledge, experience and interest of the candidates as it relates to the specific committee and decide on the successful candidate.

4.2 People appointed to such WCDHB Operational Committees and/or working groups are entitled to the remuneration (if any) offered by the committee to which they are appointed.

4.2.1 Where there is a vacancy, the Appointment Panel shall undertake a selection process that will include:

- Requesting curriculum vitae (e.g. through advertising via email to community networks)
- Interviewing and assessing candidates if required
- Reference checking

4.2.2 The Appointment Panel shall consider candidates' skills, knowledge and experience when making its decisions.

5 ADOPTED BY AND DATE

5.1 Adopted by Tatau Pounamu on XX 2014 recommendation to the WCDHB Executive Management Team on XX 2014 and adopted by WCDHB on XX 2014.

6 REVIEW

6.1 Review every three years or sooner on request.

APPENDIX 1

APPOINTMENT POLICY FOR MĀORI REPRESENTATIVES TO OPERATIONAL HEALTH COMMITTEES

1. ROLES AND RESPONSIBILITIES

1.1 To operationalise the Policy there are two key contributors, , the Tatau Pounamu Advisory Group and West Coast DHB

2 THE ROLE OF THE APPOINTMENT PANEL

2.1 The role of the Appointment Panel is to appoint an appropriate person to represent the interests of Māori on WCDHB operational health committees and associated working groups.

2.1.1 The Appointment Panel Chair is the sitting chair of Tatau Pounamu

2.2 The Panel tasks include:

- reviewing and assessing applicant information
- interviewing applicants if required
- utilising specific interview and competency tools provided
- appointing a representative with relevant skills, and demonstrated involvement in the community and experience [LT1]
- notify secretariat of successful applicant within five working days.

2.3 Tatau Pounamu Advisory Group is to engage in a culturally appropriate process to ensure that Māori are well represented

3 THE ROLE OF THE SECRETARIAT

3.1 General Manager, Maoriprovides the secretariat role.

3.1.1 The role of the secretariat is to ensure:

- the Key Māori Stakeholders are appropriately engaged
- notifying all key stakeholders, including Māori providers and wider Māori community of a request for Māori representation
- inform Appointments Panel nominees of selection to Appointment Panel
- receiving all relevant documentation from the applicants for secure storage
- notify all key stakeholders, including Māori providers and wider Māori community of successful appointee
- ensure a robust and transparent process is undertaken to appoint a Māori representative to the WCDHB Operational Committees and associated working groups.

3.2 The function of the secretariat is to assist in facilitating the seamless management of the appointments process. The secretariat tasks include:

- providing key competencies based on vacancy specification
- relevant documentation to assist with candidate assessment and appointment
- receive and collate candidates' curriculum vitae and/or additional supporting information
- complete a due diligence for each candidate, if required
- facilitate feedback to WCDHB for a response
- shortlist candidates against key competencies
- Assemble and distribute an information pack to the Appointments Panel with recommendations for consideration.

RESOLUTION TO EXCLUDE THE PUBLIC

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

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

SOURCE: **Board Secretariat**

DATE: **26 September 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 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 8 August 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 c ommercial 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.	Legal Update - Verbal	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
6.	2014-15 IEA Salary Review	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)

7.	Advisory Committee – Public Excluded Updates	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)

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
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
Thursday 11 September 2014	TATAU POUNAMU	3.00pm	Kahurangi Room, Grey Hospital
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	To be confirmed
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.