West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Friday 31 October 2014
10.15am

West Coast Regional Council
388 Main South 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 West Coast Regional Council, Greymouth
On Friday 31 October 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**
   - *26 September 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**	Michael Frampton *Programme Director*	*10.35am - 10.50am*
6.	**Clinical Leader's Update**	Mark Newsone *General Manager, Grey/Westland*	*10.50am - 11.00am*
7.	**Finance Report**	Justine White *General Manager, Finance*	*11.00am - 11.10am*
8.	**Maori Health Plan Update**	Gary Coghlan *General Manager, Maori Health*	*11.10am - 11.25am*
9.	**Oral Health Review Update**	Michael Frampton *Programme Director*	*11.25am - 11.45am*
10.	**Report from Committee Meetings**	***(Late Papers due to timing of meetings.)***	
	- CPH&DSAC *23 October 2014*	Elinor Stratford *Chair, CPH&DSAC Committee*	*11.45am– 11.55am*
	- Hospital Advisory Committee *23 October 2014*	Sharon Pugh *Chair, Hospital Advisory Committee*	*11.55am – 12.05pm*
	- Tatau Pounamu Advisory Group *23 October 2014*	Elinor Stratford *Board Representative to Tatau Pounamu*	*12.05pm – 12.10pm*
11.	**Resolution to Exclude the Public**	*Board Secretariat*	*12.10pm*

INFORMATION ITEMS

- 2014 Meeting Schedule

ESTIMATED FINISH TIME — *12.10pm*

NEXT MEETING

Friday 12 December 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

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

MINUTES OF THE WEST COAST DISTRICT HEALTH BOARD MEETING
held at St John, Waterwalk Road, Greymouth
on Friday 26 September 2014 commencing at 10.15am

BOARD MEMBERS

Peter Ballantyne (Chair); Kevin Brown; Helen Gillespie; Michelle Lomax; Peter Neame; Sharon Pugh; and Joseph Thomas.

APOLOGIES

Apologies were received and accepted from Elinor Stratford, John Vaile & Susan Wallace.

EXECUTIVE SUPPORT

David Meates (Chief Executive); Michael Frampton (Programme Director); Dr Carol Atmore (Chief Medical Officer); Gary Coghlan (General Manager, Maori Health); Kathleen Gavigan (General Manager, Buller); Carolyn Gullery (General Manager, Planning & Funding); Justine White (General Manager, Finance): Lee Harris (Senior Communications Advisor); 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 (41/14)
(Moved Helen Gillespie/seconded Joseph Thomas - carried):

"That the minutes of the Meeting of the West Coast District Health Board held at the West Coast Regional Council, Greymouth on Friday 8 August 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 National Chair's Strategy Meeting held in Wellington on 13 August 2014. He advised that the agenda covered:
  - Workforce, presented by Mick Prior and Sally Webb;

- Regionalisation presented by the lead Chairs;
- National Health Committee presented by Ann Kolbe;
- Ministerial Review Group Report (2009) presented by Murray Horn. Murray also spoke regarding HBL and was strong on taking a whole of sector approach., and also a performance improvement framework which will be addressed by Chair's & CEO's at a separate workshop. This will assist in ensuring that all DHBs are heading in the same strategic direction.

- National Chairs Meeting on 8 September. Murray Horn was also a guest speaker at this meeting and spoke again of performance improvements. There was a long discussion regarding HBL and discussion took place regarding a combined report to the incoming Minister of Health from the Sector.

- There have been 2 Partnership Group teleconference meetings since the last Board meeting and there will be face to face meeting on 30 October.

Resolution (42/14)
(Moved Sharon Pugh/seconded Kevin Brown – carried)
That the Board:
i. notes the Chair's verbal update.

The meeting moved to item 11

11. GOVERNANCE RESPONSIBILITIES – HEALTH & SAFETY

Greg Brogden, Senior Corporate Solicitor, presented this report which was taken as read.

Mr Brogden provided some background around the reports and the Board noted that there is a new piece of legislation coming into effect from April 2015.

The Board also noted that there will be a personal liability for both governance and management in the new legislation and there is a short space of time for us to get up to speed.

Mr Brogden advised that a working party has been established and a gap analysis has been developed. He advised members to read the MBIE "Good Government Practices Guidelines for Managing Health & Safety Risks" which was included in today's Board papers.

Discussion took place regarding whether the DHB will have appropriate processes in place before April 2015 and Mr Brogden advised that some of this will require a culture shift and while it is not possible to give this assurance he assured the Board that the appropriate policies and frameworks will be in place.

The Board noted that OSH is being replaced by Workforce New Zealand who are just in the process of setting up.

The Board noted that they will be kept up to date with progress around this.

Resolution (43/14)
(Moved Sharon Pugh/seconded Kevin Brown – carried)
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.

5. CHIEF EXECUTIVE'S UPDATE

The Chief Executive presented his report which was taken as read. He highlighted:

- The ongoing focus with General Practice on capability and skills with the Practice Managers undergoing training. A point was raised regarding the vacancy in Reefton and the Chief Executive advised that this is being covered at the moment and is being dealt with.
- Clinical Nurse Specialist Role around cancer services – as we continue to expand telehealth facilities we must ensure that we get the capability correct thus enabling West Coast people to be treated on the West Coast.
- In regard to Telehealth the Chief Executive advised that Dr John Garrett, recently presented to a conference in Australia and it is evident that the West Coast is at the leading edge of telehealth.
- Sitting along side telehealth is the Transalpine model of care and there is a workshop on 2 October involving 65 clinicians form both Canterbury & West Coast DHBs as we continue to rebuild the health system on the West Coast.
- The DHB has just gone through a certification process which has gone well. Feedback will come back to the DHB in the next 6 – 8 weeks.
- There is an ongoing focus on the five key priorities for improving the performance of our health system:
  - ✓ **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.

- The Chief Executive advised of the appointment of Michael Frampton to the role of General Manager, People & Capability sitting across both DHBs. A transition period will ensure that the momentum on the West Coast carries on. The Chair congratulated Michael Frampton on his appointment and acknowledged the great contribution he has made on the West Coast and stressed the importance of him retaining an interest here.

Discussion took place regarding the term of the GPs recruited in Buller and the Chief Executive commented that the 6 and 12 month terms were what we were able to secure. He added that if they had been willing to stay longer they would have been employed for a longer term.

A query was made regarding engagement with the Reefton community and the Chief Executive advised that the community are setting up a stakeholder group with appropriate representation across the community and the Mayor is looking as using some of the existing frameworks for this. He added that community engagement is underpinning everything we are doing and some dates for meetings will be provided over the next few months.

Resolution (44/14)
(Moved Joseph Thomas/seconded Kevin Brown – carried)
That the Board:

i. notes the Chief Executive's update

6. CLINICAL LEADERS REPORT

Dr Carol Atmore, Chief Medical Officer, presented this report which was taken as read.

She highlighted the following points:

- The Transalpine development workshop next week;
- The appointment of a Maternity Educator;
- The mid year intake of graduate nurses;
- Recruitment of the Associate Director of Allied Health;
- The recent Quality Workshop; and
- Facilities progress.

Resolution (45/14)
(Moved Peter Neame/seconded Helen Gillespie – 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 July 2014 which was taken as read. The report advised that 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.

Resolution (46/14)
(Moved Joseph Thomas/seconded Helen Gillespie – carried)

That the Board:
i. Notes the financial result for the period ended 31 July 2014

8. MATERNITY REVIEW – UPDATE ON PROGRESS

Michael Frampton, Programme Director, presented this update. The Board noted that significant progress has been made. An EOI has been undertaken for Buller and he assured the Board that everything possible is being done to pursue options to reinstate services there.

Resolution (47/14)
(Moved Michelle Lomax/seconded Sharon Pugh – carried)
That the Board:
i. Notes the report of progress against recommendations from the Maternity Review.

9. SCHEDULE OF MEETINGS 2015

there was no discussion on this item which was self explanatory.

Resolution (48/14)
(Moved Joseph Thomas/seconded Sharon Pugh – carried)
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.

10. HEALTH TARGET REPORT – QUARTER 4

Carolyn Gullery, General Manager, Planning & Funding, presented this report which was taken as read. The Board noted that the target for elective surgery should read 1,592, not 1,176 as stated in the report as arrangements had been made to provide more cases and additional funding was secured to support this.

Ms Gullery advised that there was good drive from Primary Care to pick up on smoking cessation and CVD targets.

Resolution (49/14)
(Moved Sharon Pugh/seconded Joseph Thomas – carried)
That the Board:
i. Notes the West Coast's performance against the health targets.

12. REPORTS FROM COMMITTEE MEETINGS

a) Peter Ballantyne, Board Chair, provided an update from the Committee meeting held on 11 September 2014.

The update was noted

b) Sharon Pugh, Chair, Hospital Advisory Committee, provided an update from the Committee meeting held on 11 September 2014.

She mentioned in particular: the design phase of the facilities project; the good work being

undertaken around DNAs; staff leave and Christmas and New Year arrangements.

The update was noted.

c) Gary Coghlan presented the update on the Tatau Pounamu Advisory Group meeting held on 11 September 2014.

Tatau Pounamu have submitted appointees to the Board for the Hospital Advisory Committee and the Community & Public Health & Disability Support Advisory Committee.

Resolution (50/14)
(Moved Joseph Thomas/seconded Helen Gillespie – carried)
That the Board

i. Confirms the appointment of Richard Wallace to the Hospital Advisory Committee and Joseph Mason to the Community & Public Health & Disability Support Advisory Committee; and
ii. Confirms that the term of appointment for these members is until July 2017, noting that the Board can conclude these appointments earlier if necessary on the recommendation of Tatau Pounamu.

The Board noted that Tatau Pounamu are currently undertaking work to revise transformational health strategy documents such as Better Sooner More Convenient, and IFHS business cases with a particular focus 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.

The Board also noted the request for a representative to work alongside them to begin the revision of the Memorandum of Understanding. Board members were asked to provide any feedback they may have regarding this process.

The update was noted

Due to Item 13 (Deputation) being scheduled for 12.25pm and the early completion of the agenda the meeting moved into Public Excluded at 12noon as follows:

14. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (51/14)
(Moved Helen Gillespie/seconded Sharon Pugh – 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 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";

The meeting moved back into Public at 12.25pm

13. DEPUTATION

Mrs Jo Partridge had requested the opportunity for her and her husband to make a deputation to the Board regarding her tragic experience with the West Coast DHB and her subsequent complaint to the Health & Disability Commissioner.

Mr & Mrs Partridge addressed the Board until 1pm outlining their experiences and disappointment.

Board members were given the opportunity to ask questions of clarification.

There being no further business the meeting went back to Public Excluded.

Resolution (50/14)
(Moved Joseph Thomas/seconded Helen Gillespie – carried)
That the Board move back into Excluded.

The Public Excluded section of the meeting commenced at 12noon, reverted back to Public at from 12.25pm – 1pm and concluded at 3.10pm with a break for lunch between 1.00pm and 1.30pm.

_____ _____

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 31 OCTOBER 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. Last update provided on 26 September 2014.	Further update at December 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: **31 October 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

Alliance Leadership Team

- The Chair of ALT continues to work with Tatau Pounamu to identify the appropriate person to provide Maori Health expertise to the Leadership Team. The West Coast Chair has been offered support by Mana Whenua ki Waitaha (of the Canterbury Alliance) to ensure good process is followed, as necessary.

Mental Health Workstream

- The development of models of care for Buller by the Mental Health workstream is progressing well. Local NGOs, staff, consumers and family members have met with the workstream. Their contributions have informed the model as well as highlighted priorities for action.
- Provision of after-hours crisis resolution in Westport is closely aligned to work on having a single point of entry to the Buller health system. Taking an integrated approach to building capacity in this area necessitates a focus on the workforce as a whole, its deployment and reconfiguration.

B: Build Primary and Community Capacity and Capability

Primary

- **South Westland Area Practice:** Increased activity within the practice is noted with an increase in tourists in the area, particularly in the glacier region. Summer season predictions for the West Coast are for higher visitor numbers than last year, with an expected flow-on impact on demand for health services.
- **RAGP and Greymouth Medical**: A weekly meeting between ED and the Practice Charge Nurse Manager has been initiated in order to assist in improving outcomes for the practice patients who present at ED. A combined practice newsletter has been produced and is currently being reviewed by Communications. It is anticipated the newsletter will be available to all patients each season and will deliver key messages. Several staff are participating in the IFHC planning meetings towards the facility rebuild.
- **Reefton Health:**
  - The Practice Manager position has been re-advertised, and the new Practice Receptionist has recently started. Management of leave balances continues.
  - There has been a high level of interest expressed by nurses to undertake postgraduate study next year.
  - The first combined community and staff stakeholder meeting to discuss the future of health services for Reefton is scheduled to take place on 21 October with two more planned before the end of the year.
  - The new PRIME car has been delivered and has had an outing already to the Buller Gorge. Nurses were relieved that the car was able to cross rough terrain to get them back to Reefton promptly; the other car would not have made it, causing considerable delays.

Community-Based Services

- **Home Based Support Services [HBSS]:** HBSS is working with District Nursing and the Palliative Care team to further enhance collaborative care for the palliative patient group. In addition, there is work being undertaken with the complex clinical care network [CCCN] to examine the direction of HBSS on the Coast, how services are organised and how HBSS works collaboratively with other services. Civil defence emergency training for HBSS staff has been completed in Westport, Greymouth and Hokitika. Information on emergency preparedness will be sent out to all clients of the service. A staff farewell has occurred for 2 HBSS staff who between them have given 60 years of service to the DHB. Work is also underway to review how our HBSS staff in South Westland can be better supported in the more remote areas by the RNS workforce.
- **Oral Health:** The level one (diagnostic) unit will be operational next term; it is currently being stocked with the appropriate equipment. Recruitment of the dental receptionist position remains problematic. The level 2 mobiles require an upgrade of the ventilation and external steps, which will be undertaken in conjunction with CDHB. The Community Dental Clinical Director and Oral Health Coordinator are working on the oral health component of the IFHC rebuild.
- **District Nursing [DN]:** A time management training session provided by the rural learning centre was well received at the regional DN meeting and will be offered to the other groups in the new year. DNs have also been connected to the priority project that has examined and worked to improve discharge process to ensure that the correct processes are in place to ensure patients are receiving the right care at the right time by the right people. Poutini Waiora have appointed 2 Kaupapa Maori nurses, one each for Hokitika and Greymouth. Orientation with the District Nursing and Clinical Nurse Specialist teams has been planned to enhance the team's collaboration within their

communities. These 2 nurses will also be encouraged and welcomed to attend MDT and IDT peer meetings for support and to build good working relationships to benefit their patients.

- **Public Health Nursing:** The new Greymouth Public Health Nurse has almost completed her orientation and is very enthusiastic about the role. She brings with her a Plunket nursing background.
  - *B4School Checks Coordinator*: Ongoing monitoring of this service to ensure that targets are met. Challenges include DNA's and staff vacancies. Recruitment for a replacement B4 School Check Coordinator is underway as the incumbent is retiring at the end of the year.
  - *Well Child*: Work is progressing with Plunket, Poutini Waiora and the DHB to look at how we can work together to provide best practice to all who are accessing this service on the West Coast.
- **Rural Nurse Specialists [RNS]:** A review is underway that will examine all aspects of the RNS role. This will include areas such as coverage, numbers, costs and revenue, equipment and communications that are required. The aim of the review is to ensure that this pivotal role is well supported and that the current model of care is both sustainable and provides good outcomes for the communities that they cover.

C: Implement the Maori Health Plan

- **Rangatahi Work Placement**: A group of eight West Coast rangatahi interested in health as a career visited the West Coast District Health Board and other key health services on the West Coast in September. This was part of an inaugural work placement programme called Kia Ora Hauora. The purpose of this programme is to promote health as a viable career for our rangatahi. The number of Maori in the health workforce is still very low; roughly 4% of the total health and disability workforce in the South Island is Maori. This is much lower than the percentage of Maori living in Te Wai Pounamu overall.
- Kia Ora Hauora is a Ministry of Health funded initiative and is led by Tumu Whakarae, General Managers of Maori Health. It was organised by the Maori Health Team at WCDHB with assistance from Mokowhiti, who are contracted to support all DHB's in the South Island to promote Maori workforce development. The programme was available to year 12/13 students from Greymouth High, Westland High, John Paul II and older students from Te Tai Poutini Polytechnic. The Buller region will be a key focus next time.
- The students experienced a wide range of health services, there were a number of very good presentations from staff working in many areas such as theatre, maternity, paediatrics, pharmacy, occupational therapy, social work, nursing, mental health, smoke free, health promotion, nutrition, Poutini Waiora and a visit to the Westland Medical Centre. This provided the students with some great insights into the health system and how it works at a local level. It was encouraging to hear some of the rangatahi comment that they would like to return home to Tai Poutini after completing their tertiary education to work within health and disability. We will continue to provide support to these students into the future.
- **Mana Mokopuna Tamariki**: The Project Advisory group has been identified and established and the Project Coordinator /Admin support is now in place. The next stage is to engage with the Focus group and begin the 'understanding needs' part of the project.
- **Whare Oranga Pai:** The model for delivery of this programme is still under development. Kylie Parkin is working with Alayna Watene and Community Public Health to develop the activity component of the model which will work alongside the Appetite for Life nutrition programme.

- **Te Herenga Hauora – South Island Regional Maori General Managers - Te Rau Puawai:** Te Rau Puawai is a partnership between Health Workforce NZ and Massey University that aims to increase the professionalism of the Maori mental health workforce by supporting those interested employees through study. Te Rau Puawai has had an 89% pass rate since 1999. Significant contributions are made towards fees and any costs associated with travel.

  Further support is provided by:

  - Access to support tutors and an academic mentor
  - Peer support
  - Cultural support
  - Needs based workshops

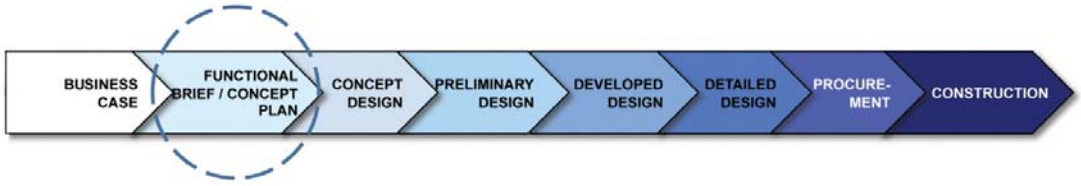
- There is an opportunity for the DHBs to work closely with Te Rau Puawai to identify those Maori employees that may want to pursue study and to link them in to this opportunity.
- **He Oranga Pounamu - Whanau ora:** Robyn Wallace Chief Executive of He Oranga Pounamu and Maania Farrar Waka Ora Programme Manager He Oranga Pounamu met with Te Herenga Hauora South Island Maori General Manager's. They were wanting feedback from the GMs on how to ensure that open communication is occurring as they move into the next phase of the Whanau Ora Programmes of Action. Waka Ora are currently reviewing current provision of the programme and identifying where best practice has already occurred. Maania will continue to have these discussions with each of the South Island General Managers/Directors Maori Health.

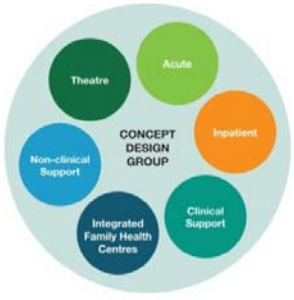
	DELIVERING MODERN FIT FOR PURPOSE FACILITIES

A: Facilities Report

- An update on current activities will be provided at the next meeting.

B: Facilities Case Update





- Over 45 clinicians have been participating in the concept design phase of the following workstreams:
  - IFHC
  - Perioperative
  - Non-clinical Support Services
  - Non-clinical Support Admin
  - Inpatient
  - Clinical Support
- A governance structure that includes the newly formed Clinical Leaders Group [CLG] is overseeing and guiding the process to ensure that the process is robust and that we continue to meet our commitments in the project timeline.

- The CLG is the key clinical and service advisory and decision making group for the facility development project and provides the clinical oversight of the facilities development process. In addition to making decisions or recommendations that ensure that the facility developments are aligned to clinical and service needs and consistent with the direction of travel for West Coast health system transformation.
- In relation to Buller, the responses to the Expression of Interest are still being evaluated .

	RECONFIGURING SECONDARY AND TRANSALPINE SERVICES

A: Hospital Services includes Secondary Mental Health Services

Hospital Services

- Recruitment for SMO vacancies remains a challenge. Positively there are two potential and strong candidates currently having discussions for Rural Hospital Medicine Specialist positions.
- A process of credentialing occurred with the Rural Hospital Medicine [RHM] cohort of SMOs. Verbal feedback from the panel, which included external peers, has been very positive. A formal written report will confirm credentialing and make any recommendations thought necessary. RHM is the second specialty to be credentialed with a programme that will see all specialties credentialed by the end of 2015.
- The transalpine meeting provided a number of services the opportunity to connect with their transalpine colleagues, and to further work toward strengthening partnerships and relationships. These discussions are well advanced within a number of specialties including anaesthetics, general medicine and maternity.

Nursing

- Nursing recruitment and vacancy rates remain stable, with normal churn within services, such as Parental Leave. Recruitment of Midwives remains a challenge; however we are in the process of employing a Midwife who will also bring with them their Registered Nurse partner.
- The return of two senior nurses to both Duty Nurse Manager [DNM] and ED roles will provide a boost to senior nurse levels.
- Clinical Nurse Managers [CNM] have begun the plans for the Christmas downsize with the forward planning of leave.
- Work is continuing in managing annual leave balances and identifying and assisting staff who have taken large amounts of sick leave.
- The new CT scanner has been installed and is now operational. Contingency plans worked well during the period of unavailability.
- The Dedicated Education Unit is now fully functional with positive feedback from the polytechnics and students.
- Training continues to be offered to ensure the use of the ISBAR handover tool. It is expected that clinicians will use this process for all handovers including from the community into the hospital.
- The Nurse Managers are monitoring the transfer volumes to tertiary hospitals in order to understand the impact on nursing resource when required for transfers.

- Work is being undertaken to compile a procedure and process for the monitoring of fridge temperatures and actions required when abnormalities are detected.
- A discussion within the senior nurses group is continuing regarding patient centred care and the participation of patients in the development of their care plans. Work is underway to facilitate action around involving and documenting patient input. Positive comments were received from certification auditors in relation to the "my care plans" on the walls above the patient beds.
- Discharge planning, DNA and theatre utilisation priority projects are well under way with plans starting to be implemented. A communication plan is being developed for the community about some of the strategies being employed to manage DNAs.
- ED continues to lead nationally in the six hour target.
- A process of audit on clinical notes continues to ensure the smoking cessation, falls risk and general documentation is at an acceptable level. And work continues within the hospital to further improve better help for smokers rates.
- Professor Andrew Hill recently presented on ERAS [Enhanced Recovery After Surgery] to all staff. This was well attended with the key message that multidisciplinary collaboration is critical to achieve shorter stays and optimise recovery after surgery.

Allied Health

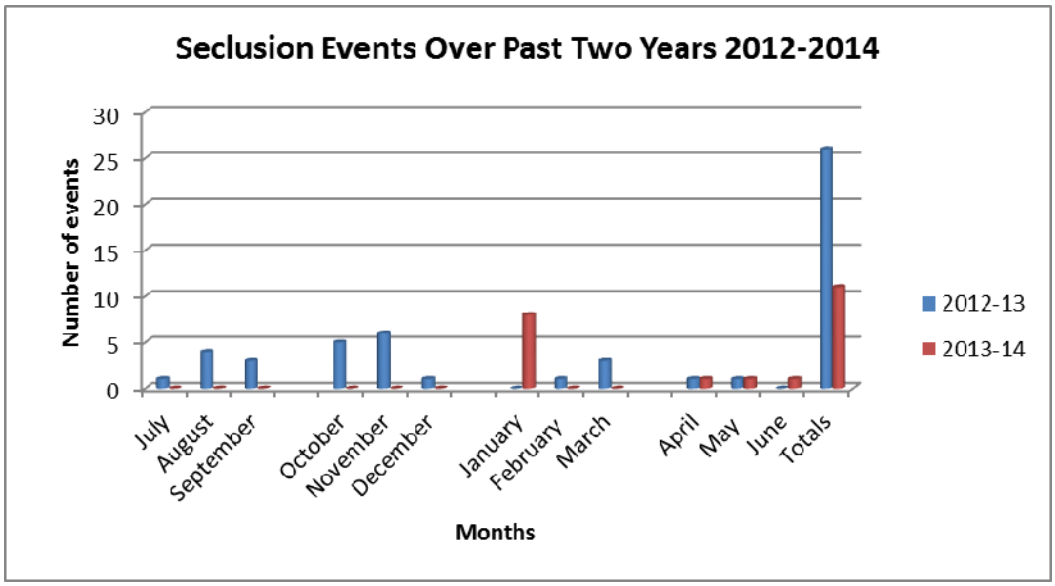
- Recruitment is in progress for an Associate Director of Allied Health [ADAH]. There has been considerable interest and it is anticipated that an appointment will be made before the end of the year. An interim ADAH is in place to provide leadership to the Allied Health Team and commence implementation of the decisions outlined in the Allied Health Leadership Framework Decision Document.
- Recruitment has commenced for a Clinical Manager Occupational Therapy and a Paediatric Occupational Therapist.
- Immediate staffing pressures within the Physiotherapy Department have been relieved by the appointment of a Paediatric Physiotherapist and the secondment of an experienced Physiotherapist from CDHB. Suitable applications have been received for the vacancies in Buller and South Westland and it is hoped these positions will be filled within the next 4-6 weeks.
- A new graduate dietitian commenced on 13 October.
- Allied Health, Hospital Services and Mental Health Services continue to work collaboratively with Allied Health CDHB to develop and support professional relationships, share service initiatives and learning and training opportunities. The Clinical Manager Physiotherapy is partnering with CDHB Physiotherapy Managers to recruit new graduates who will be available to commence work early next year.

Mental Health Services

- **Seclusion Report 2013-2014**
  - *Background*: Towards the end of 2011-2012 it became evident that the use of seclusion had become more frequent, and that patients were, on occasion, being secluded for extensive periods, which was unexpected as the Acute Inpatient Unit staff had worked to successfully reduce the use of seclusion as. By the end of 2010-2011 the use of seclusion had become a rare event. It was identified that the decision to use seclusion in the first instance, and then to maintain seclusion beyond the initial 2 hour period was influenced by a number of patient and staff factors. Having identified these issues the inpatient team have been supported in their endeavours to decrease the rate and duration of seclusion.

- *Cultural change*: Seclusion again being conceptualised as a nursing intervention rather than one initiated or directed by the psychiatrist. Seclusion being conceptualised as a treatment failure (last resort) and not a treatment solution.
- *Practice processes*: The seclusion process and requirements around mandatory assessments and decision points has been re-presented to all nursing staff; however with the seclusion again becoming a 'rare event' keeping this awareness to the front will be an ongoing challenge. Use of client debriefing process to enhance staff understanding of the impact of seclusion on individuals.
- *Service Issues*: Over the past year there has been a brief period when the unit was fully staffed; however recent resignations/secondments has reduced current staffing and there are again nursing vacancies in the unit, noting that the unit is staffed predominately by female nurses . The team continue to actively recruit, in particular for male staff to address the gender imbalance.

- **Outcome**
  - Overall the changes that the team have been able to make, and the shift in how seclusion is conceptualised, has again resulted in a significant decrease in the rates and duration of seclusion. In the first nine months of this year, seclusion has only been used during the month of January.



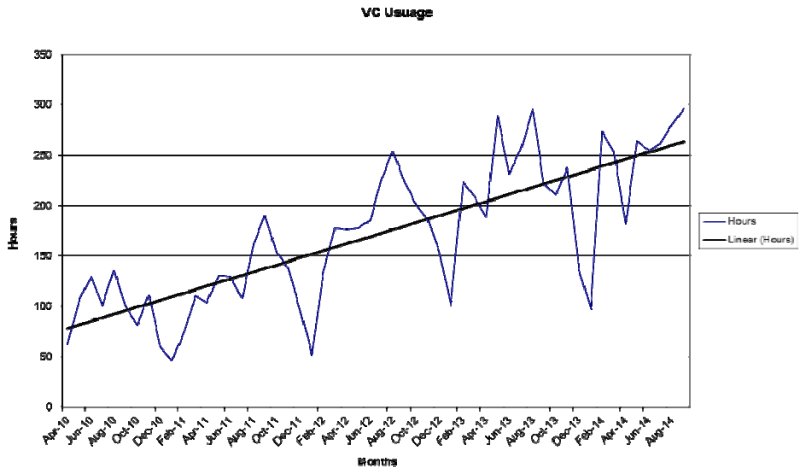
  - The clinical team are now in the process of developing and adopting guidelines for the emergency management of aggressive and violent behaviour. This will ensure the use of effective psychotropic medications begins at admission, and will aid the ongoing commitment to reducing seclusion, both the rates and duration.
  - Very positive discussions and advancement of the transalpine relationship were had at the recent transalpine meeting. These discussions have been further advanced with a meeting held between the senior clinicians and managers recently. Outcomes from this meeting included agreements to share and work together in quality processes and initiatives; collaborative recruitment of SMO staff and further advancement in discussions in what a transalpine mental health clinical governance framework may look like.

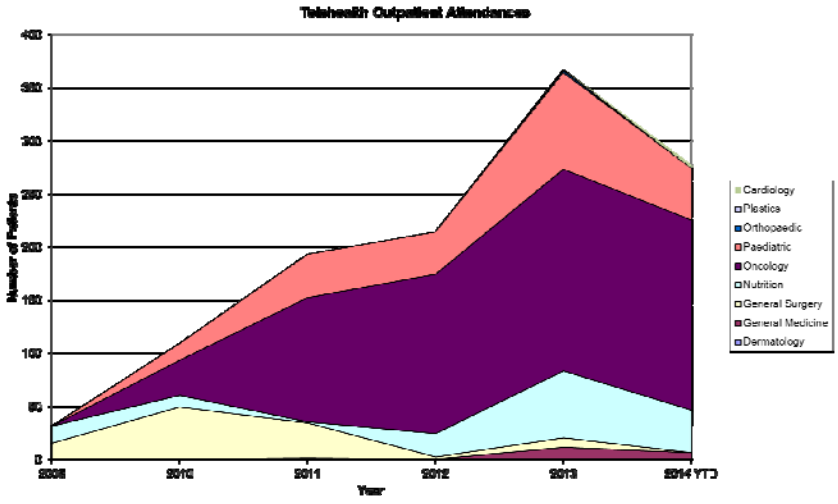
A: Improve Transport Options for Planned [Ambulatory] and Unplanned Patient Transport, Within and Beyond the West Coast

- A further meeting was recently held, and regional discussions with St John are continuing 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 transfers. 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 completing the negotiation.

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]

- Engagement continues with Primary Care, Allied Health and District Nursing around a First Level Option for Community Care. This will incorporate both the rapid and rehab response and acute demand model of care.
- The Buller Older Persons Health community conversation has identified eight key outcomes for potential further development. These are workforce, housing, transport, community care, coordination, information, quality improvement and after hours. Further community engagements will be occurring in Karamea and Ngakawau on 15 and 16 October followed by a final stakeholder meeting to formulate the group's recommendations. This will then be presented at a subsequent public meeting.

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

- A one day workshop involving Buller staff is planned to focus on gaining agreement regarding service configurations that reflect right person, right place, right time. This is a critical path for the case coordination project, the mental health workstream and the single point of entry project.
- The single point of entry work-group (part of the Buller IFHS workstream) proposes to move away from a triage model that prioritises on acuity. The group are exploring the potential of the model observed during the Midland Region visit, where people are put in the right place with appropriate clinicians coming to them.

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

- The results of the risk profiling and stratification process will be available for analysis in early October. These results will inform the two IFHS workstreams to redesign future services to meet the needs of those most at risk.

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 September 2014 was a surplus of $0.015m, which was $0.018m unfavourable against the budgeted surplus of $0.033m. The year to date position is now $0.036m unfavourable.

	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	752	51	701	1,971	153	1,818
Provider Arm	(737)	(18)	(719)	(2,122)	(268)	(1,854)
Consolidated Result	15	33	(18)	(151)	(115)	(36)

B: Implement Employee Engagement and Performance Management Processes

- Maternity services are completing training in managing performance and having constructive conversations. They will transition over to iPerform (online tool) in October. Buller are preparing their data (objectives) and will roll out the performance management programme to their staff next month.
- A paper has been submitted to EMT recommending that the employee engagement survey for the West Coast is run late this year. A decision is pending.

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 initiation of the project has now occurred. The steering group is meeting regularly and includes clinicians from both WCDHB and CDHB. Much discussion is occurring with Clinical staff in preparation for moving to electronic sign off. A CDHB resource is being used to help map the before and after process to ensure implementation of the system is done in a thorough and safety focused manner. The go live is still to be determined.

HealthOne (previously known as eSCRV)

- The HealthOne 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. Allowing seamless access to patient information between both primary and secondary systems with appropriate security and robust auditing. The first areas in Greymouth go live 17 November and will be a gradual process with all sites planning to be completed by early December. Training invitations and communications to organisation has started mid-October.

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 8 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 8 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.
- The UPS power system replacement is now going through final sign off.
- A new printer contract with the same provider CDHB uses has been approved. Full replacement of all laser printers will be starting end of October and will take approximately 3-4 weeks.

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. Recent meetings have included the Greymouth Business Persons' Association and Buller Rotary.

- Following the recent community meeting in Reefton, the engagement over the future of Reefton health services begins on Tuesday 21 October with the first of three initial stakeholder group meetings. Further community meetings will be scheduled in the new year.
- The Buller Older Persons' Health conversations continue with meetings in Karamea on October 15 and Ngakawau on October 16, with a further stakeholder group meeting and community meeting scheduled for the end of October.

Other External Communications

- The spring issue of Report to the Community – the West Coast health system's community update is underway and will be distributed this month.
- The senior communications advisor met with the Editor and Chief Reporter of the Grey Star to discuss how we can work together.
- Produced Mental Health Awareness Week material for a Messenger advertorial spread, and a flyer was also distributed in the community.
- Work continues on scoping 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 continues to meet. A small team continues to work 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.
- A staff forum about facilities, the new HealthOne electronic patient information system and other updates was held on Tuesday 14 October. Two further Grey facilities "town hall meetings" are being held with the design team and concept designs and all staff invited on Wednesday 29 October.

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:
  - Grey Hospital to get new CT scanner

Reactive Media Relations

- Issues commented on this month included responses to questions on:
  - Facilities redevelopment – Grey and Buller
  - Health of Older Persons in Buller
  - Maternity/midwifery services
  - 1080
  - GP/staffing
  - New GPs/surgeons
  - Moana public private partnership for new clinic
  - Dr Carol Atmore leaving
  - Anaesthetist locums
  - Working with bereaved parents
  - New CT scanner

- Smoking cessation – Stoptober promotional campaign
- Patient transfer/transport costs

Communications Planning

- Pandemics (Ebola etc.) and Infection Prevention & Control
- HealthOne – our new shared patient information system
- DNAs - reducing the number of people who don't turn up to their appointments
- RL6 – WCDHB's new incident management system
- Buller Older Persons' Health community 'conversations'
- Reefton Health Services
- New Grey facilities communications planning
- Maternity Review
- New GP fee schedule

	PROMOTING HEALTHY ENVIRONMENTS AND LIFESTYLES

Key Achievements/Issues of Note

- **Health Promoting Schools:** CPH's new Health Promoting Schools facilitator is currently working through the new School Community Health and Wellbeing Review Tool with West Coast priority schools. The tool supports the school community to self-review the degree to which health and wellbeing activities, practices, policies and behaviours are integrated into the school culture. It also tracks the school community's progress in relation to the key health and wellbeing indicators that are identified in the tool.
- **Keep Learning for Wellbeing/Play the Wellbeing Game:** A whole raft of taster sessions and events all over the Coast happened during Mental Health Awareness Week, 6th – 12th October. From Karamea to Franz Josef and many places in-between, there were sessions on felting, yoga, tai chi, to name but a few. Some random bursts of free compliments in the street have also resulted in lots of smiles, increased wellbeing and even free hugs! Various organisations have collaborated to make these events happen and information on all aspects of wellbeing & mental health have been available at information days around the Coast. The Wellbeing Game also began during Mental Health Awareness week. This is an on-line game that can be played by individuals and teams. It encourages the practice of the five ways to wellbeing (Connect, Give, Take Notice, Keep Learning and Be Active) and allows participants to track their use of these. The team award for the game was won by a West Coast team last year. See www.thewellbeinggame.org.nz
- **Smokefree Controlled Purchase Operations:** Three Controlled Purchase Operations (CPOs) were carried out in early October to test compliance of tobacco retailers with the Smokefree Environments Act's requirement that tobacco must not be sold to persons under 18 years of age. Volunteers under the age of 18 years were used to test if they could purchase from retailers in the Greymouth, Hokitika and South Westland areas. Of the 28 premises visited, just one sale was made and that store is now going through the enforcement process. 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.

- **Grey Food Gardening Group:** CPH has been working with the New Coasters organisation to encourage community connectedness through supporting people to grow vegetable gardens. After a couple of months off over winter some members of the group met at Grey Main School to look at their garden, share gardening ideas and swap seedlings and seeds. The group have other garden get-togethers planned in the coming months to support each other to grow some of their kai.

Report prepared by: David Meates, Chief Executive

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. September's rates continue this trend with 99.6%.
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. July has begun the 2014/15 financial year off well with 143 discharges delivered—104% of our target for the month. August is just 8 discharges under target, delivering 282 out of a planned 290. This difference is not seen as material.
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. July has seen this result continue.
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**. Results for the month of August indicate 7 smokers were missed with a result of 93%. Results for the month of September alone indicate a decrease may be ahead for Quarter 1, with a result of 93%.
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. Quarter 1 results are due in the coming weeks, with internal data suggesting an increase in performance.
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. Quarter 1 results are due in the coming weeks, with internal data suggesting an increase in performance.

CLINICAL LEADERS UPDATE

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

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

SOURCE: **Clinical Leaders**

DATE: **31 October 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 was the focus of a workshop between Canterbury and West Coast clinicians in early October. The workshop was very productive with some clear outcomes identified and further refinement of models of care and service development agreed to.

The recruitment for the 2015 intake of Nurse Entry to Practice (NETP) graduates commenced in October. The assessment centre was held over the week of 4 – 10 October in partnership with CDHB. Once again the caliber of applicants identifying the WCDHB as their first choice was very high and we have undertaken to recruit to the Health Workforce New Zealand (HWNZ) allocation for the DHB (13 including the two for entry to specialty practice in mental health).

The interim appointment of an Acting Associate Director. of Allied Health is progressing well and ensuring that the outcomes of the Decision document regarding Allied Health leadership are being implemented. Recruitment for the permanaent roll is well underway with interviews set up for November. We have also had success in recruiting physiotherapy professionals in addition to a secondment from Canterbury to provide cover until permanent staff arrive.

Quality and Safety
Christchurch Polytechnic delivered the Rapid Assessment of the Unwell Patient course here in Greymouth on the 22 – 24 October. This course is now a compulsory component of the NETP programme as part of our blended Transalpine entry to practice programme and was also offered to other front-line staff. A total of 27 nurses applied to attend. It is planned to provide this training annually.

September and October saw the roll out of the education update of the Early Warning Score (EWS), clinical information communication handover tool (ISBAR) and the "Speak Up" initiative. These sessions have been made compulsory to ensure all clinical areas are utilising these quality and safety tools effectively and consistently across the system. A large component of the education is focussed on critical thinking and reflecting on practice to reduce the risk of missed cues and improve patient outcomes. These sessions will be ongoing.

The focus on improving the speed of our RCA processes has resulted in a significant number of outstanding reports being completed.

Facilities Planning

The next phase of planning for the new Grey Hospital and Integrated Family Health Centre commenced mid September and through October, 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. Pradu Dayaram has commenced as the senior medical lead for the project.

While in Christchurch for the Transalpine workshop the clinical leaders also attended the Cantberuy Design Lab to see how "mock ups" and "design processes that include consumers and clinicians" can deliver better facility outcomes. We are exploring how something similar can be establsiehd for the West Coast.

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
Stella Ward, Executive Director Allied Health

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: **31 October 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 30 September 2014.

3. DISCUSSION

Overview of September 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 September 2014 was a surplus of $0.015m, which was $0.018m unfavourable against the budgeted surplus of $0.033m. The year to date position is now $0.036m unfavourable. The breakdown of September's result is as follows.

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	6,702	6,957	(255)	×	20,407	20,871	(464)	×
Governance & Administration	253	188	65	√	654	564	90	√
Funds & Internal Eliminations	4,848	4,536	312	√	14,121	13,608	513	√
	11,803	11,681	122	√	35,182	35,043	139	√
EXPENSES								
Provider								
Personnel	4,333	4,541	208	√	13,509	13,623	114	√
Outsourced Services	522	481	(41)	×	1,959	1,443	(516)	×
Clinical Supplies	706	612	(94)	×	2,015	1,836	(179)	×
Infrastructure	1,343	804	(539)	×	3,447	2,626	(821)	×
	6,904	6,438	(466)	×	20,930	19,528	(1,402)	×
Governance & Administration	253	188	(65)	×	654	564	(90)	×
Funds & Internal Eliminations	4,096	4,485	389	√	12,150	13,455	1,305	√
Total Operating Expenditure	11,253	11,111	(142)	×	33,734	33,547	(187)	×
Surplus / (Deficit) before Interest, Depn & Cap Charge	550	570	(20)	√	1,448	1,496	(48)	×
Interest, Depreciation & Capital Charge	535	537	2	√	1,599	1,611	12	√
Net surplus/(deficit)	**15**	**33**	**(18)**	×	**(151)**	**(115)**	**(36)**	×

4. APPENDICES

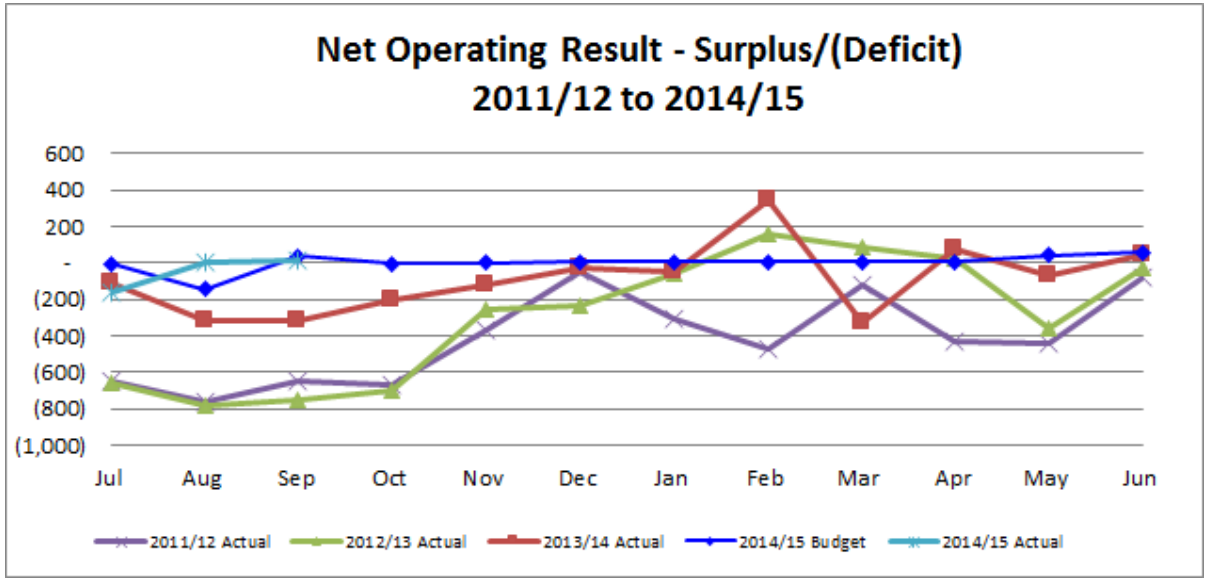
Appendix 1:	Financial Results for the period ending 30 September 2014
Appendix 2:	Statement of Financial Performance – September 2014
Appendix 3:	Statement of Financial Position – September 2014
Appendix 4:	Cashflow – September 2014

Report prepared by: Justine White, General Manager: Finance

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – SEPTEMBER 2014

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Surplus/(Deficit)	15	33	(18)	-55%	✗	(151)	(115)	(36)	31%	✗

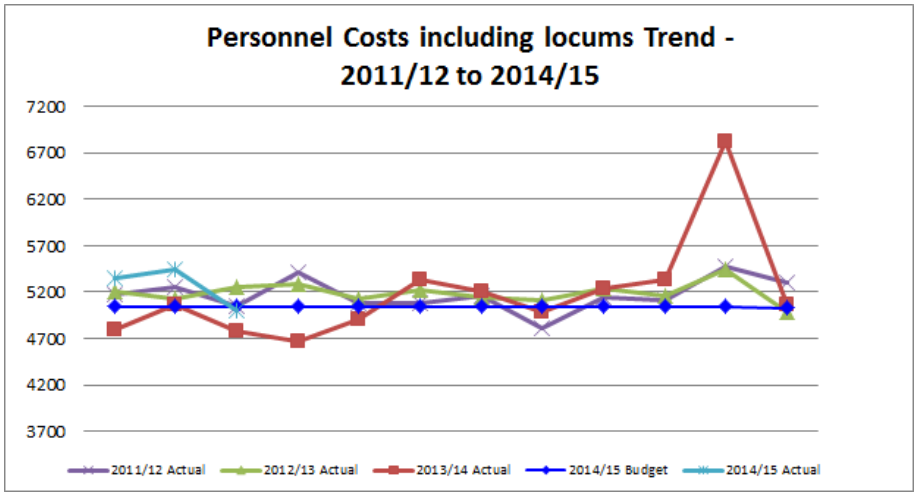


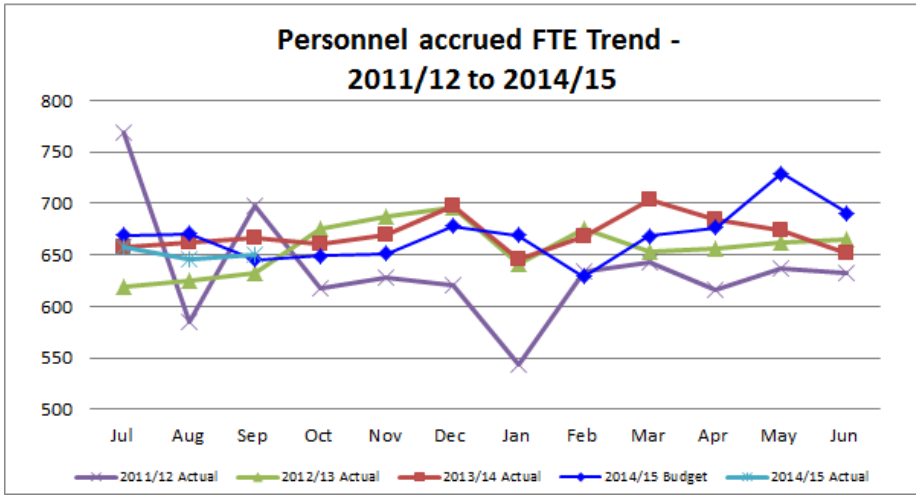
We have submitted an Annual Plan with a breakeven position.

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

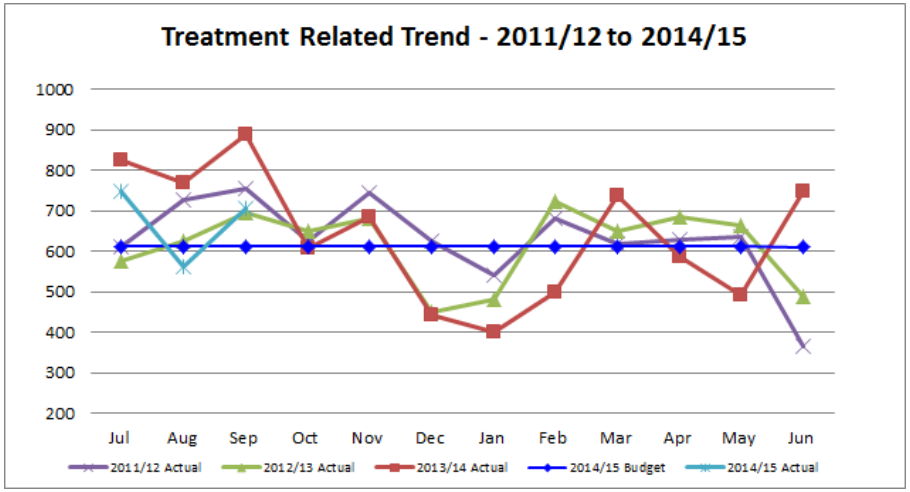


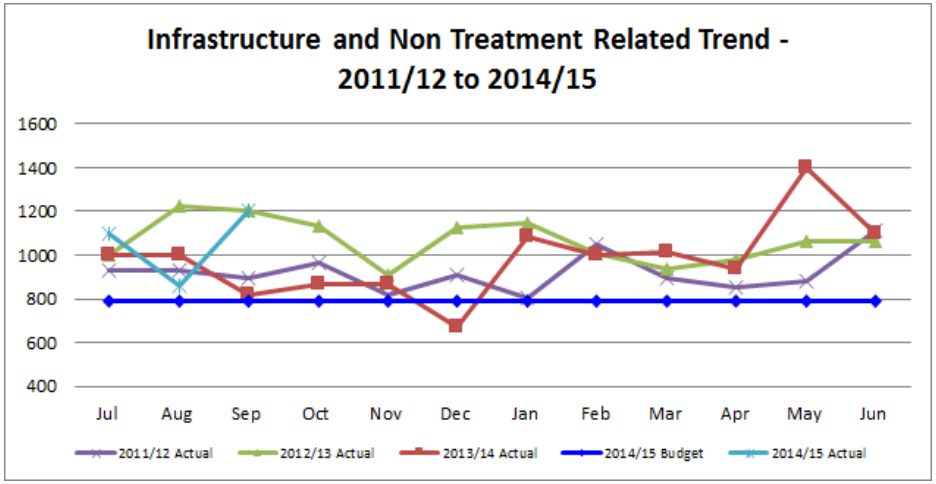


KEY RISKS AND ISSUES

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

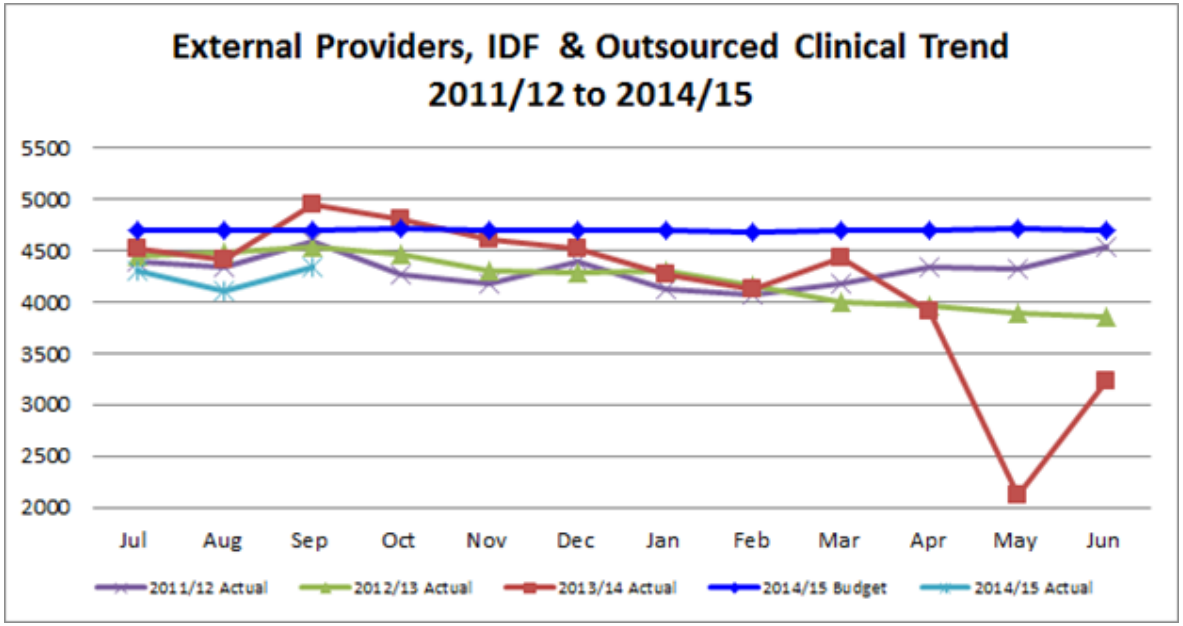




KEY RISKS AND ISSUES

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

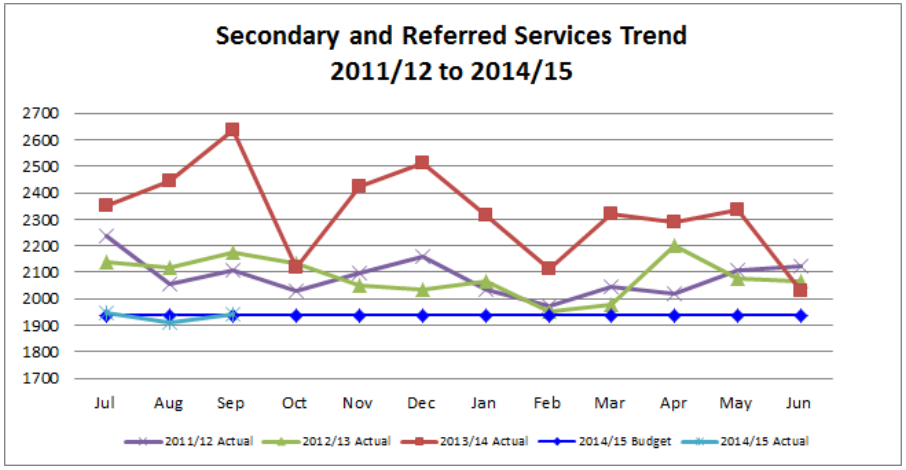
Capacity constraints within the system require continued monitoring of trends and demand for services.

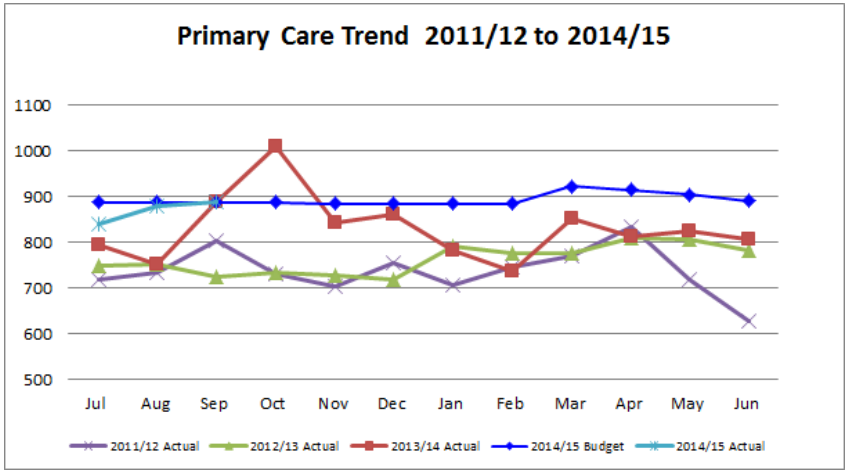
Funder Arm - Payments to External Providers

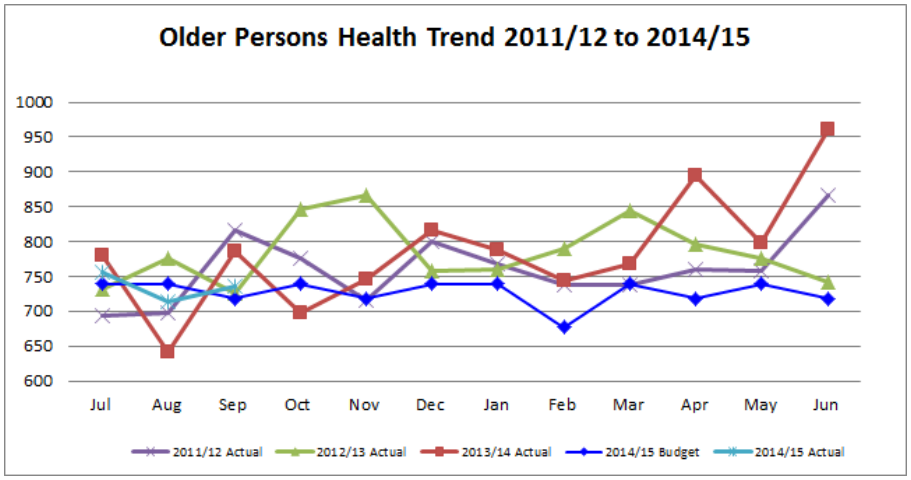
Month ended July 2014

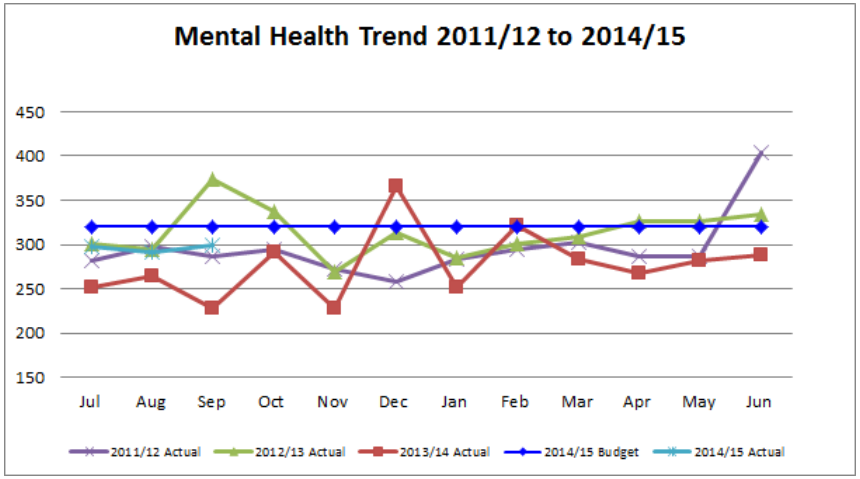
Current Month						Year to Date					2014/15 Annual Budget
Actual $000	Budget $000	Variance $000	%		SERVICES	Actual $000	Budget $000	Variance $000	%		$000
					Primary Care						
37	36	0	-1%	✗	Dental-school and adolescent	37	36	0	-1%	✗	434
	2	2	100%	✓	Maternity	0	2	2	100%	✓	20
	1	1	100%	✓	Pregnancy & 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	9,946	10,069	(123)	-1%	✗	72,537
Cash	7,750	4,881	2,869	59%	✓	10,037

KEY RISKS AND ISSUES

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

APPENDIX 2: STATEMENT OF FINANCIAL PERFORMANCE

Statement of comprehensive income

For period ending 30 September 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	11,374	11,209	165	1.5%	33,820	33,627	193	0.6%	134,509	131,279
Inter DHB Revenue	7	3	4	133.3%	26	9	17	188.9%	34	20
Inter District Flows Revenue	130	129	1	0.8%	390	387	3	0.8%	1,551	1,615
Patient Related Revenue	212	230	(18)	(7.8%)	707	690	17	2.5%	2,760	2,880
Other Revenue	80	110	(30)	(27.3%)	239	330	(91)	(27.6%)	1,323	1,237
Total Operating Revenue	11,803	11,681	122	1.0%	35,182	35,043	139	0.4%	140,177	137,031
Operating Expenditure										
Personnel costs	4,487	4,635	148	3.2%	13,847	13,905	58	0.4%	55,613	55,477
Outsourced Services	430	377	(53)	(14.1%)	1,689	1,131	(558)	(49.3%)	4,520	6,373
Treatment Related Costs	707	612	(95)	(15.5%)	2,016	1,836	(180)	(9.8%)	7,342	7,727
External Providers	2,911	2,934	23	0.8%	8,642	8,802	160	1.8%	34,757	34,383
Inter District Flows Expense	1,369	1,670	301	18.0%	3,956	5,010	1,054	21.0%	20,465	14,486
Outsourced Services - non clinical	149	129	(20)	(15.5%)	425	387	(38)	(9.8%)	1,548	1,608
Infrastructure and Non treatment related costs	1,200	754	(446)	(59.2%)	3,159	2,476	(683)	(27.6%)	9,491	12,225
Total Operating Expenditure	11,253	11,111	(142)	(1.3%)	33,734	33,547	(187)	(0.6%)	133,736	132,279
Result before Interest, Depn & Cap Charge	550	570	(20)	3.5%	1,448	1,496	(48)	3.2%	6,441	4,752
Interest, Depreciation & Capital Charge										
Interest Expense	60	114	54	47.4%	190	342	152	44.4%	1,364	713
Depreciation	407	327	(80)	(24.5%)	1,205	981	(224)	(22.8%)	3,937	4,373
Capital Charge Expenditure	68	96	28	29.2%	204	288	84	29.2%	1,140	753
Total Interest, Depreciation & Capital Charge	535	537	2	0.4%	1,599	1,611	12	0.7%	6,441	5,839
Net Surplus/(deficit)	15	33	(18)	54.5%	(151)	(115)	(36)	(31.3%)	0	(1,087)
Other comprehensive income										
Gain/(losses) on revaluation of property										
Total comprehensive income	15	33	(18)	54.5%	(151)	(115)	(36)	(31.3%)	0	(1,087)

APPENDIX 3: STATEMENT OF FINANCIAL POSITION

Statement of financial position

As at

in thousands of New Zealand dollars

30 September 2014

	Actual	Budget	Variance	%Variance	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	26,263	24,846	1,417	5.7%	26,996
Intangible assets	1,389	1,526	(137)	(9.0%)	1,517
Work in Progress	211	13,566	(13,355)	(98.4%)	74
Other investments	476	405	71	17.5%	227
Total non-current assets	28,339	40,343	(12,004)	(29.8%)	28,814
Current assets					
Cash and cash equivalents	7,750	4,881	2,869	58.8%	7,483
Patient and restricted funds	79	60	19	31.7%	79
Inventories	1,024	1,100	(76)	(6.9%)	1,010
Debtors and other receivables	8,875	4,218	4,657	110.4%	7,686
Assets classified as held for sale	136	136	0	0.00%	136
Total current assets	17,864	10,395	7,469	71.9%	16,394
Total assets	**46,203**	**50,738**	**(4,535)**	42.1%	**45,208**
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	10,695	17,695	(7,000)	(39.6%)	10,695
Employee entitlements and benefits	2,727	2,895	(168)	(5.8%)	2,636
Total non-current liabilities	13,422	20,590	(7,168)	(34.8%)	13,331
Current liabilities					
Interest-bearing loans and borrowings	3,750	3,750	0	0.00%	3,750
Creditors and other payables	9,693	7,548	2,145	28.4%	9,927
Employee entitlements and benefits	9,392	8,781	611	7.0%	9,203
Total current liabilities	22,835	20,079	2,756	13.7%	22,880
Total liabilities	36,257	40,669	(4,412)	(10.8%)	36,211
Equity					
Crown equity	70,761	70,761	0	0.00%	69,661
Other reserves	19,569	19,569	0	0.00%	19,569
Retained earnings/(losses)	(80,423)	(80,300)	(123)	0.2%	(80,272)
Trust funds	39	39	0	0.00%	39
Total equity	9,946	10,069	(123)	(1.2%)	8,997
Total equity and liabilities	**46,203**	**50,738**	**(4,535)**	**(8.9%)**	**45,208**

APPENDIX 4: CASHFLOW

Statement of cash flows

For period ending 30 September 2014

In thousands of New Zealand dollars

	Monthly Reporting				Year to Date				2013/14	2012/13
	Actual	Budget	Variance	%Variance	Actual	Budget	Variance	%Variance	Budget	Actual
Cash flows from operating activities										
Cash receipts from Ministry of Health, patients and other revenue	11,674	11,692	(68)	(0.6%)	34,273	34,896	(623)	(1.8%)	139,589	134,187
Cash paid to employees	(4,938)	(5,043)	105	(2.1%)	(15,881)	(16,129)	(532)	3.6%	(80,606)	(31,481)
Cash paid to suppliers	1096	(1,502)	2598	(173.0%)	(4,936)	(4,606)	(429)	9.6%	(18,009)	(21,406)
Cash paid to external providers	(3,041)	(2,934)	(107)	3.6%	(8,032)	(8,802)	(230)	2.6%	(35,182)	(35,998)
Cash paid to other District Health Boards	(1,239)	(1,670)	431	(25.8%)	(3,566)	(5,010)	1444	(28.8%)	(20,040)	(12,871)
Cash generated from operations	3452	483	2969	614.7%	1079	1449	(370)	(25.6%)	5,869	2,431
Interest paid	(60)	(114)	54	(47.4%)	(190)	(342)	152	(44.4%)	(1,364)	(781)
Capital charge paid	(68)	(96)	28	(29.2%)	(204)	(288)	84	(29.2%)	(1,140)	(887)
Net cash flows from operating activities	3324	273	3051	1117.6%	685	819	(134)	(16.4%)	3,349	763
Cash flows from investing activities										
Interest received	48	49	(1)	(2.0%)	131	147	(16)	(10.9%)	588	606
(Increase) / Decrease in investments	0	(80)	80		0	(240)	240		(402)	0
Acquisition of property, plant and equipment	(82)	(4,062)	3980	(98.0%)	(480)	(12,186)	11706	(96.1%)	(48,740)	(1,987)
Acquisition of intangible assets	(1)	0	(1)	#DIV/0!	(2)	0	-2	#DIV/0!	0	6
Net cash flows from investing activities	(35)	(4,093)	4058	(99.1%)	(351)	(12,279)	11,928	(97.1%)	(48,554)	(1,374)
Cash flows from financing activities										
Proceeds from equity injections	0	0	0		1	0	1		18,000	0
Repayment of equity	0	0	0		(66)	0	(66)		(66)	(66)
Cash generated from equity transactions	0	0	0		(67)	0	(67)		17,932	(66)
Borrowings raised	0	0	0		0	0	0		28,000	2,000
Repayment of borrowings	0	0	0		0	7000	(7,000)		0	0
Payment of finance lease liabilities										
Net cash flows from financing activities	0	0	0		(67)	7000	(7,067)		45,932	1,932
Net increase in cash and cash equivalents	3,289	(3,820)	7109	(186.1%)	267	(4,460)	4727	(106.0%)	727	1,311
Cash and cash equivalents at beginning of period	4,481	8,701	(4,240)	(48.7%)	7,483	9,341	(1,858)	(19.9%)	9,341	6,172
Cash and cash equivalents at end of year	7,760	4,881	2,869	58.8%	7,750	4,881	2869	58.8%	10,068	7,483

MAORI HEALTH PLAN UPDATE

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

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

SOURCE: **Maori Health**

DATE: **31 October 2014**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

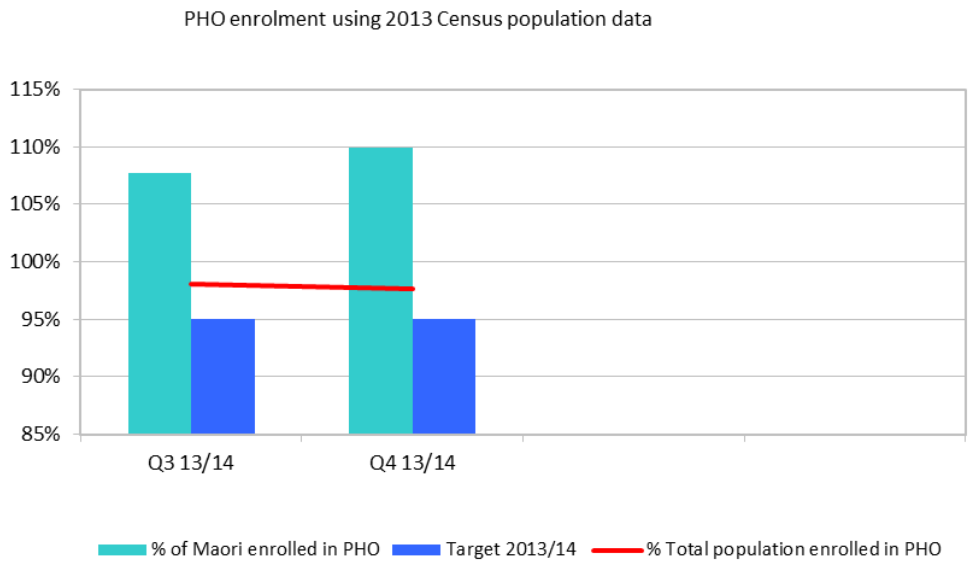
That the Board:
i notes the Maori Health Plan Update.

3. SUMMARY

Maori Health Quarterly Report – Q4, 2013/14

Access to Care

Percentage of Maori enrolled in the PHO

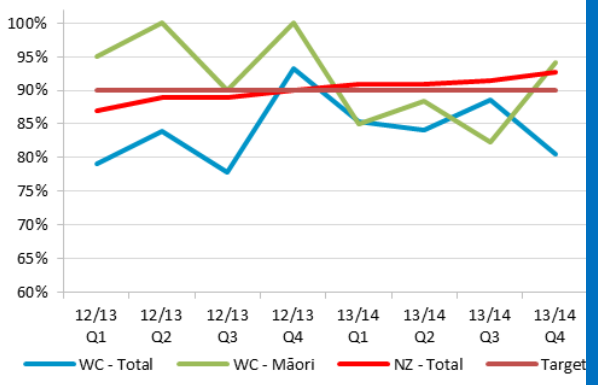


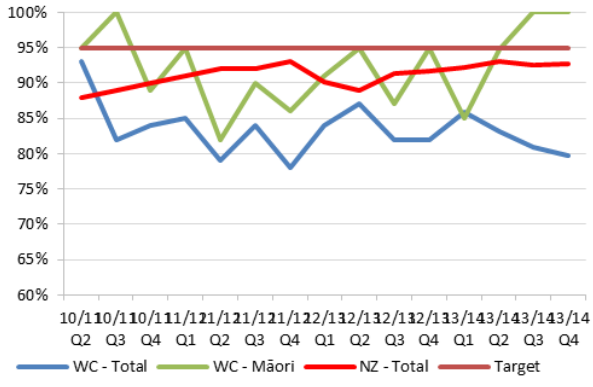
*** 2006 census population was used as the denominator.**

ACHIEVEMENTS/ISSUES OF NOTE

Enrolment in PHO: Using the 2013 population census figures 101% of Maori were enrolled with the PHO as at June 31 2014. 3205 Maori were enrolled in quarter 4 compared to 3140 in quarter 3. The Census data shows total Maori population is 3171.

Child, Youth and Maternity





Eight-month-old immunisation: 88% of Maori babies have been immunised on time at 8 months of age in quarter 4 – 71 babies out of 81 eligible. This is compared to 93% of non-Maori babies where 215 from 230 eligible babies have been immunised.

Two-year-old immunisation: 96% of Maori 2 year olds have been immunised on time in Quarter 4 – 63 from 67 eligible babies. The West Coast DHB's total coverage for Quarter 4 is 82% - 333 from 404 eligible children and 91% of non-Maori 2 year olds have been immunised on time.

A process timeline for all practices to use as guidance to ensure timely immunisation by eight months of age;

- NIR Administrator working with a key contact in each practice to identify children due, pending or overdue;
- Timely referral to Outreach Services;
- Collaboration with other Well Child service providers to refer children for immunisation; and
- Improving the enrolment process at birth

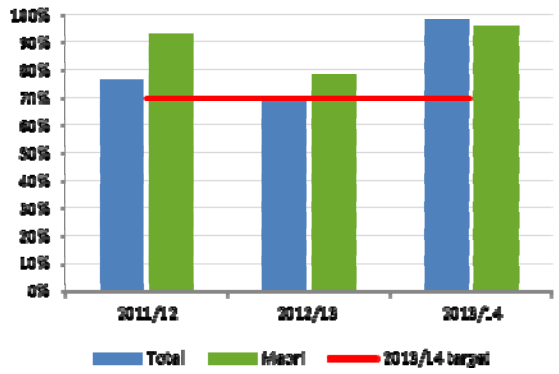
Breastfeeding: Breastfeeding results for the 12/13 year were released by the MoH during this reporting period. It is important to note that unfortunately the DHB is unable to present a full picture of breastfeeding results this year and it is Plunket services only. Poutini Waiora and the WCDHB also provide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

Breastfeeding Support: The community lactation consultancy and breastfeeding advocate have seen 6 Maori clients and provided 28 contacts for breastfeeding support. Over the 2013/2014 year there have been 5 new Mum4 Mum peer support graduates who are Maori and over the past 7 years there have been 37 Maori mums graduate as Mum4Mums. A review is currently being done of the Mum4 Mum service. A West Coast Priority Plan for Breastfeeding 2014-2016 is under development.

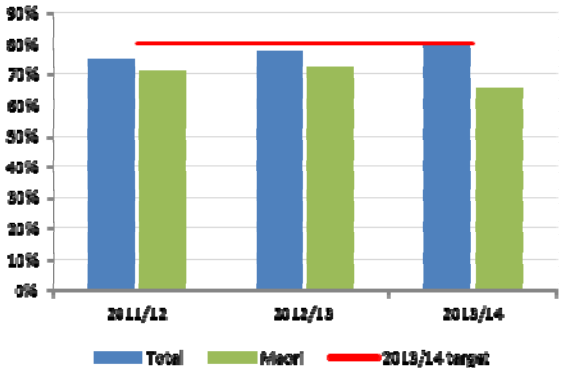
Newborn Enrolment: The Newborn enrolment form will now include a section where new Mums can consent to being contacted by a Lactation Consultant within a week of birth. The lactation consultant will then be able to determine whether additional breastfeeding support is required. This service can be provided in the home or clinic.

More Heart & Diabetes checks

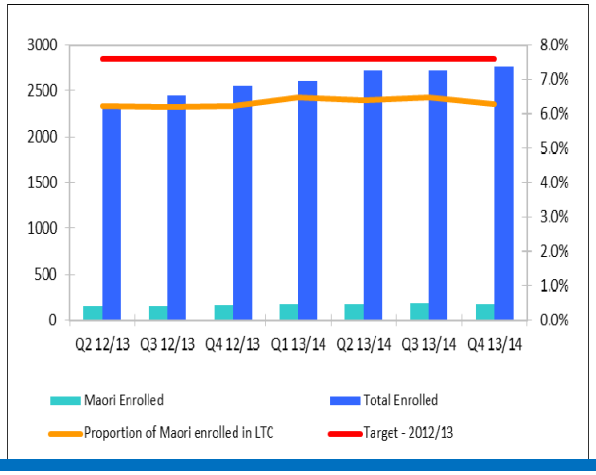
Diabetes Annual Review: % of people estimated to have diabetes who have had an annual check during the year



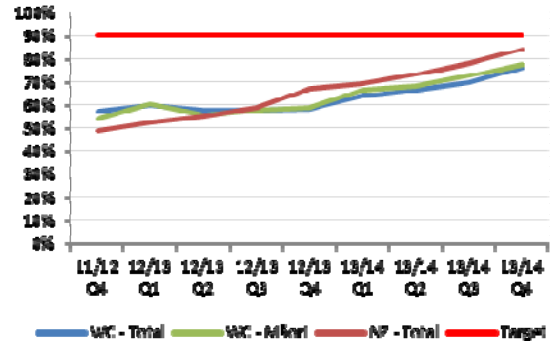
Diabetes Good Management: % of people who have HBA1c levels at or below 8.0 when assessed at their annual check



Number of people enrolled in the Long Term Condition Programme



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



Diabetes

Maori still continue to show a good rate of access to Diabetes Annual Reviews however management of their diabetes could be improved. 93% of Maori with diabetes have had Retinal Exams, 68% show HBA1c levels at or below 8.0, 75% are non-smokers and 64% are on statins.

CVD Health Target

'More heart and diabetes checks' will measure the number of completed cardiovascular Risk Assessments (CVRA) for all eligible persons within the last five years (which includes a diabetes check). The national goal is 90% since 1 July 2013.

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

A total of 63 Maori have had their CVRA check in Q4. Maori make up 7.9% of completed CVRAs this quarter. By comparison, Maori make up 9.6% (994) of the eligible cohort for CVRA on the West Coast. (The eligible age range for Maori is male 35-74 years and for female 45-74 years).

As reported previously, 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, as at Quarter 4. Data for quarter 1 is expected later this month.

The smoking profile for CVRAs completed this quarter for Maori is 62% not smoking compared with other ethnicities screened not smoking 75%.

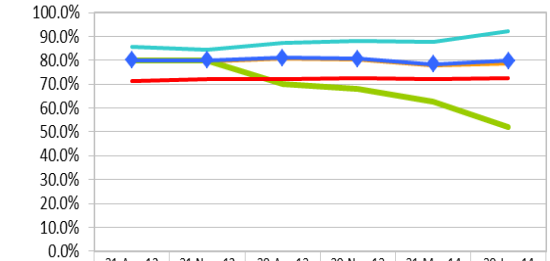
We would expect to see an increase in the number of CVRAs for Maori when the newly appointed Kaupapa Maori Nurses recently appointed in the Grey and Westland districts are working to full capacity.

Green Prescription: Quarter 4 data shows 8 referrals to the Green Prescription programme in the Grey district for Maori and only 1 referral in the Buller district. The major group of conditions this quarter is people with elevated body mass index (BMI), followed by depression/anxiety and cardiovascular disease.

Long Term Condition Management (LTC): 174 Maori are enrolled in the Long Term Conditions programme as at June 31 2014. Year to date Maori enrolment makes up 6.2% of all enrolment in the LTC programme. The target is 7.6%. For comparison Maori make up 6.2% of the enrolled population at the primary practices aged 45 years and above. Collaboration with Poutini Waiora to integrate services to support Maori identified as having LTCs is occurring however this has been slow due to 2 Kaupapa Maori Nurses leaving. There is on-going work within practices to identify eligible people and increase enrolments in level 2 and level 3.

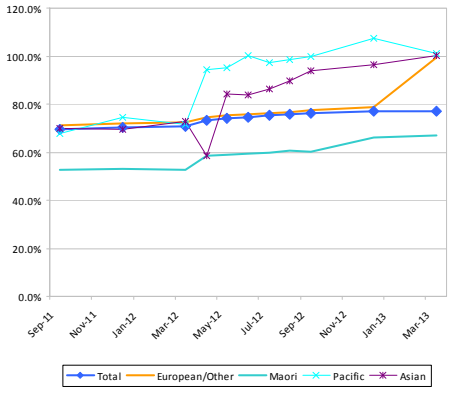
Cancer

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



	31-Aug-12	31 Nov -12	30-Apr-13	30-Nov-13	31-Mar-14	30-Jun-14
Other	79.4%	79.5%	80.6%	80.2%	77.7%	78.8%
Maori	85.6%	84.5%	87.1%	88.0%	87.5%	92.3%
Pacific	80.0%	80.0%	70.0%	68.2%	62.5%	52.0%
Total	79.9%	79.9%	81.1%	80.7%	78.3%	79.7%
All DHB's	71.3%	72.3%	72.0%	72.4%	72.3%	72.5%

Percentage of eligible Maori women (25-69) receiving cervical screening in the last 3 years ending Dec 2013



ACHIEVEMENTS/ISSUES OF NOTE

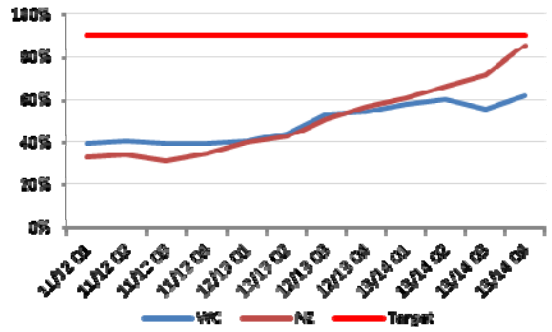
Breast Cancer Screening: Approximate 79.7% of all eligible women aged 45-69 age-groups on the West Coast have undergone breast screening for the period ending 30 June 2014. The coverage for eligible Maori women (92.3%) is higher compared to all other ethnicities on the West Coast. The West Coast DHB is the lead DHB for this target across all other DHBs nationwide with the next closest being Nelson Marlborough with 86.4% of eligible Maori women being screened

Cervical cancer screening: At the end of June 2014, the preliminary three year coverage result for cervical screening on the West Coast non-Maori was 72.8%. The coverage rate for eligible Maori women is at 71% an increase from last quarter and a sustained increase from June 2012. The process for

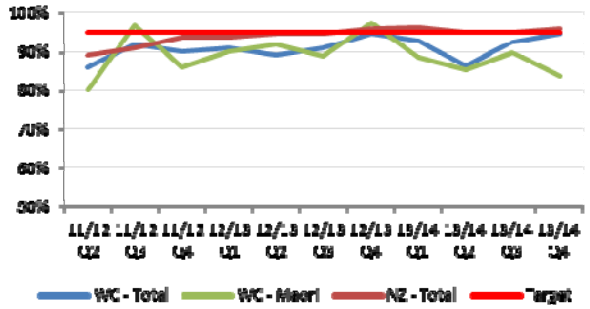
cervical screening is being embedded into the practices with overdue priority lists regularly being forwarded through to the Maori cervical screening. Additionally to this the Maori cervical screener is working very closely with Poutini Waiora to locate those hardest to reach and holding community clinics.

SMOKING CESSATION

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



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



ACHIEVEMENTS/ISSUES OF NOTE

Primary Smokefree Health Target: Results for Quarter 4 2013/14 show 62% of Maori have attended general practice and have been offered advice and support to quit, this is an increase from 58% last quarter this is compared to 59% of other New Zealand European.

There is a comprehensive plan in place to improve this target. Joe Mason Aukati Kai Paipa Smoking Cessation Co-ordinator is working with Poutini Waiora to streamline the pathway for whanau into this service. Additionally through the Healthy West Coast Workstream a plan is being developed that will give recommendations on the prioritisation of Maori access to all smoking cessation services. As part of this plan Joe Mason the Aukati Kai Paipa smoking cessation practitioner has been provided with a practice list of Maori from High Street Medical Centre who are recorded as smokers but had not yet been offered ABC. Of those that Joe has cold called he has had a great success rate of approximately 30% who are now on the AKP smoking cessation programme.

Aukati Kai Paipa: For the quarter March to June 2014 the AKP service is working with 44 clients, 11 who identify as Maori with a 33.3% validated abstinence rate at 3 months. The Aukati Kai Paipa cessation adviser is working more closely with practices and Poutini Waiora which is resulting in increased referrals to the service.

PHO Coast Quit Programme: For the quarter April to June 2014 7.7% (11) Maori accessed the Coastquit cessation service and 53 Maori have accessed the service year to date. This service has a poor access rate for Maori and this is one issue that we are aiming to address in the Maori Cessation plan.

The Maori Smoking Cessation plan is currently under development.

Secondary Smokefree Health Target: As previously reported, West Coast DHB staff provided 94.6% of hospitalised smokers with smoking cessation advice and support –just meeting the 95% target in Quarter 4. Data for quarter 1 is expected later this month.

Report prepared by: Kylie Parkin, Maori Health

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

ORAL HEALTH SERVICES REVIEW

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

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

SOURCE: **Planning and Funding**

DATE: **31 October 2014**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

In 2013 the West Coast DHB undertook a Review of Oral Health Services, in particular School Dental Services. A copy of the Review is attached as Appendix 1.

2. RECOMMENDATION

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

i note the recommendations from the Review of Oral Health Service, 2013; and
ii endorse the implementation of the review findings.

3. SUMMARY

Oral Health Service provision on the West Coast continues to be challenged by isolation, slow implementation of the Oral Health business case and the recruiting of clinical staff. These challenges have put pressure on the wider system. Consideration need to be given to strengthen transalpine linkages between the West Coast DHB and Canterbury DHB oral health services, to ensure operational, clinical and collegial support.

4. DISCUSSION

Oral Health Services on the West Coast are provided by a group of individuals who are all committed to ensuring the best outcomes for their community, however the isolation of the West Coast limits service options, creates duplication of effort and slows the implementation of changes in service models. There is a need for improved and connected information technology for dental therapists on the West Coast, including practice management system and digital x-ray services. The new models of care with the implementation of Level 1 mobile visiting all schools and the Level 2 mobiles and fixed clinics as the hubs, are expected to ensure that all children have their annual dental review on-time. The development of the integrated family health centres, in Greymouth and Buller, are also expected to improve the overall model for care for the district.

5. CONCLUSION

A number of key recommendations have been provided by the Review Team. These are:

1) Implement a process for change to develop a Trans-Alpine Oral Health Service which will include:
   a. Steering group to support the development of community based oral health services to ensure the public and private sectors support and complement each other as they work

together to minimize service gaps. This group will feed up to the West Coast Alliance. Included in their work plan will be overseeing the following recommendations.

b. Child Oral Health Services which link the West Coast and Canterbury DHB teams, and provide clinical leadership to the West Coast's dental therapists and assistants to reduce the level of professional isolation, and simplify the operation management of the West Coast service.
c. Hospital Dental Service linking West Coast and Canterbury DHB teams.

2) Complete the implementation of the oral health business case; including the de-commissioning of outdated fixed school clinics.
3) Continue to support general dental practice with further consideration to be given to Sedation and Emergency Dental Services.
4) Develop an outpatient facilities at the Grey and Buller integrated family health centres.

6. APPENDICES

Appendix 1:	Review of West Coast Oral Health Service
Report prepared by:	Bridget Lester, Planning and Funding Martin Lee, Clinical Director – Community Dental Service
Report approved for release by:	Stella Ward, Executive Director of Allied Health

West Coast DHB

Oral Health Services Review

Final Report

September 2014

Review Team:

Martin Lee
Neil Croucher
Heather Kirner
Bridget Lester

1 Executive Summary and Recommendations

Oral Health services on the West Coast are provided by a group of individuals who are all committed to ensuring the best outcomes for their community, however the isolation of the West Coast limits service options and slows the implementation of changes in service models. There is a need for improved and connected information technology for dental therapists on the West Coast, including practice management system and digital x-ray services. The new models of care with the implementation of Level 1 mobile visiting all schools and the Level 2 mobiles and fixed clinics as the hubs, are expected to ensure that all children have their annual dental review on-time. The development of the integrated family health centres, in Greymouth and Buller, are also expected to improve the overall model for care for the district. To ensure these occur, and to continue to strengthen Oral Health services on the West Coast the Review Team, has made the following recommendations.

1) Implement a process for change to develop a Trans-Alpine Oral Health Service which will include:
    a. Steering group to support the development of community based oral health services to ensure the public and private sectors support and complement each other as they work together to minimize service gaps. This group will feed up to the West Coast Alliance. Included in their work plan will be overseeing the following recommendations.
    b. Child Oral Health Services which link the West Coast and Canterbury DHB teams, and provide clinical leadership to the West Coast's dental therapists and assistants to reduce the level of professional isolation, and simplify the operation management of the West Coast service.
    c. Hospital Dental Service linking West Coast and Canterbury DHB teams.

2) Complete the implementation of the oral health business case; including the de-commissioning of outdated fixed school clinics.
3) Continue to support general dental practice with further consideration to be given to Sedation and Emergency Dental Services.
4) Develop an outpatient facility at Grey Hospital linking with the integrated family health centres in Grey month and Buller

Contents

2 The Process

This West Coast Oral Health Review "this Review" was initiated by Stella Ward, Executive Director of Allied Health, West Coast District Health Board (WCDHB). This Review was intended to address to concerns about the implementation of the child and adolescent oral health business case, inability to recruit of a dental therapist to fill a retirement vacancy, and a substantial increase in the number of children overdue for routine dental treatment. Questions had also been raised about the current level of provision of hospital dental services, whether the configuration of these services is meeting the needs of the population

The terms of reference for this Review were developed and approved by West Coast DHB Executive Management Team. A copy of these are attached in Appendix One. A Review Team was also selected. This Team had weighting towards childhood and adolescent dental, due to these areas having the highest number of concerns. The Review Team consisted of:

- Dr Martin Lee — Canterbury / West Coast DHB Community Dental Service Clinical Director
- Heather Kirner — Canterbury / West Coast DHB Community Dental Service Professional Leader
- Dr Neil Croucher — Northland DHB Dental Services Clinical Director
- Bridget Lester — Canterbury / West Coast DHB Planning and Funding

The Review Team, met on the West Coast on Monday 21 October 2013 and held interviews on the West Coast on the 22 October 2013, focusing on child oral health services (COHS) and then interviews in Christchurch on the 23 October 2013, focusing on oral health services for adolescents (OHSA) and hospital dental services (HDS).

3 Acknowledgement

The Review panel would like to acknowledge the enthusiasm, commitment, energy and expertise of all the people interviewed. Everyone wanted the best for oral health services on the West Coast and saw the need for change to realise the potential for those services.

4 Background

Publicly-funded Oral Health Services in the West Coast have three key components

- **Child Oral Health Service** – this is the service provided free to children aged 0 – 13 years of age. This service is delivered by the School Dental Service, based out of Community Services Team at Grey Hospital.
- **Adolescent Dental Service** – this service provides free services to children aged 13 – 18 years of age, and is provided by local dentists under agreement with the District Health Board, and by the Board's dental therapists in Karamea, Reefton, and Hari Hari.
- **Hospital Dental Service –** these services are provided at Grey Base Hospital for children, adolescents and adults who have complex requirements and need to be treated within a hospital setting. Note that the only service provided is dental treatment under general anaesthesia, no outpatient facility is avaialble.

Oral Health Business Case

In 2007 DHBs nationally submitted Oral Health Business cases to the Ministry of Health (MoH) which outlined a change in service model for Oral Health services. At this time there were 10 school dental clinics on the West Coast. A caravan-style mobile clinic was used to provide services to schools without a clinic and this has since been withdrawn from service.

The West Coast Oral Health Business case recommended a change in how School Dental Services operate, with a move away from the run-down and expensive to maintain/upgrade school dental clinics (which were located at nearly all primary schools) to a "hub and spoke" model. The "hubs" being clinics designed to support a full range of dental care, and not tied to school operations, and the "spokes" being mobile units which would reduce access barriers and improve efficiency.

The approval of the business case saw $1.107 million of capital and additional operating expenditure of $265,000 allocated to the WCDHB to fund the redevelopment of the oral health service. This has since seen the de-commissioning of 6 school clinics and the purchase of two Level 2 (L2) Treatment Mobiles. [1]

Four school clinics remain: Hokitika has been upgraded; Grey Main, Westport North and Westport South are still operating although none comply with current infection prevention and control standards, and have other major deficiencies.

The purchase of the mobiles and the upgrade of the Hokitaka clinic did not resulted in a substantial change of service model, as anticipated by the business case, and in 2013 the WCDHB purchased a Level 1 Mobile as a step towards the change in service model however implementation of this has not occurred.

The completion of the West Coast DHB's plans have been delayed due to operational problems within the School Dental Services and significant delays in the redevelopment of Grey and Buller Hospitals.

5 West Coast District Annual Plan Requirements

Each DHB in New Zealand is required to summit a District Annual Plan to the MoH which has key expectations and requirements for the District. The MoH has set Oral Health requirements and targets for all DHBs. In the 2013/14 year the following is required of the West Coast DHB. A breakdown of these are included in appendix two.

6 Oral Health Services

6.1 Oral Health Promotion and Education

6.1.1 Tamaraki Ora/Well Child Providers

When a child is born on the West Coast they are offered services from a number of Tamaraki Ora/Well Child Providers. These providers include Plunket, Poutini Waiora, Public Health Nursing Service and Rural Nurse Specialists. At the core well child checks, Well Child nurses provide information and education to parents on maintaining good oral health and dental development, and carry out a basic oral health screening using the 'lift the lip' method. At Plunket visits, parents are given tooth brushes and toothpaste. The MoH has recently made tooth brushes and toothpaste available to Maori services providers. Well Child providers send information to the School Dental Services when children are eight months old to enable those children to be enrolled with the dental service.

[1] A "level one" unit is designed for dental examinations and basic preventive care, is self-drive and has no facility for cleaning and sterilising instruments, which must be taken to another clinic for reprocessing. A "level two" unit has on-board instrument reprocessing equipment, and is able to support dental treatment as well as diagnostic and preventive care. The level two units are large dual axle trailers and require to be towed by a truck.

6.1.2 5-month information packages

As part of a recent oral health project information packages have recently been developed for parents of 5-month olds. These packages include information for parents regarding oral health, (referral form to the School Dental Services) and toothbrushes and tooth paste. These are distributed by general medical practices at the 5-month child immunisation event.

6.1.3 B4 School checks

B4 School Check (B4SC) is a national 4-year-old well child check and clinics are held throughout the main centres, as one-stop-shop. A Dental assessment is carried out as part of the B4SC provided by Public Nurses. If children are not enrolled with the dental service, or if there are signs of decay in the teeth, children are referred to the School Dental Services.

6.1.4 Oral Health Project Manager

In 2013 DHB had appointed an Oral Health Project manager working as part of Planning and Funding for 6 months. During this period a number of projects were put in place, including the Oral Health 5-month pack.

6.2 West Coast School Dental Services

The School Dental Services provides services at locations stretching 530km from Karamea Area School in the north to Haast School at Jacksons Bay in South Westland. The Service's three dental therapists and three dental assistants provide care for children and adolescents aged from under one-year-old through to age 17, with 1,541 preschoolers, and 3,622 school children and adolescents enrolled in the service, giving a dental therapist to patient ratio of 1:1,721[2].

For children aged from birth up to school year 8, services are provided under the Ministry of Health's "Child Oral Health Services Service Specification", which requires providers to:[3]

- Demonstrate a strategy for the enrolment of pre-school, primary school and intermediate school children. Your strategy must include the full range of educational facilities, including Kohanga Reo, Kaupapa Māori and Pacific Language Nests.
- Target in particular those groups of children who have relatively poor oral health, ie Māori, Pacific children, new migrant and refugee children, children living in low socio-economic areas and rural children, and demonstrate a strategy to focus on these groups.
- Ensure that each enrolled child has access to a basic level of oral health care, as defined in the oral health toolkit.
- Ensure accurate monitoring of oral health status of the enrolled population, including differences between Māori, Pacific people and other ethnicities, fluoridated and non-fluoridated areas and school decile (see reporting requirements below).
- Promote enrolment with a provider of adolescent dental services to all Year 8 children, with priority given to those groups of children with relatively poor oral health, ie, Māori, Pacific children, children living in low income areas and rural children.
- Demonstrate a strategy for dealing with children who do not receive their annual completion.
- Demonstrate a strategy for improving collaboration with providers of public health (health promotion) and primary care providers to improve access to oral health services, especially for preschoolers.
- Ensure that staff has access to professional development.

Services are provided from 29 locations, at the following schools (see map in Appendix A for locations), there are 4,609 pre- and school-aged children enrolled for dental services at these schools:

Awahona	Barrytown	Blackball
Blaketown	Cobden	Fox Glacier
Franz Josef Glacier	Gloriavale	Granity
Grey Main	Haast	Hokitika

[2] Based on 2013 enrolment data provided to the Review Team, by the School Dental Service
[3] http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/153

Kaniere	Karamea	Karoro
Kokatahi/Kowhiterangi	Kumara	Lake Brunner
Maruia	Paparoa Range	Paroa
Reefton	Ross	Runanga
St Patricks	Sth Westland Area	Westport North
Westport South	Whataroa	

A further 7 schools have no on-site dental service, with 554 school-aged children enrolled for dental services:

Inangahua Junction	Scared Heart	St Mary's
St Canices	Westland High	Westmount at Kaiata
Westmount at Westport		

One third of the schools have less than 50 pre- and school-aged children enrolled for dental services, half have less than 100 – the distribution is shown below.

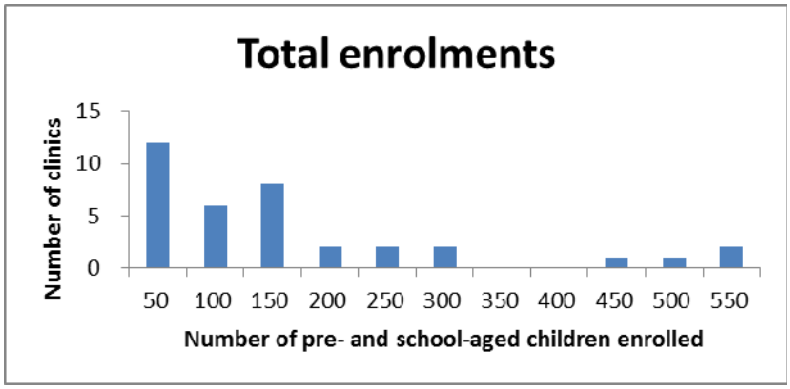


Figure 1: Number of enrolled pre- and school-aged children by clinic (WCDHB)

Services are provided from a mixture of new, renovated, and older dental clinic facilities, and new mobile units:

- four fixed clinics
  - two in old-style school dental clinics in Buller
  - one old-style school dental clinic in Greymouth
  - a recently renovated clinic in Hokitika
- 2 level two mobile units and 1 level one unit (not yet in service). The level 2 units service 25 schools.

6.2.1 Enrolment with the Service

Following receipt of an enrolment form from a Well Child provider, primary care or other health provider, children are allocated to the dental facility closest to them. They are then scheduled to receive services when the School Dental service is next in their area. Dental therapists report that preschool children also enrolled opportunistically when they accompany older siblings to scheduled visits. In addition to the targets for numbers of preschool children enrolled, DHBs are expected to have a plan in place for assessing children for dental caries-risk on enrolment, and targeting those at high risk for additional preventive care. DHBs can consider preschool children enrolled when they are actively managing their care, and are not required to have provided a dental visit for this to occur. The Service has been attempting to see all children by age one, however has no formal risk assessment processes in place to ensure additional preventive care is provided to those most at risk.

On receipt of a notification from a Well Child provider, the School Dental Service currently posts a form for parents and sign and return to complete the registration/enrolment process. An entry of enrolment is made into a spreadsheet; however there is no reconciliation between those on the register, and those who actually receive services. The School Dental Service has put in a lot of effort to increase enrollments, and currently has 87.7% of preschoolers enrolled, which includes 91.7% of tamariki Maori. Representatives from the DHB have attended health days, linked in with preschools and other relevant services.

Seven of the 36 schools at which children are enrolled do not have an on-site service and therefore no preschool-aged children are seen at those locations; 18 of the remaining 29 (62%) have less than 50 preschool children – the distribution is shown below. Those with more than 100 enrolled are: Hokitika (124), Westport South (152), Grey Main (175), and Westport North (218).

Observations: There is no requirement for parents to sign an enrolment form, and the West Coast DHB could carry out this process in a similar way to that carried out in Canterbury, where enrolment occurs on receipt of an enrolment form from a Well Child or other health provider.
However, because there is no electronic oral health record, opportunities are being missed to leverage from other health information systems, such as the National Immunisation Register and those held by general practice teams, and only very limited reporting is available.

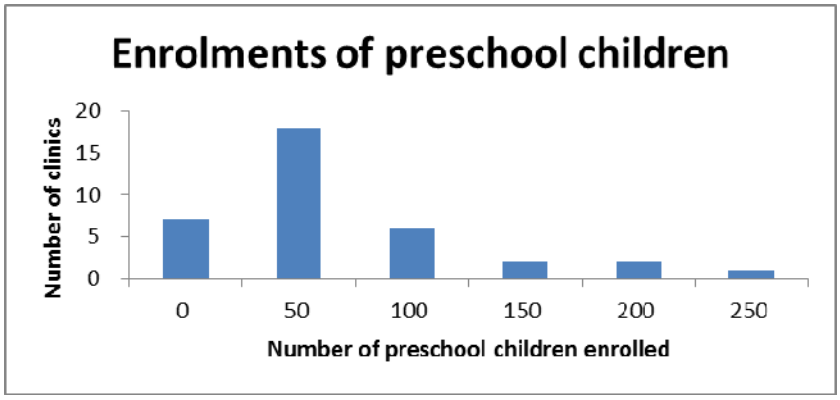


Figure 2: Enrolments of preschool children by clinic

6.2.2 School Aged children

School aged children receive dental examinations at their primary school, and in most cases this is at a level 2 mobile unit., but from Term 4 2014 also in the Level one unit. Where dental treatment is required, children who were examined in a Level 1 unit are bought to a fixed clinic or Level 2 unit for by their family for dental treatment.

6.2.3 High School Aged Children

Because there is no local dentist available, the Service offers dental care for year 9 - 13 students attending the high schools at Karamea, Reefton and Hari Hari. Families retain the option to access a dental provider elsewhere and due to this and an unknown level of non-access to care only about one third of those high school students are accessing care through the School Dental Services.

School	Number of adolescents enrolled with CDS	Number Yr9-13 on school roll (Jan 2013)
Karamea Area School	19	36
Reefton Area School	0	79

South Westland Area School	9	45
Total	**51**	**160**

6.2.4 School Dental Service Teams

The School Dental Team is made up of a team of 10 people, three dental therapists, three dental assistants, a receptionist and a coordinator. There are currently vacancies for a dental therapist and dental assistant.

6.2.4.1 Support Services

The Dental Coordinator currently works 4 hours a week for the Service. This role provides HR support for the team, develops and documents process and procedures, supports children in accessing the hospital service, and works with the team to implement the business case.

The Dental Receptionist works 30 hours per week. This role is responsible for processing registrations to the service, communication between the team, collecting and collating data for reports, and managing referrals to the hospital service.

Clinical leadership in the form of the Clinical Director and Professional Leader are provided by Canterbury DHB. Planning and Funding Canterbury/West Coast also support the service as required.

6.2.4.2 Clinical Services

The three dental therapists work fulltime during school term time, with each therapist covering a key geographical area etc Buller / Westport, Greymouth and Westland. The current vacancy is to replace a full time staff member who was based in Greymouth and retired in 2012. While there have been a number of applicants for this vacancy they have not been suitable due to either APC restrictions, supervision requirements or not being eligible for NZ registration. A dental assistant position will be advertised when a therapist is recruited.

The three dental assistants all work fewer hours than the therapist they assist:

- Buller 22 hours
- Greymouth 26 hours
- Hokitika 30 hours

Each dental team (Therapist and Assistant) manages its own schedules and arranges appointments for all visits. Because there are no two-chair facilities, each therapist is working in professional isolation, and although each team has established good working relationships with the local dentists in their area interactions are limited, especially for the Westland team as there is no longer a dentist in Hokitika. Good referral processes have been developed for children who need to be seen for more complex care by local dentists or by the hospital service.

As mentioned, difficulties recruiting to a dental therapy vacancy has led to a gap in service provision in the Grey area with relatively large numbers of children becoming overdue for their regular dental checkups. This reached a stage where schools contacted the DHB on a number of occasions over the lack of care to their students, and there were parliamentary questions on the issue. Since 2013, the West Coast clinical teams have reorganized the way they work and the number overdue has fallen considerably. At last count, there were over 975[4] children in arrears on the West Coast.

Lack of a dental IT system is a significant issue for the Service. Not only does the dental team lack basic business tools such as email and intranet access, there is no electronic patient management system. All scheduling and reporting is carried out

[4] Based on July 2014 Project data.

manually and this has a considerable impact on clinical activity. The level of information that can reasonably be attained by manual recording restricts clinical audit to all but the most basic activity.

6.3 General dental practices

There are two service agreements that can be held by dental practices under the Combined Dental Agreement: these are the Oral Health service for Adolescents and Special Dental services for Children. There are 4 dental practices on the West Coast, (three in Greymouth and one in Buller), and all hold these agreements. There was a part-time practice in Hokitika until early in 2013; however this has closed due no buyer being forthcoming following the dentist's relocation to Canterbury. Utilization data shows that there were around 1600 Adolescent visits in the 2012 year. Based on a population of around 1800 adolescents aged between 13-17years of age, this is very good uptake of adolescent services.

Three of the four practices are privately owned, with one being owner by a large national group and the other two local owner / operators. The practice in Buller is owned by the Buller District Council-controlled Buller Health Trust which employs a full-time dentist, and locums as available. As part of the review the team talked to the Dr Guy Margetts, owner of Family Dental Practice in Greymouth and the Dr Michael Shortt, full-time dentist from Westport Dental in Buller. Both practices were active in their relationships with the community and positive about their working relationships with the School Dental Services, and both prioritise referrals from the School Dental Service, but had concerns with ad-hoc contact from parents that did not have a school dental referral.

Family Dental Practice is a large practice in Greymouth, who previously had an agreement with the West Coast DHB for sedation services. This has not been renewed due to DHB concerns about the affordability. The discussion with them provided clarification to the review team, who all agreed that this agreement should be reviewed as the benefits of having the sedation service being available would fill a gap caused by the itinerant nature of the hospital-based service in Greymouth.

Westport Dental is a two chair practice with one permanent dentist and short-term dentists. When there is a second dentist they are able to book appointments without delay, but when there is no visiting dentist there is an up to three week wait for appointments (we understand they are able to see patients with acute problems promptly). Planning for the Buller Integrated Family Health Centre is underway and there is a desire to integrate both the School Dental Services and the Westport Dental Centre in the new facility. Dentist recruitment is a recurring problem in Westport, and Dr Shortt felt that beyond other quality improvements, a newer facility would help to encourage dentists to work in Westport, and enjoy its many other advantages.

The overall sense from the review team was that there was considerable good will and passion within the private-sector dental services on the West Coast.

While the availability of private-sector dental services on the Coast is currently adequate, (noting there is no service in Hokitika), the small size means they remain vulnerable to gaps created when a practitioner leaves the district, and delays in replacement. Consideration need to be given to what the DHB's role is in supporting these services.

6.4 Hospital Dental Services

The service definition for Hospital Dental Services is[5]:

> "Hospital dental services provide oral health care services for people with special needs that are most appropriately provided within a hospital setting or in other settings where necessary linkages with hospital services have been established. This may be when special care is required to provide primary care for those with a

[5] Hospital Dental Services – Oral Health Services Tier Two Service Specification

disability and unable to access care in the community, to provide secondary and tertiary care when special management is required or when dental services are required as part of other medical or surgical treatment.

"These services are complementary, rather than being alternative to the oral health care services provided for children and adolescents, emergency dental services for low income adults and dental services for adults that are not publicly funded.

And the services required to be provided are:

Primary services:

"…primary oral health care services for people needing special care because of medical, physical, intellectual or psychological conditions and disabilities, which preclude them from accessing care in the community. People needing such special care may include may include residents of community residential disability services, residents of aged residential-care rest homes, dementia and hospital care facilities; care recipients under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003; and care recipients under the Criminal Procedure (Mentally Impaired) Act 2003.

"Emergency dental services must be available for the assessment and management of: severe orofacial infections; uncontrolled oral haemorrhage; and/or orofacial trauma.

'Where a DHB does not have a hospital dental service, the Emergency Department may manage the initial emergency dental care (of conditions such as those above) and transfer the person to a DHB of service or an appropriate local oral health professional for definitive treatment.

Secondary and tertiary services:

"The Service will provide secondary and tertiary dental services for people when:

- dental treatment is an essential part of hospital treatment for a current medical or surgical condition
- a hospital admission is required because of the need for special management facilities in order to provide dental treatment, such as general anaesthetics
- general and specialist dental services as required for persons needing special care because of medical or congenital conditions and/or physical, sensory, intellectual or psychological disabilities.

"Where a DHB does not have a hospital dental service, the DHB must arrange appropriate referrals for these people to a DHB of service.

Hospital-based dental services on the West Coast are very limited – consisting only of those provided in theatre by two itinerant dental surgeons from Christchurch. No one appears to have operational responsibility for managing Hospital Dental Services on the West Coast, and by default the Central Booking Unit (CBU) makes all the arrangements. However the Dental Coordinator for Community Dental has recently become involved, and has some oversight of the waiting lists, (largely in a child safety capacity), and works with the CBU to ensure any children, whose families are not ensuring that they are accessing care, are followed up. There are no established linkages with those providing residential and other care for special needs adults and the frail elderly and it is likely that the current level of service is well below the potential demand. The review team is aware that some patients do receive care at both Christchurch and Nelson Hospitals; however the volumes are small, even taking into account the small West Coast population. For Jul-12 to Jun-13 less than 50 of the 12,010 patients treated (not involving maxillo-facial surgery) by Christchurch Hospital's dental service were from West Coast.

We understand that 50-60 children receive dental treatment each year under general anaesthesia – based on relative population size this is not much different to Canterbury.

There is no dental facility at Grey Hospital, and this limits the type of care that can be provided to the provision of dental treatment in an operating theatre under general anaesthesia. No out-patient care is provided, and patients are usually booked for treatment following assessment of referrals from both DHB and private providers. The intention is to build a dental facility in the new Greymouth Integrated Family Health Centre, and this will be a necessary step for improving the range and quality of services available for the people of the West Coast.

Both of the dentists providing care at Grey Hospital are from Christchurch (Dr Joanna Pedlow, Dr Lester Settle), and while they are both part-time CDHB employees, their services on the West Coast are under private contract. Dr Pedlow's practice is limited to paediatric dentistry and she visits approximately 10 times per year; Dr Settle provides care for special needs adults and other eligible patients requiring minor oral surgery procedures, visiting about four times per year.

The NZ Oral Health Clinical Leadership Network provided advice to the Chief Dental Officer and Ministry of Health in 2012 on improving oral health services for high-needs and vulnerable populations – those covered by the Hospital Dental Services specification. The report found that there were significant regional variations in the availability of those services, with the West Coast being among those areas with the worst access.

The potential for greater involvement of Canterbury's Hospital Dental Service in providing care on the West Coast was discussed with Dr Settle, who is clinical director for the Canterbury service, and there was general agreement that this would be a necessary step for improving the quality of dental care on the West Coast.

6.5 Dental Equipment Maintenance

Planned maintenance of dental equipment in the clinics and mobile dental units is carried out by the West Coast DHB trades team with contractors being reasonable for maintenance of the washers/sterilisers. The maintenance of the dental clinics, L1 and L2 facilities are contacted out. WOF are coordinated by fleet service, while Electrical work is contracted to Electronet.

In January 2013 the West Coast DHB's clinical engineering team came under the oversight of Canterbury DHB's CE team. Those involved view this as a positive development and it should greatly assist the West Coast team as it provides greater support and reduces duplication.

Due to the need for maintenance staff to travel considerable distances for repair work, equipment breakdown can lead to prolonged loss of services. Dental equipment is expensive, and owing to its small size, the West Coast DHB is not able to maintain a full set of spare equipment to allow for swap-in-swap-out in the event of breakdown. The retention of the old clinics in Westport and at Grey Main has meant old and unreliable equipment is still being used, and this is proving to be a maintenance burden. Currently some older equipment from disestablished dental clinics had been keep to be used as spares however this equipment will not be able to be used once the transition to new facilities is complete. Phasing out the old equipment as planned, and further development of closer collaboration with Canterbury (including the pooling of spares), and harmonisation of equipment will improve this situation.

One current issue is that the planned maintenance for equipment cannot reasonably be completed during school holidays, and the CE team will need access to the equipment during the rest of the year. Ensuring planned maintenance is kept up-to-date is essential to prevent breakdowns which will impact on clinical services. This will require good planning between the clinical and engineering teams.

6.6 Orthodontic treatment

There are currently no orthodontic services on the West Coast. Families are aware of this, and travel to services – generally in Nelson and Christchurch. A similar problem exists with other specialist medical and dental services provided in the private sector. Lack of specialist services was not raised as an issue by the West Coast practitioners, and seems to be in line with general expectations on the West Coast that people frequently need to travel to access specialist services. Note that the community's views on this matter are not represented in this review.

7 Discussion

7.1 Child oral health services

School Dental Services team works hard to improve and protect the oral health of the children of the West Coast. The 2007 Oral Health business case was designed to make their roles easier through improving facilities, streamlining administration and encouraging the use of technology solutions. The delay in the implementation of this business case and the utilisation of resources has continued to put pressure on the team. Due to its small size, and problems recruiting dental therapists when vacancies occur, they remain vulnerable to loss of staff.

The DHB needs to fast-track the implementation of the final stages of this business case, it needs to develop a schedule for the use of the level 1 and level 2 mobiles, and it needs to get an electronic patient management system (including radiography) implemented without delay. Although hardware and networking for a mobile workforce will need to be deployed from scratch, the patient management system need not be if Canterbury's Titanium dental PMS is expanded to include the West Coast.

Consideration needs to be given to staffing of this service as follows:

- The current 4 hours per week allocation for the Dental Coordinator is insufficient to carry on the work involved in fully implementing the business case, during the interview her line manager did indicated that additional hours could be available, if required.
- The three dental therapists are all working 35 hours per week, while the dental assistants are collectively only working 78 hours, producing a 27 hour gap between the total therapists' and assistants' hours. Dental assistants increase the productivity of the dental therapists they work with, with the rule-of-thumb being a 50% increase, therefore this 27 hour gap represents nearly 0.4 FTE of a dental therapist.

Although some of the Service's processes have been adapted from elsewhere, most of the West Coast CDS operations are 'home grown'. There are, for example, 70 forms used by the Service, each developed locally.

Canterbury DHB has developed and implemented their new model of care, and is able to implement this in both urban and rural areas of Canterbury and South Canterbury. There seems to be no advantage in the West Coast having a separate model of care, and given the Canterbury model is working, it should be shared and implemented across both DHBs. Strong clinical leadership and additional management support will be needed to facilitate the necessary changes, and it is expected that much of this will come from the Canterbury DHB dental services. It is clear that more regular contact is needed – both through personal contacts and telepresence. West Coast staff would benefit from working in the Canterbury system, as this is one of the only ways they will be able to work in multi-surgery facilities with professional colleagues. This work will strengthen the Trans Alpine alliance between the two DHBs.

As part of developing a stronger relationship, consideration needs to where the West Coast team sits in relation to Canterbury's Community Dental Service. The Canterbury Service is much larger, and has a number of clinical and non-clinical roles not duplicated on the West Coast. There is clearly scope for Canterbury to provide more support for the West Coast, but it is equally clear that the West Coast Service would need to adopt of the business, operational and clinical processes used by Canterbury to enable this to happen.

Even though the West Coast Service is small, the changes required to compete the business case implementation are substantial, and will not be able to be achieved without dedicated project management support.

The name of the West Coast dental service was discussed during the meeting with the staff, and there was general agreement that "Community Dental Services" more fully reflects the role of the Service, and that this be used as the Service's name. It is also the same as for the Canterbury service, and may make sharing of resources and documents easier.

One final issue – the elephant in the room – needs addressing: merging the West Coast service into Canterbury's and developing a Trans-alpine Oral Health Service. In New Zealand there are already regional services: the Auckland Regional Dental Service covers all three of the Auckland DHBs, Canterbury currently provides the service in South Canterbury, and while it works with the South Canterbury DHB at a strategic level, has complete operational responsibility, and the small Wairarapa service is being integrated into the larger Hutt Valley Service (which already provides the service in Capital and Coast's area). Larger services require proportionately less overhead, and have greater capacity to develop, implement and evaluate changes that will lead to better care for patients. We consider that a process for change be implemented that joins the West Coast and Canterbury services at a leadership and operational level while maintaining the unique identity of the West Coast service.

7.2 Adolescent Services

The review team has confidence in the high quality of services provided by the dentists on the West Coast, there were however concerns regarding isolation and the need to support them in the wider West Coast Health system. The concept of recruiting short term locums to provide service to support rural areas is an idea that needs to be further investigated. The review team understands that the West Coast DHB has a recruitment process which dental could be linked into.

There is also a need to look at what support is required in Hokitika, and whether the recent loss of the dentist has created significant access problems for adolescents. The review team was told that most adolescents are now traveling to Greymouth, but remains concerned that the travel creates another barrier to access, and considers arrangements similar to those in other West Coast centres with a high school but no dentist be considered. The team met with the principal of Hokitika Primary School (where the refurnished dental clinic is located) and had a favourable response to the concept of utilizing this facility to offer dental services to adolescents by a dental therapist or dentist.

7.3 Hospital Services

It is clear that hospital dental services on the West Coast are very limited, and although access for children requiring hospital-based treatment seems adequate, this does not appear to be the case for adults, and there are no out-patient facilities. There seems to be a need for some structure around leadership and management in this area.

The concept of working more closely with West Coast DHB was discussed with the Clinical Director of Canterbury DHB Hospital Dental Services. This could go as far as all hospital dental services for the West Coast being provided by Canterbury DHB – including provision of staff, and management of referrals. However, the current lack of out-patient dental facilities at Grey Hospital would make it difficult to improve the level of service. In the short term, this could be partially remedied by using the dental mobiles during periods, such as school holidays, when the community service is not using them. Some further work needs to be done to establish how Christchurch Hospital's dental team could better support the West Coast.

7.4 Canterbury - West Coast transalpine partnership

West Coast and Canterbury DHB work together in what is call the Trans-Alpine partnership. According to the WCDHB District annual plan "Collaboration with Canterbury continues to be a cornerstone strategy for securing reliable access to a full range of specialist services, for the most part delivered locally on the Coast and with some services delivered in Christchurch". There are currently more than 20 transalpine services being successfully delivered between the West Coast and Canterbury, included in this are collaborative relationship between the DHBs with shared service and clinical partnership arrangements that include a number of clinically-led transalpine service pathways.

7.5 Summary

West Coast Dental services are characterized by positive people working with limited structure and support. The review team accepts that the DHB has some limitations in levels of support that can be provided, but found that changes need to be made to improve the range and quality of services and their resilience, and to ensure that the services have a system

and support network behind them to avoid the need to ‘invent’ solutions on the West Coast when those solutions already exist elsewhere.

8 Key Findings

- **Professional Isolation -** Therapists work in isolation and lack the opportunities for peer contact and review and audit that are generally held to be necessary to assure patient safety and improve service quality. Clinical staff are constantly on the move but have no access to DHB information systems. [6]
- **Recruitment and retention** – the small size of the service makes it particularly vulnerable to the loss of staff, particularly dental therapists. The small size of the service also makes it difficult to provide orientation and support for new staff.
- **Service management**: too much is asked of the current management team, which lacks the skills and experience to provide effective strategic leadership and operational management for a service operating in a sector which is technically complex. Solutions are being developed (at a cost to the WCDHB) when they already exist elsewhere.
- **No system in place to coordinate and develop community oral health services:** practitioners on the West Coast are self-reliant, but ensuring the population receives the widest range of services available requires they work together.
- **Access gap for adults with special needs:** there is no outpatient facility for provision of dental care for high needs and vulnerable patients not able to be cared for in the private sector. The very small volume of patients being treated in Christchurch shows the current arrangement of relying on patients travelling to other DHBs is not working.
- **Lack of planning and scheduling around current hospital-based services:** planning for treatment of those adults and children currently offered treatment at Grey Hospital is distributed among several individuals with no clear lines of communication.

[6] The review team is aware that a plan is in place to see an IT system implemented by the second half of 2014

9 Recommendations

Service	Recommendation	Implementation	Progress to data
Governance	Develop a Trans-Alpine Oral Health Steering group to support the development of community based oral health services. The aim of this will be to ensure the public and private sectors support and complement each other as they work together to minimize service gaps. This group will feed up to the West Coast Alliance. Included in their work plan will be overseeing the following recommendations of this Review.	Identify representatives from the West Coast areas to join this group.	The Canterbury part of this has already been established, West Coast representatives just need to be identity to join this group.
Community Dental Services	Develop a Trans-alpine Community Dental Services, linking West Coast and Canterbury DHB teams	Undertake a proposal for change process to integrate the Canterbury and West Coast child oral health services. This proposal will investigate the options for models of management and provision of this service, and provide recommendations.	
	Complete the implementation of the oral health business case; in particular	• Develop a pragmatic schedule for the dental mobiles that maximizes efficiency while minimizing demands on families. • Implement a model for targeting preschool children most at risk of tooth decay with intensive preventive care. • Decommission the outdated facilities at Westport North, Westport South and Grey Main schools	Work has started on the roll out of the L1 mobile, with schools scoped and the schedule drafted. The L1 is expected to be in service by T4 2014.
General dental practice	Continue to support general dental practice with further consideration to be given to Sedation and Emergency Dental Services.	Develop a business case to the P&F leadership team regarding Sedation and Emergency Dental Services	
Hospital dental services	Develop a Trans-alpine Hospital Dental Service linking West Coast and Canterbury DHB teams.		
	Develop an outpatient facility at Grey Hospital linking with the integrated		

	family health centres in Grey month and Buller		

10 Appendices

Appendix One: Service outline WCDHB Oral Health 2013

Service area	Existing services/providers	Funding/DAP expectations	Known gaps
0-4 Well Child	• Plunket • Poutini Waiora • Rural Nurse Specialists • Public Health Nurses Information packages are also distributed by practice nurses at the 5month immunisations.	Oral health assessment (inc lift-the-lip) in WCTO schedule for Core 5 (9-12mth) to Core 9 (B4SC)	Had been gaps in Plunket services in the past. Training
Primary Care			
0-4	School Dental Services • Karamea • Reefton • Hari Hari	Child Oral Health Services Specification	Not reaching all children due to staffing issues.
5-12	School Dental Services	Child Oral Health Services Specification	Not reaching all children due to staffing issues
13-17	General Dental Practice • Westport • Buller Health Trust • Greymouth • Family Dental Centre (Albert Mall) • Greymouth Dental Centre (Guinness St) • Lumino The Dentists (Mackay St; ex Garry Rae Dental)	Combined Dental Agreement – SDSC Combined Dental Agreement – OHSA	No provider in Hokitika (as opposed to all other centres with a high school)
18+	General Dental Practice • Practices as above Dentures - Duchenne Dental Lab (@ Family Dental Centre) But chch based	Emergency Dental Services?	
Specialist			
0-4	Grey Hospital MSS IDF to CDHB (Paediatric xx cases/year? Christchurch-based surgeon, private contract)	Hospital Dental Services • ESPI	Treatment only under GA No venue for assessments Sedation?
5-12	Grey Hospital MSS IDF to CDHB Paediatric xx cases/year?. Christchurch-based surgeon, private contract	Hospital Dental Services • ESPI	Treatment only under GA No venue for assessments Sedation?

13+	Grey Hospital MSS IDF to CDHB Tx split between paediatric dental and special needs adults.	Hospital Dental Services • ESPI	Treatment only under GA No venue for assessments Sedation?
18+	Grey Hospital MSS IDF to CDHB xx cases/year? Christchurch-based surgeon, private contract	Hospital Dental Services • ESPI	Treatment only under GA No venue for assessments Sedation?
Maxillo-facial surgery	IDF to CDHB	Tier 1 Specialist Medical and Surgical Services ACC	
Orthodontics	IDF to CHDB Private providers in Nelson/Christchurch (Previous Christchurch-based provider retired, no replacement)	Severe malocclusions with means test -> Christchurch Hospital	
Other specialties: • Endodontics • Periodontics • Prosthodontics	No providers on WC		

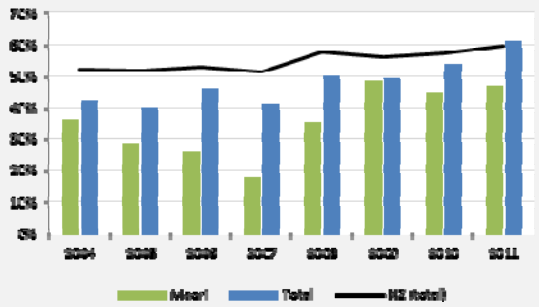
Appendix Two: Annual District Plan Requirements

Children have good oral health.

- *Oral health is an integral component of lifelong health and impacts a person's comfort in eating and ability to maintain good nutrition, self esteem and quality of life.*
- *Good oral health not only reduces unnecessary complications and hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition - helping to keep people well.*
- *Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy measure of equity of access and the effectiveness of services in targeting those at risk.*

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).	Actual 2011	Target 2013	Target 2014	Target 2015
	61%	61%	65%	≥65%



- Work collaboratively with the Canterbury DHB's Community Dental Services to support dental therapists on the Coast and improve coordination across oral health services to improve access to preventative care.

Continue to work with WellChild providers, general practice teams and schools and education services to identify children most at risk of tooth decay and support their families to maintain good oral health and access preventative care.

Develop a whole-of-DHB Oral Health Promotion Plan.

Identify further barriers to timely recall by DHB Community Dental Services and implement strategies to support caries-free teeth.

Continue to investigate and implement alternative oral health service models for adolescents to engage more young people, particularly those in low decile schools or areas without community dentists.

Implement the Level One Mobile Service in Greymouth and other priority schools on the Coast to support the preventative care model.

Review the inclusion of dental services as part of the development of Integrated Family Health Services in Westport and Greymouth.

≥77% of children aged 0-4 are enrolled with DHB-funded oral health services.

≥90% of children are examined according to planned recall.

≥75% of adolescents (<18) access DHB-funded oral health services.

Appendix Three - Utilisation from Dental Clinics

Practice	OHSA	SDSC
Buller Health Trust	411	65
Greymouth Dental Centre Limited	45	23
Hokitika Dental Centre Limited	216	0
Lumino Dental Limited	259	0
Westland Enterprises Limited (aka Family Dental Centre)	744	415
Total	1675	503

Appendix Four - West Coast Oral Health Review - Interviewees

The following people were interviewed as part of the West Coast Oral Health Review

- Maintenance and Supplies - Robert Raeder (Biomedical Technician), Ted Aldous (Works Overseer) and Mike Penna (Fitter)
- Karyn Kelly – GM Primary and Community Services
- Maureen Frankpitt – Community Services Manager
- Ralph La Salle – Acting Operational Manager
- Jenny Woods – Dental Coordinator
- Dental Service Team – including all the Dental Therapists, Dental Assistants, and Receptionist
- Hokitika Primary School Principal
- Dr Guy Margetts - Family Dental Centre, Greymouth
- Dr Lester Settle, Clinical Director Canterbury DHB Hospital Dental Services
- Dr Michael Shortt, Westport Dental Practice

Key questions asked to all people interviewed.

- What is your role / interactions with Dental Services/ Hospital Dental etc?
- How are things going from your perspective?
- What challenges do you believe they / you face
- Are you happy with the referrals to services?
- What gaps do you see in oral health service delivery?
- What opportunities do you believe we have on the West Coast?
- What would you like to improve?

RESOLUTION TO EXCLUDE THE PUBLIC

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

SOURCE: **Board Secretariat**

DATE: **31 October 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 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.	Risk Mitigation Strategy Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
4.	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)
5.	HBL Verbal Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)

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.