West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Friday 29 June 2018
at 1.00pm

St John
Water Walk Road
Greymouth

ALL INFORMATION CONTAINED IN THESE MEETING PAPERS IS SUBJECT TO CHANGE

AGENDA – PUBLIC

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

WEST COAST DISTRICT HEALTH BOARD MEETING
to be held at St John, Water Walk Road, Greymouth
on Friday 29 June commencing at 1.00pm

KARAKIA			***1.00pm***
ADMINISTRATION			***1.05pm***
	Apologies		
1.	**Interest Register**		
2.	**Confirmation of the Minutes of the Previous Meetings** • *11 May 2018*		
3.	**Carried Forward/Action List Items**		
PRESENTATION			***1.10pm***
4.	**Whanau Ora Update**	Susan Wallace *Chair, Tatau Pounamu*	*1.10pm – 1.40pm*
REPORTS FOR DECISION			***1.40pm***
5.	**Delegation for Approval of Draft Annual Plan 2018/19**	Melissa Macfarlane *Team Leader, Planning & Performance*	*1.40pm – 1.50pm*
6.	**Policy & Procedure Reviews**	Justine White *Executive Director, Finance & Corporate Services*	*1.50pm – 2.00pm*
REPORTS FOR NOTING			***2.00pm***
7.	**Chair's Update**	Jenny Black *Chair*	*2.00pm – 2.05pm*
8.	**Chief Executive's Update**	David Meates *Chief Executive*	*2.05pm – 2.20pm*
9.	**Clinical Leader's Update**	Karen Bousfield *Director of Nursing* Cameron Lacey *Medical Director* Stella Ward *Executive Director of Allied Health*	*2.20pm – 2.30pm*
10.	**Finance Report**	Justine White *Executive Director, Finance & Corporate Services*	*2.30pm – 2.40pm*
11.	**Resolution to Exclude the Public**	*Board Secretary*	*2.40pm*

INFORMATION ITEMS

- Mental Health Future Services Project Update
- 2018 Meeting Dates

ESTIMATED FINISH TIME **2.40pm**

NEXT MEETING: Friday 10 August 2018

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 Interests	
Jenny Black **Chair**	• Chair, Nelson Marlborough District Health Board • Life Member of Diabetes NZ • Chair, South Island Alliance Board • Chair, National DHB Chairs
Chris Auchinvole	• Director Auchinvole & Associates Ltd • Trustee, Westland Wilderness Trust • Trustee, Moana Holdings Heritage Trust • Justice of the Peace • Daughter-in-law employed by Otago DHB
Kevin Brown	• 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 • President Greymouth Riverside Lions Club • Justice of the Peace • Hon Vice President West Coast Rugby League
Helen Gillespie	• Employee, DOC – Healthy Nature, Healthy People Project Coordinator • Husband works for New Zealand Police • Member - Accessible West Coast Coalition Group • Member - Kowhai Project Committee
Michelle Lomax	• Daughter is a recipient of WCDHB Scholarship
Chris Mackenzie	• Development West Coast – Chief Executive • Horizontal Infrastructure Governance Group – Chair • Mainline Steam Trust – Trustee • Christchurch Mayors External Advisory Group - Member
Edie Moke	• South Canterbury DHB – Appointed Board Member • Nga Taonga Sound & Vision - Board Member (elected) Nga Taonga is the newly merged organisation that includes the following former organisations: The New Zealand Film Archive; Sounds Archives Nga Taonga Korero; Radio NZ Archive; The TVNZ Archive; Maori Television Service Archival footage; and Iwi Radio Sound Archives.
Peter Neame	• White Wreath Action Against Suicide – Board Member and Research Officer • Author and Publisher of "Suicide, Murder, Violence Assessment and Prevention" 2017 and four other books.
Nigel Ogilvie	• Managing Director, Westland Medical Centre • Shareholder/Director, Thornton Bruce Investments Ltd • Shareholder, Hokitika Seaview Ltd • Shareholder, Tasman View Ltd

Nigel Ogilvie Cont'd	• White Ribbon Ambassador for New Zealand • Wife is a General Practitioner casually employed with West Coast DHB and full time General Practitioner and Clinical Director at Westland Medical Centre • Sister is employed by Waikato DHB • Board Member West Coast PHO • Wife is Board Member West Coast PHO
Elinor Stratford	• Clinical Governance Committee, West Coast Primary Health Organisation • Committee Member, Active West Coast • Chairperson, West Coast Sub-branch - Canterbury Neonatal Trust • Trustee, Canterbury Neonatal Trust • Member, Arthritis New Zealand, Southern Regional Liaison Group • President, New Zealand Federation of Disability Information Centres • Member, West Coast Coalition Group • Chair, Kowhai Project Committee • MS - Parkinsons New Zealand – West Coast Committee Member
Francois Tumahai	• Te Runanga o Ngati Waewae - Chair • Poutini Environmental - Director/Manager • Arahura Holdings Limited - Director • West Coast Regional Council Resource Management Committee - Member • Poutini Waiora Board - Co-Chair • Development West Coast – Trustee • West Coast Development Holdings Limited – Director • Putake West Coast – Director • Waewae Pounamu – General Manager • Westland Wilderness Trust – Chair • West Coast Conservation Board – Board Member

MINUTES

MINUTES OF THE WEST COAST DISTRICT HEALTH BOARD MEETING
held at St John, Water Walk Road, Greymouth
on Friday 11 May 2018 commencing at 1.00pm

BOARD MEMBERS

Chris Mackenzie (Deputy Chair); Chris Auchinvole; Kevin Brown; Helen Gillespie; Michelle Lomax; Edie Moke; Peter Neame; Nigel Ogilvie; and Elinor Stratford.

APOLOGIES

Apologies were received and accepted from Jenny Black and Francois Tumahai

EXECUTIVE SUPPORT

David Meates (Chief Executive); Karen Bousfield (Director of Nursing); Gary Coghlan (General Manager, Maori Health); Pradu Dayaram (Medical Director); Cameron Lacey (Medical Director); Melissa Macfarlane (Team Leader, Planning & Funding); Karalyn van Deursen (Executive Director, Communications); Philip Wheble (General Manager, West Coast); and Kay Jenkins (Minutes).

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Nigel Ogilvie asked that Chairman, Life Education Trust be removed from the register.
Elinor Stratford advised that she is now a committee member of MS - Parkinson's NZ – West Coast

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 (6/18)
(Moved Elinor Stratford/seconded Nigel Ogilvie – carried

"That the minutes of the Meeting of the West Coast District Health Board held at St John, on Friday 23 March 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward items were noted.

4. ANNUAL ACCOUNTS DELEGATION.

Philip Wheble, General Manager, West Coast, presented this paper on which there was no discussion.

Resolution (7/18)
(Moved: Helen Gillespie/seconded: Michelle Lomax - carried)

That the Board, as recommended by the Quality, Finance, Audit & Risk Committee::

i. authorises either the Quality, Finance, Audit and Risk Committee Chair and the Board Chair or, if one of these should not be available, one of these two and a Board member to approve the final audited accounts for 2017/18 on the Board's behalf if required, should the timetable not fit with a Board or Committee meeting; and

ii. notes that if this delegated authority is exercised the final accounts will be circulated to Committee and Board members; and

iii. notes that the West Coast DHB Chair, Chief Executive and General Manager Finance and Corporate Services will sign the letter of representation required in respect to the 2017/18 Crown Financial Information System accounts which are required at the Ministry of Health in early August.

5. DEPUTY CHAIR'S UPDATE

The Deputy Chair, Chris Mackenzie, provided the Board with an update on a meeting held in Wellington yesterday with the Minister of Health and all DHB Chair's and Chief Executive's.

The Deputy Chair's update was noted

6. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, took his report as read.

Mr Meates provided an update on the Public meeting held in Westport with approximately 460 people in attendance. Feedback has been received and this has been made publicly available.

The Board noted that this project is competing with other Capital priorities across the country.

The update was noted.

7. CLINICAL LEADERS UPDATE

Dr Cameron Lacey, Medical Director, advised that this report differs from previous reports and feedback and guidance from the Board in regard to future reporting would be appreciated.

Karen Bousfield, Director of Nursing, commented on the International Health Workforce meeting hosted by Health Workforce New Zealand which was outlined in the update. She added that following on from this meeting Health Workforce New Zealand held a workshop and conversations were continued around Rural Health. Ms Bousfield also advised that there is $10m contestable funding available from Workforce New Zealand and some thinking is taking place regarding how the West Coast can access some of this.

The update was noted.

8. FINANCE REPORT

Philip Wheble, General Manager, West Coast, presented this report which was taken as read. The report noted that the consolidated West Coast District Health Board financial result for the month of March 2018 was a deficit of $887k, which was $672k unfavourable to budget. The year to date position of a net deficit of $2.139m is $764k unfavourable to budget.

The financial report was noted.

9. WELLBEING HEALTH & SAFETY UPDATE

David Meates, Chief Executive, presented this report which was taken as read. There was no discussion on the update.

The update was noted.

10. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (8/18)
(Moved Helen Gillespie/seconded Elinor Stratford – carried)

That the Board:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the Public Excluded meeting of 23 March 2018	For the reasons set out in the previous Board agenda.	
2.	Draft Statement of Intent	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
3.	Emerging Issues Verbal Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	9(2)(j) S9(2)(a)
4.	Clinical Leaders 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)
5.	Risk Management Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	S9(2)(j) S9(2)(a)
6.	Report from Committee Meeting – QFARC	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons	S9(2)(j) S9(2)(a)

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

There being no further business the public open section of the meeting closed at 1.55pm

The Public Excluded section of the meeting commenced at 1.55pn and concluded at 2.55pm

_____ _____

Chris Mackenzie, Deputy Chair Date

WEST COAST DISTRICT BOARD – BOARD MEETING
CARRIED FORWARD/ACTION ITEMS AS AT 29 June 2018

	DATE RAISED/ LAST UPDATED	ACTION	COMMENTARY	STATUS
1.	11 May 2018	Buller Older Persons Health Consultation	Update on recommendations	Under Action

DELEGATION FOR APPROVAL OF DRAFT ANNUAL PLAN 2018/19

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

SOURCE: **Planning and Funding**

DATE: **29 June 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper has been prepared to request that the Board delegate approval for submission of the first draft of the DHB's Annual Plan for 2018/19, due to the timing of the Board meeting and submission date for the draft Plan.

2. RECOMMENDATION

That the Board:

i. Delegates to the Chair and Deputy Chair of the Board and the Chief Executive, sign-off of the first draft of the Annual Plan for submission to the Ministry on 16 July 2018.

3. DISCUSSION

The first draft of the 2018/19 Annual Plan is being prepared for submission to the Ministry of Health in accordance with the national timeframes. The draft is due for submission 16 July.

The Statement of Intent, which the Board will approve for submission on 29 June, presents almost all of the same content as the Annual Plan, with the exception of the annual action tables.

Due to the disconnect between the timing of the Board meeting and the submission date, a request is made that the Board delegates approval of the draft Plan (for submission) to the Chair and Deputy Chair of the Board and the Chief Executive.

A QFARC meeting is scheduled for 26 July and the team anticipates providing the draft Plan to that meeting for formal endorsement. The draft would then be presented to the Board at its next meeting on 10 August 2018. The DHB is still waiting for confirmation of some national targets and there will be further edits and updates between the submission date and the Board meeting.

As with previous year any feedback from the Board would be incorporated into the final draft. The Ministry will also provide feedback following the submission of the first draft.

The planning timetable is highlighted below:

10 May	Release of planning package and guidelines to DHBs
29 June	DHB to provide the final draft Statement of Performance Expectation (SOI/SPE)
2 July	DHBs to submit final draft System Level Measures Improvement Plan
16 July	DHBs to submit draft Annual Plans, updated SPE, Regional Plans and Public Health Plans
31 July	System Level Measures Improvement Plan approved
3 September	Ministry provides formal feedback on DHB's draft Plans
TBC	DHBs to submit final Annual Plans, Regional Service Plans and Public Health Plans

Report prepared by: Melissa Macfarlane, Team Leader, Planning & Performance
Report approved by: Carolyn Gullery, Executive Director, Planning & Funding and Decision Support

POLICY AND PROCEDURE REVIEWS

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

SOURCE: **Executive Director, Finance & Corporate Services**

DATE: **29 June 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to seek the West Coast DHB Board's formal approval of the West Coast DHB's Asset Management Policy, the Fixed Asset Procedure and the Capital Expenditure Procedure.

2. RECOMMENDATION

That the West Coast DHB Board:

i. approves the draft Asset Management Policy, the Asset Management Policy, the Fixed Asset Procedure and the Capital Expenditure Procedure; and
ii. notes that the Document Control Policy and Procedure is currently under review and an amendment has been proposed for operational procedure and policies to be approved by the Chief Executive or EMT rather than requiring Board approval.

3. DISCUSSION

West Coast DHB's Document Control Policy and Procedure specifies that all policy and procedures related to financial activities must be approved by the Board. The Document Control Policy and Procedure is currently under review and an amendment has been proposed for operational procedure and policies to be approved by the Chief Executive or EMT rather than requiring Board approval. The Document Control Policy and Procedure does not require Board approval.

Fixed Asset and Capital Expenditure Procedures have been reviewed and updated and the Asset Management Policy has recently been developed.

West Coast DHB owns and manages a large and complex asset base with many high value and critical assets. It aspires to manage these assets effectively and efficiently in line with central agency expectations for investment performance.

The Asset Management Policy defines the key principles and approach to asset management at West Coast District Health Board; it has been developed to align closely with the Canterbury DHB policy.

4. APPENDICES

Appendix 1	Draft Asset Management Policy
Appendix 2	Draft Fixed Asset Procedure (clean copy and a copy showing tracked changes)
Appendix 3	Draft Capital Expenditure Policy (clean copy and a copy showing tracked changes)

Report prepared by: Justine White, Executive Director, Finance & Corporate Services

Asset Management Policy

Contents

Introduction

WCDHB owns and manages a large and complex asset base with many high value and critical assets. It aspires to manage these assets effectively and efficiently in line with central agency expectations for investment performance.

This policy should be read in conjunction with the various related policies and procedures that are referred to in the Associated Documents Section

Purpose

This policy defines the key principles and approach to asset management at West Coast District Health Board (WCDHB).

Policy

All members of the WCDHB workforce must ensure that, within their area of responsibility, assets are effectively and sustainably managed at optimal whole of life cycle cost to help meet the organisation's strategic objectives.

Scope

This policy applies to all assets that are owned, managed, or operated by the WCDHB and throughout their lifecycle.

The assets covered by this policy fall under the following categories:

Land and Buildings
Motor Vehicles
Clinical Equipment
General Equipment
Information and Communication Technology Equipment
Intangible Assets

Definitions

Assets are tangible or intangible resources, owned or leased by WCDHB, as a result of past events and from which future economic and operational benefits are expected to flow.

Asset management refers to systematic and coordinated activities and practices through which an organisation optimally and sustainably manages its assets and asset systems, their associated performance, risks and costs over their life cycles, for the purpose of achieving the organisational strategic objectives.

Asset managers are those responsible for the operation and management of an asset over the life cycle of the asset.

Level of service is the defined service quality for a particular activity or service area delivered by the asset (or group of assets), against which service performance may be measured.

Life cycle is the time interval that commences with the identification of the need for an asset and terminates with the decommissioning and disposal of the asset or any associated liabilities.

Context

Standards

The New Zealand Treasury, through its Investor Confidence Rating initiative, uses the International Infrastructure Management Manual (IIMM) framework which, in turn, is closely aligned with the ISO 55000 suite of asset management standards. To ensure adherence to international best practice, and in accordance with Treasury expectations, this policy and the associated asset management practices and processes at WCDHB will be aligned with the IIMM framework.

Documents

The hierarchy of asset management documents at WCDHB is represented in Figure 1.

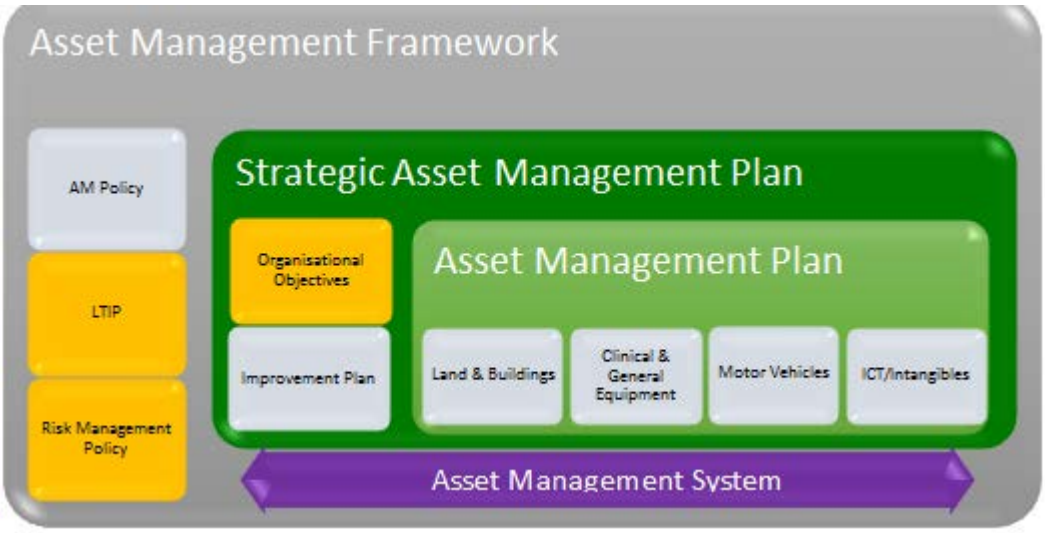


Figure 1. Key contributors to Asset Management (AM) Framework

Principles

- All asset management related activity must comply with relevant legislation, statutes and relevant WCDHB policy requirements
- Asset management decisions must prioritise maintenance of a safe and healthy work environment
- Asset management decisions must be made from a whole of life cycle approach, having regard to levels of service, current and accurate asset information, and the suitability of the asset for current and future needs
- All members of the WCDHB workforce should proactively support continual improvement of its asset management capabilities, and use appropriate asset management practices to help meet the organisation's objectives

Roles and Responsibilities

All WCDHB staff, to a greater or lesser degree, have a responsibility to appropriately manage assets under their influence. Managers have the added responsibility of demonstrating active leadership in the management of assets and for embedding best practice in everyday activities.

The key WCDHB roles with specific Asset Management responsibilities are summarised in Figure 2 below.

Position	Asset Management Responsibilities
Board of WCDHB	• Ensure WCDHB's policies are established to achieve maximum value from investments and that investments have been prioritised to provide a sustainable health system to the people of West Coast as well as regional and national requirements. • Ensure WCDHB has an appropriate monitoring framework to assess the performance of these investments and assets to deliver its strategic objectives. • Approve WCDHB's Long Term Investment Plan and Asset Management Plan.
Quality, Finance, Audit and Risk Committee	• Monitor, on behalf of the Board, WCDHB's asset management performance in terms of optimising value from investments and risk management.
Chief Executive	• Ensure that the performance of WCDHB's investments and assets are aligned with the Board's expectations. • Ensure that WCDHB has in place a robust Asset Management Framework and undertakes long term investment planning and asset management in accordance with this framework. • Ensure that WCDHB adopts and applies good financial, investment and asset management practices. • Ensure the level of resourcing is sufficient to support effective financial, investment and asset management.
Executive Management Team (EMT)	• Support the Chief Executive in the development of WCDHB's Long Term Investment Plan and Asset Management Plan to provide sustainable, prioritised investments that support the delivery of WCDHB's strategic priorities. • Ensure effective and efficient management structures and processes are in place to enable implementation and maintenance of the AM Framework.
Capital Prioritisation Committee	• Review and prioritise capital requests across the WCDHB to establish the funding allocation for a financial year within allocated base capital funding.
Executive Director, Finance and Corporate Services (as the Senior Responsible Owner of asset management for WCDHB)	Ensure the management structure is in place to effectively and efficiently: • Develop, implement and maintain the AM Framework and related policies.

	• Develop, and refresh as required, the AM Plan, in line with WCDHB strategy and the Long Term Investment Plan.
General Managers/Executive Directors, Other Divisions	• Ensure operational structures are in place to effectively and efficiently develop, implement and maintain best practice for asset management, in line with the AM Framework and related policies.
Operational Managers	• Manage assets under their supervision in line with the Asset Management Framework and their position responsibilities. • Work with the Asset Management Capability Advisor on enterprise-wide asset management improvements; setting of asset performance indicators, and measuring of performance against same; other asset-related reporting requirements.
South Island Alliance Board	• Set the strategic focus for the Alliance. • Oversee and approve the SI Health Service Plan. • Monitor the performance of the Alliance.
South Island Alliance Leadership Team	• Oversee the day-to-day Alliance activities by: ➢ Prioritising Alliance activity and agreeing on Alliance objectives ➢ Allocating resources and funding ➢ Monitoring outcomes and informing the community and stakeholders ➢ Maintaining a high level of engagement between the Alliance and DHBs
South Island Regional Capital Committee *(Draws membership from the SI Alliance Board and the SI Alliance Leadership Team)*	• Identify and, if agreed, support significant capital investments in accordance with the agreed regional service strategy and planning. • Use regional approach to leverage negotiations for significant investment purchases and procurement. • Ensure clarity in respect of significant capital investment and/or significant matters that relate to capital, that the DHBs refer to the Committee. • Inform the national process of regional issues.

Asset Management

WCDHB will actively manage all phases in an asset's lifecycle as represented in Figure 3.

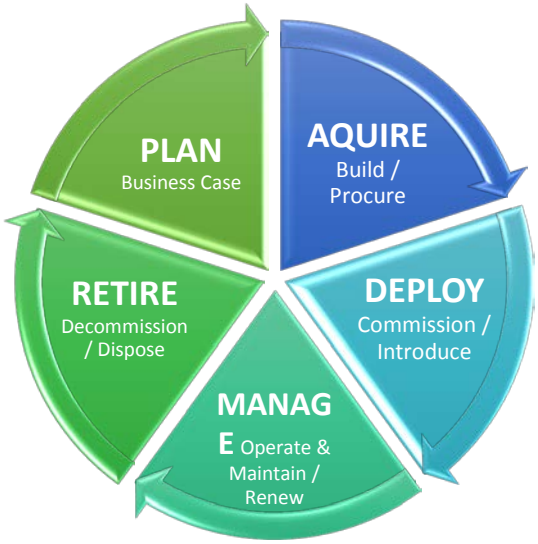


Figure 1. Phases of Asset Lifecycle

All asset management activities discussed below will be conducted in the context of:

- the criticality of the asset to the delivery of WCDHB outputs; and
- the risks, both inherent in the asset and as relevant to the strategic objectives of WCDHB.

Plan (Acquire/Upgrade/Renew/Retire)

All asset acquisition proposals will be subject to:

- justification, demonstrating alignment with organisational objectives while ensuring the cost of providing the functional outputs of the asset do not outweigh the benefits;
- where appropriate, assessment of capability and capacity of existing assets for their potential to meet user requirements through redeployment, repurposing, or alternative utilisation models to ensure best return on existing investment;
- financial assessment of all options based on whole of life costs (WOLC);
- identification of risks and mitigation strategies in accordance with the WCDHB Risk Management framework;
- compliance with WCDHB business case processes and, as required, the Better Business Case (BBC) framework where the proposed acquisition meets the NZ Treasury definition of significant investment[1] and the approval process in line with CDHB delegations.

[1] "*In terms of financial or risk thresholds, significant generally means investments that require Cabinet or Ministerial approval as per Annex 1 of Cabinet Circular CO (15), that is, high risk proposals, or proposals with whole of life costs (WOLC) in excess of $15 million, however funded." NZ Treasury website.*

Acquire (Build/Procure)

Asset acquisition approvals will be subject to:

- adherence to the WCDHB Delegation of Authority to Staff Policy;
- Government Rules of Sourcing, where applicable;
- compliance with the WCDHB Procurement Policy and;
- full consideration and assessment of through-life support models, including obsolescence, whether provided internally or through service agreements.

Deploy (Commission/Introduce/Upgrade)

During the introduction into service phase, WCDHB will:

- assess the asset and documentation for compliance with stipulated specifications and, if necessary, conduct all relevant testing, evaluation and/or certification;
- ensure all safety considerations are addressed, including all personnel training requirements before and/or during commissioning;
- issue the asset with a unique identifier and record and store all relevant information for financial, certification and asset management requirements.

Manage (Operate & Maintain/Renew)

The relevant maintenance authority or service manager of the asset will:

- assess and document the performance criteria for the asset;
- ensure an appropriate maintenance strategy and plan, reflective of the asset type and its criticality to services, is implemented;
- plan, conduct, and record all maintenance activity;
- monitor the asset condition and performance and the demand forecast to inform the maintenance, refurbishment and renewal of assets plan.

Retire (Decommission/Dispose)

Asset disposals may be subject to legal, statutory and Government policy requirements that must be fulfilled prior to disposal, as outlined in the Fixed Asset Procedure (Fixed Asset Disposal section).

Disposal of assets planning will need to consider the following:

- assessment of the proposed disposal to ensure alignment with WCDHB's strategic objectives, service delivery needs and Long Term Investment Plan;
- any applicable environmental considerations;
- agreed and approved disposal plan, where one exists; and
- operational considerations, to ensure continued services and minimal disruptions to outputs.

Risk and Criticality

For significant or critical assets, risk assessment and management will be a mandatory requirement in all strategic and operational decisions relating to those assets.

All risks, whether at operational or strategic level, will be identified, assessed, and managed in accordance with the WCDHB Risk Management Policy and associated processes.

Criticality assessment will be based on:

- safety considerations;
- impact on operational output priorities and risks;
- resilience; and
- financial impact.

Continuous Improvement

WCDHB will drive continuous improvement through a monitoring and review process that will:

- use levels of service, stakeholder feedback, and asset performance to plan improvements in service delivery of assets;
- maintain alignment with changing organisational objectives and service delivery models;
- implement changes in a controlled manner;
- measure the effectiveness of improvement actions; and
- include the Business Assurance team and, where appropriate, utilise external auditors, to validate practices and progress.

Associated Documents

This policy is complemented or supported by the following WCDHB documents:

- Annual Plan (Statement of Intent)
- Asset Management Plan [under construction]
- Delegation of Authority to Staff Policy
- Fixed Asset Procedure
- Long Term Investment Plan
- Procurement Policy
- Risk Management Policy

Review

This policy will be reviewed at least every 3 years.

Policy Owner	Executive Director Finance & Corporate Services
Policy Authoriser	West Coast DHB Board
Date of Authorisation	29th June 2018

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

Fixed Asset Procedure

1. Purpose

The West Coast District Health Board (WCDHB) will ensure that it has a process that establishes the general requirements for the control of assets.

This procedure gives guidance to the manner in which assets are identified, recorded, disposed and accounted for and should be read in conjunction with the Asset Management Policy and Asset Management Framework. For the acquisition of assets, guidance is provided under the Capital Expenditure Procedure.

2. Application/Responsibilities

This Procedure is to be followed by all WCDHB staff members and Board members.

3. Definitions

For the purposes of this Procedure:

Assets are tangible or intangible resources, owned or leased by WCDHB, as a result of past events and from which future economic and operational benefits are expected to flow. Examples include property, buildings, plant, machinery, clinical equipment, IT infrastructure and software, and vehicles.

4. Responsibilities

For the purposes of this Procedure:

The ***West Coast District Health Board*** shall:

- Ensure that WCDHB has a clear and effective system for managing its fixed assets

The ***Chief Executive*** (CE) shall:

- Designate responsibility for management of the WCDHB's fixed assets;
- Report to the Board on relevant issues.

The ***General Manager –Finance and Corporate Services*** shall:

- Manage the WCDHB fixed assets in accordance with the requirements of this procedure and other related documents listed in section 9.

5. Resources Required

Asset Disposal Form (FA2)

Asset Registration and Completion of Capital Purchase (FA3)

Fixed Asset Transfer Form (FA4)

6. Identification, recording and accounting of fixed assets

This section outlines the procedures for asset identification, recording and accounting for fixed assets.

6.01 Appropriate records of asset acquisition, maintenance, renewal and disposal information are to be maintained and entered on the Fixed Asset Register database.

6.02 Once capital expenditure (refer to Capital Expenditure Procedure for guidance) is approved a project & task number (and if required a sub task number) will be created by Finance. The Project Manager Budget Holder and Task Manager will be set up under the project and will allow for approval of spend against the project as set out in the WCDHB delegation policy.

6.03 All spend on the approved project will be recorded under that Project Number and accounted as work in progress.

6.04 Work in progress (WIP) includes the cost of direct materials, labour, and any other costs incurred.

6.05 At project completion the cost of the asset will be capitalised. Once a project (or phase of project) has been completed, the Task Manager is responsible for completing an Asset Registration and Completion form. This form has the required information that will provide asset identification, location, serial numbers etc for inclusion on the WCDHB fixed asset register. This form needs to be sent to Finance as soon as practical after the date the asset has entered into service.

6.06 All new Fixed Assets are initially recorded at cost. The cost of subsequent additions to buildings, plant and equipment consists of all appropriate costs of acquisitions and installation including materials, labour and transport costs, in line with accounting standards (GAAP).

6.07 All fixed assets are to be recorded under the following asset classes and sub classes:

Asset Class		**Asset Subclass**	
CODE	**DESCRIPTION**	**CODE**	**DESCRIPTION**
LAND	Land	LAND	Land Owned
BLDG	Buildings	SERVICE	Building Services
		FITOUT	Building Fitout
		STRUCT	Building Structure
		INFRAST	Site Infrastructure
		RESIDEN	Residential Buildings
LEASE	Leased Land and Buildings	LEASEHLD	Leasehold Improvements
		LBUILD	Leased Buildings
		LLAND	Leased Land
MOTOR	Motor Vehicles	CAR	Car
		MOBILE UNIT	Mobile Unit incl Dental

		TRUCK	Truck and Vans
		MVOTH	Other Vehicles incl Trailers
CLINEQ	Clinical Equipment	ANESTH	Anaesthesia Equipment
		BED	Beds Manual and Electric
		CART	Medical Cart
		DEFIB	Defibrillators
		DENTAL	Dental Equipment
		DIALYS	Dialysis Equipment
		ENT	ENT Equipment
		FREEZE	Medical Fridge Freezer
		BIOMED	Biomed Equipment
		SURGEQ	Surgical Instruments and Equipment
		HOIST	Patient Hoist
		IMAGE	Xray and Imaging Equipment incl MRI and CT
		INCUB	Incubator
		LABEQ	Laboratory Equipment
		LIGHT	Examination Lights
		LINAC	Linear Accelerators
		MICROS	Microscope
		MONITOR	Patient Monitoring Equipment incl ECG and EKG
		OPTHAL	Opthalmic Equipment
		PUMP	Medical Pumps
		SCOPE	Scopes
		STERIL	Sterilisers and Sanitisers
		TABLE	Treatment and Operating Tables
		VENT	Ventilator
		WARM	Warmer or warming Equipment
		MEDEQ	Other Medical Equipment
GENEQ	General Equipment	KITCHEN	Kitchen Equipment
		OFFICE	Office Equipment
		FURN	General Furnishing
		PLANT	Plant - not subject to Revaluation
		OTHEQ	Other Equipment
CULTURAL	Cultural Asset	ART	Art - Non Depreciating
		HERITAGE	Heritage Assets
		OTHCULT	Other Cultural Assets

ITCEQ	ITC Equipment	TELECOM	Telecommunication Equipment
		PC	PCs and Mobile Devices
		MFD	Multifunctional Devices
		NETWK	Network Equipment and Servers
		ITCOTH	Other ITC Equipment
INTANG	Intangible Assets	SOFTPUR	Software Purchased including Licences
		SOFTDEV	Software Inhouse developed

6.08 Donated assets are recorded at the best estimate of fair value in line with accounting standards. Donated assets are depreciated over their expected lives in accordance with the rates established for the appropriate asset class. Donated assets must comply with the WCDHB Donation Policy

6.09 The WCDHB will operate a single numbering system for the registration all asset/equipment items so that each item has a unique identifier.

6.10 Asset locations should be recorded where possible, movement of assets on a permanent basis to an alternative location shall be notified to Finance department, using the Asset transfer form.

6.11 WCDHB will perform a rolling fixed asset stocktake over a 24 month cycle to review assets across all sites. The objective of the stocktake is to:

6.11.1 Validate the presence of the asset in the specified location

6.11.2 Count the volume of the asset (if more than one)

6.11.3 Assess the condition (consider if impairment, disposal or useful life amendments are required)

6.12 Asset information is to be made readily available to all staff members who have responsibility and accountability for asset management.

7.0 Disposal of Asset

This section outlines the process in which an asset is disposed.

During the disposal process, the following aspects need to be considered:

- surplus, obsolete assets are identified
- established rationale for, the anticipated time, and method of and the expected proceeds of safe and ethical disposal of assets;
- evaluation of disposal alternatives;
- asset management system records are updated;
- ensured that an audit trail exists;
- minimised disposal costs;
- considered heritage value.

7.01 Disposal of assets must only occur when either:

7.01.1 items are no longer required by other WCDHB service/department; or

7.01.2 items are beyond economic repair as judged by staff trained in the maintenance of that item.

7.02 Where the WCDHB chooses to dispose of an asset, it must be done in a manner that ensures;

a) impartiality and integrity; this must be conducted using a fair and transparent process, such as an online sale site, blind auction, tender process etc.

b) reasonable expectation of receiving the market value for the disposed asset.

7.03 To ensure that assets are disposed in a fair and transparent manner, disposal of an asset can only occur once the disposal process has been approved. This is Part 1 of the Asset Disposal form. Staff members with delegated authority to approve asset disposal is set out is set out in the WCDHB Delegation of Authority Policy.

7.04 Once that asset has been disposed, Part 2 of the Asset Disposal Form is required to be provided to Finance. This will remove the disposed asset from the fixed asset register. The disposal form must be forwarded to Finance as soon as practicable after disposing of the asset.

Any proceeds from the sale of an asset are to be remitted directly to Finance. Finance is responsible for calculating any gain or loss on disposal per the applicable accounting standards.

7.05 WCDHB assets may be disposed of to WCDHB staff members where:

7.03.1 The WCDHB staff member disposing of the asset does not derive any benefit from that disposal; and

7.03.2 The asset is not disposed of at a discounted rate to WCDHB staff if a greater value could be realised through an alternative a method of disposal.

7.06 All assets must be made safe prior to sale or other disposal. Where assets are condemned but may be broken down as spare parts:

i. these assets must be recorded as "disposal" in the asset register with the spare parts recorded as inventory items

ii. any asset kept for spare parts must be labelled with clear identification of the item's faults.

8. Precautions and Considerations

- ➔ All new Fixed Assets are initially recorded at cost
- ➔ All assets must be made safe prior to sale or other disposal
- ➔ All assets must be disposed in an open and transparent manner
- ➔ Asset information is to be made readily available to all staff members who have responsibility and accountability for asset management

8. References

Building Act (2004).

New Zealand Public Health and Disability Act (2000).

Public Finance Act (1989).

Applicable Public Benefit Entity Accounting Standards

9. Related Documents

WCDHB Asset Management Policy

WCDHB Asset Management Framework

WCDHB Delegation Policy.

WCDHB Capital Expenditure Procedure.

Revision History	Version:	6
	Developed By:	Finance Manager
	Authorised By:	Board
	Date Authorised:	May 2002
	Date Last Reviewed:	March 2018
	Date Of Next Review:	April 2021

Fixed Asset Procedure

1. Purpose

The West Coast District Health Board (WCDHB) will ensure that it has a process that establishes the general requirements for the control of assets.

This procedure gives guidance to the manner in which assets are identified, recorded, disposed and accounted for and should be read in conjunction with the Asset Management Policy and Asset Management Framework. For the acquisition of assets, guidance is provided under the Capital Expenditure Procedure.

2. Application/Responsibilities

This Procedure is to be followed by all WCDHB staff members and Board members.

3. Definitions

For the purposes of this Procedure:

Assets are tangible or intangible resources, owned or leased by WCDHB, as a result of past events and from which future economic and operational benefits are expected to flow. Examples include property, buildings, plant, machinery, clinical equipment, IT infrastructure and software, and vehicles.

4. Responsibilities

For the purposes of this Procedure:

The ***West Coast District Health Board*** shall:

- Ensure that WCDHB has a clear and effective system for managing its fixed assets

The ***Chief Executive*** (CE) shall:

- Designate responsibility for management of the WCDHB's fixed assets;
- Report to the Board on relevant issues.

The ***General Manager –Finance and Corporate Services*** shall:

- Manage the WCDHB fixed assets in accordance with the requirements of this procedure and other related documents listed in section 9.

5. Resources Required

Asset Disposal Form (FA2)

Asset Registration and Completion of Capital Purchase (FA3)

Fixed Asset Transfer Form (FA4)

Deleted: inventorial

Deleted: land, buildings, furnishings motor vehicles, clinical equipment, general equipment, cultural assets, ITC equipment and intangible assetsequipment

Deleted: .

Deleted: The purposes of this Policy are to protect fixed assets, preserve the life expectancy of assets, avoid unnecessary duplication of assets and provide itemized listings to support reported.

Deleted: ***Fixed Assets*** is taken to mean non current assets including intangible assets that:¶
a) . are held by an entity WCDHB for use in the production or supply of goods and services, for rental to ¶
. others, or for administrative purposes and may include items held for the maintenance or ¶
. repair of such assets; and¶
b) . have been acquired or constructed with the intention of being used on a continuing basis; and¶
c) . are not intended for sale in the ordinary course of business.¶

Deleted: .

Deleted: -

Deleted: .

Deleted: Policy

Deleted: .

Deleted: This Procedure requires no specific resources.

Deleted: ¶

Deleted: Fixed Asset Transfer Form¶

Deleted: te

Deleted: 5

Deleted: December 2015

6. Identification, recording and accounting of fixed assets

This section outlines the procedures for asset identification, recording and accounting for fixed assets.

6.01 Appropriate records of asset acquisition, maintenance, renewal and disposal information are to be maintained and entered on the Fixed Asset Register database.

6.02 Once capital expenditure (refer to Capital Expenditure Procedure for guidance) is approved a project & task number (and if required a sub task number) will be created by Finance. The Project Manager Budget Holder and Task Manager will be set up under the project and will allow for approval of spend against the project as set out in the WCDHB delegation policy.

6.03 All spend on the approved project will be recorded under that Project Number and accounted as work in progress.

6.04 Work in progress (WIP) includes the cost of direct materials, labour, and any other costs incurred.

6.05 At project completion the cost of the asset will be capitalised. Once a project (or phase of project) has been completed, the Task Manager is responsible for completing an Asset Registration and Completion form. This form has the required information that will provide asset identification, location, serial numbers etc for inclusion on the WCDHB fixed asset register. This form needs to be sent to Finance as soon as practical after the date the asset has entered into service.

6.06 All new Fixed Assets are initially recorded at cost. The cost of subsequent additions to buildings, plant and equipment consists of all appropriate costs of acquisitions and installation including materials, labour and transport costs, in line with accounting standards (GAAP).

6.07 All fixed assets are to be recorded under the following asset classes and sub classes:

Asset Class		Asset Subclass	
CODE	**DESCRIPTION**	**CODE**	**DESCRIPTION**
LAND	Land	LAND	Land Owned
BLDG	Buildings	SERVICE	Building Services
		FITOUT	Building Fitout
		STRUCT	Building Structure
		INFRAST	Site Infrastructure
		RESIDEN	Residential Buildings
LEASE	Leased Land and Buildings	LEASEHLD	Leasehold Improvements
		LBUILD	Leased Buildings
		LLAND	Leased Land
MOTOR	Motor Vehicles	CAR	Car
		MOBILE UNIT	Mobile Unit incl Dental

Deleted: Process

Deleted: ¶
1.00 - Fixed assets vested from Coast Health Care Ltd. Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Coast Health Care Ltd (a Hospital and Health Service) were vested in the West Coast DHB on 1 January 2001. Accordingly, assets were transferred to the West Coast District Health Board at their next book values as recorded in the books of Coast Health Care Ltd. In effecting this transfer, the Board has recognised the cost (or in the case of Land and Buildings the valuation) and accumulated depreciation amounts from the records of Coast Health Care Ltd. The vested assets will continue to be depreciated over their remaining useful lives.¶

Deleted: f

Deleted: 1.01

Deleted: 5

Deleted: December 2015

		TRUCK	Truck and Vans
		MVOTH	Other Vehicles incl Trailers
CLINEQ	Clinical Equipment	ANESTH	Anaesthesia Equipment
		BED	Beds Manual and Electric
		CART	Medical Cart
		DEFIB	Defibrillators
		DENTAL	Dental Equipment
		DIALYS	Dialysis Equipment
		ENT	ENT Equipment
		FREEZE	Medical Fridge Freezer
		BIOMED	Biomed Equipment
		SURGEQ	Surgical Instruments and Equipment
		HOIST	Patient Hoist
		IMAGE	Xray and Imaging Equipment incl MRI and CT
		INCUB	Incubator
		LABEQ	Laboratory Equipment
		LIGHT	Examination Lights
		LINAC	Linear Accelerators
		MICROS	Microscope
		MONITOR	Patient Monitoring Equipment incl ECG and EKG
		OPTHAL	Opthalmic Equipment
		PUMP	Medical Pumps
		SCOPE	Scopes
		STERIL	Sterilisers and Sanitisers
		TABLE	Treatment and Operating Tables
		VENT	Ventilator
		WARM	Warmer or warming Equipment
		MEDEQ	Other Medical Equipment
GENEQ	General Equipment	KITCHEN	Kitchen Equipment
		OFFICE	Office Equipment
		FURN	General Furnishing
		PLANT	Plant - not subject to Revaluation
		OTHEQ	Other Equipment
CULTURAL	Cultural Asset	ART	Art - Non Depreciating
		HERITAGE	Heritage Assets
		OTHCULT	Other Cultural Assets

Deleted: 5

Deleted: December 2015

ITCEQ	ITC Equipment	TELECOM	Telecommunication Equipment
		PC	PCs and Mobile Devices
		MFD	Multifunctional Devices
		NETWK	Network Equipment and Servers
		ITCOTH	Other ITC Equipment
INTANG	Intangible Assets	SOFTPUR	Software Purchased including Licences
		SOFTDEV	Software Inhouse developed

6.08 Donated assets are recorded at the best estimate of fair value in line with accounting standards. Donated assets are depreciated over their expected lives in accordance with the rates established for the appropriate asset class. Donated assets must comply with the WCDHB Donation Policy

6.09 The WCDHB will operate a single numbering system for the registration all asset/equipment items so that each item has a unique identifier.

6.10 Asset locations should be recorded where possible, movement of assets on a permanent basis to an alternative location shall be notified to Finance department, using the Asset transfer form.

6.11 WCDHB will perform a rolling fixed asset stocktake over a 24 month cycle to review assets across all sites. The objective of the stocktake is to:

- 6.11.1 Validate the presence of the asset in the specified location
- 6.11.2 Count the volume of the asset (if more than one)
- 6.11.3 Assess the condition (consider if impairment, disposal or useful life amendments are required)

6.12 Asset information is to be made readily available to all staff members who have responsibility and accountability for asset management.

7.0 Disposal of Asset

This section outlines the process in which an asset is disposed.

During the disposal process, the following aspects need to be considered:

- surplus, obsolete assets are identified
- established rationale for, the anticipated time, and method of and the expected proceeds of safe and ethical disposal of assets;
- evaluation of disposal alternatives;
- asset management system records are updated;
- ensured that an audit trail exists;
- minimised disposal costs;
- considered heritage value.

Deleted: evaluate

Deleted: . There are 13 54 classes of fixed assets:¶
Land – residential¶
Land – non residential¶
Buildings – residential¶
Buildings – non residential¶
Improvements to Leased Assets¶
Fit out - residential¶
Fit out – non residential¶
Fit out - leased buildings¶
Equipment¶
Computers¶
Intangible Assets (software)¶
Motor Vehicles¶
Work in progress¶
Asset Class ...

Deleted: 1.09

Deleted: 5.

Deleted: Resources Required

Deleted: 1.10 . The General Manager – Finance and Corporate Services is responsible for ensuring that the WCDHB develops and regularly updates an Asset Management Plan in accordance with health sector guidelines to ensure that all requirements are met. The WCDHB Asset Management Plan must include information on:¶
Asset Acquisition¶
Asset Financing¶
Asset Disposal¶

Deleted: 1.11 . The WCDHB Asset Management Plan must also:¶
Consider current (0-1 year), medium-term (2-4years) and long-term (>5 years) asset requirements;¶
Consider adequacy of current assets to meet service delivery requirements;¶
Consider drivers for change;¶
Be updated regularly in accordance with health sector guidelines or as the asset base significantly changes.¶

Deleted: 5

Deleted: December 2015

7.01 Disposal of assets must only occur when either;

7.01.1 items are no longer required by other WCDHB service/department; or,

7.01.2 items are beyond economic repair as judged by staff trained in the maintenance of that item.

7.02 Where the WCDHB chooses to dispose of an asset, it must be done in a manner that ensures;

a) impartiality and integrity; this must be conducted using a fair and transparent process, such as an online sale site, blind auction, tender process etc.

b) reasonable expectation of receiving the market value for the disposed asset.

7.03 To ensure that assets are disposed in a fair and transparent manner, disposal of an asset can only occur once the disposal process has been approved. This is Part 1 of the Asset Disposal form. Staff members with delegated authority to approve asset disposal is set out is set out in the WCDHB Delegation of Authority Policy.

7.04 Once that asset has been disposed, Part 2 of the Asset Disposal Form is required to be provided to Finance. This will remove the disposed asset from the fixed asset register. The disposal form must be forwarded to Finance as soon as practicable after disposing of the asset.

Any proceeds from the sale of an asset are to be remitted directly to Finance. Finance is responsible for calculating any gain or loss on disposal per the applicable accounting standards.

7.05 WCDHB assets may be disposed of to WCDHB staff members where:

7.03.1 The WCDHB staff member disposing of the asset does not derive any benefit from that disposal; and

7.03.2 The asset is not disposed of at a discounted rate to WCDHB staff if a greater value could be realised through an alternative a method of disposal.

7.06 All assets must be made safe prior to sale or other disposal. Where assets are condemned but may be broken down as spare parts:

i. these assets must be recorded as "disposal" in the asset register with the spare parts recorded as inventory items

ii. any asset kept for spare parts must be labelled with clear identification of the item's faults.

8. Precautions and Considerations

- All new Fixed Assets are initially recorded at cost
- All assets must be made safe prior to sale or other disposal
- All assets must be disposed in an open and transparent manner
- Asset information is to be made readily available to all staff members who have responsibility and accountability for asset management

8. References

Building Act (2004).

Deleted: ¶
1.12 .

Deleted: ¶

Deleted: and

Deleted: ¶

Deleted: i

Deleted: ¶

Deleted: preserves

Deleted: ,

Deleted:

Deleted: ¶
1.13

Deleted: then

Deleted: f

Deleted: f

Deleted: . Where the WCDHB chooses to dispose of an asset, it must be done in a manner that preserves impartiality and integrity.

Deleted:

Deleted: Completion of Asset Disposal Form required to be provided to Finance. All diposals require the approval of the GM Finance and Corportate Services and the Chief Executive. ¶
¶
1.14 . The WCDHB Asset Management Plan is to incorporate an annual disposal planning process that is to:¶
identifies surplus, obsolete assets¶
establishes the rationale for, the anticipated time, and method of and the expected proceeds of safe and ethical disposal of assets;¶
evaluates disposal alternatives;¶
ensures asset management system records are updated;¶
ensures that an audit trail exists;¶
minimises disposal costs;¶
considers heritage value.¶
¶
1.15 . The WCDHB Finance Department must be notified of all assets sold or otherwise disposed of.¶

Deleted: 1.16

Deleted: ¶
1.17 . All assets authorised for disposal are to be removed from within their service area and stored securely.¶
¶
1.18 . WCDHB assets may be disposed of to WCDHB staff members where:¶ ...

Deleted: 7

Deleted: ¶

Deleted: <#>Properties intended for sale are stated at the lower cost and net realizable value¶ ...

Deleted: ¶

Deleted: 5

Deleted: December 2015

New Zealand Public Health and Disability Act (2000).

Public Finance Act (1989).

Applicable Public Benefit Entity Accounting Standards

9. Related Documents

WCDHB Asset Management Policy

WCDHB Asset Management Framework

WCDHB Delegation Policy.

WCDHB Capital Expenditure Procedure.

Revision History	Version:	6
	Developed By:	Finance Manager
	Authorised By:	Board
	Date Authorised:	May 2002
	Date Last Reviewed:	March 2018
	Date Of Next Review:	April 2021

Deleted: ¶
WCDHB Delegation Policy.¶
¶

Deleted: 5

Deleted: Chief Financial Manager

Deleted: December

Deleted: 2015

Deleted: June 2016

Deleted: 5

Deleted: December 2015

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

Capital Expenditure Procedure

1. Purpose

This procedure is the process for the approval and monitoring of capital expenditure (CAPEX) by the West Coast District Health Board (WCDHB).

2. Application/Responsibilities

This Procedure is to be followed by all WCDHB staff members and Board members.

3. Definitions

For the purposes of this Procedure:

Capital expenditure (CAPEX) is an expense incurred to create a future benefit to our DHB of more than 12 months and which cost or have a value in excess of $2,000. For example, new buildings or operating theatre table both have a useful life more than 12 months and will cost more than $2000.

Capital Cost is the total expenditure required to get the asset in operational order. Where applicable, this may include; freight, training, any fitout to buildings, testing of new equipment. Receipts from trade-in of end of life assets are excluded from the capital expenditure cost.

Operating Expenditure (OPEX) is taken to mean the day to day expenditure required to keep the DHB functioning. Expenses like salaries/wages, repairs and maintenance, patient consumables are all examples of operating expenditure. Operating expenditure also includes deprecation of assets that expense the portion of the assets useful life in the period that it has been used.

Capital Budget is taken to mean the approved annual plan for the expenditure on fixed assets and projects in excess of $2,000. The individual items in the capital budget are "approved in principle".

Approved in Principle does not mean that approval for capital expenditure has been given. All capital expenditure must be approved in an individual basis. Depending on value of capital expenditure the necessary forms must be approved by following the capital expenditure process outlined below.

4. Responsibilities

For the purposes of this Procedure:

the ***Chief Executive*** is required to:

- oversee all aspects of this Procedure.

all ***Staff and Board Members*** are required to:

- ensure they abide by the requirements of this Procedure.

5. Resources Required

This Procedure requires:

i) WCDHB Capex Expenditure Approval Form (FA1)

ii) WCDHB Cost Benefit Analysis Form (FA2):

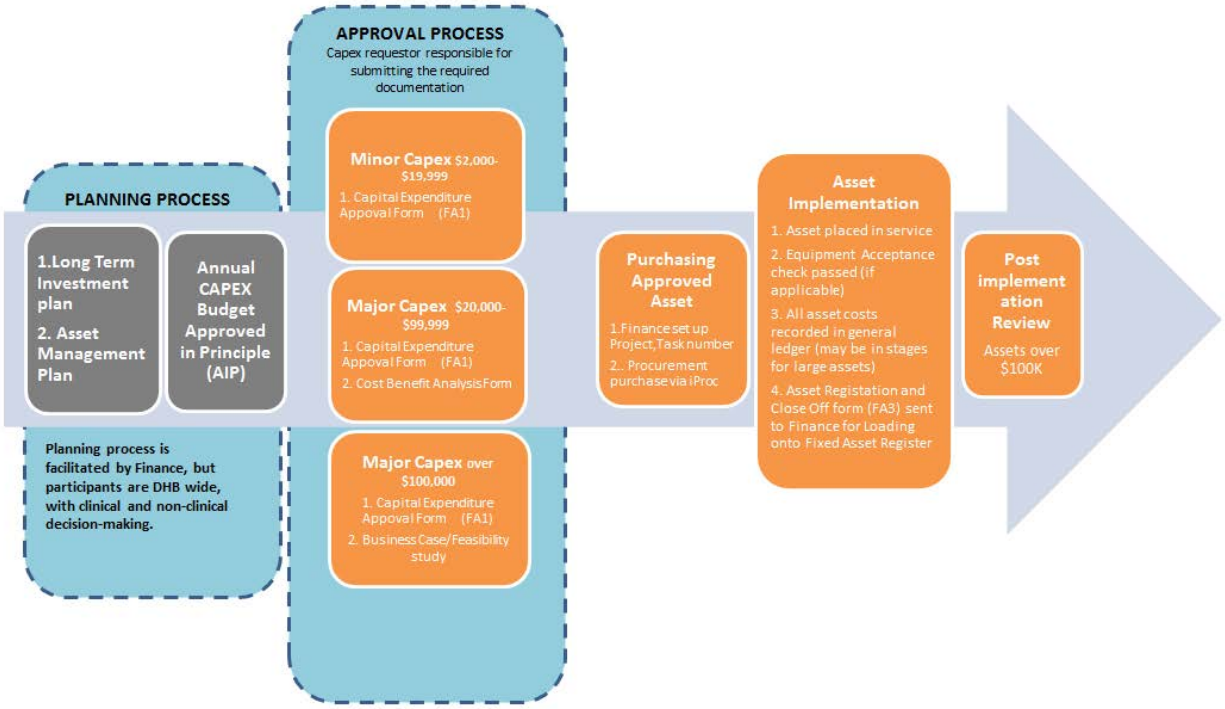
iii) WCDHB Business Case Template

iv) WCDHB Asset Registration and Completion of Capital Purchase (FA3)

Forms are located on the WCDHB Intranet under Forms>Forms

6. Process

The diagram below gives an overview of the whole capital expenditure process from planning, approval, purchasing and implementation phases.



1.0 Approval of capital expenditure must be sought before any expenditure is made or commitment to a project is given. This process must be followed if capital expenditure is funded from third parties including donated/trust funds.

1.01 All capital expenditure must be in accordance with relevant legislative requirements, WCDHB Procurement policy and Toolkit and WCDHB Delegation Policy.

1.02 All capital expenditure must align with the plans, direction and vision of the WCDHB. This is outlined in WCDHB Asset Management Policy, Framework and Plan.

1.03 Projects requiring capital expenditure must be approved as an entire project rather than on an individual item basis. Each project is to be defined as being self-contained and requiring no subsequent approvals or authorities.

1.04 The calculation of the amount of capital expenditure for which approval is being sought is to be the total cost of the item/project including any duty, freight, training, internal labour costs, working capital and capitalised interest (where applicable).

1.05 Any operating costs associated with the acquisition need to be listed. If there are ongoing preventative or service maintenance contracts associated with the acquisition the commitment to the WCDHB needs to be specified.

1.06 Applications for capital expenditure must be made on the WCDHB Capital Expenditure form

1.07 The table below shows the required documentation depending on the value of the capital expenditure:

Capital expenditure value	Required forms for capital expenditure approval
$2,000-$19,999	• Capital Expenditure Form (FA1) •
Over $20,000	• Capital Expenditure Form (FA1) • Cost Benefit Analysis Form (FA2)
Over $100,000	• Capital Expenditure Form (FA1) • Business case/feasibility study

1.08 No expenditure of capital is to proceed without an allocated project number that is to be granted by the WCDHB Finance Department. Project numbers are issued after:

i) confirmation of appropriate approval; and
ii) confirmation of availability of funds.

1.09 The purchase of the capital item will follow WCDHB procurement policies.

1.10 Capital expenditure for the maintenance of operating capacity includes replacement items required to maintain the capacity of the WCDHB to meets its operating obligations. Items required to meet health and safety, and regulatory requirements may also come within this category: Approval limits are as outlined in the WCDHB Delegation of Authority Policy

1.11 If a project is identified to have a final expenditure level in excess of 10% of the total expenditure authorised then the expenditure is to be represented (to the relevant approval authority) for authority for the additional amount required.

If an approved capital expenditure already has a contingency included in the approved amount then any spend over the authorised expenditure needs to have relevant authority for the additional spend.

1.12 No commitment or expenditure above the approved level is to be made until approval for additional expenditure has been obtained.

1.13 For capital expenditure costing $100,000 or more, a post-implementation review is to be developed and reported to the Quality, Finance, Audit and Risk and committee 12 months from the date of commissioning. The purpose of this report is to reinforce accountability, improve factual basis of project appraisal and to improve project management and governance. This paper must include a:

i) review of the outcome resulting from the expenditure; and
ii) comparison of the outcome achieved with the intended outcome and highlight any variances and outline the circumstances which created the variance; and

1.14 If the project associated with the capital expenditure has not achieved normal operation within 12 months of approval, the paper required by Section 1.13 is still required. In addition, a further paper is required within another 6-month interval.

1.15 If the required capital expenditure documentation for approved in principle items has not been received prior to the communicated deadline, the items will not carry forward to the next financial year. For the item to remain on the approved in principle list it must be resubmitted for prioritisation during the capital planning process for the next year.

1.16 Once asset has been commissioned, the capital expenditure requestor (Task Manager) is responsible for filing an Asset Registration and Close Off form (FA3) to Finance. This will move the capital expenditure from work in progress to the fixed asset register. Refer to WCDHB Fixed Asset Procedure which outlines the accounting, disposal and maintenance of a fixed asset.

2.00 Emergency Purchases

2.01 In the case of an emergency purchase the Chief Executive (or the person holding delegated authority) may approve the purchase.

2.02 For emergency purchases points 1.04 to 1.09 detailed above will not necessary apply at the time of purchase. The necessary completion of the required WCDHB Capex forms and allocation of a capital number must occur as soon as practically possible after the event.

2.03 The Chief Executive (or the person holding delegated authority) must be informed of the emergency purchase and acknowledge the purchase by signing the WCDHB Capex form.

2.04 The purchase must be listed as an emergency purchase on the WCDHB Capex Expenditure form.

7. Precautions and Considerations

- ➔ All capital expenditure must align with WCDHB's Asset Management Policy, asset management plan, direction and vision.
- ➔ Approval of capital expenditure must be sought before any expenditure is made or commitment to a project is given.
- ➔ Projects requiring capital expenditure must be approved as an entire project rather than on an individual item basis.
- ➔ For capital expenditure costing $100,000 or more, a post-implementation review is to be developed and submitted to Quality, Finance Audit and Risk committee 12 months from the date of commissioning

8. References

New Zealand Public Health and Disability Act (2000).

Public Finance Act (1989).

WCDHB Procurement Policy.

WCDHB Procurement Toolkit

WCDHB Asset Management Policy.

WCDHB Asset Management Plan

WCDHB Delegation of Authority Policy.

WCDHB Fixed Asset Procedure

9. Related Documents

WCDHB Capital Expenditure Form (FA1)

WCDHB Cost Benefit Analysis Form (FA2)

WCDHB Asset Registration and Completion of Capital Purchase (FA3)

Revision History	Version:	7
	Developed By:	Finance Manager
	Authorised By:	Board
	Date Authorised:	~~May 1999~~
	Date Last Reviewed:	March 2018
	Date Of Next Review:	November 2021

Capital Expenditure Procedure

1. Purpose

This procedure is the process for the approval and monitoring of capital expenditure (CAPEX) by the West Coast District Health Board (WCDHB).

2. Application/Responsibilities

This Procedure is to be followed by all WCDHB staff members and Board members.

3. Definitions

For the purposes of this Procedure:

Capital expenditure (CAPEX) is an expense incurred to create a future benefit to our DHB of more than 12 months and which cost or have a value in excess of $2,000. For example, new buildings or operating theatre table both have a useful life more than 12 months and will cost more than $2000.

Capital Cost is the total expenditure required to get the asset in operational order. Where applicable, this may include; freight, training, any fitout to buildings, testing of new equipment. Receipts from trade-in of end of life assets are excluded from the capital expenditure cost.

Operating Expenditure (OPEX) is taken to mean the day to day expenditure required to keep the DHB functioning. Expenses like salaries/wages, repairs and maintenance, patient consumables are all examples of operating expenditure. Operating expenditure also includes deprecation of assets that expense the portion of the assets useful life in the period that it has been used.

Capital Budget is taken to mean the approved annual plan for the expenditure on fixed assets and projects in excess of $2,000. The individual items in the capital budget are "approved in principle".

Approved in Principle does not mean that approval for capital expenditure has been given. All capital expenditure must be approved in an individual basis. Depending on value of capital expenditure the necessary forms must be approved by following the capital expenditure process outlined below.

4. Responsibilities

For the purposes of this Procedure:

the ***Chief Executive*** is required to:

- oversee all aspects of this Procedure.

all ***Staff and Board Members*** are required to:

- ensure they abide by the requirements of this Procedure.

5. Resources Required

This Procedure requires:

Deleted: Purpose

Deleted: Procedure

Deleted: <#>Application/Responsibilities ¶

Deleted: <#>Definitions ¶
There are no definitions associated with this Procedure.¶
Responsibilities ¶

Deleted: *Officer*

Deleted: *<object>*

i) WCDHB Capex Expenditure Approval Form (FA1)

ii) WCDHB Cost Benefit Analysis Form (FA2):

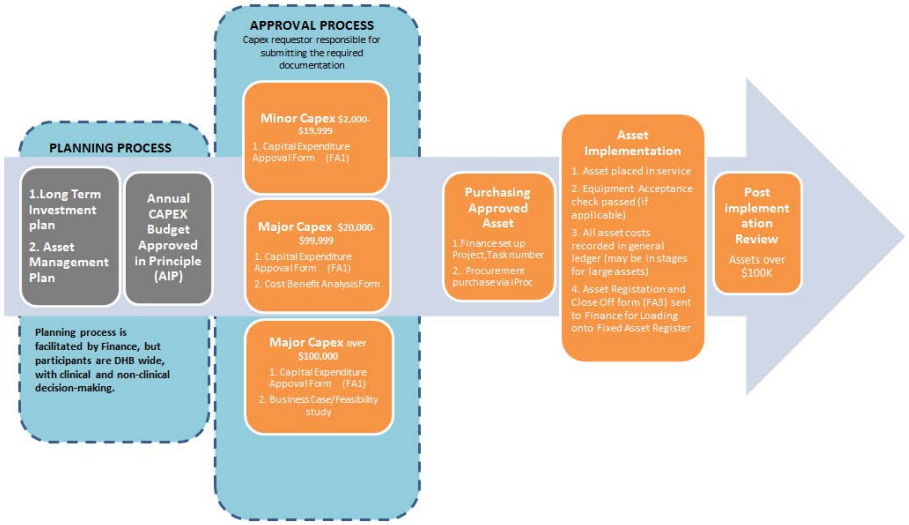
iii) WCDHB Business Case Template

iv) WCDHB Asset Registration and Completion of Capital Purchase (FA3)

Forms are located on the WCDHB Intranet under Forms>Forms

6. Process

The diagram below gives an overview of the whole capital expenditure process from planning, approval, purchasing and implementation phases.



1.0 Approval of capital expenditure must be sought before any expenditure is made or commitment to a project is given. This process must be followed if capital expenditure is funded from third parties including donated/trust funds.

1.01 All capital expenditure must be in accordance with relevant legislative requirements, WCDHB Procurement policy and Toolkit and WCDHB Delegation Policy.

1.02 All capital expenditure must align with the plans, direction and vision of the WCDHB. This is outlined in WCDHB Asset Management Policy, Framework and Plan.

Deleted: <#>WCDHB Capex Form¶
WCDHB Cash Benefit Analysis Form (CBA Form)¶
¶
Process ¶
¶

Deleted: the Ministry of Health Guidelines For Capital Investment (July 2003).

1.03 Projects requiring capital expenditure must be approved as an entire project rather than on an individual item basis. Each project is to be defined as being self-contained and requiring no subsequent approvals or authorities.

1.04 The calculation of the amount of capital expenditure for which approval is being sought is to be the total cost of the item/project including any duty, freight, training, internal labour costs, working capital and capitalised interest (where applicable).

1.05 Any operating costs associated with the acquisition need to be listed. If there are ongoing preventative or service maintenance contracts associated with the acquisition the commitment to the WCDHB needs to be specified.

1.06 Applications for capital expenditure must be made on the WCDHB Capital Expenditure form

1.07 The table below shows the required documentation depending on the value of the capital expenditure;

Capital expenditure value	Required forms for capital expenditure approval
$2,000-$19,999	• Capital Expenditure Form (FA1)
Over $20,000	• Capital Expenditure Form (FA1) • Cost Benefit Analysis Form (FA2)
Over $100,000	• Capital Expenditure Form (FA1) • Business case/feasibility study

1.08 No expenditure of capital is to proceed without an allocated project number that is to be granted by the WCDHB Finance Department. Project numbers are issued after:

i) confirmation of appropriate approval; and
ii) confirmation of availability of funds.

1.09 The purchase of the capital item will follow WCDHB procurement policies.

1.10 Capital expenditure for the maintenance of operating capacity includes replacement items required to maintain the capacity of the WCDHB to meets its operating obligations. Items required to meet health and safety, and regulatory requirements may also come within this category: Approval limits are as outlined in the WCDHB Delegation of Authority Policy.

1.11 If a project is identified to have a final expenditure level in excess of 10% of the total expenditure authorised then the expenditure is to be represented (to the relevant approval authority) for authority for the additional amount required.

If an approved capital expenditure already has a contingency included in the approved amount then any spend over the authorised expenditure needs to have relevant authority for the additional spend.

Deleted:

Deleted: ¶
Capital Expenditure Procedure ...

Deleted: Provision is made for the above two requirements on the CBA form.

Deleted: Capex Form, accompanied by a one-page summary outlining

Deleted: justification for, and explanation

Deleted: purchase.

Deleted: If the application for capital expenditure is:¶
>$10 000, a cost-benefit analysis must accompany the application; and will require a quotation process via the procurement department as detailed on the CBA FORM.¶
> $ 100 000, requires a tender process¶
>$ 100 000, a feasibility study must accompany the application.¶
¶

Deleted: capital

Deleted: Capital

Deleted: and all capital purchases will require the completion of a purchase requisition to be completed by the initiator of the capital items (or parts of the capital project).

Deleted: Board

Deleted: - Delegations.

1.12 No commitment or expenditure above the approved level is to be made until approval for additional expenditure has been obtained.

1.13 For capital expenditure costing $100,000 or more, a post-implementation review is to be developed and reported to the Quality, Finance, Audit and Risk and committee 12 months from the date of commissioning. The purpose of this report is to reinforce accountability, improve factual basis of project appraisal and to improve project management and governance. This paper must include a:

i) review of the outcome resulting from the expenditure; and

ii) comparison of the outcome achieved with the intended outcome and highlight any variances and outline the circumstances which created the variance; and

1.14

If the project associated with the capital expenditure has not achieved normal operation within 12 months of approval, the paper required by Section 1.13 is still required. In addition, a further paper is required within another 6-month interval.

1.15 If the required capital expenditure documentation for approved in principle items has not been received prior to the communicated deadline, the items will not carry forward to the next financial year. For the item to remain on the approved in principle list it must be resubmitted for prioritisation during the capital planning process for the next year.

1.16 Once asset has been commissioned, the capital expenditure requestor (Task Manager) is responsible for filing an Asset Registration and Close Off form (FA3) to Finance. This will move the capital expenditure from work in progress to the fixed asset register. Refer to WCDHB Fixed Asset Procedure which outlines the accounting, disposal and maintenance of a fixed asset.

2.00 Emergency Purchases

2.01 In the case of an emergency purchase the Chief Executive (or the person holding delegated authority) may approve the purchase.

2.02 For emergency purchases points 1.04 to 1.09 detailed above will not necessary apply at the time of purchase. The necessary completion of the required WCDHB Capex forms and allocation of a capital number must occur as soon as practically possible after the event.

2.03 The Chief Executive (or the person holding delegated authority) must be informed of the emergency purchases and acknowledge the purchase by signing the WCDHB Capex form.

2.04 The purchase must be listed as an emergency purchase on the WCDHB Capex Expenditure form.

Deleted: Over-expenditure of less than 10% is to be reported and dealt with as per Section

Deleted: 10.¶
¶

Deleted:

Deleted:

Deleted: ,

Deleted: Finance

Deleted: a

Deleted: a

Deleted: ¶
Capital Expenditure Procedure ...

Deleted: 10

Deleted: Officer

Deleted: his

Deleted: form, Cash Benefits Analysis form

Deleted: Officer

Deleted: his

Deleted:

Deleted: form and Cash Benefits Analysis

7. Precautions and Considerations

- All capital expenditure must align with WCDHB's Asset Management Policy, asset management plan, direction and vision.
- Approval of capital expenditure must be sought before any expenditure is made or commitment to a project is given.
- Projects requiring capital expenditure must be approved as an entire project rather than on an individual item basis.
- For capital expenditure costing $100,000 or more, a post-implementation review is to be developed and submitted to Quality, Finance Audit and Risk committee 12 months from the date of commissioning

8. References

New Zealand Public Health and Disability Act (2000).

Public Finance Act (1989).

WCDHB Procurement Policy.

WCDHB Procurement Toolkit

WCDHB Asset Management Policy.

WCDHB Asset Management Plan

WCDHB Delegation of Authority Policy.

WCDHB Fixed Asset Procedure

9. Related Documents

WCDHB Capital Expenditure Form (FA1)

WCDHB Cost Benefit Analysis Form (FA2)

WCDHB Asset Registration and Completion of Capital Purchase (FA3)

	Version:	7
	Developed By:	Finance Manager
Revision History	Authorised By:	Board
	Date Authorised:	~~May 1999~~
	Date Last Reviewed:	March 2018
	Date Of Next Review:	November 2021

Deleted: <#>Vehicle Purchases¶
¶
For the routine replacement of existing WCDHB motor vehicles, the Transport Officer will provide the General Manager – Corporate Services with a list of all vehicles coming up for replacement at least 2 months prior to their replacement date. The General Manager – Corporate Services will be responsible for preparing capexs for their replacement and for ensuring that proper procurement processes are followed.¶
¶
Any WCDHB Department/Service wanting a new vehicle (where one hasn't existed before) will need to prepare and justify their own capex, which will need to be approved by their General Manager, as well as the General Manager – Corporate Services¶
¶
Precautions and Considerations ¶
¶
➔ .

Deleted: <#>the plans

Deleted: <#> of the WCDHB

Deleted: ➔ .

Deleted: ➔ .

Deleted: ¶
¶
¶
¶
Capital Expenditure Procedure

Deleted: Page 3 of 4

Deleted: Document Owner: General

Deleted: - Finance

Deleted: WCDHB-Fin1, Version 6, Reviewed December 2015 ...

Deleted: December 2015

Deleted: June 2016

Deleted: ¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶
¶ ...

CHAIR'S UPDATE

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

SOURCE: **Chair**

DATE: **29 June 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a regular update from the Chair to the Board which is either verbal or written.

2. RECOMMENDATION

That the Board:
i. Notes the update from the Chair

3. SUMMARY

Given my absence at the last Board meeting, I thought I would give you an update of my activity.

I was privileged to be invited to the International Health Workforce Collaborative. This is a group of Health researchers and those interested in Health Workforce from the United States, Australia, Canada, the United Kingdom and New Zealand. They meet biennially, this was their first meeting in NZ and the topic was Effective healthcare in Rural Communities, for Transitory Populations and Innovative Solutions. Throughout all the jurisdictions the issues in common were how we shift the discussion from hospital needs, doctors providing care and expensive healthcare to a variety of people providing care, care at home or in the community, the use of IT solutions and involving the client/patient in the conversation. The interesting aspect was that there is not one solution, each community will find their own but we must learn from each other and we must involve the client and their families.

South Island Alliance
Last week, the South Island Alliance Board met with the Ministerial Advisory Group, lead by Sir Brian Roche and with Heather Simpson who is leading the Health Sector Review. We presented to them the successes and challenges of providing health services in the South Island - elderly population, geographically spread, rural and remote communities and as a group of DHBs we now require some serious capital spend on our infrastructure ie. every South Island DHB is in the middle of building or planning buildings. We also presented our strategic aims for the next year - how we will address equity of services, the continual roll out of our IT systems, shifting care and the workforce/IT required to do this.

Health Sector Review
The Health Sector Review Group is yet to be named and has until December 2019 to report. The review will not be looking at PHARMAC, Disabilities, ACC or Private Health Insurance. The draft Terms of Reference can be seen on the Ministry of Health website. A reassuring comment from Ms Simpson was that the system is not broken but given that it was designed in 2001, a lot has changed since then and it needs to be tweaked.

Ministerial Review Group
This group was set up by the Minister of Health to advise him on changes which needed to occur at the Ministry after several damning reviews and the reset required for the Ministry and the Sector to work together. Sir Brian commented that the people who work in health have a strong work ethic, but the configuration is clunky and some of the transactional costs are high. He thought there was still quite a strong institutional focus and that some of the systems in place made it hard to change that.

Dr Ashley Bloomfield, Director General of Health
Known to us at the National Chairs and CEs forum - his most recent role was as Chief Executive of Capital and Coast Health - it was great to be able to give him a warm welcome as the Director General on day 4 of his new role.

Ashley brings a fresh approach to this job - he is medically trained, has worked in the health system in many roles - Public Health Physician, Chief Executive - Internationally at WHO and also a stint in the Ministry, so he has a vast experience to use as he resets the Ministry's relationship with the sector and rebuilds the Ministry team. We all look forward to supporting him in this.

National Chairs
This group is looking ahead to the next DHB elections and how we can insure that elected members are well informed of what is expected of them, at the time of nomination and the education that they require once elected. This work has come about after the workshop that was provided in Wellington last year and the feeling that it was not value for money or time. A small group of Chairs has been working with the Institute of Directors and the Ministry of Health on a work programme that individual DHBs could use depending on their identified needs. It was suggested that rather than a National day that we might work regionally. This planning continues. We welcomed the 3 new Chairs from the 3 Auckland DHBs - Pat Sneddon, Auckland; Mark Gosche, Counties Manukau; and Judy MacGregor, Waitemata.

Looking ahead, each DHB is being invited to a workshop with the Ministry to discuss this years annual plan. I will provide an update at the meeting as we are meeting in Wellington on June 28.

Lastly, thank you to Chris for taking care of business at West Coast DHB in my absence, I appreciate the extra time involved, and also a trip to Wellington to meet the Minister. Thank you.

CHIEF EXECUTIVE'S UPDATE

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

SOURCE: **Chief Executive**

DATE: **29 June 2018**

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: West Coast Health Alliance

Alliance Leadership Team (ALT) Activity

At the last meeting in May the ALT:

- Were impressed by the high quality of nominees for this year's Open for Leadership Awards. The calibre is so high that a performance matrix was needed in order to decide a winner. ALT plans to acknowledge and celebrate all nominees this year with a joint ceremony.
- Endorsed the Rural Service Level Alliance's recommendation regarding distribution of Rural funding.
- Recognised that the 17/18 System Level Measure Improvement Plan is progressing well.
- Viewed an early draft of the 18/19 System Level Measures and approved its direction (subject to receipt of the Ministry's Annual Plan guidance for DHBs).
- Were generally happy with the current progress of the workstreams.

B: Build Primary and Community Capacity and Capability

Primary

- **Integrated Health Services – Northern Region**
  - The ongoing implementation of the new leadership structure for the Northern Region is continuing with the Manager Integrated Health Services Northern Region being appointed, starting in mid-August, and the Administration Manager appointment, starting early July. These join the existing Clinical Nurse Managers for Buller and Reefton and the Associate Clinical Nurse Managers who are already in place.
- **South Westland Area Practice**
  - The DHB remains in discussion with St John around the opportunity to co-share the St John building in Haast. A CDHB Project Manager has been appointed to oversee this task.
- **Greymouth Medical Centre**
  - The winter newsletter has been produced and staff have vaccinated the rest home residents and staff for flu along with those patients who are eligible for Zostavac.
  - Annual Cornerstone Accreditation is due in June and work is underway to complete this.

Community

- **Public Health/B4School/Vision Hearing**
  - *Public Health Nursing* – the PHN team continue to work across the services to alert health promotion messages. The newly appointed PHN in Buller has a new initiative with the High School and has set up a girls after-school group, with a focus on wellness that has been well received. There is now an opportunity to set the same up for the boys. The age targeted group is 12-15 years. HPV is well supported but the uptake is variable. Oral health support for families is still being supported as resource allows on GA days from Parfitt. A recent meeting with the Maternity Manager of McBrearty looks very positive for supporting the PHN team in the provision of the Well Child Tamariki Ora (WCTO) services. She has offered to include the team in education and also it is an opportunity to build relationships with the midwives to improve choices including PHN in the delivery of WCTO.
  - *B4School Service* – this team is working well, supported by the VHT and the PHN team, and are on schedule to meet the target for this financial year. High percentages of attendances have been maintained over the last 3 months and this is related to the use of Facebook and the attention to detail and the quality of the service the coordinator has adopted since her appointment at the beginning of February this year.
- **District Nursing**
  - Work is ongoing to create greater visibility within the system around the community nursing activities and resource requirements. One tool that will assist in this is Trendcare. This is a tool already in use within our inpatient units across the Coast to help understand demand, patient acuity and staff needs and we are looking at this to do the same for our Community teams. The Trendcare roll-out to Community will be approximately September 2018. The teams are now providing workloads daily and starting to roster on Trendcare to get prepared for the implementation.

- The DN team in Greymouth are supporting the vascular clinic that started on 1 June. This is exciting and the team will look at guidelines for this so staff have a clear direction of their role in this service provision.
- We have full staffing at the moment and this is providing good resources for service delivery across the region.

- **Clinical Nurse Specialists**
  - The CNS Diabetes is involved in 8 diabetes study days this year and she is also keen to support the local practices more.
  - Our Cancer Nurse Coordinator is working with Maori in an effort to reduce inequalities in relation to cancer treatments. She is utilising Takarangi Cultural Competences in her daily practice that she learned at the Arahura Marae.
- **Dental Service** – Dental Therapy assistants have been following up booked appointments with a phone call reminder the day before the appointment is due, in an effort to reduce the number of children not attending. This activity has resulted in a measure of success. In busy families, some parents forget the appointment so a reminder is appreciated.
- **Home Based Support Services** – an interview process has occurred for the Buller combined HBSS/DN position.

C: Implement the Maori Health Plan

- **Takarangi Cultural Competency – West Coast:** 47 people have now been through a two day Wananga on a Marae to start their learning around Cultural Competency. The Maori Health team are now providing a series of three hui that will support participants through the portfolio. The first one has been held with good attendance and there are a further two planned for July and August. The Takarangi Assessors will be coming down to assess portfolios in October.
- **South Island Workforce Development Hub - Position Statement on District Health Board Maori Workforce:** A strong stance has been taken by Te Herenga Hauora, Te Waipounamu Maori General Managers/Directors to accelerate progress and send clear and powerful messages to the sector about its expectations going forward around Maori Workforce Development. They have set six resolutions challenging all DHBs in:
  - Maori workforce proportionality for their Maori population within the next 5 years
  - Accurate collection and recording of the ethnicity of their staff
  - Provision of recruitment specialist roles where among other things knowledge and skills in Te reo Maori, tikanga Maori and strong connections to iwi, Maori networks and communities
  - Retention measures and reports to identify reasons for high turnover of Maori staff
  - Cultural competency becomes a requirement for all clinical staff and other staff that have regular contact with patients and whanau, and reward the achievement of qualifications appropriately
  - DHBs in the South Island will work together to standardise workforce terminology reports across DHBs
- **Kia ora Hauora Rangatahi Placement – August 10, 11, 12:** Planning is now underway to host the 5th placement of Rangatahi. We are working closely with our Health sector partners to make this an interactive three days for Rangatahi. They will begin with a Powhiri at Arahura Marae where they will be welcomed by local iwi to start their three day

placement.

- **Maori Mental Health:** We have held two hui to look at the model for the delivery of Maori Mental Health Services on the West Coast and how we might improve access for Maori and delivery of this service. Over 40 people have attended to date and provided input into how the model may be improved for Maori engaging in DHB mental health services. A further hui will be held in the Buller and a separate opportunity for Maori whanau in July. It is intended that recommendations and next steps will be fed back in August.

	DELIVERING MODERN FIT FOR PURPOSE FACILITIES

A: Facilities Maintenance Report

- The repairs to the weakened wall/fence around the Kahurangi building are progressing well with all strengthening brackets completed by the WCDHB carpenter and only a country-wide shortage of stainless steel bar preventing completion.
- The business case for the Grey Hospital Pedestrian Bridge has been submitted and is awaiting final sign off before the tender is awarded.
- The resource consent application for pruning of the Historic and Protected tree next to Corporate building at Grey Hospital is being finalised.
- All WCDHB Building Warrants of Fitness are current with Grey Hospital due for renewal at the end of June and electrical testing is on a rolling annual cycle.
- There have been two break-ins to the tunnel area at Buller Hospital with copper pipe being stolen. Some of this pipe was still in service and the thieves isolated the valves before removing it. The Police are investigating.

B: Partnership Group Update

Grey

- The DHB notes a considerable increase of activity on site and good progress being made in many areas with the façade installation now advancing as well as internal partitioning and services installation.
- Other areas of progress include the advancement of cabling installation, radiology secondary steel work installation, flooring preparation and vinyl installation for wet areas in the ground level north wing.
- The coal boiler has arrived on site and is ready for installation as well as the boiler house roofing material which is also on site and ready for installation.
- The scaffolding on the northern end of the building has been removed and the building exterior can clearly be seen to be taking shape.
- The WCDHB continues to work together with the project managers and Fletcher Construction to align the current construction programme with the planning for installation and delivery of new equipment as well as for the planned migration of the existing facility to the new facility.
- With increasing personnel on site daily, traffic can be busy, so please take care driving in

the area. Staff and visitors are also reminded to please follow all traffic management and parking closures on the hospital campus, which will be well sign-posted.

Buller

- Following the 5 April Westport Health Centre community meeting and public displays of the draft Buller Health facility plan, public feedback regarding the concept continues to be received and collated. The email address to send comments to is newfacilities@wcdhb.health.nz.
- Please also check the West Coast DHB Facebook page and the West Coast DHB website for regular updates on this project.

	RECONFIGURING SECONDARY AND TRANSALPINE SERVICES

A: Hospital Services includes Secondary Mental Health Services

Hospital Services

Nursing

- Recruitment in ED remains challenging; we continue to recruit for a CNM Acute Zone. Paediatrics has successfully filled their vacancy. The medical and surgical wards are also managing to fill most vacancies. A high level plan around CCDM has been formulated and sent to NZNO for feedback prior to going to the Ministry. The Safe Staffing Healthy Workplaces unit manager has looked over the plan and has endorsed our submission stating we are doing most of the components of CCDM. We continue to work towards the full roll-out of CCDM when we move into the new facility.
- NZNO negotiations continue with notification from the union expected after ratification on 15 June. Contingency planning is well underway with our final plan submitted to the national group on 6 June.
- A nurse leadership training package has been put in place to help new leaders in the organisation. Training will recommence following 12 July. This is also forming the basis for a wider leadership training program for all workforces.
- Work continues for Patient Trak and Early Warning Score (EWS) and we are taking learnings from our Canterbury colleagues ensuring we have a robust system and implementation programme.

Medical

- Recruitment remains a focus for both General Surgery and General Medicine – we have stable locum cover and are working with some potential candidates. We have had some interest in our RHM positions and are moving to confirm some strong candidates for interviews in the coming weeks.
- The RMO workforce has some vacancies following some early resignations. Many RMOs have indicated they will stay through 2019. Annual recruitment for 2019 is underway with a number of promising candidates.

Allied Health

- This month the Allied Health, Scientific and Technical workforce have farewelled one of its longest serving team members. Garry Chapman, Head of Department for the Medical Technicians has just shy of 50 years in service to the West Coast DHB. An enthusiastic historian, Garry has documented most of the changes he has seen throughout his time at the DHB, and has shared many of these treasures during the recent celebrations.

- Working groups are being established to action the Audiology review recommendations. One working group will consider service provision for those under 18 years, and another to respond to recommendations relating to the adult population.
- Physiotherapy continues to be the most at risk service area, due to ongoing challenges to recruit qualified Physiotherapists.
- Recruitment is also ongoing for Radiology, Psychology and Occupational Therapy across Hospital Services, Mental Health and Primary & Community teams.
- Consultation has concluded around radiology provision at the Buller campus and the feedback is currently being collated.
- Frontline staff recruitment challenges continue to impact on the ability of Allied Health managers and leaders to focus on the non-clinical tasks of their roles such as budgets, change processes and workforce development.
- Delays in the new build process are creating risk within our radiology service, as a number of imaging technologies reach their end of life. This means that the technology may become less reliable, equipment may no longer be able to be repaired, parts may no longer be available, and the levels of radiation emitted may become too high for staff or patient safety. These factors are being monitored regularly and this risk has been elevated on the risk register.
- Work is ongoing with our CDHB Allied Health colleagues to develop a RUFUS (rurally focused urban specialist) model of service delivery for all of our Child Development Services. This means that experienced clinicians, both from CDHB and from WCDHB, can support their transalpine colleagues to deliver the specialist care required for this high needs client group.

Mental Health

- **Operational Excellence**
    - The CAMHS service has welcomed a new Psychologist to the team joining us on the Coast from India. Currently they are being orientated to the team, the DHB, and the West Coast. They have also commenced client work and it is expected they will have a positive impact upon the psychological well-being of the client group.
    - The new Pukenga Tiaki in Buller, having completed orientation, has made a significant impact in the area in a short period of time. Processes and procedures are being looked at with deficit areas being addressed leading to increased accessibility and visibility of the service. They have also made good network connections with their colleagues in Canterbury.
    - CAMHS have appointed a new Registered Nurse to the team who has been inducted and is already contributing greatly to the case management of clients. Recruitment of another part-time psychologist and psychiatrist is nearing completion.
    - The planned move of the CAMHS service to the main site is progressing and a communications plan has been developed to inform staff, clients and wider community of this.
    - Work continues to progress to provide additional support to the Rata AOD service who continue to receive high volumes of referrals. Consultation between two other services to provide additional support is nearing conclusion.
    - Both IPU and Kahurangi have achieved full recruitment levels, the only current vacancy remains with the Buller Community Mental Health team for an RN. This is proving hard to recruit to at present and has resulted in a number of creative

solutions to support them. It should be noted the assistance from both CDHB and NMDHB that has been provided. Each has provided a staff member seconded to work in Buller for periods of between 2 to 3 months.

- Data reporting, and in particular increased use of data findings, continues to be promoted throughout mental health services. The operations manager is currently working with the data team to introduce updated and new training for staff members for each of the various systems they utilise.
- Rata AOD have had further attendance at regional workshops and continues to ensure we are service ready for SACAT (Substance Addiction Compulsory Assessment and Treatment) Act.
- The Maori Mental Health Review process has commenced; two workshops have occurred so far, in Hokitika and Greymouth. Both have been well attended by DHB and NGO staff and other providers alike.
- Work is continuing to finalise the role of the new Nurse Practitioner within mental health and addiction services. This is an exciting opportunity for the service to introduce new and innovative ways of working in the organisation, hence the time being spent currently to ensure the role and the opportunities it brings are utilised to the maximum.

- **Future Services Project**
  - A report has been provided to staff and other stakeholders on the progress of the Future Services Project. This report provides further detail around how future services will be delivered and will provide a blue print for proposals for change around locality based services and crisis response.
  - Further work will be underway soon to describe our coast wide services.
  - One of the early results of the Future Service Project work is that there is now respite care available in Westport.

	DEVELOPING TRANSPORT AND TELEMEDICINE SERVICES

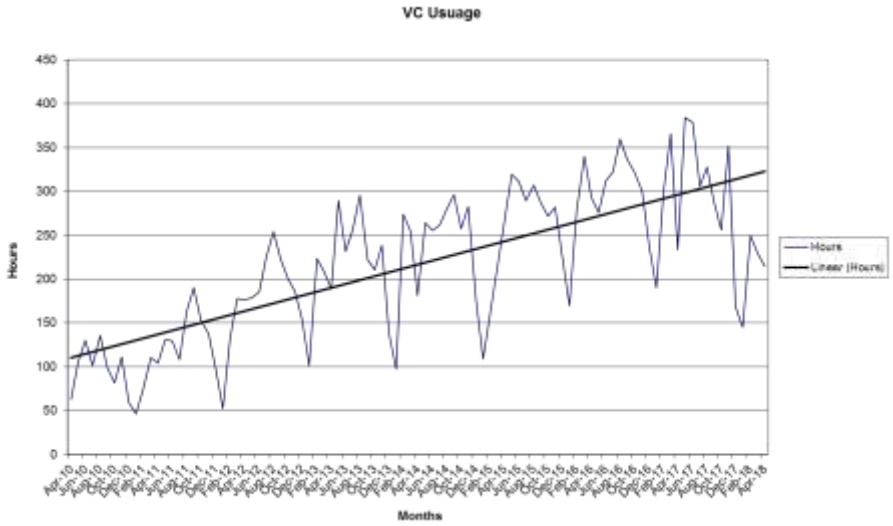
A: Improve Transport Options for Patient Transfers

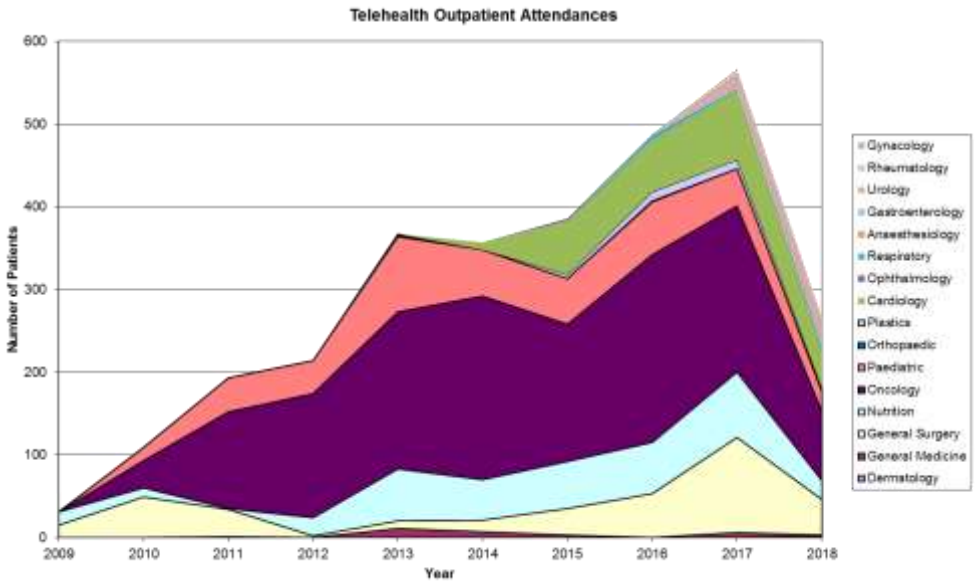
- The following transport initiatives are now embedded:
  - Non-acute patient transport to Christchurch through ambulance transfer.
  - St John community health shuttle to assist people who are struggling to get to health appointments in Greymouth.
  - Extension of the Buller Red Cross contract to provide a community health shuttle transport service between Westport and Grey Base Hospital through to August 2020.
- The Ministry of Health's review of the National Travel Assistance (NTA) policy is continuing with a detailed option analysis and recommendations report currently being prepared. High-level draft evidence briefs covering eligibility issues, scope of service, governance, administration of the policy, information technology and funding, were reviewed at national NTA Review Leadership Group meeting on 24 May. A Review Summary document seeking in-principle endorsement from the Minster of Health to the high-level proposals for improvements to the NTA scheme was subsequently endorsed by the Minister in early June.
- Group discussion in the build-up to these presentations to the Minister have concentrated

on the need to re-focus the NTA scheme to better match patient needs and achieve equity; particularly for Māori and Pacific people and those living in remote rural areas and improvements to the consistency of approach across the country. The Ministry plan to have their final options and recommendations report to the Minister, prepared by the end of June/early July. This timeframe may vary if any additional analysis is identified or requested during the development of the more detailed modelling work to inform options. Final decisions about adoption and implementation of any proposed changes put forward will be made by the Minister of Health.

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: Older Persons Health Services

- The Planning and Funding Older Persons Health team is investigating the online platform,

My Care. My Care is established in Canterbury and has allowed people to directly manage their in-home care requirements. The DHB is working directly with My Care to determine the viability of this tool for our older population.

- The Palliative Care team have started palliative care study days. The first study day was well attended by the Aged Residential Care team. Due to the success of the day more have been planned for coming months.
- There is a new online learning package called Fundamental Series: Palliative Care. This is now available to all staff, including staff in Aged Residential Care where there is a Memorandum of Understanding with the DHB, via HealthLearn, the DHB's learning management system.
- The In-Home Strength and Balance programme is progressing very well. During quarter 3 there were:
    - 3 referrals for <65s
    - 8 referrals for those aged 65-74
    - 30 referrals for those aged 75+
- Several classes were approved as certified strength and balance classes in the weeks leading up to the end of Quarter 3. Providers have begun taking class rolls to capture attendees from the beginning of Quarter 4. Currently there are 190 places available per week, across nine different classes. This number is expected to increase as more classes and providers go through the approval process.

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 May 2018 was a deficit of $600k, which was $304k unfavourable to budget. The year to date position of a net deficit of $2.737m is $1.061m unfavourable to budget.

	Monthly Reporting			Year to Date		
	Actual $'000	Budget $'000	Variance $'000	Actual $'000	Budget $'000	Variance $'000
Governance Arm	0	0	0	433	1	432
Funder Arm	352	352	0	3,432	4,479	(1,047)
Provider Arm	(952)	(648)	(304)	(6,602)	(6,156)	(446)
Consolidated Result	(600)	(296)	(304)	(2,737)	(1,676)	(1,061)

B: Effective Clinical Information Systems

- **eReferrals:** Stage 3 – electronic triage: eReferrals Stage 3, eTriage has gone live for seven services including Plastics, Gynaecology, General Surgery, General Medicine, Diabetes, Nutrition and Podiatry. Cardiology and Neurology services will be on to stage three by 14 June. Early planning around some allied health services has also begun. Profile for Macintosh is in pilot for ERMS requests at several Christchurch based clinics. WCDHB has requested for the on-boarding and engagement of Westland Medical to start occurring. This would enable all referrals from general practice within the West Coast to be received digitally.
- **New Facility Work:** A procurement process involving a Request for Proposal (RFP) for a telephony system for the new facility has been completed. The new system has been

implemented in Reefton, Hokitika, Greymouth and Buller campuses, with roll-out across the West Coast over next 2-3 months. The contract for a move to telephony over internet (SIP) has been approved and implementation is underway. A full audit of all land phone lines has been completed and some technical issues around SIP have been resolved. Late June and July should see a number of sites moved across to using SIP. New server racks are being installed into the new facility in preparation for networking links being installed into site. A business case for wifi within the new facility has been completed and is going through the approval process.

- **Telehealth RFQ:** A Telehealth Request for Quotation (RFQ) was submitted in July, closing in August. The capabilities this will introduce to WCDHB will allow increased mobility and expansion at a more sustainable price point. A business case and feasibility paper has been completed and approved. Implementation is underway with software being installed and hardware being configured. Timeframes for this implementation are challenging due to some equipment becoming end of life at the end of June 2018.
- **IT Infrastructure update:** WCDHB has undergone a request for proposal (RFP) for its Wide Area Network (WAN). This is a joint RFP with CDHB to leverage greater buying power. The result once implemented will provide a large financial saving to WCDHB, with increases in bandwidth and improved resiliency across most sites. 17 sites have now been moved across to 2 degrees with 6 sites remaining.
- **ISG Disaster Recovery Plan (DRP):** The ISG Disaster Recovery strategy was completed in late 2017. The next phase of development is the creation of a DRP, now that the DR strategy has defined the scope of the DRP. Two drafts of the DRP have been completed with more work around on the networking aspects in progress. A third draft will be completed before the end of June.
- **Patient Trak:** The electronic nursing observation tool, Patient Trak, widely deployed within the CDHB is now also being deployed into WCDHB. Lessons learned from the CDHB implementation have been applied to the West Coast implementation. This has resulted in a change in scope with a final list of equipment provided to project sponsor for funding approval.
- **eSign off for Radiology:** The project for enabling electronic sign off of results for radiology has kicked off. Weekly project reporting is established with background information gathering occurring.

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

Media interest

- **Staffing of the Diversional Therapy service at Buller Hospital**: The DHB has a 40 hour per week Diversional Therapy service that aims to support older people in our community who are socially isolated, to form new connections. One of the ways that we work to support those new connections is by facilitating group activities, using existing community resources (such as the bus or a community hall), and groups (such as craft groups or activity programmes). The Diversional Therapist supports people to build their confidence in attending.
- Provided information and updates on notifiable disease infections on the West Coast, particularly in relation to Pertussis and also concerning the uptake among staff of the seasonal influenza vaccine. At the time of asking, an estimated 45-50 percent of DHB employees had been vaccinated.
- We were asked about patient handover in light of media coverage around staff from some

companies or organisations being required to start earlier or stay later than the time they are paid for. Our response was that patient handover is within paid time.

- There were enquiries about the provision of x-ray services in Buller. The response concerned training for nurses and the frequency of transfers to Greymouth, which were very few in the acute setting.
- Newsroom.co.nz interviewed the CEO regarding the proposed new health facility in Westport. The discussion included questions on the timeline and the change in budget and scope, the standard of care at O'Conor Home and the results of the independent audit, how the proposed facility would function and serve the community in a natural disaster or emergency, the provision of one birthing suite but the clinical flexibility to use other rooms if required, the changes to the shape and design which means rooms either meet or exceed Australasian Healthcare guidelines.
- Enquiry regarding temporary relocation of West Coast DHB services in Haast to the new St John premises due to the potential of black mould. Patients were phoned to notify them of the change in location. The Haast clinic had decontamination work done, and are waiting for air sample results to validate that it is safe to reoccupy.

Publications

- CEO Update strongly featured interesting and informative reflections from nurses about their experience from days gone past – to mark and celebrate International Nurses day on 12 May.

	PROMOTING HEALTHY ENVIRONMENTS AND LIFESTYLES

Key Achievements/Issues of Note

Building healthy public policy

- CPH made a submission to the Buller District Council's Long Term Plan (LTP). Topics included improving water supplies, planning for climate change and a request to become a signatory to the Walk 21 Charter. We are currently working on a submission to the Westland District Council's draft LTP which is due in this month and awaiting the release of the West Coast Regional Council's draft LTP for comment.

Smokefree Environments

- The Bonzai Café in Greymouth has become the first café in Greymouth to make its outdoor eating area smokefree. This initiative was launched as part of promoting World Smokefree Day on 31 May. The Bonzai was approached by CPH's Trish Hunt (member of the West Coast Tobacco Free Coalition) to make their outdoor eating area smokefree. Sam White, the manager, was encouraged by the success of the Fresh Air Project in Canterbury. Since the launch last month Sam has had positive feedback from the community and local media. Other cafes on the West Coast will also be approached to become smokefree outdoors.

Smokefree Enforcement

- As the result of our last controlled purchase operation in April, penalties have now been issued to two outlets. In each case, the staff member who sold tobacco to an underage volunteer has pleaded guilty and been fined $500.00. The owner of each outlet has also received a formal warning. Compliance visits will be carried out with tobacco retailers in South Westland over the next month, with a controlled purchase operation to follow in

that region later in the year.

Nutrition

- CPH nutrition health promoters have run a successful Appetite for Life course in Hokitika, with 17 people attending. This course was in response to a request from an Early Childhood Centre, which identified growing interest amongst parents and community members in continuing the learning begun at our early childhood centre nutrition sessions. CPH staff have also been writing weekly 'nutrition bites' which are currently being distributed to three schools on the West Coast to be published in their newsletters. Each week, a nutrition topic is covered and a seasonal recipe is provided. These 'nutrition bites' will also be shared more widely through the West Coast PHO's Facebook page.

Alcohol

- CPH's Alcohol Licensing Officer presented evidence on behalf of the Medical Officer of Health during a hearing before the Westland District Licensing Committee in opposition to a proposal by a licensed premise in Franz Josef to licence their outside decks until 4.00am, Monday to Sunday. This opposition was a proactive attempt to prevent the amenity and good order of Franz Josef being reduced to more than a minor extent by the granting of the variation to this premises' licence. The Committee approved the variation and it remains to be seen what effect this has, particularly during the summer months.

Pink Shirt Day

- CPH engaged workplaces in Greymouth, including the West Coast DHB, to promote the message of reporting, and stopping work place bullying on Pink Shirt Day. This awareness day is an annual event and is focussed on creating environments where individuals are supported to prevent harm to others. In the lead up to Pink Shirt Day, CPH promoted mental health awareness through articles in the Messenger and the Westport News on topics such as understanding stress, embracing conversations about mental health (for employers), and what is bullying and cyber-bullying.

Report prepared by: Philip Wheble, General Manager West Coast DHB

Approved for release by: David Meates, Chief Executive

West Coast DHB health target report

Quarter 3 2017/18: January - March 2018

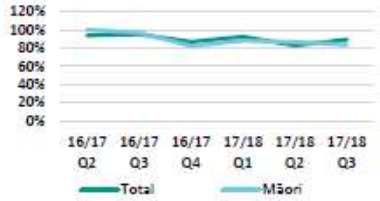
What are the health targets?

The health targets are a set of national performance measures specifically designed to improve performance of the health sector in areas that reflect significant public and government priorities. They provide a focus for action. Three of the six health targets focus on patient access, and three focus on prevention. Health targets are reviewed annually to ensure they align with health priorities and targets are set nationally for all DHBs.

DHBs report progress to the Ministry quarterly, who in turn publish the targets online and in newpapers via a national league table.

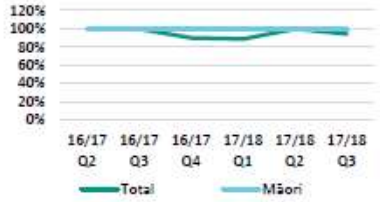
Supplementary indicators

Better help for smokers to quit: secondary smoking



This was previously the health target: better help for smokers to quit in public hospitals

Better help for smokers to quit: maternity smoking



The Ministry sources this from the national Maternity Data Set. However, the source of this data only represents around 80% of all pregnancies nationally. Therefore the Ministry provides these results for information only and will not publish them online or in newspapers.

Shorter stays in ED — 98%

Patients admitted, discharged or transferred ED within six hours. Target: 90%

The West Coast continues to achieve the ED health target, with 98% of patients admitted, discharged or transferred from ED within 6 hours during quarter three.

Improved access to elective surgery — 104%

Patients receiving planned surgery
Year-end target: 1,905

This quarter, West Coast DHB provided 1,452 elective surgical discharges, delivering 104% of planned discharges.

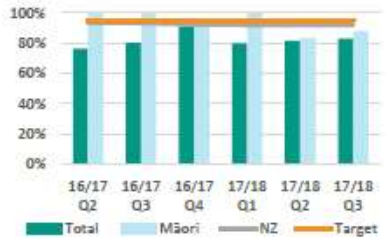
Faster cancer treatment — 81%

Patients getting their first cancer treatment within 62 days. Target: 90%

Performance against the health target continued to increase this quarter to 81% of patients receiving treatment on time. Small numbers are challenging with this result reflecting only three patients who were not seen within the 62 day period. A breach analysis is underway and every non-compliant case individually followed up. Most non-compliant cases are physically, psychologically, or diagnostically challenging.

Increased immunisation — 81%

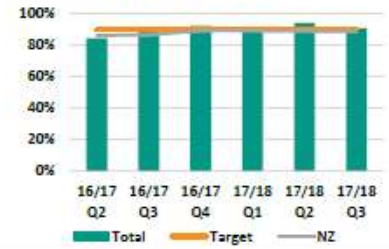
Eight-month-olds fully immunised



Six children were missed and 94% of eligible (consenting) 8-month-olds were fully immunised. This is an increase on the previous quarter. Strong results were achieved for Asian (100%) tamariki.

Better help for smokers to quit — 90%

Patients in the community who smoke are offered help to quit. Target: 90%



The DHB continues to meet this health target . Three practices have shown significant improvements and have been supported by input from the Smokefree Services Coordinator and PHO Clinical Manager.

Raising healthy kids — 100%

Children with obesity referred for support
Target: 95%

100% of children identified as obese at their Before School Check (B4SC) were offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions for quarter three.

Updated 09/05/2018: Produced by Canterbury and West Coast DHB Planning and Performance team. PTO for data definitions.

CLINICAL LEADERS UPDATE

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

SOURCE: **Clinical Leaders**

DATE: **29 June 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:
i. notes the Clinical Leaders' Update.

3. SUMMARY

WORKFORCE

Allied Health

The first of our Pharmacy Technicians is about to undertake their final assessment to become 'PACT' qualified. PACT or Pharmacy Accuracy Checking Technicians provide further capacity within the dispensary, allowing us to release Pharmacists for more complex tasks. Physiotherapy continues to be the most at risk service area, due to ongoing challenges to recruit qualified Physiotherapists.

Work is ongoing with our CDHB Allied Health colleagues to develop a RUFUS (rurally focused urban specialist) model of service delivery for all of our Child Development Services. This means that experienced clinicians, both from CDHB and from WCDHB, can support their transalpine colleagues to deliver the specialist care required for this high needs client group.

Medical

Brendan Marshall, one of our Rural Hospital Medicine Specialists is the first NZ candidate to complete the Advanced Diploma of Obstetrics. This is a major step in the move towards rural generalists working alongside specialists to deliver a safe and sustainable service on the West Coast. This was made possible through Brendan's persistence, funding from HWNZ and transalpine partnership. This role fits with our strategic direction and will be a model for the development of further positions, such that we become the flagship for NZ with advanced trained GP and Rural Hospital Medicine Specialists able to undertake emergency surgical procedures. Additionally it creates a model that increases the support and choices for women looking to give birth on the Coast.

Nursing

The nursing workforce development team recently responded to an identified gap in training and education for newly appointed nurse leaders. A comprehensive orientation and education programme for senior lead roles was drafted, following a workshop with senior nurses. This programme is designed for all senior roles including identified leaders for the future, new and current nurse managers through to the Director of Nursing. The programme was recognised as having the potential for all leads in the West Coast Health System, so has been gifted by the department of nursing to Learning and Development for refinement and implementation across all leadership roles within the WCDHB.

On 17 May 2018 a meeting was held to explore the potential of a West Coast roll-out of the Canterbury Gerontology Accelerated Programme (GAP) in 2019. This programme aims to promote a high standard of seamless care for older people within our community while recognising the unique development needs of the workforce who care for these whanau. While the original intention of the GAP was to support Registered Nurses (RNs), we would also be exploring interprofessional opportunities within this programme. Within the current RN-focussed GAP framework, motivated and enthusiastic nurses would be supported to apply to undertake:

- Postgraduate studies (supported by Health Workforce New Zealand funding administered by the WCDHB)
- 10-12 week clinical placement rotations to help develop and broaden clinical practice (supported by designated mentors within participating organisations)
- Personal and professional reflection on the experience of the programme and any practice development (supported by the RN's employer and the WCDHB Workforce Development Team)
- Innovative project implementation based on lessons learnt (supported by participating employers and relevant stakeholders)

A recent survey of stakeholders shows that there is interest to participate and host the clinical rotations, and a meeting later this month will progress programme development.

QUALITY & SAFETY

The Quality team have developed a locally provided training programme, for staff undertaking Root Cause Analysis (RCA) of serious events. This local programme will enable more West Coast staff to build skills around analysing events to improve systems and processes following such events. We will also continue to support staff to attend the two day Health Quality and Safety Commission (HQSC) Adverse Events training, where the Matt Gunter patient story is still regularly co-presented by Matt's Mother, Heather, and the WCDHB.

The nominations for this year's HQSC emerging leaders' award on the West Coast were of a very high calibre. The Alliance Leadership Team has implemented an additional process to determine the winner with a matrix style analysis to support decision making. An announcement from the HQSC regarding the winner is expected shortly.

Allied Health

Physiotherapy staff are trialling a group model for the most common Women's Health referrals, as a way to build confidence and knowledge, as well as offering a more timely service.

With the planned roll-out of regional ePharmacy over the next 12 months, there have been regular regional IPS meetings to determine a co-ordinated strategy for WCDHB (and NMDHB) to link into CDHB's instance. This will provide a solution to the department having to currently run an unsupported Windose system.

Nursing

The Resuscitation Service Coordinator has been updating the emergency trolleys within the mental health service in Greymouth, and will be running further resuscitation training, including scenarios. This work is part of the implementation of the National Early Warning Score system, and the development of appropriate response processes. It is also in preparation for the move to the new facility, when the mental health team will be further away from physical health services, and response systems will need to be tailored to this new context.

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: Clinical Leaders

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: **Executive Director, Finance & Corporate Services**

DATE: **29 June 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the financial results for the period ended 31 May 2018.

3. DISCUSSION

Overview of May 2018 Financial Result

The consolidated West Coast District Health Board financial result for the month of May 2018 was a deficit of $600k, which was $304k unfavourable to budget. The year to date position of a net deficit of $2.737m is $1.061m unfavourable to budget.

The table below provides the breakdown of May's result.

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance		Actual	Budget	Variance	
REVENUE								
Provider	7,110	7,005	105	√	79,058	77,127	1,931	√
Governance & Administration	90	69	21	√	1,253	759	494	√
Funder	5,260	5,267	(7)	X	56,319	58,049	(1,730)	X
	12,460	12,341	119	√	136,630	135,935	695	√
EXPENSES								
Provider								
Personnel	5,832	5,462	(370)	X	61,437	59,425	(2,012)	X
Outsourced Services	2	12	10	√	112	130	18	√
Clinical Supplies	774	698	(76)	X	8,320	7,638	(682)	X
Infrastructure	1,291	1,074	(217)	X	11,826	11,611	(215)	X
	7,899	7,246	(653)	X	81,695	78,804	(2,891)	X
Governance & Administration	89	69	(20)	X	820	758	(62)	X
Funder	4,907	4,915	8	√	52,887	53,569	682	√
Total Operating Expenditure	12,895	12,230	(665)	X	135,402	133,131	(2,271)	X
Surplus / (Deficit) before Interest, Depn & Cap Charge	(435)	111	(546)	X	1,228	2,804	(1,576)	X
Interest, Depreciation & Capital Charge	165	407	242	√	3,965	4,480	515	√
Net surplus/(deficit)	(600)	(296)	(304)	X	(2,737)	(1,676)	(1,061)	X

4. APPENDICES

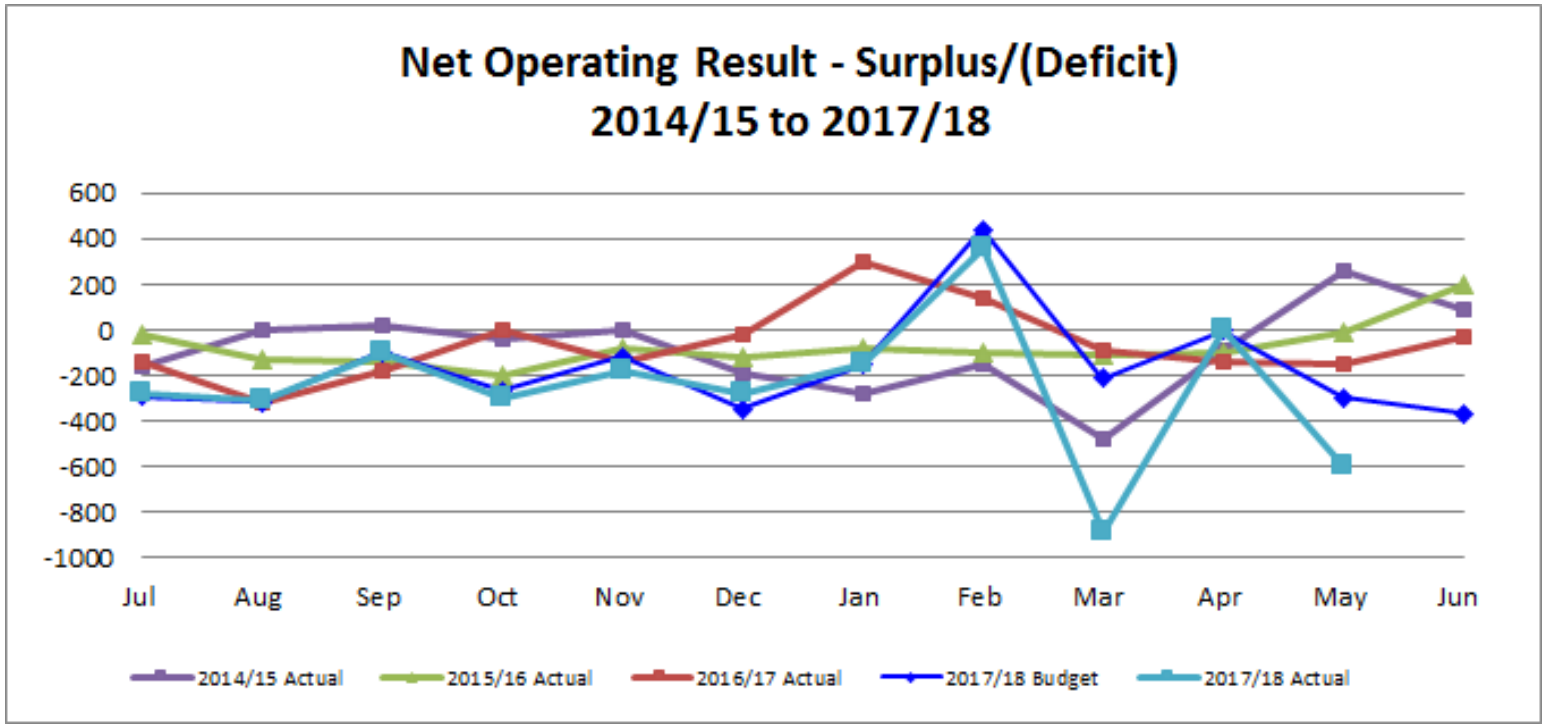
Appendix 1	Financial Result Report
Appendix 2	Statement of Comprehensive Revenue & Expense
Appendix 3	Statement of Financial Position
Appendix 4	Statement of Cashflow

Report prepared by: Justine White, Executive Director, Finance & Corporate Services

APPENDIX 1: FINANCIAL RESULT

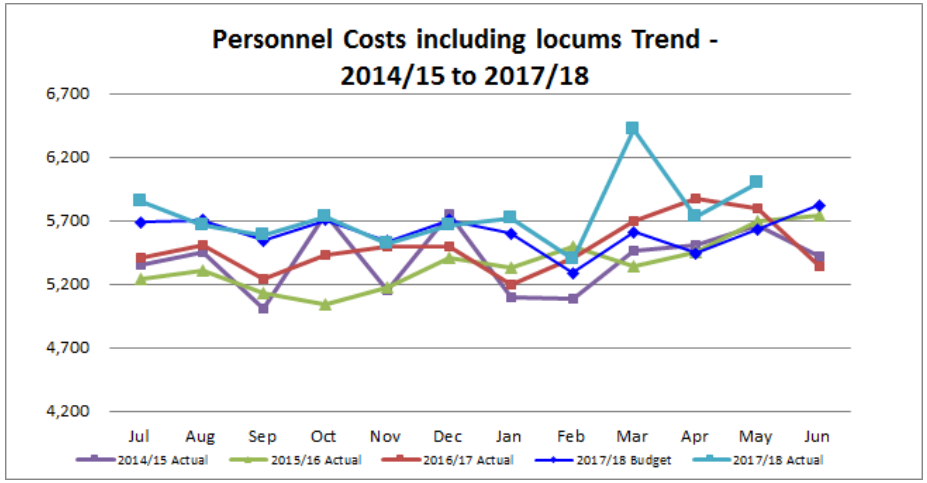
FINANCIAL PERFORMANCE OVERVIEW – MAY 2018

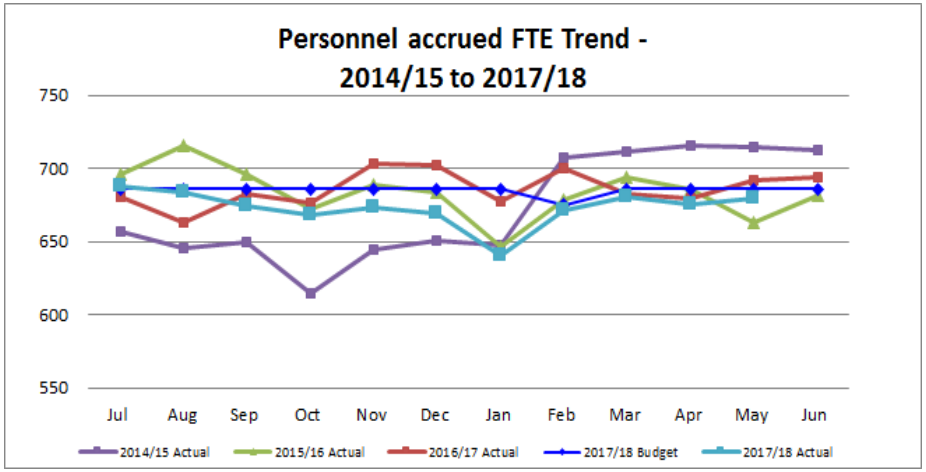
	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	(600)	(297)	(303)	102% ✕	(2,737)	(1,675)	(1,062)	63% ✕



We have submitted an Annual Plan with a planned deficit of $2.041m, which reflects the financial results anticipated in the facilities business case, after adjustment for known adjustments such as the increased revenue as notified in May 2016, the actual funding provided for the 2017/18 year, and the anticipated delays in regard to plans for ARC/Dunsford Ward in Buller.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

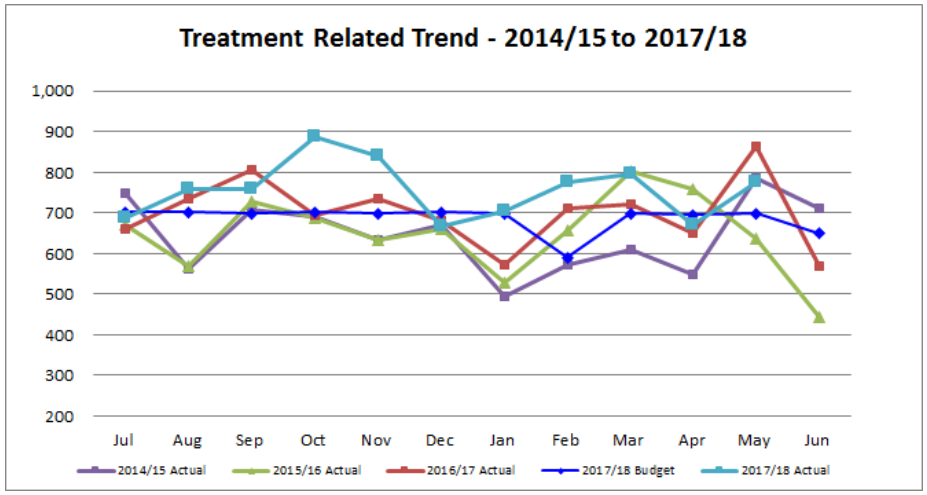


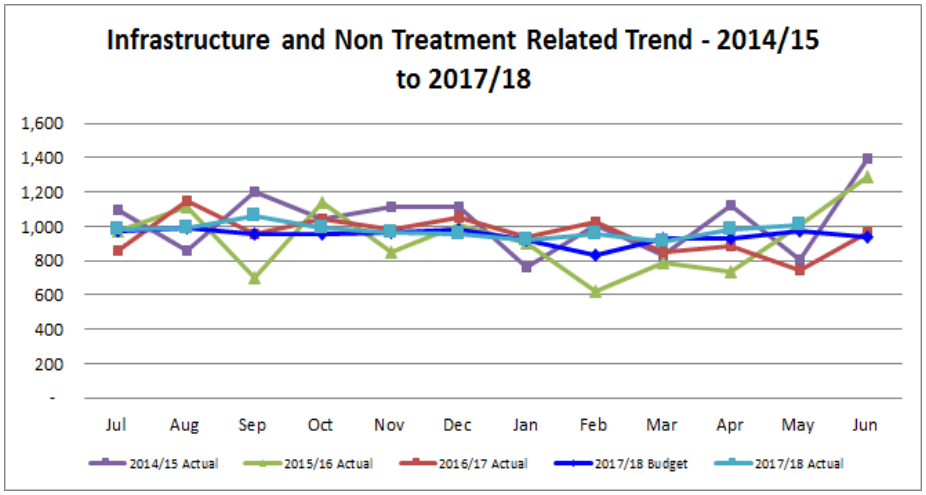


KEY RISKS AND ISSUES: Although better use of stabilised rosters and leave planning has been embedded within the business, there remains reliance on short term placements, which are more expensive than permanent staff.

The Ministry of Health has a keen focus on ensuring DHBs do not exceed their management and administration staff FTE numbers. There are many ways FTE can be calculated, depending on the purpose. Using Ministry of Health calculations we remain under our overall management and administration staff cap. Expectations from the Ministry of Health are that we should be reducing management and administration FTE each year. This is an area we continue to monitor intensively to ensure that we remain under the cap, especially with the anticipated facilities development programme.

TREATMENT & NON TREATMENT RELATED COSTS

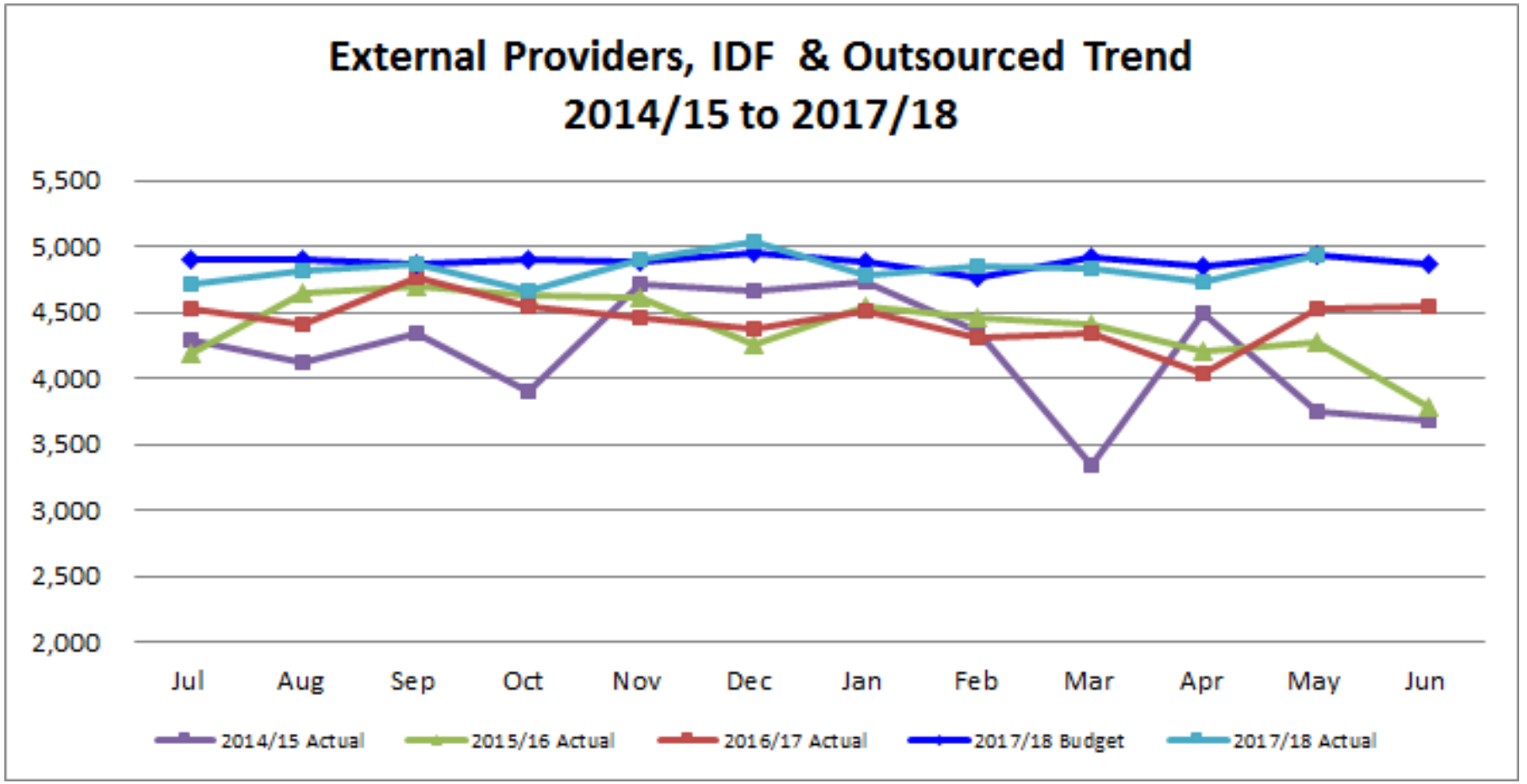




KEY RISKS AND ISSUES: High cost treatment particularly in oncology and rheumatology medicines continue to cause significant concern.

Timing influences this category significantly, however overall we are continuing to monitor to ensure overspend is limited where possible.

EXTERNAL PROVIDER COSTS

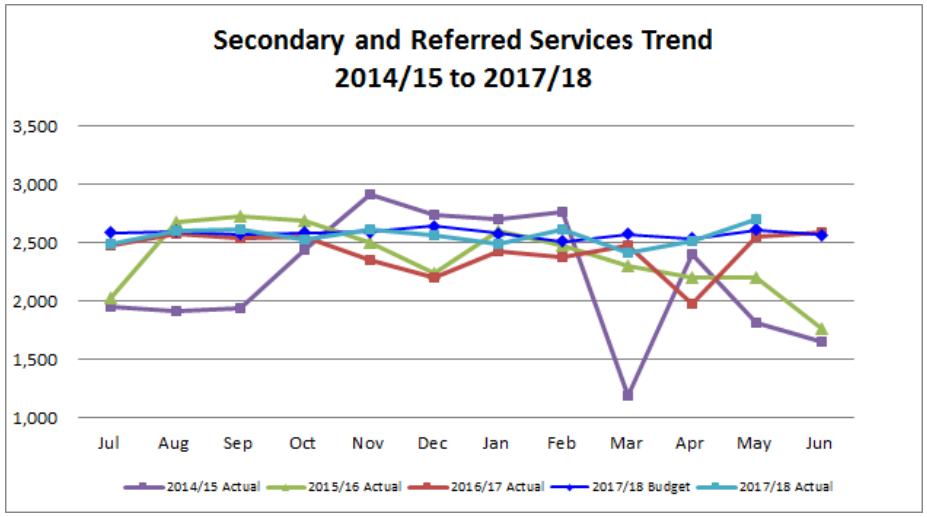


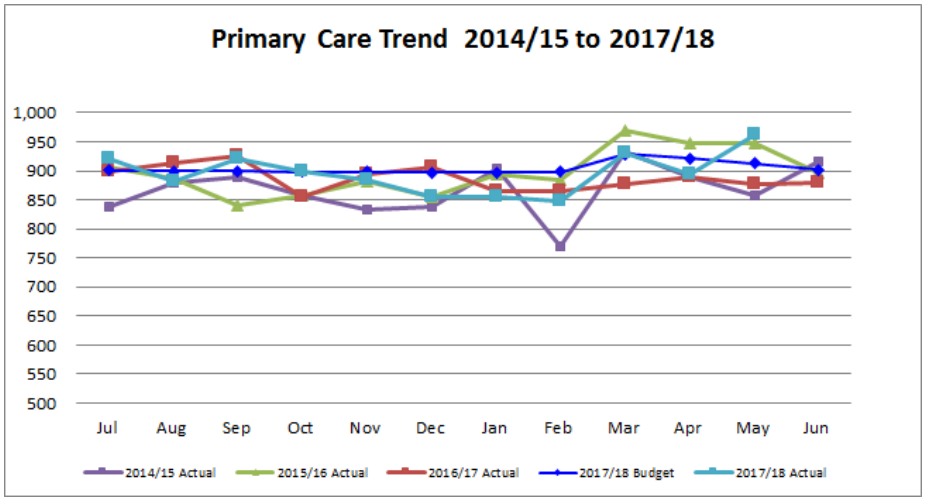
KEY RISKS AND ISSUES: Capacity constraints within the system require continued monitoring of trends and demand for services.

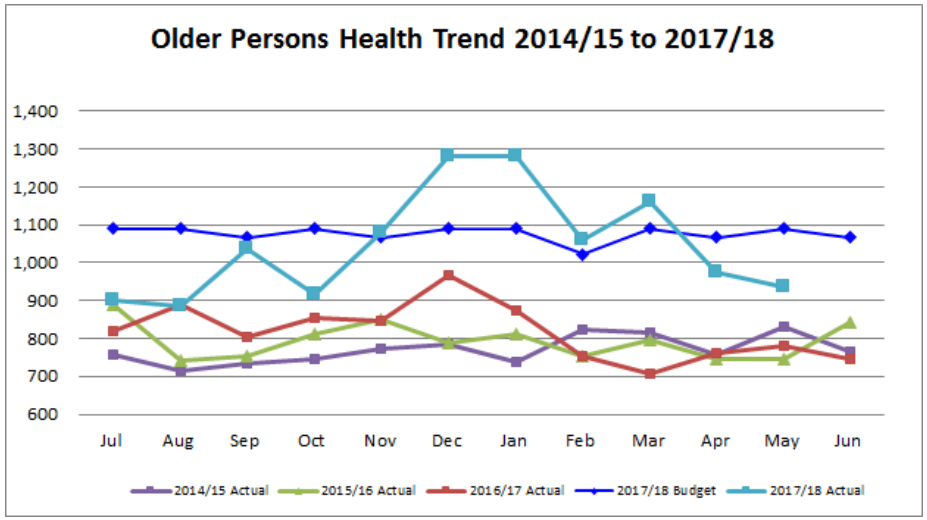
PLANNING AND FUNDING DIVISION
Month Ended May 2018

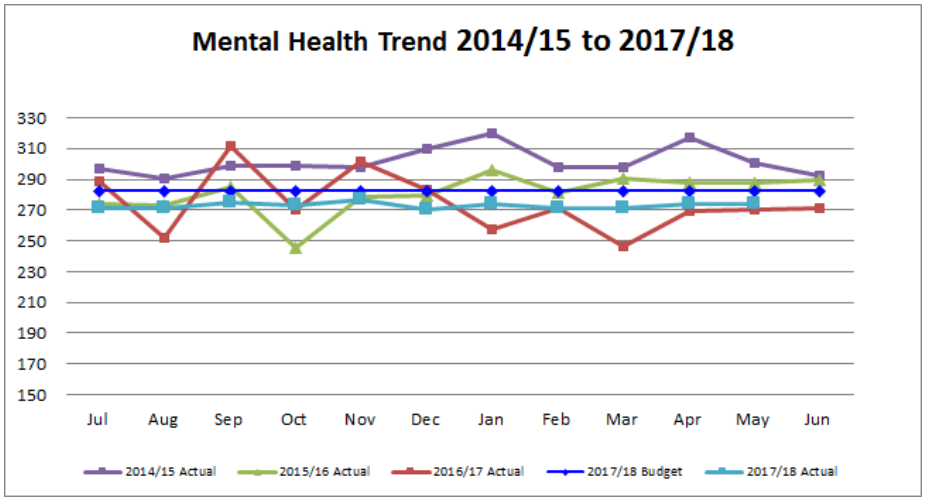
Current Month Actual $000	Budget $000	Variance $000	%		SERVICES	Year to Date Actual $000	Budget $000	Variance $000	%		2017/18 Budget $000
					Primary Care						
37	29	-8	-29%	✗	Dental-school and adolescent	274	315	41	13%	✓	344
21	22	1	4%	✓	Maternity	230	237	7	3%	✓	259
1	1	0	21%	✓	Pregnancy & Parent	15	14	-1	-5%	✗	15
0	0	0		✓	Sexual Health	0	0	0		✓	0
2	5	2	47%	✓	General Medical Subsidy	33	50	17	33%	✓	55
513	526	13	3%	✓	Primary Practice Capitation	5,805	5,788	-17	0%	✗	6,314
98	98	0	0%	✓	Primary Health Care Strategy	1,078	1,079	1	0%	✓	1,177
87	88	1	1%	✓	Rural Bonus	962	970	8	1%	✓	1,059
4	4	0	-3%	✗	Child and Youth	54	46	-8	-16%	✗	50
11	19	8	40%	✓	Immunisation	121	118	-3	-3%	✗	126
5	5	0	2%	✓	Maori Service Development	52	53	1	2%	✓	57
52	52	0	1%	✓	Whanau Ora Services	573	577	3	1%	✓	629
11	14	3	24%	✓	Palliative Care	50	153	103	67%	✓	167
9	8	-1	-9%	✗	Community Based Allied Health	100	93	-8	-9%	✗	101
80	14	-65	-461%	✗	Chronic Disease	189	156	-33	-21%	✗	170
31	28	-4	-14%	✗	Minor Expenses	317	303	-14	-5%	✗	330
962	**913**	**-49**	**-5%**	✗		**9,853**	**9,951**	**98**	**1%**	✓	**10,853**
					Referred Services						
27	28	1	4%	✓	Laboratory	280	310	30	10%	✓	338
707	650	-57	-9%	✗	Pharmaceuticals	6,661	6,835	175	3%	✓	7,446
734	**678**	**-56**	**-8%**	✗		**6,941**	**7,145**	**204**	**3%**	✓	**7,784**
					Secondary Care						
176	174	-2	-1%	✗	Inpatients	1,936	1,914	-22	-1%	✗	2,088
158	155	-3	-2%	✗	Radiolgy services	1,602	1,700	97	6%	✓	1,854
113	105	-7	-7%	✗	Travel & Accommodation	1,170	1,159	-11	-1%	✗	1,265
1,528	1,499	-30	-2%	✗	IDF Payments Personal Health	16,521	16,485	-36	0%	✗	17,984
1,975	**1,933**	**-42**	**-2%**	✗		**21,229**	**21,258**	**29**	**0%**	✓	**23,191**
3,671	**3,523**	**-148**	**-4%**	✗	**Primary & Secondary Care Total**	**38,023**	**38,354**	**331**	**1%**	✓	**41,828**
					Public Health						
19	13	-6	-48%	✗	Nutrition & Physical Activity	219	142	-78	-55%	✗	155
11	11	0	1%	✓	Tobacco control	122	123	1	1%	✓	135
30	**24**	**-6**	**-25%**	✗	**Public Health Total**	**342**	**265**	**-77**	**-29%**	✗	**289**
					Mental Health						
7	7	0	1%	✓	Dual Diagnosis A&D	78	79	1	1%	✓	86
0	0	0		✓	Inpatients	0	0	0		✓	0
20	20	0	1%	✓	Child & Youth Mental Health Services	220	222	2	1%	✓	242
5	8	3	34%	✓	Mental Health Work force	72	83	11	13%	✓	91
37	61	24	39%	✓	Day Activity & Rehab	411	675	264	39%	✓	736
11	11	0	-2%	✗	Advocacy Consumer	120	119	-1	-1%	✗	129
103	82	-21	-26%	✗	Other Home Based Residential Support	1,132	899	-233	-26%	✗	981
11	11	0	1%	✓	Advocacy Family	121	122	1	1%	✓	133
13	16	3	18%	✓	Community Residential Beds	117	176	59	33%	✓	192
67	67	0	0%	✓	IDF Payments Mental Health	732	732	0	0%	✓	798
274	**282**	**9**	**3%**	✓		**3,003**	**3,107**	**104**	**3%**	✓	**3,389**
					Older Persons Health						
0	0	0			Needs Assessment	0	0	0			0
180	151	-29	-19%	✗	Home Based Support	1802	1657	-145	-9%	✗	1,807
7	6	-1	-11%	✗	Caregiver Support	50	65	14	22%	✓	71
242	273	32	12%	✓	Residential Care-Rest Homes	2,385	3,004	619	21%	✓	3,277
14	8	-6	-72%	✗	Residential Care-Community	156	89	-68	-76%	✗	97
350	482	132	27%	✓	Residential Care-Hospital	5,383	5,304	-79	-1%	✗	5,786
9	10	1	6%	✓	Day programmes	108	112	4	3%	✓	122
7	12	6	47%	✓	Respite Care	161	135	-26	-19%	✗	148
7	1	-5	-407%	✗	Community Health	70	14	-56	-392%	✗	15
0	1	1	100%	✓	Minor Disability Support Expenditure	45	14	-31	-222%	✗	15
123	131	8	6%	✓	IDF Payments-DSS	1,353	1,444	92	6%	✓	1,576
937	**1,076**	**137**	**13%**	✓		**11,513**	**11,837**	**324**	**3%**	✓	**12,913**
1,211	**1,359**	**146**	**11%**	✓	**Mental Health & OPH Total**	**14,516**	**14,944**	**428**	**3%**	✓	**16,302**
4,912	**4,906**	**-6**	**0%**	✗	**TOTAL EXPENDITURE**	**52,881**	**53,563**	**683**	**1%**	✓	**58,419**

EXTERNAL PROVIDER COSTS









FINANCIAL POSITION

	Month Actual $'000	Month Budget $'000	Month Variance $'000			Annual Budget $'000
Equity	22,368	24,865	(2,498)	-10%	✗	104,272
Cash	11,540	10,804	736	7%	✓	12,687

KEY RISKS AND ISSUES: The equity and cash position compared to budget reflect the delay in commencing the Grey Base rebuild.

APPENDIX 2: WEST COAST DHB STATEMENT OF COMPREHENSIVE REVENUE & EXPENSE

For period ending 31 May 2018

in thousands of New Zealand dollars

	Monthly Reporting				Year to Date				Full Year 17/18	Prior Year
	Actual	Budget	Variance	%Variance	Actual	Budget	Variance	%Variance	Budget	Actual
Operating Revenue										
Crown and Government sourced	11,624	11,554	70	0.6%	127,167	127,149	18	0.0%	138,695	137,591
Inter DHB Revenue	0	0	0	0.0%	13	0	13	0.0%	1	2
Inter District Flows Revenue	143	142	1	0.7%	1,567	1,562	5	0.3%	1,706	1,661
Patient Related Revenue	554	576	(22)	(3.8%)	6,633	6,460	173	2.7%	7,017	2,666
Other Revenue	139	69	70	100.9%	1,249	764	484	63.4%	834	851
Total Operating Revenue	12,460	12,341	119	1.0%	136,629	135,935	694	0.5%	148,252	142,771
Operating Expenditure										
Personnel costs	5,990	5,629	(361)	(6.4%)	63,258	61,250	(2,008)	(3.3%)	67,073	65,887
Outsourced Services	0	0	(0)	0.0%	3	0	(3)	0.0%	0	(9)
Treatment Related Costs	774	698	(76)	(10.9%)	8,320	7,638	(682)	(8.9%)	8,288	8,402
External Providers	3,317	3,231	(86)	(2.7%)	35,571	35,003	(568)	(1.6%)	38,162	35,843
Inter District Flows Expense	1,591	1,685	94	5.6%	17,316	18,567	1,251	6.7%	20,258	17,317
Outsourced Services - non clinical	19	18	(1)	(5.9%)	223	195	(28)	(14.4%)	214	229
Infrastructure and Non treatment related costs	1,011	970	(40)	(4.2%)	10,709	10,476	(233)	(2.2%)	11,412	11,446
Total Operating Expenditure	12,702	12,231	(471)	(3.9%)	135,401	133,130	(2,271)	(1.7%)	145,406	139,116
Result before Interest, Depn & Cap Charge	(242)	110	(352)	(319.4%)	1,228	2,805	1,577	56.2%	2,846	3,655
Interest, Depreciation & Capital Charge										
Interest Expense	0	0	0	0.0%	0	0	0	0.0%	0	343
Depreciation	241	283	42	14.9%	2,693	3,116	423	13.6%	3,400	3,373
Capital Charge Expenditure	117	124	7	5.6%	1,272	1,364	92	6.7%	1,488	739
Total Interest, Depreciation & Capital Charge	358	407	49	12.1%	3,965	4,480	515	11.5%	4,888	4,455
Net Surplus/(deficit)	(600)	(297)	(303)	(102.0%)	(2,737)	(1,675)	(1,062)	(63.4%)	(2,041)	(800)
Other comprehensive income										
Gain/(losses) on revaluation of property										
Total comprehensive income	(600)	(297)	(303)	(102.0%)	(2,737)	(1,675)	(1,062)	(63.4%)	(2,041)	(800)

APPENDIX 3: WEST COAST DHB STATEMENT OF FINANCIAL POSITION

As at 31 May 2018

in thousands of New Zealand dollars

	Actual	Budget	Variance	%Variance	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	21,853	22,780	(927)	(4.1%)	23,623
Intangible assets	404	334	70	21.1%	636
Work in Progress	4,723	3,194	1,529	47.9%	3,194
Other investments	567	567	0	0.0%	0
Total non-current assets	27,547	26,874	673	2.5%	27,453
Current assets					
Cash and cash equivalents	11,540	10,804	736	6.8%	10,811
Patient and restricted funds	57	74	(17)	(23.4%)	72
Inventories	1,094	1,007	87	8.7%	1,060
Debtors and other receivables	3,913	5,123	(1,210)	(23.6%)	4,992
Assets classified as held for sale	0	0	0	0.0%	0
Total current assets	16,604	17,008	(404)	(2.4%)	16,935
Total assets	44,151	43,882	269	0.6%	44,387
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Employee entitlements and benefits	2,960	2,703	(257)	(9.5%)	2,779
Other	71	70	(1)	(1.3%)	70
Total non-current liabilities	3,031	2,773	(258)	(9.3%)	2,848
Current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Creditors and other payables	8,478	6,679	(1,798)	(26.9%)	6,875
Employee entitlements and benefits	10,274	9,564	(710)	(7.4%)	9,557
Total current liabilities	18,752	16,244	(2,509)	(15.4%)	16,431
Total liabilities	21,783	19,017	(2,767)	(14.5%)	19,280
Equity					
Crown equity	86,062	87,494	1,432	1.6%	86,062
Other reserves	22,082	22,082	0	0.0%	22,082
Retained earnings/(losses)	(85,776)	(84,710)	1,066	1.3%	(83,036)
Trust funds	0	0	0	0.0%	0
Total equity	22,368	24,865	2,498	10.0%	25,108
Total equity and liabilities	44,151	43,882	269	0.6%	44,387

APPENDIX 4: WEST COAST DHB STATEMENT OF CASHFLOW

Statement of cash flows

For period ending 31 May 2018

in thousands of New Zealand dollars

	Monthly Reporting					Year to Date			
	Actual	Budget	Variance	%Variance	Prior Year	Actual	Budget	Variance	%Variance
Cash flows from operating activities									
Cash receipts from Ministry of Health, patients and other revenue	12,306	12,320	(14)	(0.1%)	11,356	136,954	135,515	1,439	1.1%
Cash paid to employees	(5,775)	(5,499)	(276)	(5.0%)	(5,777)	(62,419)	(62,215)	(204)	(0.3%)
Cash paid to suppliers	(1,869)	(1,552)	(316)	(20.4%)	(938)	(19,207)	(17,920)	(1,287)	(7.2%)
Cash paid to external providers	(2,662)	(3,180)	518	16.3%	(2,679)	(32,296)	(34,981)	2,685	7.7%
Cash paid to other District Health Boards	(2,245)	(1,688)	(557)	(33.0%)	(1,388)	(19,451)	(18,569)	(882)	(4.7%)
Cash generated from operations	(245)	400	(645)	(161.3%)	574	3,581	1,829	1,751	95.7%
Interest paid	0	0	0	0.0%	(57)	0	0	0	0.0%
Capital charge paid	0	(124)	124	100.0%	(68)	(687)	(1,364)	677	49.6%
Net cash flows from operating activities	(245)	276	(521)	(188.8%)	449	2,894	465	2,428	521.7%
Cash flows from investing activities									
Interest received	31	35	(4)	(12.8%)	41	389	385	4	1.0%
(Increase) / Decrease in investments	0	0	0	0.0%	0	0	0	0	0.0%
Acquisition of property, plant and equipment	(350)	(208)	(142)	(68.4%)	(29)	(2,555)	(2,288)	(267)	11.7%
Acquisition of intangible assets		0	0		0		0	0	
Net cash flows from investing activities	(320)	(173)	(147)	84.9%	12	(2,166)	(1,903)	(263)	(13.8%)
Cash flows from financing activities									
Proceeds from equity injections	0	0	0	0.0%	0	0	1,432	(1,432)	100.0%
Repayment of equity	0	0	0	0.0%	0	0	0	0	0.0%
Cash generated from equity transactions	0	0	0	0.0%	0	0	1,432	(1,432)	100.0%
Borrowings raised					0				
Repayment of borrowings	0	0	0	0.0%	0	0	0	0	0.0%
Payment of finance lease liabilities	0	0	0	0.0%		0	0	0	0.0%
Net cash flows from financing activities	0	0	0	0.0%	0	0	0	0	0.0%
Net increase in cash and cash equivalents	(565)	103	(668)	(649.0%)	461	728	(8)	736	(9751.3%)
Cash and cash equivalents at beginning of period	12,104	10,701	1,403	13.1%	8,733	10,811	10,811	(0)	(0.0%)
Cash and cash equivalents at end of year	11,539	10,804	736	6.8%	9,194	11,539	10,804	736	6.8%

RESOLUTION TO EXCLUDE THE PUBLIC

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

SOURCE: **Board Secretary**

DATE: **29 June 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the Public Excluded meeting of 11 May 2018	For the reasons set out in the previous Board agenda.	
2.	Accountability Documents	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)
3.	Emerging Issues Verbal Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	9(2)(j) S9(2)(a)
4.	Clinical Leaders 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)
5.	People Strategy Presentation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons.	S9(2)(j) S9(2)(a)
6.	Insurance Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(j)

7.	Report from Committee Meeting – QFARC	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Protect the privacy of natural persons	S9(2)(j) S9(2)(a)

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

3. SUMMARY

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

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

Report Prepared by: Board Secretary

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

West Coast Mental Health Future Services Project: Locality and Community Based services

Prepared by Cameron Lacey

Date: 1 June 2018

E hara taku toa
i te toa takitahi,
he toa takitini.

My strength is not
as an individual,
but as a collective.

Kia ora koutou

Thank you to everyone who has taken time to participate in this process to help us improve our Mental Health and Addiction services. Our services will become stronger and more responsive thanks to your input and ideas.

This document provides **a snapshot of the feedback** from various sources including tāngata whaiora [people seeking wellness] and consumers with a lived experience of mental illness, staff workshops along with summaries of focus group discussions, wider community input and written feedback.

This report also **sets out the changes we are proposing**.

We want to ensure that wherever you are on the Coast and however you enter our services, you receive timely, consistent quality care and support.

We are looking to change the way we work to ensure we're always focused on the needs of the person we're supporting. We will build strong teams based in your local community at our Integrated Family Health Centres in Buller, Greymouth, Hokitika and Reefton. Easy access to primary and community mental health care closer to home will help free up specialist support for those who need it, whenever they need it.

For those working in mental health and addiction there are exciting opportunities to increase your skills, and provide care and support to people throughout their lives – from children to older people. We will develop and invest in training to ensure a well-equipped workforce that is sustainable. You will work as part of a local team of rural generalists with easy access to specialist support for clinical advice, and streamlined systems for referring people in crisis and those with more complex needs who need additional care and support.

Once again thank you for your time and for sharing your thoughts and experience – we value your involvement.

Haere ora, Haere pai
Go with wellness, go with care

Dr Cameron Lacey
Project Lead

1. Background

The Mental Health Future Services Project commenced in March 2017 in response to the 2014 Mental Health and Addiction Services Review[1]. To date two phases of the project have been completed: Development of a Mental Health & Addictions Model of Care and the Crisis Response Progress Report, including recommendations, generated out of the Crisis Response workshops. The third phase, commenced in late 2017, has focussed on the delivery of Mental Health services from a locality and community based perspective.

This second progress report presents an overview of the work undertaken as part of the locality and community based services project phase, outlining the outputs from the five workshops held, the views articulated by participants, emerging themes from the discussions, and recommendations for future service response.

The report also presents a consolidated view of the work undertaken to date, blending the model of care with the crisis response recommendations and those from the most recent work, to build a picture of what the future services for Mental Health and Addictions may look like.

The 2014 Mental Health Services Review, made the following recommendations regarding locality and community based services:

- Most services should be locality based; i.e. co-located with or working into the six general practice and health centres on the West Coast, integrated into family health centres as they become established in Westport and Greymouth and/or into community mental health providers.
- Develop the stepped continuum of care with clear and visible expectations and observable changes around new ways of working and culture.
- Clarify locality team structures and their fit with IFHC planning and structures.
- Reconfigure the existing resources to provide locally based planned and acute respite services and alternatives to admission, in and after hours crisis resolution and reduction in the level of acute inpatient beds while still retaining a critical mass of inpatient resource.

In addition to these, the review also identified key recommendations relating to child and youth services, and alcohol and other drug services as follows:

Alcohol & Other Drug (AOD) services:

- Increase the level of integration between specialist Alcohol and Drug [AOD] service and the primary teams.
- Investigate the possibility of providing detoxification in the community. Increase the range of services [e.g. detoxification] available to local communities through workforce development.

Child & Adolescent Mental Health (CAMHS) services:

- It is important to undertake a process to identify the optimal CAMHS focus as a specialist service, balancing maintaining CAMHS specialty expertise and support with more efficient and locally-integrated and responsive service delivery.
- Identify the optimal CAMHS focus as a specialist service balancing maintaining a critical mass of CAMHS specialty expertise and support with more efficient locally integrated and responsive service delivery. CAMHS has its primary interface with integrated locality based service delivery.

The anticipated outcomes of a review of locality and community based service responses are:

- Improved staff wellbeing and satisfaction and sustainability
- Improved equity of crisis response services

[1] WCDHB, (2014). *Mental Health and Addictions Service Review*, WCDHB, Greymouth

- Personnel matched to the service demand
- Safe and sustainable staffing levels
- Enable 24 hour coverage, 7 days a week
- Improve the interface with key departments
- Improve the interface with primary and community care and grow their capability and capacity for management of MH&A issues
- Reduced fragmentation and duplication of service delivery
- Support district-wide focus of service delivery
- Strengthen responses to local need
- Provide increased clarity of functions
- Continuity of care
- Greater alignment with national and regional directions
- Increased ability to provide cross cover
- Reduced travel time for clients in need of specialist services
- Reduction in waiting times for a response to a referral

2. Work completed to date

2.1 Project plan

The Mental Health Future Services Project began in March 2017 and follows previous activity in the Mental Health Workstream and subsequent project support. The first phase of activity was to propose a model of care which:

- outlines the direction of the previous MH review
- summarises subsequent activity
- describes the current context for health services on the West Coast, including the primary and community project work
- demonstrates alignment with the above

The second phase focused on exploring the needs of crisis response. Crisis response services had been identified as a priority area for the Mental Health Future Services Project, arising out of specific recommendations in the 2014 review and the adverse event investigation recommendations.

The third and current phase is exploring locality and community based services, what service response this might include and how they will work together as part of an integrated family health service response. Three key questions being asked as part of this work are:

- IFHS: How this could work for mental health services?
- What do we mean by "single team"?
- What are the implications for the IFHS if crisis response is delivered locally?

2.2 Mental Health & Addiction Model of Care[2]

The principles underpinning the Mental Health Services model of care are:

- It must be person-centred
- There is a clearly articulated destination with clear goals and pathways to achieve it
- It is integrated, enabling connectedness through a culture of collaboration
- It is adequately resourced through the use of innovative and skilled resources
- It can be evaluated through key measures to ensure the right destination is reached
- There is transparent, fair and distributed leadership
- It respects and values the contributions of staff

In addition to the principles above, integrated, mental health care delivery across the West Coast should:

- Utilise mental health staff with specialised skills to enhance patient care across spectrum of severity and illness course
- Develop mental health skills across the health sector
- Adopt a recovery approach which recognises the need to attend to development of hope, secure sense of self, supportive relationships, empowerment, social inclusion, coping skills and meaning in addition to treating acute symptoms

[2] WCDHB, (2017). *Mental Health and Addiction Services on the West Coast Model of Care*, WCDHB, Greymouth

The ultimate aim of the model of care is to support people to participate in their lives as optimally as they can within the constants of their health and disability challenges. For most people staying well is straightforward, while for others it is a far greater challenge, needing significant intervention and support from a range of health professionals and services. While these people may require a varying range of inputs to respond to their needs when unwell, their aim remains the same as everyone else; to stay well and maintain the best possible level of wellness they can.

A stepped care model is proposed that involves the WCDHB service working in partnership with primary and community/NGO organisations to deliver most services in the community, close to where people live. The WCDHB mental health and addictions workforce is envisaged as working at the top of its scope to provide responsive care to people with acute needs, and ongoing support to primary and community services so crises are avoided and the system becomes proactive rather than reactive. Greater use of technology, including phone and internet based services will support early intervention and self-managed care with access to support networks across the community.

The model of care includes two main elements – planned integrated mental health care and specialist mental health services. It is on this basis that work commenced in phase 2, considering crisis response for the West Coast.

2.3 Crisis Response

The model of care development was followed by the crisis response stream of work. This second phase of work established the following themes:

Clarity for community:

There is a need for all of our community and not just health services to be part of any mental health response including mental health crisis. There are opportunities to improve connection and visibility between mental health promotion work that is occurring in our communities and mental health services. This work needs to acknowledge and address barriers to mental health care particularly stigma. Empowering individuals and communities to initiate a response to mental health crises requires aligned messaging, provision of community resources and information regarding supports available across the spectrum of health and health promotion services.

Streamlined process:

The majority of participants identified the need for a single contact point to begin accessing crisis services. It was recognized that whilst there may be a range of current services that could be appropriate to respond to the presentation dependent on the urgency and acuity, it was desirable to have a single point of contact who would need to ensure the contacting person received a seamless service that was connected to and consistent with any previous mental health treatment plan.

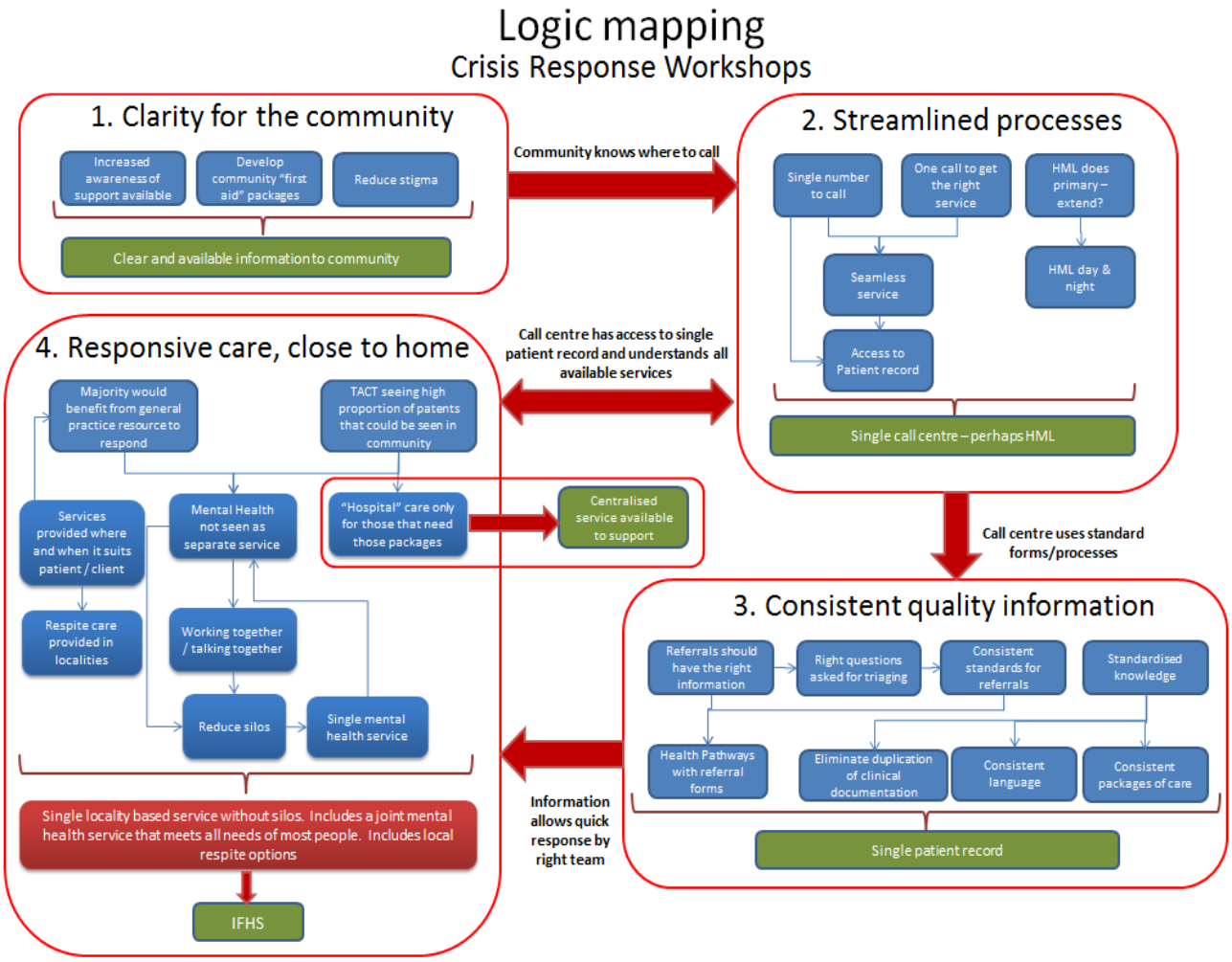
Consistent quality information:

Identifying the urgency and type of response required was acknowledged as a critically important skill to ensure a safe clinically appropriate service response. There was recognition that there is significant difficulty matching people's differing needs and acuity in mental health crisis to the right service. While there is some messaging to the community that their primary care service should be the first point of contact for health matters, this was not consistent with community expectations for mental health who frequently contacted the current TACT service although up to 60% of contacts could have received an appropriate response by other health services. If a single point of contact for all crisis response was established it was highlighted that this service would need to have detailed, accurate and up-to-date knowledge of local mental health service providers and be efficient at assisting the community to navigate to the appropriate service.

Responsive care, close to home:

There was consistent support to move towards delivering more crisis response close to people's homes and connected to their usual health care home. In some regions, this already occurs for people not currently receiving care from community mental health teams, despite current service design indicating the majority of crisis response should occur from a centralised DHB service. Crisis response already occurs in local communities for people who are receiving mental health services (either DHB or NGO) who then receive support from the TACT team if there is urgency and high risk acuity. There are opportunities to enhance collaborations across service providers to broaden the range of crisis response options available in local communities including peer support, NGO involvement and respite care.

These four themes were reflected in the logic map below:



From this work four recommendations were agreed:

1. Provision of single call centre for triaging of crisis referrals.
2. Crisis response services delivered in locality based services
3. Broadening the range of access to crisis response services in communities (including respite)
4. Further consideration of the 'single mental health service concept'.

This information is outlined in detail as part of the first Progress Report (2017)[3], and lays the foundation stones on which the third phase of work, looking at locality and community based services, was built.

[3] WCDHB, (2017). *West Coast Mental Health Future Services Project: Crisis Response Progress Report*, WCDHB, Greymouth

2.4 Summary of steps in Locality & Community Based Services stream

The locality and community based services stream began in November 2017. The table below provides an overview of the activity undertaken to date and what can be expected from this point forward.

Locality & Community Based services project stream
Workshops with key community based providers and stakeholders
Workshops with AOD and CAMHS providers and stakeholders
Feedback to workshop groups to check minutes and emerging themes
Write up progress report
Distribution of progress report to stakeholders and consumer forums for feedback
Collation of all feedback
Preparation of agreed outcomes into detailed operational guideline document

2.4.1 Workshops with staff

Three workshops were held across the West Coast in November 2017. Invitations were sent to a range of health sector clinicians aiming for representation from primary care, NGOs, PHO mental health services, and community mental health staff at each of the workshops. See appendix 1 for details of workshop date and location.

This initial round of workshops focused on three main areas:

- IFHS: How this could work for mental health services?
- What do we mean by “single team”?
- What are the implications for the IFHS if crisis response is delivered locally?

Following these workshops it was felt that there was a need to take a closer, more focused look at both AOD and CAMHS services. As a result two additional workshops were scheduled for February 2018: one focused on AOD and one on CAMHS. See appendix 1 for details of workshop dates and locations.

These two workshops had a set of questions to consider, specific to their areas of practice and drawing from the discussions generated from the earlier three workshops. Representation continued to draw from a broad range of providers and stakeholders, including NGOs, the PHO, AOD and CAMHS staff, and Māori Mental Health representatives.

The AOD workshop focused on the following questions:

- What are the components and functions of AOD services needed for the WC community?
- What is the skill mix needed for each of these functions?
- What options are there for providing these functions?
- The age range: Where should youth sit?
- What are the options for retaining specialist skills and knowledge?

The CAMHS workshops focused on the following questions:

- What are the components and functions of a child and adolescent mental health system needed for the WC community?
- What is the skill mix needed for each of these functions?
- What options are there for providing these functions?
- The age range – what is best?
- What are the options for retaining specialist skills and knowledge?

Minutes from the five workshops can be viewed in appendix 1.

3. Workshop Questions Overview

3.1 Locality and Community Based Services Workshops

3.1.1 Question one: How would community/localised mental health services work?

At all three workshops similar areas were identified as being of importance as mental health services transitioned to a community/locality based model. These were:

- Ensuring that the full health and social needs of clients are met when they first enter the service, not just their mental health. This includes, but is not limited to; employment, housing, family issues, custody, courts, dental, general health etc. It was suggested that this would need not just an operational change but also a cultural change from within the service itself so that taking into account all facets of a client's life, not just their mental health, became business as usual. Further suggestions included utilising community and NGO support workers earlier on in the clients journey, including them in the clients integrated care plan, and allowing the client to have input into who is their clinician, similar to the way a woman is allowed to choose their own midwife.
- Collaborative, seamless working relationships between all providers and stakeholders. This included, but again was not limited to; Police, Oranga Tamariki, community pharmacy, NGOs, WINZ, Housing NZ, ACC etc. It was believed better relationships would help ensure clients full needs were met, leading to better client outcomes. It was further suggested that providers and stakeholders having direct access to each other was important to ensure collaboration and good working relationships. This referred to business as usual becoming phone calls and one on one interaction, rather then just sending papers via mail/email. It was further suggested that closer working relationships between ED, police and CCU in-patients would be required, especially overnight, with ED staff receiving more mental health training a result.
- Making the care team collectively responsible for the client journey was required. This included pooling resources and skills from across the mental health spectrum including incorporating NGO mental health and addiction services from the patient's initial entry into the system. There would need to be a streamlining of NGO services as in some areas the same services were being offered by different NGOs which was leading to confusion.
- Consent processes and privacy agreements for all providers become streamlined. It was believed this would help the client flow through the system and access resources from differing providers easier.

Recommendations did differ about what services should be fully integrated and what services should be peripheral, with the majority of contentious services being non-health or support related e.g. WINZ, police, community support, advocacy/citizens advice, respite. The level of stakeholder/service integration would need to be further investigated and discussed with individual providers.

There was significant uncertainty about how to resolve concerns about clinical responsibility arising from a move to integrated service delivery.

3.1.2 Question two: What are the implications for Community Mental Health teams if crisis response is provided locally?

Definitions of data discussed at the workshop:

The triage figures include all referrals which have not met criteria and have subsequently been closed (Triage only service complete). The times are recorded at the time the referral was initiated, to provide an indication of the number of callouts across 24 hours in each region.

The MH Crisis Call outs are mental health crisis which occur within hours 8am-5pm and count clients known to the service (open referral). The MH Tact Crisis Call Outs are presentations directly to TACT.

Full data tables are attached in appendix 2.

Buller District

The total number of triage calls in the Buller region was 235 for the 2016-17 year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs Monday-Friday 8am – 5pm was 129 for the year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs Monday-Friday 5pm-9m was 46 per year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs between 9pm and 8am was 17 per year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs between 8am and 9pm on Weekends was 70 per year.

Grey District

The total number of triage calls in the Grey region was 470 for the 2016-17 year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs Monday-Friday 8am – 5pm was 524 for the year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs Monday-Friday 5pm-9m was 134 per year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs between 9pm and 8am was 61 per year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs between 8am and 9pm on Weekends was 196 per year.

Westland District

The total number of triage calls in the Westland region was 128 for the 2016-17 year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs Monday-Friday 8am – 5pm was 62 for the year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs Monday-Friday 5pm-9m was 22 per year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs between 9pm and 8am was 8 per year. The number of MH Crisis Call outs and MH Tact Crisis Call Outs between 8am and 9pm on Weekends was 25 per year.

For a full break down of the data please see appendix 2.

Daytime/weekdays

Westport and Hokitika workshops identified similar implications and concerns regarding weekday, daytime crisis response. They identified access and availability to senior medical officers/psychiatrists as being of particular concern with transport options/availability to Greymouth based psychiatrists being identified as an issue (who would do this? – Police? Specialised transport? Etc). More resources for local triage, particularly around staffing, training, and cultural support workers was further identified as issues of concern however it was suggested that the DHB and NGOs could work together collaboratively to tackle these issues. It was further suggested that a review of how we currently collaboratively operate could be carried out to discover how the DHB and NGOs could work together more effectively going forward.

The Greymouth workshop suggested that mental health nurses could work as extensions of general practise teams to support long term conditions, assess need for hospitalisation and create care plans. It was also suggested that mental health services become extensions of the new IFHC facility and harness the extended opening hours, as well as developments in digital medicine such as online counselling.

Evenings

Staffing was the number one area of concern in providing crisis response locally in all areas of the West Coast. The need to meet legislative requirements with duly authorised officers (DAO) to respond to call outs was noted. Adequate staffing was a common concern along with the need to resource them e.g. computers, vehicles, SMO/psychiatrist access. The Hokitika workshop identified distance to the crisis location as a huge issue for their area as it could sometimes be over 4.5 hours to the crisis location and police were often unable to assist or simply unavailable in certain areas. Westport identified police support as being important and suggested that

nurses and police should respond in pairs to a crisis call out rather then just two health professionals. Phone triaging was also suggested.

Overnight

Staffing was again the resounding issues identified across the West Coast. This extended to the training and availability of DAOs, access to psychiatrists/SMOs and respite care, the need for adequate staff to respond to call outs, and what would happen if there were two callouts at once when the on call staff were already responding to a crisis.

Saturday/Sunday

Staffing, transport, resourcing and police assistance were again bought up in regards to weekend implications of locality based crisis response across the whole region. Other concerns such as remote access to notes and the implications on-call could have of staff lives were also identified. It was suggested that a West Coast wide approach to triaging, with the inclusion of the PHO and NGOs be implemented.

3.1.3 Question three: What might a single mental health system look like?

The vision of what a single mental health system may look like was similar across the West Coast. All areas identified shared, centralised single patient records, standardised documentation/referral forms, increased information sharing, collaboration and resource sharing, and improved, streamlined triaging processes.

The main barriers identified related to funding, reporting, and recruiting/retention. Funding arrangements with NGOs were highlighted, as were worries about privately run, profit driven general practices, and fear of change from within the health system. In regards to the stigma associated with mental health, some felt a single system would reduce it while others felt it would increase or remain the same.

3.2 AOD Workshop

3.2.1 Question one: What are the components and functions of AOD services needed for the West Coast?

A range of different components and functions were identified in the AOD workshop with several that were identified by all involved as important for AOD services. These were:

- Cultural competency including considerate and robust provision of responsive, considerate, competent and inclusive cultural practices. This provision was extended to included whānau/family.
- Early intervention with the need for AOD and OST practitioners linked to this function. This led to the identification of relapse prevention, aftercare (group based therapies, rational recovery, AA/NA/AIATEFN/ALANON and/or other practices), and prevention practices (education, information and a psychosocial approach) being highlighted as of importance.
- Localised, small, multi-versal one-stop-shop residential care treatment, with ‘local’ i.e. West Coast based, with specialist residential care treatment continuing to be available regionally. Support by clinicians, the health system, and the wider West Coast community, for care in the community was identified by many as important for clients on the West Coast.
- Community based treatment services were identified by all as the most important component and function of AOD services. This included the provision of a skilled workforce, peer support, family inclusion, community support, a home detox option from a multi disciplinary team, day programme, access to inpatient care.
- Collaboration, communication, and coordination for easy client flow through the system, and increased, responsive relationships with other organisations (e.g. Police, CIFS, aged care, schools etc.) were further identified as important functions and components.

From the work done on this question seven main functions were identified for use in moving the conversation forward and using as the overriding functions for the AOD workshop discussion. These were:

1. Education
2. Comprehensive, brief screening
3. Appropriate risk assessment
4. Treatment
5. Relapse prevention
6. High and complex needs
7. Coexisting disorders

3.2.2 Question two: What is the skill mix needed for each of these functions?

This question explored the seven functions identified in the previous question. Many of the skills needed for each of the above seven functions overlapped and were listed under two or more functions. However, most functions had at least one skill that appeared more frequently. The main areas identified for each of the functions were as follows:

- Education: health promotion with links and coordination between health professionals, NGOs, community groups, schools and other West Coast organisations.
- Screening: a broad range of people/professions were listed as it was identified that screening can take place at many different stages. They ranged from neighbours and employers through to specialist clinical staff.
- Assessment: trained health professionals from across the spectrum.
- Treatment: this function had the most diverse, extensive skill mix list due to the broad nature of treatment. Listed skills included detox, OST, psychologists, holistic approaches and appropriate models of care (based on culture and age).
- Relapse prevention: group work, written plan of care and experienced, well trained workforce were all listed.
- High and Complex needs: this was the area were specialist services were listed.
- Coexisting disorders: holistic approach and competent specialists from across the skill and resource spectrum.

3.2.3 Question three: What options are there for providing these functions – where should each of these providers/functions sit?

Again, using the seven identified functions, participants were asked to list which organisation/service should offer each of the functions, considering organisations/services such as Community & Public Health (CPH), the PHO, the Integrated Family Health Centre (IFHC)/CMH, community NGOs, Specialist Services, regionally from Canterbury, or from another source. Many services were listed more than once under several of the functions.

The main providers listed for each function were:

Education	Only CPH was listed with one group explaining that they believed CPH was best due to their health promotion, big picture approach.
Screening	The PHO, IFHC, and NGOs were listed as possible providers with one group writing 'All'.
Assessment	Same response as 'Screening' but with specialist services listed also
Treatment	This was an extensive list as each different type of possible treatment option had different providers listed. The most listed provider however was CMH/AOD services.
Relapse prevention	NGOs and the PHO were the most listed providers with peer support also being put forward as an option.
High and complex needs	IFHC, NGOs, AOD services and CMH
Coexisting disorders	IFHC, CMH and the PHO

3.2.4 Question four: What should the age range be for AOD services?

It was unanimously decided that the full age spectrum should be included within AOD services, making no distinction in regards to a client's age at time of referral/out reach. However, it is important to note that the needs of children & youth with AOD are different to adults and caution must be taken to avoid adopting an Adult approach to AOD with youth.

3.3 CAMHS Workshop

3.3.1 Question one: What are the components and functions of a child and adolescent mental health system needed for the West Coast community? Do you think these components and functions are currently being delivered?

Many different components and functions were listed as being needed for the West Coast Community. Some were seen as already being delivered (e.g. counselling, psychologists, transalpine support), some where identified as sometimes being offered (e.g. family therapy, interagency collaboration), and others were identified as not being delivered (e.g. respite, forensic services, adequately sized and skilled workforce). Other functions were identified differently by the different groups. For example some stated that Whānau Ora and a culturally competent workforce were sometimes delivered while others stated it was not delivered. Please see appendix 1 for more detailed workshop notes.

3.3.2 Question two: What are the pros and cons of a generalist versus specialist workforce and what should the age range be?

A generalist workforce was seen as being able to provide flexible, fluid staff that could work across the age range. It would provide base training for all with the opportunity for staff to upskill on a wider scope leading to a stable, sustainable workforce. It was believed it would allow the workforce to be able to meet the needs of the client rather then the needs of the service.

In contrast, a generalist workforce was believed to be able to lead to the risk of loosing the voice of the child, as they could be seen as 'mini adults' and treated as such. It was worried that when a less common diagnosis was presented the workforce would not have the skills required to treat the client. Another important area that was stressed in regards to the negative impact a generalist workforce could have was the need for clinicians to understand that children at different stages of development and age needed different types of treatment and

different focus. It was important that child development stages were understood for proper care and identification of need.

In regards to what the age range for the West Coast CAMHS service should be there were several view points expressed. It was suggested that people should be placed in a service based on their developmental age, rather then their physical age. For example, a 25 year old with a younger developmental age should not be in adult mental health services, but rather in CAMHS. It was suggested by some that divisions should be by groups e.g. infant/toddler/ children etc. and by others that there should be cross over between specialists, adult mental health services and CAMHS, especially for the 16-25 year age group as this was an especially vulnerable group. It was noted that there is still ongoing confusion, especially around the late teen's age group, around where people should sit within West Coast mental health services.

3.3.3 Question three: What should be the role/function of non generalists, generalists, and NGOs?

With regards to what roles and functions should come under the NGO, generalist, or non-generalist banners, many of the same sprung up under all three headings. For example, crisis work, triage and assessment were listed under all three headings while clinicians with specific expertise, such as eating disorders or forensics were only listed under non-generalist.

The majority of roles and functions were listed under all three headings as it was widely recognised that different situations called for different expertise and interventions at different times. It spoke to the fluid nature required for client care.

4. Emerging themes

4.1 Workshop emerging themes

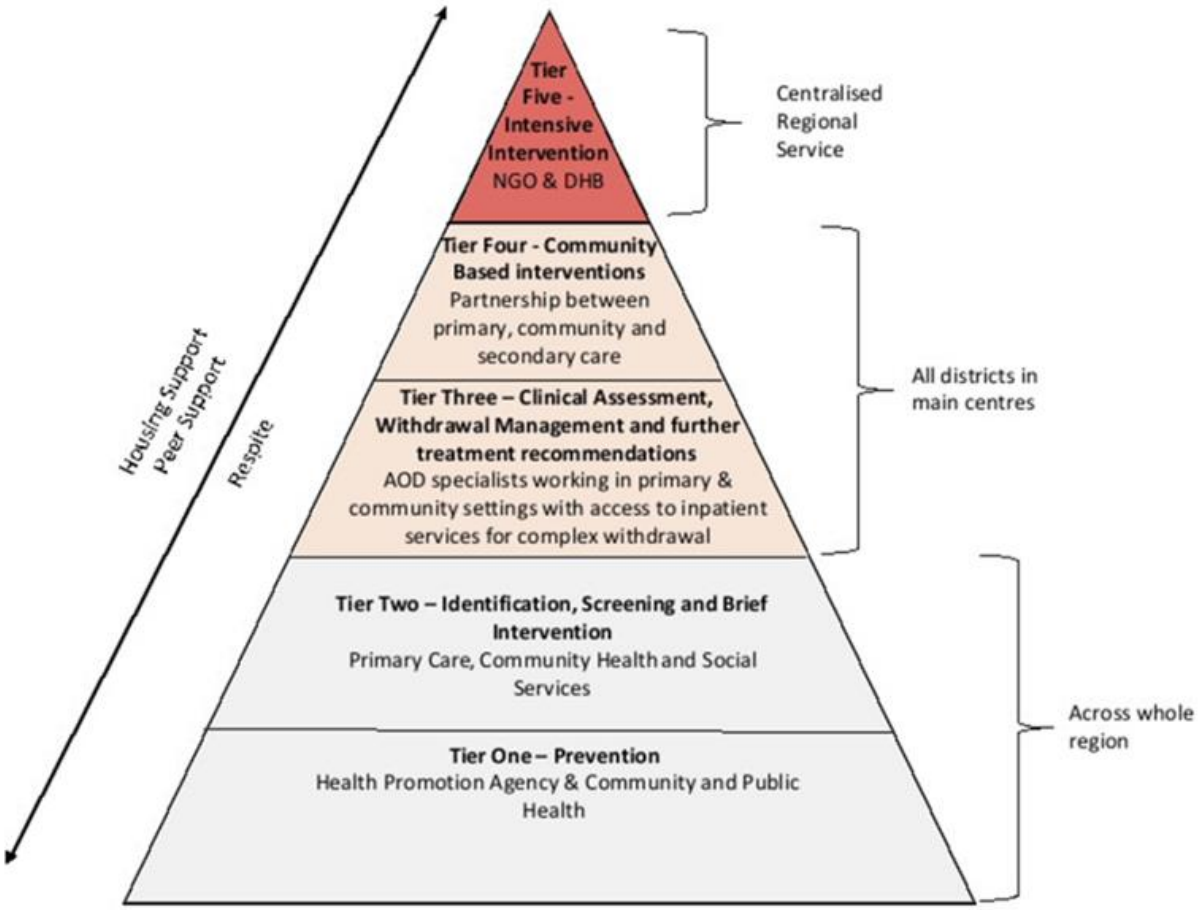
From the five workshops undertaken, including the AOD and CAMHS workshops, three main themes emerged for consideration:

1. ***Build capacity across primary and community to respond to most needs locally/Foster and Build Community Capacity***

Locality based services need to be based on a stepped care model. This includes supporting communities to identify mental health and addiction problems and having a range of options to meet those needs. Primary and community/NGO organisations have a central role in a stepped care model through services such as cultural and peer support, housing and recovery services, and respite care. Friends, family/whānau and the wider workforce such as Probation, WINZ, and Oranga Tamariki, can all play an important role in supporting people to get help early and remain well after an episode of care.

Ready access to specialist advice supports a stepped care model by giving confidence that the right approach is being taken and there is back up for people with issues that are beyond local capacity.

This stepped care approach is illustrated in the pyramid model of care diagram included below. Whilst it describes the range of AOD services, the tiers could apply across mental health and addiction services. The addition of cultural competence across the tiers is also required. It reflects a five tier model that strengthens community capacity and ensures care is delivered as close to the person's home as possible in order to best meet their needs.



2. Promote rural generalism across the age range

It is well established internationally and within New Zealand that rual communities suffer dispproportinately from a shortage of health professionals including mental health professionals. The WCDHB has experienced dificulties in recruiting and sustaining sub-specialist skilled mental health clinicians over a prolonged period of time – this was one of the critical factors leading to the 2014 Mental and Addictions review.

The promotion of rural generalism in medicine and allied health in Australasia is a growing initiative to respond to some of these workforce shortages. Across the WCDHB there has been a move towards rural generalist clinicians such as Rural Hospital Medicine doctors, rural nurse specialists, allied health professionals working across traditional specialities and other advanced nursing roles.

The current team strucuture, positions and skill mix of mental health continues to support a mental health subspeciality approach and one theme emerging across the workshops was for moving towards a generalist approach to mental health.

A major challenge driving need for change is the sustainability of current service design. Many of the mental health and addiction sector teams are comprised of teams of approximately four individuals. This creates enormous challenges for sustainability – for example when one person leaves, and another is on leave the workload doubles for those remaining. In order to be more sustainable we need to move to a service delivery design that is less reliant on individuals, with greater flexibility and ability to cover workloads during periods of reduced FTE (e.g. recruitment and leave).

3. Ensuring appropriate and timely access to specialist support when it is most needed

While the two previous emerging themes have described the need for greater capacity in the community to respond to the needs of most people with mental health needs, with a well supported workforce equipped to respond from a sound skills base, there will also be times when an intensive specialist response is necessary. Access to services and clinicians with specialist knowledge and skills must be timely and clearly defined through identified pathways.

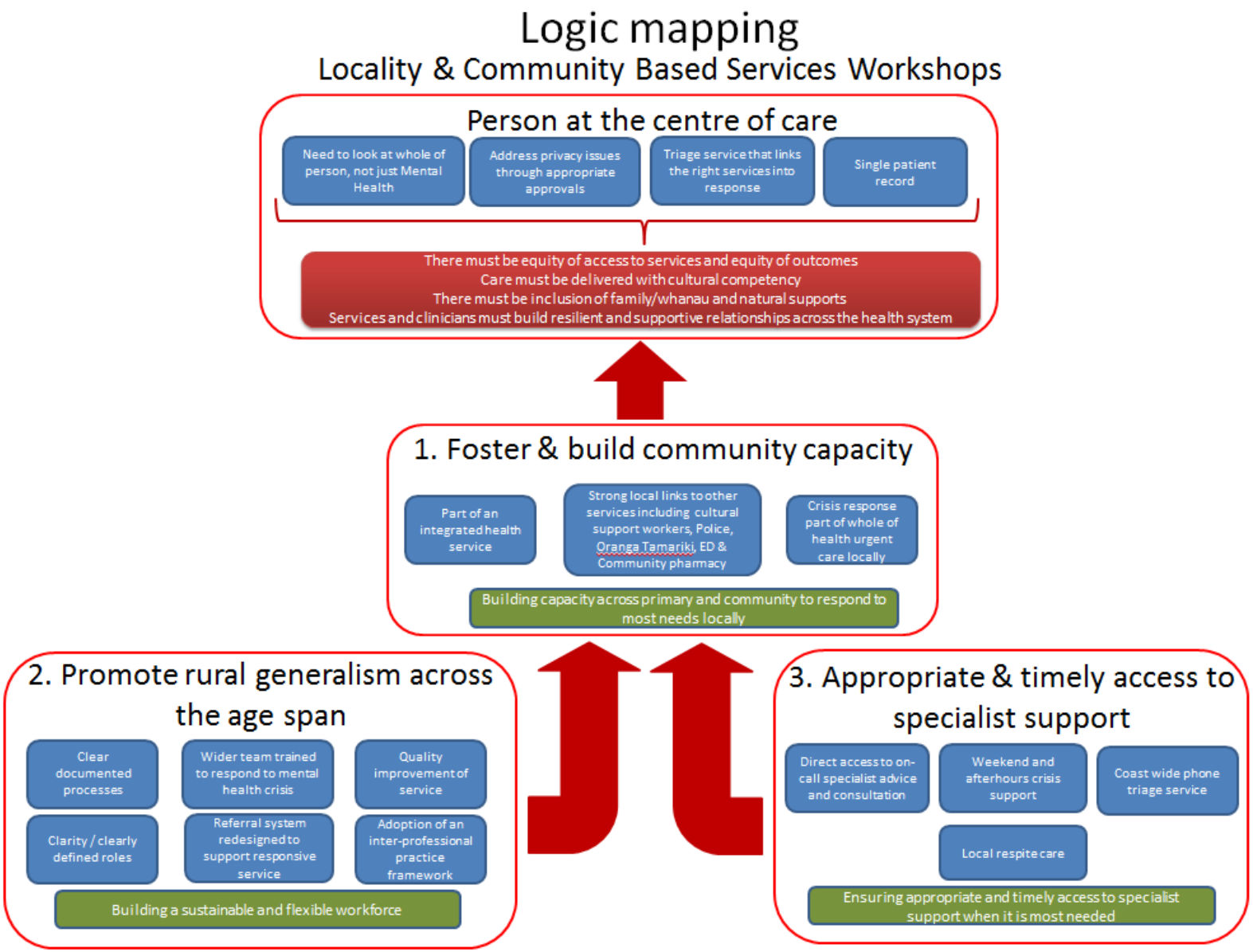
Specialist services and clinicians are also critical in supporting the development of capability and expertise in the community services through provision of education and training activities, peer support, advice and consultation.

4.2 Logic mapping

Strong messages emerged throughout the work undertaken around four underpinning principles of care provided in the community and across the system as a whole:

- There **must** be equity of access to services and equity of outcomes
- Care **must** be delivered with cultural competency
- There **must** be inclusion of family/whanau and natural supports
- Services and clinicians **must** build resilient and supportive relationships across the health system

With these underpinning principles in mind a logic map has been developed to describe and visually reflect the emerging themes and how they connect together.


Logic mapping
Locality & Community Based Services Workshops
Person at the centre of care
Need to look at whole of person, not just Mental Health
Address privacy issues through appropriate approvals
Triage service that links the right services into response
Single patient record
There must be equity of access to services and equity of outcomes
Care must be delivered with cultural competency
There must be inclusion of family/whanau and natural supports
Services and clinicians must build resilient and supportive relationships across the health system
1. Foster & build community capacity
Part of an integrated health service
Strong local links to other services including cultural support workers, Police, Oranga Tamariki, ED & Community pharmacy
Crisis response part of whole of health urgent care locally
Building capacity across primary and community to respond to most needs locally
2. Promote rural generalism across the age span
Clear documented processes
Wider team trained to respond to mental health crisis
Quality improvement of service
Clarity / clearly defined roles
Referral system redesigned to support responsive service
Adoption of an inter-professional practice framework
Building a sustainable and flexible workforce
3. Appropriate & timely access to specialist support
Direct access to on-call specialist advice and consultation
Weekend and afterhours crisis support
Coast wide phone triage service
Local respite care
Ensuring appropriate and timely access to specialist support when it is most needed

5. Proposed actions arising out of Locality & Community Based Services stream activity

Each workshop generated a list of possible solutions or actions to inform delivery of future mental health services. Most solutions are relevant across all the services engaged in the workshop process, with the odd one specific to a particular service or consumer group.

The following sections outline the proposed actions, able to be developed and implemented immediately, and recommendations where, if agreed, further work would be required to facilitate any potential changes to how services are delivered in the future. Where the action or recommendation relates to a specific service or consumer group, this distinction is stipulated.

5.1 Proposed actions

The five proposed actions below describe activities that, if supported, can be developed and implemented without the requirement for a structural change to services, contracts or individual roles. They have been grouped under each of the emerging themes as described above.

Theme 1: Foster and build community capacity

1. *Develop a shared approach to consent and confidentiality across the system:*

   An issue around privacy and constraints around sharing patient information between services was initially raised in some of the earlier workshops and continued to be discussed subsequently as a barrier to services working more collaboratively. How do we approach confidentiality and client privacy in an integrated environment? Broad views were articulated in their response to this key question. As a result there needs to be a piece of work undertaken in collaboration with the community health project to build a cohesive approach to information sharing as an enabler to working together.

2. *Shared training plan across the PHO and mental health and addictions teams*

   To improve sustainability of the workforce and delivery of training, common training needs across the services and organisations should be identified and action taken to establish a consistent and collaborative training plan to respond to those identified needs. This is a critical activity in building capacity across providers.

Theme 2: Promote rural generalism across the age span

3. *Adoption of an Interprofessional Practice Framework*

   To resolve the dilemma of managing clinical responsibility the Interprofessional Practice (IPP) Framework is proposed. The differences between the current multi-disciplinary way of working and interprofessional practice are described below:

What are the differences?

Multi-disciplinary vs Interprofessional

Multi-disciplinary

- Independent practice
- Guided by professional standards
- Professions report to depts.
- Leadership by rank or profession
- Rigid role boundaries
- Conflict attributed to individuals
- Little attention to team process

Interprofessional

- Interdependent practice
- guided by professional & team standards
- Discussion & collaboration
- Leadership by skill or primary issue
- Flexible role boundaries
- Conflict is a team responsibility
- Routine attention to team process issues

Patient care has become more complex, resulting in increased specialisation in all the health care professions, and in-depth exploration of issues by each specific profession. However, this means that no one health care provider can meet all the complex needs of a patient and his/her family. Increased specialisation means we have fewer opportunities to interact with other disciplines and professions. An example of IPP at present is the West Coast DHB Complex Clinical Care Network (CCCN).

4. *Adoption of the South Island Interprofessional Learning Framework that supports moving towards developing generalist mental health clinicians.*

   This is consistent with the strategic direction of the DHB (e.g. Rural Nurses, Rural Hospital Medicine). This aims to develop mental health clinicians who are able to work across a broad range of mental health and addictions conditions and age ranges. It acknowledges the need for a comprehensive training plan to achieve this. Adopting the principles of Interprofessional Education will enhance the sustainability of training across the workforce (http://caipe.org.uk/resources/principles-of-interprofessional-education/).

   An example of this is a training plan to increase mental health skills in current primary care in NMDHB. This adopted a Practice Nurse credentialing programme in partnership with the Primary Health Organisation and the College of mental health nurses, Te Ao Maramatanga and IFHC. The aim was to increase skills and confidence of practice nurses when supporting people with mental health issues.

Theme three: Appropriate and timely access to specialist support

5. *Identification of barriers to patients receiving care according to their needs from across the MH sector*

   While it was recognised and agreed that patients should receive their care as close to their home locality as possible it was also recognised that there are barriers to this happening, along with access to timely specialist support, advice and consultation by appropriately skilled staff. It is important to identify, understand and build a corrective actions plan to address and remove these barriers to ensure improved access to the right care at the right place and time from the right service/clinician.

5.2 Recommendations for the design of future mental health services

Ten recommendations have been identified from the Locality & Community Based Services stream of work. The recommendations reflect activities that, if supported, may impact on how services are structured or delivered, or change individual roles. These activities may require a formal consultation and change process before implementation could occur. It is important that these recommendations are considered carefully and that feedback is received to ensure they accurately describe the direction that future mental health services should take. It is expected that the Health Equity Assessment Tool (HEAT) will be utilised across all recommendations to prepare for and measure any implementations.

The recommendations are outlined below, again grouped under the emerging themes:

Theme 1: Foster and build community capacity

1. *Integration of TACT team into locality teams:*

   It is recommended that the TACT team becomes part of the locality & community based services. This would see some of the current TACT team members integrating into each of the Community Mental Health teams based in Greymouth, Buller and Westland, providing crisis response from Monday to Friday with some possible extended hours delivered from Greymouth. This requires the triage function to be provided as per the recommendations in the crisis response progress report (delivered either external or internal).

   Action: Establish a small group to develop the necessary details regarding options of rostering configurations. Some options may include:

   - One staff member to be on duty for crisis response 8.30am – 4.30pm in each locality, Monday to Friday

- One staff member to be on duty for crisis response 12noon- 8pm in each locality, Monday to Friday 4pm to 8pm is the period of the evening when work is most common therefore staffing will need to reflect this and other times of high demand.
- Same shift pattern in the weekends with staff working from the inpatient unit at Grey Base Hospital, covering the whole coast.
- Consider expanding Buller weekend cover arrangements to Westland
- The review meeting with the SMO changed to 8.30am in Greymouth with teams from Westland and Buller joining via video conference.

It is further recommended that once the final roster has been developed with subject matter experts, consulted on, and agreed, the roster will be published and implemented, and reviewed at 6-9 months post implementation. There could also be regular roster meetings scheduled to provide support through the implementation period and to problem solve issues that may arise. Staff in the community teams could be offered the opportunity to participate in the roster.

2. *Adoption of shared documentation across MH Sector*

Action: To move towards working as a single mental health service the following developments are recommended:

- Single consent form and confidentiality as discussed in the actions above
- Single point of referral at each locality
- Adoption of the South Island risk assessment form across the sector
- Identifications of common assessment components and other opportunities for consistency

3. *Establishment of consistent and collaborative approach to screening and assessment practices*

Action: In order to promote community capacity and respond to most needs locally the establishment of standardised tools and approaches will be useful to promote consistency across providers and services. For this to be successful some considerations are recommended:

- Identification and adoption of a common screening approach
- A single point of assessment, either locality or NGO based
- Review the evaluation being undertaken by the PHO for the Long Term Conditions pilot in Buller to determine if this should be adopted across all IFHCs to improve “Equally Well” outcome
- Prevention and health promotion remains with CPH

4. *Review requirements for safe and efficient assessment procedures*

This links to the RCA recommendation to ‘Review Lone Worker Protocols’. At this stage there is significant inconsistency of approach to initial assessments between crisis and community teams, for example differences in location preference and numbers of staffing. This needs to be resolved ahead of integration of the crisis response function within locality. Access to regional process will likely assist this work.

5. *The provision of some alcohol and other drug treatments to be delivered through community and locality based NGOs.*

Action: Consider options to reconfigure community based treatment options to more effectively meet the patient’s needs from the right environment when it is most needed. Some options to consider:

- Home detox
- Day programmes and individual treatments for uncomplicated presentations

Theme 2: Promote rural generalism across the age span

6. Integration of some CAMHS and AOD staff into locality teams to work across age span

Action: This recommendation acknowledges considerable work is needed to achieve this including:

- Establishment of a comprehensive training plan
- Retaining opportunities for staff with advanced skills and areas of particular interest
- Co-ordination of a clear mechanism to ensure access to appropriate support from an interprofessional team approach to get specialised Child & Adolescent input

7. Supporting Opiate Substitution Therapy (OST) to be delivered through the IFHC

Rather than maintaining a separate and specific service to respond to OST needs in the community, consideration should be given to moving this into the locality, delivered through services and providers within the IFHC including advanced nursing roles. Work is needed to understand the best way to achieve this.

Theme three: Appropriate and timely access to specialist support

8. Identification and definition of the role and scope of a Coast-wide Child & Adolescent team.

Action: In responding to this recommendation some key questions need to be answered, and aspects given serious consideration. Some of these are noted below:

- Should this provide care for all 5-12 year olds (or the relevant developmental stage) or can some of this be delivered by locality teams? If so, which aspects can be delivered locally?
- Are there alternative age ranges (e.g. youth up to 25 year olds) that need to be considered?
- How would the service provide timely consultation and liaison to locality teams?
- What skill-mix is required?
- Could this team be transalpine?

9. Development of a workforce strategy around the development and utilisation of advanced nursing roles within Mental Health as part of the future services design

Action: With the introduction of a new advanced nursing role in Mental Health Service, there is a need to ensure that workforce development for nurses as part of the future services design is given a strong focus.

- The roles must align with the model of care and service direction that is evolving from the work being undertaken
- Identification of advanced nursing roles is required which can support timely access to specialist advice and consultation

10. The provision of specialist alcohol and other drug treatment is reconfigured to more effectively meet the patient's needs from the right environment when it is most needed.

Action: In considering the most effective provision of specialist treatment the following options need to be considered:

- Medical detox services: This continues to be provided through a regional residential service
- Complex and Co-existing disorders: A West Coast-wide addiction team be established, similar to that recommended for CAMHS in recommendation 1 above.

6. Progress Report Feedback

The Community and Locality Progress Report has now been through several stages of consultation over the past months. Firstly, the report was distributed to stakeholders and workshop participants for initial feedback. This included, but was not limited to:

a. Workshop participants
b. MH services, PHO, NGOs, Primary care
c. Consumers and consumer council
d. Other workstreams
e. Tatau pounamu
f. ALT and Transalpine and regional services

Presentations were then held across the West Coast with stakeholders and consumers to discuss the proposed actions and recommendations within the report, and asked for feedback to ensure the emerging themes, proposed actions, and recommendations were generally supported.

Feedback received as part of the consultation period, both verbally and via email submissions, was broadly supportive of the direction of change proposed for Mental Health Services on the West Coast. Much of the feedback was concerned about the practicalities of implementation and how the change would happen. In order to respond to these questions a Frequently Asked Questions sheet has been developed and can be found in Appendix 3.

It is now time to begin work on the recommendations and actions outlined in the report. Over the coming months small working groups will be established to begin some focussed work on the changes required to achieve the vision for Mental Health services across the Coast. This work will consider how to operationalise the changes described in the document, who needs to be involved, the best way to phase the changes, and the resources and training required to ensure success.

Again, any interested parties who wish to be part of the detailed work can request involvement via the email address below:

mhfeedback@westcoastdhb.health.nz

Appendix 1 Individual workshop summaries

Workshop Participants

The following organisations were represented at the workshops: Emerge Aotearoa, TACT – CMHT (Buller, Greymouth, and Hokitika), PHO, local clinicians (GP's, psychiatrists, nurses, psychologists), PACT, Poutini Waiora, AOD services, ED and Primary Care, Foote Ward, DHB Māori Health.

Workshop 1: Community Mental Health Services – Greymouth workshop 20th November 2017

Focus areas for workshop:

1) How would community/localised mental health services work

- Full needs of the client need to be met at the entry level. This could be achieved by having associated services present when the client first presents e.g. employment, housing, family, custody, courts etc.
- Seamless service is needed more than simply location based e.g. police, Oranga Tamariki, ED, community pharmacy. We need to continue to develop our existing relationships with other parties
- Localities with a single practitioner on site during night shift could have these practitioners supplied with some form of TACT related training
- Needs to be a multi disciplinary triage with pooled resources/skills. Currently multi agency collaboration requires referral, time, politics, leading to some patients dropping through the system
- A collaborative model with the client at the centre, makes the client the winner
- Single vs. Collective point of entry pros and cons needs more discussion
- Suggested that a cultural change is needed to start taking into account all facets of a clients life, as well as their mental health
- Consent processes and privacy agreements between the different providers differ. This needs to be addressed collaboratively in order to discover where and what is stopping the flow of patients through the services
- Need to look at how other areas within the health system work collaboratively e.g. older people's health (CCCN)
- Mental health nurses could work as part of an extended GP team
- Direct access between GP's and psychiatrists
- Community/NGO support workers could be utilised earlier in the process and be part of the clients integrated plan
- Direct access to each other in order to work closer and more collaboratively – pick up the phone, don't send a piece of paper
- More mental health training is needed for ED staff
- 5-9pm cover could be on call, rather than shift

Saturdays/Sundays

- Two Duly Authorised Officers (DAO's) would be needed for callouts. If they were out of cell phone coverage this service would need to be back filled. Resourcing would also be an issue: cell phones, cars, employment, illness/annual leave coverage etc.
- Telephone/follow up load would need to be investigated as well as after hours requirements such as methadone prescribing
- On average there are four callouts per weekend

Overnights

- A closer working relationship between ED, police and CCU in-patients
- Planned vs. unplanned needs to be factored in.
- Staff with appropriate training for crisis response is important. We must work within our scope of practice, ensuring they are appropriate going forward

- Specialist knowledge/training is paramount

2) What are the implications for Community Mental Health Teams if crisis response is provided locally

Daytime/Weekdays

- Mental health nurses working as part of an extended general practice team:
    - Supporting long term conditions
    - Asses need for hospitalisation
    - Plan of care created
- Mental Health as an extension of the Urgent Care Facility and new IFHC build. Utilise extended opening hours. Could use two RNs or one RN and a health support worker
- Harness support from the digital world – utilise online counselling etc.

3) What a single mental health system might look like

- Central files, all stored in the same place
- GP as the central point with other services seamlessly transitioning in and out as necessary
- Reduction of the stigma around mental health – understanding etc.
- A service without barriers, based on caring for the whole person
- Removal of 'Box 3' from the current logic map (as outlined in the Crisis Response Progress Report, 17 August, 2017)
- Redesign of the current referral system – it is the biggest encumbrance to the present system
- A shift/reconfiguration of current resources:
    - Location based acknowledges this
    - Community knows of the new system
    - Stigma is reduced
    - Current awareness and collective willingness to create this change and to work differently
    - Optimum input into developing new systems – integrated, client centred

Workshop 2: Community Mental Health Services – Westport workshop 21st November 2017

Focus areas for workshop:

1) How would community/localised mental health services work

- The majority of services were believed to be important areas to include within a fully integrated mental health system. These included, but are not limited to:
    - PHO primary mental health
    - Triage services
    - Primary care
    - Māori meatal health services
    - Child and Adolescent mental health
    - Crisis response
    - Community support
    - NGO providers
    - GPs
    - Allied health
    - Dental
    - Rest homes
    - NGOs
    - ACC, housing NZ, WINZ, Police, Oranga Tamariki, etc.
- Hub – central place for referrals, patients given the right place, right time, right service, recovery focused
- Involve WINZ, police etc. on the outside, but linked
- Hub – Support, IFHS – Treatment
- Move away from the case manager model
- Team to be responsible, though ultimately doctors are which may be hard to get over
- Client should choose their clinician, like you do for midwives
- Mental health nurses need to know about the cases and their responsibility

2) What are the implications for Community Mental Health Teams if crisis response is provided locally

Daytime/Weekdays

- Two community mental health nurses or one mental health nurse and one other trained clinically needed to respond to the initial call
- Cultural support worker needs to be available – ideally in person or via VC
- Psychiatrist visits twice per week
- Transport to see a psychiatrist could be an issue – police? Specialised transport?
- Telemedicine not appropriate under the mental health act.
- Availability/access to a senior medical officer a concern

Evenings

- Don't believe anything would change – status quo would remain
- Afterhours TACT
- Crisis service, allied health, TACT person Buller based – with Police support?
- Duly Authorised Officers on call
- Nurses and police always go in pairs
- Phone triaging
- Buller support from Greymouth, possibly with Police support if needed

Overnight

- Two staff need to respond to call outs – one must be a Duly Authorised Officer
- Access to an on call psychiatrist
- Access to local respite care
- Have been 21 callouts in a 12 month period however this could change when the service is available locally

- Recruitment of extra staff a concern
- What happens if there are two calls at once?

Saturdays/Sundays

- One Duly Authorised Officer on call locally
- GP or urgent GP available
- People need to be available to do a comprehensive mental health assessment
- Telemedicine assessment with a psychiatrist
- Back up staff need to be rostered on call – mental health nurses, support workers etc.
- PHO could assist mental health nurse as Duly Appointed Officer
- Who would assist with transport?

3) What a single mental health system might look like

- Seamless/wrap around service
- Clearly defined roles
- Single patient record
- Responsive triage
- Universal referral form
- Outreach as needed with those who wont engage
- Client choice
- Inequities addressed in care– housing, income, social issues etc. – involve PHO navigators, community mental health support, NGO's etc.
- Rural outreach
- An understanding of how it fits with Coast Medical
- Up skilling of workers – nurses, Whanau Ora, holistic/integrated approach etc.
- Quality improvement focus on the service
- Single phone in point that is always manned and always gets a response
- Peer support – case managers
- Shared, computerised access to information
- It would have a single funder
- It would have a range of expertise
- It would be part of coast wide, integrated services – supported by West Coast /Canterbury DHB
- It would provide present services under one umbrella
- NGO's would not necessarily be incorporated - related to funding and referrals process
- Free service
- Adequate facilities – Building/Rooms/Transport
- Close links with crisis response
- Information sharing and collaboration for the best use of skills, free up time, and reduce the number of different clinicians that patients tell the same things to
- Clear triaging process/assessment
- Referral form should indicate the level of need – Mild-severe
- Clear triaging process – appropriate skills essential, clinical responsibility is unclear
- Need to see milder unwell clients in a timely manner while still responding to the needs of severely unwell clients
- Physical and mental health of concern to some clients – this should be addressed collaboratively
- Inequity lens – Rural lens
- Funding arrangements with NGOs of concern – this is seen as the only barrier
- Ensure peer support is appropriate for each client, not a blanket approach
- Barriers identified – funding, reporting, recruiting

Workshop 3: Community Mental Health Services – Hokitika workshop 22nd November 2017

Focus areas for workshop:

1) How would community/localised mental health services work

What would be provided:

- GP
- Psychiatrist
- Māori health
- Peer/community support
- District nurses
- Pharmacy
- Crisis response
- AOD
- iCAMHS
- community mental health nurse
- Allied health e.g. dietician, podiatrist, OT, physio etc.

What would be accessible but not integrated:

- Specialists e.g. Neurologists
- Community support
- Advocacy
- Police
- Respite
- Vocational
- budgeting
- WINZ
- Citizens advice

General discussion

- Clinical responsibility/specialist services still undecided
- Māori health/mental health should be integrated, more holistic
- Noted that some organisations were not represented – were they on board with this work?
- Issues with inconsistent services e.g. age groups
- Crisis response – lack of resources
- Many NGOs are offering the same services – this is causing confusion
- Very little resourcing to help clients with housing

2) What are the implications for Community Mental Health Teams if crisis response is provided locally

Daytime/Weekdays

- Rostered triage – would need to work collaboratively with NGOs for joint triaging and review how we currently do this
- 58 people for the year, this does not include people triaged in Hokitika
- More resources would be needed to set up a triaging service
- Staff resources would need to be increased
- A senior medical officer may be needed

Evenings

- This has previously been tried
- Maintaining the status quo lessons safety, makes financial expenses rise

- Case managers have full case loads
- Staffing an issue – two always needed
- Distance an issue – 4.5hrs each way from Hokitika to Jacksons Bay – Police are often unable to assist or unavailable in certain areas
- Separate crisis team – more staff the only way forward. Need to ensure they get full 9hr breaks. They would need resourcing – computers, vehicles, SMO access, DAOs etc.

Overnight

- Independent specialist triaging phone service – experienced staffer with mental health and local knowledge, doesn't have to be a nurse, could be other allied health professional
- Triaging phone service could be based anywhere, rostered on, with access to systems used.
- One Duly Authorised Officer plus a mental health professional on call to respond overnight – two needed for safety

Saturdays/Sundays

- Not feasible for community mental health team to cover
- Has implications for next days work and time off – call outs, time in lieu etc.
- Police availability a big issue – Hokitika is unknown, South Westland has a single police officer based in Franz Josef
- Transport implications from the mental health act
- Upskilling needed
- Location of staff and distance a concern, as is what happens when there is a second call out
- Duly Authorised Officers needed
- What to do if clients are intoxicated an issue
- Remote access to notes an issue
- Number of people on the roster a barrier
- On-call implications on staff lives a concern – sleep disruptions, where you can go, what you can do (cell phone coverage), general nervousness even if not called out etc.
- Need a coast wide approach to triaging with PHO and NGOs included

3) What a single mental health system might look like

Issues

- How would clinical responsibility work
- Increased risk of burn out for psychiatrist with increased caseload/responsibility, especially if just dealing with severe cases
- What does it mean for PRIMHD data?
- The differing conditions of work for staff a concern
- Stigma – peoples perception of the service
- Differing standards between NGOs
- Currently extra costs to client if referred back to their GP
- Roles need to be clearly defined
- Peoples responses can be a barrier – fear of change
- Question the financial costs of these changes i.e. upskilling, reorientation of staff
- Adequate supervision and training opportunities needed
- Merging the two systems a concern
- GP being privately owned is a concern – profit driven
- GPs don't like dealing with mental health

Advantages

- Shared resources – staff and facilities

- Single access point – one system
- Shared values, beliefs, understanding – more clarity around roles and responsibilities
- Calderdale framework
- Collaborative use of peoples skillset – access to a broader skill base
- Easier to retain relationships
- Improved information sharing between NGOs and mental health services
- Standardised documentation
- Increased access for patients to services such as counselling and other specialist services
- Less wait time for services
- More continuity of care

AOD Workshop – Greymouth **27th February 2018**

1) What are the components and functions of AOD services needed for the West Coast community?

- Considerate and robust provision of Kaupapa and mainstream - both cultural responsiveness
- Co-existing disorders
- High and complex needs e.g. cognitive disorders
- Services meet the needs of young and older people – whole age spectrum
- Community input
- Support families – COPMIA, familial trust
- Needles exchange
- OST
- MVCOT relationships – what's available where?
- Brief intervention
- Education – police, schools, other services
- Culturally competent workforce
- Access to specialist residential treatment
- Relationships with other organisations e.g. SIFS, aged care,
- Acute response
- Where people are presenting – referral process, early intervention
- Residential access – Christchurch
- Detox – home, inpatient, GP, day program, skilled workforce, facilities, peers, family, community
- Treatment pathways
- Relapse prevention – Aftercare, AA/NA/AIATEFN/ALANON/Other, rational recovery, early intervention
- Needs appropriate assessment/intervention
- Gambling
- Risk assessment comprehensive brief screening
- Integrated services – flow
- Cultural competency
- Competence across all – screening, assessment, etc.
- Education and training
- Do we need a 'place'? E.g. house, or do we need access to a house?
- A pathway that focuses on the person, which is intelligent and workable
- Explore current connections e.g. Cobden house, AA
- Collaboration, communication, coordination
- Everybody should know where they are and where they are going
- Prevention – education, information, psychosocial approach
- Screening
- Easy access to service
- Assessment, skilled workforce, strength based
- Early intervention
- Family inclusive – culturally inclusive
- Home detox option – medical, expert skill base from multi discipline team, other clinical expertise, respite or hospital beds
- Pharmacological, social, psychosocial interventions and support i.e. cultural, community, consumer supports - AA, NA, RR, Alanon
- Specialist services – OST, co-existing disorders, mental health including CAMHS, vocational/educational support, residential program, day program, services for cognitively impaired age care, needles exchange, night shelter
- AOD – substances, gambling, nicotine

- Education/information – AA, NA, GA, etc.
- Location/points of contact e.g. 0800 number
- Peer support – value and increasing capacity
- Support for care in the community
- Professionals for hospital care and community care
- Brief intervention
- Screening, assessment, treatment
- AOD/OST – planning practitioners
- Facilities for – crisis care, medical and detox care, detoxification/social care
- Residential care treatment – localised, small, multi-versal one stop shop
- Aftercare
- Relapse prevention – groups
- Wet house/space for the homeless coming into the area (increasing need)

Main areas/functions identified

1 – Education
2 – Comprehensive, brief screening
3 - Appropriate risk assessment
4 – Treatment
5 – Relapse prevention
6 – High and complex needs
7 – Coexisting disorders

2) What is the skill mix needed for each of these functions

1. Education
    - Willingness to assist
    - Kaupapa
    - Community/volunteer groups
    - Police (DARE)
    - Peer support
    - NGOs/Health Professionals – upskilling needed
    - Public health/health promotion – not essential to be clinical, needs specialist knowledge and very good communication skills
    - Any relevant community resources
    - Integrated and patient focused provision
    - Schools
    - Practice nurse – will need training
    - Coordinator
    - Health promotion – community, schools, industries

2. Screening
    - Anyone can screen
    - Nursing/ED/Med centre/SW and community groups
    - Audit tools/health pathways – consistency regarding tools/outcomes
    - Family violence
    - All agencies trained in screening tools – brief intervention advice, knowledge of pathways
    - Triage
    - Primary/community
    - More development of cultural services
    - GP

- School counsellors
- Health and safety advisors
- Employers
- Practise nurses
- Support workers

3. Assessment
- Specific training in need/risk
- Health professionals – across the spectrum
- Clinician – could be practise nurse, RNS etc.
- AOD practitioners
- Planning with people and whanau

4. Treatment
- Qualified OST – what does this look like?
- Coordination, administration, rules
- B.I.G/detox – legal requirements?
- Range of people to deliver holistic approach drawing on experiences and opportunities
- Clear pathways for people of all ages
- Appropriate models of care – culture/age
- Self help options
- Day programmes
- Residential options
- AOD practitioners
- OST
- Social worker
- OT
- GP
- Psychologist
- Family inclusive
- Competent and well trained in assessment and treatment
- Specialists – various levels – community – brief assessment
- Across the spectrum – primary/NGOs/ED/Secondary
- Detox – home (detox nurse), social (NGO/AOD practitioner under medical guidance), medical (supervised nurse practitioner, psychologist)
- Gambling
- Group interventions e.g. day programs

5. Relapse prevention
- Need a WRITTEN plan
- Need experience in issue/relapse/long term
- Look at most appropriate – can they reach
- NGOs/peers/family/community
- Respite
- Crisis care
- After care
- Workforce with AOD skills
- Group work – reassessment
- Organised groups – consumer driven, specialist facilitated (AA, self care, peer)

6. High and complex needs

- More health professionals
- Residential needs
- Experience in AOD complex/needs/gaps
- Specialist services e.g. CCCN
- Specialists
- Consultant psychiatrist to consult with cultural competencies
- Psychologist
- Experienced, skilled workforce
- Specialist liaison – access to behavioural, medical, psychological, CCCN, support workers
- MDT – nurses, OT, AOD etc.

7. Coexisting disorders
    - Holistic
    - Across the skill and resource spectrum
    - Good teamwork
    - CMH/AOD
    - Skill based training
    - Competent specialists – psychiatrist access
    - MDT

General
- Communication – alliances, working together (no silos, clear pathways)
- Peer support training
- Consumer advocacy
- Gambling
- Residential access
- Equity is the overlying premise
- Consumer input across all points (1-7)
- Family/Whānau is a theme that runs through all the services
- Can be people from across the spectrum – from a worried neighbour to a skilled specialist professional

3) What options are there for providing these functions – where should each of these providers/functions sit: CPH, PHO, IFHC/CMH, NGO, Specialist, Regional, Other

1. Education
    - CPH
    - CPH – health promotion – big picture approach

2. Screening
    - PHO
    - IFHC
    - NGO
    - All
    - CMH

3. Assessment
    - IFHC
    - Continuum across agencies
    - NGOs
    - Specialist services

- AOD/CMH/IFHC

4. Treatment
   - IFHC – Detox (inpatient or home with a clinicians supervision), OST
   - NGO – groups, respite
   - Peer support
   - Requires integrated approach – Detox (NGO/IFHC/Peer), Gambling (NGO), Needle (regional), Residential (regional), OST (NGO/Specialist) etc.
   - Detox – home, social, medical (regional) – CMH/AOD/IFHC
   - Day programme – CMH, AOD, IFHC
   - Residential – regional
   - Needle exchange – irrelevant
   - OST – AOD, CMH
   - Gambling – CMH, AOD, IFHC

5. Relapse prevention
   - NGO
   - Peer support
   - PHO
   - CMH
   - PHO/NGO – depends on level of intensity

6. High and complex needs
   - IFHC e.g. CCCN
   - NGOs
   - AOD services
   - CMH specialists

7. Coexisting disorders
   - IFHC
   - CMH
   - PHO
   - AOD
   - Working across age continuum and cultural responsiveness

General
- OST could be delivered by an NGO
- Residential treatment - ideally delivered locally

4) What should the age range be for AOD services?

- It was unanimously decided that the full age spectrum should be included within AOD services, making no distinction in regards to a client's age at time of referral/out reach etc.

CAMHS Workshop – Greymouth **27th February 2018**

1) What are the components and functions of a child and adolescent mental health system needed for the West Coast community? Do you think these components and functions are currently being delivered?

Components/Functions	Yes	Sometimes	No
Screening	X		
Assessment	X		
Triaging	X		
Respite			X
Carer support/NASC	X		
Transalpine support	X		
Developmentally appropriate and child/family focused		X	
Offer – age range		X	
Child/youth appropriate spaces – location/attractive		X	
Psychiatrists	X		
Psychologists	X		
OTs	X		
Nurses	X		
AOD counsellors	X		
Councillors	X		
Social workers	X		
Music/play/art therapists	X		
Support staff – admin etc.	X		
Supporting SPHC	X		
Public health/community ED	X		
Treatment options – parenting	X		
Treatment options – families	X		
Preventative services programmes			
Under 12 groups/service provisions			
Access technology	X		
Education/training	X		
Stronger links with education/social services		X	
Consumer advocates		X	
Family start	X		
Peer supports - schools	x		
NGOs	X		
Supervision	X		
Link with paediatrics – child development services	X		
Māori cultural support	X		
Full assessments of families and young people	X		
Different pathways and levels of interventions	X		
Advice, education and guidance provided at all stages	X		
Accessible and responsive service	X		
A locally available response to young people in crisis who may need short term admission			X
Crisis response service – 24/7	X		
Specialist psychiatric input	X		
Competent, skilled workforce who can work with young people and children			X

Components/Functions	Yes	Sometimes	No
Flexibility across the workforce who can cope with changing demands			X
Forensic, specialist skills and staff competent in this			X
Quick response		X	
Develop a range of community based options			X
Regional responses		X	
Functional CAMHS		X	
Therapeutic interventions – assessment and diagnosis, screening, medication, multi-model therapy, safety planning, AOD assessment and interventions		X	
Access to respite			X
Access to inpatient beds	X		
Early intervention, prevention. screening		X	
Family inclusive	X		
Interagency collaboration and agreement – multiagency inclusive practice		X	
Whānau Ora – valuing people and culture, valuing family			X
Culturally competent workforce			X
Māori peer support		X	
Access to counselling for all (no counselling for under 12 yr olds)			X
Clear pathways to and between services	X		
Access to psychiatrist	X		
Community resources for education and prevention, and parenting programmes			X
A screening function (not enough capacity)			X
Access to specialist inpatient services	X		
Staff who are well trained and culturally competent			X
Family therapy, attachment work		X	
Play therapy			X
Music therapy	X		
Art therapy	X		
Forensic services			X
Access to AOD counselling	X		
Transitioning CAMHS clients to Adult services		X	
Whānau Ora		X	
Group programmes for adolescents			X

2) What are the pros and cons of a generalist versus specialist workforce and what should the age range be?

Pros of a generalist workforce

- Some therapists can work across age range e.g. music therapists
- C&Y community workers can be trained across a range of ages and skill set requirements – can connect with other services in their organisations to share training etc.
- E skills plus welly workforce Wharaurau will identify key competencies
- Base training for all – strengths, Whānau Ora, cultural ability
- Child and family at the centre as a specialist service
- All could do assessments/crisis work, but still require more specialised skilled staff
- Flexibility and enthusiasm to change style of work

- Using community resources to tailor a package for the individual and family, instead of fitting the box
- Opportunity for staff to upskill in a wider scope
- Consistency of care
- Easier to share resources
- Able to meet the needs of the client rather then the service
- A more sustainable workforce who can work with a wider range of clients and is not limited

Cons of a generalist workforce

- If all are generalists, what would you do when a less common diagnosis was presented e.g. eating disorder
- Risk of loosing the voice of the child if generalist – they become little adults
- At what point does a person decide generalist services are required?
- A focus/understanding/skill level to work with C&Y as well as particular interest in field of practice C&Y workers and generalist
- NZ training e.g. Welly workforce provides training but requirements are two years experience and workplace learning
- Important to understand child development stages
- Different focus needed for different age groups
- Existing practice
- Perceptions of what people see as specialist

Age discussion

- Confusion around age, especially around late teens
- Division should be by groups – infant/toddler/children (specialist 0-18), 16-25 years should be cross over between both teams (adult MH, C&Y, specialist) as there is an increased suicide rat in this group, especially for Māori clients and increased inequalities in this group
- Pre teen downwards should be specialist care - they need a wider range of treatment options
- Fluid age range – stage rather then age
- Age range of children is relevant to go capacity e.g. ACT, CBT, AOD, anxiety
- Younger children have wider range of need and communication e.g. trauma, learning development

3) What should be the role/function of non generalist, generalist, and NGOs?

- Whānau Ora approach across all areas

NGO

- Counselling
- Parenting programmes
- Whaka papa
- Whanautanga
- Group programmes
- Preventative programmes
- ASD coordination
- Respite
- Specialising
- Carer support
- Peer support
- Education
- Consumer advocate
- Cultural support

- Psychiatric education
- Psychologists
- Crisis
- Specific management of acute presentation
- Support and family intervention work
- Preventive
- Public health
- Navigation role
- OT
- Nurses
- A&D
- Carer support (NASC)
- Triage
- Assessment
- Screening
- Autistic spectrum disorder (ASD)

Generalist

- Crisis work
- Counselling
- Group programmes
- Triaging
- Wharetapa Wha
- Upskilling PHNs and Paediatricians to assess children for health issues
- Holistic knowledge
- Psychiatrists
- Psychologists
- Screening
- Social workers
- Nurses
- Risk assessments
- Brief intervention counsellors
- SWIS
- ASD coordination
- Navigation role
- OT
- ASD
- A&D
- Assessment
- Rural generalist psychiatrist

Non-generalist

- Psychotropic medicine (access to psychiatrists)
- Access to speciality areas e.g. eating disorders, psychotic disorders. Forensics, inpatient treatment
- Crisis work
- Consult liaison (availability for NGOs)
- ASD diagnosis
- Psychologists
- Music/art/play therapy
- ASD
- Eating disorders

- Forensics
- Youth aid
- IPU
- Parenting
- SPHC
- NASC
- Age specific skill set/therapy
- Specific management of acute presentation
- Prescribing
- Specialists like speech language therapy
- Transalpine, regional, and national services
- A&D
- Assessment
- Child and adolescent psychiatrist
- OT
- Nurses

Appendix 2: Mental Health Triage and Crisis Callouts

Number of MH Triage/Screening Contacts By Domicile June 2016-2017

		Monday - Friday															Saturday - Sunday													
		08:00 to 16:59					17:00 to 20:59					21:00 to 07:59					08:00 to 16:59					17:00 to 20:59					21:00 to 07:59				
Domicile	Team	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year
Buller	Buller CMH	19	37	23	23	102	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	CAMHS	7	6	1	4	18	3	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	AOD	8	3	3	5	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	TACT	10	22	8	9	49	0	9	5	3	17	0	1	1	0	2	1	6	5	6	18	2	0	0	3	5	0	1	0	0	1
	All teams					188					21					2					18					5					1
Domicile	Team	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year
Grey	Grey CMH	14	18	41	19	92	0	0	1	1	2	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	CAMHS	12	5	6	0	23	2	1	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	AOD	7	13	5	5	30	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	TACT	25	71	33	54	183	12	18	18	6	54	2	5	1	2	10	6	22	13	13	54	2	3	6	4	15	0	1	0	2	3
	All teams					328					59					11					54					15					3
Domicile	Team	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year
Westland	Westland CMH	9	10	8	0	27	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	CAMHS	2	1	3	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	AOD	2	1	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	TACT	7	24	10	9	50	1	9	5	0	15	1	1	0	0	2	0	7	5	6	18	0	1	0	3	4	0	0	0	2	2
	All teams					86					16					2					18					4					2

Number of MH Crisis Call Outs By Patient Domicile

		Monday - Friday															Saturday - Sunday														Totals
		08:00 to 16:59					17:00 to 20:59					21:00 to 07:59					08:00 to 16:59					17:00 to 20:59					21:00 to 07:59					
Region	**Locality**	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	
Buller	Westport	4	8	10	8	30	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Fairdown 7891	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Hector	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Karamea	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Totals					34					0					1					0					0					0	35
Region	**Locality**	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	
Grey	Greymouth	9	6	4	5	24	0	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Runanga	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Murchison	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Totals					26					4					0					0					0					0	30
Region	**Locality**	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	
Westland	Ruatapu 7883	0	2	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Hokitika	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Totals					4					0					0					0					0					0	4

Number of MH TACT Crisis Call Outs By Patient Domicile

		Monday - Friday															Saturday - Sunday														Totals
		08:00 to 16:59					17:00 to 20:59					21:00 to 07:59					08:00 to 16:59					17:00 to 20:59					21:00 to 07:59					
TACT Regional Service	**Locality**	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	Q1	Q2	Q3	Q4	Total - Year	
	Arnold Valley	2	2	6	0	10	0	0	0	0	0	0	0	0	0	0	0	0	3	1	4	0	0	1	1	2	0	0	1	0	1	
	Charleston	3	0	0	0	3	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	
	Dobson 7872 1 0 0 1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	
	Granity 7823 1 0 0 1	2	0	3	4	9	0	0	0	2	2	0	0	0	1	1	0	0	2	0	2	0	0	0	1	1	0	0	0	0	0	
	Greymouth 21 2 2 25	158	102	114	110	484	45	25	33	27	130	12	19	11	19	61	58	35	27	37	157	8	4	9	11	32	3	1	3	1	8	
	Haast 7886 1 0 0 1	3	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	HariHari	0	1	2	2	5	0	2	0	0	2	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	
	Hokitika 1 1 3 5	8	18	17	6	49	7	6	3	2	18	0	5	2	0	7	6	9	4	3	22	1	1	0	0	2	0	1	2	1	4	
	Karamea	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Lake Haupiri 787 1 0 0 1	1	0	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Reefton	7	4	7	6	24	3	0	3	1	7	1	0	2	0	3	3	7	5	2	17	1	1	1	0	3	0	0	0	0	0	
	Ross	0	0	1	0	1	1	0	0	1	2	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Westport	28	16	3	12	59	6	13	10	8	37	1	3	3	5	12	8	14	8	3	33	1	4	4	4	13	1	2	4	2	9	
	Totals					653					198					85					238					53					22	1249

Appendix 3 Frequently Asked Questions

Locality and Community Based Services Progress Report
Feedback FAQs

How will information sharing, the consent processes and privacy agreements for all providers be streamlined?

There is currently a working group looking at developing streamlined processes and consent form etc. across the whole health system, including mental health. This relates directly to how the IFHC model will operate across all departments. Existing models such as CCCN and other interagency collaborations such as FVIARS already have some of these elements in place.

How will specialist support for the generalist workforce be provided?

There are three elements of support required for a generalist workforce:

1) Education and training – this will require a dedicated resource to ensure that our workforce has the appropriate skills and access to training programs that are appropriate to increase their skills and knowledge in areas where it is needed.
2) Coast wide resources to ensure appropriate standards are being met.
3) Specialist roles in some clinical areas to support training and deliver consultation advice and review standards. For example, there is likely to be Coast wide CAMHS and AOD specialist roles.

Is generalism the direction because CAMHS is struggling?

The generalism direction is to ensure sustainability. At the moment there may be one service highlighted as struggling but in the past others services have faced similar scenarios regarding the sustainability of their workforce.

What are the pros and cons of generalism?

Pros:

- A broader range of people can provide the same services
- More sustainable
- Provides opportunities for further staff development

Cons:

- Requires robust training
- Requires ensuring we do not drop standards of care

How are we going to attract staff to the West Coast?

Recruitment to a generalist workforce is an area of significant focus by the West Coast DHB as a whole. There is significant work already underway to improve our recruitment strategies across the DHB of which mental health services will need to provide input to. This will provide an opportunity for the West Coast DHB to have a point of difference that should assist with recruitment. We will be recruiting people to roles that are unique to rural environments and provide a unique opportunity for work and training. We will not be recruiting to a role that they could do in a larger centre.

When will the details of how the crisis response teams will function be finalised?
In regards to crisis work, the more detailed design of how services will function such as who will work what hours, with what resources, in what regions etc. will be part of the next phase of work. This will require a range of people to have input and assist the current project team. Topics will include, but are not limited to, rostering, transport issues, regional sustainability and creation of an operations manual. Some of these details are already in different stages of implementation within TACT, for example the UK Mental health triage scale. Crisis services are not returning to the old model but is being completely redesigned.

How will the paper work requirements be mitigated so that clinical staff can carry out clinical work?
As we create a detailed operations manual we will revisit how paper work is done and the processes taken. Administrative and documentation tasks required will be reviewed as part of this process.

Will guidelines for the expectations of when psychiatrists should be involved and what their roles will be, be drawn up?
These guidelines are already largely covered in the West Coast adaption of the Canterbury Suicide Prevention Model. This document provides guidelines around what the nature of the service required is and the frequency of that service. Psychiatrist resource is included in this.

What is the long term plan for OST prescribing?
Long term OST prescribing will be part of the function of an IFHC and advanced nursing roles will support this. This aligns with the national direction for OST prescribing.

How will primary care be better engaged going forward?
There are many opportunities arising from the development of the IFHCs for mental health services to work on integration between existing primary care and the whole range of specialist services.

How will a culturally competent workforce be developed and how will the HEAT tool be used in the change process?
Cultural competency will be included as a training requirement for a generalist workforce and will be overseen by the person in the training role with input from appropriate partners, utilising other opportunities that currently exist within the health system and beyond.

The HEAT tool will be applied as a test against any change before we progress to implementation and will also be utilised in post-implementation analysis.

How will the stigma and discrimination towards mental health patients from staff be addressed?
We recognise that stigma is an issue that affects all aspects of our community and health professions. The move toward a more integrated health system will give us a better foundation to have conversations and interactions with staff that will provide us opportunities to address this important issue.

What will be done about NGO resources?
We have already progressed work to increase the range of NGO services available in the different regions of the West Coast. It is likely there will be an opportunity to revisit the breadth and scope of all of our NGO services with new opportunities for service development.

How will respite and peer support services be provided West Coast wide?
Respite and peer support are areas that have been highlighted as of particular concern and work is underway to start to explore opportunities in the regions that will meet the community needs. This work is in its initial stage and is therefore a work in progress. In the future we envisage these services being flexible and responsive to the needs of the community.

How is this change in services going to be resourced (funded)?
The West Coast DHB has indicated that they are strongly committed to supporting the development of a robust mental health system. Development of this service is about reallocation of resources to the areas of greatest need.

The national Mental Health Inquiry is also encouraging as it represents an overarching commitment nationally to equitable, robust mental health systems and has the potential to create new funding avenues.

Are there any examples around the country of other areas doing what is proposed on the West Coast?
Current examples include:

- Crisis teams being responsive across the age span: Nelson-Marlborough
- Centralised crisis response phone call centre: Counties Manukau
- Centralised triage functions: in place at several DHBs nationally
- SMHS team partnership with the PHO: Tairawhiti

Clinical responsibility/accountability – who would this sit with?
This is covered by the Professional Practice framework.

What is the extent of the consultation process?
The Progress Report was distributed to a range of stakeholders who were also invited to presentations throughout the West Coast. Meetings were held with mental health consumers throughout the West Coast for their feedback on the direction of the work. Presentations will also be given to the DHB Workstreams, Consumer Council, Joint Advisory Committee, Alliance Leadership Team and several other entities.

What are the implications of these changes for Māori mental health services?
Māori mental health services are undergoing a separate review which is currently underway. Details about stakeholder and community hui opportunities will be released shortly.

How will health and social services work together better?

Whilst our focus at the moment is largely on local mental health service delivery we are mindful of the range of questions that the National Mental Health and Addictions Inquiry is asking and one of those is this very question. We will thus be guided by the national developments in this space. However we do acknowledge that one of the principles in our document is to have effective relationships with local social service partners and we are committed to this principle.

REVISED FEBRUARY 2018

WEST COAST DHB – MEETING SCHEDULE

FEBRUARY – DECEMBER 2018

DATE	MEETING	TIME	VENUE
~~Friday 9 February 2018~~	BOARD MEETING	10.15am	St John, Water Walk Rd, Greymouth
~~Friday 23 March 2018~~	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
~~Friday 23 March 2018~~	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
~~Thursday 26 April 2018~~	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 11 May 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 11 May 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 7 June 2018	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 29 June 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 29 June 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 26 July 2018	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 10 August 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 10 August 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 13 September	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 28 September	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 28 September 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 25 October 2018	QFARC Meeting	1.30pm	Boardroom, Corporate Office
Friday 2 November 2018	Advisory Committee Meeting	10.30am	St John, Water Walk Rd, Greymouth
Friday 2 November 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth
Thursday 6 December 2018	QFARC Teleconference (if required)	1.30pm	Boardroom, Corporate Office
Friday 14 December 2018	BOARD MEETING	1.00pm	St John, Water Walk Rd, Greymouth

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

REVISED FEBRUARY 2018