West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

BOARD MEETING

Thursday 10 December 2020
at 10.30am

Westport Bridge Club
12A Lyndhurst Street - Westport

ALL INFORMATION CONTAINED IN THESE MEETING PAPERS IS SUBJECT TO CHANGE

MEMBERS

WEST COAST DISTRICT HEALTH BOARD

BOARD MEMBERS

Rick Barker (Chair)
Tony Kokshoorn (Deputy Chair)
Chris Auchinvole
Susan Barnett
Sarah Birchfield
Helen Gillespie
Anita Halsall-Quinlan
Edie Moke
Peter Neame
Nigel Ogilvie
Francois Tumahai

EXECUTIVE SUPPORT

(Attendance dependent on Agenda items)

Andrew Brant (*Acting Chief Executive)*
Gary Coghlan (*General Manager, Maori Health)*
Savita Devi *(Chief Digital Officer)*
David Green (*Acting Executive Director, Finance & Corporate Services)*
Brittany Jenkins (*Director of Nursing)*
Paul Lamb *(Acting Chief People Officer))*
Ralph La Salle *(Acting Executive Director, Planning, Funding & Decision Support)*
Jacqui Lunday-Johnstone *(Executive Director, Allied Health)*
Dr Graham Roper *(Interim Medical Director, Workforce, Legislative and National Representation)*
Karalyn van Deursen (*Executive Director, Communications)*
Stella Ward *(Chief Digital Officer)*
Philip Wheble (*General Manager, West Coast)*
Bianca Kramer (*Governance Support)*

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 Westport Bridge Club – 12A Lyndhurst Street – Westport
on Thursday 10 December 2020 commencing at 10.30am

KARAKIA			***10.30am***
ADMINISTRATION			
	Apologies		
1.	**Interest Register**		
2.	**Confirmation of the Minutes of the Previous Meetings** • *30 October 2020*		
3.	**Carried Forward/Action List Items**		
PRESENTATION			***10.40am***
4.	**Allied Health Strategic Direction**	Jane George *Executive Director, Allied Health*	*10.40am-11.05am*
REPORTS FOR NOTING			***11.05am***
5.	**Chair's Update – Verbal Update**	Hon Rick Barker *Chair*	*11.05am – 11.15am*
6.	**General Manager's Update**	Philip Wheble *General Manager – West Coast*	*11.15am – 11.30am*
7.	**Finance Report**	David Green *Acting Executive Director, Finance & Corporate Services*	*11.30am – 11.40am*
8.	**Clinical Leader's Update**	Clinical Leaders	*11.40am – 11.50am*
9.	**People Report**	Paul Lamb *Acting Chief People Officer*	*11.50am – 12.00pm*
10.	**Cyber Security and Infrastructure Update**	Savita Devi *Chief Digital Officer*	*12.00pm – 12.10pm*
11.	**Resolution to Exclude the Public**	*Governance Support*	*12.10pm – 12.10pm*

INFORMATION ITEMS

- 2021 Meeting Dates

ESTIMATED FINISH TIME **12.10pm**

NEXT MEETING: **12 February 2021**

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

Name	Interests	Pecuniary (Y/N)	Type of Conflict (Actual / Perceived / Potential)
Rick Barker **Chair**	• **Deputy Chair - Hawke's Bay Regional Council** • **Director - Napier Port** • **Director - Hawke's Bay Regional Council Investment Company**	N N N	
Tony Kokshoorn **Deputy Chair**	• **Dixon House, Greymouth** - Trustee • **Greymouth Evening Star Newspaper**– Shareholder • **Hokitika Guardian Newspaper** – Shareholder • **Greymouth Car Centre** - Shareholder • **Daughter a Doctor at Christchurch Hospital** • **MS Parkinsons Society** - Patron	N Y Y N N	
Chris Auchinvole	• **Justice of the Peace** Justices of the Peace carry out important functions in the administration of documentation and justice in New Zealand • **Daughter-in-law employed by Otago DHB**	N N	
Susan Barnett	• **Employed by the West Coast DHB** as a Public Health Nurse based in Reefton (0.2FTE). • **Son employed by Deloitte** – used for risk management auditing	Y N	
Sarah Birchfield	• **Accessible West Coast Coalition Group** - Member • **Canterbury/West Coast Disability Action Plan Committee** – Member • **Active West Coast Committee** – Member • **Growing Up Well On The West Coast Steering Group** – Member	N N N N	
Helen Gillespie	• **Department of Conservation** – Employee - Partnerships Manager. My current role with DOC is to lead Healthy Nature Healthy People – an initiative seeking to make a positive difference to the lives of all New Zealanders through nature.	Y N	

	• **Accessible West Coast Coalition Group** - Member - I represent the Department of Conservation in the Coalition Group. The Department, like many other agencies and organisations is seeking to create greater accessibility for people • **Kowhai Project Committee** – Member - I am a member of this committee in a voluntary capacity and am able to share examples of nature in health settings to support patients, staff and visitors.	N N	
Anita Halsall-Quinlan	• Nothing to report	N	
Edie Moke	• **New Zealand Blood Service** - Board Member (appointed). The NZBS was founded in 1998, and is the only Blood service in NZ collecting all of the blood donations used in our hospitals. These blood donations are used to produce whole blood, plasma and platelet units used by our DHBs.	N	
Peter Neame	• **White Wreath Action Against Suicide** – Board Member and Research Officer White Wreath is a non-denominational, non-political and anti-discriminatory body supporting people who have been directly affected by suicide and those who are affected by mental illness/disorders. • **Author and Publisher** of "Suicide, Murder, Violence Assessment and Prevention" 2017 and four other books.	N N	Perceived
Nigel Ogilvie	• **Westland Medical Centre** - Managing Director • **Thornton Bruce Investments Ltd** - Shareholder/Director • **Hokitika Seaview Ltd** - Shareholder • **Tasman View Ltd** - Shareholder, • **White Ribbon Ambassador for New Zealand** • **Sister** is employed by Waikato DHB • **West Coast PHO** - Board Member • **Wife** is a General Practitioner casually employed with West Coast DHB and full time General Practitioner and Clinical Director at Westland Medical Centre • **Wife** is Board Member West Coast PHO • **Southern ALT Workstream -** Chair	Y N N N N N Y Y Y N	Actual Perceived Actual Perceived
Francois Tumahai	• **Te Runanga o Ngati Waewae** – Chair This is one of 18 Ngai Tahu regional Papatipu Rūnanga which exist to uphold the	N	

	mana of their people over the land, the sea and the natural resources. Te Rūnanga o Ngāti Waewae is based at Arahura a short distance from Hokitika on the West Coast. **Poutini Environmental** - Director Poutini Environmental is the authorised body for resource management, cultural impact assessment and resource consent certification. • **Arahura Holdings Limited** – Chief Executive • **West Coast Regional Council Resource Management Committee** – Member Provides a broad direction and framework for managing the West Coast's natural and physical resources under the Resource Management Act 1991. • **Poutini Waiora Board** - Chair Poutini Waiora is a Maori Health and Social Service provider that delivers holistic care to whanau across Te Tai O Poutini. • **Development West Coast** – Trustee Development West Coast (DWC) was set up as a Charitable Trust in 2001 to manage, invest and distribute income from a fund of $92 million received from the Government. It is governed by a Deed of Trust which specifies DWC's Objects - to promote sustainable employment opportunities; and generate sustainable economic benefits for the West Coast, both now and into the future. • **West Coast Development Holdings Limited** – Director • **Putake West Coast** – Director This is a joint venture between Development West Coast and Putake Honey to develop a West Coast wholesale honey business. • **Ngai Tahu Pounamu** – Director Waewae Pounamu is the home of Ngāti Waewae Pounamu carving • **Westland Wilderness Trust** – Chair • **West Coast Conservation Board** – Board Member The West Coast Tai Poutini Conservation Board serves a conservation advisory role, along with offering community perspective on conservation management issues for the West Coast region. • **New Zealand Institute for Minerals to Materials Research** (**NZIMMR)** – Director • **Westland District Council** – Councillor	N N N Y N N N N N N N N	Actual

MINUTES

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

MINUTES OF THE WEST COAST DISTRICT HEALTH BOARD MEETING
held at Board Room Corporate Office, Greymouth
on Friday 30 October 2020 commencing at 10.00am

BOARD MEMBERS

Hon Rick Barker (Chair); Tony Kokshoorn (Deputy Chair); Chris Auchinvole; Susan Barnett; Sarah Birchfield; Anita Halsall-Quinlan; Edie Moke (via zoom); Nigel Ogilvie; and Francois Tumahai

APOLOGIES

Helen Gillespie and Peter Neame

EXECUTIVE SUPPORT

Andrew Brant (Chief Executive); Philip Wheble (General Manager, West Coast); Norma Campbell (Director of Midwifery). Gary Coghlan (General Manager Maori Health); David Green (Executive Director, Finance & Corporate Services), Jane George (Director of Allied Health, Scientific & Technical West Coast District); Paul Lamb (Chief People Officer), Ralph La Salle (Executive Director, Planning & Funding & Decision Support); Jacqui Lunday Johnstone *(*Executive Director, Allied Health*)* (via zoom), Karalyn van Deursen (Executive Director, Communications) (via zoom)

Gary Coghlan said the karakia

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Remove: Edie Moke – Trustee Ngta Taonga Sound & Vision

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 MEETING

Resolution (53/20)
(Moved: Tony Kokshoorn /Sarah Birchfield - carried)
"That the minutes of the Meeting of the West Coast District Health Board held at Meeting Room 1, Te Nikau Hospital & Health Centre, on Thursday 24 September 2020 be confirmed as a true and correct record, with the following amendments:

i. A board member queried the minutes which did not contain questions she asked at the previous meeting, those points were around.
   a. Does the Celo app work in remote areas, such as South Westland? Which has limited cell cover? Could this cause teething problems?
   b. Most Allied Health referrals are made from pediatricians, to OT/physio/SLT what is the feedback you have received from pediatricians regarding this new model of care using Kaiawhina?
   c. High and very high needs clients with complex needs that might need modifications or sensory report, what will be the process and who will follow this up with the client?

ii. Page 4 – paragraph seven should read 'discussion around Te Nikau Nursing'

The Chair introduced Andrew Brant, Acting Chief Executive and provided a brief overview of Mr Brant's previous work history. Mr Brant

Those who joined the meeting via zoom informed those present that the sound quality was too crackly to hear the discussions.

3. CARRIED FORWARD/ACTION LIST ITEMS

A brief discussion around the following items on the carried forward list took place.

ACTION
Progress around employment of more people with disabilities This is contained in the P&C report provided in today's papers
Report on telehealth usage pre, during, and after COVID-19 This is an agenda item for today's meeting
Emergency Management Presentation There was a brief discussion around the use of the Civic Centre in the aftermath of an Alpine Fault rupture. With the hospital being **Resolution (43/20)** (Moved: Rick Barker /Sarah Birchfield - carried) "That Tony Kokshoorn be the Board's representative to liaise with Civil Defence and Grey District Council to resolve any issues in relation to the use of the Civic Centre in the aftermath of the Alpine Fault rupture."
TXT reminders not holding enough information – only dates need location to be added The information provided by the Chief Digital Officer didn't answer the original question asked. It was mentioned if other organisations were able to provide more detail – date/time/venue/provider. **Action:** Philip Wheble will investigate further
P&C to provide update on Exit Interviews **Action:** Information will be provided at the December meeting
Allied Rural Health Model of Care This will be presented to the board at the next meeting
Low numbers of Maori staff and what is being done. **Action:** This is an agenda item for today's meeting – Maori Health Workforce presentation by Mr Gary Coghlan, General Manager Maori Health.

The carried forward items noted. Chris A and Tony - Carried

4. MAORI HEALTH WORKFORCE - Presentation

Gary Coghlan, General Manager Maori Health, prior to starting the presentation Mr Coghlan read from a memo sent to all CE's, General Managers Maori Health and the dashboard against the targets to increase Maori participation in the workforce. There are six targets identified as a 30 June 2020:

i. 'each DHB will have a percentage of employees who have their ethnicity recorded in their employee profile as unknown' – there has been a reduction in employees with 'unknow' ethnicity since June 2019. Until recently the WCDHB had the highest level of 'ethnicity unknown' but that has now halved.
ii. 'each DHB will employ a Maori workforce that reflects the Maori population proportionally for the region by 2030' – each DHB is behind on this target, the WCDHB has improved by 2% and doing the best of all DHB's
iii. 'each DHB will employ a Maori workforce with occupational groupings which reflects the Maori population proportionally for the region by 2040' – the only area where there is an exception around Maori in some DHBs is in the area of care and support roles.

And

vi. 'each year turn-over of Maori staff shall be no greater than the DHB turn-over for all staff' – for most DHBs the turnover of Maori Staff is disproportionally higher, but not in all.

Mr Coghlan said the General Managers Maori Health will work with People & Capabilities to establish a working group to develop a framework to support data development and collection for targets 4 and 5 and will continue to report on the remaining targets on a quarterly basis.

Mr Coghlan mentioned he will be working with his colleague at Auckland DHB, as a result of the first meeting they have committed to look at what might work in the short-term between four DHBs (WCDHB, CDHB and two Auckland based DHBs).

Mr Coghlan proceeded to present his PowerPoint presentation, he explained the inclusion of the words on the first slide 'with your food basket and my food basket the people will thrive', this means that if you are going to develop around Maori workforce, Maori cannot do it alone it needs to be done in partnership, we are in this together.

The aim is to develop a health and disability workforce that reflects the Maori population, Maori values and Maori models of practice. This should be proportional and mirror the number of Maori and Pacific people in the region. There is a long term plan where this should be accomplished by 2030.

The Position Statement on Maori Workforce endorsed by the National DHB Chief Executives in 2019 covers recruiting, retaining and growing Maori staff. The Workforce Strategy Group agreed targets focus on increasing Maori participation in the workforce with six agreed targets – four of which were mentioned earlier by Mr Coghlan.

Mr Coghlan talked through the final slides of his presentation covering Maori Workforce Initiatives including the Transalpine with targeted initiatives from recruiting Maori, Hiring Managers Tool Kit and Cultural Competency Framework and local WCDHB initiatives and training.

Cultural Competency Framework, Mr Coghlan mentioned three points, Leading Self, Leading Others and Leading Health. If there is unconscious bias, racism etc in the workplace you need to lead your way out and into a better situation. Mr Coghlan said he has noticed over the years this point has improved.

Discussion took place around the recruitment of staff and how to encourage more Maori to apply for positions, along with the collection of ethnicity data of successful applicants. Mr Lamb, Acting Chief People Person, confirmed there is now a focus on the collection of the ethnicity data whether during the recruitment/application or induction process. The Chair mentioned that we also have to respect those that do not want to state their ethnicity. It was suggested that rather than sending out forms to new employees asking ethnicity maybe something as simple as a chat would be more helpful.

Clarification on a comment made earlier by Mr Coghlan 'a workforce that reflects the proportional Maori and Pacific population in the region being accomplished by 2030' – it was asked why does it have to take so long? Mr Coghlan informed everyone that this target will be met and each of the nine years will see an increase and also this is a National Strategy and all the targets are reported on a quarterly basis. The Chair indicated understanding that some would like to see things done quickly, it also takes time to get people through training for some positions like nursing/radiology and longer for some others, it would be too easy to obtain the target by employing Maori as cooks/cleaners but that isn't the goal. If it was simple it would have been achieved decades ago, with some pathways already in place like Kai Ora Hauora. Mr Coghlan referenced his presentation saying the WCDHB has 43 through the Kai Ora Hauora with a large amount of input from clinicians. Of those 43 25% have gone onto careers in the health sector. Studentships developed by this DHB have a high percentage of Maori doing very well in them. There are a lot of opportunity for Maori through Health Workforce NZ and the team tries hard to engage Maori with this process and some go onto careers with this funding.

The Chair thanked Mr Coghlan for his presentation.

Resolution 45/20)

(Moved: Rick Barker / seconded Anita Halsall-Quinlan – carried)

That the Board:

i. note the Maori Health Workforce presentation

5. VENTILATOR & RESPIRATORY EQUIPMENT

David Green, Acting Executive Director Finance & Corporate Support presented the paper which was taken as read.

Resolution (54/20)

(Moved: Tony Kokshoorn/ seconded Sarah Birchfield – carried)

That the Board:

i. notes that Cabinet has agreed to supply additional ventilators and respiratory equipment to DHBs as part of Covid-19 preparedness, free of capital charge,
ii. notes the equipment allocated to West Coast District Health Board is valued at $48,393 (Appendix 1),
iii. approves equity funding of $48,393.

6. PROPOSED MEETING SCHEDULE FOR 2021

The Chair proposed that we adopt the schedule and alterations can be made if any changes are required.

Resolution (55/20)

(Moved: Francois Tumahai / seconded Tony Kokshoorn)

That the Board:

i. Confirms support for the proposed schedule of meetings for 2021 (refer Appendix 1 attached); and
ii. Delegates authority to the Chief Executive, in consultation with the Chair of the Board and/or relevant Committee Chairperson, to alter the date, time or venue of a meeting, or cancel a meeting, should circumstances require this.

7. CHAIR'S UPDATE

The Chair mentioned the opening on Te Nikau with the Prime Minister in attendance, the Sod Turning at the new Buller site where things are now moving along.

There have been some "settling in" issues in Te Nikau, some on-going staffing issues but everything is being worked on with good progress. There have been other issues with Te Nikau with the gateway into the facility and some other minor issues which will be worked on.

The DHB is overall in good health and the only major concern the Chair does have is the deficit continuing to grow, and it cannot continue to do so.

The Chair's Update was noted

8. CHIEF EXECUTIVE'S UPDATE

Mr Andrew Brant, Acting CE thanked Mr Wheble for the excellent report written on his behalf and took the report as read.

Mr Brant said it was a privilege to be asked to set in as the CE for the WCDHB and CDHB and took the opportunity to acknowledge the work done by the previous CE, Mr David Meates, especially the Transalpine agreement. He also thanked the wider management team and those stepping into the vacant management roles. Mr Brant gave a brief overview of his previous and current health involvement. Mr Brant has stepped into the role of acting CE for both DHB's and will be in the role until at least the end of the year. He four things foremost in his thoughts with CDHB are:

1. To keep everything going, and moving in the right direction
2. The move into and opening of the new Hagley facility
3. Accelerating the future, which is a financial programme to try and get things back on track
4. A little bit of a strategic shift

Mr Brant wanted to acknowledge Mr Wheble and his team, he indicated they are a very impressive team and we should be proud of what is being achieved by the WCDHB. The results showing achievements against the Annual Plan is impressive. The innovation of the Rural Generalism model and the outstanding Nursing Model. It has been a very positive experience visiting the WCDHB and seeing what is being done here.

Mr Brant said his main question is 'what is next?'. There is the fantastic relationship with CDHB, our performance results and he is very interested in our 3-5 year plan is. Interested in the different services and its plan to support those services. It's an exciting time for the West Coast.

The Chair mentioned two points came out of a discussion he had had with Mr Brant, one being that when in an acting role it is felt decision making is left alone as there is a new person coming into the role, that worries him as organisations like the WCDHB are run on decisions and they need to be made and he expects Mr Brant to make them when needed, secondly the relationship with CDHB has been very helpful for the WCDHB and he feels that now might be an opportune time to refresh and rethink of what our requirements are, things have grown here in that time and competencies increased The Chair indicated that he would like the senior management on the Coast along with some of the board members to sit down and discuss the next step forward and are there new ways to do things.

It was asked what the timeline was for appointing a new CE to the DHB's. Mr Brant responded by saying that a recruitment firm has been engaged and they are currently recruiting for CE and the positions on the Executive Management Team that are vacant after a number of resignations. The is a possibility that the CE position maybe appointed by the end of the year, but that doesn't mean the

person will start then. The recruitment of the management positions would probably identify a number of suitable candidates and then once in place the new CE would be part of that appointment process. Mr Brant took the opportunity to acknowledge those that have stepped up into the vacant roles. The Chair indicated that he expects the WCDHB Board to be consulted in the process.

A comment about financial processes was made, we have had presentations on how the budget is set, how costs are assessed for the period and have a clear understanding on how things work, and we still don't quite get it right. Mr Brant said as a general reflection of a DHB budget over the year, revenue is largely fixed, it's all really about costs and managing those costs. There is an expectation to come in on budget, both an under and over spend is not what is wanted. With these larger budgets trying to land on a very precise number is not easy. In other sectors it's more looking at profit margins or looking at revenue opportunities, the environment for DHB budgeting is tricky. The Chair mentioned the board are passive observers and they need to get hold of it and manage it. The tools used to set the budget are historical information, planning assumptions signalled by the MoH, with a lot of those not known until after the setting of the budget and this a frustrating time, previously these were made available a lot earlier which made the budgeting easier. Mr La Salle said then you have the unknown, in health you don't know what is going to happening, these things cannot be predicted. It doesn't take much of something happening to cause ripples in the budget, especially here on the West Coast. It is not a Coast only problem with 19 of the 20 DHB's coming in over budget for the 2019/20 financial year.

The Chair went around the table asking if anyone had any question regarding the report provided.

It was asked who the new faces at the table were and what positions they hold:

1. Graham Roper – Acting Chief Medical Officer, part time CMO and part time clinical
2. Ralph La Salle – Acting Executive Director Planning & Funding and Decision Support
3. David Green – Acting Executive Director Finance & Corporate Services
4. Paul Lamb – Acting Chief People Officer
5. Jane George – WCHB Director Allied Health, Scientific &
6. Norma Campbell – Director of Midwifery CDHB & WCDHB

A question asked about the congestion in the front entrance of Te Nikau. Mr Wheble said they are looking at two points one is reducing the number of people in the waiting room area, and moving the phlebotomy service, it is hoped that by next week there will be a plan in place for the service. The second part of this is to get the information of the flow out to the community, what happens when you walk in the door. Mr Wheble said he had been to a community meeting where this was one point of discussion. Now when you walk in the door there is a rolling electronic screen providing information to the public.

Mr Wheble added that the DNA rates and the piece of work that has been done by both the Maori Health Team and Central Booking Unit. A 6% reduction had been mentioned at the previous board meeting, the most recent figure is showing a further reduction with the Maori DNA rates now sitting at 3%. Now this proven process can be rolled out to the wider DHB and health system.

It was asked if the main door to Te Nikau are locked at the certain time in the evening, Mr Wheble said that after 8-9pm the doors are locked. There is a button to gain access, but Mr Wheble will look into this to ensure it is clear.

The Chair asked about the RFP process for the main contractor for the Buller Hospital build and when it is likely to be completed. Mr Wheble indicated that should be completed at the end November It was requested that a time-line for the Buller rebuild be provided.

The Chair asked about the comment 'Inpatient numbers during September picked up with more surgeries being performed' and asked if these numbers could be made available.

Resolution (56/20)
(Moved: Rick Barker/seconded Edie Moke (carried)
That the Board:

i. notes with it appreciated the effort to reduce the DNA's in Maori Health and forwards its appreciation to all concerned for an impressive result

Resolution (57/20)
(Moved: Tony Kokshoorn /seconded Anita Halsall-Quinlan (carried)
That the Board:

i. notes the report.

9. FINANCE REPORT

David Green, Acting Executive Director Finance and Corporate Services presented report which was taken as read.

The report covers the month of September with an unfavourable variance. The drivers of the variance are the Holidays Act Compliance and until the remediation of that is complete the liability is likely to increase. The MoH has instructed all DHB's to make an allowance for this on a monthly basis. What has happened in the September figures is another provision for the Holidays Act has been added. On top of that there is the Te Nikau depreciation that was due to come in in October but came in in August and that sits at $162K/month. If those are adjusted out for the month of September, there is a surplus of $60K. Mr Green mentioned how it doesn't take much to have an impact on the results.

The Chair asked that future reports where there is an overrun he would like to see an analysis of what they are and would also like to see some advice on what can be done about it. He would like the Board to be focused on a balanced budget.

It was asked why there was no commentary for either Allied Health or Support under the 'Personnel Costs (including Outsourced Personnel) & FTE graph. Mr Green indicated that like the other areas it has a portion of the Holidays Act Compliance but he doesn't have any further breakdown. He will obtain more of an explanation for the next report. What is going to cloud the results of Business as Usual will be the addition of the Holidays Act as it is spread across all areas. Mr Green will add another column with BAU showing.

It was asked to have a bit more of a discussion around the $324K depreciation and will this figure be carried through to the end of the financial year? Mr Green said new facility was meant to come on-line on 1 October with depreciation starting at that date, but instead it was transferred on 1 August which meant there were two months of depreciation not budgeted in the annual plan. The MoH are aware of that and Mr Green is expecting that to be an allowable variance. Mr Green confirmed it will sit there until the end of the financial year, unless we are able to make savings in other areas.

A question was asked in relation to the Holidays Act Compliance at $475K, is that likely to carried through as well? Mr Green said that we have made inroads into the personnel cost for September and feels we will improve on that as we settle into the new facility. Mr Green informed everyone that he is not clear how nationally this will work but assumes there will be some additional funding to flow through as all the DHBs are in the same position. Going forward we will be accruing a third of that for the rest of the year, so the full financial year impact is $2M.

In terms of the Holiday Act Compliance, when we were first talking about this there was no end date in sight, do we know when this will be finalised. Paul Lamb, Acting Chief People Officer, answer

there is no specific end date but there are a number of milestones to be achieved through to the ratification phase which should ensure all our systems and processes are compliant.

Resolution (58/20)
(Moved: Sarah Birchfield /seconded Chris Auchinvole – carried)
That the Board:

i. notes the financial results for the period ended 31 July 2020

10. CLINICAL LEADER'S UPDATE

Norma Campbell, Director of Midwifery CDHB & WCDHB, presented the report which was taken as read.

Ms Campbell informed everyone that the Clinical Leaders have been getting involved with Quality and the Quality Framework, how to manage serious incident reviews, workforce recruitment continues to be challenging. It has been referred to in other parts of the papers, primary care and improving the GP workforce available and there have been some good success up in Buller and also Central – the progression of the rural generalist role is starting to show dividends with the ability to share staff across sites and creates connections between different workforce areas. This also has a knock-on effect with supervision and training of the GP Registrars that are coming through.

There is also work being done around inter-professional education, Ms Campbell can speak to the work being done in Maternity where they have had the Comp Workshop where everyone from ambulance staff to theatre attended and they ran scenarios to give confidence. Ms Fielder who is a Canterbury based Obstetrician who is now working across the transalpine to support rural generalism specifically in midwifery. Ms Fielder reviewed some cases against the recognised standard and each time showed that the rural generalist followed the process and provided first class care. Ms Campbell said the mindset that these are not fully trained for their wide scope needs to be changed.

There has been some of Early Years work initiated, it has been a challenge for a number of reasons, including COVID-19.

The new Clinical Board has been launched and they have had their first full meeting. There is a wide range of clinicians from the three DHB locations along with representation from the consumer council. How best to feed back to this Board was also discussed.

Jacqui Lunday Johnstone, Executive Director, Allied Health, indicated that there were some issues around the work they are doing to strengthen sustainability across the Allied Health professions as they have had some resignations, which are not helping in that space, there are some leadership vacancies. They are also working closely on the children's perspective with the SI Alliance strengthening the CDS, this has been held up due to the financial side of things, but progress is being made. A presentation will be brought to the next board meeting around the work being done on the Allied Health Strategy.

The Chair asked that for the next board meeting if a paper could be provided which sets out where we are at in journey of getting the rural generalist model fully embedded and what actions need to be done and a timeline. Also a description of services that are going to be provided at Buller and how they interact with Te Nikau, if the same could be provided for Reefton as well. Not just the medical but all the different areas, nursing, midwifery etc that make up the rural generalist.

It was asked for the comment made earlier about the successful work done in Buller could be elaborated on. Graham Roper, Acting Chief Medical Officer, explained that it related to recruitment of GPs, job offers have gone to two, there is also the remote GP which has started. The rural generalists from Grey have been able to go up to Buller and help.

It was asked whether the patient information system used shares the information. Mr Roper informed everyone that one of the problematic areas with our technology is in primary care, MedTech is used and is a very good system for primary care but it doesn't integrate with the new Apostle system but MedTech system is the same across all primary practices. There is proposal for a new technology platform which would integrate with the hospital based system and the primary practice based system.

Mr Wheble, General Manager West Coast, provided the information that one of the GP will be starting in Buller in February and the other in March. Within the last three months there have been three GPs brought on for Buller and one has already started and with a .75 of a rural generalist, also two nurse practitioners are being training and will be going into their first stage of acting as nurse practitioners in the New Year. What we are seeing for both Grey and Westport is quite a significant change from a very high reliance on locums to shifting it significantly the other way.

It was asked with the new doctors coming what would the new waiting time be to see a GP for a routine appointment. Mr Wheble said it comes down to a few days. It was asked until the new GPs are here and working what is the current waiting time for a routine appointment, Mr Wheble explained that his data isn't current but five days was the figure he had, but early November there is a shortage of GPs so that will rise. Mr Wheble confirmed that these are permanent GPs starting next year, and they will be expected to work across both planned and unplanned, though with the rural generalists going up to Buller they will free up the GPs to work in the planned care.

An update was requested in regard to resurgence planning for COVID-19 which had been discussed at a previous meeting. Mr Wheble informed everyone that there is a large piece of work that the Emergency Planner is working on with the teams around continency planning. It was asked when it is likely to be ready, Mr Wheble informed that there are plans in place but they are continually being updated. Ms Campbell added that the evidence varied and it's the fine turning so there are pathways and plans.

It was asked where we were at with applications for GPs for Reefton. Mr Wheble informed everyone that there were no specific Reefton applications as the focus has been on Westport. The strategy is that once Westport is working well, then to focus on how the rural generalist can rotate around the system including both Reefton and South Westland. Mr Wheble also said they are keen on rotating the medical teams around the system. Ms Campbell said they are also looking right across the system with a lot of work being done in the Alliance space, around community and engaging with the community around long term conditions and how they manage them, care plans, thinking about what we have always done is not necessarily the way we should always do them.

Resolution (59/20)
(Moved: Susan Barnett /seconded: Sarah Birchfield – carried)
That the Board:

i. notes the Clinical Leader's update.

11. PEOPLE REPORT

Mr Paul Lamb, Acting Chief People Officer, presented the report which was taken as read.

Mr Lamb advised everyone that this report contained new data, along with new analytics which go into more detail of the workforce makeup.

A question was asked about item on the carried forward list "Progress around employment of more people with disabilities", Mr Lamb directed everyone to where this information was provided in the report. A brief discussion followed about where this information would sit for future reports.

Mr Lamb gave an overview of what data is able to be extracted from the recruitment system. It was asked whether they could determine how many hits against the number of applications are being received and whether there was a trend, with the difference in numbers between hits and applications it was asked if we are missing something on the webpage or is something discouraging applicants and how we can improve on that. Mr Lamb mentioned some other things like is the website accessible, especially to those that have difficulties accessing things on-line. There can also be a lack of confidence, if you are asked at the application stage to declare a certain position e.g. do you live with a disability, or ethnicity, it could be felt that this was a way of filtering them out. It was suggested that those might be questions that are asked at a later stage when some trust is built up.
Development of a policy for exit interviews, Mr Lamb indicated he would have a draft policy for review at the next meeting.

The fact that 30% of the WCDHB workforce is due to reach retirement age was discussed briefly. The Chair indicated that needs a long term discussion on how best to deal with that, it's not something that can be changed rapidly.

Resolution (60/20)
(Moved: Susan Barnett /seconded: Edie Moke – carried)
That the Board:
i. notes the People Report.

12. TRACKING TELEHEALTH

Ralph La Salle (Executive Director, Planning & Funding & Decision Support presented the report which was taken as read. Mr La Salle asked the board to take this as a taster of things to come, with an updated report for the next meeting.

The Chair thanked Mr La Salle for the report but was disappointed that we haven't achieved more in telehealth as it appears to be moving back to where it was. There are great opportunities in telehealth to improve efficiencies and use of time, reduce travel and costs etc. If the report can come back to the next meeting with tightened up the definitions, as well as giving us some ideas about how we might progress this forward as a policy to increase the amount of use of telemedicine. Excepting that first appointments where people need a diagnosis in person, but how to use it remotely for subsequent appointments. It is felt that this would reduce that amount of DNA, increase the throughput of work. Mr Brant indicated maybe not a target for services but say this is the proportion we are looking for, so services can see what they are trying to achieve.

It was mentioned telemedicine was used prior to COVID-19 and over that period, and has been established as a way to work around those that cannot get to a face to face consultation. But with COVID-19 the use of telephone consultations has also been in use and they need to be recorded as well.

A question was asked about travel assistance and if the use of telehealth/telephone consults are going to reduce travel time and costs should there not be a corresponding reduction in that area as well. Is that data worth capturing as well? Mr La Salle answered by saying that to qualify you need to have a lot of treatments, very few one off appointments qualify and for a specialist appointment you need to be over 350km away from the appointment location. Though it was possible and the data does need to be watched, but is not the primary target.

Resolution (61/20)
(Moved: Rick Barker /seconded: Edie Moke – carried)
That the Board:
i. notes the preliminary information on telehealth requested, along with insights.

13. ANNUAL PLAN UPDATE 2020/21

Ralph La Salle (Executive Director, Planning & Funding & Decision Support presented the paper which was taken as read. Mr La Salle informed the board that this is a standard confirmation that the Annual Plan has been signed by the Minister of Health.

Resolution (62/20)
(Moved: Chris Auchinvole /seconded: Edie Moke – carried)
That the Board:

i. notes the letter of approval from the Minister of Health.

Mr La Salle added information of the WCDHB successfully obtaining two sources of funding, details will be added to the information section for the next board meeting.

14. RESOLUTION TO EXCLUDE THE PUBLIC

The Chair asked why item 3 was on the Public Exclude agenda, Mr Green informed everyone it had been received as 'In Confidence'.

Resolution (63/20)
(Moved: Rick Barker /seconded: Tony Kokshoorn' – carried)

That the Board:

i resolve that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, & 9.

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 6 August 2020 and the Public Excluded Special meeting of 24 September 2020	For the reasons set out in the previous Board agenda.	
2.	Ministry of Health Quarterly Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
3.	NZHP FPIM Service Agreement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
4.	2020-21 IEA Remuneration Strategy	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
5.	Chair and Chief Executive 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)

7.	Draft Annual Accounts	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
6.	Rating Summary Update Q4 2019/20	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
8.	Clinical Leaders 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)
9.	People & Capability 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)

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 5, 8, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982";

There being no further business the public open section of the meeting closed at 12:20pm. The Public Excluded section of the meeting commenced at 1:55pm and concluded at 3.03pm.

_____ _____

Hon Rick Barker, Chair Date

CARRIED FORWARD/ACTION ITEMS

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

WEST COAST DISTRICT BOARD – BOARD MEETING
CARRIED FORWARD/ACTION ITEMS AS AT 30 OCTOBER 2020

	DATE RAISED/ LAST UPDATED	ACTION	COMMENTARY	STATUS
1.	21 February 2020	Cultural Competency	Update for Board	To be scheduled
2..	21 February 2020	MAX – People & Capability Service Portal	Presentation to future meeting	To be scheduled
3.	27 March 2020	Finance 101	Presentation	To be re-scheduled
4.	7 August 2020	Suicide Prevention	Update for Board – 12 months from 7 August Amended to six months	To be scheduled
5.	7 August 2020	Update on occupational therapist vacancies	Update for Board	Provided 24 September – again at December meeting
6.	24 September 2020	Emergency Management Presentation	Presenter to provide report back on use of Civic Centre and communication vulnerabilities on the West Coast and a way forward	Future date

CARRIED FORWARD/ACTION ITEMS

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

7.	24 September 2020	AF8 Group provide a presentation to Board	To be added for future presentation	To be scheduled
8.	24 September 2020	2019/2020 Year in Review	To be added for future presentation	To be scheduled
9.	24 September 2020	TXT reminders not holding enough information – only dates need location to be added	Update to the Board - CDO	October meeting
10.	24 September 2020	P&C to provide update on Exit Interviews	Draft Exit Interview Policy	December meeting
11	24 September 2020	Allied Rural Health Model of Care	Presentation to Board	On the agenda for this meeting
12.	24 September 2020	Low numbers of Maori staff and what is being done	Update to the board – P&C	October meeting
13.	30 October 2020	Timeline for Buller Rebuild	Mr Wheble to update the Board	December meeting
14.	30 October 2020	Access to Te Nikau after hours	Mr Wheble to ensure process is clear	December meeting
15.	30 October 2020	Rural Generalist – 'where are we at'	Across the board, not just medical	December meeting
16.	30 October 2020	Use of Telehealth – Tracking	Updated report	December meeting
17.	30 October 2020	Information relating to two successful funding applications	For Information Papers – Ralph La Salle	December meeting

ALLIED HEALTH
West Coast
Whenu Whakaora

Allied Health
Canterbury District Health Board
Te Poari Hauora ō Waitaha

ALLIED HEALTH
2020–2025
STRATEGIC PLAN

Contents

Foreword

Over the last few months, Allied Health, Scientific and Technical staff have made a significant contribution to our Covid-19 pandemic response. It has been inspiring to see how responsive and flexible our teams have been in meeting the needs of the system, working in new ways including extensive use of digitally enabled clinical activity and being incredibly focused on wrapping services around our most vulnerable patients, whānau and communities.

I am incredibly proud of what Allied Health have collectively delivered and continue to deliver during this transition and recovery phase.

We have been engaging with leaders and practitioners across Canterbury and the West Coast in the months prior to lockdown on our future direction and how we best mobilise our collective Allied Health response in service of the organisation, people and the communities we serve.

This document is the sum of our efforts to date reflecting our shared vision of how Allied Health can work together to deliver a step change in how we work differently while evolving our focus on different things. This will enable us to continue to become more proactive, preventative and community focused rather than reactive and somewhat hospital centric.

We have further work to do in co-creating our improvement plan and in order to support this expect to see a significant focus on improvement skills development. Strengthening our leadership structure will be central to our efforts, as will our commitment to implementing the South Island Career Framework.

Foreword

You can expect to hear more about the Disability Action Plan, our Healthy Food and Drink Plan and our work with Community and Public Health partners to drive a renewed focus on Recovery and Wellbeing; as well as partnerships with Primary Care to support Planned Care, Urgent Care and Rehabilitation and Enablement initiatives. We are also working closely with our Hauora Māori colleagues on how we strengthen our focus on equity of access, diversity and inclusion.

The depth and breadth of diverse Allied Health skills and capabilities to reach across people's lives makes us ideally placed to lead and support services towards a greater focus on prevention and early intervention and enablement, as well as contributing significantly to supporting people to live independently in their local communities, reducing dependence on health care services and enhancing personal outcomes.

It is an exciting time for Allied Health, and I look forward to working together with our leaders, practitioners and our multidisciplinary team colleagues to co-create these initiatives that will support improved outcomes, enhanced equity and greater connectivity with our colleagues and partners across the system.

Whāia te pae tawhiti kia tata, ko te pae tata kia mau, kia tina.

Seek the distant horizon to bring it close, the horizon that is close, hold strong.

Jacqui Lunday Johnstone - Executive Director Allied Health, Scientific and Technical, Canterbury and West Coast District Health Boards

Who we are

Allied Health, Scientific and Technical (AHST) are the second largest group of health professionals in both the West Coast and Canterbury DHBs. We are a diverse group who work across all parts of the system providing diagnostics, therapeutic treatments, rehabilitation and enablement across the whole life course, as well as informing and implementing preventative/wellbeing focused services and interventions.

Our interventions are pivotal to a range of health pathways and enabling people to remain well, live independently and avoid unnecessary admission to hospital or aged residential care.

Our Mission Statement

To improve, promote and protect the health of the people in the community and foster the well-being and independence of people who experience disabilities and reduce disparities.

Our Vision – Tā Mātou Matakite

To improve, promote, and protect the health and well-being of the Canterbury community.
Ki te whakapakari, whakamanawa me te tiaki i te hauora mō te oranga pai o ngā tāngata o te rohe o Waitaha.

Our Values – Ā Mātou Uara

Care and respect for others.
Manaaki me te whakaute i te tangata.

Integrity in all we do.
Hāpai i ā mātou mahi katoa i runga i te pono.

Responsibility for outcomes.
Te Takohanga i ngā hua.

Canterbury District Health Board

Allied Health
Canterbury District Health Board
Te Poari Hauora ō Waitaha

Our vision is of an integrated West Coast health system that is both clinically sustainable and financially viable; a health system that wraps care around the patient and helps people to stay well in their own community.

West Coast District Health Board

ALLIED HEALTH
West Coast
Whenu Whakaora

About us

We are:

Diverse

16% of our workforce identify as Maori or Pasifika

Far Reaching

The Allied Health workforce consists of over 20 professions across Canterbury and West Coast with 2,212 staff

Forward Thinking

Allied Health professionals are an innovative and versatile group who help connect the system along each step of the care continuum

We need:

Enhanced Leadership Structure

90% of survey respondents agreed an Allied Health programme of leadership development is needed to develop their skills

Cohesive Governance

70% of survey respondents recognise the need for streamlined, clear governance and leadership across professions

Increased Community Based Care

Currently, 79% of our workforce are hospital based

We are working towards this by:

Enhanced Collaboration

Working in close collaboration with the community, stakeholders, people and whānau we serve

Digitally Enabled Workforce

Equitable focus on providing digitally enabled models of care across the Canterbury and West Coast to improve outcomes

Creating Opportunities

Maximise the contribution of Allied Health to priority areas to support transformation and enable the development of sustainable and resilient transalpine service delivery

Introduction

Te Tiriti o Waitangi is that foundation of our nation and we must work diligently to give effect to Te Tiriti in ways that are meaningful to our Tiriti partner. Our work also must address health inequity in all parts of our system.

The Allied Health Professional (AHP) workforce commits to improving outcomes and addressing health inequity for Māori. We recognise that this requires a range of options and will require specific and dedicated planning and implementation. AHP staff will continue to evolve our work with Māori Health workers and kaupapa Māori organisations and structures to optimise service delivery with Tangata whaiora and whānau.

Building on our recent experiences, knowledge and skills, together with new models of care and technologies, we will focus our resources to deliver high quality Allied Health services which improve timely, responsive and equitable access to care. Our service models will evolve to support the Stepped Model of Care (see Appendix II), contribute to the broader healthcare team and provide high value, efficient person and whānau-centric services. We are committed to reducing health inequities, reducing waiting times and working closely with consumers and their families to achieve optimum health and wellbeing for our community. Using the Stepped Model of Care Framework (Appendix II), priorities in our service development will be the prevention of unnecessary hospitalisation, early intervention, supported self-management and the enablement of sustainable health and wellbeing.

We will foster innovation, continuous quality improvement and effective clinical governance. We will continue to provide high quality student, internship and new employee experiences as well as support continuing professional development of our workforce, actively engaging in inter-professional learning wherever possible. We will strengthen our workforce capacity and capability with skill sharing and skill delegation using quality improvement tools, enhancing proven models of care and enabling the workforce to practice at the top, and where appropriate at an extended, scope of practice. We will evolve our workforce to reflect the diversity of the community we serve.

OUR KEY PRIORITIES ARE:

- Workforce Development
- Enhancing Leadership
- Partnership, Participation and Empowerment
- Digital Optimisation
- Professional Practice and Skills Development
- Research, Innovation and Improvement Science

Key Priorities

WORKFORCE DEVELOPMENT

Having the right workforce with the right skills in the right places is going to be a significant challenge for sustainable and effective multi-professional service delivery in the future. It will also be essential for us to focus on the things that deliver greatest value to the system and enhance the experiences and wellbeing of those who use our services and their whānau, while also reflecting our commitment to Tō Tātou Ora and supporting our people to be well and stay well.

Our commitment is to evolve our workforce in a way that is more reflective of the diversity and richness of the communities we serve. This includes enabling a greater representation of Māori and Pasifika in our registered health professionals and Kaiāwhina across the CDHB and WCDHB. We also need to explore ways of supporting more people with disabilities into our system in keeping with our policy on diversity, inclusion and belonging.

STRATEGIC PRIORITIES

1. We will focus on skill mix enrichment and building the capacity and capability of our Kaiāwhina workforce.

2. We will work in partnership with our academic partners and Kia ora Hauora to improve awareness of and access to careers in Allied Health and support recruitment from our Māori and Pasifika communities into our professional programmes.

3. We are committed to implementing Career Frameworks and using these to support a robust approach to career development and strengthen capability where it is most needed, enhancing our ability to deliver service impact in priority areas.

4. We will progress rural health models of care and strengthen our rural communities' access to Allied Health.

5. We will enhance early career development opportunities of Allied Health professions across the Canterbury and West Coast health systems and new entry to specialist practice programs that focuses on our people - keeping them at the centre of everything we do

Key Priorities

ENHANCING LEADERSHIP

There has never been a time where our commitment to clear, coherent and effective transalpine Allied Health leadership has been more important (see Appendix I). The experiences of our collective responsive to Covid-19 have crystalized the need for us to evolve and consolidate our leadership arrangements and streamline professional working arrangements in order to enhance our capacity to deliver flexible responsiveness, avoid duplication of effort, and expedite rapid decision making.

Our leaders and teams have done an incredible job of embracing both the challenges and opportunities that recent events have created and it will be important for us to capitalise on these successes – especially the significant gains of using digitally enabled clinical intervention, welfare support and team connectivity.

STRATEGIC PRIORITIES

1. We will strengthen and evolve our leadership infrastructure to reflect our strategic priorities, support transformation and enable the development of sustainable and resilient transalpine service delivery.

2. We will create opportunities for collective Allied Health leadership experience, beyond individual professions, to maximise the contribution of Allied Health to priority areas.

3. We will create opportunities for Allied Health leaders to build capacity and capability in the use of data and improvement methodologies to support system impact.

4. We will support the evolution of clinical leadership roles across Allied Health that underpin service transformation and enhance equity and outcomes for the people whānau and communities we serve.

5. We will actively invest in cocreating our approach to enabling system and service improvement across Allied Health.

Key Priorities

PARTNERSHIP, PARTICIPATION AND EMPOWERMENT

A consistent theme from our engagement sessions with AH staff and stakeholders was the need to evolve the ways in which we connect with and understand the experiences and expectations of those who use our services.

Feedback included many ideas on how we could develop resources to better support people in managing their symptoms and self-care, along with better utilising Allied Health expertise in supporting people to stay well and independent to avoid dependence on health care professionals and unnecessary hospital admissions. These are great ideas and worthy of more focus, energy and attention as we go forward and build our repertoire of digital resources and contribution to the pathways of planned care.

STRATEGIC PRIORITIES

1. We will use data gathered from the experiences and perspectives of our Tangata whaiora, whānau/ people and families in care to inform and shape the development of increased access, improved service delivery and supported self-management approaches in identified areas of priority.

2. We will streamline access and triage for Allied Health as well as enhance pathways of transition of care to avoid duplication of effort and multiple assessments by different practitioners.

3. We will focus on where prevention, early intervention and enablement can impact on hospital acquired conditions and reduce unnecessary bed days as well as support reduced length of stay and early discharge.

4. We will systematically explore how to deliver universal and targeted support to people, clients and whānau that is underpinned by evidence and best practice.

5. We will champion Te Tiriti o Waitangi and the principles of diversity, inclusion and belonging in the way we partner with the people, whānau and communities we serve to co-produce our future models of service deliver and resource development to meet their needs and expectations.

Key Priorities

DIGITAL OPTIMISATION

Allied Health professionals are an innovative and versatile group who help connect the system along each step of the care continuum, from emergency and acute care through to outpatient care, community health and primary prevention. We have considerable untapped potential in the utilisation of digital health and are well positioned to maximise the benefits achievable from digitally enabled consultation, review and rehabilitation for individuals and groups.

Many of the recent Covid-19 experiences have provided the opportunity to build confidence and competence in the use of digital technologies in a variety of ways. These and other experiences will assist with optimising the use of digital technology to enhance Tangata whaiora, whānau / person, family care service delivery options. The use of digital technology can also provide alternative and effective mechanisms for some other aspects of health care delivery such as team meetings, supervision and professional development to supplement face to face options.

STRATEGIC PRIORITIES

1. We will use data analytics to plan, evaluate and modify Allied Health services.
2. We will implement digitally enabled models of care across the Canterbury and West Coast that leverage the benefits of technology and provide efficient care that is timely and responsive.
3. We will advocate for and support the development of Allied Health services that are technologically enabled and health information that empower people to take greater responsibility for their wellbeing.

Key Priorities

PROFESSIONAL DEVELOPMENT & CLINICAL EDUCATION

In order to achieve our transalpine vision and strategic priorities we need to strengthen the capability and capacity of our students, intern, newly graduated and experienced professional and kaiāwhina workforce to effectively meet the challenges of increasing demands on the health care system. Acknowledging the importance of profession specific requirements, we will also take opportunities to optimise inter-professional learning and enhance inter-professional models of care wherever possible.

STRATEGIC PRIORITIES

1. We will collaborate with our leaders and stakeholders to develop a shared vision/ plan that ensures the workforce is able to respond to changing community healthcare needs and service requirements while evidencing the impact of the changes and improvements that are implemented

2. We will develop and implement sustainable training pathways from early career to advanced roles for Allied Health professionals and support staff.

3. We will adopt inter-professional education and learning approaches that build collaborative practice approaches and support integrated person-centred care.

4. We will build our capacity and capability to support positive practice and teaching.

5. We will partner with our academic institutions to further develop and strengthen existing models to improve student learning and experiences and evidence their impact.

Key Priorities

RESEARCH, INNOVATION & IMPROVEMENT SCIENCE

The implementation and integration of research evidence and improvement systems is vital for the delivery of high-quality Allied Health services. Allied Health clinicians can facilitate not only their own learning, but the learning of others through sharing of knowledge, resources and information and utilising opportunities to engage in both formal and informal workplace learning situations.

Building the capacity and capability of the Allied Health workforce to participate in research will further develop and enhance new, evidence informed services and models of care. Fostering research partnerships across health teams and academic institutions will provide opportunities for both parties and ensure that Allied Health researchers are well placed to make an effective contribution to ongoing health service improvement.

Transalpine clinical governance needs further development and leadership to provide the necessary quality assurance and improve the consistency of agreed standards across and between professions.

STRATEGIC PRIORITIES

1. We will encourage, promote and celebrate Allied Health research across all professional disciplines within the Canterbury Health system.
2. We will ensure the accessibility of and promote research evidence to support decision making by clinicians, managers and policy makers.
3. We will raise the profile of research activities within the Canterbury Health system to attract and retain high quality Allied Health professionals.
4. We will strengthen clinical governance consistency and quality improvement activities to increase collaborations, reduce duplication and eliminate waste.
5. We will work in partnership with people with lived experience and their whānau/ caregivers in the evolution of our improvement innovations.

Appendix I

In late 2019 we held an Allied Health Leaders workshop.

The below results came from a series of questions on the current leadership and governance structure in Allied Health.

90% of survey respondents agree we need a unified approach to leadership across each profession for the system

80% of survey respondents agree we need to create more opportunities for leaders to work outside of the box and gain experience beyond their profession

80% of survey respondents agree we need to develop integrated AH leadership roles to support change and focus on priority areas for change improvement

100% of survey respondents agree that leaders need an opportunity to develop skills in change management and/or improvement approaches

Appendix II - Stepped Model of Care

TE TIRITI O WAITANGI

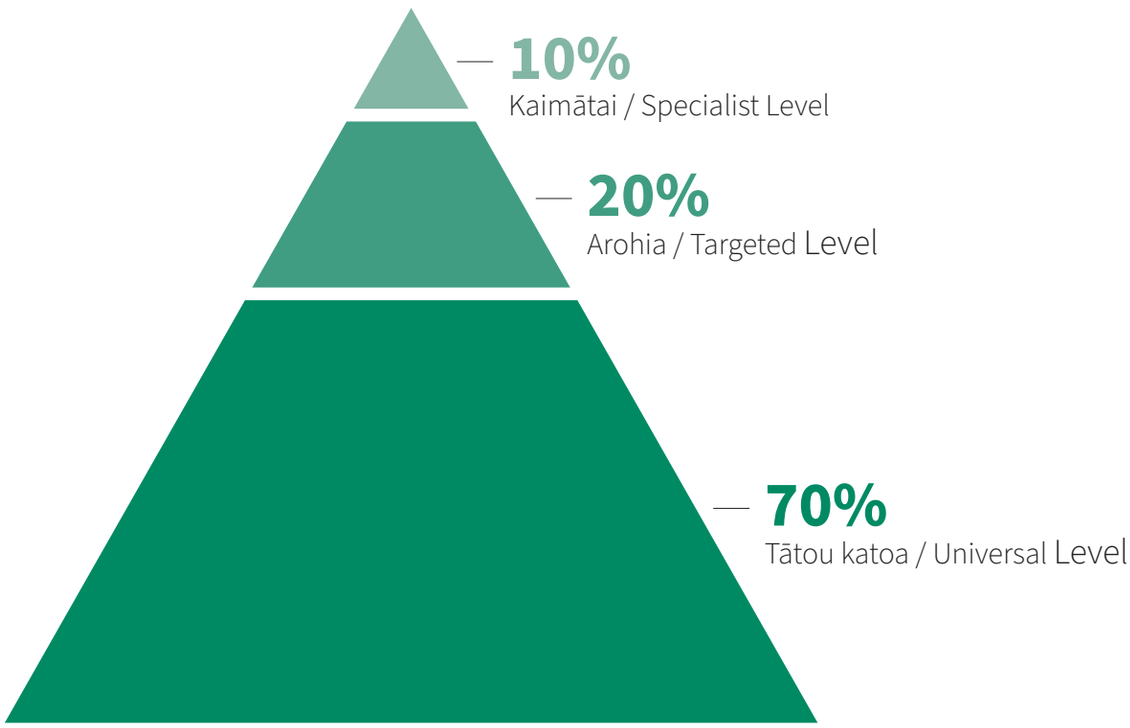
The Allied Health Professionals (AHP) workforce commits to improving outcomes and addressing health inequity for Māori. We recognise that this requires a range of options and will require specific and dedicated planning and implementation. At all levels of the Stepped Care Model, together with each of the identified enablers, AHP staff work with Māori Health workers and kaupapa Māori organisations and structures to optimise service delivery with Tangata whaiora and whānau.

STEPPED CARE

The concept of 'Stepped Care' often represented in a Pyramid diagram is generally widely understood across the health and social service sectors. The Pyramid depicts across its broad base that most people (approximately 70%) will be able to have their needs met in this step. For some (approximately 20%) targeted responses and / or interventions will resolve the issue(s) and for a few (approximately 10%) with more complex problems and depicted as the point of the pyramid, specialised interventions will be required.

For the purposes of this document the Allied Health Strategic Plan applies the following broad interpretations which can be applied to identified cohorts of the population.

Appendix II - Stepped Model of Care



Kaimātai / Specialist Level

This level is for those whose health and wellbeing needs cannot fully be met through Tātou katoa or Arohia levels. At this level person-centred, family inclusive and recovery focussed interventions (direct or indirect) would be provided. AHPs use strengths-based approaches and build self-reliance and confidence to achieve sustainable recovery and wellbeing.

Arohia / Targeted Level

AHP service provision at this level are for those in the identified cohort recognised as having more specific health care needs. Such services would include tailored advice, activities, actions and learning to improve health and wellbeing.

Tātou katoa / Universal Level

This includes general health and wellbeing information and services to the whole identified cohort. It recognises the value of health and wellbeing promotion, prevention and early intervention activities and that these are an essential component and core competency for all AHPs. Examples of activities included at this level include the provision of evidence based and/ or evidence informed information and literature to Tangata whaiora / service users and their whānau / families or caregivers; collaborating with other service providers by providing consult and advice into activities and programmes to improve outcomes as well as enhance the provider's skills and confidence; working with partners to increase Tangata whaiora / service user participation and fostering the development and maintenance of nurturing homes and inclusive communities.

Enablers

DIGITALLY ENABLED HEALTH CARE DELIVERY

The experiences of the recent pandemic have significantly improved competence and confidence in using digitally enabled service provision both for clinicians and those receiving service. Acknowledging that it is not a 'one size fits all' approach, there are many opportunities to further build on the impressive work achieved under 'lockdown' to embed a mix of face to face and digitally enabled service delivery to become the norm.

It is imperative that the benefits of using technology continue to be enhanced and utilised. In the stepped model of care much of the Tātou katoa and Arohia levels can involve the use of digitally enabled health care. At the Kaimātai level it would be expected to be a mix of face to face and digitally enabled work. This is essential if we are to achieve enhanced access, reduce waiting time and increase service provision of AHP staff, within the current fiscal and human resourcing context.

ENHANCED ACCESS TO AHP STAFF

In order to achieve optimum promotion, prevention and early intervention opportunities and outcomes, people must be able to easily access the AHP skillset. This would include the means for direct access without barrier causing and / or exclusionary criteria. It is recognised that outcomes are significantly improved if Tangata whaiora or whānau are easily able to make contact when they first become concerned about a health or wellbeing issue. Models such as a single point of referral supported by robust triaging tools and processes, would provide the mechanism for optimising access whilst at the same time minimising risk and offering signposting to the other appropriate resources or support.

Enablers

WORKFORCE COMPETENCIES AND SKILL MIX

To honour our commitment to Te Tiriti o Waitangi, all staff need to have a high degree of knowledge and understanding of the causes and drivers of health inequity for Māori. Learning and development programme(s) to ensure this is met and maintained must be agreed and delivered in partnership with our Māori Health Leads.

With the known mix of increased demand and an ageing workforce, it is imperative that we agree the core and specialist competencies for the AHP workforce. To fully meet the objectives of a Stepped care model all AHP staff need to be confident and competent in the Tātou katoa and Arohia levels. Any training gaps identified can be met through inter-professional learning programmes.

Equally we must utilise the recognised tools available to facilitate skill sharing and delegation to the kaiawhina/assistant workforce across all of the Allied Health Professions. Further expanding this would release some clinical time to undertake the work only AHP staff can undertake.

ESCALATION PATHWAYS

In general, if people can easily access effective services for their health need as early as possible, there is likely to be a reduced demand for specialist intervention. However, to ensure the continued provision of high quality AHP services at all levels of the Stepped Care Model, staff must have competence and confidence in identifying and accessing escalation pathways. Work to refine and adapt existing tools and pathways to achieve this is an important component of this model and requires a high level of commitment and trust across all AHP teams and the wider health care services.

ALLIED HEALTH
West Coast
Whenu Whakaora

Allied Health
Canterbury District Health Board
Te Poari Hauora ō Waitaha

Reference: 2407339 - Authorised by Executive Director of Allied Health, July 2020

GENERAL MANAGER UPDATE

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

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

SOURCE: **General Manager West Coast**

DATE: **10 December 2020**

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 General Manager West Coast and the leadership team 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.

2. RECOMMENDATION

That the Board:

i. notes the General Manager's update.

Health care Home / Māori Health	**DELIVERING COMPREHENSIVE STABLE AND SAFE SERVICES IN THE COMMUNITY**

A: Reinvigorate the West Coast Health Alliance

These key messages highlight the activity of our Alliance and include examples of leveraging our integration with Canterbury and the rest of the South Island to progress local development in areas of need. At their October meeting the Alliance Leadership Team:

- Agreed to three recommendations regarding Shared Care Plans, being:
  - That all members of ALT be able to describe the difference between Shared Goals of Care and Shared Care Plans and the system benefits of Shared Care Plans;
  - That ALT supports each of the Workstreams to incorporate Shared Care Plans into their work programme by supporting workstream members (including Consumer members) to access and attend education about Shared Care Plans and workstreams determine one or two measures that will assist with progressing utilisation of Shared Care Plans; and
  - That ALT write to the Information Services Service Level Alliance of the South Island Alliance to understand how West Coast might support a regional solution to allow non-data-contributing health partners to access the platforms where Shared Care Plans are hosted.

- Were pleased with the workplans received from the three new Locality Workstreams and have provided feedback. The workplans include some exciting work ahead which will create opportunities for whole-of-system learning including different approaches to long-term conditions management.
- Suggested that a presentation be made to the Board on the Alliance's role in transforming the system to enable the best possible health and wellbeing outcomes for West Coasters – covering: ALT structure, the work that the Alliance is focused on, the locality based workplans and the shared care tools that the system is utilising.

B: Build Primary and Community Capacity and Capability

Integrated Locality Services

- **Integrated Health Services - Northern**
  - Recruitment of GPs for the Northern team is ongoing with the successful recruitment of two new GPs. Along with this, we have our Rural Generalist support from Grey and two new Nurse Practitioners early next year. We have been enjoying returning locums who are complementing the clinical team.
  - Work continues to improve care for our communities through a focus on long term conditions and reducing the wait time for planned appointments in primary care.
  - Maximising the use of telehealth in the primary setting has been a focus and we have more clearly identified the patients who best fit this service and are adjusting accordingly.
  - The Northern Alliance workstream have monthly scheduled meetings with the focus of helping people with long term conditions to stay well at home.
  - We are fortunate to have a very enthusiastic and knowledgeable Northern Consumer Group and we are valuing our engagement in this process.
  - 25 November was 12 months to the day when Buller decanted into their 'Left Wing'.
- **Integrated Health Services – Central**
  - Services have largely settled into Te Nikau but some more work toward further integration is required, particularly in relation to the volume of activity and flow in the unplanned acute care area.
  - Community engagement and information to explain entering the building (particularly out of hours), accessing clinical care and paying fees (where applicable) is ongoing.
  - WCDHB employed GP and Nurse Practitioner FTE, to support the 9880 enrolled population of Te Nikau Health Centre, is slowly stabilising and the use of short-term locums reducing.
  - The West Coast Alliance Central Group is on track with their recently agreed work plan (relating to improvements in supporting people with long term conditions).
  - The Consumer Council locality group has agreed a plan to use feedback from the PHO patient survey (in data collection phase now) and the themes from feedback received directly by WCDHB to guide our priorities and actions. Current trends would suggest timely access to and continuity of primary care continues to be a concern for the local community.
- **Integrated Health Services – Southern**
  - Interviews are underway for a suitably qualified Nursing or Allied Health Case Manager for mental health. A recent team-wide planning day highlighted important future directions for the team that have also been identified and endorsed at the WCDHB Mental Health Service Leadership Group level. This case management position being

able to be filled by a 'suitable' mental health professional from Nursing or Allied Health backgrounds is an important step in that service evolution.

- Both the Southern Consumer Council and the Southern Alliance Workstream are now meeting regularly and have clearly defined processes and work plans to follow. Two additional Consumer Representatives have joined the Consumer Council and members of the Consumer Council have agreed to provide 'co-design' input into the identified Alliance projects.
- The newly appointed Public Health Nurse Southern has commenced recently and is settling into her role. As previously noted, the scope of this position has been broadened slightly such that there is a clearly defined working relationship with the South Westland RNS team to foster collegial support and learning. This sits comfortably alongside the other key linkage with the Central PHN team from whom our new appointee has received a tremendous orientation programme.
- An update on progress with the relocation of Haast services from the Hannah's Clearing site into the Haast township has been received which identifies several minor items to be completed by building or other trades which will in turn enable the Westland District Council to issue a Code of Compliance certificate. A relocation plan has been drafted that can be adjusted once confirmed dates are received.
- Work continues on quality improvement initiatives previously reported, including District Nurses documenting their notes into a patient's electronic record; District Nurses providing regular support to South Westland Rural Nurse Specialists as demand requires and as resources permit; developing a systematic approach to the transfer of patients back to their home settings after hospitalisation; and improving coordination of multiple appointments for patients.

C: Hauora Maori Update

Workforce Development

- **National Working Group:** GM Māori is working with Tumu Whakarae, Māori Workforce Lead and GM Human Resources, Auckland DHB on a programme of work that will accelerate progress against the priorities laid out in Whakamaua: Māori Health Action Plan, 2020-2025 and supported by Tumu Whakarae to move towards the target: *All DHBs will set in place steps to significantly and meaningfully realise cultural competence for all clinical staff, the Board and other staff groups that have regular contact with patients and whānau.*

- As part of the programme we will evaluate models of cultural competence in practice and share some of the exemplars of good practice across the DHBs. The aim is to work with an Industry Training Organisation to credentialise cultural competency training to fit within the NZQA framework.

- **Takarangi**: The third Takarangi programme has been held at Te Tauraka Waka a Māui Marae 12/13 November with 19 WCDHB and 3 CDHB staff attending. Staff will continue to be supported with the development of their portfolios. There are now 53 staff who are engaged in the programme and at varying levels of developing their portfolio. Dates are being planned for 2021 with nine already enrolled.

- **HEAT Tool Sessions:** There have been seven Health Equity Assessment Tool training sessions held to date with the following services; Central Booking Unit, Population Health, Mental Health x 3, Paediatric Dental Pathway and Emergency management.

- HEAT tool sessions consist of a presentation to set the scene and for participants to challenge their thinking about health equity, root causes and how interventions can either negatively or positively impact on disparities. The group then apply the tool to a project of their choice. The three stages of the tool are; 1) Identify if there is an inequity 2) intervening to reduce inequities 3) evaluating how the intervention has impacted on inequities. Follow-up sessions are held after three months after the training.
- **DNA project:** Work continues with the CBU team re Māori not attending their Out Patient Appointments. Over the last 4 months DNA rates have been consecutively under 8% (first time since 2015). October 2020 was the lowest at 1.55% (Other ethnicity = 4.3%). The challenge is to now expand the learnings to other appointment dependent services.

Pae ora o Te Tai o Poutini

- The Pae ora o Tē Tai o Poutini evaluation has been completed. The evaluation was undertaken with two projects – Whakakotahi (a diabetes management programme) and GP/Nurse Practitioner/Kaupapa Māori Nurse Prescriber led clinics. The pilot programmes have comprehensively demonstrated that by providing care in a different way whānau will engage, become more independent in the management of their health, and begin to have positive health outcomes.
- The findings have been presented to whānau who participated in the evaluation, hui were held in Greymouth, Hokitika and Buller. Another presentation was given to managers and health professionals within the DHB and Primary care. The challenge is now to understand the learnings and work collectively to build on the opportunities presented to us through the findings of this evaluation.

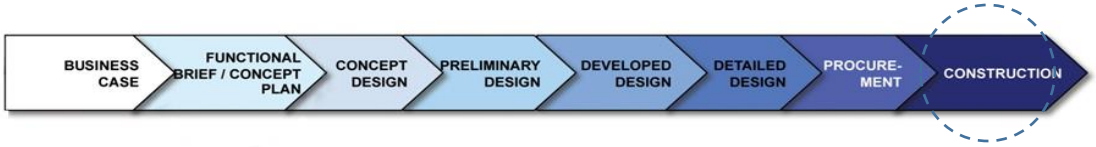
	DELIVERING MODERN FIT FOR PURPOSE FACILITIES

A: Facilities Maintenance Report

- The main focus of the team is very much concentrated on rectifying defects and actioning change requests in Te Nikau.
- The maintenance team are working closely with the contractors and the clinical staff to facilitate defect remediation whilst causing minimal disruption in a working hospital.
- Planned maintenance schedules are being formulated for all plant and equipment in Te Nikau. This includes the migration to Maximo as an Asset Management Information System and the migration of all the As Built documentation and asset information. Warranties are dependent on this planned maintenance being successfully completed during the 12-month Defect Notification Period as is our Building Warrant of Fitness.
- We are working closely with the demolition team to ensure that our staff, patients and visitors remain safe and the other buildings are not adversely affected.
- The new coal boiler will be turned off on 30 December to allow the diesel boiler to run the site for the summer period. This is part of the design strategy which took into account both the capital and operational costs of providing heat to the campus.

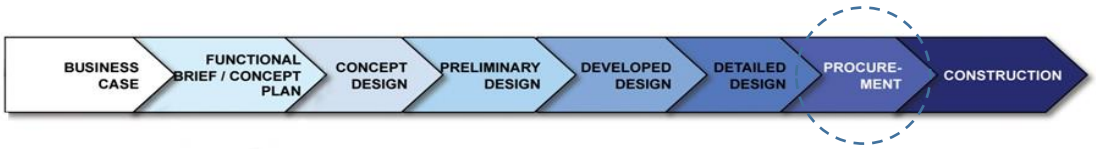
B: New Facilities Redevelopment Update

Grey



- Defecting Liability Period processes are continuing to work well with prompt attention from Fletchers to accepted construction defects.
- Additional scope items approved in September 2020 have undergone design and have progressed to pricing and consenting stages. These items include; RAGP building relocating to Cowper Street, Ambulance Bay Screen, Loading Bay Canopy, Medical Gas Enclosure, Carpark Seal Upgrade, Walkway Canopies, Paths & Lighting.
- Stage 1 demolition works continue. Asbestos removal is expected to be complete by the end of November 2020 and demolition is on track to commence on 7 December 2020.
- Stage 2 and 3 demolition works planning has commenced. The DHB are still occupying these areas for storage however intend to exit by 31 December 2020.

Buller



- Asbestos removal is continuing. Following this the demolition of buildings will commence. The contractor has also started the removal of contaminated ground and strip of the site. This was not due to commence till mid-December however has been brought forward to meet the programme requirements. The stage 1 asbestos removal and demolition is still due for completion February 2021 and the project is still within programme.
- Request for Proposal (RFP) for the main building contract has been sent to the shortlisted respondents with a close date of 16 December 2020.

	RECONFIGURING SECONDARY AND TRANSALPINE SERVICES

A: Rural Inpatient & Transalpine Services and Secondary Mental Health Services

Nursing

- Interviews are in progress for a permanent Clinical Nurse Manager Acute Zone. Nursing has had a successful recruitment drive for the Acute Zone with some experienced emergency nurses being offered positions.
- CCDM partnership training took place the week of 16 November. Feedback suggested this was a valuable and highly productive workshop giving staff a number of actions to work on over the year ahead.

- Whilst CCDM implementation has been slow, Council is confident it will move forward quickly towards the goal of having the programme completed next year. The operational working group have reignited and are looking forward to seeing some parts of the programme completed.
- CCDM dashboards are being designed by our Canterbury partners with the WCDHB offering to do the trial of the Variance Response Management System to iron out any issues which may occur.
- Two Nurse Consultants have visited Buller to meet the teams and ensure consistency of policy and procedures and to support the team.
- Two staff members from Buller will be working in Te Nikau next month. It is hoped this will encourage others to do the same and learnings will be shared across the system.
- Data collected from District Nursing over the past three years is going to Planning & Funding for analysis. Once analysed, work can begin on staffing levels needed in the Central region.
- Train the Trainer for Inter-Rater Reliability (IRR) testing has been completed. The trained staff will now start the testing next month. This testing is to ensure data integrity prior to FTE calculation.

Rural Inpatients and Transalpine Service

- Elective services continue to be delivered with improving wait times. With the recent approval and funding from the Ministry of Health for our plan to ensure waiting times are met over the next 3 years it has enabled us to purchase more clinics where those opportunities arise.
- Neurology Services are provided from CDHB and these have been pressured due to a national shortage of Consultant Neurologists. West Coast patients have had to travel to Canterbury for face-to-face clinics since August but in the New Year this is expected to be resolved as the CDHB staffing pressures ease.
- Oncology services remain pressured due to a shortage of staff at CDHB and this is causing delays to some chemotherapy referrals across the upper South Island. We have weekly region-wide meetings to keep abreast of developments and monitor the situation and presently care continues to be delivered to our patients without being adversely affected by this issue.
- The training of laboratory staff in the use of the rapid testing machine for COVID-19 has been completed. This machine enables us to test high priority cases where a result is required in less than 24 hours and, therefore, enables us to mount a response quickly in these cases.
- Inpatient numbers during September picked up with more surgeries being performed. The general ward has reviewed the precautions with which any suspect case of COVID-19 will be managed in preparation for the laboratory being able to conduct urgent testing.
- The Respiratory Service upgrade to its spirometry software has improved result turnaround times.
- We have had positive feedback from GPs regarding the colonoscopy and gastroscopy reports now being electronically available (in colour). We have now been able to cease the printing and manual scanning of these and they are automatically accessible as part of the patient's health record.

- We have completed the recruitment for the National Bowel Screening Programme Project Manager (responsible for outcome equity, project delivery and engagement) and NBSP Project Specialist (responsible for documentation and project plans). They will partner with community and clinical team stakeholders to ensure the successful implementation of the National Bowel Screening Programme on the West Coast. The Ministry of Health has provisionally set the commencement month as May 2021.

Maternity

- Births for Te Nikau Maternity in October were 11. As well, Gloriavale had 2 births and there were 2 home births. No births in Kawatiri again during October. We have a couple of busy months coming up.
- One of our Enrolled Nurses, who has worked in Maternity for over 30 years, is retiring at the end of December. Staffing at present is adequate and we have an independent midwife joining us on 1 January 2021.
- Education is back in full swing and busy with numerous workshops being held and well attended. This includes the Perinatal Anxiety and Depression Aotearoa (PADA) Seminar, National Perinatal Pathology Service Workshop and our STABLE (Stabilisation Care of Sick Infants) course, as well as newborn life support. STABLE was well attended including Doctors, Midwives and Consultants. Our newer midwives and some of the older ones attended helicopter training at St John. This is always enjoyed by the attendees. Our last Emergency Skills day is being held in November for the year. This is for the midwives as part of their recertification programme.
- Te Nikau have a few new mums returning to work from parental leave and we have been able to offer them a breastfeeding and expressing room. This allows us to achieve "Breastfeeding support in the workplace" status. Great feedback from the staff already utilising this room.
- The acting Clinical Midwife Manager has taken on the role permanently which commenced mid-October.

Allied Health

- Our locality based teams are continuing to further develop the inter-professional way of working and are working on strategies to strengthen inter-locality collaboration.
- Planning the translation of the transalpine strategy framework for Allied Health, Scientific and Technical into local activity is in progress.
- We are continuing our recruitment efforts within OT for Central and Northern, with the Buller candidate withdrawn from the position. We have had a good response to our latest round of advertising and interviews are on the way.
- There are current vacancies in Dietetics, Physiotherapy and Kaiawhina (Allied Health Assistants); all are being advertised currently.
- A new Allied Health Team Manager Central role has been advertised in conjunction with the Team Manager vacancy in Northern. We are recruiting to a Clinical Lead Occupational Therapy.
- The Director of Allied Health, Scientific and Technical and the Associate Director have been supporting the Northern AH team since the resignation of the AH Team Manager.

- The South Island Career Framework has come into effect and a couple of roles have been identified for the scoping process.
- Allied Health therapies are part of a SIAPO project to replace paper referrals (faxes included) with an electronic referral process. This programme will on-board all referral processes over time, starting with referrals from outside the DHB such as from GPs and other community based providers.
- Allied Health will participate in the HEAT tool training and a project has been identified to address DNA rates using this tool.
- An SLA has been set up with CDHB providing complex wheelchair and seating clinics in each locality four times a year. They will be supporting local therapists to gain and sustain basic accreditation in this area.
- Jacqui Lunday Johnstone will be providing more details about the strategic direction during today's presentation.

Mental Health

- Our new Occupational Therapist has started in the central region. Currently orientating through Te Nikau, we will work with CDHB SMHS Occupational Therapy leads to develop the role within Manaakitanga before looking ahead to supporting our community teams.
- Work with the local Methamphetamine Impact Group is ongoing. Current aim is to ensure that those with methamphetamine addiction and misuse are supported through health care, and avoid criminal justice where possible.
- We had our first Mental Health Interagency Forum that has been set up to coordinate our mental health services for children and adolescents on the Coast. We have numerous services supporting various treatment pathways and so the immediate goal is to ensure clear signposting to these services with a shared understanding of the different admission criteria, resources and skill sets.
- Recent recruitment has been positive, filling vacancies in Manaakitanga. We are hoping to line up recruitment into our crisis response service, AOD and CAMHS in the New Year.
- In the New Year, we will be working with our colleague at CDHB SMHS psychology services to advertise and recruit into a much needed clinical psychologist position for our adult service. This has been a recognised gap in our service provision that we are looking forward to filling.

	DEVELOPING TRANSPORT AND TELEMEDICINE SERVICES

A: Improve Transport Options for Patient Transfers

- Several transport initiatives are in place to support the safe transfer of patients. The Greymouth branch of St John operate a community health shuttle to assist people in the local area who require assistance getting to health appointments in Greymouth. St John also provide planned ambulance transfers for non-acute patients needing care in Christchurch.

- An agreement with the Buller Branch of the New Zealand Red Cross to provide a subsidised community health shuttle service between Westport and Te Nikau is in place until August 2021. This is a shorter-term agreement, as New Zealand Red Cross have signalled they will be transitioning away from providing community transport throughout the country. The New Zealand Red Cross have offered to help identify potential alternatives. In the meantime, Buller Taxis have initiated a free medical shuttle service from Westport to Nelson and to Greymouth at their own initiative. This service trial commenced in October 2020.
- The September result indicated that National Travel Assistance is tracking within budget for the 2020/21 Financial Year. Expenditure for the first three months of 2020/21 is currently down against year-to-date budget by 13%. However it is noted that claims can be lodged by eligible patients any time within 12 months of treatment, so expenditure against annual budget is not always evenly matched.

B: Champion the Expanded use of Telemedicine Technology

- A paper was discussed at the last meeting of the Board. As a result, a regular report in the form of a 'dashboard' is being prepared.
- The South Island Regional Facilitator/Project Manager - Telehealth visited the West Coast during the week of 25 November and is working with key people in our system to progress the South Island Alliance Telehealth Workplan.
- The West Coast DHB is represented on both the South Island Alliance's Telehealth Governance and Telehealth Steering groups.

	INTEGRATING THE WEST COAST HEALTH SYSTEM

A: Older Persons Health Services - Supporting older people to remain at home

- **Aged Residential Care (ARC) update:** Following stakeholder consultation, the West Coast DHB has finalised its 'Management of a COVID or suspected COVID outbreak in a West Coast Aged Residential Care Facility' Plan which provides an agreed response appropriate to the West Coast.
- **Falls Prevention Update:** The West Coast Falls Prevention Coalition ran a very successful Workshop on 17 November with 32 people in attendance, providing input from aged residential care, Poutini Waiora, home and community support services, local community strength and balance class providers, non-government organisations, primary care, the Accident Compensation Corporation and the West Coast District Health Board including representatives from nursing, geriatrician, allied health, the Complex Clinical Care Network and the Planning and Funding team.
- The Workshop included a seven member 'Expert Couch' question and answer session followed by breakout groups to provide feedback and brainstorming on the seven topics of discussion being:

  1. Community Strength and Balance classes
  2. The In-Home Strength and Balance Programme
  3. Appropriate use of medication to maximise bone health and minimise falls risk

4. Prompt surgical response and rehabilitation pathway including Early Supported Discharge
5. Reducing environmental factors contributing to falls
6. Identification and referral of those at risk of falls
7. Self-help tools.

- The Coalition will review all the feedback from the Workshop at their December meeting. This will inform the development of the West Coast Falls Prevention Action Plan.

BUILDING CAPACITY TO TRANSFORM THE SYSTEM

A: Live Within our Financial Means

- The consolidated financial result for the month of October, including the impacts of Covid-19 ($222k favourable YTD) and Holidays Act compliance ($652k unfavourable YTD), was a surplus of $62k - $346k favourable and YTD a deficit of 735k - $387k unfavourable.

	Monthly Reporting			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
	$'000	$'000	$'000	$'000	$'000	$'000
Governance Arm	(201)	(154)	(47)	(597)	(649)	52
Funder Arm	938	365	573	2,333	1,459	874
Provider Arm	(675)	(495)	(180)	(2,471)	(1,158)	(1,313)
Consolidated Result	**62**	**(284)**	**346**	**(735)**	**(348)**	**(387)**

B: Effective Clinical Information Systems

Facilities:

- We have completed the remaining tasks to fully decamp all IT services out of the old Grey Hospital building.
- Preparation is underway to cut over the computing services to the new Haast clinic.

Community Patient Administration System implementation: The business case has been approved and implementation dates will be confirmed once the contract terms are agreed.

Care Capacity Demand Management (CCDM): The CCDM council approved the technical delivery and approach for a Capacity at a Glance dashboard. ISG is planning implementation during the first quarter of the year.

Update and improvement to antivirus system: In conjunction with Datacom and Canterbury DHB we are implementing the Cloud Strike AV solution, with the project due to be completed by mid-December.

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

Communications and Engagement

- Preparation of publications including advertisements:
  - Strength and Balance (Falls Prevention) advertising
  - 2020 Quality Accounts publication (in draft).

- During October/November 2020, we responded to enquiries about Buller Health staffing levels and ambulance transportation from Westport to Greymouth. We also received enquiries about rural generalism, Neurology services, the roll out of the National Bowel Screening Programme and COVID-19 pop-up testing centres.

Media releases:

- Protect yourself against Legionnaires' this spring (28/10/2020)
- November edition of our CE Update (11/11/2020)
- Busy weekend of events offers a timely reminder to stay home if you are unwell (12/11/2020).

Social media posts:

- It's Cyber Smart Week! (19/10/2020)
- Catch up on your free vaccination to avoid catching measles (19/10/2020)
- Stepping up your cyber defence is easier than it sounds (20/10/2020)
- Keeping your passwords secure makes it hard for attackers to get your online stuff (21/10/2020)
- Turn on two-factor authentication (22/10/2020)
- Update your devices (23/10/2020)
- Check your privacy (24/10/2020)
- World Patient Safety Day (17/09/2020)
- Protect yourself against Legionnaires' this spring (29/10/2020)
- Latest edition of our CE Update (11/11/2020)
- Timely reminder to stay home if you are unwell (12/11/2020).

CE Update stories – November 2020

In the November edition of the CE Update, Acting Chief Executive Andrew Brant thanks everyone for the warm welcome and introduction to the West Coast Health System. He talks about the implementation of a rural generalist model and touches on the official opening of Te Nīkau Hospital & Health Centre and future of Buller Health.

- The lead story outlines how Te Nīkau Hospital & Health Centre works with an emphasis on what to expect when you access the Urgent Care services. The article also provides an overview of services available on the ground floor, opening and visiting hours as well as contact details.
- Fit testing of N95 masks is being conducted by the Wellbeing Health and Safety Team across the Coast to support keeping people safe in their work. This involves checking to make sure that the masks fit and produce a tight enough seal to protect the wearer.
- The 'What's happening with Holidays Act compliance' story covers off the progress that has been made over the past 10 months by the Canterbury and West Coast DHBs as part of a shared Holidays Act Compliance Programme.
- We celebrate Pradu Dayaram's contribution to the West Coast health system over the 35 years he spent working for the DHB. An abridged version of this article also appeared in the Greymouth Star on 14/11/2020.
- 'Farewell to Patricia O'Connell' pays tribute to Midwife Patricia (Paddy) O'Connell who recently retired after providing maternity services to Coasters for over 47 years. This article also appeared in the Greymouth Star on 15/11/2020.
- 'Tribute to Mark Smith, a wise doctor, esteemed colleague, inspirational leader', acknowledges the work of Canterbury DHB's Clinical Director Haematology who died suddenly from a medical event in September.

- 'Tech neck' highlights the fact that as a health organisation, we spend more and more time on mobile phones, laptops, computers, and tablets. This in turn leads to a common health issue called 'tech neck' – musculoskeletal discomfort usually associated with looking down at a device. It provides some useful tips on how to avoid neck strain.
- The 'Training to help recognise and respond to elder abuse' article talks about the creation of an elder abuse and neglect learning package for staff to help staff recognise and respond to abuse of older people.
- The 'New video shows how to prevent pressure injuries' article highlights the fact that pressure injuries are considered to be largely preventable and identifies a number of ways to prevent them.

Regular updates:

- One minute with Hellen Walker, Personal Assistant to Manager Integrated Health Services – Northern Region
- Cobden School's donation of children's toys and art supplies a welcomed gift
- Health Quality & Safety Commission New Zealand E-digest, Issue 123
- Activity & Nutrition Aotearoa newsletter
- eCALD – Enhancing CALD Cultural Competence newsletter
- Bouquets.

Healthy Environment & Lifestyles	**PROMOTING HEALTHY ENVIRONMENTS AND LIFESTYLES**

Key Achievements/Issues of Note

- **COVID-19 response:** There have been no cases on the West Coast since our last report. The only cases in CPH's regions have been linked to managed isolation and quarantine facilities, including the two health workers in Christchurch. There were a significant number of cases from a group of international mariners and the West Coast team supported this response. Our Health Protection Officer worked with the WCDHB's Emergency Planner to assist organisations planning events to develop their own robust COVID-19 response plans to reduce the risk of disease transmission. This included plans for activities such as the Greymouth motorcycle street race, the MS Craft Fair and AgFest.
- **Māori health promotion:** We are near completion of the "Tuhono kia tu maia" project in which 18 whānau Māori identified their aspirations for their tamariki and the challenges and opportunities that affect their parenting. Whānau identified substantial challenges that affect them including limited access, quality and consistency of health services, racism they face within support systems, and additional long-term health needs. We have assisted a local group to organise and hold a kapa haka festival this month to allow the tamariki in our community to showcase their learning and enjoyment of te ao and te reo Māori.
- **Drinking water:** A workshop was held in mid-October between two of CPH's Drinking Water Assessors and the Buller District Council's three waters management team regarding Council's current draft water safety plan (WSP) for Reefton. Buller is the first council on the West Coast to submit a WSP under the recently revised Ministry of Health NZ Drinking-water Safety Plan Framework. In the short term, major works at Reefton are about to start to upgrade the main reservoir and replace the old cast iron rising/falling main that feeds the reservoir. Council staff are aware that they need to manage the risks to the supply while the upgrade

works are happening and they are planning a communications, monitoring and remedial treatment strategy to be in place for the busy summer season.

- **Nutrition and food security:** CPH continues to facilitate and contribute to the Food Security Network for the West Coast. The connections created via this network have enabled knowledge and skills to build capacity on the ground, including the organisation of a start-up community edible garden. These connections supported a Kawatiri-based community edible gardener to apply for $20,000 worth of funding through a Ministry of Social Development "Food Secure Communities" grant to carry out a feasibility study over the next two years.
- **Smokefree:** With the recent inclusion of vaping under the Smokefree Environments Act, the Smoke-free Enforcement Officer is in the process of planning tobacco and vape retailer compliance visits, and subsequent Controlled Purchase Operations across the West Coast. CPH worked with the event organisers of AgFest to promote the event as Smokefree and Vapefree through the use of signage during the event.
- **Alcohol harm reduction:** Currently the Alcohol Licensing Officer, Police and the Grey District Licensing Inspector are working with the licensee and Duty Managers from a Grey District licensed premises to mitigate alcohol related harm after some serious alcohol-related harm including intoxication. This includes a range of actions including host responsibility, signage and staff training. Enforcement action is also pending.
- **Health in All Policies:** We continue to engage around housing with the West Coast Sector Forum. The focus will be on housing options for older people. During this period, we also developed submissions on:
    - Reducing the impact of plastic on our environment, drawing on the importance of this to the Coast given the issues with landfills and flooding in recent years (October)
    - Westland District reduced speed limits – largely supporting the proposal to improve health and wellbeing outcomes, especially in support of walking and cycling. (October)
- **Mental wellbeing:** We continue to contribute to the West Coast Welfare Co-ordinating Group and at a recent meeting shared the resources and kits from the 'Getting Through Together' campaign run by AllRight? and the Mental Health Foundation. We also supported community workplace wellbeing workshops from the Mental Health Foundation, which ran in Franz Josef, Greymouth and Westport on 22, 23 and 24 November, respectively. We also promoted the AllRight? website campaign and the community wellbeing workshops at a meeting of the West Coast Cross Sector Forum and gave some physical resources to the group. Members were encouraged to share the information with their workplace and clients.

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

Approved for release by: Andrew Brant, Acting Chief Executive

FINANCE REPORT FOR THE PERIOD ENDED 31 OCTOBER 2020

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

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

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

DATE: **10 December 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this paper is to provide a regular monthly report of the financial results of the West Coast District Health Board and other financial related matters.

2. RECOMMENDATION

That the Board:

i. notes the financial result and related matters for the period ended 31 October 2020.

3. DISCUSSION

Overview of October 2020 Financial Result

The consolidated West Coast District Health Board financial result for the month of October 2020 was a surplus of $62k, which was $346k favourable to the draft annual plan. The year to date net deficit of $735k is $387k unfavourable to the draft annual plan.

This result includes the impact of the Holidays Act compliance provision and the impact of Covid-19. This month we have excluded the impact of the Holidays Act compliance provision and the impact of Covid-19 in the Appendix 1 tables and graphs.

	Monthly Reporting				Year to Date				Full Year 20/21
	Actual	Budget	Variance	%Var	Actual	Budget	Variance	%Var	Budget
Operating Revenue									
Crown and Government sourced	14,190	13,405	785	5.9%	54,686	53,617	1,069	2.0%	160,834
Inter DHB Revenue	4	10	(6)	(59.1%)	16	39	(23)	(59.1%)	117
Inter District Flows Revenue	223	154	69	45.1%	692	616	76	12.3%	1,962
Patient Related Revenue	650	719	(69)	(9.6%)	2,685	2,861	(176)	(6.1%)	8,499
Other Revenue	47	61	(14)	(22.6%)	184	244	(60)	(24.6%)	4,312
Total Operating Revenue	15,114	14,348	766	5.3%	58,263	57,376	887	1.5%	175,725
Operating Expenditure									
Personnel costs	6,837	6,594	(243)	(3.7%)	26,682	25,491	(1,191)	(4.7%)	77,918
Outsourced Services	0	0	0	0.0%	9	0	(9)	0.0%	1
Treatment Related Costs	793	782	(11)	(1.4%)	3,095	3,098	3	0.1%	9,255
External Providers	3,700	3,732	32	0.8%	14,471	14,927	456	3.1%	44,781
Inter District Flows Expense	2,307	2,109	(198)	(9.4%)	8,947	8,435	(512)	(6.1%)	25,306
Outsourced Services - non clinical	120	121	1	0.9%	480	484	4	0.9%	1,453
Infrastructure and Non treatment related costs	881	823	(58)	(7.0%)	3,712	3,853	141	3.6%	10,495
Total Operating Expenditure	14,638	14,161	(477)	(3.4%)	57,396	56,288	(1,108)	(2.0%)	169,209
Result before Interest, Depn & Cap Charge	476	188	288	153.4%	867	1,088	(221)	(20.3%)	6,515
Interest, Depreciation & Capital Charge									
Interest Expense	0	0	0	0.0%	0	0	0	0.0%	0
Depreciation	346	387	41	10.6%	1,329	1,096	(233)	(21.2%)	4,082
Capital Charge Expenditure	68	85	17	20.0%	273	340	67	19.7%	4,740
Total Interest, Depreciation & Capital Charge	414	472	58	12.3%	1,602	1,436	(166)	(11.6%)	8,822
Net Surplus/(deficit)	62	(284)	346	121.8%	(735)	(348)	(387)	(111.2%)	(2,306)
Other comprehensive income									
Gain/(losses) on revaluation of property									
Total comprehensive income	**62**	**(284)**	**346**	**121.8%**	**(735)**	**(348)**	**(387)**	**(111.2%)**	**(2,306)**

in thousands of New Zealand dollars

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: Alexis Bainbridge, Assistant Accountant

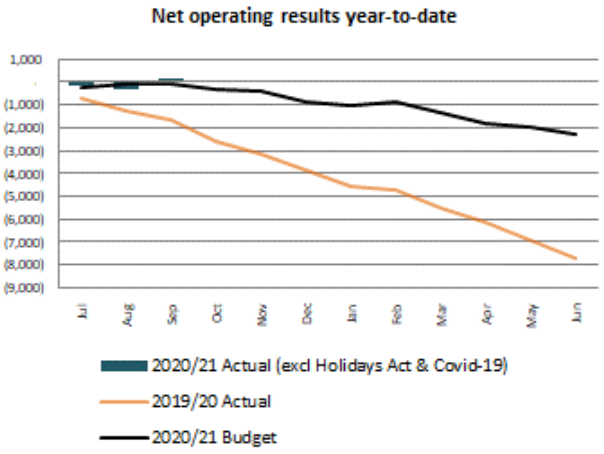
Report approved by: David Green, Acting Executive Director, Finance & Corporate Services

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – October 2020

Net operating results (excluding Holidays Act compliance provision & Covid-19)

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	74	(284)	358	-126% ✓	(305)	(348)	43	-12% ✓



West Coast DHB has reported a surplus of $74k for the month of October 2020 excluding the impact of the Holidays Act and Covid-19. This is a favourable variance to the deficit in the draft annual plan of $284k. The YTD variance is $43k favourable.

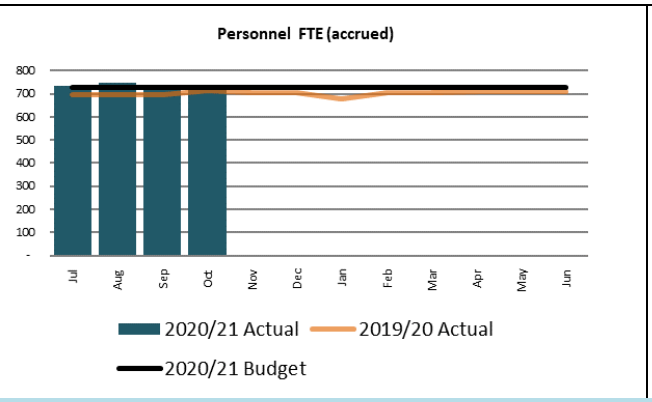
The main variances are:

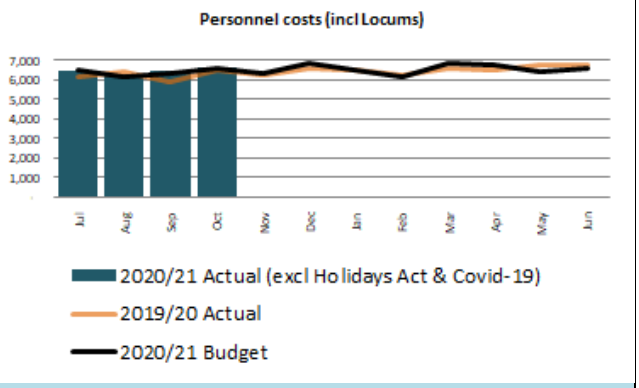
- YTD $324k Depreciation on Te Nikau hospital recognised two months in advance of budget. The variance is a permanent variance of $324k to the annual plan for the year. This unfavourable variance is offset by favourable depreciation in other areas.
- Personnel costs were slightly unfavourable to plan by $26k. Outsourced personnel continue to be unfavourable. With a relatively small medical workforce (circa 36 FTE), any variation in the planned workforce can have a large difference. The outsourced variance includes the impact of 1 GP on long term sick leave (with cover circa $30-35k per month), as well as most of the Buller establishment FTE being filled by locums, as well as the continued use of locums, including RMOs, across other areas of the DHB. We are working on rostering and our rural generalist programme to reduce the reliance on locum use, and personnel costs in general.
- The 19/20 IDF wash up was settled in October resulting in a net unfavourable impact for WCDHB of $47k. IDF Expenditure is also unfavourable to budget by $83k per month due to a budget omission and will continue to be unfavourable for the remainder of the year.
- We recognised 3 months of Debt Equity revenue from the MoH in October ($480k), which was budgeted to come in from January 2021. This will have a favourable impact from October to December, but the favourable variance will start to reduce from January.

Commentary is provided on variance to the draft Annual Plan that was submitted in July 2020, with the annual deficit of $2.306m.

Personnel costs (including Outsourced Personnel) & FTE

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Medical	1,835	1,621	(214)	-13%	✗	6,819	6,257	(562)	-9%	✗
Nursing	2,686	2,822	136	5%	✓	10,925	11,075	150	1%	✓
Allied Health	1,004	1,063	59	6%	✓	4,191	4,186	(5)	0%	✗
Support	312	330	18	5%	✓	990	947	(43)	-5%	✗
Management & Admin	783	757	(26)	-3%	✗	2,891	3,027	136	4%	✓
Total	**6,620**	**6,594**	**(26)**	0%	✗	**25,816**	**25,491**	**(325)**	-1%	✗





KEY RISKS AND ISSUES:

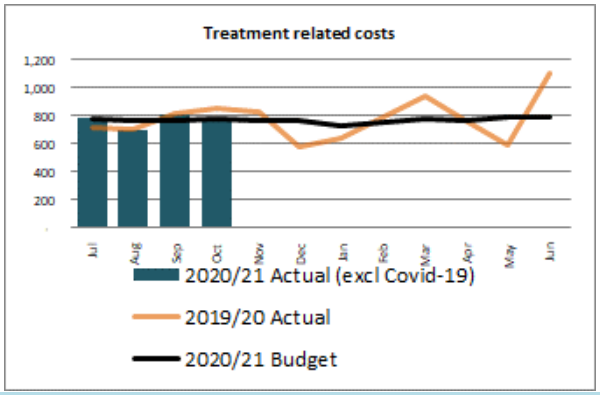
Better stabilised rosters and leave planning has been embedded within the business, but there remains reliance on short term placements, which are more expensive than permanent staff.

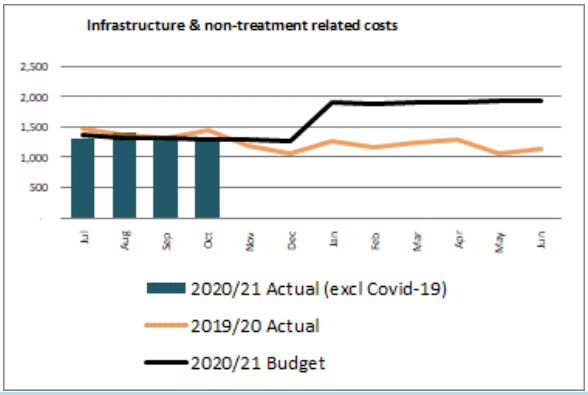
Unfavourable variance in Medical costs is driven by high locum use due to short staffing particularly in RMOs (-6FTE) and the primary practices Central (long term sick leave) and Northern (require 8 FTE in total - locum & staff - but currently have only 1.4 FTE and 1 long term locum). Recruitment is being undertaken in Northern with a 1 FTE new permanent doctor starting early next year and possibly another on a 12 month term, 3 new RMOs start 16 November 2020, leaving 3 to be recruited.

The unfavourable variance in Management & Admin is due to $19K Cleaning Supervisors (the move to in-house cleaning began in October), offset by favourable variance in Support services where the budget is sitting.

Treatment and non-treatment related costs

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Treatment related costs	787	782	(5)	-1%	✗	3,078	3,098	20	1%	✓
Non Treatment related costs	1,284	1,295	11	1%	✓	5,294	5,289	(5)	0%	✗





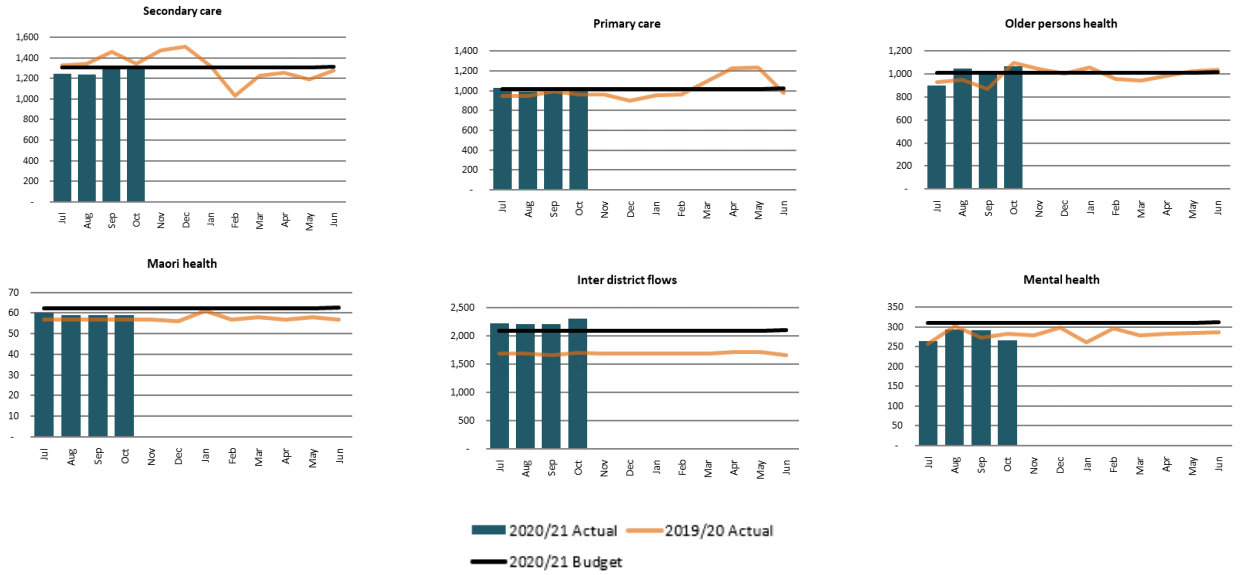
KEY RISKS AND ISSUES:

Treatment related costs: high blood costs have been masked YTD by low theatre implant purchases.

Non treatment related costs are impacted by the extra 2 months of depreciation on the Te Nikau facility - $364k YTD. This is offset by favourable depreciation in other areas, as well as YTD favourable variances particularly in hotel, laundry, & cleaning costs.

External provider & inter district flows costs

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Secondary Care	1,293	1,316	23	2%	✓	5,063	5,265	202	4%	✓
Primary Care	1,018	1,026	8	1%	✓	4,046	4,103	57	1%	✓
Older Person's Health	1,065	1,016	(49)	-5%	✗	4,011	4,064	53	1%	✓
Mental Health	265	311	46	15%	✓	1,114	1,244	130	10%	✓
Maori Health	59	63	4	6%	✓	237	250	13	5%	✓
IDF	2,307	2,109	(198)	-9%	✗	8,947	8,435	(512)	-6%	✗
Outsourced Clinical	120	121	1	1%	✓	489	485	(4)	-1%	✗
Total	6,127	5,962	(165)	-3%	✗	23,907	23,846	(61)	0%	✗



KEY RISKS AND ISSUES:

Secondary Care
Cataracts: Expenditure is expected to catch up with budget by the end of the financial year.

Primary Care
PHO Non-Devolved capitation payments to PHOs are higher than budget, reflecting higher Low Cost Access (Unfavourable $33k), Care Plus (Unfavourable $4k), and Community Services Card (Unfavourable $3k) payments. However, all three of these areas are directly offset by additional revenue received from the Ministry of Health.

The community pharmacy budget was set against PHARMAC's February 2020 forecast. PHARMAC revised their forecast in June resulting in an increase of $400K. From July to September costs have been within our budget, but the October level is an indication that community pharmaceuticals will likely approach PHARMAC's revised forecast.

Mental Health
The positive variance is in AOD reflecting revenue received from the Ministry but the FTE contracts not yet being delivered against. This will remain favourable until the budget is transferred to the provider-arm to cover the new FTE in 2021/22.

IDFs
The variance is mainly driven the washup that occurred in October, as well as a budget issue which will continue for the remainder of the year.

Financial position

	YTD Actual $'000	YTD Budget $'000	YTD Variance $'000			Annual Budget $'000
Equity	123,915	141,111	(17,196)	-12%	✗	150,148
Cash	3,622	736	2,886	392%	✓	6,382
Capex	2,928	5,088	2,160	42%	✓	11,264

KEY RISKS AND ISSUES:

Variances to Equity
Drawdown of equity for the Buller IFHC totalling $4M was in the draft annual plan to be received in both July and October, but these have not yet been drawn down.

A further $11.30M Holidays Act compliance provision at June 2020 was not included in the Annual Plan opening Equity.

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

Statement of comprehensive revenue and expense

For period ending 31 October 2020

in thousands of New Zealand dollars

	Monthly Reporting				Year to Date				Full Year 20/21
	Actual	Budget	Variance	%Var	Actual	Budget	Variance	%Var	Budget
Operating Revenue									
Crown and Government sourced	14,190	13,405	785	5.9%	54,686	53,617	1,069	2.0%	160,834
Inter DHB Revenue	4	10	(6)	(59.1%)	16	39	(23)	(59.1%)	117
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Patient Related Revenue	650	719	(69)	(9.6%)	2,685	2,861	(176)	(6.1%)	8,499
Other Revenue	47	61	(14)	(22.6%)	184	244	(60)	(24.6%)	4,312
Total Operating Revenue	15,114	14,348	766	5.3%	58,263	57,376	887	1.5%	175,725
Operating Expenditure									
Personnel costs	6,837	6,594	(243)	(3.7%)	26,682	25,491	(1,191)	(4.7%)	77,918
Outsourced Services	0	0	0	0.0%	9	0	(9)	0.0%	1
Treatment Related Costs	793	782	(11)	(1.4%)	3,095	3,098	3	0.1%	9,255
External Providers	3,700	3,732	32	0.8%	14,471	14,927	456	3.1%	44,781
Inter District Flows Expense	2,307	2,109	(198)	(9.4%)	8,947	8,435	(512)	(6.1%)	25,306
Outsourced Services - non clinical	120	121	1	0.9%	480	484	4	0.9%	1,453
Infrastructure and Non treatment related costs	881	823	(58)	(7.0%)	3,712	3,853	141	3.6%	10,495
Total Operating Expenditure	14,638	14,161	(477)	(3.4%)	57,396	56,288	(1,108)	(2.0%)	169,209
Result before Interest, Depn & Cap Charge	476	188	288	153.4%	867	1,088	(221)	(20.3%)	6,515
Interest, Depreciation & Capital Charge									
Interest Expense	0	0	0	0.0%	0	0	0	0.0%	0
Depreciation	346	387	41	10.6%	1,329	1,096	(233)	(21.2%)	4,082
Capital Charge Expenditure	68	85	17	20.0%	273	340	67	19.7%	4,740
Total Interest, Depreciation & Capital Charge	414	472	58	12.3%	1,602	1,436	(166)	(11.6%)	8,822
Net Surplus/(deficit)	62	(284)	346	121.8%	(735)	(348)	(387)	(111.2%)	(2,306)
Other comprehensive income									
Gain/(losses) on revaluation of property									
Total comprehensive income	**62**	**(284)**	**346**	**121.8%**	**(735)**	**(348)**	**(387)**	**(111.2%)**	**(2,306)**

APPENDIX 3: WEST COAST DHB STATEMENT OF FINANCIAL POSITION

As at 31 October 2020

in thousands of New Zealand dollars

	Actual	Budget	Variance	%Var	Prior Year
Assets					
Non-current assets					
Property, plant and equipment	149,331	153,017	(3,686)	(2.4%)	20,620
Intangible assets	417	847	(430)	(50.8%)	497
Work in Progress	10,127	11,946	(1,819)	(15.2%)	14,715
Other investments	320	320	0	0.0%	320
Total non-current assets	160,195	166,130	(5,935)	(3.6%)	36,152
Current assets					
Cash and cash equivalents	3,622	736	2,886	392.1%	6,152
Patient and restricted funds	46	56	(10)	(17.9%)	47
Inventories	1,073	1,160	(87)	(7.5%)	1,130
Debtors and other receivables	4,559	4,491	68	1.5%	4,542
Assets classified as held for sale	0	0	0	0.0%	0
Total current assets	9,300	6,443	2,857	44.3%	11,871
Total assets	169,495	172,573	(3,078)	(1.8%)	48,023
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Employee entitlements and benefits	2,340	2,399	59	2.5%	2,678
Other	63	62	(1)	(1.6%)	63
Total non-current liabilities	2,403	2,461	58	2.4%	2,741
Current liabilities					
Interest-bearing loans and borrowings	0	0	0	0.0%	0
Creditors and other payables	13,561	11,694	(1,867)	(16.0%)	12,122
Employee entitlements and benefits	30,268	17,307	(12,961)	(74.9%)	18,872
Total current liabilities	43,829	29,001	(14,828)	(51.1%)	30,994
Total liabilities	46,232	31,462	(14,770)	(46.9%)	33,735
Equity					
Crown equity	214,806	220,358	5,552	2.5%	93,858
Other reserves	25,100	25,098	(2)	(0.0%)	25,100
Retained earnings/(losses)	(116,643)	(104,345)	12,298	11.8%	(104,670)
Trust funds	0	0	0	0.0%	0
Total equity	123,263	141,111	17,848	12.6%	14,288
Total equity and liabilities	**169,495**	**172,573**	**(3,078)**	**(1.8%)**	**48,023**

APPENDIX 4: WEST COAST DHB STATEMENT OF CASHFLOW

For period ending 31 October 2020

in thousands of New Zealand dollars

	Monthly Reporting				Year to Date			
	Actual	Budget	Variance	%Var	Actual	Budget	Variance	%Var
Cash flows from operating activities								
Cash receipts from Ministry of Health, patients and other revenue	16,089	14,340	1,749	12.2%	58,947	57,344	1,603	2.8%
Cash paid to employees	(6,516)	(6,594)	78	1.2%	(26,716)	(25,491)	(1,225)	(4.8%)
Cash paid to suppliers	(1,436)	(1,728)	292	16.9%	(8,435)	(7,582)	(853)	(11.3%)
Cash paid to external providers	(3,955)	(3,732)	(223)	(6.0%)	(15,326)	(14,927)	(399)	(2.7%)
Cash paid to other District Health Boards	(2,052)	(2,109)	57	2.7%	(8,092)	(8,435)	343	4.1%
Cash generated from operations	2,130	179	1,951	1091.0%	378	910	(532)	(58.5%)
Interest paid	0	0	0	0.0%	0	0	0	0.0%
Capital charge paid	0	(85)	85	100.0%	0	(340)	340	100.0%
Net cash flows from operating activities	2,130	94	2,036	2169.9%	378	570	(192)	(33.7%)
Cash flows from investing activities								
Interest received	3	8	(5)	(62.5%)	14	32	(18)	(56.3%)
(Increase) / Decrease in investments	3	0	3	0.0%	6	0	6	0.0%
Acquisition of property, plant and equipment	(446)	(2,272)	1,826	80.4%	(2,828)	(4,672)	1,844	(39.5%)
Acquisition of intangible assets	0	0	0	0.0%	(100)	(416)	316	
Net cash flows from investing activities	(440)	(2,264)	1,824	(80.6%)	(2,908)	(5,056)	2,148	42.5%
Cash flows from financing activities								
Proceeds from equity injections	0	2,000	(2,000)	100.0%	0	4,000	(4,000)	100.0%
Repayment of equity	0	0	0	0.0%	0	0	0	0.0%
Cash generated from equity transactions	0	2,000	(2,000)	100.0%	0	4,000	(4,000)	100.0%
Borrowings raised								
Repayment of borrowings	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%
Net increase in cash and cash equivalents	1,690	(170)	1,860	(1093.2%)	(2,530)	(486)	(2,044)	420.8%
Cash and cash equivalents at beginning of period	1,932	905	1,027	113.6%	6,152	1,218	4,934	405.1%
Cash and cash equivalents at end of period	**3,622**	**736**	**2,886**	**391.9%**	**3,622**	**736**	**2,886**	**392.0%**

CLINICAL LEADERS UPDATE

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

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

SOURCE: **Clinical Leaders**

DATE: **10 December 2020**

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 OF COLLECTIVE MAHI

This month, the Clinical Leaders have been supporting progress with a variety of quality improvement efforts aimed at improving care delivery and outcomes. This includes establishing a local steering group to support data-driven improvements regarding the prevention, early detection, and early management of deteriorating patients; while also refining a number of policies/procedures/documentation suites and documentation systems. These activities have been made possible through collaborations with consumers, clinicians, clinical and operational leadership, and quality.

We are doing our part to support national planning around the Critical Care/ICU surge workforce and are working locally, and with our colleagues across the South Island, to ensure we have robust education and service escalation plasn to support any increased demand in these services.

We have supported selection of this year's DHB studentship recipients, and are working with Hauora Māori and Workforce Development to finalise this year's project. This project will see students working in partnership with key staff to draft detailed implementation plans that will support early workforce pipeline activities that were recommended to the DHB by 2019 studentship recipients. These include the Teddy Bear Hospital concept, a mentorship/scholarship programme for West Coast students enrolled in a health programme, and community open days to encourage communities across the region to engage with their local health providers.

We are working on improving compliance with our local incident management policy. The action plan for improvement will be overseen by the DHB's Clinical Board.

We are working to rapidly progress implementation of our local Care Capacity Demand Management (CCDM) programme and are excited to announce that we have successfully recruited to our CCDM Coordinator position. We have reinvigorated the CCDM Working Group and will be increasing the frequency of our CCDM Council hui. We are collaborating with CDHB to identify opportunites to share technologies and other innovations to support implementation of key parts of the programme (i.e. dashboards and visual aids to support Variance Response Management). We are starting the FTE calculations process for our acute mental health inpatient area.

We are also excited to acknowledge the collaborations between mental health consumers, clinicians, leadership, and quality which have led to national recognition in terms of being a case study for how to successfully reduce the use of Seclusion. The team celebrated 174 seclusion-free days in November.

NURSING

We are excited to be supporting our first District Nurse to submit their application to Nursing Council to become endorsed as a Registered Nurse Prescriber. We are refining how this skillset will best add value to clients within this service.

In partnership with operational leadership and other Clinical Leaders, we are working to regularly evaluate various models of care and associated workforce models across the Coast to ensure that these are fit-for-purpose and future-proofed.

MEDICAL

The consultation paper on the Rural Generalist workforce was released and feedback from clinical services, individual clinicians and ASMS is ongoing. Some aspects of this proposal and the feedback made it into the mainstream media last week and there were a number of inaccuracies about the model printed. Rural generalism will not do away with on-site specialist services. Rural generalism will focus on improving primary (GP) and community care, create a team of professionals that support each other, have greater support from CDHB and continue to have health professionals working in extended scopes of practice.

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:
Brittany Jenkins, Director of Nursing
Gary Coghlan, GM-Hauora Māori
Graham Roper, Acting Chief Medical Officer
Heather McPherson, Clinical Director (Mental Health)
Jacqui Lunday-Johnstone, Executive Director of Allied Health
Jane George, Director of Allied Health, Scientific & Technical
Norma Campbell, Director of Midwifery

PEOPLE REPORT

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

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

SOURCE: **People and Capability**

DATE: **10 December 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The West Coast DHB is building a motivated workforce committed to doing their best for the patient and the system. This includes:

- Promoting equity, fairness, and a safe and healthy workplace;
- Recruiting and retaining a sustainable health workforce;
- Delivering high quality care through generalist and specialist health; and
- Collaborating with CDHB to deliver transalpine healthcare.

For every Board meeting, we release our monthly People Dashboard for the West Coast DHB providing an overview of our workforce and what's changing, and the impact of our wellbeing, health and safety metrics. Appendix 1 provides the workforce dashboard for the West Coast DHB as at 31 October 2020.

2. RECOMMENDATION

That the Board:
i. Notes the People Report.

3. DISCUSSION

Wellbeing, Health and Safety

We conducted a Safe365 Health and Safety Maturity Assessment with representatives from West Coast DHB management, employees and our Health and Safety Representatives. The results of this assessment, along with the other 19 DHBs, will be presented to the 20 DHB CE Group in December and presented to QFARC in early 2021.

HR Business Partnering

Employee Exit Survey Process

We have revisited our existing employee exit survey process currently available through our HR service portal, max.. This will enable us to gather higher quality data and analysis going forward.

Core People Operations

Replacing our Core People Systems

- In September we were provided notice that our payroll and HR system vendor will be ceasing support for our current system from April 2022. Our current system is also used by eight other DHBs, so a national conversation has commenced in response.

- As the timeframe to complete a procurement process and implement a replacement system(s) is extremely short, the affected DHBs have agreed to jointly seek an extension to the period committed by the vendor to support our system, however, there is no guarantee that the vendor will agree to this.
- Alongside the short notice period and the scale of organisations also using the system, there is a limited NZ-based pool of technical expertise available to support aspects of the replacement programme.
- It is therefore essential that the procurement process for the replacement of our HR and payroll system is begun immediately.
- We are currently participating in the development of an All-of-Government Payroll marketplace and will be able to access support from DIA (Department of Internal Affairs) for the RFP.HR and Payroll System Replacement.

Vacancy progress update

Vacancies across the organisation remain at steady levels post our Covid-19 response with the majority of current vacancies occurring within our Allied Health teams. We have placed ten Allied Health roles in the past three months. Medical recruitment has been busier than usual this period following the confirmation and release of the medical leadership change proposal. There are several new medical leadership positions associated with this change which we are looking to fill with internal applicants.

Employment Relations, Compensation and Benefits

Holidays Act Compliance Programme

The Programme continues to progress/deliver to plan with key milestones met as expected:

- *Rectification Phase* - focused on 'fixes' to payroll systems and business practises to ensure that future payroll activity complies with the Holidays Act:
    - Detailed design is underway for four key areas of non-compliance; 'How we hold annual leave', 'What is a week', 'Multi-job employees' and 'Casual employees and working patterns'.
    - Planning has started for the roll-out of the time and attendance system, Microster, to the West Coast DHB – milestones will be shared next report. Having Microster in place is a prerequisite to reaching and maintaining compliance as it will ensure consistent practise for capturing time and attendance information, required for calculating leave entitlements.
- *Remediation Phase* - a retrospective review of non-compliance and the sequential recalculation of all leave instances for current and former employees from 1 May 2010:
    - EY has been confirmed as the remediation partner and planning has commenced.
    - Initial planning indicates that remediation payments will commence from February 2022.
    - Options for electronically capturing information from the last ten years of paper timesheets is underway. This is a huge manual exercise and the programme team, along with EY and key stakeholders, are working to identify which option will provide the best quality information in the most pragmatic way. Details of how this will be achieved will be available in the next report.

Collective Bargaining

We currently have bargaining underway for the following collective agreements, with no agreements being met yet:

- NZNO MECA
- STONZ MECA
- Allied and Public Health MECA
- E Tu Support Services SECA

Pay Equity

An offer has gone out to clerical / admin staff and the PSA is currently holding Report Back meetings with staff to discuss the offer. The offer is set out in a two staged approach.

- *Stage 1:* $2,500 flat rate pay adjustment to all employees covered by the claim, effective 30 November 2020. Payment currently scheduled to be processed in Q1 of 2021.
- *Stage 2:* Work programme to finalise new national pay scales and job banding structure with the union.

This settlement will automatically cover all eligible employees; however, we have provided employees with the option to 'opt-out' of the above process if they wish.

Talent, Leadership and Capability

Rural Generalist Recruitment

- We have engaged a specialist recruitment agency, Ochre, to commence a targeted search for more rural hospital generalists

Culture and Leadership Development Programme

- We delivered Success and Development training to 37 managers.
- We introduced Success and Development as part of a Māori staff hui to encourage engagement in development conversations with their leaders

4. CONCLUSION

This report remains a work in progress as we refine our approach and content, dashboards, metrics and insights. We welcome feedback.

5. APPENDICES

Appendix 1:	WCDHB People Dashboard – 31 October 2020
Appendix 2:	WCDHB Current Vacancies Report
Report prepared by:	Natasha Smith, Programme Manager, People Analytics, People and Capability
Report approved for release by:	Paul Lamb, Chief People Officer

Monthly WCDHB People Analytics Dashboard – 31 October 2020

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

Our Vision *An integrated health system that is clinically sustainable and financially viable and wraps care around the patient to help them stay well*

Transalpine Health Service | Transport | Settings | Health Care Home | Integrated Information Systems | Health Professionals | Healthy Environment & Lifestyles | Single Point of Referral for Complex Care | Māori Health

Our People Objectives

Building a motivated workforce committed to doing their best for the patient and the system…

- **Promoting equity, fairness, and a safe and healthy workplace**
- **Recruiting and retaining a sustainable health workforce**
- **Delivering high quality care through generalist and specialist health**
- **Collaborating with CDHB to deliver transalpine healthcare**

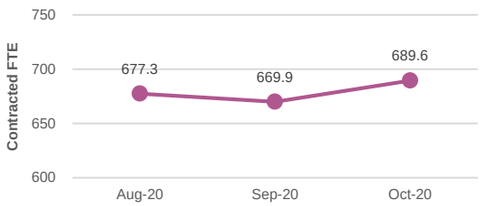
What's changing in our workforce?

Contracted FTE

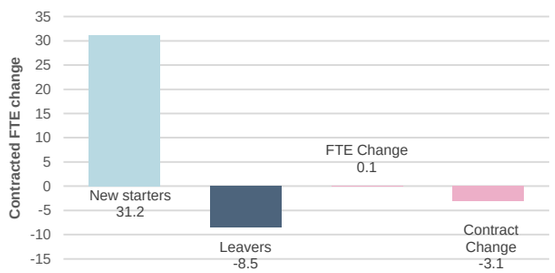
Key Insights

- Following four consecutive months with a falling FTE, this month has seen an increase of 19.6 FTE.
- The majority of this growth is within the support workforce, with 31 new permanent cleaners, orderlies and gardeners (19.6 FTE)
- Note our diversity statistics are now reported on a quarterly basis in the Diversity Dashboard

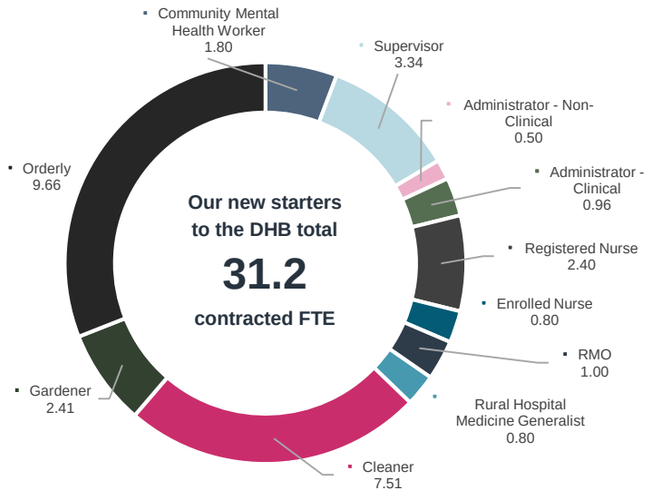
Contracted FTE Trend – *Last three months*



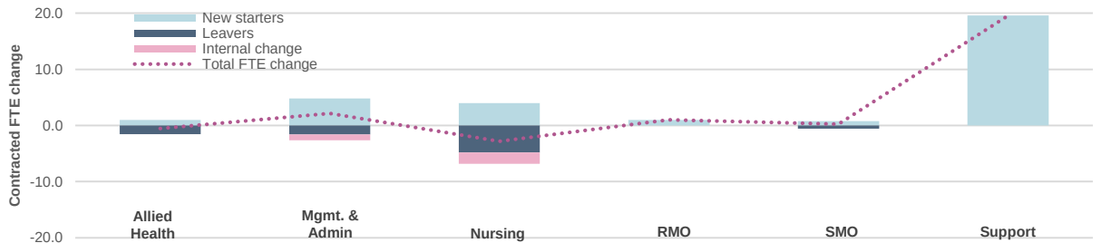
Appointment Changes by Type: *Oct. 2020*



Occupation breakdown of new starters to the West Coast DHB by FTE: *Oct. 2020*



Contracted FTE Changes by Role: *Oct. 2020*



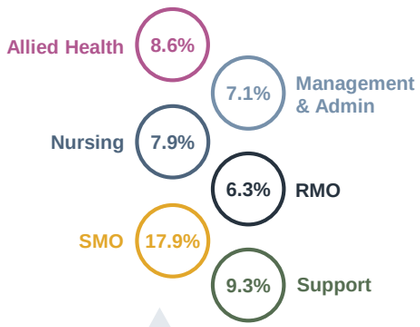
What's changing in our workforce?

Recruitment

Key Insights

- Our overall unplanned turnover rate is 8.3% (rising from 8.0% last month). This is lower than the average unplanned turnover for the NZ public service sector (11.8% in 2019).
- We still have two long-standing vacancies for GPs in our Reefton and South Westland clinics. More detail about our current vacancies is provided in Appendix 3 Vacancy Report.
- Of our vacancies at the end of October, 5 Allied Health FTE relate to new Occupational Therapist positions.

Attrition Rate by Role over the last 12 months

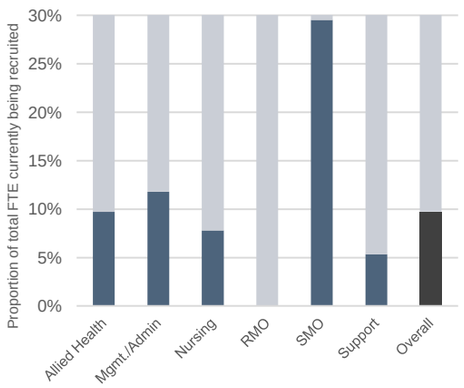


Attrition rate is an indicator of engagement. High rates can impact continuity of service provision and staff wellbeing for those carrying additional load

Proportion of Vacancies Being Recruited For *By Role*

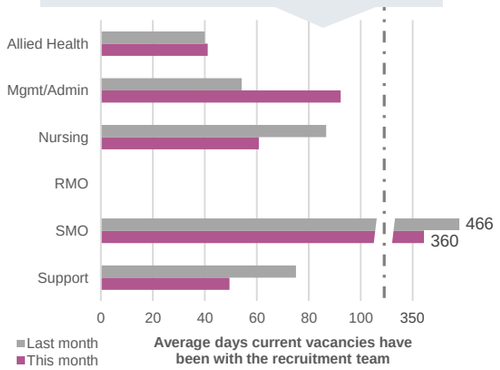
Vacancies are indicative of talent sourcing and development strategies. Higher vacancies can place operational pressures on our people.

74.4 **Vacancies [FTE]** as at 31 Oct.



Average Days Positions Vacant by Role *September vs. October 2020*

Average days positions are vacant highlights which professions have been vacant the longest. Increases in days to fill will reduce the average days vacant.

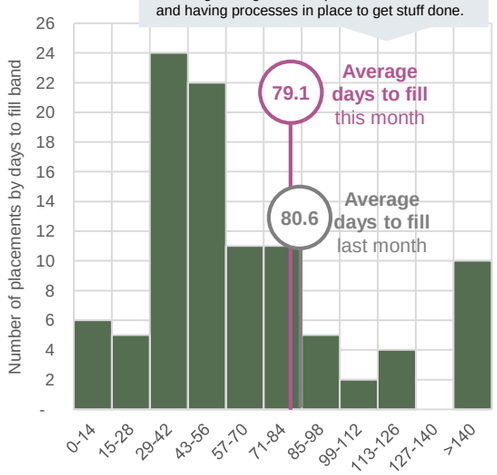


106.3 **Average days vacant [This month]**

136.5 **Average days vacant [Last month]**

Days to Fill Vacancy from Notification: Previous 6 Months

Average days to fill is indicative of our talent sourcing strategies, our reputation and brand, and having processes in place to get stuff done.



Monthly WCDHB People Analytics Dashboard – 31 October 2020

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

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- **Collaborating with CDHB to deliver transalpine healthcare**

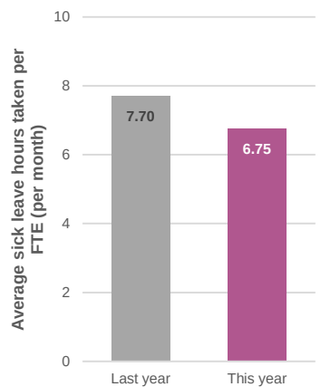
What's the impact of our Wellbeing, Health and Safety efforts?

Key Insights

- On average, our employees have taken 6.75 hours sick leave per month per FTE over the last 12 months; an improvement on the previous 12 month period (7.70 hours). This is reflective of national trends in low flu numbers during the COVID-19 pandemic.
- A small number of SMOs on long-term illness or injury leave are skewing the average sick days taken per FTE for that workforce.
- In October, our people took more annual leave than the same month last year for this first time since July. We still have a significantly high level of annual leave balances across the DHB so we are running a campaign to encourage our people to take annual leave over the Summer months.
- During the past 12 months there has been an increase in the number of musculoskeletal injuries, driving targeted injury prevention programmes.
- Our rate of injuries continues to decrease since July, and remains well below the peak in January this year.

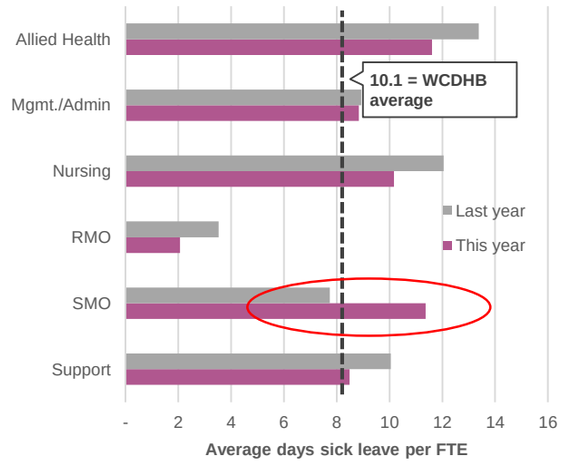
Average sick leave hours taken per FTE per month

Sick leave utilisation can be considered a proxy for the general wellbeing of our workforce and the success of our efforts to support our people to be and stay well.

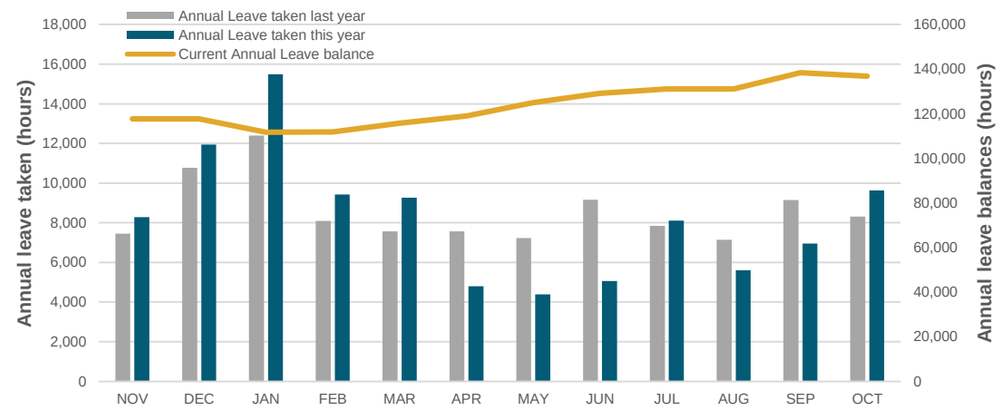


Sick leave days taken per FTE over 12 months by role

In the last 12 months, our employees took on average 10.1 days sick leave per FTE, compared to 11.4 days in the 12 months prior.

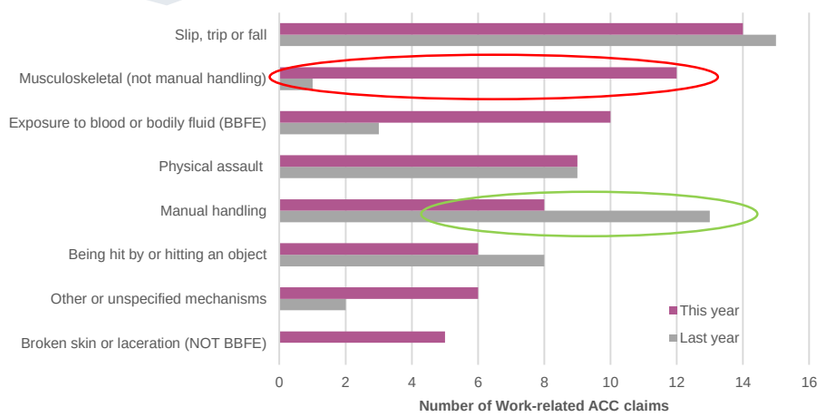


Annual Leave Taken hours and Balance for the last 24 months for the DHB:



Mechanism of Harm: Work Injuries

Number of injuries in the last 12 month period compared to the previous 12 months. *This is taken from data up to end of September 2020.*



70 Total number of Work Injuries (This Year)

51 Total number of Work Injuries (Last Year)

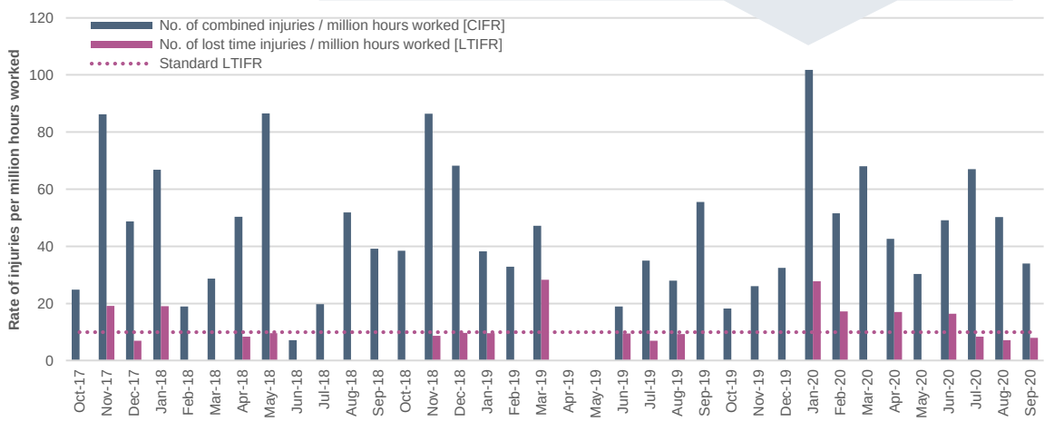
WorkSafe Notifiable Events

We have not had any workplace incidents or injuries requiring notifying to WorkSafe in the past three months.

	Notifiable Events		
Event type	Aug-20	Sep-20	Oct-20
Death	-	-	-
Notifiable illness or injury	-	-	-
Notifiable incident	-	-	-

Combined & Lost Time Injury Frequency: Last three years

The Combined Injury Frequency Ratio [CIFR] is based on the number of all ACC accepted medical treatment claims per million hours worked. The Lost Time Injury Frequency Ratio [LTIFR] is the Number of lost time injuries to million hours; it continues to be above the ACC Healthcare Levy Risk Group Average (Standard) of 10. *This is ACC data taken to end of September 2020.*



CYBER SECURITY AND INFRASTUCTURE UPDATE

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

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

SOURCE: **Information Services Group (ISG)**

DATE: **10 December 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The Board has requested an update on the safety of West Coast DHB ICT systems – in particular, cyber security and infrastructure.

2. RECOMMENDATION

That the Board:

i. notes that there continues to be a Transalpine approach to cyber security;
ii. notes that we aim to achieve the cyber security maturity target of Level 3 by 30 June 2021;
iii. notes that focus areas for the next 12 months, over and above continuous improvement are the implementation of an improved endpoint protection solution (in progress), firewall and web security replacement, continued security / email education, and improving identity / access management;
iv. notes that our security workload continues to be extremely high and we are taking a number of steps to address resourcing issues, so we can effectively respond to the increased cyber security threats and risk to the NZ Health Sector;
v. notes that infrastructure improvements have been implemented and more systems will be converged over time to benefit the West Coast DHB, via our Transalpine relationship with Canterbury DHB.

3. SUMMARY – CYBER SECURITY

Cyber security comprises of technologies, processes and controls that are designed to protect systems, networks and data from cyber-attacks. Cyber security includes controlling physical access to the hardware, as well as protecting against harm that may come via network access, data and code injection. Effective cyber security reduces the risk of cyber-attacks and protects organisations and individuals from the unauthorised exploitation of systems, networks and technologies.

The Transalpine Risk and Security role focuses on the validation of security related policies to make sure they are in line with relevant government and industry standards. The role is also responsible for the continuous improvement of our IT security controls and making sure IT risks are appropriately managed through policy, system design, training and processes. The role includes security solution architecture, operational leadership and reporting within the IT security governance and risk management framework to assure the business that we are managing our obligations. Secondary tasks include selecting appropriate security solutions, oversight of any vulnerability audits and assessments, and providing guidance on operational and project security matters.

4. CURRENT STATE: CYBER SECURITY GOVERNANCE AND MANAGEMENT AREA UPDATES

Our current cyber security risk is detailed below:

Category Type	Description	Action Plans	Consequence	Likelihood	Risk Level	Risk Owner
Service Delivery	Availability of information systems is interrupted due to cyber- attacks. This impacts on the delivery of BAU activities compromising optimal patient care.	1. Modern up to-date anti-virus systems, firewalls, malware cleaning systems are in place 2. Planning to roll-out Phishing online training for staff	Severe	Unlikely	High	ISG – Miles Roper

Our current cyber security status is detailed in the tables below. We are monitoring our improvement against the base state reported to Canterbury DHBs QFARC in 2018. The updates list our subsequent actions, intended and taken since this date which apply to both West Coast and Canterbury DHB.

(Refer to Appendix 1 and 2 for information about the maturity model and measurement criteria).

End User Device Security

1 May 2018 State	Actions Taken and Intended
▪ Current maturity is at level 2. ▪ Some policies exist that relate to end user device security. ▪ No specific end user computer security policy.	▪ Develop end user device security maturity to level 3. ▪ Finish and promulgate mobile device and working from home policy to achieve level 3. ▪ ICT Asset Management policy to be implemented (has been signed off by WCDHB EMT) ▪ Digital Security Course to be rolled out to WCDHB (has been rolled out to CDHB, but with low uptake to date). ▪ Complete end point protection replacement (in progress).

Data Security

1 May 2018 State	Actions Taken and Intended
▪ Current maturity is at level 1. ▪ Draft polices exist but need to be reviewed and then signed off by EMT. ▪ Exchange based email can be currently accessed without 2 factor authentication (2FA).	▪ Some policies impacting this area have been developed and signed off by both EMTs but still require union consultation; one more policy is in development. ▪ CDHB/WCDHB Digital Security Course on healthLearn which includes aspects of data security to be rolled out once WCDHB specific differences have been reviewed. ▪ Undertake email phishing education campaign. ▪ Onboard to the CDHB process of auto deactivation for unused accounts. ▪ Move to Exchange On Line which will require 2FA for email access.

Physical Security

1 May 2018 State	Actions Taken and Intended
▪ Current maturity is at level 2. ▪ Policies and processes defined but have not been reviewed in the last 12 months. ▪ Methods of this security area may need to be refreshed in line with updated technologies (e.g. Tape vault).	▪ Transalpine Security Manager to review current state and identify and implement technologies that will enhance physical security. ▪ Digital Security Course to be rolled out on healthLearn which includes aspects of physical security. ▪ Policy in this area is about to go out for working level review. ▪ Security Services Manager working towards NZ Protective Security Requirements Framework for WCDHB and CDHB.

Vulnerability Management

1 May 2018 State	Actions Taken and Intended
▪ Current Maturity level 1 – 2. ▪ No formal management framework in place. ▪ Vulnerability management infrastructure components exist. ▪ No Vulnerability Management policy exists. ▪ Independent testing is occurring every second year.	▪ Transalpine Security Manager to review vulnerability management infrastructure for gaps. ▪ Transalpine Security Manager to develop vulnerability management framework and policy. ▪ Develop vulnerability management to level 3 within 12 months. ▪ New Endpoint Protection tool currently being deployed has core vulnerability identification capabilities. ▪ Currently developing a vulnerability management framework. ▪ Improve disciplines around deploying and maintaining secure infrastructure.

Event and Incident Management

1 May 2018 State	Actions Taken and Intended
▪ Current Maturity level 1-2. ▪ Focus on continued improvement of incident event and management processes.	▪ Review and inculcate processes around cybersecurity incidents. ▪ Review how WCDHB and CDHB complete event and incident management to ensure stronger alignment. ▪ Strawman cybersecurity incident response plan to be further developed. ▪ Commence Distributed Denial of Service Planning – WCDHB use 45 systems that are external facing, CDHB 115.

Network Security

1 May 2018 State	Actions Taken and Intended
▪ Current Maturity level 2. ▪ Network and communication and security policy exists. ▪ Policy has been updated in line with HISO 10029:2015 standard. ▪ Continue working on network security with support from our vendor. ▪ Continue improving process for controlling environment changes, with more focus on change request planning. ▪ Regular service reviews continue to be held with datacentre and network vendors (CCL / 2 Degrees).	▪ Infrastructure Services Manager to submit updated policy to WCDHB EMT for signoff. ▪ Continue to phase out older 2008R2 servers. ▪ Complete firewall replacement procurement.

5. CYBER SECURITY EXTERNAL ASSESSMENTS AND FUTURE FOCUS

Distributed Denial of Service (DDOS) Attacks
The Ministry of Health has requested health entities review and as appropriate increase their DDOS preparedness. To date 45 applications or websites have been identified which may be directly impacted by a successful DDOS attack or result in West Coast DHB staff being unable to or having difficulty with access. These are either hosted externally or have external connections. The West Coast DHB has some DDOS protection from 2Degrees, and limited in-house protection. We are currently investigating what further mitigation is available and the cost of this.

If an attack on the West Coast DHB was to overwhelm defences in place at the time, the majority of applications will remain working for users on site; the main exceptions being ServiceNow (Max, ISG/Oracle service desk tool), Microsoft Teams and Office 365/Email users who have migrated to Office online. External email will not be able to be sent/received. Applications that ISG has moved to the Cloud will largely be unaffected by a direct attack as the connection to the Cloud in this instance is private. Several external applications including Microsoft Teams and Office 365/Email would be able to be accessed if offsite, or onsite via phones/devices using 4G.

It should be noted that this DDOS activity is competing with other security work given security resource constraints.

Key Initiatives
By working as a Transalpine team, we can leverage and benefit from the security work Canterbury DHB has been undertaking. The following are key initiatives we will be rolling out which have recently been deployed at Canterbury DHB.

- The current process for deactivating unused accounts is manual and resource heavy. Canterbury DHB has implemented an automated system which works well and the West Coast DHB will be onboarding to this system during Q1 2021.
- Canterbury DHB is conducting a phishing education campaign from March 2020 to March 2021. West Coast DHB's last phishing education campaign was completed in 2017 and it recently experienced a phishing attack which successfully compromised an email account. West Coast DHB is planning to roll out this Phishing education tool during Q1 2021, after the automated deactivation process is completed.
- Security Awareness Training – Canterbury DHB has completed a healthLearn module which educates staff on good security practises. West Coast DHB will be on boarding to this module during Q1 2021.
- Improving security of email – The migration to a new email security tool for both Canterbury and West Coast DHB is close to completion with minimal tidy up work remaining. The migration to a new end-point protection tool has just commenced following recent completion of signoff and contract processes.

Resources
The security workload continues to be extremely high and we are taking the following steps to address resourcing issues:

- Clarifying reporting lines for two staff members who have some security responsibilities one of which is funded by West Coast DHB.
- Canterbury DHB included additional FTE in the End Point Protection Business Case to monitor and/or remediate issues as resourcing is required to support our improved modern detection capability. A job evaluation is currently being finalised before approval to recruit is sought.
- Canterbury DHB is drafting a Business Case for a Cybersecurity Analyst to meet the policy, risk assessment and compliance workload, including DDOS.

6. ISG INFRASTRUCTURE

In 2017 a Disaster Recover strategy was approved which outlined a series of important steps to improve the infrastructure resilience of ISG systems for the West Coast DHB. These capabilities have been implemented with the completed move to Te Nikau.

Prior to DR Strategy	As at November 2020
Singular Storage area Network system (SAN) at end of life and end of support	Move to Infrastructure as a service for 80% of server infrastructure using tier 3 datacentre based in Christchurch.
Physical servers running virtual server environment at end of life stored within a single server room based in Greymouth	Remaining local virtual servers for core infrastructure such as building management system, login systems and printing are load balanced across two physical server rooms in separate buildings within Greymouth campus.
Singular fibre optic cable running to Greymouth exchange from Greymouth hospital	Two fibres running fully diverse paths to Greymouth exchange.
Singular fibre optic path from exchange until Cobden bridge for national fibre network	Fully diverse paths from exchange to national fibre network
No diverse network options at sites such as Buller, Hokitika, Reefton, Moana, Franz etc	3/4G cellular backup where possible at network sites
No communications backup should network fail at core sites Greymouth, Hokitika, Buller and Reefton	Satellite backup system integrated to telephony system at base sites, and hand satellite phones at outer clinics

7. CONCLUSION

The West Coast DHB continues to make progress in the cyber security space, with a conscious Transalpine focus. Some of the accompanying technology improvements have started to occur, and the introduction of a modern End Point Protection suite will be another step on that path. The completion and continued management of policies and education will assist the organisation to achieve its target of Level 3 maturity. Our security workload continues to be extremely high and we are taking a number of steps to address resourcing issues, so we can effectively respond to the increased cyber security threats and risk to the NZ Health Sector.

Infrastructure improvements have also been implemented and more systems will be converged over time via our Transalpine relationship with Canterbury DHB.

8. APPENDICES

Appendix 1: Security Maturity Model (ref: Gartners IT Score Maturity Levels for Information Security).
Appendix 2: Security Maturity Model Measurement Criteria (ref: SANS Security Maturity Model).
Appendix 3: West Coast DHB High level Infrastructure roadmap

Report prepared by: Miles Roper, Chief Information Officer
Mike De Ruiter, Transalpine Risk and Security Manager

Report approved for release by: Savita Devi, Acting Chief Digital Officer
Dr Andrew Brant, Chief Executive

APPENDIX 1

Security Maturity Model (ref: Gartner's IT Score Maturity Levels for Information Security)

Maturity Level	Description
1. Initial	▪ Ad Hoc Activities ▪ Initial Executive awareness ▪ IT Centric approach
2. Developing	▪ Security Officer appointed ▪ User Awareness outreach ▪ Formal program initiated
3. Defined	▪ Polices and process defined ▪ Security organisation defined ▪ Improving user awareness
4. Managed	▪ Governance Body established ▪ Info-Centric approach ▪ Effective metrics ▪ Security organisation working well
5. Optimising	▪ Information owners accountable ▪ Risk aware culture ▪ Refinement for changes in in business, technology and compliance environments

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

APPENDIX 2

Security Maturity Model Measurement Criteria (ref: SANS Security Maturity Model)

	Level 1	Level 2	Level 3	Level 4	Level 5
Security Program	No formal security program in place	Formal Security program in draft mode	Security Program formalised and updated in last two years	Security Program formalised up to date and functioning	Model security program; anticipates change aligned with IT, business risk and procurement
Security Policies	Security Policies missing, outdated, or incomplete	Security policies started, covering major issues (e.g. acceptable use, passwords, wireless use, BYOD)	Complete set of security policies written	Security Policies published, review cycle established no gaps	Security policies readily available on the internet, all affected users required to read annually, documented assessment of knowledge
Security Infrastructure	Critical components of security infrastructure missing	All security infrastructure components in place some may be obsolete, not updated or not monitored	All Security infrastructure components up-to-date and managed periodically	All Security infrastructure components monitored continuously; possible use of third-party managed security services	All Security infrastructure components monitored continuously; initial response to incidents automated; alignment with CERT and regulatory standards

High level Infrastructure roadmap

The table below lists the systems or functions which relate to infrastructure, and their path to being fully merged as part of a Transalpine functioning service or team. Transalpine means they operate via a single instance of the system, with staff based in Christchurch and on the West Coast working on the same system.

Infrastructure System	Pre 2018	2019	2020	2021
Wireless	Adhoc	Transalpine		
Firewall	Local	Local	Local	Transalpine
Mobile Device Management (MDM)	Adhoc	Adhoc	Adhoc	Transalpine
Citrix	Local	Local	IaaS	Transalpine
PC build system	Local	Local	Transalpine	
Server patching	Local	Transalpine		
Mailgateway	Local	Local	Transalpine	
Webgateway	Local	Local	Local	TBD
Antivirus	Local	Local	Transalpine	
Mail (Microsoft exchange)	Local	Local	Local	Transalpine
Video Conferencing system	Local	Vidyo (Local)	Hybrid	Transalpine
Backups	Local	Transalpine		
Service Desk	Local	Transalpine		

RESOLUTION TO EXCLUDE THE PUBLIC

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

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

SOURCE: **Governance Support**

DATE: **10 December 2020**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i resolve that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, & 9.

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 6 August 2020 and the Public Excluded Special meeting of 24 September 2020	For the reasons set out in the previous Board agenda.	
2.	Laboratory Solutions Pre-Analytical Handling & High Volume Analysers Contract	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
3.	Collective Insurance MDBO Risk Sharing Agreement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
4.	Chair and Chief Executive 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)
5.	Clinical Leaders 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)

6.	People & Capability 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)
7.	Risk Management Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
8.	Rating Summary Update Q4 2019/20	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	9(2)(j)
9.	QFARC Report	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)

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 5, 8, 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: Governance Support