

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



**DISABILITY SUPPORT
ADVISORY COMMITTEE
MEETING**

27 MAY 2009

**AGENDA
AND
MEETING PAPERS**

All information contained in these committee papers is subject to change

AGENDA

FOR THE WEST COAST DHB DISABILITY SUPPORT ADVISORY COMMITTEE MEETING TO BE HELD IN THE BOARD ROOM, CORPORATE OFFICE, GREYMOUTH ON WEDNESDAY 27 MAY 2009 COMMENCING 10.00AM

1. Welcome / Introductions / Apologies
2. Karakia
3. Disclosure of Advisory Committee Members' Interests
4. Agenda Check
5. Minutes of the Last Meeting - 15 April 2009
6. Action / Responsibility List, Matters Arising & Updates
7. Advisory committee schedule for preparing reports and papers 2009
8. Correspondence
9. General Business
 - 9.1 Workplan
 - a) GM Planning and Funding Report to DSAC
 - (i) Health Targets
 - b) Report Against the District Annual Plan
 - c) Update Against the WISE Plan
 - d) Development of DSAC Workplan

NEXT MEETING - Wednesday 8 July 2009

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.

DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS' DISCLOSURES OF INTERESTS

Member	Disclosure of Interest
CHAIR John Vaile WCDHB Member	Member - CCS Westport Branch Director - Vaile Hardware Ltd
DEPUTY CHAIR Elinor Stratford WCDHB Member	Manager - Disability Information Service Member - NZCCS Greymouth Branch Chairperson - West Coast Sub-branch - Canterbury Neonatal Trust Trustee - Canterbury Neonatal Trust Vice-Chair Victim Support, Greymouth Member - Clinical Governance Committee West Coast PHO
Mohammed Shahadat WCDHB Member	Director - Asia Pacific Immigration Consultants Ltd, trading as Aspac Immigration Consultants
Patricia Nolan	Member - Brain Injury Association Member - Independent Living Centre Committee Member - Hokitika CCS Disability Action
Lynnette Beirne	Secretary of the West Coast Stroke Support Group Educator, Arthritis New Zealand Committee Member, Southern Regional Stroke Committee
Kevin Brown	Trustee, Juvenile Diabetes Trust Member, CCS Councillor, Grey DC Wife employed by West Coast DHB pharmacy Trustee, WestPower
Rick Barber	Trustee, Greymouth High School Member, Runanga o Ngati Waewae Executive

MINUTES OF THE DISABILITY SUPPORT ADVISORY COMMITTEE MEETING HELD WEDNESDAY 15TH APRIL 2009 IN THE BOARDROOM, CORPORATE OFFICE, GREYMOUTH

Present	John Vaile, Chairman, WCDHB member Elinor Stratford Lynnette Beirne Graeme Axford Mohammed Shahadat Patricia Nolan Kevin Brown
In Attendance	Wayne Turp, GM Planning and Funding Torfrida Wainwright, Planning and Funding Analyst Juliette Reese, Minute Secretary
Apologies	Rex Williams (West Coast DHB Chair) Joel George (Acting CEO, West Coast DHB)
Absentees	Rick Barber

1. APOLOGIES, WELCOME

The Chair welcomed those present to the meeting.

The committee noted that no apology had been received from Rick Barber. There was some discussion around Rick Barber's attendance at DSAC meetings and the consequences of not attending without submitting an apology. A request has been made for Juliette to confirm Rick's attendance record at the DSAC meetings.

2. KARAKIA

Wayne Turp and the committee members said the karakia.

3. DISCLOSURES OF INTEREST

No changes noted.

4. AGENDA CHECK

There were no changes to the agenda

5. MINUTES OF THE PREVIOUS MEETING HELD 4th MARCH 2009

It was RESOLVED that the Minutes of the Disability Services Advisory Committee meeting held 4th March 2009 were a true and accurate record.

Moved: Kevin Brown. Seconded: Elinor Stratford. Carried Unanimously.

6. MATTERS ARISING

Action Points - Correspondence from Robert Miedema

Wayne Turp notes that this correspondence will be ongoing. As yet the GM Corporate Services has not responded as correspondence only received 6th April 2009. John Vaile has requested that this letter be acknowledged. Wayne Turp to check that Wayne Champion has acknowledged Robert Meidema's letter.

DSAC Chair's Report to Board

Received.

Repainting Carparks

Kevin Brown raised the issue of the Carpark being repainted. Wayne Turp advised that this was undertaken each year as part of the hospital maintenance program. Kevin commented that he has been attending committee meetings for 16 months and in that time the carpark has still not been repainted. Wayne will confirm when the repainting is scheduled.

Elinor Stratford notes that Wayne Champion has confirmed that the resealed disabled carpark will be repainted.

7. CORRESPONDENCE

- Copy of Robert Meidema's letter dated 24th March 2009.

8. GENERAL BUSINESS

GM Planning and Funding Report to DSAC

The report was taken as read. Wayne Turp invited questions / comments around the report.

Workforce

Lynnette Beirne commented that as the training was unpaid there was no incentive to attend. Last year workers lost a day each Thursday to attend.

Tor Wainwright advises that she is in negotiation with providers re incentives, such as an increase in salary on completion of the course.

Residential Care for Elderly in Buller.

There was discussion and clarification around the RFP process and communication of progress and results to outside parties. The GM P & F explained that it is not appropriate for Board or Advisory Committee members to be given details of the tenderers or their progress through the tendering process as this would breach due process and tendering policy and procedure. Board members hold responsibility for approving any recommendations made by Management on conclusion of the tendering process. It is at this point that advisory members and other interested parties can receive a detailed briefing on future service delivery.

The meeting was adjourned at 10.03am to attend the Workshop.

The meeting was taken from adjournment at 12.25pm. Moved Elinor Stratford, seconded Graham Axford, carried unanimously.

9. DSAC WORKPLAN

Resulting from discussion at the workshop, Wayne Turp and Tor Wainwright will make some amendments to the draft plan and submit this in time to be considered at the next meeting.

10. NEXT MEETING

The next meeting is scheduled for Wednesday 27 May 2009, Board Room, Corporate Office, Greymouth.

There being no further business to discuss, the meeting concluded at 12.25pm

MATTERS ARISING FROM DISABILITY SERVICES ADVISORY COMMITTEE MEETINGS

Meeting Date	Action Item	Action Responsibility	Reporting Status
4 March 2009	Matters Arising	GM Planning and Funding to consider Practical vs Legislative requirements for disabled parking long term under the Sustainability Project.	DSAC to take this over as part of their strategic focus.
4 March 2009	Matters Arising	GM Planning and Funding to raise to GM Facilities the Committees short term suggestions around improving parking clarity and visibility.	Update to be given next meeting 27 May 2009.
15 April 2009	Matters Arising	GM Planning and Funding to confirm Wayne Champion has acknowledged Robert Meidema's letter of 24 th March 2009.	Ongoing
15 April 2009	Matters Arising	Juliette Reese to confirm Rick Barber's attendance record for the committee	by 1 st May 2009
15 April 2009	Matters Arising	GM Planning and Funding to confirm when carparking repainting is scheduled	Update to be given next meeting 27 May 2009

DSAC Advisory Committee Timeframes - Actions for Committee Members

Summary to November 2009

This document to be tabled for discussion

CORRESPONDENCE

No correspondence received

GM PLANNING & FUNDING REPORT TO THE DISABILITY SUPPORT ADVISORY COMMITTEE

TO: Members, Disability Support Advisory Committee

FROM: Wayne Turp, General Manager Planning & Funding

DATE: May 2009

STRATEGIC ISSUES

The key planning and funding activity over the last six week has been the preparation and submission of the draft 2009/10 District Annual Plan and Statement of Intent. The process this year has been unusual in that a number of statutory components and requirements were not known at the time of submitting the first draft. The second draft including the new Ministerial expectations and new Minister's health Targets is now with the Ministry of Health and, subject to their approval, will be submitted to the Minister of health for formal acceptance and sign-off before the end of June 2009. In addition to the new health targets, the Statement of Intent has been reconfigured to meet the Office of the Auditor General's expectations for Crown Entities. (Please see appendix one for further detail of these).

Older Persons' Services

Carelink

Carelink is now progressing on strengthening the links between itself and related services, such as specialist AT&R services, mental health, short-term home support, district nursing and primary health and on developing the role of the Advisor of Older Peoples Services.

The Ministry of Health has notified WCDHB that funding is now available to start implementing the InterRAI assessment system during 0809, and plans are now being made for staff training and to confirm the IT relationship with Canterbury as host DHB for this project.

Patient pathways

The stroke patient pathway group continues its work. The dementia patient pathway has reported back.

A community focus for specialist service for older people

It looks unlikely that we have received funding for the proposal for a Wrap-Around Service for Frail Older people that was submitted jointly with the West Coast PHO to the MoH's Rural Innovations Fund. Other avenues are being investigated for developing a community rehabilitation function on the West Coast (including the setting up of step-up/down beds).

Residential Care

Negotiations are still being held with the preferred provider for residential care beds in Westport.

Regular meetings between West Coast DHB staff and residential care staff continue, with the next one planned for early June.

A variation to the Aged Residential Care contract is currently being negotiated on our behalf as part of a national process. This will add a substantial increase to the unit price, funded by an additional \$18 million from the government (approximately \$180,000 for the West Coast).

Dementia

Carelink is working on a new method of individualised funding for people who are assessed as needing specialist dementia care but who could feasibly be managed within a non-specialist residential facility with some extra resource for staffing etc. A draft contract and specification has been circulated and is being discussed with residential providers. This is aimed at tackling the problem of too few specialist dementia care beds on the Coast.

Respite and Day-care

New contracts for respite and day-care are still being processed, and it is hoped to get this service up and running within the next month or so. Negotiations continue with Presbyterian Support Services (Upper South island) to start a Home Share service on the West Coast in July, offering daycare and dementia daycare based in individual homes.

The government has given DHBs additional funding (around \$25,000 pa for WCDHB) for 'dedicated respite care beds'. A recent DHBNZ national meeting discussed how this might be implemented, including the implications for other short-term use of residential care beds.

Workforce

Negotiations with the homecare providers' contracts to fund the upskilling of home-care workers are still being negotiated and hopefully will be in place by 1 July.

Home support

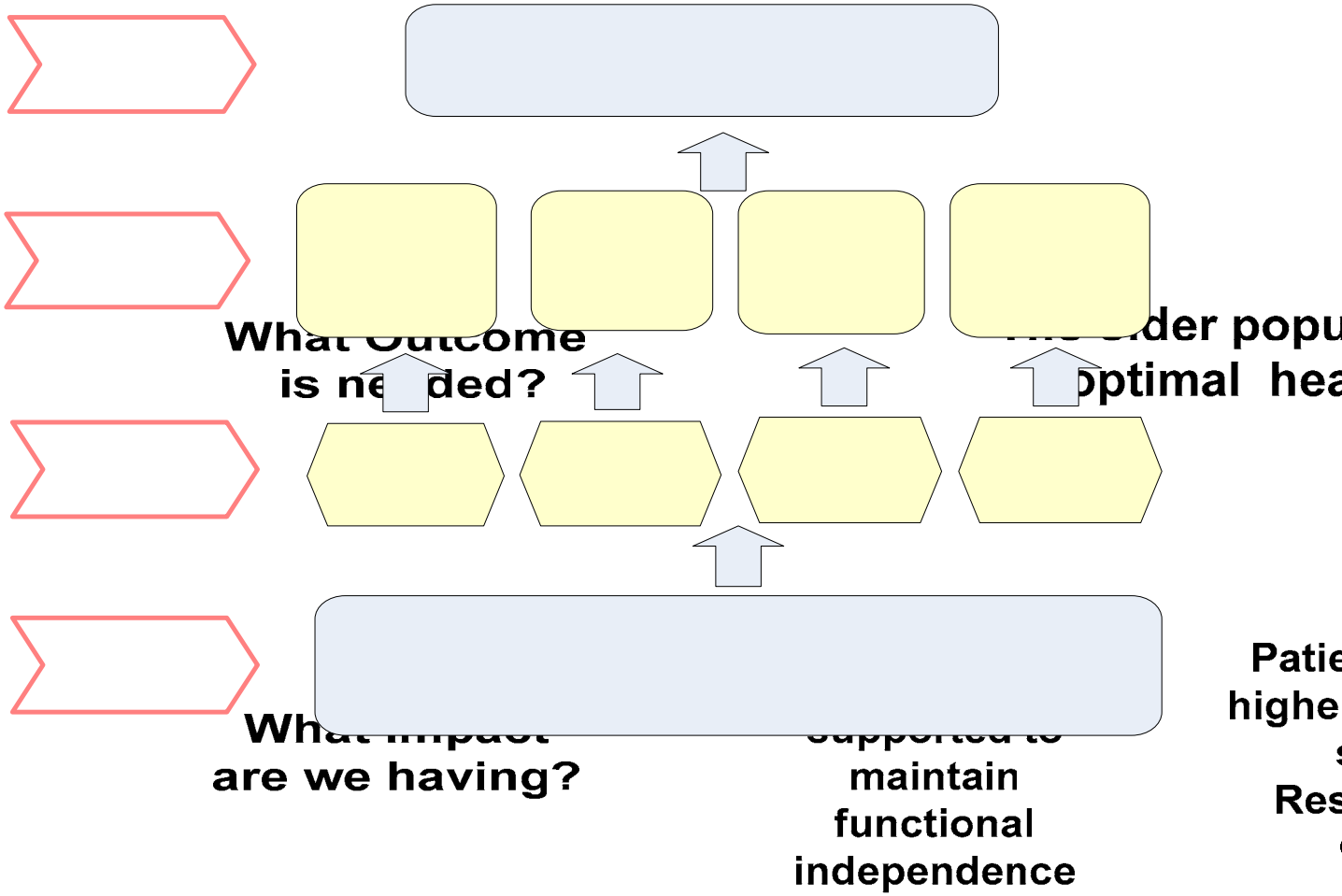
Planning is underway to prepare a tender for a new model of homecare services, based on a package-funded and restorative model. Information is being sought from other DHBs as to what has worked in other places e.g. Nelson Marlborough

Regional Health of Older People planning and funding

At the request of the South Island Planning and Funding General Managers meeting, the Planning and Funding analyst is working with her Canterbury counterpart on a proposal to combine the functions of the P&F role for older people's services for the five South Island DHBs.

Author: Wayne Turp, 18 May 2009

Outcomes for Support Services



What Services are we providing?

Home Based Support Services

Aged Care

How do we organise to achieve these results

Improve supervision of

Alignment of dedic

Improve targeting of

Support Services Output Class

This section outlines the Support services we intend to deliver to our population. Each aggregate includes people with long-term disabilities; people with mental health problems and people who have age-related disabilities.

These outputs are aggregated into: Home-based support services, Residential Care support services, Day Services, and Palliative Care services.

Outputs	Measures	Baseline	09-10	10-11	11-12
Non-residential Support Services	Outcome: more people with high needs supported at home Measure: proportion of 65+ population in rest home level care Target: match South Island average for % of 65+ population in rest home level care	5.8% of 75+ year olds on West Coast (4.7% SI)	5.5%	5.0%	4.7%
Residential Care Support Services	Outcome: appropriate access to residential care Measure: proportion of 65+ population in hospital and dementia level care is close to South Island average Target: match South Island average for % of 65+ population in hospital and dementia care	0.4% of 75 year olds on West Coast (2.8% SI)	1%	2%	3%
Day Services	<i>Included in Non-residential Support Services above</i>				
Palliative Care Services	Patients requiring specialised palliative care are provided with appropriate care to meet their individual clinical needs.	100%	100%	100%	100%

DHB Reporting Requirements

2009/10

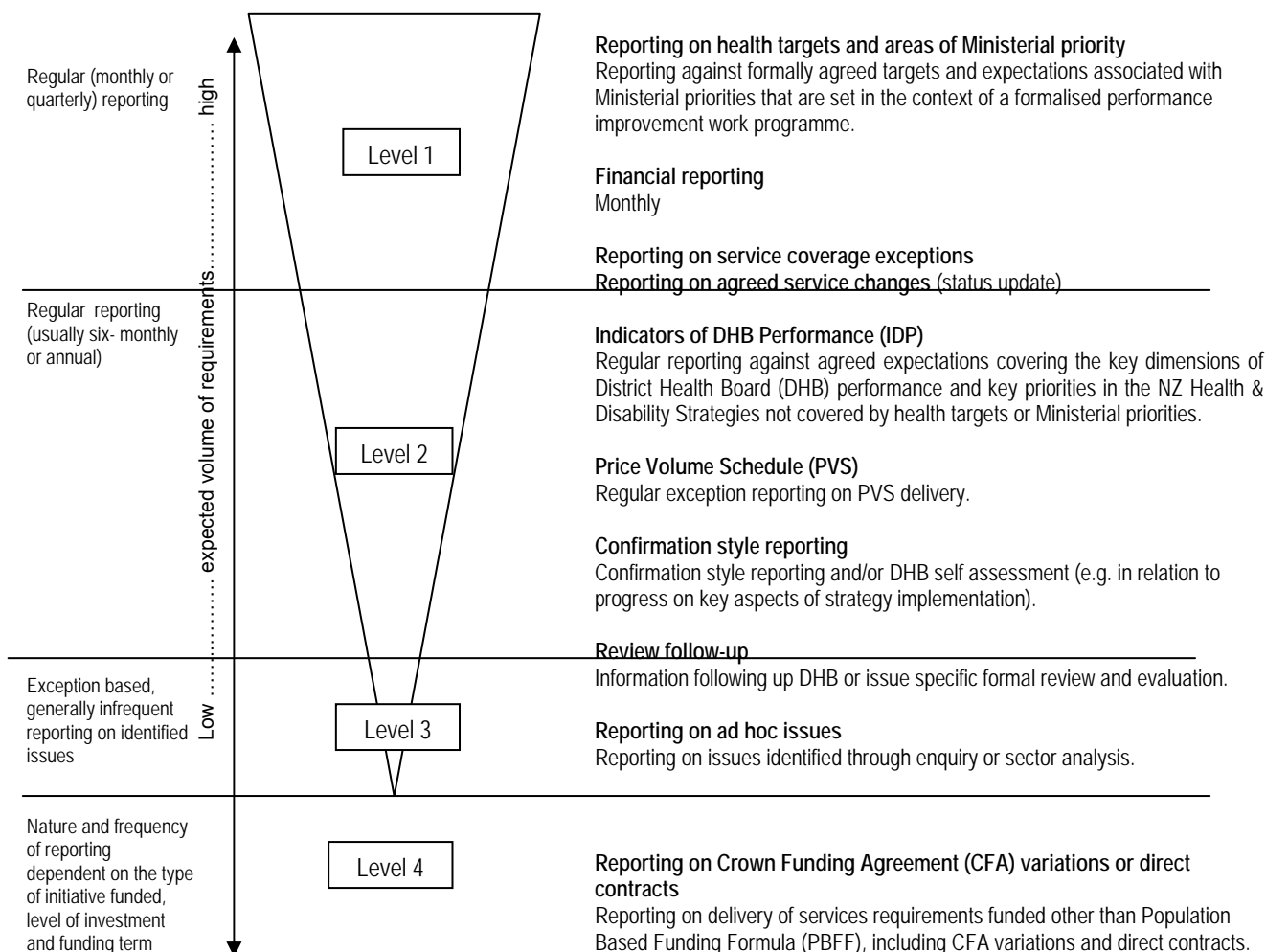
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2009/10 DHB Performance Reporting Framework

Reporting where there are formal performance expectations



Other reporting

One-off reporting on change / development issues potentially requiring the Minister's approval, reporting to assist the development of the performance reporting framework and information to support the functioning of the health system (**not** for formal accountability purposes).

Figure 1: 2009/10 DHB Performance Reporting Framework

Reporting to gain approval for significant change / development

- **Definition:** proposals and reports relating to the management of service changes and capital and asset management, as required
- **Nature of reporting:** dependent on the issue – likely to be reporting on a standard template basis for the purposes of Minister level interaction / approval.

Reporting to assist the development of the performance reporting framework

- **Definition:** not currently performance information, but intended to become performance information in out years i.e. information needed for baseline establishment
- **Nature of reporting:** dependent on the area of development – restricted to one or two areas of development per year.

Information provision for health system purposes

- **Nature of reporting:** information provided to national information systems national collections, to support machinery of government, in relation to service specifications, in relation to provider contract reporting, for benchmarking and to support policy development.

2009/10 DHB Performance Reporting Framework

As presented in the diagram on the previous page. The DHB reporting framework has four levels:

- Level 1 – reporting on performance improvement in relation to health targets and key annual priorities
- Level 2 – performance reporting in relation to the key dimensions of DHB performance
- Level 3 – reporting in response to issues identified through enquiry or sector analysis
- Level 4 – reporting on CFA variations and direct contracts.

The performance reporting framework was introduced in 2008/09 to reflect the sector's sharpening focus on and increased effort directed at performance improvement. Reports are focused on the government's key priorities and health targets.

Level 1: 2009/10 Health Targets overview

Each of the health targets reflects a priority health area for the government and aims to focus efforts to improve our performance, and ensure our health system is contributing to maintaining and improving health outcomes in these important areas.

Health targets should be seen within the context of the broader health priority that they are part of. They are indicative of progress in a wider range of services provided in each priority area. The targets are also one part of a comprehensive performance management and accountability system in the health sector and are designed to challenge the health system as a whole to continue to do better.

The Sector Capability and Innovation Directorate of the Ministry will proactively work with the sector to build capability, share best practice and innovations, and assist the sector to achieve improved performance and achieve the health targets. Target 'Champions' will continue to provide a leadership role in assisting the sector.

Figure 2: 2009/10 Health Targets

Area	Long term Target	2009/10 National target		2009/10 DHB target	
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95%	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	95%	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to elective surgery	Increase the volume of elective surgery by an average of 4,000 discharges per year (compared with the recent average increase of 1400 per year).	4,000	additional elective surgical discharges	—	additional electives surgical discharges
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.	100%	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).	100%	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).
Increased immunisation	85 percent of two year olds are fully immunised by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012.	85%	of two year olds are fully immunised by July 2010	—%	of two year olds (Maori) are fully immunised by July 2010
				—%	of two year olds (Pacific) are fully immunised by July 2010
				—%	of two year olds (Other ethnicity) are fully immunised by July 2010
				—%	of two year olds (All ethnicities) are fully immunised by July 2010
Better help for smokers to quit	80 per cent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012. Introduce similar target for primary care from July 2010 or earlier, through the PHO Performance Programme.	80%	of hospitalised smokers are provided with advice and help to quit by July 2010	80%	of hospitalised smokers are provided with advice and help to quit by July 2010

Better diabetes and cardiovascular services	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	__%	Increased percent of the eligible adult population (Maori) have had their CVD risk assessed in the last five years (suggestion is 2%)
			__%	Increased percent of the eligible adult population (Pacific) have had their CVD risk assessed in the last five years (suggestion is 2%)
			__%	Increased percent of the eligible adult population (Other ethnicity) have had their CVD risk assessed in the last five years (suggestion is 2%)
			__%	Increased percent of the eligible adult population (All ethnicities) have had their CVD risk assessed in the last five years (suggestion is 2%)
	Increased percent of people with diabetes attend free annual checks	Increased percent of people with diabetes attend free annual checks	__%	Increased percent of people with diabetes (Maori) attend free annual checks
			__%	Increased percent of people with diabetes (Pacific) attend free annual checks
			__%	Increased percent of people with diabetes (Other Ethnicity) attend free annual checks
			__%	Increased percent of people with diabetes (All Ethnicities) attend free annual checks
	Increased percent of people with diabetes have satisfactory or better diabetes management.	Increased percent of people with diabetes have satisfactory or better diabetes management.	__%	Increased percent of people with diabetes (Maori) have satisfactory or better diabetes management.
			__%	Increased percent of people with diabetes (Pacific) have satisfactory or better diabetes management.
			__%	Increased percent of people with diabetes (Other ethnicity) have satisfactory or better diabetes management.
			__%	Increased percent of people with diabetes (All ethnicities) have satisfactory or better diabetes management.

Level 1: 2009/10 Health Targets

Level 1: 2009/10 Health Targets

Progress towards each target will be assessed, reported to the Minister of Health and publicly reported on the Ministry of Health web-site each quarter.

In most cases, specific assessment criterion are set out for each target. Although quarterly progress will be updated on the Ministry of Health web-site, a formal assessment of target achievement will not be made until the final quarter.

Where a health target description does not include specific assessment criterion, the following criterion will apply:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O	<ol style="list-style-type: none"> 1. Applied in the fourth quarter only—this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	<ol style="list-style-type: none"> 1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	P	<ol style="list-style-type: none"> 1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved – escalation required	N	<ol style="list-style-type: none"> 1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

Shorter stays in Emergency Departments (ED)

Indicator: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Note that a target date for achievement will be set once current performance data has been collected.

Target Champion – Mike Ardagh, Professor of Emergency Medicine

Rationale

Emergency Department (ED) length of stay is an important measure of service quality in emergency departments, because:

- EDs are designed to provide urgent (acute) health care; the timeliness of treatment delivery (and any time spent waiting) is by definition important for patients
- long stays in emergency departments are linked to overcrowding of the ED
- the medical and nursing literature has linked both long stays and overcrowding in EDs to negative clinical outcomes for patients such as increased mortality and longer inpatient lengths of stay
- overcrowding can also lead to compromised standards of privacy and dignity for patients, for instance, through the use of corridor trolleys to house patients.

Definition

Each DHB will be required to submit their numerator data (number of patient presentations to the ED with an *ED length of stay* less than six hours) and their denominator data (number of patient presentations to the ED) to the Ministry **separately for each relevant ED facility**. In addition, for the first and fourth quarters, DHBs are to provide narrative comment on the quality of their data, steps taken to meet the target and improve the quality of emergency department care, and any difficulties encountered with implementation of the target.

Numerator:

The number of patient presentations to the ED with an *ED length of stay* less than six hours.

Denominator:

The number of patient presentations to the ED.

Explanation of terms:

1. *ED length of stay* for a patient equals the time period from *time of presentation*, to *time of admission, discharge or transfer*.

2. *Time of presentation*; the time of first contact between the patient and the triage nurse or clerical staff, whichever comes first.
3. *Time of admission*; the time at which the patient is physically moved from ED to an *inpatient ward*, or the time at which a patient begins a period of formal observation, whether in ED observation beds, an observation unit, or similar. The physical move will follow, or be concurrent with, a formal admission protocol, but it is the patient movement that stops the clock, not associated administrative decisions or tasks.
4. *Inpatient wards* include short stay units (or units with a similar function). Under certain circumstances, a 'decant' ward designed to deal with surge capacity will qualify as an inpatient ward. Key criteria are that patients should be in beds rather than on trolleys, and be under the care of appropriate clinical staff.
5. *Time of discharge*; the time at which a patient being discharged from the ED to the community physically leaves the ED. For the avoidance of confusion; if a patient's treatment is finished, and they are waiting in the ED facilities only as a consequence of their personal transport arrangements for pickup, they can be treated as discharged for the purposes of this measure.
6. *Time of transfer*, the time at which a patient being transferred to another facility physically leaves the ED.

Inclusions and exclusions:

1. Data provided to the Ministry of Health will be provided at facility level, for all EDs of level 3 and above, within a DHB, according to the role delineation model, as elaborated in the ED service specification. Where a DHB has more than one facility, the overall percentage calculated for the DHB will be a weighted result, not a simple average of the results of individual facilities.
2. All presentations between 00:00 hours on the first day of the quarter, and 00:00 hours on the first day of the next quarter, are included – *excepting*;
3. Patients who do not wait for treatment will be removed from both the denominator and the numerator, and;
4. GP referrals that are assessed at the ED triage desk (using the Australasian Triage Scale), but are then directed to an Admission and Planning Unit or similar unit without further ED intervention, are excluded from the measure (here the term 'ED intervention' can encompass minor procedures such as analgesia or administration of intravenous fluids, for instance).
5. Patients that present to the ED for pre-arranged outpatient-style treatment are excluded from the measure.
6. No exceptions from measurement are made for particular clinical conditions.

In certain situations it may be that good clinical practice or a particular service model will compromise the ability to meet Health Target expectations, and that this will begin to become apparent as data is collected. Where this situation arises, the Ministry will discuss this with the DHB affected, and the definition can be re-interpreted on a case-by-case basis where relevant.

Interpretation

A high percentage is better than a low percentage.

Relationship with triage times

- Previous analysis by the Ministry of Health suggests there is a weak correlation between triage and length of stay.

- Triage data will continue to be collected from DHBs by the Ministry of Health as part of hospital benchmark data reporting and will form a new Indicator of DHB Performance for 2009/10 with triage 1, 2 and 3 rates collected on a quarterly basis.
- As part of an upcoming review of accountability measures, consideration will be given to:
 - extending the reporting of triage rates to include triage 4 and 5
 - tightening the definitions used in triage rate reporting
 - making triage rate reporting a formal accountability measure.

2009/10 Deliverables

Key Information:

Each DHB will be required to submit their data (numerator, denominator) to the Ministry separately for each relevant facility. A reporting template will be supplied by the Ministry.

In addition, for the first and fourth quarters, DHBs are to provide narrative comment on the quality of their data, steps taken to meet the target and improve the quality of emergency department care, and any difficulties encountered with implementation of the target.

Supporting Information:

Other supporting quantitative information will also be provided to the Ministry. There are no targets associated with this information. Instead, it will be used by the Ministry in developing a rounded view of performance against target:

- the admission rate from ED to inpatient settings
- average midnight bed occupancy over all hospital beds.

Information for analysis at local level:

While it will not be collected by the Ministry, each DHB should collect and hold patient-level data that includes the triage level of the patient, and the time of key milestones in the ED patient journey, in particular, the time of presentation, and time for admission, discharge, or transfer. This material may be required for analysis and discussion with the Ministry, if expectations (as set out below) are not met. The Ministry has begun to consider the future collection of this patient-level data through national data collections by 2010/2011.

Reporting period

All quantitative data (including supporting information) is to be supplied quarterly. This information will need to be available by the 20th day following the end of the relevant quarter.

Qualitative narrative is to be supplied in the first and fourth quarters only.

Expectations

All DHBs (and all individual facilities) are expected to achieve a benchmark of 95 percent against this Health Target.

The following achievement scale will be applied:

2009/10 Final

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- achieved = the DHB has met the target percentage for the quarter, and all facilities have also met targets
- partially achieved = the DHB has met the target percentage for the quarter, though some facilities have not reached their target
- not achieved = performance by the DHB has fallen below the target.

For the first and second quarter of the 2009/2010 year, the target will be piloted, with an expectation that modifications may be made to the measure definition for the subsequent quarters based on any flaws uncovered during implementation.

The target would be fully operational in a final form for the four quarters of the 2010 calendar year.

Escalation

From the third quarter of 2009/2010 onward, where any facility fails to achieve its target, the DHB is responsible to carry out an audit of patients with ED length of stay greater than six hours, in order to determine the reasons for failure to achieve target. The audit results and remedial actions should be reported to the Ministry by the quarter following the reported failure to achieve.

Improved access to elective surgery

Indicator: The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1400 per year).

Target Champion – Kieran McCann, Manager, Elective Services

Rationale

As signalled in the 2009/10 Minister's Letter of Expectations, the government wants the public health system to deliver **better, sooner, more convenient** healthcare for all New Zealanders.

Over the period 2000/01 to 2007/08 the number of publicly funded elective surgical discharges rose by an average of 1,432 discharges per annum. The growth in elective surgical discharges did not keep up with population growth over this period. The Minister has set an expectation that the annual increase in elective surgical discharges will improve. The growth in elective surgical discharges will increase access and should achieve genuine reductions in waiting times for patients.

2009/10 Deliverables

The number of elective surgical discharges provided nationally will increase by an average of 4,000 discharges per annum.

DHBs will be required to report on progress quarterly on an exception basis against the target agreed in their District Annual Plan. This level of reporting will provide early warnings of any DHB that may be experiencing difficulty in achieving their annual target and provide the opportunity for corrective actions to be undertaken.

Reporting period

Quarterly reporting. *Note* reporting for this measure operates on a delayed timetable – not as per the Operational Policy Framework – as the hospital activity needed for reporting is not available until one month after the quarter ends. Data will be made available to DHBs via the Electives Services Quickplace website. Electives services Managers, GMs Funding and Planning will be notified via email that the data is available.

Expectations

At a national level DHBs will deliver an average increase of 4,000 elective discharges each year in surgical specialties. Each DHB will identify a minimum level of elective surgery to be provided to the people living in its regions in the 2009/10 District Annual Plan (DAP). The level of surgery to be provided should be determined by the DHB's actual level of service in the previous financial year (2007/08), the level of service planned in the current financial year (2008/09), and the achievement of equitable access to elective surgery relative to other DHBs.

There will be four levels of achievement for this indicator; Outstanding Performer, Achieved, Partially Achieved and Not Achieved. A rating will be determined for each indicator.

Quantitative measures

DHBs will set a target number of publicly funded, casemix included, elective discharges in a surgical specialty (defined by surgical purchase units excluding dental) for people living within the DHB region. Performance will be measured using data from the National Minimum Data Set (NMDS).

Achievement Levels

	Full Year	Quarterly (year to date)
Outstanding Performer	DHB delivers at least 5% more elective surgical discharges than their agreed target.	DHB delivers at least 5% more elective surgical discharges than their agreed target.
Achieved	DHB delivers their agreed target number of elective surgical discharges.	DHB delivers their agreed target number of elective surgical discharges.
Partially Achieved	DHB does not deliver their agreed target but delivers more elective surgical discharges than the previous year.	DHB delivers less than their agreed quarterly target but submits a report that meets Ministry approval by providing the reasons for under-delivery and an action plan as to how it will address the under-delivery and achieve the full year target.
Not Achieved	DHB delivers less than the number of elective surgical discharges required for partially achieved (above).	DHB delivers less than their agreed quarterly target and either does not submit a report or does not submit a report that meets Ministry approval.

Baseline information

Elective services health target baselines can be found on the Ministry of Health website under Health Target Reporting.

<http://www2.moh.govt.nz/QuickPlace/electiveservices/Main.nsf>

Shorter waits for cancer treatment

Indicator: Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.

Target Champion – John Childs, National Clinical Director Cancer Programme

Rationale

Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Development of indicators that mark quality cancer treatment is, however, restricted by the lack of routinely collected information on common treatment. In the interim, waiting times for radiation oncology treatment have been chosen as a representative indicator of specialist treatment, and is an area with waiting time issues for patients. This is justifiable, because radiotherapy is of proven effectiveness in reducing the impact of a range of cancers, and delay to radiotherapy is likely to lead to poorer outcomes of treatment. A **six week wait time is currently targeted**. The expectation will move to **four weeks by December 2010**.

2009/10 Deliverables

1. Cancer Centre DHBs – wait time templates

Completed monthly templates that measure the interval between the patient's first specialist assessment and the beginning of radiation treatment along with other related measures, are supplied on time and complete from each Cancer Centre as detailed in the reporting template located on the nationwide service framework library web site **NSFL homepage:** <http://www.nsfl.health.govt.nz/>.

1. All DHBs – Confirmation and exception reports

Provide a report confirming the DHB has reviewed the monthly wait time templates produced by the relevant Cancer Centre(s) for the quarter. Non-cancer centre DHBs should source this information from Cancer Centre DHBs .

Where the monthly wait time data identifies:

- any patients domiciled in the DHB waiting more than 6 weeks, due to capacity issues, and/or
 - wait time standards were not met, for patients in priority categories A and B
- DHBs must provide a report outlining the resolution path that has been agreed with the cancer centre.

Interpretation issues

First specialist assessment is currently used as a proxy for a formal decision to treat. It is intended that the indicator is adjusted to measure the time between a formal decision to treat and the start of radiation treatment, as soon as data on decision to treat data can be reliably collected by all cancer centres.

Wait times outside the acceptable treatment standard occur either when a service is facing capacity issues or when a patient chooses to wait for treatment or there are

clinical reasons for delay. Where there are clearly identified reasons for delays, other than service capacity issues, the target will be treated as met.

Reporting period

Deliverable 1 - Monthly supply of templates (within 2 weeks of the end of the month).

Deliverable 2 – Quarterly supply of confirmation and exception reports.

Target Expectations

Achievement Levels

- A **not achieved** rating will apply where for one month or more in the period under review there were some patients who did not receive radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D).
- A **partial achievement** rating will apply where for two of the three months under review, all patients received radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D).
- An **achieved** rating will apply where for all of the months under review, all patients receive radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D).
- An **outstanding** performer/sector leader rating will apply, at the end of the 12 month period, where all patients are treated within four weeks of their first specialist assessment (excluding category D).

Increased immunisation

Indicator: 85 percent of two year olds are fully immunised by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012.

Target Champion – Pat Tuohy, Chief Advisor, Child and Youth Health

Rationale

The national immunisation goal is 95% of children fully immunised at two years of age by ethnicity.

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates, depending on the infectiousness of the disease and the effectiveness of the vaccine. New Zealand's current immunisation rates are low by international standards and are not sufficient to prevent or reduce the impact of vaccine preventable diseases such as measles and Pertussis (Whooping Cough).

Increasing coverage for 2-year olds will require improvements in the whole immunisation system that should increase the other measures as well. Coverage for 2-year olds tells us whether children have received the full series of infant immunisations when they are most vulnerable and also tells us which children are not being reached by our immunisation system. It is a commonly-used measure internationally. It is still important that DHBs measure coverage at other milestone ages as this will provide more information about the immunisation system.

2009/10 Immunisation Coverage Targets

Immunisation coverage will be measured using the National Immunisation Register. Achieving this target will require different rates of improvement, and some DHBs will have final targets above or below 95 percent coverage. These will be set by the DHB in negotiation with the Target Champion. This target will be reported for Maori, Pacific (where relevant), and Other ethnic groups.

DHB local targets are to be set for:

- DHB total
- Māori
- Pacific.¹

¹ The requirement to set a Pacific target applies only to those DHBs with high Pacific populations. These DHBs are: Counties Manukau, Auckland, Waitemata, Waikato, Capital & Coast, Hutt Valley and Canterbury DHBs.

DHBs are expected to set targets that will reduce inequalities. This will be demonstrated by presenting and agreeing Māori and Pacific targets (where relevant). DHBs should set targets with the aim of eliminating inequalities by 2012.

Note: To assist with setting the immunisation health targets, see the section below called: "Obtaining immunisation coverage baselines to assist with setting the 2009/10 immunisation coverage health targets – National Immunisation Register (NIR) Datamart report instructions."

Assessing DHB Immunisation Coverage

Progress towards the health target will be assessed quarterly.

The target will be assessed on the based on 3 months data for the previous quarter.

The assessment requirements for each quarter are set out below:

Table 1: Quarters 1, 2 & 3 assessment

Rating	Explanation
Achieved	The DHB has reached the year's total population immunisation coverage target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Partially Achieved	The DHB's immunisation coverage is progressing towards achieving the target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Not Achieved	The DHB's immunisation coverage has made no progress in the last two quarters or is worsening.

Table 2: Quarter 4 assessment

Rating	Explanation
Outstanding Performer	<ul style="list-style-type: none"> • The DHB has substantially exceeded the year's immunisation coverage target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan); and/or • The DHB has reached the year's immunisation coverage target for children 24 months of age for: <ul style="list-style-type: none"> ○ the total population, and ○ the Maori population group, and where applicable ○ the Pacific population.
Achieved	The DHB has reached the year's total population immunisation coverage target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Partially Achieved	The DHB's immunisation coverage is progressing towards achieving the target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).
Not Achieved	The DHB's immunisation coverage has failed to substantially progress towards the target for children 24 months of age (as agreed with Target Champion, and as documented in the District Annual Plan).

2009/10 Deliverables

How to report on immunisation coverage and progress towards the targets

Each quarter, DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan.

DHBs can access information from the NIR Datamart to guide their report on their progress towards the target. A User Guide is available on NIR Datamart to assist DHBs with extracting and reporting immunisation coverage data from the NIR Datamart.

Reporting period

Quarterly- assessed on the basis of results from the previous quarter.

Obtaining immunisation coverage baselines to assist with setting the 2009/10 immunisation coverage health targets - NIR Datamart report instructions

Percentage of eligible children fully immunised at 24 months of age – total DHB population, Māori and Pacific

- Use the NIR Datamart 'Milestone Ages DHB (Excl PCV7).rep" report.

- For the 'Report to date': use the first day of the previous month².
 1. For example if today's date is 15 April 2008, use 1 March 2008 and enter '01/03/2008' as the 'Report to date'
- Print the report from the '3 month' tab
- Use the 24 month milestone age data in the report from the 'Total', 'Māori' and 'Pacific' columns.

² The first day of the previous month is used to ensure the complete month's data has been loaded onto the NIR Datamart.

Better help for smokers to quit

Indicator: 80 percent of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95 percent by July 2012. Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.

Target Champion – Ashley Bloomfield, Chief Advisor Public Health

Rationale

Smoking kills an estimated 5000 people in New Zealand every year, and smoking-related diseases are a significant opportunity cost to the health sector. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.

Definition and Interpretation

Eligible population:

- Hospitals: all adults 15+ admitted to hospital either acutely or for elective procedures
- Primary Health Organisations: 15 to 75 years old enrolled in the PHO

Data is expected to be collected, and progress tracked, by facility and by ethnicity for Total, Māori and Pacific population groups.

2009/10 Deliverable

In quarters one and two, DHBs will submit qualitative reports outlining the system changes being introduced to meet the target.

The Ministry will provide a baseline percentage for DHBs, and from quarter three onwards will provide quarterly data for each DHB.

In quarters three and four DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan.

Some DHBs may introduce or use local Patient Management Systems to capture data and the Ministry will also accept this information as part of a DHBs' quarterly report.

The Ministry will provide DHBs with a reporting template for both qualitative and quantitative reports in June 2009.

Reporting period

Quarterly information will need to be available by the 20th day following the end of the relevant quarter.

Expectations

The tobacco target is a local target each DHB is individually accountable for. The expectation in 2009/2010 is that DHBs will build on work undertaken to date via the tobacco control plans. It is expected that progress towards meeting the target will demonstrate an upwards trajectory through the first year to meet the target by fourth quarter.

The following achievement scale will be applied:

- achieved = the DHB has met the target and all facilities have also met the 80% target.
- partially achieved = data submitted demonstrates progression towards the 80 % target (ie an improvement from baseline or previous report).
- not achieved = data submitted does not demonstrate progression towards the 80 % target.

Note: The primary care target will be monitored via the PHO Performance Programme indicators, which include recording of smoking status. This target will require smoking status to be routinely asked about, recorded, and then acted on through offering brief advice to quit and referral for further quit support. Activities are already underway to support GPs and other professionals to do this, including making NRT available on prescription from the middle of this year. The lead-in time for this target is to allow primary care to put in place the changes needed both to provide this advice and support to smokers routinely and to monitor progress in achieving the target.

Better diabetes and cardiovascular services

Indicator: Indicator:

- (a) increased percent of the eligible adult population will have had their CVD risk assessed in the last five years
- (b) increased percent of people with diabetes will attend free annual checks
- (c) increased percent of people with diabetes will have satisfactory or better diabetes management.

Target Champion – Sandy Dawson, Chief Advisor, Clinical Service Development

Rationale

Chronic disease comprises the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly.

Diabetes is important as a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of a health service for people in most need.

Reporting period

To be reported quarterly³. Quarterly for the period to end of previous quarter.

Timing of reporting should occur as follows:

- in the first quarter, DHBs should report on rates to 30 June of the previous year
- in the second quarter, DHBs should report on rates to 30 September of the previous year
- in the third quarter, DHBs should report on rates to 31 December of the previous year
- in the fourth quarter, DHBs should report on rates to 31 March of the previous year.

Health target:	Cardiovascular disease (CVD)
Indicator:	CVD Risk Assessment (CVDRA)
Deliverables:	The absolute percentage increase in the following indicator over the annual reporting period: Numerator: The number of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years. Denominator: The number of people in the eligible population.

³ Note: Quarterly reporting for the diabetes indicators are those detection and management measures from the annual Get Checked data. Get Checked spreadsheets are still to be completed in full, in the third quarter.

	<p>The population eligible for CVDRA is as follows:</p> <ol style="list-style-type: none"> 1. Māori/Pacific & Indian subcontinent men <u>35-79</u> years of age 2. Māori/Pacific & Indian subcontinent women <u>45-79</u> years of age 3. NZ European & other men <u>45-79</u> years of age 4. NZ European & other women <u>55-79</u> years of age. <p>This target will be reported for Māori, Pacific, and Other ethnic groups. DHB performance against targets will be distributed quarterly by the Ministry of Health to all DHBs.</p>
Commentary:	<p>The PHO Performance Programme includes an indicator based on CVD risk assessment, which is reported by PMS systems and forwarded to PHOs. Aggregate (non-identifiable) data is reported by the PHO to the national PHO Performance Programme. However, this data will not be available in a robust enough form for use in establishing targets and reporting as a national target during 2009/10. For this reason, it has been decided to use an interim indicator for CVD based on laboratory data. This decision is based on the assumption that whenever a CVD risk assessment is performed, the individual must have had a fasting lipid group test (FLG) and a serum glucose or HBA1c (if the person has diabetes). The national laboratory warehouse data will be used to identify the proportion of individuals with one or more FLG, and one or more glucose or one or more HBA1c test in a five year period. The Ministry expects that the PHO Performance Programme data will be available to use to establish targets for the 2010/11 year.</p>

Health target:	Diabetes detection and follow-up
Indicator:	Proportion estimated to have diabetes accessing free annual checks
Deliverables:	<p>Numerator: (Data source: DHB) The number of unique individuals with type I or type II diabetes on a diabetes register, whose date of their free annual check is during the reporting period (reported for Māori, Pacific, and Other ethnic groups).</p> <p>Denominator: (Data Source: the Ministry distributes this to all DHBs for DAP planning) The expected number of unique individuals to have type I or type II diabetes, as at the start of the reporting period (reported for Māori, Pacific, and Other ethnic groups).</p>

Health target:	Diabetes management
Indicator:	Proportion on the diabetes register who have satisfactory or better diabetes management (HBA1c = 8.0% or less)
Deliverables:	<p>Numerator: (Data source: DHB). The number of people with type I or type II diabetes on a diabetes register that had an HbA_{1c} of equal to or less than 8% and at their free annual check during the reporting period (reported for Māori, Pacific, and Other ethnic groups).</p> <p>Denominator: (Data Source: DHB). The number of people with type I or type II diabetes on the diabetes register, whose date of their free annual check is during the reporting period (reported for Māori, Pacific, and Other ethnic groups).</p>
Commentary:	<p>This indicator will be aligned with the PHO Performance Programme in future.</p> <p>Indicators based on HBA1c are challenging to improve in communities, but remain the best predictor of diabetes complications. This indicator has been validated in the USA as a measure of “quality-adjusted life years saved”.</p>

Health Targets: feedback on your March 2009 draft DAP

The table below provides brief feedback on the Ministry's review of the draft DAP you submitted in March 2009. The feedback below relates to Health Targets for:

- Immunisation,
- Diabetes/CVD
- Tobacco.

The Ministry is mindful that this feedback was developed prior to the Health Targets for 2009/10 being confirmed, and some elements of the feedback may now be less relevant than they were in March 2009. However, we feel it is important to provide you with this initial feedback in case it assists you to address these Health Targets areas in your 2009/10 draft DAP. For technical information on how to set local targets for 2009/10 please refer to the Nationwide Service Framework Library (<http://www.nsfl.health.govt.nz/>).

West Coast DHB	Ministry Comment	Suggestion
Immunisation	Further detail on immunisation Health Targets is required. For technical information on how to set local targets for 2009/10 please refer to the Nationwide Service Framework Library (http://www.nsfl.health.govt.nz/).	Please include a Maori and Pacific specific target for 2009/10 coverage at 24 months.
Diabetes/ CVD	Very "static" diabetes targets have been provided, but are displayed differently in different sections of the DAP. Please could these targets be reviewed and made consistent? You have not clearly identified the amount of funding you are allocating in 2009/10 towards improving diabetes.	Please revise your diabetes target for 2009/10. Please attempt to quantify the amount of funding you are allocating in 2009/10 towards improving diabetes services
Tobacco Control	DHBs will need to become more accountable for local activity and monitoring specifically of these cessation activities to meet this health target.	Please describe local activity and monitoring specifically of these cessation activities to meet this health target.

Please note that the Ministry has already provided you with initial feedback on how the first draft of your DAP addressed shorter stays in Emergency Departments, improved access to elective surgeries, and shorter waits for cancer treatment (please refer to the letters from the Ministry with feedback on your draft DAP dated 9 April 2009 and 21 April 2009).

Area	Long term Target	2009/10 National target			
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours			0.95
Improved access to elective surgery	Increase the volume of elective surgery by an average of 4,000 discharges per year (compared with the recent average increase of 1400 per year).	4,000 additional elective surgical discharges			
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.	100% of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).			1
Increased immunisation	85 percent of two year olds are fully immunised by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012.	85% of two year olds are fully immunised by July 2010			
					%
					%
					%
					%
Better help for smokers to quit	80 per cent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012. Introduce similar target for primary care from July 2010 or earlier.	80% of hospitalised smokers are provided with advice and help to quit by July 2010			0.8
Better diabetes and cardiovascular services	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years			%
					%
					%
	Increased percent of people with diabetes attend free annual checks	Increased percent of people with diabetes attend free annual checks			%
					%
					%
	Increased percent of people with diabetes have satisfactory or better diabetes management.	Increased percent of people with diabetes have satisfactory or better diabetes management.			%
					%
					%

of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six h

additional electives surgical discharges

of patients in category A, B and C wait less than six weeks between first specialist assessment and the t

of two year olds (Maori) are fully immunised by July 2010

of two year olds (Pacific) are fully immunised by July 2010

of two year olds (Other ethnicity) are fully immunised by July 2010

of two year olds (All ethnicities) are fully immunised by July 2010

of hospitalised smokers are provided with advice and help to quit by July 2010

Increased percent of the eligible adult population (Maori) have had their CVD risk assessed in the last five

Increased percent of the eligible adult population (Pacific) have had their CVD risk assessed in the last f

Increased percent of the eligible adult population (Other ethnicity) have had their CVD risk assessed in t

Increased percent of the eligible adult population (All ethnicities) have had their CVD risk assessed in th

Increased percent of people with diabetes (Maori) attend free annual checks

Increased percent of people with diabetes (Pacific) attend free annual checks

Increased percent of people with diabetes (Other Ethnicity) attend free annual checks

Increased percent of people with diabetes (All Ethnicities) attend free annual checks

Increased percent of people with diabetes (Maori) have satisfactory or better diabetes management.

Increased percent of people with diabetes (Pacific) have satisfactory or better diabetes management.

Increased percent of people with diabetes (Other ethnicity) have satisfactory or better diabetes managem

Increased percent of people with diabetes (All ethnicities) have satisfactory or better diabetes managem

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start of radiation oncology treatment (excludes category D patients).

ve years (suggestion is 2%)

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the last five years (suggestion is 2%)

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PROGRESS REPORT AGAINST THE DISTRICT ANNUAL PLAN

TO: Members, Disability Support Advisory Committee

FROM: Wayne Turp, GM Planning and Funding

DATE: 15 May 2009

Author: Wayne Turp, 15 May 2009

5.3 Progressing the NZ Disability Strategy

Objective						
Improved access to health and disability services						
Action (s)	Led by:	Result (s)	IDP/SOI /SPA	2008/2009 Timeframe	Status	Comment
<ul style="list-style-type: none"> Maintain liaison with disability advocacy groups, as shown by continued involvement with the Disability Network Meetings and the Disability Information Services Trust Board Fund disability awareness training for both West Coast DHB staff and the community, as shown by maintenance of the contract with Disability Information Services Establish a formal linkage between Carelink (see below) and the Disability Information Service (DIS), to bring together information and advocacy for disability at all ages, as shown by a formal agreement with Carelink outlining complementary roles of the agencies Undertake a formal review of progress in implementing the West Coast Disability Strategic Action Plan, as shown by <ul style="list-style-type: none"> An approved Board policy paper identifying areas that 	GM Planning and Funding	<ul style="list-style-type: none"> Continued attendance of Planning and Funding staff at Disability Information Service board meetings Number of DHB and other local agency staff who have participated in disability awareness training and have an understanding of disability access issues is increased (target to be set once baseline data as at 1 July 2008 have been established) 			Green	Attendance and support has been maintained Baseline of 1 July 2008 was not set
	HOP	<ul style="list-style-type: none"> Formal agreement in place between Carelink and DIS Clear accountabilities and timeframes are followed in the implementation of the plan DHB facilities comply with audit requirements 			Orange	The April meeting of the WCDHB's Disability Services Advisory Committee has been allocated to review the WCDHB's Disability Action Plan
	GM Planning and Funding					G



Achieved



Partial Achievement



Not achieved – Escalation required



No report – Escalation required

1

<p>need more work, ways of monitoring progress, detailed timeframe and process for implementation and available resources</p> <ul style="list-style-type: none"> o A review of the existing audit of the accessibility of DHB facilities and services (both physical and otherwise), which identifies areas needing further audit (e.g. a barrier-free audit) 						<p>sites concerned. WCDHB is investigating options for improving parking in the vicinity of the Dementia Unit.</p>
Objective	Improve knowledge of health and disability services needs for people living on the West Coast					
Action (s)	Led by:	Result (s)	IDP/SOI /SPA	2008/2009 Timeframe	Status	Comment
<ul style="list-style-type: none"> • Consult with Disability Information Services as to appropriate ways of responding to the New Zealand Sign Language Act 2006, as shown by a policy paper on this topic approved by the West Coast DHB 	GM Planning and Funding	<ul style="list-style-type: none"> • A policy paper on this topic is approved by the West Coast DHB • Clear information to guide West Coast DHB as to how to respond to the requirements of the Act 			Orange	Material has been collected but paper not yet prepared.



Achieved



Partial Achievement



Not achieved – Escalation required



No report – Escalation required

5.5 Improving the Health of Older People

Objective	Services will better reflect older people's wish to live, and be supported, at home for longer					
Action (s)	Led by:	Result (s)	IDP/SOI /SPA	2008/2009 Timeframe	Status	Comment
<ul style="list-style-type: none"> Protect older people's health, independence and interdependence, through developing health promotion services for older people. During 2008/09, the HEHA workers will implement the plan for improving older peoples access to and uptake of physical activity opportunities, and expanding falls prevention programmes Protect older people's health, independence and interdependence, through improving healthy housing options for older people through intersectoral initiatives Deal with illness and disability 	HOP	<ul style="list-style-type: none"> The number of physical activity options available to older people in West Coast communities is increased (target to be set once baseline data for 1 July 2008 have been established) The number and proportion of older people reporting being physically active are increased (target to be set once baseline data for 1 July 2008 have been established) The number and proportion of older people participating in falls prevention programmes are increased (target to be set once baseline data for 1 July 2008 have been established) The home insulation scheme on the West Coast is re-established 			<p>Orange</p> <p>Physical activity promotion is being progressed through the older persons HEHA team</p> <p>The ACC-funded falls prevention programme has been re-established in the Greymouth and Westland areas, and work is being done to extend it to other areas.</p> <p>ACC's Vitamin D supplement programme for people in residential homes is operational.</p> <p>Red</p> <p>Subsidised home insulation is no longer a government priority, despite health benefits. Lack of P&F resources to explore further options right now</p> <p>Orange</p> <p>Carelink and PHO have sent a joint application in to the national Rural</p>	



Achieved



Partial Achievement



Not achieved – Escalation required



No report – Escalation required

3

<p>before they worsen through improving primary health care for older people by setting up formal linkage between Carelink (the reconfigured NASC service), the PHO and other services provided through the Chronic Conditions Management Strategy, specifically improving co-ordination of care to the frail elderly</p> <ul style="list-style-type: none"> • Deal with illness and disability before they worsen through the reconfiguration of long-term support services: <ul style="list-style-type: none"> ○ Establish local supportive housing in West Coast communities, with a focus on affordable rental housing complexes for low income older people ○ Increase the availability and usage of respite care, day-care and carer support services ○ Establish a new funding model for home-support services, based on greater flexibility and a restorative model of care ○ Greater collaboration between 		<ul style="list-style-type: none"> • A lower than national average rate of ambulatory sensitive admissions for people aged 65+ years is maintained • Formal linkages are established between Carelink and the Chronic Conditions Management project, other relevant aspects of PHO work, the Disability Information Service, the NASC services for under 65 people with disability and the mental health NASC, and patient support groups (e.g. Stroke Foundation, Arthritis Society, etc) This includes formal arrangements for collaborating in the provision of publicity, information and advocacy • The number of supportive housing options for low income elders in West Coast communities is increased (target to be set once baseline data for 1 July 2008 have been established) • The number of older people using respite, day care and carer support services is increased (target to be set once baseline data for 1 July 2008 have been established) • New contracts in place for a restorative home support service 			<p>Orange</p> <p>Orange</p> <p>Orange</p>	<p>Innovation Fund to pilot a 'wrap-around' service for frail older people.</p> <p>Carelink has funded Disability Info Service to coordinate other health and support agencies to provide expos in outlying centres during 2009</p> <p>Housing NZ has expressed interest in providing housing for people with age-related disabilities. We are exploring whether to do an RFP for this or incorporate this within an overall homecare review</p> <p>New contracts are being finalised with providers for a wider range of respite and daycare services, on a new spec and price.</p> <p>Negotiations are underway with Presbyterian Support services to set up a HomeShare daycare services for older people (including those with dementia)</p> <p>Discussions with home support providers continue on a new contract for a restorative model – a tender is expected to be released</p>
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G

Achieved

O

Partial Achievement

R

Not achieved – Escalation required

B

No report – Escalation required

<p>specialist health services and residential providers, to improve skills in residential care and reduce inappropriate acute hospital admissions</p> <ul style="list-style-type: none"> ○ Increase the number of longstay hospital and dementia beds to match the expected change in the 80+ year age population, and while keeping stable the number of rest home beds • Ensure a smooth path into and out of specialist services, through setting up Carelink to co-ordinate access to community services • Reconfigure specialist services 		<ul style="list-style-type: none"> • Availability of flexible funding for home support • An increase in the number of carers who have basic or higher level training, through support for training initiatives (target to be set once baseline data for 1 July 2008 have been established) • Attendance of residential staff in DHB training programmes • Adoption of common clinical pathways and protocols • Residential staff attend DHB case meetings; additional mechanisms for clinical collaboration are also established • Residential care residents have access to specialist community nursing and allied health services • A formal mechanism for dialogue and collaboration between residential providers and DHB services is established • Appropriate changes in the number of designated residential care beds • An increase in the number of longstay hospital and dementia beds, in line with population increase • The resourcing of the planned number and type of staff under an appropriate service spec 			<p>Green</p> <p>Orange</p> <p>Orange</p> <p>Orange</p> <p>Orange</p>	<p>in the second half of 2009</p> <p>Carelink has set up a flexible funding budget</p> <p>Negotiations are progressing with the 2 home support providers to contract for training for home based carers</p> <p>Collaboration efforts between WCDHB and residential care staff continues via a regular quarterly meeting, residential staff invited to share WCDHB training, ongoing discussion on staffing & recruiting issues, including access to specialist nursing.</p> <p>Access to allied health is limited by the continued lack of WCDHB allied health staff & consequent focus on hospital-based service. The outcomes of an audit of OT and Physio are being pursued</p> <p>A proposal for a Community Rehabilitation and Transitional Service was prepared for consideration in the 0910 budget.</p> <p>Residential providers continue to face acute RN staffing problems, and to restrict the number of hospital level patients they can accept.</p> <p>An initial draft report has been completed for an internal DHB dementia pathway process</p> <p>Carelink is developing a template for providing individualised funding for people with dementia who are</p>
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Achieved



Partial Achievement



Not achieved – Escalation required



No report – Escalation required

<p>for older people towards a stronger community focus and outreach function</p> <ul style="list-style-type: none"> • Improving stroke services • Put in place a strong organisational infrastructure for older peoples' services <ul style="list-style-type: none"> ○ Employ a Co-ordinator of Older Persons Services, with clear management and budgetary responsibilities ○ Maintain the local WISE stakeholder groups, meeting quarterly to monitor progress on the plan's implementation ○ Maintain a WISE older persons' webpage within 		<ul style="list-style-type: none"> • Referral protocols in place, including clear linkage to hospital discharge planning processes • InterRAI assessment tool is in operation • Clear pathway and protocols identified and implemented for dementia assessment and management across the continuum of care • Data reports available on expenditure and volumes, to aid the management and planning of long-term support services • Instances of delayed assessments for dementia are reduced (target to be set once baseline data for 1 July 2008 have been established) • Participation of at least some staff from all relevant sectors in the SMART goal-setting training programme • Waiting times for community allied health assessments are reduced (target to be set once baseline data for 1 July 2008 have been established) • Increased resources put into initiatives to improve the recruitment and retention of allied health staff, including health assistance projects (target to be set once baseline data for 1 July 2008 have been established) • Local short-stay non-acute beds are established with allied health 			<p>Orange</p> <p>Orange</p> <p>Orange</p> <p>Orange</p> <p>Orange</p>	<p>residing in non-specialist ARC facilities.</p> <p>Carelink is working on providing data on expenditure and volumes. The lack of linkage between WCDHB financial systems and the national dataset is a problem</p> <p>The new dementia outreach nurse is working very closely with Carelink</p> <p>SMART goal-setting training programme has been deferred until later in 2009, because of the delay in setting up Carelink and the lack of clarity around the configuration of AT&R under the sustainability project.</p> <p>Changes to allied health services are dependent on the senior management consideration of the July 2008 proposal from allied health heads of department,</p> <p>Funding pressure means that the</p>
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G

Achieved

O

Partial Achievement

R

Not achieved – Escalation required

B

No report – Escalation required

<p>West Coast DHB's public website, to act as an information-sharing and training resource for the whole sector</p>		<p>input for slow-stream rehabilitation in each main West Coast community</p> <ul style="list-style-type: none"> Stroke pathway of care is completed in a multidisciplinary / multi-agency process, and gaps in services and changes needed are identified Protocols for stroke management are completed, and these protocols are adopted by all relevant services in the continuum of care National guidelines for the management of stroke patients and the prevention of secondary stroke are closely adhered to There is an identifiable voice for older person's health and support services and issues within the West Coast DHB, which is well-known to and supported by the sector and local communities 			<p>Orange</p> <p>Orange</p> <p>Green</p>	<p>Community Rehab and Transition Service proposal is unlikely to be funded in 0910 and other ways of providing this service are being explored</p> <p>The stroke pathway process is continuing within hospital services</p> <p>The WISE groups continue in Greymouth and Westport.</p>
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Achieved



Partial Achievement



Not achieved – Escalation required



No report – Escalation required

5.6 Implementing the Healthy Eating Healthy Action Strategy

Objective	Implement the Healthy Eating Healthy Action Strategy					
Action (s)	Led by:	Result (s)	IDP/SOI /SPA	2008/09 Timeframe	Status	Comment
<ul style="list-style-type: none"> Implement an Older Persons' Physical Activity Programme that includes increasing physical activity, enhancing nutrition and reducing falls 	HEHA Manager	<ul style="list-style-type: none"> Falls prevention programmes are established and function within West Coast communities Hospital admissions for falls in older West Coast residents are reduced (target to be set by 30 June once baseline data established) Collaborative programmes are established that reduce falls, improve nutrition and increase physical activity amongst West Coasters aged 65 years and over Older residents are aware of programmes available to improve nutrition and reduce obesity in their community 	Target 8 POP-02 POP-03		G	<p>The ACC Tai Chi Falls Prevention training will be provided in Greymouth in May for up to 20 community members. ACC and HEHA will jointly funding community members to complete this training and provide ACC accredited Tai Chi courses throughout the region. The WCPHO continues to provide the ACC Falls Prevention and Tai Chi programmes in the Grey and Westland districts.</p> <p>Various community groups that provide HEHA related services for older West Coasters received funding through the HEHA Community Grant round in February.</p>
<ul style="list-style-type: none"> Determine the needs / gaps / issues associated with older adults' participation in physical activity and consumption of healthy foods 	HEHA Manager	<ul style="list-style-type: none"> Baseline needs analysis data are established The specific needs of older Māori residents are established 	Target 8 POP-02 POP-03		G	<p>Complete. Additional analysis on the West Coast HEHA Older Persons dataset is being undertaken by the Public Healthy Analysts at C&PH.</p>
<ul style="list-style-type: none"> Provide an environment that promotes engagement in physical activity and the selection of healthy options 	HEHA Manager	<ul style="list-style-type: none"> The West Coast DHB is accredited as Breastfeeding Friendly The West Coast DHB is 	Target 8 POP-02 POP-03		G	<p>As indicated above.</p> <p>WCDHB was a target workplace for the Walk to Work day. This was</p>



Achieved



Partial Achievement



Not achieved – Escalation required



No report – Escalation required

8

		<p>accredited as a Cycle Friendly Business</p> <ul style="list-style-type: none"> • An additional three employees sign up to the Coach Corp programme • Workplace programmes that increase physical activity and improve nutrition of employees are established and implemented 				<p>well attended by staff. During Heart Week WCDHB staff were provided with apples and messages about healthy living for a healthy heart. Staff have been encouraged to participate in Spring into Action.</p> <p>Each edition of the Westerly has a HEHA section that provides tips and advice around healthy eating / cooking and physical activity.</p>
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Achieved



Partial Achievement



Not achieved – Escalation required



No report – Escalation required

UPDATE AGAINST THE WISE PLAN

TO: Members, Disability Support Advisory Committee

FROM: Torfrida Wainwright, Planning and Funding Analyst

DATE: 18 May 2009

Box = end result

Underline = meetings

Bold = documents

WISE + number = WISE plan objective referred to

Project and Tasks	Deliverables and by when	Progress
1. Set up Community Co-ordinating Service (see also Homecare review and InterRAI below) – Carelink		
<ol style="list-style-type: none"> 1. Ongoing project team – extend to DIS, other NASCs and PHO 2. Recruit new Project Co-ordinator 3. Draft Implementation Plan and get EMT approval 4. Support new project co-ordinator 	<ol style="list-style-type: none"> 1. <u>Co-ordinate</u> meetings Feb – July 2. Implement Plan approved by EMT 1 June 3. Community Co-ordination Service starts 1 March 2008 	<p>Carelink is well under way , participating in upcoming road shows in Westland and Buller and making connections to related services e.g. AT&R, mental health, community nursing and home support etc</p>
2. Develop and implement a clear model of care and plan for funding long-term support services		
<ol style="list-style-type: none"> 1. Receive responses to the Request for Expressions of Interest (REOI), outlining direction and seeking interest 2. Discuss REOI with providers individually and jointly (including AT&R and other internal DHB), and clarify internally what we want, how it fits with other West Coast DHB plans e.g. Sustainability Project 3. Send out RFP and/or start negotiations for services in a staged process: <ul style="list-style-type: none"> • Long-term residential (alongside ARC process) with restorative focus (i.e. greater clinical and rehab specialist input) • Short-term non-acute/respites/rehab (see 4 below) • Homecare with restorative focus (see 5 below) 	<ol style="list-style-type: none"> 1. <u>Meetings</u> with DHB and non-DHB providers completed (includes secondary care, AT&R, residential and homecare) and a clear funding plan finalised with bed numbers and expenditure levels – by end April 2. RFP out and/or <u>negotiations</u> started by 1 June for <ul style="list-style-type: none"> • Additional longstay beds, with greater clinical and rehabilitation input • Short-stay non-acute beds for long-term rehab, carer support respites care & palliative care • Restorative homecare service 3. Services in place by 1 July 2008 	<p>RFP for all residential care beds in Westport – negotiations are continuing with the preferred provider</p> <p>Most current contracts for respite care & daycare are in the process of being terminated and replaced with new contracts that have a more comprehensive spec and higher price</p> <p>Negotiations are underway with Presbyterian Support Services (Upper Sth Is) to provide Homeshare, a home-based day support / activity service, including for people with dementia. This is expected to get underway by 1 July.</p> <p>Discussions continue with the residential providers regarding the overall provision of short-term nursing care beds for respite/palliative/ convalescence etc. This may be affected by the government's requirement on DHBs to provide 'dedicated respite care beds' as a condition for additional funding for 0910.</p> <p>A proposal for a Wrap-Around Service for Frail Older people, including access to non-acute beds, was jointly submitted by West Coast PHO and WCDHB to the Rural Innovations Fund.</p> <p>The national ARC contract is being renegotiated at a substantially higher price due to extra government funding, amounting to around \$180,000 pa for West Coast facilities.</p>

4. Stronger community role for specialist health of older peoples services (including non-acute rehab beds)		
<ol style="list-style-type: none"> 1. Work with AT&R to develop plan for a stronger role in advising, training and supporting primary and community services, including home-based carers, residential care facilities and primary nursing/medical services 2. Discuss location and resourcing of short-stay non-acute beds for longer term rehab, get agreement to this from all stakeholders, organise funding and contracting arrangements and commission the beds 3. Improved stroke service organised by AT&R 	<ol style="list-style-type: none"> 1. Plan developed for a stronger community role for AT&R (part of Secondary care planning) – by 1 Sept 2007 2. <u>Additional resources</u> available for advising, training and supporting primary and community based services, particularly allied health 3. Plan developed for new non-acute rehab beds by end April 2007 and agreed with stakeholders 4. <u>New beds</u> established by 1 January 2008 5. <u>Improvements</u> to stroke service in place by 1 January 2008 	<p>A new stroke pathway of care process continues, and a dementia pathway group has just reported. These pathways are focussed on the clinical pathway through hospital services.</p> <p>No funding was received in the 0910 budget for a Community Rehabilitation and Transitional Care Service, so Carelink is looking at alternative ways of making this type of service happen.</p>
5. Reconfigure home-care services on restorative model		
<ol style="list-style-type: none"> 1. Discuss ways of implementing restorative model with potential providers as part of REOI discussions, including DHB and non-DHB 2. Ensure adequate community allied health resources are available – develop plan for this (alongside plan for stronger community role for AT&R) 3. Ensure adequate appropriate training initiatives are in place – meet trainers, work with HR 4. Develop a work plan for implementation of a restorative model (including carer training, allied health and other resourcing, funding/contracting method, link to Carelink etc) and get EMT approval 5. Consultation on proposed changes 6. Possibly pilot a restorative approach at Buller Health as part of a staged West Coast rollout 	<ol style="list-style-type: none"> 1. <u>Meetings</u> with potential DHB and non-DHB providers during March/April 2. <u>Discuss</u> development of community allied health services with DHB provider, and write EMT paper to get approval for increased resources 3. Meetings on training held mid 2007 and <u>training initiatives in place</u> by 1 March 2008 4. Homecare work plan completed for EMT approval by 30 June (priority given to getting Carelink up and running, but this can be done alongside) 5. Consultation document available 	<p>Contracts are being negotiated with the two homecare agencies re provision of subsidised training for West Coast carers. This initiative is tracking a little behind schedule but is expected to get underway mid 2009.</p> <p>The senior management team has been working on a response to the proposal for change to the structure of Allied Health and HOP services</p> <p>Discussions have started with homecare providers on a package of care approach, and information has been collected on the specs, prices and process used by other DHBs, particularly Nelson Marlborough. We expect to undertake a RFP process for a new model of homecare delivery in the second half of 2009.</p> <p>A collaborative forum between West Coast DHB and residential sector staff continues to meet to discuss issues of common concern, and subgroups have been working on issues of nursing workforce and access to medical services.</p>

<p>7. Finalise contracts and providers</p>	<p>by 1 July. Consultation period July-August</p> <p>6. <u>Start pilot restorative approach</u> at Buller Health by 1 March 2008</p> <p>7. <u>Rollout of restorative approach</u> in all contracts by 1 July 2008</p>	<p>The lack of dementia rest home beds is being addressed thru Carelink's flexible funding system, with rest home residents being considered on a case by case basis for additional funding to allow additional carer staffing.</p>
<p>6. Implement InterRAI standard assessment tool in Community Co-ordinating Service</p>		
<p>1. Include InterRAI planning and costing in Carelink implementation plan, following national guidelines</p> <p>2. Possibly pilot InterRAI at Buller Health, also as an evaluation of how current assessment practice compares to InterRAI benchmark (explore such high rest home entry, gaps in current homecare etc)</p> <p>3. Participate in national roll-out of InterRAI if it happens</p>	<p>1. InterRAI costing and planning included in CCS implementation plan by 1 June</p> <p>2. <u>Possible pilot</u> started 1 Sept 2007 and completed 30 June 2008</p> <p>3. InterRAI proposal approved by EMT by 31 December 07 and <u>rolled out</u> from 1 Oct 2008</p>	<p>WCDHB has been confirmed as one of the first DHBs to be given funding to start to roll out InterRAI during 0809, and detailed planning is now happening on staff training and the relationship with Canterbury DHB as host DHB.</p>
<p>7. Encourage supportive housing developments</p>		
<p>1. Include in REOI discussions</p> <p>2. Contact councils, Abbeyfields groups, residential providers and other potential funders and providers to set up joint projects</p>	<p>1. Raise in REOI <u>discussions</u> in March/April</p> <p>2. <u>Discuss</u> with all potential funders/providers in Grey, Buller and Westland by 30 June, and have <u>joint agreements in place</u> in all areas by March 08</p>	<p>The feasibility of encouraging supportive housing arrangements, using Housing NZ's offered resources is being explored and may be included in the upcoming home support tender or a s separate tender</p> <p>Abbeyfields groups in Westport and Greymouth are progressing</p>
<p>8. Implement health promotion part of WISE plan, including falls prevention and Disability Action Plan</p>		
<p>1. Alan Lloyd (SISSAL) and new HEHA worker to get this underway</p> <p>2. Monitor implementation of Disability Action Plan</p>	<p>1. <u>New worker</u> by 1 April 07 and <u>expanded programmes in place</u> by 1 July 08</p> <p>2. Ongoing <u>meetings</u> with DIS</p>	<p>The two 0.5 FTE HEHA workers continue to implement the recommendations of their report</p> <p>Work has started on reviewing the Disability Action Plan</p>

9. WISE plan – make sure it is implemented and monitored

1. WISE groups supported in quarterly monitoring and advisory role	1. <u>WISE groups</u> in Greymouth and Westport meeting quarterly	Quarterly meetings held in March
2. Keep West Coast DHB website updated	2. Ongoing updating of website	RFPs posted on the website



Mission Statement: To fund a continuum of quality health services aimed at providing improved health outcomes and maximise the independence of people with disabilities.

Objective	Responsibility	Next Due Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
Annual processes							
1. District Strategic Plan	GM Planning & Funding	July 09	Annually		✓		The 10 year District Strategic Plan is to be reviewed and revised in time to inform the 2010/2011 DAP & SOI
2. District Annual Plan	GM Planning & Funding	December 09	Annually		✓		Combined Board and Advisory Committee workshops to develop this will occur over December '09 and January '10.
3. Statement of Intent	GM Planning & Funding	January 09	Annually		✓		Combined Board and Advisory Committee workshops to develop this will occur over December '09 and January '10.
4. Annual Report	Chief Finance Officer / GM Planning & Funding	September 09					
5. Health Needs Assessment	GM Planning & Funding						The 4 yearly update of the HNA is due for completion by July 2010
Quarterly and six-monthly progress reporting							
6. WCPHO Quarterly report	PHO	May 09	Quarterly		✓		Progress against relevant primary and community health strategic priorities
7. West Coast Public Health and Environmental Health Plan	CPH	February 08	Six-monthly		✓		
8. Public Health Joint Governance							Information update from Public Health Joint Governance Group
9. District Annual Plan 'traffic light report'	GM Planning & Funding,	May 09	Quarterly		✓		Exception reporting against the DAP Goals and objectives
10. Indicators of DHB performance (IDPs)	GM Planning & Funding,	May 09					Quarterly progress reporting against Ministerial priorities and Government Health Targets
Regular review of key priority areas (District)							
11. Reducing Inequalities							
12. Improving Maori Health and implementing He Korowai Oranga							
13. Improving the Health of Older People							
14. Implementing the Healthy Eating Healthy Action Strategy							
15. Minimise Family Violence, Child Abuse and Neglect							



Objective	Responsibility	Next Due Date	Reporting Frequency	Progress			Comment
				Behind	On Target	Complete	
16. Workforce							
Regular review of key priority areas (Regional)							
South Island Health Services Plan							
Health South (public health network)							

Draft for discussion

WEST COAST DISTRICT HEALTH BOARD AND ADVISORY COMMITTEE TIMETABLE JANUARY 2009 TO DECEMBER 2009

DATE	MEETING	TIME	VENUE
Thursday 29 January 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 4 March 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 5 March 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 6 March 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 6 March 2009	ARF	1.00 PM	Boardroom, Corporate Office
Thursday 19 March 2009	BOARD	10.00 AM	Boardroom Corporate Office
Wednesday 15 April 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 16 April 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 17 April 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 17 April 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 1 May 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 27 May 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 28 May 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 29 May 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 29 May 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 12 June 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 8 July 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 9 July 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 10 July 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 10 July 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 24 July 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 19 August 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 20 August 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 21 August 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 21 August 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 4 September 2009	BOARD	10.00 AM	Boardroom Corporate Office
Wednesday 30 September 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 1 October 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 2 October 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 2 October 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 16 October 2009	BOARD	10.00 AM	Boardroom, Corporate Office
Wednesday 11 November 2009	DSAC	10.00 AM	Boardroom, Corporate Office
Thursday 12 November 2009	CPHAC	1.00 PM	Boardroom, Corporate Office
Friday 13 November 2009	HAC	10.00 AM	Boardroom, Corporate Office
Friday 13 November 2009	ARF	1.00 PM	Boardroom, Corporate Office
Friday 27 November 2009	BOARD	10.00 AM	Boardroom, Corporate Office

ABBREVIATIONS

# NOF	Fractured Neck of Femur (broken hip)
1°	Primary
2°	Secondary
3°	Tertiary
A&E	Accident & Emergency
A+	Auckland Healthcare
ADHB	Auckland DHB
ALOS	Average Length of Stay
ANDRG	Australian National Diagnosis Related Group
APAU	Adult and Paediatric Assessment Unit
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation Unit
BDC	Buller District Council
BOPDHB	Bay of Plenty DHB
C&CDHB	Capital and Coast DHB
CAA	Child Acute Assessment
CAMHS	Child & Adolescent Mental Health Service
CAP	Canterbury Association of Physicians
CC	Complications & Co-morbidity
CCMAU	Crown Companies Monitoring Unit
CCN	Clinical Charge Nurse
CCU	Critical Care Unit
CD	Clinical Director
CDHB	Canterbury DHB
CEA	Collective Employment Agreement
CFA	Crown Financing Agency
CHA	Crown Health Association
CHL	Canterbury Health Labs
CICU	Cardiac Intensive Care Unit
CMDHB	Counties Manukau DHB
COMRAD	Radiology Reporting System
CPAC	Clinical Priority Assessment Criteria
CPHAC	Community & Public Health Advisory Committee
CSC	Community Services Card
CSSD	Central Sterile Supplies Department
CTA	Clinical Training Agency
CWD	Case Weighted Discharge
DAO	Duly Authorised Officer
DAP	District Annual Plan
DDG	Deputy Director General
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DNA	Did Not Attend

DON	Director of Nursing
DOSA	Day Of Surgery Admission
DRG	Diagnostic Related Grouping
DSAC	Disability Services Advisory Committee
DSD	Disability Support Directorate
DSP	District Strategic Plan
DSS	Disability Support Services
EAP	Employee Assistance Programme
ED	Emergency Department
EMT	Executive Management Team
ENT	Ear, Nose and Throat
ER	Employment Relations
ESR	Institute of Environmental Science and Research
FSA	First Specialist Assessment
GP	General Practitioner
HAC	Hospital Advisory Committee
HAHS	Hospital and Health Services
HBDHB	Hawke's Bay DHB
HEHA	Health Eating – Health Action
HFA	Health Funding Authority
HHS	Hospital & Health Service
HMD	Hospital Monitoring Directorate (former CCMAU)
HNA	Health Needs Analysis
HOP	Health of Older Persons
HR	Human Resources
HTG	Hospital Technical Group
HUHC	High User Health Card
HVDHB	Hutt Valley DHB
ICD 9	International Code of Diseases
ICU	Intensive Care Unit
IDF	Inter District Flow
IEA	Individual Employment Agreement
IEC	Individual Employment Contract
IPA	Independent Practice Association (GP Group)
IRF	Inter Regional Flow
ISDN	Integrated Services Digital Network
ISSP	Information Services Strategic Plan
IT	Information Technology
Kai Arahi	Term generally refers to “guide” and / or advisor
KPI's	Key Performance Indicators
LDHB	Lakes DHB
LMC	Lead Maternity Carer
MDHB	MidCentral DHB
MECA	Multi Employer Collective Agreement
MHAC	Mental Health Advisory Committee
MOH	Ministry of Health
MOSS	Medical Officer Special Scale. A doctor with 4+ years post-graduate experience but not a specialist
MRT	Medical Radiation Technologist

NDHB	Northland DHB
NGO	Non Government Organisation
NHI	National Health Index
NICU	Neonatal Intensive Care Unit
NMDHB	Nelson Marlborough DHB
NRT	Nicotine Replacement Therapy
NZBS	New Zealand Blood Service
NZCM	New Zealand College of Midwives
NZNO	New Zealand Nurses Organisation
O&G	Obstetrician and Gynaecologist
ODHB	Otago DHB
OIA	Official Information Act
OP	Outpatients
OPD	Operational Policy Framework
Ora Services	Term used to describe all activities that promote health and prevent diseases that are undertaken in the primary care setting for children and their families and whanau
PBFF	Population Based Funding Formula
PCG	Project Control Group
Pegasus	One of the IPA's
PHO	Primary Health Organisation
PMS	Patient Management System
PNA	Professional Nursing Advisor
Primary Services	Services that receive self referred patients
PRIME	Primary Response in Medical Emergencies
PSA	Public Services Association
QA	Quality Assurance
QHNZ	Quality Health New Zealand
RDA	Resident Doctors Association
RFP	Request for Proposal
RHA	Regional Health Authority
RHMU	Residual Health Management Unit
RMO	Registered Medical Officer. A junior doctor with 0-4 years post-graduate experience
Runanga	Tribal Council
SCDHB	South Canterbury DHB
SDHB	Southland DHB
Secondary Services	Services where a primary carer must refer patients. Provided in a hospital supported by specialists, and meeting standard clinical criteria
SHO	Senior House Officer
SIRMHN	South Island Regional Mental Health Network
SMO	Senior Medical Officer
SMT	Senior Management Team
SOI	Statement of Intent
SSC	State Services Commission
SSP	Statement of Service Performance
Stargarden	Payroll System
STD	Sexually Transmitted Diseases
TAIRDHB	Tairāwhiti DHB
Tamariki	Children – usually refers to children up to and including 14 years of age
Tangata Whenua	People of the land”, most commonly referring to traditional Maori iwi occupants of a region or district

TARADHB	Taranaki DHB
Tino Rangatiratanga	Sovereignty / Autonomy
VLCA	Very Low Cost Access
WAIKDHB	Waikato DHB
WAIRDHB	Wairarapa DHB
WAITDHB	Waitemata DHB
WCDHB	West Coast DHB
Whanau	Family and Extended Family
Whanau Ora	Health and wellbeing of families
WHANDHB	Whanganui DHB
WISE	West Coast Improving Services for Elderly
WTF	Waiting Times Fund
XM	Crossmatch
YTD	Year to Date