2017/18
ANNUAL PLAN

Incorporating the 2017/18
Statement of Performance Expectations &
Statement of Financial Expectations

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

Statement of Joint Responsibility

The West Coast District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2011. Each DHB is categorised as a Crown Agent under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident population.

This Annual Plan has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and Ministerial expectations set in 2016/17.

The Plan also contains the DHB's Statement of Performance Expectations and Statement of Financial Expectations. These will be presented to Parliament, as part of the DHB's Statement of Intent, and will be used at the end of the year to compare the planned and actual performance of the DHB. Audited results will be presented in the DHB's Annual Report for 2017/18.

The West Coast DHB has made a strong commitment to 'whole of system' service planning. We are working in partnership with other service providers and engaging with individuals, their families and the West Coast community to design and deliver service solutions to better meet the needs of our population.

In keeping with this commitment, the actions in this Annual Plan present a picture of the collective activity that will be delivered by the West Coast DHB and our alliance partners in the coming year.

This includes activity delivered through our local West Coast Alliance with the West Coast Primary Health Organisation (PHO), the South Island Regional Alliance with our partner South Island DHBs, and our transalpine agreements with the Canterbury DHB.

We also recognise our role in actively addressing disparities in health outcomes for our Māori population and are committed to making a real difference in the future of our tamariki. While the total number of Māori on the West Coast is small, Māori make up 12% of our total population. We work closely with Tatau Pounamu and Poutini Waiora, both directly and through the West Coast Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of the Treaty of Waitangi.

In signing this Annual Plan, we are satisfied that it fairly represents our joint intentions and activity and is in line with Government expectations for 2017/18.

Jenny Black
CHAIR | WEST COAST DHB

Chris Mackenzie
DEPUTY CHAIR | WEST COAST DHB

Stella Ward
CHAIR | WEST COAST HEALTH ALLIANCE

David Meates
CHIEF EXECUTIVE | WEST COAST DHB

Honourable Dr David Clark
MINISTER OF HEALTH

December 2017

Approval of the Minister of Health

Office of Hon Dr David Clark

MP for Dunedin North
Minister of Health
Associate Minister of Finance

Ms Jenny Black
Chair
West Coast District Health Board
PO Box 387
Greymouth 7840

21 DEC 2017

Dear Ms Black

West Coast District Health Board 2017/18 Annual Plan

To formalise ongoing accountability and to provide surety, I have approved and signed your DHB's 2017/18 Annual Plan.

I would like to thank you, your board, and the DHB's staff for their efforts in developing your Annual Plan for 2017/18. I also appreciate your DHB's significant efforts to provide valuable health services to the public in a challenging environment, and I am confident that we can work together to improve outcomes for the population.

I understand your DHB has planned a deficit for 2017/18 and in the out years. I trust that you have contingencies in place to ensure you achieve this planned result for 2017/18.

As you deliver services for your population, keep in mind that I will shortly be providing a Letter of Expectations to DHBs for the 2018/19 financial year that will provide further clarity on my priorities for DHB planning, such as public provision of health services, improving access to primary care, reducing inequalities and improving mental health services.

Please note that approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

Please ensure that a copy of this letter is attached to any copies of your signed Annual Plan that are made available to the public. Thank you again for your leadership and efforts to deliver high quality and equitable health outcomes for your population.

I look forward to working with you in the future.

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Mr David Meates, Chief Executive, West Coast District Health Board

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Table of Contents

Foreword from the Chair and Chief Executive

32,600
reasons to make
a difference

The West Coast DHB aspires to support our people to achieve the health outcomes they want for themselves and their family and whānau.

Our vision is a health system with the patient and their needs at the centre, and this means we have to be creative at times in order to find ways that our health system can be flexible and sustainable.

We aim to enable our system to provide the right care, in the right place, at the right time, reducing the need for patients to make multiple visits, increasing access to care through the use of technology and wrapping services around the people we care for.

Like all DHBs, we face the challenges of an ageing population, increasing service demand and treatment costs, and workforce shortages. However, delivering a high quality, sustainable health service in a rural area is particularly challenging, and we are the most rural region in the country by far. Our rurality magnifies the operating pressures we face and we must consider all our challenges with this overarching factor in mind.

LEADING IN RURAL HEALTH

For the West Coast to achieve its vision there is no option but to lead the way in modelling rural health service delivery and develop a single, truly integrated, service model. The West Coast is already leading in many aspects of rural health care:

- The use of telehealth provides our communities the opportunity to see specialists without leaving their local area.
- Our Rural Nurse Specialists provide local health care to our most rural locations along the Coast.
- Reefton has local community members working together with our health care team identifying initiatives to improve health and wellbeing.
- Westport mental health and primary care teams are trialling an integrated approach to mental and physical health services for long-term mental health clients.
- Our Rural Hospital Medicine Specialists work in our Emergency Department, our wards and in our general practices, including travelling to our most remote places such as Karamea.

Significant work will be undertaken in the coming year to further develop our integrated approach to community health care services. This will include progressing our vision through locality-based integrated health services focused on the needs of local populations.

JOINED-UP OLDER PERSONS' HEALTH SERVICES

We often hear how wonderful staff have been in our older persons' health services, how caring and compassionate, how attentive and inquiring. Even so, there are also areas where we can do better. There will be a greater focus on improved access to supports and timeliness in gaining those supports in 2017/18. This will include respite services, home-based support services, community rehabilitation services and improved community dementia services.

NEW FACILITIES

This year we will be finalising our plans to transition to the new Grey Base health facilities—Including what we need to take with us, what needs to be replaced, and where people will work in the new or existing facilities.

There's also other planning going on. We've already merged our two general practices in Greymouth to iron out any inconsistent systems before operating from the new Integrated Family Health Centre (IFHC). In Buller, we are finalising site details for another purpose-built IFHC and determining how we will work within it.

A DIALOGUE WITH OUR DISTRICT

We have focused on listening to our communities better, with several grass-roots community meetings over the past year, and we plan to continue this open dialogue as we move forward. While our Board sets our strategic direction, we will seek input from our communities to ensure we are travelling along the right path, and we will communicate widely to ensure our people understand the choices we are making.

We look forward to continuing our journey with you all.

Jenny Black
CHAIR

David Meates
CHIEF EXECUTIVE

December 2017

Part I

Overview

The West Coast DHB

1.1 Who are we?

The West Coast District Health Board (DHB) is one of twenty DHBs charged by the Crown with improving, promoting and protecting the health and independence of their resident populations.

The West Coast DHB has the smallest population of any DHB in New Zealand. We are responsible for 32,600 people, 0.7% of the total New Zealand population.

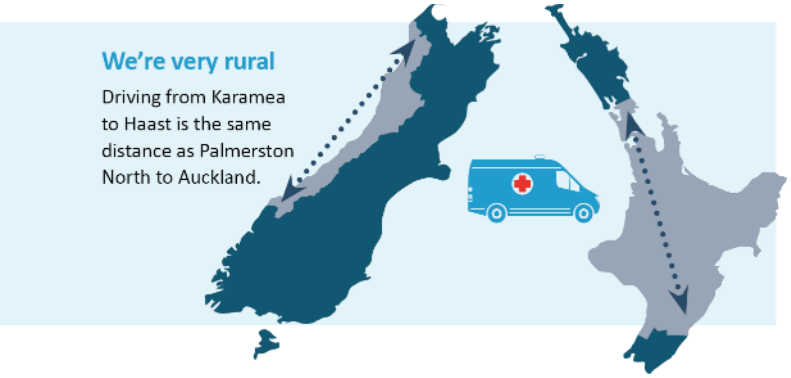
We own and manage three major health facilities in Greymouth, Westport, and Reefton and five general practices across the West Coast.

We are a major employer, with over 1,000 people employed across our hospital and primary care services. We also hold and monitor more than 40 service contracts with other organisations and individuals, who provide health and disability services to our population. This includes the West Coast PHO.

In 2015/16 there were over 11,000 presentations at the Grey Hospital Emergency Department, 21,000 specialist appointments and 140,000 general practice consultations. We also delivered 246 babies, provided 1,942 elective surgeries, 5,504 radiology tests and over 93,000 hours of home based support.

While we are the smallest DHB by population, we have the third largest geographical area, making the West Coast DHB the most sparsely populated DHB in the country with only 1.4 people per square kilometre.

Our district extends from Karamea in the north, to Jackson Bay in the south, and Otira in the east. It comprises three Territorial Local Authorities: Buller, Grey, and Westland districts. Grey district has the largest population, with an estimated resident population of 13,550 people.



1.2 What do we do?

Like all DHBs, we receive funding from Government with which to purchase and provide the services required to meet the needs of our population, and we are expected to operate within allocated funding.

In 2017/18 we will receive approximately $148 million dollars to meet the needs of our population. In line with legislation we use our funding to:

Plan the strategic direction of our health system and, in collaboration with our clinical leaders and alliance partners, determine the services required to meet the needs of our population.

Fund the health services needed for our population, and, through our collaborative partnerships with other service providers, ensure services are responsive, coordinated and effective.

Provide the majority of the health services delivered to our population, through our hospital and specialist services and our DHB owned general practices.

Promote and protect our population's health and wellbeing through prevention, education and the delivery of evidence-based public health initiatives.

1.3 Our transalpine service model

Like many small DHBs, population numbers on the West Coast cannot support provision of a full range of specialist services. In some instances, we must refer patients to larger centres with more specialised capacity.

Since 2010, West Coast DHB has shared executive and clinical services with the Canterbury DHB. This includes a joint Chief Executive and clinical directors, as well as shared public health and corporate service teams.

While the West Coast has always had informal clinical arrangements with the Canterbury DHB, the shared model has allowed these to be formalised through clinically-led transalpine service pathways. This formal arrangement enables the West Coast DHB to develop the workforce and infrastructure needed to ensure we can meet the needs of our population, in a clinically and financially sustainable way.

Canterbury specialists now provide regular outpatient clinics and surgical lists on the West Coast. Deliberate investment in telemedicine technology is also improving access to specialist advice while saving families the inconvenience of travelling long distances for assessment and treatment.

542 West Coast patients had their specialist appointments using telehealth technology in 2016, saving patients more than 18,000km of travel.

1.4 Our population profile

The West Coast DHB population has an older age structure compared with New Zealand as a whole, with a higher proportion of people aged over 65 (18%), compared with the national average (15%).

Many conditions become more common with age, including heart disease, stroke, cancer, and dementia. As the average age of our population increases, more people are likely to need treatment and support, putting further pressure on our health system.

Deprivation is an indicator of the need for health services and the West Coast has a lower mean personal annual income ($20,400) compared to the rest of New Zealand ($24,400). Higher proportions of our population are receiving unemployment or invalid benefits, have no educational qualifications and lack access to a motor vehicle or telephone.

Ethnicity, like age and deprivation, is also a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others.

There are currently 3,920 Māori living on the West Coast (12% of our population) and by 2026 Māori will represent 14.4% of our total population. While gains have been made, West Coast Māori continue to have poorer overall health status than other ethnicities in the region. We need to carefully consider the needs of our growing Māori population in our future planning.

1.5 Population health

West Coasters have higher overall morbidity and mortality rates and a lower life expectancy compared with the New Zealand average.

A reduction in known risk factors such as poor diet, lack of physical activity, tobacco smoking, and hazardous drinking could dramatically reduce the impact of these conditions for our population and reduce the load on our health system.

The most recent results from the 2011-2014 New Zealand Health Survey found that:

- Almost a third (31.8%) of our total adult population are classified as obese.
- 22% of our population are current smokers (higher than the national average) and smoking rates amongst Māori are even higher.
- 16% of our population are likely to drink in a hazardous manner. While this rate is on a par with the national average, it still amounts to more than one in every eight adults on the Coast.

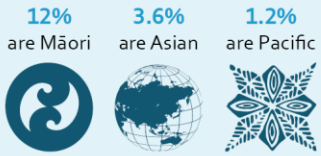
This presents an opportunity for our health system to work collaboratively with other sectors to improve health outcomes for our population.

Our population's ageing

Our population is older than the NZ average. By 2026, one in four people (24.4%) will be older than 65.

Our population's diverse

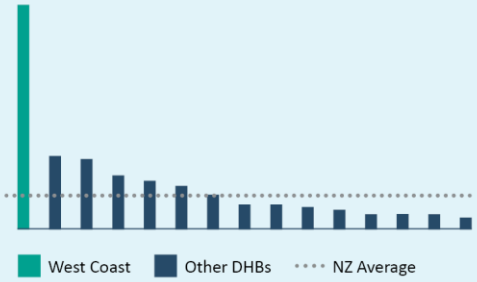
Our population is becoming more diverse. By 2026, 14.4% of our population will be Māori.



Our population's spread out

With more than 0.7 square kilometers per person, our DHB is the most rural by almost 12 times the NZ average.

KM² per person

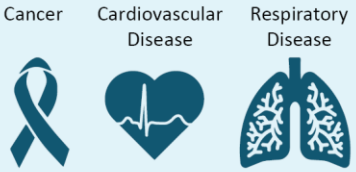


Our population's isolated

Not only are they sparsely populated, but 3.4% of households have no access to telecommunication systems. This is the highest proportion in New Zealand.

Many deaths are preventable

The leading causes of death, and illness on the West Coast are largely preventable.



Our Strategic Direction

1.6 National context

Like health systems world-wide, the challenges DHBs are facing are well understood. Populations are ageing, more people are living with long-term conditions, demand is increasing, treatment costs are rising, and workforce shortages are ever-present. Increasing pressure on government funding also means we are having to do more with less.

There is a clear understanding that these pressures mean that health services cannot continue to be provided in the same way they always have.

If we are to continue to improve health outcomes within current resources we need to integrate and connect services, not only across the health system, but across all public services.

The long-term vision for New Zealand's health service is articulated through the New Zealand Health Strategy. The overarching intent is to support all New Zealanders to 'live well, stay well, get well'.

The Strategy identifies five key themes to give the health sector a focus for change:

- People powered
- Closer to home
- One team
- Smart system
- High value and performance.

Our direction is further guided by a range of population or condition specific strategies, including: He Korowai Oranga (Māori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Healthy Ageing Strategy, Rising to the Challenge (Mental Health and Addiction Service Development Plan), the Disability Strategy and the United Nations Convention on the Rights of People with Disabilities.

DHBs are also expected to commit to government priorities and provide 'better, sooner, more convenient health services', and 'better public services'. The Minister of Health's letter of expectations signals annual expectations and priorities for DHBs. This Annual Plan outlines how the West Coast DHB will meet the expectations set by the previous Health Minister in 2017/18, focusing on:

- Delivering against the NZ Health Strategy
- Living within our means
- Working across government
- Delivering on national health targets
- Streamlining of planning including developing a longer-term outlook and increasing regional alignment.

1.7 Regional commitment

In delivering its commitment to better public services, and better, sooner, more convenient health services the Government also has clear expectations of increased regional collaboration between DHBs.

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23.3%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Alliance to better address our shared challenges.

Our jointly developed South Island Regional Health Services Plan outlines the agreed regional activity for the next three years. West Coast has made a strong regional commitment and is engaged in a number of regional work streams including: cancer, child health, information services, electives and stroke services.

Our regional commitment is outlined in the South Island Regional Health Services Plan.[1]

1.8 The West Coast vision

The vision for the West Coast health system is one born out of past experience and collective clarity around the future challenges we face. Developed with input from our partner organisations, staff and community – our vision is already guiding the decisions we make and the actions we take as an organisation.

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

At the centre of this vision is our community; our whānau; our patients. The foundational goal is that future health services on the West Coast will be:

People-centred: This means services will be focused on meeting people's needs and will value their time as an important resource. We will minimise waiting times and reduce the need for people to attend services at multiple locations or times, or far from home, unless there are good clinical reasons to do so.

While this provides our foundation, further clarity is required to guide our decisions and actions and ensure success in developing a truly person-centred service. To this end, our vision also provides us with clarity in how we will achieve this. This clarity will be critical as

[1] *The South Island Regional Health Services Plan can be found on the South Island Alliance website: www.sialliance.health.nz.*

our teams and our people face complex decisions on determining the future of our health system.

Future health services on the West Coast will be:

Integrated: This means the most appropriate health professional will be available and able to provide care where and when it is needed. Services will be supported by the timely flow of information to enable clinical decision-making at the point of care.

Based on a single system: This means services and providers will work in a mutually supportive way for the same purpose, to support people to stay well. Resources will be flexible both across services and across the wider West Coast health system.

Viable: This means our health system will achieve levels of efficiency and productivity that will allow an appropriate range of services to be sustainably maintained. There will also be a stable workforce of health professionals in place to provide these services.

Our Challenges

Meeting the health needs of the West Coast population is a complex business, further complicated by the challenges of delivering health services to a relatively small population over a large geographical area.

While many of the challenges we face are the same as other DHBs, our biggest challenge is our rurality.

The total land area we cover is 23,283 square kilometres but our population is just 0.7% of New Zealand's total population. Geographically we are the third largest DHB in the country but the most sparsely populated, with a population density of just 1.4 people per square kilometre.

Our geography creates significant challenges, often requiring patients or health professionals to travel long distances to receive or deliver services. This magnifies operating the pressures we face and means that we must consider all our other challenges with this overarching factor in mind.

Workforce challenges: Our workforce is relatively small, but must provide a broad range of complex services at a consistently high standard. In our rurally isolated environment we face significant difficulties in recruiting and retaining a suitable health workforce.

Facility pressures: A number of our current health facilities are outdated, inefficient and expensive to maintain. Many are poorly located and do not support the model of care needed to deliver our vision. Careful consideration must be given to the long-term future of all the facilities we own and operate.

Fiscal pressures: Meeting growing service demand, increasing treatment and infrastructure costs, and expectations around wages and salary increases is an ongoing challenge. We are also balancing community expectations regarding access to new and complex services in a small rural environment.

In meeting these challenges the West Coast will become a leader in the provision of rural health services: identifying opportunities to add value, reducing duplication across our system, and redirecting funding into services that will provide the greatest return in terms of health gain.

Important steps have been taken towards enabling our vision including connecting clinical information systems, establishing shared transalpine pathways with the Canterbury DHB, introducing the Complex Clinical Care Network and commencing the development of Integrated Family Health Services.

In the coming year we will deliver new health facilities that will support our vision by allowing us to further integrate primary and community services and improve the experience of people in our health system.

The following critical success factors are the strategic components needed for us to achieve our vision and become a leader in the provision of rural health services.

The integration of services to improve patient flow:

A healthcare home and point of continuity with general practice

A single point of referral for complex care

Locally delivered hospital-level services backed by closer transalpine collaboration

The prioritisation of resources for greater effect:

Support for healthier environments and lifestyles

Strengthened responsiveness to Māori

Connected information systems and extended use of telemedicine

Improved transport solutions

A strong, stable and engaged workforce

Modern, fit-for-purpose facilities and integrated family health services

The following section outlines the collective activity we have planned for the coming year to address our challenges, enable our vision and deliver on Ministerial expectations.

Part II

The Year Ahead

Delivering on National Priorities and Targets

The following section highlights the specific actions the DHB will undertake in the coming year to deliver on the national priorities and expectations in 2017/18. These actions are taken from the project and operational work plans of: hospital and specialist services and the local West Coast Alliance, and the transalpine and regional work plans we share with the Canterbury DHB and our partner South Island DHBs.

In the coming year, working in collaboration with our partners in the West Coast Alliance, we will also look to improve our performance against the national System Level Measures, which are focused on the longer-term health of our population. We have developed a System Level Measures Improvement Plan for 2017/18, identifying local health needs and where we will strive to make a difference. The Improvement Plan (attached as Appendix 6) is complementary to this Annual Plan and together they provide a picture of the activity planned across the West Coast Health System for the coming year.

Over the last several years we have made some positive progress for Māori on the West Coast. There has been substantial improvement in engagement levels in childhood immunisation and B4 School Checks programmes, and reductions in avoidable hospital admissions. We are determined to make further progress. Throughout this section of the Annual Plan, actions specifically targeted at improving Māori health are indicated by the Equity Outcome Action code (EOA).

Prime Minister's Youth Mental Health Project				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	NZ Health Strategy Link - Value & High Performance	Establish a process to make the Marama Real Time Survey available to all clients accessing the Child and Adolescent Mental Health Services (CAMHS).	Q1: Process developed. Q4: 50% of clients accessing CAMHS in Greymouth have completed the Real Time Survey.	PP25: Delivery of actions agreed under the Prime Minister's Youth Mental Health Project. 95% of year nine children in decile one to three schools receive a HEEADSSS assessment.
		Working with high schools and area schools, offer and encourage uptake of health assessments (including HEEADSSS screening) by all students new to school in years 9 and above.	Q1: Communication delivered to schools on the availability of assessments for new students. Q4: Data regarding the uptake of the service is evaluated.	
		Working with the ED and Mental Health Service teams, develop a pathway for young adults (aged 14 and above) who have presented at ED with self-harm.	Q2: Options investigated. Q3: Referral pathway and guidelines developed.	
		Working with Poutini Waiora and the Māori Mental Health Team, host a hui for rangatahi users of CAMHS to inform service improvements. (EOA)	Q2: Hui hosted. Q3: Feedback analysed and recommendations delivered.	

Reducing Unintended Teenage Pregnancy – Better Public Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue to build on the substantive activities identified in the 2016/17 annual plan to reduce unintended teenage pregnancy.	NZ Health Strategy Link - People Powered	Establish an Interagency Advisory Group for sexual and reproductive health, to provide leadership and support for the development of cross sector initiatives.	Q1: Advisory Group established. Q4: Integrated pathways and targeted services developed.	PP38: Quarterly report on delivery of agreed Annual Plan actions.
		Working across the DHB's sexual health, school-based health and primary care teams, develop a Coast-wide model for access to sexual and reproductive health advice including Long-Acting Reversible Contraception (LARC).	Q1: Age range of eligibility for free primary care sexual health consultations expanded. Q2: Free contraception scope expanded to include LARC.	
		Working with Poutini Waiora, review the effectiveness of current sexual health promotion campaigns and responses to unintended pregnancy for hapu rangatahi under 19 years. (EOA)	Q2: Review complete. Q3: Opportunities identified. Q4: Improvements underway.	

Supporting Vulnerable Children – Better Public Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to continue activity to contribute to the reduction in assaults on children.	One Team	Continue to audit the use of the Child Injury Assessment Flowchart for all ED presentations (injury and medical) for children up to 24 months.	Q1: Ongoing quarterly audit. Q2: Initial scoping meeting to understand current processes. Q3: Formal follow-up process documented as part of the child protection policy.	Contribution towards the national goal: 5% reduction in the number of children physical abused.
		Formalise a process to follow up and support, post discharge, all children (0-24 months) presenting at ED. (EOA)		

Healthy Mums and Babies – Better Public Health Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to activity to support women to register with a Lead Maternity Carer (LMC) in the first trimester of pregnancy with equitable rates for all population groups.	One Team	Invest in a Sustainability Package for self-employed LMCs to ensure equitable access to Maternity care for pregnant woman across the West Coast, including remote rural areas. (EOA)	Q1: Sustainability Packages in place for all self-employed LMC midwives. Q4: Review of uptake and LMC registrations.	PP38: Quarterly report on delivery of agreed Annual Plan actions. 80% of pregnant women are registered with a LMC in the first trimester – baseline 54% at Dec 2015.
		Continue to promote early registration with an LMC through advertising across the community including primary care, retailers, cafés and social media.	Q1: Strategy developed. Q2: Advertising distributed.	

Keeping Kids Healthy – Better Public Health Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to activity to reduce hospital admission rates for avoidable conditions for children 0-12 years of age. *Note: Leading avoidable conditions for this age group include oral health and respiratory conditions.*	NZ Health Strategy Link - One Team	Continue to invest in the Smokefree Pregnancy Incentive Programme for pregnant women and their nominated support person, to increase the proportion of babies born smokefree.	Q1: Programme uptake reviewed. Q4: Increased percentage of women set a quit date following referral to the Programme.	PP38: Quarterly report on delivery of agreed Annual Plan actions. Contribution towards the national goal: 15% reduction in hospital admission rates for avoidable conditions in children aged 0-12 years – baseline 39.8 per 100,000 June 2016. Hospital admission rates for avoidable conditions for West Coast children 0-12 years maintained at <27.4 per 100,000.[2]
		Continue to work with the Well Child Tamariki Ora (WCTO) providers and the South Island WCTO Steering Group to ensure infants are receiving core contacts in their first years of life, to identify and address health issues earlier.	Q1: Local representation on SI WCTO Steering Group confirmed Q1: Joint education for WCTO and LMC providers in place Q4: Options for a shared information system across all WCTO providers investigated.	
		Develop a referral pathway from the community oral health service to the public health nursing team for at risk families who need extra support with oral hygiene and good nutrition. (EOA)	Q1: Co-design of pathway between the community oral health service and the public health nursing team. Q3: Pathway in place.	

[2] *The West Coast's hospital admission rates for avoidable conditions in children aged 0-12 years is the third lowest in the country (27.4 per 100,000 people at June 2016). The DHB's contribution to the national target will be to maintain a lower than average rate and to focus particularly on reducing the equity gap between Māori and non-Māori at the younger end of this age group. While West Coast's rates are still low nationally for 0-4 year olds, there is an equity gap for this population with Māori rates for 0-4 years old being higher. This work is highlighted in our System Level Improvement Plan which is available on the DHB's website.*

Increased Immunisation – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	NZ Health Strategy Link - Value & High Performance	Continue to support general practice teams to refer unvaccinated (hard-to-reach) children to the Missed Event and Outreach Immunisation service.	Q1: Fortnightly practice-level reports provided to general practice to identify missing and unvaccinated children.	95% of eight-month-olds are fully immunised. 95% of two year olds are fully immunised. 95% of four year olds are fully immunised. 75% of all eligible girls are fully immunised for HPV. 75% of the population aged 65+ receive an influenza vaccination.
		Alongside the Year 8 Human Papillomavirus (HPV) school vaccination programme, investigate options to support general practice to vaccinate for HPV, including a recall programme. Engage with Poutini Waiora to identify opportunities to promote the HPV programmes to rangatahi youth. (EOA)	Q2: Decision on HPV programme options made. Q3: Promotion opportunities identified. Q4: General practice recall programme in place for children at 14 years of age.	
		Working with Poutini Waiora and the West Coast PHO, identify opportunities for general practice teams to increase influenza vaccination coverage, focusing on older Māori. (EOA)	Q1: Working Party established. Q2: Opportunities identified. Q3: Improvements underway.	

Shorter Stays in Emergency Department (ED) – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify the quality improvement activities to be undertaken in response to the 2016/17 National ED Quality Framework results. *Note: Delivery of the Short-Stay Unit actions is dependent on the facilities development progressing to agreed timeframes.*	NZ Health Strategy Link - Value & High Performance	Establish a Nurse Practitioner role to work across primary/community and ED acute service areas to identify and reduce unnecessary ED presentations.	Q2: Role scoped. Q3: Recommendation presented. Q4: Service designed.	95% of patients are admitted, discharged, or transferred from an Emergency Department (ED) within six hours. <20% of patients admitted from ED Short-Stay Unit to inpatient wards. >8 average for in-patient survey domain 'Rate your experience of communications out of 10'. Reduction in triage 4-5 presentations to Grey ED to <64% - baseline at June 2016. Reduction in ED attendances to <342 per 1,000 people – baseline at June 2016.
		Implement a Short-Stay Unit in the new Grey-base Hospital facility, to streamline and support the improved flow and observation of patients.	Q1: Short-Stay Unit model scoped and protocols developed. Q3: New approach implemented. Q4: Monitoring of admissions.	
		Further develop clinical pathways that complement those already in place and improve delivery against key quality elements in the national framework.	Q1: Opportunities identified. Q2: Pathways developed.	
		Working with Poutini Wairoa, improve responsiveness to Māori patients, acknowledging their strong desire to have whānau involved in decisions about their care and treatment. (EOA)	Q1: Opportunities identified. Q3: Improvements implemented.	
		Working with South Island Alliance, support the development of a regional ED Information Solution to streamline workflow within the ED department.	Q1: Regional proposal agreed. Q2: Solution identified. Q4: Implementation commenced.	

Improved Access to Elective Services – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	NZ Health Strategy Link - Value & High Performance	Review production and capacity plans and determine outsourcing needs (and inter-district flow volumes) in order to meet health target expectations.	Q1: Production planning complete. Q1: Contracting requirements for outsourcing complete. Q4: Elective and Ambulatory Initiative delivery in line with plan.	1,905 elective surgeries delivered. 10 additional elective orthopaedic and general surgeries delivered. Bariatric Initiative volumes delivered. Delivery of all national ESPI targets including: 100% of people receive their first specialist assessment within four months of referral (ESPI2). 100% of people receive treatment within four months of the decision to treat (ESPI5). SI4: Delivery in line with agreed Intervention Rates. OS3: Elective average length of stay at or below 1.40 days.
		Working with the South Island Alliance, identify opportunities around regional capacity, standardisation and efficiency.	Q1: Ongoing participation in Regional Electives Workstream. Q4: Bariatric Initiative delivery in line with plan.	
		Further develop the transalpine orthopaedic model with a focus on delivering appropriate volumes of elective surgery locally. Continue to develop and integrate clinical pathways for elective surgery not able to be provided locally.	Q1: Sustainable orthopaedic model developed and agreed. Q2: Implementation underway. Q4: Two new integrated electives pathways in place.	
		Further expand the use of telemedicine for specialist review and assessment, to better reach vulnerable population groups and reduce the burden of travel for these populations. (EOA)	Q2: Opportunities to reduce did not attend rates identified. Q3: Implementation underway.	

Faster Cancer Treatment – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify sustainable service improvement activities to improve the access, timeliness and quality of cancer services.	NZ Health Strategy Link - One Team	Support the Cancer Nurse Coordinator to continue to work with clinical staff to actively review waiting lists to ensure services meet national wait time targets and improve data collection.	Q1: Quarterly reporting and monitoring of Faster Cancer wait times.	PP29: Improved waiting times for diagnostic services. 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. 85% of patients receive their first cancer treatment (or other management) within 31 days of date of decision-to-treat.
		Working with Canterbury DHB, maintain referral pathways and ensure continuity of care for West Coast patients.	Q1: Crucial dates of referral defined and agreed for services provided by Canterbury DHB.	
		Working with the Southern Cancer Network, participate in regional planning and delivery of identified services improvements, including standardisation of MOSAIQ applications.	Q2: Identify and agree any improvement actions from South Island 'Route to Service' review. Q3: Core chemotherapy protocols and common patient assessment templates adopted.	
		Engage locally in supporting the regional Te Waipounamu Māori Cancer Pathway Project to support improvements for Māori. (EOA)	Q2: Consultation with consumers on strategies to increase cervical screening uptake. Q4: Agreed actions and recommendations implemented.	

Better Help for Smokers to Quit – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Support the use of IT tools in patient data management to facilitate increased support for smokers to quit.	NZ Health Strategy Link - Smart System	Continue to use dashboards and performance reports to identify and highlight opportunities for service improvement.	Q1: Quarterly general practice performance reports circulated and visible. Q1: Monthly Ward performance reports circulated and visible.	90% of PHO enrolled patients who smoke are offered brief advice/support to quit. 90% of pregnant women who identify as smokers upon registration with a LMC are offered brief advice/support to quit. 95% of hospitalised patients who smoke are offered brief advice/support to quit.
		Continue to invest in and promote the Smokefree Pregnancy Incentive Programme for pregnant women.	Q4: Increased LMC referrals to the incentives programme. Q4: Increased proportion of referred women proceeding and setting a quit date.	
		Working with Poutini Waiora, use practice enrolment registers and client lists to identify Māori smokers, and offer stronger support to quit smoking. (EOA)	Q4: Increased proportion of Māori smokers accepting a referral to cessation services.	

Raising Healthy Kids - Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017. *Refer also to actions under the Childhood Obesity Action Plan.*	NZ Health Strategy Link - Closer to Home	Working with the Healthy West Coast Alliance Workstream, monitor the health target progress and provide clinical leadership to ensure all children are being appropriately assessed and referred for support where needed.	Q1: Quarterly audit of assessments and referrals instigated. Q2: Actions to address gaps and issues Identified and implemented.	95% of children identified as obese at their B4 School Check are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. SI5: Delivery of Whānau Ora.
		Working with Poutini Waiora, review the information provided to parents regarding B4 School Checks to ensure the information is culturally appropriate and engaging for Māori families. (EOA)	Q1: Review complete. Q2: Opportunities for improvement realised. Q4: Increased uptake by Māori.	
		Support the use of the BeSmarter tool as part of all B4 School Checks to normalise conversations with families about healthy weight in childhood.	Q1: All B4 School Check nurses trained to use BeSmarter. Q2: BeSmarter conversation tool incorporated as normal practice.	

Bowel Screening				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Contribute to development activities for the national bowel screening programme. *Note: West Coast go live for the programme is not until 2019/20.*	NZ Health Strategy Link - Value & high Performance	Working with the South Island Alliance, participate in the delivery of actions to position South Island DHBs for the rollout of the National Bowel Screening Programme (NBSP).	Q1: Workforce and IT support for rollout of NBSP included in regional work plans. Q4: Regional Bowel Screening Centre progressing as planned.	PP29: Improved waiting times for diagnostic services. 90% of people receive their urgent diagnostic colonoscopy within two weeks. 70% of people receive their non-urgent diagnostic colonoscopy within six weeks. 70% of people receive their surveillance colonoscopy within twelve weeks of the planned date.
		Take action to position the West Coast DHB for the rollout of the NBSP, including improving equity of access to endoscopy services. (EOA)	Q1: Endoscopy Nurse Coordinator recruited to anchor service locally. Q2: Local data prepared for the National Endoscopy Quality Improvement Programme. Q4: West Coast endoscopy service standards aligned to regional and national criteria.	
		Working with primary care, identify priority 'at risk' populations and actions to engage these population in readiness for the NBSP rollout. (EOA)	Q3: Options for engaging at risk populations identified. Q4: Resource implications identified and considered.	

Mental Health

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Improve population mental health, especially for priority populations, by increasing uptake of treatment and support earlier, further integrating mental and physical health care and co-ordinating mental health care with wider social services.	NZ Health Strategy Link - Value a& High Performance	Working with the Mental Health Leadership Team, complete the design and delivery of a new integrated model of care for mental health services.	Q1: Project Plan agreed and implementation underway.	PP38: Six monthly report on delivery of actions agreed in annual plan. Two GP practices are enrolling people with mental health conditions in the LTCM programme. >500 people access Brief Intervention Counselling in primary care. 80% of people referred for non-urgent specialist MH/AOD services are seen within 3 weeks. 95% of people referred for non-urgent specialist MH/AOD services are seen within 8 weeks. Seclusion rate reduction.
		As part of the redesign, invest in strengthening the community response for people with mild to moderate mental health conditions.	Q2: Use of the national AOD Healthline scoped. Q3: Community Mental Health and AOD model agreed.	
		As part of the redesign, invest in targeting the specialist response for people with more complex mental health conditions.	Q2: Crisis Response model agreed. Q4: Inpatient Unit and Child & Adolescent model agreed.	
		Actively engage with Māori stakeholder groups in the development of the new model of care. (EOA)	Q1: Feedback gathered. Q2: Mental Health KPI Dashboard reporting by ethnicity.	
Identify actions to reduce the use of seclusion.		Invest in training for frontline staff to increase the focus on debriefing, and embed sensory modulation into everyday practice to provide alternatives to seclusion.	Q1: Seclusion training packaged. Q2: Debrief audit complete. Q3: Sensory modulation profiles being completed for inpatients. Q4: 95% of frontline staff have received de-escalation training.	

Implementing the Healthy Ageing Strategy

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Deliver on priority actions identified in the Healthy Ageing Strategy 2016, including: working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of integrated falls and fracture prevention services, and working with the Ministry and wider sector to develop future models of care.	NZ Health Strategy Link - Closer to Home	Collaborating with ACC, enhance the Community Falls Prevention Service by increasing the availability of Strength and Balance programmes in people's homes and in community settings.	Q1: Lead agency in place. Q2: Gap analysis completed. Q3: Collaborative Strength and Balance programme in place.	PP23: Implementing the Healthy Ageing Strategy. >25 referrals to the Community Falls Prevention Service. >95% of long-term HBSS clients have an interRAI assessment and have a completed care plan in place. >75% of ARC residents have had a subsequent interRAI long term care facility assessment within 230 days of admission. Reduction in the time taken from referral to interRAI assessment.
		Working with the Health of Older People Alliance, develop the Flexible Integrated Rehabilitation Support Team (FIRST) to support earlier discharge from hospital.	Q1: Review FIRST Pilot results. Q3: Fractured Neck-of-Femur (NOF) Pathway developed.	
		Working with Poutini Waiora, develop an integrated approach to the assessment and support of Māori patients. (EOA)	Q1: Working group established. Q4: Poutini Waiora nurses trained in the use of the interRAI tools.	
		Working with the Ministry, develop and implement future models of Home Based Support Services - as per Part-B of the In-Between Travel Settlement.	Q1: Continued implementation of the national In-Between Travel and Pay Equity settlements. Q2: Stakeholder engagement on future of West Coast Health of Older People Services underway.	
		Working with the South Island Alliance, support delivery of the Health of Older People regional work plan.	Q4: Relevant actions within the work plan delivered.	

Implementing the Healthy Ageing Strategy - Continued				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify actions to regularise and improve the training of the kaiāwhina (non-regulated) workforce across home based and community support services.	NZ Health Strategy Link - Closer to Home	Invest in the training and development of Allied Health Assistants through the Careerforce training programme.	Q4: New staff enrolled in Careerforce training within three months of commencing in roles.	PP23: Implementing the Healthy Ageing Strategy.
		Using the Calderdale Framework principles, implement Clinical Task Instructions (CTIs) for Allied Health Assistants and Home Based Support Services (HBSS) workers.	Q2: Locally focused programme to implement CTIs for Allied Health Assistants developed. Q4: Programme to implement CTIs for HBSS staff developed (in partnership with HBSS providers).	
		Working with the Māori Health Team, consider opportunities to embed cultural competence training within the Calderdale Framework. (EOA)	Q4: Equity Lens (HEAT) applied to locally developed Calderdale Framework training programmes.	

Living Well With Diabetes				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue to implement the actions in Living Well with Diabetes 2015-2020, a plan for people at high risk of (or living with) diabetes in line with the Quality Standards for Diabetes Care.	NZ Health Strategy Link - Closer to Home	Working with the Local Diabetes Team, monitor and review access to services that support people with diabetes to stay well and identify actions to improve service delivery and engagement.	Q1: Ongoing monitoring of annual diabetes checks and retinal screens. Q2: Podiatry clinics re-established. Q4: >90% of the population diagnosed with diabetes have had an annual check.	Delivery of agreed actions from the national Living Well with Diabetes Plan. >80% of people with diabetes (having an annual check) have good or acceptable glycaemic control (HbA1c <64 mmol/mol).
		Undertake an annual stocktake against the national Quality Standards to further inform service improvement.	Q2: Stocktake review completed. Q3: Recommendation for improvement made to Alliance.	
		Facilitate collaboration between Poutini Waiora and general practice teams, to identify and contact Māori eligible for enrolment in the Long-Term Conditions Management (LTCM) Programme. (EOA)	Q4: >233 Māori enrolled in the LTCM programme (6.1%). Q4: 90% of eligible Māori males have had a cardiovascular risk assessment in the last five years.	

Implementation of the Childhood Obesity Plan				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to progress DHB-led initiatives in support of the childhood obesity plan. *Note: Refer also actions under the Raising Healthy Kids Health Target.*	NZ Health Strategy Link - Closer to Home	Participate in the implementation of the South Island Regional Childhood Obesity (Healthy Weight) Programme.	Q1: Common regional protocols, pathways and guidelines applied. Q2: BeSmarter conversation tool incorporated into all B4 School checks as normal practice.	PP38: Six monthly report on delivery of actions agreed in annual plan. >60% of babies are breastfeeding at three months.
		Working with the Healthy West Coast Alliance Workstream, review nutrition and physical activity to determine capacity to deliver service support for overweight children and their families.	Q1: Healthy West Coast work plan reviewed and agreed. Q2: Early Childhood Nutrition Health Promoter engaged to increase community messaging.	
		Engage pregnant Māori women with a Mum4Mum peer supporter prior to giving birth, to support breastfeeding and weight management support. (EOA)	Q1: Proactive peer support engagement process in place. Q4: Increased number of Māori women engaged in Mum4Mum.	

Child Health				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify barriers for accessing timely care for young people and their families who are served by the Ministry of Vulnerable Children, Oranga Tamariki. Commit to support national work to improve health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	NZ Health Strategy Link - Value & High Performance	Working with Oranga Tamariki, ensure all children currently in care have received a Gateway Assessment to identify health needs and support earlier intervention. Prioritise assessments for Māori children who have not previously received an assessment (EOA).	Q2: Data on historic Gateway Assessments collated. Q3: Data cross-matched and gaps in assessments identified. Q4: 95% of children in care have received a Gateway Assessment.	PP38: Six monthly report on delivery of actions agreed in annual plan. A reduction in the equity gap for Ambulatory Sensitive Admission rates for children 0-4 years to <1,033 per 100,000 – baseline at September 2016.
		Continue to audit the use of the Child Injury Assessment Flowchart for all ED presentations (injury and medical) for children up to 24 months.	Q1: ED staff trained in using the Child Injury Assessment form. Q4: 50% of children presenting at ED have a Child Injury Assessment Form completed.	
		Working with Oranga Tamariki, investigate options to develop collaborative care plans or pathways to address the health needs of children served by Oranga Tamariki. (EOA)	Q2: Briefing to Oranga Tamariki staff regarding the DHB focus on support for vulnerable families. Q4: Collaborative care plan options or pathways identified.	

Disability Support Services				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify the mechanisms and processes in place to support people with a disability when they interact with hospital based services.	NZ Health Strategy Link - One Team	Develop a communications plan, including regular engagement with the disability sector and using people's experience of the health system, to inform improvement practices.	Q1: Quarterly update to the disability community on actions to improve patient experience.	PP38: Six monthly report on delivery of actions agreed in annual plan.
		Develop and implement a policy on the use of sign language including access to interpreters with a specific focus on the Emergency Department. (EOA)	Q2: Policy scoped and developed. Q3: Policy implemented.	
		Working with people with disabilities and their families, develop an eLearning tool to capture their experience in our system and increase awareness amongst staff. (EOA)	Q3: eLearning tool developed. Q4: eLearning tool promoted.	

Implementation of the Pharmacy Action Plan				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue to deliver on the national Pharmacy Action Plan	NZ Health Strategy Link - One Team	Working with the Pharmacy Workstream, promote the role of the Pharmacist in the health care team.	Q1: Ongoing uptake of Medicine Use Review Service. Q4: Ongoing uptake of Pharmacy Long-term Conditions Service.	PP38: Six monthly report on delivery of actions agreed in annual plan. >120 people access Medicine Use Reviews (to reduce harm from medications use). >80% of Complex Clinical Care Network case management meetings include a pharmacist.
		Support Pharmacists to enhance their cultural competency. (EOA)	Q3: Minimum of two pharmacists have received cultural training.	
		Support local implementation of national contracting arrangements, once agreed, to support the vision of integrated pharmacist services in the community.	Q4: Agreed decisions actioned.	

Supporting Primary and Community Service Integration				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Describe activity to demonstrate how the DHB is working with the district Alliance to move care closer to home for people through improved integration with the broad health and disability sector.	NZ Health Strategy Link - Closer to Home	Support the development and implementation of a new model of care for primary and community services, incorporating service changes in preparation for the move to the new Grey Base Hospital and IFHC, including the extension of primary care hours.	Q2: Model of care for primary and community services agreed and implementation underway. Q2: Primary care urgent care service model in place.	>3 West Coast general practices have an e-portal in place. A reduction in the equity gap for Ambulatory Sensitive Admission rates for children 0-4 years to <1,033 per 100,000 – baseline at September 2016. Acute Hospital Bed Day rates remain below the national rate at <371 per 1,000 people – baseline at September 2016.
		Support development of a centralised Hub for primary and community assessment and coordination services, to enhance integration and support consistent and sustainable access to a wider range of services.	Q2: Hub implementation plan is developed and approved. Q3: Implementation underway.	
		Working through the Buller and Reefton IFHS workstreams, support continued integration of services and actions to improve equity of access for people in our most remote rural areas. (EOA)	Q1: Opportunities identified. Q2: Implementation underway.	
		Working through the Alliance, identify actions to address barriers for our Māori population to improve access to primary and community care. (EOA)	Q1: Cultural competency training program in place. Q1: Alliance workstreams have identified improvement actions.	
Improve performance against the national System Level Measures.	One Team	Working with the West Coast Alliance, refresh and refine the Coast's System Level Measure (SLM) Improvement Plan, outlining joint activity to achieve the new national System Level Measures.	Q1: Implementation of agreed Improvement Plan underway. Q4: Confirmation of measures and updated actions for 2018/19.	Improved performance against the national SLM in line with the 2017/18 Improvement Plan.

Commitment to Quality and Patient Safety				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Demonstrate, how you will improve patient experience, as measured by the Health Quality & Safety Commission national patient experience survey in the domain area: 'Improving communication - with consumers and families'.	NZ Health Strategy Link - Value & High Performance	Engage in the Releasing Time to Care Programme, focusing on completion of the Admission and Discharge Modules to improve the quality of information given to patients and families.	Q2: Teams complete assessment of areas for improvement. Q3: Process improvements are embedded and realised.	PP38: Six monthly report on delivery of actions agreed in annual plan. 85% of general practices are offering the primary care patient experience survey to patients. >35% response to national inpatient experience survey. Consistently high in-patient survey results for the domain – 'Rate your experience of communications out of 10' - baseline 8.4 at June 2016.
		Working with the Consumer Council and the DHB's Māori Health Team, seek to improve processes for capturing patient and family feedback to inform ways we can work better with Māori. (EOA)	Q2: Existing feedback system reviewed. Q3: Opportunities for improvement identified.	
		Establish 'Improving Our Communication' as an organisation goal for the DHB, to raise visibility and engage staff in identifying and making improvements.	Q1: Inclusion of survey results in clinical and business meetings. Q2: Improving Communication goal introduced at orientation.	

Living Within Our Means				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to managing finances prudently, and in line with Ministerial expectations ensure all planned financials align with previously agreed results.	NZ Health Strategy Link - Value & High Performance	Working with the West Coast Alliance, develop and implement the System Level Improvement Plan to support integration, enable earlier intervention, and reduce service demand across our hospital services by improving the health status of our population.	Q1: System Level Improvement Plan developed and agreed. Q2: Ongoing monitoring of deliverables and activity. Q4: Improvements realised.	Delivery of year-end financial performance in line with agreed Annual Plan results.
		Implement the agreed Project Plans for the transformation of mental health and primary and community services to support integration, enable earlier intervention, and reduce wait times and duplication of resources.	Q1: Implementation plan (for mental health) agreed and implementation underway. Q2: Implementation plan (for primary and community) agreed and implementation underway.	
		Continue to expand the use of telemedicine and virtual specialist assessments to reduce the amount of time patients and clinicians spend travelling across the West Coast.	Q4: >5% of first specialist assessment and follow-up outpatient appointments are provided via telehealth.	

Commitment to Regional Activity				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify any significant actions the DHB is undertaking to deliver on the Regional Service Plan.	NZ Health Strategy Link - One Team	Working through the South Island Alliance, support the development of regional pathways and models to improve equity of access, system quality, and consistency of practice in elective service areas. (EOA)	Q1: Baselines for access by DHB and ethnicity identified and monitored regionally. Q3: Sustainable South Island plan for orthopaedic services agreed.	Delivery of regional elective volumes. Delivery of regional cardiac surgery volumes. 6% of eligible stroke patients are thrombolysed. 80% of stroke patients are admitted to an organised stroke service with a demonstrated stroke pathway.
		Provide input into the development of a South Island model for cardiac services, ensuring appropriate access to surgery, percutaneous revascularisation, and coronary angiography.	Q2: STEMI Pathway (with St John Ambulance) implemented. Q4: Single South Island cardiac services model agreed and implementation underway.	
		Continue to engage with the Regional Stroke Network to support the delivery of a sustainable organised stroke service pathway on the West Coast.	Q4: Regional plan for remote support via telestroke agreed. Q4: Regional intra-arterial clot retrieval protocols in place.	
		Continue to participate and provide support across the wider Alliance work plan including Major Trauma and Hepatitis C workstreams.	Q4: Regional destination policies maintained. Q4: Common Hepatitis C agenda established across South Island.	

Local and Regional Enablers

Enhancing our organisational strength and capability

Investing in our People				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify particular workforce issues that need to be addressed at a local level around capability and capacity.	NZ Health Strategy Link - One Team	Promote the West Coast DHB as an employer of choice through targeted national and international advertising.	Q1: 12 month marketing plan agreed and in place.	Improved wellbeing outcomes are evident. Māori recruited onto a health career pathway (100 individuals across South Island). Māori graduates transitioned into health sector workforce (25 individuals across the South Island).
		Invest in the ongoing implementation of the Workforce Wellbeing Strategy to support the wellbeing of our people and retain talent within the organisation.	Q4: Three General Wellbeing workshops delivered. Q4: Three Strengths workshops delivered.	
		Design and implement a Leadership and Development framework to build people's leadership capability and provide them with the confidence and technical skills to play a leadership role in the organisation.	Q2: Leadership and Talent Framework in place. Q3: Operational leadership learning and development programme in place.	
		Continue to participate in the regional Kia Ora Hauora Māori Workforce Development Service to support Māori health workforce capacity development. (EOA)	Q1: Quarterly updates on delivery against regional plan. Q4: Continued uptake of Hauora Māori scholarships.	

Connecting Our Information Systems				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Demonstrate how the DHB is regionally aligned, and where it is leveraging digital hospital investments including: implementation of order entry and nursing documentation and ePA and eOrders.	NZ Health Strategy Link - Smart System	Working with the Regional Health IT Workstream, ready the DHB to implement the new regionally shared Patient Information Care System (PICS) as it is rolled out across the South Island.	Q4: Business Case developed for implementation of South Island PICS on West Coast.	PP38: Delivery of actions agreed in the Annual Plan. SI2: Quarterly reports from regional leads. 90% of GP referrals are sent electronically. 95% of the West Coast population have an integrated patient-centric clinical record available through a regional view.
		Working with the Regional Health IT Workstream, implement electronic orders for radiology results on the West Coast.	Q4: Electronic Orders (eOrders) implemented.	
		Develop a business case for implementing the electronic prescribing and medications administration (ePA) system on the Coast.	Q1: Business Case developed. Q2: Implementation underway.	
		Leverage the work in Canterbury DHB to implement the Patient Track system for nursing documentation.	Q3: Timelines for Patient Track implementation agreed.	

Financial Summary

Further detail on the DHB's financial outlook for 2017/18 can be found in Appendix 5 of this Plan.

Prospective Statement of Financial Performance – year ending 30 June

Statement of Comprehensive Income	2015/16 Audited Actual $'000	2016/17 Forecast $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Revenue					
Ministry of Health Revenue	128,912	131,477	136,234	141,223	145,839
Other Government Revenue	8,520	7,777	4,167	3,769	3,820
Other Revenue	3,857	3,517	7,851	7,624	7,624
Total Revenue	**141,289**	**142,771**	**148,252**	**152,615**	**157,282**
Expenditure					
Personnel	57,142	57,416	59,796	59,790	60,865
Outsourced	7,284	8,692	7,487	7,851	7,168
Clinical Supplies	7,781	8,402	8,288	8,100	8,182
Infrastructure & Non Clinical	11,129	11,446	11,416	9,940	9,422
Payments to Non-DHB Providers	52,649	53,161	58,419	59,979	61,258
Interest	651	343	-	-	-
Depreciation & Amortisation	4,572	3,373	3,400	5,326	5,217
Capital Charge	978	739	1,488	6,234	6,225
Total Expenditure	**142,186**	**143,571**	**150,294**	**157,220**	**158,337**
Other Comprehensive Income					
Revaluation of Land & Building	-	-	-	-	-
Total Comprehensive Income / (Deficit)	**(897)**	**(800)**	**(2,041)**	**(4,605)**	**(1,055)**

Prospective Financial Performance by Output Class – year ending 30 June

Prospective Summary of Revenue & Expenses by Output Class	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Early Detection			
Total Revenue	23,678	24,414	25,020
Total Expenditure	42,639	44,256	44,692
Net Surplus / (Deficit)	**(18,961)**	**(19,842)**	**(19,672)**
Rehabilitation & Support			
Total Revenue	22,445	22,717	23,369
Total Expenditure	32,395	34,033	35,105
Net Surplus / (Deficit)	**(9,949)**	**(11,316)**	**(11,736)**
Prevention			
Total Revenue	2,082	2,150	2,221
Total Expenditure	2,409	2,499	2,519
Net Surplus / (Deficit)	**(327)**	**(349)**	**(298)**
Intensive Assessment & Treatment			
Total Revenue	100,047	103,334	106,672
Total Expenditure	72,851	76,432	76,021
Net Surplus / (Deficit)	**27,196**	**26,902**	**30,651**
Consolidated Surplus / (Deficit)	**(2,041)**	**(4,605)**	**(1,055)**

Service Configuration

SERVICE COVERAGE

All DHBs are required to deliver a minimum level of service to their population, in accordance with the national Service Coverage Schedule. This Schedule is incorporated as part of the Crown Funding Agreement between the Crown and DHBs, under Section 10 of the New Zealand Public Health and Disability (NZPHD) Act, and is updated annually.

DHBs are responsible for ensuring that service coverage is maintained for their population. The West Coast DHB works to identify service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways.

At this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2017/18. However, we are mindful of continuity risks while we decant and transfer services into the new Grey Base Hospital, particularly with regards to radiology services and operating theatres. We are working with neighbouring DHBs and the Ministry of Health to assess and alleviate these risks, but anticipate that meeting diagnostic and elective surgery wait time targets will be a significant challenge during this period.

SERVICE REDESIGN

Through the West Coast Alliance, we are working with our primary and community partners to redesign the way we deliver health services to better meet the needs of our population and ensure the future sustainability of our health system. We anticipate that new models of care and service delivery will continue to emerge with the development of more integrated family health services on the West Coast.

In line with our shared decision-making principles, we look to our clinically-led alliance workstreams and leadership groups for advice on the development of new service models. We also endeavour to keep a steady stream of information flowing across our system and our community with regards to the transformation of services.

At times, we may wish to negotiate, enter into or amend current service agreements or arrangements to assist in meeting our objectives and delivering against the vision and goals outlined in this Plan. In doing so (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000), we will seek to ensure that any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations in respect to our agreements with the Crown.

Listed below are the anticipated service changes for the coming year.

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
Location and configuration of services	Services on the Grey Base Hospital Campus	Relocation of services in line with the completion of the new Grey Base Hospital and IFHC.	Increased integration of services and sustainable service delivery.	Local
Location and configuration of services	Rural Academic General Practice and Grey Medical	Relocation and merger of rural academic and general practice services in line with the completion of the IFHC on the Grey Base site.		Local
Location and redesign of service model	Northern locality: Westport, Buller and Reefton	The DHB is working in the northern locality to redesign models of care, including the development of integrated family health services and a sustainable after-hours model.	Increased integration and sustainable service delivery.	Local
Location, configuration and redesign of service model	Coordination, assessment and management services	The DHB will look to bring assessment, coordination, and management services together into one integrated HUB. This is likely to include: phone services and rostering, needs assessment, and home and community service coordination.	Increased integration and sustainable service delivery.	Local
Redesign of service model	Home and Community Based Support Services	Working under the guidance of the West Coast Alliance, the DHB will complete the redesign of the model of care for home and community based support services. This will include consideration of the future of DHB aged residential care services.	Increased service capacity and integration, and improved patient outcomes.	Local
Redesign of service model, reconfiguration of services and location	Primary and Community Services	Working under the guidance of the West Coast Alliance, the DHB will complete the redesign of the model of care for primary and community services. This will include reviewing our approach to the provision of planned/unplanned care and extending general practice hours to support a new primary acute care service model.	Increased service capacity and integration, and improved patient outcomes.	Local

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
Reconfiguration of services	Dementia Services	The DHB will look to reconfigure dementia services currently under hospital management to sit alongside primary and community services as part of the wider integrated service model.	Increased service integration and improved patient outcomes.	Local
Reconfiguration of services	Infusion Services	The DHB will look to reconfigure infusion services currently under hospital management to sit alongside primary and community services as part of the wider integrated service model.	Increased service integration and improved patient outcomes.	Local
Reconfiguration of services	Orthotics Services	The DHB will look to reconfigure orthotics services currently under hospital management to sit alongside primary and community services as part of the wider integrated service model.	Increased service integration and improved patient outcomes.	Local
Change of provider	Podiatry Services	The DHB will look to outsource these services in response to workforce sustainability issues.	Sustained service delivery.	Local
Redesign of service model, reconfiguration of services and change of location	Mental Health Services	Under the guidance of the Mental Health Leadership Team, the DHB is working to complete the transformation of the model of care for mental health services. This will include a shift of some secondary based services into the community and increased transalpine support from Canterbury.	Increased service capacity and integration, and improved patient outcomes.	Local
Redesign of service models	General Surgery, Cancer and Anaesthesia services	The DHB will continue to redesign service models to support the adoption of collaborative transalpine pathways between West Coast and Canterbury DHBs.	Increased service capacity and equity of access to services.	Local Regional
Redesign of service model and contracting arrangements	Community Pharmacy and Pharmacist Services	Under the guidance of the West Coast Alliance, the DHB will work with Pharmacy providers to implement the national pharmacy contracting arrangements and develop local services in alignment with the direction of the national Pharmacy Action Plan.	Increased service integration, improved service quality and improved patient outcomes.	Local National
Reconfiguration of services	Corporate and Management Services	The DHB will complete the reconfiguration of its management structure to better align responsibilities with the new integrated service models.	Increased integration and sustainability of service provision	Local
Potential redesign of service models, change of provider and/or location of service	Secondary and Care Services	The DHB will continue to review capacity and costs across all service areas, and look to prioritise resources onto areas of the most immediate or greatest need. This includes aligning practice and intervention rates with national service specifications or accepted practice in other DHBs, and may impact on the configuration and scope of some services.	Reduction in operating costs, increased capacity and greater patient and system returns.	Local Regional

Part III

Managing Our Business

Organisational Strengths

This section highlights how we will organise and manage our business in order to support our vision and enable the successful delivery of more integrated health services across our community.

Further detail on our goals and aspiration for the next three years is available in our Statement of Intent, on our website; www.westcoastdhb.health.nz.

3.1 Organisational culture

The way in which we work, the values of our organisation and the manner in which we interact with others are all key factors in our success.

CLINICAL AND CONSUMER LEADERSHIP

Clinical leadership is intrinsic to our success. Through our shared clinical/management model, clinical input is embedded at all levels of the decision-making process, across operational services and alliance workstreams. Strategic and operational decisions are further informed through the following formal mechanisms:

The Clinical Board: where members support and influence the DHB's vision and play an important role in raising the standard of patient care.

The Consumer Council: where members ensure a strong and viable voice for consumers in health service planning and service redesign.

PARTNERSHIPS

We are also aware that our vision is wider than just the DHB. Working collaboratively has enabled us to respond to the changing needs of our population and is a critical factor in achieving our goals and objectives. The DHB's strategic partnerships include:

The West Coast District Alliance: where the DHB and the PHO come together with other local service providers to improve the delivery of healthcare and realise opportunities to better integrate our system. This includes the development of the West Coast's System Level Improvement Plan for 2017/18 which is attached to this Plan (Appendix 6).

Tatau Pounamu: where the DHB actively engages with Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Members of Tatau Pounamu also bring a Māori perspective to the redesign of services across a number of the West Coast Alliance workstreams.

Our Transalpine Partnership: where the Canterbury and West Coast DHBs work together to provide sustainable access to specialist services for our population. The partnership includes shared clinical pathways, information systems, corporate services, and joint clinical and management positions.

3.2 Commitment to quality

Over the last several years, we have sharpened our focus on improving the quality and safety of the services provided by the West Coast DHB.

With a culture of reporting well established, safety issues are becoming more transparent and are empowering the organisation to respond to needed improvement. The implementation of the South Island Incident and Risk Management System (Safety 1st) is assisting in identifying trends and real time tracking of events, allowing us to examine incidents as they happen and take action to improve quality and safety.

The national Health Quality and Safety Commission (HQSC) Quality and Safety markers continue to be part of the set of measures used by our governance groups to monitor the effectiveness of our improvement activity. Performance against the HQSC markers is reported to the DHB's Clinical Board and to the Board's Quality, Finance, Audit and Risk Committee. They are also reported annually to our community in our Quality Accounts which can be found on the DHB's website.

Contracted services are also aligned with national quality standards and auditing of contracted providers includes quality audits.

Refer to Part II for quality activity in line with national expectations for the coming year.

3.3 Performance management

The West Coast DHB has invested in the development of 'live data' systems where real time information on the day-to-day operations within our hospitals enables more responsive decision making and planning.

Our financial and non-financial performance is monitored fortnightly by the Executive Team and monthly by the DHB's Board and its Quality, Finance, Audit and Risk Sub-Committee. The DHB also reports monthly and quarterly to the Ministry of Health against key financial and non-financial reporting indicators (refer to Part IV for the non-financial performance framework and expectations).

On an annual basis, our financial and non-financial performance is audited against our Statements of Service and Financial Performance Expectations (refer to Appendix 4 and 5). The results are published annually as the DHB's Annual Report.

At a broader level, we monitor our performance over the longer-term against a core set of desired population outcomes, to evaluate the effectiveness of our strategies and investments decisions.

Further reference to the DHB's outcome goals can be found in the DHB's Statement of Intent.

3.4 Asset management

Having the right assets in the right place, and managing them well, is critical to the ongoing provision of high-quality and cost-effective health services.

Our capital intentions are updated annually to reflect known changes in asset states and intentions in line with our Grey Base Hospital and Integrated Family Health Centre redevelopment. Refer to Appendix 5 for our major capital investments for the coming year.

The DHB is also developing a Long Term Investment Plan, looking at where we need to invest to support the delivery of our vision over the next ten years. It is anticipated that this Investment Plan will be completed in 2018/19, in alignment with the timeframes for the Treasury-led Investor Confidence Rating Programme.

3.5 Ownership interests

The West Coast DHB has an interest in the South Island Shared Service Agency Limited, now functioning as the South Island Alliance Programme Office.

Jointly funded by the five South Island DHBs, the regional Programme Office provides audit and project management services and drives regional service development on behalf of the South Island DHBs. Further detail on the activity of the regional Alliance can be found at www.sialliance.health.nz.

The West Coast DHB also has an ownership interest in the New Zealand Health Partnership Limited (NZHPL).

A limited liability company owned and jointly funded by all 20 DHBs, the Partnership enables DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB is participating in the Finance, Procurement and Supply Chain programme, with NZHPL facilitating the move of all 20 DHBs to a shared services model for these services.

We do not intend to acquire shares or interests in any other companies, trust or partnerships in 2017/18.

Organisational Capability

3.6 Investing in our people

To meet the needs of our population and achieve our vision, we need a motivated workforce committed to doing their best for the patient and the system.

The DHB is committed to being a good employer. We promote equity, fairness, a safe and healthy workplace, and have a clear set of organisational values and core operational policies—including a Code of Conduct, a Wellbeing Policy, and an Equality, Diversity and Inclusion policy.

In our rurally isolated environment we face significant difficulties in recruiting and retaining a suitable health workforce. This has led to an-over reliance on locum and contract staff, the cost of which is unsustainable long-term. Recruiting and retaining a capable health workforce is one of our critical success factors.

We identify available talent and expand workforce capability through: participation in the regional Workforce Development Hub; links with the education sector; sharing training resources; and support for internships and clinical placements in our hospitals.

We invest in a Rural Learning Centre in Greymouth, to encourage people to work rurally by reducing isolation factors and providing peer support and mentoring. We are also engaged in the South Island Kia Ora Hauora Programme, aimed at increasing the number of Māori working in our health system.

While our aim is to support service delivery as close to home as possible, in some areas our rurality and small size means that we cannot sustainably meet all the needs of our population without assistance.

Over the past several years, we have deliberately established a number of joint clinical and executive roles as part of our transalpine partnership with the Canterbury DHB. Shared corporate services teams including Finance, Planning & Funding, Information Services, and People and Capability also provide considerable support to our service teams.

As part of our commitment to our workforce we are reviewing our HR processes and systems and engaging in a number of conversations about how we continue to put people at the heart of all that we do. Refer to Part II of this document for workforce activity in line with national expectations for the coming year.

3.7 Investing in information systems

Improved access to patient information enables more effective clinical decision-making, improves standards of care and reduces the time people spend waiting.

Information management is a national priority, and DHBs are expected to implement the national Health Information Technology Plan.

The South Island DHBs have determined collective actions to deliver on the national plan and the West Coast DHB is committed to this approach. We have already adopted several major regional systems, including: Health Connect South (award winning), HealthOne, and the Electronic Referral Management System (ERMS).

Our transalpine partnership with Canterbury makes shared information systems increasingly important. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs and replacing our old hospital-based patient administration system with the new single South Island Patient Information Care System (PICS).

Telehealth, videoconferencing and mobile technology is also an important factor in addressing our rurality and isolation challenges. This investment has both saved patient and clinical time by reducing the need to travel for assessments. We will continue to expand the use of telemedicine and connect up the system electronically with the roll-out of the shared mental health portal over the next two years.

Refer to Part II for information services activity in line with national expectations for the coming year.

3.8 Investing in facilities

In the same way that quality systems, workforce and information technology underpin and enable our transformation, health facilities can both support and hamper the quality of the care we provide.

The West Coast is in the midst of significantly transforming the way health services are delivered to our community, in order to improve the clinical and financial sustainability of our system.

The new $77.8m Grey Based Hospital and Integrated Family Health Centre (IFHC) will underpin this transformation by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service provision.

Anticipated activity for 2017-2018 includes:

Grey Base Hospital and IFHC: Construction is underway and completion of the Hospital and IFHC is anticipated in the second quarter of 2018.

Grey Base Energy Centre: The replacement Energy Centre is part of the Grey Base Hospital redevelopment and is planned for completion in 2018.

Buller IFHC: The DHB engaged with the Buller community in 2015 on the development of a future service model for the district. DHB staff and clinical teams have since worked with an appointed design team to develop a full concept design and implementation business case for an IFHC in Buller.

Options have been considered by the Ministry appointed Hospital Redevelopment Partnership Group and we expect to move forward with the development of the service models and facility in 2018.

3.9 Cross-sector investment

Recognising the wider influences that shape the health and wellbeing of our population, the West Coast DHB also works in partnership with other public and private organisations from outside the health sector to improve health outcomes for our population.

We work closely with local and regional councils, Housing New Zealand, ACC, Police, and the Ministries of Justice, Education and Social Development to influence and support the creation of social and physical environments that reduce the risk of ill health.

At a national level, we are committed to implementing national cross-agency programmes including: the Prime Minister's Youth Mental Health Project, the Children's Action Plan and the Whānau Ora programme, for the benefit of our population and the wider health system.

Our cross-sector work includes:

The Family Violence Interagency Response System Group: The DHB is part of this interagency group with Police, Women's Refuge, Presbyterian Support and the Ministry for Vulnerable Children, Oranga Tamariki. Regular interagency meetings assess risk in reported cases of family violence so that collective responses can be planned.

The Buller Interagency Forum: The forum involves a number of local and central government agencies and community organisations including the DHB. Providing an opportunity to share information about service provision and projects, the focus is on promoting community wellbeing across the Buller community.

Part IV

Monitoring Our Performance

Making a Difference

As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

DHBs have a number of different roles and associated responsibilities. In our governance role, we are striving to improve health outcomes for our population; as a funder, we are concerned with the effectiveness of the health system and the return on our investment; and as an owner and provider of services, we are concerned with the quality of the services we deliver and the efficiency with which we deliver them.

There is no single performance measure or indicator that can easily reflect the impact of all the work we do.

In developing our vision, we established three high-level strategic objectives.

Alongside these objectives, we have identified a number of associated long-term outcomes that are important to our stakeholders and, over time, will provide an insight into how well our health system is performing. These main measures of performance are set out in detail in our Statement of Intent and reported annually in our Annual Report.

These desired longer-term outcomes are also captured in our local System Level Measures Improvement Plan which defines success from a whole of health system perspective. This Improvement Plan is developed collectively through our local Alliance and is monitored quarterly, as a means of evaluating the success of our collective initiatives.

Refer to Appendix 3 for the Intervention Logic Diagram illustrating how the West Coast DHB's actions impact on the health of our population, contribute to the goals of the South Island region and deliver on Government expectations.

The DHB's Statement of Intent, Annual Report and the System Level Improvement Plan can all be found on the DHB's website, www.westcoastdhb.health.nz.

4.1 Accountability to our community

Over the shorter term, we evaluate our performance by monitoring ourselves against a forecast of the services we plan to deliver to our community, and the standards we expect to meet.

The results are reported publically in our Annual Report, alongside our year-end financial performance.

Our statement of performance expectations presents the DHB's planned performance for 2017/2018 and is attached to this document as Appendix 4.

The DHB's forecast of financial performance for 2017/18 is attached, as Appendix 5.

4.2 Accountability to our Minster

As a Crown entity, responsible for Crown assets, the DHB also provides regular financial and non-financial performance reporting to the Ministry of Health on a monthly, quarterly and annual basis.

Our obligations include quarterly performance reporting in line with the Ministry's non-financial monitoring framework. This framework aims to provide a rounded view of performance in key priority areas rather than across all health services or DHB activity and uses a mix of performance markers across four dimensions. The dimensions reflect the DHB's functions as governor, funder, owner and provider of health and disability services:

- Policy Priorities (PP): achieving Government priority goals, objectives and targets
- System Integration (SI): meeting service coverage requirements and supporting sector inter-connectedness
- Ownership (OS): providing quality services, efficiently
- Outputs (OP): purchasing the right mix and level of services with acceptable financial performance.

Three additional dimensions covered in 2017/18 are:

- Health Strategy (HS): delivery of aligned actions
- Developmental (DV): no target or expectation set
- System Level Measure (SLM): indicates a measure that is also part of the national SLM framework.

The national framework and expectations for 2017/18 are set on the following pages.

National Reporting Framework 2017/18

National Performance Measure	2017/2018 Performance Expectation		
HS: Supporting delivery of the NZ Health Strategy	Quarterly highlight report against the Strategy themes.		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	>3.8% of the population access special services.	
	Age 20-64	>3.8% of the population access special services.	
	Age 65+	>3.0% of the population access special services.	
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan in place.		
	95% of audited files meet accepted good practice.		
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks.		
	95% of people seen within 8 weeks.		
PP10: Oral Health Mean DMFT score at Year 8		Year 1	1.08
		Year 2	1.08
PP11: Children caries-free at five years of age		Year 1	63%
		Year 2	63%
PP12: Utilisation of DHB-funded dental services by youth (School Year 9 up to and including age 17 years)		Year 1	85%
		Year 2	85%
PP13: Improving the number of children enrolled in DHB funded dental services	Children (age 0-4) enrolled.	Year 1	95%
		Year 2	95%
	Children (0-12) not examined according to planned recall.	Year 1	≤10%
		Year 2	≤10%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)			
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.		
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.		
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).		
Focus Area 3: Cardiovascular health	90% of the eligible population have had their cardiovascular risk assessed in the last 5 years.		
	Report on percentage of 'eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past 5 years'.		
Focus Area 4: Acute heart service	70% of high-risk patients receive an angiogram within 3 days of admission.		
	95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.		
	95% of patients undergoing cardiac surgery at the regional cardiac centres have completion of Cardiac Surgery registry data collection within 30 days of discharge.		
Focus Area 5: Stroke services	6% or more of potentially eligible stroke patients are thrombolysed 24/7.		
	80% of stroke patients are admitted to a stroke unit or an organised stroke service with demonstrated stroke pathway.		
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.		
PP21: Immunisation coverage	95% of two year olds fully immunised		
	95% of four year olds fully immunised		
	75% of girls fully immunised – HPV vaccine		
	75% of 65+ year olds immunised – Influenza vaccine		
PP22: Actions to improve system integration including System Level Measures	Report on activities in the Annual Plan.		
PP23: Improving the Healthy Ageing Strategy	Report on activities in the Annual Plan.		
	95% of older people who have received long-term home and community support services in the last three months have had an interRAI Home Care or Contact Assessment and have a completed care plan.		

PP25: Prime Minister's youth mental health project	Initiative 1: School Based Health Services	Report on implementation of SBHS in decile one to three secondary schools, teen parent units and alternative education facilities, and actions undertaken to implement *Youth Health Care in Secondary Schools: framework for continuous quality improvement* in each school with SBHS.
	Initiative 3: Youth Primary Mental Health	Reported through PP26 (see below).
	Initiative 5: Responsiveness to Youth	Report on actions to ensure high performance of the youth service level alliance (SLA), or equivalent, and actions of the SLA to improve health of the DHB's youth population.
PP26: The Mental Health & Addiction Service Development Plan	Focus Area 1: Primary Mental Health	Report as specified.
	Focus Area 2: District Suicide Prevention and Postvention	Report as specified.
	Focus Area 3: Improving Crisis Response Services	Report as specified.
	Focus Area 4: Improving outcomes for children	Report as specified.
	Focus Area 5: Improving employment and addressing physical health needs of people with low prevalence conditions.	Report as specified.
PP27: Supporting Vulnerable Children	Report on activity in the Annual Plan.	
PP28: Reducing Rheumatic fever	Report on reducing the Incidence of First Episode Rheumatic Fever	
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
	95% of accepted referrals for CT scans will receive their scan within 6 weeks (42 days).	
	90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	
	90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days), 100% within 30 days.	
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.	
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.	
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of the Ethnicity Data Audit Toolkit (EDAT).	
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.	
PP36: Reduce the rate of Māori under the Mental Health Act (section 29 community treatment orders)	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
PP37: Improving breastfeeding rates	60% of infants are exclusively or fully breastfed at three months.	
PP38: Delivery of response actions agreed in annual plan	Report on activity in the Annual Plan.	
SI1: Ambulatory sensitive hospitalisations	0-4 years	SLM Target - A reduction in the equity gap for Ambulatory Sensitive Admission rates for children 0-4 years to <1,033 per 100,000.
	45-64 years	Ambulatory Sensitive Admission rates for adults 45-64 years maintained at <2,652 per 100,000.
SI2: Delivery of Regional Plans	Provide a progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates	Major joint replacement procedures - target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - target intervention rate of 27 per 10,000 of population.	
	Cardiac surgery - target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularizations - target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - target rate of at least 34.7 per 10,000 of population.	

SI5: Delivery of Whānau Ora	Focus Area 1: Engagement with Commissioning Agencies		Report as specified.
	Focus Area 2: Mental Health		Report as specified.
	Focus Area 3: Asthma		Report as specified.
	Focus Area 4: Oral Health		Report as specified.
	Focus Area 5: Obesity		Report as specified.
	Focus Area 6: Tobacco.		Report as specified.
SI7: SLM total acute hospital bed days per capita			As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI8: SLM patient experience of care			As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI9: SLM amenable mortality			As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI10: Improving cervical screening coverage		80% coverage for all ethnic groups and overall (ages 25-69).	
SI11: Improving breast screening rates		70% coverage for all ethnic groups and overall (ages 50-69).	
OS3: Inpatient Average Length of Stay		Elective	1.40 days (75th centile of national performance).
		Acute	2.30 days (75th centile of national performance).
OS8: Reducing Acute Readmissions to Hospital			TBA – indicator definition currently under review.
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	Group A: >2% and <= 4% Group B: >1% and <=3% Group C: >1.5% and <=6%
		Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
		Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
		Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%
		Invalid NHI data updates	TBA
	Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
		National Collections File load Success	>= 98% and <99.5%
		Assessment of data reported to NMDS	>= 75%
		Timeliness of NNPAC data	>= 95% and <98%
	Focus Area 3: Improving quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	
Output 1: Mental health output Delivery Against Plan			Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on delivery of programmes or places is within 5% (+/-) of the year-to-date plan.
DV4: Improving patient experience			No performance expectation/target.
DV6: SLM youth access to and utilisation of youth appropriate health services			No performance expectation/target.
DV7: SLM number of babies who live in a smoke-free household at six weeks post-natal			No performance expectation/target.

Part V

Further Information for the Reader

Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Intervention Logic Diagram (Statement of Intent 2017-2021)
Appendix 3	West Coast DHB Statement of Performance Expectations 2017/18
Appendix 4	West Coast DHB Statement of Financial Expectations 2017/18
Appendix 5	West Coast's System Level Improvement Plan 2017/18

Documents of interest

The following documents can be found on the West Coast DHB's website (www.westcoastdhb.org.nz/publications) and read in conjunction with this Annual Plan. They provide additional parts of the picture on health service delivery and transformation across our health system.

- West Coast DHB Statement of Intent 2017-2021
- West Coast DHB Public Health Action Plan 2017/18
- West Coast DHB Quality Accounts 2017/18
- South Island Regional Health Services Plan 2016-2019

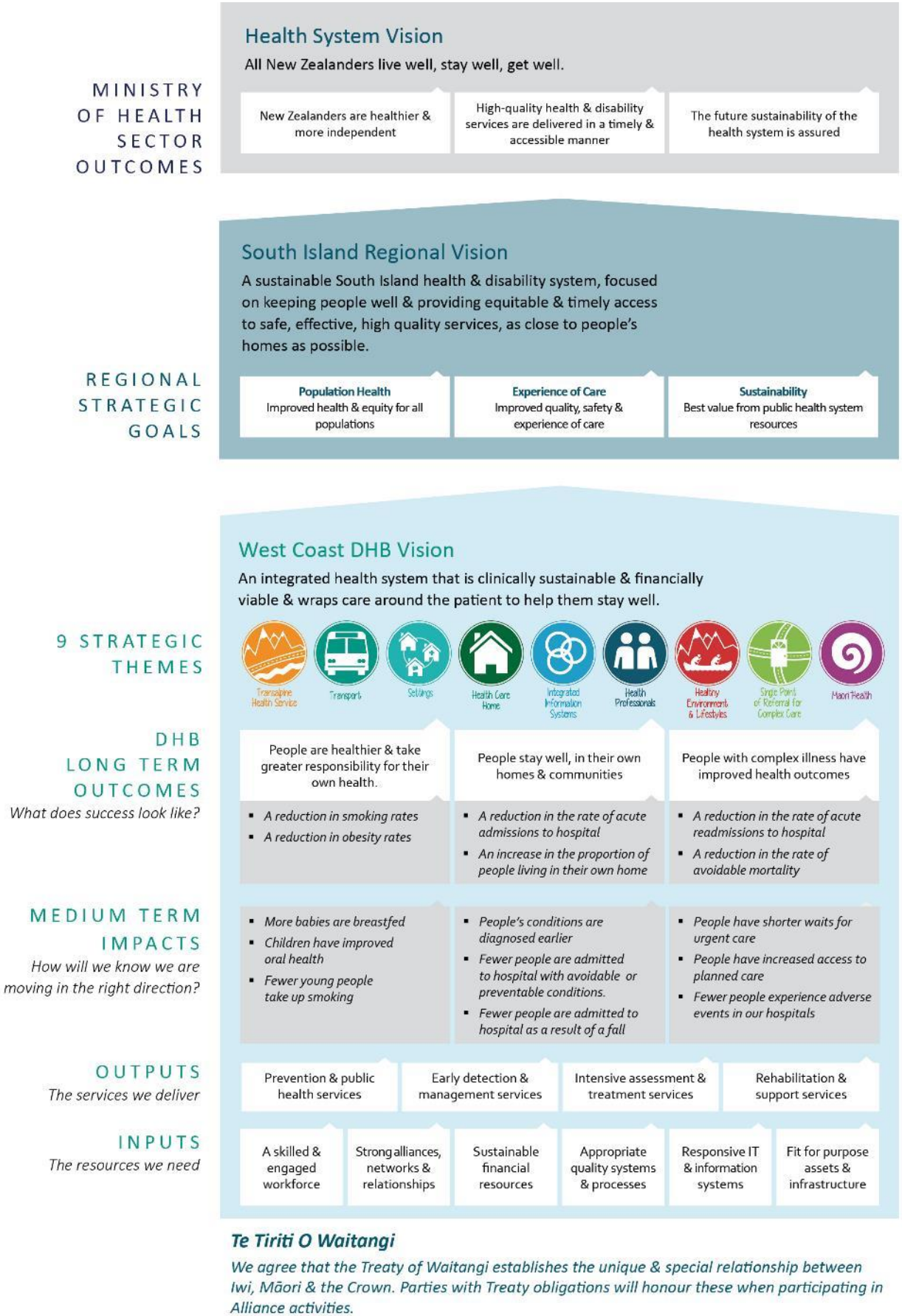
References

Unless specifically stated, all West Coast DHB documents referenced in this Plan are available on the West Coast DHB website, www.westcoastdhb.health.nz. All referenced Ministry of Health documents are available on the Ministry's website, www.health.govt.nz. The Crown Entities Act 2004 and the Public Finance Act 1989, referenced in this document, are available on the Treasury website, www.treasury.govt.nz.

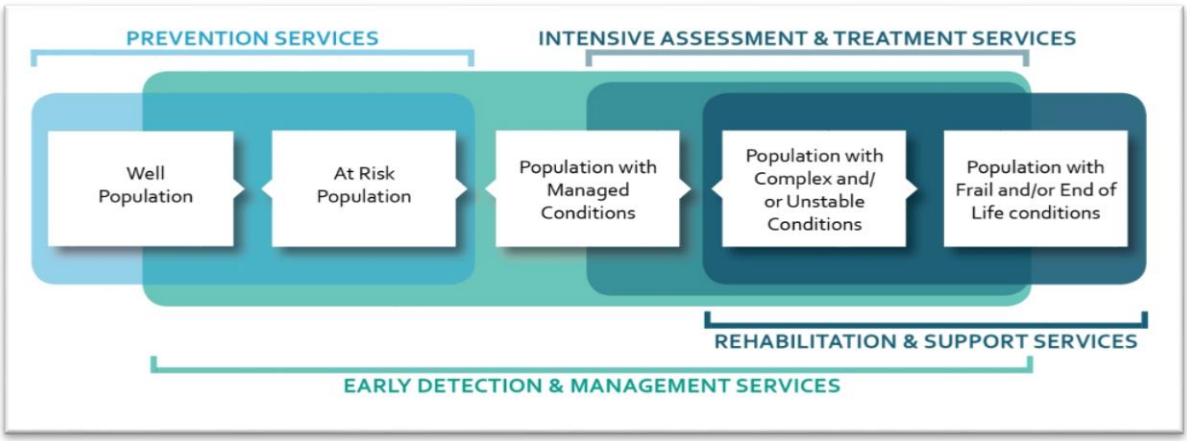
Appendix 1 Glossary of Terms

Alliance	The West Coast District Alliance	The Alliance is a collective alliance of healthcare leaders, professionals and providers from across the West Coast providing leadership to enable the transformation of the health system in collaboration with system partners and on behalf of the population.
CCCN	Complex Clinical Care Network	The Complex Clinical Care Network is a multidisciplinary team providing a single point of referral for patients from general practice, ambulance and inpatient services. Under the restorative delivery model, clients are assessed using comprehensive assessment tools and an individual goal-based care plan is developed with them.
	Crown Entity	Crown Entity is a generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister but are included in the financial statements of the Government.
ERMS	Electronic Referral Management System	ERMS is a system available from the GP desktop which enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including: wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in West Coast, Canterbury and South Canterbury and rolling out across the remainder of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring that needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in New Zealand.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs in New Zealand with a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them. PHOs provide these services either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Secondary Care	Specialist or complex care that is typically provided in a hospital setting.
	Primary Care	Professional health care provided in the community, usually from a general practice, covering a broad range of health and preventative services and often a person's first level of contact with the health system.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Highly specialised care often only provided in a smaller number of locations.

Appendix 2 Overarching Intervention Logic



Appendix 3 Statement of Performance Expectations



Evaluating our performance

As both the major funder and provider of health services on the West Coast, the decisions we make and the way in which we deliver services have a significant impact on people's health and wellbeing.

Having a limited pool of resources and faced with growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes. These longer term health outcomes are highlighted in our Statement of Intent which can be found on our website, www.westcoastdhb.health.nz.

Over the shorter term, we evaluate our performance on an annual basis by providing a forecast of the services we plan to deliver and the service standards we expect to meet. The results are then presented in our Annual Report.[3]

The following section presents the West Coast DHB's statement of performance expectations for 2017/18.

Because it would be overwhelming to measure every service we deliver, services have been grouped into four service classes. These reflect the full health and wellbeing continuum (illustrated above): from keeping people healthy and well, through identifying and treating illness, to supporting people to age well.

Against each service class we have identified a mix of service measures which we believe are important to our community and stakeholders, and provide a fair indication of how well the DHB is performing.

In presenting our performance picture, we have not simply presented the volume of services delivered. The number of people who receive a service is often less important than whether enough of the right people received the service, or whether the service was delivered at the right time. We have therefore presented a mix of measures that address four key aspects of performance: Access (A); Timeliness (T); Coverage (C); and Quality (Q).

SETTING STANDARDS

In setting performance standards, we consider the changing demography of our population, areas of increasing service demand, and the assumption that resources and funding growth will be limited.

Targets reflect the strategic objectives of the DHB: increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions and maintaining access to services, while reducing waiting times and delays in treatment.

Wherever possible, past years' results have been included in our forecast to give context in terms of our current performance and what we are trying to achieve, and to support evaluation of our performance over time.

It should be noted that while targeted interventions can reduce service demand in some areas, there will always be some service demand the DHB cannot influence such as: demand for maternity, dementia or palliative care services.

It not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region. Service level estimates have been provided to give context in terms of the use of resources across our health system.

[3] *The DHB's Annual Report is tabled in Parliament every year and is available on our website: www.westcoastdhb.health.nz.*

PERFORMANCE EXPECTATIONS

Like all DHBs, with a growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority on the West Coast.

All of our targets are universal and have been set with the aim of bringing performance for all population groups to the same level. Working with local stakeholders, the DHB has identified a number of particular areas for improving Māori health. These indicators are identified in this forecast (◆) and will be reported by ethnicity in our year-end Annual Report to highlight progress in reducing equity gaps for Māori.

Many of the performance standards presented in our forecast for 2017/18 are national expectations set for all DHBs, including the six national health targets. The DHB is committed to maintaining high standards of service delivery, however our small population size can make some of these expectations particularly challenging for the West Coast DHB to meet.

NOTES

Rather than repeating footnotes, the following symbols have been used in the performance tables:

Δ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.

† Performance data relates to the calendar year rather than the financial year.

◇ National Health Targets are set to be achieved by the final quarter of any given year. In line with national performance reporting, baselines refer to the final quarter (April-June) result.

◆ This measure has been identified as a key priority area for Māori, and progress by ethnicity will be reported in the Annual Report.

E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources.

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Prevention services are publically funded services that promote and protect the health of the whole population or targeted sub-groups. These services seek to address individual behaviours by targeting physical and social environments and norms that can influence and support people to make healthier choices and are, in this way, distinct from treatment services.

The four leading long-term conditions; cancer, cardiovascular disease, diabetes, and respiratory disease—make up 80% of the disease burden for our population. By supporting people to make healthier choices we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequalities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Health Promotion and Education Services				
These services inform people about risk and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A [4]	172	200	>100
Babies exclusive/fully breastfed at LMC discharge (4-6 weeks)	Q [5] ◆	75%	n.a	75%
Babies exclusive/fully breastfed at 3 months	Q [5] ◆	59%	54%	60%
People provided with Green Prescriptions for additional physical activity support	A [6]	478	543	>500
Green Prescription participants more active 6-8 months after referral	Q [6]	86%	58%	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	C [7] ◇◆	90%	79%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	C ◇◆	98%	97%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	C [8] ◇◆	100%	100%	90%
Mothers smokefree at two weeks postnatal	Q [9] ◆	81%	76%	95%

[4] This programme aims to improve breastfeeding rates and to create a supportive breastfeeding environment. Evidence shows that infants who are not breastfed have a higher risk of developing chronic illnesses during their lifetimes.
[5] These measures are part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The Framework covers health promotion, education, screening and support and checks are provided free to all children from birth to five years. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available at the time of printing.
[6] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a national patient survey competed by Research NZ on behalf of the Ministry of Health. In 2017 a decision was made nationally to shift to bi-annual surveys. The next survey will be in 2017/18.
[7] Professionals providing brief advice to smokers is shown to increase the chances of smokers making quit attempts. The ABC programme refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support.
[8] This measure is collected via the National Maternity Dataset which covers approximately 80% of pregnancies nationally. The measure is a developmental measure nationally and results are used to indicate trends rather than absolute performance. Targets are set nationally.
[9] This measure is part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available at the time of printing.

Population-Based Screening Services				
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Four-year-olds provided with a B4 School Check (B4SC)	C [10] ◆	92%	74%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q [11] ◇◆	new	new	95%
Young people (Year 9) in decile 1-3 schools receiving a HEEADSSS assessment	C [12] †	46%	68%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	C [13] ◆	74%	75%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	C [13] ◆	75%	76%	70%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Children fully immunised at eight months of age	C [14] ◇◆	85%	78%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q [15] ◇	98%	100%	95%
Young women (Year 8) completing the HPV vaccination programme	C [16] †◆	53%	43%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	C [17] †◆	64%	61%	75%

[10] The B4 School Check is the final core check under the Well Child/Tamariki Ora Framework, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.

[11] This measure is the new national Raising Healthy Kids health target, introduced in Q1 of 2016/17.

[12] A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.

[13] The cervical and breast screening measures refer to participation in national screening programmes and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment.

[14] The West Coast DHB has a large community within its population who decline immunisations or opt off the National Immunisation Register (NIR) and this makes delivering all of the national immunisation targets extremely challenging. The DHB strives to offer and encourage immunisation to all the eligible population and to immunise all those who opt-in to the programmes.

[15] 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children - but may have chosen to decline immunisations or opt off the NIR.

[16] The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme consists of two vaccinations and is free to young women and men under 26 years of age. The target for 2017/18 is the proportion of young women born in 2004 completing the programme.

[17] The denominator for this measure changed in 2016/17, from the number of people enrolled with a PHO, to the population according to the 2013 Census projections. Results from previous years will not be directly comparable.

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

The New Zealand health system is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age.

Our vision of an integrated system presents a unique opportunity. For most people, their general practice team is their first point of contact with health services and is a vital point of continuity in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services, we are better able to support people to stay well, identify issues earlier and reduce complications, acute illness or unnecessary hospital admissions. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or coordinated support.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Primary Care (General Practice) Services				
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible, responsive service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Proportion of the population enrolled with the Primary Health Organisation (PHO)	C ◆	91%	89%	95%
Number of integrated HealthPathways in place across the West Coast health system	Q [18]	614	654	650
Young people (0-19) accessing brief intervention counselling in primary care	A [19] Δ	126	219	>80
Adults (20+) accessing brief intervention counselling in primary care	A [19] Δ	413	558	>300
General practices offering the primary care patient experience survey	Q [20]	-	new	85%
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Q [21] ◆	5,144	4,757	<4,757

Long-Term Conditions Management (LTCM) Services				
These services are targeted at people with high health needs due to having a long-term or chronic condition. High levels of enrolment and engagement with the general practice LTCM programme are indicative of success.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-Term Conditions Management (LTCM) programme	A [22] ◆	3,666	3,793	>2,000
Population identified with diabetes having an annual LTCM review	C	96%	91%	90%
Population with diabetes having an HbA1c test at their LTCM review showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q	69%	63%	80%
Eligible population having a cardiovascular disease risk assessment in the last 5 years	C [23] ◆	91%	91%	90%

[18] The HealthPathways website helps ensure a consistent approach to care and equitable access to services, by providing general practice with online access to clinically designed pathways that guide patient care and provide advice on treatment.

[19] The Brief Intervention Counselling service aims to support people with mild to moderate mental health concerns to improve their health outcomes and quality of life. The service includes the provision of free counselling sessions and extended GP consultations.

[20] The Patient Experience Survey is a national online survey used to determine patients' experience in primary care and how well they perceive their care is managed. The survey has been piloted in a small number of DHB regions and is now being rolled-out across the country. The information will be used to improve the quality of service delivery and patient safety.

[21] Some hospital admissions are seen as avoidable through early intervention and treatment, and the rate of these admissions provides an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. The DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based off the latest national series provided by the Ministry of Health being to June 2016. Baselines have been reset to reflect the current series and results are as at June of each year.

[22] This measure refers to the primary care run LTCM programme where patients who are enrolled with the PHO are provided with an annual review, targeted care plan and packages of care, appropriate referrals and self-management advice to help change their lifestyle, improve their health and reduce the negative impacts of their condition. Cardiovascular disease and diabetes are two of the four leading long-term conditions on the Coast and are targeted by the programme, along with chronic obstructive pulmonary disease.

[23] The eligible population is set nationally: Māori, Pacific or Indian, males 35-74, females 45-74 all other males 45-74 and females 55-74.

Oral Health Services				
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Children (0-4) enrolled in DHB oral health services	C † ◆	100%	87%	95%
Children (0-12) enrolled in DHB oral health services, being examined according to planned recall	T † ◆	89%	78%	90%
Adolescents (13-17) accessing DHB-funded oral health services	C †	70%	75%	85%

Pharmacy and Referred Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment and is therefore indicative of a successful service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Number of subsidised pharmaceutical items dispensed in the community	A [24] Δ	443k	455k	E.<600K
Number of community-requested radiological tests delivered by Grey Hospital	A	5,289	5,504	E. >5,000
People receiving their urgent diagnostic colonoscopy within 2 weeks	T [25] ◇	83%	100%	90%
People receiving their Magnetic Resonance Imagining (MRI) scans within 6 weeks	T [25] ◇	88%	80%	90%
People receiving their Computed Tomography (CT) scan within 6 weeks	T [25] ◇	100%	100%	95%

[24] This measure covers pharmaceutical items dispensed by community pharmacies to people living in the community. Hospital dispensed items are excluded. This may still include some non-West Coast residents who had prescriptions filled while on the Coast.

[25] The diagnostic measures are national performance measures (PP29) and baselines are as at the final month of the year (June) in line with national results published by the Ministry of Health. Targets are aligned to national standards set for all DHBs. Small population numbers on the West Coast can distort performance against these measures. For example, the total number of people seen outside the target time for MRIs scans in 2015/16 was 12 people. These wait times refer to non-urgent scans.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events and others are planned, where access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives, and result in improved confidence in the health system.

As an owner of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These quality and patient safety measures are national markers, championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement. [26]	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Rate of staff compliance with good hand hygiene practice	Q [27] ◇	83%	81%	80%
Hip and knee replacement patients receiving routine antibiotics before surgery	Q [28] ◇	100%	95%	95%
Hip and knee replacement patients receiving antiseptic skin preparation in surgery	Q [28] ◇	100%	100%	100%
Response rate to the national inpatient patient experience survey	Q [29]	27%	35%	>30%
Response to the communications domain in the inpatient patient experience survey – 'rate your experience of communications out of 10'.	Q	8.8	9.3	>8.0

Maternity Services				
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Women registered with a Lead Maternity Carer (LMC) by 12 weeks of pregnancy	C [30] †◆	56%	54%	80%
New mothers attending DHB-funded parenting/pregnancy courses	C	69%	100%	>30%
Number of maternity deliveries in West Coast DHB facilities	A	256	246	E. 300
Baby friendly hospital accreditation achieved in DHB facilities	Q [31]	Yes	Yes	Yes

[26] These quality measures are national markers monitored by the NZ Health Quality & Safety Commission. Performance reporting is aligned to the HQSC reports (being the quarter to June of each year) and standards are set nationally.

[27] This measure is based on ward audits of medical and surgical wards conducted according to Hand Hygiene NZ standards. The 2015/16 result has been updated from that previously published in the Annual Report, to reflect the full year rather than the Q3 result available which was the most recent available at the time of printing.

[28] Cefazolin and cefuroxime are antibiotics recommended as routine for patients receiving surgical hip and knee replacements to prevent infection complications. Skin preparation with antiseptic is also recommended to prevent infection.

[29] There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. The inpatient patient experience survey runs quarterly in all district health board hospitals and covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs.

[30] This measure comes from the national Maternity Collection and is provided by calendar year – the 2015/16 result being 12 months to December 2015. Updated data was provided by the Ministry. In line with the adoption of this measure, the new national Better Public Services measures and baselines where provided to all DHBs. The aim is to engage mothers with the health system early in their pregnancy to promote good health and wellbeing of both mother and baby.

[31] The Baby Friendly Initiative is a worldwide programme led by the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises the standard.

Acute and Urgent Services				
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times seen as indicative of a responsive system.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
General practices providing telephone triage outside business hours	C	88%	88%	100%
Presentations at the Grey Base Hospital Emergency Department (ED)	A	11,376	11,742	E.<13,000
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T [32]	85%	80%	85%
Proportion of the population presenting at Grey Base Hospital ED (per 1,000 people)	Q	354	349	<342
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T ◇	50%	80%	90%
Acute inpatient average length of hospital stay (standardised)	Q [33]	2.35	2.40	2.30

Elective and Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service. The West Coast DHB is also striving to reduce travel time for patients.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
First Specialist Assessments provided	A [34]	6,663	6,591	E.>6,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [35]	5.5%	12.5%	>10%
Elective/arranged surgical discharges (surgeries provided)	A ◇	2,053	1,942	1,905
Elective inpatient average length of hospital stay (standardised)	Q [33]	1.63	1.55	1.40
Outpatient consultations provided	A	16,903	15,257	E. >13k
Proportion of outpatient appointments provided by telemedicine	Q [36]	1.9%	2.3%	>5%
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [37] Δ ◆	6.9%	5.9%	<6%

[32] This measure demonstrates whether people presenting in ED are seen in order of clinical need and reflects national triage standards: Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.

[33] This measure is a national performance measure (OS3). By shortening hospital length of stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective surgery. Importantly, addressing the factors that influence a patient's length of stay includes: reducing the rate of patient complications and infection, better use of the time clinical staff spend with patients and integration activity to support patients to return home sooner. Performance is balanced against readmission rates to ensure earlier discharge is appropriate and service quality remains high.

[34] This measure counts both medical and surgical assessments but only the first specialist assessments (where the specialist determines treatment) not the follow-up assessments after treatment has occurred. This measure is aligned to the national elective services reporting definitions which are DHB of domicile and track assessments provided for West Coast residents no matter where they are delivered.

[35] Non-contact assessments are those provided without the need for a hospital appointment. This aligns to the West Coast DHB's vision of reducing waiting times and unnecessary travel for patients and their families.

[36] This measure has been updated to reflect the proportion of total outpatient appointments delivered using telehealth or videoconferencing technology—reducing unnecessary travel for patients and their families.

[37] This measure is calculated as the proportion of all medical and surgical outpatient appointments where the patient was expected to attend on the day, but did not. When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes and it is costly in terms of wasted resources for the DHB.

Specialist Mental Health Services				
These are services for those most severely affected by mental illness and/or addictions, who require specialist intervention and treatment. Reducing waiting times, while meeting increasing demand for services, is indicative of a responsive service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Proportion of the population (0-19) accessing specialist mental health services	C [38] Δ	6.1%	5.5%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	C Δ	5.0%	5.2%	>3.8%
People referred for non-urgent mental health and alcohol and other drug services seen within 3 weeks	T [39]	77%	81%	80%
People referred for non-urgent mental health and alcohol and other drug services seen within 8 weeks	T	93%	94%	95%

Specialist Assessment, Treatment and Rehabilitation (AT&R) Services				
These are services provided to restore functional ability and enable people to live as independently as possible. An increased proportion of people discharged home, rather than into aged residential care (ARC), reflects a successful outcome.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Admissions into inpatient AT&R services	A [40]	124	91	E.<150
Inpatients (aged 75+) receiving a falls assessment	Q [41] ◇	88%	88%	90%
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q [42] Δ	83%	82%	80%

[38] These measures are national performance measures (PP6), and standards are set based on national expectations that at least 3% of the population will need access to specialist mental health services during their lifetime. West Coast rates are high and with the DHB vision being to better support people earlier and closer to home, it is expected that current rates will come down over time, as more people are appropriately seen and supported in primary and community settings. Results are provided nationally using data submitted by providers to the national PRIMHD database and produced a quarter in arrears.

[39] These are national DHB performance measures (PP8). Performance results are provided nationally and are three months in arrears.

[40] An increasing focus on restorative care being delivered in people's own homes (via the DHB's Complex Clinical Care Network) will result in fewer people needing to be admitted into our hospitals in order to access assessment, treatment and rehabilitation services.

[41] While there is no single solution to reducing falls, an essential first step is to assess an individual's risk of falling, and acting accordingly. In line with national expectations, the DHB aims to assess all the falls risk of all older inpatients and develop a falls plan to reduce risk.

[42] While living in ARC is appropriate for a small proportion of our population, for most people, remaining safe and well in their own homes provides a higher quality of life. A discharge from AT&R to home (rather than ARC) reflects the quality of services in terms of assisting that person to regain their functional independence and the DHB has identified this measure from this perspective. However, the DHB notes the impact of very small numbers on this measure and the understanding that as more rehabilitation services are made available in people's homes and communities, only the most complex patients will need to access AT&R in hospital. A higher proportion of these people are likely to need ongoing support and care. The measure excludes those who were ARC residents prior to AT&R admission.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes or regain functional ability after a health related event. These services are considered to provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enable people to maximise their independence. In preventing deterioration, acute illness or crisis, these services have a major impact on the sustainability of our health system by reducing acute demand, unnecessary ED presentations and the need for more complex interventions. These services also support patient flow by enabling people to go home from hospital earlier.

Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Rehabilitation Services				
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A [43]	-	new	yes
People (65+) supported by the community-based Falls Prevention Service	A [44]	-	16	>25
People referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	C [45]	41%	31%	80%

Home and Community-Based Support Services				
These are services designed to support people to continue living in their own homes and to maintain their independence. Largely demand driven, clinical assessment ensures access to services is appropriate and equitable.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Meals on Wheels provided	A [46] Δ	37,306	33,561	E. 35,000
Number of home and community district nursing visits provided to long-term clients	A Δ	4,171	4,246	E. >4,000
Number of people supported by long-term home and community support services	A Δ	792	786	E. >740
Proportion of people receiving long-term home and community support services who have had a clinical assessment of need using the interRAI assessment tool	Q [47] Δ	93%	93%	95%

[43] Flexible Integrated Rehabilitation Support Team (FIRST) is a new service that will work with clients in their own homes to enable them to remain as independent as possible. It will be part of the broader continuum of care for adults, ensuring a seamless transfer of services between the hospital and the community. The target has been set to ensure that the service is established and available for our population.
[44] Falls are one the leading causes of hospital admission for people aged over 65. The Falls Prevention Service provides care for people 'at-risk' of a fall, or following a fall, and supports people to stay safe and well in their own homes. The service was introduced in 2015/16.
[45] The New Zealand Clinical Guidelines for Stroke Management set out expectations around the provision of stroke services where services are provided by a coordinated interdisciplinary team with expertise in stroke and rehabilitation, across a pathway that consists of early and ongoing comprehensive assessment and treatment, proven to support improved outcomes for stroke patients.
[46] Meals on Wheels is a subsidised service available for people who can't prepare a hot meal without help because of a medical condition or a disability, who have no family or whānau help readily available, and need the meal to maintain good nutrition and independence. This may be a short intervention or a longer-term solution to support people to stay well in their own homes.
[47] The International Residential Assessment Instrument (interRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning by using evidence based practice guidelines to ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live.

Respite and Day Services				
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need addressed. Largely demand-driven, access to services is expected to increase over time, as more people are supported to remain safe and well in their own homes.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
People supported by aged care respite services	A Δ	56	61	E. 70
Number of mental health planned and crisis respite service bed-days accessed	A Δ	457	365	E. 500

Aged Residential Care Services				
With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Number of ARC rest home bed-days provided	A Δ	40,488	35,363	E. <50,000
Number of ARC hospital bed-days provided	A Δ	37,537	37,843	E. <40,000
Number of ARC dementia bed-days provided	A Δ	5,399	5,439	E. >4,000
Number of ARC psychogeriatric bed-days provided	A Δ	2,167	3,314	E. >2,000
People entering ARC having had a clinical assessment of need using interRAI	Q Δ	97%	90%	95%

Appendix 4 Statement of Financial Expectations

Meeting our financial challenges

Funding from the Government, via the Ministry of Health, is the main source of DHB funding. This is supplemented by revenue agreements with ACC, research grants, donations, training subsidies and patient co-payments.

While health continues to receive a large share of government funding, clear signals have been given to the health sector that we must rethink how we will meet our population's need within a more moderate growth platform.

Like the rest of the health sector, the West Coast DHB is experiencing growing financial pressure from increasing demand and treatment costs, rising wage expectations and heightened public expectations.

We are also facing a number of unique challenges due to our size and geographic isolation and are in the midst of a significant redevelopment, remediation and repair programme. Additional fiscal challenges for the West Coast include:

Over-reliance on locum staff: Difficulties recruiting staff to the West Coast means the DHB is still filling a number of permanent positions with locums. While the use of locums allows services to be maintained in the short term, this reduces continuity of care and is an expensive and unsustainable solution.

The costs of inter-district flow: Because of our small size, we rely heavily on larger DHBs to provide more complex specialist services for our population. While the service prices are set nationally, cost increases have historically exceeded funding increases.

The costs of seismic remediation: The level of facilities repair required to attain moderate compliance with current building codes will put significant financial pressure on the DHB. While some of the more immediate repairs have been completed, the remainder form part of the future facilities build.

There is no easy solution. Truly improving the health of our population is the only way to get ahead of the demand curve. This means redesigning services to provide people with the right care and support, at the right time and in the right place. Savings will be made, not in dollar terms, but in terms of costs avoided through more effective utilisation of the resources available and a reduced demand for services.

While these gains may be slow, they are the foundation from which we will build a more effective and sustainable health system. The DHB is committed to continuing its deliberate strategy in this regard.

West Coast's financial outlook

The West Coast DHB is predicting a $2.041m deficit result for the 2017/18 year.

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $148m to meet the needs of our population in 2017/18.

This represents a 3.9% increase on the previous year and whilst this equates to a $5m increase in funding, this includes revenue for pay equity settlements, which come with associated expenditure. This forecast is based on receiving the minimum percentage funding increase available to DHBs in 2017/18.

As part of its package the West Coast DHB also receives transitional funding which is vital to the fiscal sustainability of our health system.

MAJOR ASSUMPTIONS

Revenue and expenditure estimates in the DHB's Annual Plan for 2017/18 have been based on current government policy settings, services delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results. In preparing our financial forecasts, we have made the following assumptions:

- Population-based funding levels for 2017/18 are based on the funding advice received by the Ministry in June 2017
- Out-years funding is assumed at an average of 2.5% increase per annum.
- The West Coast DHB will continue to receive Crown Funding on an early payment basis
- Costs of compliance with a new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement
- The approved forecasted deficit will be funded via Crown deficit support (equity injections)
- Work will continue on the facilities redevelopment for Grey and Buller under the nationally appointed Hospital Redevelopment Partnership Group
- Funding for all aspects of pay equity settlements will be cost neutral as they will be fully funded.
- Work will continue on the facilities redevelopment for Grey and Buller under the nationally appointed Hospital Redevelopment Partnership Group
- The associated costs and capital expenditure for the Grey redevelopment have been included in the capital budget with an estimated completion date of June 2018. The net operating result, for 2017/18 and out-years, reflects the modelling as

per the detailed business case approved by cabinet in 2014 (adjusted for the 2014/15 transitional funding repayment as well as known changes such as capital charge changes).

Given the recent changes to debt and equity, the project will be 100% equity funded by the Crown. As a consequence, future operating costs associated with financing the development will increase significantly after the interim funding arrangements in relation to this change cease (anticipated after year two)

- Revaluations of land and building will continue and will impact on asset values. In addition to periodic revaluations, further impairment in relation to redevelopment and remediation of our facilities may be necessary
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluations. External provider increases will also be settled within available funding levels
- Treatment related costs will increase in line with known inflation factors, reasonable price impacts on providers and foreseen adjustments for the impact of growth within services
- National and regional initiative savings and benefits will be achieved as planned
- Transformation will not be delayed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved in line with the Board's strategy
- There will be no further disruptions associated with pandemics or natural disasters.

While the West Coast DHB is still working through options in relation to funding for the Buller redevelopment (as approved in April 2014), the associated development costs and any capital or lease expenditure have not been included in this Plan.

Closing the gap

Alongside the effective transformation of our health services we are focused on efficiency and productivity improvements that will take the wait and waste out of our system.

The DHB will carefully consider all opportunities and options to ensure the most effective use of our collective resources including:

- Integrating systems, services and process to remove variation, duplication and waste
- Improving production planning to ensure we use our resources in the most effective way
- Empowering clinical decision-making to reduce delays and improve the quality of care
- Prioritising services that deliver maximum health benefit and are sustainable long-term
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services
- Tightening cost growth including moderating treatment, back office, support and FTE costs.

Service changes proposed for the coming year are outlined in service configuration section (Part II) of this Plan.

Asset planning and investment

GREYMOUTH REDEVELOPMENT

In December 2012 the Minister of Health appointed the Hospital Redevelopment Partnership Group (HRPG) to govern the West Coast DHB's facility redevelopment. The West Coast HRPG provides project governance, which includes oversight of the project programme and budget.

In 2014 approval was given for a new Grey Base Hospital and IFHC redevelopment. Construction commenced on the combined project in May 2016 with completion scheduled for June 2018. The revised budget for this development is $77.8m.

The redevelopment includes a second tranche which will include the upgrade/replacement of the energy centre on the Grey Base Hospital site.

Planning for redevelopment of the mental health facility is also expected to start in 2017/18.

BULLER REDEVELOPMENT

In Buller, the DHB and clinical teams have worked together with an appointed design team to develop a full concept design for the IFHC development.

An Implementation Business Case has been progressed and options submitted to the HRPG as we move closer to bringing this facility to life. The notional cost for the development of the Buller IFHC is $12m.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $2.5m for the 2017/18 year. In addition to the normal capital requirements, the Grey redevelopment requires further investment in capital equipment than would normally be afforded, such as Information Technology infrastructure.

Strategic capital for 2017/18-2020/21 comprises of:

- Mental health redevelopment (notionally $5m)
- Phased upgrade of clinics outside Westport and Greymouth (notionally $0.5m per clinic)
- Secondary tranche Grey Base Hospital redevelopment (notionally $5m)
- Move to the South Island Patient Information Care System (notionally $2.5m)

- Investment in other strategic IT / integration systems, including regional IT systems, (notionally $1.8m-$2.2m p.a.).

We anticipate that the above capital intentions will be funded by internal cash except for the Buller IFHC, mental health facility refurbishment and secondary tranche Grey Base Hospital redevelopment projects, whereby 40-45% Crown capital support would likely be required.

Debt and equity

MINISTRY OF HEALTH

The Ministry of Health (formerly the Crown Health Financing Agency) agreed, with Cabinet approval, to convert all outstanding DHB debt funding into equity funding. The total term West Coast DHB debt outstanding on 15 February 2017 ($14.445m) was swapped for the equivalent amount of equity.

The higher equity balance will result in an increase in the amount of capital charge payable to the Crown. The gap between debt (interest) and equity (capital charge) financing is currently 3.75% (2.25% versus 6.00%).

EQUITY

The Grey Base Hospital and IFHC redevelopment is expected to be completed in the second quarter of 2018 at which time the asset will be transferred from the Ministry of Health to the DHB. Following the asset transfer, the Ministry will simultaneously increase the equity of the DHB estimated at $77.8 million.

The West Coast DHB will require deficit funding (equity) in order to offset the deficits signalled in outlying years. The DHB is also repaying $68K equity annually as part of an agreed FRS-3 funding repayment programme with the Ministry of Health.

Additional considerations

SUBSIDIARY COMPANY AND PARTNERSHIPS

With an annual budget of just over $6m, the South Island Alliance Programme Office is jointly funded by the five South Island DHBs to provide audit, project management and regional service development services. West Coast DHB's contribution for 2017/18 will be approximately $0.148m.

With an annual budget of over $54m, the New Zealand Health Partnership Limited is jointly funded by all 20 DHBs to enable DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB's contribution to the running of the Health Partnership for 2017/18 will be approximately $0.567m.

DISPOSAL OF LAND

The West Coast DHB currently has a stock of assets, consisting of parcels of land within Greymouth and Westport, a number of which have existing leasehold arrangements. The DHB will assess the future of these properties based on future models of care and facilities requirements.

Necessary approvals will be sought to dispose of any of the DHB's properties identified as surplus to requirements. Normal policy is that DHBs will not dispose of any estate or interest in any land without having first undertaken required consultation and obtained the consent of the responsible Minister. With approval, land would be valued and offered to parties with the statutory right to receive an offer under the Public Works Act and Ngāi Tahu Settlement Act (and any other relevant legislation), before being made available for public sale.

In the coming year this is likely to include the disposal of land to accommodate the development of an Integrated Family Health Centre in Buller.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

No compensation is sought by the Crown in line with the Public Finance Act Section 41(D).

ACQUISITION OF SHARES

Before the West Coast DHB subscribes, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister(s) and obtain their approval.

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies refer to the DHB's Statement of Intent 2017-2021, available on our website, www.westcoastdhb.health.nz.

Forecast Financial Statements

Statement of comprehensive income – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Income						
Ministry of Health revenue	128,912	131,477	136,234	141,223	145,839	148,319
Patient related revenue	2,884	2,666	7,017	6,747	6,747	6,747
Other operating income	9,166	8,220	4,581	4,225	4,276	4,332
Interest income	327	408	420	420	420	424
Total Income	141,289	142,771	148,252	152,615	157,282	159,822
Operating Expenses						
Personnel	57,142	57,416	59,796	59,790	60,865	63,065
Outsourced services (clinical and non clinical)	7,284	8,692	7,487	7,851	7,168	7,242
Treatment related costs	7,781	8,402	8,288	8,100	8,182	8,264
External service providers (include Inter-district outflow)	52,649	53,161	58,419	59,979	61,258	61,874
Depreciation & amortisation	4,572	3,373	3,400	5,326	5,217	5,490
Interest expenses	651	343	-	-	-	-
Other expenses	11,129	11,446	11,416	9,940	9,422	9,293
Total Operating Expenses	141,208	142,833	148,806	150,986	152,112	155,228
Operating surplus before capital charge	81	(61)	(553)	1,629	5,170	4,594
Capital charge expense	978	739	1,488	6,234	6,225	6,865
Surplus / (Deficit)	(897)	(800)	(2,041)	(4,605)	(1,055)	(2,271)
Other comprehensive income	-	-	-	-	-	-
Total Comprehensive Income	**(897)**	**(800)**	**(2,041)**	**(4,605)**	**(1,055)**	**(2,271)**

Statement of financial position – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
CROWN EQUITY						
General funds	72,563	86,062	167,267	171,803	172,789	174,992
Revaluation reserve	22,082	22,082	22,082	22,082	22,082	22,082
Retained earnings	(82,236)	(83,036)	(85,077)	(89,681)	(90,736)	(93,006)
TOTAL EQUITY	**12,409**	**25,108**	**104,272**	**104,204**	**104,136**	**104,068**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	11,850	10,811	12,687	11,563	10,262	12,234
Trade & other receivables	5,941	4,685	5,123	6,555	6,555	6,555
Inventories	986	1,060	1,007	1,007	1,007	1,007
Assets classified as held for sale						
Investments (3 to 12 months)						
Restricted assets	74	72	74	74	74	74
TOTAL CURRENT ASSETS	18,851	16,628	18,891	19,199	17,898	19,870
CURRENT LIABILITIES						
Trade & other payables	10,411	9,249	9,249	9,249	9,249	9,249
Capital charge payable	-	-	-	-	-	-
Employee benefits	6,975	7,201	7,201	7,201	7,201	7,201
Restricted funds	74	70	70	70	70	70
Borrowings	3,500	-	-	-	-	-
TOTAL CURRENT LIABILITIES	20,960	16,519	16,519	16,519	16,519	16,519
NET WORKING CAPITAL	(2,109)	108	2,372	2,680	1,379	3,351
NON CURRENT ASSETS						
Investments (greater than 12 months)	567	567	567	567	567	567
Property, plant, & equipment	26,858	26,500	103,730	103,851	105,574	104,012
Intangible assets	681	636	306	(191)	(681)	(1,159)
TOTAL NON CURRENT ASSETS	28,106	27,703	104,603	104,227	105,460	103,420
NON CURRENT LIABILITIES						
Employee benefits	2,643	2,703	2,703	2,703	2,703	2,703
Borrowings	10,945	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	13,588	2,703	2,703	2,703	2,703	2,703
NET ASSETS	**12,409**	**25,108**	**104,271**	**104,203**	**104,135**	**104,067**

Statement of movement in equity – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Total Equity at Beginning of the Period	12,496	12,409	25,108	104,272	104,204	104,136
Total Comprehensive Income	(897)	(800)	(2,042)	(4,605)	(1,055)	(2,271)
Other Movements						
Contribution back to Crown - FRS3	-	-	-	-	-	-
Contribution from Crown - Capital	-	13,499	77,800	-	-	-
Contribution from Crown - Operating Deficit Support	878	-	3,474	4,605	1,055	2,271
Other Movements	(68)	-	(68)	(68)	(68)	(68)
Total Equity at End of the Period	**12,409**	**25,108**	**104,272**	**104,204**	**104,136**	**104,068**

Statement of cashflow – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	127,546	132,551	136,683	141,223	145,839	148,319
Other receipts	18,530	12,995	11,115	11,042	10,391	10,511
Interest received	327	408	416	420	420	424
	146,403	145,954	148,214	152,685	156,650	159,254
Cash was applied to:						
Payments to employees	65,175	65,782	67,906	69,849	67,335	69,672
Payments to suppliers	72,237	75,515	77,848	77,312	78,927	79,498
Interest paid	651	343	-	-	-	-
Capital charge	978	739	1,488	6,234	6,225	6,865
GST - net	(767)	706	-	-	-	-
	138,274	143,085	147,242	153,395	152,487	156,035
Net Cashflow from Operating Activities	**8,129**	**2,869**	**972**	**(710)**	**4,163**	**3,219**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	12	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	-	12	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	2	-	-	-
Purchase of property, plant, & equipment	2,859	2,970	2,500	4,950	6,450	3,450
	2,859	2,970	2,502	4,950	6,450	3,450
Net Cashflow from Investing Activities	**(2,859)**	**(2,958)**	**(2,502)**	**(4,950)**	**(6,450)**	**(3,450)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	-	(946)	-	-	-	-
Equity Injection - Deficit Support	1,000	-	3,473	4,604	1,054	2,271
Loans Raised	-	-	-	-	-	-
	1,000	(946)	3,473	4,604	1,054	2,271
Cash applied to:						
Other	68	4	68	68	68	68
Equity Repayment	-	-	-	-	-	-
	68	4	68	68	68	68
Net Cashflow from Financing Activities	**932**	**(950)**	**3,405**	**4,536**	**986**	**2,203**
Overall Increase/(Decrease) in Cash Held	6,202	(1,039)	1,875	(1,124)	(1,301)	1,972
Add Opening Cash Balance	5,648	11,850	10,811	12,687	11,563	10,262
Closing Cash Balance	**11,850**	**10,811**	**12,687**	**11,563**	**10,262**	**12,234**

Summary of revenue and expenses by arm – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Funding Arm						
Revenue						
MoH Revenue	127,783	130,287	135,470	139,989	144,584	147,042
Patient Related Revenue	-	-	-	-	-	-
Other	1,487	1,661	1,705	1,740	1,775	1,810
Total Revenue	129,270	131,948	137,175	141,729	146,359	148,852
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	89,913	91,421	94,694	96,616	98,259	99,241
Mental Health	14,340	14,192	14,504	14,649	14,794	14,941
Disability Support	18,045	18,063	20,873	21,080	21,293	21,507
Public Health	637	599	560	565	571	577
Maori Health	625	811	818	826	835	844
Governance & Admin	826	826	827	827	827	827
Total Expenditure	124,386	125,913	132,276	134,563	136,579	137,937
Net Surplus/(Deficit)	**4,884**	**6,035**	**4,899**	**7,166**	**9,780**	**10,915**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**4,884**	**6,035**	**4,899**	**7,166**	**9,780**	**10,915**

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Governance & Funder Admin						
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	2,596	2,462	2,805	2,481	2,515	2,549
Total Revenue	2,596	2,462	2,805	2,481	2,515	2,549
Expenditure						
Personnel	1,401	994	1,189	1,040	1,055	1,070
Outsourced services	400	705	870	712	719	726
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	795	762	746	599	605	611
Total Expenditure	2,596	2,462	2,805	2,351	2,379	2,407
Net Surplus/(Deficit)	**-**	**0**	**0**	**130**	**136**	**142**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**0**	**0**	**130**	**136**	**142**

Summary of revenue and expenses by arm – year ending 30 June (continued)

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Provider Arm						
Revenue						
MoH Revenue	1,129	1,190	764	1,234	1,255	1,277
Patient Related Revenue	2,884	2,666	7,017	6,747	6,747	6,747
Other	78,843	78,893	76,327	76,662	77,415	78,182
Total Revenue	82,856	82,750	84,108	84,643	85,417	86,206
Expenditure						
Personnel	55,741	56,421	58,607	58,750	59,810	61,995
Outsourced services	6,884	7,987	6,617	7,139	6,449	6,516
Depreciation	4,572	3,373	3,400	5,326	5,217	5,490
Interest & Capital Charge	1,629	1,082	1,488	6,234	6,225	6,865
Other	19,811	20,722	20,936	19,095	18,687	18,668
Total Expenditure	88,637	89,584	91,048	96,544	96,388	99,534
Net Surplus/(Deficit)	**(5,781)**	**(6,835)**	**(6,940)**	**(11,901)**	**(10,971)**	**(13,328)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(5,781)**	**(6,835)**	**(6,940)**	**(11,901)**	**(10,971)**	**(13,328)**

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
In House Elimination						
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Total Revenue	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Total Expenditure	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-

Summary of revenue and expenses by arm – year ending 30 June (continued)

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
CONSOLIDATED						
Revenue						
MoH Revenue	128,912	131,477	136,234	141,223	145,839	148,319
Patient Related Revenue	2,884	2,666	7,017	6,747	6,747	6,747
Other	9,493	8,628	5,001	4,645	4,696	4,756
Total Revenue	141,289	142,771	148,252	152,615	157,282	159,822
Expenditure						
Personnel	57,142	57,416	59,796	59,790	60,865	63,065
Outsourced services	7,284	8,692	7,487	7,851	7,168	7,242
Depreciation	4,572	3,373	3,400	5,326	5,217	5,490
Interest & Capital Charge	1,629	1,082	1,488	6,234	6,225	6,865
Other	71,559	73,009	78,123	78,019	78,862	79,431
Total Expenditure	142,186	143,571	150,294	157,220	158,337	162,093
Net Surplus/(Deficit)	**(897)**	**(800)**	**(2,041)**	**(4,605)**	**(1,055)**	**(2,271)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(897)**	**(800)**	**(2,041)**	**(4,605)**	**(1,055)**	**(2,271)**

Appendix 5 System Level Improvement Plan

ANNUAL PLAN

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