Annual Plan

2018/19

Incorporating the 2018/19 Statement of Performance Expectations

Photo courtesy of Wendy Elwood

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 2001. 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 populations.

This document is our Annual Plan which has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and the expectations of the Minister of Health.

This document sets out our strategic goals and objectives, and describes what we aim to achieve in terms of improving the health of our population and ensuring a sustainable future for our health system. It also contains our Statement of Performance Expectations for the coming year.

The Statement of Performance Expectations is presented to Parliament and is used at the end of the year to compare the planned and actual performance of the DHB. Audited results are presented in our Annual Report.

In line with the New Zealand Health Strategy, the West Coast DHB has made a strong commitment to 'whole of system' service planning. We work in partnership with other service providers and engage with individuals, their families and our community to meet the needs of our population.

Clinically-led alliances have been established as vehicles for implementing system change. Our alliance framework means we share a joint vision for the health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our local West Coast Alliance with the West Coast PHO, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the Canterbury DHB.

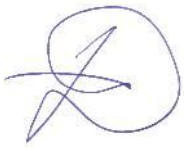
We also recognise our role in actively addressing disparities in health outcomes for Māori and are committed to making a difference. We work closely with Tatau Pounamu and Poutini Waiora, both directly and through our Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of the Treaty of Waitangi.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity, and is in line with Government expectations for 2018/19.

Jenny Black
CHAIR | WEST COAST DHB

Chris Mackenzie
DEPUTY CHAIR | WEST COAST DHB

David Meates
CHIEF EXECUTIVE | WEST COAST DHB



Honourable David Clark
MINISTER OF HEALTH

November 2018

Letter of Approval

Hon Dr David Clark

MP for Dunedin North
Minister of Health

Associate Minister of Finance

11 FEB 2019

Ms Jenny Black
Chair
West Coast District Health Board
jenny.black@nmdhb.govt.nz

Dear Jenny

West Coast District Health Board 2018/19 Annual Plan

This letter is to advise you I have approved and signed West Coast District Health Board's (DHB's) 2018/19 Annual Plan for one year.

I have been clear that my expectation for the total DHB sector financial position was that it was an improvement on 2017/18. I am concerned that this expectation is unlikely to be met. I have previously emphasised to you that it is important DHBs are doing all they can locally to manage in a financially prudent way.

I understand your DHB has planned deficits for 2018/19 and the out years. I encourage your Board to consider appropriate activities to ensure that you reduce the projected deficit in 2018/19 and the coming years. I note the challenges your DHB faces in the next few years from costs related to capital developments. Managing these will require a concerted effort and I trust that you will continue to work with the Ministry of Health to evaluate and improve your financial performance.

Your Production Plan is still to be confirmed, and you will work with the Ministry to resolve this.

I am aware you are planning a number of service reviews in the 2018/19 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. 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.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders. I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2018/19 Annual Plan. I look forward to seeing your achievements.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr David Clark
Minister of Health

cc: Mr David Meates, Chief Executive, West Coast District Health Board, david.meates@cdhb.govt.nz

Table of Contents

Statement of Joint Responsibility i
Letter of Approval ii
Foreword from the Chair and Chief Executive iv

Overview 1

Who are we and what do we do? 1
Introducing the West Coast DHB 2
Our Operating Challenges 4
Our Strategic Direction 4
Our Immediate Focus 6

The Year Ahead 7

What can you expect from us? 7
Delivering on National Priorities and Targets 8
Financial Summary 21

Medium-Term Outlook 22

How are we organising our business to achieve our vision? 22
Managing Our Business 23
Investing in Our Future 24

Improving Health Outcomes 30

Are we making a difference? 30
Monitoring Our Performance 31

Appendices 36

Further information for the reader 36
Appendix 1 Glossary of Terms 38
Appendix 2 Minister's Letter of Expectations 2018/19 39
Appendix 3: Significant Actions by Life Course 2018/19 43
Appendix 4 Overarching Intervention Logic Diagram 44
Appendix 5 Statement of Performance Expectations 45
Appendix 6 Statement of Financial Expectations 56
Appendix 7 System Level Improvement Plan 66

Foreword from the Chair and Chief Executive

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

The West Coast district has some unique characteristics compared to the rest of New Zealand, in terms of our population's health status, socio-demographics, our small population size, and the large geographical area we cover. This means we need to work differently to overcome these challenges and deliver on our vison.

People also often forget that we do much more than just run hospitals. We will be responsible for the health and wellbeing of 32,410 people in the coming year. It's our job to improve health outcomes for our population through the delivery of high quality population health and healthcare services, and a commitment to innovation, education and workforce development.

Our resources are limited and this means we have to be focused and smart about how we achieve and sustain success. As an integrated health system, we understand that there are many organisations that have an interest in the health and wellbeing of our population. It makes sense to work collaboratively to gain the maximum benefit for our population.

We also understand that our health system is dynamic. As new demands, technology and expectations emerge, we must adapt to meet those challenges. We must constantly improve the way in which we operate, to deliver a more integrated and cohesive system that works in the best interests of our population.

Moving forward

Already important steps have been taken towards achieving a more sustainable future for health services on the West Coast. We are improving clinical information systems, adopting telehealth technology to reduce the time people spend traveling and formalising our transalpine partnership with the Canterbury DHB to ensure access to specialist services.

We are leading the way in the development of a truly rural workforce, and overseeing the evolution of our rural generalist model. We continue to develop and grow our rural nursing workforce, including nurse practitioners and prescribing nurses, and are beginning to see the impact of our Allied Health workforce strategy. Importantly, these workforce strategies are interlinked to support the creation of one truly rural workforce that will provide greater continuity and access to care.

Engagement with primary and community services is positive, and we are introducing more streamlined and efficient service models. We are also taking a more restorative and patient-centred approach to moderate the growth in demand for hospital and aged residential services.

These are achievements we can be proud of, but they are only the start. Health inequalities persist between population groups. A strong focus on reducing these inequalities will be at the forefront of our efforts over the next few years.

We are ambitious. We want to be a system that is recognised as a leader in the delivery of rural health by the people who live and work here. We will continue to work with our partner organisations, through the West Coast Alliance, to support the delivery of our vision and to help us meet the expectations of Government. Together we have developed a System Level Measures Improvement Plan that sits alongside this document, and highlights where we will focus collective effort and investment in 2018/19.

We want services to be more accessible and available closer to people's homes. Over the last few years we have charted a course for transformation and system integration to better support the needs of our population. In the coming year we will continue that journey by implementing the recommendations of our local mental health review, embedding our new primary/community service model and strengthening our three locality-bases.

We want to make sure our community, our people and our patients have a say in how we plan and deliver health care. We will be encouraging our community, stakeholders and workforce to participate in the national health sector reviews, to ensure that a strong rural voice is heard and considered.

To support the delivery of our vision, our People Strategy will build our workforce capacity to do more in our communities and delivery care closer to home. We will look to increase the number of Māori working in our health system so that our workforce better reflects the population we serve. By creating an environment where people can thrive, our People Strategy will shape our culture and accelerate our transformation.

The year ahead

2018/19 will be a big year of change and forward momentum. Service improvements will cover the range of preventative, planned, urgent, and restorative care, delivered across our community and in our hospitals.

This work will set the DHB and the West Coast Health System on a more viable pathway for the future. As a more integrated and cohesive system, we will be better placed to respond and adapt to the challenges we face.

Jenny Black
CHAIR

David Meates
CHIEF EXECUTIVE

Overview

Who are we and what do we do?

Introducing the West Coast DHB

1.1 Who are we?

The West Coast District Health Board (DHB) is one of twenty DHBs in New Zealand, 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 32,410 people, 0.7% of the total New Zealand population.

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

We own and manage four major health facilities in Westport, Reefton, Greymouth, and Hokitika; and own four of the seven general practices on the West Coast.

We are a major employer, with over 1,000 people employed across our hospital, community and primary care services. We also hold and monitor more than 80 service contracts with other organisations and individuals, who provide health and disability services to our population. This includes the West Coast PHO.

In 2016/17 we provided over 125,000 general practice consultations, 22,000 specialist appointments and 1,979 elective surgeries. We delivered over 5,800 radiology tests and more than 7,000 childhood immunisations. We also delivered 250 babies and responded to over 11,000 presentations in our Grey Base Hospital Emergency Department.

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.

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, with the expectation of operating within allocated funding.

In 2018/19, we will receive approximately $153 million dollars to meet the needs of our population. In accordance with legislation and consistent with Government objectives, we use that funding to:

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

Fund the health services required to meet the needs of our population and, through our collaborative partnerships and ongoing performance monitoring, ensure these services are safe, equitable, integrated 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 investment in health protection, promotion and education services 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, joint executive directors and clinical leads, and 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.

1.4 Our population profile

The West Coast has a relatively static population with the DHB being responsible for 32,410 people in 2018/19, almost unchanged over the last 10 years.

However, the West Coast population has an older age structure and a higher proportion of people aged over 65 (19%), compared with the national average (16%).

This is one of the biggest challenges for our health system. 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, care and long-term support, putting increasing pressure on our health system resources.

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 3,900 Māori living on the West Coast (12% of our population) and by 2026 that proportion will increase to 13%.

Our Māori population has a considerably different age structure, with 41% of our Māori population being under 20 years of age, compared to 24% of the total West Coast population.

1.5 Our population's health

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

Like the rest of New Zealand, more people on the West Coast are living with long-term conditions such as cancer, heart disease, respiratory disease and depression, leading to an increasing demand for health services.

While gains have been made, West Coast Māori continue to have poorer overall health status than other ethnicities. We are carefully considering the needs of our growing Māori population in our future planning.

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.

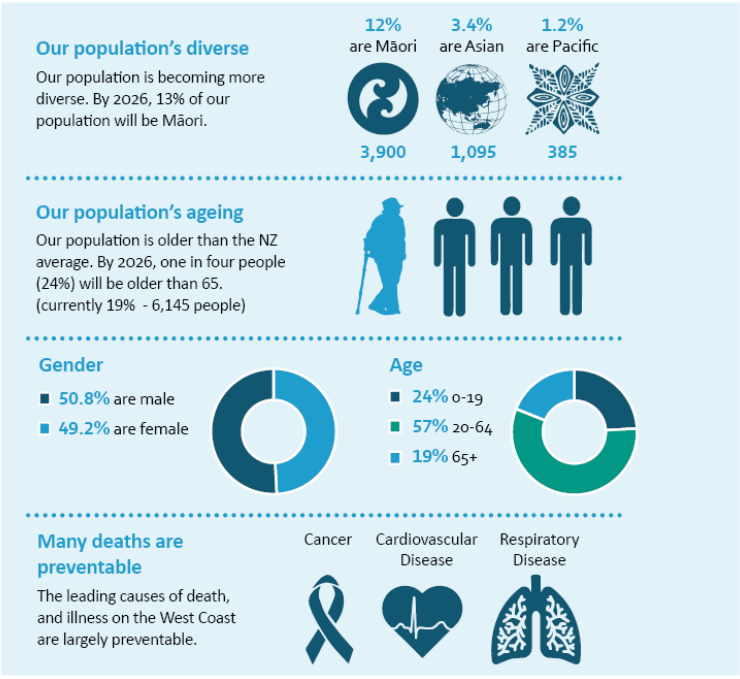
All four major risk factors also have strong socio-economic gradients, so a healthier population focus would contribute greatly to reducing health inequalities between population groups.

The most recent combined results from the 2014-2017 New Zealand Health Survey found that:

- More than a third (35%) of our total adult population are classified as obese. Rates for our Māori population are higher (56%).
- 10% of our total adult population identified as inactive (little or no physical activity). Rates for Māori were slightly higher (13%).
- 26% of our population are current smokers (higher than the national average). Smoking rates amongst Māori are higher (44%).
- 16% of our adult population are likely to drink in a hazardous manner. While this rate is lower than the national average, it still amounts to more than one in every eight adults on the Coast. [1]

Taking a population health approach is an essential component of our strategy to address determinants of health and achieve better health equity and wellbeing for our population. This also presents an opportunity for our health system to work collaboratively to improve health outcomes.

The DHB's Healthy West Coast Alliance Workstream is taking the lead in driving the development of strategies and initiatives to make healthier choices easier. They are supported by Canterbury DHB's public health unit who deliver public health services on our behalf.



Based on the Stats NZ Dec 2017 Population Projections

[1] *Results from the NZ Health Survey should be interpreted with caution, particularly for Māori. Small population numbers can impact significantly on results. Refer to www.health.govt.nz.*

Our Operating Challenges

Like health systems world-wide, the shared challenges DHBs are facing are well understood. Populations are ageing, service 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.

While the West Coast DHB has begun to achieve positive momentum, we still have a way to go in realising our vision. Meeting the health needs of our population is complex and progress is further hampered by our unique operational challenges.

1.6 Geographical pressures

Our biggest challenge is our rurality.

Geographically we are the third largest DHB in the country, covering a total land area of 23,283 square kilometres. However, we are also the smallest by population and the most sparsely populated. With only 0.7% of the country's population living on the West Coast, we have a population density of just 1.4 people per square kilometre.

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

1.7 Workforce pressures

Our workforce is small, but we still need to provide a broad range of complex and specialised services. In our rurally isolated environment, we face significant difficulties in recruiting and retaining people and attracting those with the broadest range of skills.

This is further complicated by national workforce shortages, meaning we are competing with other DHBs across the country for a limited pool of people. We are already thinking differently about the future with greater use of technology supporting remote health services, increased development of generalist roles and the implementation of the Calderdale Framework.

To meet the growing needs of our population, and deliver on our vision, we need to be able to attract and develop more of the right people with a passion for rural health. We also need to motivate people to work to the full extent of their scope of practice.

1.8 Fiscal pressures

Meeting growing service demand, increasing treatment and infrastructure costs, and national expectations around wage and salary increases is an ongoing challenge. West Coast DHB is also balancing community expectations regarding access to new and complex services in a small rural environment.

Each DHB is funded to cover the cost of services provided to their population. Because of our small size, we rely on the Canterbury DHB to provide the more complex specialist services for our population and must pay for those services. We have agreed a fixed funding agreement with Canterbury for these services.

1.9 Facilities pressures

Completion of the Grey Base Hospital, and an agreed solution for Buller, remain critical to our future sustainability. However, ongoing delays mean Grey Base will not be operational until 2019 and it will be even later before a new Westport facility is complete.

Delays in realising anticipated efficiencies from the new facilities are putting increasing pressure on budgets. The new facilities also require greater capital investment in equipment than would normally be afforded in any given year.

At the same time, a number of our other health facilities are outdated, inefficient and expensive to maintain. Many are seismically compromised or 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 across the West Coast.

Our Strategic Direction

There is a clear understanding that the pressures facing the West Coast health system mean that health services cannot continue to be provided in the same way. We are committed to a new direction.

1.10 Locally driven

Six years ago, we sought input from staff, partner organisations and our community, on the development of a vision for the future of our health system.

We realised that our ageing population and the increasing prevalence of long-term conditions were placing significant pressure on our ability to meet the needs of our population, and that future funding and workforce constraints would further limit our capacity.

If we were to improve health outcomes within current resources, we needed to integrate and connect services, not only across our health system, but across all public services. We needed to work together to meet our collective challenges and do the right thing for our population. Together, we developed a vision that recognised our future was not about our hospitals.

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 our vision is our community; our whānau and 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.

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 across services and across the wider West Coast health system.

Clinically and financially viable - This means our health system will achieve levels of efficiency 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.

1.11 Nationally consistent

The long-term vision for New Zealand's health sector is articulated through the NZ Health Strategy. The central theme is all New Zealand's *'live well, stay well and get well'*. The Strategy identifies five key themes to give the sector a focus for change:

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

Our direction is also guided by a range of national strategies, including: the Māori Health Strategy (He Korowai Oranga); the Pacific Health Strategy ('Ala Mo'ui); the Healthy Ageing Strategy; the Disability Strategy; and the United Nations convention on the Rights of People with Disabilities.

DHBs are also expected to commit to government priorities. The Minister of Health's Letter of Expectations signals annual priorities and expectations for DHBs. The 2018/19 expectations signal a strong focus on improving the delivery of public health services and improving equity in health outcomes.

There is increased emphasis on:

- Population health services
- Primary health services
- Mental health services
- Utilisation of the wider health workforce
- Improving the health and wellbeing of infants, children and youth
- A reduction in the burden of long-term conditions
- Accountability for improved performance
- A stronger response to climate change.

This document outlines how we will meet those expectations in the coming year. The Minister's Letter of Expectations for 2018/19 is attached as Appendix 2.

A summary of significant initiatives the DHB will deliver to meet the national expectations, by life course groupings, is also attached as Appendix 3.

1.12 Regionally responsive

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%) 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 Regional Alliance to address our shared challenges and develop more responsive and effective health services.

Our jointly developed South Island Regional Health Services Plan outlines our agreed regional activity for 2018/19. The West Coast has made a strong regional commitment and is engaged in a number of priority areas including: cancer, child health, mental health, cardiac, electives, major trauma and stroke services.

Regionally the South Island DHBs have also invested in HealthOne. This single shared electronic health record has been rolled out across the South Island, avoiding duplication of costs and simplifying access to patient information, no matter where the patient is treated.

The HealthOne system is accessed over 3,000 times a day by health professionals across the South Island and won the award for Best Technology Solution for the Public Health Sector at the NZ Hi-Tech Awards in 2017.

The Regional Health Services Plan can be found on the Alliance website: www.sialliance.health.nz.

Our Immediate Focus

1.13 Our performance story so far

In working to deliver on our vision, we have been purposeful and deliberate in planning how we would make the best use of the resources we have available.

We have started to do things differently. We made a commitment to working more collaboratively with our partner organisations through the West Coast Alliance and have formalised our transalpine partnership with the Canterbury DHB.

Engagement with our health services is positive. At the end of 2016/17, 90% of our population were enrolled with primary care, 80% of all eight-month-old children were fully immunised and 3,860 people were enrolled in our Long-term Conditions Management Programme.

We delivered more electives than the previous year, exceeding our national target by 73 surgeries. The average length of stay in our hospitals remained lower than the national average, and more people aged over 65 were living in their own homes for longer.

Connecting information systems and sharing data is a key enabler of our vision. Updated information systems are giving us access to real-time information, at the point of care, improving the quality of the care we provide and reducing the time people waste waiting.

Telemedicine has been embraced by many of our services and in 2016/17, 512 West Coast people had their specialist appointments using telehealth technology, saving patients more than 18,000km of travel and many hours away from work and home.

1.14 Critical success factors

Because our resources are increasingly limited, we will need to ensure our investment and effort is directed into activity and services that will provide the greatest return in terms of health gain.

In continuing to transform, the West Coast aims to become a leader in the provision of rural health services and identify opportunities to add value and reduce duplication and waste across our system.

Our Board has identified nine Strategic Themes that highlight the factors seen as critical to both our immediate and long-term success. These align closely with the themes of the New Zealand Health Strategy.

Operating intentions to support progress in these areas are highlighted throughout this Plan.

1.15 Focus for 2018/19

In agreeing local priorities with the Ministry of Health for 2018/19, five focus areas were signalled.

These areas align with the national direction and the Strategic Themes identified by our Board. Action in support of these local priorities is also highlighted through this Plan.

- *Integrated sustainable services:* The DHB will progress the implementation of the new models of care for primary/community and mental health services, including the development of locality based integrated family health services and continued investment in telehealth technology.
- *Workforce models:* The DHB will progress with the development of a rural workforce model that supports the transformation of services and creates an environment where our people thrive.
- *Accessible primary care:* The DHB will look to complete the redesign of its model of care for planned and unplanned care. This will include a new approach to the provision of after-hours, urgent and emergency level care.
- *Financial sustainability:* The DHB will provide early indications of the need for equity support.
- *The capital build programme:* The DHB and Ministry will work together to support the completion of the Grey Base and Buller developments and on joint messaging to keep our community informed of direction and progress.

The Ministry and the DHB will undertake joint work to look at consistent rules for counting telehealth events and capturing the work delivered in this space.

The Ministry will also work with the DHB over the coming year to ensure traditional contracting, reporting and funding mechanisms do not create artificial barriers or restrict development of the new models of care.

The Year Ahead

What can you expect from us?

Delivering on National Priorities and Targets

The following section highlights the activity the DHB will undertake to deliver on national priorities and expectations in 2018/19. This activity, and the associated actions and targets, are reflected in the work plans of our West Coast Alliance, the project and operational work plans of our hospital and specialist services and corporate services teams, our System Level Measures Improvement Plan, our Public Health Action Plan and the transalpine and regional work plans we share with our partner South Island DHBs.

Together with our Public Health Action Plan (available on the DHB's website), West Coast's System Level Measures Improvement Plan provides a broader picture of the activity planned across our health system for the coming year and is an appendix to this Annual Plan.

Over the last several years, we have made some positive inroads into improving health outcomes for Māori living on the West Coast, with strong engagement in childhood immunisation and B4 school programmes and reductions in avoidable hospital admissions. We are determined to make further progress. Throughout this section actions aimed at improving Māori health outcomes are indicated by the Equity Outcome Action code (EOA).

2.1 Government Planning Priority - Mental Health

Population Mental Health Services			NZHS Link - One Team
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Outline actions to improve population mental health and addictions, especially for priority population, in the following focus areas: *Increasing uptake of treatment and support earlier in the course of mental illness and addiction.* *Further integrating mental health, addiction and physical health care.* *Coordinating mental health care with wider social services.* *Outline actions to ensure staff and community are able to participate in the Government Inquiry into Mental Health and Addiction.*	Establish a Mental Health Workstream under the West Coast Alliance to oversee the implementation of the new model of care.[2]	Q1: Alliance Mental Health Workstream established.	PP43: Delivery of Annual Plan actions. >150 young people (0-19) accessing brief intervention counselling in primary care. >450 Adults (20+) accessing brief intervention counselling in primary care. 80% of people (0-64) referred to specialist mental health and addiction services are seen within 3 weeks 95% of people (0-64) referred to specialist mental health and addiction services are seen within 8 weeks.
	Support general practice to expand enrolment in the primary care Long-term Conditions Management Programme to include people with mental health issues. (EOA)	Q4: 50% of practices enrolling people with mental health issues in the LTCM programme.	
	Continue to collaborate with social services, (MSD and Education) through Te Ara Mahi, to support people with mental health issues into employment or further education.	Q4: Increased number of clients supported into employment or education.	
	Realign resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based community health model. Implement the new Crisis Response model to provide improved access to crisis services across the age and severity continuum.	Q2: Afterhours crisis response phone service established. Q4: Mental health services integrated into locality bases. Q4: Additional resource in place in the inpatient unit to respond to crises afterhours.	
	Review the current provision of Māori Mental Health Services and develop a complementary model that provides cultural support for Māori with mental health needs across both the age and severity continuum. (EOA)	Q1: Stakeholder Hui held. Q2: Recommendations proposed. Q3: Revised Model Adopted.	
	Continue to progress implementation of the national Supporting Parents Healthy Children guidelines and confirm priority actions.	Q2: Implementation Plan agreed. Q3: Priority actions identified. Q4: Progress review completed.	
	Coordinate the Inquiry Panel visit and provide opportunities for agencies to be represented and heard by the Panel. Publish any further submission and feedback dates to ensure people are aware of the opportunity to participate.	Q1: Agencies given opportunity to be represented. Q1: DHB actively participates in Mental Health Inquiry and provides feedback to the Panel.	

[2] *This work is part of the Mental Health Future Services Project, following on from the Mental Health and Addictions Services Review undertaken in 2014. Consultation on the new model of care for Mental Health and Addiction services was undertaken in 2017/18.*

Mental Health and Addictions Improvement Activities		NZHS Link - One Team	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Outline your commitment to the HQSC mental health and addictions improvement activities with a focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020) and improving transitions.	Provide Safe Practice Effective Communication (SPEC) training for all inpatient staff. Integrate weekly meetings with staff and patients to enable patient participation in decision-making to enhance the environment and safe practices of the unit. Invest in environmental and therapeutic practice changes to support staff to provide a safe therapeutic environment for all inpatients. Include cultural expertise in environmental improvements to build cultural awareness amongst staff and improve access to cultural support for consumers and whānau. (EOA)	Q1: 95% of frontline staff receive SPEC de-escalation training Q2: Integrated meetings being held weekly. Q3: Additional dedicated Occupational Therapy FTE in place to support sensory modulation and meaningful activity for inpatients. Q4: Safe ward concept embedded into everyday practice. Q4: Equity of consumer experiencing seclusion being monitored.	PP7: Delivery of Annual Plan actions. Reduction in seclusion hours and seclusion events. 95% of clients discharged will have a transition or wellness plan in place. 95% of audited files meet accepted good practice. 80% of inpatients are seen in community services within 7 days of discharge.
	Commence discharge planning on entry to Mental Health Services and embed the primary nursing model and process for engaging community teams at the earliest opportunity. Build awareness and patient participation in relapse prevention/wellness planning. Engage staff and patients in the Marama real-time feedback survey to identify opportunities to improve service delivery, particularly for Māori consumers. (EOA)	Q1: Transition from inpatient to community services reviewed. Q2: Updated pathway in place. Q3: Patient participation in discharge processes evident. Q4: 75% of discharged patients complete the Marama survey. Q4: 75% of discharged Māori patients complete the Marama survey.	

Addictions Services		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify actions to improve performance against the PP8 addiction related waiting times targets.	Realign resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based community health model. Implement the new Crisis Response model to provide improved access to crisis services across the age and severity continuum. Investigate options to increase community-based respite, withdrawal management and recovery support, particularly for Māori as a high need population. (EOA)	Q1: Additional mental health respite capacity available in Buller. Q2: Additional community-based AOD support options identified. Q4: Increased AOD capacity available.	PP8: Delivery of Annual Plan actions. 80% of people (0-64) referred to specialist addiction services are seen within 3 weeks 95% of people (0-64) referred to specialist addiction services are seen within 8 weeks.

2.2 Government Planning Priority - Primary Health Care

Access			NZHS Link – Closer to Home
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to the implementation of new national primary care initiatives to reduce the cost of access to primary care services - including extending zero fees for children from under 13 to under 14 and reducing fees for community service care holders. *Describe actions that will ensure the delivery of the national initiatives.*	Work with the West Coast PHO to implement the national zero fees policy, extending zero fees for children under 13 to zero fees for children under 14. (EOA) Work with local Pharmacies to ensure they have updated systems to align with the national policy. (EOA) Work with the West Coast PHO to implement the national lower fees for Community Services Card holder policy once details are released nationally. (EOA) Update the DHB and PHO websites in line with the implementation of zero fees policy, showing details of practices fee arrangements.	Q2: Proposed new zero fees model communicated and agreed with West Coast general practices. Q2/Q3: Implementation of zero fees model for children <14 (both in and out of hours). Q4: PHO/DHB websites updated to reflect changes in fees.	95% of the total population are enrolled with primary care. 95% of children <14 have zero fee access to general practice services and prescriptions.

Integration		NZHS Link – Closer to Home	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify actions that demonstrate the DHB continues to work with the district alliances on integration including: *Strengthening the alliance.* *Broadening membership and focus of the alliance.* *Developing services, based on robust analytics.*	Continue to invest in the West Coast Alliance as a mechanism for leading service and system improvements.[3] Work through the Alliance Leadership Team to fill the vacant Chair role. Engage system partners in the Alliance's new Mental Health Workstream to support the implementation of the locality-based mental health service model. Ensure a strong Māori voice and focus on Alliance workstreams. (EOA) Monitor system performance against the national System Level Measures to identify areas for improvement and focus.	Q1: New Alliance Chair appointed. Q2: Work plan for the new Mental Health Workstream endorsed by the Alliance Leadership Team. Q2: Equity reporting dashboard developed. Q4: Delivery of the actions agreed in the 2018/19 System Level Measures (SLM) Improvement Plan.	PP22: Delivery of Annual Plan actions. Improved performance in line with the 2018/19 SLM Improvement Plan.
Reference the jointly developed and agreed SLM Improvement Plan.	Work through the West Coast Alliance to refresh and refine the Improvement Plan, outlining collective activity to improve performance in 2018/19.[4]	Q1: Implementation of agreed Improvement Plan underway. Q1: Quarterly review of progress against the Improvement Plan.	Improved performance in line with the 2018/19 Improvement Plan.
Identify actions to assist in the utilisation of other workforces in primary health care settings.	Continue to develop a rural generalist workforce model to support the transformation of service models on the Coast. Continue to recruit and develop nurse practitioners to support care in primary health settings. Invest in a lead role to support an integrated Dietetic and Nutrition Service, working across DHB, PHO and CPH areas of service delivery.	Q1: Rural Hospital Medical Specialist with extended scope in Obstetrics engaged. Q3: Lead clinician in place to provide oversight to nutrition services. Q4: Three Nurse Practitioners working in primary care.	Further opportunities for the extended scope of rural medical generalists identified.
Identify actions to improve newborn enrolment with general practice.	Work with PHO, LMCs and maternity services to establish a process to support general practice enrolment as part of the current newborn multi-enrolment process. Complete a review of the multi-enrolment form to ensure it is meeting the stakeholder needs. Work with Plunket and Poutini Waiora to develop a Kaupapa Māori Pregnancy & Parenting Education Programme to support the wellbeing of wahine hapū and pepe. (EOA) Ensure the Programme emphasises the importance of enrolling with primary care to support engagement with health services. (EOA)	Q2: Process to support general practice enrolment developed. Q2: Kaupapa Māori PPE Programme developed. Q3: Newborn enrolment form review completed.	PP18: Delivery of Annual Plan actions. 85% of newborns enrolled with general practice by 3 months of age.

[3] Although the Alliance has only two formal partners (the DHB and the PHO), it has broad representation from other organisation and service providers across work streams including: Plunket, Poutini Waiora, St John, Oranga Tamariki, Ministry of Education, Te Putahitanga O Te Waipounamu, Presbyterian Support, and community pharmacy, ARC and Home-based support providers.

[4] West Coast's System Level Improvement Plan is attached as Appendix 7 to this Plan.

CVD and Diabetes Service Improvement			NZHS Link - One Team
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to maintaining a rate of 90% in undertaking CVD and Diabetes Risk Assessments for the eligible population. *Describe specific actions to reach this target.* *Identify three priority areas for quality improvement in diabetes care and services.*	Work with the PHO and general practices to maintain the high proportion of the eligible population receiving a CVD and Diabetes Risk Assessment at or above 90%.[5] Engage Poutini Waiora Nurses to identify and contact Māori men who are eligible for CVD and Diabetes Risk Assessments to lift the rates for this high-risk population. (EOA)	Q1: Monthly performance reporting by general practice. Q1: Monthly performance reporting by ethnicity.	PP20: Delivery of Annual Plan actions. 90% of the eligible population have had a Cardiovascular Disease risk assessment in the last 5 years. 90% of eligible Māori men (35-44 years) have had a cardiovascular disease risk assessment in the last 5 years. 90% of the population identified with diabetes have an annual HbA1c test. >80% of the population identified with diabetes (having an HbA1c test) have good or acceptable glycaemic control (HbA1c <64 mmol/mol).
	Work with Health Quality & Safety Commission (HQSC) to further advance the Whakakotahi work plan initiatives by trialling evidence-based care pathway improvements in two primary care pilot sites.[6]	Q1: Two Whakakotahi pilots underway. Q4: Completion of Phase I of the pilot with assessment of pathway improvements.	
	Establish a visiting specialist vascular surgical outpatient service to support diagnosis and treatment for West Coast patients, without the need to travel. (EOA)	Q1: Visiting Specialist Vascular service is established.	
	Continue to support community-based initiatives to engage and enrol people with diabetes in the Long-term Conditions Management Programme so that people can be supported to make lifestyle changes to help reduce their risk, with a particular focus on Māori as a high needs population group. (EOA)	Q1: Retinal screening expo and clinic in Reefton and Greymouth. Q4: Pre-diabetes and high risk CVRA dietitian clinics occur in three general practices. Q4: Three Living Well with Diabetes courses delivered.	

Pharmacy Action Plan			NZHS Link - One Team
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to engage with the agreed national process to develop and implement a new contract to deliver integrated pharmacist services in the community. *Identify key actions to support the vision of the Pharmacy Action Plan.*	Participate in the national process to develop and implement a new service agreement for integrated community pharmacy services. Offer and explain the new service agreement to each pharmacy, including the opportunity to improve integration of local services.	Q2: All West Coast pharmacies accept their new service agreement.	West Coast pharmacies have new 'evergreen' pharmacy service agreements in place. >900 people enrolled in Long-term Conditions Service. >20 people receive a Medicines Use Review (MUR) from their pharmacist.
	Further develop the Pharmacy Long-term Conditions Service, to improve access to pharmacist support for people on multiple regular medicines. (EOA) Support more pharmacists to provide medication use reviews (MURs) for people taking many or high-risk medicines. (EOA)	Q3: Two more West Coast pharmacists accredited to provide MURs.	
	Work with the national Expert Advisory Group to develop a Minor Ailments (pharmacy) Initiative to ease access to timely treatment for Community Service Cardholders. (EOA)	Q4: Minor Ailments Initiative developed and put forward for approval.	

[5] The Proportion of the total population having a CDV Risk Assessment is high with 90% of the total eligible population and 88% of the total Māori population receiving checks (as at Q4 2017/18). Māori Men (aged 35-44) are a high-risk group and uptake of risk assessments is lower for this group (72.4%). This is the DHB's area of focus for the coming year.

[6] These action areas were identified though the DHB's Self-Assessment against the national Diabetes Standards undertaken in 2017.

Support to Quit Smoking		NZHS Link - One Team	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Please identify activities that continue to support delivery of smoking ABC in primary care.	Identify smoking patients newly enrolling in the primary care Long Term Conditions Management Programme (LTCM) for mental health concerns, with the goal of offering them stronger support to quit smoking.	Q2: Process for capturing new patients established. Q4: Identified patients contacted by Stop Smoking Service.	90% of PHO enrolled patients who smoke are offered brief advice/support to quit. 90% of West Coast households with a newborn have their Smokefree status recorded at the first WCTO core check.
	Work with the Buller Health Practice to identify Māori smokers and ex-smokers who have not been appropriately screened for COPD. (EOA) Work with Poutini Waiora to engage those patients in spirometry clinics, where screening can be performed, smoking cessation advice and/or referral given and other opportunistic interventions offered. (EOA) Establish a process for extending invitations to whānau members where appropriate. (EOA)	Q2: Process for capturing Māori smokers and ex-smokers age 35 or over established. Q4: Identified patients and appropriate whānau invited for COPD screening.	
	Work with the PHO and Well Child Tamariki Ora providers collecting Smokefree status data to improve data collection and establish how whānau being offered brief advice and cessation support can be captured.	Q2: Data collection for smokefree household measure in place. Q4: Process for ABC data capture in Patient Management System investigated.	

2.3 Government Planning Priority - Child Heath

Child Wellbeing		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify the most important focus areas to improve child wellbeing that will realise a measurable improvement in equity for your DHB. *Identify key actions that demonstrate how the DHB is building its understanding of population needs, including those of high-needs populations, and making connections with and between local service providers of maternal health, child health and youth focused services.*	Work with Lead Maternity Carers (LMCs), Well Child Tamariki Ora providers and local Stop Smoking Services to increase the number of pregnant women (and their partners) engaging in the Smokefree Pregnancy Incentives programme and setting a quit date. Extend the schedule for incentives to support continued engagement with cessation services beyond birth, to promote a smokefree home environment for babies.	Q1: Smokefree Pregnancy Incentives programme model reviewed. Q2: Opportunities to enhance the Programme actioned. Q4: Successes of women who have successfully quit are celebrated.	PP27: Delivery of Annual Plan actions. Avoidable hospital admission for children aged 0-4 maintained at or below the national average.[7] Equity gap in ASH rates reduced for Māori children. 70% of babies are breastfeeding at 3 months. 95% of children (0-4) are enrolled with Community Dental Services. 90% of enrolled children (0-12) are examined according to plan. 85% of adolescents (13-17) are accessing DHB-funded oral health services.
	Continue to train volunteer peer supporters through the Mum4Mum programme, with a focus on training more Māori supporters to extend the reach of the service. (EOA) Investigate strategies to link young mothers, isolated rural mothers and Māori mothers (as high need groups) to a Mum4Mum supporter during the antenatal period. (EOA)	Q2: Opportunities to enhance the programme actioned. Q4: An increased number of Māori mothers trained as peer supporters.	
	Establish a Transalpine (cross-system) Oral Health Service Development Group to support a whole of life approach to good oral health.[8] Promote the Newborn Enrolment Form to support early enrolment of children with the Community Oral Health Service. (EOA) Engage health promoters, practice nurses and schools in programmes and initiatives that	Q1: West Coast Service Development Group membership confirmed. Q1: Childhood Nutrition Health Promotion role supporting Early Childhood Education Centres is established.	

[7] The DHB aims to maintain ASH rates lower than the national average rate and to focus on reducing the equity gap between Māori and non-Māori children. This work is further highlighted in our System Level Improvement Plan attached as Appendix 7 to this Plan.
[8] Oral health is a leading driver of avoidable hospital admissions for children. The DHB is working to improve the consistency of oral health services and to increase engagement with services from a young age to improve future wellbeing and equity of health outcomes.

	promote good oral health, reduce risk factors and identify issues early. Identify opportunities for health promotion and education for families whose children are hospitalised for dental surgery. (EOA)	Q2: Practice Nurses completing the 'Lift the Lip' checks at immunisation events. Q2: 'Water Only' policies in place in schools.	
	Continue to invest in the Violence Intervention Programme (VIP) and activity to support a reduction in harm and adverse health outcomes, including VIP training for staff.	Q1: VIP training sessions ongoing. Q4: VIP audit results >70/100.	

Maternal Mental Health Services		NZHS Link – Closer to Home	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to completing a stock-take of community-based maternal mental health services currently funded by the DHB, both antenatal & postpartum, by the end of quarter 2. *Commit to identify the number of women accessing primary maternal mental health services, and report in quarter 4.*	Continue to support the use of free general practice consultations for pregnant women with medical, mental health or social issues that may be exacerbated by pregnancy. (EOA) Promote the maternal mental health service referral pathway using HealthPathways. Review the timeliness of referrals from LMCs to Well Child providers, with a focus on Māori wahine as a population of higher need. (EOA)	Q1: Review of maternal mental health pathway complete. Q2: Promotion of pathway to increase uptake. Q3: Review of referral timeliness completed and opportunities for improvement identified.	PP44: Delivery of Annual Plan actions.
	Identify all community-based DHB funded services and initiatives currently in place to support maternal mental health. Identify the number of women being supported by DHB funded community-based maternal mental health services.	Q2: Stocktake report completed. Q4: Access report provided to the Ministry of Health.	

Supporting Health in Schools		NZHS Link – Closer to Home	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify actions currently under way to support health in schools (primary and secondary) by the end of quarter 2.	Continue to support the Health Promoting Schools framework in lower decile schools and schools with a high proportion of Māori and Pacific students. (EOA) Support the roll out of the 'Water Only in Schools' programme as part of good oral health promotion and an enabler to wellbeing. Review the results of the 2018 Wellbeing Survey in Greymouth Schools and contribute to the development of recommended actions for service improvement. Identify all actions and initiatives currently underway to support health in primary and secondary schools on the West Coast.	Q2: Schools recruited to develop 'Water Only' policy. Q2: School Wellbeing Survey reviewed. Q2: Stocktake report completed. Q3: Service improvement recommendations developed and agreed.	PP39: Delivery of Annual Plan actions.

School-Based Health Services (SBHS)		NZHS Link – Closer to Home	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to have completed a stocktake of health services in public secondary schools in the DHB catchment by the end of quarter 2. *Commit to develop an implementation plan,*	Work with decile 4 schools to engage them in the SBHS programme. Undertake a stocktake of all school-based health services (SBHS) currently provided in public secondary schools on the West Coast. Work with decile 1-4 schools to identify barriers to participation in routine health	Q2: Stocktake report completed. Q2: Barriers to access for Māori identified. Q4: Implementation plan for expanding SBHS to all schools completed and provided to the Ministry of Health.	PP25: Delivery of Annual Plan actions. 95% of year nine children in decile 1-4 schools receive a HEEADSSS assessment.

including timeframes, for how school-based health services could be expanded to all public secondary schools in the DHB catchment by the end of quarter 4.	assessments with particular focus on Māori children. (EOA) Work with schools and providers to develop an implementation plan for expanding school-based health services to all public secondary schools on the West Coast.	Q4: SBHS in place in all 1-4 decile schools.	

Immunisation			NZHS Link - One Team
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify actions that demonstrate how you will work as one team, across all immunisation providers within your region and in collaboration with other child services, to improve immunisation rates and equity for the key milestone ages in early childhood.[9]	Continue to monitor and evaluate immunisation coverage at DHB, PHO and general practice level, to maintain coverage and identify unvaccinated children. Fill the vacant Māori provider role on the cross-system Immunisation Advisory Group to ensure a strong focus on Māori as a priority group. (EOA) Continue with a focus on pregnancy vaccination, supporting LMCs to have the conversation with pregnant women. Share refreshed immunisation process charts and include tips and prompts for having difficult immunisation conversations. Support general practice to promote the co-delivery model for HPV and Tdap.	Q1: Quarterly review of vaccination and decline rates by ethnicity. Q1: Māori representative on the Immunisation Advisory Group. Q2: Refreshed process chart issued to general practice. Q2: HPV and Tdap Information and education resources issued to general practice. Q4: Options for difficult conversation training for practice nurses explored.	PP21: Delivery of Annual Plan actions. 50% of pregnant women vaccinated for Pertussis. 95% of 8-month-olds fully immunised. 95% of 2-year-olds fully immunised. 95% of 5-year-olds fully immunised.

Responding to Childhood Obesity			NZHS Link – Value and High Performance
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Please identify activities that continue to respond to children identified as obese at their B4 school check.	Engage a community-based dietitian to work alongside the Public Health Nurse to provide nutrition advice and support to families/ whānau regarding healthy weight in childhood at the time of their B4SC.	Q2: Dietitian attending B4SC Clinic days in Greymouth. Q4: Resource required to provide support at all clinics identified.	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. <30% of children identified as obese in the B4SC programme decline a referral for support.
	Provide primary care teams with training/education regarding healthy weight in childhood to support appropriate onward referrals for family/ whānau support.	Q2: Training and education needs identified by practices. Q4: Training/education delivered.	
	Work with the local Ministry of Education to develop a process to better support children with disabilities to access B4SCs and have an opportunity to discuss healthy weight in childhood with a dietitian. (EOA)	Q1: Process for identifying children with higher needs developed. Q4: Process agreed with Ministry of Education.	

[9] *West Coast's immunisation results are impacted by higher than average 'opt off' and decline rates. Around half of the people opting off have strongly held religious views on this issue, which are unlikely to change. The DHB continues to use best endeavours to reach the national target and challenges its team to ensure we are immunising 100% of those children whose parents consent to immunisation on time.*

2.4 Government Planning Priority - System Settings

Strengthen Public Delivery of Health Services		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify activity planned to strengthen access to public health services.	Continue to implement the planned/ unplanned care model, incorporating service changes including a new approach to the provision of after-hours, urgent and emergency care as the DHB transitions to the new Grey Base Hospital and develops its model of care in Westport. Work with the Ministry to ensure external contracting, reporting and funding mechanisms do not create artificial barriers or restrict development of the new model.	Q2: Communication plan for new planned/unplanned care pathways developed. Q3: New model allows people to be seen and treated in the right place. Q4: Primary care hours extended to provide greater access to care.	SI16: Delivery of Annual Plan actions. Avoidable hospital admissions for adults (45-64) maintained below national rates. Reduction in the proportion of the population presenting at ED. Delivery of national ESPI targets. Elective average length of hospital stay at or below 1.45 days. Outpatient DNAs <6%. New extended scope roles in place.
	Establish a centralised Hub for the delivery of primary and community assessment and coordination services to enhance the integration of services.	Q4: Centralised support service (that includes bookings and community assessments) in place.	
	Realign resources to support the implementation of the locality-based services model with three integrated health service spokes in Northern [Buller], Central [Grey] and Southern [Westland].	Q1: Northern integrated health service in place. Q4: Central and Southern integrated health services in place.	
	Consider the provision of services currently under hospital management and explore how the DHB might better meet the needs of the population as part of the wider integrated service model.	Q1: Review of OT and Audiology Services completed. Q1: Opportunities to provide greater access to residential dementia services explored.	
	Invest in the development of a rural generalist workforce model to enable the transformation of our models of care and support the sustainability of our system. Design a communications and recruitment strategy that communicates the rural generalist model and attract professionals interested in this way of working.	Q4: Rural education and training cluster implemented. Q1: Communications and recruitment strategy implemented. Q4: Pathways for the continued development of rural medical generalists identified.	

Shorter Stays in Emergency Departments		NZHS Link – Value and High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Please identify activities that continue to improve patient flows through hospital.	Implement a Short Stay Unit in the new Grey-base Hospital facility, to streamline and support the improved flow and observation of patients.	Q1: Develop criteria for short stay admission and discharge. Q2: Determine workforce requirements and agree FTE. Q3: Recruit workforce (timing dependent on new facility opening) Q4: Unit operational.	95% of patients are admitted, discharged, or transferred from an Emergency Department (ED) within 6 hours. <20% of patients admitted from ED Short-Stay Unit to inpatient wards. >8 out of 10 average for in-patient survey domain rate your experience of communications. Reduction in triage 4-5 presentations to Grey Base ED to <64% - baseline as at June 2016. ED attendances <356 per 1,000 people baseline at June 2018.
	Establish a duty nurse (patient flow manager) manager role, within hours, to assist with patient flow and admission and discharge planning across the wards.	Q1 Role scoped and agreed. Q2 Role recruited. Q3 Review of impact and focus.	
	Map the patient journey for Maori across the rural health continuum (primary care to secondary care) and determine areas of focus to improve earlier engagement. (EOA)	Q3: Journey Mapped. Q4: Opportunities identified and prioritised.	

Elective Services		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Provide three specific actions that will support your delivery of the agreed number of Elective Discharges, in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Establish a clinical governance alliance to support a 'One Service' approach to the provision of orthopaedics across Canterbury and West Coast DHBs. (EOA)[10] Invest in additional capacity in plastics to improve timely access to treatment for West Coast patients. (EOA)	Q2: Transalpine Orthopaedic clinical governance alliance established. Q2: Process for support of a Plastics Fellow, as part of the transalpine plastics service, in place.	PP45: Delivery of Annual Plan actions. 1,916 elective surgeries delivered. Elective and Ambulatory Initiative delivered as agreed. Delivery of all national ESPI targets. Delivery in line with Standardised Intervention Rates. Elective average length of hospital stay at or below 1.45 days. Outpatient DNAs <6%.
	Review current booking system processes to identify opportunities to improve the uptake of appointments and access to services. Facilitate cross-system collaboration between booking teams and Poutini Waiora to identify solutions for better engaging with Māori as a high needs group. (EOA) Develop criteria to help identify patients who would be suitable for telehealth clinics, to reduce their need to travel. (EOA) Work with the Ministry to develop consistent rules for counting telehealth events, to ensure activity is appropriately captured.	Q1: DNA service level data used to identify initial areas of focus. Q2: Electronic delivery of patient appointments enabled. Q3: Business case developed for software-based VC capability. Q4: Telehealth criteria developed. Q4: Process for counting telehealth events in place that supports recognition of activity.	
	Engage with Poutini Waiora to established closer links with Māori patients at the pre-presentation and discharge phases of care to support people to attend appointments. Deliver Tikanga Best Practice training to staff, to support patients to feel culturally comfortable with the care they are given.	Q3: Process in place to offer Māori patients access to additional support through their elective patient journey. Q4: Four Tikanga Best Practice sessions delivered.	

Disability Support Services			NZHS Link - One Team
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to developing training for front line staff and clinicians that provides advice and information on what might be important when interacting with a person with a disability, by the end of quarter 2. *Commit to report on what percentage of staff have completed the training, by quarter 4.*	Form a transalpine West Coast/Canterbury DHB Diversity Training Group to develop a diversity education framework. Engage with the DHB Disability Steering Group and Māori and Pacific leads to ensure content is consumer focused and culturally appropriate. (EOA) Engage subject matter experts to develop disability training modules, building on the e-learning work completed in 2017/18. Track uptake and feedback on modules as a means of evaluation.	Q1: Diversity Training Group established. Q2: Diversity education framework approved. Q2: Development of training modules complete. Q3: Disability training modules launched on HealthLearn. Q4: Report on uptake of training modules by staff.	SI14: Delivery of Annual Plan actions. Percentage of staff completing disability training modules. Percentage of staff rating content positively.

[10] *Orthopaedic and Plastics services are pressure points for the West Coast where timely access to treatment has been an issue. These areas will be a focus for the DHB in the coming year, to ensure our population has equitable access to services.*

Cancer Services		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Implement improvements in accordance with national strategies and demonstrate initiatives that support the areas outlined below: *Describe actions to ensure equity of access to timely diagnosis and treatment for all patients.* *Describe actions to implement the national prostate cancer decision support tool (Kupe) to improve the referral pathway across primary and secondary services.* *Describe actions to provide support to people following their cancer treatment (survivorship).*	Continue to use data/intelligence systems to monitor the 62-day and 31-day wait time targets and support discussions with specialties which are missing targets. Undertake breach analysis for patients outside the 62-day target to assess any emergent systemic issues that might need urgent corrective action and identify opportunities to reduce process delays. Work in partnership with the Southern Cancer Network to support regional initiatives and tumour stream pathway developments that improve equity of access for West Coast patients. (EOA)	Q1: Quarterly monitoring of cancer wait times and analysis of any cases where there are delays. Q2: Improvements identified and implementation underway. Q3: Adopt learnings from the Southern Cancer Network equity assessment framework pilot.	PP30: Delivery of Annual Plan actions. 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 2 weeks. 85% of patients receive their first cancer treatment (or other management) within 31 days of date of a decision-to-treat.
	Engage locally in supporting the regional Te Waipounamu Māori Cancer Pathway Project to support improved outcomes for West Coast Māori. (EOA) Adopt a collective approach to improving cervical and breast screening rates for Māori women.	Q2: Cancer Korero Booklet developed and disseminated. Q4: Three cancer korero hui held to improve cancer health literacy amongst Māori whānau. Q4: Cultural competency training and education package developed and presented to GP practices.	
	Incorporate references and links to Kupe (the national prostate cancer decision support tool) into the HealthPathways and HealthInfo to support men to understand the risks and benefits of treatment before having a prostate cancer check.	Q2: Kupe link on HealthPathways to support GPs to have conversations with their patients. Q2: Kupe link on HealthInfo to support patients and their families to make informed decisions.	
	Continue to engage with and provide input into community initiatives that support people following their cancer treatment and their families. Engage with the Southern Cancer Network to identify opportunities for the Coast arising from the regional engagement and survivorship initiative pilot.	Q2: Input and support provided to the Cancer Society (Living Well Programme) and Poutini Waiora for delivery of survivorship initiatives. Q2: Input into regional feedback sessions on end of treatment needs. Q4: Review of regional opportunities.	

Healthy Ageing		NZHS Link – Closer to Home	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Demonstrate the DHB is working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in falls and fracture prevention services as reflected in the associated 'Live Stronger for Longer' Outcome Framework and Healthy Ageing Strategy.	Work with partner organisations through the Health of Older People Workstream and Falls Coalition to enhance and integrate falls and fracture prevention services. Engage local providers to accredit community strength & balance classes, including a number specifically designed and targeted towards older Māori. (EOA) Embed the fracture pathway to ensure people with a fractured Neck-of-Femur (NOF) are referred to the in-home Falls Prevention service.	Q1: St John representative attending Falls Coalition meetings. Q2: Review and integration of osteoporosis and falls prevention referral pathways completed. Q3: Māori focused community strength & balance class accredited. Q3: NOF pathway embedded. Q4: Virtual Fracture Liaison Service operational.	PP23: Delivery of Annual Plan actions. 720 places available at accredited strength & balance classes. 120 referrals made to the Falls Prevention Service. Increased proportion of older Māori, with identified falls risk, referred to strengths & balance or falls prevention services.
Identify actions contributing to DHB and Ministry led development of Future	Encourage service providers to consider Māori health needs from 50+ to enable older Māori to maintain good health. (EOA)	Q2: InterRAI reporting framework in place, and assessment rates tracked by ethnicity.	95% of long-term HBSS clients have an InterRAI assessment and have a

Models of Care for home and community support services.	Engage the Māori Needs Assessor to complete InterRAI assessments to ensure an appropriate response for older Māori with complex health issues. (EOA) Employ a Clinical Nurse Specialist (CNS) to embed and promote the early supported discharge service (FIRST) ensuring the screening and referral of older people to appropriate discharge options.	Q2: CNS appointed to support FIRST. Q3: Baseline established for the rate of InterRAI assessments per 1,000 population. Q4: Three people admitted to the FIRST service.	completed care plan in place.
Outline current activity to identify drivers of acute demand for people aged 75+ presenting at ED.	Analyse the 75+ cohort presenting at ED and investigate potential interventions. Analyse the 75+ cohort with repeat acute admissions and investigate potential interventions. (EOA)	Q1: Analysis of ED and repeat acute admissions undertaken by age and ethnicity. Q2: Strategies to address repeat cohort presentations and admission identified.	SI17: Total acute bed days per capita maintained below the national average. Reduction in the acute medical admission rate for people 75+.

Improving Quality		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify actions to improve equity in outcomes and patient experience as measured by the Atlas of Healthcare Variation for gout, asthma, or diabetes	Promote and provide free seasonal flu vaccinations for people at higher risk including Māori over 65 years, pregnant women and people with a recent asthma related hospital admission.[11] Engage Poutini Waiora to support practices who are struggling to reach their target population. (EOA) Undertake analysis of Atlas indicators to identify opportunities to increase influenza vaccinations for target populations after hospital admission.	Q1: Analysis of Atlas indicators shared to support targeted actions for high need populations. Q2: Difference in coverage reporting between the National Immunisation Register and the general practice patient management system is clarified to better target those who have not had a flu vaccination.	SI17: Delivery of Annual Plan actions. 75% of the population 65 and older have received a free influenza vaccine.
Identify actions to improve the patient experience as measured by the DHB's lowest-scoring question in the HQSC's national inpatient experience surveys.	Work with consumers and staff to co-design and articulate the role of a 'nominated or preferred' contact person. Work with consumers to develop material describing and clarifying the role. Develop an organisational change process, including training and materials for staff who collect patient details, to ensure a patient's nominated or preferred person is identified in the early stages of admission.	Q1: Terminology agreed. Q2: Procedure for contact details collection updated to include nominated contact person. Q3: Organisational change process confirmed and tested. Q4: Change process approved and implemented.	Improved result for survey question "Did hospital staff include your family/whānau or someone close to you in discussion about your care?" - Baseline 65% at June 2017.

[11] *Those who have a hospital admission for asthma are recommended to receive an influenza vaccine as part of their preventive care. The West Coast is not meeting the population target of 75% of people (aged 65 and over) having a seasonal flu vaccination. Older Māori are a key group at risk of asthma and influenza and a subsequent acute hospital presentation, and are a focus for the West Coast DHB.*

Climate Change		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to individual and collective efforts to reduce carbon emissions and, where appropriate, promote the adoption of CEMARS (or other carbon neutral scheme). *Commit to undertake a stocktake to identify activity/actions being delivered to positively mitigate or adapt to the effects of climate change, in quarter 2.*	Link into the Canterbury Sustainability Governance Group to support development of a Sustainability Strategy. Establish energy monitoring through the use of Energypro software to build up a history of energy use and identify opportunities for improvement. Review current inter-hospital truck transport service to identify opportunities to reduce mileage and use of fossil fuels. Undertake a stocktake of current initiatives being delivered to mitigate or adapt to the effects of climate change. With support from Canterbury DHB, seek to introduce the CEMARS and Energy-Mark accreditation programmes.	Q2: West Coast Sustainability Champions Identified. Q2: Process for links into Canterbury DHB Sustainability Governance Group established. Q1: Energypro monitoring in place. Q2: Truck transport review complete and opportunities identified. Q2: Stocktake of current actions completed.	PP40: Delivery of Annual Plan actions. Reduction in internal truck transport kilometres by 33%.

Waste Disposal		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify actions to raise awareness and actively promote the use of DHB pharmaceutical waste collection and disposal arrangements. *Undertake a stocktake to identify activity/actions to support the environmental disposal of hospital and community waste products, in quarter 2.*	Distribute materials to pharmacies for educating patients about returning unused and expired medicines and used sharps. Undertake a stocktake on current disposal processes for each category of waste to identify opportunities for improving waste disposal arrangements.	Q1: Educational materials distributed to pharmacies. Q2: Stocktake report completed and submitted to the Ministry of Health.	PP41: Delivery of Annual Plan actions.

Fiscal Responsibility		NZHS Link - Value & High Performance	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Commit to delivering best value for money by managing DHB finances in line with the Minister's expectations. *Identify local improvement activities to respond to Government intentions.*	Work with our system partners through the West Coast Alliance to support people to stay well in the community and reduce unnecessary hospital admissions. Implement an integrated operational reporting framework to identify opportunities to reduce duplication and waste and enhance efficiency. Continue to expand the use of telemedicine and virtual assessments to reduce the amount of time patients and clinicians waste travelling. Implement the agreed project plans for the transformation of our mental health and primary/community services models to support integration and make the best use of available resources. Invest in the development of a rural generalist workforce model to enable the transformation of our models of care and support the sustainability of our system.	Q1: System Level Measures Improvement Plan agreed. Q1: Ongoing review of service performance and implementation of service changes to capture identified opportunities. Q4: Increased use of telehealth technology to support the delivery of specialist services. Q4: Implementation of three locality-based integrated health services [Northern, Central & Southern]. Q4: Implementation of the locality-based mental health teams to support the new mental health model. Q4: Opportunities captured from employment of rural medical generalists and nurse practitioners.	Delivery of year-end service performance in line with standards set in the Annual Plan. Delivery of year-end financial performance in line with forecasts set in the Annual Plan.

Delivery of Regional Service Plan		NHS Link – One Team	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify significant actions the DHB is undertaking to deliver on the Regional Service Plan. *In particular, identify local actions to support planned elective activity.*	Align the Canterbury and West Coast orthopaedic service to achieve one fully transalpine service across both DHBs. Review processes to ensure equity of access for West Coast population. (EOA)	Q2: Business rules aligned Q3: Triage and preadmission processes aligned. Q3: Capacity planning aligned.	SI2: Delivery of Annual Plan actions. Delivery of all national ESPI targets. Elective services delivery in line with Standardised Intervention Rates. 80% of stroke patients admitted to a recognised stroke service with a demonstrated stroke pathway.
	Work with the regional DHBs and South Island Alliance Programme Office (SIAPO) to implement the national vascular services framework. Agree the provision of specialty nursing input into local nursing teams to better support community care and reduce the need for West Coat patients to travel for hospital/outpatient visits. (EOA)	Q1: Regional capabilities defined. Q2: Regional pathway implemented. Q3: Vascular imaging aligned. Q4: Vascular destination policy clear and treatment/referral pathways in place for six major vascular conditions.	
	Continue to engage with the regional stroke network to support the delivery of a sustainable stroke service on the West Coast. Continue to support the development of a sustainable regional clot retrieval service to build capacity and expertise across the South Island. (EOA) Participate in the Acute Stroke Telehealth pilot for out-of-hours acute stroke service to improve equity of access. (EOA)	Q2: Stroke telehealth link in place. Q4: Timeframes for implementation of regional intra-arterial clot retrieval service agreed. Q4: Regional stroke pilot evaluated and opportunities identified.	

Financial Summary

Further detail on the DHB's financial outlook and assumptions for 2018/19 can be found in Appendix 6 of this Plan.

2.5 Prospective Statement of Financial Performance – to 30 June 2021

Statement of Comprehensive Income	2016/17 Audited Actual $'000	2017/18 Forecast $'000	2018/19 Plan $'000	2019/20 Plan $'000	2019/21 Plan $'000
Revenue					
Ministry of Health Revenue	131,558	136,789	141,248	144,104	146,730
Other Government Revenue	8,520	7,777	4,167	3,769	3,820
Other Revenue	2,694	4,602	7,137	7,337	7,312
Total Revenue	**142,772**	**149,169**	**152,552**	**155,210**	**157,862**
Expenditure					
Personnel	57,483	60,132	61,977	63,974	65,466
Outsourced	8,692	8,663	8,480	8,437	8,520
Clinical Supplies	8,402	8,919	7,750	7,809	7,901
Infrastructure & Non Clinical	11,446	11,934	11,820	12,125	12,297
Payments to Non-DHB Providers	53,094	58,152	62,978	63,481	63,995
Interest	343	-	-	-	-
Depreciation & Amortisation	3,373	2,911	4,110	4,939	5,305
Capital Charge	739	1,387	1,524	5,748	5,748
Total Expenditure	**143,572**	**152,099**	**158,639**	**166,513**	**169,232**
Other Comprehensive Income					
Revaluation of Land & Building	-	3,599	-	-	-
Total Comprehensive Income / (Deficit)	**(800)**	**669**	**(6,087)**	**(11,303)**	**(11,370)**

2.6 Prospective Financial Performance by Output Class – to 30 June 2021

Prospective Summary of Revenue & Expenses by Output Class	2018/19 Plan $'000	2019/20 Plan $'000	2020/21 Plan $'000
Early Detection			
Total Revenue	73,508	74,793	73,741
Total Expenditure	76,443	80,237	81,545
Net Surplus / (Deficit)	**(2,935)**	**(5,444)**	**(7,804)**
Rehabilitation & Support			
Total Revenue	6,884	7,001	8,420
Total Expenditure	7,159	7,512	7,635
Net Surplus / (Deficit)	**(275)**	**(511)**	**785**
Prevention			
Total Revenue	6,055	6,161	6,328
Total Expenditure	6,296	6,610	6,717
Net Surplus / (Deficit)	**(241)**	**(449)**	**(389)**
Intensive Assessment & Treatment			
Total Revenue	66,109	67,260	69,372
Total Expenditure	68,745	72,156	73,334
Net Surplus / (Deficit)	**(2,636)**	**(4,896)**	**(3,962)**
Consolidated Surplus / (Deficit)	**(6,087)**	**(11,300)**	**(11,370)**

Medium-Term Outlook

How are we organising our business to achieve our vision?

Managing Our Business

We aim to be a responsive organisation, respected for the quality of the service we deliver, and successfully delivering against strategic goals and national targets. 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.

3.1 Patient-focused culture

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

The DHB is committed to the development of a culture that focuses on the patient. Forums and community meetings have been held to provide updates on the transformation of our health system and to enable us to hear and respond to the views and concerns of our community, patients and their families.

We have also invested in leadership and engagement programmes that encourage staff to ask 'What is best for the patient?' and empower our people to redesign the way we deliver services.

We will further amplify the patient voice and engage with our community by increasing consumer input into our Health Alliance with consumer representation on Alliance work streams and project groups.

3.2 Effective leadership

We are fortunate to have Board members who contribute a wide range of expertise to their governance role. To support good governance, we have an outcomes-based decision-making and accountability framework that enables our Board to monitor service performance and provide direction.

Clinical leadership and consumer engagement is also intrinsic to our success. Clinical and consumer input into decision-making is embedded at all levels of our organisation, across primary and secondary services and increasingly across our local alliance.

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.

3.3 Collective impact

Our vision is based on bringing to life a truly integrated health and social sector. To complete our transformation, the whole system needs to be working together to do the right thing for our patients and our population. Working collaboratively enables us to respond to the changing needs of our population, and is a critical factor in achieving our goals and objectives. The DHB's major 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 health services and realise opportunities to improve health outcomes. This focus includes the delivery of the West Coast's annual System Level Improvement Plan, which is incorporated and included as an appendix to this Plan.

Tatau Pounamu: Where, under a shared memorandum of understanding, 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.

Transalpine Partnership: An initial priority of connecting up the Canterbury and West Coast health systems to reduce duplication is now helping to formalise clinical pathways and enable sustainable access to specialist services for our population. The two DHBs share senior clinical positions as well as management expertise, corporate services teams and information systems.

Public Health Partnership: All DHBs have a statutory responsibility to improve, promote and protect the health and wellbeing of their populations. Community and Public Health is a division of the Canterbury DHB and takes a lead in the delivery of public health strategies and services for our population. Our 2018/19 Public Health Action Plan is available on our website.

3.4 Commitment to quality

Our commitment to quality improvement is in line with our vision and the NZ Triple Aim: improved quality, safety and experience of care; improved health and equity for all; and better value from public health resources.

As a partner in the regional Quality and Safety Alliance, we work with the other South Island DHBs to implement quality and safety improvements through a community of practice. We also support each other to meet commitments under the national Health Quality and Safety Commission (HQSC) programmes.

The regional implementation of the South Island Incident and Risk Management System (Safety 1st) is assisting with real time tracking of events, allowing us to examine incidents as they happen and take action to improve quality and patent safety. With a culture of reporting now well established, safety issues are

becoming more transparent and empowering the organisation to respond to needed improvement.

West Coast DHB also has a focus on improving patient experience in our services. We have made a commitment to using our inpatient experience survey results to improve the way we communicate with patients and their families. Our focus for the coming year is reflected in the action tables in this Plan.

The national HQSC Quality and Safety Markers are used by our governance groups to monitor patient safety and track the effectiveness of improvement activity. Our performance against the Markers is reported to the Board's Quality, Finance, Audit and Risk Committee and to our community through our Quality Accounts which can be found on our website.

The delivery of externally contracted services is also aligned with national quality standards, and auditing of contracted providers includes quality audits.

3.5 Performance management

The DHB's Board is responsible to the Minister of Health for the overall performance of the DHB. The Board delivers against this responsibility by setting strategic direction and policy that is consistent with Government objectives, meets the needs of our population, and ensures sustainable service provision.

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 service and financial performance is monitored by the Executive Team and the DHB's Board and its Quality, Finance, Audit and Risk Sub-Committee. The DHB's performance is presented in a public forum to the Board's Advisory Committees. The DHB also reports monthly and quarterly to the Ministry of Health against key financial and non-financial reporting indicators.

At a broader level, we monitor our performance against a core set of desired population outcomes, which helps to evaluate the effectiveness of our investment decisions. Our goals are captured in the DHB's Outcome Framework which defines success from a population health perspective and is used as a means of evaluating the success of our collective initiatives.

Our system's performance is audited annually against our Statement of Performance Expectations. The results are published annually in the DHB's Annual Report. Further detail on the DHB's outcome goals can be found in the Monitoring our Performance section.

3.6 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.

As an owner of Crown assets, the DHB is accountable to Government for the financial and operational management of those assets.

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 redevelopments.

The DHB is also developing a Long-term Investment Plan with a ten-year outlook. This Plan will reflect the anticipated impact of changing patterns of demand and new models of care on our future asset requirements, and will support future investment decisions.

As at 30 June 2017, the West Coast DHB had $44.387M worth of assets on its books. Refer to the Financial Performance section (page 57) for a breakdown of the DHB's major capital investments to 2021.

3.7 Ownership interests

The West Coast DHB has two ownership interests that support the delivery of health services.

The South Island Shared Service Agency Limited: functions as the South Island Alliance Programme Office. It is jointly owned and funded by the five South Island DHBs and provides audit services and drives regional service development on our behalf.

The New Zealand Health Partnership Limited: is owned and funded by all 20 DHBs and aims to enable DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB participates in the Finance, Procurement and Supply Chain programme.

We do not intend to acquire shares or interests in any other companies, trust or partnerships in 2018/19.

Investing in Our Future

3.8 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.

In our rurally isolated environment, we face significant difficulties in recruiting and retaining the right people with the right skills to support our system. This has led to an over-reliance on locum and contract staff, which reduces the continuity of care for our population and is unsustainable financially. Attracting and retaining capable people, with a real passion for rural health, is one of our critical success factors.

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

The DHB is committed to implementing the national Care Capacity Demand Management agreement by June 2021.

As part of our commitment to our workforce, we are also reviewing our people processes and systems and engaging in conversations about how we can put our people at the heart of all that we do.

There is a strong commitment to making things better. The DHB has committed to a People Strategy to ensure actions that will positively motivate and support the wellbeing of our people.

In implementing our People Strategy, we will create a culture where:

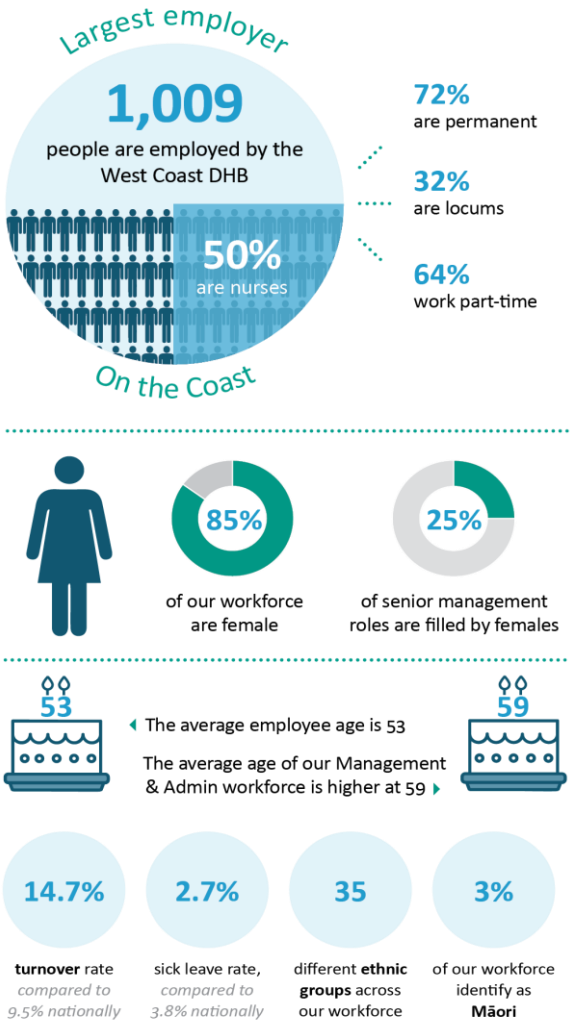
- Everyone understands their contribution
- Everyone can get stuff done
- Everyone is empowered to make it better
- Everyone is enabled to lead
- Everyone is supported to thrive.

A range of initiatives will be developed and rolled out over the next few years to deliver on the priorities in our People Strategy. We will be measuring the impact we make and using what we learn to inform our next steps. We will also involve our people every step of the way to ensure we are focused on what is important.

Alongside our People Strategy, we also 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. [12]

We are increasingly focused on adopting a key workforce strategy of rural generalism, defined as the provision of a broad scope of health care in the rural context. This is an internationally proven strategy and we are applying this model across all our professions - medical, allied and nursing.

As part of a rural generalist workforce each profession will work to the full extent of their scope of practice, as part of a multi-disciplinary team, to provide services to our community. Developing a core workforce of rural generalists will ensure the West Coast DHB has a more sustainable workforce, and people on the West Coast will have access to better care, closer to home. It will also provide opportunities for our workforce to develop and use a broad set of skills and attract people who want to work in a more integrated model.



Our transalpine arrangements with Canterbury will be essential to the success of the rural generalist model, with a core workforce of rural generalists on the West Coast supported by specialist teams from Canterbury.

Other areas of workforce development and investment for the period of this Plan include:

Māori Health Workforce: The DHB seeks to encourage greater participation of Māori in the health workforce, with Māori currently making up 12% of the West Coast population but just 3% of our DHB workforce.

As part of this focus West Coast participates in the national Kia Ora Hauora programme, aimed at increasing the number of Māori working in health by supporting pathways into tertiary education, local Māori health scholarships and work placements.

The DHB is also committed to building a culturally competent workforce and will continue to advance the Takarangi Competency framework, an evidence-based model that influences and shapes practice. Leading on from two successful hui held in 2017, the next phase of development will be to support the first cohort of students as they work their way through the core

[12] *Refer to the South Island Regional Health Services Plan for regional workforce actions for 2018/19.*

competencies and build their portfolios. Further hui in 2018/19 will provide opportunities for more staff to participate and build their skills and understanding.

In the coming year, in collaboration with Canterbury DHB, we will support a review of recruitment practices with an emphasis on improving practices that may unintentionally limit job placement prospects for Māori applicants. This will include design of a strategy, workshops for staff responsible for recruitment, and an action plan to address issues identified as a result of applying the Health Equity Assessment Tool (HEAT).

The DHB will also engage with staff to improve the collection and recording of ethnicity data to support improved workforce planning.

Healthy Ageing Workforce: West Coast has an older population with a high proportion of people aged over 65 (19%) compared with the national average (16%). By 2026, this proportion will grow to 24% - one in every four people. The ageing of our population is one of our biggest challenges and will put significant pressure on our infrastructure and workforce.

The DHB will continue to support the work of the South Island Workforce Development Hub to identify workforce gaps and support skill development and training for vulnerable workforces. This includes collection of non-DHB aged care workforce data, being undertaken by DHB Shared Services and the Ministry of Health as part of the rollout of pay equity.

Locally, we have established a Health of Older People Workstream under our district alliance, where we work together to identify service and workforce gaps and determine the best models of care to support our ageing population.

Under the guidance of the alliance, we have invested in the development of a multi-disciplinary Complex Clinical Care model. Clinically-led by a geriatrician, the team includes primary care, allied health, district nursing, home-based support, mental health, and pharmacy providers who work collaboratively to wrap care around each person. This model enables the transfer of knowledge and upskilling of support workers and has improved the quality of care.

In the coming year, we are focusing on Assessment Treatment and Rehabilitation services, looking to establish a similar multidisciplinary team approach in these services areas. We will also provide and support education opportunities for health professionals and support workers on End-of-Life care, with palliative care workshops planned for 2018/19.

Our own workforce is ageing and this is an important consideration in the DHB's workforce planning. The average age is 53 years with management and administration services being our oldest workforce group with an average age of 59.

With the onset of increased retirements, and difficulties attracting talent to the Coast, leadership development for those who are managing others will help improve levels of employee satisfaction and reduce turn-over levels. Training also serves to improve levels of engagement amongst older workers who might otherwise enter into retirement earlier than if they were still learning and developing.

The DHB will create a leadership development plan and implement self-directed e-learning and a level-specific leadership development plan based on the State Service Sector development framework.

We will also develop a Strategic Recruitment Plan for finding talent for the Coast, including replacements for the accelerating numbers of nurses being lost due to retirement. This will be supported by the assignment of a Strategic People Partner to undertake workforce planning for the West Coast, with a workshop to identify workforce need in the first quarter of the year.

3.9 Investing in health literacy

The West Coast DHB takes a leadership role in improving health literacy and making it easier for people to make informed decisions about their health and wellbeing. Our commitment is inherent in our vision and the first of our three strategic objectives: *'The development of services that support people to stay well and enable them to take greater responsibility for their own health and wellbeing'.*

We have invested in HealthInfo, our local information website, designed to give people access to up-to-date information about health conditions, local support groups, medications, medical tests and procedures, end of life planning, and tips for staying fit and well. HealthInfo includes a video tutorial to help people navigate the site and find information and has printable factsheets for people without web access.

We support staff development in health literacy practice and communication through HealthLearn, an e-learning platform developed by the Canterbury DHB and now available across the South Island. We offer an online foundation course in cultural competency and one on one working with people with disabilities. Both courses aim to improve communication, challenge assumptions and build people's confidence.

Areas of investment for the period of this Plan include:

- Increased adoption and use of the national Patient Experience Survey.
- Evaluation of the content of HealthInfo for two priority issues affecting older people.
- Improving the cancer health literacy of whānau and support service staff in the WCDHB.

3.10 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.

Connecting up health services electronically is central to our vision and, by allowing us to realise opportunities to reduce duplication, is a key factor in the future sustainability of our health system.

Improving information management and capability is also a national priority, and DHBs are expected to align their direction with the national Digital Health Strategy.

The South Island DHBs have determined collective actions to deliver on the Strategy. The West Coast DHB is committed to this approach. We have already invested in several major regional systems, including the award-winning Health Connect South, HealthOne and the Electronic Referral Management System.

Our transalpine partnership with Canterbury DHB makes shared information systems increasingly important. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs.

Telehealth, videoconferencing and mobile technology, that support staff working remotely, are an important factor in addressing our rurality and isolation challenges. Investment to date has already 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 digitalisation of our new hospital, including telehealth, PatientTrak and e-Sign-off for radiology.

Areas for investment for the period of this Plan include:

- Increased focus on application portfolio management through the coming year, including consolidating a list of mission-critical IT business systems and services and embedding lifecycle management.
- Development and approval of a business case for implementation of the South Island Patient Information Care System (PICS) on the West Coast, with implementation of PICS underway by the third quarter of 2018/19.
- Increased development and use of digital capability, including implementation of e-Sign-off for radiology within Health Connect South in the third quarter of 2018/19.
- Improved technical security maturity to further secure the information we hold, with appointment of a transalpine security and risk manager and implementation of a revised single set of transalpine security policies (aligned to HISF standards) by the third quarter of 2018/19.
- Implementation of PatientTrak e-observation technology to support the delivery of safer care by the end of the second quarter of 2018/19.
- Implementation of new TeleHealth capability providing improved mobility and greater access to the technology across the wider health system, with 90% of telehealth moved to the new solution by the end of 2018/19.
- Development and approval of a business case for e-Pharmacy completed by the third quarter 2018/19, with implementation beginning in the fourth quarter of 2018/19.

3.11 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. The new Grey Base 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 delivery.

Unfortunately, ongoing delays with the building programme mean that the DHB is yet to realise anticipated efficiency savings, and increased construction costs are creating significant pressure.

It is critical that the Grey Base redevelopment is completed without further delay, and that a decision is made on the Buller solution so that this can also move forward.

Areas of investment for the period of this Plan include:

Grey Base Hospital and IFHC: Completion of the Hospital and IFHC, now anticipated in the second quarter of 2019.

Grey Base Energy Centre: The replacement Energy Centre is part of the Grey Base Hospital redevelopment and completion is now anticipated in 2019.

Buller IFHC: The DHB is engaged in determining the future model for the Buller district. DHB staff and clinical teams are working with the Ministry of Health design team to confirm the final facility design. We expect to confirm the facility development in 2018/19.

3.12 Cross-sector investment

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

Locally, we are working closely with district and regional councils, Housing NZ, ACC, Police, and the Ministries of Social Development, Education and Justice to influence and support the creation of social

and physical environments that improve population health.

We are also working closely with local agencies and partner organisations and investing in a number of initiatives aimed at improving health outcomes for the most vulnerable in our community.

Areas of investment for the period of this Plan include:

The Family Violence Interagency Response Group: The DHB is a partner in 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 and implemented.

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 forum promotes community wellbeing across the Buller community.

The Community Strength and Balance Programme: The DHB is working in collaboration with ACC to enhance our Falls Prevention Programme by providing increased access to community-based Strength and Balance Programmes for people at risk of injury from falls.

3.13 Investing in service redesign

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 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 2018/19. However, we are mindful of continuity risks while we decant and transfer services into the new Grey Base Hospital, particularly with regards to radiology and operating services. We are working with neighbouring DHBs and the Ministry of Health to assess and alleviate these risks, but anticipate that meeting national expectations may be a challenge during this period.

SERVICE REDESIGN

We work in partnership 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 through this collaborative work.

Consistent with our shared decision-making principles, we look to our clinically-led alliance work streams 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 service changes and the transformation of services.

In the coming year, the DHB will review capacity and costs across all service areas and look to prioritise resources into areas of 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, scope and location of some services.

At times, we may wish to negotiate, enter into or amend service agreements or arrangements to assist in meeting our objectives and delivering the goals outlined in this document. 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.

Anticipated service changes, identified for the period of this Plan, are highlighted on the following page.

Area Impacted	Description of Change	Anticipated Benefit	Driver
Central locality: Grey Base Hospital Campus	The DHB will relocate and reconfigure services in line with migration into the new Grey Base Hospital and Integrated Family Health Centre (IFHC).	Increased integration of services and sustainable service delivery.	Local
Secondary, Primary and Community Services	The DHB is working to redesign its model of care, including the development of three locality based integrated family health service areas and a sustainable after-hours model. This may result in the reconfiguration and relocation of some services.	Improved access, increased integration and sustainable service delivery.	Local
Needs assessment, coordination and management services	To support the model of care, the DHB is looking to bring needs assessment, coordination and management services together into one integrated HUB. This may result in the reconfiguration and relocation of some services.	Increased service integration, reduced duplication and improved patient experience.	Local
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 planned and unplanned care. This will include a new approach to the provision of after-hours, urgent and emergency level care.	Improved access, increased integration and improved outcomes.	Local
Infusion Services Orthotics Services Radiology Services Audiology Services Dementia Services	The DHB is considering the provision of a number of services, currently under hospital management, and exploring how we might better meet the needs of our population as part of the wider integrated service model.	Increased integration, sustainable service delivery and improved patient outcomes.	Local
Mental Health Services	Working under the guidance of the West Coast Alliance Mental Health Workstream, the DHB will implement the redesigned model of care for mental health services. This will include reconfiguration of the DHB's mental health service teams to align with the wider locality-based community service model. This will also include the redesign of the current Crisis Response and Māori Mental Health Service models.	Improved access, increased integration, sustainable service delivery and improved patient outcomes.	Local
Community Pharmacy Services	The DHB will work with Pharmacy providers to implement the new national pharmacy contract and develop local services in alignment with the national Pharmacy Action Plan direction.	Increased integration, improved service quality and improved outcomes.	National
Specialist services	The DHB will continue to explore how to best meet the needs of our population with ongoing redesign of transalpine pathways and service models with Canterbury DHB.	Increased integration, sustainable service delivery and improved outcomes.	Local
Primary care services	The DHB will review the location of primary care services to capture co-location opportunities, and align delivery with emerging integrated and locality-based service models.	Increased integration, sustainable service delivery and improved outcomes.	Local
Corporate and Management Services	The DHB will complete the reconfiguration of its management structure to better align responsibilities with the emerging integrated and locality-based service models.	Increased integration, improved service quality and improved outcomes.	Local

Improving Health Outcomes

Are we making a difference?

Monitoring Our Performance

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 strive to improve health equity and health outcomes for our population. As a funder, we are concerned with the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver and the efficiency with which it is delivered.

There is no single performance measure or indicator that can easily reflect the impact of the work we do. In line with our vision for the future of our health system, we have developed an over-arching intervention logic and system performance framework.

The framework helps to illustrate our population health and outcomes-based approach to performance improvement. It also encompasses national direction and expectations, through the inclusion of national targets and system level measures.

At the highest level the framework reflects our three strategic goals, where we believe success will have a positive impact on the health of our population.

Under each goal we have identified a number of population health outcomes measures that are important to our stakeholders and, over time, will provide insight into how well our health system is performing. These outcome measures are set out in detail in our Statement of Intent and reported annually in our Annual Report.

The long-term outcome measures are also captured in our local System Level Measures Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

Refer to Appendix 4 for the Intervention Logic Diagram illustrating how the services the DHB funds or provides will impact on the health of our population, contribute to the goals of the wider South Island region and deliver on the expectations of Government.

4.1 Accountability to our community

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

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

Refer to Appendix 5 for the DHB Statement of Service Performance for 2018/19 and Appendix 6 for the DHB's Statement of Financial Performance for 2018/19.

4.2 Accountability to the Minister

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.

The DHB's obligations include quarterly performance reporting in line with the Ministry's non-financial performance monitoring framework. This framework aims to provide a rounded view of DHB performance in key priority areas and uses a mix of performance markers across four dimensions. These 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.

The national framework and expectations for 2018/19 are set on the following pages.

National DHB Performance Framework 2018/19

Performance measure		Performance expectation	
HS: Supporting delivery of the New Zealand Health Strategy		Quarterly highlight report against 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 specialist services.	
	Age 20-64	>3.8% of the population access specialist services.	
	Age 65+	>3.0% of the population access specialist services.	
PP7: Improving mental health services using wellness and transition (discharge) planning		95% of clients discharged will have a quality transition or wellness plan.	
		95% of audited files meet accepted good practice.	
		Report on activities in the Annual Plan.	
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.	
		Report on activities in the Annual Plan.	
PP10: Oral Health- Mean DMFT score at Year 8		Year 1	0.94
		Year 2	0.94
PP11: Children caries-free at five years of age		Year 1	58%
		Year 2	58%
PP12: Utilisation of DHB-funded dental services by adolescents (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 will have had their CVD risk assessed in the last 5 years.		
	90% of 'eligible Māori men in the PHO aged 35-44 years' will have had their CVD 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 and ≥99% within 3 months.		
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF		
	Composite Post ACS Secondary Prevention Medication Indicator: in the absence of a documented contraindication/intolerance, all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes). Expected target for 2018/19 is >85%.		
Focus Area 5: Stroke services	10% or more of potentially eligible stroke patients' thrombolysed 24/7.		
	80% of stroke patients admitted to a stroke unit or 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.		

	60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team i.e. RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.
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 – flu vaccine.
	Report on activities in the Annual Plan.
PP22: Delivery of actions to improve system integration including SLMs	Report on activities in the Annual Plan.
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.
	Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4–6 for assessment urgency. Baseline to be established.
PP25: Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile 1-3 secondary schools, teen parent units and alternative education facilities, and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas: Primary Mental Health; District Suicide Prevention and Postvention; Improving Crisis Response Services; Improving Outcomes for Children; and Improving Employment & Physical Health Needs of people with low prevalence conditions.
PP27: Supporting child well-being	Report on activities in the Annual Plan.
PP28: Reducing Rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever ≤ 0.2 per 100,000 for the South Island DHBs.
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, and 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 2 weeks (14 calendar days, inclusive), 100% within 30 days.
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days), 100% within 90 days.
	70% of people waiting for a surveillance colonoscopy will wait no longer than 12 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.
	Report on activities in the Annual Plan.
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 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	70% of infants are exclusively or fully breastfed at 3 months.
PP39: Supporting Health in Schools	Report on activities in the Annual Plan.
PP40: Responding to climate change	Report on activities in the Annual Plan.

PP41: Waste disposal	Report on activities in the Annual Plan.	
PP43: Population mental health	Report on activities in the Annual Plan.	
PP44: Maternal mental health	Report on activities in the Annual Plan.	
PP45: Elective surgical discharges	1,916 publicly funded, casemix included, elective and arranged discharges for people living within the DHB region.	
SI1: Ambulatory sensitive hospitalisations	0-4	See SLM Improvement Plan.
	45-64	<3,892 per 100,000 people.
SI2: Delivery of Regional Plans	Provision of 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 (SIRs)	Major joint replacement - a target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - a target intervention rate of 27 per 10,000 of population.	
	Cardiac surgery a target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.	
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.	
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed SLM Improvement Plan.	
SI8: SLM patient experience of care	As specified in the jointly agreed SLM Improvement Plan.	
SI9: SLM amenable mortality	As specified in the jointly agreed SLM Improvement Plan.	
SI10: Improving cervical screening coverage	80% coverage for all ethnic groups and overall.	
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.	
SI12: SLM youth access to and utilisation of youth appropriate health services	See SLM Improvement Plan.	
SI13: SLM number of babies who live in a smoke-free household at six weeks post-natal	See SLM Improvement Plan.	
SI14: Disability support services	Report on activities in the Annual Plan.	
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan.	
SI16: Strengthening Public Delivery of Health Services	Report on activities in the Annual Plan.	
SI17: Improving quality	Report on activities in the Annual Plan.	
SI18: Improving newborn enrolment in General Practice	55% of newborns enrolled in General Practice by 6 weeks of age. 85% of newborns enrolled in General Practice by 3 months of age. Report on activities in the Annual Plan.	
OS3: Inpatient length of stay	Elective LOS suggested target is 1.45 days, which represents the 75th centile of national performance.	<1.45 days.
	Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	<2.30 days.
OS8: Reducing Acute Readmissions to Hospital	Improvement on baseline – standardised rate 10.7%.	
OS10: Improving the quality of identity data within the National Health Index and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>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 the 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 the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
Shorter stays in emergency departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.	
Faster cancer treatment	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.	
Increased immunisation	95% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	
Better help for smokers to quit	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months and 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	
Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	

Appendices

Further information for the reader

Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Minister's Letter of Expectations 2018/19
Appendix 3	Significant Actions by Life Course 2018/19
Appendix 4	Overarching Intervention Logic Diagram
Appendix 5	Statement of Performance Expectations 2018/19
Appendix 6:	Statement of Financial Performance 2018/19
Appendix 7	System Level Improvement Plan 2018/19

Documents of interest

The following documents can be found on the West Coast DHB's website (www.westcoastdhb.health.nz). Read in conjunction with this document. They provide additional context to the picture on health service delivery and transformation across our health system.

- West Coast DHB Statement of Intent
- West Coast System Level Measures Improvement Plan
- West Coast DHB Public Health Action Plan
- West Coast DHB Disability Action Plan
- West Coast DHB Quality Accounts
- South Island Regional Health Services Plan

References

Unless specifically stated, all West Coast DHB documents referenced in this document are available on the West Coast DHB website, www.westcoastdhb.health.nz. Referenced regional document are available from the South Island Alliance Programme Office website: www.siapo.health.nz. 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 our 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 Minister's Letter of Expectations 2018/19

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

Dear Ms Black

Letter of expectations for District Health Boards and Subsidiary Entities for 2018/19

This letter sets out the Government's expectations for District Health Boards (DHBs) and their subsidiary entities for 2018/19.

The Government wishes to signal an increased priority for primary care, mental health, public delivery of health services, and a strong focus on improving equity in health outcomes.

This Government listened to New Zealanders, and campaigned on these concerns. We will deliver on our democratic mandate to ensure New Zealand has a strong and effective public health service that we can all be proud of. To achieve this we want the public health service to be accessible and affordable for all New Zealanders, and to ensure that appropriate services are provided in the right locations at the right times.

Our Approach

Our Government wants to improve population health. Population health approaches and services are essential components of strategies to address determinants of health and achieve better health equity and wellbeing. I expect DHBs to work closely with and support their local public health units and health promotion providers. New Zealanders have made it clear that they are concerned about the increasing unaffordability of primary health services, regional inequity of access to secondary health services, and inadequate mental health service provision nationwide.

Our Government takes a longer term view. To this end, we will review the primary care funding formula and DHB targets, as well as wider sector settings. The Ministerial Advisory Group will also advise me on further opportunities to improve equitable health outcomes for all New Zealanders including how the system needs to change to enable those improvements. It is expected that you will be fully supportive of this work, and where appropriate will provide direct contribution.

We intend to better resource primary care in order to deliver better health outcomes, and to reduce the growing pressure on emergency services. In Budget 2018, we will lay out our plan to reduce the cost of access to primary care for New Zealanders.

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In our first 100 days we have introduced legislation to increase access to medicinal cannabis, and launched the Government Inquiry into Mental Health and Addiction. We expect your staff and members of your community to participate in the Inquiry and I expect you will encourage your people to do this.

Funding

There is no doubt that there has been a low priority on funding health in recent years. In contrast to other countries, core Crown health expenditure in New Zealand dropped as a proportion of the overall economy between 2008 and 2017. It is a credit to those who serve across the health sector that health outcomes have held up as well as they have despite nine years of under investment. Please pass on my sincere thanks to your staff for their commitment and service to the public, particularly during difficult times.

The Government is committed to delivering a well-funded public health service. That is why we will invest $8 billion to meet cost pressures and deliver new initiatives over the next four years. While this is more generous than before, much of the new funding will be absorbed in the service improvements already signalled by the Government. The public will rightly want to see the health system delivering more for them in return for the increased investment.

Capital Planning

I expect that your DHB will continue to focus on long term capital planning. This work should include service planning and understanding the state of your assets. I anticipate the need to prioritise the available capital funding, and your work in this area will assist in this process. I also require you to continue to work regionally when developing business cases for investment.

Accountability for Improved Performance

We will hold DHB Chairs directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management tightly accountable for improved performance within each DHB, particularly in relation to equity of access to health services and equity of health outcomes.

Under the previous government, relationships across the health sector became strained. My expectation is that the Ministry Advisory Group will work with the Ministry of Health to strengthen these relationships.

I trust that you will work with your regional DHBs to support regional delivery of services where appropriate. There should be strong shared responsibility and accountability across regions to ensure that regional services are delivered well and support equity of access for the population.

I expect that you will incorporate and share best practice innovation with the wider sector. Clinical leaders play a key role in this work. Strong and proactive relationships with the Ministry, other DHBs, primary health organisations (PHO), non-governmental organisations, and other stakeholders across the sector will be required. I am looking for increased collaboration across all parts of our health

service to deliver more affordable primary care, improved elective surgery volumes, improvements in equity of access to services, and a higher quality of care.

I will be meeting and speaking with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to work together to deliver in the Government's priority areas, and to keep within budget.

Workforce

To deliver affordable, accessible and quality care, workforce changes will be needed. This includes greater utilisation of different workforces in primary care settings. With a growing and aging population, there will be more work for all, and an increased emphasis on the use of generalist workforces for less specialised tasks will be required. Health care professionals from allied health, nursing, medicine and related fields will need to operate at the top of their scope of practice. I expect DHBs to be bold in their vision for change while also remaining responsive to the concerns raised by the workforce.

I understand DHB Chief Executives have collectively signed up to having Care Capacity Demand Management fully in place in all DHBs by July 2021 with oversight of progress and feedback on milestones monitored by the Safe Staffing and Health Workplaces Governance Group. I encourage you to proceed with timely implementation and expect that acute mental health inpatient services are a first priority. I also encourage you to address wider workforce development to better respond to mental health issues, in line with the *Mental Health and Addiction Workforce Action Plan*.

Additionally, to ensure greater community-based care and assist in workforce development, I expect all DHBs to adhere to the Medical Council's requirement for Community Based Attachments for interns.

We are also interested in expanding the role of health-based professionals in school settings. This includes considering the role of health-based professionals in primary and early education in the future, and extending School Based Health Services so all secondary schools have a comprehensive youth health service.

Expansion of PHARMAC model to manage hospital medicines

PHARMAC's role in managing hospital medicines has steadily increased. Most recently, since 2013 PHARMAC has made decisions on the adoption of new technology in hospital medicines. In my letter of 27 April 2018, I confirmed that from 2018/19 the full budget management responsibility for all remaining hospital medicines will move from DHBs to PHARMAC, in order to support our wider health priorities.

National Patient Flow

As you will be aware, National Patient Flow is a new developmental national collection that the Ministry and DHBs have been implementing over the past three years. The collection will provide information at key points of the patient journey through secondary and tertiary care, helping DHBs to quantify unmet referred

demand for services, and to better understand and improve their patient management processes.

I anticipate that this will become a core national collection in the future, and I expect DHBs to continue working in partnership with the Ministry with a focus on improving data submission and data quality for the National Patient Flow collection during 2018/19.

Planning for 2018/19 and the future

We are focused on ensuring better health outcomes for the public, and have clear expectations for all DHBs. This includes the following.

- Increasing the rate of organ donations. DHBs are expected to manage the associated costs within their baselines.
- Improving the health and wellbeing of infants, children and youth. I expect that your 2018/19 annual plan shows how you will achieve this, particularly for Māori, Pacific people, and people living in high areas of deprivation.
- Improving equity and reducing the burden caused by long term conditions, in particular diabetes. I expect DHBs in their contracts with PHOs to explicitly require improvements in performance and reporting. I expect DHBs to incentivise PHOs to demonstrate improvement in primary care settings and increase PHO accountability for effectively managing long term conditions with particular regard to diabetes.
- The Government also wants to support our health system to implement a strong response to climate change, this will include working with other DHBs, other agencies and across Government. Plans to address climate change and health, need to incorporate both mitigation and adaptation strategies, underpinned by cost benefit analysis of co-benefits and financial savings.

Your DHB's annual plan for 2018/19 will need to reflect my expectations. In addition, I am not requiring your DHB to refresh your Statement of Intent in 2018/19. However, I will expect all DHBs to demonstrate a renewed focus on their strategic direction by refreshing their Statements of Intent in 2019/20.

Finally, I would like to thank you and your DHB again for your ongoing work to improve the health of New Zealanders. The public deserves the highest standards of leadership and performance, and by working together we can ensure that improvements are made for our population.

Yours sincerely

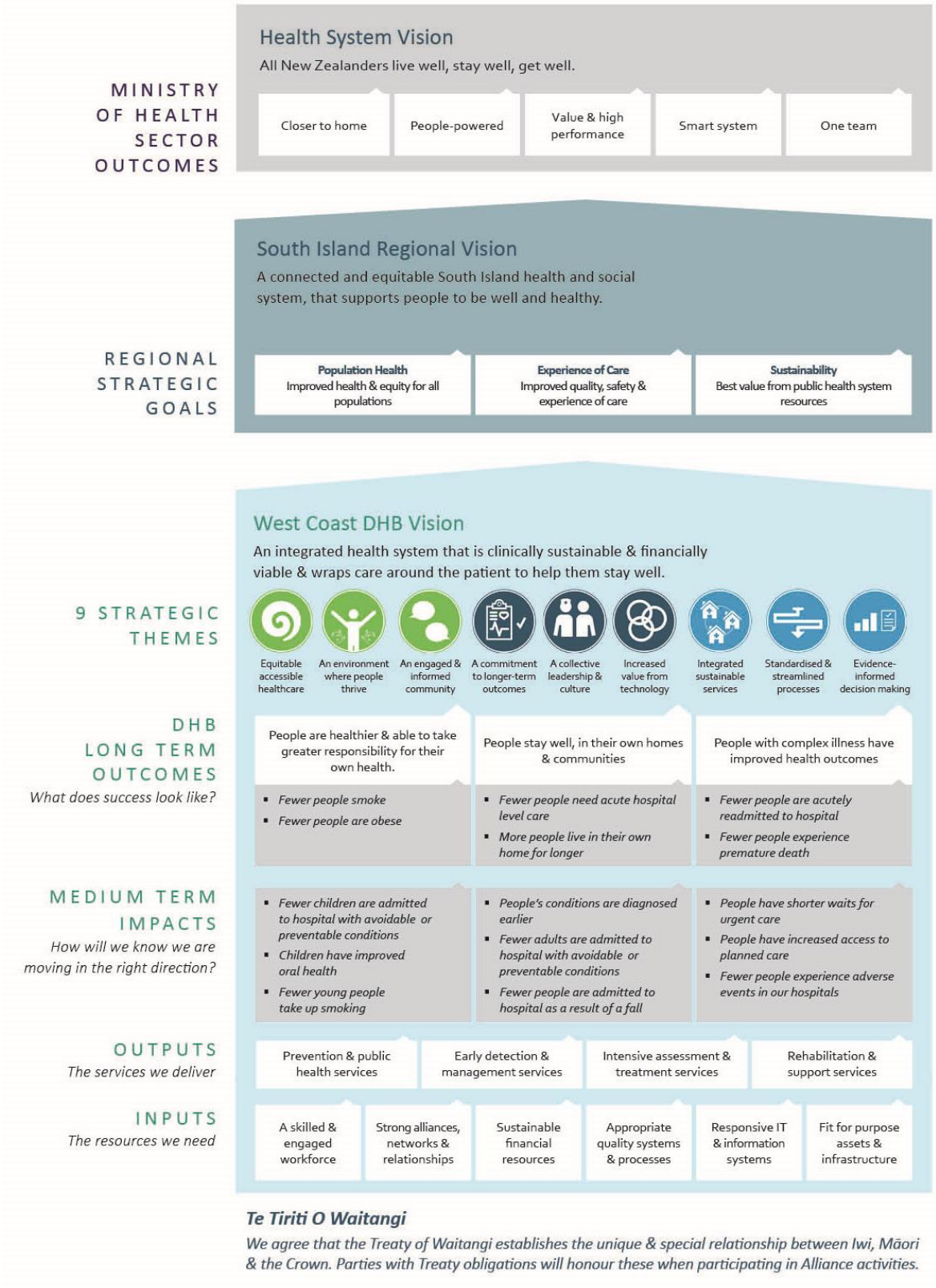
Hon Dr David Clark
Minister of Health

Appendix 3: Significant Actions by Life Course 2018/19

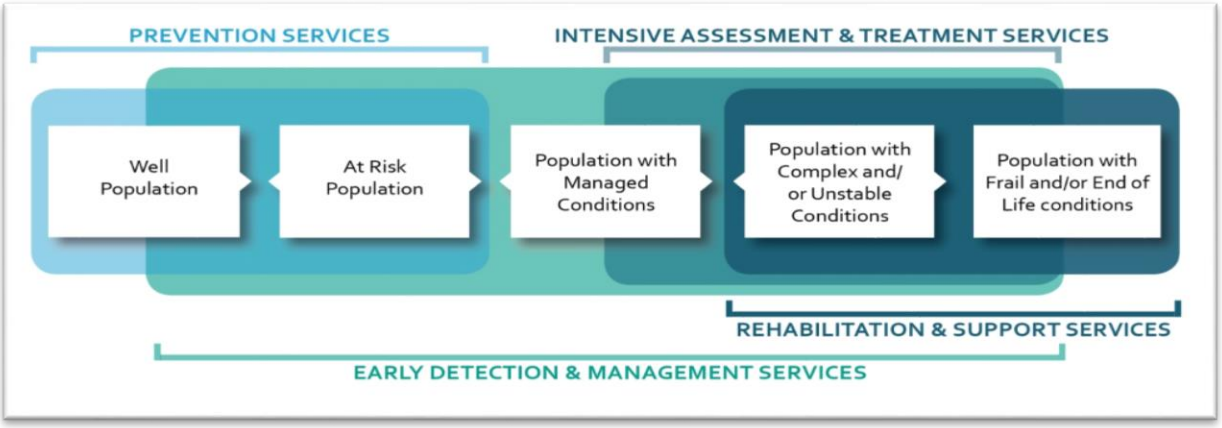
The following is a summary of the significant initiatives the DHB will deliver to meet population challenges and deliver on national expectations in 2018/19 - set out by life course groupings.

Life Course Group	Major initiative to Improve Performance in 2018/19	Priority Area	Page Ref
Pregnancy	Work with Plunket and Poutini Waiora to develop a Kaupapa Māori Pregnancy & Parenting Education Programme to support the wellbeing of wahine hapū and pepe. (EOA)	Integration	10
Early years & childhood	Develop a system-wide oral health strategy, and support the delivery of key actions identified by the Transalpine Oral Health Development Group, to address factors impacting on children's engagement with dental services, with a focus on Māori children. (EOA)	Child Wellbeing	12
Adolescence & young adulthood	Review the results of the 2018 Wellbeing Survey in Greymouth Schools and contribute to the development of recommended actions for service improvement.	Supporting Health in Schools	13
Adulthood	Realign resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based community health model.	Population Mental Health	8
	Review the current provision of Māori Mental Health Services and develop a complementary model that provides cultural support for Māori with mental health needs across both the age and severity continuum. (EOA)	Population Mental Health	8
Older Age	Continue to work with partner organisations through the Falls and Fractures SLA to enhance and integrate falls and fracture prevention services, with a focus on accreditation of community strength & balance classes targeted towards Māori. (EOA)	Healthy Ageing	17

Appendix 4 Overarching Intervention Logic Diagram



Appendix 5 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 the Monitoring Our Performance section.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are presented in our Annual Report at the end of the year.

The following section presents the West Coast DHB's Statement of Performance Expectations for 2018/19.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service we deliver, services have been grouped into four service classes. These are common to all DHBs and reflect the types of services provided across the full health and wellbeing continuum (illustrated above):

- Prevention Services
- Early Detection and Management Services
- Intensive Assessment and Treatment Services
- Rehabilitation and Support Services.

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

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time.

To ensure a balanced, well rounded picture, the mix of measures identified address four key aspects of service performance:

Access (A)
How well are people accessing services, is access equitable, are we engaging with all of our population?

Timeliness (T)
How long are people waiting to be seen or treated, are we meeting expectations?

Quality (Q)
How effective is the service, are we delivering the desired health outcomes?

Experience (E)
How satisfied are people with the service they receive, do they have confidence in us?

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 reach of prevention programmes, reducing acute or avoidable hospital admissions and maintaining access to services while reducing waiting times and delays in treatment.

We also seek to improve the experience of people in our care and public confidence in our health system.

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

It's 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.

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.

UNDERSTANDING PERFORMANCE EXPECTATIONS

With a growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority for the DHB.

All of our performance targets are universal, set with the aim of reducing disparities between population groups. A number of key focus areas have been identified to improve Māori health. These are signalled with the following symbol (◆). These service measures will be reported by ethnicity in our year-end Annual Report to highlight progress in achieving this goal.

Many of the performance targets presented in our forecast are national expectations set for all DHBs. Our small population size can mean that a small number of people can have a disproportionate impact on our results, and performance can vary year on year. While the West Coast DHB is committed to maintaining high standards of service delivery, we note that some of the national expectations are particularly challenging to meet in this regard.

NOTES FOR THE READER

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.

◇ Many national targets and performance measures are set to be achieved by the final quarter of any given year. In line with national expectations, baselines refer to the final quarter.

E Services are demand driven. 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.

◆ This measure has been identified as a key focus area for Māori. Progress by ethnicity will be reported in our Annual Report.

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Prevention services are publicly 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 therefore 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 also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Health Services – Healthy Environments				
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [13]	31	15	E. 15
Licensed alcohol premises identified as compliant with legislation	Q [14]	73%	85%	90%
Networked drinking water supplies compliant with Health Act	Q [15]	100%	95%	97%

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	2015/16 Result	2016/17 Result	2018/19 Target
Four-year-olds provided with a B4 School Check (B4SC)	A [16]◆	74%	90%	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 [17]◇◆	new	81%	95%
Women aged 25-69 having a cervical cancer screen in the last three years	A [18]◆	75%	75%	80%
Women aged 50-69 having a breast cancer screen in the last two years	A [18]◆	76%	77%	70%

[13] The expected number of submissions varies in a given year - it may be higher, for example, when Territorial Authorities are consulting on their draft long-term plans or less if the DHB is involved in the planning or pre-consultation phase. This measure includes submissions on national policy documents or legislation and local and regional council annual and long-term plans, by-laws and policies (excluding submissions on specific resource consents). It includes joint submissions made with Active West Coast, West Coast Tobacco Free Coalition and Healthy West Coast.

[14] New Zealand law prevents retailers from selling alcohol to young people aged under 18 years, with the aim of reducing alcohol-related harm for this age group. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. If the volunteer is refused alcohol the licensed premise is said to have complied with the Sale and Supply of Alcohol Act. Compliance can be seen as a proxy measure of the success of education and training and reflects a culture that encourages a responsible approach to alcohol.

[15] This measure relates to the percent of network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies (large, medium, minor, small and rural agricultural).

[16] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing health concerns to be identified and addressed early.

[17] This measure is a national performance measure (Raising Healthy Kids). Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational attainment and quality of life. The referral allows families to access support to maintain healthier lifestyles.

[18] 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.

Health Promotion and Education Services				
These services inform people about risk factors 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	2015/16 Result	2016/17 Result	2018/19 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A [19]	200	208	>100
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q [20]◆	83%	82%	75%
Babies exclusively/fully breastfed at three months	Q [20]◆	58%	61%	70%
People provided with Green Prescriptions for additional physical activity support	A [21]	543	558	>500
Green Prescription participants more active six to eight months after referral	Q [21]	58%	-	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q [22]◇◆	79%	91%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q [22]◇◆	97%	87%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q [23]◇◆	100%	89%	90%

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	2015/16 Result	2016/17 Result	2018/19 Target
Children fully immunised at eight months of age	A [24]◇◆	78%	80%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q [25]◇	100%	95%	95%
Young women (Year 8) completing the HPV vaccination programme	A [26]†◆	43%	39%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A [27]†◆	61%	55%	75%

[19] 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. The percentage of babies being breastfed can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period.

[20] These breastfeeding measures are part of the national Well Child/Tamariki Ora (WCTO) Quality Framework and standards are set nationally. The results are from the most recent Well Child Performance Report. The three-month breastfeeding baseline relates to the six months to December 2017 and the LMC breastfeeding baseline relates to the six months to June 2017. Three-month breastfeeding data from Well Child providers is currently not able to be combined so performance from the largest provider (Plunket) is presented.

[21] 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 2016/17, a decision was made nationally to shift to bi-annual surveys. The next surveys will be in 2017/18 and 2019/20.

[22] Evidence shows that the majority of smokers want to quit and need help to do so. The ABC programme has a cessation focus and refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support. The provision of profession advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts.

[23] This measure is part of the national measures set (Better Help for Smokers). Data is sourced from the Ministry of Health's national Maternity Dataset which covers approximately 80% of pregnancies nationally. As such, the measure is seen as developmental and results are used to indicate trends rather than absolute performance. Standards have been set nationally in line with other smoking targets.

[24] This measure is a national performance measure (Increased Immunisation) and standards are set nationally. The West Coast DHB has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. The DHB's focus is to immunise all those who opt-in to the immunisation programme.

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

[26] 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 2018/19 is the proportion of young women born in 2005 completing the programme.

[27] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including pregnant women, people aged over 65 and people with long-term or chronic conditions. The population data sources for this measure changed in 2016/17, from PHO enrolment registers to 2013 Census population projections. Results from previous years are not 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 and 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?

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	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A ◆	89%	90%	95%
Newborns enrolled with a PHO by three months of age	A [28]◆	77%	77%	85%
Young people (0-19) accessing brief intervention counselling in primary care	A [29]Δ	219	200	>150
Adults (20+) accessing brief intervention counselling in primary care	A [29]Δ	558	548	>450
Number of integrated HealthPathways in place across the health system	Q [30]	654	655	E. 600
Proportion of general practices offering the primary care patient experience survey	E [31]	new	new	85%

Long-Term Condition Services				
These services are targeted at people with high health needs with the aim of reducing complications and crisis through earlier intervention and treatment and by supporting people to better manage and control their conditions.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A [32]◆	3,793	3,860	>3,000
Population identified with diabetes having an annual LTCM review	A ◆	91%	74%	90%
Population with diabetes having an HbA1c test at their LTCM review showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q [33]◆	63%	54%	80%
Eligible population having a cardiovascular disease risk assessment in the last 5 years	A [34]◆	91%	91%	90%

[28] This measure is part of the national Well Child/Tamariki Ora (WCTO) Quality Framework and standards are set nationally. The results have been updated to reflect results from the September 2016 and September 2017 Well Child Framework Reports.
[29] 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.
[30] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The pathways support consistent access to treatment and care no matter where people present.
[31] 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.
[32] This measure refers to the primary care run programme where enrolled patients are provided with an annual review, targeted care plan and self-management advice to help change their lifestyle, improve their health and reduce the negative impacts of their condition.
[33] Diabetes is a leading long-term condition and a contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.
[34] Cardiovascular disease is a leading cause of death on the West Coast. By identifying those at risk of cardiovascular disease early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious event. Targets and eligible population is set nationally: Māori, Pacific or Indian: males 35-74, females 45-74; and all other males 45-74, 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	2015/16 Result	2016/17 Result	2018/19 Target
Children (0-4) enrolled in DHB funded oral health services	A [35]†◆	87%	97%	95%
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T †◆	78%	93%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A †	75%	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.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of subsidised pharmaceutical items dispensed in the community	A [36Δ]	455k	466k	E.<500K
People (65+) being dispensed 11 or more long-term medications (rate per 1,000)	Q [37]	4.4	4.2	E. 4.4
Number of community-referred radiological tests delivered at Grey Base Hospital	A	5,504	5,817	E.>5,000
People receiving their urgent diagnostic colonoscopy within two weeks	T [38◇]	100%	100%	90%
People receiving their Magnetic Resonance Imagining (MRI) scans within six weeks	T [38◇]	80%	92%	90%
People receiving their Computed Tomography (CT) scan within six weeks	T [38◇]	100%	100%	95%

[35] These oral health measures are national DHB performance measures (PP12 and 13) and standards are set nationally. Oral health is an integral component of lifelong health and wellbeing. Early and continued contact with oral health services helps to set life-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[36] This measure relates to 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.

[37] The use of multiple medications is most common in the elderly and can lead to reduced drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and high costs for the system with little health benefit. Multiple medication use requires monitoring and review to validate whether all of the medications are complementary and necessary.

[38] These measures are national DHB performance measures (PP29) and refer to non-urgent scans. By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and by reducing long waits for diagnosis or treatment improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). Standards are set nationally and in line with national reporting the results presented refer to the final month of each year (June).

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. 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.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Staff compliant with good hand hygiene practice	Q [39]◇	81%	80%	80%
Hip and knee replacement patients receiving routine antibiotics before surgery	Q [40]◇	95%	96%	95%
Inpatients (aged 75+) receiving a falls risk assessment	Q [41]◇	88%	91%	90%
Response rate to the national inpatient patient experience survey	E [42]	35%	28%	>30%
Proportion of patients who felt 'hospital staff included their family/whānau or someone close to them in discussions about their care'	E	54%	76%	65%

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	2015/16 Result	2016/17 Result	2018/19 Target
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A [43]†◆	54%	79%	80%
Number of maternity deliveries in West Coast DHB facilities	A	246	250	E. 300
Baby friendly hospital accreditation achieved in DHB facilities	Q [44]	Yes	Yes	Yes

[39] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. Standards are set nationally and results refer to the final quarter (April-June).
[40] 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.
[41] While there is no single solution to reducing falls, an essential first step is to assess an individual's risk of falling and act accordingly.
[42] 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.
[43] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report.
[44] 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 are indicative of a responsive system.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of presentations at the Grey Base Hospital Emergency Department (ED)	A [45]	11,742	11,382	E.<13,000
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T [46]	80%	79%	85%
Proportion of the population presenting at ED (per 1,000 people)	Q	349	342	<356
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 [47]◇	80%	56%	90%
Average acute inpatient length of stay (bed days per 1,000 people)	Q [48]	2.40	2.36	2.30

Elective and Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment. 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	2015/16 Result	2016/17 Result	2018/19 Target
Number of First Specialist Assessments provided	A [49]	6,591	7,232	E.>6,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [50]	12.5%	16%	>10%
Number of elective/arranged surgical discharges (surgeries provided)	A ◇	1,942	1,979	1,916
Average elective inpatient length of stay (bed days per 1,000 people)	Q [48]	1.55	1.34	1.45
Number of outpatient consultations provided	A	15,257	15,479	E. >13k
Proportion of outpatient appointments provided by telemedicine	Q [51]	2.3%	3.3%	>5%
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [52]Δ◆	5.9%	5.6%	<6%

[45] This measure is aligned to the national Shorter Stays in ED performance measures and counts presentations to the ED in line with the national measure definition. This measure excludes those who do not wait and those with pre-arranged appointments.

[46] 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.

[47] This measure is the national performance measure (Faster Cancer Treatment). Standards are set nationally.

[48] This measure is a national DHB performance measure (OS3). By shortening the average length of a hospital stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective (planned) 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 spent 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.

[49] 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.

[50] Non-contact assessments are those where advice or assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients.

[51] Increasing value from technology is a key strategic focus for the DHB and the use of telehealth or videoconferencing technology helps to reduce unnecessary travel for patients, their families and clinical staff – particularly when specialists are based in other DHBs. This measure has been updated to reflect the proportion of total outpatient appointments delivered using telehealth.

[52] 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. 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.

Specialist Mental Health and Alcohol and Other Drug (AOD) 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 demand for services, is indicative of a responsive service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population (0-19) accessing specialist mental health services	A [53Δ]	5.5%	5.3%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	A [Δ]	5.2%	5.7%	>3.8%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T [54]	81%	76%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	94%	89%	95%
Adult inpatients accessing community services within 7 days of discharge	Q [55]	70%	71%	80%

[53] The access measures are national DHB performance measures (PP6). Standards are set based on 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 part of the DHB's strategy being to better support people earlier and closer to home, it is expected that rates will come down over time. Data is sourced from the Ministry's national PRIMHD dataset and results are provided three months in arrears. Providers include non-government service providers who provide specialised mental health services and submit records to the national dataset.

[54] The wait time measures are national DHB performance measures (PP8). Standards are set nationally. Data is sourced from the Ministry's national PRIMHD database and results are provided three months in arrears.

[55]This measure is seen as an indicator of suicide prevention activity and patient safety, reflecting continued support for people who have experienced an acute psychiatric episode requiring hospitalisation. Research indicates that people have increased vulnerability immediately following discharge, including higher risk for suicide, while those leaving hospital with a formal discharge plan and links with community services and supports are less likely to experience early readmission. Data is sourced from the NZ Mental Health and Addictions KPI Programme reports (indicator KPI 19) and standards are set nationally.

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 care 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 enables 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?

Assessment, Treatment and Rehabilitation (AT&R) 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	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of AT&R inpatients discharged home rather than into residential care	Q[56Δ]	88%	91%	80%
Proportion of inpatients referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	Q	31%	91%	80%
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A [57]	new	yes	3
People (65+) supported by the community-based Falls Prevention Service	A [58]	16	117	>120

Home-Based Support Services				
These are services designed to support people to continue living in their own homes and to maintain their functional independence. Largely-demand driven, clinical assessment ensures access to services is appropriate and equitable.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of Meals on Wheels provided	A [59Δ]	33,561	33,772	E. 35,000
People supported by district nursing services	A [Δ60]	1,071	1,628	E. >1,000
People supported by long-term, home-based support services	A [Δ]	786	1,079	E. >1,000
Proportion of people supported by long-term, home-based support services who have had a clinical assessment of need using the InterRAI assessment tool	Q [61Δ]	93%	93%	95%

[56] A discharge from AT&R services to home, rather than into aged residential care, is seen as reflective of the quality and effectiveness of services in assisting that person to regain their functional independence. With appropriate community supports, people who are able to remain safely in their own homes and communities and to 'age in place' report higher levels of satisfaction and quality of life.

[57] The Flexible Integrated Rehabilitation Support Team (FIRST) provides a range of home-based rehabilitation services to facilitate people's early discharge from hospital. The service is a comprehensive part of the broader continuum of care for older people, ensuring a seamless transfer of care between hospital and community settings.

[58] 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.

[59] 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.

[60] This measure previously counted district nursing visits and has been updated to reflect the people supported by our system. The initial baseline for 2015/16 reflect seven months to June 2016. The previous counts reflected 3,830 visits in 2016/17.

[61] 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 Support 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, or to give carers a break. 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	2015/16 Result	2016/17 Result	2018/19 Target
Number of mental health planned and crisis respite service bed-days accessed	A Δ	365	482	E. 500
Older people supported by aged care respite services	A Δ	61	45	E. 70

Aged Residential Care Services				
With an ageing population, demand for aged residential care (ARC) is expected to increase. However, 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	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population (75+) accessing rest home level services in ARC	A [62Δ]	5.47%	4.64%	E.<6.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A Δ	6.05%	6.21%	E.<6.5%
Proportion of the population (75+) accessing dementia services in ARC	A Δ	0.84%	0.85%	E. 0.85%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A Δ	0.44%	0.47%	E. 0.45%
People entering ARC having had a clinical assessment of need using InterRAI	Q Δ	90%	100%	95%

[62] *These Aged Residential Care (ARC) measures refer to people accessing DHB funded ARC services and excludes people choosing to enter ARC and pay privately, and people living independently in a retirement village. The South Island has historically had higher ARC rates than national levels. Access rates for more complex care such as dementia and psychogeriatric care are driven by the age of our population and less amendable. However, by providing high quality health services for older people to help them maintain health and remain in their own homes for longer, we expect to see a reduction in demand for rest home level care relative to the more complex care interventions.*

Appendix 6 Statement of Financial Expectations

West Coast's financial outlook

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, if we are to be sustainable, 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 also face a number of unique challenges due to our size and geographic isolation which add to our fiscal challenges, including:

Over-reliance on locum staff: Difficulties in recruiting staff to the rurality of the West Coast means the DHB has to rely heavily on locums to fill gaps. While the use of locums allows services to be maintained in the short term, this reduces continuity of care for patients and is an expensive and unsustainable solution.

The costs of inter-district flow: Each DHB is funded to cover the cost of services provided to their resident population. Because of our small size, we rely on larger DHBs to provide more complex specialist services for our population and must pay for those services. While the service prices are set nationally, cost increases have historically exceeded annual funding increases.

In addition we are in the midst of a significant facilities redevelopment and remediation programme which adds further financial pressure including:

The costs of seismic remediation: The level of remediation 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.

The cost of building delays: Delays in completion of our hospital and IFHC redevelopments increase construction costs and delay anticipated operational savings as efficiencies cannot be realised.

There is no easy solution. Improving the health of our population is the only way to reduce the demand curve. Savings will be made, not in dollar terms, but in costs avoided through more effective use of available resources. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system. The DHB is committed to continuing its deliberate strategy in this regard.

Planned results

The West Coast DHB is predicting a $6.087 million dollar deficit result for the 2018/19 year.

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $153m to meet the needs of our population in 2018/19.

This represents a 2.27% increase on the previous year and whilst this equates to a $4.137m increase in funding, it includes revenue for pay equity settlements which come with associated expenditure. The DHB's forecast is based on receiving the minimum percentage funding increase available to DHBs in 2018/19.

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 this document 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 2018/19 are based on the funding advice received by the Ministry in May 2018.
- Out-years funding is assumed at an average of 1.82% increase per annum.
- The West Coast DHB will continue to receive Crown Funding on an early payment basis.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Funding for all aspects of pay equity settlements will be cost neutral and fully funded. We have assumed that additional funding will be received from the Crown for the expired nursing settlement that is currently being negotiated. The quantum of this revenue has been assumed as cost neutral over the anticipated 2% previously advised and included.
- 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.
- The approved forecasted deficit will be funded via Crown deficit support (equity injections).

- Work will continue on the facilities redevelopment for Grey Base and Buller under the nationally appointed Hospital Redevelopment Partnership Group.
- The associated costs and capital expenditure for the Grey Base redevelopment have been included in the capital budget with an estimated completion date of April 2019.

  The net operating result, for 2018/19 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.
- 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 total associated development costs and any capital or lease expenditure have not been included in forecasts.

Closing the gap

Alongside the transformation of our health services we are focused on efficiency 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 all available resources including:

- Integrating systems and services and improving production planning to ensure we use our resources in the most effective way.
- Streamlining and standardising processes to remove variation, duplication and waste.
- 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 the Managing Our Business section of this document.

Capital 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 originally scheduled for June 2018. Completion is now scheduled for the second quarter of 2019. The revised budget for this development is currently $77.8m and it is expected that there will be additional costs. At this stage we anticipate an additional $10-13m. These additional costs will be finalised in due course.

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 2018/19.

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 is yet to be confirmed.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $2.6m for the 2018/19 year. In addition to the normal capital requirements, the Grey redevelopment requires greater investment in capital equipment than would normally be afforded, for example additional Information and Technology infrastructure.

Strategic capital for 2018/19-2021/22 comprises of:

- Mental health redevelopment (notionally $5m).
- Grey Base Hospital furniture, fit out and equipment (notionally $1.7m).
- Phased upgrade of clinics outside Westport and Greymouth (notionally $0.450m per clinic).
- Secondary tranche Grey Base Hospital redevelopment (notionally $5m).
- Move to the South Island Patient Information Care System (notionally $1.8m).
- Investment in other strategic IT/integration systems, including regional IT systems, (notionally $0.5m - $1m p.a).

We anticipate 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, where 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 at that time was 3.75% (2.25% versus 6.00%).

EQUITY

The Grey Base Hospital and IFHC redevelopment is now expected to be completed in the second quarter of 2019 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 for the value of the build.

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 $5m, 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's contribution for 2018/19 will be approximately $0.170m.

With an annual budget of over $9.3m, 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 2018/19 will be approximately $0.082m.

DISPOSAL OF LAND

The DHB currently has a stock of assets, consisting of properties and parcels of land right across the West Coast, a number of which have existing leasehold arrangements. The DHB is engaged in an ongoing process of considering the future of these assets based on future models of care and facilities requirements.

Necessary approvals will be sought to dispose of any DHB land identified as surplus to requirements. This includes first undertaking the required consultation and obtaining the consent of the responsible Minister. Land would also 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.

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. These are presented in the DHB's Statement of Intent, available on our website www.wcdhb.health.nz.

Statement of comprehensive income – year ending 30 June

As at 30 June for the years ending 2016/17 to 2021/22

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/6/20 Plan $'000	30/06/21 Plan $'000	30/06/22 Plan $'000
Income						
Ministry of Health revenue	131,558	136,789	141,248	144,104	146,730	149,642
Patient related revenue	2,666	7,187	6,860	6,634	6,634	6,634
Other operating income	8,140	4,812	4,084	4,112	4,138	4,166
Interest income	408	380	360	360	360	360
Total Income	142,772	149,169	152,552	155,210	157,862	160,802
Operating Expenses						
Personnel	57,483	60,132	61,977	63,974	65,466	67,082
Outsourced services (clinical and non clinical)	8,692	8,663	8,480	8,437	8,520	8,607
Treatment related costs	8,402	8,919	7,750	7,809	7,901	7,982
External service providers (include Inter-district outflow)	53,094	58,152	62,978	63,481	63,995	64,492
Depreciation & amortisation	3,373	2,911	4,110	4,939	5,305	5,351
Interest expenses	343	-	-	-	-	-
Other expenses	11,446	11,934	11,820	12,125	12,297	12,377
Total Operating Expenses	142,833	150,712	157,115	160,765	163,484	165,891
Operating surplus before capital charge	(61)	(1,543)	(4,563)	(5,555)	(5,622)	(5,089)
Capital charge expense	739	1,387	1,524	5,748	5,748	6,348
Surplus / (Deficit)	(800)	(2,930)	(6,087)	(11,303)	(11,370)	(11,437)
Other comprehensive income	-	(3,599)	-	-	-	-
Total Comprehensive Income	**(800)**	**669**	**(6,087)**	**(11,303)**	**(11,370)**	**(11,437)**

Statement of financial position – year ending 30 June

As at 30 June for the years ending 2016/17 to 2021/22

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/6/20 Plan $'000	30/06/21 Plan $'000	30/06/22 Plan $'000
CROWN EQUITY						
General funds	86,062	85,994	166,675	172,694	183,929	195,231
Revaluation reserve	22,082	25,681	25,681	25,681	25,681	25,681
Retained earnings	(83,036)	(85,968)	(92,054)	(103,357)	(114,727)	(126,164)
TOTAL EQUITY	**25,108**	**25,707**	**100,302**	**95,018**	**94,883**	**94,748**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	10,811	11,724	10,665	5,571	8,077	10,630
Trade & other receivables	4,992	3,725	3,726	3,726	3,726	3,726
Inventories	1,060	1,058	1,058	1,058	1,058	1,058
Assets classified as held for sale	-	-	-	-	-	-
Investments (3 to 12 months)	-	-	-	-	-	-
Restricted assets	72	54	54	54	54	54
TOTAL CURRENT ASSETS	16,935	16,561	15,503	10,409	12,915	15,468
CURRENT LIABILITIES						
Trade & other payables	9,188	11,917	11,917	11,917	11,917	11,917
Capital charge payable	-	-	-	-	-	-
Employee benefits	7,243	7,525	7,321	7,322	7,323	7,323
Restricted funds	70	70	70	70	70	70
Borrowings	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES	16,501	19,512	19,308	19,309	19,310	19,310
NET WORKING CAPITAL	434	(2,951)	(3,805)	(8,900)	(6,395)	(3,842)
	-	-	-	-	-	-
NON CURRENT ASSETS	-	-	-	-	-	-
Investments (greater than 12 months)	567	519	604	604	604	604
Property, plant, & equipment	26,250	30,136	105,547	103,084	100,256	97,380
Intangible assets	636	446	399	2,673	2,861	3,049
TOTAL NON CURRENT ASSETS	27,453	31,101	106,550	106,361	103,721	101,033
NON CURRENT LIABILITIES						
Employee benefits	2,779	2,443	2,443	2,443	2,443	2,443
Borrowings	-	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	2,779	2,443	2,443	2,443	2,443	2,443
NET ASSETS	**25,108**	**25,707**	**100,302**	**95,018**	**94,883**	**94,748**

Statement of movement in equity – year ending 30 June

As at 30 June for the years ending 2016/17 to 2021/22

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/06/22 Plan $'000
Total Equity at Beginning of the Period	12,409	25,108	25,707	100,302	95,018	94,883
Total Comprehensive Income	(800)	669	(6,087)	(11,303)	(11,370)	(11,437)
Other Movements						
Contribution back to Crown - FRS3	-	-	-	-	-	
Contribution from Crown - Capital	14,377	-	77,801	-	-	-
Contribution from Crown - Operating Deficit Support	(878)	-	2,949	6,087	11,303	11,370
Other Movements	-	(68)	(68)	(68)	(68)	(68)
Total Equity at End of the Period	**25,108**	**25,707**	**100,302**	**95,018**	**94,883**	**94,748**

Statement of cashflow – year ending 30 June

As at 30 June for the years ending 2016/17 to 2021/22

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/06/22 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	132,632	136,808	141,249	144,104	146,730	149,642
Other receipts	12,608	12,689	10,943	10,746	10,772	10,800
Interest received	408	420	360	360	360	360
	145,648	149,917	152,552	155,210	157,862	160,802
Cash was applied to:						
Payments to employees	65,900	67,444	69,327	71,077	72,639	74,327
Payments to suppliers	76,218	77,056	83,123	84,748	85,539	86,211
Interest paid	343	-	(1)	1	1	1
Capital charge	739	1,296	1,524	5,748	5,748	6,348
GST - net	706	362	(2,822)	-	-	-
	143,906	146,158	151,152	161,574	163,926	166,887
Net Cashflow from Operating Activities	**1,742**	**3,759**	**1,401**	**(6,364)**	**(6,064)**	**(6,085)**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	12	7	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	12	7	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	2,720	2,785	5,341	4,749	2,665	2,664
	2,720	2,785	5,341	4,749	2,665	2,664
Net Cashflow from Investing Activities	**(2,708)**	**(2,778)**	**(5,341)**	**(4,749)**	**(2,665)**	**(2,664)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	(68)	-	2,949	6,087	11,303	11,370
Equity Injection - Deficit Support	-	-	-	-	-	-
Loans Raised	-	-	-	-	-	
	(68)	-	2,949	6,087	11,303	11,370
Cash applied to:						
Other	4	68	68	68	68	68
Equity Repayment	-	-	-	-	-	
	4	68	68	68	68	68
Net Cashflow from Financing Activities	**(72)**	**(68)**	**2,881**	**6,019**	**11,235**	**11,302**
Overall Increase/(Decrease) in Cash Held	(1,038)	913	(1,059)	(5,094)	2,506	2,553
Add Opening Cash Balance	11,849	10,811	11,724	10,665	5,571	8,077
Closing Cash Balance	**10,811**	**11,724**	**10,665**	**5,571**	**8,077**	**10,630**

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

As at 30 June for the years ending 2016/17 to 2021/22

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/6/22 Plan $'000
Funding Arm						
Revenue						
MoH Revenue	130,368	135,636	140,275	143,112	145,758	148,649
Patient Related Revenue	-	-	-	-	-	-
Other	1,661	1,789	1,887	1,913	1,939	1,966
Total Revenue	132,029	137,426	142,162	145,025	147,697	150,615
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	91,354	95,415	102,133	103,729	105,359	106,994
Mental Health	14,192	14,549	14,818	15,047	15,278	15,516
Disability Support	18,063	21,590	21,804	21,982	22,160	22,343
Public Health	599	642	619	624	630	634
Maori Health	811	814	824	826	829	831
Governance & Admin	826	826	828	844	860	878
Total Expenditure	125,846	133,836	141,026	143,052	145,116	147,196
Net Surplus/(Deficit)	**6,183**	**3,589**	**1,136**	**1,973**	**2,581**	**3,419**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**6,183**	**3,589**	**1,136**	**1,973**	**2,581**	**3,419**

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/6/22 Plan $'000
Governance Arm						
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	2,462	2,829	873	890	905	925
Total Revenue	2,462	2,829	873	890	905	925
Expenditure						
Personnel	994	1,167	1,211	1,241	1,340	1,363
Outsourced services	705	943	994	997	1,007	1,017
Depreciation	-	1	-	1	1	1
Interest & Capital Charge	-	-	-	-	-	-
Other	761	717	427	474	434	436
Total Expenditure	2,460	2,828	2,632	2,713	2,782	2,817
Net Surplus/(Deficit)	**2**	**2**	**(1,759)**	**(1,823)**	**(1,877)**	**(1,892)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**2**	**2**	**(1,759)**	**(1,823)**	**(1,877)**	**(1,892)**

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

As at 30 June for the years ending 2016/17 to 2021/22

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/6/22 Plan $'000
Provider Arm						
Revenue						
MoH Revenue	1,190	1,153	973	992	973	991
Patient Related Revenue	2,666	7,187	6,860	6,634	6,634	6,634
Other	78,802	77,746	79,733	81,241	82,774	84,343
Total Revenue	82,658	86,086	87,566	88,867	90,381	91,968
Expenditure						
Personnel	56,489	58,965	60,766	62,733	64,126	65,719
Outsourced services	7,987	7,720	7,486	7,440	7,513	7,590
Depreciation	3,373	2,910	4,110	4,938	5,304	5,350
Interest & Capital Charge	739	1,387	1,524	5,748	5,749	6,349
Other	21,054	21,624	19,143	19,461	19,764	19,923
Total Expenditure	89,641	92,606	93,029	100,320	102,456	104,931
Net Surplus/(Deficit)	**(6,983)**	**(6,520)**	**(5,463)**	**(11,453)**	**(12,075)**	**(12,963)**
Other Comprehensive Income	-	(3,599)	-	-	-	-
Total Comprehensive Income	**(6,983)**	**(2,921)**	**(5,463)**	**(11,453)**	**(12,075)**	**(12,963)**

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/6/22 Plan $'000
In House Elimination						
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(74,377)	(77,171)	(78,048)	(79,571)	(81,121)	(82,704)
Total Revenue	(74,377)	(77,171)	(78,048)	(79,571)	(81,121)	(82,704)
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(74,377)	(77,170)	(78,048)	(79,571)	(81,121)	(82,704)
Total Expenditure	(74,377)	(77,170)	(78,048)	(79,571)	(81,121)	(82,704)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**

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

As at 30 June for the years ending 2016/17 to 2021/22

	30/06/17 Actual $'000	30/06/18 Forecast $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/6/22 Plan $'000
CONSOLIDATED						
Revenue						
MoH Revenue	131,558	136,789	141,248	144,104	146,731	149,640
Patient Related Revenue	2,666	7,187	6,860	6,634	6,634	6,634
Other	8,547	5,193	4,445	4,473	4,497	4,530
Total Revenue	142,772	149,170	152,553	155,211	157,862	160,804
Expenditure						
Personnel	57,483	60,132	61,978	63,974	65,465	67,083
Outsourced services	8,692	8,663	8,480	8,437	8,520	8,607
Depreciation	3,373	2,911	4,110	4,939	5,305	5,351
Interest & Capital Charge	739	1,387	1,524	5,748	5,749	6,349
Other	73,284	79,006	82,548	83,416	84,193	84,851
Total Expenditure	143,572	152,100	158,640	166,514	169,232	172,241
Net Surplus/(Deficit)	**(800)**	**(2,930)**	**(6,087)**	**(11,303)**	**(11,370)**	**(11,437)**
Other Comprehensive Income	-	3,599	-	-	-	-
Total Comprehensive Income	**(800)**	**669**	**(6,087)**	**(11,303)**	**(11,370)**	**(11,437)**

Appendix 7 System Level Improvement Plan

To be inserted here

Annual Plan

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