WEST COAST DISTRICT HEALTH BOARD

ANNUAL PLAN

Incorporating the 2019/20 Statement of Performance Expectations

2019/20

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.

Linking with our Statement of Intent, 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 the sustainability of our health system. It also contains our Statement of Performance Expectations for the coming year and actions we will take in response to national priorities and expectations in 2019/20.

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

The West Coast DHB has made a strong commitment to 'whole of system' service planning. We work collaboratively and in partnership with other service providers, agencies and community organisations to meet the needs of our population and support a number of clinically-led Alliances as key vehicles for implementing system improvement and change.

Our alliance framework means we share a joint vision for the future of our 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.

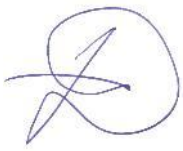
The DHB recognises its role in actively addressing disparities in health outcomes for Māori and we are committed to making a difference. We work closely with Tatau Pounamu and Poutini Waiora, directly and through the West Coast Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of Te Tiriti o 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 2019/20.

Jenny Black
CHAIR | WEST COAST DHB

Chris Mackenzie
DEPUTY CHAIR | WEST COAST DHB

David Meates
CHIEF EXECUTIVE | WEST COAST DHB



Honourable David Clark 11/11/19
MINISTER OF HEALTH

September 2019

Letter of Approval

Hon Dr David Clark

MP for Dunedin North
Minister of Health

Associate Minister of Finance

11 NOV 2019

Ms Jenny Black
Chair
West Coast District Health Board

Dear Jenny

West Coast District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed West Coast District Health Board's (DHB's) 2019/20 Annual Plan for one year.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan on the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

I am aware that you have advised the Ministry of Health (the Ministry) of an improving out-years position. However, I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 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.

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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 that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your annual plan.

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 2019/20 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

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Foreword from the Chair and Chief Executive

The West Coast DHB is the smallest and the most rural health system in the country. This presents a number of unique challenges, and in response we have committed a new approach which recognises our strengths and seeks to build a much more integrated and resilient system.

While our vision is simple, it is ambitious - an integrated health system that is both clinically and financially viable; a health system that wraps care around people and helps them to stay healthy and well in their own community.

Transforming the way we work

Over the past few years we have charted a course to transform our health system and better respond to your health needs. A strong platform now exists to launch the next phase of our journey, to really accelerate integration, bring health services closer to your home and provide the right mix of support in the right place, at the right time.

With the development of three locality bases, in Westport, Greymouth and Hokitika, services traditionally seen as hospital-based will begin to be available in primary and community settings.

We will do this by enhancing general practice and investing more in community-based health services to build capacity and capability and better support the integration of services such as: palliative care, mental health and addiction services, community nursing, restorative care and rehabilitation services.

Transforming our workforce models

In supporting this direction, we need to ensure that we have strong teams in place. The development of a truly rural workforce is at the heart of our transformation and is one of the most complex and challenging aspects of our vison. Establishing a rural generalist model will take strong clinical leadership and ongoing conversations within and beyond our health sector.

We envisage a future where our people will work across traditional boundaries, to support the creation of one truly rural workforce that will provide greater continuity and access to care for our population. We are committed to developing and growing our rural workforce model, with deliberate investment in training and support for people to work at the top of their scope in 2019/20.

Addressing equity

We are also strengthening our focus on actions that will improve health outcomes for Māori. These actions are outlined in our Annual Plan and System Level Measures Improvement Plan. To support this work, we are deliberately investing in strategies to build a workforce that better reflects the diversity of our community.

Launching new facilities

Te Nikau (the new Grey Hospital and Health Centre) will underpin our transformation in the coming year, by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service delivery.

Construction of the new administration building on Cowper Street is expected to commence shortly. Our Board also endorsed the final Buller Health facility concept in May 2019. A facilities mock-up space is expected to be established this year, allowing staff, consumers and the wider community to engage in the next phases of design and 'test' the layout to ensure that things are functional and fit for purpose. The new facility is expected to be complete by September 2021.

The DHB is also investing in the Haast community with a new rural clinic based in the Haast town centre. This modern facility will enable greater collaboration with St John and support our rural nurse specialists to provide the best care for our southern community.

Collaborating for better outcomes

In supporting our communities to thrive, we welcome the opportunity of working with a whole range of agencies, local authorities, education, social welfare and justice, and will be looking for new ways to collaborate in the coming year.

We will continue to work with our regional counterparts, particularly Canterbury DHB, as part of our shared transalpine model, to support the delivery of services for our community and to progress regional priorities outlined in the South Island Regional Health Services Plan. We will also continue our planned investment in regional information systems and solutions that will support our transformation.

In our health system, achieving the best outcomes for our community relies on everyone coming together. We cannot achieve our goals without the dedication and hard work of our staff and other health providers across the district, and we thank them for their ongoing commitment and dedication. We also thank our local community for their advice and input into service design and for keeping our focus on what matters for patients, whānau and our community.

We look forward to bringing our vision to life in 2019/20.

David Meates
Chief Executive

Jenny Black
Chair, West Coast DHB

September 2019

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 our resident population.

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

In 2019/20, we will receive approximately $159.7 million dollars to meet the needs of our population. In accordance with legislation, and consistent with Government objectives, we will use that funding to:

Plan the future direction of our health system and, in collaboration with clinical leads and alliance partners, develop demand strategies and 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 collaborative partnerships and ongoing performance monitoring, ensure these services are safe, equitable and effective.

Provide health services to our population, through our hospital and specialist services, general practices, and community and home-based support services.

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.

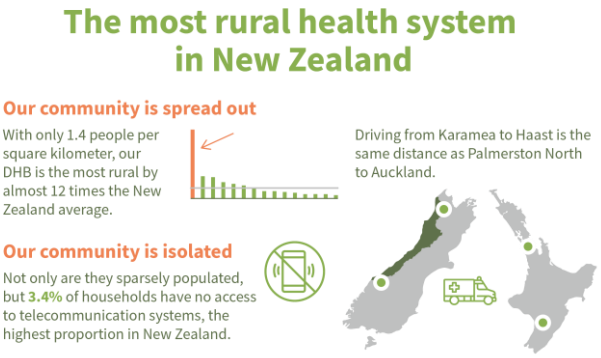
1.2 What makes us different?

The West Coast DHB has the smallest population of any DHB in New Zealand. We are responsible for 32,410 people, or 0.65% 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 operate four major health facilities in Westport, Reefton, Greymouth and Hokitika and eight smaller clinics in our more remote areas. Unlike most other DHBs, we own and operate four of the seven general practices on the Coast and we also operate a district nursing and home-based support service. This makes us a major local employer, with more than 1,000 people directly employed by the West Coast DHB.

In addition, we hold and monitor more than 80 service contracts with other organisations and individuals who also provide health and disability services to our population, including pharmacies, lead maternity carers, aged residential care providers, public health and Māori health providers and the West Coast PHO.



As New Zealand's smallest DHB, our population levels and the resources we have available to us mean we cannot provide a full range of specialist services on the West Coast. In some instances, we must refer patients to larger centres with more specialised capacity.

A formal transalpine service partnership established with the Canterbury DHB means Canterbury specialists provide regular outpatient clinics and surgical lists on the West Coast. This arrangement, and our deliberate investment in telemedicine technology, provides our population with improved access to highly specialised services and helps to save people and their families from having to travel long distances for assessment and treatment.

The West Coast and Canterbury DHBs have shared operational resources since 2010. This includes a joint chief executive, executive directors, clinical leads and corporate service teams.

1.4 Our population profile

The West Coast has a relatively static population, almost unchanged for the last ten years and predicted to decrease slightly over the next ten years. However, our population has an older age structure, compared to NZ as a whole, with 19.4% of our population aged over 65, compared with the national average of 15.8%.

By 2025 one in every four people on the West Coast will be over 65 years of age.

Many long-term conditions become more common with age, including heart disease, stroke, cancer, and dementia. As the average age of our population increases more people will need treatment and support, putting increasing pressure on our system.

Deprivation is a strong predicator of the need for health services and a key driver of health inequities. In 2018, one in every ten residents on the West Coast (3,003 people) were living in areas classified as socio-economically deprived. Higher proportions of our population are receiving unemployment or invalid

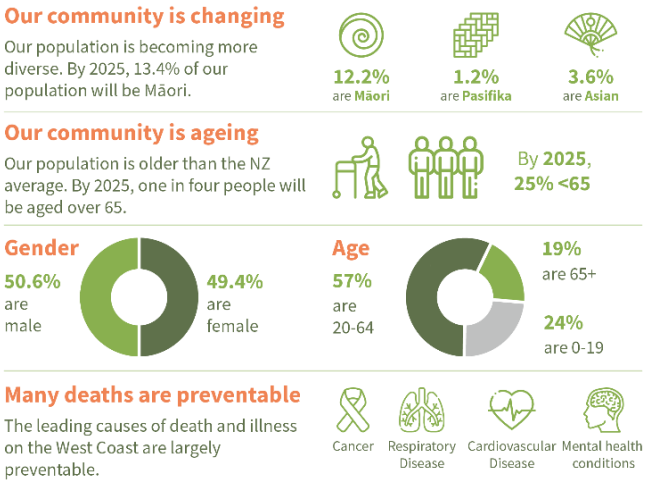
benefits, have no educational qualifications and do not have access to a motor vehicle or telephone. [1]

We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others. Ethnicity, like age and deprivation, is a strong predicator of need for health services. There are currently 3,970 Māori living on the West Coast (12.2% of our population) and by 2025 that proportion is predicted to increase to 13.4%.

Our Māori population has a considerably younger age structure, with 10.3% of our Māori population aged under five, compared to 5.7% of the total population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on the health needs of our younger Māori population.

The communities we serve

We are responsible for 32,465 people



Based on the Stats NZ Dec 2018 Population Projections

1.5 Our population's health

West Coasters have higher morbidity and mortality rates resulting in a slightly a lower life expectancy (80.4 years) compared with the national average (81.4 years). West Coast Māori continue to have poorer overall health status and life expectancy (78.3 years). However, the equity gap for life expectancy on the Coast is reducing and at 2.1 years is considerably better than the national gap, where Māori life expectancy (75.1 years) is almost 6.3 years lower than the total population.

Like the rest of New Zealand, an increasing number of people on the West Coast are living with long-term conditions such as heart disease, respiratory disease, cancer, diabetes and depression.

The increasing prevalence of long-term physical and mental health conditions is one of the major drivers of demand for health services and the main cause of health loss and death amongst adults. In 2017/18, over 4,100 people (13% of our population) were identified as having one or more long term conditions.[2]

A reduction in known risk factors such as smoking, poor diet, lack of physical activity and hazardous drinking could dramatically reduce pressure on our health system and greatly improve health outcomes for our population. All four major risk factors have strong socio-economic gradients, so population health interventions that reduce these risk factors will also contribute to reducing health inequities between population groups.

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

- 26% of our population are current smokers (higher than the national average). Smoking rates amongst Māori are higher (44%).
- More than a third (35%) of our total adult population are classified as obese. Rates for our Māori population are higher (56%).
- Our population's fruit and vegetable intake is similar to the national average (41.1% vs 39.8%) however Māori rates were lower at 30.8%.
- 10% of our total adult population were identified as inactive (little or no physical activity). Rates for Māori were slightly higher (13%).
- 16% of our adult population are likely to drink in a hazardous manner. While this rate is lower than the national average, it reflects hazardous drinking habits for one in every eight adults on the Coast. [3]

1.6 Our Operating Challenges

As we develop strategies and redesign service models to respond to our population's health needs and the increasing pressures on our system, we need to be mindful of our unique operational challenges.

Rurality: Geographically we are the third largest DHB in the country, covering a total land area of 23,283 square kilometres, but we are the smallest by population. This means patients and health professionals often have to travel long distances to access or deliver services. Our rurality is one of our biggest challenges and magnifies all the operating pressures we face.

[1] PHO enrolments and Stats NZ population projections provided by Ministry of Health July 2018.

[2] People enrolled with the West Coast PHO Long-Term Conditions Management Programme June 2018.

[3] Results from the NZ Health Survey should be interpreted with caution as small population numbers can have a distorting impact on results. Regional results for the 2017/18 Survey are expected to be release in 2019. Refer to www.health.govt.nz.

Service fragmentation: Because of our small population size and long travel distances, services are often fragmented and person dependent. A history of over-reliance on hospital services also means not all of our services are being delivered by the most appropriate person or in the most appropriate settings.

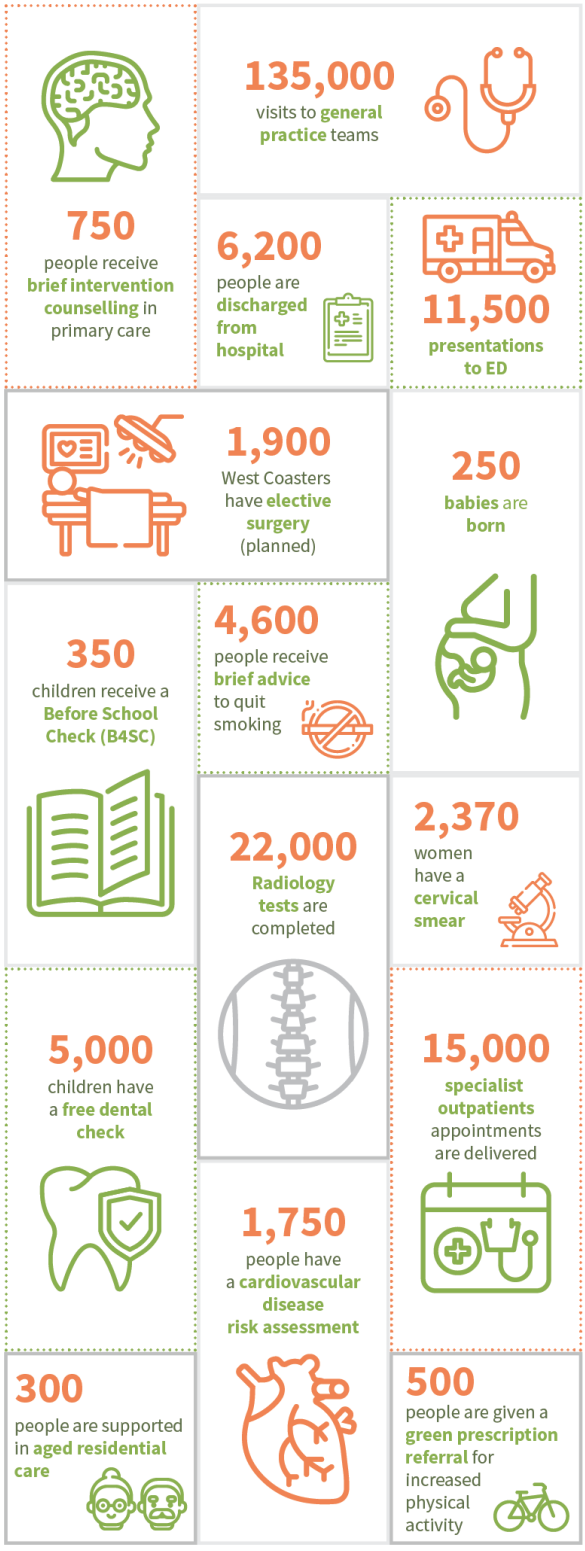
Workforce shortages: In our isolated environment, recruiting and retaining specialised staff is difficult and further complicated by the ageing of our workforce and national workforce shortages. This has led to an over-reliance on locums and contractors, which reduces the continuity of care for our population and is unsustainable financially. The development and recruitment of a highly skilled rural-generalist workforce, able to flex across traditional service areas, is a critical factor in terms of the future sustainability of our services.

Facilities pressures: A number of our health facilities are outdated, expensive to maintain, poorly located or seismically compromised. They do not support the more flexible models of care needed to response to our population's need, create inefficiencies and add to financial pressure. Completion of Grey Hospital and Health Centre (Te Nikau) and Buller Health Centre are critical to our future success. Careful consideration also needs to be given to the long-term future of all the facilities we own and operate across the West Coast.

Financial viability: Meeting increasing service demand, treatment and infrastructure costs, and national expectations around wage and salary increases is a significant challenge. Our population is not growing and we receive limited annual increases in funding. Financial pressures mean the DHB needs to carefully consider where we commit resources and reallocate investment into activity and services that will provide the greatest return in terms of health gain.

Variation: Unlike larger urban DHBs, the biggest challenge for the West Coast health system is less about managing volume and more about managing variation. Not all variation is negative, some helps us deliver more patient centred care. However, variation in the demand for a service, in the capacity of the individuals and teams that provide the service, or in the way in which services are provided, all affect the flow of patients through our system. To ensure we can consistently provide the best possible care to our community, we need to understand and manage this variation and reduce the negative impacts on service provision, patient experience and health outcomes.

In an average West Coast year



All figures are based on the average across the last three financial years as reported in the West Coast DHB's 2017/18 Annual Report

Our Strategic Direction

1.6 The West Coast Vision

Our resources are limited and the pressures facing our health system mean that services cannot continue to be provided in the same way. In order to improve the health and wellbeing of our population, we need to integrate and connect services across our health system and ensure greater collaboration between teams and with our patients, whānau and community.

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

Our vision is underpinned by three strategic objectives:

- The development of services that support people to stay well and enable them to take greater responsibility for their own health.
- The development of primary/community-based services that support people in the community and provide a point of ongoing continuity, which for most people will be general practice.
- The freeing-up of hospital-based specialist resources to be more response to episodic events, provide timely access to more complex care and specialist advice to primary care.

Delivering on our strategic objectives and achieving our vision will result in a health system that is:

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 travel to multiple locations, at inconvenient times, or far from home, unless there are good clinical reasons to do so.

Integrated: This means improved continuity, coordination and consistency of care with the most appropriate health professional available and able to provide care, where and when it is needed. Services will be supported by the timely flow of information to enable informed clinical decision-making.

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 and tools and processes will help to manage and reduce variation.

Clinically sustainable 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 be a stable workforce of health professionals in place to provide these services, with strong clinical leadership to support the provision of safe and effective care.

1.7 Nationally consistent

The West Coast vison is closely aligned to the Government's long-term vision for the health sector, as articulated through the NZ Health Strategy with its central theme 'live well, stay well, get well.'

It also reflects alignment with the Government theme 'Improving the well-being of New Zealanders and their families' and the priority outcomes: Support healthier, safer, more connected communities; Make New Zealand the best place in the world to be a child; and Ensure everyone who is able to, is earning, learning, caring or volunteering.

The Minister of Health's annual Letter of Expectations also signals priorities and expectations for DHBs. The expectations for the coming year signal a strong focus on equity in health and wellness.

The priorities emphasised for 2019/20 are:

- Improving child wellbeing;
- Improving mental wellbeing;
- Improving wellbeing through prevention;
- Better population health outcomes, supported by a strong, equitable public health & disability system;
- Better population health outcomes, supported by primary health care;
- Strong fiscal management.

The National Priorities section of this Plan outlines how we will deliver on the Minister's expectations in the coming year. The Minister's Letters of Expectation for 2019/20 are attached as Appendix 2.

It is also important that all twenty DHBs are working collaboratively to capture service improvements, share innovations, and meet the needs of the population of New Zealand in a fair and equitable way. The DHB Chief Executives are looking to identify and capture opportunities as part of a Collective Improvement Programme and we are committed to contributing to this programme of work as it is developed.

1.8 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 Health Services Plan outlines our regional direction, priorities and agreed work programme for 2019-2022. There are six regional priority focus areas: Data and Information; First 1,000 Days; Mental Health; Acute Demand Management; Social Determinants of Health; and Advance Care Plans.

West Coast DHB has made a strong regional commitment and is engaged in a number of work streams including: cardiac, child health, major trauma, mental health, cancer, telehealth, and workforce.

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

1.9 Committed to achieving equity

Not everyone living on the West Coast experiences the same health outcomes, and some people experience advantages and opportunities that others do not.

Social determinants, such as education, employment, housing and geographical location can impact on opportunity as can aspects of a person's identity including age, gender, ethnicity, social class, sexual orientation, ability or religion. Equity is about fairness and we are committed to reducing disparities and achieving equity in health outcomes for our population, particular for our growing Māori population.

Acknowledging and taking steps to address inequities in our system can be confronting and challenging, but is necessary if we are to progress towards equity. By making this commitment we acknowledge that we will need to evolve our workforce, build health literacy and cultural capabilities and redesign service delivery models, to better meet the diverse needs of all the people in our community.

The DHB's planning is guided by a range of national strategies, including: He Korowai Oranga (the Māori Health Strategy), Ala Mo'ui (Pathways to Pacific Health and Wellbeing), the Healthy Ageing Strategy and the NZ Disability Strategy. We are also supported by tools such as the Health Equity Assessment Tool (HEAT) to assess, identify and address disparities.

Actions to deliver health equity are identified in the National Priorities section of this Plan, identified with the code EOA, Equity Outcome Action.

Our Immediate Focus

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

Nine Strategic Themes highlight factors have been identified as critical to our immediate and long-term success. These align closely with the themes of the New Zealand Health Strategy and provide overarching framework for the way services will be planned, developed and delivered.

This focus was reiterated in strategic discussions held with the Ministry of Health as part of the DHB's annual planning in June 2019, where key challenges and the DHB's future focus were discussed.

In the coming year, we are working on several large changes to enable the creation of three integrated locality bases (central, northern and southern) supported by a rural inpatient service and improved coordination services. This direction will improve access to services closer to people's homes, improve clinical support and help to reduce variation, with new standardised and streamlined processes.

The development of a highly skilled, rural-generalist workforce, able to flex across traditional service areas, is critical to our future success. Our focus for the coming year includes the deliberate creation of an environment where our people can thrive including access to professional education, leadership training, clinical support and a collective leadership culture.

Connecting information systems and sharing data is another critical success factor. Updated information systems give us access to real-time information at the point of care, improving clinical decision-making and reducing the time people waste waiting. Support for progressing this work and capturing increased value from available technology will include deliberate investment in shared electronic systems, telehealth technology and data analytics.

Improving equity is a critical factor in our longer-term success and our investment in information systems will help to support a greater focus on equity across our health system. Real time data identifying disparities in access or engagement will enable more informed decision making on models of service delivery that better support equitable health outcomes for our population. This will also be supported by investment in our Takarangi Cultural Competency Framework.

The successful completion and migration into Te Nikau (the new Grey Hospital and Health Centre) and the development of the Buller Health Centre are also major pieces of work for the DHB in the coming year. These facilities will support the realisation of integrated service delivery models that will help to ensure the future sustainability of our health system.

THE YEAR AHEAD

What can you expect from us?

2

Delivering on National Priorities and Targets

The following section highlights the activity the DHB will undertake to deliver on national priorities and expectations in 2019/20. This activity, and the associated actions and targets, is reflected in the work plans of our local and regional alliances and the project and work plans of our operational and corporate services teams.[4]

Over the last several years, we have made some positive inroads into improving health outcomes for Māori people living on the West Coast, with strong engagement in childhood immunisation and Well Child programmes and reductions in avoidable hospitals 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).

System Outcome	Government Priority Outcome
E We have health Equity for Māori and other groups	W Make New Zealand the best place in the world to be a child
L We live longer in good health	E Ensure everyone who is able to, is earning, learning, caring, or volunteering
Q We have improved quality of life	G Transition to a Clean, Green, and Carbon Neutral New Zealand
	C Support healthier, safer and more connected communities

2.1 Improving Child wellbeing

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Immunisation	L W
Expectations: ▪ Establish innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5. ▪ Outline actions to further strengthen your school-based immunisation programme to better meet the needs of Māori and Pacific youth.	

Actions to Improve Performance	Milestones	Measures of Success
Focus on increasing the uptake of vaccinations during pregnancy, as an opportunity to build relationships with mothers and provide early protection for babies.	Q2: Survey of new parents to understand declines and improve messaging. Q2: Education Programme developed to support vaccination conversations with women. Q3: Opportunity to provide additional pregnancy vaccinations through community pharmacy investigated nationally.	60% of pregnant women vaccinated for Pertussis (whooping cough). Childhood vaccination decline rates are reduced. 95% of 8 month olds fully immunised. 95% of 2 year olds fully immunised. 95% of 5 year olds fully immunised. 75% of young boys and girls (year 8) complete the HPV vaccination programme.
Continue to monitor and evaluate immunisation coverage to identify opportunities to maintain high immunisation coverage across all ages, with a particular focus on improved coverage at age five and equity across population groups. (EOA)	Ongoing: Provision of Immunisation Register (NIR), Missed Event and Outreach Service support to general practice teams to reduce declines for childhood vaccinations. Quarterly: Evaluation of vaccination coverage rates by the Immunisation SLA to identify opportunities to further improve coverage and respond to emerging issues.	
Further strengthen the school-based Human Papillomaviruses (HPV) immunisation programme and identify innovative solutions to reduce the equity gaps in coverage rates for young Māori students. (EOA)	Ongoing: Provision of support to general practice to enable the co-delivery of HPV and DTdap at age 11, including development of resources.[5] Q2: Consult with Māori groups to better understand barriers to adolescent vaccinations. Q2: Trial of an online consenting process for the school-based HPV programme underway.	

[4] Our System Level Measures (SLM) Improvement Plan is developed in collaboration with our Alliance partners and is attached as an appendix to this Annual Plan. Together with this Annual Plan, our Public Health Action Plan and the South Island Regional Health Services Plan (available on the DHB's website) the SLM Improvement Plan provides a broader picture of the activity planned across the West Coast health system for the coming year.

[5] DTaP - adult diphtheria and tetanus vaccine and adult acellular pertussis vaccine.

Planning Priority: School-Based Health Services	L W

Expectations:

- Commit to providing quantitative reports in Q2 and Q4 on the implementation of school-based health services (SBHS) in decile 1 to 4 secondary schools (and decile 5 if applicable), teen parent units and alternative education facilities.
- Outline current activity to implement Youth Health Care in Secondary School Framework for continuous quality improvement in SBS schools.
- Outline the current activity to improve the responsiveness of primary care to youth.
- Commit to providing quarterly narrative reports on the actions of the Youth Health (SLA) to improve health of the DHB's youth population.
- Outline actions to ensure high performance of the Youth Health SLA (or equivalent).

Actions to Improve Performance	Milestones	Measures of Success
Continue to support the delivery of SBHS in all decile one to four schools and alternative education settings across the West Coast.	Quarterly: Provision of quantitative reports on the delivery of SBHS to the Ministry. Q1: Rollout to decile 5 schools confirmed with the Ministry of Health.	95% of year nine children in decile 1-4 schools receive a HEEADSSS (Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety) assessment.
Work with schools to review the data captured during Universal Health Assessments and identify actions that support wellbeing, using the 'Youth Health Care in Secondary Schools' Framework.	Q2:Q4: Template developed to provide feedback to schools on SBHS activity, includes student feedback.	
Maintain an integrated approach to responding to the needs of young people on the Coast, with active oversight from the cross-sector Child & Youth Health Alliance Work Stream (Coast's SLAT equivalent). (EOA) *Strong Māori leadership and representation on the Child & Youth Work Stream ensures actions and programmes are targeting inequities for high need populations.*	Quarterly: Provision of qualitative reports on delivery against the Child & Youth Health work plan. Q2: Options for delivery of sexual health advice in schools, to address barriers to support for young people, explored and scoped.	

Planning Priority: Midwifery Workforce – Hospital and LMC	E L E

Expectations:

- Develop, implement, and evaluate a midwifery workforce plan to support: undergraduate training, including clinical placements; recruitment and retention of midwives; changes to models of care that use the full range of the midwifery workforce within DHBs; and service delivery mechanisms that make best use of other health workforces to support both midwives in their roles and pregnant women.
- Detail the actions that you will take towards implementing Care Capacity Demand Management (CCDM) for midwifery by June 2021 and outline the most significant actions the DHB will undertake in 2019/20 to progress implementation of CCDM for midwifery.

Actions to Improve Performance	Milestones	Measures of Success
Identify key stakeholders to support the development of a South Island Maternity Workforce Plan to support undergraduate training and workforce planning to better meet the future demands of our population.	Q1: Regional Workshop held. Q4: Regional Maternity Workforce Plan drafted.	80% of women are registered with an LMC by 12 weeks of pregnancy. Baseline established for proportion of midwives identifying as Māori. CCDM implemented for midwifery June 2021.
Establish regular meetings with Ara and University of Otago to further develop the graduate workforce pipeline, with a particular focus on the increased enrolment of Māori midwifery students. (EOA)	Quarterly: Joint meetings with Ara and Otago. Q3: Appoint a new graduate midwife.	
Stocktake planned retirements across the maternity workforce, to identify opportunities to phase retirements, minimise system impacts and plan for recruitment.	Q2: Stocktake complete.	
Continue to invest in the development of a rural generalise workforce model to support the transformation of service models on the Coast, with a focus on enabling the use of other workforces to support midwives and mothers.[6]	Q1: Workshop held, focusing on the role of the wider team in supporting mother and baby. Q2: Opportunities identified.	
Support the implementation of Care Capacity Demand Management (CCDM) for midwifery by June 2021, working with other DHBs to ensure a consistent approach to implementation of CCDM for maternity services. *Refer to the CCDM action table for further detail and timeframes for implementation of CCDM.*	Q1: Director of Midwifery engaged as a member of the CCDM Council to support implementation. Q2: Active participation by midwifery leaders in national CCDM forums.	

[6] The West Coast has a Rural Hospital Medical Specialist with extended scope in Obstetrics supporting the midwifery model on the Coast.

Planning Priority: First 1000 days (conception to around 2 years of age)	E L W

Expectations:

- Identify the most important focus areas to ensuring the population needs for pregnant women, babies, children and their whānau are well understood and identify key actions that demonstrate how the DHB will meet these needs including realising a measurable improvement in equity for your DHB. Actions should include a comprehensive approach to prevention and early intervention services across priorities via maternity, Well Child Tamariki Ora, National SUDI Prevention Programme, and other services.
- Identify what action you will take to identify barriers to achieving well integrated services across the first 1000 days.
- Identify the actions the DHB is taking to increase the proportion of children at a healthy weight in their first 1000 days to be measured by the proportion of children at a healthy weight at age four.

Actions to Improve Performance	Milestones	Measures of Success
Engage Maternity Services in the development of a West Coast Maternity Strategy that takes a life course approach to preparing for pregnancy, being pregnant, birthing and becoming a parent, with a focus on achieving equitable outcomes for Māori women and babies. (EOA)	Q1: Key stakeholders identified and engaged in Strategy development. Q3: West Coast Maternity Strategy in place.	90% of babies have their first WCTO core check on time. 85% of newborns enrolled with general practice by 3 months of age. 70% of babies are fully/exclusively breastfed at 3 months of age. 95% of eight-month old babies are fully immunised. 90% of four-year-olds provided with a B4 School Check (B4SC). 95% of four-year-olds (identified as obese at their B4SC) are offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention.
Continue to invest in key programmes of work that support the most important focus areas across the first 1,000 days of a child's life. *Delivery is overseen by the cross-sector Child & Youth Health Alliance Work Stream who support and champion the integration of child and youth services.*	Ongoing: Actions to address the key modifiable risk factors for SUDI (see page 11). Ongoing: Actions to increase the proportion of smokefree households (see page 12). Ongoing: Actions to maintain high rates of childhood immunisation (see page 9).	
Work with Poutini Waiora to establish drop-in breastfeeding session, facilitated by a Lactation Consultant or Mum4Mum Peer Supporter, to increase access to face-to-face breastfeeding advice and support for Māori women. (EOA) Promote breastfeeding as an important component, alongside other nutrition interventions, in supporting a healthy weight for children.	Q1: Breastfeeding sessions scheduled. Q2:Q4: Promotion of breastfeeding alongside other nutritional interventions.	
Contribute to the national Well Child Tamariki Ora (WCTO) programme review and advocate for children living in remote rural areas and those living with disabilities. (EOA)	Q2: Child & Youth Alliance workstream engaged in the WCTO review.	
Complete analysis of the data for Core 1 WCTO Checks to find gaps where families are receiving this contact later than expected, and address issues to support earlier intervention at this crucial period. (EOA)	Q2: Core 1 Check data analysis complete. Q3: Actions to address gaps identified.	

Planning Priority: Family Violence and Sexual Violence (FVSV)	Q C

Expectation: Identify the actions that the DHB considers are the most important contribution to reducing family violence and sexual violence, including the reasons why the action(s) are important and the impact you expect them to achieve.

Actions to Improve Performance	Milestones	Measures of Success
Work alongside the Violence Intervention Programme team to increase the number of bridging/refresher training sessions provided, to ensure staff understand and implement the updated Child Protection & Partner Abuse policies and procedures.	Q1: Training programme developed. Q2: Increased sessions available.	Increase number of staff attending VIP Training sessions. Violence Intervention Programme audit results >70/100.
Develop a transalpine Canterbury/West Coast DHB Elder Abuse & Neglect Policy to support our growing older population from harm. Seek feedback from Kaumatua to ensure culturally appropriate responses to disclosures are embedded. (EOA)	Q1: Elder Abuse and Neglect Policy in place. Q4: Compliance review completed.	
Develop an Elder Abuse & Neglect training package in conjunction with Age Concern, Canterbury DHB, Police and Public Trust, to support the implementation of the Policy.	Q2: Training programme developed. Q3: Sessions available.	

Planning Priority: SUDI	E L W C
Expectation: Describe contributions towards building strong working relationships across the Maternal and Child Health sector to address the key modifiable risk factors for SUDI.	

Actions to Improve Performance	Milestones	Measures of Success
Engage key stakeholders in the development of a West Coast Maternity Strategy (refer above, First 1,000 Days).	Q1: Key stakeholders identified and engaged in Strategy development. Q3: West Coast Maternity Strategy in place.	Number of Māori women completing the Pregnancy & Parenting Education Programme. >50% of women referred to the Smokefree Pregnancy and Newborns Incentive Programme complete the Programme. 95% of West Coast households with a newborn have their smokefree status recorded at the first WCTO core check. Minimum of 68 Safe sleep devices provided to whānau identified at risk.
Complete the development and implementation of a Kaupapa Māori Pregnancy & Parenting Education Programme, to support hapū wahine and whānau. (EOA)	Q1: Culturally appropriate Kaupapa Māori P&P Education Programme available. Quarterly: Monitoring (by ethnicity) of the number of women engaged.	
Continue to provide smokefree advice across all settings and deliver wrap-around stop smoking services for pregnant women (and their partners) who want to stop smoking, through continued investment in the Smokefree Pregnancy and Newborns Incentives Programme.	Quarterly: Monitoring of smokefree service performance, advice, cessation referrals, quit rates and smokefree status. Quarterly: Progress against the smokefree pregnancy and smokefree homes actions in the West Coast's SLM Improvement Plan.	

2.2 Improving mental wellbeing

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Inquiry into Mental Health and Addiction	E L Q C

Expectations: DHBs are to outline actions contributing to the direction identifying opportunities to build on existing foundations and include actions in relation to improving and/or addressing all of the following areas of focus:

Embedding a wellbeing focus

- Demonstrate a focus on wellbeing and equity at all points of the system.
- Improve the physical health outcomes for people with mental health and addiction conditions.

Building the continuum / increasing access and choice - *refer to population mental health table below*

Crisis response – *refer to population mental health table below*

Suicide prevention – *refer to population mental health table below*

Workforce

- Partner with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training.
- Demonstrate a commitment to lived experience and whānau roles being supported and employed across all services.
- Support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs.

NGOs

- Identify how you will use cost pressure funding from Budget 2019 to ensure NGOs in your district are sustainable.

Mental Health and Wellbeing Commission

- Work collaboratively with any new Commission.

Forensics

Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2019. Contribute, where appropriate, to the Forensic Framework project.

Actions to Improve Performance	Milestones	Measures of Success
Expand the number of practices engaging people with mental health conditions in the Primary Care LTCM Programme, to support improved wellbeing and physical health outcomes for this high need group. (EOA)	Q4: Enrolment into the Long-Term Conditions Management Programme expanded in three general practices.	>3.8% of the population (0-19) access specialist mental health services. >3.8% of the population (20-64) access specialist mental health services. 80% of young people (0-19) referred to specialist mental health services are seen within 3 weeks. 95% of young people (0-19) referred to specialist mental health services are seen within 8 weeks.
Complete realignment of resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based integrated health services team model.	See table below for action that will support the continuum of care and the DHB's response to crisis and suicide prevention.	
Provide a workforce development/training package to ensure all those working in the crisis response develop the appropriate knowledge and skills to support people with mental health and addiction needs, no matter where in the system they present.	Q1: MH Nurse Educator and Quality Lead engaged to drive workforce development. Q2: MH development package agreed and first training element underway. Q4: All staff trained in UK MH Triage Scale.	

Implement agreed Pay Equity uplift to support the sustainability of local NGO service providers.	Ongoing: Pay Equity uplift applied to contracts as renewed.	
Work collaboratively with any new Mental Health and Wellbeing Commission, to support He Ara Oranga actions.	Ongoing.	
Work with the Ministry to improve and expand the capacity of forensic services in line with Budget 2019 investment, including participating in how best to allocate increased FTE capacity across regions. Provide input into the national Forensic Framework Project as this work commences.	Q1: Additional FTE capacity confirmed to support community and inpatient teams. Q1: Stocktake of existing workforce development plans and programmes provided to the Ministry.	

Planning Priority: Population Mental Health

E L C

Expectations: The DHB will improve population mental health and addiction by increasing uptake of treatment and support earlier intervention, further integrating mental health, addiction and physical health care, and co-ordinating mental health care with wider social services - especially for priority populations including vulnerable children, youth, Māori and Pacific populations.

Include actions in relation to all the focus areas below (relevant actions may be cross referenced to the Inquiry response section above):

- Options across the primary care spectrum to help ensure early intervention and continuity of care.
- Improved options for acute responses, including improving crisis team responses and improved respite options.
- Suicide prevention and postvention efforts to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives and integration of mental health and addiction services.
- Equally Well, to improve the physical health outcomes for people with low prevalence mental health and addiction conditions.
- Ongoing commitment on reporting to PRIMHD.
- Improving access (MH01) and reducing waiting times (MH03). – *refer also the mental health and addictions table below.*
- Ongoing commitment to transition/discharge plans and care plans for people using mental health and addiction services (*refer table below*).

DHBs should also include actions in relation to improving some of the areas of focus below:

- Supporting Parents Healthy Children (COPMIA) to support early intervention in the life course.
- Improving co-existing problems responses via improved integration and collaboration between other health and social services.
- Reducing inequities including reducing the rate of Māori under community treatment orders.
- Improving employment, education and training options for people with low prevalence conditions.
- Implementing models of care for addiction treatment, reference to Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

Actions to Improve Performance	Milestones	Measures of Success
Complete realignment of resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based integrated health services team model.[7]	Ongoing: Complete implementation of the proposal for change for mental health services. Q2: Crisis response function embedded in locality teams and phone service in place out-of-hours. Q4: Increased respite options in place.	>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.
Complete Māori mental health services review and support a complementary model that provides improved cultural support for Māori across the continuum. (EOA)	Q2: Revised model proposed and change underway. Q4: Complementary model in place.	
Review the function of specialist CAMHS and AOD services and roles in the context of the evolving locality-based teams, to strengthen connections and build support across the full continuum of care.	Q4: Review of future specialist CAMHS and AOD services direction completed.	
Include dedicated Co-Existing Problems clinical FTE in locality-based teams, to strengthen connections and build support across the full continuum of care.	Q2: Co-Existing Problems position in place in Westport locality team.	
Continue to monitor local service utilisation data, and report (using PRIMHD), to national systems, to support improved decision-making and service planning.	Ongoing: Balancing metrics/data captured and reported through PRIMHD.	
Establish a work group to identify actions to increase the responsiveness of suicide prevention activity for Māori and, through active local engagement, ensure a 'by rangitahi for rangitahi' approach that is tikanga Māori and whānau centred. (EOA)	Q2: Work group established. Q3: Equity tool applied.	

[7] The mental health services proposal for change (including the Māori Metal Health services review) were a priority in 2018/19, but final decisions were delayed until the Minister of Health's response to the recommendations of the national mental health services inquiry could be considered. This work will be progressed in 2019/20.

Planning Priority: Mental Health and Addictions Improvement Activities		
Expectations: Outline your commitment to the HQSC mental health and addictions improvement activities including: ▪ Actions to support a continued focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020) Actions to improve transitions (aligned to performance measure MH02) and engagement with the next steps of the HQSC programme.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue to support use of the newly established sensory room and modulation and talking therapies, to provide a safe therapeutic environment for patients. Establish weekly meetings, with support from the Health Quality and Safety Commission (HQSC), to consider learnings from other DHBs and identify actions to further minimise restrictive care, with a focus on Māori. (EOA)	Quarterly: Monitoring (by ethnicity) of seclusion and compulsory treatment order rates. Q2: Guidance from HSQC incorporated into the model of care.	Reduction in seclusion hours and 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.
Engage with service users to include their perspective and ensure a co-design approach to environmental changes that enhance admission and inpatient experience.	Q1: Service user perspective included in HQSC project groups.	
Design and implement a new process to improve the quality of information provided to patients, whānau and nominated contacts pre-discharge. Determine the impact of the primary nursing model (implemented in 2018/19) on the inpatient unit environment and transitions to community services to capture opportunities for improvement.	Quarterly: Monitoring of transition planning to lift the quality of plans and raise the focus with staff. Q2: New discharge information sheet in place. Q4: Impact of primary nursing model evaluated.	

Planning Priority: Addiction		
Expectations: ▪ Identify actions to improve performance against the MH03 performance measure (addition related waiting times), to support an independent/high quality of life for people with addiction issues. ▪ Provide (Q1) an outline of the existing and planned AOD services for your region including those for women, Māori and Pacific, older people, opioid substitution and criminal justice clients, and LGBTIQ communities, ensuring equitable health for all New Zealanders. ▪ Outline how you will ensure the quality of AOD services to support healthier New Zealanders live an independent high-quality life. ▪ Describe how your DHB is giving appropriate priority to meeting service demands within baseline funding.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue to engage with Poutini Waiora to deliver Kaupapa Māori AOD services, to support Māori and their whānau by taking a holistic approach to the recovery process. (EOA) Continue to engage with PACT services, to support adults and young people at risk of addiction and those with co-existing mental health and addiction issues.	Quarterly: Monitoring (by ethnicity) of AOD wait times to address any emergent issues. Q2: Co-Existing Problems position in place in Westport locality team, to strengthen connections and build support across the continuum of care.	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.
Fully implement the new community-based AOD service, provided by Salvation Army, to increase community-based AOD capacity and support timely access to services with a focus on Māori as a high-need population group. (EOA)	Q2: Community-based AOD service operational across the Coast. Q4: >100 people engaged with the new service.	
Review the function of specialist DHB AOD services in the context of the evolving locality-based teams, and realign currently resources to support earlier intervention.	Q1: Review underway. Q4: Review of future specialist AOD services direction completed.	
Work with Canterbury DHB to explore options for an improved approach to the provision of Opioid Substitution Treatment, to improve the management of treatment.	Q2: Pilot underway in Canterbury. Q4: Recommendations made for future provision of Opioid Substitution Treatment on the Coast.	

Planning Priority: Maternal Mental Health Services	L C
Expectations: ▪ Informed by the outcome of your 2018/19 stocktake of primary maternal mental health services in your district, and the volumes of women accessing these services, identify the actions you plan to take in 2019/20 to improve access and to address any identified issues. ▪ Indicate how equity of access and outcomes for Māori and Pacific women will be addressed and measured.	

Actions to Improve Performance	Milestones	Measures of Success
Continue to invest in current community-based services to support women, and their partners in need of additional support before and after the birth of a child. (EOA)	Ongoing: Free brief intervention counselling for provided for people needing mild-moderate mental health support. Ongoing: Free Plunket-led individual and group programmes provided for people needing higher-level mental health and parenting support.	Updated co-designed Maternal Mental Health Pathway in place. Proportionate uptake of programmes by ethnicity.
Use the stocktake of primary maternal mental health service to inform the mapping of maternity services as part of the development of a West Coast Maternity Strategy. Engage with Well Child Tamariki Ora providers to highlight issues for postpartum mothers and explore options to improve service access, with a focus on Māori as a population of higher need. (EOA)	Q1: Continuum of maternity services mapped and Maternal Mental Health Service gaps identified. Q1: Key stakeholders identified and engaged in Maternity Strategy development. Q3: Refreshed maternal mental health pathway in place and socialised across the system.	

2.3 Improving wellbeing through prevention

Government Theme: Improving the well-being of New Zealanders and their families
: Build a productive, sustainable and inclusive economy

Planning Priority: Cross-sectoral collaboration	Q E W C
Expectation: Outline how the DHB has, and will continue to, demonstrate leadership in the collaboration between and integration of health and social services, especially housing.	

Actions to Improve Performance	Milestones	Measures of Success
Work with the local Ministry of Social Development team to develop processes that support at risk whānau, moving into and within the West Coast DHB region, to enrol with appropriate health services including primary care, Well Child and community dental services. (EOA)	Q2: Opportunities for information sharing identified. Q4: Process for supporting families defined.	>95% of the population are enrolled with the PHO. 85% of new-borns are enrolled with general practice by 3 months of age. 95% of children (0-4) are enrolled with the community dental service.
Work with Community and Public Health, through the Healthy West Coast workstream, to support the establishment of a cross-sector Food Security Steering Group and the development of community initiatives that support healthier choices and behaviours. (EOA)	Q1: Food Security Steering Group established. Q2: Action plan developed.	
Work with Sport Canterbury West Coast and the three District Councils to review the West Coast Spaces & Places Sport & Recreation Facility Plan, to maximise access to physical activity opportunities for Coasters including those living with a disability. (EOA)	Q4: Spaces & Places Sport & Recreation Facility Plan reviewed.	

Planning Priority: Climate Change	L G
Expectations: ▪ Identify and undertake further areas for action to positively mitigate or adapt to the effects of climate change and its impacts on health. ▪ Identify actions that improve the use of environmental sustainability criteria in procurement processes.	

Actions to Improve Performance	Milestones	Measures of Success
Measure current energy use, using the newly installed Energypro software, to build up a history and identify areas for improvement.	Q2: Baseline measurement of greenhouse gas emissions determined. Q4: Monitoring and comparison of energy use against previous baseline commenced.	Reduction of WCDHB carbon emissions per square metre against baseline (once established).

Utilise existing staff engagement mechanisms to promote participation of staff in identifying actions which could contribute to reducing carbon emissions.	Q2: Opportunities provided for staff to make positive change.	Reduction in internal truck transport kilometres by 33%.
Review inter-hospital truck transport, to identify opportunities to reduce mileage and use of fossil fuels.[8]	Q3: Truck transport review complete.	
Increase emphasis on sustainability requirements in DHB procurement policies and practices, to positively mitigate environmental impacts on health.	Q1: Sustainability questions included in tenders. Q4: Procurement policy updated, in line with MBIE guidance (once released).	

Planning Priority: Waste Disposal	
Expectation: Identify further areas for action to support the environmental disposal of hospital and community (e.g. pharmacy) waste products (including cytotoxic waste).	

Actions to Improve Performance	Milestones	Measures of Success
Continue to promote clear messages to the public that people should return their surplus/expired medicines and used medicine sharps to pharmacies for safe disposal.	Q1: Educational materials distributed to local pharmacies.	Reduction of waste.
Work with the local Council, Waste Contractor and Suppliers to identify additional opportunities for the disposal of mixed and plastic recycling.	Q2: Options for mixed and plastic recycling reviewed with Council and Disposal Agent. Q4: Options for supplier-reduction/removal, of waste and packaging material reviewed.	
Identify options to redeploy outdated and surplus DHB furniture not required for new Hospital fit-out, to reduce the load going to land fill.	Q3: Redeployment and auction of old and surplus furniture and equipment.	

Planning Priority: Drinking Water	
Expectation: Provide actions the DHB will undertake to support their Public Health Unit to deliver and report on the drinking water activities in the environmental health exemplar.	

Actions to Improve Performance	Milestones	Measures of Success
Work with the Public Health Unit to maintain an accredited Drinking Water Unit and accredited Assessors to support their role in ensuring drinking water safety. Support the Public Health Unit in their role in managing and mitigating public health risks by highlighting water issues and advice through the Healthy West Coast Alliance.	Q2: IANZ accreditation of Unit. Ongoing: IANZ accreditation of Drinking Water Assessors. Ongoing: Management and mitigation of public health risks discussed with Council staff and elected officials as required.	100% of network suppliers (serving 100+ people) receive compliance reports. 100% of Water Safety Plans assessed and reported on within 20 working days. 100% of drinking water suppliers have had a Water Safety Plan inspection completed in the last 3 years. Percentage of networked drinking water supplies compliant with the Health Act.
Conduct an annual review of network drinking-water supplies, serving more than 100 people, and provide a report to water suppliers on their compliance.	Q1: Annual review completed. Q2: Compliance reports completed.	
Undertake assessments of water suppliers' Water Safety Plans, as required, and provide a timely report to suppliers to support effective management of any risks to supplies.	Water Safety Plans assessed as required. Quarterly: Monitoring of assessments.	
Conduct inspections of drinking water supplies with approved Water Safety Plans, to certify implementation of the Safety Plans.	All drinking water supplies with a Water Safety Plan inspected every 3 years. Quarterly: Monitoring of inspections.	
Contribute to Māori health and wellbeing through the ongoing provision of technical advice on drinking water to local Rūnanga and Marae, to improve access to potable (safe to drink) water. (EOA)	Q3: Q4: Training on the Iwi Management Plan provided to Health Protection and Policy staff involved in resource management work.	

[8] This work was delayed due to staff capacity constraints in 2018/19 and will be picked up this year.

Planning Priority: Healthy Food and Drink	L C

Expectations:

- Commit to implementing Healthy Food and Drink Policies in DHBs that align with the National Healthy Food and Drink Policy.
- Commit to including a clause in your contracts with health provider organisations stipulating an expectation that they develop a Healthy Food and Drink Policy covering all food and drinks sold on site/s, and provided by their organisation to clients/service users/patients (excluding inpatient meals and meals on wheels), staff and visitors under their jurisdiction. Any policy must align with the Healthy Food and Drink Policy for Organisations (https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations).
- Commit to reporting in Q2 and Q4 on the number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts.
- Work with your PHU to commit to reporting in Q2 and Q4 on the number of Early Learning Settings, primary, intermediate and secondary schools that have current 1) water-only (including plain milk) policies, and 2) healthy food policies. Healthy food policies should be consistent with the Ministry of Health's Eating and Activity Guidelines.

Actions to Improve Performance	Milestones	Measures of Success
Socialise and implement the recently endorsed West Coast DHB Healthy Food and Drink Policy.	Q1: Communication of the DHB Policy. Q4: Audit of current Food and Drink items provided across DHB sites.	DHB Healthy Food and Drink Policy fully implemented across all DHB sites. Healthy Food and Drink Policies implemented by health provider organisations. Number and proportion of education providers adopting water-only and Healthy Food Policies.
Work regionally to agree consistent approach to health service provider contracts that stipulates the expectation providers will develop and implement a Healthy Food and Drink Policy, in line with the national policy for organisations. Engage with providers to provide support and advice in developing their Policies, with a focus on our Māori service provider to target higher need populations. (EOA) Track the number of provider contracts with a Healthy Food and Drink Policy.	Q2: Service provider contract clause agreed. Q4: Service provider contracts include Healthy Food and Drink Policy expectations. Q4: Service provider contracts include Healthy Food and Drink Policy expectations. Q2:Q4: Monitoring report on progress.	
Work with education providers in early learning settings, primary, intermediate and secondary schools to support the adoption of water-only and healthy food policies in line with the Healthy Active Learning Initiative.	Q2:Q4: Monitoring report on progress and adoption of policies by schools, kura and early learning services.	

Planning Priority: Smokefree 2025	E Q C W

Expectation: Identify activities that advance progress towards the Smokefree 2025 goal, including supporting Ministry funded wrap-around stop smoking services for people who want to stop smoking, and which address the needs of hāpu, wāhine and Māori.

Actions to Improve Performance	Milestones	Measures of Success
Continue to provide smokefree advice across all settings and deliver wrap-around stop smoking services for people who want to stop smoking, through Oranga Hā - Tai Poutini –including continued investment in the Smokefree Pregnancy and Newborns Incentives Programme.	Quarterly: Monitoring of smokefree advice, cessation service referrals and quit rates, by ethnicity and key target groups.	90% of pregnant women who identify as smokers upon registration with an LMC are offered brief advice and support to quit smoking. 90% of PHO enrolled patients who smoke are offered brief advice and support to quit smoking. 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking. 90% of households with a newborn have their smokefree status recorded at the first WCTO core check.
Establish a particular focus on Māori, people with Chronic Obstructive Pulmonary Disease (COPD), pregnant women, parents of children with respiratory illness and households with a new baby, as vulnerable population groups in need of extra support to stop smoking. (EOA)	Q1: Targeted smokefree actions agreed in the SLM Improvement Plan. Quarterly: Progress against the smokefree actions in the SLM Plan.	
Work with Oranga Hā – Tai Poutini to collate and combine service data with other cessation programmes, to provide a complete picture across the West Coast and identify areas where target groups need more support. (EOA)	Quarterly: Monitoring of combined results by Healthy West Coast Alliance Workstream.	
Work with Oranga Hā - Tai Poutini to investigate a whānau ora approach incorporating a Noho Marae (overnight marae stay) for young Māori women who smoke, to better engage and motivate them to stop smoking. (EOA)	Q2: Whānau Ora model agreed. Q4: First Noho Marae held.	

Planning Priority: Breast Screening	E L C
Expectation: All DHBs will set measurable participation and equity targets from baseline data and describe actions to: ▪ Achieve participation of at least 70% of women aged 45-69 years in the most recent 24-month period. ▪ Ensure equity gaps are eliminated for priority group Pacific women.	

Actions to Improve Performance	Milestones	Measures of Success
Work with the PHO and BreastScreen Aotearoa to implement a process for checking screening terms and results so that these are filed and captured accurately in the practice patient management system.	Q2: Results checking process in place at practices. Q3: Breast screening results, and recall lists, are accurately identifying women to be screened.	Reduction in the equity gap for priority women (current baseline to March 2019): Māori 67.7% Pacific 48.0% Other 72.5% Non-Māori 72.8% 70% of all women (45-69) have has a breast screen in the last two years (24 months).
Work with ScreenSouth and Poutini Waiora to capture opportunities for joint promotion and delivery of screening and support for the recall of women to improve rates for Māori and Pacific women. (EOA) *ScreenSouth has adopted a strong focus on priority group women - including the introduction of monthly screening appointment targets and a DNA/DRA process for women who don't make appointments.*	Ongoing: Provision of dedicated Māori and Pacific screening clinics using the mobile screening unit. Q1: Screening appointment targets for Māori and Pacific women embedded. Q4: Further opportunities for the mobile unit to come to smaller community areas identified.	
Utilise Poutini Waiora Whānau Ora nurses, who are integrated in general practice teams, to contact Māori and Pacific women who are not engaging with breast screening and support them to attend appointments. (EOA)	Ongoing: Provision of overdue breast screening coverage reports to Poutini Waiora (from the PHO) to support Poutini Waiora nurses to contact Māori and Pacific women to encourage breast screening. Ongoing: Assistance with travel and support at appointments provided by Poutini Waiora nurses. Q3: Review successful strategies implemented to improve cervical screening rates for opportunities to improve breast screening rates.	
Provide health promotion materials via general practices, rural communities, community pharmacies and social media, to promote the importance of breast screening for priority populations (Māori and Pacific). (EOA)	Q4: Health promotion material distributed across the Coast and awareness campaign promotes breast screening on local social media.	

Planning Priority: Cervical Screening	E L C
Expectation: All DHBs will set measurable participation and equity targets from baseline data and describe actions to: ▪ Achieve participation for at least 80% of women aged 25-69 years in the most recent 36-month period. ▪ Ensure equity gaps are eliminated for priority group women.	

Actions to Improve Performance	Milestones	Measures of Success
Establish a whole-of-system Cervical Screening Working Group to develop and review monthly performance and identify opportunities to coordinate efforts to improve screening rates. (EOA) *This Working Group will include the DHB, PHO and Poutini Waiora (the DHB's Māori Health Provider) with a targeted focus on Māori, Pacific, Asian women to achieve equity.*	Ongoing: Provision of cervical screening coverage reports to general practice (from the PHO) to support improved recall and screening. Q1: Working Group established. Q2: Regular performance reports developed. Q3: Collective plan agreed.	Reduction in the equity gap for priority women (current baseline to March 2019): Māori 70.5% Pacific 65.6% Asian 59.0% Other 75.9% 80% of all women (25-69) have had a cervical smear in the last three years (36 months).
Support the PHO to work closely with general practice and the local NCSP office to use data matching to identify and recall priority group women, particularly those who are unscreened or overdue. (EOA) Ensure overdue cervical screening coverage reports are provided to Poutini Waiora (via the PHO) to support catch-up and screening. Offer free cervical smears to priority women, wherever screening is completed, and ensure practices have a process in place to claim through the NCSP Office. (EOA) Offer weekend and outreach screening appointments with Māori smear takers. (EOA) Work with DHB-owned practices to investigate provision of after-hours appointments to target women who struggle to access during business hours. (EOA)	Q1:Q4: All seven GP practices supported to recall priority women. Q1:Q4 Overdue screening reports provided to Poutini Waiora. Ongoing: Weekend and outreach appointments offered with Māori smear taker. Q4: Minimum of 50 free smears provided for priority group women. Q4: After-hours appointment availability scoped.	

Develop targeted invites for women in priority groups as they become eligible for screening, that also link to other free services i.e. HPV vaccination and long-acting reversible contraception to promote a wellbeing approach. (EOA)	Q2: Well woman consultations scoped. Q4: Targeted invitations developed and in use.	

2.4 A strong and equitable public health and disability system

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Engagement and obligations as a Treaty partner		E E C
Expectations: Specify in the annual plan the processes the DHB uses to meet Tiriti o Waitangi obligations including: ▪ Actions to establish/maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement. ▪ Actions to foster Māori capacity for participating in the health and disability sector and for providing for the needs of Māori. ▪ Actions to build the capability of all DHB staff in Māori cultural competency and Te Tiriti o Waitangi.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Maintain a Memorandum of Understanding with Tatau Pounamu and actively engage with Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Engage members of Tatau Pounamu and Māori leader from across the system in the West Coast Alliance work streams to bring a Māori perspective to the redesign of local services.	Ongoing: Tatau Pounamu meetings attended by WCDHB Board members and Senior DHB staff. Q1: Tatau Pounamu Annual Work plan developed. Q1: Targeted equity actions agreed in the 2019/20 SLM Improvement Plan and Annual Plan. Q3: Tatau Pounamu input into development of the 2020/21 SLM Plan and DHB Annual Plan. Q4: Board hui held on a local Marae.	Tatau Pounamu Annual Work shared with DHB's Board. SLM Improvement Plan demonstrates strong equity focus in every priority area. Percentage of staff completing Takarangi Cultural Competency. Reduction in the equity gap between Māori and Non- Māori across two key priority areas.
Continue to invest in the newly developed Takarangi Competency framework, an evidence-based model that influences and shapes practice and supports improved cultural competency, to improve the experience of Māori presenting to our service.	Ongoing: Support provided to staff from the DHB and the wider system to complete their Takarangi Portfolios. Q4: Minimum of one Takarangi hui held.	
Develop an Equity Outcomes Framework that will enable regular reporting and monitoring of equity outcomes across the West Coast to support open discussion and identification of areas for improvement.	Q2: Equity Action Group established. Q3: Equity reporting framework developed and implemented.	

Planning Priority: Delivery of Whānau Ora		Q E C
Expectations: Identify the significant actions that the DHB will undertake in this planning year to: ▪ Contribute to the strategic change for whānau ora approaches within the DHB systems and services, across the district, and to demonstrate meaningful activity moving towards improved service delivery ▪ Support and to collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and to identify opportunities for alignment. (All Pacific priority DHBs need to also include Pasifika Futures in this activity).		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue to support the Whānau Ora model and team approach for Māori with Diabetes in the Whakakotahi pilot practice and expand the programme to at least one more general practice. (EOA) Facilitate a Quality Improvement approach to the Whakakotahi project with the aim of evidencing measurable improvements within the system and a whānau ora approach to service delivery. *The project supports an integrated diabetes pathway through engagement with Māori patients and communities, led by the PHO in partnership with Poutini Waiora.*	Q2: Model in place in two practices. Q4: Report on outcomes shared with the Healthy West Coast Alliance Workstream. Q4: Quality Improvement Plan identifies learnings for future service delivery.	30 Māori are provided with wrap around support to improve diabetes outcomes. >90% of Māori identified with diabetes have an annual HbA1c test. >60% of Māori identified with diabetes (via an HbA1c test) have good or acceptable glycaemic control (HbA1c <64 mmol/mol).
Collaborate with Te Pūtahitanga whānau ora navigators to identify opportunities for alignment between DHB and Poutini Waiora kamahi to align priorities and increase support to whānau. (EOA)	Q4: At least two opportunities identified and implemented.	

Planning Priority: Care Capacity Demand Management (CCDM)		
Expectations: ▪ Detail the actions that you will take towards implementing Care Capacity Demand Management (CCDM) for nursing by June 2021 in your annual plans. ▪ Outline the most significant actions the DHB will undertake in 2019/20 to progress implementation of CCDM for nursing. Ensure the equitable outcomes actions (EOA) are clearly identified.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Establish a CCDM Governance Council to provide leadership and oversight of the care capacity demand management programme. Introduce Hauora Māori membership at a CCDM Governance Council level, to ensure equity is considered in the rollout of the programme. (EOA)	Q1: CCDM Council established. Q1: CCDM Governance Council membership includes GM-Māori Health.	GM-Māori Health or proxy has attended 80% of CCDM Council meetings. Trendcare acuity tool used to demonstrate staffing resource is consistently matched with patient demand and to support continuous improvement.
Implement paper-based Variance Response Management (VRM) plans across the acute care departments, to underpin the delivery of the CCDM programme.	Q1: CCDM Working Group established. Q1: Departmental VRM response plans determined. Q1: Mandatory safe staffing incident forms implemented within Safety First. Q2: Education provided to teams on the use of the traffic light Variance Indicator System. Q3: Variance Indicator System and departmental VRM response plans implemented.	
Gather appropriate information to support formation of a Core Data Set, to inform improvements and evaluate the effectiveness of CCDM.	Q1: Options for a centralised data warehouse explored. Q2: Stocktake on current data measures completed, to inform development of a core data set. Q3: Options to support a dashboard to visibly display the Core Data Set explored. Q4: Dashboard solution identified and implemented. Q4: Move to electronic data display, following migration into new Greymouth facility.	50% of the Core Data Set will be recorded centrally to enhance bi-monthly reporting to nursing staff. Core data set is used to evaluate the effectiveness of CCDM.
Utilise existing systematic process for determining and budgeting staffing FTE and skill mix to ensure the provision of timely, appropriate, safe care in both acute and non-acute clinical settings. Gather quality data to inform current FTE calculations, with a view to re-start 18 months of data collection in May 2020, following migration to the new facility in Greymouth (which will impact FTE requirements).	Q1: Annual IRR testing complete, ensuring data integrity. Q1-Q3: Data collection undertaken to inform FTE calculations, budgeting, and skill mix. Q4: Re-start data collection to inform new staffing levels and skill mix for the new facility.	IRR test results >95%. <5% shifts below target.

Planning Priority: Disability		
Expectations: ▪ Commit to ongoing training for front line staff and clinicians that provides advice and information on what needs to be considered when interacting with a person with a disability. Report on percentage of staff completing the training by the end of Q4 2019/20. ▪ Outline how the DHB collects and manages patient information to ensure staff know which patients have visual, hearing, physical and/or intellectual disabilities.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Implement the first stage of the healthLearn learning management system upgrade, to support delivery of modules and reporting on uptake. Engage subject matter experts to develop disability training modules, building on the e-learning work completed in 2018/19. (EOA) Engage with the DHB Disability Steering Group and Māori leads, to ensure content is consumer focused and culturally appropriate. (EOA) Track uptake and feedback on modules, as a means of evaluation and to identify improvements.	Q1: First stage system upgrade complete. Q2: Development of training modules complete. Q2: Disability training modules launched. Q3: Reporting on uptake of training modules by staff commenced.	The number of modules dedicated to, or inclusive of, content targeted at raising disability awareness increases each quarter. Percentage of staff completing disability training modules.

Continue to include identification of patient's impairments (by the admitting nurse) at the point of admission and document these on the nursing history form, to inform planned nursing care and/or interventions.	Q1: Audit tool developed to ensure impairments are being captured. Q2: Tool incorporated as part of monthly quality audit of patient files.	Percentage of staff rating disability content positively. 95% compliance rate of patient files audited.

Planning Priority: Planned Care	

Expectations: DHBs need to outline the actions they will take in order to support the following:

Part One (p1): Current Performance Actions

- Outline actions to sustain or improve Planned Care delivery to meet increasing population health need and maintain timely access to Planned Care services including Radiology Diagnostics and Elective services. Actions need to include how DHBs will enable delivery of the agreed level of Planned Care interventions; and ensure that patients wait no longer than four months for a First Specialist Assessment and Treatment. Delivery and improvements will be measured against the agreed Planned Care Measures, and quarterly qualitative reports.

Part Two (p2): Three Year Plan for Planned Care

- DHBs are required to plan, design and start implementation of a Three-Year Plan to improve Planned Care services. The plan is required to include a description of actions that demonstrate how DHBs will address the following five Planned Care Priorities:
  - Gain an improved understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed;
  - Balance national consistency and the local context;
  - Support consumers to navigate their health journeys;
  - Optimises sector capacity and capability; and
  - Ensures the Planned Care Systems and supports are designed to be fit for the future.
- DHBs are expected to engage with DHB Consumer Councils and other key stakeholders in the development of their plan.
- DHBs should identify for both part one and two who in their population is experiencing inequities and include actions or strategies to be implemented to address the identified inequities.

Actions to Improve Performance	Milestones	Measures of Success
Improving and Sustaining Planned Care Performance Rollout electronic triage to all Planned Care services to strengthen triage process and reduce waiting times. Increase clinical capacity for ophthalmology through the provision of increased specialist sessions or further work on outsourcing. Undertake weekly monitoring of waiting times and waitlist volume for each specialty, to increase the visibility of planned care delivery and ensure equitable access to services for our population. (EOA) Monitor the delivery of Planned Care interventions against planned interventions, and where delivery falls below the plan, identify and address barriers.	Q1: Electronic triage rolled out to two further services. Q1: Weekly automated reporting of ESPI2 performance initiated for each specialty. Q2: Increased capacity sourced for ophthalmology. Q2: Weekly automated reporting of ESPI5 performance initiated for each specialty. Q3: Electronic triage rolled out to 2 further services.	Delivery against national Planned Care Measures expectations – 3,211. ESPI2 compliance achieved for all specialties, except Plastics, by Dec 2019. ESPI5 compliance achieved for all specialties, except Plastics and Orthopaedics, by December 2019. Provision of 60 additional cataract or other eye surgeries.
Develop a Plastic Surgery recovery plan to achieve ESPI2 and ESPI5 compliance, including investigating opportunities for primary care to support the recovery in line with the new Planned Care strategy. Develop and implement a pathway for the management of minor and intermediate skin lesions in primary care.	Q1: Issues relating to large follow up lists and lack of capacity for routine patients identified. Q2: Opportunities for primary care to support plastics delivery identified and plan developed. Q2: Planned Care skin lesion procedure volumes agreed with Ministry of Health. Q2: Plastics recovery plan developed. Q3: Plastics recovery plan implemented.	Plastics ESPI2 and ESPI5 non-compliance reduced by 50% by June 2020. Primary planned care target for lesions met. ESPI2 and ESPI5 compliance achieved for Plastics by Dec 2020.
Complete the transalpine Orthopaedic Surgery recovery strategy to achieve ESPI2 and ESPI5 compliance, including engaging administrative and clinical staff to book people at the right time and utilising all resources across the district efficiently.	Q1: Orthopaedics ESPI 2 recovery plan complete. Q2: Transalpine Operations Manager appointed. Q2: Orthopaedic surgery production plan developed, based on conversion rate from FSA to surgery. Q3: Transalpine action plan implemented to address barriers to ESPI5.	ESPI2 compliance achieved for Orthopaedics by September 2019. ESPI5 compliance achieved by June 2020.
Three-Year Plan for Planned Care Development Develop a three-year Planned Care strategy, aligned with our locality-based, whole of system approach, to provide increased and equitable access to planned care for our population. (EOA)	Q1: Outline of the proposed approach to developing the three-year plan is presented to the Ministry, including outline of engagement, analysis and development activities. Q2: Service analysis/stocktake completed.	Three-year Planned Care Plan submitted to the Ministry of Health. Initiation of identified services for transfer to

Undertake a stocktake to identify Planned Care services that could be delivered in primary care, and where capacity exists across the three West Coast localities to allow more services to be delivered closer to home. Engage with clinical leads, West Coast Alliance, NGOs, Consumer Council and Tatau Pounamu in the development of the Planned Care strategy, to better understand local priorities and ensure a whole of system approach with a clear focus on equity.	Q2: Consultation undertaken with stakeholders. Q2: Summary of analysis and consultation presented to stakeholders (identifying local health needs, priorities and preferences). Q3: Three-year Planned Care Plan completed. Q4: Update provided on initial actions outlined in the three-year plan.	primary care settings is commenced.
Improving equity and access for Māori Review primary care referrals and outpatient DNA rates, to identify barriers for Māori and develop a plan to improve attendance at planned clinics. (EOA) Partner with Poutini Waiora to investigate opportunities for providing general practice/nurse led clinics in Māori community settings, to increase access to health services for Māori. (EOA)	Q2: Outpatient referral and DNA rate analysis completed. Q2: Scoping project for establishing GP/Nurse led clinics into the community completed. Q3: Outpatient DNA action plan agreed and implementation underway. Q4: Equity gaps monitored and reported monthly.	Reduction in Māori DNA rates at specialist outpatient clinics. <6% of outpatient appointments were booked but the patient did not attend.

Planning Priority: Acute Demand		
Expectations: ▪ Provide a plan on how the DHB will implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021. For example, this should include a description of the information technology actions and ED clinical staff training actions, milestones and timeframes. ▪ Patient Flow: Provide an action that improves management of patients to ED with long-term conditions. ▪ Patient Flow: Provide an action that improves patient flow for admitted patients.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Implement a Primary Unplanned Care area within the new Grey Base facility, where the locality-based integrated health services team work together to ensure people presenting are seen by the right person, in the right service, at the right time.	Q1: Staff across the integrated team have a good understanding of each other's roles and scope. Q2: Workforce and FTE needs determined. Q3: Training calendar developed, to ensure staff have the necessary skills to work within this area. Q3: Primary Unplanned Care area operational.[9]	Increased proportion of staff engaged in Takarangi Framework – base 3% June 2019. Reduction in triage 4 and 5 presentations to the ED - base 56% Q4 2018. 95% of patients are admitted, discharged or transferred from 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.
Encourage staff to engage in the Takarangi Cultural Competency Framework, to improve the experience of Māori presenting to our service and support the improved (and appropriate) flow of patients though improved communication and delivery of key messages. (EOA)	Q1: Promote the Takarangi Cultural Competency Framework to clinical Leaders and front-line staff working in the Primary Unplanned Care area. Q2: Profile the experiences of those completing the programme to highlight the benefits. Q4: Review the percentage of staff completing and working on Takarangi portfolios.	
Work towards implementing the Care Capacity Demand Management (CCDM) programme to help improve the flow of patients, by enabling the DHB to better match the capacity to care with patient demand. This work will also improve the quality of care for patients, the working environment for staff, and the use of health resources.	Q1: All new staff understand what CCDM means and how this helps with patient care. Q2: Training and education of all nursing staff is in place, to be implemented the first week each new nurse arrives into the organisation.	
Implement SNOMED coding in the Emergency Department alongside the implementation of the South Patient Information Care System (PICS).	Q2: Options confirmed for implementing SNOMED into the current patient management system until SI PIC is operational. Q3: SNOMED training and education launched. Q4: Implementation of SI PIC's begins.	

[9] This action is aligned to the completion of the new Grey Base facility which is yet to be confirmed, but is anticipated in quarter three of 2019/20.

Planning Priority: Rural health	E Q C
Expectations: Outline how the DHB has considered the health needs and the factors affecting health outcomes for rural populations when making decisions regarding access to and sustainability of health services.	

Actions to Improve Performance	Milestones	Measures of Success
Engage clinical leads, consumers and stakeholders in the development of major strategies through the West Coast Alliance and Tatau Pounamu, co-design workshops, hui and public engagement, to better understand the priorities and issues of all of our communities. (EOA)	Q1: Key stakeholders engaged in development of a West Coast Maternity Strategy. Q1: 2019/20 Alliance work plan agreed.	>95% of the population are enrolled with general practice. Reduction in the equity gap that exists for ASH (avoidable hospital admission) rates between Māori and Total 0-4-year-old populations. Acute hospital bed day rate maintained below the national average. Readmission rates (at 28 days) maintained below the national average.
Continue to engage with staff and stakeholder as part of the implementation of the locality-based model of care, incorporating a new approach to the provision of planned and unplanned care across the three integrated localities in Northern [Buller], Central [Grey] and Southern [Westland]. Work with staff to realign resources to support the implementation of the new locality-based service model and ensure timely and equitable access to care. (EOA) Work with the Ministry to ensure external contracting, reporting and funding mechanisms do not create artificial barriers or restrict development of the new model.	Ongoing: Complete implementation of the integrated locality-based model of care. Q2: Communication plan for new planned/unplanned care pathways developed. Q4: Central and Southern integrated health services in place.	
Undertake the last elements of consultation to complete the realignment of resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based integrated health services team model.	Ongoing: Complete implementation of the proposal for change for mental health services. Q2: Crisis response function embedded in locality teams and phone service in place out-of-hours.	
Complete the upgrade of telehealth facilities, moving to a more accessible mobile-bases solution to facilitate easier access for rural communities to specialist consultations, clinical education and peer support. (EOA)	Q4: New mobile-based telehealth capability embedded and uptake increased.	

Planning Priority: Healthy Ageing	E Q C
Expectations: ▪ Identify actions, working with ACC, HQSC and the Ministry of Health, to promote and increase enrolment in S&B programs and improvement of osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework ▪ Identify actions to align local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS. ▪ Outline current activity to identify and address the drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations)	

Actions to Improve Performance	Milestones	Measures of Success
Continue to work with the Canterbury Falls and Fractures Service Level Alliance and WCDHB Falls Collation Group to enhance and integrate falls and fracture prevention services. Embed the fracture pathway to ensure people with a fractured Neck-of-Femur (hip) or Humerus (arm) are referred to the in-home Falls Prevention Programme. Embed the Fracture Liaison Services to ensure people with a frailty fracture receive appropriate support and follow-up. Identify and accredit community Strength & Balance classes targeted towards older Māori. (EOA)	Quarterly: Reporting to the national Hip Fracture Registry. Q1: Options explored for implementing automatic referrals to the Falls Prevention or Fracture Liaison Service. Q3: Three culturally appropriate Strength & Balance classes accredited.	720 places available at accredited strength & balance classes. 120 people seen by the Falls Prevention Service. 95% of long-term HBSS clients have had an InterRAI assessment and have a completed care plan in place. Proportion of people (75+) presenting to ED maintained below the national average Reduction in the equity gap that exists in the Acute Hospital Bed Day rate for Māori and Total populations.
Continue to engage across the DHB and with partner organisations to socialise and embed the restorative model of care across our system. Continue to work with the CCCN to ensure appropriate, equitable and timely assessment of people's needs using the InterRAI assessment tool. (EOA) Capture learnings from Non-Acute Rehab demonstration pilots to establish pathways to improve the flow through our inpatient environment and identify those appropriate for early supported discharge in a timelier way.	Q2: Identify and address key drivers of longer wait times for InterRAI assessments. Q4: Baseline established for the rate of InterRAI assessments per 1,000 population. Q4: ACC Non-Acute Rehab casemix pathways implemented, and supported discharge uptake increased to 10 patients.	

Continue to work through the Health of Older Persons Workstream to identify appropriate restorative pathways for older people to support people to keep well in their own homes and communities. Promote the use of personalised, acute and advance care plans to enable the delivery of consistent, managed care and to support people at end of life. Work with the West Coast PHO to focus initially on the development of acute care plans for Māori (aged over 50) enrolled in the primary care Long-term Conditions Management Programme, as a high need group. (EOA)[10]	Q1 Use of health care plans socialised across the West Coast health system through stories and patient voices. Q2: Monitoring established (by ethnicity) of the number of care plans completed. Q2: Process in place to identify Māori enrolled in the LTCM Programme without acute care plans in place to enable contact and follow-up.	

Planning Priority: Improving Quality	
Expectations: ▪ Identify actions to improve equity of outcomes, measured by the Atlas of Healthcare Variation (choose gout, asthma or diabetes) ▪ Identify actions to improve patient experience as measured by your DHB's lowest-scoring responses in the Health Quality & Safety Commission's national patient experience surveys. ▪ Please ensure that the local measure included in your plan relates to the action in your plan. ▪ Identify actions to align activities with the New Zealand Antimicrobial Resistance Action Plan (MoH 2017).	

Actions to Improve Performance	Milestones	Measures of Success
In response to the differential rates of hospital admission for children due to asthma or wheeze, work with general practices and Poutini Waiora to identify key actions that will reduce asthma and respiratory related hospital admissions for Māori (outlined in SLM Improvement Plan).	Q1: Targeted asthma and smoking related actions agreed in the SLM Improvement Plan. Q2:Q4: Progress against the SLM actions.	Reduction in the number of children (aged 0-4) admitted with ambulatory sensitive respiratory related illness – base 63 events Q4 2018/19. Reduction the rate of childhood admissions due to asthma or wheeze – base 4.1 per 1,000 2016. Improved result for the Patient Experience survey question *'Did hospital staff include your whānau or someone close to you in discussion about your care?'* - base 53% June 2018.
Complete implementation of the 'nominated' contact person process, to improve results against the DHB's lowest scoring Patient Experience Survey question: *'Did hospital staff include your whānau or someone close to you in discussion about your care?'* (Partnership Domain). [11] Undertake a co-design process with consumers, and their whanau to develop education material that reinforces the role of a nominated person. Focus on engagement with Maori to ensure processes are culturally appropriate. (EOA) Provide staff training to reinforce the need to establish and engage with the patient's nominated person.	Q2: Co-design focus groups run. Q2: Information system changes made to include nominated contact person and draft procedure for contact details collection finalised. Q2: Education material and tools agreed. Q3: New process launched in CDHB Ward 27 as a pilot site, to test processes and information. Q4: Staff training and rollout underway.	
Work with Canterbury DHB leads to strengthen transalpine approach to antimicrobial stewardship, to ensure an ongoing focus on reducing the inappropriate use of antibiotics, associated with increasing antimicrobial resistance.[12] Participate in the development of the ACC funded national antimicrobial guidelines, with a focus on enabling a consistent approach across the South Island. (EOA) Update antimicrobial guidelines as required, based on shifts in local resistance patterns and changes to national and international guidelines. Agree information flow processes across Public Health, DHB, Primary Care and ARC to support the management of infectious outbreaks including antibiotic resistant organisms. Work with the PHO to support the advanced training programme for rural nurse specialist to ensure best practice antimicrobial stewardship.	Q1: Access to Canterbury DHB's Pink Book (antimicrobial guidelines) is enabled. Q1:Q4: HealthPathways are reviewed and revised as required. Q2:Q4: Regional meeting to seek agreement on regional hospital prescribing guidelines. Q4: Information flow agreed and documented. Ongoing: Use of ICNet to support real-time notification of organisms requiring infection prevention and control input.	Local antimicrobial guidelines updated, based on local susceptibility patterns, national/international guidelines and evidence, and local expert opinion. Regional agreement reached on hospital antimicrobial guidelines for key indications. Adoption of national antimicrobial guidelines.

[10] The Primary Care Long-term Conditions Management Programme aims to provide enrolled patients 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 long-term condition.

[11] The inclusion of a family/whanau member or significant other for patients is an important indicator of a partnership with patients and a factor in ensuring good outcomes. Currently the DHB has limited ability to capture and record a contact other than next of kin. This work is part of the DHB's Always Event project and will expand our ability to recognise other people who are important to the patient and ensure staff recognise the importance of engaging with them.

[12] Canterbury and Coast DHBs share microbiology and infection, prevention and control advice, guidance and clinical guidelines.

Planning Priority: Cancer Services	L E C

Expectations:

- Describe actions to ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway (e.g. system/service improvements to minimise breaches of the 62-day FCT target for patient or clinical consideration reasons)
- Identify two priority areas for quality improvement from the Bowel Cancer Quality Improvement Report 2019.
- Commit to working with the Ministry to develop a Cancer Plan and to implementing and delivering on the local actions from within the Plan.

Actions to Improve Performance	Milestones	Measures of Success
Work with West Coast PHO, Poutini Waiora, Community and Public Health, Cancer Society, and Tatau Pounamu to offer support and encourage Māori whānau to engage in screening and seek early advice and intervention. (EOA)	Q2: Health Hui held to promote health initiatives and an understanding of the benefits of cancer screening and early intervention. Q4: Second Health Hui held.	70% of women (50-69) have a breast cancer screen every two years. 80% of women (25-69) have a cervical cancer screen every three years. 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.
Continue to use data/intelligence systems to monitor the 62-day and 31-day wait times for patients, and undertake breach analysis for patients who wait longer than target to assess any emergent systems issues and identify opportunities to reduce process delays.	Quarterly: Monitoring (by ethnicity) of cancer wait times, analysis of any cases outside of time frames and action taken to address emergent issues.	
Engage with the Southern (regional) Cancer Network on the progressive implementation of the Route to Diagnosis project recommendations and support equity of access for West Coast patients. (EOA)	Q4: West Coast process aligned with regional Routes to Diagnosis recommendations.	
Informed by the 2018 national Bowel Cancer Quality Improvement Report, commence preparation for the local roll-out of the national bowel cancer screening programme, in line with Ministry of Health timeframes.	Ongoing: Development of an implementation and improvement plan for bowel cancer care.	
Work with the Ministry of Health to develop a Cancer Plan, and support progressive implementation to deliver on the local actions from within the Cancer Plan.	Ongoing: Development of a local action plan once the national Cancer Plan is developed.	

Planning Priority: Bowel Screening	L C

Expectations: All DHBs will describe actions to ensure diagnostic colonoscopy wait time indicators are consistently met; this requires active management of demand, capacity and capability.

DHBs providing the National Bowel Screening Programme will describe actions to:

- Implement initiatives that contribute to the achievement of national targets for NBSP. All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to services.
- Ensure screening colonoscopy wait time indicators (indicator 306: time to first offered diagnostic assessment) is consistently met.
- Achieve participation of at least 60% of people aged 60-74 years in the most recent 24-month period.

Ensure participation equity gaps are eliminated for priority groups.

Actions to Improve Performance	Milestones	Measures of Success
Actively manage colonoscopy demand through matching of available capacity, to ensure diagnostic colonoscopy waiting time indicators are consistently met. (EOA) Continue to support the Endoscopy Coordinator to work across services and with patients to improve access to information, increase engagement with endoscopy services and improve follow-up process.	Weekly: Review of colonoscopy waiting lists to accommodate provision of diagnostic endoscopy within clinically indicated response timeframes. Ongoing; Monitoring of colonoscopy results by DHB Operational Leadership Group to ensure wait time indicators are met and delays are promptly responded to.	90% of people accepted for an urgent diagnostic colonoscopy receive their procedure with 14 days, 100% within 30 days. 70% of people accepted for a non-urgent diagnostic colonoscopy receive their procedure within 42 days, 100% in less than 90 days. 70% of people waiting for a surveillance colonoscopy receive their procedure within 84 days, 100% in 120 days.
Work with the West Coast PHO and Poutini Waiora to support bowel cancer awareness promotion through primary care networks, with a specific focus on Māori, to de-stigmatise and encourage people to present earlier with symptoms and concerns. (EOA)	Ongoing: Promotion of bowel cancer messages. Q2: Health Hui held to promote health initiatives and an understanding of the benefits of cancer screening and early intervention. Q4: Second Health Hui held.	
Prepare 'Phase One Implementation' information for the business case to support the implementation of the National Bowel Screening Programme on the West Coast. Commence 'Phase two Planning' in preparation for the roll-out across the Coast in 2020/21.	Q3: Phase One Implementation information provided to the Ministry of Health. Q4: Bowel cancer champion and/or lead clinician identified.	

Planning Priority: Workforce – Workforce Diversity	Q E E

Expectations:

- Set out workforce actions, specific to your DHB that you intend to work on in the 2019/20 planning year.
- Outline how these actions relate to both a strong public health system and EOA focus area actions.
- Ensure that you have considered workforce actions for the priority areas in your plan, especially mental health and child health.

Work in collaboration with DHB Shared Services and, where appropriate, with the Ministry of Health to:

- Identify workforce data/intelligence that is collected and understand workforce trends to inform workforce planning
- Understand workforce data/intelligence requirements that best support DHBs in order to undertake evidence-based workforce planning
- Support your responsibility to upskill, provide education and train health work forces
- Provide training placements and support transition to practice for eligible health work force graduates and employees. Planning must include PGY1, PGY2 and CBA placements, and how requirements for nursing, allied health, scientific and technical health work forces in training and employment will be met
- Form alliances with training bodies such as educational institutes (including secondary and tertiary), professional colleges, responsible authorities, and other professional societies to ensure that we have a well trained workforce.

DHBs are expected to develop a sustainable approach to nursing career pathways. In 2019-20, it is expected that DHBs will develop actions that support equitable funding for professional development for nurse practitioners.

Actions to Improve Performance	Milestones	Measures of Success
Introduce and socialise unambiguous, consistent terminology for our clinical workforce and their activities throughout the DHB and in our external communications. Progress the Rural Generalist (Medical) project with: an implementation plan for rural generalists to support General Medicine and Obstetrics; a governance group to drive change; and updates to the roster to clearly articulate workforce expectations. Continue to progress our rural Allied Health workforce strategy with introduction of the Rurally Focused Urban Specialists (RUFUS) model in child development services and the development of a rural kaiawhina (non-regulated) workforce strategy.	Q1: Rural Generalist Project Governance Group in place. Q2: Glossary/lexicon developed and socialised. Q3: Alignment of learning opportunities across DHB operations teams, West Coast Alliance and South Island Regional Workforce Hub. Q4: RUFUS model for Child Development Services finalised.	Number of new roles in place. Improved professional development package in place for Nurse Practitioners. Increase in staff retention rates. Reduction in the time taken to fill vacancies. Percentage of staff completing Takarangi Cultural Competency – base 3% June 2019. 90% of patients responded positively to the inpatient survey question "Was cultural support available when you needed it?" Māori workforce closer aligned to the proportion of Māori in the population – base 3.4% April 2019.[13]
Continue to develop the rural nursing workforce with investment in a Rural Nurse Specialist development pathway and ongoing recruitment, training and development of nurse practitioners. Review the West Coast's current allocation for Nurse Practitioner professional development to identify opportunities to ensure resources offered are consistent with continuing competence requirements and enable access to forums that promote professional contributions to quality care and ongoing improvement.	Q1: Regional discussions instigated to explore opportunities for standardisation of a professional development package. Q3: Review of current allocation complete with recommendations for improvements made to executive team. Q4: New Nurse Practitioner professional development package finalised and implemented.	
Establish an integrated workforce development cluster (with local training bodies, high schools, providers, clinical and Māori leaders) to facilitate system-wide education and training opportunities and support the development of our rural generalist workforce model and pathways to develop our Māori nurse and midwifery workforce. (EOA)	Q3: Workforce Development Cluster established. Q4: Three-year work plan and associated measures for success agreed.	
Continue to invest in the Takarangi Cultural Competency Framework, Te Tiriti o Waitangi and Tikanga Best Practice Guidelines development programmes, to support our commitment to equity and improve cultural competency across our core workforce. (EOA)	Q1: Clinical Leaders and front-line staff working in the Primary Unplanned Care area encouraged to engage in the Takarangi Cultural Competency Framework. Q2: Takarangi Hui held for next round.	
Work in tandem with the Canterbury DHB to support and encourage greater participation of Māori in our health workforce and build on the learnings from the joint workshops held in 2018/19. (EOA)	Q3: Targeted attraction and recruitment programme for Māori workforce developed. Q4: Targeted attraction and recruitment programme for Māori workforce launched.	
Expand and promote the Essentials of Leadership and Management programme (aligned with the People Strategy: Everyone Enabled to Lead) to lift the capability of	Q1: Our Learning Pathways launched online. Q2: Delivery of 12 'User Stories', which include feedback and evaluation processes for learners.	>12% completion rate for learning modules.

[13] This figure is likely to be understated, 49% of DHB employees have no ethnicity declared. Of those declaring their ethnicity 6% have identified as Māori.

clinical and operational leaders through anytime, anywhere learning.	Q3: A reviewed roadmap document for year 2020 published for stakeholder engagement. Q4: Delivery of a further 12 'User Stories'.	

Planning Priority: Workforce - Health Literacy	E E C	
Expectations: ▪ As a result of the health literacy review completed in the 2018/19 planning year (if you do not have one already in place), develop a Health Literacy Action Plan that describes the service improvements you plan to make in the short, medium and long term. ▪ Outline actions within the Health Literacy Action Plan that support a health system focus on: services being easy to access and navigate, effective health worker communication, clear and relevant health messages that empower everyone to make informed choices. Where health literacy actions are set out in other sections of the annual plan ensure that these are considered within the Health Literacy Action Plan, as well as briefly cross-referencing these actions in this section.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Participate in a collaborative health literacy review (with the Canterbury DHB) to assist in the formulation of a Health Literacy Action Plan. (EOA) *It is the intent that health literacy strategies and resources will be developed in collaboration with the groups for whom the improvement or resource is aimed to benefit.*	Q2: Health Literacy Review scoped, and team formed to undertake the Review. Q4: Health Literacy Review report is complete and recommendations made to inform the development of a Health Literacy Action Plan.	Patient satisfaction ratings across the two inpatient survey domains: Communication and Partnership.
Undertake a co-design process with consumers and whānau to develop education material that reinforces the role of a nominated person in the early stages of admission. Focus on engagement with Māori to ensure processes are culturally appropriate. (EOA) [14] Provide staff training to reinforce the need to establish and engage with the patient's nominated person.	Q2: Co-design focus groups run. Q2: Education material and tools agreed. Q4: Staff training underway. Q4: Rollout underway.	

Planning Priority: Delivery of Regional Service Plan (RSP) Priorities	Q C	
Expectations: Identify significant actions the DHB is undertaking to deliver on the Regional Service Plan in the following areas: ▪ Actions to support the implementation of the New Zealand Framework for Dementia Care. o Provide input into a regional stocktake of dementia services and related activity, which will be completed and provided to the Ministry by the end of quarter two (via the S12 measure). o Using the stocktake, work with your regional colleagues to identify and develop an approach to progress your DHB's priority areas for implementing the Framework by the end of quarter four. o Report on work to progress the implementation of the New Zealand Framework for Dementia Care in quarters three and four. ▪ Identify the DHB's role in supporting the delivery of the regional hepatitis C work and objectives. o Describe how the DHB will work in collaboration with other DHBs in the region to implement the hepatitis C clinical pathway o Describe how the DHB will work in an integrated way to increase access to care and promote primary care prescribing of the new pangenotypic hepatitis C treatments.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Capture the range of Dementia Services available on the West Coast and provide as input to the regional stocktake. Using the stocktake and, in line with the national NZ Framework for Dementia Care, identify priorities to address service gaps and improve the experience of people with dementia and their families. Engage with primary, community and aged care partners to develop strategic and service responses that support earlier diagnosis and referral to services and improve access to support for those caring for people with dementia. *This work feeds into the actions identified in the Regional Alliance Initiative 'Dementia is Everybody's Business'.*	Q1: Stocktake of Dementia services complete. Q2: Stocktake provided to the regional team and to the Ministry of Health. Q2: Priority focus areas identified and response underway. Q3:Q4: Report on progress implementing the NZ Framework for Dementia Care.	Progress against the regional initiative Dementia is Everybody's Business'. Progress in implementing the NZ Framework for Dementia Care.

[14] The inclusion of a family/whānau member or significant other for patients is an important indicator of a partnership with patients and a factor in ensuring good outcomes. This work is part of the DHB's Always Event project and will expand our ability to recognise other people who are important to the patient and ensure staff recognise the importance of engaging with them.

Participate in the regional Hepatitis C work stream to support implementation of an integrated approach to the screening, treatment and management of Hepatitis C. Develop and deliver against a local action plan, aligned with Regional Plan, which ensures at-risk and 'treatment naïve' populations are reached. (EOA) Engage with primary care partners to support them to provide the majority of treatment services for individuals with Hepatitis C. *Refer to the 2019/20 Regional Health Services Plan for more detail on the Hepatitis C work plan.*	Q1: Regional Hepatitis C work plan is agreed. Q2: Local Action Plan is developed. Q2: Local HealthPathway aligned to national guidelines. Q3:Q4: Report on progress against the regional Hepatitis C work plan.	Each GP practice with known Hep C+ patients has active engagement with a secondary care community clinic nurse. At risk individuals are tested, those lost to follow-up are identified.

2.5 Better population health outcomes supported by primary health care

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Primary Health Care Integration	QEEC

Expectations:

- DHBs should ensure clear accountability throughout the entire alliance structure - include a description of this accountability cascade from PHO and DHB Boards to the Alliance Leadership Team (ALT) and then to individual Service Level Alliances including decision making, reporting, budget to support the Alliance and total budget available to the ALT for service planning and delivery.
- DHBs are expected to continue to work with their district alliances on integration including: strengthening their alliance (e.g., appointing an independent chair, establishing an alliance programme office, expanding the funding considered by the alliance); broadening the membership of their alliance; developing services, based on robust analytics, that reconfigure current services and address equity gaps.
- Identify actions you are taking with your Rural Service Level Alliance to develop resilient rural primary care services.
- Identify actions to assist in the utilisation of other workforces in primary care settings, particularly nurses and pharmacists in rural areas.
- Identify actions to improve access to primary care services, particularly for high needs patients.

Actions to Improve Performance	Milestones	Measures of Success
Continue to invest in the West Coast Alliance as a mechanism for leading service and system improvements across the West Coast.[15]	Quarterly: Monitoring of system performance and progress against the Alliance work plans. Q1: Independent Alliance Chair appointed. Q1: Alliance 2019/20 work plan approved.	>95% of the population are enrolled with general practice. >3,000 people enrolled in the primary care LTCM Programme. Improved system performance in line with the 2018/19 SLM Improvement Plan. Reduction in the equity gap that exists for ASH (avoidable hospital admission) rates between Māori and Total 0-4-year-old populations. Reduction in the equity gap that exists in the Acute Hospital Bed Day rate for Māori and Total populations.
Deliver on the commitment of the Alliance to include the consumer voice in all activity, by engaging consumer representation for each work stream and providing regular feedback to the DHB Consumer Council.	Q2: All Alliance work streams have consumer representation. Quarterly: Activity report provided to the DHB Consumer Council.	
Refresh and refine the System Level Measure (SLM) Improvement Plan, agreeing collective activity to improve performance in 2019/20 with a deliberate focus on closing health equity gaps. (EOA)	Q1: Refreshed SLM Improvement Plan in place. Quarterly: Progress against the actions agreed in the SLM Improvement Plan.	
Establish an integrated workforce development cluster to facilitate cohesive system-wide education and training opportunities, to support the development of our rural generalist workforce model and the delivery of high quality and culturally appropriate care.	Q2: Workforce Development Cluster established. Q3: 1-3-year work plan and associated measures for success agreed.	
Continue to expand the number of general practices offering people with long-term mental health conditions enrolment in the primary care Long-Term Conditions Management Programme, to support improved physical health and wellbeing for this high needs group. (EOA)	Q4: Three general practices have expanded enrolment into the Long-Term Conditions Management Programme.	

[15] Refer to Appendix 4 for an overview of the accountability structure for the West Coast's Alliance.

Planning Priority: Pharmacy	Q L C

Expectations:

- Identify actions to support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice) by June 2020.
- Identify actions to support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) by working with pharmacists, the public, primary care and the wider health care team to commission integrated local services that prioritise local need and support equitable health outcomes.
- Identify local strategies that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age.
- Commit to reporting the outcomes of these local strategies to improve influenza vaccination rates in Q2 of the following financial year.

Actions to Improve Performance	Milestones	Measures of Success
Participate in the national review of the Integrated Community Pharmacy Services Agreement (ICPSA), to better support the role of pharmacists in the integrated health care team.	Q4: Offer and explain the revised national ICPSA agreement to pharmacies, including opportunities to improve the integration of local services.	>25 people receive a Medicines Use Review MUR from a pharmacist. >900 people enrolled in the Pharmacy LTC Service. Three West Coast general practices have the Electronic Prescription Service in place.
Continue to invest in the Pharmacy Long-Term Conditions Service to improve access to community pharmacist advice and support, for people with chronic conditions and those taking multiple or high- risk medications. Investigate the widening of eligibility for enrolment in the Pharmacy Long-Term Conditions (LTC) Service to more closely align with the general practice LTC Management programme with a higher focus on Māori. (EOA)	Quarterly: Monitoring of Medicines Use Reviews delivered by community pharmacists. Q2:Q3: Widening of eligibility for enrolment in the Pharmacy LTC Service scoped. Q4: Options for enhancing the LTC Service presented for agreement.	
Through the Pharmacy Alliance Workstream, implement key initiatives that support closer integration of pharmacy and primary care teams and improve the quality of care and sustainability of West Coast services.	Q2:Q4: Provide support to general practice to implement the NZ Electronic Prescription Service to enable the smooth, safe transfer of medicines information between GP and pharmacy systems. Q3: Proposal developed for further integration of pharmacists into general practice teams to optimise prescribing for complex patients.	
Work with PHO and Pharmacy Leads to identify local strategies to support an integrated approach to improving influenza vaccination rates with a focus on older people and Māori, as high need groups. (EOA)	Q1: Current influenza vaccination rates reviewed for equity gaps and areas of improvement. Q3: Plan for 2019/20 season developed. Q4: Promotion of free flu vaccinations from general practice and community pharmacies.	75% of the population aged 65+ receive a free influenza vaccination. Report on outcomes of local strategies (Q2 2020).

Planning Priority: Diabetes and other long-term conditions	E Q C

Expectations:

- Identify the most significant actions the DHB will take across the sector to strengthen public health promotion to focus on the prevention of diabetes and other long-term conditions.
- Identify how the DHB will ensure all people with diabetes will have equitable access to culturally appropriate diabetes self-management education and support services and how the DHB will measure programme outcomes or evaluate their effectiveness.
- Commit to monitoring PHO/practice level data to improve equitable service provision and inform quality improvement.
- Identify actions to improve early risk assessment and risk factor management for people with high and moderate cardiovascular disease risk, by supporting the spread of best practice from those producing the best and most equitable health outcomes.

Actions to Improve Performance	Milestones	Measures of Success
Continue to support delivery of the primary care-led Long-Term Conditions Management Programme, including community-based lifestyle change initiatives, to strengthen the focus on the prevention of diabetes and other long-term conditions.	Quarterly: Monitoring of PHO/Practice level data to improve equitable service provision and inform quality improvement. Quarterly: Community-based lifestyle change and LTCM management initiatives delivered.	>3,000 people enrolled in the primary care LTCM Programme. Percentage of Māori population engaged in the LTCM Programme aligns to proportion of the population. >90% of the population identified with diabetes have an annual HbA1c test.
Continue to support the Whānau Ora model and team approach for Māori with Diabetes in the Whakakotahi pilot practice and expand the programme to at least one more general practice. (EOA)	Q2: Model in place in two practices. Q4: Report on outcomes shared with the Healthy West Coast Alliance Workstream.	
Engage with Canterbury DHB to confirm a Clinical Leadership model for delivery of a transalpine (secondary level) Diabetes Service, with support for primary practice.	Q2: Clinical Leadership model in place.	

Provide training and support to Clinical Nurse Specialists to increase capability in relation to the use of insulin pumps and continuous glucose monitors, to better support West Coast patients living well in the community. (EOA)	Q1: Training provider confirmed. Q3: Training delivered.	>60% of the population identified with diabetes (having an HbA1c test) have good or acceptable glycaemic control (HbA1c <64 mmol/mol). Percentage of people assessed as high risk who have had an annual review.[16]
Work with Maternity Services to improve the process for referring women who develop Gestational Diabetes to primary care for ongoing postnatal follow up.	Q2: Referral process mapped. Q4: New Referral Pathway in place	
Establish an integrated approach to the prevention and management of cardiovascular disease (CVD) and the introduction of the new national guidelines for CVD risk assessment and management in primary care. (EOA) Collaborate with Poutini Waiora and the West Coast PHO to identify and contact Māori men aged 35 -44 who are overdue for CVD Risk Assessments.	Ongoing: Monitoring of CVD risk assessment rates and targeted support to practices with lower rates. Q1: Joint CVD Improvement Plan approved.	

[16] This is a new measure and baselines are yet to be confirmed.

Financial Summary

Further detail on the DHB's financial outlook and assumptions for 2019/20 can be found in Appendix 6 of this Plan.

2.6 Prospective Statement of Financial Performance – to 30 June 2022

	2017/18	2018/19	2019/20	2020/21	2020/22
	Audited Actual	Unaudited Actual	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000
Revenue					
Ministry of Health Revenue	136,789	142,732	147,127	150,937	154,855
Other Government Revenue	3,839	3,682	3,949	3,756	3,783
Other Revenue	8,540	8,200	8,578	8,496	8,652
Total Revenue	**149,168**	**154,614**	**159,654**	**163,189**	**167,290**
Expenditure					
Personnel	60,132	67,605	66,649	69,802	71,546
Outsourced	8,663	8,708	9,113	9,190	9,283
Clinical Supplies	8,919	8,018	8,265	8,688	8,819
Infrastructure & Non Clinical	11,935	12,517	11,648	11,968	10,863
Payments to Non-DHB Providers	58,152	64,519	66,388	67,053	67,553
Depreciation & Amortisation	2,911	3,390	3,226	4,174	4,073
Capital Charge	1,387	1,407	978	6,559	7,759
Total Expenditure	**152,099**	**166,164**	**166,267**	**177,434**	**179,896**
Other Comprehensive Income					
Revaluation of Land & Building	3,599	-	-	-	-
Total Comprehensive Income / (Deficit)	**668**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**

2.7 Prospective Financial Performance by Output Class – to 30 June 2022

	2019/20	2020/21	2021/22	2022/23
	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000
Revenue				
Prevention	3,528	3,599	3,689	3,782
Early detection and management	30,573	31,244	32,029	32,834
Intensive assessment & treatment	103,800	106,056	108,721	111,455
Support & rehabilitation	21,751	22,290	22,850	23,425
Total Revenue	**159,652**	**163,189**	**167,290**	**171,496**
Expenditure				
Prevention	3,990	4,586	4,650	4,752
Early detection and management	32,524	34,618	35,098	35,871
Intensive assessment & treatment	107,662	115,373	116,974	119,549
Support & rehabilitation	22,089	22,857	23,174	23,684
Total Expenditure	**166,265**	**177,434**	**179,896**	**183,856**
Surplus/(Deficit)	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**

MEDIUM-TERM OUTLOOK

How are we organising our business to achieve our vision?

Managing Our Business

This section highlights how we will organise and manage our business to support the realisation of our vision, enable the delivery of equitable, integrated and sustainable services and improve the health and wellbeing of our population.

3.1 Partnering for better outcomes

Our vision is based on bringing to life a truly integrated system. Working collaboratively with our health and social service partners is a critical factor in achieving our goals and objectives.

The DHB's major strategic partnerships include:

The West Coast Alliance: Where the DHB and the PHO come together with other local service providers to improve the delivery of public health services and realise opportunities to improve health outcomes. This focus includes delivery against the West Coast's System Level Improvement Plan, which is incorporated into the DHB's Annual Plan.

The Consumer Council: The DHB is committed to a culture that focuses on the patient and supports consumer participation in the design of services and strategies to improve wellbeing. We seek input from consumers through our Alliance work, with consumers represented on work streams. The DHB also has a Consumer Council, to ensure a strong and viable voice in health service planning and redesign. In the coming year we will work with the Council to develop a framework to support greater local community engagement with locality teams.

The Family Violence Interagency Response Group: Regular interagency meetings assess risk in reported cases of family violence, so that collective responses can be planned and implemented. The DHB is a partner in this work alongside Police, Women's Refuge, Presbyterian Support and Oranga Tamariki.

Transalpine Partnership: Connecting up the Canterbury and West Coast health systems is enabling more coordinated care, reducing duplication and supporting more sustainable access to specialist services for our population. The two DHBs also share a Chief Executive, executive management team, clinical leads, 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 & 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. This includes the development of the West Coast's Public Health Action Plan, which is incorporated into our Annual Plan and supported locally by the West Coast Alliance.

3.2 Commitment to Māori

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.

As a Crown agency, we recognise our responsibilities to uphold our obligations under the Te Tiriti o Waitangi. We work to improve the quality of care and equity of health outcomes for Māori and to address any systemic inequity, consistent with the recognised Tiriti principles of partnership, participation and protection.

The relationships and partnerships we build with our Māori stakeholders are fundamental to this work. We have a memorandum of understanding with Tatau Pounamu, our Māori advisory group, where we actively engage 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 and the building of capacity across community services through participation in the West Coast Alliance.

We also promote a culture that addresses disparities through open discussion, the use of the Health Equity Assessment Tool (HEAT), universal performance targets and professional development and mentoring. A crucial vehicle for this work is our Takarangi Competency framework, an evidence-based model that influences and shapes practice and supports improved cultural competency amongst our workforce.

3.3 Commitment to quality

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

West Coast DHB is committed to health excellence, with a strong focus on service quality and system performance. Working in partnership with patients and whānau is central to improved performance and we have made a commitment to using our inpatient experience survey results to improve the way we communicate with patients and their families.

The national Health Quality and Safety Commission (HQSC) Quality & Safety Markers supplement our local performance framework and are used to monitor patient safety and the effectiveness of improvement activity. We report results to our community in our Quality Accounts which can be found on our website.

Expectations for externally contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. We also work with the other South Island DHBs, as a partner in the regional Quality and Safety Alliance, to implement quality and safety improvements.

3.4 Performance management

To support good governance, we have an outcome-based decision-making and accountability framework that enables our stakeholders, Board and executive to monitor service performance and provide direction.

At the broadest level, we monitor our health system performance against a core set of desired population outcomes, captured in our outcomes framework. The framework defines success from a population health perspective and is used as a means of evaluating the effectiveness of our investment decisions.

The DHB's service and financial performance is monitored through monthly and quarterly reporting to our Board and to the Ministry of Health against key financial and non-financial indicators aligned to the national performance framework. Our service performance is also audited annually against our Statement of Performance Expectations set out in section 4 of this document. The results are published in our Annual Report which can be found on our website.

The national DHB performance framework is presented in section 4 of this Plan. Refer to the DHB's Statement of Intent for service performance and outcomes goals.

3.5 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 at 30 June 2018, the West Coast DHB had $47.663M worth of assets on its books. As an owner of Crown assets, we are 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 facilities redevelopment.

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.

3.6 Ownership interests

The West Coast DHB has an ownership interest in two partnerships to support the delivery of health services.

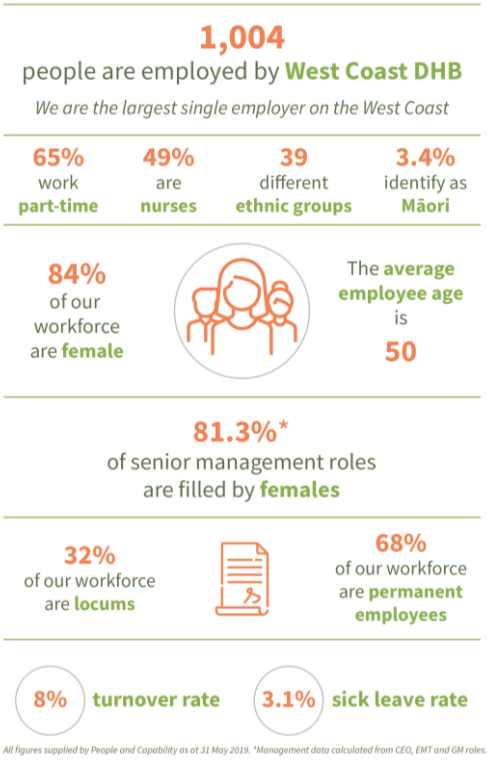
The South Island Shared Service Agency Limited: functions as the South Island Alliance Programme Office. It is jointly owned and funded by the five South Island DHBs and provides audit services and drives regional service development on our behalf.

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. The 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 2019/20.

Building Our Capability

3.7 Investing in our people



The DHB is committed to being a good employer. We promote equity, fairness, a safe and healthy workplace, and have a clear set of organisational values and core operational policies. These include a Code of Conduct, Equality, Diversity and Inclusion Policy and a Wellbeing Policy. The DHB is will also implement the national Care Capacity Demand Management agreement by June 2021.

In our rurally isolated environment, we face significant difficulties in recruiting and retaining people with the right skills to support our system. Attracting and retaining capable people, with a real passion for rural health, is one of our critical success factors.

We are 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 positively motivate and support the wellbeing of our people.

A range of initiatives will be developed and rolled out to deliver on the priorities that matter to our people, and in doing so 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.

Alongside our People Strategy work, we identify available talent and expand workforce capability through participation in the regional Workforce Development Hub, links with the education sector, sharing of education resources and support for internships and clinical placements in our hospitals.

The DHB has also identified two key areas of workforce development for the period of this Plan:

Rural Generalist Workforce: The DHB is deliberately investing in the development of a rural-generalist model, a proven strategy for more remote rural health systems. We are applying this model across all our professions – medical, allied health and nursing - and as part of this strategy each profession will work to the full extent of their scope of practice and as part of a multi-disciplinary team.

A core workforce of rural generalists will support improved sustainability of services, the development of more integrated models of care and improve the continuity of care for our population. For example, a rural generalist doctor could be qualified to work in obstetrics or anaesthetics as well as in general practice and hospital medicine.

This move to a less siloed and more sustainable model will also provide opportunities for our workforce to evolve and will help us attract people who want to work in a more integrated rural-based model.

Māori Health Workforce: The DHB also seeks to encourage greater participation of Māori in the health workforce. Employee ethnicity data shows Māori make up 12% of the West Coast population but just 3.4% of the DHB workforce.[17]

In support of this direction the DHB is participating 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.

In collaboration with Canterbury DHB, we are supporting a review of recruitment practices, particularly those that may unintentionally limit job placements for Māori applicants.

With 49% of staff having no ethnicity recorded, we are engaging with staff to improve the collection and recording of ethnicity data to improve workforce planning and support.

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.

Other areas of workforce development and investment for the period of this Plan are outlined in section 2.

3.8 Investing in information systems

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

The South Island DHBs have determined collective actions to deliver on the national Digital Health Strategy. The West Coast DHB is committed to this approach and has heavily invested in the move to regional and sub-regional solutions, implementing Health Connect South, HealthOne and the shared Electronic Referral Management System. The next focus will be implementation of the (single) South Island Patient Information Care System (PICS).

Our transalpine partnership with Canterbury DHB provides critical support to the West Coast in regards to applications management and support for planned upgrades. We now share many of the same software solutions and are working to implement a combined transalpine service desk.

Supported by a new Transalpine Security Manager, the DHB is also focused on security improvements, including: improvements to the authentication of systems, joint policies and a move to joint security appliances. The West Coast DHB has contributed to a consolidated transalpine list of mission, clinical and business critical systems and will be expanding this to include the systems we maintain locally.

Telehealth, videoconferencing and mobile technology that support staff to work remotely, are an important factor in addressing our isolation challenges. We will continue to expand this capability in the coming year, with the move to a more accessible mobile-based telehealth solution, providing more remote communities on the Coast with access to telehealth options.

There are also a host of technological advancements being incorporated into Te Nikau to improve patient care. Digitisation of the facility is occurring through the use of regional solutions which promote electronic workflows: electronic orders, e-referrals and Patientrack, an e-observations platform designed to support patient safety.

Areas for investment for the period of this Plan include:

- Implementation of a combined transalpine service desk, in quarter one.
- Approval of the e-Pharmacy business case, with project start planned for quarter one.
- Approval and implementation of electronic orders for radiology, to support improved workflows in Te Nikau, in quarter two.

[17] Note: This number is likely to be understated with 49% of our workforce not declaring their ethnicity. Of those who have declared their ethnicity 6.0% have identified as Māori.

- Approval of the business case for implementation of South Island PICS, with project start planned for quarter four.
- Implementation of new mobile-based telehealth capability, providing improved mobility and greater access to the technology across the wider health system, by the end of 2019/20.

The DHB will report quarterly to the Ministry of Health on our ICT investment to support collective decision making and maximise the value of sector investment.

3.9 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 DHB is in the midst of significantly transforming the way we deliver health services to our community. Te Nikau (the new Grey Hospital and Health Centre) will underpin this transformation by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service delivery.

Delays with the building programme have meant the DHB has been unable to realise anticipated efficiency savings over the past year. It is critical that Te Nikau is completed without further delay.

Areas of investment for the period of this Plan include:

- Te Nikau: The Grey Base redevelopment is now expected to be completed (with migration of services and staff into the new facilities) in the third quarter of 2019/20.

- Grey Base Energy Centre: A replacement Energy Centre is part of the Grey redevelopment and completion is anticipated in 2019.
- DHB Administration Block: A concept design has been agreed for a new administration building in Greymouth. The building will provide a facility for all DHB personnel not based at Te Nikau. Construction is expected to commence in 2019, with completion early 2020.

- Buller Health Centre: In December 2018 approval was given for the $20m Buller project. Management of the project has been transferred back to the DHB and the design phase for the new facility has begun. At this stage we anticipate confirming the construction contract in 2019 with the new facility anticipated in 2021.

- Grey Base Mental Health Facility: The current mental health facility is subject to a seismically related section 124 notice that expires in June 2020. A master site plan is currently being scoped with reference to a replacement facility, more aligned to the new model of care for mental health. A business case will then be developed.
- Relocation of the Hannah's Clearing Clinic: An opportunity has been presented to relocate the Clinic based in Hannah's Clearing to the Haast Township, collocated in the same building as St John. Scoping and design work is underway to understand the implications of a move.

Service Configuration

3.10 Service coverage & redesign

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

Responsibility for ensuring service coverage is shared jointly between the DHB and the Ministry of Health. The DHB identifies service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways and takes appropriate action to ensure service coverage is maintained.

At this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2019/20. However, we are mindful of continuity risks while we decant and transfer services into Te Nikau, 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 will be a challenge during this period.

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 continue to review capacity and costs across all service areas and look to prioritise resources into areas of greatest need as we change the way we work and prepare to migrate to new facilities. This will also include aligning practice and intervention rates with national specifications or accepted practice in other DHBs, and may impact on the configuration, scope and location of some services.

We anticipate new models of care and service delivery will emerge through this work and 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, for the period of this Plan, are highlighted in the table below.

Area Impacted	Description of Change	Anticipated Benefit	Driver
Grey Base Campus	The DHB will be migrating services into Te Nikau (the new Grey Base Facility) in the coming year. This will result in the relocation and reconfiguration of services.	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 future 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 Meals on Wheels	The DHB is considering the provision of a number of services, currently under hospital management, and exploring how we might better and more sustainably meet the needs of our population as part of the wider integrated service model. This may result in the reconfiguration and relocation of some services.	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 service teams to align with the wider locality-based community service model and redesign of the Crisis Response, CAMHS, AOD and Māori mental health service models.	Improved access, increased integration, sustainable service delivery and improved patient outcomes.	Local National
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

IMPROVING HEALTH OUTCOMES

Are we making a difference?

Monitoring Our Performance

4.12 Improving health outcomes

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

DHBs have a number of different roles and associated responsibilities. In our governance role we are concerned with health equity and outcomes for our population and the sustainability of our health system. As a funder, we strive to improve 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, the efficiency with which it is delivered and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of the work we do and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an over-arching intervention logic and system outcomes framework.

The framework helps to illustrate our population health-based approach to performance improvement, by highlighting the difference we want to make in terms of the health and wellbeing of our population. It also encompasses national direction and expectations, through the inclusion of national targets and system level performance measures.

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

Aligned to each wellbeing goal, we have identified a number of population health indicators which, over time, will provide insight into how well our 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 outcomes are also captured in our local System Level Measure Improvement Plan, where we collaborate with our partner organised to improve health outcomes for our population.

Refer to Appendix 3 for the Intervention Logic Diagram which illustrates how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to the goals of the wider South Island region and delivers on the expectations of Government.

4.13 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's Statement of Performance Expectations for 2019/20 and Appendix 6 for the DHB's Statement of Financial Expectations for 2019/20.

4.14 Accountability to the Minister

As a Crown entity, responsible for Crown assets, the DHB also provides a wide range of 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 five dimensions. These dimensions reflect the key areas of national priority:

- Improved Child Wellbeing (CW)
- Improved Mental Health Wellbeing (MH)
- Improved Wellbeing through Prevention (PV)
- Better population health outcomes supported by a Strong and equitable public health and disability System (SS)
- Better population health outcomes supported by Primary Health Care (PH).

The national framework and expectations for 2019/20 are set on the following pages.

National DHB Performance Framework 2019/20

Performance Measure		Performance Expectation		
CW01	Children caries free at 5 years of age	Year 1		60%
		Year 2		60%
CW02	Oral health: Mean DMFT score at school year 8	Year 1		0.88
		Year 2		0.88
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	>=95%
			Year 2	>=95%
		Children (0-12)not examined according to planned recall	Year 1	<=10%
			Year 2	<=10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1		>=85%
		Year 2		>=85%
CW05	Immunisation coverage at 8 months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month olds fully immunised.		
		95% of five- year olds fully immunised.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – Influenza vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	New-born enrolment with General Practice	55% of new-borns enrolled in General Practice by 6 weeks of age.		
		85% of new-borns enrolled in General Practice by 3 months of age.		
CW08	Increased immunisation (two-year-olds)	95% of two-year olds will have completed all age-appropriate immunisations due between birth and age two years.		
CW09	Better help for smokers to quit (maternity)	90% 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.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme are offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		
CW11	Supporting child wellbeing	Provide report as per measure definition		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance (SLA) and actions of the SLA to improve health of the DHB's youth population.		
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to ≤ 0.2 per 100,000.		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori , other & total	>3.8% of the population access specialist services	
		Age (20-64) Māori , other & total	>3.8% of the population access specialist services	
		Age (65+) Māori , other & total	>3.0% of the population access specialist services	
MH02	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.		
MH03	Shorter waits for non-urgent mental health and addiction services	Mental Health (Provider Arm)	80% of people seen within 3 weeks.	
			95% of people seen within 8 weeks.	
		Addictions (Provider Arm & NGO)	80% of people seen within 3 weeks.	
			95% of people seen within 8 weeks.	
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified.		
MH05	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.		
MH06	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.		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall.		

SS01	Faster cancer treatment (31 days)		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS02	Ensuring delivery of Regional Service Plans		Provide reports as specified.		
SS03	Ensuring delivery of Service Coverage		Provide reports as specified.		
SS04	Delivery of actions to improve Wrap Around Services for Older People		Provide reports as specified.		
SS05	Ambulatory sensitive hospitalisations (ASH adult)		<3,496 per 100,000 people		
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*	3,122 planned interventions		
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)	
			ESPI 2	0% – no patients are waiting over four months for FSA	
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)	
			ESPI 5	0% - zero patients are waiting over 120 days for treatment	
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool	
		Planned Care Measure 3: *Diagnostic waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)	
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans receive their scan, and scan results are reported, within 6 weeks (42 days).	
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans receive their scan, and scan results are reported, within 6 weeks (42 days).	
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.		
		Planned Care Measure 6: *Acute Readmissions*	Improve on March 2019 baseline <=10.5.		
SS08	Planned care three year plan		Provide reports as specified		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>1.5% to <=6%	
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%	
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%	
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%	
			Invalid NHI data updates	Still TBC	
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures.	> or equal to 90% and <95 %	
			National Collections completeness	> or equal to 94.5% and <97.5%	
			Assessment of data reported to the NMDS	> or equal to 75%	
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified		
SS10	Shorter stays in Emergency Departments		95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)		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.		
SS12	Engagement and obligations as a Treaty partner		Reports provided and obligations met as specified.		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to support people with LTC to self-manage and build health literacy.		
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*		
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity		
		Focus Area 3: Cardiovascular health	Provide reports as specified		
		Focus Area 4: Acute heart service	**Indicator 1:** Door to cath - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.		
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and		

			Indicator 2b: ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and LVEF<40% should also be on a beta-blocker (5-classes). ** An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.*
			Indicator 5: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of the procedure.
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7
			Indicator 3: In-patient rehabilitation: 80% of patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation**:** 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy		90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 14 calendar days or less, 100% within 30 days or less.
			70% of people accepted for a non-urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.
			70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.
			95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.
SS16	Delivery of collective improvement plan		Deliverable tbc
SS17	Delivery of Whānau ora		Provide reports as specified.
PH01	Delivery of actions to improve system integration and SLMs		Provide reports as specified.
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers		Provide reports as specified.
PH03	Access to Care (PHO Enrolments)		Meet and/or maintain the national average enrolment rate of 90%.
PH04	Primary health care :Better help for smokers to quit (primary care)		90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
Annual plan actions – status update reports			Provide reports as specified.

APPENDICES

Further Information

5

Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Minister's Letters of Expectation 2019/20
Appendix 3	Overarching Intervention Logic Diagram
Appendix 4	Alliance Structure Overview
Appendix 5	Statement of Performance Expectations 2019/20
Appendix 6	Statement of Financial Performance Expectations 2019/20
Appendix 7	System Level Improvement Plan 2019/20
Appendix 8	Public Health Action Plan 2019/20

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 documents 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 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.
	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.
	Secondary Care	Specialist or complex care that is typically provided in a hospital setting.
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 Letters of Expectation 2019/20

Hon Dr David Clark

MP for Dunedin North

Minister of Health Associate Minister of Finance

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

12 JUL 2019

Tēnā koe Jenny

UPDATE: Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out an update to the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20. This builds on my December 2018 letter, attached for your reference. I want to emphasise that my strong focus remains on the expectations set out in that letter.

I also want to acknowledge your engagement with the important conversations we have been having on improving financial sustainability and clinical performance.

While I recognise there are a number of challenges, it is my expectation that DHBs ensure their local communities can access high quality sustainable services that deliver equitable outcomes.

Wellbeing Budget

Budget 2019 is about delivering better wellbeing for all New Zealanders and driving intergenerational change. There are five key priorities – taking mental health seriously, improving child poverty, supporting Māori and Pasifika aspirations, building a productive nation, and transforming the economy.

Budget 2019 builds on last year's Vote Health investment. A record $19.871 billion is being invested for 2019/20 to support a stronger, more sustainable health and disability system.

Our Government has signalled a willingness not just to invest, but also to make the fundamental changes needed to deliver long term and sustainable change. Budget initiatives are also based around evidence on what will make the greatest contribution to the long term improvement of living standards and wellbeing.

Monitoring improved performance

High performing DHBs are needed to support the delivery of the Government's priorities. I am concerned about the sector's overall financial position, and some areas of service performance.

As you are aware I have worked with the Ministry of Health (Ministry) to ensure DHB performance is supported through a stronger performance programme. This will help DHBs to be more sustainable, and to improve financial and clinical performance to ensure better and more equitable outcomes for New Zealanders. I have made it clear that you have a responsibility to address the range of performance challenges in partnership with the Ministry.

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Your DHB's performance will be reported to me regularly, and I support the use of data and benchmarking to identify variation as well as opportunities for improvement. This will also support collaboration across DHBs regionally and nationally to make the most of our collective capability. I expect all DHBs to contribute to, and participate in, such work to help ensure the system is safe, equitable, efficient, and maximises the resource use across the whole system.

Fiscal responsibility

I have made my expectations on improving financial performance very clear, and DHBs need to have a plan to return to financial sustainability.

You have been provided with your confirmed budget allocations for 2019/20 and I expect you to be considering ways to contain expenditure, including maximising available capability and resources in the system, tightly managing recruitment and staff leave, and improving consistency of clinical pathways and decision-making.

Continuing to do things in the same way as we are now is not sustainable operationally, clinically or financially. There will be a dedicated focus in 2019/20 on strengthening sustainability planning and establishing an on-going sustainability programme.

You will be aware that Budget 2019 invests an extra $94.7 million over four years to help improve DHB financial sustainability. This new funding will enable DHBs to work more collaboratively across your regions, to share and build on best practice, to implement new service models that transform the way we use workforce and facilities, and to make the best use of the available funding and capacity in your region.

Capital investment

Budget 2019 invests $1.7 billion over two years for capital investment projects, building on last year's investment to restore our hospitals and health facilities. This funding will be prioritised for mental health projects, high growth areas with increased demand, and health facilities that are no longer fit for purpose. I urge that in all investment, environmental sustainability be a significant consideration.

Some business cases for new infrastructure projects are already well advanced and have been indicatively prioritised for consideration. I expect this process to be completed with DHBs being advised of the outcomes in July/August 2019.

The Ministry of Business, Innovation and Employment is developing a new framework which will focus on skills development and training as a requirement of construction projects. New construction procurement guidelines will also be applied across government. I expect you to apply the changes to the procurement of new construction projects.

National Asset Management Plan

In the long term, we need to better map out future infrastructure requirements. This will enable the Government to make more informed decisions, and better prioritise remediation work and plan for new facilities.

I am pleased that you are actively supporting the National Asset Management Plan programme of work. I expect that any requests for information from the project team are responded to in a timely manner.

It is also my expectation that you will update your DHB's Asset Management Plans. These are a requirement of the Ministry, and will assist in the formulation of the capital investment pipeline, and the ongoing work on the National Asset Management Plan.

The Budget also provides some funding to lift capacity and capability within the Ministry, notably to establish a new health infrastructure unit that will provide better support to DHBs.

Update on my priority areas

Improving child wellbeing

As you know, child wellbeing is a key priority for this Government. I expect your annual plans to reflect how you are actively working to improve childhood immunisation coverage and eliminate inequity, especially for Māori.

As I have said in my earlier letter of expectations, I expect you to support the reduction of family violence and sexual violence through addressing abuse as a fundamental healthcare responsibility.

Improving mental wellbeing

Mental health and addiction is a top priority in the Wellbeing Budget with $1.9 billion over four years being invested into a range of mental wellbeing initiatives and mental health and addiction facilities. These strongly align with the Government's response to He Ara Oranga, the report of the independent inquiry into mental health and addiction.

We have a unique opportunity to improve the mental health and wellbeing of all New Zealanders. We need to embed a focus on wellbeing and equity at all points of the system. We also need to focus more on mental health promotion, prevention, identification, and early intervention.

It is my expectation that you will work closely with the Ministry and key partners in your region to help drive this transformation; your leadership is essential.

Improving wellbeing through prevention

Our Government's vision is for a welfare system that ensures people have an adequate income and standard of living, are treated with respect, can live in dignity and are able to participate meaningfully in their communities. DHBs have an important and ongoing role working alongside social sector partners to improve the welfare and health system outcomes for their population.

I have introduced a new priority section in DHB annual plans, given the considerable overlaps between people engaging with the welfare system as well as the health and disability support system. Over half the proportion of working age people receiving a main benefit have a health condition or a disability, or care for someone with a health condition or disability.

Better population health outcomes supported by a strong and equitable public health and disability system

Planned Care

I am confident that the changes to how planned care is planned, funded and monitored will remove the current disincentives to developing better ways of delivering services.

The new planned care approach will enable DHBs to deliver more appropriate, timely, high quality services to support the health and wellbeing of New Zealanders. DHBs will be able to provide care in the most appropriate setting, with the right workforce.

There will also be a greater focus on equity, quality, and people's experience of our services. I expect DHBs to create robust plans for these services and to consistently meet volume, waiting time, and other quality expectations.

Cancer Action Plan

I have asked the Ministry to work with you and other stakeholders to develop a Cancer Action Plan. I expect you to support and drive the development of this important work, and to deliver on the local actions within your Plan.

Health Research Strategy Implementation

Research, evidence and innovation is critical to addressing inequities and in continuously improving the quality and outcomes of services provided.

I am aware that the Ministry is working with DHBs and other government agencies to develop a work programme to implement the Health Research Strategy. I encourage you to continue to work closely with the Ministry to progress this important work.

Workforce

DHBs have a key role in training our health and disability workforce. I expect that all DHBs continue to maintain a strong focus on this area to build capacity and capability, and to implement an equitable approach to funding professional development.

In your current annual plan I expect you to develop a sustainable approach to nursing career pathways, including actions to support equitable funding for professional development for nurse practitioners.

Care Capacity Demand Management

At the end of last year I outlined my expectation that DHBs are to implement Care Capacity Demand Management (CCDM) in line with the process and timetable set out in the 2018-2020 MECA.

I expect to see significant progress on CCDM implementation this year, as well as detailed planning to ensure full implementation by June 2021.

I expect you to confirm that you have met my expectation to include implementing CCDM in the performance expectations of your Chief Executive and that you are updating these expectations to include implementation in midwifery services.

Devolution of the pay equity appropriation

I have supported the devolution of the pay equity appropriation. I expect you to work with the Ministry to ensure a seamless transition of responsibilities.

The Ministry has an ongoing stewardship responsibility to ensure that Care and Support Workers (Pay Equity) Settlement Act obligations are met.

The Government's agenda to improve the health and wellbeing of New Zealanders is significant, as evidenced by the sizable investments being made. I am confident that DHBs will present strong plans to support delivery of our priorities and I am looking forward to seeing progress against both measures and activities during the year.

I have appreciated the willingness shown by DHB teams to focus on equity and outcomes, and have confidence that you will all embrace the direction and implement plans to deliver it.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

19 DEC 2018

Ms Jenny Black
Chair
West Coast District Health Board

Dear Jenny

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

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Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing

carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Appendix 3 Overarching Intervention Logic Diagram

Te Tiriti O Waitangi

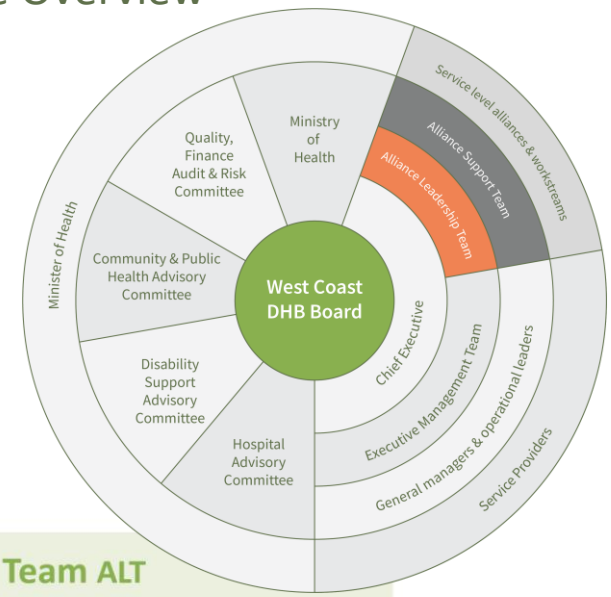
We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Māori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

Appendix 4 Alliance Structure Overview

West Coast Health System

OUR VISION

An Integrated West Coast health system that is both clinically sustainable and financially viable. A health system that wraps around the patient and helps people stay well in their own community.



DHB Board

Set the strategic direction for our health system, in line with national expectations and policy.

In collaboration with clinical leaders and alliance partners, determine the services required to meet the needs of our population.

Fund the health services required and, through a cycle of continuous performance monitoring, ensure services are safe, equitable, integrated and effective.

Promote and protect the health and wellbeing of the West Coast population and the health and wellbeing of our workforce.

Alliance Leadership Team ALT

Selected to lead our alliance and the work that falls within the agreed scope of alliance activities. Independent Chair appointed in 2019.

- Provide system-level oversight, monitoring of work streams and ensuring connectedness and a whole of system approach by alliance activities.
- Provide a range of competencies/expertise required to support the alliance to achieve its objectives.

- Medical Primary & Secondary
- Nursing Primary & Secondary
- Allied Health
- Public Health
- Māori Health
- Mental Health
- Planning & Funding

Alliance Support Group ASG

Facilitates, administers & supports the work streams and leadership team.

- Provide feedback to work streams and advice to ALT, as well as reporting back to their own organisations.
- Allocate resources to operationalise/implement priorities.

- GM West Coast DHB
- Executive Officer PHO
- Te Kaihautu Poutini Waiora
- Alliance Programme Manager

Programme Office

Work Streams

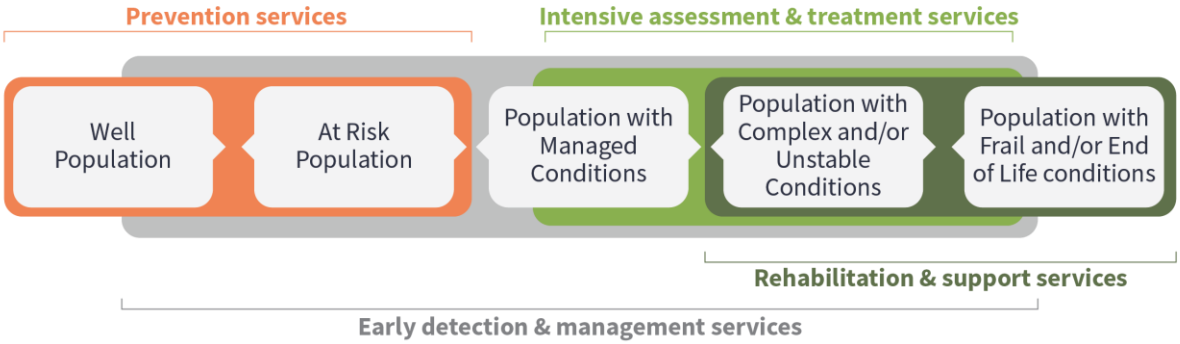
Propose transformational service improvement, identify areas requiring redesign and innovation.

- Report regularly to ALT, against annual work plans
- Feed into annual planning around deliverables

Health of Older People
Pharmacy
Mental Health
Child & Youth Health

Healthy West Coast
Grey | Westland IFHS
Reefton IFHS
Buller IFHS

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 outcomes are highlighted in the DHB's Statement of Intent.

On an annual basis, we evaluate our performance by providing a statement of performance expectations, i.e. 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 2019/20.

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 that matter most to our population:

Access (A)
Are services accessible, 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 increase 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 inequities 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.

◇ The measure is reported nationally as a key DHB performance target and in line with national performance reporting, fourth quarter (April-June) results are reported as the annual result.

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

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

Where does the money go?

In 2019/20 the DHB will receive approximately $159.6 million dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2019/20, by service class.

	2019/20
Revenue	
Prevention	3,528
Early detection & management	30,573
Intensive assessment & treatment	103,800
Rehabilitation & support	21,751
Total Revenue - $'000	159,652
Expenditure	
Prevention	3,990
Early detection & management	32,524
Intensive assessment & treatment	107,662
Rehabilitation & support	22,089
Total Expenditure - $'000	166,265
Surplus/(Deficit) - $'000	-(6,613)

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services promote and protect the health of the whole population or targeted sub-groups and influence individual behaviours by targeting changes to physical and social environments that engage, influence and support people to make healthier choices. These services include: the use of legislation and policy to protect the population from environmental risks and communicable disease; education programmes and services to raise awareness of risk behaviours and healthy choices; and health protection services such as immunisation and screening programmes that support people to modify lifestyles and maintain good health.

By supporting people to make healthier choices, we can reduce the major risk factors that contribute to poor health such as smoking, poor diet, obesity, lack of physical exercise and hazardous drinking. 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 inequities 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	2016/17 Result	2017/18 Results	2019/20 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [18]	15	14	E. 15
Licensed alcohol premises identified as compliant with legislation	Q [19]	85%	95%	90%
Networked drinking water supplies compliant with Health Act	Q [20]	95%	63%	97%

Health Promotion and Education Services				
These services inform people about risk factors and support them to make healthy choices. Success is evident through high levels of engagement with services.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A	208	191	>100
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q [21]◆	77%	72%	75%
Babies exclusively/fully breastfed at three months	Q [21]◆	56%	61%	70%
People provided with Green Prescriptions for additional physical activity support	A [22]	558	458	>400
Green Prescription participants more active six to eight months after referral	Q [22]	-	65%	>50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC) in the last 15 months	Q ◆	91%	88%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q [23]◆	93%	91%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q [24]◆	95%	98%	90%

[18] Submissions influence policy in the interests of improving and protecting the health of the population and providing a healthy and safe environment for our population. The number of submissions varies in a given year and may be higher (for example) when Territorial Authorities are consulting on long-term plans.

[19] New Zealand law prevents retailers from selling alcohol to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. 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.

[20] This measure relates to the percentage of (water) 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.

[21] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. These breastfeeding measures are part of the national Well Child/Tamariki Ora Quality Framework, data from providers is not able to be combined so performance from the largest provider (Plunket) is presented. Baselines have been reset to present a full (12 month) result rather than the final quarter (six months) as previously presented.

[22] 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 bi-annual national patient survey completed by Research NZ on behalf of the Ministry of Health.

[23] The ABC programme has a cessation focus and refers to health professionals asking about smoking status, providing Brief advice and providing Cessation support. The provision of professional advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts. The baselines for the hospital smoking measure has been reset to present full year (12 month) results, rather than the final quarter of each year (April-June).

[24] This data is sourced from the national Maternity Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance. Standards have been set nationally in line with other smoking targets, baselines differ to previous year being reset to present full year results.

Population-Based Screening Services				
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Four-year-olds provided with a B4 School Check (B4SC)	A [25]◆	90%	98%	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 [26]◆	81%	96%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A [27]◆	75%	74%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A [27]◆	77%	72%	70%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Children fully immunised at eight months of age	A [28]◆	82%	83%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q	97%	96%	95%
Young people (Year 8) completing the HPV vaccination programme	A [29]†◆	39%	39%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A [30]†◆	55%	56%	75%

[25] 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.

[26] 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. This is a national performance measure, and baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter result (Jan-June).

[27] 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. The measures refer to national screening programme results and standards.

[28] The West Coast 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. '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. Baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter of the year (April-June) as previously presented.

[29] The Human Papillomavirus (HPV) vaccination aims to protect young people 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 groups for 2019/20 is the proportion of young people born in 2006 completing the programme during the year. Baseline results refer to young women only, the programme was widened in 2019/20.

[30] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for more vulnerable people at risk of serious complications, including people aged over 65, people with long-term or chronic conditions or pregnant women.

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

Early detection and management services help to maintain, improve and restore people's health. These services include detection of people at risk, identification of disease and the effective management and coordination of services for people with long-term conditions. These services are by nature more generalist and accessible from multiple providers at a number of different locations. Providers include general practice, allied health, personal and mental health service providers and pharmacy, radiology and laboratory service providers.

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. Cancer, cardiovascular disease, diabetes, and respiratory disease are the four leading long-term conditions for our population.

Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and reduces the burden of long-term conditions through improved self-management and the avoidance of complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

General Practice Services				
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A ◆	90%	94%	95%
New-borns enrolled with a PHO by three months of age	A [31]◆	77%	83%	85%
Young people (12-19) accessing brief intervention/counselling in primary care	A [32]Δ	200	215	>150
Adults (20+) accessing brief intervention/counselling in primary care	A [32]Δ	548	527	>450
Number of integrated HealthPathways in place across the health system	Q [33]	655	632	E. >600
Proportion of general practices offering the primary care patient experience survey	E [34]	new	86%	100%

Long-Term Condition Services				
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A [35]◆	3,860	4,099	E>3,500
Population identified with diabetes having an annual LTCM review	A ◆	74%	79%	>90%
Population with diabetes, having an HbA1c test at their LTCM review, showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q [36]◆	54%	54%	>60%

[31] This is a national performance measure and results have been reset in June 2019 as national data sources move from the PHO register to the National Enrolment Service (NES). The Ministry of Health provided estimates for DHB's annual enrolment rates for 2018 and 2019 based off the new system.

[32] 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.

[33] 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 in the health system people present.

[34] 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 information will be used to improve the quality of service delivery and patient safety.

[35] This measure refers to the primary care 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 long-term condition.

[36] 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.

Oral Health Services				
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Children (0-4) enrolled in DHB funded oral health services	A [37]†◆	97%	108%	95%
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T †◆	93%	95%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A †	75%	77%	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	2016/17 Result	2017/18 Results	2019/20 Target
Number of subsidised pharmaceutical items dispensed in the community	A Δ	466k	460k	E.<500K
People being dispensed 11 or more long-term medications (rate per 1,000)	Q [38]†	4.2	4.5	E. <4.4
Number of community-referred radiological tests delivered at Te Nikau	A	5,817	6,199	E.>5,000
People receiving their urgent diagnostic colonoscopy within two weeks	T [39]	90%	90%	90%
People receiving their Magnetic Resonance Imagining (MRI) scans within six weeks	T [39]	80%	84%	90%
People receiving their Computed Tomography (CT) scan within six weeks	T [39]	100%	100%	95%

[37] 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.

[38]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. Data is sourced from the HQSC Atlas of Healthcare Variation.

[39] 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). The radiology measures are national DHB performance indicators referring to wait times for non-urgent scans. Baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results.

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 (but not always) provided in hospital settings, which enables the collocation of expertise and equipment. A proportion of these services are delivered in response to acute events, others are planned, and access is determined by clinical triage, treatment thresholds, capacity, 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 are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Staff compliant with good hand hygiene practice	Q [40]◇	80%	82%	80%
Inpatients (aged 75+) receiving a falls risk assessment	Q ◇	91%	92%	90%
Response rate to the national inpatient patient experience survey	E [41]◇	28%	58%	>30%
Proportion of inpatients who responded in the survey that 'hospital staff included their family/whānau or someone close to them in discussions about their care'	E◇	76%	53%	65%

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 and efficient service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Proportion of the population (0-19) accessing specialist mental health services	A [42]Δ	5.3%	5.4%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	A Δ	5.7%	5.9%	>3.8%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T [43]	76%	81%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	89%	95%	95%

[40] 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 in line with national reporting results for the quality measures refer to the final quarter of each year (April-June). The 2017/18 results have been update to reflect the final quarter's results which were not available at the time of printing the 2017/18 annual report. Further detail and quarterly results for several years can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[41] There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers and family-centred care have been linked to improved health and clinical, financial, service and satisfaction outcomes. The DHB inpatient experience survey covers four domains of patient experience: communication, partnership, co-ordination and physical and emotional needs. Response rates to the national survey vary around the country with an average of 25% across all DHBs in June 2018, with four DHBs achieving above 30%. West Coast aims to be consistently at this level. Further detail and full results can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[42] There is a national expectation that around 3% of the population will need access to specialist level 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 national PRIMHD dataset and results are three months in arrears.

[43] Timely access to appropriate intervention and treatment, by reducing long waits for diagnosis or treatment, contributes to improved quality of care and health outcomes and improves people's confidence in the health system. These measures are national DHB performance indicators and standards are set nationally. Data is sourced from the national PRIMHD database and results are three months in arrears.

Maternity Services				
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A [44]†◆	79%	80%	80%
Number of maternity deliveries in West Coast DHB facilities	A	250	264	E. 250
Baby friendly hospital accreditation achieved in DHB facilities	Q [45]	Yes	Yes	Yes

Acute and Urgent Services				
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of presentations at the Te Nikau Emergency Department (ED)	A [46]	11,382	11,616	E.<13,000
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T [47]	79%	82%	85%
Proportion of the population presenting at ED (per 1,000 people)	Q	342	356	<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 [48]	68%	80%	90%
Average acute inpatient length of stay (bed days per 1,000 people)	Q [49]	2.36	2.34	2.30

Elective and Arranged Services				
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of First Specialist Assessments provided	A	7,232	7,022	E.>6,000
Number of planned care intervention delivered	A [50]	new	new	3,211
Average elective inpatient length of stay (bed days per 1,000 people)	Q [49]	1.34	1.20	1.45
Number of outpatient consultations provided	A	15,479	14,328	E.>13,000
Proportion of outpatient appointments provided by telemedicine	Q [51]	3.3%	4.2%	>5%
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [52Δ]◆	5.6%	6.13%	<6%

[44] 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 the 2017/18 data is yet to be released.

[45] 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.

[46] This measure is aligned to the national Shorter Stays in ED indicator and excludes those who do not wait and those with pre-arranged appointments.

[47] 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.

[48] This is a national DHB performance measure and baselines differ to previously printed results, having been reset from final quarter (rolling six months from Jan-June of each year) to full year (12 month) results. There was a definition change for this measure in 2017/18, allowing patients to delay their treatment or for treatment to be delayed due to clinical considerations without impacting on the result, 2016/17 results are therefore not directly comparable.

[49] By shortening the average length of a hospital stay, the DHB delivers on the national improved hospital productivity priority and frees up resources to provide more elective (planned) surgery. Addressing the factors that influence length of stay includes reducing the rate of complications and infection and activity to support patients to return home sooner. This is a national DHB performance indicator and standards are set nationally.

[50] The new planned care intervention measure reflects a change in national expectation that continues to recognise the delivery of elective surgery but also recognises the delivery of minor procedures and non-surgical interventions that are required to improve people's health and wellbeing. The new measure also recognised interventions delivered in both hospital and community settings. The West Coast's planned care interventions target is made up of three components: elective surgical discharges (1,883), Minor Procedures (1,230) and Non-Surgical Interventions (9).

[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 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 the proportion of all medical and surgical outpatient appointments where the patient was expected to attend but did not.

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. Services are mostly provided to older people, or people with mental health or complex personal health conditions, following a clinical 'needs assessment'.

These services are considered to provide people with a much higher quality of life as a result of being able to stay active and positively connected to their communities. Even when returning to full health is not possible, access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness, crisis or deterioration of function, these services have a major impact on the sustainability of our health system, by reducing acute service demand and the need for more complex interventions or residential care. These services also support patient flow by enabling people to go home from hospital earlier.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services restore or maximise people's health following a health-related event and service utilisation is monitored to ensure people are appropriately supported.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A [53]	yes	2	10
People (65+) supported by the community-based In-Home Falls Prevention Service	A [54]	117	148	>120
Proportion of inpatients referred to an organised stroke service after an acute event	Q[55]	89%	96%	80%
Proportion of AT&R inpatients discharged home rather than into residential care	Q[56Δ]	79%	90%	80%

Home-Based Support Services				
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of Meals on Wheels provided	A [Δ]	33,772	34,977	E. 35,000
People supported by district nursing services	A [Δ]	1,628	1,645	E. >1,000
People supported by long-term home-based support services	A [Δ]	1,079	1,211	E. >1,000
Proportion of people supported by long-term home-based support services who have had a clinical assessment of need (using InterRAI) in the last 12 months	Q [57Δ]	93%	91%	95%

Aged Residential Care Services				
While demand will increase as our population ages, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Proportion of the population (75+) accessing rest home level services in ARC	A [58Δ]	4.6%	4.4%	E.<6.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A [Δ]	6.2%	6.6%	E.<6.5%
Proportion of the population (75+) accessing dementia services in ARC	A [Δ]	0.8%	1.2%	E. 1.0%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A [Δ]	0.5%	0.6%	E. 0.4%
People entering ARC having had a clinical assessment of need using InterRAI	Q [Δ]	100%	100%	95%

[53] 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 part of the broader continuum of care for older people, ensuring a seamless transfer of care between hospital and community settings.

[54] Falls are one of the leading causes of hospital admission for people aged over 65. The community-based 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.

[55] This is a national DHB performance measure. Baselines differ to previously printed results, being reset from final quarter to full year results, one quarter in arrears.

[56] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge home reflects the effectiveness of services in terms of assisting people to regain functional independence.

[57] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used to support clinical decision making and care planning, ensure assessments are of high quality and that people receive appropriate and equitable access to services irrespective of where they live.

[58] By providing services that help older people maintain functional independence they are able to remain in their own homes for longer, reducing the demand for rest-home-level care. Access rates for more complex care such as dementia and psychogeriatric care are less amenable and growth is more attributable to the aging of our population. Measures refer to people accessing DHB funded ARC services and exclude people paying privately.

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 Grey Base 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 $6.613 million-dollar deficit result for the 2019/20 year.

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $159.7m to meet the needs of our population in 2019/20.

This represents a 3.26% increase on the previous year and whilst this equates to a $5m 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 2019/20.

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, service 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 2019/20 are based on the funding advice received by the Ministry in May 2019 and further updated with Planned Care funding advice in June 2019.
- Out-years funding is assumed at an average of 2.41% 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 settlements that are 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 under the nationally appointed Hospital Redevelopment Partnership Group.
- Work will continue on the facilities redevelopment for Buller Integrated Family Health Centre project, managed by West Coast DHB and governed by West Coast 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 late 2019.

  The net operating result, for 2019/20 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.

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 third quarter of 2019/20. 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 other aspects of the Grey Base site.

Planning for redevelopment of the mental health facility is also expected to start in 2019.

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.

In December 2018 the $20m Buller IFHC project was approved, with the ongoing project management moving to West Coast DHB.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $3.987m for the 2019/20 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 2019/20-2021/23 comprises of:

- Mental health redevelopment (notionally $5m).
- Te Nikau furniture, fit out and equipment (notionally $1.7m).
- Reefton IFHC redevelopment (notionally $4m).
- Phased upgrade of clinics outside Westport and Greymouth (notionally $0.450m per clinic).
- Secondary tranche Grey Base 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 per annum).

We anticipate the above capital intentions will be funded by internal cash except for the Buller IFHC, Mental Health, Reefton IFHC facility redevelopment and secondary tranche Grey Base redevelopment projects, where Crown capital support would likely be required.

Debt and equity

Te Nikau is now expected to be completed in the third quarter of 2019/20 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 2019/20 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 2019/20 will be approximately $0.2m.

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.

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Statement of Comprehensive Income – year ending 30 June

As at 30 June for the years ending 2017/18 to 2022/23

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited Actual	Unaudited Actual	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Income						
Ministry of Health revenue	**136,789**	**142,732**	147,127	150,937	154,855	158,876
Patient related revenue	7,187	7,249	7,746	7,401	7,512	7,623
Other operating income	4,812	4,303	4,577	4,646	4,715	4,786
Interest income	380	330	204	205	208	211
Total Income	**149,168**	**154,614**	159,654	163,189	167,290	171,496
Operating Expenses						
Personnel	60,132	67,605	66,649	69,802	71,546	73,235
Outsourced services (clinical and non clinical)	8,663	8,708	9,113	9,190	9,283	9,374
Treatment related costs	8,919	8,018	8,265	8,688	8,819	8,951
External service providers (include Inter-district outflow)	58,152	64,519	66,388	67,053	67,553	68,051
Depreciation & amortisation	2,911	3,390	3,226	4,174	4,073	4,282
Interest expenses	-	-	-	-	-	-
Other expenses	11,935	12,517	11,648	11,968	10,863	11,004
Total Operating Expenses	**150,712**	**164,757**	**165,289**	**170,875**	**172,137**	**174,897**
Operating surplus before capital charge	**(1,544)**	**(10,143)**	**(5,635)**	**(7,686)**	**(4,847)**	**(3,401)**
Capital charge expense	1,387	1,407	978	6,559	7,759	8,959
Surplus / (Deficit)	**(2,931)**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**
Other comprehensive income						
Revaluation of land and Buildings	**(3,599)**	-	-	-	-	-
Total Comprehensive Income	**668**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**

Statement of Financial Position – year ending 30 June

As at 30 June for the years ending 2017/18 to 2022/23

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited Actual	Unaudited Actual	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
CROWN EQUITY						
General funds	85,994	85,926	191,932	206,108	218,646	250,937
Revaluation reserve	25,681	25,098	25,098	25,098	25,098	25,098
Retained earnings	(85,968)	(96,935)	(103,548)	(117,793)	(130,399)	(142,759)
TOTAL EQUITY	**25,707**	**14,089**	**113,482**	**113,413**	**113,345**	**133,276**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	11,724	6,362	4,460	3,793	4,176	2,607
Trade & other receivables	3,725	3,931	4,428	3,931	3,931	3,931
Inventories	1,058	1,077	1,098	1,077	1,077	1,077
Assets classified as held for sale	-	-	-	-	-	-
Investments (3 to 12 months)	-	-	-	-	-	-
Restricted assets	54	56	56	56	56	56
TOTAL CURRENT ASSETS	**16,561**	**11,426**	**10,042**	**8,857**	**9,240**	**7,671**
CURRENT LIABILITIES						
Trade & other payables	11,917	12,582	12,779	11,611	11,602	11,608
Capital charge payable	-	-	-	-	-	-
Employee benefits	7,525	14,052	13,893	14,052	14,052	14,052
Restricted funds	71	62	62	62	62	62
Borrowings	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES	**19,513**	**26,696**	**26,734**	**25,725**	**25,716**	**25,722**
NET WORKING CAPITAL	**(2,952)**	**(15,270)**	**(16,692)**	**(16,868)**	**(16,477)**	**(18,051)**
NON CURRENT ASSETS	-	-	-	-	-	-
Investments (greater than 12 months)	519	320	320	320	320	320
Property, plant, & equipment	30,137	31,062	131,778	129,647	128,957	150,050
Intangible assets	446	376	499	2,713	2,943	3,357
TOTAL NON CURRENT ASSETS	**31,102**	**31,758**	**132,597**	**132,680**	**132,220**	**153,727**
NON CURRENT LIABILITIES						
Employee benefits	2,443	2,399	2,423	2,399	2,398	2,400
Borrowings	-	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	**2,443**	**2,399**	**2,423**	**2,399**	**2,398**	**2,400**
NET ASSETS	**25,707**	**14,089**	**113,482**	**113,413**	**113,345**	**133,276**

Statement of Movement in Equity – year ending 30 June

As at 30 June for the years ending 2017/18 to 2022/23

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited Actual	Unaudited Actual	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Total Equity at Beginning of the Period	25,107	25,707	14,088	113,482	113,413	113,345
Total Comprehensive Income	668	(11,550)	(6,613)	(14,245)	(12,606)	(12,360)
Other Movements						
Contribution back to Crown - FRS3	-	-	-	-	-	-
Contribution from Crown - Capital	-	-	100,000	-	-	20,000
Contribution from Crown - Operating Deficit Support	-	-	6,074	14,245	12,606	12,360
Other Movements	(68)	(68)	(68)	(68)	(69)	(68)
Total Equity at End of the Period	**25,707**	**14,088**	**113,482**	**113,413**	**113,345**	**133,276**

Statement of Cashflow – year ending 30 June

As at 30 June for the years ending 2017/18 to 2022/23

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	136,808	142,861	147,127	150,937	154,855	158,876
Other receipts	12,689	12,327	11,766	18,803	9,773	14,838
Interest received	420	330	204	205	208	211
	149,917	**155,519**	**159,097**	**169,945**	**164,836**	**173,925**
Cash was applied to:						
Payments to employees	67,444	68,123	74,586	77,897	79,004	81,155
Payments to suppliers	77,056	86,864	87,828	89,024	89,169	95,254
Interest paid	-	-	-	-	-	-
Capital charge	1,296	1,407	978	6,559	7,759	8,959
GST - net	362	(157)	(451)	213	34	-
	146,158	**156,237**	**162,941**	**173,693**	**175,966**	**185,368**
Net Cashflow from Operating Activities	**3,759**	**(718)**	**(3,844)**	**(3,748)**	**(11,130)**	**(11,443)**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	7	(24)	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	7	(24)	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	(135)	-	-	-	-
Purchase of property, plant, & equipment	2,785	4,687	13,064	3,464	2,664	2,664
	2,785	**4,552**	**13,064**	**3,464**	**2,664**	**2,664**
Net Cashflow from Investing Activities	**(2,778)**	**(4,576)**	**(13,064)**	**(3,464)**	**(2,664)**	**(2,664)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	-	-	9,000	-	-	-
Equity Injection - Deficit Support	-	-	6,074	6,613	14,245	12,606
Loans Raised	-	-	-	-	-	
	-	**-**	**15,074**	**6,613**	**14,245**	**12,606**
Cash applied to:						
Equity Repayment	68	68	68	68	68	68
Other	-	-	-	-	-	
	68	**68**	**68**	**68**	**68**	**68**
Net Cashflow from Financing Activities	**(68)**	**(68)**	**15,006**	**6,545**	**14,177**	**12,538**
Overall Increase/(Decrease) in Cash Held	913	(5,362)	(1,902)	(667)	383	(1,569)
Add Opening Cash Balance	10,811	11,724	6,362	4,460	3,793	4,176
Closing Cash Balance	**11,724**	**6,362**	**4,460**	**3,793**	**4,176**	**2,607**

Summary of Revenue and Expenses by Arm – year ending 30 June

As at 30 June for the years ending 2017/18 to 2022/23

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Funding Arm	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	135,636	141,835	146,111	149,902	153,794	157,789
Patient Related Revenue	-	-	-	-	-	-
Other	1,789	2,165	2,386	2,423	2,459	2,495
Total Revenue	137,426	144,000	148,497	152,325	156,253	160,284
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	95,415	102,373	104,682	106,502	108,181	109,883
Mental Health	14,549	15,126	15,832	16,064	16,300	16,541
Disability Support	21,590	22,416	23,129	23,308	23,490	23,676
Public Health	642	631	635	641	647	652
Maori Health	814	824	842	845	848	850
Governance & Admin	826	828	840	874	887	900
Total Expenditure	133,836	142,198	145,960	148,234	150,353	152,502
Net Surplus/(Deficit)	**3,589**	**1,802**	**2,537**	**4,091**	**5,900**	**7,782**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**3,589**	**1,802**	**2,537**	**4,091**	**5,900**	**7,782**

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Governance Arm	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	2,828	865	889	922	934	950
Total Revenue	2,828	865	889	922	934	950
Expenditure						
Personnel	1,167	1,130	1,184	1,213	1,241	1,265
Outsourced services	943	974	915	919	929	938
Depreciation	1	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	717	415	450	468	472	475
Total Expenditure	2,828	2,519	2,549	2,600	2,642	2,678
Net Surplus/(Deficit)	**1**	**(1,654)**	**(1,660)**	**(1,678)**	**(1,708)**	**(1,728)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**1**	**(1,654)**	**(1,660)**	**(1,678)**	**(1,708)**	**(1,728)**

Summary of Revenue and Expenses by Arm – year ending 30 June (continued)

As at 30 June for the years ending 2017/18 to 2021/23

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Provider Arm	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	1,153	897	1,016	1,035	1,062	1,085
Patient Related Revenue	7,187	7,249	7,746	7,401	7,512	7,623
Other	77,746	79,284	81,079	82,688	84,329	86,007
Total Revenue	86,086	87,430	89,841	91,124	92,903	94,715
Expenditure						
Personnel	58,965	66,475	65,465	68,589	70,305	71,970
Outsourced services	7,720	7,735	8,198	8,271	8,354	8,436
Depreciation	2,910	3,390	3,226	4,174	4,073	4,282
Interest & Capital Charge	1,387	1,407	978	6,559	7,759	8,959
Other	21,624	20,120	19,462	20,187	19,209	19,479
Total Expenditure	92,606	99,127	97,329	107,780	109,700	113,126
Net Surplus/(Deficit)	**(6,520)**	**(11,697)**	**(7,488)**	**(16,656)**	**(16,797)**	**(18,411)**
Other Comprehensive Income	(3,599)	-	-	-	-	-
Total Comprehensive Income	**(2,921)**	**(11,697)**	**(7,488)**	**(16,656)**	**(16,797)**	**(18,411)**

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
In House Elimination	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(77,171)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Total Revenue	(77,171)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(77,170)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Total Expenditure	(77,170)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
CONSOLIDATED	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	136,789	142,731	147,127	150,937	154,856	158,874
Patient Related Revenue	7,187	7,249	7,746	7,401	7,512	7,623
Other	5,192	4,634	4,782	4,852	4,922	5,001
Total Revenue	149,169	154,614	159,655	163,190	167,290	171,498
Expenditure						
Personnel	60,132	67,605	66,651	69,804	71,547	73,238
Outsourced services	8,663	8,709	9,113	9,190	9,283	9,374
Depreciation	2,911	3,390	3,226	4,174	4,073	4,282
Interest & Capital Charge	1,387	1,407	978	6,559	7,759	8,959
Other	79,007	85,053	86,300	87,708	87,234	88,005
Total Expenditure	152,101	166,164	166,268	177,435	179,896	183,858
Net Surplus/(Deficit)	**(2,931)**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**
Other Comprehensive Income	(3,599)	-	-	-	-	-
Total Comprehensive Income	**668**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**

Appendix 7 System Level Measures Improvement Plan

Available on the DHB's website www.wcdhb.health.nz.

Appendix 8 Public Health Action Plan

Available on the DHB's website www.wcdhb.health.nz.

Annual Plan

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