WEST COAST DISTRICT HEALTH BOARD

ANNUAL PLAN

Incorporating the 2020/21

Statement of Performance Expectations

2020/21

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 the DHB's 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, the Annual Plan describes our strategic goals and objectives 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 2020/21 and the actions we will take to deliver on national priorities and expectations in the coming year.

The Statement of Performance Expectations 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 several clinically-led Alliances as key vehicles for implementing system improvement and change.

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 Alliance with the West Coast PHO, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the Canterbury DHB.

We recognise our 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 our Kaupapa Māori provider (Poutini Waiora) in a spirit of communication and co-design that encompasses the principles of Te Tiriti o Waitangi and seeks to address equity for Māori.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity and is in line with Government expectations for 2020/21.

Honourable Rick Barker
CHAIR | WEST COAST DHB

Tony Kokshoorn
DEPUTY CHAIR | WEST COAST DHB

David Meates
CHIEF EXECUTIVE | WEST COAST DHB

Honourable Chris Hipkins
MINISTER OF HEALTH

August 2020

Letter of Approval

Hon Chris Hipkins

MP for Remutaka
Minister of Education
Minister of Health
Minister of State Services
Leader of the House
Minister Responsible for Ministerial Services

25 September 2020

Hon Rick Barker
Chair
West Coast District Health Board

Dear Rick

West Coast District Health Board 2020/21 Annual Plan

This letter is to advise you that I have approved and signed West Coast District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

I am pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

I encourage you to continue discussions with your fellow Chairs about how you can share skills and expertise in order to ensure that your financial performance is consistent with the agreed plan. I particularly encourage you to ensure that your senior executives maintain the tight fiscal controls that will be necessary to sustain improvements in the out years. Your focus on strengthening financial management and performance, including through collaboration with your fellow Chairs, remains critical to creating a sustainable financial path.

The Ministry will shortly engage with you on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. I encourage you to accept offers from the Ministry to utilise this funding.

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. 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 does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

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I am aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

Please also ensure that a copy of this letter is attached to any copies of your signed Plan that are made available to the public.

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

I look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Hon Chris Hipkins
Minister of Health

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Foreword from the Chairs and Chief Executive

Message from Rick Barker

Chair West Coast DHB

I would firstly like to acknowledge the huge commitment of our staff and all those people working across and with our health system in responding to the COVID-19 pandemic. As this global event continues to dominate thinking I am heartened by the ability of our staff to adapt to new challenges, go the extra distance and constantly improve the responsiveness of the services we provide. Thank you all for what you have done and continue to do.

Improving health outcomes for our population is a key area of focus for the Board and we know there continues to be inequity in health outcomes, particularly for Māori, people with disabilities and those on low incomes. We will be challenging ourselves and our leadership team to improve the availability, quality and effectiveness of the services we provide to enhance the quality of people's lives.

Outlined in this Annual Plan are comprehensive programmes that aim to prevent disease, promote and improve the health of children and young people, provide an integrated response for people with mental health issues, and support older people to stay healthy and well in their own homes. This Plan also outlines our commitment to ensuring our Māori population have access to services they need to improve whānau ora.

To ensure a sustainable long-term impact we will work with local authorities, government departments, community agencies and other health providers to address the determinants of health that are often the underlying driver of illness.

Building better relationships at all levels is also an area of focus for the Board, creating confidence and trust through open and transparent communication with our community, clinical leaders and people working in our health system, all of whom become patients from time to time. The Board is committed to increasing engagement and interaction with our community in the coming year and we see this as a critical factor in achieving our strategic goals.

This will be a big year with considerable change for our system and we are ready to take up the challenge and do our best for the people of the West Coast. I look forward to engaging in conversations with you about how our health system is making a difference and where we can do better.

Message from Susan Wallace

Chair Tatau Pounamu

E ngā mana o Poutini, tēnā koutou. E ngā reo o ngā tai mihi tāngata, tēnā koutou. E ngā karangatanga maha, tēnā koutou katoa.

The DHB's Annual Plan for 2020/21 reflects our collective commitment to working together and to co-designing solutions that will improve the health and wellbeing of our people and of everyone here on Te Tai o Poutini (West Coast).

Working with Māori to determine priorities, the inclusion of tangible activities and Equitable Outcome Actions (EOAs) identified throughout the Plan, seeking to build a more representative health workforce and increasing leadership opportunities for Māori across the DHB are some of the key components of the plan, which we, along with the Board believe are a step in the right direction.

Tatau Pounamu looks forward to working with the DHB to support this direction and to inspire more Māori to take up opportunities within our health system and to confidently access the health care services they need.

In the coming year we will continue to develop a stronger and closer relationship with the DHB Board and will work together on the development of a Tai o Poutini Māori Health Improvement Plan. This will be a long-term strategy focused on generational change for our people, using their voice and aspirations gathered by engaging with whānau, hapū, iwi hoki o Te Tai o Poutini to identify things that are important to them and how we can make long-lasting change. I encourage you to get involved with this process and to take up the opportunity offered to have a say in the future direction of our health services. *Nāu te rourou, nāku te rourou, ka ora ai te iwi.*

I believe that if the health system can recognise that what is good for Māori health is good for the entire population, the system will truly be able to wrap itself around those in the greatest need. This is a challenge to the Board and to everyone who works across and within the West Coast health system, a challenge we are ready for and willing to take on with you.

Kua takoto te mānuka. Me mahitahi tātou mō te oranga o te katoa – The challenge has been laid. Let us work together for the wellbeing of everyone.

Message from David Meates

Chief Executive West Coast DHB

Our vision for the West Coast health system is 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 homes and community. At the heart of our vision is a fundamental re-orientation of our current service model to an integrated system that has the patient firmly at the centre.

This year's Annual Plan includes a continued and clear commitment to the integration of community, primary and secondary health services and stronger alignment with the Canterbury DHB and other community agencies to increase our capacity and enhance the range of services available to people living on the West Coast.

We will also place a greater focus on equity, targeting investment to provide the greatest return in terms of health gain, working collectively with our community to support change in areas that have been harder to tackle and creating an environment that will accelerate health gain for Māori. This work will include the development of a Māori Health Improvement Plan and an Early Years (child health) Strategy in the coming year.

Key actions and activity to progress our Rural Generalist workforce model have been highlighted through our Annual Plan. The Rural Generalist model will help provide continuity of care for our population by addressing workforce shortages, enabling people to work to the full extent of their scope and reducing service fragmentation. This will be an exciting piece of work and we will be working closely with clinical leads and workforce groups as we progress these changes.

Our integrated model will be further supported with the completion of our Integrated Family Health Centres, with the opening of Te Nikau in July 2020 and the Buller Health Centre underway for completion in 2022. These facilities will help improve the responsiveness of our health system, by supporting new ways of working, extending general practice opening hours and increasing access to telehealth for our most rural clinics – reducing the time people waste waiting and travelling to access care.

While meeting increasing service demand, treatment and infrastructure costs continue to be a significant challenge. An integrated health system is the foundation we need to deliver more responsive and sustainable health services. We need to carefully consider where we commit resources, and in the coming year will reallocate funding into activity and services that provide the greatest return in terms of health gain for the West Coast population.

I am proud of the efforts and innovative thinking of the people who come to work every day across our health system. You all make a huge contribution to the health and wellbeing our population. I look forward to working with you to deliver on the commitments within this Plan and to further improve health services on the West Coast.

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 2020/21, we will receive approximately $175 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.

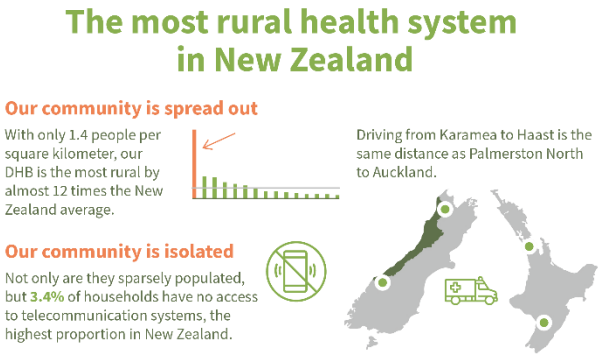
1.2 What makes us different?

The West Coast DHB has the smallest population of any DHB in New Zealand. We are responsible for 32,550 people, or 0.7% of the total New Zealand population.

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

We own and 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; 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, midwives, aged residential care providers, public health and Māori health providers and the West Coast PHO.



As New Zealand's smallest and most rural 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.

The West Coast DHB will always need to refer people to larger centres for highly specialised care, such as: neurosurgery, forensic services, some cardiac care and cancer treatments, specialised burns treatments and neo-natal intensive care.

However, a formal transalpine service partnership, established with the Canterbury DHB in 2010, means Canterbury specialists are providing regular outpatient clinics and surgical lists on the West Coast. This partnership, and a deliberate investment in telehealth technology, is providing our population with improved access to specialised services without having to travel long distances for assessment and treatment.

This direction is being further supported by the introduction of a rural-generalist workforce model, a proven strategy for remote rural health systems.

This model will provide continuity of care for our population by addressing workforce shortages and service fragmentation. By improving service access, it will also help us to support people to stay well, reduce health inequalities and improve health outcomes – key goals for our health system.

The rural generalist model will be applied across all professions (medical, nursing and allied health), with a core workforce of rural generalists working to the full extent of their scope of practice. For example, a rural generalist doctor could be qualified to work in both general practice and hospital settings with a specialty in obstetrics, general medicine or anaesthetics. Our rural generalists will be members of multi-disciplinary teams working alongside both local and Christchurch-based specialists, enhancing the capacity, capability and resilience of our health system.

Our future is dependent on the development of this more integrated and sustainable workforce model and key actions and activity to progress this work have been highlighted through our Annual Plan.

1.4 Our population profile

The West Coast population of 32,550 people has been almost unchanged for the last ten years and is predicted to decrease slightly over the next ten years.

Our population's age structure is older than the rest of New Zealand, with 21.8% of our population aged over 65, compared with the national average of 16.2%.[1]

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 care 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. The 2018 Census recorded one in every ten residents on the West Coast were living in areas classified as socio-economically deprived. Higher proportions of our population were receiving unemployment or invalid benefits, had no educational qualifications and did not have access to a motor vehicle or telephone.

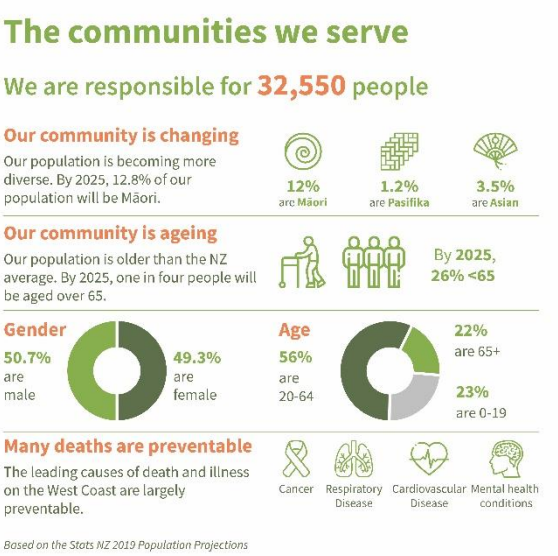
We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others. Ethnicity, like age and deprivation, is a strong predicator of need for health services. There are currently 3,890 Māori living on the West Coast (12% of our population) and by 2025 that proportion is predicted to increase to 12.8%.

Our Māori population has a considerably younger age structure, with 10.3% of our Māori population aged under five, compared to 5.6% 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.

1.5 Our population's health

West Coasters have higher morbidity and mortality rates resulting in a slightly lower life expectancy (80.4 years) compared with the national average (81.4 years).

While West Coast Māori continue to have poorer overall health status and life expectancy (78.3 years), the inequity is reducing and at 2.1 years the differential between Māori and non- Māori 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 main drivers of demand for health services and the primary cause of health loss and death amongst adults. In 2018/19, over 4,000 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 improve health outcomes for our population. All four have strong socio-economic links, so reducing these risk factors will also contribute to reducing health inequities between population groups.

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

- 26% of our population are current smokers, much higher than the national average of 16.2%. Smoking rates amongst Māori are higher at 44%.
- More than a third (35%) of our total adult population are classified as obese. Rates for our Māori population are higher at 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 at 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] Unless otherwise referenced figures comes from Stats NZ population projections provided by Ministry of Health February 2020.

[2] People enrolled with the West Coast PHO Long-Term Conditions Management Programme June 2019.

[3] Combined results from the 2014-2017 New Zealand Health Surveys have been used as small population numbers can have a distorting impact on annual results. Results incorporating the 2017/18 and 2018/19 Surveys are yet to be released. Refer to www.health.govt.nz.

1.6 Our Operating Challenges

Like the rest of the health sector, the West Coast DHB is experiencing growing demand pressures as our population ages and increasing fiscal pressures as treatment and wage costs raise. We also face several unique challenges due to our size and geographic isolation which add to our operating 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.

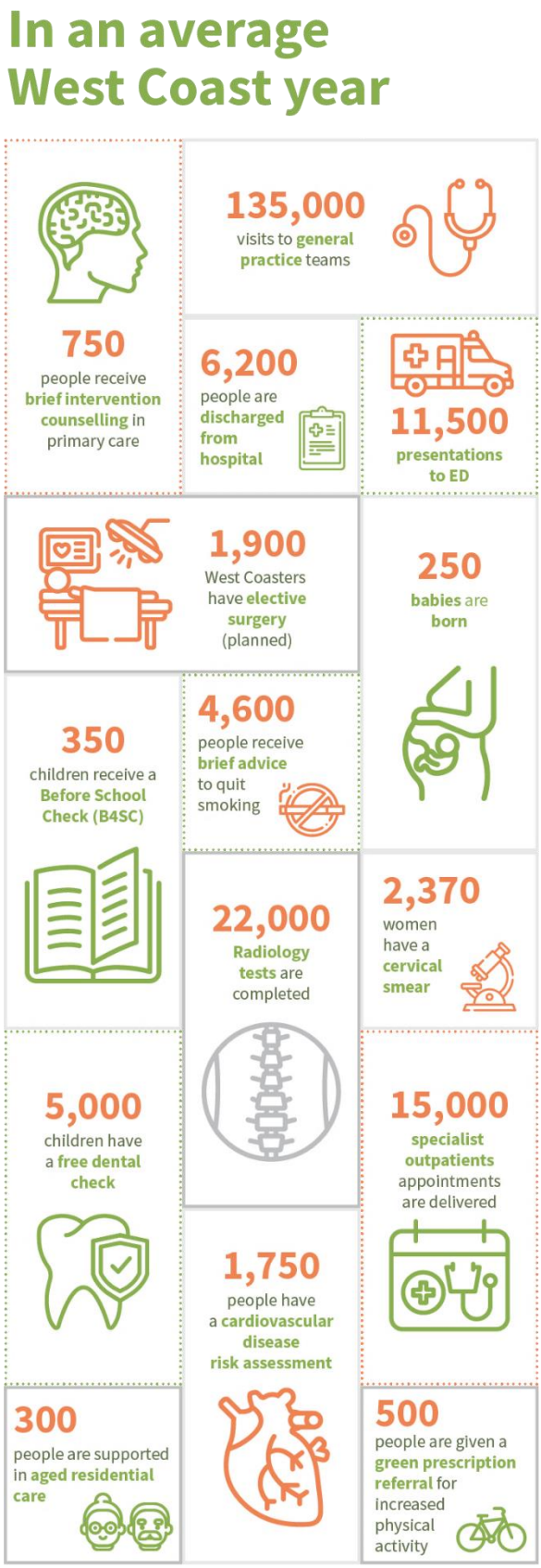
Workforce shortages: In our isolated environment, recruiting and retaining specialised staff is difficult and further complicated by the ageing of our workforce and national workforce shortages. This has led to an over-reliance on locums and short-term contractors, which reduces the continuity of care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

Service fragmentation: Because of our small population size, long travel distances and workforce challenges, services are often fragmented and person dependent. A history of over-reliance on hospital services also means services are not always delivered by the most appropriate person or in the most appropriate setting. Our locality-based service delivery model will support the development of multi-disciplinary teams and bring more services closer to people's homes.

Facilities pressures: Several of our health facilities are outdated, expensive to maintain, poorly located or seismically compromised. They create inefficiencies, add to financial pressures and do not support the more flexible models of care needed to respond to our population's needs. Completion of Te Nikau (the Grey Hospital and Integrated Health Centre) and the Buller Health Centre are critical to our future success.

Financial viability: Our population is static, and we receive limited annual increases in funding. Meeting increasing service demand, treatment and infrastructure costs, and national expectations around wages and salaries is a significant challenge. We need to carefully consider where we commit resources and reallocate funding into activity and services that will provide the greatest return in terms of health gain.

Variation: Our small size means any variation, in service demand, the capacity of the individuals and teams, or the way services are provided can have a significant impact on service provision, patient experience and the financial viability of our system. We need to take a new approach, recognising our strengths, but working collectively to build a more integrated and resilient system, better able to provide consistent and effective care to our population.



Our Strategic Direction

1.6 The West Coast Vision

Our resources are limited and the multifaceted pressures facing our health system mean that services cannot continue to be provided in the same way.

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 responsive 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 the ability 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 between 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 New Zealand Health Strategy with its central theme 'live well, stay well, get well.'

It also reflects alignment with the Government theme 'Improving the wellbeing 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 signals priorities and expectations for DHBs. The expectations for the coming year signal a strong focus on equity, wellness and stronger fiscal management.

The priorities emphasised for 2020/21 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.

The National Priorities section of this Plan outlines how we will deliver on the Minister's expectations in the coming year. The Minister's Letter of Expectation for 2020/21 is attached as Appendix 2.

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 1.2 million people, almost a quarter (23.5%) of the total New Zealand 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: First 1,000 Days; Mental Health and Addictions; Ageing Population, Information into Action; Workforce Development and Redesign; and Community Health and Wellbeing.

West Coast DHB has made a strong regional commitment and is engaged in several workstreams 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 and religion. Equity is about fairness and we are committed to reducing disparities and achieving equity in health outcomes for our population, particularly 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 work in partnership with our community to co-design service delivery models to better meet their needs.

The DHB's planning is guided by a range of national strategies, including: He Korowai Oranga (the Māori Health Strategy), Ola Manuia 2020-2025 (Pacific Health and Wellbeing Action Plan), Healthy Ageing Strategy, New Zealand Disability Strategy and the UN Convention on the Rights of Persons with Disabilities. We are also supported by tools, such as the Health Equity Assessment Tool, to 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 taking a fresh approach to its thinking, the West Coast DHB aims to become a leader in the provision of rural health services.

Nine Strategic Themes have been identified as critical to our immediate and long-term success; they provide an overarching framework for the way our services will be designed, developed and delivered. Actions and activity aligned with these themes are reflected through the next section of this Plan and include:

A greater focus on equity, using data to identify disparities and target investment to provide the greatest return in terms of health gain. Collective action will support change in areas that have been harder to tackle. We will partner with Tatau Pounamu and engage with iwi, hapū whānau and our Kaupapa Māori health provider and, together, we will develop strategies, shift cultural and social norms and create an environment that will accelerate health gain for Māori.

A new approach to informing and engaging our community. This will include the co-design of an Early Years (child health) Strategy, working with consumers, stakeholders and partner organisations to change long-term outcomes for our next generation.

The development of a collective leadership culture. In 2020/21, this will include the deliberate expansion of our rural generalist model with enhanced access to professional education and leadership training and the expansion of the scope of key clinical roles.

Actions to capture increased value from technology. This will include deliberate investment in shared electronic systems and telehealth technology to improve clinical decision-making and reduce the time people waste waiting and travelling.

The development of integrated sustainable services. This will include the continued realignment of mental health resources to strengthen community-based teams, and increased investment in primary mental health to bring services closer to people's homes, reduce waiting times and improve the continuum of care for those in need of additional support.

The successful migration into Te Nikau and the development of the Buller Health Centre are also major pieces of transformational work for the DHB in 2020/21. These facilities will support the realisation of our integrated service delivery model.

A greater focus on streamlining and standardising processes and using data to drive decision making. In 2020/21 the use of new systems to capture finance and workforce data will ensure out-years planning is robust and supports system sustainability. This work will support us to improve our financial position and ensure our limited funding is directed into services providing the greatest return on investment.

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 2020/21. This activity, the associated actions and the measures of success are reflected in the workplans of our local and regional alliances and our operational and corporate services teams.

It is important to note that this does not reflect all the activity happening across our health system. Our System Level Measures (SLM) Improvement Plan is developed in collaboration with our Alliance partners and is attached as an appendix to this Plan, as is the DHB's Statement of Service Performance for 2020/21. Together with the South Island Regional Services Plan (available on the DHB's website), these documents provide a broader picture of the activity planned across the West Coast health system for the coming year.

Over the last several years, we have made some positive inroads into improving health outcomes for Māori living on the West Coast, with strong engagement in childhood immunisation and wellbeing programmes. We are determined to make further progress in 2020/21.

Actions and activity aimed at improving Māori health outcomes are indicated by the Equity Outcome Action code (EOA). Alignment with government priority and national health system outcomes is indicated using the following codes:

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

2.1 Give Practical effect to He Korowai Oranga - The Māori Health Strategy

Government Theme: Improving the wellbeing of New Zealanders and their families

Planning Priority: Engagement and Obligations as a Treaty Partner	E C
MoH Expectation: The NZPHD Act specifies the DHBs' Te Tiriti o Waitangi obligations; specify how the DHB will meet these obligations, including maintaining processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement. Identify Specific plans and strategies for Māori health improvement, including working in partnership with Māori to develop and implement these and training of Board members (as per the NZPHD Act 2000) in Te Tiriti o Waitangi and Māori health and disability outcomes.	

Actions to Improve Performance	Milestones	Measures of Success
Maintain our strategic relationship with Tatau Pounamu (our Iwi Governance Group) to promote Māori participation in the development of strategies to improve Māori health with regular performance reporting to inform strategic thinking and identify opportunities for improvement. (EOA)	Q1-Q4: Quarterly reporting on progress and performance.	Equity actions agreed with Tatau Pounamu reflected in the DHB's Annual Plan and reporting processes. Refreshed MOU adopted by Tatau Pounamu and Board. Key measures of Pae Ora agreed and published. Collective Māori Health Improvement Plan developed. Board training programme delivered. Demonstrated reduction in equity gaps for Māori across priority population health measures.
In partnership with Tatau Pounamu, review the Memorandum of Understanding with the DHB Board to ensure it captures shared expectations and strategies to progress Māori health improvement and equity. (EOA)	Q3: MoU reviewed.	
Design and make publicly available a Māori Health Profile to support strategic thinking and action to address areas of inequity and track progress towards Pae Ora (Healthy Futures) for Māori on the West Coast. (EOA)	Q2. Māori health profile complete.	
In partnership with Tatau Pounamu, engage with iwi, hapū whānau and Māori in our community to develop a longer-term strategy for improving Māori health outcomes, in line with national direction but targeting local priority areas. (EOA)	Q3. Consultation undertaken, and priorities identified.	
Prepare a proposal for the DHB's Board on options for training in Te Tiriti o Waitangi, Māori health equity and outcomes. (EOA)	Q1. Proposal presented to Board.	

Planning Priority: MHAP- Accelerate the spread and delivery of Kaupapa Māori Services	E W	
MoH Expectation: Articulate the DHBs plans to ensure that Māori capability and capacity is supported, enabling Māori to participate in the health and disability sector and provide for the needs of Māori.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Invest in a local Hapū Wānanga (Kaupapa Māori antenatal education programme) that promotes SUDI prevention and supports access to smoking cessation, safe sleep devices and breastfeeding support. (EOA)	Q1: Contract for delivery of Hapū Wānanga in place.	Increased service options available for Māori on the Coast. Increased financial investment in Kaupapa Māori services. Opportunities for application to the Ministry's Te Ao Auahatanga Hauora Māori: Māori Health Innovation Fund scoped and submitted.
Invest in an additional clinical mental health role to support increased capability and capacity within our Kaupapa Māori service provider and enhance mental health and addiction service options for Māori. (EOA)	Q2: New Kaupapa Māori mental health role in place.	
Work with our Kaupapa Māori provider to identify the learnings from the COVID-19 response and invest the national COVID-19 funding (allocated through Te Herenga Hauora) to embrace new ways of working. (EOA)	Q1: Opportunities captured.	
In partnership with Poutini Waiora and the West Coast PHO, complete the evaluation of the Pae Ora O Te Tai O Poutini Pilot and use the findings to support future development of the primary care model. (EOA)[4]	Q3: Evaluation findings and recommendations circulated.	

Planning Priority: Planning Priority: MHAP- Shifting Cultural and Social Norms	E E	
MoH Expectation: Shifting cultural norms within the health and disability system is critical to ensuring that Māori can live and thrive as Māori and that we address racism and discrimination in all its forms. DHBs will have plans to further these aims including: actions to build the knowledge of all DHB staff in Te Tiriti o Waitangi, actions to address bias in decision making and actions to enable staff to participate in cultural competence and cultural safety training and development.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue to invest in the Takarangi Competency Framework, Te Tiriti o Waitangi and Tikanga Best Practice programmes to support our commitment to equity and improve the cultural competency of our workforce. (EOA)	Q2: Takarangi staff Hui held. Q4: ≥3 Treaty training sessions held. Q4: ≥3 Tikanga Māori Beliefs and Practices sessions held.	Increased number of staff complete cultural competency training. Increased proportion of patients responded positively to the inpatient survey question '*Was cultural support available when you needed it?*': baseline 79% (Q2 2019).
Utilise the "Bias in Health Care" modules from the Health Quality and Safety Commission (HQSC), to highlight potential bias in clinical decision making as a learning tool for clinical staff. (EOA)	Q1: Bias in Health Care modules live on HealthLearn.	
In partnership with the PHO, develop an education package to advance the skills our primary care staff to confidently and competently respond to Māori clients, improving outcomes for at risk groups in primary care settings. (EOA)	Q4: Cultural Safety education package developed and delivered to at least five practices.	

Planning Priority: MHAP- Reducing Health Inequities- The Burden of Disease for Māori	E W C	
MoH Expectation: Achieving equity in health and wellness for Māori is an overall goal of the health and disability system. It is mandated by article three of Te Tiriti o Waitangi and is an enduring principle of Te Tiriti. DHBs should use this section to outline any equity focused initiatives that don't fit elsewhere and provide a summary and cross refence for those major initiatives elsewhere in their plan.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Rangatahi (Child Health and Wellbeing) - *Refer to the Child Health & Wellbeing action tables for further initiatives in this priority area.*		
Collaborate with Community & Public Health to advocate for, and support, policies that will improve oral health for our most vulnerable populations, including water fluoridation and reduced sugar/ sugar free policies. (EOA)	Q3: Fluoridation and Sugar-Free Policies refreshed.	95% of Māori children (0-4) are enrolled with community oral health services. 90% of Māori children (0-12) are examined on time.
Introduce a process to identify children being lost to recall and re-engage them and their whānau with school and community oral health services. (EOA)	Q2: New recall process in place.	
Establish a pathway to facilitate improved access to hospital or specialist dental services on the West Coast for people with special dental or health conditions.	Q3: Pathway in place.	

[4] The Pae Ora O Te Tai O Poutini Pilot aims to assist whānau to more readily access primary care on the Coast by enabling nurse and GP led clinics in Māori community settings. The evaluation of the pilot is being funded by the Ministry of Health's Te Ao Auahatanga Hauora Māori: Māori Health Innovation Fund.

Develop an Oral Health Promotion Programme (with a focus on Māori children) to increase engagement with services and promote good oral health habits. (EOA)	Q4: Promotion Programme in place.	59% of Māori children are caries-free (no holes or fillings) at age five. 85% of Māori adolescents (13-17) access DHB-funded oral health services.
Mental Health and Wellbeing- *Refer to the Improving Mental Wellbeing action tables for further initiatives in this priority area.*		
Following on from a series of Māori Health Hui in 2019/20, invest in an additional clinical mental health role to support increased capability and capacity within our Kaupapa Māori service provider and enhance mental health and addiction service options for Māori. (EOA)	Q2: New Kaupapa Māori mental health role in place.	80% of young Māori (0-19) referred to specialist mental health services are seen within 3 weeks. 80% of Māori inpatients are seen in community services within 7 days of discharge.
Partner with the PHO, Poutini Waiora and Te Putahitanga (the Māori Whānau Ora Commissioning Agency), to enhance our integrated approach to mental health and wellbeing with a successful bid for the next tranche of primary mental health and addiction support initiative funding. (EOA)	Q2-Q3: Kaupapa Māori funding bid submitted.	
Promote a 'by rangitahi for rangitahi' approach that is tikanga Māori and whānau centered to increase the responsiveness of suicide prevention activity. (EOA)	Q2: Action identified.	
Planned Care		
Identify services with high Māori Did Not Attend rates and support the service to take a whānau ora approach to identify and eliminate barriers to access. (EOA)	Q1: Priority services identified.	Reduction in Māori DNA rates for outpatient clinics: baseline 14% (2018/19).
Introduce the tracking of Did Not Attend (DNA) rates as a regular item on the agenda of GM and DHB Board agendas to support shared learnings and capture opportunities. (EOA)	Q1: DNA tracking live. Q3: Changes underway.	

Planning Priority: MHAP- Strengthening System Settings		
MoH Expectation: DHBs have a role to play in ensuring that the system settings across their parts of the health and disability system support the overall goal of pae ora (healthy futures) including how services are commissioned and provided and joint ventures with other local agencies. Document the plans you have in this area.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Achieve a collective understanding of what equity is across the Operational Leadership Team and develop an equity framework to visibly measure service gaps and monitor improvement in equity over time. (EOA)	Q2: Equity position statement endorsed.	Performance against Māori health equity framework on Executive and Board agendas. Evidence of increased application of HEAT tools in decision-making. Demonstrated engagement of Māori in development of the Early Years Strategy. Early Years Strategy approved by Tatau Pounamu.
Improve the consideration of Māori health equity and health outcomes in service planning by engaging the Hauora Māori team and applying the HEAT tool to all significant Clinical Quality Improvement projects and process redesign. (EOA)	Q2: Introduction of HEAT Tool to quality processes.	
Redesign processes within the DHB's Planning & Funding Division to enhance the Māori voice in Resource Allocation and Funding decisions. (EOA)	Q1: New process in place.	
Engage with Māori stakeholders and communities to better understand the priorities and issues for children and their whānau and develop a Rural Early Years Strategy to improve engagement with services, service options and outcomes for our most vulnerable populations. (EOA)	Q2: Engagement underway. Q4: Draft Strategy complete.	

2.2 Improving Sustainability

Government Theme: Improving the wellbeing of New Zealanders and their families

Planning Priority: Improved Out Year Planning Processes		
MoH Expectation: Identify the three or four most significant actions the DHB will take to improve its outyear planning processes – both from a financial and workforce perspective. At least two of the actions should identify milestones for delivery to be completed by December 2020 to support 2021/22 planning.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Financial Planning		

Implement a new finance reporting and forecasting tool to assist with improving financial forecasts and aligning financial forecasts with workforce planning.	Q1: Implementation complete. Q2: Forecasts aligned to workforce plans.	Improve delivery of forecast financial position. Delivery against savings plans.
Enhance the business partnership model with Finance, to support the delivery of savings targets while ensuring ongoing operational performance.	Q1: New process in place to support delivery of savings targets.	
Workforce Planning		
Work towards full implementation of Care Capacity Demand Management (CCDM) for nursing and midwifery in all units/wards by June 2021, to better align workforce planning with service demand and patient acuity.	Q2: Acute mental health FTE calculations commence. Q3: Core Data Set workplan approved.	TrendCare acuity tool used to ensure staffing resource is consistency matched with patient demand. Roster and further direction for rural generalist model agreed.
Progress the next steps in our Rural Generalist (medical) strategy to further embed Rural Generalists in Obstetrics & Gynaecology (O&G) and Internal Medicine as well as greater support for primary care.	Q1-Q2: Change proposal on Rural Generalist roster and ways of working complete. Q3-Q4: Transalpine Clinical Directors in place for O&G and Internal Medicine.	

Planning Priority: Savings Plans - In-Year Gains	L

MoH Expectation: DHBs are expected to undertake appropriate cost analysis and develop realistic savings plans that do not risk compromising the quality and safety of services or improved equity for their populations. Highlight a subset of five initiatives from your savings plans that are expected to have most significant impact in the 2020/21 year. Include a brief rationale why this was selected, key actions and milestones, quantification of the expected in-year impact and indicate where actions form part of the DHB's COVID-19 Recovery Programme (CRP).

Actions to Improve Performance	Milestones	Measures of Success
Advance our Rural Generalist workforce model, to support the development of a clinical and financially sustainable system by: enabling staff to work to the full extent of their scope, improving the continuity of care and reducing dependence on locums and contractors. (CRP)	Q1: Change proposal on Rural Generalist roster and ways of working complete. Q2: Decision on change proposal made and implemented.	Reduction in use of locums and contracted specialists. In-Year savings $215K.
Optimise investment in shared electronic systems and telehealth technology, to reduce delays in care, sessions where patient do not attend appointments, and the time specialist, clinical staff and patients waste travelling. (CRP)	Q1-Q2: Opportunities for introducing In-Home telehealth consultations captured. Q2-Q3: Remote GP role implemented.	Increased use of telehealth. Reduction in DNA rates for outpatient clinics: baseline 7.7% (2018/19). In-Year savings $62K.
Complete the migration of services into Te Nikau, to support the realisation of key aspects of our integrated service delivery model, extended general practice hours and the streamlining and standardising of processes. (CRP)	Q1: Migration into Te Nikau. Q2: Integrated unplanned care area operational. Q3: Extended general practice opening hours.	Reduction of Triage 4&5 presentations to the ED: baseline 54% (2018/19). In-Year savings $95K.
Consider the provision of services in hospital settings that could be more sustainably delivered in the community, to capture opportunities to integrate and realign resources to provide the greatest return in terms of health gain.	Q1-Q2: Identified service shifts initiated. Q3: Capacity for the migration of planned care into primary care settings identified. Q4: Further areas of service change identified.	Realignment and reduction of service costs. In-Year savings $136K.
Capture opportunities to optimise revenue opportunities for the West Coast health system.	Q1: Regional applications submitted for National Sustainability Programme funding. Q2-Q3: Bid for the next tranche of primary mental health initiative funding submitted.	Increased revenue captured. In-Year savings $600K.

Planning Priority: Savings Plans - Out-Year Gains	L

MoH Expectation: Highlight a subset of five initiatives from your savings plans that are expected to have most significant impact in the next two out years. Include a brief rationale explaining why the action was selected and quantification of the expected impact in each of the out years.

Ensuring workforce planning supports innovative models of care is a key factor supporting improved system sustainability. Specify key workforce development actions and initiatives the DHB will undertake during 2020/21 to support innovative models of care to be delivered in out years.

Actions to Improve Performance	Milestones	Measures of Success
Refer to optimising investment in shared electronic systems and telehealth technology highlighted above.	Q1-Q4: Opportunities identified and implemented.	Operational teams assessing and scoring new

Refer to the integration of services and the realignment of resources into services providing the greatest return on investment highlighted above.	Q1-Q4: Ongoing review of services and contracts.	treatment procedure projects using ECRI. Audit of non-catalogue requests indicates material reduction compared to previous year. Improved return from DHB-owned assets. Out-Year savings $300K.
Work towards independent implementation of the New Treatment and Technology's Programme by August 2022, using ECRI's Heath Technology Assessment service to support the business to acknowledge fiscal constraints when considering implementing new technologies, initiatives or services.	Q3-Q4: West Coast supported (by Canterbury DHB) to join ECRI. Q3-Q4: Process mapped out for engagement with key projects. Q3-Q4: Audit for evidence of mirrored change and collective purchasing.	
Consider the future use of all DHB-owned houses, facilities and land to optimise investment and reduce surplus assets.	Q2-Q3: Review underway. Q4: Proposal submitted.	
Refer to the development of the Rural Generalist workforce model highlighted in the section above.	Q1-Q4: Ongoing development of the model.	Reduction in the growth of administrative positions. Enhanced capacity of our non-registered workforce. Out-Year savings $320K.
Review administrative resources following the move to Te Nikau with view to upskilling existing staff and developing universal administrative positions to make more efficient use of administrative resources across the organisation.	Q3: Review underway. Q4: Proposal put to Operational Leadership Group for approval.	
Develop and promote workforce development / career development resources to support increased capability amongst our non-registered workforce to enhance their role in the care and support of our community. (EOA)	Q4: Career pathway and resources developed.	

Planning Priority: Working with Sector Partners to Support Sustainable System Improvements	LE
MoH Expectation: Identify the three or four most significant actions the DHB will undertake during 2021 (collaboratively with sector partners) to support sustainable system improvements and improved Māori health outcomes and Pacific health outcomes.	

Actions to Improve Performance	Milestones	Measures of Success
In partnership with Tatau Pounamu, engage with iwi, hapū whānau and Māori in our community to develop a longer-term strategy for improving Māori health outcomes, in line with national direction but targeting local priority areas. (EOA)	Q3. Hui undertaken, and priority areas and actions identified.	Earlier diagnosis and improved management of conditions for Māori. Delivery against the SLM Improvement Plan. Reduction in Ambulatory Sensitive Hospital Admission for adults: baseline 3,501 per 100,000 (Sept 2019). Reduction in Acute Bed Days: baseline 304 per 1,000 people (2018/19).
Work through the West Coast Alliance to develop and deliver on the System Level Measures (SLM) Improvement Plan for 2020/21.	Q1: SLM Approved and action underway.	
Facilitate collaboration between DHB Palliative, Cardiac, Diabetic and Respiratory Clinical Nurse Specialists (CNS) and nurses from the DHB's Kaupapa Māori service provider to identify and manage early exacerbations of long-term conditions and reduce acute hospital presentations. (EOA)	Q2: Poutini Waiora nurses working alongside CNSs in the unplanned care area.	
Collaborate regionally, through the South Island Alliance Operational Leadership Group, to develop 3-4 innovative change projects to put forward for National Sustainability Programme funding (one of which will be vascular-focused) to support equitable access to specialist services for our population. (EOA)	Q1: Applications submitted.	

2.3 Improving Child Wellbeing- Improving maternal, child and youth wellbeing

Government Theme: Improving the wellbeing of New Zealanders and their families

Planning Priority: Maternity and Midwifery Workforce	QC
MoH Expectation: Identify key actions that demonstrate how the DHB will meet population needs for pregnant women, babies, children and their whānau, including realising a measurable improvement in equity and commit to implementing and evaluating a midwifery workforce plan to support undergraduate midwifery training clinical placements, recruitment and retention, service delivery mechanisms and initiatives that make best use of other health workforces to support both midwives in their roles and pregnant people.	

Actions to Improve Performance	Milestones	Measures of Success
Develop and implement LMC sustainability agreements to improve the recruitment and retention of LMC midwives in the region and ensure consistent access to services for women living on the West Coast.	Q1: Agreements in place.	80% of women are registered with an LMC by 12 weeks of pregnancy.

Develop a hub and spoke model, in collaboration with the Maternal Fetal Medicine team in Canterbury DHB, to improve service access for Coast women and their babies by reducing the burden of travel. (EOA)	Q2: Hub and spoke model developed	
Define how new rural nurse specialists and rural generalist roles can support our midwifery workforce to provide maternity care for women living in the most remote parts of the West Coast. (EOA)	Q3: Roles in maternity care defined.	
Collaborate, through the South Island Workforce Development Hub, to develop a strategy to recruit and retain midwives in rural settings, including development of a pathway to support a dual nursing/midwifery scope of practice. (EOA)	Q4: Dual scope pilot underway.	

Planning Priority: Maternity and Early Years	E Q W

MoH Expectation: Identify actions that contribute to the Strategy's Plan of Action to redesign maternity and early years interventions that support the needs of pregnant women, infants, babies, children and their whānau. Demonstrate how the DHB will meet these needs, including: commitments to health equity and how outcomes will be addressed, health promotion and health protection activities the DHB will undertake to advance progress on SUDI work and actions the DHB is taking to reduce inequity of access to community-based midwifery services, ultrasound scanning, pregnancy and parenting education and Well Child Tamariki Ora services.

Actions to Improve Performance	Milestones	Measures of Success
Refresh the Alliance's Child & Youth workstream to better enable a system-wide approach to support maternity and early years interventions that focus on achieving equitable health outcomes for Māori women and babies (in line with the West Coast DHB's Maternity Strategy). (EOA)[5]	Q2: New workstream membership and objectives established.	85% of newborn babies are enrolled with general practice by 3 months of age. A minimum of 68 safe sleep devices are provided to at risk whānau. 90% of babies have their first WCTO core check on time. >50% of women referred to the Smokefree Pregnancy Incentive Programme complete the Programme. 70% of babies are fully/exclusively breastfed at 3 months of age.
Establish locality-based Maternity Consumer Hubs as a means of maintaining consumer engagement and understanding local issues and challenges as we progress the implementation of our Maternity Strategy.	Q1: Forums dates agreed for 2020/21. Q2: First forum held.	
Invest in a local Hapū Wānanga (Kaupapa Māori antenatal education programme) that promotes SUDI prevention and supports access to smoking cessation, safe sleep devices and breastfeeding support. (EOA)	Q1: Contract for delivery of Hapū Wānanga in place.	
Audit the uptake and redistribution of whahakura or pepi pods to confirm they are being shared with whānau who have risk factors present for their pepi and that whānau understand the need for a safe sleep space.	Q3: Audit complete.	
Establish a process to ensure general practice and other early childhood support services are notified when babies are discharged from NICU and Maternal Fetal Medicine services in Canterbury, to ensure a continuum of care and timely support is in place for West Coast families. (EOA)	Q2: Notification process in place.	

Planning Priority: Immunisation	E Q W

MoH Expectation: Outline actions to contribute to healthier populations by establishing innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5 years that will meet the needs of your overall population.

Actions to Improve Performance	Milestones	Measures of Success
Develop a process to identify women who have not been vaccinated during pregnancy, to support LMCs, GP teams and our Kaupapa Māori provider to reach these women and better promote vaccinations, particularly to Māori and Pacific women where vaccination rates are lower. (EOA)	Q1-Q2: Process established and implemented.	50% of pregnant women vaccinated against Pertussis (whooping cough). 95% of 8-month olds fully immunised. 95% of 2-year olds fully immunised. 95% of 5-year olds fully immunised.
Use service data to refresh the childhood Immunisation Service Model to respond to current challenges within the system, with a focus on improving links between NIR and Outreach Services to ensure Māori, Pacific and vulnerable children moving in and out of the district are reached by service providers. (EOA)	Q1-Q2: Proposal for refresh of service model agreed and implemented.	
Review the impact of COVID-19 on the delivery of childhood immunisations, with a focus on prioritising children who missed vaccinations during this time.	Q1: Rates reviewed and catch-up implemented.	

[5] The DHB's Maternity Strategy is a whole-of-system plan developed with considerable community input. The local Strategy is closely aligned to the national Plan of Action and implementation will be overseen by the West Coast Alliance's Child & Youth workstream, which includes PHO, Māori, DHB and Public Health representatives. Refer to the Smoking and Immunisation planning priority sections of this Plan that also contribute to this work and to the West Coast System Level Measures Improvement Plan that highlights key actions to reduce or prevent hospital admissions for children under four years.

Implement the Immunisation Conversation Programme, trialled in Canterbury, to support LMCs, GP teams, Well Child and Kaupapa Māori providers to have difficult conversations with parents who are undecided about vaccinations.	Q4: Programme implemented.	100% of all children, whose parents' consent, are fully vaccinated. Māori child vaccination decline rates are reduced.
Implement the catch-up MMR programme for young people (15-29), with a focus on reaching young Māori and reducing the equity gap in uptake. (EOA)	Q1: MMR catch-up programme launched.	
Engage with the Executive Director of Māori Health and the Hauora Māori Team to develop strategies and innovative solutions to maintain high immunisation rates amongst Māori children on the West Coast. (EOA)	Q1-Q4: Ongoing engagement with Māori leads.	

Planning Priority: School-Based Health Services	E Q W

MoH Expectation:

- Commit to providing quantitative reports in quarter two and four on the implementation of school-based health services (SBHS).
- Outline how the DHB will catch up on psychosocial/wellbeing assessments that have been delayed due to COVID-19 restrictions.
- Outline the current activity the DHB will undertake to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.
- Outline the current activity the DHB is taking to improve the responsiveness of primary care to youth.
- Commit to providing quarterly narrative reports on the actions of the youth service level alliance team (SLAT) to improve the health of the DHB's youth population and outline the actions the DHB is taking to ensure high performance of the SLAT.

Actions to Improve Performance	Milestones	Measures of Success
Monitor the delivery of SBHS in all decile one to five schools and alternative education settings across the West Coast and provide quantitative reports on service performance to the Ministry of Health in quarters 2 and 4.	Q2: Report provided. Q4: Report provided.	CW12 report completed and provided as required. Children identified as high need by schools prioritised for assessment. 95% of year nine children in decile 1-5 schools receive a HEEADSSS (Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety) Assessment. Uptake of sexual health consultations and LARC.
Review service delivery to determine the impact of COVID-19, and work with the public health nursing team to agree a catch-up plan and prioritise assessments for young people identified by schools as higher need. (EOA)	Q1: Gaps identified and catch-up plan in place.	
Provide schools with an annual overview of SBHS delivery and feedback from the student surveys to support the Framework for Continuous Quality Improvement.	Q2: Dashboard provided to schools.	
Provide free sexual and reproductive health consultations in general practice for young people under 25 years and promote access to low-cost Long-Acting Reversible Contraception (LARC) to reduce cost barriers to access. (EOA)	Q1-Q4	
Explore opportunities to improve access to contraceptives through Registered Nurse Prescribing, with a focus on nurses working with high schoolers.	Q2: RN interest scoped Q4: Options identified.	
Provide quarterly reports to the Alliance Leadership Team and Ministry of Health on the progress of the Child & Youth workstream against the 2020/21 workplan.	Q1-Q4: Quarterly progress reports provided.	

Planning Priority: Family Violence and Sexual Violence	Q L C

MoH Expectation: Provide the actions for the upcoming year that your DHB considers is the most important contribution to reducing family violence and sexual violence, including: the reasons why the action(s) are important and the expected impact.

Actions to Improve Performance	Milestones	Measures of Success
Maintain our commitment to the Violence Intervention Programme (VIP) and deliver regular training sessions to ensure staff understand their role in helping to identify and support people at risk of family violence.	Q1-Q4.	Number of staff attending VIP Training sessions. Screening and disclosure rates across departments. VIP audit results maintained at greater than 80/100. Number of men accessing regular support and participating in programmes. Feedback and evaluation from provider programmes.
Collaborate with the Women's Refuge, MSD and the Te Rito Family Violence Network to support the Te Rito Community Champions Project, by providing training and mentoring for local Community Champions, to increase community leadership in reducing violence in the home.	Q1: Community training and mentoring delivered.	
Collaborate with the Women's Refuge and Safe Men Safe Family to facilitate culturally inclusive education and support for Māori men who are perpetrators (and often victims) of Family Violence, to support behavioural change. (EOA)	Q1-Q4	
Collaborate with the Te Rito Family Violence Network to establish a programme of Equine Therapy for male survivors of trauma or sexual abuse, to help participants develop trust and manage post-traumatic stress and depression.	Q3-Q4: Two programmes offered.	

Take part in a South Island Child Protection Forum, convened by the South Island Child Health SLA, to support staff to gain confidence in identifying and managing child protection issues and working across disciplines and DHBs.	Q4.	WCDHB representatives attend the South Island Child Protection Forum.

2.4 Improving Mental Wellbeing

Government Theme: Improving the wellbeing of New Zealanders and their families

Planning Priority: Mental Health and Addiction System Transformation		E Q L C W
MoH Expectation: DHBs should identify opportunities to build on existing foundations and include actions in the annual plan in relation to improving and / or addressing the following focus areas: Placing people at the centre of all service planning, implementation and monitoring programmes; Embedding a wellbeing and equity focus; Increasing access and choice of sustainable, quality, integrated services across the continuum; Suicide prevention; Workforce; Forensics; and Commitment to demonstrating quality services and positive outcomes.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Collaborate and work with the Ministry, Mental Health and Wellbeing Commission, Suicide Prevention Office and key partners and stakeholders to drive transformation in line with the recommendations of He Ara Oranga – as highlighted below.	Q1-Q4: Ongoing transformation and investment.	Demonstrated alignment with He Ara Oranga.
1. Placing People at the centre of all service planning, service implementation and monitoring programmes		
Map the number of lived experience and peer support workers supported or employed across policy, strategy and quality programmes, to identify strengths and gaps, with a focus on supporting Māori peer support and whānau roles. (EOA)	Q1: Stocktake complete.	Marama Real-Time Survey numbers increased by 50%. Increased number of peer support and whānau roles across the system.
Expand use of the Marama Real-Time survey in the Manaakitanga inpatient unit across other community services to capture a broad range of feedback from services users and identify themes for improvement, in observance of the Code of Health and Disability Consumers Services Rights.	Q2: Report on survey findings.	
Evaluate the success of the new in-reach model, where NGOs resource the Help Desk in the Inpatient Unit to connect consumers/whānau with wider community services, targeted at young people who find it hardest to access services. (EOA)	Q3: Evaluation recommendations implemented.	
2. Embedding a wellbeing and equity focus		
Using the model already adopted in Westport and Hokitika practices, encourage a further general practice to expand their Long-Term Conditions Management programme to include people with long-term mental health conditions, to support improved wellbeing and physical health outcomes for this high need group. (EOA)	Q4: Model expanded to a third and fourth general practice.	>150 young people (0-19) access brief intervention counselling in primary care. >450 adults (20+) access briefing intervention counselling in primary care. >3.8% of the population access specialist mental health services. 80% of people referred to specialist mental health services are seen within 3 weeks. 95% of people referred to specialist mental health services are seen within 8 weeks. 80% of acute inpatients access community services within 7 days of discharge.
Engage with Te Ara Mahi to increase service referrals and improve employment, education and training options for people with low prevalence conditions.	Q2.	
Provide weekly cultural activity in the Manaakitanga Inpatient Unit, to better engage with Māori service users and provide opportunity for recovery through karakia, mihi and traditional activities. (EOA)	Q2-Q4.	
Implement a Supporting Parents Health Children audit tool to allow data collection and quality auditing to begin in the new year.	Q2: Audit tool in use.	
Develop and introduce Family Care Plans to mental health teams as part of the Supporting Parents Health Children initiative.	Q2: Family Care Plans in use.	
3. Increasing access and choice of sustainable, quality, integrated services across the continuum		
Maintain the delivery of brief intervention counselling in primary care to support earlier intervention for people with mild to moderate mental health needs.	Q1-Q4.	
Complete the realignment of resources across our mental health services to strengthen community-based teams and support them to work alongside general practice teams as part of the locality-based service model, improving the continuity of care and access to respite services to reduce unsustainable acute demand.	Q1-Q4.	
Invest in an additional clinical mental health role to support increased capacity and capability within our community-based Kaupapa Māori service provider and enhance service options for Māori. (EOA)	Q2: Role in place.	
Undertake an annual review of contract delivery and apply cost pressure funding to support the sustainable delivery of mental health services across the Coast.	Q1-Q4: Ongoing contract review.	
Partner with the PHO, our Kaupapa Māori provider and Te Putahitanga (the Māori Whānau Ora Commissioning Agency), to enhance our integrated approach to	Q2-Q3.	

mental health and wellbeing, and strengthen the focus on promotion, prevention, identification and early intervention, with a successful bid for the next tranche of primary mental health initiative funding. (EOA)		
4. Suicide Prevention		*See measures above.*
Identify actions to increase the responsiveness of suicide prevention activity for Māori and promote a 'by rangitahi for rangitahi' approach that is tikanga Māori and whānau centred and focused on earlier intervention. (EOA)[6]	Q2: Actions identified.	
Collaborate with the Office of Suicide Prevention and Clinical Advisory Services Aotearoa to implement a new postvention counselling service pathway to improve access to counselling for people bereaved by suicide. (EOA)	Q3: Pathway established.	
Agree a Project Plan to support improved Mental Wellbeing with health promotion activities planned across West Coast communities.	Q4: Wellbeing promotion delivered.	
Continue to gather data in support of the implementation of the national suicide prevention strategy 'Every Life Matters' and evaluate local initiatives to better to promote wellbeing, respond to suicidal behaviour and offer support after a suicide.	Q1-Q4.	
5. Workforce		
Develop and promote workforce development / career development resources to support increased capability amongst our non-registered workforce to enhance their role in the care and support of our community. (EOA)	Q4: Career pathway and resources developed.	
Provide Talking Therapies training to enhance the skill set of our mental health workforce in helping people bring about the changes they want in their lives.	Q4: Four additional staff trained.	
Work with Te Pou to promote workforce development training to strengthen people's capabilities when working with people and whānau experiencing mental health and addiction issues.	Q1-Q4: Workforce development options promoted.	
6. Forensics		
Provide input into the national Forensic Framework Project to improve the consistency and quality of current and future services as opportunities arise.	Q1-Q4	
Examine the feasibility of providing youth forensic capacity through the court liaison role, to increase service access for youth with mental health challenges. (EOA)	Q2	
7. Commitment to demonstrating quality services and positive outcomes		
Track and monitor service utilisation data, and reporting into national systems (including PRIMHD), to support improved decision making and service planning.	Q1-Q4	

Planning Priority: Mental Health and Addictions Improvement Activities		E C
MoH Expectations: Outline your commitment to mental health and addictions improvement activities with a continued focus on minimising restrictive care and improving transitions.		
Actions to Improve Performance	Milestones	Measures of Success
Develop a process to utilise, and make visible, the findings from file audits (of wellness and transition plans) to identify, inform and work with staff to address common areas that require improvement.	Q2: Audit themes visible to staff.	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.
Prioritise the completion of relapse prevention plans to increase the number of consumers arriving into the Manaakitanga Inpatient Unit with a plan in place.	Q1-Q4.	
Embed the first five competencies from the Takarangi Competency Framework into everyday practice to better respond to Māori patients and their whānau. (EOA)	Q2-Q4.	
Hold weekly review meetings, with support from the Health Quality and Safety Commission, to consider learnings from other DHBs and identify actions to further minimise restrictive care, with a focus on Māori as an over-represented group. (EOA)	Q1-Q4.	Seclusion event analysis conducted for 80% of all events. Engagement in whānau meetings increases.
Embed a service wide analysis of every seclusion, personal and environmental event, with a focus on providing early intervention for deteriorating patients.	Q1-Q4.	

[6] This work was identified in 2019/20 but delayed due to staff capacity. A work group was established to lead the work, which will get underway this year.

Input into the new facility design and business case for Central (Greymouth) Mental Health Services, including Manaakitanga, with an emphasis on environmental suitability that supports de-escalation and the safety of patients and staff.	Q4: Business case completed.	Reduction in seclusion hours and events.

Planning Priority: Addiction		
MoH Expectations: ▪ Identify actions to improve MH03 addiction related waiting times targets performance to support an independent/high quality of life for people with addiction issues. ▪ Identify how your DHB is reconfiguring or expanding services in line with the AOD national model of care ▪ Demonstrate local level, cross-agency coordination for alcohol and other drug issues, including with local AOD service providers. ▪ Describe how your DHB is giving appropriate priority to meeting service demands within baseline funding.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Review of the function of specialist Child and Adolescent Mental Health Service (CAMHS) in the context of the evolving locality-based approach, to strengthen connections between primary, community and specialist teams and build support for people across the full continuum.	Q3: Review completed.	80% of people referred to specialist addiction services are seen within 3 weeks 95% of people referred to specialist addiction services are seen within 8 weeks.
Include dedicated clinical Co-Existing Problems FTE in locality-based teams, to strengthen connections and support people with the most complex issues. (EOA)	Q1-Q4	
Implement the review of the function of specialist Alcohol and Other Drug (AOD) service in the context of the evolving locality-based approach, and national model, and strengthen connections between teams to better meet service demand.	Q4: Review actions implemented.	
Track and monitor service utilisation data to maximise the use of the community-based Salvation Army AOD service, strengthening referral pathways and reducing waiting times. Focus particularly on access for Māori as a high need group. (EOA)	Q2 Service data evaluated.	
Implement a quality framework for the service provision of Opioid Substitution Treatment, to improve the management of treatment and support an independent/high quality of life for people with addiction issues.	Q4: Quality framework in place.	
Collaborate with the other South Island DHBs to ensure the allocation of regional resource enhances access to community-based detoxification on the West Coast.	Q1-Q4	

Planning Priority: Maternal Mental Health Services		
MoH Expectation: Identify actions you plan to take to ensure a continuum of care is evident for maternal mental health to increase responsiveness to women and their whānau during and post pregnancy. This includes services in primary, secondary and tertiary level.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Collaborate with the PHO, Plunket and Canterbury DHB to maintain access to community-based and specialist level maternal mental health services for West Coast women and their partners, before and after the birth of a child.	Q1-Q4	Proportionate uptake of maternal mental health services by Māori women. Number of 'hits' on the revised Maternal Mental Health Pathway.
Socialise the revised Maternal Mental Health Pathway with Lead Maternity Cares, Well Child providers and primary care, highlighting links to infant mental health services and early parenting support to improve the whole-of-system response for women and their whānau in need of additional support.	Q1: Maternal Mental Health Pathway Live on HealthPathways.	
Establish locality-based Maternity Consumer Hubs, to provide an opportunity for women and their whānau to identify local challenges and strengthen links between providers working with women in the first 1,000 days.	Q2: First Consumer Hub forum held.	
Engage with Poutini Waiora, Well Child and Whānau Ora nurses, to understand their training and education needs to support an improved response for Māori women experiencing mild-moderate mental health issues post pregnancy. (EOA)	Q3: Engagement underway.	

2.5 Improving Wellbeing through Prevention

Government Themes: Improving the wellbeing of New Zealanders and their families
Build a productive, sustainable and inclusive economy

Planning Priority: Environmental Sustainability	L G

MoH Expectation:

- Undertake actions that mitigate and adapt to the impacts of climate change and enhance the co-benefits to health.
- Develop and implement a sustainability action plan.
- Identify actions that improve the use of environmental sustainability criteria in procurement processes.
- If already measuring emissions (or other measures of environmental sustainability, such as energy, water or waste data), work with the Ministry of Health to report baseline measurements to support potential future emissions targets.

Actions to Improve Performance	Milestones	Measures of Success
Collaborate with the Canterbury DHB, through Transalpine Environmental Sustainability Governance Group, to develop an Environmental Sustainability Operational Policy and Implementation Plan.	Q1-Q4	Reduction in energy consumption per square metre. CEMARS certification and Energy Mark certification obtained.
Develop intranet sustainability pages to support the sharing of resources, initiatives and projects and encourage staff to make sustainable changes.	Q2: Pages live.	
Include environmental sustainably questions in procurement tenders to mitigate future environmental impacts on health by designing waste out of our system.	Q1-Q4	
Commence reporting on Carbon Offsetting for travel carried out under Senior Medical Officer's Continuing Medical Education agreements.	Q1: Reporting underway.	
In collaboration with EECA, employ a graduate engineer to assist with energy reduction activities and begin work towards obtaining CEMARs (Certified Emissions Measurement and Reduction Scheme) certification.	Q1-Q4	
Establish pathways to monitor energy use across DHB sites and identify areas for energy savings.	Q2-Q4	

Planning Priority: Antimicrobial Resistance (AMR)	L C

MoH Expectation: Identify activities that advance progress towards managing the threat of antimicrobial resistance, including alignment with the New Zealand Antimicrobial Resistance (AMR) Action Plan (2017 – 2022) and identify activities that the DHB will undertake to advance AMR management across primary care, community (in particular age-related residential care services) and hospital services.

Actions to Improve Performance	Milestones	Measures of Success
Establish a pharmacy champion to work with Community & Public Health, the PHO and our Kaupapa Māori provider to develop and deliver a Coast-wide campaign for World Antibiotic Awareness week. (EOA)	Q1: Champion in place Q2: Campaign launched	Improved antibiotic health literacy amongst vulnerable population. Surveillance activities monitor the burden of infection and provide for early warning and investigation of problems. Timely detection and management of outbreaks. Antimicrobial guidelines reviewed relative to sensitivity rates and audit outcomes.
Produce Antibiotic Awareness Week resources, for educational sessions, in both Te Reo and English to increase antibiotic health literacy amongst Māori. (EOA)	Q2. Resource Produced.	
Engage prescribers and pharmacy in the development of a policy to ensure a consistent method of documentation of antimicrobial indication and duration for inpatients across all DHB facilities (in line with national policies).	Q2	
Conduct an annual audit on all cultures completed through the West Coast laboratory to ensure ongoing appropriateness of empiric antibiotic use on the West Coast. Refresh antimicrobial prescribing guidelines as required.	Q4: Audit complete.	
Maintain a continuous improvement cycle of auditing antimicrobial use against local guidelines, to identify areas to improve practice and update guidelines.	Q1: Audit undertaken. Q3: Update guidelines, re-establish practice.	
Analyse antimicrobial reports from ESR to identify sensitivity rates and support reporting from the Infection Prevention and Control Committee to the Clinical Quality Improvement Team and DHB Executive Management Team to raise the organisational focus on antimicrobial resistance.	Q1-Q4: Reporting to leadership Teams in place.	
Engage with aged residential care facilities and clinical nurse specialists to review and update our Long-Stay Facilities Antimicrobial Procedures.	Q3-Q4.	

Planning Priority: Drinking Water	E L G C
MoH Expectation: The DHB must work to ensure high quality drinking water as outlined in the drinking water section of the environmental and border health exemplar. Commit to delivering and reporting on the drinking water activities and measures in the exemplar.	

Actions to Improve Performance	Milestones	Measures of Success
Deliver and report on the drinking water activities and measures in the Ministry of Health Environmental Health exemplar to ensure high quality drinking water.	Q2: Progress report Q4: Progress report	100% of network suppliers (serving 100+ people) receive compliance reports. Percentage of networked drinking water supplies compliant with the Health Act.
Provide technical advice on marae drinking water quality to local rūnanga to contribute to Māori health and wellbeing. (EOA)	Q1-Q4	

Planning Priority: Environmental and Border Health	L C
MoH Expectation: Commit to undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation by delivering on the activities and reporting on the performance measures contained in the Environmental and Border Health exemplar.	

Actions to Improve Performance	Milestones	Measures of Success
Deliver and report on the activities contained in the Ministry of Health Environmental and Border Health exemplar, including undertaking compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation, to improve the quality and safety of our physical environment.	Q1-Q4: Quarterly Border Health report delivered.	All regulatory performance measures reported as required. Number of contacts with rūnanga representatives.
Maintain relationships with local rūnanga to support ongoing partnership in addressing environmental health issues. (EOA).	Q1-Q4.	

Planning Priority: Healthy Food and Drink	L C W
MoH Expectations: Create supportive environments for healthy eating and healthy weight by undertaking the following activities: ▪ Implementing your DHB Healthy Food & Drink Policy, and ensure that it aligns with the National Healthy Food & Drink Policy ▪ Including a clause in your contracts with health provider organisations stipulating an expectation that they develop a Healthy Food & Drink Policy. Any policy must align with the Healthy Food & Drink Policy for Organisations. ▪ Reporting in Q2 and Q4 on the number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts. ▪ Reporting in Q2 and Q4 on the number of Early Learning Services, primary, intermediate and secondary schools that have current water-only (including plain milk) policies; and healthy food policies, consistent with the Ministry of Health's Eating and Activity Guidelines.	

Actions to Improve Performance	Milestones	Measures of Success
Audit the implementation of the West Coast DHB's Healthy Food and Drink Policy, and ensure alignment to national policy, to ensure the DHB is taking a lead in creating supportive environments to promote healthy eating and healthy choices.	Q4: Audit of DHB sites.	Healthy Food and Drink Policy fully implemented across all DHB sites. Proportion of providers with Healthy Food and Drink Policies clause in their service contracts.
Track and report on the number and proportion of provider contracts that include the clause stipulating providers will develop a Healthy Food and Drink Policy that aligns to national policy.	Q2: Report on progress. Q4: Report on progress.	
Collaborate with education providers in early learning settings, primary, intermediate and secondary schools to support the adoption of water-only (including plain milk) and healthy food policies in line with national Healthy Active Learning Initiative, with an emphasis on education providers with higher proportions of Māori, Pacific, and/or lower socioeconomic status students. (EOA)	Q2:Q4: Report on adoption of policies.	

Planning Priority: Smokefree 2025	L C W
MoH Expectation: Commit to undertake compliance and enforcement activities relating to the Smokefree Environments Act 1990 and outline the activities the DHB will undertake to 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 hapū wāhine and Māori.	

Actions to Improve Performance	Milestones	Measures of Success
Collaborate with the PHO, Poutini Waiora and Oranga Ha - Tai Poutini to maintain delivery of a range of smoking cessation support options, with a deliberate focus on Māori, hapū wāhine and whānau of children under 5 years of age. (EOA)	Q1-Q4	90% of pregnant women, identifying as smokers on registration with an LMC, are offered brief advice and support to quit. 90% of PHO enrolled patients who smoke are offered brief advice and support to quit. 95% of hospitalised smokers are offered brief advice and support to quit. 90% of households with a newborn have their smoking status recorded at the first WCTO core check. All regulatory performance measures reported 6-monthly.
Review referrals to stop smoking services by LMC midwives to identify and address gaps and barriers to women accessing these services, as a priority area. (EOA)	Q1: Review complete.	
Promote quit options for patients with mental health concerns who are enrolled in the primary care Long-Term Conditions Management programme. (EOA)	Q2-Q3	
Through the West Coast Tobacco-free Coalition, inform submissions on tobacco-related issues including the proposed vaping legislation.	Q1-Q4	
Undertake compliance activities relating to the Smokefree Environments Act 1990, including delivering and 6-monthly reporting on the activities relating to the public health regulatory performance measures.	Q1-Q4	
Collaborate with the Cancer Society, Community & Public Health and the PHO to advance Fresh Air Project/Smokefree Outdoor Dining initiatives in Westport and Greymouth.	Q1-Q4	
Track and monitor the delivery of smokefree advice and activity across all settings, to identify service and equity gaps and opportunities for further focus.	Q2: Report on activity Q4: Report on activity	

Planning Priority: Breast Screening	L C
MoH Expectation: DHBs will describe and implement initiatives that contribute to the achievement of national targets for BreastScreen Aotearoa. All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to breast screening services.	

Actions to Improve Performance	Milestones	Measures of Success
Collaborate with BreastScreen South and the PHO to identify overdue priority women and those not enrolled in the national breast screening programme at a practice level and provide practices with targeted follow-up to lift rates. (EOA)	Q2: Shared BSS/PHO reporting in place.	70% of all women (45-69) have had a breast screen in the last 24 months. Reduction in the equity gap for priority women (current baseline to Dec 2019): Māori 69.4% Pacific 42.9% Total 75.6%
BreastScreen South will prioritise Māori and Pacific wāhine when allocating screening appointments to reduce equity gaps. (EOA)	Q1-Q4	
BreastScreen South will reduce recall time to 20 months to assist with 'on time' screening for Māori and Pacific wāhine. (EOA)	Q1-Q4	
Collaborate with the PHO to deliver query build training to general practices to assist them to set and track targets for reaching priority group women. (EOA)	Q3: Query Build training delivered.	
Deliver education to practices to support an understanding of barriers that affect participation in screening particularly for Māori and Pacific wāhine. (EOA)	Q3: Education delivered to >5 practices.	
Collaborate with Community & Public Health, the West Coast PHO, Poutini Waiora and BreastScreen South to deliver a 'Top and Tail' programme – a clinic that will combine breast and cervical screening, whānaungatanga, kai and education targeting Māori and Pacific wāhine. (EOA)	Q4: Pilot 'Top and Tail' clinic held in Greymouth.	

Planning Priority: Cervical Screening	E L C
MoH Expectation: DHBs will describe and implement initiatives that contribute to the achievement of national targets for Cervical Screening. All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to breast screening services.	

Actions to Improve Performance	Milestones	Measures of Success
Meet quarterly with the PHO and Poutini Waiora to review screening data and coordinate efforts to improve rates for priority women. (EOA)	Q1-Q4.	80% of all women (25-69) have had a cervical smear in the last 36 months. Reduction in the equity gap for priority women (current baseline to Dec 2019): Māori 70.9% Pacific 70.7% Asian 58.5% Other 76.0% Total 74.6%
Deploy the DHB's Māori Pathway Navigator to support practices with overdue women with recalls and holding bi-monthly cervical screening clinics. (EOA)	Q1-Q4.	
Encourage practices to engage with Poutini Waiora's Māori RN smear taker, who will work in practices to focus on delivery of screening for Māori wāhine. (EOA)	Q1-Q4.	
Collaborate with the PHO to deliver query build training to general practices to assist them to set and track targets for reaching priority group women. (EOA)	Q3: Query Build training delivered.	
Deliver education to practices to support an understanding of barriers that affect participation in screening particularly for Māori, Pacific and Asian women. (EOA)	Q3: Education delivered to >5 practices.	
Collaborate with Community & Public Health, the West Coast PHO, Poutini Waiora and Breastscreen South to deliver a 'Top and Tail' programme – a clinic that will combine breast and cervical screening, whānaungatanga, kai and education targeting Māori and Pacific wāhine. (EOA)	Q4: Pilot 'Top and Tail' clinic held in Greymouth.	
Following migration to the new Te Nikau facility, utilise the extended general practice opening hours to introduce evening screening clinics to target women who struggle to access general practice during business hours. (EOA)	Q3.	

Planning Priority: Reducing Alcohol Related Harm	L C
MoH Expectation: Commit to undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012. This must include delivering and reporting on the activities relating to the nine public health regulatory performance measures contained in the previous Vital Few Report. In addition, outline the activities the DHB will undertake to advance activities relating to reducing alcohol related harm.	

Actions to Improve Performance	Milestones	Measures of Success
Undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012, including delivering and reporting on the activities relating to the public health regulatory performance measures.	Q1-Q4.	All regulatory performance measures reported 6-monthly. Number of active alcohol accords. Number of engagements with Māori organisations and agreement for support.
Maintain and support intersectoral alcohol accords in our district.	Q1-Q4.	
Identify and begin to work with Māori partners and organisations on the West Coast to strengthen the Māori voice in alcohol licensing decision-making, including local alcohol policies. (EOA)	Q1: Engagement underway.	

Planning Priority: Sexual Health	E L C
MoH Expectation: Outline the activities the DHB will undertake to advance sexual health services and sexual health promotion work.	

Actions to Improve Performance	Milestones	Measures of Success
Provide free condom packs and health promotion information via the West Coast Community Health Information Centre (EOA).	Q1-Q4	Report on uptake of public health services in Q2 and Q4. Increased uptake of sexual health consultations and Long-Acting Reversible Contraception by priority populations.
Provide free sexual and reproductive health consultations in general practice for young people under 25 years and promote access to low-cost Long-Acting Reversible Contraception to reduce cost barriers for young people. (EOA)	Q1-Q4	
Explore opportunities to improve access to contraceptives through Registered Nurse Prescribing with a focus on nurses working with Māori and Pacific populations, high schoolers and our more remote communities. (EOA)	Q2: RN interest scoped. Q4: Options identified.	
Establish a Syphilis Working Group with Canterbury DHB and Community & Public Health to ensure actions to prevent new syphilis cases and congenital syphilis are aligned across the two regions and support the National Syphilis Action Plan.	Q2: Working Group Established.	

Planning Priority: Communicable Diseases	LC
MoH Expectation: Outline the activities the DHB will undertake to advance communicable diseases control work.	
Actions to Improve Performance	**Milestones**	**Measures of Success**
Monitor and report communicable disease trends and outbreaks.	Q1-Q4.	Report 6-monthly on the number of: Reports sent to health professionals. Notifications completed. Outbreaks recorded. Media releases and other publicity distributed.
Follow up communicable disease notifications to reduce disease spread, with a focus on culturally appropriate responses. (EOA)	Q1-Q4.	
Identify and control communicable disease outbreaks, with a focus on culturally appropriate responses. (EOA)	Q1-Q4.	
Develop and deliver public health information and education to improve public awareness and understanding of communicable disease prevention.	Q1-Q4.	

Planning Priority: Cross Sectoral Collaboration including Health in All Policies	EE
MoH Expectation: Outline the activities the DHB will undertake to advance work relating to implementing a cross sectoral collaboration approach, including using the Health in All Policies (HiAP) model, to influence healthy public policy and thereby achieve equity.	
Actions to Improve Performance	**Milestones**	**Measures of Success**
Deliver Broadly Speaking training (including the use of HEAT and other equity tools) to staff from the DHB and other health and social service agencies, to support and grow Health in All Policies work in our region. (EOA)	Q1-Q4	Number of non-health agencies attending Broadly Speaking training sessions. Number of joint initiatives agreed through the Health West Coast Alliance. 6-monthly report on progress.
Collaborate with the member organisations of the Health West Coast Alliance (Community & Public Health, the West Coast PHO, Poutini Waiora and Sport West Coast) to develop and deliver a joint workplan, to support collaborative work and improve health outcomes in our region. (EOA)	Q1-Q4	
Through Community & Public Health, develop DHB submissions related to policies impacting on our community's health. (EOA)	Q1-Q4	

2.4 Better Population Health Outcomes Supported by a Strong and Equitable Public Health & Disability System

Government Theme: Improving the wellbeing of New Zealanders and their families

Planning Priority: Delivery of Whānau Ora	EQCW
MoH Expectation: Identify significant actions to contribute to the strategic change for whānau-centred approaches within the DHB systems and services across the district, and to demonstrate meaningful activity moving towards improved service delivery Identify actions to support and collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and to identify opportunities for alignment.	
Actions to Improve Performance	**Milestones**	**Measures of Success**
Prioritise two clinical areas where Māori are repeatedly presenting to services, and design and implement a whānau ora approach to enable a more integrated response to care for the person and their whānau. (EOA)	Q2: Areas identified. Q3: Changes underway.	Whānau ora tool used to engage Māori and improve clinical outcomes. A reduction in ambulatory sensitive hospital admissions for children 0-4 years. A reduction in ambulatory sensitive hospital admissions for adults 45-64 years. Reduction in Māori DNA rates at outpatient clinics – baseline 14% (2018/19).
Implement a new approach to the co-design of an Early Years Strategy to better capture the voice and contribution of people that experience inequities. (EOA)	Q2-Q4.	
Identify services with high Did Not Attend (DNA) rates and support services to take a whānau ora approach to identify and eliminate barriers to access, with emphasis on Māori and Pacific patients and those living in low decile areas. (EOA)	Q1: DNA tracking live. Q2: Opportunities identified. Q3: Changes underway.	
Partner with the PHO, Poutini Waiora and Te Putahitanga (the Māori Whānau Ora Commissioning Agency), to enhance our integrated approach to mental health and wellbeing with a joint bid for the next tranche of primary mental health and addiction support initiative funding. (EOA)	Q2-Q3.	

Planning Priority: Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan	E C
MoH Expectation: Commit to supporting delivery of the Pacific Health Action plan once it is agreed.	

Actions to Improve Performance	Milestones	Measures of Success
Review the national Pacific Health and Wellbeing Action Plan to identify key actions for the West Coast and complete an action plan to support delivery.	Q3-Q4.	Pacific health actions agreed.

Planning Priority: Care Capacity Demand Management (CCDM)	E C
MoH Expectation: Detail the actions that you will take to ensure full implementation of Care Capacity Demand Management (CCDM) for nursing and midwifery in all units/wards by June 2021 and outline the most significant actions the DHB will undertake in 2020/21 in each component of the programme; governance, patient acuity data, core data set, variance response management and FTE calculations.	

Actions to Improve Performance	Milestones	Measures of Success
Provide formal partnership training for the Care Capacity Demand Management (CCDM) Council members and adopt a Council charter to assist with effective governance level decision-making.	Q1: CCDM Council charter in place.	Q2: 100% of staff working in our integrated acute care department will have received refresher patient acuity training. TrendCare acuity tool used to demonstrate staffing resource is consistency matched with patient demand. Core Data Set used to enhance monthly reporting to nursing staff. Inter-Rater Reliability test results >95%. <5% of nursing shifts are below target. CCDM implemented for nursing and midwifery in all wards by June 2021.
Engage the Directors of Nursing and Midwifery in the CCDM Council to ensure variance response management is enabled in the Maternity ward.	Q1: DOM and DON engaged in CCDM.	
Provide Takarangi and/or Tipu Ora cultural competency training for the CCDM Coordinator, TrendCare Coordinator, and CCDM administrator to promote cultural safety within our CCDM Programme. (EOA)	Q2: Training underway.	
Deliver monthly progress reports to the CCDM Council, including progress on Core Data Set development, Variance Response Management plan implementation and FTE calculations.	Q1-Q4	
Pending Variance Response Management stocktake and Inter-Rater Reliability testing results, commence FTE calculations for the acute mental health inpatient ward (which is not impacted by migration to new facilities).	Q2: acute mental health FTE calculations commence.	
Following migration to new facilities in Greymouth, commence patient acuity refresher training for staff in the newly integrated acute care departments to ensure accurate patient acuity data in our new model of care.	Q3: Refresher training underway.	
Following migration to new facilities in Greymouth, utilise the Core Data Set stocktake to develop a Core Data Set workplan for CCDM Council approval.	Q3: Core Data Set workplan approved.	
Communicate agreed Core Data Set workplan and process to staff.	Q4	
Following migration to new facilities in Greymouth, complete the Variance Response Management stocktake.	Q4: Variance stocktake completed.	
Following migration to new facilities in Greymouth, commence an FTE calculation stocktake to prepare FTE calculations in our new acute care wards.	Q4: acute care FTE stocktake complete.	
Prioritise employment of Māori and Pacific nurses into any identified vacancies resulting from implementation of the CCDM Programme to increase the cultural diversity and responsiveness of our workforce. (EOA)	Q3-Q4	

Planning Priority: Disability Action Plan	E E
MoH Expectation: Commit to working with the Ministry of Health to develop your own or a regional Disability Action Plan to be published by July 2021, to improve access to quality health services and improve the health outcomes of disabled people.	

Actions to Improve Performance	Milestones	Measures of Success
Through the Disability Steering Group, and working with consumers and key stakeholders, complete the refresh of the Transalpine (Canterbury/West Coast) Disability Action Plan to improve health outcomes for disabled people. (EOA)	Q2: Updated Plan approved	Refreshed Disability Action Plan agreed and published.

Planning Priority: Disability	E E
MoH Expectation: 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. Outline how the DHB knows if a patient has a disability and communicates this to staff and how the DHB will work with the Ministry of Health to ensure that key health information for the public and public health alerts and warnings is accessible by people with a disability.	

Actions to Improve Performance	Milestones	Measures of Success
Collaborate with the Disability Working Group and other key stakeholders to continue developing the Diversity and Inclusion Framework.	Q1: Diversity and Inclusion Hui held.	Number and percentage of staff completing training. Diversity and Inclusion Framework developed.
Continue to provide disability training (via HeathLearn) for staff on what needs to be considered when interacting with a person with a disability (while the Diversity and Inclusion Framework is developed).	Q1-Q4.	
Engage with primary care, Māori and residential providers to advocate the use of electronic Shared Care plans for people with a disability, particularly for those with intellectual disability and/or communication challenges. (EOA)[7]	Q1-Q4	Increasing number of Shared Care plans accessible in the system. Increasing number of key health information and alerts made available in Easy Read. Increasing number of key health information and alerts translated into New Zealand Sign Language.
Make key health information to the public available on the front page of the DHB website (including public health alerts) and vet all new content to ensure it is compliant with the national Web Accessibility Standards. (EOA)	Q1-Q4	
Train the Communications Team in the use of Easy Read, to improve the accessibility of key health communications provided by the DHB. (EAO)	Q2: Training delivered.	
Track the number of key public health information messages, health alerts and warnings the DHB issues each year, and the number translated into New Zealand Sign Language.	Q4. Report on volumes.	

Planning Priority: Planned Care	E L C
MoH Expectation: In 2020/21 DHBs will be in the first year of implementing their Three-Year Plans to improve Planned Care delivery. The Three-Year Plans will be addressing the five Planned Care Strategic Priorities. Identify five key actions (one for each Strategic Priority) that will be undertaken in 2020/21 as part of the Three-Year Plan and outline how the DHB will engage with DHB Consumer Councils and other key stakeholders in the ongoing implementation of their plan.	

Actions to Improve Performance	Milestones	Measures of Success
Engage with the Consumer Council, Alliance Leadership Team and Tatau Pounamu around the model of service delivery for planned care services in the new facility in Greymouth, to identify further opportunities to align direction with local need and consumer priorities and ensure a clear focus on equity. (EOA)	Q1-Q3.	Delivery against national Planned Care Measures expectations. 100% of patients wait less than four months for their First Specialist Assessment (ESPI 2). 100% of patients wait less than four months from decision to treat to treatment (ESPI 5). Reduction in Māori DNA rates for First Specialist Assessments – baseline to be established. <6% of outpatient appointments are booked but not attended.
Ensure all planned care services (in primary and secondary settings) are using the National Prioritisation Scoring System to align access with other regions. (EOA)	Q1-Q4	
Complete implementation of the orthopaedic and plastic surgery ESPI recovery plan to reduce delays in treatment in these pressure areas.	Q1 – Q4	
Track and monitor delivery of planned care interventions in primary care to ensure delivery of agreed intervention targets.	Q1-Q4	
Implement the DNA Action Plan (currently being developed) to help people better navigate the system and improve attendance at planned clinics, with emphasis on Māori and populations living in low decile areas. (EOA)	Q2: Implementation underway.	
Following the opening of the new Te Nikau facility, expand planned care delivery hours in general practice in Greymouth (8am to 8pm).	Q3.	
Engage with the West Coast PHO Clinical Governance Committee to explore options for further migration of planned care services into primary care settings to optimise sector capability and build future capacity.	Q3: Further capacity identified.	
Partner with Poutini Waiora to explore opportunities for the delivery of general practice/nurse-led clinics in Māori community settings to increase access to planned care services for Māori. (EOA)[8]	Q4	

[7] Shared Care Plans are developed in general practice with the input of the individual and their primary support/s. The Plans are electronic and can be viewed in primary and secondary care settings, allowing health professionals engaged in a person's care to understand their needs and expectations.

[8] This was identified in 2019/20 but was delayed until planned care pathways were fully embedded in general practice and capacity was better understood.

Planning Priority: Acute Demand	E Q C E
MoH Expectation: Identify actions the DHB will take to implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021. This should include a description of the information technology actions and ED clinical staff training actions, milestones and timeframes and actions the DHB will take to address the growth in acute inpatient admissions.	

Actions to Improve Performance	Milestones	Measures of Success
Implement SNOMED (standardised terminology) coding in the Emergency Department to enable submission into national data collections by 2021, alongside the implementation of our new integrated South Island Patient Information Care System (PICS).	Q1: Value proposition for implementing SNOMED into our old IPM system. Q2: SNOMED training and education held. Q3: SNOMED built into our new system.	Reduction of Triage 4&5 presentations to the ED – baseline 54% 2018/19. 95% of patients are admitted, discharged or transferred from ED within 6 hours. <6% of outpatient appointments are booked but not attended (DNA). Reduction in Māori DNA rates for outpatient clinics – baseline 14% (2018/19). >8 out of 10 average for impatient survey domain: Rate your Experience of Communication.
Establish a voluntary team (friends of the Hospital) to meet and greet patients, utilising local Iwi and kaumatua to establish connections with Māori and Pacific whānau who are frequent attenders to ED. (EOA)	Q2. Team established.	
Establish an unplanned care area within the new Te Nikau facility with primary care, allied, mental health and secondary services working together to ensure patients are seen by the right person, in the right service, at the right time.	Q2: Unplanned area operational. Q3: Gaps in skills and training identified. Q4: Workforce and FTE needs refined.	
Facilitate collaboration between DHB Palliative, Cardiac, Diabetic and Respiratory Clinical Nurse Specialists and Poutini Waiora nurses to identify and manage early exacerbations of long-term conditions to reduce acute presentations. (EOA)	Q2: Poutini Waiora nurses working alongside Clinical Nurse Specialists within the integrated unplanned care area.	
Following the opening of the Te Nikau facility, expand planned care delivery hours in the general practice (8am to 8pm).	Q3: Opening hours extended. Q4: Identify demand for further extended hour services.	

Planning Priority: Rural health	Q C
MoH Expectation: Describe a minimum of two actions that improve access to services in rural communities.	

Actions to Improve Performance	Milestones	Measures of Success
Engage clinical and Māori health leads, stakeholders and consumers in the development of a Rural Early Years Strategy to better understand the priorities and issues for children and their whānau across our three localities and improve access and engagement with services. (EOA)	Q2: Engagement underway. Q4: Draft complete.	Increased telehealth service options available. Extended hours urgent care available from general practice in Greymouth.
Investigate opportunities for introducing 'In-Home' telehealth consultations, including work with consumer groups and a review of outpatient booking forms to promote telehealth as the first option with face to face as a backup option.	Q2-Q3.	
Following the opening of the new Te Nikau facility, expand planned care delivery hours in general practice in Greymouth (8am to 8pm).	Q3: Opening hours extended.	

Planning Priority: Healthy Ageing	Q C
MoH Expectation: Implement actions identified in the Healthy Ageing Strategy 2016 and contribute to the Government's priority of 'Improving the wellbeing of New Zealanders and their families', as follows: ▪ Working with ACC, HQSC and the Ministry of Health, to promote innovative delivery of Strength and Balance programs and improvement in data driven osteoporosis management especially in alliance with primary care as reflected in the associated "Live Stronger for Longer" Outcome Framework. ▪ Working with ACC on the non-acute rehabilitation pathway service objectives, to help older people regain or maintain their ability to manage their day-to-day needs after an acute episode. ▪ Aligning 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. ▪ Implementing DHB priorities for dementia services, identified in your 2019/20 regional stocktake. ▪ Delivering activity in the community and primary care settings to identify frail and vulnerable older people, with a focus on Māori and Pacific peoples, and put interventions in place to prevent the need for acute care and restore function.	

Actions to Improve Performance	Milestones	Measures of Success
Collaborate with the ACC, Aged Residential Care (ARC) providers and general practice, through the local Falls Coalition, to embed a pathway that supports	Q4: Pathway embedded.	720 places available at accredited community

automatic referral to the Falls Prevention Service for all patients post a fractured neck of femur (NOF) or humerus.[9]		Strength and Balance classes. 120 people access the Falls Prevention Service. 95% of long-term HCSS clients have an InterRAI assessment and a care plan in place. Increased number of Māori with completed InterRAI assessments. Proportion of the population (75+) presenting to ED maintained below the national average. Reduction in the equity gap that exists in the Acute Hospital Bed Day rate.
Expand the implementation of ACC non-acute rehabilitation (NAR) bundles of care, to target those living in the Buller region who would benefit from accessing the Earlier Supported Discharge service. (EOA)	Q4.	
Collaborate with the Technical Advisory Service and the Ministry of Health to align local service specifications and implement the National Framework for Home and Community Support Services (HCSS), when it is formally released.[10]	Q1-Q4	
Track and monitor service delivery to ensure that all clients in receipt of HCSS for more than six weeks (long-term) have had a needs assessment using the InterRAI geriatric assessment tool, and progressively implement the proposed national review and re-assessment timeframes for those long-term clients.	Q1-Q4: Quarterly review of delivery of InterRAI assessments.	
Appoint a Māori clinical assessor as part of the Complex Clinical Care Network team to support an increase in the number of InterRAI assessments delivered for older Māori. (EOA)	Q1: Māori assessor appointed. Q2: Cohort identified and targeted.	
Investigate practical solutions to issues raised by the Dementia Stocktake, to promote timely dementia diagnoses - including implementing a new diagnosis tool (M-ACE) in general practice and scoping Specialist Dementia Nurses roles.	Q3: M-ACE tool introduced. Q4: Roles scoped.	
Identify a "frail" cohort of patients (via interRAI) and trial a referral process that supports access to appropriate services to reduce acute demand and restore function, including Strength and Balance programs where appropriate.	Q2: Cohort identified. Q3: Pathway developed. Q4: Process in place.	

Planning Priority: Improving Quality		
MoH Expectation: Improving Equity: Using the Health Service Access Atlas (Atlas of Healthcare Variation) which reports seven questions from the national primary care patient experience survey, consider which of your patient groups are experiencing the most barriers. Specify improvement activity to address these barriers and drive equity of outcomes in one of the three identified topics of: Diabetes, Gout or Asthma. Improving Consumer Engagement: Commit to participation in the quality and safety marker for consumer engagement by demonstrating that you will set up a governance group (or an oversight group) of staff and consumers to guide implementation of the marker, upload data onto the consumer engagement QSM dashboard using the SURE framework as a guide and report against the framework twice yearly.		
Actions to improve performance	**Milestones**	**Measures of Success**
Improving Equity		A reduction in respiratory-related ambulatory sensitive hospital admissions for children 0-4 years. Improved response to the HQSC primary care experience survey question *'In the last 12 months was there a time when you did not visit a GP or nurse because of cost?'*. Baseline 26.6% 2016. Demonstration of increasing maturity against the Quality and Safety Marker.
Retrospectively review cases of children presenting to ED with respiratory conditions, who are not admitted, to identify barriers to earlier intervention and opportunities to improve referrals to the DHB's Clinical Nurse Specialist (CNS) service for support.	Q1-Q2.	
Working with Paediatrics, general practice and the CNS Service, use data from the case review to map the optimal referral pathway for respiratory presentations.	Q2-Q3.	
Establish a Multi-Disciplinary Team to provide ongoing oversight of respiratory presentations and evaluate the impact of the revised pathway for Māori. (EOA)	Q4.	
Improving Consumer Engagement		
Engage the West Coast Consumer Council in the governance role to guiding implementation of the quality and safety marker, with support from the Quality Team.	Q1-Q4	
Agree the process for information collection and reporting against the marker.	Q2.	
Upload the marker data onto the Health Quality and Safety Commission's consumer engagement HQSM dashboard, using the SURE framework as a guide	Q3-Q4.	
Evaluate the impact on the quality and safety of service provision by reporting against the framework twice yearly.	Q2: Report completed. Q4: Report completed.	

[9] Patients referred to the West Coast falls prevention programme are triaged by the falls champion, with those able to attend a community Strength and Balance class referred to one and those who are frailer seen by the falls champion who delivers the modified Otago exercise programme in their home.

[10] The West Coast DHB has already implemented the Auckland University case mix model and uses the service information collected to help enable and inform a restorative model of care for older people on the Coast. West Coast DHB is well positioned to implement the national specifications when they are released.

Planning Priority: New Zealand Cancer Action Plan 2019-2029		L C
MoH Expectation: Identify the actions you will take to sustain or improve cancer care and implement the Cancer Plan. Actions need to include how DHBs will ensure that the 31-day and 62-day cancer waiting time measures are met.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Collaborate with the PHO, Poutini Waiora, Community & Public Health, Cancer Society and Tatau Pounamu to offer local support to Māori whānau to engage in screening, seek early advice and understand cancer diagnosis to reduce inequity of outcomes for Māori. (EOA)	Q1: Cancer kōrero booklet promoted.	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.
Use data/intelligence systems to monitor the 62-day and 31-day wait times for access to cancer treatment and undertake a breach analysis for every patient who waits longer than target to identify any emergent systems issues and capture opportunities to reduce process delays.	Q1-Q4.	
Engage our cancer workforce in Tikanga and Takarangi training to improve cultural competency and support our goal of ensuring cultural safety and reducing bias in clinical decision making. (EOA)	Q1-Q4.	

Planning Priority: Bowel Screening and Colonoscopy Wait Times		E L C
MoH Expectation: As a DHB prepares to implement bowel screening, it must be consistently meeting all diagnostic colonoscopy wait times and have no patients waiting longer than maximum wait times in the months prior to the readiness assessment. Describe actions to ensure recommended urgent, non-urgent and surveillance diagnostic colonoscopy wait times are consistently met and actions to ensure there are no people waiting longer than the maximum wait times for any indicator.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Refresh data systems to ensure the DHB complies with new reporting requirements under the Ministry's framework for monitoring symptomatic colonoscopy and bowel screening performance.	Q1.	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.
Undertake monthly waiting list review of colonoscopy wait lists and wait times to identify any emergent systems delays and prompt corrective actions and management, through our Endoscopy User Group.	Q1-Q4.	
Embed dedicated theatre session time to provide timely access to colonoscopy.	Q1-Q4	
Provide training and education to community nurses and general practice teams in preparation for the roll-out of the National Bowel Screening Programme, to ensure that symptomatic patients are promptly triaged and processed. (EOA)	Q1-Q4.	
Collaborate with the PHO, Poutini Waiora and Community & Public Health to deliver bowel cancer awareness health promotion initiatives through primary and community care networks with a focus on Māori communities, to de-stigmatise the screening process and to encourage uptake of bowel screening checks among Māori as a target population. (EOA)	Q1-Q4: Health Hui delivered in Māori settings.	
Undertake the 'Phase Two' work identified in the 'Phase One' plan for the roll-out of the National Bowel Screening Programme, linking in with key partner organisations and the National and Southern Regional Bowel Screening Centres.	Q1-Q4.	
Subject to meeting the prerequisites of the readiness assessment, commence implementation of the National Bowel Screening Programme on the West Coast.	Q4.	

Planning Priority: Workforce – Workforce Diversity		Q L E E
MoH Expectation: Set out workforce actions, specific to your DHB that you intend to work on in the 2020/21 planning year. Outline how these actions relate to both a strong public health system and EOA focus area actions and identify actions that support equitable funding for professional development for nurse practitioners.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
DHB Workforce Priorities		Increased uptake of rural training placements.
Collaborate, with training bodies, high schools and local iwi to promote health careers locally.	Q2: Hui held to consider recommendations made by our 2019 Studentship/Scholarship recipients. Q4: Studentship recommendations implemented.	

Develop a prioritisation strategy to support uptake of rural training placement opportunities, prioritising opportunities for Māori and Pacific students. (EOA).	Q2: Placement prioritisation strategy developed and approved. Q3: DHB-subsidised housing promoted to education providers and students considering training placements on the West Coast.	Number of new or expanded rural generalist roles in place. Updated Nurse Practitioner development package in use across all service areas. Reduction in time taken to fill vacancies.
Implement our Rural Generalist model to support a more sustainable service model and provide continuity of care for our population.	Q1: Opportunities identified to support the obstetrics pathway on the Coast in line with the Rural Generalist Model. Q2: Opportunities identified to support general medicine on the Coast in line with the Rural Generalist Model. Q4: Pathway to support a dual nursing/midwifery scope of practice developed and pilot underway.	
Build on the work begun in 2019, to support access to continued professional development for Nurse Practitioners.	Q1: Support for two Northern Region Nurse Practitioner interns to complete their training and submit portfolios. Q2: Review the professional development package (updated in 2019) with Nurse Practitioner staff and other DHBs. Q3: Identify opportunities to improve the development package.	
Develop and promote workforce development resources to support the increased capability of our non-registered workforce. (EOA)	Q4: Career pathway / workforce development resources developed and promoted.	
Use the six targets outlined by Te Tumu Whakarae (the national Māori GMs Group) to inform our actions to improve equity and increase participation in our health workforce.		Increased number of Māori, Pacific and people with disabilities applying for roles in our health. Increased number of leaders have completed cultural competency training, including Takarangi, and have a plan in place to attend further training. Increased number of Māori staff are participating in the leadership programme. Māori workforce closer aligned to the proportion of Māori in the population – baseline 4.4% Dec 2019.
Build business intelligence infrastructure to track progress towards equity outcomes for Māori. (EOA)	Q1: Set of metrics and data requirements to measure progress against Te Tumu Whakarae targets developed and prioritised. Q2: Dashboards for first set of metrics implemented. Q4: Metrics and dashboards reviewed and refined.	
Implement affirmative action measures to increase the number of Māori, Pacific people and people living with disabilities in our workforce. (EOA)	Q1: Process for people who meet minimum requirements to go to interview stage developed and tested. Q2: Hiring managers educated on best practice for hiring for diversity and guidelines that reduce bias in hiring process implemented.	
In partnership with Māori, improve the cultural competency of our workforce and leaders. (EOA)	Q1: Hui held to co-design cultural competency learning pathway. Q2: Cultural competency integrated into the self-learning pathway. Q3: Te Reo Māori incorporated into all Talent, Leadership, and Capability-building Learning Material. Q4: Leaders that have completed Takarangi cultural training identified and a plan in place for further training opportunities.	

Planning Priority: Workforce - Health Literacy	E C
MoH Expectation: Identify actions to develop a Health Literacy Action Plan that describes the service improvements you plan to make in the short, medium and long-term.	

Actions to Improve Performance	Milestones	Measures of Success
Collaborate with the PHO, Poutini Waiora, Community & Public Health, Cancer Society and Tatau Pounamu to promote the Cancer kōrero (booklet) to support Māori to better understand the risk factors for cancer, engage in screening, seek early advice and understand their cancer diagnosis. (EOA)	Q1: Cancer kōrero promoted.	Health Literacy Action Plan launched. Improved patient satisfaction ratings across the inpatient survey domains: Communication and Partnership.
Identify a Health Literacy Champion to build health literacy within the DHB and across the wider health and disability system.	Q2: Health Literacy Champion identified.	
Following on from the health literacy review conducted in Canterbury 2019/20, develop a Health Literacy Action Plan for the West Coast identifying short, medium and long-term service improvements.	Q3: Action Plan development underway.	

Planning Priority: Workforce – Cultural Safety	E E
MoH Expectation: Identify actions to support cultural safety within the DHB.	

Actions to Improve Performance	Milestones	Measures of Success
Continue to invest in the Takarangi Competency Framework, Te Tiriti o Waitangi and Tikanga Best Practice programmes to support our commitment to equity and improve the cultural competency of our workforce. (EOA)	Q2: Takarangi Hui held for next intake of staff. Q4: ≥3 Te Tiriti o Waitangi training sessions held. Q4: ≥3 Tikanga Māori Beliefs & Practices sessions.	90% of patients responded positively to the inpatient survey question '*Was cultural support available when you needed it?*' – baseline 79% Q2 2019.
Work with the PHO to develop an education package to advance the skills of primary care staff to respond to the needs of Māori clients, improving outcomes for at risk groups in primary care setting. (EOA)	Q4: Cultural Safety education package developed and delivered to at least five general practices.	
Advance the skill development of Nurse Practitioner and Clinical Nurse Specialist (mental health) roles to confidently and competently respond to Māori clients presenting with mental illness. (EOA)	Q2: Cultural safety training options discussed and documented in success and development plans. Q4: Agreed cultural safety training commenced.	

Planning Priority: Workforce - Leadership	E E

MoH Expectations: Identify actions, initiatives and programmes that your DHB has in place to support staff who are in, and staff who are progressing into leadership, management and governance roles. Identify actions/initiatives/programmes which facilitate healthy and culturally reinforcing working environments that support health equity.

Actions to Improve Performance	Milestones	Measures of Success
Develop the Hub for the Essentials of Leadership and Management (HELM) and increase uptake from West Coast audiences.	Q2: Relevant learning packages available on HELMLEADERS.ORG.	All West Coast leaders have completed some leadership development through HELM. Improved scores on AskYourTeam survey associated with leadership and culture. Number of people with a success and development plans in place.
Launch 'leading-self' leadership pathway to support leaders and those with leadership potential including links to relevant content and the Our Leadership Koru.	Q2. Leading Self pathway on HELMLEADERS.ORG.	
Scope the work required for developing a 'Leading-Others' leadership pathway, including determining work with internal and external partners.	Q2: Content review complete. Q3: Gap analysis of current learning content complete.	
In partnership with Māori, develop a leadership development programme to progress Māori into leadership roles. (EOA)	Q2: Hui held to co-design programme. Q3: First phase agreed.	
Deploy the success and development framework to support succession planning and role progression.	Q2: Success and development learning resources released.	
Assess areas with a low number of success and development plans and put in place a plan to increase uptake.	Q3: Plan to increase uptake in place.	

Planning Priority: Workforce – COVID-19	Q E

MoH Expectations: Identify actions that your DHB will take to work with the Ministry and wider community providers to plan a cross-sector approach in responding to a public health need, such as COVID-19, that impacts on service delivery and on the health and disability workforce availability to meet that need. These actions may include an agreed plan between your DHB and community providers (including Māori and Pacific providers, ARC, home care and support services, disability support services and mental health and addiction services).

Actions to Improve Performance	Milestones	Measures of Success
Establish a West Coast multiagency Psychosocial Recovery and Wellbeing Committee to support the implementation of *Kia, Kaha, Kia Maia, Kia Ora Aotearoa – COVID-19 psychosocial and mental wellbeing recovery plan* to support our community to adapt and thrive over the next year.	Q1: Committee established. Q1: Focus area leads facilitate implementation.	Local and regional recovery plans developed and implemented in line with *Kia, Kaha, Kia Maia, Kia Ora Aotearoa.* Cross-sector pandemic plan reviewed and updated. Response to aspirations and need of Māori incorporated into pandemic planning.
Engage regionally with Canterbury and South Canterbury DHBs, through the Regional Recovery and Wellbeing Committee to respond to the national direction and recovery.	Q1: Regional plan developed.	
Work with community providers and public health services to update our cross-sector pandemic plan, incorporating the learnings from the COVID-19 response.	Q1: Pandemic plan updated.	

Work with our Kaupapa Māori provider to identify the learnings from the COVID-19 response and invest the national COVID-19 funding (allocated through Te Herenga Hauora) to embrace new ways of working. (EOA)	Q1: Opportunities captured.	

Planning Priority: Data and Digital	Q G C

MoH Expectation: List all major digital initiatives, and associated milestones, and indicate multi-year initiatives.

- Explain how your IT Plan is aligned with the Regional ISSP.
- Note the digital systems/investments that will improve equity of access to services.
- Note the initiatives that demonstrate collaboration across community, primary and secondary care.
- Describe plans/initiatives that will enable the delivery of health services via digital technology.
- Indicate plans for providing consumers with access to their health information.
- Indicate plans for taking part in the digital maturity assessment programme and/ or implementing an action plan following the assessment.
- Indicate plans for implementing/maintaining Application Portfolio Management to improve asset management.
- Indicate plans to leverage approved standards and architecture in all digital system initiatives and investments.
- Indicate how IT security maturity will be improved across all digital systems.
- Indicate plans for improving alignment with national digital services, national data collections and data governance and stewardship.
- Commit to submitting quarterly reports on the DHB ICT Investment Portfolio to Data and Digital.

Actions to Improve Performance	Milestones	Measures of Success
Continue the roll-out of the regionally shared Electronic Referral Management System implementing e-triage within the DHB.	Q2.	All applicable services are using electronic triage of referrals. South Island DHBs linked through single PICS system. Increased use of telehealth technology to improve access to services. Legacy patient management system updated. Improved digital maturity. Improved security maturity and greater protection against cybersecurity incidents.
Complete implementation of the Regional Service Provider Index.	Q2.	
Deliver ISG support to ensure Te Nikau hospital and IFHC are fully operational with all ISG functions in place to support clinical teams.	Q2.	
Expand telehealth capability within Te Nikau to support the new locality-based model of care and equity of access to services for our most remote populations. (EOA)	Q2.	
Implement the (single) South Island Patient Information Care System (PICS), aligning the West Coast with Canterbury and Nelson Marlborough DHBs.	Q3: PICS live.	
Commence implementation of our faxing replacement solution including completing the RFI process and addressing change management.		
Collaborate with the PHO and general practice to implement the new Community System which in Phase 1 replaces the legacy primary care patient management system and in Phase 2 supports implementation of patient portals to provide consumers with greater access to their health information.	Q4: Legacy system replaced.	
Build on the digital maturity assessment completed in December 2019, with implementation of Phase 2 of the community system and ongoing work with Canterbury DHB to provide greater integration of systems and processes.	Q1-Q4.	
Improve Application Portfolio asset management by implementing cloud first systems and completing the migration of remaining Citrix environments to the data centre (cloud provider).	Q4: New Community system is cloud based.	
Support implementation of the National Bowel Screening Programme to support equity of access to services for our population. (EOA)	Q4: System is live.	
In alignment with Canterbury DHB, implement the following activities to improve our IT Security Maturity to Level 3: - Procurement of a phishing education tool - Development and delivery of security awareness training for staff - Moving our email environment onto Office 365 – Exchange online.	Q4.	
Work with the Ministry of Health on implementation of the National Health Information Platform (nHIP).	Q4.	
Submit quarterly reports to the Ministry of Health on the DHB ICT Investment Portfolio on data and digital.	Q1-Q4.	

Planning Priority: Implementing the New Zealand Health Research Strategy	E E

MoH Expectation: Commit to working with the Ministry of Health to co-design and co-invest in a programme of work to support the implementation of the New Zealand Health Research Strategy through building the capacity and capability across DHBs to enhance research and

innovation. Identify actions that demonstrate how you are working regionally to create research and analytics networks to support staff and build capacity and capability and actions that demonstrate how research policies and procedures will be developed for your DHB to ensure that clinical staff have a supportive framework to engage in research and innovation activities.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Identify a champion within the West Coast DHB to work with the Ministry of Health to design a programme of work to support the implementation of the New Zealand Health Research Strategy by supporting local research and innovation capability.	Q1. Champion Identified.	Increased number of DHB staff engaged in research and innovation. Number of Transalpine Health Research Grant applications submitted and awarded. Five Transalpine Health Research Council of New Zealand career development positions embedded in research projects.
Formalise a Transalpine Research Partnership with the Canterbury DHB to create pathways for staff to engage in research and innovation and identify regional priorities for research activity.	Q2: Transalpine partnership in place.	
Develop research policies and procedures to provide a supportive framework for clinical staff to engage in research and innovation activities, which gives priority to reducing inequity for Māori in our communities. (EOA)	Q2: Research and Innovation framework developed.	
Work with the South Island Alliance Programme Office to develop a plan for how we will work regionally to create research and analytics networks.	Q4: Regional plan developed.	
Provide a summary update on progress to the Board and Ministry of Health.	Q4. Summary provided.	

Planning Priority: Delivery of Regional Service Plan Priorities and Relevant National Service Plans	Q C
MoH Expectation: Identify your role in supporting the delivery of the regional hepatitis C work. Include actions that demonstrate how the DHB will support implementation of key priorities in the National Hepatitis C Action Plan, work in collaboration with other DHBs in the region to implement the hepatitis C clinical pathway and work in an integrated way to increase access to care and promote primary care prescribing of new pangenotypic hepatitis C treatments	

Actions to Improve Performance	**Milestones**	**Measures of Success**
Review and update the local Hepatitis C HealthPathway to ensure access to diagnostics and treatment is aligned with national recommendations.	Q2.	Each GP practice with known hepatitis C positive patients has active engagement with a secondary care/community nurse. At risk individuals are tested and those lost to follow-up are identified.
Collaborate with the Canterbury DHB and regional Hepatitis C Coordinator to develop a multidisciplinary transalpine clinical network to ensure effective collaboration and messaging between primary and secondary care.	Q2: Network in place	
Engage with Poutini Waiora and work in partnership to identify and treat at risk or 'treatment naive' Māori living with hepatitis C. (EOA)	Q3: Partnership established	
Collaborate with local providers and the regional Hepatitis C Coordinator to identify economic barriers to accessing testing and treatment and if appropriate, consider options for implementation of a financial assistance programme.	Q4.	

2.5 Better Population Health Outcomes Supported by Primary Health Care

Government Theme: Improving the wellbeing of New Zealanders and their families

Planning Priority: Primary Health Care Integration	L E E C
MoH Expectation: DHBs are expected to continue to strengthen integration and their relationship with their primary care partners. Describe at least two actions which strengthen integration and improve access to a range of services for patients and demonstrate how you are working with Māori Health providers and NGOs to develop these services.	

Actions to Improve Performance	**Milestones**	**Measures of Success**
Complete a reorientation of the West Coast Alliance workstreams to align with the DHB locality model and to improve focus on primary care integration priorities in each locality. Ensure Te Ao Māori views are represented in each locality and DHB membership is complemented by membership from Non-Government Organisations (NGOs) to ensure a strong equity focus. (EOA)	Q1: Alliance workstreams re-oriented. Q1: Membership re-oriented.	Alliance workstream membership representative of locality communities. 85% of newborn babies are enrolled with general practice by 3 months of age. 95% of the population is enrolled with the PHO. 90% of Māori men (35-44) have had a cardiovascular
Review Māori enrolment rates and the quality of ethnicity data following the COVID-19 pandemic and lockdown and work with the West Coast PHO to develop a recovery plan where required. (EOA)	Q1: Rates reviewed and responded to.	
Implement alternative options for Māori men aged 35-44 years who are due for their Cardiovascular Disease risk assessment to increase access and uptake of	Q2: Recall process updated to reflect alternative options.	

screening – offering appointments outside of normal business hours, physically in the new Te Nikau facility or virtually via telehealth. (EOA)		disease risk assessment in the last 5 years. A reduction in respiratory-related ambulatory sensitive hospital admissions for children 0-4 years.
Using Emergency Department data relating to respiratory presentations in young children (age 0-4 years), work with primary care, paediatrics, Clinical Nurse Specialists and our Kaupapa Māori provider to review and map the optimal referral pathway for acute respiratory episodes.	Q2: Draft pathway for acute respiratory episodes developed. Q4: Pathway in place.	

Planning Priority: Emergency Ambulance Centralised Tasking	L C
MoH Expectations: The DHB will include a commitment statement that they will actively participate with the National Ambulance Sector Office (NASO) in the design and planning phases to centralise the tasking and coordination of aeromedical assets in New Zealand.	

Actions to Improve Performance	Milestones	Measures of Success
Maintain our commitment to the 10-year plan to achieve a high functioning and integrated National Air Ambulance service and actively participate through the National Ambulance Collaborative to achieve this. Support changed governance arrangements to improve the partnership with DHBs, MOH and ACC across all elements of the National Ambulance Sector Office (NASO) work programme and support the design and planning for tasking and coordination of aeromedical services.	Q1-Q4: Ongoing commitment maintained.	Status update report on programme.

Planning Priority: Pharmacy	Q E C
MoH Expectation: ▪ Describe actions the DHB is undertaking to implement integrated models of care that ensure older people have equitable access to the medicine's optimisation expertise of pharmacists. ▪ Describe actions the DHB has commissioned locally under the Integrated Community Pharmacy Services Agreement (ICPSA), to reduce the difference in local access and outcomes for your population. ▪ Describe the local actions/strategies the DHB has initiated 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.	

Actions to Improve Performance	Milestones	Measures of Success
Collaborate with pharmacists to achieve a locally consistent, clinically-informed process for pharmacists completing medicines reconciliation in general practice.	Q4: Process agreed.	Increased number of MTAs delivered. IDT meetings, in an increased number of settings, have access to pharmacist expertise. 75% of older people (65+) receive an influenza vaccination. Utilisation of cultural training programmes. Increased proportion of general practices using NZePS.
Enable pharmacists to provide Medicines Therapy Assessments (MTAs) to general practitioners for people likely to have potentially harmful polypharmacy.	Q4. MTA enabled.	
Identify opportunities to engage pharmacists in interdisciplinary team meetings (IDTs) where complex individual cases are discussed to ensure older people living in the community and ARC to have access to the medicine's optimisation. (EOA)	Q1-Q2.	
Commission pharmacies to provide funded influenza and MMR immunisations, in collaboration with general practice, to improve the uptake of vaccinations amongst more vulnerable groups in the community. (EOA)	Q1-Q4: Vaccinations reported quarterly by ethnicity.	
Engage a community pharmacist as a member of the West Coast Immunisation Advisory Group to support system-wide influenza vaccination planning.	Q1.	
Extend access to the DHB's cultural training programmes to non-clinical pharmacy staff to improve the interactions with Māori visiting pharmacies. (EOA)	Q2. Options identified and promoted.	
Survey pharmacies on the resilience of their services to pandemics, natural disasters and other civil emergencies, including identified vulnerabilities and mitigating measures, to build on strengths and improve system planning.	Q1. Survey complete. Q2: Follow-up actions identified.	
Engage with general practices to shift further prescription and pharmacy referral flows to digital transmission, using the New Zealand electronic prescription service (NZePS), to enable timely low-contact healthcare.	Q2-Q4, report NZePS uptake.	

Planning Priority: Long-term Conditions including Diabetes	L C
MoH Expectation: Identify actions that demonstrate how the DHB will improve primary and community care activity to prevent, identify and support management of long-term conditions targeting those with the poorest outcomes Diabetes: Identify actions that demonstrate how the DHB will ensure that all people with diabetes will be effectively managed through diabetes annual reviews, retinal screening, access to specialist advice, improve modifiable risk factors by targeting those at high-risk and provide	

culturally appropriate diabetes self-management education and support services and evaluate the effectiveness of the DSME. Identify health promotion and health protection activities the DHB has agreed to undertake to prevent diabetes and other long-term conditions.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Maintain the primary-care-led Long-Term Conditions Management (LTCM) Programme, to prevent, identify and enhance the management of cardiovascular disease, diabetes and chronic obstructive pulmonary disease, with a particular focus on Māori, Pacific people and those in high deprivation areas. (EOA).[11]	Q1-Q4.	>3,500 people actively enrolled in the primary care LTCM Programme. Proportion of Māori engaged in the LTCM programme is reflective of the population. 90% of Māori men (35-44) have had a cardiovascular disease risk assessment in the last 5 years.[12] 90% of the population identified with diabetes have had an annual review and HbA1c test. >60% of the population identified with diabetes (having an HbA1c test) have good glycaemic control (HbA1c <64 mmol/mol).
Though the West Coast PHO, provide Safe Effective Clinical Outcomes training to practice nurses, including improved understanding and consideration of health literacy needs from the perspective of the patient and their whānau.	Q1-Q4.	
Progressively expand the Whakakotahi whānau ora model across general practices, to better engage with high need, low access, Māori patients and provide wrap-around support to them and their whānau. (EOA)	Q4: Model expanded to a third practice.	
Share PHO/practice level data with Poutini Waiora to enable their Māori nurses to contact and engage with Māori men who are eligible for cardiovascular disease and diabetes risk assessments to lift the rates for this high-risk population. (EOA)	Q1-Q4.	
Deploy diabetes nurse specialists to work with Poutini Waiora and GP teams to support highly complex patients (with existing complications) who are not regularly accessing services to improve the continuity of care. (EOA)	Q1-Q4	
Collaborate with the PHO and Poutini Waiora to deliver culturally-appropriate, community-based initiatives and Diabetes Self-Management Education (DSME) to help people make lifestyle changes and reduce risk factors associated with their condition. (EOA)	Q1-Q4: Three diabetes courses delivered. Q1-Q4: Four retinal screening expos held.	
Use outcomes data to evaluate the uptake and effectiveness of the DSME for Māori, to identify gaps and inform opportunities for quality improvement. (EOA)	Q2-Q4.	

[11] People enrolled in the LTC programme receive: an in-depth annual review for each condition, a package of care based on their level of need, a jointly developed care plan and referral to other PHO programmes, nutrition and physical activity programmes, community support programmes, social services, community pharmacy and health professionals as required to support the management of their condition.

[12] Note this measure is part of a national CVD performance measures set which is currently under review. This measure may change during the year.

Financial Summary

Further detail on the DHB's financial outlook and assumptions for 2020/21 can be found in Appendix 6 of this Plan.

2.6 Prospective Statement of Financial Performance – to 30 June 2024

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
Ministry of Health Revenue	142,732	149,100	159,189	161,524	163,937	166,393
Other Government Revenue	-	-	-	-	-	-
Other Revenue	11,881	12,324	16,535	19,248	19,452	19,683
Total Revenue	**154,613**	**161,424**	**175,724**	**180,772**	**183,389**	**186,076**
Expenditure						
Personnel	67,605	66,964	70,515	71,520	73,296	76,208
Outsourced	8,708	10,757	8,857	9,036	8,700	8,834
Clinical Supplies	8,018	8,906	9,255	9,204	9,408	9,540
Infrastructure & Non Clinical	12,518	11,520	10,494	10,692	11,484	11,648
Payments to Non-DHB Providers	64,518	66,875	70,087	70,892	69,935	69,355
Depreciation & Amortisation	3,390	2,766	4,082	4,540	4,296	4,356
Capital Charge	1,407	700	4,740	8,690	8,712	8,844
Total Expenditure	**166,164**	**168,488**	**178,030**	**184,574**	**185,831**	**188,785**
Other Comprehensive Income						
Revaluation of Land & Building	-	-	-	-	-	-
Total Comprehensive Income / (Deficit)	**(11,551)**	**(7,064)**	**(2,306)**	**(3,802)**	**(2,442)**	**(2,709)**

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

	2019/20	2020/21	2021/22	2022/23	2023/24
	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue					
Prevention	3,571	3,878	3,989	4,046	4,116
Early Detection and Management	30,913	33,646	34,613	35,113	35,627
Intensive assessment & treatment	104,962	114,216	117,498	119,199	120,945
Support & rehabilitaion	21,978	23,984	24,673	25,031	25,398
Total Revenue	**161,424**	**175,724**	**180,772**	**183,389**	**186,076**
Expenditure					
Prevention	4,059	4,607	4,774	4,808	4,885
Early Detection and Management	32,961	34,735	36,012	36,257	36,834
Intensive assessment & treatment	109,130	115,793	120,050	120,866	122,788
Support & rehabilitaion	22,337	22,895	23,737	23,899	24,279
Total Expenditure	**168,488**	**178,030**	**184,574**	**185,831**	**188,785**
Surplus / (Deficit)	**(7,064)**	**(2,306)**	**(3,802)**	**(2,442)**	**(2,709)**

MEDIUM-TERM OUTLOOK

3

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 design and 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 workstreams. The DHB also has a Consumer Council, to ensure a strong and viable voice in health service planning and redesign.

Transalpine Partnership: Connecting 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.

South Island Regional Health Alliance: The Regional Alliance enables the region's five DHBs to work collaboratively and combine resources to meet shared challenges. As a small DHB, this regional support will mean we are better positioned to respond to the changes in technology and demographics that will have a significant impact on our health sector in the coming years. The West Coast DHB is represented across most regional workstreams and takes the lead across three of the seventeen working groups.

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 achieving health equity for Māori.

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 Manawhenua Advisory Group, where we actively engage with Māori leaders in the planning 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 New Zealand 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 DHB performance framework. Our service performance is also audited annually against our Statement of Performance Expectations set out in Appendix 5. The results are published in our Annual Report which can be found on our website.

The national DHB performance framework is presented in the Monitoring Our Outcomes section of this Plan.

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 2019, the West Coast DHB had $43.182M 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: is an unlisted company, no longer trading or operating. The functions are conducted by the South Island Alliance Programme Office, via an agency agreement with the five South Island DHBs.

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.

The West Coast DHB does not intend to acquire shares or interests in any other companies, trust or partnerships in 2020/21.

Building Our Capability

3.7 Investing in our people

In our rurally isolated environment, 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 our current workforce and attract new people to the West Coast health system.

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:

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

A core workforce of rural generalists will improve the sustainability of services, support a more integrated model of care and provide 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 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 our health workforce. Employee ethnicity data shows Māori make up 12% of the West Coast population but just 4.4% of the DHB workforce.[13]

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 reviewing recruitment practices, particularly those that may unintentionally limit job placements for Māori applicants.

With a third of our staff having no ethnicity recorded, we are also engaging with staff to improve the collection and recording of ethnicity data to improve workforce planning and support.

Alongside our deliberate strategy to lift our Māori staff numbers, the DHB is 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.

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

Other areas of workforce development and investment in 2020/21 are outlined in the Delivering Against National Priorities section of this Plan.

[13] Note: This number is likely to be understated with 34.3% of our workforce not declaring their ethnicity. Of those who have declared their ethnicity 5.8% have identified as Māori. December 2019 results.

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 regard to applications management and support for planned upgrades. We now share many of the same software solutions and 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 and cloud providers.

Telehealth, videoconferencing and mobile technology are an important factor in addressing our isolation challenges. We will continue to expand this capability in the coming year, providing more remote communities on with access to telehealth options.

We are imbedding opportunities identified through our Covid-19 response to sustain and amplify positive changes to our work environment. Many activities were already planned, but we are re-prioritising and responding with accelerated delivery. Our focus areas include service virtualisation, adoption of collaboration tools such as Microsoft Teams and expanded use of Telehealth capability.

There are also a host of technological advancements being incorporated into Te Nikau to improve patient care. Digitisation of the facility is occurring using regional solutions which promote electronic workflows including electronic orders and e-referrals.

Refer to the Delivering on National Priorities and Targets section of this Plan for detail on areas of focus for the period of this Plan.

3.9 Investing in facilities

The West Coast DHB is in the midst of significantly transforming the way we deliver health services to our community. As one of our three locality bases, 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.

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.

Delays with the building programme have meant the DHB has been unable to realise anticipated efficiency savings over the past several years. However, we look forward to the significant impact the move into this new facility will have on our model of care in 2020/21.

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 July 2020. With $4m having been made available from Government for the completion of the building, including canopies for the entrance.

- Grey Base Energy Centre: A replacement Energy Centre is part of the Grey Base redevelopment and completion is anticipated in 2020/21.
- 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 of the facility is now complete. A two-stage procurement process is underway for a contractor to demolish the buildings and a construction contractor to complete the new build. Services have already been decanted from buildings that will need to be demolished to commence construction. The project is expected to be complete in 2022.
- 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 has been approved by the Board with reference to possible locations for a replacement facility, more aligned to the new model of care for mental health services.
- A business case is currently being developed, with $15m having been made available from Government for the replacement of the Mental Health Inpatient Unit.

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 2020/21. 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 areas of service changes, for the period of this Plan, are highlighted in the following table. The changes identified will require further consideration and discussion with staff, providers, the DHB's Board and the Ministry of Health as they are developed and not all anticipated changes will progress.

Type of Service Change	Description of Anticipated Change and FTE impact	Anticipated Benefit	Driver
Reconfiguration of services and change in the model of service delivery.	Te Nikau Migration The DHB will be migrating into Te Nikau in the coming year. As part of this relocation the DHB will introduce a new approach to the provision of planned, unplanned and after-hours care and will identify where the integration of services would deliver more efficient, responsive and sustainable care. This will include a reconfiguration of FTE resources.	Increased integration of services, flexibility of staffing resource and more responsive and sustainable service delivery.	Local
Change in location, and provider and potential reconfiguration of services.	Planned Care In line with national direction the DHB will increase its focus on the provision of planned procedures in primary care settings. This may result in the reconfiguration of some services currently provided in hospital settings.	Improved access, earlier intervention and more sustainable service delivery.	National
Reconfiguration of service and change in location and model of service delivery.	Mental Health Services The DHB will complete implementation of its redesigned model of care for mental health services. This includes the reconfiguration of service teams to align with the locality-based model and a reduction in 3.9 allied mental health FTE. The DHB will also review the function of specialist AOD and CAMHS in the context of the locality-based service model to strengthen connections between service teams which may also include reconfiguration of FTE resources and/or a change in workforce mix in these areas.	Earlier intervention, increased integration, and improved health outcomes.	Local
Reconfiguration of services and change in the model of service delivery.	Rural Generalist Workforce Model The DHB will progress the next step in our Rural Generalist (medical) strategy to further embed Rural Generalists in Obstetrics & Gynaecology (O&G), Internal Medicine and Anaesthetics as well as providing greater support for primary care. This work will include a reconfiguration of FTE resources and a reduction in the use of locums and contracted specialists.	Improved continuity of care, increased integration and more sustainable service delivery.	Local COVID
Establishment of new service.	Kaupapa Māori Antenatal Education Programme The DHB will invest in a local Hapū Wānanga that promotes SUDI prevention, access to smoking cessation, safe sleep devices and breastfeeding support.	Increase service access and improved health outcomes.	Local
Establishment of new service.	Kaupapa Māori Mental Health Services The DHB will support increased capability and capacity within our Kaupapa Māori service provider through investment in an additional clinical mental health FTE.	Increase service access and improved health outcomes.	Local
Change in the model of service delivery.	Maternity Health Services The DHB will develop a hub and spoke model for Maternal Fetal Medicine, in collaboration with the team in Canterbury DHB.	Increased access and reduced travel for patients.	Local
Change in the model of service delivery.	Community Pharmacy Services The DHB will continue to work with pharmacy providers to develop integrated, consumer-focused, services in alignment with the national Pharmacy Action Plan direction and support the commissioning of pharmacies to provide funded influenza and MMR immunisations alongside general practice. This includes a shift of 4 FTE DHB Pharmacists into community pharmacy services.	Increased integration, improved access and improved health outcomes.	National Local COVID
Change in the model of service delivery.	Outpatient Services and Primary Care Services The DHB will review traditional models of service based on face-face outpatient and general practice activity and seek to support alternative models that incorporate virtual, telehealth, remote GP and nurse-led service provision.	Increased flexibility and access and more cost effective and efficient services.	Local COVID
Change in the model of service delivery	Cleaning and Café Services The DHB is bringing cleaning and café staff in-house. This will increase DHB staffing levels by an additional 19 FTE in 2020/21.	More cost effective and efficient services.	Local
Reconfiguration of the service delivery model.	Care Capacity Demand Management The DHB will work towards full implementation of Care Capacity Demand Management for nursing and midwifery by June 2021. This is likely to result in a reconfiguration of FTE resources to better align with demand.	Consistent care and alignment of workforce planning with service demand.	National
Potential change in location, scope and	Needs Assessment, Coordination and Management Services	Increased integration, reduced duplication	Local

configuration of services.	The DHB is considering options to bring needs assessment, coordination and management services together into one integrated hub to support a more efficient, responsive and sustainable service model.	and improved patient experience.	
Potential change in location, provider and service delivery model.	Mortuary Services The DHB is reconsidering the provision of this service and the feasibility of alternative service options.	Improved patient experience and reduced service costs.	Local
Potential reconfiguration of services.	Clerical and Administration Services The DHB will review clerical administrative resources, following the move to Te Nikau, with a view to upskilling existing staff and developing universal positions to make more efficient use of administrative resources across the organisation. This may result in a reconfiguration and/or reduction in FTE.	Increased flexibility and efficiency and reduced service costs.	Local
Potential change in location, scope, provider and service delivery model.	Infusion Services, Orthotics Services, Radiology Services, Audiology Services, Podiatry Services, Equipment Provision The DHB is considering the provision of several services, currently provided in hospital settings, to capture opportunities to integrate and realign resources to provide the greatest return in terms of health gain. This work will include reconsideration of the scope of service, where they sit outside of the DHB's service coverage schedule. This may result in a reconfiguration and/or reduction in FTE where services shift outside of the DHB.	Improved access, earlier intervention, more sustainable service delivery and improved health outcomes.	Local
Potential establishment of new service.	Postvention Counselling The DHB will seek to develop a new postvention counselling service pathway for people bereaved by suicide, in collaboration with the Office of Suicide Prevention and Clinical Advisory Services Aotearoa (CASA).	Improved access, patient experience and health outcomes.	Local
Potential change in service delivery model or reconfiguration of services.	Kaupapa Māori Services The DHB will seek to identify the learnings from the COVID-19 response and invest the national COVID-19 funding (allocated through Te Herenga Hauora) to embrace new ways of working with our Kaupapa Māori provider.	Improved access, patient experience and health outcomes.	COVID
Potential change in service delivery model or reconfiguration of services.	Pandemic Planning The DHB will work with community providers and public health services to review and update our cross-sector pandemic plan, incorporating the learnings from the COVID-19 response.	Improved access, patient experience and health outcomes.	COVID
Potential change in the scope and configuration of services and the model of service delivery.	Tertiary Services The DHB will continue to explore how to best meet the needs of our population with ongoing redesign of transalpine and regional pathways and the integration of service models with Canterbury DHB.	Increased integration, equity of access and more sustainable service delivery.	Regional

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 overarching intervention logic and an 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 identifies 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 several population health indicators which will provide insight into how well our system is performing over time. These population health indicators are set out in our Statement of Intent and reported against annually in our Annual Report.

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 service performance by monitoring ourselves against a forecast of the service we plan to deliver and the standards we expect to meet. This forecast is set out in our Statement of Performance Expectation.

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 2020/21 and Appendix 6 for the DHB's Statement of Financial Expectations.

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 System (SS)
- Better population health outcomes supported by Primary Health Care (PH).

The national framework and expectations for 2020/21 is set out on the following pages.

National DHB Performance Framework 2020/21

Performance Measure		Performance Expectation			
Improving child wellbeing					
CW01	Children caries free at 5 years of age			Year 1	59%
				Year 2	59%
CW02	Oral health: Mean DMFT score at school year 8			Year 1	<0.85
				Year 2	<0.85
CW03	Improving the number of children enrolled and accessing Community Oral Health services	≥95% of pre-school children (0-4) years of age will be enrolled in the Community Oral Health Service		Year 1	>=95%
				Year 2	>=95%
		≤10% of pre-school and primary school children enrolled with the Community Oral Health Service will be overdue for their scheduled examinations with the Community Oral Health Service.		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	95% of eight-month olds fully immunised.			
		95% of five- year olds have completed all age-appropriate immunisations due between birth and five years of age.			
		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	Newborn enrolment with General Practice	The DHB has reached the Total population target for children enrolled with a general practice by six weeks of age (55%) and by three months of age (85%), has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for its Māori population group, and (where relevant) the Pacific population group, for both targets.			
CW08	Increased immunisation at two-years	95% of two-year olds 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.			
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile 1-5 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.			
Improving mental wellbeing					
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 and 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.			
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care.	(MoH expectations yet to be confirmed)			

Improving wellbeing through prevention					
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.		
Better population health outcomes supported by strong and equitable public health and disability system					
SS01	Faster cancer treatment -31-day indicator		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)		<3,501 per 100,000 people (September 2019 baseline)		
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*	MoH planned care interventions expectations TBC.		
		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	
			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 three months (90 days)	
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans receive their scan, and scan results are reported, within six 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 six 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 5: *Cardiac Urgency Waiting Times (Only the Five Cardiac units are required to report)*	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.		
		Planned Care Measure 6: *Acute Readmissions*	The proportion of patients who were acutely readmitted post-discharge improves from base levels.	Improve on September 2019 baseline <=10.9.	
		Planned Care Measure 7: *Did Not Attend Rates for First Specialist Assessment by Ethnicity (Developmental)*	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.		
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	(MoH expectations TBC)	
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95 %	
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5%	
			Assessment of data reported to the NMDS	Greater than or equal to 75%	
		Focus Area 3: Improving the quality of the Programme for the Integration of MH 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, milestones and measures 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.*
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.
			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 three 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 three 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*, and a statin (3 classes); ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), Beta-blocker if LVEF<40% (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 two months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within two 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 within 24 hours of their presentation to hospital
			Indicator 2: Reperfusion Thrombolysis /Stroke Clot Retrieval 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 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 seven 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 seven 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.	
SS17	Delivery of Whānau Ora		Appropriate progress identified in all areas of the measure deliverable.
SS18	Financial outyear planning & savings plan		Provide reports as specified.
SS19	Workforce outyear planning		Provide reports as specified.
Better population health outcomes supported by primary health care			
PH01	Delivery of actions to improve system level measures (SLMs)		Provide reports as specified.
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers		All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90%.
PH03	Access to Care (PHO Enrolments)		The DHB has an enrolled Māori population of 95% or above.
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
Other Requirements			
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 2020/21
Appendix 3	Overarching Intervention Logic Diagram
Appendix 4	Alliance Structure Overview
Appendix 5	Statement of Performance Expectations 2020/21
Appendix 6	Statement of Financial Performance Expectations 2020/21
Appendix 7	System Level Improvement Plan 2020/21

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 Disability Action Plan
- 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.
	Baby Friendly Hospital Initiative	A worldwide programme led by the World Health Organization and UNICEF to encourage a high standard of care. An assessment/accreditation process recognises the standard.
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.
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, streamlining the referral process and ensuring referrals are directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	A set of six wait time focused 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.
	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 by providing evidence-based practice guidelines, ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from 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.
	Poutini Waiora	A Māori Health and Social Service provider that delivers holistic care to whānau across the West Coast. The service is primarily mobile with kaimahi visiting whānau in their homes or in community settings. Poutini Waiora has a number of service contracts with the DHB.
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.
PRIMHD	Programme for the Integration of Mental Health Data	The Ministry of Health's national mental health and addiction information collection holding both activity and outcomes data collected from district health boards and non-governmental organisations. PRIMHD is part of the Ministry's national data warehouse.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
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.
	Tatau Pounamu	Tatau Pounamu is the Manawhenua Advisory Group made up of the manawhenua health advisors mandated by the Papatipu Rūnanga as the Te Tiriti o Waitangi partners to West Coast DHB. Tatau Pounamu works with West Coast DHB to develop and implement strategies for Māori health gain, support the delivery of health and disability support services consistent with Māori cultural concepts, values, and practices, and support Māori aspirations for health, reducing inequalities between Māori and other New Zealanders.
	Tertiary Care	Highly specialised care often only provided in a smaller number of locations.

Appendix 2 Minister's Letters of Expectation 2020/21

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Hon Rick Barker
Chair
West Coast District Health Board

Tēnā koe Rick

Letter of Expectations for district health boards and subsidiary entities for 2020/21

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2020/21.

DHBs make positive differences in the lives of New Zealanders and I look forward to working with you and your new Board to deliver the wider changes we need to improve outcomes. Strong and sustained leadership provides a foundation for high-performing DHBs and is critical to overall sector performance.

The Government intends to deliver long term, sustainable change to support improved wellbeing for New Zealanders. In the coming months we will receive the final report from the New Zealand Health and Disability System Review. Many of you have contributed to the review, and I thank you for that. The interim report aligned strongly with our Government's priorities and the changes we have underway to deliver better outcomes for Māori and improving equity and wellbeing. I expect you to be prepared and ready to implement Government decisions resulting from the review.

Wellbeing and equity underpin my priorities. Appendix one details expectations for the five system priorities:

- improving child wellbeing
- improving mental wellbeing
- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

This letter will outline my expectations for a range of matters that contribute to performance across these priority outcomes.

Governance

The DHB Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance and delivery on the Government's priorities.

I expect you to hold your Chief Executive (CE) and senior leadership team to account for their financial performance and on the delivery of equitable health outcomes for your population.

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As Chair, you will need to provide leadership and direction to the Board, providing guidance and support to members to ensure they effectively govern the DHB. Please ensure that you have a process in place to review the performance of the Board on a regular basis.

Sustainability

Every DHB must clearly demonstrate how strategic and service planning will support improved system sustainability, including models of care and the scope of practice of the workforce. You should address how your DHB will work with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost increases and deficit levels.

Please ensure that your 2020/21 planning documents clearly identify your DHB's approach to financial and clinical sustainability at both a strategic level and operationally across each of my priority areas.

Service performance

I expect you to challenge and support your CE and senior leadership team to identify ways to respond to the challenges the DHB faces, including timely, high quality delivery of planned care, reducing the length of emergency department stays and increasing immunisation coverage. You will oversee progress on the plans they develop to address these issues.

You need to ensure that workforce and delivery plans support innovative models of care and don't merely add FTE to maintain existing approaches. I expect this to be supplemented with other activities, such as managing annual leave liabilities and maximising productivity in theatres and wards.

Achieving equity

Achieving equity in health outcomes and ensuring fairness in access to and experience of care is essential. I will always expect you to consider equity as you develop plans across priority areas and to prioritise resources to achieve equity across population groups. This will include improving health outcomes for Maori and Pasifika, and an explicit focus on addressing racism and discrimination in all of its forms across all aspects of your operations.

Embedding Te Tiriti o Waitangi and achieving pae ora (healthy futures) for Māori

Māori-Crown relations are a priority for this Government, and I expect your DHB to meet your Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I expect you to develop your plans in partnership with your iwi/Māori partnership boards and include a statement from the Chair of the partnership board in your annual plan alongside statements from yourself and your CE.

Achieving pae ora (healthy futures) for Māori is an important goal for the entire health and disability system. While this includes achieving equity in health outcomes for Māori, responding to our obligations under the Treaty of Waitangi goes beyond that. A critical aspect is enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. I expect your plan to specify how you will work with iwi and Māori communities in your district to achieve this goal.

Financial performance and responsibility

The 2018/19 and 2019/20 budgets have provided the largest increases in funding that DHBs have ever had. To improve service and financial performance, you must focus on good

decision-making within your sphere of control and influence. Most of the issues driving costs are within the control of the DHB, including the number and mix of full-time equivalent staff.

A central challenge in the public health system is to deliver a wide range of quality health services to New Zealanders while remaining within budget. You will be aware of your DHB's financial position and my expectation is that you and your Board will deliver improved financial management and performance; this is especially true for those DHBs that have struggled in recent years.

The In-Between Travel (IBT) appropriation will be devolved from 1 July 2020. I expect you to work with the Ministry of Health (the Ministry) to ensure a seamless transition of responsibilities. The Ministry has an ongoing stewardship responsibility to ensure that all IBT obligations are met.

Capital investment

Timely delivery of the business cases prioritised for investment from the Budget appropriation should be a strong focus. You must comply with financial performance expectations for capital investments requiring Crown equity. You will also be expected to deliver a business case within the budget parameters set, and ensure all investments are procured in a timely manner.

Business cases for high priority projects should continue to be developed irrespective of their immediate investment status and I will seek your assurance that this work is progressing.

I expect all DHBs to follow the guidelines for construction procurement developed by the Ministry of Business, Innovation and Employment. I also expect DHBs to support the initiatives being developed under the Construction Accord. Information on these initiatives will be provided as the work develops.

The Government is supporting a range of capital infrastructure initiatives. The wider public good from our capital projects must be realised, which requires adherence to certain principles. An example is the NZ Green Building Council (NZGBC) Green Star rating for new building developments. Capital builds ought to meet a 5-star standard in the absence of any other mature standard, and this aim should be written into design thinking from the outset. This should result in longer term efficiencies, both financial and environmental. During 2020/21, you will need to engage with the Ministry and other partners as we continue to evolve approaches to sustainable facility design.

National Asset Management Plan

I would like to thank your DHB for supporting the first iteration of the National Asset Management Plan (NAMP) and ask that you continue to engage with the NAMP work as we develop and implement the next phases. Please continue to strengthen your DHB's asset management approach, including focusing on critical service assets, embedding asset management practices and ensuring you appropriately govern service improvement and asset performance.

Service user councils

Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality and Safety Commission (the Commission) has provided guidance to support an effective approach – 'Engaging with consumers: A guide for district health boards' and 'Progressing consumer engagement in primary care'. I am aware that many DHBs already

have strong service user councils and I want to strengthen this across all districts and regions.

The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.

My priority areas

I have clearly communicated my priorities for the health system. I expect your annual plans to address these priorities to meet the needs of all population groups, especially those groups that experience the most significant inequities. The actions you commit to in your plan must contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention. Appendix one details expectations for the five system priorities, which will be further described in the planning guidance your DHB receives from the Ministry.

I look forward to engaging with you on your planning intentions, receiving your planning documents for 2020/21 and working with you as your DHB delivers on your commitments. I appreciate you are receiving this letter at a time when our system is facing emerging pressures from COVID-19. I am pleased to see the way the sector has worked together during the early response phase and I know DHBs will continue to support our collective system response.

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

Appendix one: Ministerial planning priority areas

Improving child wellbeing

The Child and Youth Wellbeing Strategy and Programme of Action (the Strategy) launched in August 2019 provides a clear pathway to ensuring New Zealand is the best place in the world for children and young people to live. I expect your annual plans to reflect how you are working to improve the health and wellbeing of infants, children, young people and their whanau. Your plans should focus on improving equity of outcomes (especially for Māori); on children and young people of interest to Oranga Tamariki; and children with greater need, including children and young people with disabilities.

I expect DHBs to increase childhood immunisation rates, especially for Māori. The recent measles outbreaks remind us of the impact of communicable diseases on our communities and the health sector and the importance of achieving full immunisation. I expect DHBs to work closely with their primary care providers to prioritise immunisation, including a renewed focus on robust pre-call and recall processes and immunisation outreach services.

I expect DHBs to focus on family and sexual violence screening, early intervention and prevention to ensure victims and families receive effective and timely health care and perpetrators are supported to break the cycle of family and sexual violence.

High quality maternity care is fundamental to ensure children get the best possible start in life. As part of their commitment to the Midwifery Accord signed in April 2019, I expect DHBs to implement a plan to improve recruitment and retention of midwives. You should use Care Capacity Demand Management (CCDM) work to ensure optimal staffing in maternity facilities.

Working with a full range of stakeholders, the Ministry has developed a comprehensive Maternity Action Plan to support a flexible, innovative and sustainable maternity system. I expect DHBs to work with all elements of the maternity system to ensure responsiveness to Māori and equitable access to quality maternity care, including maternal and infant mental health services.

Improving mental wellbeing

He Ara Oranga: Report on the Government Inquiry into Mental Health and Addiction and the Government's response, has set a clear direction for mental wellbeing in New Zealand. Supported by the investments announced in the 2019 Wellbeing Budget, we have a unique opportunity to improve the mental health and wellbeing of New Zealanders. Your leadership will drive system transformation in the mental health and addiction sector.

Collective action is needed to achieve equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes, including Pacific peoples, youth and Rainbow communities. You will work with the Ministry, the Initial Mental Health and Wellbeing Commission and the Suicide Prevention Office to support system transformation and the rollout of the Government's priority initiatives.

The mental health and addiction system must respond to people at different life stages and levels of need. I expect DHBs to work individually and collectively on mental health and addiction promotion, prevention and early intervention at the primary and community level. At the specialist end of the continuum you should ensure those with the most need have access to sustainable quality mental health and addiction services.

Improving New Zealanders' mental wellbeing will require collaboration with communities and non-government organisations (NGOs). I consider that DHBs have a social responsibility to

support the sustainability of NGOs and to empower communities to engage in the transformation of New Zealand's approach to mental health and addiction. This includes offering your expertise at no charge to NGOs and community organisations to support participation in new service delivery, particularly for communities who experience disproportionately poorer outcomes.

I expect you to contribute to the development of a sustainable and skilled workforce. You must invest to diversify, train and expand both the existing and new workforces. You should focus on training workforces to support the Government's primary mental health and addiction initiatives and communicate proactively with the Ministry about opportunities to expand coverage to reach underserved populations.

Improving wellbeing through prevention

Environmental sustainability

Ensure that you continue to contribute to our Government's priority of environmental sustainability, including green and sustainable facility design as noted above in the section on Capital Investment. I expect your annual plan to reflect your work to progress actions to mitigate and adapt to the impacts of climate change and enhance the co-benefits to health from these actions.

Antimicrobial resistance

I am concerned about the increasing threat of antimicrobial resistance (AMR) to our health security. DHBs have a key role in minimising this threat. The issues are systemic and require long-term planning and sustained actions.

I expect your annual plan to reflect actions that align with the objectives of the New Zealand Antimicrobial Resistance Action Plan and demonstrate you are working towards a sustainable approach to containing AMR.

Smokefree 2025

Smoking remains a major preventable cause of premature death, morbidity and health inequities. My expectation is that you work towards achieving Smokefree 2025. I expect to see effective community-based wrap-around interventions to support people who want to stop smoking, with a focus on Māori, Pacific people, pregnant women and those on a low income. The interventions should reflect your regional and programme provider collaborative efforts.

Bowel Screening

The National Bowel Screening Programme remains a priority for this Government. DHBs are expected to achieve national bowel screening targets (where applicable) and consistently meet diagnostic colonoscopy wait times. It is crucial that symptomatic patients are not negatively impacted by screening demand. DHBs must work individually and collectively to develop a sustainable endoscopy workforce, including support of training positions for nursing and medical trainees to meet growing demand in this area.

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

National Cancer Action Plan

On 1 September 2019 the Prime Minister, Rt Hon Jacinda Ardern and I launched the National Cancer Action Plan and its four key outcomes. DHBs have an important responsibility to drive the necessary changes and deliver of these outcomes.

I have established a National Cancer Control Agency, which will report to me on the implementation of the Cancer Action Plan. You will work with and take direction from the Agency to reach national standards of care and improve quality.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the general population. Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.

Accessibility means that your DHB provides a barrier-free environment, including information and communications for the independence, convenience and safety of a diverse range of people. This includes people who may have access needs, including disabled people, older people, parents and carers of young children and travellers.

Enabling disabled people to access health services includes ensuring that all key public health information and alerts are translated into New Zealand Sign Language. It means consulting disabled patients (including people with sensory, intellectual or physical impairments) on their preferred means of communication for appointment notifications and the like.

As with previous years, your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities. DHBs also need to implement policies and procedures to collect information about disabled people within your patient population. DHBs should also ensure contracts with providers reflect the requirement to either ensure accessibility or put in place plans to transition to a more accessible service.

Healthy ageing

If our ageing population continues to grow as current trends suggest, the number of people with dementia, and the associated financial and social consequences, will grow commensurately. This Government is determined to make a positive difference in the lives of people with dementia, their families, whānau, friends and communities. I expect your DHB to work with your region to implement the regional dementia priorities.

Please ensure the DHB develops models of care to identify frail and vulnerable older people in community settings, in particular Māori and Pacific peoples, and provides supports to restore function and prevent the need for acute care.

Workforce

I expect DHBs to develop bargaining strategies that progress the Government Expectations on Employment Relations in the State Sector.

I expect bargaining strategies to progress consistent employment arrangements and support agile, innovative workforces to deliver services. Employment arrangements should encourage people to grow, develop and thrive in a work environment that supports transdisciplinary teams and innovative models of care. I expect commitments made in bargaining to be met, including working party commitments, Accords or programmes, such as the CCDM programme.

DHBs have an essential role in training our future workforce and providing learning and development opportunities for current workforces. I expect you to continue to utilise current workforces to support innovative and transdisciplinary practice across models of care and enable people to work to their full scope of practice.

DHBs must create environments in which all health and disability workforces thrive. DHBs should facilitate healthy and culturally reinforcing working environments that support health equity outcomes for all.

Workplace violence

I am concerned about what appears to be increased levels of violence in the health workplace. In accordance with the Health and Safety Act 2016, DHBs are responsible for the health and safety of their staff, patients and visitors. I expect DHBs to keep staff, patients and visitors safe by implementing appropriate policies, procedures and training to maintain public trust and confidence in the health and disability sector.

Health Research Strategy implementation

Research and innovation, analytics and technology are all crucial to achieving an equitable, sustainable health system and better patient outcomes.

The New Zealand Health Research Strategy (2017-2027) is the key platform for us all and it is important to implement the strategic priorities. In the next year, we should focus on developing a flourishing research and innovation culture in our DHBs in both primary and secondary care.

I have asked the Ministry to work with you and other stakeholders to build up DHB people and resources to support and enhance research, innovation and analytics so the system can make better use of the evidence and innovation and contribute to the Health Research Strategy objectives. Please work with the Ministry to design and invest in the programme of work with a focus on creating regional research and analytics networks that support staff engaged with research and innovation.

National Health Information Platform (nHIP/Hira)

Digital health services are important to me and to all New Zealanders and I expect DHBs to ensure the digital services you use are safe, secure, integrated, reliable and provide appropriate access to data and information.

I also expect you to support the Ministry in developing and designing nHIP/Hira services and to prioritise nHIP/Hira implementation activities in your annual plan.

Planned care

The refreshed approach to deliver elective and arranged services, under a broader planned care programme, will build on the development of the three-year plan you started in 2019/20. Timely access to planned care remains a priority. I urge you to take advantage of the increased flexibility in where and how you deliver these services; to ensure improved equity

of access and sustainability of service delivery; and to provide services that meet your population's health care needs, support timely care and make the best use or your workforce and resources.

I am particularly concerned, across many DHBs, about the number of people waiting beyond expectations for first specialist assessments, planned care interventions, ophthalmology follow-ups and diagnostic radiology services. Please ensure you have appropriate plans in place to support timely care.

Measuring Health System Performance

The System Level Measures (SLM) programme provides a framework for continuous quality improvement and integration across the health system. I intend to build upon the SLM framework by publicising local progress in responding to my national priorities from quarter one 2020/21. I expect DHBs to work with all health system partners to agree local actions and the contributory measures needed to make a tangible impact on health system performance. This will require broadening of alliances to include partners beyond the primary health organisations (PHOs). Equity gaps are evident in all SLMs and in nearly all districts. Where equity gaps exist, I expect local actions and contributory measures to focus on addressing these gaps.

Care Capacity Demand Management

I continue to expect significant progress on implementing all components of the CCDM programme this year, including detailed plans for full implementation in all units in nursing and midwifery by June 2021. Full implementation includes annual FTE calculations and agreed budgeted FTE in place. I expect timely reporting, including your assessment on progress towards meeting the June 2021 deadline for full implementation of CCDM. It is vital that nurses and midwives see the impact of CCDM FTE increases and effective variance response management on safe staffing levels and that the core data set drives quality improvement. It remains my expectation that CE performance expectations include delivering CCDM expectations within agreed timelines.

Better population health outcomes supported by primary health care

Primary care

Primary care makes a significant contribution to improving health outcomes and reducing demand on hospital services. Continuing to improve primary health care remains a priority for this Government.

DHBs must work with their primary care partners and lead their alliance(s) to develop and implement models of care that improve equity for Māori and other high needs populations through services that target the needs of these populations. I expect these new models of care to use broader multi-disciplinary teams, strengthened inter-professional collaboration and improved integration between secondary, primary and community care. I expect high-quality information and data to be shared through formal agreements and used to support decision-making, particularly in improving outcomes for Māori.

Long-term conditions

As I have previously advised, I expect DHBs to explicitly require improvements in performance and reporting on long-term conditions in their contracts with PHOs. DHBs should incentivise PHOs to improve equity, reduce the burden of long-term conditions, demonstrate improvements in primary care settings and increase accountability for effectively managing long-term conditions, especially diabetes.

Pharmacy

Progress has been made on the strategic vision of the Pharmacy Action Plan 2016. I expect this progress to accelerate as you work with the pharmacy sector to develop funding models and models of care that are equity focused and centred on service users. Please ensure your DHB enables pharmacist vaccinators to deliver a broader range of vaccinations to improve access.

Rural workforce

DHBs with rural communities should build on 2019/20 and improve access to services for rural people. I expect you and your rural alliance partners, including rural hospitals, to explore the opportunities to use the Ministry's rural workforce initiatives to strengthen your rural workforce and improve the sustainability of rural services.

Supporting delivery of the Māori health action plan

The sector has recently engaged in the development of a Māori Health Action Plan to further implement He Korowai Oranga: the Māori Health Strategy and improve Māori health outcomes. I expect all DHBs to demonstrate delivery and implementation of this plan in 2020/21 planning documents.

Improving wellbeing through public health service delivery

Public Health Units (PHUs) are key to protecting and improving health and you should ensure that your DHB has strong and sustainable public health capability and capacity. I expect to see PHU plans integrated with DHB Annual Plans where appropriate in 2020/21.

Over the next year, a programme is underway to develop criteria and to confirm the accountability arrangements for public health service delivery. I encourage your PHU and DHB to get involved in this process and support the programme.

Appendix 3 Overarching Intervention Logic Diagram

Te Tiriti O Waitangi

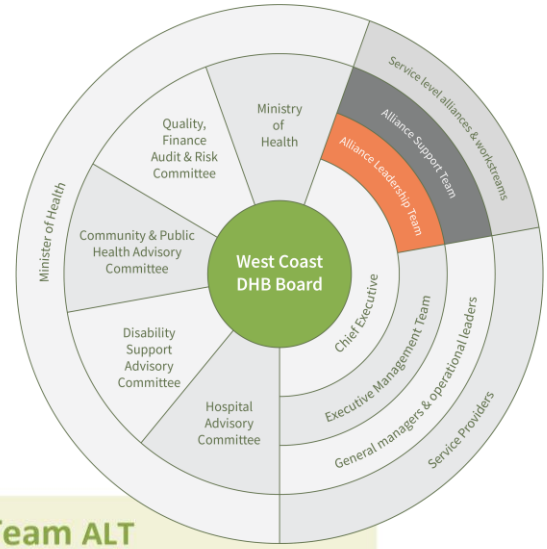
We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Māori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

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

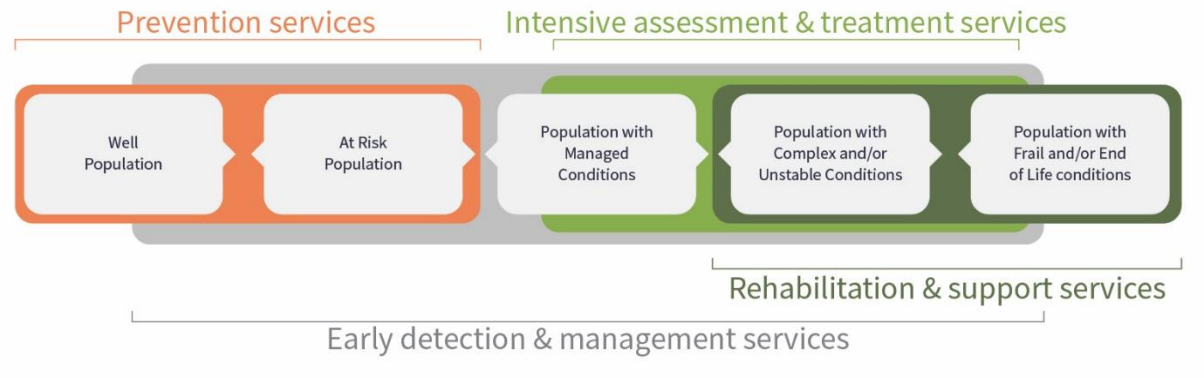
Propose transformational service improvement, identify areas requiring redesign and innovation.

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

Northern Integrated Family Health System
Central Integrated Family Health System

Southern Integrated Family Health System
Healthy West Coast

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 and increasing fiscal pressures, 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 track our performance against an annual statement of performance expectations, our 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 2020/21.

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.

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.

It is important to include a mix of service measures under each service class to ensure a balanced, well-rounded picture and provide a fair indication of how well the DHB is performing.

The mix of measures identified in our Statement of Performance Expectations address the four key aspects of service performance we believe are most important to our community and stakeholders:

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.

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.

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.

PERFORMANCE EXPECTATIONS

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.

The pressures on our system will be compounded by the unknown impact of the COVID 19 pandemic. Our future environment may be quite different, depending on how the pandemic plays out in New Zealand and around the world. While many of the longer-term population goals and service level expectations (outlined in our Statement of Intent and Statement of Performance Expectations) are unlikely to change, our ability to deliver against them will be compromised.

Population health outcomes are heavily influenced by changes in people's environments and economic situations, and negative impacts are anticipated.

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.

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.

◆ These measures have been identified as key focus areas for Māori. Progress by ethnicity will be reported in the DHB's Annual Report.

Where does the money go?

In 2020/21 the DHB will receive approximately $175 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 2020/21, by service class.

	2020/21
Revenue	
Prevention	$3,878
Early detection & management	$33,646
Intensive assessment & treatment	$114,216
Rehabilitation & support	$23,984
Total Revenue - $'000	$175,724
Expenditure	
Prevention	$4,607
Early detection & management	$34,735
Intensive assessment & treatment	$115,793
Rehabilitation & support	$22,895
Total Expenditure - $'000	$178,030
Surplus/(Deficit) - $'000	($2,306)

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services are those that 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 to 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 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 also designed to spread consistent messages to large numbers 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	2017/18 Results	2018/19 Results	2020/21 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q[14]	14	14	E.15
Licensed alcohol premises identified as compliant with legislation	Q[15]	95%	96%	90%
Networked drinking water supplies compliant with Health Act	Q[16]	81%	81%	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	2017/18 Results	2018/19 Results	2020/21 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A	191	193	E>150
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q[17]◆	77%	76%	75%
Babies exclusively/fully breastfed at three months	Q◆	61%	61%	70%
People provided with Green Prescriptions for additional physical activity support	A[18]	458	458	E>400
Green Prescription participants more active six to eight months after referral	Q	65%	n.a	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC) in the last 15 months	Q[19]◆	88%	96%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q◆	91%	91%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[20]◆	98%	100%	90%

[14] 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.

[15] 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 is seen as a proxy measure of the success of education and training and reflects a culture that encourages a responsible approach to alcohol.

[16] 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. Water quality annual reports are published one year in arrears, the latest report for 2017/18 can be found on the Ministry of Health website. Results for 2018/19 are expected in June 2020.

[17] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. These measures are part of the national Well Child/Tamariki Ora Quality Framework and data from providers is not able to be combined so performance from the largest provider (Plunket) is presented.

[18] 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 biannual patient survey completed by Research New Zealand on behalf of the Ministry. 2018/19 results are not yet available.

[19] 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.

[20] 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 ABC programme smoking targets.

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	2017/18 Results	2018/19 Results	2020/21 Target
Four-year-olds provided with a B4 School Check (B4SC)	A[21]◆	98%	93%	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◆	96%	94%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A[22]◆	74%	72%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A[22]◆	72%	77%	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	2017/18 Results	2018/19 Results	2020/21 Target
Children fully immunised at eight months of age	A[23]◆	83%	79%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q	96%	96%	95%
Young people (Year 8) completing the HPV vaccination programme	A[24]❖◆	39%	30%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A[25]❖◆	56%	55%	75%

[21] 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. 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. A referral for children identified with weight concerns allows families to access support to maintain healthier lifestyles.

[22] 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.

[23] 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.

[24] 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 people under 26 years of age. Baseline results refer to young women only, the programme was widened to include boys in 2020/21. The 2018/19 HPV result is subject to data quality issues and we believe is under-reflecting performance.

[25] 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?

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.

Early detection and management services are those that help to maintain, improve and enable people's good health and wellbeing. 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 different locations. Providers include general practice, allied health, personal and mental health service providers and pharmacy, radiology and laboratory service providers.

The DHB is introducing new technologies and developing a workforce with the skills to provide a wider range of preventative treatment and services, closer to people's homes. Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with local 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 helps to improve their quality of life by reducing 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	2017/18 Results	2018/19 Results	2020/21 Target
Newborns enrolled with a PHO by three months of age	A◆	83%	95%	85%
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A◆	94%	94%	95%
Young people (12-19) accessing brief intervention/counselling in primary care	A[26Δ]	215	159	E>150
Adults (20+) accessing brief intervention/counselling in primary care	AΔ	527	498	E>450
Number of integrated HealthPathways in place across the health system	Q[27]	632	683	E>600
Proportion of general practices offering the primary care patient experience survey	E[28]	86%	100%	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	2017/18 Results	2018/19 Results	2020/21 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A[29]◆	4,099	4,045	E>3,500
Enrolled population (15-74), identified with diabetes, having an annual diabetes review	A◆	79%	85%	>85%
Population with diabetes, having an annual review and HbA1c test, demonstrating acceptable glycaemic control (HbA1c <64 mmol/mol)	Q[30]◆	54%	53%	60%

[26] 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.

[27] 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.

[28] 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.

[29] 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.

[30] 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	2017/18 Results	2018/19 Results	2020/21 Target
Children (0-4) enrolled in school and community oral health services	A[31]❖◆	108%	101%	95%
Enrolled children (0-12) receiving their oral health exam according to planned recall	T❖◆	95%	96%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A❖	77%	76%	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	2017/18 Results	2018/19 Results	2020/21 Target
Number of subsidised pharmaceutical items dispensed in the community	AΔ	460k	471k	E<500K
People being dispensed 11 or more long-term medications (rate per 1,000)	Q[32]❖	4.5	n.a	<4.1
Number of community-referred radiological tests delivered	A	6,199	6,035	E>5,500
People receiving their urgent diagnostic colonoscopy within two weeks	T[33]	90%	88%	90%
People receiving their Magnetic Resonance Imagining (MRI) scans within six weeks	T	84%	82%	90%
People receiving their Computed Tomography (CT) scan within six weeks	T	100%	99.7%	95%

[31] 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.

[32]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 and the 2018/19 result is not yet available.

[33] 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 refer to non-urgent scans.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are those more complex services provided by health professionals and specialists working closely together to respond to the needs of people with more severe, complex or life-threatening health conditions. They are usually (but not always) provided in hospital settings, which enables the co-location of specialist expertise and equipment. Some services are delivered in response to acute events, others are planned and access is determined by clinical referral and triage, treatment thresholds and national service coverage agreements.

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2017/18 Results	2018/19 Results	2020/21 Target
Staff compliance with good hand hygiene practice	Q[34]	82%	84%	80%
Inpatients (aged 75+) receiving a risk assessment to reduce serious harm from falls	Q	92%	68%	90%
Patients responding to the national inpatient patient experience survey	E[35]	58%	28%	>30%
Proportion of patients who responded in the survey that 'hospital staff included their family/whānau or someone close to them in discussions about their care'	E	53%	55%	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	2017/18 Results	2018/19 Results	2020/21 Target
Proportion of the population (0-19) accessing specialist mental health services	A[36Δ]	5.4%	5.3%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	A[Δ]	5.9%	5.6%	>3.8%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T	81%	81%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	95%	92%	95%

Maternity Services				
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2017/18 Results	2018/19 Results	2020/21 Target
Number of maternity deliveries in West Coast DHB facilities	A	264	241	E.250
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[37❖◆†]	80%	n.a	80%
Baby Friendly Hospital accreditation achieved in DHB facilities	Q	Yes	Yes	Yes

[34] 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. In line with national reporting results refer to the final quarter of each year (April-June). Further detail and quarterly results for the past several years can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[35] There is growing evidence that patient experience is a good indicator of the quality of health services and stronger partnerships and family-centred care have been linked to improved health outcomes. The national DHB inpatient experience survey covers four patient experience domains: communication, partnership, co-ordination and physical and emotional needs. Response rates vary around the country with an average of 24% across all DHBs in Q2 2019. DHBs are required to have at least 30 responses for results to be meaningful and West Coast aims to be consistently at this level.

[36] 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 it is expected they will come down as the DHB implements in its strategy to better support people earlier and closer to home. Data is sourced from the national Mental Health dataset (PRIMHD) and results are three months in arrears.

[37] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report – data is a year in arrears and the 2018/19 data is yet to be released.

Acute and Unplanned 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	2017/18 Results	2018/19 Results	2020/21 Target
Number of unplanned presentations at the Emergency Department (ED)	A	11,616	11,829	E<13,000
People admitted, discharged or transferred from ED within 6 hours of presentation	T	98%	98%	95%
Proportion of people presenting in ED (in triage 1-3), seen within clinical guidelines	T[38]	82%	77%	85%
Proportion of people presenting at ED triaged in category 4 or 5	A	56%	54%	<60%
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral.	T	80%	72%	90%

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	2017/18 Results	2018/19 Results	2020/21 Target
Number of First Specialist Assessments provided	A	7,022	6,240	E>6,000
Proportion of people that wait <4 months for their First Specialist Assessment	T	87.7%	97.0%	100%
Number of planned care intervention delivered	A[39]	new	new	TBC
Proportion of people that wait <4 months from a commitment to treat to treatment	T	96.8%	89.0%	100%
Number of outpatient consultations provided	A	14,328	13,663	E>13,000
Proportion of outpatient appointments provided by telemedicine	Q[40]	4.2%	5.1%	>5%
Outpatient appointments where the patient was booked but did not attend	Q[41Δ◆]	6.1%	7.7%	<6%

[38]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.

[39] The new planned care intervention measure reflects a change in national expectations, recognising the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing including those delivered in community settings. The West Coast's planned care target is made up of three components: elective surgical discharges, Minor Procedures and Non-Surgical Interventions. At the time of printing the target was yet to be confirmed by the Ministry of Health.

[40] 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.

[41] When appointments are missed, it can negatively affect people's recovery and long-term outcomes. It is also a costly waste of resources for the DHB.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services are those that provide people with the support they need to continue 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 assessment of the person's needs.

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 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	2017/18 Results	2018/19 Results	2020/21 Target
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A[42]	2	9	15
People (65+) supported by the community-based In-Home Falls Prevention Service	A[43]	148	143	>120
Proportion of stroke patients admitted to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q	96%	94%	80%
Proportion of AT&R inpatients discharged home rather than into residential care	Q[44Δ]	90%	85%	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	2017/18 Results	2018/19 Results	2020/21 Target
Number of Meals on Wheels provided	A[Δ]	34,977	36,511	E>35,000
People supported by district nursing services	A[Δ]	1,645	1,797	E>1,600
People supported by long-term home-based support services	A[Δ]	1,211	1,100	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[45]	91%	75%	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	2017/18 Results	2018/19 Results	2020/21 Target
Proportion of the population (75+) accessing rest home level services in ARC	A[46Δ]	4.4%	3.8%	E<5.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A[Δ]	6.6%	6.4%	E.<6.5%
Proportion of the population (75+) accessing dementia services in ARC	A[Δ]	1.2%	1.1%	E.1.0%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A[Δ]	0.6%	0.3%	E.0.4%
People entering ARC having had a clinical assessment of need using InterRAI	Q	100%	88%	95%

[42] 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.

[43] 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.

[44] 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.

[45] 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.

[46] By helping older people maintain functional independence they are able to safely 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 ageing 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 increasing demand for health care within a more moderate growth platform.

Like the rest of the health sector, the West Coast DHB is experiencing growing financial pressure driven by increasing demand, rising treatment costs and wage expectations and heightened public expectations. We also face several unique challenges due to our size and geographic isolation which add to our fiscal pressures:

Rurality: Geographically we are the third largest DHB in the country, but we are the smallest by population. This means people must travel long distances to access or deliver services and the operational costs of service delivery are magnified.

Workforce shortages: Difficulties in recruiting staff to the West Coast means the DHB relies heavily on locums and contractors to fill gaps. While the use of locums allows services to be maintained in the short term, this reduces continuity of care and is an expensive and unsustainable solution.

Facilities pressures: Several of our health facilities are outdated, expensive to maintain, poorly located or seismically compromised. The level of remediation required to attain moderate compliance with current building codes is significant. We have also experienced long delays in completion of the Te Nikau facility, which has led to increased construction costs and delayed anticipated operational savings.

Financial Viability: 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. Multi-Employer Collective Agreements (MECA) settled in the past have also significantly exceeded the affordability parameters of the DHB. The flow-on effects of these settlements, to other staff groups and external providers organisations will put immense pressure on the financial sustainability of our health system.

Variation: Our small size means any variation, in service demand, capacity, treatment regime, staffing or infrastructure requirements can have a significant financial impact on our bottom line.

Forecast financial results

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $175m to meet the needs of our population in 2020/21.

This represents an 8.4% increase on the previous year and whilst this equates to a $13.5m increase in funding, it includes revenue for pay equity settlements and capital change on new facilities, which come with associated expenditure. The DHB's forecasts are based on receiving the minimum percentage funding increase available to DHBs in 2021/22.

The West Coast DHB is predicting a $2.3m deficit result for the 2020/21 year.

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

Closing the gap

Alongside the transformation of our workforce and service delivery models we are focused on driving and capturing efficiency improvements that will ensure the future viability of our health system.

If we are to be sustainable, we must rethink how we will meet our population's growing health need within a more moderate growth platform. There is no easy solution. Savings will be made, not in dollar terms, but in costs avoided through more effective use of available resources and improvements in the health of our population. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system.

The DHB's focus for the coming year will include:

- Integrating finance and operational systems and improving workforce and production planning to ensure we are using our resources in the most effective way.
- Progressing the implementation of our Rural Generalist workforce model to reduce our reliance on locums and contractors.
- Optimising investment in shared electronic systems and telehealth technology to reduce delays in care, DNAs and travel costs.
- Integrating, realigning and prioritising services that deliver maximum health benefit and are sustainable long-term.
- Capturing opportunities to increase revenue with successful bids for national funding
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.

- Considering the future use of all DHB assets to optimise investment.
- Tightening cost growth including moderating treatment, back office, support and FTE costs.
- Streamlining and standardising processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.

Savings identified for the coming year and two out-years have been highlighted in the Delivering Against National Priorities and Targets section of this Plan. Service changes proposed for the coming year are outlined in the Service Configuration section.

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 2020/21 are based on the funding advice received by the Ministry in June 2020 and West Coast DHB is assuming an 8.4% increase in 2020/21.
- The West Coast DHB will receive additional funding to cover increase in capital charges once Te Nikau facility is completed.
- Out-years funding is assumed at an average increase of 2.41% 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 has been folded into the DHB's population-based funding. 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 completion and migration date of August 2020.

  The net operating result, for 2020/21 and out-years, largely 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).
- 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.

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 first half of 2020/21 financial year. The revised budget for this development is currently $122.5m. The total costs are yet to be finalised.

The Grey Base redevelopment includes a second tranche upgrade/replacement of other aspects of the Grey Base site. The Board has approved the preliminary site masterplan for the Grey Base campus and the business case for the new Mental Health Facility is progressing, with $15m having been made available from Government for replacement of the Mental Health Inpatient Unit.

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.

The Buller facilities design has been approved and services have been decanted to allow for the staged demolition to make way for the new facility. The IFHC is expected to be completed in February 2022.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $3.3m for the 2020/21 year. In addition to the normal capital requirements, the Grey Base redevelopment requires greater investment in capital equipment than would normally be afforded, for example additional Information and Technology infrastructure.

Strategic capital for 2020/21-2021/22 comprises of:

- Mental Health & Grey Base redevelopment including demolition and enabling.
- Reefton IFHC redevelopment (notionally $4m).
- Phased upgrade of clinics outside Westport and Greymouth (notionally $0.450m per clinic).
- 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 first quarter of 2020/21 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 $20m Buller IFHC project is being funded with equity drawdowns as the project progresses.

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 2020/21 will be approximately $0.180m.

With an annual budget of over $14m, 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 2020/21 will be approximately $0.25m.

DISPOSAL OF LAND

The West Coast DHB has land and building assets located right across the West Coast, some of which are subject to leasehold interests and arrangements. The DHB is engaged in a process of considering the future of these assets based on our new locality model and future facilities requirements. It is anticipated that recommendations on the future of some DHB assets will be made in 2020/21.

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 Claims Settlement Act (and any other relevant legislation), before being made available for public sale.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

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

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. These are presented in the DHB's Statement of Intent, available on our website www.wcdhb.health.nz.

Statement of Comprehensive Income – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Income						
Ministry of Health revenue	**142,732**	**149,100**	159,189	161,524	163,937	166,393
Patient related revenue	7,249	7,123	8,499	7,512	7,620	7,776
Other operating income	4,302	5,119	7,988	11,652	11,736	11,811
Interest income	330	82	48	84	96	96
Total Income	**154,613**	**161,424**	175,724	180,772	183,389	186,076
Operating Expenses						
Personnel	67,605	66,964	70,515	71,520	73,296	76,208
Outsourced services (clinical and non clinical)	8,708	10,757	8,857	9,036	8,700	8,834
Treatment related costs	8,018	8,906	9,255	9,204	9,408	9,540
External service providers (include Inter-district outflow)	64,518	66,875	70,087	70,892	69,935	69,355
Depreciation & amortisation	3,390	2,766	4,082	4,540	4,296	4,356
Interest expenses	-	-	-	-	-	-
Other expenses	12,518	11,520	10,495	10,692	11,484	11,648
Total Operating Expenses	**164,757**	**167,788**	**173,290**	**175,884**	**177,119**	**179,941**
Operating surplus before capital charge	**(10,144)**	**(6,364)**	**2,434**	**4,888**	**6,270**	**6,135**
Capital charge expense	1,407	700	4,740	8,690	8,712	8,844
Surplus / (Deficit)	**(11,551)**	**(7,064)**	**(2,306)**	**(3,802)**	**(2,442)**	**(2,709)**
Other comprehensive income						
Revaluation of land and Buildings	**-**	**-**	-	-	-	-
Total Comprehensive Income	**(11,551)**	**(7,064)**	**(2,306)**	**(3,802)**	**(2,442)**	**(2,709)**

Statement of Financial Position – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
CROWN EQUITY						
General funds	85,926	93,858	231,354	239,786	239,718	239,650
Revaluation reserve	25,098	25,098	25,098	25,098	25,098	25,098
Retained earnings	(96,935)	(103,998)	(106,304)	(110,106)	(112,548)	(115,257)
TOTAL EQUITY	**14,089**	**14,958**	**150,148**	**154,778**	**152,268**	**149,490**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	6,362	1,218	6,383	1,634	520	7
Trade & other receivables	3,931	4,491	4,491	4,491	4,491	4,491
Inventories	1,077	1,160	1,160	1,160	1,160	1,160
Assets classified as held for sale						
Investments (3 to 12 months)						
Restricted assets	56	56	56	56	56	56
TOTAL CURRENT ASSETS	**11,426**	**6,925**	**12,090**	**7,341**	**6,227**	**5,714**
CURRENT LIABILITIES						
Trade & other payables	12,582	15,092	14,749	12,440	12,640	13,416
Capital charge payable	-	-	-	-	-	-
Employee benefits	14,052	14,052	14,052	14,052	14,052	14,052
Restricted funds	62	62	62	62	62	62
Borrowings	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES	**26,696**	**29,206**	**28,863**	**26,554**	**26,755**	**27,530**
NET WORKING CAPITAL	**(15,270)**	**(22,281)**	**(16,773)**	**(19,213)**	**(20,528)**	**(21,816)**
NON CURRENT ASSETS						
Investments (greater than 12 months)	320	320	320	320	320	320
Property, plant, & equipment	31,062	38,819	167,457	174,116	172,650	170,877
Intangible assets	376	499	1,543	1,954	2,224	2,509
TOTAL NON CURRENT ASSETS	**31,758**	**39,638**	**169,320**	**176,390**	**175,194**	**173,706**
NON CURRENT LIABILITIES						
Employee benefits	2,399	2,399	2,399	2,399	2,398	2,400
Borrowings	-	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	**2,399**	**2,399**	**2,399**	**2,399**	**2,398**	**2,400**
NET ASSETS	**14,089**	**14,958**	**150,148**	**154,778**	**152,268**	**149,490**

Statement of Movement in Equity – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Total Equity at Beginning of the Period	25,708	14,089	14,958	150,148	154,777	152,267
Total Comprehensive Income	(11,551)	(7,064)	(2,306)	(3,802)	(2,442)	(2,709)
Other Movements						
Contribution back to Crown - FRS3	-	-	-	-	-	-
Contribution from Crown - Capital	-	2,001	130,500	8,500	-	-
Contribution from Crown - Operating Deficit Support	-	6,000	7,064	-	-	-
Other Movements	(68)	(68)	(68)	(68)	(68)	(68)
Total Equity at End of the Period	**14,089**	**14,958**	**150,148**	**154,777**	**152,267**	**149,490**

Statement of Cashflow – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	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	142,861	148,630	159,189	161,524	165,528	166,393
Other receipts	12,327	12,533	16,440	19,164	12,408	20,363
Interest received	330	204	96	84	96	96
	155,519	**161,367**	**175,725**	**180,772**	**178,032**	**186,852**
Cash was applied to:						
Payments to employees	68,123	76,963	77,918	79,044	80,460	83,485
Payments to suppliers	86,864	86,904	91,634	94,609	90,480	92,099
Interest paid	-	-	-	-	-	-
Capital charge	1,407	630	4,740	8,690	8,712	8,844
GST - net	(157)	406	12	-	(3,586)	492
	156,237	**164,903**	**174,304**	**182,343**	**176,066**	**184,921**
Net Cashflow from Operating Activities	**(718)**	**(3,536)**	**1,421**	**(1,571)**	**1,966**	**1,931**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	(24)	24	12	(2)	-	12
Receipt from sale of investments	-	-	-	-	-	-
	(24)	24	12	(2)	-	12
Cash was applied to:						
Purchase of investments & restricted assets	(135)	-	-	-	-	-
Purchase of property, plant, & equipment	4,687	9,564	11,264	11,608	3,012	2,388
	4,552	**9,564**	**11,264**	**11,608**	**3,012**	**2,388**
Net Cashflow from Investing Activities	**(4,576)**	**(9,540)**	**(11,252)**	**(11,610)**	**(3,012)**	**(2,376)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	-	2,000	8,000	8,500	-	-
Equity Injection - Deficit Support	-	6,000	7,064	-	-	-
Loans Raised	-	-	-	-	-	
	-	**8,000**	**15,064**	**8,500**	**-**	**-**
Cash applied to:						
Equity Repayment	68	68	68	68	68	68
Other	-	-	-	-	-	
	68	**68**	**68**	**68**	**68**	**68**
Net Cashflow from Financing Activities	**(68)**	**7,932**	**14,996**	**8,432**	**(68)**	**(68)**
Overall Increase/(Decrease) in Cash Held	(5,362)	(5,144)	5,165	(4,749)	(1,114)	(513)
Add Opening Cash Balance	11,724	6,362	1,218	6,383	1,634	520
Closing Cash Balance	**6,362**	**1,218**	**6,383**	**1,634**	**520**	**7**

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

As at 30 June for the years ending 2018/19 to 2023/24

Funding Arm	2018/19 Audited Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Revenue						
MoH Revenue	141,835	147,794	158,090	160,456	162,857	165,301
Patient Related Revenue	1,827	2,057	1,845	2,088	2,124	2,166
Other	338	344	3,572	7,308	7,320	7,327
Total Revenue	144,000	150,195	163,506	169,852	172,301	174,795
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	102,373	105,637	109,907	111,500	111,755	111,598
Mental Health	15,125	15,803	17,065	16,308	16,548	16,713
Disability Support	22,415	22,017	26,296	23,508	23,688	23,925
Public Health	631	1,142	595	636	648	654
Maori Health	824	805	899	852	852	861
Governance & Admin	828	840	893	876	900	912
Total Expenditure	142,197	146,244	155,654	153,680	154,391	154,663
Net Surplus/(Deficit)	**1,803**	**3,951**	**7,852**	**16,172**	**17,910**	**20,132**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**1,803**	**3,951**	**7,852**	**16,172**	**17,910**	**20,132**

Governance Arm	2018/19 Audited Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	864	840	940	924	948	961
Total Revenue	864	840	940	924	948	961
Expenditure						
Personnel	1,130	1,210	1,207	1,236	1,260	1,291
Outsourced services	974	918	945	936	936	950
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	415	550	534	468	480	487
Total Expenditure	2,519	2,678	2,686	2,640	2,676	2,728
Net Surplus/(Deficit)	**(1,655)**	**(1,838)**	**(1,746)**	**(1,716)**	**(1,728)**	**(1,767)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(1,655)**	**(1,838)**	**(1,746)**	**(1,716)**	**(1,728)**	**(1,767)**

Provider Arm	2018/19 Audited Actual $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Revenue						
MoH Revenue	897	1,306	1,099	1,068	1,080	1,092
Patient Related Revenue	8,877	9,297	10,009	9,312	9,444	9,624
Other	77,656	79,156	85,738	82,404	84,072	84,912
Total Revenue	87,430	89,759	96,846	92,784	94,596	95,628
Expenditure						
Personnel	66,475	65,754	69,307	70,284	72,036	74,917
Outsourced services	7,735	9,839	7,911	8,100	7,764	7,884
Depreciation	3,390	2,766	4,082	4,540	4,296	4,356
Interest & Capital Charge	1,407	700	4,740	8,690	8,712	8,844
Other	20,120	19,876	19,217	19,428	20,412	20,700
Total Expenditure	99,127	98,935	105,258	111,042	113,220	116,701
Net Surplus/(Deficit)	**(11,697)**	**(9,176)**	**(8,412)**	**(18,258)**	**(18,624)**	**(21,073)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(11,697)**	**(9,176)**	**(8,412)**	**(18,258)**	**(18,624)**	**(21,073)**

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

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
In House Elimination	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(77,680)	(79,370)	(85,567)	(82,788)	(84,456)	(85,308)
Total Revenue	(77,680)	(79,370)	(85,567)	(82,788)	(84,456)	(85,308)
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(77,679)	(79,369)	(85,567)	(82,788)	(84,456)	(85,308)
Total Expenditure	(77,679)	(79,369)	(85,567)	(82,788)	(84,456)	(85,308)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
CONSOLIDATED	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	142,732	149,100	159,191	161,524	163,937	166,396
Patient Related Revenue	10,704	11,354	11,854	11,400	11,568	11,790
Other	1,178	970	4,682	7,848	7,884	7,892
Total Revenue	154,614	161,424	175,727	180,772	183,389	186,079
Expenditure						
Personnel	67,605	66,964	70,517	71,522	73,297	76,211
Outsourced services	8,709	10,757	8,857	9,036	8,700	8,834
Depreciation	3,390	2,766	4,082	4,540	4,296	4,356
Interest & Capital Charge	1,407	700	4,740	8,690	8,712	8,844
Other	85,054	87,301	89,838	90,788	90,827	90,542
Total Expenditure	166,165	168,488	178,033	184,576	185,832	188,788
Net Surplus/(Deficit)	**(11,550)**	**(7,064)**	**(2,306)**	**(3,804)**	**(2,443)**	**(2,709)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(11,550)**	**(7,064)**	**(2,306)**	**(3,804)**	**(2,443)**	**(2,709)**

Appendix 7 System Level Measures Improvement Plan

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

West Coast DHB 2020/21 Annual Plan

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