TATAU POUNAMU

Ki Te Tai o Poutini

MANAWHENUA ADVISORY GROUP

Friday 13 September 2019

@ 10.00 am Board Room, Corporate Services

Agenda and Meeting Papers

ALL INFORMATION CONTAINED IN THESE COMMITTEE PAPERS IS SUBJECT TO CHANGE

TATAU POUNAMU ADVISORY GROUP MEMBERS INTEREST REGISTER

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

Member	Disclosure of Interest
Susan Wallace - Chair Te Runanga o Makaawhio	• Tumuaki, Te Runanga o Makaawhio • Member, Te Runanga o Makaawhio • Member, Te Runanga o Ngati Wae Wae • Director, Kati Mahaki ki Makaawhio Ltd • Director, Kōhatu Makaawhio Ltd • Co-Chair, Poutini Waiora Board ▪ Area Representative-Te Waipounamu Maori Womens' Welfare League ▪ Representative, Te Rununga O Ngai Tahu (Makaawhio) TRONT ▪ Member of Westland High School Board of Trustees ▪ Trustee, Te Pihopatanga O Aotearoa Trust
Ned Tauwhare	▪ West Coast community Response Forum (MSD) Ngai Tahu Rep ▪ Te Rununga o Ngati Waewae Member ▪ Te Rununga o Ngati Waewae Advisor – Kawatiri Role ▪ Te Rununga o Ngati Waewae Advisor – Te Ha o Kawatiri ▪ Te Rununga o Ngati Waewae Advisor – Buller Inter Agency ▪ Te Rununga o Ngati Waewae Advisor – Reefton Partership Forum ▪ West Coast District Health Board Consumer Council – Maori Representative ▪ Te Whare Akoanga Committee (Grey High School)

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING

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

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING
STRATEGIC PLANNING DAY
Corporate Office Boardroom, Friday 19 July 2019
10.00 – 1.00pm

PRESENT:

Anne Ginty, Mawhera Community Representative
Chris Auchinvole, WCDHB Board Representative
Maree Mahuika, Forsyth, Te Runanga O Makaawhio Representative
Ned Tauwhare, Te Rūnanga O Ngāti Waewae
Susan Wallace, Te Runanga o Makaawhio

IN ATTENDANCE:

Gary Coghlan, General Manager Maori Health
Kylie Parkin, Programme Manager, Maori Health
Philip Wheble, General Manager West Coast District Health Board
Joseph Mason, Community Public Health
Richelle Schaper, Poutini Waiora

MINUTE TAKER: Megan Tahapeehi

Mihi Whakatau/Karakia
Susan Wallace & Gary Coghlan

Whakawhanaugatanga
Tatau Pounamu members introduced themselves and we welcomed the newly elected members, Joseph Mason representing Te Runanga o Ngati Waewae to replace Francois Tumahai and Richelle Schaper as our Kawatiri representative in place of Gina-Lee Duncan.

The Chair introduced Whakawhanaungatanga process asking each member to identify their "super power" and what they wanted to achieve for Tatau Pounamu over the next 12 months which were:

- Focus on Health of the Older Persons
- Tatau Pounamu making a difference to our Maori Health statistics relevant to the Te Tai Poutini
- Continuing to communicate to the Board what Tatau Pounamu is doing and what are the priorities and ensuring these relationships are maintained, developed and strengthened.
- The principals that are set by Tatau Pounamu will help guide what we communicate out to our communities.
- Clear understanding of how Tatau Pounamu works for us and how we can truly make a difference.
- Working towards having more Maori into professional roles and how we can improve current staff culturally.
- As a governance group making a change to strategy
- Who are we in the community, profiling what we do better
- Strategically placing ourselves so our voice has the most impact in terms of health services on the West Coast.
- Little steps towards bigger picture.
- Show success to get external influence

"Super Powers" – Members
- Practice what I preach
- Arranger, Maximiser
- Listening and finding a solution to political situations

- Pono, Tika, Aroha – Guiding principals
- God
- Different flair from Maori Health
- Power behind your super powers

Chair thanked everyone for their participation, noting the point of the exercise was not only to get to know a little more about each other but to recognise the different skills, experiences and "super powers" we each bring to the table.

She advised that the aspirations identified for the next 12 months would be pulled together and presented for agreement at the next Hui. This would be used with the TP Work plan be guide and measure our progress.

ACTION: Aspirations to be pulled together into a statement for next hui.

Tatau members agreed strengthening our relationship and way we communicate with the board was one of our strategic focus areas going forward.

ACTION: Invite the Board Chair along to some of our 2019 scheduled meetings. The Board Chair will attend our next hui on Friday 13 September in Greymouth.

AGENDA

1. **Terms of Reference**

   Tatau Pounamu members worked through TOR page by page, with no amendments identified. On that basis Tatau Pounamu reconfirmed by consensus the document in its current form.

2. **Memorandum of Understanding**

   The Memorandum of Understanding is due for renewal. Process requires that it be discussed by Poutini Ngai Tahu and any changes identified then discussed with WCDHB, agreed to and then signed. Any changes made will affect the TOR which will need to be updated and signed off via the Board.

ACTION: The Tatau Chair will advise of an appropriate date for these to be discussed.

3. **Tatau Pounamu Work Plan**

- The existing work plan that has not been updated for some time was reviewed briefly and it was decided that the following areas would be updated and then distributed prior to the next Hui in September for further review for approval. The following areas were highlighted for amendment:

    - Update the terminology where provider names have changed eg; Rata Te Awhina to Poutini Waiora.
    - Include that key reporting updates are received quarterly from; PHO, Poutini Waiora, CPH, Mental Health, Salvation Army, Maori Women's Welfare (Sharon Marsh), WCDHB Leadership Team. Reports or in person.
    - Take the equity actions out of the Annual Plan and included these into the Work Plan template.
    - Ensure that there is key Maori representation on working groups/committees.
    - Ensure that reports or requests are received in advance of time for Tatau Pounamu feedback. At meetings isn't always good timing so email or contacting prior to Hui is often better.

- **ACTION: Discussion then arose around creating a sub group of Tatau Pounamu member to address feedback and response queries when they come in and in a timely manner.**

- Include a section in the Work Plan that identifies what Tatau Pounamu want to achieve over the next 12 months.
- Finalise a Communications Strategy - What is the role of Tatau Pounamu? Discussions were had briefly at our final meeting in December 2018 around an overarching Whanau Ora statement that would feed into a Comms Strategy. To date no further work has been achieved around this. The notes from the December meeting talked about some alignment to what Te Putahitanga were doing within Whanau Ora. **ACTION: Megan will distribute the notes form the December meeting.**
- Community engagement was discussed as something they wanted to achieve this year. Two members talked about doing some work around our Kaumatua and having some hui to show support to these people. **ACTION: Ned and Marie to have some further discussions with Gary and Kylie.**

Adobe Acrobat Document

4. Annual Plan

- **The latest Annual Plan update was provided to Tatau Pounamu members for comment and update.**

Chair acknowledged the latest iteration of the plan and the work that has been carried out. She reminded Tatau Pounamu about their initial feedback, highlighting particularly the equity actions within the plan, their concerns about the lack of aspiration within the actions, which members felt in some cases were very low level and the lack of urgency given many were timed to be actioned in the last quarter. Tatau Pounamu conceded that as this was the first year Equity actions had been included in the plan some leeway should be given Year 1, however, this would be an area TP would pay particular attention to, with an expectation that there be a vast improvement in 2020 plan,

Tatau Pounamu had a further discussion with Phillip Wheble, Grey/Westland General Manager about working to bring effective change or impact over the next 12 months. Mr Wheble advised that engagement with Planning and Funding was important and discussions alongside that group needed to happen to ensure a collective agreement was meet in whatever Tatau Pounamu wanted to achieve. Tatau discussed the potential of one or two of the following:

- Kaumatua Hui "Year of the Kaumatua"
- Mental Health
- Maori Mental Health
- Equity

Discussion also arose around community engagement and how Tatau Pounamu could help to achieve that from what they see as priorities. It was thought that Kawatiri (Buller) would be a good start for community engagement. (Would require partnering up with locality managers and the Maori community)

5. Dr Shahista Nisa – Leptospirosis

- Tatau Pounamu supported the request from Dr Nisa.

ACTION: Megan to prepare a response letter for Chair sign off.

6. Board Hui on Marae

- Further discussions will be had with the Board Chair when she attends the next Tatau Pounamu hui in September.

7. September Tatau Pounamu Hui

- **ACTION: Members bring diaries to prepare for 2010 meeting dates**

MATTERS ARISING SEPTEMBER MEETING 2019

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

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
1.	September 2019	**Workforce Development Plans/Annual Plan** Regular updates provided. Awaiting formal MOH sign off.	Kylie Parkin	**July Meeting**
2.	September 2019	**DNA Update** Ongoing work and discussions continue in this area,	General Manager, Maori	**July Meeting**
3.	September 2019	**Improved Access to Hokitika Health Services** Ongoing.	Chair	**July Meeting**
4.	September 2019	**Hospital Rebuild** Positive engagement and korero continues to occur.. Local iwi continue to stay engaged with the facilities team as work progresses in these areas.	Francois Tumahai	**July Meeting**

DISCUSSION ITEMS

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

TO: **Members**
Tatau Pounamu Advisory Group

SOURCE: **Chair**

DATE: **Friday 13 September 2019**

Report Status – For: **Decision** ☐ **Noting** ☑ **Information** ☐

1. ORIGIN OF THE REPORT

The verbal and in person updates from the following:

2. RECOMMENDATION

That Tatau Pounamu Advisory Group notes the following updates:

- National Bowel Screening
- Child & Youth Wellbeing Strategy
- Facilities Update

OVERVIEW: THE FRAMEWORK

Our Vision: New Zealand is the best place in the world for children and young people.

Essence: Whakatōngia te kākano aroha i roto i ā tātou taitamariki kia puāwai i roto i tō rātou tupuranga aranui oranga.
Plant the seed of love in our children and they will blossom, grow and journey towards the greatest pathway of life.

CHILDREN and YOUNG PEOPLE ...

... are LOVED, SAFE and NURTURED

This means:
- they feel loved and supported
- they have family, whānau and homes that are loving, safe and nurturing
- they are safe from unintentional harm
- they are safe from intentional harm (including neglect, and emotional, physical and sexual abuse)
- they are able to spend quality time with their parents, family and whānau

Indicators:
- Feeling loved
- Feeling safe
- Family/whānau wellbeing
- Injury prevalence
- Harm against children
- Quality time with parents

... have WHAT they NEED

This means:
- they and their parents or caregivers have a good standard of material wellbeing
- they have regular access to nutritious food
- they live in stable housing that is affordable, warm and dry
- their parents or caregivers have the skills and support they need to access quality employment

Indicators:
- Material wellbeing
- Child Poverty: Material Hardship
- Child Poverty: Low income BHC50
- Child Poverty: Low income AHC50
- Food insecurity
- Housing quality
- Housing affordability

.. are HAPPY and HEALTHY

This means:
- they have the best possible health, starting before birth
- they build self esteem and resilience
- they have good mental wellbeing and recover from trauma
- they have spaces and opportunities to play and express themselves creatively
- they live in healthy, sustainable environments

Indicators:
- Prenatal care
- Prenatal exposure to toxins
- Subjective health status
- Preventable admissions to hospital
- Mental wellbeing
- Self-harm and suicide

... are LEARNING and DEVELOPING

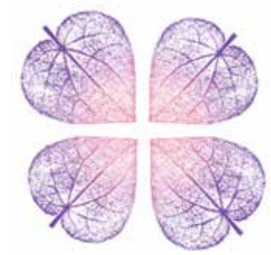
This means:
- they are positively engaged with, and progressing and achieving in education
- they develop the social, emotional and communication skills they need as they progress through life
- they have the knowledge, skills and encouragement to achieve their potential and enable choices around further education, volunteering, employment, and entrepreneurship
- they can successfully navigate life's transitions

Indicators:
- Early learning participation
- Regular school attendance
- Literacy, numeracy and science skills
- Social skills
- Self-management skills
- Youth in employment, education or training

... are ACCEPTED, RESPECTED and CONNECTED

This means:
- they feel accepted, respected and valued at home, school, in the community and online
- they feel manaakitanga: kindness, respect and care for others
- they live free from racism and discrimination
- they have stable and healthy relationships
- they are connected to their culture, language, beliefs and identity including whakapapa and tūrangawaewae

Indicators:
- Ability to be themselves
- Sense of belonging
- Experience of discrimination
- Experience of bullying
- Social support
- Support for cultural identity
- Languages



... are INVOLVED EMPOWERED

This means:
- they contribute positively at home, at school and in their communities
- they exercise kaitiakitanga: care of the land and connection to nature
- they have their voices, perspectives, and opinions listened to and taken into account
- they are supported to exercise increasing autonomy as they age, and to be responsible citizens
- they and their families are supported to make healthy choices around relationships, sexual health, alcohol, tobacco, and other drugs

Indicators:
- Involvement in community
- Representation of youth voice
- Making positive choices
- Criminal offending

The following principles reflect the values New Zealanders have said are important. They guide the development and implementation of the Strategy.

1. Children and young people are taonga.
2. Māori are tangata whenua and the Māori-Crown relationship is foundational.
3. Children and young people's rights need to be respected and upheld.
4. All children and young people deserve to live a good life.
5. Wellbeing needs holistic and comprehensive approaches.
6. Children and young people's wellbeing is interwoven with family and whānau wellbeing.
7. Change requires action by all of us.
8. Actions must deliver better life outcomes.
9. Early support is needed.

Child and Youth Wellbeing

OVERVIEW: CURRENT PROGRAMME OF ACTION

Priorities

1. Reduce child poverty and mitigate the impacts of poverty and socio-economic disadvantage
2. Better support those children and young people of interest to Oranga Tamariki and address family and sexual violence
3. Better support children and young people with greater needs, with an initial focus on learning support and mental wellbeing

CHILDREN and YOUNG PEOPLE ...

... are LOVED, SAFE and NURTURED

Actions to support parents, caregivers, families and whānau:
- Extend paid parental to 26 weeks
- Expansion of Whānau Ora
- Prototype nurse-led family partnership
- New model of intensive intervention

Actions to prevent harm and abuse:
- National strategy and action plan to address family and sexual violence
- Early years violence prevention sites
- Investment in family violence prevention activities, including in diverse communities
- Work programme to prevent online child sexual exploitation and abuse

Actions to support victims and their families and whānau:
- Ensuring safe, consistent and effective responses to family violence
- Improve regional capability to respond to family violence
- Improve access to sexual violence services, eg kaupapa Māori and crisis support services, and improve justice process for victims

Actions to improve the quality of State care:
- Oranga Tamariki Action Plan
- National Care Standards
- Improve outcomes for Māori within the Oranga Tamariki system

... have WHAT they NEED

Actions to improve earnings and employment:
- Increase the minimum wage to $20 per hour by 2021
- Increase employment support through the Ministry of Social Development
- Support for disabled people and people with health conditions

Actions to create a fairer and more equitable welfare system:
- Continue to implement the Families Package
- Indexation of main benefits to wages
- Repeal s.192 of the Social Security Act
- Overhaul the welfare system

Actions to improve housing quality, affordability, and security:
- Establish 6,400 new public housing places
- Implement Healthy Homes Standards
- Warmer Kiwi Homes programme
- Strengthening Housing First
- Funding for continued provision of transitional housing

Actions to help families with the cost of the essentials:
- Free school lunch prototype
- Initiatives to reduce costs of schooling
- Implement lower-cost primary healthcare

.. are HAPPY and HEALTHY

Actions to improve maternity and early years support:
- Redesigning maternity services through the five-year Maternity Whole of System Action Plan
- Review of the Well Child Tamariki Ora programme
- Intensive Parenting Support: Expanding the Pregnancy and Parenting Service

Actions to inspire active, healthy and creative children and young people:
- Healthy Active Learning programme
- Extend and enhance nurses in schools initiative (School Based Health Services)
- Delivery of Strategy for Women and Girls in Sport and Active Recreation
- Creatives in Schools

Actions to increase support for mental wellbeing:
- Expand access and choice of primary mental health and addiction support
- Forensic mental health services for young people
- Suicide prevention strategy
- Promote wellbeing in primary and intermediate schools

... are LEARNING and DEVELOPING

Actions to improve the quality of the education system:
- Develop a statement of National Education and Learning Priorities
- Address learners' needs by improving data quality, availability, timeliness and capability
- Response to review of home-based early childhood education
- Reform of vocational education

Actions to increase equity of educational outcomes:
- Equity Index to provide more equitable resourcing to schools and kura
- Improve learning support: Learning Support Action Plan
- Improve and accelerate education outcomes for Pacific learners
- Fees-Free Tertiary Education and training

Actions to support life transitions:
- New service to support transition out of care or youth justice custody
- Programmes for young people not in education, employment or training

... are ACCEPTED, RESPECTED and CONNECTED

Actions to address racism and discrimination:
- Government work programme to address racism and discrimination
- Restart Te Kotahitanga: supporting equitable outcomes for Māori learners

Actions to increase sense of belonging and cultural connections:
- Implement Maihi Karauna – The Crown's Strategy for Māori Language Revitalisation
- Te Ahu o Te Reo Māori
- Action Plan for Pacific Aotearoa Lalanga Fou
- Funding to support Pacific realm languages
- Implement initiatives under section 7AA of the Oranga Tamariki Act 1989

Actions to promote positive and respectful peer relationships:
- Initiatives to prevent and respond to bullying in schools
- Expand healthy relationship programmes in secondary schools

... are INVOLVED EMPOWERED

Actions to increase representation of child and youth voice:
- Youth Action Plan development
- Youth Health and Wellbeing Survey – whataboutme?
- Youth Voice Project

Actions to improve advocacy for children and young people's rights:
- Build public service competency and capability in children's rights
- Implement the Child Impact Assessment Tool across central government
- Strengthen independent oversight of Oranga Tamariki system and children's issues

Actions to encourage positive contributions:
- Investment in community based youth justice facilities
- Paiheretia te Muka Tāngata initiative: Whānau Ora support for Māori in the Corrections system
- Increased services for children and young people with concerning/harmful sexual behaviours

Child and Youth Wellbeing

CHAIR'S UPDATE

TO: **Members**
Tatau Pounamu Advisory Group

SOURCE: **Chair**

DATE: **Friday 13 September 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

Verbal Update

2. RECOMMENDATION

That the Tatau Pounamu Advisory Group notes and approves any verbal discussion of update.

GM UPDATE TATAU POUNAMU

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

TO: **Tatau Pounamu Chair & Members**

SOURCE: **General Manager, Maori Health**

DATE: **Friday 13 September 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is provided to Tatau Pounamu Manawhenua Advisory Group as a regular update

2. RECOMMENDATION

That the Tatau Pounamu Manawhenua Advisory Group notes this report;

Kia ora Hauora Rangatahi Placement/Exposure Day

The West Coast DHB has completed very successful Kia ora Hauora Rangatahi Placement Programme alongside an Exposure Day pilot.

The Exposure day was in collaboration with Kia ora Hauora, West Coast DHB and Greymouth High School to provide an earlier opportunity of experiencing the health workforce and what there is to offer within its pathways. The one day Exposure Day for year 9/10 provided interactive sessions with our nursing department, physiotherapy, emergency department and discussions with some of our clinical doctors.

We completed our regular yearly 3x day rangatahi placement at the beginning of August and the calibre of students this year was very good. There was a good corium of local Maori and probably the first time where a majority of the group spoke and understood Te reo with an impressive level of fluency

Takarangi Cultural Competency

Participants from the 2018/19 placement have been reengaged as we prepare for a visit from Moe Milne again in November. The intent is to sign off another 4-5 portfolios and to also use her time for professional supervision, cultural competency, a Hui with our DHB Maori staff and mental health.

He waka eke noa – "A canoe which we are all in with no exception"

We are working with Canterbury DHB in the development of a Maori and pacific island workforce plan. The scope of this work is advice that develops the number and capacity of Maori and Pacific Island people working in both DHB. The vision is to build a workforce that mirrors the communities we all serve and a workforce where all feel they are included in and valued by.

The idea is to promote and actively grow our Maori and Pacific workforce using a much focused equity lense approach. The membership includes Allied health, nursing, medical Workforce specialists There is a strong representation from the Maori and Pacifica workforce.

Hapu Wananga

Recently a small roopu travelled to Christchurch hosted by Te Puawaitanga to gather ideas for a Kaupapa Maori Hapu Wananga programme to be developed and delivered by Poutini Waiora. Te Puawaitanga have been very open with sharing their programme and resources with us and have offered continued support as we move closer towards developing hapu Wananga for our whanau on Te Tai Poutini. Our local programme will be funded through SUDI funding; this will allow more flexibility to deliver a Kaupapa Maori and holistic programme.

Cancer Strategy

The Right Honourable Prime Minister Jacinda Ardern and Honourable Minister of Health Dr David Clark released the 'New Zealand Cancer Action Plan 2019–2029' on the 1 September. The Government has a strong focus on achieving equity of outcomes and contributing to wellness for all particularly Māori and Pacific peoples.

Outcome 1: New Zealanders have a system that delivers consistent and modern cancer care – Te huanga 1: He pūnaha atawhai

New Zealanders should expect to receive high-quality cancer care services now and in the future. To make our health and care systems future-proof, we need an approach that involves strong governance, accountability and stewardship. To continue to lift our performance in cancer care, we need to ensure we have strong national leadership, a skilled and sustainable workforce and the right information to make the best decisions possible.

Outcome 2: New Zealanders experience equitable cancer outcomes – Te huanga 2: He taurite ngā huanga

Following a cancer diagnosis, all New Zealanders should experience the best treatment and care, regardless of where they live, whether rural or urban, or who they are. This is critical to ensure we achieve equitable cancer outcomes for all our people.

We will develop service models that better support Māori and Pacific peoples to improve their outcomes. We will partner with different population groups and support our workforce to carry out culturally responsive care, and enable an equal chance of success. Essential to this is increasing the number of Māori and Pacific people in the cancer health workforce, as well as developing cultural safety across the wider workforce.

Outcome 3: New Zealanders have fewer cancers – Te huanga 3: He iti iho te mate pukupuku

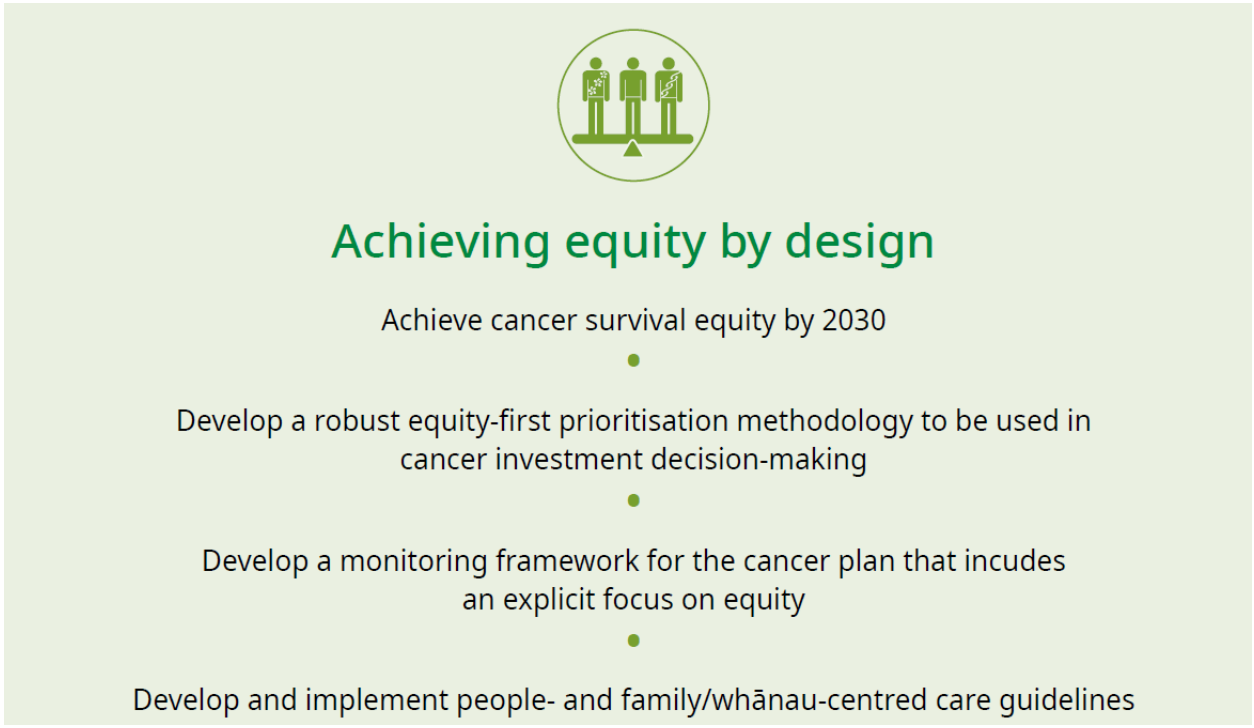
Prevention of cancer could be the biggest contributor to improving overall cancer outcomes, as well as achieving equity.

Outcome 4: New Zealanders have better cancer survival – Te huanga 4: He hiki ake i te oranga

Surviving many cancers is dependent on early diagnosis and an overall system that is well coordinated, information-rich, focused on improving outcomes and that can respond in a timely, effective and appropriate way.

By ensuring New Zealanders receive people- or family/whānau-centred cancer care that is appropriately timed and of high quality, from early detection through to living well with and beyond cancer and end-of-life care, we can lift our survival rates.

We need a cultural shift in the way we deliver health services to all New Zealanders, particularly Māori, Pacific people and other priority populations, to better reflect the needs and values of our communities and deliver modern and consistent care. We need to raise awareness of cancer among our families/whānau and communities, to ensure they make the best decisions they can about their health.



See the Cancer Action Plan 2019 – 2029 on our website: https://www.health.govt.nz/publication/new-zealand-cancer-action-plan-2019-2029

Have your say: https://consult.health.govt.nz/cancer-services/cancer-action-plan

Child Health Strategy

Ministry of Health - Maori Health Action Plan

The Ministry of Health is working with the health and disability sector to develop a Māori Health Action Plan to support and further embed He Korowai Oranga, with a five-year outlook. This will be an important tool ensuring the health and disability sector is working collaboratively to deliver high-quality and effective services that support Māori health and wellbeing.

What the Māori Health Action Plan aims to achieve

The Māori Health Action Plan aims to improve health outcomes for Māori by:

- Setting out priority areas for action, key progress measures, and milestones to meet Treaty of Waitangi obligations for improving Māori health and to achieve equitable health outcomes for Māori.
- Strengthening Māori-Crown relationships, ensuring a shared commitment to act, and enable Māori whānau, hapū and iwi to exercise control over their pathway to health and wellbeing.
- Supporting the role of Mātauranga Māori in the development and delivery of health services to Māori, including the provision of Rongoā Māori.
- Promoting collective action by Government agencies, social sectors (including health), and communities in working towards pae ora.
- Enabling changes across the broader social, economic and behavioural determinants of health as key levers improving Māori health.

You can also provide feedback via an online survey, open until **Friday 20 September**. Alternatively, please get in touch by email: maorihealth@health.govt.nz.

Child Health Strategy

The first ever Child Health Strategy has been launched on the 8th September. The Department of the Prime Minister and Cabinet led the development of the Strategy, in collaboration with other agencies and with the help of 10,000 New Zealanders – including over 6000 children and young people. It draws on the best evidence from social science and cultural wellbeing frameworks.

The strategy has a strong focus on the use of Maori models of care and wellbeing, co-design and the partnership with Maori. Locally we will analyse the strategy and identify how we will use it to drive local strategy and approaches.

Find out more – childyouthwellbeing.govt.nz

West Coast DHB
Annual Plan 2018/19

Delivery against National Priorities & Targets

Photo courtesy of Wendy Elwood

Status Report Quarter 4
April - June 2019

Status Key:

✓	Completed As Planned
↺	Underway (but not yet completed)
×	Delayed / At Risk

Mental Health Services

Population Mental Health Services

NZ Health Strategy link - One Team

Status Report for 2018/19

Performance Reporting Link – PP43

Key Actions from the Annual Plan	Milestones	Status	Comment
Establish a Mental Health Workstream under the West Coast Alliance to oversee the implementation of the new model of care.	Q1: Alliance Mental Health Workstream established.	✓	Workstream established with whole of system membership in place.
Expand enrolment in the Long-term Conditions Management (LTCM) Programme to include people with mental health issues. (EOA)	Q4: 50% of Westport practices enrolling people with mental health issues in the LTCM Programme.	✓	Enrolment in the Buller practice and Coast Medical is ongoing. Rollout of expanded LTCM will commence in Westland from 01 July 2019.
Continue to collaborate with social services, (MSD and Education) through Te Ara Mahi, to support people with mental health issues into employment or further education.	Q4: Increased number of clients supported into employment or education.	✓	There were 6 referrals to Te Ara Mahi vocational services during this period and 30 for the year.
Realign resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based community health model. Implement the new Crisis Response model to provide improved access to crisis services across the age and severity continuum.	Q2: Afterhours crisis response phone service established.	↺	There was an initial delay in this work, to allow the teams to consider the recommendations from the national MH Inquiry. The West Coast's Direction for Change document, supporting implementation of a locality based approach for our mental health services, has since been released (June). Implementation is underway and the after-hours crisis response phone service will be the first focus. Additional resource is also being configured for the inpatient unit.
	Q4: Mental health services integrated into locality bases.	↺	
	Q4: Additional resource in place in the inpatient unit to respond afterhours.	↺	
Review the current provision of Māori Mental Health Services and develop a complementary model that provides improved cultural support for Māori across the continuum. (EOA)	Q1: Stakeholder Hui held.	✓	As above, this work was also delayed to consider the national inquiry recommendations. An engagement Hui was held with a positive participation from across the sector. Feedback was circulated to stakeholders for further input and next steps are now being worked through.
	Q2: Recommendations proposed.	✓	
	Q3: Revised Model Adopted.	↺	
Continue to progress implementation of the national Supporting Parents Healthy Children guidelines and confirm priority actions.	Q2: Implementation Plan agreed.	✓	Action items have been agreed and work is ongoing to finalise reporting requirements.
	Q3: Priority actions identified.	✓	
	Q4: Progress review completed.	✗	
Coordinate the national Mental Health Inquiry Panel visit and provide opportunities for agencies, providers and consumers to be represented and heard by the Panel.	Q1: Publish submission and feedback dates to encourage participation.	✓	Completed in the first quarter of the year.
	Q1: Actively participate and provide feedback to the Panel.	✓	

Key Performance Measures	Result	Comment
>150 Young people (0-19) accessing brief intervention counselling in primary care.	47	
>450 Adults (20+) accessing brief intervention counselling in primary care.	116	
80% of people referred to specialist mental health services are seen within 3 weeks.	84.5%	This result continues to be impacted by those waiting for psychometric testing which is currently provided by an external contractor with limited capacity.
95% of people referred to specialist mental health services are seen within 8 weeks.	93.3%	

Mental Health Improvement Activities

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP7

Key Actions from the Annual Plan	Milestones	Status	Comment
Provide Safe Practice Effective Communication (SPEC) training for inpatient staff. Integrate weekly meetings (with staff and patients) to enable patient participation in decision-making to enhance the environment and safe practices of the unit. Invest in environmental and therapeutic practice changes to support staff to provide a safe therapeutic environment for inpatients. Include cultural expertise in environmental improvements to build cultural awareness amongst staff and improve access to cultural support for consumers and whānau. (EOA)	Q1: 95% of frontline staff receive SPEC de-escalation training.	✓	An Occupational Therapist is currently being recruited to the service.
	Q2: Integrated meetings held weekly.	✓	
	Q3: Additional Occupational Therapy FTE in place to support sensory modulation and meaningful activity for inpatients.	↺	
	Q4: Safe ward concept embedded into everyday practice.	✓	
	Q4: Equity of consumers experiencing seclusion being monitored.	✓	
Commence discharge planning on entry to Mental Health Services, embed the primary nursing model and process for engaging community teams at the earliest opportunity and build patient awareness and participation in transition/wellness planning.	Q1: Transition from inpatient to community services reviewed.	✓	Primary nursing is now embedded with early allocation to Community Mental Health Teams to support the patient journey/pathway. Family involvement in discharge meetings is the current focus.
	Q2: Updated pathway in place.	✓	
	Q3: Patient participation in discharge processes evident.	✓	
Engage staff and patients in the Marama real-time feedback survey to identify opportunities to improve service delivery, particularly for Māori consumers. (EOA)	Q4: 75% of discharged patients complete the Marama survey.	↺	Most feedback has been provided prior to discharge and changes are being implemented to support use of the survey.
	Q4: 75% of discharged Māori patients complete the Marama survey.	↺	

Key Performance Measures	Result	Comment
95% of clients discharged with a transition plan in place (inpatient services)	38.4%	PRIMHD, the Mental Health Quality Team and the Mental Health Team Managers are now required to report monthly to the Clinical Risk Meeting to ensure the target is met by the next quarter.
95% of audited files meet accepted good practice.	53.8%	

Addictions Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP8

Key Actions from the Annual Plan	Milestones	Status	Comment
Realign resources to strengthen community mental health teams and support them to work alongside primary care teams as part of the locality-based community health model.	Q1: Additional mental health respite capacity available in Buller.	✓	Respite is now being provided by a local ARC provider, in partnership with Community Mental Health Team, and this is working well.
Implement the new AOD Crisis Response model to provide improved access to crisis services across the age and severity continuum.	Q2: Additional community-based AOD support options identified.	✓	A new service has commenced and is being implemented by the Salvation Army.
Investigate options to increase community-based respite, withdrawal management and recovery support, particularly for Māori. (EOA)	Q4: Increased AOD capacity available.	✓	

Key Performance Measures	Result	Comment
80% of people referred to specialist addiction services are seen within 3 weeks.	64.1%	We anticipate increased community options and the realignment of resources across locality bases will improve wait times going forward.
95% of people referred to specialist addiction services are seen within 8 weeks.	83.5%	

Primary Care Services

Service Access

NZHS Link – Closer to Home

Status Report for 2018/19 | Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with the West Coast PHO to implement the national zero fees policy, extending zero fees for children <13 to zero fees for children <14. (EOA) Work with local Pharmacies to ensure they update systems to align with the national policy. (EOA) Work with the West Coast PHO to implement the national lower fees for Community Services Card holder policy. (EOA) Update the DHB and PHO websites in line with the implementation of zero fees policy, showing details of practices' fee arrangements.	Q2: Proposed new zero fees model communicated and agreed.	✓	All general practices on the West Coast have signed up to the zero fees for children under 14 years and the initiative to provide 'lower cost general practice visits'. Adults with a Community Services Card (CSC) who are enrolled with a general practice pay no more than $18.50 for a standard visit and young people (14 to 17), who have a parent or caregiver with a CSC are charged no more than $12.50.
	Q2/Q3: Implementation of zero fees model for children <14 (both in and out of hours).	✓	
	Q4: PHO/DHB websites updated to reflect changes in fees.	✓	
	Q4: 95% of children <14 have zero fee access to general practice services and prescriptions.	✓	

System Integration

NZHS Link – Closer to Home

Status Report for 2018/19 | Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to invest in the West Coast Alliance as a mechanism for leading service and system improvements. Engage system partners in the Alliance's new Mental Health Workstream to support the implementation of the locality-based mental health service model. Ensure a strong Māori voice and focus on Alliance workstreams. (EOA) Monitor system performance against the national System Level Measures (SLM) to identify areas for improvement and focus.	Q1: New Alliance Chair is appointed to vacant role.	✓	An independent Chairperson has been identified and they will be in place for the first meeting of 19/20. Work to highlight equity through various reports continues with performance results for Māori included wherever this is captured. Narrative relating to activity to address inequity is included at all levels of performance reporting. Work to develop a refreshed dashboard is underway, capturing ideas from other DHBs. Actions in the SLM Improvement Plan have been delivered.
	Q2: Work plan for the Mental Health Workstream endorsed by the Alliance Leadership Team.	✓	
	Q2: Equity reporting dashboard developed.	↺	
	Q4: Delivery of the actions agreed in the SLM Improvement Plan.	✓	
Work through the West Coast Alliance to refresh and refine the SLM Improvement Plan, outlining collective activity to improve performance in 2018/19.	Q1: Implementation of agreed SLM Improvement Plan underway.	✓	The SLM Plan was agreed and approved by the Ministry. It is now being implemented.
	Q1: Quarterly review of progress against the Improvement Plan.	✓	
Continue to develop a rural generalist workforce model to support the transformation of service models on the Coast. Invest in a lead role to support an integrated Dietetic and Nutrition Service, working across DHB, PHO and CPH areas of service delivery. Recruit and develop more nurse practitioners to support care in primary health settings.	Q1: Rural Hospital Medical Specialist (with extended scope in Obstetrics) engaged.	✓	The lead clinician for Nutrition Service continues to be discussed in the context of the DHB's new organisational structure and the services' plans for the coming year. Three Nurse Practitioners are in place; one in unplanned care, one in LTCM and one in Mental Health.
	Q3: Lead clinician engaged to provide oversight to nutrition services.	↺	
	Q4: Three Nurse Practitioners working in primary care.	✓	

CVD and Diabetes Service Improvement

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP20

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with the PHO and general practices to maintain the proportion of the eligible population receiving a CVD and Diabetes Risk Assessment at or above 90%. Engage Poutini Waiora to identify and contact Māori men to lift the Risk Assessment rates for this high-risk population. (EOA)	Q1: Monthly performance reporting by general practice.	✓	The West Coast PHO is actively monitoring results by ethnicity and working with Poutini Waiora to implement key actions to support the uptake of CVD assessment by Māori men as a high-risk group.
	Q1: Monthly performance reporting by ethnicity.	✓	
Work with Health Quality & Safety Commission to further advance the Whakakotahi work plan by trialling evidence-based care pathway improvements in two primary care pilot sites. Target improvements in engagement with Maori as a high risk group. (EOA)	Q1: Two Whakakotahi pilots underway.	✓	The pilot project in the Buller region was re-scoped and linked in with Poutini Waiora to better support Maori with diabetes. The initial evaluation has indicated this has been successful in targeting high risk groups. The Grey Medical Practice in Greymouth is now looking at implementing the pilot trialled in Buller, targeting high risk groups. The second pilot project in Greymouth, focussing on pre-diabetes, was halted as patient data evaluation did not support project continuation.
	Q4: Completion of Phase I of the pilot with assessment of pathway improvements.	✓	
Establish a visiting specialist vascular surgical outpatient service to support diagnosis and treatment for West Coast patients, without the need to travel. (EOA)	Q1: Visiting Specialist Vascular service established.	✓	
Continue to support community-based initiatives to engage and enrol people with diabetes in the primary care LTCM Programme so that people can be supported to make lifestyle changes to help reduce their risk, with a particular focus on Māori as a high needs population group. (EOA)	Q1: Retinal screening expo and clinic in Reefton and Greymouth.	✓	Four week-long Retinal Screening Expo clinics were held this year in Reefton and Greymouth in August 2018, Greymouth and Westport in November 2018, Greymouth and Hokitika in March 2019 and Westport in June 2019.
	Q4: Three pre-diabetes and high risk CVD dietitian clinics delivered.	✓	
	Q4: Three Living Well with Diabetes courses delivered.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
90% of the eligible population had a CVD risk assessment in the last 5 years.	87.3%	86.5%	305 more people needed to have complete their CVDRA to meet the target for the whole population.
90% of eligible Maori men (35-44) have had a CVD risk assessment in the last 5 years.		70.9%	Only 29 more Maori men needed to be reached to meet this target.
90% of the population with diabetes, have had an annual HbA1c test.	81%	81%	To reach the target, another 11 Maori and 77 non-Maori would have needed to have had their annual HbA1c tests in the last year.

Pharmacy Action Plan

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Participate in the national process to develop and implement a new service agreement for integrated community pharmacy services. Offer the new agreements and opportunities to improve integration of local services.	Q2: West Coast pharmacies have new 'evergreen' pharmacy service agreements in place.	✓	All West Coast pharmacies are signed up to the new agreements.
Further develop the Pharmacy Long-Term Conditions Service, to improve access to pharmacist support for people on multiple regular medicines. (EOA) Support more pharmacists to provide medication use reviews (MURs) for people taking many or high-risk medicines. (EOA)	Q3: Two more pharmacists accredited to provide MURs.	✗	This was an ambitious target with limited availability of pharmacists to provide medicines management support for patients via LTC and MUR services. The number of people enrolled in LTC service has fallen and is now at 657.
	Q4: >20 people receive a MUR from their pharmacist.	✗	
	Q4: >900 people are enrolled in the Long-Term Conditions Service.	✗	
Work with the national Expert Advisory Group to develop a Minor Ailments (pharmacy) Initiative to ease access to timely treatment for Community Service Cardholders. (EOA)	Q4: Minor Ailments Initiative developed and put forward for approval.	✗	The Expert Advisory Group is still to complete development of a Minor Ailments service model.

Newborn Enrolment

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – SI18

Key Actions from the Annual Plan	Milestones	Status	Comments
Establish a process to support general practice enrolment as part of the current new-born multi-enrolment process and complete a review of the multi-enrolment form to ensure it is meeting the stakeholder needs. Work with Plunket and Poutini Waiora to develop a Kaupapa Māori Pregnancy & Parenting Education Programme. (EOA) Ensure the Programme emphasises the importance of enrolling with primary care to support engagement with health services. (EOA)	Q2: Process to support general practice enrolment developed.	✓	A proposed model for Kaupapa Māori PPE has been developed. Planning is underway for delivery of the first cohort.
	Q2: Kaupapa Māori PPE Programme developed.	✓	
	Q3: New-born enrolment form review completed.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
85% of new-borns are enrolled with general practice by 3 months of age.	110%	83.3%	15 out of 18 Maori babies were enrolled with a general practice by three months of age on the West Coast for quarter four

Support to Quit Smoking

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Identify smoking patients newly enrolling in the primary care LTCM Programme for mental health concerns, with the goal of offering them stronger support to quit smoking.	Q2: Process for capturing new patients established.	✓	All patients enrolled in the LTCM are asked about their smoking and offered support to quit.
	Q4: Identified patients contacted by Stop Smoking Service.	✓	
Work with the Buller Health Practice to identify Māori smokers and ex-smokers who have not been appropriately screened for COPD. (EOA) Work with Poutini Waiora to engage those patients in spirometry clinics, where screening, smoking cessation advice and other opportunistic referrals can be offered. (EOA)	Q2: Process for capturing Māori smokers and ex-smokers age 35+ established.	✓	The Buller Health team including Respiratory Nurses Specialist along with Poutini Waiora Whānau Ora nurses have proactively invited smokers and ex-smokers to come along with their whānau to undertake spirometry testing and engage in discussions about smoking cessation options and other lifestyle changes.
	Q4: Identified patients and appropriate whānau invited for COPD screening.	✓	
Work with the PHO and Well Child Tamariki Ora providers (collecting smokefree status data) to improve data collection and establish how whānau being offered brief advice and cessation support can be captured.	Q2: Data collection for smokefree household measure in place.	✓	The new data capture system was implemented in early March. It was agreed that the offer of brief advice to whānau through a WCTO visit should be captured in the WCTO notes.
	Q4: Process for ABC data capture in Patient Management System investigated.	✓	

Key Performance Measures	Total Result	Maori Result	Comment
90% of PHO enrolled patients who smoke are offered brief advice/support to quit.	96%	96%	The PHO continues to maintain high rates of smoking status ever recorded for patients (99%).
90% of West Coast households with a newborn have their smokefree status recorded at the first core Well Child check.			Data has not been released by Ministry of Health for this measure

Child Health Services

Maternal Mental Health Services

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP44

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to support the use of free general practice consultations for pregnant women with medical, mental health or social issues that may be exacerbated by pregnancy. (EOA) Promote the maternal mental health service referral pathway using HealthPathways. Review the timeliness of referrals from LMCs to Well Child providers, with a focus on Māori as a population of higher need. (EOA)	Q1: Review of maternal mental health pathway complete.	✓	The DHB continues to support stronger relationships between West Coast LMCs and WCTO providers, in order to support timely referral and handover.
	Q2: Promotion of pathway to increase uptake.	✓	
	Q3: Review of referral timeliness completed and opportunities for improvement identified.	✓	The DHB continues to advocate for improved visibility of all WCTO Core check data in order to support quality improvement actions in this area.
Identify all community-based DHB funded services and initiatives currently in place to support maternal mental health and the number of women being supported.	Q2: Stocktake report completed.	✓	A stocktake has been completed and submitted to the Ministry. Work continues to improve data capture in relation to the Maternal Mental Health Pathway so that referral and access rates to services can be reported and monitored. In 2018/19, 3 women accessed the free primary practice appointments available for women experiencing mental health concerns in pregnancy.
	Q4: Access report provided to the Ministry of Health.	✓	

Child Wellbeing

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP27

Key Actions from the Annual Plan	Milestones	Status	Comments
Work collectively to increase the number of pregnant women (and partners) engaging in the Smokefree Pregnancy Incentives programme. Extend the schedule for incentives to support continued engagement with cessation services beyond birth, to promote a smokefree home environment for babies.	Q1: Pregnancy Incentives programme model reviewed.	✓	The programme continues to track well with good uptake from women. Success stories have not yet been published as women have been reluctant to 'go public' with their story, however overall results of the programme will be shared in the DHB Quality Accounts and one whānau (two sisters and their partners) is working with the DHB on a story for early in the new year.
	Q2: Opportunities to enhance the Programme actioned.	✓	
	Q4: Successes of women who have successfully quit are celebrated.	↺	
Continue to train volunteer peer supporters through the Mum4Mum programme, with a focus on Māori supporters to extend the reach of the service. (EOA) Investigate strategies to link high need populations to a Mum4Mum supporter. (EOA)	Q2: Opportunities to enhance the programme actioned.	✓	Only one new Mum4Mum supporter trained this year has identified as Māori. A further two unfortunately withdrew their commitment prior to commencing training. The team continues to work with key stakeholders to try and identify women who are willing to complete the training course.
	Q4: An increased number of Māori mothers trained as peer supporters.	↺	
Establish a Transalpine Oral Health Service Development Group to support a whole of life approach to good oral health. Promote the Newborn Enrolment Form to support early enrolment of children with the Community Oral Health Service. (EOA) Identify opportunities for health promotion and education for families whose children are hospitalised for dental surgery. (EOA)	Q1: West Coast Development Group membership confirmed.	✓	The Healthy West Coast Alliance workstream is leading the development of a cohesive Oral Health Promotion plan that capitalises on opportunistic contacts as well as creating supportive environments.
	Q1: Childhood Nutrition/Health Promotion role supporting Early Childhood Centres established.	✓	
	Q2: Practice Nurses complete 'Lift the Lip' checks at immunisations.	✓	
	Q2: 'Water Only' policies in place in West Coast schools.	✓	
Continue to invest in the Violence Intervention Programme (VIP) and activity to support a reduction in harm and adverse health outcomes.	Q1: VIP training sessions ongoing.	✓	Audit results were positive 84/100.
	Q4: VIP audit results >70/100.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
95% of children (0-4) are enrolled with Community Dental Services.	101%	90%	There are denominator issues with these ethnicity results, which are based on projected population figures. The 'Other' population enrolment rate was 105%. In total there were 5,089 children enrolled.
90% of enrolled children (0-12) are examined according to plan.	96%	93%	There were 225 children overdue, 60 of those children were Maori.
85% of adolescents (13-17) are accessing DHB-funded oral health services.	75.7%		The DHB was 160 young people short of the target.

Supporting Health in Schools

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP39

Key Actions from the Annual Plan	Milestones	Status	Comments
Support the Health Promoting Schools framework in lower decile and schools with a high proportion of Māori/Pacific students. (EOA) Support the roll out of the 'Water Only in Schools' programme as part of good oral health promotion and an enabler to wellbeing. Undertake a stocktake of all initiatives currently underway to support health in schools. Review the 2018 Greymouth Schools Wellbeing Survey and identify actions for improvement.	Q2: Schools recruited to develop 'Water Only' policy.	✓	Poutini Waiora is now leading work around defining Wellbeing using the WHO model and how to incorporate supports for this into daily school business.
	Q2: School Wellbeing Survey reviewed.	✓	
	Q2: Stocktake report completed.	✓	
	Q3: Service improvement recommendations developed and agreed.	✓	

Immunisation

NZHS Link – One Team

Status Report for 2018/19

Performance Reporting Link – PP21

Key Actions from the Annual Plan	Milestones	Status	Comments
Monitor and evaluate immunisation coverage at DHB, PHO and general practice level, to maintain coverage and identify unvaccinated children. Fill the vacant Māori provider role on the Immunisation Advisory Group to ensure a strong focus on Māori as a priority group. (EOA) Continue with a focus on pregnancy vaccinations and LMCs having immunisation conversations. Share refreshed immunisation process charts and prompts for difficult immunisation conversations. Support general practice to promote the co-delivery model for HPV and Tdap.	Q1: Quarterly review of vaccination and decline rates by ethnicity.	✓	Work is underway on the development of the Difficult Conversations training programme with a programme outline developed and a model for delivery being confirmed for 2019/20.
	Q1: Māori representative on the Immunisation Advisory Group.	✓	
	Q2: Refreshed process chart issued to general practice.	✓	
	Q2: HPV and Tdap Information and education resources issued.	✓	
	Q4: Difficult Conversations training options explored for practice nurses.	↺	

Key Performance Measures	Total Result	Maori Result	Comments
95% of 8-month-olds fully immunised.	75%	85%	Four consenting children were missed this quarter with a high combined opt-off and decline rate of 20.3%.
95% of 2-year-olds fully immunised.	82%	88%	Two consenting children were missed this quarter. The combined opt-off and decline rate was 16.6%.
95% of 5-year-olds fully immunised.	90%	83%	Two consenting children were missed this quarter. The combined opt-off and decline rate was 7.7%

School-Based Health Services (SBHS)

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP25

Key Actions from the Annual Plan	Milestones	Status	Comments
Engage decile 4 schools in the School Based Health Services (SBHS) programme. Undertake a stocktake of all SBHS currently provided in West Coast secondary schools. Work with decile 1-4 schools to identify barriers to participation in routine health assessments with particular focus on Māori children. (EOA) Work with schools and providers to develop an implementation plan for expanding SBHS to all public secondary schools on the West Coast.	Q2: Stocktake report completed.	✓	SBHS are now in place at three of the four decile 1-4 schools and both Alternative Education facilities on the Coast. Work continues to finalise a MoU with the last school. An implementation plan has been provided to MoH, which outlines timeframes, enablers and constraints for full roll out of SBHS to all secondary schools on the West Coast.
	Q2: Barriers to access identified.	✓	
	Q4: Implementation plan completed and provided to MOH.	✓	
	Q4: SBHS in place in all West Coast 1-4 decile schools.	↺	

Key Performance Measures	Total Result	Maori Result	Comments
95% of eligible year nine students received a Routine Health Assessment (including a HEEADSSS assessment) in the last calendar year.	54%	32%	Changes in staffing within the Public Health Nursing team have impacted on service delivery.

Responding to Childhood Obesity

NZHS Link – Value and High Performance

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Engage a community-based dietitian to work alongside Public Health Nurses to provide advice and support to families regarding healthy weight in childhood at their B4 School Check.	Q2: Dietitian attending B4SC clinic days in Greymouth.	✓	A dietitian continues to attend B4 Schools Clinics held in Greymouth to provide information/hand-outs, as well as meeting with families and providing support and advice. The dietitian resource required to cover all B4SC clinics has been identified and work continues with the team to ensure this model is supported whenever possible outside of the Grey district.
	Q4: Resource required to provide support at all clinics identified.	✓	
Provide primary care teams with training and education regarding healthy weight in childhood to support appropriate onward referrals for family/whānau support.	Q2: Training and education needs identified by practices.	✓	
	Q4: Training/education delivered.	✓	
Work with the Ministry of Education to develop an improved process for children with disabilities to access B4 School Checks and discuss healthy weight in childhood with a dietitian. (EOA)	Q1: Process for identifying children with higher needs developed.	✓	
	Q4: Process agreed with Education.	✓	

Key Performance Measures	Total Result	Maori Result	Comments
95% of children identified as obese at their B4 School Check are offered a referral to a health professional for clinical assessment and family-based lifestyle intervention.	100%	100%	Results for the Raising Healthy Kids measure are reflective of local data. Ministry will not be releasing quarter four results. 166 checks were completed during quarter four. 14 children were identified as obese and offered a referral.

Older Person's Health Services

Healthy Ageing

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP23

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with partner organisations through the Health of Older People Workstream and Falls Coalition to enhance and integrate falls and fracture prevention services. Engage local providers to accredit community strength & balance classes, including a number specifically designed and targeted towards older Māori. (EOA) Embed the fracture pathway to ensure people with a fractured Neck-of-Femur (NOF) are referred to the in-home Falls Prevention Service.	Q1: St John representative attending Falls Coalition meetings.	✓	A Maori focussed community exercise class is being held, however the class is not yet accredited and we continue to work with them to achieve this. The NOF pathway work has been delayed due to some wider work being done with ATR within Grey Base hospital. The Fracture Liaison Service will progress very shortly with the appointment of a new staff member.
	Q2: Review and integration of osteoporosis and falls prevention referral pathways complete.	✓	
	Q3: Māori focused community strength & balance class accredited.	↺	
	Q3: NOF pathway embedded.	↺	
	Q4: Virtual Fracture Liaison Service operational.	↺	
Encourage service providers to consider Māori health needs from 50+ to enable older Māori to maintain good health. (EOA) Engage the Māori Needs Assessor to complete InterRAI assessments to ensure an appropriate response for older Māori with complex health issues. (EOA) Employ a Clinical Nurse Specialist to embed and promote the early supported discharge service (FIRST) ensuring the screening and referral of older people to appropriate discharge options.	Q2: InterRAI reporting framework in place and assessment rates tracked by ethnicity.	✓	Recruitment is ongoing for a Maori Clinical Assessor; Poutini Waiora is engaged in the process but as yet this process has not been successful in identifying a candidate. Six clients have completed the FIRST programme since August 2018.
	Q2: CNS appointed to support FIRST.	✓	
	Q3: Baseline established InterRAI assessments per 1,000 population.	✓	
	Q4: Three people admitted to the FIRST service.	✓	
Analyse the 75+ cohort presenting at ED and investigate potential interventions. Analyse the 75+ cohort with repeat acute admissions and investigate potential interventions. (EOA)	Q1: Analysis of ED and repeat acute admissions undertaken.	✓	We have reviewed acute admissions from ED and are in the process of identifying areas where alternative community pathways could be used. The PHO is also identifying all patients who have LTCH conditions and ensuring they have an acute care plan in place
	Q2: Strategies to address repeat cohort presentations and admission identified.	✓	

Key Performance Measures	Result	Comments
720 places available at approved strengths and balance classes.	506	There were 261 attendees at classes in the last quarter.
120 referrals made to the Falls Prevention Service.	105*	This is a preliminary number, the final month is yet to be confirmed.
95% of long-term Home Based Support Services clients have had an InterRAI assessment and have a completed care plan in place.	N/A	During quarter four 81 homecare inteRAI assessments were completed and 43 contact inteRAI assessments.

Improving Systems

Strengthened Delivery of Public Health Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – SI16

Key Actions from the Annual Plan	Milestones	Status	Comments
Implement the planned/ unplanned care model, incorporating a new approach to the provision of after-hours and urgent and emergency care as the DHB transitions to the new Grey Hospital and develops its model of care in Westport. Work with the Ministry to ensure external contracting, reporting and funding mechanisms do not create artificial barriers or restrict development of the new model.	Q2: Communication plan for new planned/unplanned care pathways developed.	↺	Planned and unplanned pathways have been implemented at Grey Medical and we continue to work on improving these and widening the coverage to our community. Delays to the facilities build in Grey will mean some actions around the new model and extended hours won't be implemented until 2019/20.
	Q3: New model allows people to be seen and treated in the right place.	↺	
	Q4: Primary care hours extended to provide greater access to care.	×	
Establish a centralised Hub for the delivery of assessment and coordination services to enhance the integration of services.	Q4: Centralised support service (that includes bookings and community assessments) in place.	↺	A project is underway but further work around this will continue into the next year. Co-location is a key enabler and the new administration facilities that will be completed at the end of the calendar year will enable this to occur.
Realign resources to support implementation of the locality-based services model with three integrated health service spokes in Northern [Buller], Central [Grey] and Southern [Westland].	Q1: Northern integrated health service in place.	✓	The implementation of the locality based services model is now underway for the Central and Southern areas. The Northern area is already in place.
	Q4: Central and Southern integrated health services in place.	↺	
Consider the provision of services currently under hospital management and explore how the DHB might better meet the needs of the population as part of the wider integrated service model.	Q1: Review of OT and Audiology Services completed.	✓	The review of OT has been completed, and a review of the audiology service is now underway. Work is underway to understand capacity for dementia services.
	Q1: Opportunities to provide greater access to residential dementia services explored.	✓	
Invest in the development of a rural generalist workforce model to enable the transformation of models of care and support the sustainability of our system. Design a communications and recruitment strategy that communicates the rural generalist model and attract professionals interested in this way of working.	Q1: Communications and recruitment strategy implemented.	✓	Implementation of the rural education and training cluster is now underway. Obstetrics, General Medicine and Anaesthetics will be the services where we will develop our rural medical generalist approach. Training programmes have been identified to enable this. We have one Rural Generalist with an extended scope in Obstetrics.
	Q4: Rural education and training cluster implemented.	✓	
	Q4: Pathways for development of rural medical generalists identified.	✓	
	Q4: Extended scope roles in place.	✓	

Disability Support Services

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – SI14

Key Actions from the Annual Plan	Milestones	Status	Comments
Form a transalpine West Coast/Canterbury DHB Diversity Training Group to develop a diversity education framework. Engage the Disability Steering Group and Māori and Pacific leads to ensure content is consumer focused and culturally appropriate. (EOA) Engage subject matter experts to develop disability training modules, building on the e-learning work completed in 2017/18. Track uptake and feedback on modules as a means of evaluation.	Q1: Diversity Training Group established.	↺	There have been initial delays with this work but a number of enablers are now in place or underway: the appointment of the Care Starts Here Programme Manager, the initiation of the Diversity Inclusion and Belonging Policy, and the coming together of members from the Disability Steering Group to discuss 'what change looks like'. This provides the basis for a diversity learning framework and there is more clarity on the scope of training linked to the intended behaviour change. This work has been reprioritised for 2019/20.
	Q2: Diversity education framework approved.	×	
	Q2: Development of training modules complete.	×	
	Q3: Disability training modules launched on HealthLearn.	×	
	Q4: Report on uptake of training modules.	×	

Key Performance Measures	Result	Comment
Percentage of staff completing disability training modules.	1,423	This relates to the current online training module available for staff through healthLearn.
Percentage of staff rating content positively.	NA	The currently online module does not include evaluation measures

Shorter Stays in Emergency Departments

NZHS Link – Value and High Performance

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Implement a Short Stay Unit in the new Grey-base Hospital facility, to streamline and support the improved flow and observation of patients.	Q1: Criteria for short stay admission and discharge developed.	✓	This work is underway with short stay criteria developed and workforce projections completed. However, further implementation has been held-up due to ongoing delays with the new Grey Base Hospital build.
	Q2: Workforce requirements and FTE determined.	✓	
	Q3: Recruitment underway.	↺	
	Q4: Unit operational.	↺	
Establish a duty nurse (patient flow manager) manager role, within hours, to assist with patient flow and admission and discharge planning across the wards.	Q1 Role scoped and agreed.	✓	This position has been recruited to with a start date of Q1 19/20. The impact of the role will be reviewed after the position has been in place for a year.
	Q2 Role recruited.	✓	
	Q3 Review of impact and focus.	×	
Map the journey for Maori across the rural health continuum (primary to secondary care) and determine areas of focus to improve earlier engagement. (EOA)	Q3: Journey Mapped.	↺	This action has been delayed due to a change in staff, however meetings have now been set for this project to commence in quarter one 19/20.
	Q4: Opportunities identified and prioritised.	×	

Key Performance Measures	Total Result	Maori Result	Comment
95% of patients are admitted, discharged, or transferred from ED within 6 hours.	98.2%	98.3%	
<20% of patients are admitted from ED short stay unit to inpatient wards.	37%		586 patients were admitted in Q4.
<64% of presentations to Grey Base ED Reduction are triage level 4-5.	54%		The ethnicity breakdown of this measure will be available Q1 19/20
>8/10 average for in-patient survey domain rate your experience of communications.	8.5	NA	Latest result to November 2018.

Cancer Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP30

Key Actions from the Annual Plan	Milestones	Status	Comments
Use data/intelligence systems to monitor the 62-day and 31-day wait time targets and support discussions with specialties missing targets. Undertake breach analysis for patients outside the 62-day target to assess emergent systemic issues that might need corrective action and identify opportunities to reduce process delays. Work with the Southern Cancer Network to support regional initiatives and tumour stream pathway developments that improve equity of access for West Coast patients. (EOA)	Q1: Quarterly monitoring of cancer wait times and analysis of any cases where there are delays.	✓	Monitoring of cancer wait time delays for individual patients is actively undertaken by West Coast DHB's Cancer Nurse Coordinator. The Te Wai Pounamu Maori Leadership Group has endorsed the Southern Cancer Network Equity Assessment Framework for progressive implementation in all work programmes.
	Q2: Improvements identified and implementation underway.	✓	
	Q3: Adopt learnings from the Southern Cancer Network equity assessment framework pilot.	✓	
Engage locally in the regional Te Waipounamu Māori Cancer Pathway Project to support improved outcomes for West Coast Māori. (EOA) Adopt a collective approach to improving cervical and breast screening rates for Māori women.	Q2: Cancer Korero Booklet developed and disseminated.	↺	Publication of the Cancer Korero booklet is underway and it is anticipated this will be completed in Q1 2019/20. The three planned cancer korero hui to promote cancer korero have also been delayed until Q2 19/20. Cultural competency training has been delivered to General Practices in Greymouth and to Poutini Waiora, with further training planned for other areas.
	Q4: Three cancer korero hui held to improve cancer health literacy amongst Māori whānau.	×	
	Q4: Cultural competency training and education package developed and presented to GP practices.	✓	
Incorporate references and links to Kupe (the national prostate cancer decision support tool) into HealthPathways and HealthInfo to support men and their families to understand the risks and benefits of treatment, before having a prostate cancer check.	Q2: Kupe link on HealthPathways to support GPs to have conversations with their patients.	✓	Kupe links have been established.
	Q2: Kupe link on HealthInfo to support patients and their families to make informed decisions.	✓	
Continue to engage with and provide input into community initiatives that support people and their families following, cancer treatment. Engage with the Southern Cancer Network to identify opportunities for the Coast arising from the regional engagement and survivorship initiative pilot.	Q2: Input and support provided to the Cancer Society (Living Well Programme) and Poutini Waiora for delivery of survivorship initiatives.	✓	A Living Well workshop held Greymouth on 13 April 2019, with a host of smaller targeted group sessions also being delivered. West Coast DHB is engaged in the following regional priority focus areas: improving lung cancer pathways, roll-out of MOSAIQ, and increased use of clinical Multi-Disciplinary Meetings for reviewing individual patient care. The DHB's Cancer Nurse Coordinator also sits on the regional Clinical Governance and Operational Leadership Group.
	Q2: Input into regional feedback sessions on end-of-treatment needs.	✓	
	Q4: Review of regional opportunities.	✓	

Key Performance Measures	Total Result	Maori Result	Comment
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.	73.7%*	NA	Small numbers are challenging with this result reflecting only five patients who were not seen within the 62 day period. Every non-compliant case individually followed up. Most non-compliant cases are physically, psychologically, or diagnostically challenging. *Note: Ethnicity data is not provided by the MoH and results for Q4 are preliminary.*
85% of patients receive their first cancer treatment (or other management) within 31 days of date of a decision-to-treat.	89.6%*	NA	

Elective Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP45

Key Actions from the Annual Plan	Milestones	Status	Comments
Establish a clinical governance alliance to support a 'One Service' approach to orthopaedics across Canterbury and West Coast DHBs. (EOA) Invest in additional capacity in plastics to improve timely access to treatment. (EOA)	Q2: Transalpine Orthopaedic clinical governance alliance established.	✓	Transalpine Orthopaedic Service in place with joint governance.
	Q2: A Plastics Fellow is in place, as part of the transalpine plastics service.	✓	Several visits by the Plastics Fellow occurred during 2018. We now have regular plastics visits.
Review current booking system processes to identify opportunities to improve the uptake of appointments and access to services. Facilitate cross-system collaboration between booking teams and Poutini Waiora to identify solutions for better engaging with Māori. (EOA) Develop criteria to help identify patients who would be suitable for telehealth clinics, to reduce their need to travel. (EOA) Work with the Ministry to develop consistent rules for counting telehealth events, to ensure activity is appropriately captured.	Q1: DNA service level data used to identify initial areas of focus.	↺	Further data development is required to enable identification of cohorts for the DNA project. This will take place in Q1 2019/20. Electronic delivery of patient appointments is being tested before being fully enabled. Rollout of software-based VC has commenced with telehealth criteria developed and clinics identified and counted via the DHBs patient management system.
	Q2: Electronic delivery of patient appointments enabled.	↺	
	Q3: Business case developed for software-based VC capability.	✓	
	Q4: Telehealth criteria developed.	✓	
	Q4: Process for counting telehealth events in place to recognise activity.	✓	
Engage with Poutini Waiora to established closer links with Māori patients at the pre-presentation and discharge phases to support people to attend appointments. Deliver Tikanga Best Practice training to staff, to support patients to feel culturally comfortable with the care they are given.	Q3: Process in place to offer Māori patient's additional support through their elective patient journey.	↺	Engagement work underway via Tautau Pounamu. Training has not been able to be delivered due to capacity constraints and will resume in again in 2019/20
	Q4: Four Tikanga Best Practice sessions delivered.	✗	

Key Performance Measures	Total Result	Maori Result	Comment
1,916 elective surgeries delivered.	101.3%	NA	The West Coast DHB had provided 1,940 elective surgical discharges to June 2019, slightly higher than anticipated.
100% of people are seen for their First Specialist Assessment within four months (ESPI2).	97%	NA	Results as are at June 2019 and relate to 25 patients who waited outside of timeframes for their FSA and 24 who waited outside of the timeframe for treatment. FSAs have improved from 72 patients waiting outside of timeframes in May and are largely related to plastics patients. Those waiting for treatment included 11 plastics and 8 orthopaedic patients.
100% of people receive treatment within four months of the commitment to treat (ESPI5).	89%	NA	
Average elective length of hospital stay at or below 1.45 days.	1.19	NA	
Outpatient DNAs and maintained at or below 6%.	8.3%	13%	The DNA project has been prioritised for 2019/20.

Service Quality Part I

NZHS Link - Value & High Performance

Status Report for 2018/19			Performance Reporting Link – SI17
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Provide free seasonal flu vaccinations for people at higher risk including Māori over 65 years, pregnant women and people with a recent asthma related hospital admission. (EOA) Engage Poutini Waiora to support practices struggling to reach their target population. (EOA) Undertake analysis of Atlas indicators to identify opportunities to increase influenza vaccinations for target populations, after hospital admission.	Q1: Analysis of Atlas indicators shared to support targeted actions for high need populations.	✓	Key actions identified and highlighted in the DHB's SLM Improvement Plan. Work is underway with practices to remind them of the correct process for messaging NIR re vaccinations given in practice.
	Q2: Difference in coverage reporting between the NIR and general practice patient management system is clarified, to better target those who have not had a flu vaccination.	✓	

Key Performance Measures	**Total Result**	**Maori Result**	**Comment**
75% of the population 65+ have received a free influenza vaccine.	55%	50%	2018 flu season.

Service Quality Part II

NZHS Link - Value & High Performance

Status Report for 2018/19			Performance Reporting Link – SI17
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Work with consumers and staff to co-design and articulate the role of a 'nominated or preferred' contact person. Work with consumers to develop material describing and clarifying the role. Develop an organisational change process, including training and materials for staff who collect patient details, to ensure a patient's nominated or preferred person is identified in the early stages of admission.	Q1: Terminology agreed.	✓	The procedure, patient and family information document has been developed and is being consulted on. This work has been delayed due to staff capacity but has been prioritised for completion in 2019/20.
	Q2: Procedure for contact details collection updated to include nominated contact person.	↺	
	Q3: Organisational change process confirmed and tested.	↺	
	Q4: Change process approved and implemented.	↺	

Key Performance Measures	**Result**	**Comment**
>65% of inpatients felt 'staff included their family/whānau or someone close to them in discussion about their care'.	67%	

Waste Disposal

NZHS Link - Value & High Performance

Status Report for 2018/19			Performance Reporting Link – PP41
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Distribute materials to pharmacies for educating patients about returning unused and expired medicines and used sharps.	Q1: Educational materials distributed to pharmacies.	✓	
Undertake a stocktake on current disposal processes for each category of waste to identify opportunities for improving waste disposal arrangements.	Q2: Stocktake report completed and submitted to the Ministry of Health.	✓	

Climate Change

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP40

Key Actions from the Annual Plan	Milestones	Status	Comments
Link into the Canterbury Sustainability Governance Group (SGG) to support development of a Sustainability Strategy.	Q2: West Coast Sustainability Champions Identified.	✓	A Sustainability Governance Group (SGG) has been established. The transalpine maintenance and commercial managers sits on this group representing the West Coast
	Q2: Links into CDHB Sustainability Governance Group established.	✓	
Establish energy monitoring (using Energypro software) to build up a history of energy use and identify opportunities for improvement.	Q1: Energypro monitoring in place.	✓	The system has been introduced.
Review current inter-hospital truck transport service to identify opportunities to reduce mileage and use of fossil fuels.	Q2: Truck transport review complete and opportunities identified.	✗	Due to capacity constraints this transport review has been delayed until 2019/20. We expect transport kilometres will not reduce this year.
	Q4: Reduction in internal truck transport kilometres by 33%.	✗	
Undertake a stocktake of current initiatives being delivered to mitigate or adapt to the effects of climate change.	Q2: Stocktake of current actions completed.	✓	Stocktake complete and submitted to the Ministry of Health.
With support from Canterbury DHB, seek to introduce the CEMARS and Energy-Mark accreditation programmes.	Q4: CEMARS and Energy-Mark accreditation programmes introduced.	↺	We are working with CDHB to investigate support for improved energy-management systems.

West Coast DHB

Equity Outcomes Actions

Delivery against National Priorities & Targets from the 2018/19 Annual Plan

Photo courtesy of Wendy Elwood

Status Report Quarter 4

April - June 2019

Status Key:

✓	Completed As Planned
↺	Underway (but not yet completed)
×	Delayed / At Risk

Mental Health Services

Population Mental Health Services:
Leads: Gary Coughlan, Kylie Parkin

NZ Health Strategy link - One Team

Status Report for 2018/19 — Performance Reporting Link – PP43

Key Actions from the Annual Plan	Milestones	Status	Comment
Review the current provision of Māori Mental Health Services and develop a complementary model that provides improved cultural support for Māori across the continuum. (EOA)	Q1: Stakeholder Hui held.	✓	This work was initially delayed to consider the national inquiry recommendations. An engagement Hui was held with a positive participation from across the sector. Feedback was circulated to stakeholders for further input and next steps are now being worked through.
	Q2: Recommendations proposed.	✓	
	Q3: Revised Model Adopted.	↺	

Key Performance Measures	Result	Comment
80% of people referred to specialist mental health services are seen within 3 weeks.	84.5%	This result continues to be impacted by those waiting for psychometric testing which is currently provided by an external contractor with limited capacity.
95% of people referred to specialist mental health services are seen within 8 weeks.	93.3%	

Mental Health Improvement Activities
Leads: Cameron Lacey, Paula Mason, Simon Evans

NZHS Link - One Team

Status Report for 2018/19 — Performance Reporting Link – PP7

Key Actions from the Annual Plan	Milestones	Status	Comment
Provide Safe Practice Effective Communication training for inpatient staff. Integrate weekly meetings (with staff and patients) to enable patient participation in decision-making to enhance the environment and safe practices of the unit. Invest in environmental and therapeutic practice changes to support a safe therapeutic environment for inpatients. Include cultural expertise in environmental improvements to build cultural awareness amongst staff and improve access to cultural support for consumers and whānau. (EOA)	Q1: 95% of frontline staff receive SPEC de-escalation training.	✓	An Occupational Therapist is currently being recruited to the service.
	Q2: Integrated meetings held weekly.	✓	
	Q3: Dedicated (additional) Occupational Therapy FTE in place to support sensory modulation and meaningful activity for inpatients.	↺	
	Q4: Safe ward concept embedded into everyday practice.	✓	
	Q4: Equity of consumers experiencing seclusion being monitored.	✓	
Engage staff and patients in the Marama real-time feedback survey to identify opportunities to improve service delivery, particularly for Māori consumers. (EOA)	Q4: 75% of discharged patients complete the Marama survey.	↺	Most feedback has been provided prior to discharge and changes are being implemented to support use of the survey.
	Q4: 75% of discharged Māori patients complete the Marama survey.	↺	

Key Performance Measures	Result	Comment
95% of clients discharged with a transition plan in place (inpatient services)	38.4%	PRIMHD, the Mental Health Quality Team and the Mental Health Team Managers are now required to report monthly to the Clinical Risk Meeting to ensure the target is met by the next quarter.
95% of audited files meet accepted good practice.	53.8%	

Addictions Services

Leads: Cameron Lacey, Sandy McLean

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP8

Key Actions from the Annual Plan	Milestones	Status	Comment
Investigate options to increase community-based respite, withdrawal management and recovery support, particularly for Māori. (EOA)	Q4: Increased AOD capacity available.	✓	A new service has commenced and is being implemented by the Salvation Army.

Key Performance Measures	Result	Comment
80% of people referred to specialist addiction services are seen within 3 weeks.	64.1%	We anticipate increased community options and the realignment of resources across locality bases will improve wait times going forward.
95% of people referred to specialist addiction services are seen within 8 weeks.	83.5%	

Primary Care Services

Service Access

Leads: Ginny Brailsford

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with the West Coast PHO to implement the national zero fees policy, extending zero fees for children <13 to zero fees for children <14. (EOA) Work with local Pharmacies to ensure they update systems to align with the national policy. (EOA) Work with the West Coast PHO to implement the national lower fees for Community Services Card holder policy. (EOA) Update the DHB and PHO websites in line with the implementation of zero fees policy, showing details of practices' fee arrangements.	Q2: Proposed new zero fees model communicated and agreed.	✓	All general practices on the West Coast have signed up to the zero fees for children under 14 years and the initiative to provide 'lower cost general practice visits'. Adults with a Community Services Card (CSC) who are enrolled with a general practice pay no more than $18.50 for a standard visit and young people (14 to 17), who have a parent or caregiver with a CSC are charged no more than $12.50.
	Q2/Q3: Implementation of zero fees model for children <14 (both in and out of hours).	✓	
	Q4: PHO/DHB websites updated to reflect changes in fees.	✓	
	Q4: 95% of children <14 have zero fee access to general practice services and prescriptions.	✓	

System Integration

Leads: Jenni Stephenson, Kylie Parkin

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to invest in the West Coast Alliance as a mechanism for leading service and system improvements. Engage system partners in the Alliance's new Mental Health Workstream to support the implementation of the locality-based mental health service model. Ensure a strong Māori voice and focus on Alliance workstreams. (EOA) Monitor system performance against the national System Level Measures (SLM) to identify areas for improvement and focus.	Q1: New Alliance Chair is appointed to vacant role.	✓	An independent Chairperson has been identified and they will be in place for the first meeting of 19/20. Work to highlight equity through various reports continues with performance results for Māori included wherever this is captured. Narrative relating to activity to address inequity is included at all levels of performance reporting. Work to develop a refreshed dashboard is underway, capturing ideas from other DHBs. Actions in the SLM Improvement Plan have been delivered.
	Q2: Work plan for the Mental Health Workstream endorsed by the Alliance Leadership Team.	✓	
	Q2: Equity reporting dashboard developed.	↺	
	Q4: Delivery of the actions agreed in the SLM Improvement Plan.	✓	

CVD and Diabetes Service Improvement

Leads: Peter McIntosh

NZHS Link - One Team

Status Report for 2018/19			Performance Reporting Link – PP20
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Work with the PHO and general practices to maintain the proportion of the eligible population receiving a CVD and Diabetes Risk Assessment at or above 90%. Engage Poutini Waiora to identify and contact Māori men to lift the Risk Assessment rates for this high-risk population. (EOA)	Q1: Monthly performance reporting by general practice.	✓	The West Coast PHO is actively monitoring results by ethnicity and working with Poutini Waiora to implement key actions to support the uptake of CVD assessment by Māori men as a high-risk group.
	Q1: Monthly performance reporting by ethnicity.	✓	
Work with Health Quality & Safety Commission to further advance the Whakakotahi work plan by trialling evidence-based care pathway improvements in two primary care pilot sites. Target improvements in engagement with Maori as a high risk group. (EOA)	Q1: Two Whakakotahi pilots underway.	✓	The pilot project in the Buller region was re-scoped and linked in with Poutini Waiora to better support Maori with diabetes. The initial evaluation has indicated this has been successful in targeting high risk groups. The Grey Medical Practice in Greymouth is now looking at implementing the pilot trialled in Buller, targeting high risk groups. The second pilot project in Greymouth, focussing on pre-diabetes, was halted as patient data evaluation did not support project continuation.
	Q4: Completion of Phase I of the pilot with assessment of pathway improvements.	✓	
Continue to support community-based initiatives to engage and enrol people with diabetes in the primary care LTCM Programme so that people can be supported to make lifestyle changes to help reduce their risk, with a particular focus on Māori as a high needs population group. (EOA)	Q1: Retinal screening expo and clinic in Reefton and Greymouth.	✓	Four week-long Retinal Screening Expo clinics were held this year in Reefton and Greymouth in August 2018, Greymouth and Westport in November 2018, Greymouth and Hokitika in March 2019 and Westport in June 2019.
	Q4: Three pre-diabetes and high risk CVD dietitian clinics delivered.	✓	
	Q4: Three Living Well with Diabetes courses delivered.	✓	

Key Performance Measures	**Total Result**	**Maori Result**	**Comments**
90% of the eligible population had a CVD risk assessment in the last 5 years.	87.3%	86.5%	305 more people needed to have complete their CVDRA to meet the target for the whole population.
90% of eligible Maori men (35-44) have had a CVD risk assessment in the last 5 years.		70.9%	Only more Maori 29 men needed to be reached to meet this target
90% of the population with diabetes, have had an annual HbA1c test.	81%	81%	To reach the target, another 11 Maori and 77 non-Maori would have needed to have had their annual HbA1c tests in the last year.

Pharmacy Action Plan

Leads: Mike James, Ginny Brailsford

NZHS Link - One Team

Status Report for 2018/19			Performance Reporting Link – PP22
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Further develop the Pharmacy Long-Term Conditions Service, to improve access to pharmacist support for people on multiple regular medicines. (EOA) Support more pharmacists to provide medication use reviews (MURs) for people taking many or high-risk medicines. (EOA)	Q3: Two more pharmacists accredited to provide MURs.	✗	This was an ambitious target with limited availability of pharmacists to provide medicines management support for patients via LTC and MUR services. The number of people enrolled in LTC service has fallen and is now at 657.
	Q4: >20 people receive a MUR from their pharmacist.	✗	
	Q4: >900 people are enrolled in the Long-Term Conditions Service.	✗	
Work with the national Expert Advisory Group to develop a Minor Ailments (pharmacy) Initiative to ease access to timely treatment for Community Service Cardholders. (EOA)	Q4: Minor Ailments Initiative developed and put forward for approval.	✗	The Expert Advisory Group is still to complete development of a Minor Ailments service model.

New-born Enrolment

Leads: Jenni Stephenson

NZHS Link – Closer to Home

Status Report for 2018/19			Performance Reporting Link – SI18
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Establish a process to support general practice enrolment as part of the current new-born multi-enrolment process. Complete a review of the multi-enrolment form to ensure it is meeting the stakeholder needs. Work with Plunket and Poutini Waiora to develop a Kaupapa Māori Pregnancy & Parenting Education Programme. (EOA) Ensure the Programme emphasises the importance of enrolling with primary care to support engagement with health services. (EOA)	Q2: Process to support general practice enrolment developed.	✓	A proposed model for Kaupapa Māori PPE has been developed. Planning is underway for delivery of the first cohort.
	Q2: Kaupapa Māori PPE Programme developed.	✓	
	Q3: New-born enrolment form review completed.	✓	

Key Performance Measures	**Total Result**	**Maori Result**	**Comments**
85% of new-borns are enrolled with general practice by 3 months of age.	110%	83.3%	15 out of 18 Maori babies were enrolled with a general practice by three months of age during quarter four

Support to Quit Smoking

Leads: Jenni Stephenson

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with the Buller Health Practice to identify Māori smokers and ex-smokers who have not been appropriately screened for COPD. (EOA) Work with Poutini Waiora to engage those patients in spirometry clinics, where screening, smoking cessation advice and other opportunistic referrals can be offered. (EOA)	Q2: Process for capturing Māori smokers and ex-smokers age 35+ established. Q4: Identified patients and appropriate whānau invited for COPD screening.	✓ ✓	The Buller Health team including Respiratory Nurses Specialist along with Poutini Waiora Whānau Ora nurses have proactively invited smokers and ex-smokers to come along with their whānau to undertake spirometry testing and engage in discussions about smoking cessation options and other lifestyle changes.
Work with the PHO and Well Child Tamariki Ora providers (collecting smokefree status data) to improve data collection and establish how whānau being offered brief advice and cessation support can be captured. (EOA)	Q2: Data collection for smokefree household measure in place. Q4: Process for ABC data capture in Patient Management System investigated.	✓ ✓	The new data capture system was implemented in early March. It was agreed that the offer of brief advice to whānau through a WCTO visit should be captured in the WCTO notes.

Key Performance Measures	Total Result	Maori Result	Comment
90% of PHO enrolled patients who smoke are offered brief advice/support to quit.	96%	96%	The PHO continues to maintain high rates of smoking status ever recorded for patients (99%).
90% of West Coast households with a newborn have their smokefree status recorded at the first core Well Child check.			No data released by Ministry of Health for this measure

Child Health Services

Maternal Mental Health Services

Leads: Jenni Stephenson and Sandy McLean

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP44

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to support the use of free general practice consultations for pregnant women with medical, mental health or social issues that may be exacerbated by pregnancy. (EOA) Promote the maternal mental health service referral pathway using HealthPathways. Review the timeliness of referrals from LMCs to Well Child providers, with a focus on Māori as a population of higher need. (EOA)	Q1: Review of maternal mental health pathway complete. Q2: Promotion of pathway to increase uptake. Q3: Review of referral timeliness completed and opportunities for improvement identified.	✓ ✓ ✓	The DHB will continue to support stronger relationships between West Coast LMCs and WCTO providers in order to support timely referral and handover. The DHB continues to advocate for improved visibility of all WCTO Core check data in order to support quality improvement actions in this area.

Child Wellbeing

Leads: Jenni Stephenson, Kylie Parkin, Maureen Frankpitt

NZHS Link - Value & High Performance

Status Report for 2018/19			Performance Reporting Link – PP27
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Continue to train volunteer peer supporters through the Mum4Mum programme, with a focus on Māori supporters to extend the reach of the service. (EOA) Investigate strategies to link high need populations to a Mum4Mum supporter. (EOA)	Q2: Opportunities to enhance the programme actioned.	✓	Only one new Mum4Mum supporter trained this year has identified as Māori. A further two unfortunately withdrew their commitment prior to commencing training. The team continues to work with key stakeholders to try and identify women who are willing to complete the training course.
	Q4: An increased number of Māori mothers trained as peer supporters.	↺	
Establish a Transalpine Oral Health Service Development Group to support a whole of life approach to good oral health. Promote the Newborn Enrolment Form to support early enrolment of children with the Community Oral Health Service. (EOA) Identify opportunities for health promotion and education for families whose children are hospitalised for dental surgery. (EOA)	Q1: West Coast Development Group membership confirmed.	✓	The Healthy West Coast Alliance workstream is leading the development of a cohesive Oral Health Promotion plan that capitalises on opportunistic contacts as well as creating supportive environments.
	Q1: Childhood Nutrition/Health Promotion role supporting Early Childhood Centres established.	✓	
	Q2: Practice Nurses complete 'Lift the Lip' checks at immunisations.	✓	
	Q2: 'Water Only' policies in place in West Coast schools.	✓	

Key Performance Measures	**Total Result**	**Maori Result**	**Comments**
95% of children (0-4) are enrolled with Community Dental Services.	101%	90%	There are denominator issues with these ethnicity results, which are based on projected population figures. The 'Other' population enrolment rate was 105%.
90% of enrolled children (0-12) are examined according to plan.	96%	93%	There were 225 children overdue, 60 of those children were Maori.
85% of adolescents (13-17) are accessing DHB-funded oral health services.	75.7%		The DHB was 160 young people short of the target.

Supporting Health in Schools

Leads: Gail McLauchlan

NZHS Link – Closer to Home

Status Report for 2018/19			Performance Reporting Link – PP39
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Support the Health Promoting Schools framework in lower decile and schools with a high proportion of Māori/Pacific students. (EOA) Support the roll out of the 'Water Only in Schools' programme as part of good oral health promotion and an enabler to wellbeing. Undertake a stocktake of all initiatives currently underway to support health in schools. Review the 2018 Greymouth Schools Wellbeing Survey and identify actions for improvement.	Q2: Schools recruited to develop 'Water Only' policy.	✓	Poutini Waiora is now leading work around defining Wellbeing using the WHO model and how to incorporate supports for this into daily school business.
	Q2: School Wellbeing Survey reviewed.	✓	
	Q2: Stocktake report completed.	✓	
	Q3: Service improvement recommendations developed and agreed.	✓	

School-Based Health Services (SBHS)

Leads: Jenni Stephenson

NZHS Link – Closer to Home

Status Report for 2018/19			Performance Reporting Link – PP25
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Engage decile 4 schools in the School Based Health Services (SBHS) programme. Undertake a stocktake of all SBHS currently provided in West Coast secondary schools. Work with decile 1-4 schools to identify barriers to participation in routine health assessments with particular focus on Māori children. (EOA) Work with schools and providers to develop an implementation plan for expanding SBHS to all public secondary schools on the West Coast.	Q2: Stocktake report completed.	✓	SBHS are now in place at three of the four decile 1-4 schools and both Alternative Education facilities on the Coast. Work continues to finalise a MoU with the last school. An implementation plan has been provided to MoH, which outlines timeframes, enablers and constraints for full roll out of SBHS to all secondary schools on the West Coast.
	Q2: Barriers to access identified.	✓	
	Q4: Implementation plan completed and provided to MOH.	✓	
	Q4: SBHS in place in all West Coast 1-4 decile schools.	↺	

Key Performance Measures	**Total Result**	**Maori Result**	**Comments**
95% of eligible year nine students received a Routine Health Assessment (including a HEEADSSS assessment) in the last calendar year.	50%	32%	Changes in staffing within the Public Health Nursing team have impacted on service delivery.

Immunisation

Leads: Bridget Lester

NZHS Link – One Team

Status Report for 2018/19			Performance Reporting Link – PP21
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Monitor and evaluate immunisation coverage at DHB, PHO and general practice level, to maintain coverage and identify unvaccinated children. Fill the vacant Māori provider role on the Immunisation Advisory Group to ensure a strong focus on Māori as a priority group. (EOA) Continue with a focus on pregnancy vaccinations and LMCs having immunisation conversations. Share refreshed immunisation process charts and prompts for difficult immunisation conversations. Support general practice to promote the co-delivery model for HPV and Tdap.	Q1: Quarterly review of vaccination and decline rates by ethnicity.	✓	Work is underway on the development of the Difficult Conversations training programme with a programme outline developed and a model for delivery being confirmed for 2019/20.
	Q1: Māori representative on the Immunisation Advisory Group.	✓	
	Q2: Refreshed process chart issued to general practice.	✓	
	Q2: HPV and Tdap Information and education resources issued.	✓	
	Q4: Difficult Conversations training options explored for practice nurses.	↺	

Key Performance Measures	**Total Result**	**Maori Result**	**Comments**
95% of 8-month-olds fully immunised.	75%	85%	Four consenting children were missed this quarter with a high combined opt-off and decline rate of 20.3%.
95% of 2-year-olds fully immunised.	82%	88%	Two consenting children were missed this quarter. The combined opt-off and decline rate was 16.6%.
95% of 5-year-olds fully immunised.	90%	83%	Two consenting children were missed this quarter. The combined opt-off and decline rate was 7.7%

Older Person's Health Services

Healthy Ageing

Leads: Diane Brockbank, Steve Johnston, Sandra Teasdale

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP23

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with partner organisations through the Health of Older People Workstream and Falls Coalition to enhance and integrate falls and fracture prevention services. Engage local providers to accredit community strength & balance classes, including a number specifically designed and targeted towards older Māori. (EOA) Embed the fracture pathway to ensure people with a fractured Neck-of-Femur (NOF) are referred to the in-home Falls Prevention Service.	Q1: St John representative attending Falls Coalition meetings.	✓	A Maori focussed community exercise class is being held, however the class is not yet accredited and we continue to work with them to achieve this. The NOF pathway work has been delayed due to some wider work being done with ATR within Grey Base hospital. The Fracture Liaison Service will progress very shortly with the appointment of a new staff member.
	Q2: Review and integration of osteoporosis and falls prevention referral pathways complete.	✓	
	Q3: Māori focused community strength & balance class accredited.	↺	
	Q3: NOF pathway embedded.	↺	
	Q4: Virtual Fracture Liaison Service operational.	↺	
Encourage service providers to consider Māori health needs from 50+ to enable older Māori to maintain good health. (EOA) Engage the Māori Needs Assessor to complete InterRAI assessments to ensure an appropriate response for older Māori with complex health issues. (EOA) Employ a Clinical Nurse Specialist to embed and promote the early supported discharge service (FIRST) ensuring the screening and referral of older people to appropriate discharge options.	Q2: InterRAI reporting framework in place and assessment rates tracked by ethnicity.	✓	Recruitment is ongoing for a Maori Clinical Assessor; Poutini Waiora is engaged in the process but as yet this process has not been successful in identifying a candidate. Six clients have completed the FIRST programme since August 2018.
	Q2: CNS appointed to support FIRST.	✓	
	Q3: Baseline established InterRAI assessments per 1,000 population.	✓	
	Q4: Three people admitted to the FIRST service.	✓	

Key Performance Measures	Result	Comments
720 places available at accredited strengths and balance classes.	506	There were 261 attendees at classes in the last quarter.
120 referrals made to the Falls Prevention Service.	105*	This is a preliminary number, the final month is yet to be confirmed.
95% of long-term Home Based Support Services clients have had an InterRAI assessment and have a completed care plan in place.	N/A	During quarter four 81 homecare inteRAI assessments were completed and 43 contact inteRAI assessments. Total clients (and %) have not been able to be confirmed internally.

Improving Systems

Shorter Stays in Emergency Departments

Leads: Julie Lucas

NZHS Link – Value and High Performance

Status Report for 2018/19 — Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Map the journey for Maori across the rural health continuum (primary to secondary care) and determine areas of focus to improve earlier engagement. (EOA)	Q3: Journey Mapped.	↺	This action has been delayed due to a change in staff, however meetings have now been set for this project to commence in Q1 19/20.
	Q4: Opportunities identified and prioritised.	×	

Key Performance Measures	Total Result	Maori Result	Comment
95% of patients are admitted, discharged, or transferred from ED within 6 hours.	98.2%	98.3%	
<64% of presentations to Grey Base ED Reduction are triage level 4-5.	54%		The ethnicity breakdown of this measure will be available Q1 19/20

Cancer Services

Leads: Kylie Parkin, Andrea Reilly

NZHS Link - Value & High Performance

Status Report for 2018/19 — Performance Reporting Link – PP30

Key Actions from the Annual Plan	Milestones	Status	Comments
Engage locally in the regional Te Waipounamu Māori Cancer Pathway Project to support improved outcomes for West Coast Māori. (EOA) Adopt a collective approach to improving cervical and breast screening rates for Māori women.	Q2: Cancer Korero Booklet developed and disseminated.	↺	Publication of the Cancer Korero booklet is underway and it is anticipated this will be completed in Q1 19/20. The three planned cancer korero hui to promote cancer korero have also been delayed until Q2 19/20. Cultural competency training has been delivered to General Practices in Greymouth and to Poutini Waiora, with further training planned for other areas.
	Q4: Three cancer korero hui held to improve cancer health literacy amongst Māori whānau.	×	
	Q4: Cultural competency training and education package developed and presented to GP practices.	✓	

Key Performance Measures	Total Result	Maori Result	Comment
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.	73.7%*	NA	Small numbers are challenging with this result reflecting only five patients who were not seen within the 62 day period. Every non-compliant case individually followed up. Most non-compliant cases are physically, psychologically, or diagnostically challenging. *Note: Ethnicity data is not provided by the MoH and results for Q4 are preliminary.*
85% of patients receive their first cancer treatment (or other management) within 31 days of date of a decision-to-treat.	89.6%*	NA	

Elective Services

Leads: Robin Rutter-Baumann, Kylie Parkin, Gary Coughlan

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP45

Key Actions from the Annual Plan	Milestones	Status	Comments
Review current booking system processes to identify opportunities to improve the uptake of appointments and access to services. Facilitate cross-system collaboration between booking teams and Poutini Waiora to identify solutions for better engaging with Māori. (EOA) Develop criteria to help identify patients who would be suitable for telehealth clinics, to reduce their need to travel. (EOA) Work with the Ministry to develop consistent rules for counting telehealth events, to ensure activity is appropriately captured.	Q1: DNA service level data used to identify initial areas of focus.	↺	Further data development is required to enable identification of cohorts for the DNA project. This will take place in Q1 19/20. Electronic delivery of patient appointments is being tested before being fully enabled. Rollout of software-based VC has commenced with telehealth criteria developed and clinics identified and counted via the DHBs patient management system.
	Q2: Electronic delivery of patient appointments enabled.	↺	
	Q3: Business case developed for software-based VC capability.	✓	
	Q4: Telehealth criteria developed.	✓	
	Q4: Process for counting telehealth events in place to recognise activity.	✓	
Engage with Poutini Waiora to established closer links with Māori patients at the pre-presentation and discharge phases to support people to attend appointments. Deliver Tikanga Best Practice training to staff, to support patients to feel culturally comfortable with the care they are given.	Q3: Process in place to offer Māori patient's additional support through their elective patient journey.	↺	Engagement work underway via Tautau Pounamu. Training has not been able to be delivered due to capacity constraints and will resume in again in 2019/20
	Q4: Four Tikanga Best Practice sessions delivered.	✗	

Key Performance Measures	Total Result	Maori Result	Comment
1,916 elective surgeries delivered.	101.3%	NA	The West Coast DHB had provided 1,940 elective surgical discharges to June 2019, higher than anticipated.
100% of people are seen for their FSA within four months (ESPI2).	97%	NA	Results as are at June 2019 and relate to 25 patients who waited outside of timeframes for their FSA and 24 who waited outside of the timeframe for treatment. FSAs have improved from 72 patients waiting outside of timeframes in May.
100% of people are treated within four months of the commitment to treat (ESPI5).	89%	NA	
Average elective length of hospital stay at or below 1.45 days.	1.19	NA	
Outpatient DNAs and maintained at or below 6%.	8.3%	13%	The DNA project has been prioritised for 2019/20.

Service Quality

Lead: Bridget Lester

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – SI17

Key Actions from the Annual Plan	Milestones	Status	Comments
Provide free seasonal flu vaccinations for people at higher risk including Māori over 65 years, pregnant women and people with a recent asthma related hospital admission. (EOA) Engage Poutini Waiora to support practices struggling to reach their target population. (EOA) Undertake analysis of Atlas indicators to identify opportunities to increase influenza vaccinations for target populations, after hospital admission.	Q1: Analysis of Atlas indicators shared to support targeted actions for high need populations.	✓	Key actions identified and highlighted in the DHB's SLM Improvement Plan. Work is underway with practices to remind them of the correct process for messaging NIR re vaccinations given in practice.
	Q2: Difference in coverage reporting between the NIR and general practice patient management system is clarified, to better target those who have not had a flu vaccination.	✓	

Key Performance Measures	Total Result	Maori Result	Comment
75% of the population 65+ have received a free influenza vaccine.	55%	50%	2018 flu season.

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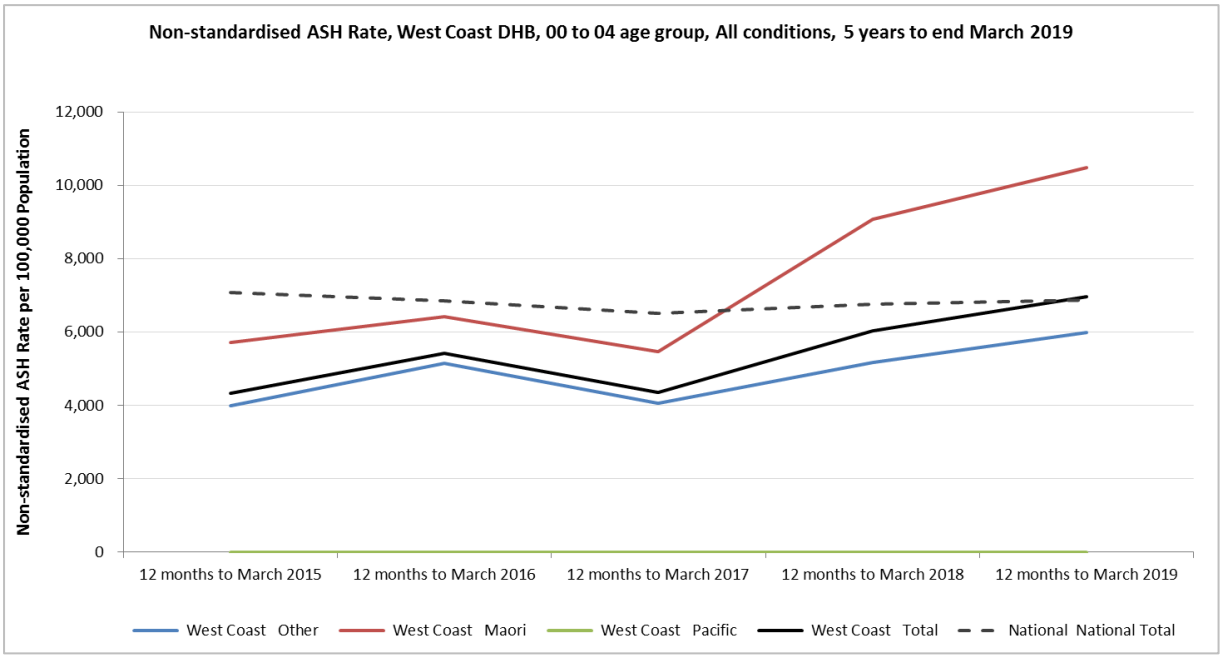
Ambulatory Sensitive Hospitalisations (0-4 year olds)



Objective	Action	Status of actions
Reduced avoidable hospital admissions among children: Oral Health ***Target:*** *>95% Māori pre-schoolers enrolled in DHB-funded oral health services* ***Result:*** *90% Māori pre-schoolers enrolled in DHB-funded oral health services* *Total population enrolment was 101.2% suggesting a mismatched between actual population and the projected population used for this calculation.*	• Support the establishment of the Oral Health Service Development group ensuring appropriate West Coast and Māori representation to maintain a focus on rural and ethnicity outcome gaps. • Continue promotion of the Newborn Enrolment Form to support early enrolment of children with the Community Oral Health Service. • Support Practice Nurses to complete the "Lift the Lip" check at immunisation events and refer concerns to the Dental Therapists • Support the implementation of "Water Only in Schools" across the Coast as a good oral health promotion tool • Continue to support the Childhood Nutrition Health Promotion role working in Early Childhood Education Centres Coast-wide • Continue to develop opportunities for health promotion and education with families whose children are hospitalised for dental surgery.	✓
Reduced avoidable hospital admissions among children: Breastfeeding ***Target:*** *70% Māori babies are breastfed at three months*	• Continue to train volunteer peer supporters through the Mum4Mum programme to extend the reach of the service to rural communities. Ensure the Mum4Mum volunteers continue to be reflective of the ethnicities of women residing on the Coast. This will include a target of 4 Māori mums completing training.	↺

✓ This action is on track

✘ This action is behind &/or has risks

➲ This action is delayed though expected to be completed by year end.

Result: *41% Māori babies are breastfed at three months*[1]	• Investigate strategies to link priority and high needs mothers (e.g. young mothers, isolated rural mothers, and Māori mothers) to a Mum4Mum volunteer during the antenatal period. *Two Māori mothers were recruited to the Mum4Mum training currently underway but withdrew at the last minute; one has agreed to join the next course. This will bring the number trained by end of year to 2 (one trained in Q2).*	

[1] WCTO QIF result at May 19 for the period Jul – Dec 18

System Level Measures Framework
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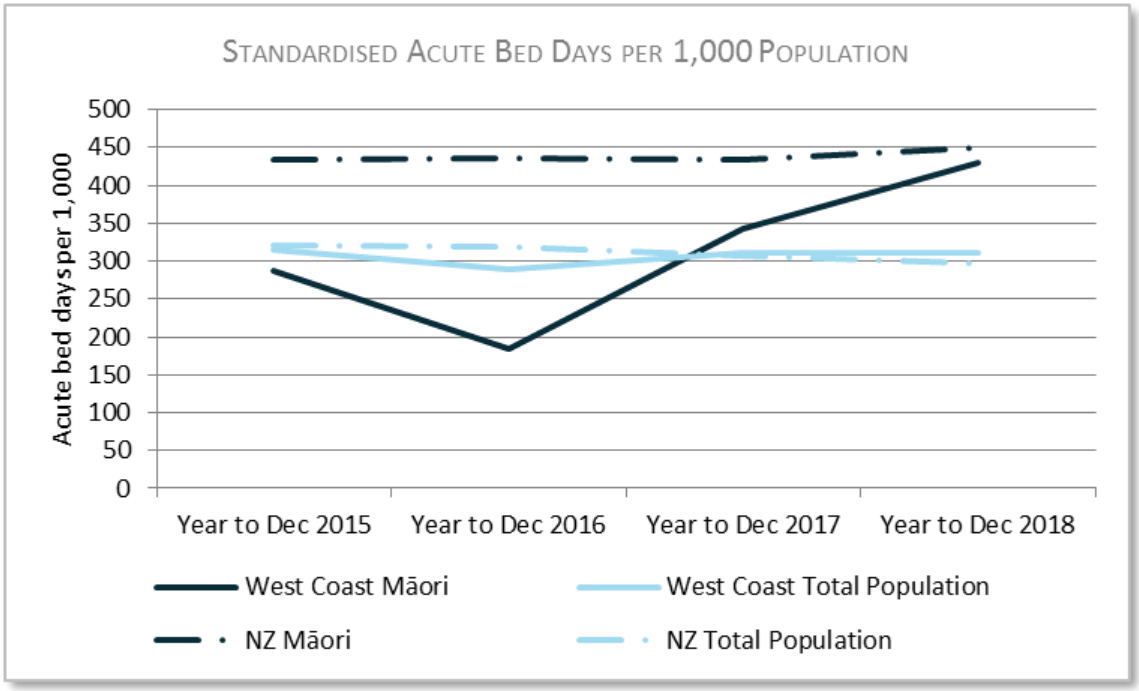
Acute Hospital Bed Days

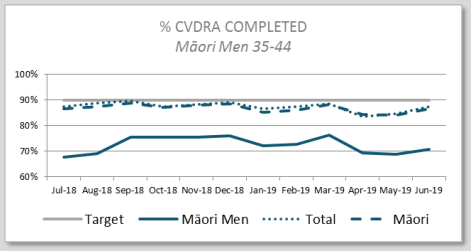


Objective	Action	Status of actions
Improved management of the demand for acute care: Influenza vaccination for 65+ ***Target:*** *60% Māori ,65 and older, received an influenza vaccine as at 31 Dec 2017* ***Result:*** *49% Māori, 65 and older, received an influenza vaccine in the 2018 season.* *The National result for this group was 45%.*	• Understand the difference in population coverage reporting between National Immunisation Register (NIR) and the practices' patient management systems. • Develop a process to ensure more timely capture of vaccination event in the NIR that more closely match practice information. • Promote and provide free seasonal flu vaccinations for people 65 years and older at general practices and community pharmacy. • Celebrate the individual practices who have reached the target population and share learning from those practices with others. • Continue to use Poutini Waiora staff and their connections with whānau to support practices who are struggling to reach their target population.	✓
Improved management of the demand for acute care: More heart & diabetes checks ***Measure:***	• Facilitate collaborative working between Poutini Waiora and general practices to identify and contact Māori eligible for Cardiovascular Disease Risk Assessments. • Continue to provide practice-specific target performance data in the Primary Bulletin (to practices) supported by advocacy messages targeting clinicians to support the delivery of Cardiovascular Disease Risk Assessments, with a focus on Māori men.	✓

✓ This action is on track

✘ This action is behind &/or has risks

➲ This action is delayed though expected to be completed by year end.

		
Improved management of the demand for acute care: COPD screening ***Target:*** *90% Māori smokers or ex-smokers registered at Buller Health practice, aged 35 years or older, receive spirometry screening and lifestyle coaching* ***Result:*** *X% Māori smokers or ex-smokers registered at Buller Health practice, aged 35 years or older, receive spirometry screening and lifestyle coaching*	• Work with the Buller Health Practice to identify all smokers and ex-smokers registered at the practice who have not been appropriately screened for COPD • Work with Poutini Waiora to engage those patients in Spirometry clinics where screening can be performed, smoking cessation advice and/or referral given as well as other appropriate opportunistic interventions offered. • Extend the invitation to whānau members as necessary • Explore roll out to other practices	✓

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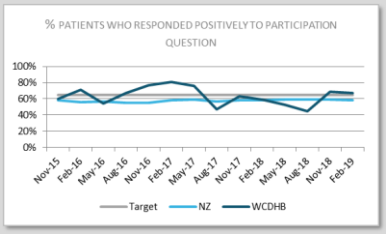
Patient Experience of Care

Objective	Action	Status of actions
Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience: Hospital services using the adult inpatient survey ***Measure:***  	• Work with the consumer council to co-design the 'nominated' patient contact role including defining whether the term 'nominated' or 'preferred' is used. • Develop promotional material for consumers describing the role • Develop an organisational change process for DHB staff that emphasises the importance of data capture *Staff capacity was a barrier to the above actions being completed; these have been carried forward into the 2019/20 plan.*	↺
Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience: Hospital mental health services using the Marama Real-Time survey ***Target:*** *50% of consumers discharged from the mental health inpatient service have complete a patient experience survey* ***Result:*** *48% of consumers discharged from the mental health inpatient service have complete a patient experience survey*	• Work with the Community Mental Health Teams to develop process for offering the Marama Real-Time Survey to consumers who have been discharged after an inpatient stay. • Work with the WCDHB Quality Team to develop regular quarterly reporting to the service regarding consumer feedback. • Work with the DHB Consumer Council and their networks to promote completion of the survey.	✓
Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience: Uptake of the primary care patient experience survey ***Target:*** *40% of patients have provided an email address to practices to enable participation in the primary care experience survey* ***Result as at Nov 2018:*** *28.6% email addresses provided* *HQSC have stopped reporting numbers of patients with email addresses provided due to data quality issues.*	• Develop a communications plan to promote and encourage consumers of primary care to complete the survey upon receiving an invitation • Ensure general practices are supported to collect email contacts for patients through training and education provided by the PHO. • Work with the DHB Consumer Council and their networks to promote completion of the survey.	✓

✓ This action is on track

✘ This action is behind &/or has risks

➲ This action is delayed though expected to be completed by year end.

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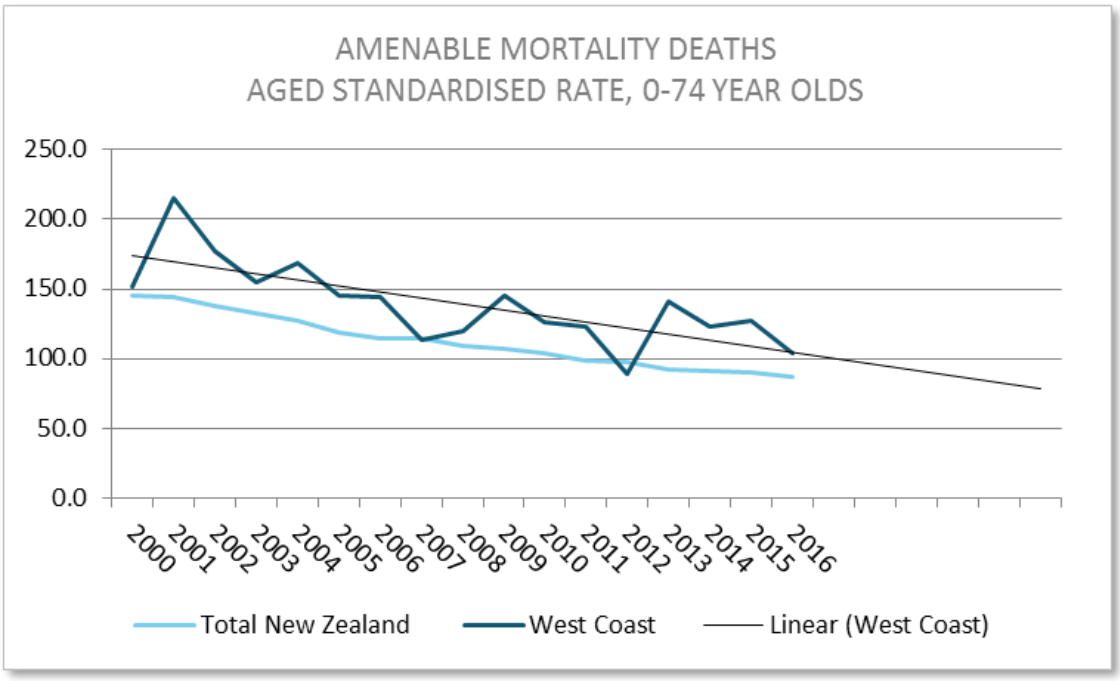
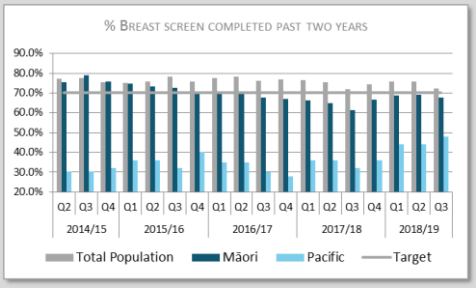
Amenable Mortality

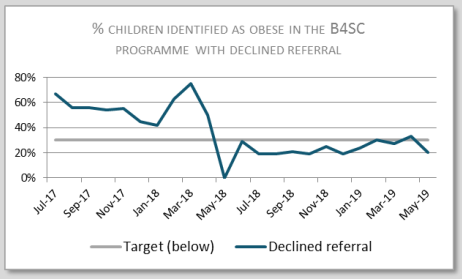


Objective	Action	Status of actions
Reduction in the number of avoidable deaths and reduced variation for population groups: Breast screening ***Measure:***  	• Identify a champion in each practice to lead and support improvements in screening rates. • Work with the practices to improve the rates of women consented for breast screening by ensuring they have access to, and regularly monitor, data that identifies eligible women who have no documented consent in the Patient Management System. • Support practices with processes for checking results received from BreastScreen Aotearoa so that screening terms and results are filed and captured accurately in the practice patient management system. • Utilise Poutini Waiora Whānau Ora nurses (who are integrated in general practice teams) to support Māori and Pasifika women who are not engaging with breast screening. • Increase health promotion to practices, rural communities, community pharmacies and via social media to increase awareness and promote the importance of breast screening for priority populations (Māori and Pacific).	✓
Reduction in the number of avoidable deaths and reduced variation for population groups: Long term conditions management ***Target:***	• Support the Mental Health Project Team to explore options for model of care • Consult with mental health service consumers about their experience • Agree the model for future integration of mental health	✓

✓ This action is on track

✘ This action is behind &/or has risks

➲ This action is delayed though expected to be completed by year end.

A model to improve capacity of primary care to manage those with long term mental health issues is agreed. ***Result:*** *Model agreed for Westland June 2019.*	management into primary care	
Reduction in the number of avoidable deaths and reduced variation for population groups: Childhood obesity ***Measure:***  	• Deliver Health Promotion activities in Early Childhood Education and primary school settings that raise awareness of the importance of healthy weight in childhood e.g. "Water Only in School" policy development. • Provide Dietitian nutrition advice and support to all families/whānau regarding healthy weight in childhood at the time of their B4SC, working alongside the Public Health Nurse in this clinic setting. • Provide primary care teams with training/education regarding healthy weight in childhood and support appropriate onward referrals for family/whānau support.	✓

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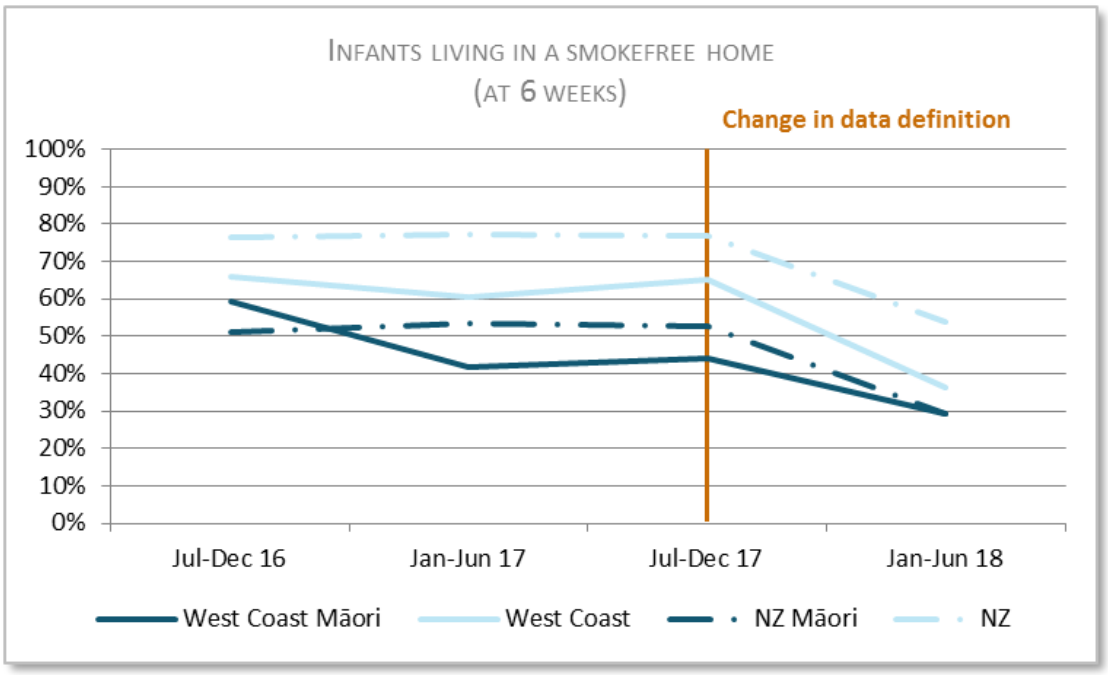
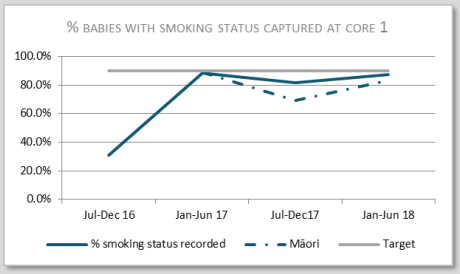
Smokefree Infants



Objective	Action	Status of actions
A healthy start in life: Smokefree homes ***Measure:***  	• Implement improvements to the data capture systems for DHB funded WCTO providers that support mandatory collection of the Smokefree status. • Provide education to the WCTO and Lead Maternity Carer workforce regarding the new measure and its definition. • Monitor monthly smokefree data completion rates for DHB funded providers and provide support and guidance to clinicians where this has not been completed. • For women and whānau being supported by the Smokefree Pregnancy and Newborn Incentive programme, provide advice that WCTO providers will capture this data at the first core check around 4-6 weeks after their baby is born.	✓
A healthy start in life: Smokefree pregnancy ***Target:*** *75% of women (both Māori and non-Māori) set a quit date following referral to the Smokefree Pregnancy and Newborn Incentive Programme.* ***Result:*** *40% of women set a quit date following referral to the Smokefree Pregnancy and Newborn Incentive Programme.* *This was an improvement from 20% in 2017. The number of Māori women engaged was <10 and therefore % result is not reported.*	• Extend the schedule for incentives to support continued engagement with the cessation service beyond birth for mothers from the current 2 weeks post-birth up to 16 weeks in order to promote a smokefree environment for babies during the most vulnerable early months. • Incorporate messaging about the increased risk of Sudden Unexplained Death in Infancy (SUDI) into promotion of the programme. • Continue to offer support to women who choose not to set a quit date immediately, throughout their pregnancy and beyond. • Celebrate the success of women how have successfully quit through media stories.	✓

✓ This action is on track

✘ This action is behind &/or has risks

➲ This action is delayed though expected to be completed by year end.

System Level Measures Framework
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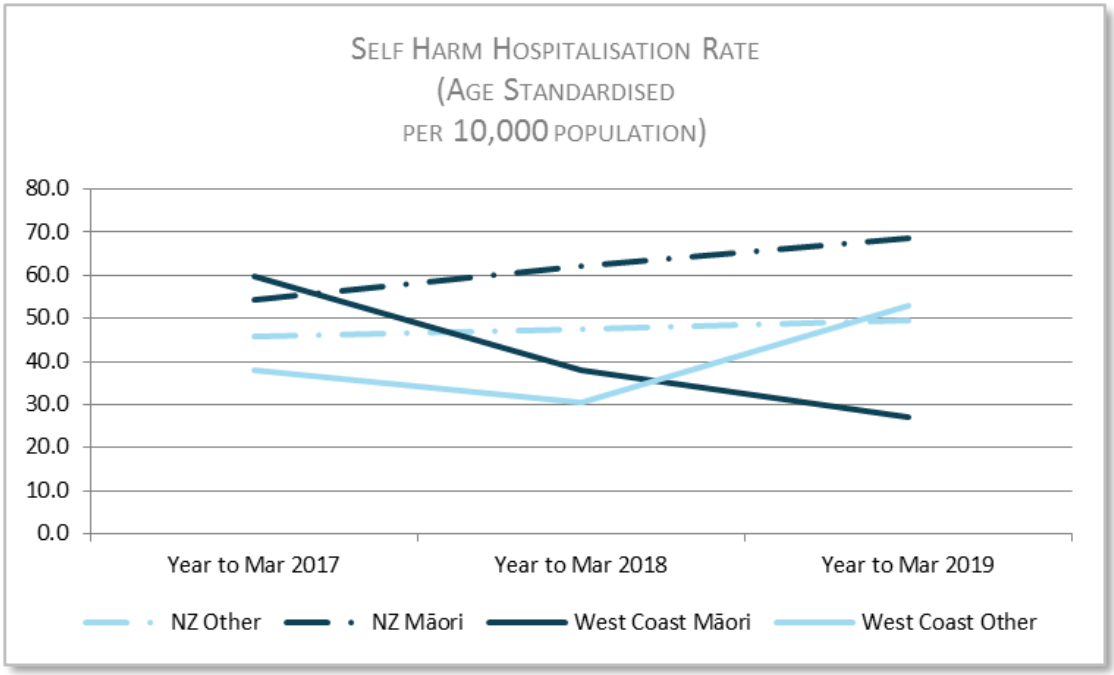
Youth Access to and Utilisation of Youth Appropriate Health Services



Objective	Action	Status of actions
Young people feel safe and supported by health services: Youth feel supported ***Target:*** *50% of young people who present to ED with self-harm or suicidality and are discharged to the community were referred to the PHO Brief Intervention Counselling Service.* ***Result:*** *17% of young people who presented to ED with self-harm or suicidality and are discharged to the community were referred to the PHO Brief Intervention Counselling Service.* *However, if those supported by DHB Community Mental Health teams or TACT are also included, this result improves to 61%.*	• Work with the ED in Greymouth and the unplanned care team in Westport to define referral criteria for young people who would benefit from PHO counselling. • Work with DHB Mental Health service and the ED to develop a process for routine referral to the PHO Mental Health Service following discharge for ongoing counselling and support. • Develop a process for regularly reporting back to ED and PHO regarding progress towards this target. *Process for Westport has been identified and electronic referral via MedTech due to be implemented. Discussions are continuing between ED and Crisis response team in Greymouth regarding best way forward; these have been carried forward into the 2019/20 plan.*	↺

✓ This action is on track ✘ This action is behind &/or has risks ➲ This action is delayed though expected to be completed by year end.

TATAU POUNAMU
MANAWHENUA ADVISORY GROUP
2019 MEETING SCHEDULE

DATE	TIME	VENUE
Friday 8 February 2019	10.00 – 1.00pm	Board Room, Corporate Services
Friday 15 March 2019	10.00 – 1.00pm	Board Room, Corporate Services
Friday 3 May 2019	10.00 – 1.00pm	Board Room, Corporate Services
Friday 21 June 2019	10.00 – 1.00pm	Board Room, Corporate Services
Friday 19 July 2019	10.00 – 1.00pm	Board Room, Corporate Services
Friday 13 September 2019	10.00 – 1.00pm	Board Room, Corporate Services
Friday 18 October 2019	10.00 – 1.00pm	Board Room, Corporate Services
Friday 6 December 2019	10.00 – 1.00pm	Poutini Waiora, Hokitika

MEETING DATES & TIMES
ARE SUBJECT TO CHANGE

WEST COAST DHB – MEETING SCHEDULE WITH DUE DATES

FEBRUARY – DECEMBER 2019

DATE	MEETING	TIME	DUE DATES FOR PAPERS
Thursday 7 February 2019	QFARC Meeting	1.30pm	Tuesday 29 January 2019
Friday 15 February 2019	Advisory Committee Meeting	10.00am	Tuesday 5 February 2019
Friday 15 February 2019	BOARD MEETING	1.00pm	Tuesday 5 February 2019
Friday 29 March 2019	Advisory Committee Meeting	10.00am	Tuesday 19 March 2019
Friday 29 March 2019	BOARD MEETING	1.00pm	Tuesday 19 March 2019
Thursday 2 May 2019 (in place of ANZAC Day)	QFARC Meeting	1.30pm	Tuesday 23 April 2019
Friday 10 May 2019	Advisory Committee Meeting	10.00am	Tuesday 30 April 2019
Friday 10 May 2019	BOARD MEETING	1.00pm	Tuesday 30 April 2019
Tuesday 18 June 2019	Special QFARC Teleconference	2.30pm	Thursday 13 June 2019
Friday 28 June 2019	Advisory Committee Meeting	10.00am	Tuesday 18 June 2019
Friday 28 June 2019	BOARD MEETING	1.00pm	Tuesday 18 June 2019
Thursday 25 July 2019	QFARC Meeting	1.30pm	Tuesday 16 July 2019
Friday 9 August 2019	Advisory Committee Meeting	10.00am	Tuesday 30 July 2019
Friday 9 August 2019	BOARD MEETING	1.00pm	Tuesday 30 July 2019
Friday 27 September 2019	Advisory Committee Meeting	10.00am	Tuesday 17 September 2019
Friday 27 September 2019	BOARD MEETING	1.00pm	Tuesday 17 September 2019
Thursday 24 October 2019	QFARC Meeting	1.30pm	Tuesday 15 October 2019
Friday 1 November 2019	Advisory Committee Meeting	10.00am	Tuesday 22 October 2019
Friday 1 November 2019	BOARD MEETING	1.00pm	Tuesday 22 October 2019
Thursday 28 November 2019	QFARC Teleconference (if required)	1.30pm	Tuesday 19 November 2019 (if req)
Friday 13 December 2019	BOARD MEETING	10.00am	Tuesday 3 December 2019

The above dates and venues are subject to change. Any changes will be publicly notified.