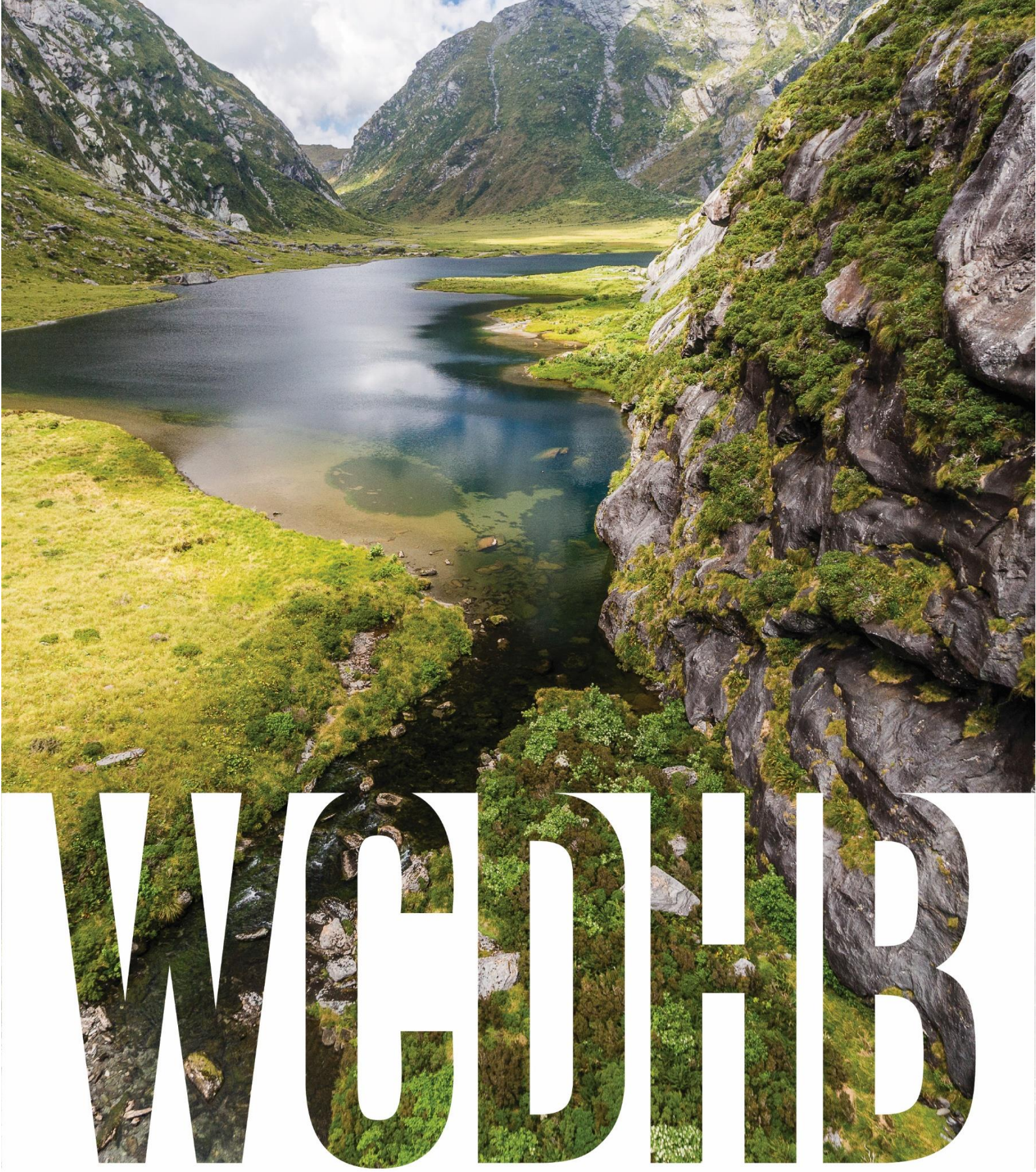


# WCDHB

## WEST COAST DISTRICT HEALTH BOARD ANNUAL PLAN 2021/22

Incorporating the 2021/22 Statement of Performance Expectations



Cover picture provided by Development West Coast – reflecting Haast on the West Coast.

# Statement of Joint Responsibility

The West Coast District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2001. Each DHB is categorised as a Crown Agent under the Crown Entities Act and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

This document is the DHB's Annual Plan which has been prepared under the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and the expectations of the Minister of Health.

Linking with our Statement of Intent, and System Level Measures Improvement Plan, the Annual Plan describes our strategic and operational goals in terms of improving the health of our population and ensuring the sustainability of our health system. It also highlights the actions we will take to deliver on national priorities and expectations in the coming year and presents our financial forecasts and our Statement of Performance Expectations for 2021/22.

The Statement of Performance Expectations is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in the DHB's Annual Reports, published annually on our website.

The West Coast DHB works collaboratively and in partnership with other service providers, agencies and organisations to improve health outcomes for the West Coast population. This includes our participation in several clinically-led Alliances, the West Coast Alliance with the West Coast PHO, the South Island Regional Alliance with our four partner South Island DHBs, and our transalpine partnership with the Canterbury DHB.

We also recognise our role and responsibility in actively addressing inequities in health outcomes for Māori and are committed to making a difference. We work closely with Tatau Pounamu (our Manawhenua advisory group) and Poutini Waiora (our kaupapa Māori provider) in a spirit of partnership and co-design that encompasses the principles of Te Tiriti o Waitangi and seeks to achieve health equity for Māori on the West Coast.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity for the coming year and is in line with Government expectations for 2021/22.

Honourable Rick Barker
CHAIR | WEST COAST DHB

Tony Kokshoorn
DEPUTY CHAIR | WEST COAST DHB

Dr Peter Bramley
CHIEF EXECUTIVE | WEST COAST DHB

Honourable Andrew Little
MINISTER OF HEALTH
17 November 2021

Honourable Grant Robertson
MINISTER OF FINANCE
17 November 2021

August 2021

# Letter of Approval from the Minister of Health

**Hon Andrew Little**

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

Hon Rick Barker
Chair
West Coast District Health Board

17 November 2021

Tēnā koe Rick

**West Coast District Health Board 2021/22 Annual Plan**

This letter is to advise you that we have jointly approved and signed West Coast District Health Board's (DHB's) 2021/22 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Supporting readiness and management of COVID-19.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also acknowledge the importance of your Board delivering on the Plan in a fiscally prudent way.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

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

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand
+64 4 817 8707 | a.little@ministers.govt.nz | beehive.govt.nz

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

Nāku noa, nā

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Peter Bramley
Chief Executive of West Coast DHB

# Table of Contents

# Foreword from the Chairs and Chief Executive

Tēnā Koutou Katoa

Firstly, a big thank you to our staff and the staff of our community providers for their commitment and dedication over the past year, particularly their ability to adapt to the rapid changes in the way we deliver health care and for seeing us through the first wave of COVID-19. We are the smallest DHB in the country, but we are incredibly proud of the innovation and partnership happening across our health system.

In the coming year we will continue to support the implementation of the COVID-19 vaccination programme, a significant undertaking for our team, our health system and our community. We will also support the changes proposed by the national Health and Disability Sector Review, focusing on continuing to provide the best possible care to our population, while preparing for a smooth transition to the new national bodies.

In line with national expectations our Annual Plan for 2021/22 highlights our ongoing commitment to our community and to the expectations of Government.

We will continue to work with iwi and Tatau Pounamu (our Iwi Advisory Board), with Poutini Waiora (our kaupapa Māori service provider), and with our Māori community to meet our obligations as a treaty partner. This will include partnering with iwi in the coming year to undertake a redesign process to better tailor mental health and addiction service to the needs of our local population and to foster community-led solutions to improve health outcomes.

Equity of access and improving health outcomes for Māori remains a high priority for this Board and Tatau Pounamu. Over the past year our teams have focused their collective effort on reducing 'Did Not Attend' rates for Māori. An improved understanding of barriers to access and what we can do differently to better meet people's needs has resulted in a significant improvement in attendance rates. In the coming year we will be expanding this work and using the learnings to improve service access in other areas and will also be supporting the implementation of Whakamaua (the national Māori Health Action Plan). Key actions to improve equity of access and health outcomes in 2021/22 are highlighted throughout this Plan as Equitable Outcome Actions (EOA).

Improving the mental wellbeing of our community is a key focus in our plan for the coming year, along with improving child wellbeing. The DHB will be partnering with the Ministry of Education to engage with stakeholders to design a school-based programme that provides mental health and wellbeing support to primary and intermediate tamariki on the West Coast. This initiative, along with our work on our Early Year's Strategy, has the potential to support significant change for our young people.

We are committed to implementing the national Bowel Screening Programme and are working closely with ScreenSouth to improve the uptake of Breast and Cervical Screening by West Coast women, as a means of improving wellbeing through prevention. Innovative community-based clinics and locally driven outreach programmes will help to support improved uptake of the screening programmes. We will also look to embrace the learning from the Whakakotahi and Pae Ora o Te Tai o Poutini pilots to support a whānau ora approach to service delivery and improve Māori engagement in screening and long-term conditions programmes to enable earlier intervention and improve health outcomes for our population.

Supporting our ageing population and people with disabilities are priorities for our Board. In the coming year we will build on our fragility pathways work to better identify people with emerging signs of fragility to support people earlier and will implement the refreshed Disability Action Plan to improve our response for people living with disabilities across the Coast.

Our innovative Rural Generalist Workforce Model continues to be central to improving our responsiveness to our community and ensuring the longer-term sustainability of our health system. This unique workforce model, specifically designed for a rural environment, will see rural generalists working alongside traditional specialists across both primary and specialist services and will enable our health system to provide a high quality, consistent service for our population. Significant inroads have been made in the past year and continued momentum will see this integrated model further embedded in obstetrics, gynaecology and general medicine in 2021/22.

The West Coast DHB will partner with the Canterbury DHB, investing in the development of three new Equity and Diversity focused roles to support the DHB to attract and develop our Māori health workforce and lift the cultural competency and equity focus across the DHB. We will also continue to look after the wellbeing of our workforce and support a positive

culture across our organisation, by taking what we have learned from the recently completed Tāngata Ora – Our People Survey to identify where we can better support and enable our people to do their best work.

We continue to invest in information systems and solutions to improve the way we deliver care to our community. The deployment of Indici, our new single patient management system, across primary and community services will support more informed clinical decision making and improve the integration and continuity of care provided. The Indici patient portal will also provide enrolled patients with greater access to their health information and give people the ability to manage their engagement with general practice.

The opening of Te Nīkau and the migration of our services has also been a significant undertaking over the past year and will enable a step-change in the way we deliver services with greater integration, shared working spaces and digital services enabling remote consultation and treatment. We look forward in the coming year to the development of the Buller Health Centre which is expected to be complete in 2022.

Our experience over the past year has demonstrated more than ever that people's health needs and expectations are always evolving. Being a small DHB has its challenges but it also means we can be nimble and more flexible in how we respond to our community needs. We will be looking to our partner organisations and communities across the Coast as we embark on several key co-design programmes and prepare for the transition to the new health system. Tatau Pounamu, the Board and staff of the West Coast DHB are fully committed to taking up the challenges and we hope you will take any opportunities to participate and help to design our integrated and healthy future.

Rick Barker
Chair West Coast DHB

Susan Wallace
Chair Tatau Pounamu

Peter Bramley
Chief Executive West Coast DHB

August 2021

# OVERVIEW

## Who are we and what do we do?

# Introducing the West Coast DHB

## 1.1 Who are we?

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

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

In 2021/22, we will receive approximately $188m dollars to meet the needs of our population. In accordance with legislation, and consistent with Government objectives, we will use that funding to:

Plan and, in collaboration with clinical leads, alliance partners, and iwi, develop demand strategies and determine the services we need in place to improve the health and wellbeing our population.

Fund the health services required to meet the needs of our population and, through collaborative partnerships and ongoing performance monitoring, ensure these services are safe, equitable and effective.

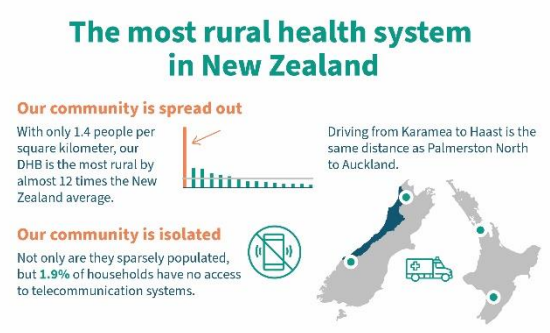
Provide health services to our population, through our hospital and specialist services, general practices, and community and home-based support services.

Protect our population's health and wellbeing through investment in health protection, promotion and education services and the delivery of evidence-based public health initiatives.

## 1.2 What makes us different?

The West Coast DHB has the smallest population of any DHB in New Zealand. We are responsible for 32,395 people, just 0.6% of the total New Zealand population.

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




Unlike most other DHBs, we own and operate four of the seven general practices on the Coast; we also operate a district nursing and home-based support service. This makes us a major local employer and more than 1,000 people are employed by the DHB.

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

As New Zealand's smallest and most rural DHB, our population levels and the resources we have available to us mean we cannot provide a full range of specialist services on the West Coast.

A transalpine service partnership, established with the Canterbury DHB in 2010, means Canterbury specialists are providing regular outpatient clinics and surgical lists on the West Coast. This partnership, and a deliberate investment in telehealth technology, is providing our population with improved access to specialised services and reducing the need to travel long distances for assessment and treatment.

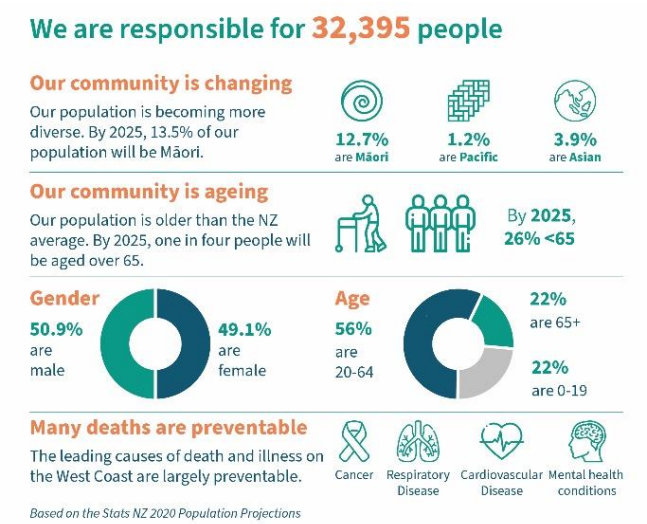
## 1.3 Our population profile

While the population of New Zealand continues to grow the West Coast population of 32,395 has been relatively static and is predicted to slowly decrease over the next ten years. As a result, our population's age structure is significantly older than the rest of New Zealand, with 22% of our population aged over 65, compared with the national average of 16%.

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

Our population is increasingly diverse and there are currently 4,120 Māori living on the West Coast (12.7% of our population). By 2025 that proportion is predicted to increase to 13.3%. This is contrary to the trend for overall population on the West Coast and is driven by migration and a younger age structure amongst our Māori population.

Latest population statistics show 9.7% of our Māori population is aged under five, compared to 4.7% of our non-Māori population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on the health needs of our younger Māori population.




We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others and, along with age and ethnicity, deprivation and disability are strong predictors of the need for health services.

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

The 2013 national Disability Survey suggests 24% of the total population and 26% of Māori identify as disabled. The Survey estimated around 41,000 people were living with a disability in the Nelson, Tasman, Marlborough and West Coast region. Using the national rate, that would translate to almost 7,800 people in our population. For adults the main impairments are physical (47%) and hearing (20%) disabilities and for children they are learning, speaking, and developmental delays (54%).

## 1.4 Our population's health

West Coast Māori continue to have poorer overall health status and a lower life expectancy (78.3 years) than the national rate (80.4 years), but the inequity is slowly reducing. At 2.1 years, the differential between Māori and non-Māori on the West Coast is considerably better than the national gap, where Māori life expectancy (75.1 years) is almost 6.3 years lower than non-Māori.

Many long-term conditions become more common with age, including heart disease, stroke, and dementia. As people age they develop more complex health needs and are more likely to need specialist services. The increasing prevalence of long-term physical and mental health conditions is one of the main drivers of demand for health services on the Coast.

In 2019/20, almost 4,000 people (12% of our population) were identified as having one or more long-term conditions, such as heart disease, respiratory disease, cancer, diabetes and depression, and were enrolled with our primary care long-term conditions programme.

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

- 26% of our total population and 44% of our Māori population are current smokers, much higher than the national average of 16.2%.
- More than a third (35%) of our total adult population and more than half (56%) of our Māori population are classified as obese.
- 10% of our total adult population were identified as inactive (little or no physical activity). Rates for Māori were similar at 13%.
- 16% of our adult population are likely to drink in a hazardous manner. While lower than the national average, it reflects hazardous drinking habits for one in eight adults on the Coast.

A reduction in these known risk factors could dramatically improve health outcomes for our population and reduce pressure on our health system. All four risk factors have strong socio-economic links, so changing these behaviours would also contribute to reducing health inequities between population groups.

## 1.5 Our operating challenges

Like the rest of the health sector, the West Coast DHB is experiencing growing demand pressure as our population ages; and increasing fiscal pressure as treatment and wage costs raise.

Persistent inequities in health outcomes tell us that we need to do things differently and we cannot address the wider determinants of health inequity on our own. We need to partner with iwi, other government agencies and service providers to increasingly address socio-economic factors that impact significantly on health status, access and outcomes.

We also face several unique challenges due to our size and geographic isolation which add to our operating challenges.

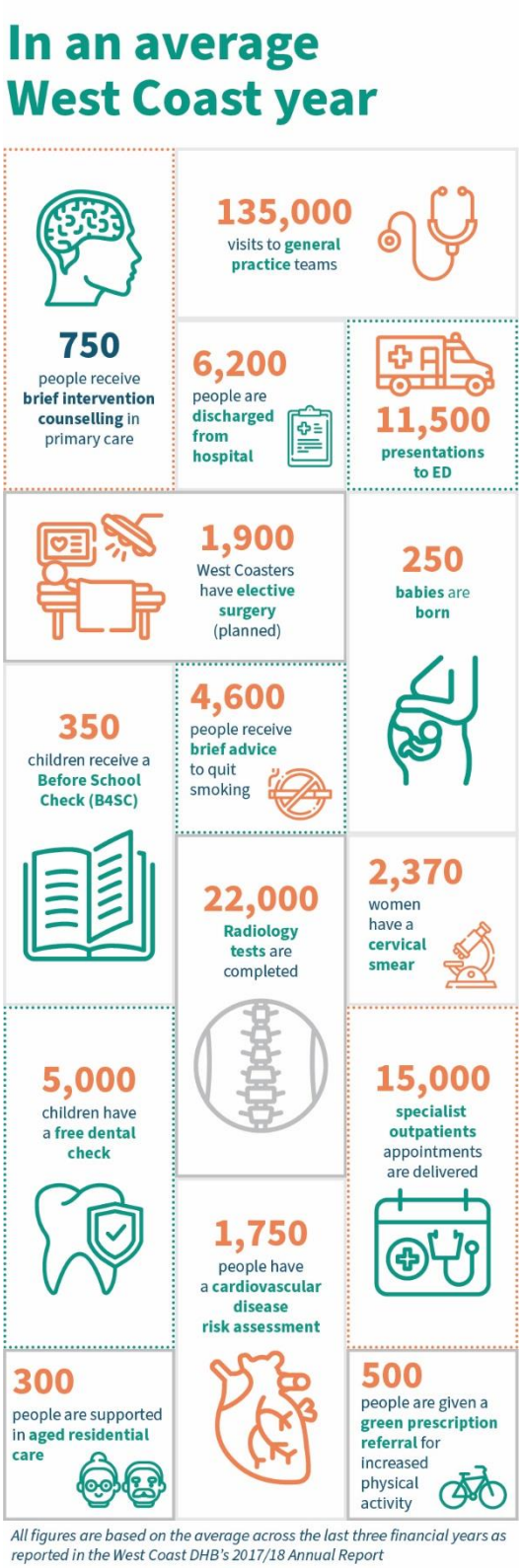
Rurality: Covering the largest geographical area with the smallest population and health workforce means patients and health professionals often have to travel long distances to access or deliver services. Our rurality is one of our biggest challenges and magnifies all the operating pressures we face.

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

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

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

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




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

# Our Strategic Direction

## 1.6 The West Coast vision

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

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

Our vision is underpinned by three strategic objectives:

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

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

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

Integrated: This means improved continuity and coordination of care, having the most appropriate health professional available and the ability to provide the right care, where and when it is needed. Transfer between services will be seamless and supported by the timely flow of information to enable informed clinical decision-making.

Based on a single system: This means services and providers will work in a mutually supportive way to support people to stay well. Resources will be flexible between services and across the wider West Coast health system and tools and processes will help to manage consistency and reduce variation.

Clinically sustainable and financially viable: This means our health system will achieve levels of efficiency that will allow an appropriate range of services to be sustainably maintained within our operating budget. There will be a stable workforce of health professionals in place to provide these services, with strong clinical leadership to support safe and effective care.

## 1.7 Nationally consistent

The West Coast vison is closely aligned to the Government's long-term vision for the health sector, as articulated through the New Zealand Health Strategy and the Government outcomes: Support healthier, safer, more connected communities; and Make New Zealand the best place in the world to be a child.

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

The priorities emphasised for 2021/22 are:

- Giving practical effect to Whakamaua (the national Māori Health Action Plan);
- Improving sustainability;
- Improving child wellbeing;
- Improving mental wellbeing;
- Improving wellbeing through prevention;
- Better population health outcomes supported by a strong, equitable public health & disability system;
- Better population health outcomes supported by primary health care.

The Minister's letter also signals expectations for DHBs to continue to support the COVID-19 response, and to maintain their focus as the national Health & Disability System Review recommendations are implemented.

The Delivering on Government Priorities section of this Plan outlines how we will deliver on the Minister's expectations in the coming year. The Minister's Letter of Expectation for 2021/22 is attached as Appendix 2.

## 1.8 Regionally responsive

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for almost 1.2 million people, 23.3% of the total New Zealand population.

While each DHB is individually responsible for the provision of services to its own population, we work collaboratively through the South Island Regional Alliance to develop more innovation and efficient health services and improve health outcomes for the collective population of the South Island.

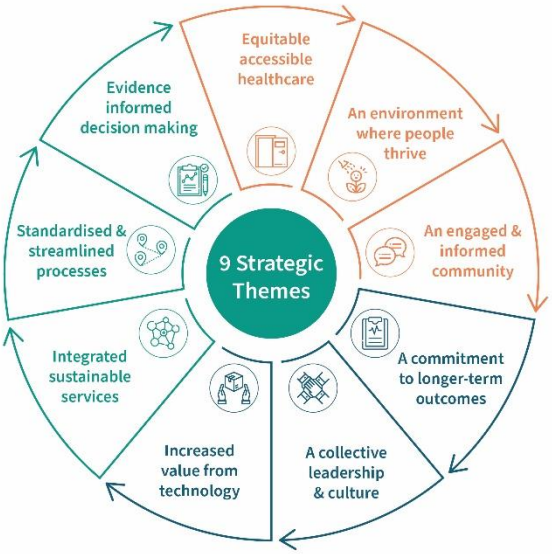
We are currently working on a refocus and reset of priorities for the Regional Alliance to better support vulnerable service areas, address the inequities evident across our health system and respond to the recommendations of the National Health and Disability System Review.

The West Coast DHB has made a strong commitment to this regional work, and activity from the current regional work programme is reflected through our Annual Plan. Further information on the Regional Alliance can be found on the Alliance website: www.sialliance.health.nz.

# Our Immediate Focus

In taking a fresh and innovative approach to its thinking, the West Coast DHB aims to become a leader in the provision of rural health services, developing an integrated health system that is both clinically sustainable and financially viable.

Nine Strategic Themes have been identified as critical to our success; they provide an overarching framework for the way services will be designed, developed and delivered. Actions aligned with these themes are reflected through the Plan, with the most significant areas of immediate focus for 2021/22 being:




A greater focus on equity. Using data to identify disparities and target investment, collective action will support change in areas that have been harder to tackle. We will partner with Tatau Pounamu and engage with iwi, hapū whānau, our Māori health providers and community to develop an improvement strategy in line with Whakamaua (the national Māori Heath Action Plan), to create an environment where Māori can thrive. This will include building on the success of the Whakakotahi QI diabetes project and capturing the opportunities identified in the Pae Ora o Te Tai o Poutini evaluation, to accelerate and spread the delivery of kaupapa Māori and whānau-centred services and reduce health inequities and health loss for Māori.

Delivering longer-term outcomes. We will continue to work collaboratively, across our health and disability system and between DHBs, to ensure our investment is directed into activity and services that will provide the greatest impact for our population. This will include embedding the national Cancer Action Plan and National Bowell Screening Programme, developing our 'Growing Up Well on the West Coast' Early Years Strategy and delivering on our Disability Action Plan. Cross-sector investment and integration will also continue to be a key focus with ongoing partnerships with Education to support strong developmental pathways for children with disabilities and with ACC to reduce harm and enhance recovery following injury for our older population.

Implementing our rural-generalist workforce model. A proven strategy for remote rural health systems this move will support us to build a core of rural generalists across all our workforce groups - nursing, allied health and medical. The model will support people to work to the full extent of their scope of practice; our nursing workforce is already well advanced in this space. Making this transformation will provide continuity of care for our population and improve the quality of care provided by addressing workforce shortages and service fragmentation. Sustainability funding from the Ministry of Health will help to support delivery of our Medical Rural Generalist Strategy in the coming year, specifically in obstetrics and primary care to cover remote areas in Reefton and South Westland.

Moving to modern fit for purpose facilities. Capturing the efficiencies from our migration into Te Nīkau, the development of the Buller Health Centre and agreement on the redevelopment of our Mental Health facility are major pieces of transformational work for the DHB in 2021/22. These modern facilities will help to support the realisation of our integrated service delivery model and enable more efficient service delivery.

Capturing increased value from technology. A new patient management system (Indici) will be rolled-out across all DHB-owned general practices and community services and into our unplanned care services at Te Nīkau. This deliberate investment in a shared electronic system will help to improve clinical decision-making and continuity of care and reduce duplication and the time people waste waiting for treatment. The new system will support an improved patient portal, encouraging engagement with patients and enabling people to take greater control of their health care. It will also support e-prescribing, allowing general practice to direct scripts electronically to the patient's nominated pharmacy, and improving the quality of patient care.

Lessons learnt during the COVID-19 lockdown will also help us to improve access to telehealth options for more people across the Coast, with the Microsoft Teams solution offering a more accessible system that more people can access and operate. Digital enablement funding from the Ministry of Health will support the DHB to make this transition in the coming year.

Supporting the National Direction. The DHB is also committed to supporting the national changes in response to the National Health System Review, implementing the national COVID-19 Vaccination Programme and ensuring preparedness in the event of a COVID-19 resurgence or outbreak.

# THE YEAR AHEAD

## What can you expect from us in 2021/22?

# Delivering on Government Priorities

The following section highlights the activity the DHB will undertake to deliver in response to expectations across the forty-two national planning priorities identified in 2021/22. In reviewing the Plan, the DHB's Board have selected seven areas where they wish to see a heightened focus locally for the coming year. These have been signalled in the following section with a star.

It is important to note that this does not reflect all the activity happening across our health system. Our System Level Measures (SLM) Improvement Plan is developed in collaboration with our Alliance partners and is attached as an appendix to this Plan, as is the DHB's Statement of Service Performance for 2021/22. These documents sit alongside this Annual Plan to provide a broader picture of where we will be focusing our effort and investment over the coming year.

The activity highlighted through the Plans is reflected in the workplans of our local and regional alliances and our operational and corporate services teams. Delivery against the actions and performance measures in the Plan is publicly reported to our Board every quarter.

## 2.1 Commitment to Māori health

The values of our organisation, the way we work, and the way in which we interact with each other are all key factors in achieving health equity for Māori.

As a Crown agency, we recognise our obligations and responsibilities under Te Tiriti o Waitangi and we are working to develop a local Māori Health Improvement Plan to give effect to He Korowai Oranga and Whakamaua the national Māori Health Strategy and Action Health.

We have a memorandum of understanding and strategic partnership with Tatau Pounamu, our Manawhenua Advisory Group, where we actively engage with Māori leaders in the design and development of health strategies and services to support Māori aspirations for health and achieve equity of access and health outcomes. Members of Tatau Pounamu also bring a Māori perspective and leadership to the redesign of services and setting of strategic direction through participation in the West Coast Alliance.

We are supporting our people to develop their understanding of te ao Māori and their ability to meaningfully engage with Māori stakeholders, consumers and whānau. A crucial vehicle for this work is our Takarangi competency framework, an evidence-based learning model that influences and shapes practice and supports improved cultural competency.

We have made a commitment to achieving greater Māori participation in our health workforce. Māori make up 12.7% of the West Coast population but just 6.3% of the DHB workforce. We are participating in the national Kia Ora Hauora programme, increasing the number of Māori working in health, by supporting pathways into tertiary education, local Māori health scholarships and work placements. We are also reviewing and revising recruitment practices that may be unintentionally limiting job placements for Māori applicants and supporting professional development and pathways for Māori staff into leadership roles in our health system.

In seeking to achieve health equity and improve health outcomes for Māori on the West Coast, we promote a culture that addresses disparities through open discussion, the use of the Health Equity Assessment Tool (HEAT), universal performance targets and regular reporting of service performance and population health metrics by ethnicity.

We also work collaboratively with Poutini Waiora (our kaupapa Māori health and social services provider) to provide increased service options and choice for Māori and support the development of services and service models, based on tikanga and underpinned by the values embedded in manaakitanga, whānaungatanga, rangatiratanga and wairuatanga.

## 2.2 Commitment to health equity

On the West Coast, as in the rest of New Zealand, people have differences in health outcomes and experiences that are not only avoidable but unfair and unjust.

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

In acknowledging and taking steps to address inequities in our system we will need to evolve our workforce, build our cultural capability and work in partnership with our community to co-design service delivery models to better meet their needs. We also need to recognise that people with different levels of advantage require different service approaches and resources to achieve equitable outcomes.

The DHB is guided in this space by a range of national strategies, including: He Korowai Oranga (the Māori Health Strategy), Ola Manuia 2020-2025 (Pacific Health and Wellbeing Action Plan), Healthy Ageing Strategy, New Zealand Disability Strategy and the UN Convention on the Rights of Persons with Disabilities.

Actions and activity aimed at improving health equity are indicated throughout the following section by the Equity Outcome Action code (EOA).

## 2.3 Give Practical effect to Whakamaua - Māori Health Action Plan 2020-25

| Planning Priority: Engagement and Obligations as a Treaty Partner | |
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| **Action to Improve Performance** | **Milestone** |
| Engage our iwi Advisory Board, Tatau Pounamu, in the completion of a West Coast Māori Health Profile, to inform strategic thinking and identify opportunities to accelerate Māori health improvement and equity. (EOA)[1] | Q2: West Coast Māori Health Profile complete. |
| In partnership with Tatau Pounamu, work with iwi, hapū whānau and our Māori community to develop a longer-term strategy for improving Māori outcomes in line with Whakamaua (the national Māori Health Action Plan). (EOA)[1] | Q2: Consultation undertaken.<br>Q3: Improvement plan developed and approved. |
| Establish a process for Tatau Pounamu to support Māori representation on workstreams or governance groups and develop a pool of Māori talent for people to draw upon, to grow Māori leaders across our system and ensure greater depth for succession planning. (EOA) | Q1: Two Māori members appointed to the West Coast Disability Steering Group.<br>Q3: Talent pool identified. |
| Engage with the Ministry of Health to offer Māori DHB Board members, Tatau Pounamu members and Māori members on the West Coast Alliance workstreams the opportunity to participate in the Māori governance and leadership workshop developed by the Ministry. (EOA) | Q1 Māori Board members participate in training workshop. |
| Deliver a series of information/education sessions to the DHB's Board and Tatau Pounamu to enable informed participation in driving equity conversations and strategy. (EOA) | Q1: Programme in place.<br>Q2-Q4: Sessions delivered. |

| ★ Planning Priority: Whakamaua Objective: Accelerate and Spread the Delivery of Kaupapa Māori and Whānau-centred Services | |
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| **Action to Improve Performance** | **Milestone** |
| Collaborate with training bodies, high schools and local iwi to build on existing workforce initiatives to promote health careers to local Māori. (EOA)<br>Support the Rangatahi Exposure Day and Rangatahi Placement Programme with Kia ora Hauora. (EOA)<br>Establish a process with Kia Ora Hauora to promote employment pathways and opportunities with the West Coast DHB to Kia Ora Hauora graduates. (EOA) | Q1: Dates for Rangatahi Exposure Days agreed.<br>Q2: Promotion process in place with Kia Ora Hauora.<br>Q4: Two Rangatahi Exposure Days completed. |
| Review our approach to the West Coast DHB summer holiday studentship programme to instil an equity perspective and refresh the promotional material, position descriptions and interview process to encourage participation by Māori. (EOA) | Q2: Material refreshed.<br>Q4: Increased uptake of studentships by Māori. |
| Provide support to Poutini Waiora in securing national primary mental health and addictions initiative funding and work collaboratively to support the development of a primary kaupapa Māori mental health service. (EOA) | Q1: Ongoing support dependant on success of bid. |
| Scope the potential for the West Coast DHB's Māori Mental Health team to work more closely with primary and community services, to improve the continuity of care for Māori needing mental health and addiction support. (EOA). | Q2: Options scoped.<br>Q3: Proposal put forward. |
| Engage with Tatau Pounamu and Poutini Waiora, as the DHB transitions to Microsoft Teams, to increase access to telehealth services for Māori across the West Coast, particularly those in our more remote areas. (EOA)<br>Seek feedback from Māori service users regarding their experience of telephone/video consults over the acute COVID-19 period to inform improvements in the service going forward. (EOA) | Q1: Feedback sought.<br>Q2 Feedback reviewed and presented to Clinical Leads and Information Service Group. |
| Seek feedback from Poutini Waiora and service users regarding their experience of e-prescribing over the acute COVID-19 period and investigate options to provide Poutini Waiora kaupapa Māori nurses with the technical capability to provide this option. (EOA) | Q2: Feedback reviewed and presented.<br>Q4: IT capability confirmed, and options considered. |

[1] This work was delayed in 2020/21 due to resource constraints and redeployments and has been prioritised for 2021/22.

| Planning Priority: Whakamaua Objective: Shift Cultural and Social Norms | |
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| **Action to Improve Performance** | **Milestone** |
| Embed the recruitment strategy introduced in 2020/21, to support Māori job applicants, who meet the minimum requirements for positions, to advance to the interview stage, to promote the diversification of our workforce. (EOA) | Q1: Pool of Māori identified to support interviews.<br>Q4: Impact of policy reviewed. |
| Building on our investment in the Takarangi Competency Framework, develop a tiered cultural competency pathway for people as they progress through the stages of their careers; leading self, leading others and leading health. (EOA) | Q2: Framework developed and presented to operational leadership group for approval. |
| Facilitate opportunities for our clinical workforce to participate in MIHI 501 Health Professionals Course: Application of the Hui Process/Meihana Model to Clinical Practice, to promote positive engagement, appropriate care/treatment and health advocacy that supports Māori health equity. (EOA) | Q1 Business proposal agreed.<br>Q4 Number of staff enrolled and completing MIHI 501. |
| Support Māori working in our health system to respond to institutional racism by providing in-house and online training in the following areas: addressing bias in decision-making, understanding health equity, Te Tiriti o Waitangi and HEAT tool training. (EOA) | Q2: Hui for Māori staff held, and package of training delivered.<br>Q4: 5 HEAT sessions delivered, and a repository of HEAT training sessions developed. |

| ★ Planning Priority: Whakamaua Objective: Reduce Health Inequities and Health Loss for Māori | |
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| **Action to Improve Performance** | **Milestone** |
| Work with the Healthy West Coast Alliance to investigate the feasibility of supporting wāhine Māori smokers through noho marae style intensive support, to reduce smoking rates among this high priority population. (EOA) | See the Smokefree 2025 section of this plan. |
| Develop an Immunisation Engagement and Communication Plan, in partnership with Māori, Pacific and other consumer voices in our communities, to help promote immunisation and increase education around the importance of immunisation, particularly amongst high need and hard to reach populations. (EOA) | Q1: Hui on key messages.<br>Q2: Engagement and Communication Plan developed. |
| Engage with Breastscreen South, Poutini Waiora and the PHO to consider how the mobile screening unit might be used to offer breast screening in community settings to encourage uptake by Māori and Pacific women. (EOA) | Q2: Options and logistics investigated<br>Q3: Marae based event planned. |
| Engage our Iwi Advisory Board, Tatau Pounamu, in the completion of a West Coast Māori Health Profile, to inform strategic thinking and identify opportunities to accelerate Māori health improvement and equity. (EOA) | Q2: West Coast Māori Health Profile complete. |
| Refresh the DHB's Māori Health Performance Dashboard in line with the Whakamaua indicators set and the DHB's Māori Profile and System Level Measures, to increase access to performance results and encourage conversations about equity. (EOA) | Q1: Refreshed dashboard presented at public Board meetings quarterly.<br>Q2: Online view developed. |
| Work with Tatau Pounamu to co-design an evaluation framework for reviewing specific service areas and the effectiveness of current programmes and service models in addressing areas of inequity for Māori. (EOA) | Q4 Evaluation framework developed, and first evaluation undertaken. |

| Planning Priority: Whakamaua Objective: Strengthen System Accountability Settings | |
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| **Action to Improve Performance** | **Milestone** |
| Engage with Tatau Pounamu on the redevelopment of the Mental Health Unit as the business case is progressed and agree on participation and consultation for design phases should approval of the business case be given. (EOA) | Q1:Q4: Ongoing engagement on the redevelopment of the Mental Health Unit. |
| Engage with Poutini Waiora, Tatau Pounamu, the wider Māori health sector and the West Coast PHO to build on the success of the Whakakotahi QI project and capture the opportunities identified in the Pae Ora o Te Tai o Poutini evaluation, to improve health outcomes for Māori. (EOA)<br>In doing so, develop and submit a proposal for Te Ruinga funding, with Poutini Waiora, to engage a project facilitator to progress the development of the Pae Ora model. (EOA) | Q1: Socialisation of the Pae Ora evaluation.<br>Q1: Funding proposal submitted to the Ministry.<br>Q2: Facilitator engaged.<br>Q4: Pathway for development of whānau ora community clinics agreed. |
| Partner with iwi to undertake a collective redesign process to better tailor mental health and addiction service to local population characteristics and needs and to foster community - led solutions to prioritise health equity for Māori. (EOA) | Q1: Plan for undertaking design submitted to the Ministry.<br>Q2: Co-design underway. |

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| | Q4: Priority projects identified. |
| Appoint two Māori members to the newly formed West Coast Disability Steering Group, identified and supported by Tatau Pounamu, to ensure a strong Māori voice in the Disability Strategy implementation. (EOA) | Q1: Members in place. |
| In line with the Regional Child Development Service workplan, scope and recruit a kaupapa Māori role that supports West Coast whānau to access Child Development Services and supports improved cultural competency within the existing workforce. (EOA) | Q2: Position in place.<br>Q4: Update on actions and activity. |
| Provide support to Poutini Waiora in securing national primary mental health and addictions initiative funding and work collaboratively to support the development of a primary kaupapa Māori mental health service. (EOA) | Q1: Ongoing support as required.[2] |
| Participate in the refresh and realignment of the South Island Regional Alliance work to identify opportunities to shift resource and funding to focus on achieving health equity for people in the South Island and for Māori as a priority population. (EOA) | Q1: Five priority areas identified for regional focus.<br>Q2: Action plan agreed. |

## 2.4 Improving sustainability (confirming the path to breakeven)

| ★ Planning Priority: Short Term Focus 2021/22 | |
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| **Action to Improve Performance** | **Milestone** |
| Rural General Workforce Model: Capture opportunities provided by national sustainability funding to implement the Rural Generalist Workforce Model on the Coast.<br>Focus on building our permanent workforce, reducing silos between care settings and providing greater access to 24/7 care to reduce acute episodes of care and readmission, improve health outcomes and support the clinical and financial sustainability of our health system. | Q2: Recruitment and training strategy finalised and recruitment underway.<br>Q4: Additional 3 FTE Rural Generalists employed (1 RG Obstetrics and 2 RG Rural Primary Care).<br>Q4: Reduction in locum, contracted and agency staff costs - $200k. |
| Clinical Procurement: Using local and national data and analytics, identify opportunities to avoid cost increases in overall spend on clinical consumable expenditure.<br>Work in partnership with the Canterbury DHB to focus on consolidating suppliers, and rationalising and standardising equipment and delivery models, without impacting on patient care. | Q2: Top 20 clinical consumables identified in terms of costs and focus underway to reduce costs in key areas.<br>Q4: Avoided costs anticipated at $120k. |
| Utilise service demand and workforce planning tools to support the ongoing review of production plans, rosters and community-based service contracts to better anticipate, respond and manage people resources cost effectively, creatively and responsively.<br>Focus on significant cost pools and areas of changing demand, to drive recurrent efficiencies that will have a current year (2021/22) impact and maintain a pipeline of savings for 2022/23. | Q1: External provider contracts reviewed, and opportunities captured.<br>Q2: High cost expenditure areas reviewed, and opportunities captured.<br>Q4: Anticipated savings $250k. |

| Planning Priority: Medium Term Focus (three years) | |
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| **Action to Improve Performance** | **Milestone** |
| System Integration: Capture opportunities and learnings from our COVID-19 response to support the deployment of a single patient management system (Indici) and patient portal across primary care and urgent care settings, to support more informed clinical decision-making, streamline processes, integrate care and reduce duplication.<br>Focus on incorporating preventative care into all care responses to reduce acute episodes of care, ambulatory sensitive hospital (ASH) admissions and readmissions, improve health outcomes and support the clinical and financial sustainability of our health system. | Q2: Indici deployed across general practice.<br>Q3: Indici deployed into the urgent care setting.<br>Q4: Development or refresh of pathways of care for people with long term conditions.<br>Q4: Reduction in ASH rates for adults 45-65 - baseline 3,017 per 100,000 people (Sep 2020). |
| Digital Enablement: Capture opportunities provided through the national digital enablement funding to increase uptake of telehealth and virtual services across all care settings on the West Coast.<br>Focus on transitioning to Microsoft Teams to improve the scalability, usability and performance of telehealth services and broaden access to more remote areas of the Coast to increase consumer engagement, provide access to earlier intervention, and reduce DNAs, acute presentations and readmissions. | Q2: Transition to Microsoft Teams completed.<br>Q3: Options for integrating the telehealth booking processes with the patient booking system investigated.<br>Q4: Options to provide kaupapa Māori nurses with the technical capability to provide virtual services investigated. |

[2] These actions will be dependent on the West Coast bid securing national funding.

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| Investigate options for integrating the telehealth booking processes with the patient booking system to streamline processes, reduce opportunities for missing appointments and better capture events.<br>Share learning opportunities to support the sustainability of our system and improve equity of access across the region. | Q4: Increase in the total return travel distance saved for patients – baseline average kms saved per month 69,588 (9 months to April 2021).1<br>Q4: Increased number of telehealth consultations – baseline total telehealth visits 10,645 (12 months to April 2021).<br>Q4: Reduction in number of patients missing telehealth appointments - baseline average DNA rate 3.3% (12 months to April 2021). |
| Continued implementation of the Rural Generalist Workforce Model highlighted in the section above, including identification of increased capability amongst our non-registered workforce to enhance their role in the care and support of our community. | Year 1: Reduction in the use of locum, contracted and agency staff -$200k.<br>Year 2: Enhanced capacity of our non-registered workforce - $100k. |
| Improved Asset Management: Complete a full facility review of all DHB owned land and properties to ensure optimum use of available assets and disposal of any surplus assets to ensure the future sustainability of the portfolio and reduce maintenance and operating costs of assets with no future role. | Year 1: Disposal of surplus property underway and increased return from property portfolio - $2M.<br>Year 2: Completion of disposal processes and improved return from property portfolio - $2M. |

## 2.5 Improving maternal, child and youth wellbeing

| Planning Priority: Maternity Care | |
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| **Action to Improve Performance** | **Milestone** |
| Complete COVID-19 resurgence planning to identify actions to ensure service improvement opportunities. | Q1: COVID-19 resurgence planning completed.<br>Q4: Service improvement opportunities implemented. |
| Continue to develop transalpine processes to enable better access to virtual maternity services and reduce the need for West Coast women to travel to Canterbury with a focus on foetal medicine and antenatal maternity care. (EOA)<br>Develop pathways to enable opportunities for education and professional development in conducting telehealth sessions between CDHB and WCDHB maternity services.<br>Seek feedback on the use of telehealth as the workforce gains confidence through exposure to sessions to identify ongoing improvements and champion change. | Q1-Q4: Virtual support provided from CDHB birthing suite to Te Nīkau Rural Generalists.<br>Q1: Education and professional development pathways in place.<br>Q1-Q4: Feedback supports ongoing development. |
| Identify opportunities with the newly established 'Whare Manaaki' in Greymouth to provide maternal health services in a broader whānau-based setting. (EOA) | Q3: West Coast maternity services linked with Whare Manaaki. |
| Review ultrasound capacity across all West Coast facilities with a focus on achieving equity of access across all locality bases. (EOA)<br>Implement the Gestational Assessment Protocol (GAP), an ACC funded digital programme, to support risk assessment and earlier intervention and improve outcomes for mother and baby. (EOA) | Q1: Audit of maternity referrals declined by ultrasound service.<br>Q1: GAP Contract signed, and implementation commenced.<br>Q4: Assessment of GAP implementation including impact of ultrasound capacity. |
| Bring Pregnancy & Parenting education (PPE) providers together to promote a complementary approach to the delivery of PPE, build on the success of the local Hapū Wānanga programme and improve engagement with Māori, Pacific and high-need mothers. (EOA) | Q1: PPE stakeholder group established.<br>Q3: Annual PPE programme developed across the region. |
| Work regionally to review referral process to Well Child Tamariki Ora services, as part of the South Island Alliance WCTO Quality Improvement initiative and implement the national Well Child Tamariki Ora review recommendations (expected to be released in Q2 2021/22). | Q1: Current pathway reviewed.<br>Q3: Service improvement opportunities implemented. |
| Identify opportunities to streamline processes for the Newborn Metabolic and Hearing screening programme, to ensure we are adhering to lead times and enabling earlier intervention and treatment. | Q1: Review of pathways across all birthing facilities.<br>Q3: Introduction of a paper free system for screening data. |
| Implement sustainability contracts to support midwives working in Buller to access and contract locum support and build succession plans. | Q1: Sustainability contracts implemented.<br>Q2-Q4: Professional development opportunities identified and taken. |

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| Identify opportunities for West Coast midwives to attend and engage in professional development in Canterbury to grow their skills and confidence and build peer support networks.<br>Support West Coast rural generalist midwives to develop and be part of interdisciplinary care through shared education and development of collective standards and guidelines. | Q2-Q4: Report on shared education and development of standards and guidelines. |
| Connect with Nursing Leaders across the South Island to promote the rural workforce pathway and recommendations of the South Island Workforce Development Hub to grow and develop the midwife workforce. | Q2: Nursing Leaders connect.<br>Q4: Key messaging developed for students |
| Building on the CCDM implementation, use Trendcare data from maternity services to identify and respond to workforce gaps and ensure safe staffing levels in our services. | Q2: Trendcare data reviewed.<br>Q4: Workforce realigned. |
| Review the current processes in place for Perinatal & Maternity Mortality Reviews to enhance performance, capture opportunities to strengthen and align transalpine processes. | Q1: Review complete.<br>Q4: Revised process developed for West Coast reviews. |
| Support the development of the DHB's 'Growing Up Well on the West Coast' Early Years Strategy, to encourage early engagement with maternity services, an improved maternity journey and the best start in life for our children. (EOA) [3] | Q1: Connected working group in place to support the Growing Up Well Strategy development.<br>Q4: Strategy in place. |
| Review and update the maternal mental health pathway to ensure there are culturally safe support options for women and whānau experiencing maternal mental health distress, and capacity to support referrals is in place locally. (EOA) | Q1: Review underway.<br>Q4: Pathway updated. |
| Retrospectively review cases of children (aged 0-4) presenting to the Emergency Department with respiratory conditions who are not admitted, to identify the current state of referral to the DHB's Clinical Nurse Specialist (CNS) service for ongoing support and management. [4]<br>Using data from the review work with paediatrics, general practice and the CNS service to map the optimal referral pathway for children with respiratory presentations.<br>Implement a multi-disciplinary team approach to reduce the number of frequent presenters. | Q1: Review undertaken.<br>Q2: Mapping exercise complete.<br>Q3: New pathway in place.<br>Q4: Review of ASH admissions for respiratory conditions. |

| Planning Priority: Immunisation | |
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| **Action to Improve Performance** | **Milestone** |
| Undertake a quality improvement review of the current process undertaken by the National Immunisation Register team to identify children from infancy to age five who are overdue for immunisations to lift immunisation coverage rates. In doing so ensure:<br>National Immunisation Register and National Enrolment Service ethnicity for children match and if not, the child's ethnicity is confirmed. (EOA)<br>Māori and Pacific children overdue for vaccinations are referred to the Missed Events Service within the agreed timeframes. (EOA)<br>Māori and Pacific families, who agree to be referred to Outreach Immunisation Services, are given a priority referral. (EOA) | Q1: Review complete.<br>Q2: Processes confirmed and updated with the team.<br>Q3: Improvement in Māori and Pacific coverage rates across all age milestones.<br>Q4: National targets are met across all age milestones. |
| Hold a hui to develop an Immunisation Engagement and Communication Plan, in partnership with Māori, Pacific and other consumer voices in our communities, to help promote immunisation and increase education around the importance of immunisation, particularly amongst high need and hard to reach populations. (EOA) | Q1: Hui on key messages.<br>Q2: Plan developed. |
| Identify two priority actions from the Immunisation Engagement and Communication Plan to deliver in 2021/22. | Q2: Priorities identified<br>Q4: Two priorities delivered. |
| Partner with our kaupapa Māori provider and public health team to develop and deliver community-led education and awareness sessions on the importance of immunisation for Māori. (EOA) | Q3: Annual sessions planned and delivered. |
| Develop a process to support general practice to improve Māori ethnicity data collection for Kaumatua, to support this group to be prioritised for Influenza vaccinations. (EOA) | Q1: Process agreed. |

[3] The Early Years Strategy will build on the work undertaken to develop our Maternity Strategy and is being developed in partnership with our community and key stakeholders with a strong focus on achieving equity of outcomes for Māori mothers, babies and children.
[4] Respiratory conditions are the largest contributor to the West Coast's Ambulatory Sensitive Hospital Admission rates for children aged 0-4 years and this work is expected to help to reduce avoidable hospital admissions and improve long-term respiratory health outcomes.

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| | Q3: Increase in Māori influenza vaccination coverage: baseline 44% (2019/20). |
| Provide an updated process chart to general practice to raise awareness around the timeframes for the new 12-month Immunisation event. | Q1. Updated process chart distributed. |
| Develop a pathway to identify children who are overdue for their 12- and 15-month immunisations and link them back to the general practice, to support the practice to prioritise and reach the families of children overdue for vaccinations. | Q1: Pathway agreed and implemented. |
| Provide quarterly reports on performance to the West Coast Locality workstreams to support conversations about equity and opportunities for improvement. (EOA) | Q1-Q4 |
| Collaborate with general practice to ensure that both programmes (COVID-19 and childhood vaccination) are well resourced and delivery of the COVID-19 programme does not negatively impact on the delivery of childhood vaccinations.<br>Work with the West Coast PHO to ensure ongoing visibility and delivery of the national childhood immunisation programme.<br>Ensure that capacity is maintained across the LinKIDS, Missed Events and Outreach Immunisation Teams to support delivery of childhood immunisations, undertaking monthly meetings with service providers to identify staffing requirements and monitor coverage. | Q1-Q4: Engage retired and casual workers to fill vaccinator requirements.<br>Q1-Q4: Ongoing communication between West Coast general practice localities and COVID-19 workforce management.<br>Q1-Q4: Monthly monitoring of overdue children, including outreach waitlists. |
| Contributory Measure CW07: Proportion of newborn children enrolled with a PHO by three months of age. | Increase on 2019/20 baseline to >85% for all population groups:<br>Māori: 74%<br>Total Population: 90% |
| Contributory Measure CW05: Proportion of eligible children fully immunised at eight months of age. | Increase on 2019/20 baseline to >95% for all population groups:<br>Māori: 81%<br>Total Population: 78% |

| Planning Priority: Youth Health and Wellbeing | |
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| **Action to Improve Performance** | **Milestone** |
| Following on from the work completed in 2020/21, work to ensure a youth friendly pathway is in place for young people who make an unplanned presentation to the new Te Nīkau Grey Health Centre with mental distress.<br>In doing so implement the key actions outlined in the West Coast's System Level Measures Improvement Plan for 2021/22 including:<br>Utilising the new mental health educator resource in acute care to support clinicians to confidently and appropriately manage youth presenting with mental health issues.<br>Reviewing young consumers' feedback from the Primary Care Patient Experience Survey about walk-in appointments for gaps and opportunities to improve.<br>Increasing the responsiveness of suicide prevention activity for Māori and promoting a 'by rangitahi for rangitahi' approach that is tikanga Māori and whānau centred. (EOA) | Q1: MH educator FTE providing support in ED.<br>Q4: Review of patient experience survey complete. |
| Engage with the key findings from the youth oral health survey presented to the Transalpine Oral Health Service Development Group (OHSDG) in 2020/21 to improve engagement with oral health services by priority youth populations, which is low on the West Coast.<br>Collaborate with the OHSDG and our Public Health and Hauora Māori teams to complete an Oral Health Promotion and Education Plan with practical actions to address the barriers identified in the following five key areas: education, relationships, communication, logistics, and apathy. (EOA)<br>Appoint a Clinical Lead for Oral Health to drive improvements across the service and integration with other providers to respond to children at risk of poor oral health outcomes. | Q1: Youth oral health survey results revisited.<br>Q2: Oral Health Promotion and Education Plan completed.<br>Q2: Clinical Lead appointed for Oral Health.<br>Q4: Minimum of two priorities from the Plan actioned. |
| Public Health Nurses will incorporate the key feedback from the Youth Health Survey, undertaken in 2020/21, into their continuous improvement plan for each school to ensure young people's needs and aspirations are influencing service provision and delivery models, and to increase engagement with the School Based Health Service. | Q1: Continuous improvement plans reviewed.<br>Q4: Student survey repeated. |
| Engage with DHB regions where telehealth options have been used for delivery of SBHS, to understand how the West Coast might introduce a similar service option for SBHS where face-to-face service delivery is not possible. | Q1/Q2: Learnings from other regions captured.<br>Q3/Q4: Logistics investigated, and options put forward. |

| Planning Priority: Family Violence and Sexual Violence | |
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| **Action to Improve Performance** | **Milestone** |
| Enhance the DHB's response to family harm by participating in the Family Violence Interagency Response System (FVIARS) to support an effective community response from government, health and social agencies to people and whānau at-risk. (EOA)<br>Place additional focus on the impact COVID-19 has had on the safety of whānau affected by family harm. | Q1: DHB representative participating in FVIARS.<br>Q1-Q4: DHB information requirements for FVIARS meetings are met. |
| Implement a new online VIP introduction module for all new staff, which will further increase training options and improve continuity and training availability in the event of another COIVD-related lockdown or other unforeseen circumstances. | Q1: New online VIP module available.<br>Q4: Increased number of staff attending VIP and VIP associated training. |
| In collaboration with Te Rito Family Violence Network and Safe Men Safe Family, facilitate the delivery of culturally inclusive education and support programmes for Māori men who are perpetrators (and victims) of family violence, to support behavioural change. (EOA) | Q1-Q4: Weekly programme delivery as required.<br>Q1-Q4: Number of Māori men accessing regular support and participating in programmes. |

## 2.6 Improving mental wellbeing

| Planning Priority: Improving Mental Wellbeing | |
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| **Action to Improve Performance** | **Milestone** |
| Through the Healthy West Coast Alliance, work with partner health and social service agencies to support individuals, whānau and communities to access the resources they need to live in healthy environments that support their mental health and wellbeing. | Q1-Q4: Delivery of the Healthy West Coast Alliance workplan. |
| Promote the referral pathway and consumer eligibility to Puāwaitanga (online counselling services) to our mental health service, general practice and community-based providers and to consumers, to enhance support options for individuals and whānau who may have barriers to attending traditional face-to-face counselling services. (EOA)<br>Review consumer uptake of Puāwaitanga to confirm ongoing support for the service and to understand and respond to the demand from our population. | Q1: Referral pathways communicated to providers.<br>Q2-Q4: Service uptake monitored. |
| Embed our locality-based service model to support an integrated approach across primary and specialist mental health and addiction services to support the wellbeing of our community and enable a rapid integrated response in the event of any future pandemic/ outbreak.<br>Realign clinical FTE to provide additional support to the high-need Northern Locality to strengthen the community-based mental health team and improve the continuity of care for that population. (EOA) | Q1: Additional Northern locality Clinical FTE in place.<br>Q1-Q4: Ongoing review of demand and service utilisation data by operational leadership team. |
| Partner with the Ministry of Education, using national funding from the Ministry of Health (MoH), to engage with stakeholders and design a school-based programme that provides mental health and wellbeing support to all primary and intermediate tamariki in the district. | Q1: Plan for undertaking the co-design submitted to the Ministry of Health.<br>Q3: Proposed service description from co-design process, submitted to MOH. |
| Partner with iwi, using national funding from the Ministry of Health, to undertake a collective redesign process to better tailor mental health and addiction service to local population characteristics and needs and to foster community-led solutions to prioritise health equity for Māori. (EOA) | Q1: Plan for undertaking the co-design submitted to the Ministry of Health.<br>Q2: Co-design underway.<br>Q4: Priority projects identified. |
| Develop and implement a model whereby Pukenga Atawhai roles are embedded into clinical teams and engaged with crisis response call outs and assessments, to provide an improved cultural response to Māori in crisis. (EOA) | Q1: Model in place during business hours.<br>Q2: Reporting established to identify number of crisis contacts with Pukenga Atawhai engaged. |
| Review the uptake of the Opioid Substitution Treatment pathway and identify further opportunities to improve and expand community-based treatment and support for Māori with addictions. (EOA) | Q3: Review complete.<br>Q4: Improvements actioned. |
| Establish a Connecting Care Governance Group to identify and oversee improvements in transition and discharge planning to ensure patients are well supported on discharge.<br>Develop discharge packs for service users to support people's transition back to the community.<br>Apply the HEAT tool to this work to appropriately consider the needs of Māori service users and ensure we are not inadvertently widening equity gaps. (EOA) | Q1: Governance Group established.<br>Q2: Discharge packs available.<br>Q3: Report on the application of the HEAT tool and improvements actioned. |

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| Commence work with service users to support them to complete Advanced Directives, to ensure their aspirations and wishes are specified and implemented, should they become unwell in the future. | Q3: Advanced Directives being recorded. |
| Develop and establish a training package that supports staff to adopt a more patient-centred approach to treatment planning to improve engagement and continuity of care. | Q4: First group of staff trained. |
| Contributory Measure MH03: Proportion of long-term clients discharged from adult specialist mental health services with a transition or wellness plan in place. | 95% of all long-term clients have a transition or wellness plan in place on discharge. |
| Contributory Measure MH07: Proportion of people discharged from mental health and addiction inpatient services for whom a community service contact is recorded in the seven days immediately following that discharge. | Increased proportion of people discharged seen in seven days - 2019/20 baseline:<br>Māori: 77%<br>Total Population: 78% |

## 2.7 Improving wellbeing through prevention

| Planning Priority: Communicable Diseases – Current Context – COVID-19 | |
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| **Action to Improve Performance** | **Milestone** |
| Implement the key actions in our COVID-19 Programme Plan, COVID-19 Response Plan, and COVID-19 Quality Plan developed by our Community & Public Health team to minimise COVID-19's impact on health, wellbeing and equity in our communities, and support a positive community response. (EOA) | Q2&Q4: COVID-19 status and response reported to the Ministry. |
| Monitor and report communicable disease trends and outbreaks. | Q2&Q4: Number of reports sent to health professionals. |
| Follow up communicable disease notifications to reduce disease spread, with a focus on culturally appropriate responses. (EOA) | Q2&Q4: Number of notifications completed. |
| Identify and control communicable disease outbreaks, with a focus on culturally appropriate responses. (EOA) | Q2&Q4: Number of outbreaks recorded. |

| Planning Priority: Environmental Sustainability | |
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| **Action to Improve Performance** | **Milestone** |
| Update the Staff Vehicle Transport Policy with additional focus on environmental considerations, including guidance on use of multi-person public transport and alternative transport options for essential workers during escalated COVID-19 levels. | Q1. Draft finalised and circulated for review.<br>Q2: Final document approved and implemented. |
| Investigate the ability to reimburse employees for the cost of use of alternative forms of electric transport such as electric scooters and e-bikes in place of fossil fuel options such as taxis, reducing our environmental footprint and reducing risks from multi-person transportation alternatives during heightened COVID-19 alert levels. | Q1: Scoping completed.<br>Q2: Recommendations made.<br>Q4: Policy implemented. |
| Establish a pathway to measure, verify and report emissions from 1 July 2022 in line with the DHB obligations under the Carbon Neutral Government Programme and to support the setting of credible emissions reduction targets and plans for 2025 and 2030. | Q2: Key actions to support reporting identified.<br>Q4: Process in place to report total tCO2e emissions. |

| Planning Priority: Antimicrobial Resistance | |
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| **Action to Improve Performance** | **Milestone** |
| Audit staff hand hygiene compliance against national requirements and provide feedback on compliance rates to clinical areas on a quarterly basis to lift compliance rates. | Q1-Q4: Audits completed and disseminated. |
| Provide targeted education around hand hygiene, appropriate use of gloves, and the 5 Moments Of Hand Hygiene for staff, to keep hand hygiene top of mind. | Q1-Q4: Education sessions run with clinical areas with low compliance. |
| Produce resources and promotion targeting staff for World Hand Hygiene Day in May 2022. | Q4: Resources and education campaign launched. |

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| Establish a pharmacy champion to work with Community & Public Health, the West Coast PHO and our kaupapa Māori provider to develop and deliver a Coast-wide awareness campaign for World Antibiotic Awareness week.[5] | Q1: Champion in place.<br>Q2: Campaign launched. |
| Produce Antibiotic Awareness Week resources for educational sessions in te reo, to increase antibiotic health literacy amongst Māori. (EOA) | Q2. Resource produced. |
| Engage the wider system in antimicrobial resistance (AMR) management by establishing an AMR network between hospital services, primary care and ARC services to ensure regular communication and consistent messaging is shared across the system. | Q2: Key leads identified.<br>Q4: Network established and communications underway. |

| Planning Priority: Drinking Water | |
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| **Action to Improve Performance** | **Milestone** |
| Until Taumata Arowai (the new national drinking water agency) is established, continue to deliver and report on the drinking water activities and measures in the Ministry of Health Environmental Health exemplar to ensure high quality drinking water.<br>Monitor compliance of networked drinking water supplies in accordance with the Health Act. | Q2&Q4: Report on the percentage of networked water supplies (by class) where timely response was provided by the PHU to transgressions, contamination or interruption in accordance with drinking water legislation and standards. |
| Highlight non-compliant supplies, water supplies which predominantly serve Māori or Pacific populations, or those which potentially pose a public health risk, to Taumata Arowai at handover. (EOA) | Q1: Handover to Taumata Arowai highlights key water supplies or water supply risks. |

| Planning Priority: Environmental and Border Health | |
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| **Action to Improve Performance** | **Milestone** |
| Maintain relationships with local rūnanga to support an ongoing partnership in addressing environmental health issues. (EOA). | Q2&Q4: Number of issues identified, addressed and/or under action. |
| Deliver and report on the activities contained in the Ministry of Health Environmental and Border Health exemplar, including undertaking compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation, to improve the quality and safety of our physical environment. | Q2&Q4: COVID-19 border management status and response reported. |

| Planning Priority: Healthy Food and Drink Environments | |
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| **Action to Improve Performance** | **Milestone** |
| Using the audit of DHB site (completed in 2020/21) identify areas in need of support and engage with them to comply with the DHB's Healthy Food and Drink Policy. In doing so:<br>Share the success stories from exemplar DHB sites or organisations to inspire change. | Q2: Review of audit results and sharing of success stories.<br>Q4: Support targeted to non-compliant DHB sites. |
| Collaborate with education providers in early learning settings, primary, intermediate and secondary schools to support the adoption of water-only (including plain milk) and healthy food policies in line with national Healthy Active Learning Initiative.<br>Place emphasis on education providers with higher proportions of Māori, Pacific, and/or lower socio-economic status students. (EOA) | Q2&Q4: Report proportion of schools and ECECs with water-only and healthy food policies. |

| Planning Priority: Smokefree 2025 | |
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| **Action to Improve Performance** | **Milestone** |
| Building on the lessons learnt during the COVID-19 response, look to embed remote smoking cessation support as an ongoing service option, to reduce travel time and improve access to support for people in more remote areas and to improve the resilience of the service in the case of similar future events. (EOA) | Q1: Review current practice and service user feedback.<br>Q2: Scope and develop plan for remote service option. |

[5] This activity was delayed due to the redeployment of staff in response to COVID-19. This action is significant as it involves community engagement and education to ensure the message is shared with the public, not just staff, and has been reprioritised for 2021/22.

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| | Q3: Seek agreement and approval for the new approach. |
| Inform and prepare submissions on the Smokefree 2025 plan, with a focus on reducing supply and the impact on Māori and Pacific as priority populations. (EOA) | Q2: Report on activity.<br>Q4: Report on activity. |
| Undertake compliance activities relating to the Smokefree Environments Act 1990, including delivering and reporting on the activities relating to the public health regulatory performance measures, to reduce uptake of smoking amongst young people. (EOA) | Q2: Report on activity.<br>Q4: Report on activity. |
| Building on the Smokefree Pregnancy and Newborn Incentivisation Programme, work with the Healthy West Coast Alliance to support wāhine Māori smokers through noho marae style intensive support, to reduce smoking rates amongst this high priority population. (EOA) | Q2: Options scoped.<br>Q3: Options presented for endorsement and approval.<br>Q4: Service underway. |
| Track and monitor the delivery of ABC (Ask, give Brief advice and offer Cessation Advice) across primary and secondary care to identify general practices and departments who need more support to ensure priority populations are being supported to stop smoking. (EOA) | Q1-Q4: Monitor rates quarterly to ensure volumes are maintained and priority areas targeted. |

| Planning Priority: Breast Screening | |
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| **Action to Improve Performance** | **Milestone** |
| Mobilise the mobile screening unit to enable 'catch up' of priority women whose breast screening has been delayed by a lockdown or similar event. (EOA) | Q1: Process in place to identify women whose screens are delayed. |
| Support ScreenSouth to prioritise Māori and Pacific women when allocating routine screening appointments and increase recall times to every 20 months to assist with the 'on-time' screening of priority women. (EOA) | Q1-Q4: Prioritisation process in place and ongoing. |
| Support ScreenSouth to connect with Poutini Waiora to offer supported attendance at clinics to encourage and engage hard-to-reach women in breast screening. (EOA) | Q1: Process agreed.<br>Q4: Reduction in the equity gaps for priority women 45-69 - baseline Māori 66%, Pacific 66%, Total 76% (Mar 2021). |
| Engage with ScreenSouth, Poutini Waiora and the PHO to consider how the mobile screening unit might be used to offer breast screening in community settings to encourage uptake by Māori and Pacific women. (EOA) | Q2: Options and logistics investigated<br>Q3: Marae based event planed.<br>Q4: Report on the women attending clinics. |
| Investigate the feasibility of using the extended hours at Te Nīkau to offer evening screening clinics to priority women to increase engagement. (EOA) | Q2: Options and logistics investigated.<br>Q3: Clinic option tested.<br>Q4: Report on the women attending clinics. |
| ScreenSouth and West Coast PHO use data matching to identify overdue women and those not enrolled in the national screening programme, to enable practices to follow-up with women and encourage screening. | Q1-Q4: Data matching and follow up undertaken.<br>Q4: Increased uptake of screening by priority women 45-69 - baseline Māori 66%, Pacific 66% (Mar 2021). |
| Facilitate quarterly meetings with ScreenSouth, Poutini Waiora, Population Health and Community & Public Health and the West Coast PHO to identify joint strategies to support women who have missed appointments or who have declined screening, to reduce barriers to access and lift rates for priority women. (EOA) | Q1: Quarterly meetings set.<br>Q1: Baseline for missed appointments identified.<br>Q4: Increase in screening attendance rates. |
| Actively promote mobile screening clinic dates and hold an annual Health Promotion hui to raise awareness among Māori and Pacific women of the importance of screening and promote other key healthy behaviours. (EOA) | Q2: Health Promotion hui held. |

| Planning Priority: Cervical Screening | |
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| **Action to Improve Performance** | **Milestone** |
| Build a picture of screening performance across locality bases to share with the Alliance and Operational leadership teams to encourage conversations about equity and improve coverage for priority women, including target setting for DHB practices. (EOA) | Q1: Performance picture developed and tested.<br>Q2: Locality map shared, and strategies deployed. |

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| | Q4: Increased uptake of screening by priority women 25-69 - baseline Māori 71%, Pacific 67% (Mar 2021). |
| Investigate the feasibility of using the extended hours at Te Nīkau to offer evening screening clinics to priority women to increase engagement. (EOA) | Q2: Options and logistics investigated.<br>Q3: Clinic option tested.<br>Q4: Report on the women attending clinics. |
| Partner with the West Coast PHO, Poutini Waiora and the Population Health team, to deliver screening clinics at community sites across the West Coast, as an alternative to general practice to reach priority women, those in more remote locations and women not enrolled with general practice. (EOA)<br>Provide an option for hard-to-reach women to have cervical screening in their own homes. (EOA) | Q1-Q4: Cervical screening clinics held in alternative locations.<br>Q4: Reduction in the equity gaps for priority women 25-69 - baseline Māori 71%, Pacific 67%, Total 74% (Mar 2021). |
| Utilise cervical screening data, and data from our Population Health team on new families coming into the area, to deploy outreach services (including the DHB's Māori Pathway Navigator and Poutini Waiora Māori Smear taker) to support practices with recalls and screening for overdue women, prioritising Māori and Pacific women. (EOA) | Q1-Q4: Data sharing processes in place.<br>Q1-Q4: Tracking of screening data to identify practices in need of support. |
| Building on the successful work reducing DNA rates for Māori in 2021/22, introduce a process whereby women booked for colposcopy are contacted ahead of their appointments to identify and mitigate barriers to attendance. In doing so:<br>Link in with the outreach services to prioritise contact for priority group women to ensure equity of access. (EOA) | Q1: DNA process introduced with booking unit and outreach services.<br>Q4: Increased rate of attendance at appointments. |

| Planning Priority: Reducing Alcohol Related Harm | |
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| **Action to Improve Performance** | **Milestone** |
| Maintain and support intersectoral alcohol accords in our district, to reduce alcohol related harm in West Coast communities.<br>By sharing this commitment with other partners, work can continue when one or two organisations are redirected into other priorities ensuring resilience across the system. | Q2&Q4: Progress report against Alcohol Plan and Strategy objectives. |
| Undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012, including delivering and reporting on the activities relating to the public health regulatory performance measures, to encourage delayed teen drinking. | Q2&Q4: All regulatory performance measures reported as required. |
| Identify and commence work with Māori partners and organisations on the West Coast to strengthen the Māori voice in alcohol licensing decision-making, including local alcohol policies. (EOA) | Q2&Q4: Number of engagements with local Māori communities. |

| Planning Priority: Sexual and Reproductive Health | |
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| **Action to Improve Performance** | **Milestone** |
| Promote the availability of free sexual health and reproductive health consultations in general practice and the free sexual health services (assessment, diagnosis & treatment provision) available at the DHB's sexual health clinics to reduce cost barriers for young people. (EOA) | Q2: Promote the services.<br>Q4: Report on update. |
| Review the Wellness Clinic initiative rolled-out in Buller High School, which provides access to contraception and sexual health services through a Registered Nurse-led Clinic, to understand how this has improved access to services for young people.<br>Investigate the feasibility of rolling this initiative out to further high schools. (EOA) | Q2 Review of service uptake.<br>Q4: Capacity for third school investigated and school identified. |
| Implement initiatives from the Canterbury & West Coast Syphilis Working Group action plan to prevent new syphilis cases and congenital syphilis across the two regions and support the National Syphilis Action Plan, with a particular focus on action to support young Māori and Pacific communities. (EOA) | Q2&Q4: Working group initiatives implemented as agreed. |

| Planning Priority: Cross Sectoral Collaboration including Health in All Policies | |
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| **Action to Improve Performance** | **Milestone** |
| Continue to deliver Broadly Speaking training (including the use of HEAT and other equity tools) to staff from the DHB and other health and social service agencies, to support and grow Health in All Policies work and capacity in our region. | Q2&Q4: Number of Broadly Speaking training sessions held, and number of non-health agencies attending. |
| Collaborate with the member organisations of the Healthy West Coast Alliance (CPH, the PHO, Poutini Waiora and Sport West Coast) to deliver on a joint workplan, to support collaborative health promotion work and improve health outcomes in our region. | Q2: Joint workplan developed.<br>Q4: Report of joint activities progressed. |
| Work in partnership with Tatau Pounamu, Poutini Waiora, Māori whānau, hapū and other Māori organisations, agencies and communities to respond to COVID-19 and develop mana enhancing actions to support and protect Māori whānau and communities. (EOA) | Q2&Q4: Partnership activities reported. |
| Engage through our Community & Public Health team and the Healthy West Coast Alliance, to develop submissions related to policies impacting on our community's health. (EOA) | Q2&Q4: Number of submissions made. |

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

| Planning Priority: Delivery of Whānau Ora | |
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| **Action to Improve Performance** | **Milestone** |
| Partner with our kaupapa Māori provider and public health team to develop and deliver community-led education and awareness sessions on the importance of immunisation for Māori. (EOA) | Q3: Annual sessions planned and delivered. |
| Develop a process to support general practice to improve Māori ethnicity data collection for Kaumatua, to support this group to be prioritised for influenza vaccinations. (EOA) | Q1: Process agreed.<br>Q3: Māori vaccination coverage increases. |
| Build on the work undertaken in 2020/21 (with the Oral Health and Respiratory departments) to reduce the number of missed appointments and prioritise bookings to lift the appointment attendance rate for Māori, to ensure Māori are accessing services earlier and receiving the treatment and support they need. (EOA) | Q1: Share learnings from Oral Health and Respiratory.<br>Q2: Identify next service areas of focus.<br>Q3: Highlight progress. |
| Engage with Poutini Waiora, Tatau Pounamu and the West Coast PHO to build on the successful Whakakotahi QI project and capture the opportunities identified in the Pae Ora o Te Tai o Poutini evaluation, to improve health outcomes for Māori on the West Coast. In doing so:<br>Socialise the evaluations to inform clinical practice and encourage services to adopt whānau ora approaches for Māori living with long-term conditions. (EOA)<br>Identify what is required to develop and deliver whānau ora community clinics, to provide alternative delivery models in our community. (EOA) | Q1: Socialisation of the Pae Ora evaluation.<br>Q1: Clinical partnership opportunities identified.<br>Q4: Pathway for development of whānau ora community clinics agreed. |

| Planning Priority: Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 | |
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| **Action to Improve Performance** | **Milestone** |
| With leadership from the Hauora Māori team and the Canterbury DHB Pacific Portfolio Manager, form a small action group to identify priorities from Ola Manuia (the national Pacific Health Plan) where we could focus resources to improve the health and wellbeing of Pacific people living on the West Coast. (EOA) | Q2: Action Group formed.<br>Q2: Areas of Priority identified.<br>Q4: Action Plans underway. |
| Use census data and the Ola Manuia indicators to develop a profile of Pacific people living on the West Coast to inform and focus activity and track performance. (EOA) | Q2: Profile complete. |
| Connect in with the implementation of the Pacific Health Action Plan and the development of a cultural capability / competency programme to help our health system better engage with and support our Pacific population. (EOA) | Q1: Links established with the Canterbury DHB Pacific team.<br>Q4: Cultural capability programme developed. |

| Planning Priority: Care Capacity Demand Management (CCDM) | |
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| **Action to Improve Performance** | **Milestone** |
| Submit monthly reporting to Care Capacity Demand Management (CCDM) Council regarding progress with the Core Data Set, Variance Response Management (VRM), and FTE calculations.<br>Complete FTE calculations for the Integrated Ward (includes Critical Care Unit) and Children's Ward. Launch the Core CCDM Data Set dashboard (Phase One) to make the core data measure set visible and to support improved workforce planning.<br>Report key results from the DHB's Self-Assessment and Evaluation of full implementation by the Safe Staffing, Healthy Workplaces Unit.<br>Continue to work to develop Phase Two of the Core Data Set to include the remaining seven core data set measures or alternative measures not available as part of Phase One.<br>Trendcare Coordinator and CCDM Coordinator to work together to develop regular manager meetings to discuss CCDM KPI's and facilitate patient acuity data improvement.<br>Ensure continued TrendCare Champion /Inter-Rater Reliability (IRR) Tester representation and complete any training required.<br>Initiate business as usual IRR testing in preparation for FTE Calculations to ensure quality patient acuity data is available.<br>Finalise the Standard Operating Procedures (SOPs) and launch the Canterbury/West Coast Variance Response Management (VRM) dashboard to make hospital-wide care capacity and patient demand visible in real time to support variance response management.<br>Recommence the 12-monthly FTE calculation cycle, starting with mental health.<br>Begin FTE calculations for remaining eligible ward (Foote Ward) depending on data quality. | Q1-Q4: Monthly and quarterly CCDM reporting submitted.<br>Q1: FTE calculations completed for Integrated Ward and Children's Ward and Core Data Set dashboard in use.<br>Q2: Results of Evaluation reported.<br>Q2: Core (Phase 2) Data Set Dashboard complete.<br>Q2: Regular manager meetings in place.<br>Q2: Sufficient TrendCare Champion/IRR Tester representation ensured and IRR Testing complete.<br>Q2: SOPs finalized and VRM dashboard in use as part of West Coast pilot.<br>Q3: CCDM 100% implemented for Nursing & Midwifery.<br>Q3: 12-month FTE cycle re-commenced.<br>Q4: FTE Calculations started in Foote Ward. |
| Provide quarterly updates to the Ministry of Health on the FTE calculation progress including agreement on FTE levels, budgets and recruitment levels. | Q1-Q4: Quarterly reports provided to the Ministry of Health. |

| ★ Planning Priority: Health Outcomes for Disabled People | |
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| **Action to Improve Performance** | **Milestone** |
| Review and update the Emergency Coordination Centre communication plan and include key contacts from the disability community to ensure communication in and out of the ECC is inclusive of the disability provider network and the people they support. (EOA) | Q1: ECC contacts updated. |
| Through the newly formed West Coast Disability Steering Group, commit to implementing the national Accessible Information Charter, to raise awareness of the importance of accessible information and identify key actions to improve the inclusivity of our health services for disabled people across the West Coast. (EOA) | Q2: Charter signed.<br>Q4: Key priority actions agreed in DSG workplan. |
| Appoint two Māori members to the newly formed West Coast Disability Steering Group, identified and supported by Tatau Pounamu, to ensure a strong Māori voice in the implementation of the Disability Strategy. (EOA) | Q1: Members in place. |
| Review delivery against the equity focused actions in the DHB's refreshed Disability Action Plan to ensure progress in improving outcomes for Māori with disabilities. (EOA) | Q3: Review completed. |

| Planning Priority: Planned Care | |
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| **Action to Improve Performance** | **Milestone** |
| Building on the learnings from the Did-Not-Attend initiative in 2020/21, continue to target reductions in the number of missed appointments to support improved engagement with services, and prioritise priority populations where missed appointments are higher to improve health equity for our high need populations. (EOA)<br>Use the learning from this work to support the system to recover from any future major events. | Q1-Q4: Ongoing tracking and review of missed appointment and targeting of services areas in need of additional support. |
| Ensure each Locality Operations Manager has active Tatau Pounamu, Consumer Council participation and Alliance workplans in place, to support them to identify and respond to unmet need, consumer's health preferences and inequities in their locality. (EOA) | Q1- Q4: Monthly consumer council meetings held in each locality.<br>Q1-Q4: Three-year planned care plan is reviewed and updated as required. |

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| Review the consistency of our Clinical Priority Assessment Criteria (CPAC) scores to understand our prioritisation in comparison to other South Island DHBs and identify opportunities and actions to improve equity of access for our population. (EOA) | Q2 Review complete.<br>Q2: Opportunities identified. |
| Implement the South Westland Alliance project to support people to navigate their health journey, by improving the transfer of care for inpatients awaiting discharge back into the community. (EOA) | Q1: Project plan endorsed<br>Q2: Pilot underway.<br>Q4: Evaluation underway. |
| Identify pressure points and opportunities for shifting resources, in conjunction with implementation of our Rural Generalist model, to support delivery of minor procedures and non-surgical interventions in community settings and closer to people's homes. | Q1: Pressure points and opportunities identified. |
| Identify roles or service areas to pilot application of the Calderdale Framework to support the professional development of our health care professionals and enable them to work across their whole of scope of practice. | Q1: Focus roles identified.<br>Q2: Calderdale briefing day held for staff.<br>Q3: Pilot underway. |
| Utilise the Planned Care Initiative funding to progress the implementation of our whole of system Rural Generalist model, to ensure timely and equitable access to planned care and support the delivery of the DHB's three-year Planned Care Plan. (EOA) | Q1-Q2: Recruitment and training strategy finalised and recruitment underway.<br>Q3: Strategy implemented.<br>Q4: No patients wait over 120 days for their First Specialist Assessment ESPI 2. |
| Implement the continuous improvement actions agreed in the DHB's three-year Planned Care Plan, to delivery timely and equitable access to planned care for our population.<br>Focus on Orthopaedic and Plastics, as areas where we have the longest waits. (EAO) | Q1: Orthopaedics and Plastics plans in place.<br>Q2-Q3: Tracking of wait times to identify and implement further recovery actions.<br>Q4: No patients wait over 120 days for treatment ESPI 5. |
| Contributory Measure (ESPI2): Proportion of patients waiting longer than four months for their First Specialist Assessment. | Improvement on (June 2020) baseline to <0.4% waiting over 120 days.<br>Baseline 12.2%. |
| Contributory Measure (ESPI5): Proportion of orthopaedic patients waiting over 120 days following a commitment for treatment. | Improvement on (June 2020) baseline to <0.4% waiting over 120 days.<br>Baseline 35.7% |

| Planning Priority: Acute Demand | |
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| **Action to Improve Performance** | **Milestone** |
| Following deployment of the new patient management system, develop a report using ED presentation data (via Indici and SNOMED) to inform the development or refresh of pathways of care for people with long term conditions. | Q3: Indici deployed into the urgent care setting.<br>Q4: Report developed. |
| Explore the use of Indici and SNOMED data to trigger alerts to the appropriate general practice or community service, to enhance the integration of care and improved outcomes for our population. | Q4: Exploration of opportunities. |
| Engage with Poutini Waiora (our kaupapa Māori provider), and the West Coast PHO to build on the progress being made against the national System Level Measures (SLM) and deliver the agreed key actions and activity in the SLM Improvement Plan to maintain our low acute bed rates for the total population and for Māori.<br>Track and monitor progress through the West Coast Alliance to ensure continued progress and identify collective responses to opportunities and barriers identified. | Q1: SLM Improvement Plan agreed for 2021/22.<br>Q1-Q4: Quarterly monitoring of progress presented to the Alliance Leadership Team. |
| Engage with Poutini Waiora, Tatau Pounamu, the wider Māori health sector and the West Coast PHO to build on the success of the Whakakotahi QI project and capture the opportunities identified in the Pae Ora o Te Tai o Poutini evaluation, to improve the management of long-term conditions and reduce unnecessary ED presentations and hospital admissions for Māori. (EOA) | Q1: Socialisation of the Pae Ora evaluation.<br>Q2: Facilitator engaged.<br>Q4: Pathway for development of whānau ora community clinics agreed. |
| Progress the implementation of our Rural Generalist model, building our rural general workforce (across our nursing, allied health and medical workforces), to increase access to timely, integrated care. In doing so:<br>Reduce the traditional 'silos' between care settings enabling the implementation of an integrated care model that will better support people earlier in their health journey reducing avoidable acute presentations. | Q1: Rural Generalist recruitment strategy finalised.<br>Q3: Strategy implemented. |

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| Provide greater access to 24/7 care to improve the continuity of care for our population, particularly those priority populations at risk of an acute episode or readmission following an inpatient event. (EOA) | |
| Capture opportunities from the deployment of the single patient management system (Indici) across our urgent care and primary care spaces in Te Nīkau, to support more informed clinical decision-making and identify and respond to people's wider health needs, incorporating preventative care into the acute response where possible to achieve improved health outcomes. | Q2: Indici deployed across general practice.<br>Q3: Indici deployed into the urgent care setting.<br>Q3: Opportunities to integrate care identified. |
| Invest in the creation of a Mental Health Clinical Nurse Specialist/Educator role across acute and community mental health services, to reduce waiting times for people requiring mental health and addiction support who present to the Emergency Department. | Q2: CNS in place.<br>Q4: Report on impact of the role. |
| Develop and implement a model whereby Pukenga Atawhai roles are embedded into clinical teams and engaged with crisis response call outs and assessments, to provide an improved cultural response to Māori in crisis. (EOA) | Q1: Model in place during business hours. |
| Encourage at least two of the urgent care team to complete their Takarangi competencies, to ensure there are a growing number of people who can apply the principles in their everyday work. (EOA) | Q2: Engagement of staff.<br>Q4: Two or more staff who have finished their portfolios. |

| Planning Priority: Rural Health | |
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| **Action to Improve Performance** | **Milestone** |
| Progress with the implementation of our Medical Rural Generalist Strategy, building our rural generalist workforce (specifically in obstetrics and primary care) to cover remote areas such as Reefton and South Westland, build the resilience of our health system and improve the continuity of care for our population by reducing our reliance on a locum workforce. | Q4: Additional 3 FTE Rural Generalists employed (1 RG Obstetrics and 2 RG Rural Primary Care). |
| Refer to the Data and Digital section of the plan for the planned progress in transitioning to a Microsoft Teams environment to improve the scalability, usability and performance of telehealth services, broadening access to services to more remote areas of the Coast and supporting the delivery of services closer to home. (EOA) | Q2: Transition to Microsoft Teams complete. |
| Engage with Poutini Waiora, Tatau Pounamu and the West Coast PHO to build on the successful Whakakotahi QI project and capture the opportunities identified in the Pae Ora o Te Tai o Poutini evaluation, to improve health outcomes for Māori on the West Coast.<br>Socialise the evaluations to inform clinical practice and encourage services to adopt whānau ora approaches for Māori living with long-term conditions. (EOA)<br>Support the implementation of our Home and Community Support Services (HCSS) change proposal to align with the national HCSS framework and enable integration with the locality interdisciplinary teams. (EOA)<br>Scope what is required to develop and deliver whānau ora community clinics to enable alternative delivery models. (EOA) | Q1: Socialisation of the Pae Ora evaluation.<br>Q1: Clinical partnership opportunities identified.<br>Q2: HCSS change proposal implemented.<br>Q4: Pathway for development of whānau ora community clinics agreed. |

| ★ Planning Priority: Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022 | |
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| **Action to Improve Performance** | **Milestone** |
| Plan and conduct an Emergency Simulation Exercise, to test recently developed pandemic response planning in Aged Residential Care and identify gaps for improvement. | Q2: Emergency Simulation Exercise completed. |
| Plan and conduct an Emergency Simulation Exercise to test recently developed pandemic response planning with Home and Community Support Services and identify gaps for improvement. | Q2: Emergency Simulation Exercise completed. |
| Building on the frailty pathway work in 2020/21, regularise the use of the InterRAI Service Allocation Tool (SAT), to better identify those patients with emerging signs of frailty. | Q3: Frailty cohort defined. |
| Engaging with the Māori Complex Clinical Assessor, develop a pathway to prioritise our response to Māori who are identified with emerging signs of frailty. (EOA) | Q3: Pathway agreed. |
| Develop a pathway for referrals to community strength and balance classes for the cohort identified by the SAT tool. | Q4: Pathway developed. |
| Complete and upload a Dementia Navigation Map of local services to HealthPathways to support access to dementia services available on the West Coast. (EOA) | Q4: Map on HealthPathways. |

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| Engage with our kaupapa Māori provider to develop a focus on Dementia services by Māori for Māori. (EOA) | Q3: Input into service map and workshop. |
| Facilitate a Dementia study day/workshop to provide information on 'Walking in Another's Shoes' programme and early diagnosis of dementia, to support improved care and quality of life for people with dementia. | Q4: Workshop delivered. |
| Fully integrate ACC Non-Acute Rehabilitation (NAR) bundles of care into our Early Supported Discharge (ESD) model, including the use of standardised algorithms to ensure people have access to services according to need. (EOA) | Q4: NAR bundles fully integrated. |
| Deploy the Early Supported Discharge Service across all our locality bases, to ensure people can access the service irrespective of where they live on the West Coast. (EOA) | Q4: Early Support Discharge Service available Coast-wide. |

| Planning Priority: Health Quality & Safety (quality improvement) | |
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| **Action to Improve Performance** | **Milestone** |
| Engage with the Health Quality and Safety Commission (HQSC) to identify opportunities to enhance our clinical governance and quality model, to support improvements in patient safety and quality. | Q1: Workshop held with HQSC.<br>Q3: Enhancements made. |
| Build on the learnings from COVID-19 to improve staff hand hygiene related to glove use and increase cleaning of hands pre and post glove use from an average of 87% to 95% (Hand Hygiene Gold Auditing Programme). In doing so:<br>Assess current practice, including staff perceptions and issues, to identify and address barriers and behaviours. | Q1: Current state assessed.<br>Q2: Strategies developed and tested to address root causes.<br>Q4: Strategies implemented. |
| Engage with the work being done on the Gout HealthPathway in Canterbury, to reduce the use of non-steroidal anti-inflammatory drugs by our Māori and Pacific populations, to reduce the associated kidney disease risk. (EOA) | Q3: Community HealthPathway updated.<br>Q3: HealthInfo Gout information updated. |
| Building on the Health Quality and Safety Commission Quality and Safety Marker (QSM) work in 2020/21, support the Consumer Engagement QSM Implementation Steering Group in their work, by developing a practical development pathway to increase meaningful consumer engagement in service activity. | Q2: Complete maturity self-assessment of all WCDHB service areas.<br>Q3: Interview engagement leaders and understand how they developed. |
| Using the information gathered from engagement leaders' interviews, plan and promote leaders and leadership in engagement in the organisation to increase service maturity in priority engagement elements in lower rated areas. | Q4: Promotion occurring in services with lower ratings. |
| Report against the Consumer Engagement QSM twice-yearly via the online form on the Commission's website. | Q1: Report delivered.<br>Q3: Report delivered. |

| Planning Priority: Te Aho o Te Kahu – Cancer Control Agency | |
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| **Action to Improve Performance** | **Milestone** |
| **New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi** | |
| Support the Te Aho o Te Kahu (Cancer Control Agency) ACT-NOW project by:<br>Working towards the implementation of ACT-NOW treatment regimens for medical oncology and malignant haematology.<br>Ensuring data standards in our oncology e-prescribing system are compliant, via MOSAIQ.<br>Implementing process to transfer local data into the national repository in line with CDHB roll-out. | Q1-Q4: Implementation of data submission into national repository, in line with the roll-out conducted by CDHB (as tertiary lead DHB service) timeframes. |
| Work with Te Aho o Te Kahu the Southern Hub, to adopt and implement the national cancer-related Health Information Standards Organisation (HISO) standards. In doing so:<br>Demonstrate evidence of implementation and compliance with the HISO standards as they are rolled out in regional documents and policies.<br>Enhance Faster Cancer Treatment (FCT) reporting to include ethnicity data so reporting has ethnicity reporting fields to HISO standards. (EOA) | Q2: Confirm HISO standards and interoperability within regional and Multi-Disciplinary Meeting platforms.<br>Q4: Ethnicity Data included against all FCT performance data. |
| Participate in the business case evolution of the planned linear accelerator (LINAC) replacement programme, consistent with the CDHB Performance Support and Infrastructure capital programme. | Q1-Q4: Business case developed via CDHB and Southern Hub timeframes. |

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| Participate in the regional planning via the Te Aho o Te Kahu the Southern Hub to support the development of satellite LINAC business case for our region, as required. | |
| **New Zealanders experience equitable cancer outcomes – He taurite ngā huanga** | |
| Participate in Te Aho o Te Kahu travel and accommodation project to improve equity of access and support to cancer services/treatment.<br>Look to implement the recommendations of this project, particularly those that ensure equity of access for Māori and rural communities who currently experience greater barriers to accessing cancer services. (EOA) | Q1-Q4: Participation as required. |
| Consider the Te Aho o Te Kahu recommendations, based on feedback from the 15 Māori community hui being held in 2021, and agree an action plan to address equity for our population. (EOA)<br>Facilitate Māori -driven community-based initiatives to engage and encourage whānau to participate in the National Bowel Screening Programme (NBSP), as part of strengthening our drive toward equity in health outcomes in cancer (EOA)<br>Work with CDHB (as regional tertiary care provider) to develop quality improvement plans/initiatives that address unwarranted variation in care. (EOA)<br>Provide cultural competency training for primary care workforce to improve service responsiveness to Māori and Pacific individuals and whānau. (EOA)<br>Support improvement of ethnicity data quality and collection across the health system, to help better understand the scope and scale of inequity in cancer. (EOA) | Q1: Engagement in the Māori community hui.<br>Q2: Mapping and implementation of hui recommendations with Tatau Pounamu within our local context.<br>Q3: Extend wider community engagement in parallel with Bowel Screening hui.<br>Q1–Q4: Workforce cultural competency training delivered to DHB primary care health professionals and support staff.<br>Q1–Q4: Workforce training on data gathering, capture and prioritisation delivered. |
| **New Zealanders have fewer cancers – He iti iho te mate pukupuku** | |
| Collaborate with Poutini Waiora, Community & Pubic Health, the West Coast PHO and other health agencies to address the modifiable risk factors for cancer and promote screening and earlier intervention as referenced in the following sections:<br>• Healthy Food & Drink Environments (page 18).<br>• Smokefree 2025 (page 18).<br>• Reducing Alcohol Related Harm (page 20).<br>• Breast Screening (page 19).<br>• Cervical Screening (page 19).<br>• Bowel Screening (page 27).<br>• Long Term Conditions Management (page 31). | Refer to relevant section in Annual plan for actions and milestones to improvement performance in these areas. |
| **New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te o ranga** | |
| Continue to implement and report progress against our Bowel Cancer Service Improvement Plan (to improve performance against national waiting time standards for endoscopy services.<br>Continue to review diagnosis of colorectal cancer following emergency presentation and inequities in the proportion of patients presenting to ED and review more regularly for those whose results lie outside the 99.8% limit above the mean.<br>Consider work to improve awareness of the symptoms of bowel cancer, with a focus on groups disproportionately affected by emergency diagnosis.<br>Engage Tatau Pounamu and Poutini Waiora in the development of an equity project to enable Māori on the West Coast to be offered a free appointment for a cancer screening check for signs, symptoms and familial cancer history review, when they reach the age of 50. (EOA)<br>Support delivery of Te Aho o Te Kahu hui planned in 2021/22 as part of the national strategy on improving equity and outcomes for Māori and Pacific populations. (EOA) | Q1-Q4: Progress against improvement plan reported.<br>Q1-Q4: Review of ED presentations reported.<br>Q2: Bowel cancer symptoms promotion opportunities identified.<br>Q2: Equity screening project developed and agreed.<br>Q3-Q4: Hui dates for West Coast promulgated by Te Aho o Te Kahu. |
| Revise and update the DHB's Bowel Cancer Quality Service Improvement Plan following publication of the second national bowel cancer QPI results in Q3 2020/21. | Q4: Bowel Cancer Quality Service Improvement Plan revised. |
| Develop a DHB Lung Cancer Service Improvement Plan within our local context, based on the results of the Lung Cancer Quality Improvement Monitoring Report and the national Lung Cancer Quality Improvement Plan (expected to be released in Q4 2020/21).<br>Engage the local Cancer Team and Equity Advisory Group to review data from the Lung Cancer QIP Report where West Coast DHB is below national average, to help inform service improvements and incorporate a strong equity focus for Māori. (EOA) | Q2: Working group formed.<br>Q4: Quality improvement plan developed and aligned with national and South Island regional plans developed in association with Te Aho o Te Kahu. |

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| Develop a DHB Prostate Cancer Service Improvement Plan based on the results of the Prostate Cancer Quality Improvement Monitoring Report (expected to be released in Q3 2020/21).<br>Engage with Tatau Pounamu and the Equity Advisory Group to review prostate cancer quality performance indicator data where the West Coast DHB is below national average, to help inform service improvements and incorporate a strong equity focus for Māori. (EOA)<br>Support clinician participation in an annual quality forum as requested, to facilitate development of a national Prostate Cancer Improvement Plan and inform and review local service delivery. | Q4: Undertake audit and provide clinician-led feedback to Te Aho o Te Kahu within six weeks of release of the Prostate Cancer QPI report.<br>Q1-Q4: Milestones and associated timeframes to be considered following release of Prostate Cancer QPI report in Q4 2021.<br>Q1-Q4: Clinician engagement in annual forum as dates are set. |
| Use data intelligence systems to monitor the 62-day and 31-day wait times for access to cancer treatment and undertake a breach analysis for every patient who waits longer than target, to identify any emergent systems or data issues and capture opportunities to reduce process delays.<br>Work in partnership with Te Aho o Te Kahu and the Ministry of Health to improve the FCT data quality and implement business rule changes as required. | Q1-Q4: Monthly and quarterly qualitative reports monitored for any system or data issues.<br>Q1-Q4: Business rules applied as required.<br>Q1-Q4: Delivery against the 62-day and 31-day wait time targets for all population groups. |
| Implement the cancer COVID-19 guidance developed by Te Aho o Te Kahu should there be a COVID-19 resurgence to ensure minimal impact on cancer diagnostics and treatment services for patients/whānau.<br>To support our readiness to help provide service continuity for our population:<br>▪ Continue to implement our Rural Generalist model to support continuity of access to cancer diagnostic and treatment services.<br>▪ Continue to build on the use of telehealth for patient consultations and clinical multi-disciplinary team meetings.<br>▪ Continue to provide patients in priority population groups with priority booking for secondary service to reduce missed appointments. (EOA) | Q1-Q4: Use the national guidance to respond to any further COVID-19 resurgence, as required. |

| Planning Priority: Bowel Screening and Colonoscopy Wait Times | |
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| **Action to Improve Performance** | **Milestone** |
| Continue to implement and report progress against our Bowel Cancer Service Improvement Plan to identify and respond to areas of pressure, with a focus on reducing long-waits and ensuring equity for our population. | Q1-Q4: Progress against Improvement Plan reported. |
| Implement our Rural Generalist Workforce model to support the provision of an integrated primary and secondary service and increase the stability of our workforce to ensure we have the capacity to deliver colonoscopies within national wait time expectations. | Q2: Recruitment and training strategy finalised and recruitment underway. |
| Facilitate weekly meetings between the Endoscopy User Group and National Bowel Screening Programme (NBSP) Clinical Lead to prioritise colonoscopy referrals to ensure NBSP indicators are constantly meet.<br>Support the delivery of national expectations by making regular weekly theatre sessions available to deliver colonoscopies to patients on the NBSP pathway. | Q1: Weekly colonoscopy theatre sessions available.<br>Q1-Q4: Targets for colonoscopies consistently met for all population groups. |
| Build on the successful work reducing missed appointments for Māori in 2021/22, and apply the lessons learnt to the scheduling of colonoscopy appointments to increase appointment uptake and mitigate barriers to attendance for Māori as a high-risk population group. (EOA) | Q1: DNA process introduced with booking unit.<br>Q4: Increased rate of attendance at appointments. |
| Engage the local National Bowel Screening Programme Steering Group in monitoring the local delivery of the Programme to identify areas where participation is low and work with them to review and identify strategies to meet national targets across all population groups. (EOA) | Q1-Q4: Quarterly monitoring of participation rates in place.<br>Q4: 60% of priority populations engaged in the NBSP. |
| Proactively engage with local community networks, service providers, iwi and priority populations to promote and encourage participation in the NBSP. (EOA) | Q1: Programme of engagement in place. |
| Work with the West Coast PHO and Poutini Waiora to provide community outreach and additional support in localities where screening rate suggests additional input is required to lift engagement. (EOA) | Q1-Q4: Monitoring of participation rates used to identify and respond to populations of need. |
| Engage Tatau Pounamu and Poutini Waiora in the development of an equity project to enable Māori on the West Coast to be offered a free appointment for a cancer screening check for signs, symptoms and familial cancer history review, when they reach the age of 50. (EOA) | Q2: Equity screening project developed and agreed. |

| ★ Planning Priority: Health Workforce | |
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| **Action to Improve Performance** | **Milestone** |
| Build on the success of our Remote GP initiative, offering consultations with a remotely located GP at the Te Nīkau and Buller IFHCs, by exploring options to extend this across other professional groups and services where appropriate, to build the capacity and resilience of our system. | Q1: Report on uptake and patient experience with remote GP consultations.<br>Q2-Q3: Explore and scope other service options.<br>Q4: Expand to other service areas, where possible. |
| Develop guidelines to enable staff to work remotely, where their role allows them to remain productive while working flexibly between the workplace and home. | Q2: Guidelines finalised, released and socialised. |
| Work in partnership with our unions to reinvigorate our local Bipartite Action Group (BAG), in doing so ensure the forum is meaningful for all parties, promotes the principles of constructive engagement, is connected to the national BAG, and is linked into local resurgence planning and initiatives to increase workforce flexibility and mobility. | Q1: BAG action plan agreed and documented.<br>Q2: Terms of Reference updated and approved. |
| Endeavour to fill required vaccinator and swabbing workforce from outside of the current workforce.<br>Strengthened relationships with local general practice to enable time-sharing secondment of practice nurses to fill vaccinator requirements.<br>Train vaccinators in swabbing to enable diversion to swabbing duties as required.<br>Reduce barriers to accessing COVID-19 testing for our Māori and Pacific populations through the provision of swab-training to local Māori health providers. (EOA)<br>Through partnership with Poutini Waiora reduce barriers to accessing COVID-19 vaccination through establishment of mobile clinic at Arahura Marae. (EOA) | Q1-Q4: Engage retired and casual workers to fill vaccinator requirements.<br>Q1-Q4: Ongoing communication between West Coast general practice localities and COVID-19 workforce management.<br>Q2-Q4: Refresher swab-training sessions facilitated with Māori Health providers. |
| Embed the diversity recruitment strategy introduced in 2020/21, to support Māori and Pacific job applicants, who meet the minimum requirements for positions, to advance to the interview stage, to promote the diversification of our workforce. (EOA) | Q1: Pool of Māori to support interviews identified.<br>Q4: Impact of policy reviewed. |
| Invest in the development of three new Equity and Diversity focused roles to support the DHB to attract, retain and develop our Māori health workforce and lift the cultural competency and equity focus across the DHB. (EOA) | Q1: Three new roles in place.<br>Q4: Increase in the proportion of Māori in the DHB workforce.<br>Q 4 Cultural competency staff workshops underway |
| Engage our leaders in Te Huarahi Hautu, a comprehensive training programme for DHB people leaders, to equip them with the tools to reach their full potential, ensure they model behaviour that reflects our values and vison and build organisational competency in management.<br>Key components are the Health Equity and How We Hire Around Here modules, aimed at upskilling hiring managers in recognising and responding to equity issues and in the technical aspects of the recruitment process to improve diversity in line with the policy above. (EOA) | Q1: Te Huarahi Hautu underway.<br>Q3: Review of WCDHB leaders completing the Health Equity and How We Hire modules. |
| Partner with our local Consumer Council and Tātau Pounamu to increase the diversity of consumer representation at decision-making tables. (EOA) | Q1: Two Māori members appointed to the West Coast Disability Steering Group. |
| Building on the cultural competency work from 2020/21, track the uptake of the Takarangi competency training and encourage at least one to two staff in each service area or department to complete their Takarangi competencies, to ensure there are a growing number of staff who can apply the principles in their everyday work. (EOA) | Q4: Increasing number of services/departments have one or more staff who have finished their portfolios. |
| Introduce strategies to ensure there are staff available, who understand the underpinning values of the DHB, to greet patients in all areas of the Te Nīkau facility, to improve the patient experience and improve the flow of patients in our new Te Nīkau facility. | Q3: Staff on the bottom floor of Te Nīkau are welcoming patients as they arrive for their appointments. |
| Implement workplace violence prevention and control strategies in line with national WorkSafe Guidance. The first stage of this programme is the trial of the Victorian 10-point plan within Specialist Mental Health Services. | Q3: Trial the Victorian 10-point plan in SMHS. |
| Develop and implement Lone Worker Guidelines to improve the safety of West Coast DHB staff who work alone in the community. | Q2: Guidelines drafted and consulted.<br>Q3. Guidelines tested<br>Q4. Guidelines and processes implemented |

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| Annual Staff Engagement Survey: Introduce regular staff engagement 'pulse' surveys to monitor and better understand the wellbeing, safety and motivation levels of our people and implement actions and strategies in response to the issues identified. | Q1: First baseline survey results released.<br>Q2: Key actions identified and response strategies underway.<br>Q3: Pulse survey completed to monitor impacts. |
| Develop and implement a DHB-wide Safe Moving and Handling Programme to reduce musculoskeletal injuries from moving and handling incidents, which make up half of all DHB ACC claims.<br>Undertake a Hazardous Substances Review and prepare an Action Plan to reduce the risk to staff and patients. | Q3. Programme approved, and trainers employed.<br>Q4. Training commenced in Older Person's Health and Rehabilitation Services.<br>Q2: Hazardous Substances Review and Action Plan completed.<br>Q4: Hazardous Substances Plan implemented. |

| Planning Priority: Data and Digital Enablement | |
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| **Action to Improve Performance** | **Milestone** |
| Complete the transition to Microsoft Teams to improve the scalability, usability and performance of telehealth services. | Q2: Transition complete. |
| Investigate options for integrating the telehealth booking processes more closely with the patient booking system to streamline the process, reduce opportunities for missing appointments and better capture events delivered. | Q3: Options investigated. |
| Complete the deployment of Indici, the new single patient management system, across DHB-owned general practices, to support more informed clinical decision making and improve the integration and continuity of care provided. | Q2: Deployment of Indici across general practice complete. |
| Complete the deployment of the Indici patient portal in general practice, to provide enrolled patients with greater access to their health information, manage their bookings and increase engagement with general practice. | Q2: Deployment of Indici patient portal complete. |
| Deploy the Indici system into the Te Nīkau urgent care setting to support more informed clinical decision making, improve the quality of care provided and capture workflow efficiencies from the use of a single integrated patient management system. | Q3: Deployment of Indici into Te Nīkau complete. |
| Engage with Nelson Marlborough DHB to identify the opportunities for the West Coast from the work they are doing on implementing an integrated digital meds charting solution to reduce medication errors. | Q3: Opportunities identified. |
| Engage with the Hauora Māori team, our kaupapa Māori provider and Tatau Pounamu as we deploy our revamped patient portal, to improve uptake of the portal among Māori on the Coast. (EOA) | Q1: Engagement underway. |
| Using the national digital enablement funding, employ a Telehealth Project Manager to support increased uptake of telehealth services across the West Coast, through service and consumer engagement, transition to new tools, training and increased visibility of telehealth use and access. (EOA) | Q1: Role in place.<br>Q4: Increased uptake of telehealth. |
| Complete the transition to Microsoft Teams to improve the accessibility of telehealth services for patients and providers, reducing barriers to accessing services for people in more remote parts of the West Coast. (EOA) | Q2: Transition to Microsoft Teams complete. |

| Planning Priority: Implementing the New Zealand Health Research Strategy | |
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| **Action to Improve Performance** | **Milestone** |
| Prioritise supporting locality approval requests relating to COVID-19 research (that meet the West Coast DHB criteria). | Q1-Q4: COVID-19 related research prioritised. |
| West Coast's Research Champion will actively engage with the Ministry of Health and Health Research Council to support the implementation of the New Zealand Health Research Strategy and build the capacity and capability to support local research and innovation. | Q1-Q4 – Participation in MoH and HRC information sessions. |
| Formalise the Transalpine Research Partnership with the Canterbury DHB to enable delivery of our joint Canterbury and West Coast Health System Research Strategy, creating pathways | Q2: Partnership endorsed by Canterbury and West Coast Executive Teams. |

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| for staff to engage in research and innovation and identifying regional priorities for research activity.[6] | |
| Socialise the West Coast locality approval process for research activity and create an online presence that raises the profile and enables staff to access key documents and information online. | Q2: Research page live on West Coast DHB website.<br>Q2: Locality approval process available online. |
| Establish and grow a local research network, to support staff to engage and build their research capability and apply for future Health Research Council funding. | Q1: Network established.<br>Q4: Minimum of two staff apply for HRC funding. |
| Identify and prioritise research and innovation activity that can be carried out with Māori stakeholders or that gives priority to reducing inequity in our communities. (EOA) | Q2: Promote equity focused project development. |

## 2.9 Better population health outcomes supported by primary health care

| ★ Planning Priority: Primary Care | |
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| **Action to Improve Performance** | **Milestone** |
| Continue to ensure people who meet the criteria for COVID-19 testing are receiving tests and appropriate advice and treatment and systems are in place to ensure our system can cope with upsurges in demand for testing at times of elevated community anxiety. | Q1-Q4: Track demand and identify and respond to pressure points as needed. |
| Complete the deployment of Indici, the new single patient management system and patient portal, across DHB-owned general practices, to support more informed clinical decision making, improve the integration and continuity of care provided and provide enrolled patients with greater access to their health information and ability to manage their engagement with general practice. | Q2: Deployment of Indici across general practice complete.<br>Q2: Deployment of Indici patient portal complete.<br>Q4: Report on uptake of patient portal services. |
| Build on the successful Whakakotahi QI project and capture the opportunities identified in the Pae Ora o Te Tai o Poutini evaluation, to improve health outcomes for Māori on the West Coast. (refer to the rural health section) (EOA) | Q1: Socialisation of the Pae Ora evaluation.<br>Q4: Pathway for whānau ora community clinics agreed. |
| Support engagement with the DHB's Hauora Māori team, Poutini Waiora and general practice as we deploy the revamped patient portal and Microsoft Team instances, to improve uptake of the patient portal and telehealth options among Māori on the Coast. (EOA) | Q1: Engagement underway.<br>Q4: Report on uptake of patient portal services by Māori. |
| Using data from the Primary Care Patient Experience Survey, support the West Coast PHO to work with general practices to deliver an action learning programme and a series of quality improvement projects to improve people's experience of care in general practice on the West Coast. | Q1: Quality improvement leads identified.<br>Q2: First quality improvement projects underway.<br>Q4: All general practices can demonstrate a quality improvement programme informed by the results of patient experience surveys. |

| Planning Priority: Pharmacy | |
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| **Action to Improve Performance** | **Milestone** |
| Provide general practices with support to implement new technologies for the direct and secure transmission of scripts from their patient management system to the dispensary system of the patient's preferred pharmacy, minimising the inefficient handling of paper scripts and faxes and improving access and experience for patients. | Q2: First practices directly transmitted scripts to pharmacies.[7]<br>Q4: All practices with systems capable of connecting to NZePS are connected and issuing NZePS-barcoded scripts. |
| Provide regular immunisation education to pharmacies to ensure authorised pharmacists are confident to vaccinate and understand the importance of reaching our priority populations. (EOA) | Q4: Education delivered to pharmacist vaccinators.<br>Q4: Increase in the delivery of influenza vaccinations delivered by pharmacists. |

[6] This work was planned in 2020/21, but due to redeployment of staff to the COVID-19 response, this has been reprioritised for 2021/22.

[7] The DHB is deploying Indici, a new single patient management system, across all its general practices, this new system will enable the direct transfer of scripts and timeframes for this work are indicative and dependant on completion of the Indici deployment.

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| Highlight pharmacy as an option in the newly developed Immunisation Engagement and Communications Plan, to help promote the delivery of immunisations by pharmacists and increase awareness of vaccination options for our priority and hard to reach populations. (EOA) | Q2: Communications plan updated.<br>Q4: Increase in the proportion of the population receiving an influenza vaccination – baseline Māori 44%, Total 58% (2019/20). |
| Building on the Medications Therapy Assessment work completed in 2020/21, scope and develop a proposal to integrate pharmacists into general practice teams to improve medicinal therapy management for patients with long-term conditions to build capacity and capability across the general practice teams and improve continuity of care for patients. | Q2: Proposal developed.<br>Q3: Approval and funding sought for the model.<br>Q4: Recruitment of pharmacy support underway (subject to approval of proposal). |

| Planning Priority: Reconfiguration of the National Air Ambulance Service Project – Phase Two | |
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| **Action to Improve Performance** | **Milestone** |
| Maintain our commitment to the national plan to achieve a high functioning and integrated National Air Ambulance Service (NASO) and actively participate through the National Ambulance and Retrieval Quality and Safety Group (clinical governance) processes to achieve this. | Q1-Q4: Ongoing commitment maintained. |
| As part of a national DHB working group, support the development of clinical and operational quality measures and KPIs for inter hospital transfers. In doing so:<br>Endorse and implement the collection and reporting of the KPIs through the NASO performance monitoring and reporting system.<br>Provide timely and accurate safety issue reporting to clinical and operational governance to support quality improvement and inform national standard operational procedures. | Q1: KPI framework endorsed by DHBs.<br>Q2: Data collection underway.<br>Q4: National work programme delivering against KPIs. |
| Participate in a stocktake of clinical flight equipment and certifications to contribute to the development of inter-operability and compatibility recommendations for aircraft and stretcher systems. | Q4: National stocktake completed and recommendations agreed |
| Through the national DHB working group, seek to achieve health equity for rural and priority populations by undertaking a review to understand the challenges and improvements required. (EOA) | Q4: National review completed, and recommendations agreed. |
| Maintain ongoing engagement with NASO and Air Retrieval attending Emergency Care Coordination Team (ECCT) meetings, to ensure operational issues are dealt with quickly, improving patient experience and outcomes. | Q1-Q4: Ongoing attendance of NASO and Air Retrieval at ECCT meetings. |

| Planning Priority: Long Term Conditions | |
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| **Action to Improve Performance** | **Milestone** |
| Through the PHO Green Prescription service, invest in the delivery of an Active Families project to promote physical activity and nutritional advice as a means of preventing the onset of poor health.<br>Begin with a focus on the children in Cobden School in Greymouth and applying the learnings of the Whakakotahi QI diabetes project to support engagement with Māori and Pacific pupils and their whānau. (EOA) | Q1: Programme in place in Cobden School.<br>Q4: Up to 20 whānau supported through Active Families. |
| Support the West Coast Primary Health Organisation (PHO) to continue to engage general practices in the delivery of the core elements of the Primary Care Long Term Conditions Management (LTCM) programme to reduce risk factors, promote self-management, ensure regular LTCM reviews and improve health outcomes for our population.[8] | Throughout Q1-Q4 practices will utilise a quality improvement framework to manage LTCs |

[8] The Primary Care Long-Term Conditions Management (LTCM) Programme, overseen by the West Coast PHO, uses a quality improvement approach to improve the management of people at-risk or with long-term conditions, encouraging the use of LTC dashboards and NHI-level reports to identify and recall patients with high and moderate levels of risk. People enrolled in the LTCM programme receive: an in-depth annual review for each condition, a package of care based on their level of need, a jointly developed care plan and referral to other PHO programmes, nutrition and physical activity programmes, community support programmes, social services, community pharmacy and health professionals as required to support the management of their condition. The programme has a strong focus on Māori, Pacific people and those in high deprivation areas.

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| Actively engage practice-based quality teams in the quality improvement programme delivered by the PHO to support the LTCM Programme, including education on reviewing NHI-level reports and LTCM dashboards to support the improved recall of patients with high and moderate risk. | Q1: Position in place to support quality improvement focus.<br>Q2-Q4: Workshops underway.<br>Q4: Increase in proportion of the population enrolled in the LTCM programme having their annual LTCM reviews. |
| Develop a locality-based performance report that presents System Level Measures (SLM) by locality, to drive conversations around equity and identify strategies to improve the engagement of people with high and moderate risk in the Primary Care LTCM Programme. | Q1: SLM Dashboard presented to the Alliance Leadership Team.<br>Q1. Socialise the SLM plan with staff across primary and secondary services. |
| Through the West Coast PHO, support the delivery of a suite of services for people with diabetes, alongside their appointment for retinal screening.<br>Supported by dietitians, diabetes clinical nurse specialists, Green Prescription, health promotion, and PHO mental health teams, these 'one-stop' clinics help hard-to-reach people with diabetes to better manage their health and wellbeing, as many have multiple long-term conditions and do not regularly attend general practice. | Q2: 2 Clinics held.<br>Q4: 4 Clinics held. |
| Support the West Coast PHO to work with general practice to target the delivery of Cardiovascular Disease Risk Assessment (CVDRAs) to younger Māori men who are eligible for the reviews but traditionally more difficult to engage in the LTCM programme. (EOA)<br>Invite men in this cohort to appointments outside of normal business hours to reduce barriers to accessing CVDRAs.<br>Engage Poutini Waiora nurses to provide outreach services to complete screening in workplaces or at home.<br>Trial virtual consultations and phlebotomy at appointments as a means of reducing barriers to accessing and completing the CVDRAs. | Q1: CVDRAs offered outside of normal business hours.<br>Q2: Report on uptake of outreach CVDRA services.<br>Q3: Trial of alternative CVDRA engagement.<br>Q4: Increase in proportion of Māori men (35-44) having a CDVRA in the last five year – baseline 66% (Dec 2019). |
| In line with the regional Hepatitis C workplan, implement point of care antibody test (a simple finger prick test that gives results in five minutes) in primary care in our northern and central localities, to enable earlier intervention and treatment for this high-need population group. | Q4: Point of care testing in place in Westport and Greymouth. |
| Support the West Coast PHO to work with general practice to ensure people undergoing a LTCM review for Chronic Obstructive Pulmonary Disease (COPD) have an exacerbation plan in place, to improve their self-management and health outcomes and to reduce ambulatory sensitive (avoidable) hospital admissions for this cohort of people. (EOA)[9]<br>Work with the Respiratory Clinical Nurse Specialists to ensure exacerbation plans are communicated with other key health service providers including St. John, Poutini Waiora, community pharmacy and the DHB's ED team.<br>Utilise system-wide tools, including shared care plans, to ensure the acute care response is informed by patients' individual needs and choice. | Q1: COPD champion identified in general practice.<br>Q2: Education provided to practice staff on having planning conversations with patients and developing individualised plans.<br>Q4: Increase in the proportion of the population having a LTCM review for COPD who have an exacerbation plan in place – baseline Māori 63%, Total Population 69% (May 2021). |
| Maximise the use of personalised shared and acute-care plans to support self-management in the community and the integration of care between providers to improve health outcomes for people with complex conditions and reduce unnecessary admissions to hospital. | Q1: Baseline of shared care plans established.<br>Q2: Training provided to general practice teams.<br>Q4: Increase in the number of plans available on HealthOne. |
| Contributory Measure SS13: Proportion of the population enrolled with a Primary Health Organisation (aged 15-74) who have completed a Diabetes Annual Review in the past 12 months. | Increase on 2019/20 baseline to >90% for all population groups:<br>Māori: 84%<br>Total Population: 61%. |
| Contributory Measure SS05: Age standardised ambulatory sensitive hospitalisations rates for adults (45 to 64 years). | Reduction in the equity gaps for Māori - baseline 12 months to June 2020:<br>Māori – 4,677 per 100,000<br>Total Population – 3,063 per 100,000. |

[9] Chronic Obstructive Pulmonary Disease is a leading contributor to the West Coast's Ambulatory Sensitive Hospital Admission rates and ED presentations for adults both Māori and non-Māori and this work is expected to help to reduce avoidable hospital admissions and improve long-term health outcomes.

# Managing Our Finances

The West Coast DHB understands its fiscal responsibilities and we are committed to living within our means. The projected statement of financial performance for the West Coast DHB is show below. Further detail on the DHB's financial outlook and assumptions for 2021/22 can be found in Appendix 5.

## 2.10 Prospective Statement of Financial Performance – to 30 June 2025

| | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|
| | Unaudited Actual $'000 | Plan $'000 | Plan $'000 | Plan $'000 | Plan $'000 |
| **Revenue** | | | | | |
| Ministry of Health Revenue | 166,369 | 175,784 | 181,224 | 187,188 | 193,215 |
| Other Government Revenue | 1,763 | 1,545 | 1,882 | 1,906 | 1,954 |
| Other Revenue | 10,927 | 10,707 | 10,519 | 10,808 | 11,110 |
| **Total Revenue** | **179,059** | **188,036** | **193,625** | **199,902** | **206,279** |
| **Expenditure** | | | | | |
| Personnel (excl Holidays Act Remediation) | 71,265 | 74,667 | 75,358 | 76,460 | 78,099 |
| Outsourced | 10,398 | 9,866 | 9,881 | 10,063 | 10,258 |
| Clinical Supplies | 9,804 | 10,229 | 10,536 | 10,884 | 11,232 |
| Infrastructure & Non Clinical | 10,469 | 11,008 | 11,286 | 11,717 | 11,986 |
| Payments to Non-DHB Providers | 73,708 | 78,808 | 80,312 | 82,129 | 83,988 |
| Interest | - | - | - | - | - |
| Depreciation & Amortisation | 5,382 | 6,354 | 6,552 | 6,744 | 6,948 |
| Capital Charge | 3,102 | 6,204 | 6,504 | 6,504 | 6,504 |
| **Total Expenditure** | **184,128** | **197,136** | **200,429** | **204,501** | **209,015** |
| **Surplus / (Deficit) before Holidays Act Remediation** | **(5,069)** | **(9,100)** | **(6,804)** | **(4,599)** | **(2,736)** |
| Holidays Act Remediation expense | 2,747 | 2,583 | 2,635 | 2,687 | 2,741 |
| **Surplus / (Deficit)** | **(7,816)** | **(11,683)** | **(9,439)** | **(7,286)** | **(5,477)** |
| **Other Comprehensive Income** | | | | | |
| Revaluation of Land & Building | 5,518 | - | - | - | - |
| **Total Comprehensive Income / (Deficit)** | **(2,298)** | **(11,683)** | **(9,439)** | **(7,286)** | **(5,477)** |

## 2.11 Prospective Financial Performance by Output Class – to 30 June 2025

| | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|
| | Plan $'000 | Plan $'000 | Plan $'000 | Plan **$'000** |
| **Revenue** | | | | |
| Prevention | 3,698 | 3,483 | 3,585 | 3,695 |
| Early detection and management | 33,778 | 34,846 | 36,007 | 37,188 |
| Intensive assessment & treatment | 122,329 | 126,230 | 130,282 | 134,505 |
| Rehabilitation & Support | 28,231 | 29,066 | 30,028 | 30,891 |
| **Total Revenue** | **188,036** | **193,625** | **199,902** | **206,279** |
| **Expenditure** | | | | |
| Prevention | 3,888 | 3,638 | 3,707 | 3,788 |
| Early detection and management | 35,629 | 36,304 | 37,065 | 37,922 |
| Intensive assessment & treatment | 130,270 | 132,647 | 135,313 | 138,614 |
| Rehabilitation & Support | 29,932 | 30,475 | 31,103 | 31,432 |
| **Total Expenditure** | **199,719** | **203,064** | **207,188** | **211,756** |
| **Surplus/(Deficit)** | **(11,683)** | **(9,439)** | **(7,286)** | **(5,477)** |

# STEWARDSHIP

How are we managing our business to achieve our vision?

# Managing Our Business

This section highlights how we will organise and manage our business to support the delivery of equitable, integrated, clinically sustainable and financially viable health services.

## 3.1 Partnering for better outcomes

Our vision is based on delivering a truly integrated system and we cannot hope to achieve our strategic goals and objectives without working collaboratively with our health and social service partners, consumers and clinical leads.

The DHB's major strategic partnerships include:

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

The Consumer Council: The DHB is committed to a culture that focuses on the patient and supports consumer participation in the design of services and strategies to improve wellbeing. We seek input from consumers through our Alliance work, with consumers represented on workstreams. The DHB also has a Consumer Council, to ensure a strong and viable voice in health service planning and redesign.

The Clinical Board: Clinical leadership is intrinsic to our success and the DHB's Clinical Board has a shared leadership structure between consumers, tangata whenua, and clinicians. The Board takes the lead in ensuring the DHB has effective systems and processes in place to prioritise and enable clinical governance and foster an environment of excellence in rural care for our community, whānau, and visitors.

Manawhenua: We have a memorandum of understanding and strategic partnership with Tatau Pounamu, our Manawhenua Advisory Group, where we actively engage with Māori leaders in the design and development of health strategies to support Māori aspirations for health and achieve equity of access and outcomes. Members of Tatau Pounamu also bring a Māori perspective and leadership to the redesign of services and setting of strategic direction through participation in the West Coast Alliance.

Transalpine Partnership: Connecting the Canterbury and West Coast health systems is enabling more coordinated care, reducing duplication and supporting more sustainable access to specialist services for our population. The two DHBs also share a Chief Executive, executive management team, clinical leads, corporate services teams and information systems.

Public Health Partnership: All DHBs have a statutory responsibility to improve, promote and protect the health and wellbeing of their populations. Community & Public Health (a division of the Canterbury DHB) takes a lead in the delivery of public health services for our population. Priorities for the coming year are reflected in the DHB's Annual Plan and supported locally by the Healthy West Coast Alliance.

South Island Regional Health Alliance: The Regional Alliance brings the region's five DHBs together to work collaboratively to develop more innovation and efficient health services. The South Island DHBs are currently working on a refocus and reset of priorities for the Regional Alliance to better support vulnerable services, address the inequities evident across our health system and respond to the recommendations of the National Health and Disability System Review.

## 3.2 Performance management

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

At the broadest level, we monitor our health system performance against a core set of desired population outcomes, captured in our Statement of Intent and System Level Measures Improvement Plan. These frameworks define success from a population health perspective and are used as a means of evaluating the effectiveness of our investment decisions.

The DHB's service performance is monitored through quarterly and monthly reporting to our Board and to the Ministry of Health against key indicators aligned to the national DHB performance framework. This includes our quarterly Māori Health Dashboard report, reflecting service performance by ethnicity.

Our service performance is also audited annually against our Statement of Performance Expectations (Appendix 4), the results of which are presented in our Annual Report available on our website.

## 3.3 Financial management

West Coast DHB's key financial indicator is operating expenditure. This is monitored through quarterly and monthly reporting to our Executive Management Team, Chief Executive, Board and Ministry of Health. The DHB's Board also has a Quality, Audit, Finance and Risk sub-Committee which supports good financial governance and provides advice to the DHB's Board.

In common with DHBs across the country, the West Coast DHB has found it increasingly difficult to achieve a breakeven position and has posted a small financial deficit for each of the last three years.

For the coming year, the West Coast DHB has made a strong commitment to living within our means. Efficiencies are expected to be achieved through the transformation of our workforce and service delivery models and the delivery of process improvements. The DHB will also look to implement further measures to ensure a tight level of fiscal control over cost pressures.

Further information about the West Coast DHB's planned financial position for 2021/22 and forecasts for out-years is contained in Appendix 5.

## 3.4 Continuous quality improvement

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

West Coast DHB is committed to health excellence, with a strong focus on service quality and patient safety. Understanding people's experience of our service is central to improving our performance. We have made a commitment to using our inpatient experience survey results to improve the way we communicate with people and their families and whānau.

The national Health Quality and Safety Commission (HQSC) Quality & Safety Markers supplement our local performance framework and are used to monitor patient safety and the effectiveness of improvement activity. We report results to our community in our Quality Accounts which can be found on our website. We have been working with the HQSC team on several quality improvement projects around diabetes and seclusion rates and will be working with them in the coming year on our clinical governance model.

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

## 3.5 Risk Management

The DHB has a formal risk management and reporting system which incorporates bi-monthly reporting of the high and extreme risks to the Executive Management Team. The high and extreme risks are also reported twice a year to the Board's Quality, Finance, Audit and Risk Committee and all risks are reported to the Committee once a year. The DHB is committed to managing risks in accordance with the latest in risk management standards with the DHB's Risk Management Policy and Framework being aligned with the components of the current ISO 31000:2018 Risk Management Standard.

## 3.6 Asset management

As at 30 June 2021, the West Coast DHB had $163m worth of assets on its books (net book value). We are accountable to Government for the financial and operational management of those assets and our capital intentions are updated annually to reflect changes in asset states and planned investment in the coming year.

The West Coast DHB is looking to advance its asset management planning with a view to taking a more strategic approach to asset maintenance, replacement and investment. A revised Asset Management Plan will be informed by the National Asset Management Plan currently being developed by the Ministry of Health.

This DHB's plan will reflect the anticipated impact changing patterns of demand and new models of care will have on our future asset requirements and will support future investment decisions.

## 3.7 Ownership interests

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

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

The South Island Shared Service Agency Limited: is an unlisted company, no longer trading or operating. The functions are conducted by the South Island Alliance Programme Office, via an agency agreement with the five South Island DHBs.

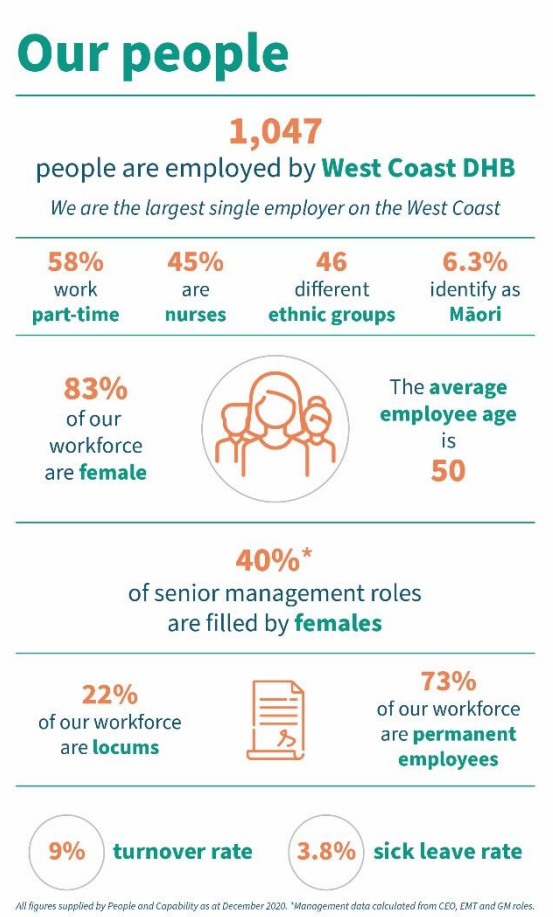
We do not intend to acquire shares or interests in any other companies, trust or partnerships in 2021/22.

# Building Our Capability

## 3.8 Investing in our people

The development of a highly skilled and stable rural-generalist workforce, with a real passion for rural health, is a critical factor in the future sustainability of the West Coast health system.

Recruiting and retaining staff into rurally isolated environments has become increasingly complicated by the ageing of the health workforce and national workforce shortages in specialist areas. On the West Coast, this has led to an over-reliance on locums and short-term contractors, which has reduced the continuity of care for our population and increased the vulnerability of person-dependant services. This is an expensive and ultimately unsustainable solution.




### Rural Generalist Model

The DHB is deliberately investing in a rural-generalist workforce model, a proven strategy for more remote rural health systems. This model will apply across all professions (medical, nursing and allied health), and as part of this strategy each professional will work to the full extent of their scope of practice as a member of an integrated multi-disciplinary team.

Having a core workforce of rural generalists will support a more integrated model of care, reduce the fragmentation of service delivery and help to address workforce shortages. For example, a rural generalist doctor could be qualified to work in obstetrics or anaesthetics as well as in general practice and hospital medicine. This will help our system better respond to variation and fluctuation in service demand and will encourage integration across services areas, reducing duplication and improving the continuity of care for patients. Our rural generalists will also be members of multi-disciplinary teams working alongside Christchurch-based specialists, further enhancing the capacity and capability of our health system.

This move will provide opportunities for our current workforce to evolve and will help us attract people who want to work in a more integrated rural-based model with strong links into the tertiary provider. Feedback and support for the proposal for change was sought at the end of 2020 with implementation of the rural generalist model underway.

### People Strategy

The DHB has also committed to a People Strategy to positively motivate and support our current workforce and attract new people to the West Coast health system. As a good employer, we promote equity, fairness and a safe, healthy workplace. Workplace Health and Safety is integral to our organisation. We have several strategic health and safety programmes and reviews underway to support the safety of our employees, including Safe Moving and Handling, Violence Prevention and Hazardous Substances reviews, and development of Lone Worker guidelines. We also have a clear set of organisational values and operational policies to that effect, including our Equality, Diversity & Inclusion Policy and Wellbeing Policy. The DHB will also implement the national Care Capacity Demand Management agreement.

We identify available talent and expand workforce capability through participation in the regional Workforce Development Hub, links with the education sector, support for scholarships, internships and clinical placements in our hospitals and participation in the national Kia Ora Hauora programme, aimed at increasing the number of Māori working in health.

In collaboration with Canterbury DHB, we are reviewing recruitment practices, particularly those that may unintentionally limit job placements for Māori applicants. We are also working jointly to support the career aspirations of our people so that they can grow and develop. The DHB has introduced Te Huarahi Hautu, a comprehensive training programme for DHB people leaders, to equip them with the tools to reach their full potential, ensure they model behaviour that reflects our values and vison and build organisational competency in management.

Key actions and activity to progress this work have been highlighted in Section 4 of this Plan.

## 3.9 Investing in information systems

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

The South Island DHBs are developing a regional Data and Digital Health Strategy, to deliver on the national Digital Health Strategy and support the integration of patient information systems and services across the South Island. The West Coast DHB is committed to this approach and has invested in the move to regional and sub-regional solutions, implementing Health Connect South, HealthOne and the shared Electronic Referral Management System. The next focus will be the (single) South Island Patient Information Care System (SIPICS).

Our transalpine partnership with Canterbury DHB provides critical support to applications management and technology upgrades and supports a host of

security improvements. We now share many of the same software solutions, a combined transalpine service desk and joint policies, and are moving to joint security appliances and cloud providers.

Locally, telehealth, videoconferencing and mobile technology are an important factor in addressing our isolation challenges. We continue to expand this capability, providing more remote communities with access to telehealth options. We are embracing the learnings from the COVID-19 response to amplify positive changes to our work environment. Our focus includes service virtualisation and the rollout of more accessible digital tools such as Microsoft Teams which will enhance the accessibility of telehealth services.

A host of digital advancements have been incorporated into Te Nīkau to improve patient care, including electronic orders and e-referrals. The DHB is now investing in the implementation of a single patient management system (Indici) across all the DHB-owned general practices and into our unplanned care area at Te Nīkau. This will include development of a patient portal and will greatly enhance clinical decision making, support our integrated care model and improve the continuity of care for our population.

Key actions and activity to progress this work have been highlighted in Section 4 of this Plan.

## 3.10 Investing in facilities

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

The West Coast DHB owns several health facilities in poor condition where the unsuitable design is hindering new ways of working, constraining capacity and having a negative impact on the quality of care we provide.

The completion of Te Nīkau (our new Grey Hospital and Health Centre) in the past year has enabled a significant step forward in the way we deliver care on the West Coast. The modern, fit-for-purpose facility will support more responsive, integrated service delivery and has allowed us to complete our models of care changes and cement a new way of working.

The new integrated (Medical & Surgical) inpatient unit for example, allows multi-skilled staff to care for patients in spaces that are flexible enough to accommodate patients from differing specialities and the integration of our planned and unplanned care space has supported capacity for longer opening hours in our general practice.

The replacement of our Energy Centre was part of the Grey Base redevelopment and was completed in parallel with the Te Nīkau facility. This is a more energy efficient plant, with an electronically connected building management system allowing efficient control and early warning should there be issues.

The next significant areas of investment for our health system are:

Buller Health Centre: In December 2018 approval was given for the $21m Buller project. Management of the project is with the DHB and the design of the new facility has been completed with significant clinical input to support new ways of working. The project is expected to be complete in 2023.

Grey Base Mental Health Facility: The current mental health facility is in poor condition and does not support the delivery of contemporary mental health care to patient and whānau. A master site plan has been approved by the Board with reference to possible locations for a replacement facility, more aligned to the new model of care for mental health services.

An initial business case submitted to the Capital Investment Committee in July 2021 is being revised, with $15m having been made available from Government for the replacement of the Mental Health Inpatient Unit. We expect to work through options and approvals in 2021/22 and, subject to those approvals, we anticipate work to begin on the facility in 2024.

# Reconfiguring Services

## 3.11 Service coverage

Responsibility for ensuring service coverage is shared jointly between the DHB and the Ministry of Health and we are responsible for taking appropriate action to ensure that service coverage is delivered for our population, including those priority populations who may have high or differing needs.

In the current environment of increasing resource constraints and rising service demand, it is likely that service levels and access to services in some locations may have to be adjusted. The DHB identifies service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways, and takes appropriate action to ensure service coverage is maintained.

We are not seeking any formal exemptions to the Service Coverage Schedule for 2021/22.

## 3.12 Service change

As we consolidate our new ways of working in Te Nīkau, move forward with the development of our rural generalist model and embrace new technologies, we expect that the configuration, scope, delivery model or location of some services will need to change.

The DHB is also aware that we must strive to live within our means and manage our business in a fiscally responsible manner. In doing so we will look to ensure we are delivering service as effectively and efficiently as possible and will prioritise resources into the areas of

greatest need and where we can make the biggest impact in terms of health outcomes for our population.

Changes to services are always carefully considered, not only for the benefits they bring but also the impact they may have on other stakeholders. Consistent with our shared decision-making approach, we look to our clinically-led alliances, leadership groups and our community for advice on the development of new services and service models and engage with the Ministry with regards to significant service change.

The DHB is permitted (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000) to negotiate, enter into or amend service agreements or arrangements to assist in meeting its objectives and goals. In doing so, we will seek to ensure any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations or agreements with the Crown.

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

## Service Change Anticipated in 2021/22

| Type of Service Change | Description of Anticipated Change | Anticipated Benefit | Driver |
|---|---|---|---|
| Change in location and provider. | Planned Care: In line with national direction the DHB will increase its focus on the provision of planned procedures in primary care settings. This may result in the reconfiguration of some services currently provided in hospital settings. | Improved access and earlier intervention. | National |
| Reconfiguration of service and change in location and model of service delivery. | Mental Health Services: The DHB will complete implementation of its redesigned model of care for mental health services. This includes the reconfiguration of service teams to align with the locality-based model and support for increased kaupapa Māori service delivery. | Earlier intervention, integration, and improved health equity and outcomes. | Local |
| Reconfiguration of services and change in the model of service delivery. | Rural Generalist Workforce Model: The DHB will progress the implementation of our Rural Generalist Strategy to further embed Rural Generalists in Obstetrics & Gynaecology (O&G), Internal Medicine and Anaesthetics as well as providing greater support for primary care. This work will include a reconfiguration of FTE resources and a reduction in the use of locums and contracted specialists. | Improved continuity of care and integration and more sustainable service delivery. | Local<br>COVID-19 |
| Change in the model of service delivery. | Outpatient Services and Primary Care Services: The DHB will review traditional models of service based on face-to-face outpatient and general practice activity and seek to support models that incorporate virtual, telehealth, remote GP and nurse-led service provision. We will also look to capture the model of care opportunities identified in the Pae Ora o Te Tai o Poutini evaluation to improve health outcomes for Māori. | Increased flexibility, equity of access and more cost effective and efficient services. | Local<br>COVID-19 |
| Change in the model of service delivery. | Te Nīkau Acute Care Services: The DHB will be staffing the new Short Stay Unit within Te Nīkau. This has multiple benefits to clinical safety and service provision and will include providing more flexible support to our Paediatric Unit, General Ward, ED and Unplanned Primary Care service areas as demand fluctuates.<br>The increased investment in this area will be supported by the redirection of resource and staff from other nursing services (following a roster review and the migration of services to the new facilities), ensuring that this improved service model does not increase overall nursing FTE. | Increased staffing flexibility, and alignment of workforce planning with service demand. | Local |
| Reconfiguration of the service delivery model. | Care Capacity Demand Management: The DHB will work towards full implementation of Care Capacity Demand Management for nursing and midwifery. This is likely to result in a reconfiguration of FTE resources to better align with demand. | Consistent care and alignment of workforce planning with service demand. | National |
| Potential change in location, scope and configuration of services. | Needs Assessment, Coordination and Management Services: The DHB is bringing needs assessment, coordination and management services together into one integrated hub to support a more efficient, responsive and sustainable service model. This is underway across our Home-Based Support Services and in 2021/22 the DHB will consider alignment in other service areas.<br>The DHB is also building on its frailty pathway work for our older population, which will include regularising the use of the InterRAI Service Allocation Tool, to better identify those patients with emerging signs of frailty and developing a pathway to prioritise our response to Māori identified with signs of frailty. | Increased integration, equity of access and health outcomes, reduced duplication and improved patient experience. | Local |

| | | | |
|---|---|---|---|
| Reconfiguration of the service delivery model. | Home and Community Support Services (HCSS): The DHB is completing a proposal for change related to HCSS, to align with the national HCSS framework and to better link in our support workers with the locally based health team. The intention of this change is to place the client at the centre and help them and their whānau navigate their health journey. This will result in a reconfiguration and/or reduction in FTE. | Increased integration, reduced duplication and improved patient experience. | Local |
| Potential reconfiguration of services. | Clerical and Administration Services: The DHB will review clerical administrative resources, following the move to Te Nīkau, with a view to upskilling existing staff and developing universal positions to make more efficient use of administrative resources across the organisation. This may result in a reconfiguration and/or reduction in FTE. | Increased flexibility and efficiency and reduced service costs. | Local |
| Potential change in location, scope, provider and service delivery model. | Infusion, Orthotics, Radiology, Audiology, and Podiatry Services, and Equipment Provision: The DHB is considering the provision of several services, currently provided in hospital settings, to capture opportunities to integrate and realign resources to provide the greatest return in terms of health gain. This work will include reconsideration of the scope and location of service. | Improved access, more sustainable service delivery and improved equity of health outcomes. | Local |
| Potential change in the scope and configuration of services and the model of service delivery. | Tertiary Services: The DHB will continue to explore how to best meet the needs of our population with ongoing redesign of transalpine and regional pathways and the integration of service models with Canterbury DHB. | Increased integration, equity of access and more sustainable service delivery. | Regional |

## Shifts or additions in workforce Full Time Equivalents (FTE)

| Division | Staff Group | Description | FTE Increase | Driver |
|---|---|---|---|---|
| COVID-19 Vaccination Team | Nursing | Employment of fixed term positions funded by the Ministry of Health to deliver the COVID-19 Vaccination Programme on the West Coast. | + 11.25 | National |
| | Management & Admin | | +5.5 | |
| Short Stay Unit | Nursing | Staffing the short stay unit to provide flexibility across ED & paediatric services and additional clinical support into paediatrics (1FTE staffed per shift) and support variance in staffing in the acute area. Reflecting the change in service model in this area. | +5.5FTE | Local |
| Te Nīkau Nursing review | Nursing | Review of rosters and requirements across services based in Te Nīkau / Greymouth following the migration to new facilities and the change in service models in this area. | -4.33FTE | |
| Community Nursing Buller | Nursing | Reduction in staffing as part of roster review. | -0.9FTE | |
| Home & Community Services | Nursing | Reduction in nursing supporting HCSS in line with change of structure and service model in this area. | -2.18FTE | |
| Support Services & Facilities | Support | Increase in FTE related to the in-sourcing of cleaning services that occurred in 2020/21. | +8.4FTE | Local |
| Allied Health | Administration | Increase fixed term FTE funded through research grant to support engagement with community around health services for our children | +0.84FTE | Local |
| Mental Health Service | Nursing | Clinical Nurse Educator position funded by Ministry to improve mental health responses in acute areas such as ED. | +0.4FTE | National |

# IMPROVING HEALTH OUTCOMES

Are we making a difference?

# Monitoring Our Performance

## 4.1 Improving health outcomes

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

DHBs have several different roles and associated responsibilities. In our governance role we are concerned with health equity for our population and the sustainability of our health system. In our funder role, we strive to improve the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver, the efficiency with which it is delivered, the experience of the people we serve, and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of our work and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an overarching intervention logic and an outcomes framework which is highlighted in our Statement of Intent, available on our website.

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

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


Aligned to each goal, we have identified several population health indicators which will provide insight into how well our system is performing over time. These indicators are also reflected in the DHB's System Level Measures Improvement Plan developed in partnership with the West Coast PHO and available on our website.

## 4.2 Improving service performance

Over the shorter-term, we evaluate our service performance by monitoring ourselves against a forecast of the service we plan to deliver and the standards we expect to meet. This forecast is set out in our Statement of Performance Expectations (Appendix 4).

The DHB reports annually against the Statement of Performance Expectations in our Annual Report, which can be found on our website.

The DHB also reports quarterly against a set of key quality indicators and patient experience indicators established by the national Health Quality and Safety Commission. Some of these measures are reflected in the Statement of Service Performance, all can be found on the HSCQ website www.hqsc.govt.nz.

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

## 4.3 Accountability to the Ministry

The DHB's reporting obligations include quarterly service level performance reporting to the Ministry of Health, in line with the national non-financial performance monitoring framework.

This framework has been updated for 2021/22 to provide a line of sight between DHB activity and the health system priorities that support delivery of the Government's priority goals for New Zealand. The health and disability system has been asked to focus on the following health system priorities:

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

The national framework and the standards expected for 2021/22 are set out on the following pages.

# National DHB Performance Framework 2021/22

| Performance Measure | | Performance Expectation | | |
|---|---|---|---|---|
| **Improving Child Wellbeing** | | | | |
| CW01 | Children caries free at 5 years of age | | Year 1 | 59.2% |
| | | | Year 2 | 59.2% |
| CW02 | Oral health: Mean DMFT score at school year 8 | | Year 1 | <0.85 |
| | | | Year 2 | <0.85 |
| CW03 | Improving the number of children enrolled and accessing Community Oral Health services | Children Enrolled: ≥95% of pre-school children (aged 0-4) will be enrolled in the Community Oral Health Service | Year 1 | >=95% |
| | | | Year 2 | >=95% |
| | | Children Examined According to Planned Recall: ≤10% of pre-school and primary school children enrolled with the Community Oral Health Service will be overdue for their scheduled examinations with the Community Oral Health Service. | Year 1 | <=10% |
| | | | Year 2 | <=10% |
| CW04 | Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years | | Year 1 | >=85% |
| | | | Year 2 | >=85% |
| CW05 | Immunisation coverage | 95% of eight-month-olds fully immunised. | | |
| | | 95% of five-year-olds have completed all age-appropriate immunisations due between birth and five years of age. | | |
| | | 75% of girls and boys fully immunised – HPV vaccine. | | |
| | | 75% of 65+ year olds immunised – Influenza vaccine. | | |
| CW06 | Child health (breastfeeding) | 70% of infants are exclusively or fully breastfed at three months. | | |
| CW07 | Newborn enrolment with General Practice | The DHB has reached the Total population target for children enrolled with a general practice by six weeks of age (55%) and by three months of age (85%), has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for its Māori population group, and (where relevant) the Pacific population group, for both targets. | | |
| CW08 | Increased immunisation at two-years | 95% of two-year olds have completed all age-appropriate immunisations due between birth and age two years. | | |
| CW09 | Better help for smokers to quit (maternity) | 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking. | | |
| CW10 | Raising healthy kids | 95% of obese children identified in the Before School Check (B4SC) programme are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. | | |
| CW12 | Youth mental health initiatives | Focus Area 1: Youth Service Level Alliance Team – provide reports as required. | | |
| | | Focus Area 2: School Based Health Services – provide reports as required. | | |
| | | Focus Area 3: Youth Primary Mental Health Services – refer MH04 | | |
| **Improving Mental Wellbeing** | | | | |
| MH01 | Improving the health status of people with severe mental illness through improved access | Age (0-19) Māori, Other & Total | >3.8% access specialist services | |
| | | Age (20-64) Māori, Other & Total | >3.8% access specialist services | |
| | | Age (65+) Māori, Other & Total | >3.0% access specialist services | |
| MH02 | Improving mental health services using wellness and transition (discharge) planning | 95% of clients discharged will have a quality transition or wellness plan. | | |
| | | 95% of audited files meet accepted good practice. | | |
| MH03 | Shorter waits for mental health services for under 25-year olds. | Provide reports as specified. | | |
| MH04 | Rising to the Challenge: The Mental Health and Addiction Service Development Plan | Provide reports as specified. | | |

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| MH05 | Reduce the rate of Māori under the Mental Health Act: Section 29 Community Treatment Orders | | Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year. | |
| MH06 | Output delivery against plan | | Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan. | |
| MH07 | Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care. | | Provide reports as specified. | |
| Improving wellbeing through prevention | | | | |
| PV01 | Improving breast screening coverage and rescreening | | 70% coverage for all ethnic groups and overall. | |
| PV02 | Improving cervical screening coverage | | 80% coverage for all ethnic groups and overall. | |
| Better population health outcomes supported by strong and equitable public health and disability system | | | | |
| SS01 | Faster cancer treatment -31-day indicator | | 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat. | |
| SS03 | Ensuring delivery of Service Coverage | | Provide reports as specified. | |
| SS04 | Delivery of actions to improve Wrap Around Services for Older People | | Provide reports as specified. | |
| SS05 | Ambulatory Sensitive Hospitalisations (ASH adult) | | <3,017 per 100,000 people (September 2020) | |
| SS07 | Planned Care Measures | Planned Care Measure 1: Planned Care Interventions | TBC by MoH | |
| | | Planned Care Measure 2: Elective Service Patient Flow Indicators | ESPI 1 | 100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less) |
| | | | ESPI 2 | 0% – no patients are waiting over four months for FSA |
| | | | ESPI 3 | 0% - zero patients in Active Review with a priority score above the actual Treatment Threshold |
| | | | ESPI 5 | 0% - zero patients are waiting over 120 days for treatment |
| | | | ESPI 8 | 100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool |
| | | Planned Care Measure 3: Diagnostic waiting times | Coronary Angiography | 95% of patients with accepted referrals for elective coronary angiography receive their procedure within three months (90 days) |
| | | | Computed Tomography | 95% of patients with accepted referrals for CT scans receive their scan, and scan results are reported, within six weeks (42 days). |
| | | | Magnetic Resonance Imaging | 90% of patients with accepted referrals for MRI scans receive their scan, and scan results are reported, within six weeks (42 days). |
| | | Planned Care Measure 4: Ophthalmology Follow-up Waiting Times | No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service. | |
| | | Planned Care Measure 6: Acute Readmissions | The proportion of patients who were acutely readmitted post-discharge improves 0.1% point from base levels. | <=11.2 (base 12 months to December 2019) |
| | | Planned Care Measure 7: Did Not Attend Rates for First Specialist | Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year. | |

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| | | Assessment by Ethnicity (Developmental) | | |
| SS09 | Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections | Focus Area 1: Improving the quality of data within the NHI | New NHI registration in error (causing duplication) | >1.5% to <=6% |
| | | | Recording of non-specific ethnicity in new NHI registration | >0.5% and < or equal to 2% |
| | | | Update of specific ethnicity value in existing NHI record with a non-specific value | >0.5% and < or equal to 2% |
| | | | Validated addresses excluding overseas, unknown and dot (.) in line 1 | >76% and < or equal to 85% |
| | | | Invalid NHI data updates | TBC by MoH |
| | | Focus Area 2: Improving the quality of data submitted to National Collections | NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures. | Greater than or equal to 90% and less than 95 % |
| | | | National Collections completeness | Greater than or equal to 94.5% and less than 97.5% |
| | | | Assessment of data reported to the NMDS | Greater than or equal to 85% and less than 95% |
| | | Focus Area 3: Improving the quality of the Programme for the Integration of MH data (PRIMHD) | Provide reports as specified | |
| SS10 | Shorter stays in Emergency Departments | | 95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours. | |
| SS11 | Faster Cancer Treatment (62 days) | | 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. | |
| SS12 | Engagement/obligations as a Treaty partner | | Reports provided and obligations met as specified. | |
| SS13 | Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke) | Focus Area 1: Long term conditions | Report on actions, milestones and measures to support people with LTC to self-manage and build health literacy. | |
| | | Focus Area 2: Diabetes services | Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care. | |
| | | | Ascertainment: target 95-105% and no inequity | |
| | | | HbA1c<64mmols: target 60% and no inequity | |
| | | | No HbA1c result: target 7-8% and no inequity | |
| | | Focus Area 3: Cardiovascular health | Provide reports as specified | |
| | | Focus Area 4: Acute heart service | Indicator 1: Door to cath - Door to cath within three days for >70% of ACS patients undergoing coronary angiogram. | |
| | | | Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and<br>Indicator 2b: ≥ 99% within three months. | |
| | | | Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. an echocardiogram or LVgram). | |
| | | | Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes); ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), Beta-blocker if LVEF<40% (5-classes).<br>*An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents. | |

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| | | | Indicator 5: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within two months of the procedure. |
| | | | Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within two months of the procedure. |
| | | Focus Area 5: Stroke services | Indicator 1 ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway within 24 hours of their presentation to hospital |
| | | | Indicator 2: Reperfusion Thrombolysis /Stroke Clot Retrieval 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7) |
| | | | Indicator 3: In-patient rehabilitation: 80% of patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission |
| | | | Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge. |
| SS15 | Improving waiting times for Colonoscopy | 90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 14 calendar days or less, 100% within 30 days or less. | |
| | | 70% of people accepted for a non-urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less. | |
| | | 70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less. | |
| | | 95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system. | |
| SS17 | Delivery of Whānau Ora | Appropriate progress identified in all areas of the measure deliverable. | |
| Better Population Health Outcomes Supported by Primary Health Care | | | |
| PH01 | Delivery of actions to improve system level measures (SLMs) | Provide reports as specified. | |
| PH02 | Improving the quality of ethnicity data collection in PHO and NHI registers | All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90%. | |
| PH03 | Access to Care (PHO Enrolments) | The DHB has an enrolled Māori population of 95% or above. | |
| PH04 | Primary health care: Better help for smokers to quit (primary care) | 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months | |
| Other Requirements | | | |
| Annual plan actions – status update reports | | Provide reports as specified. | |

# APPENDICES

## Further Information for the reader

5

# Appendices and Attachments

| | |
|---|---|
| Appendix 1 | Glossary of Terms |
| Appendix 2 | Minister's Letters of Expectation 2021/22 |
| Appendix 3 | Overarching Intervention Logic Diagram |
| Appendix 4 | Statement of Performance Expectations 2021/22 |
| Appendix 5 | Statement of Financial Performance Expectations 2021/22 |
| Appendix 6 | System Level Improvement Plan 2021/22 |

# Documents of interest

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

- West Coast DHB Statement of Intent
- West Coast DHB System Level Measures Improvement Plan
- West Coast DHB Disability Action Plan

# References

Unless specifically stated, all West Coast DHB documents referenced in this document are available on the West Coast DHB website, www.westcoastdhb.health.nz. Referenced regional documents are available from the South Island Alliance Programme Office website: www.siapo.health.nz. Referenced Ministry of Health documents are available on the Ministry's website: www.health.govt.nz. The Crown Entities Act 2004 and the Public Finance Act 1989, referenced in this document, are available on the Treasury website: www.treasury.govt.nz.

# Appendix 1 Glossary of Terms

| | | |
|---|---|---|
| Alliance | The West Coast Alliance | The Alliance is a collective alliance of healthcare leaders, professionals and providers from across the West Coast providing leadership to enable the transformation of our health system in collaboration with system partners and on behalf of the population. |
| CCCN | Complex Clinical Care Network | The Complex Clinical Care Network is a multi-disciplinary team providing a single point of referral for patients from general practice, ambulance and inpatient services. Under the restorative delivery model, clients are assessed using comprehensive assessment tools and an individual goal-based care plan is developed with them. |
| ERMS | Electronic Referral Management System | ERMS is a system available from the GP desktop which enables referrals to public hospitals and private providers to be sent and received electronically, streamlining the referral process and ensuring referrals are directed to the right place and receipt is acknowledged. |
| ESPIs | Elective Services Patient flow Indicators | A set of six wait time focused indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services. |
| | Health Connect South | A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in West Coast, Canterbury and South Canterbury and rolling out across the remainder of the South Island. |
| interRAI | International Resident Assessment Instrument | A suite of geriatric assessment tools that support clinical decision making by providing evidence-based practice guidelines, ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need. |
| NHI | National Health Index | An NHI number is a unique identifier assigned to every person who uses health and disability services in New Zealand. |
| | Poutini Waiora | A kaupapa Māori Health and Social Service provider, delivering holistic care to whānau across the West Coast. The service is primarily mobile with kaimahi visiting whānau in their homes or in community settings. Poutini Waiora holds a number of service contracts with the DHB. |
| PBF | Population-Based Funding | The national formula used to allocate each of the twenty DHBs in New Zealand with a share of the available national health resources. |
| PHO | Primary Health Organisation | Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them. PHOs provide these services either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care. |
| PRIMHD | Programme for the Integration of Mental Health Data | The Ministry of Health's national mental health and addiction information collection holding both activity and outcomes data collected from district health boards and non-governmental organisations. PRIMHD is part of the Ministry's national data warehouse. |
| | Public Health Services | The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. |
| SIAPO | South Island Alliance Programme Office | A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island. |
| | Tatau Pounamu | Tatau Pounamu is the Manawhenua Advisory Group made up of the manawhenua health advisors mandated by the Papatipu Rūnanga as the Te Tiriti o Waitangi partner to West Coast DHB. Tatau Pounamu works with West Coast DHB to develop and implement strategies for Māori health gain, support the delivery of health and disability support services consistent with Māori cultural concepts, values, and practices, and support Māori aspirations for health, reducing inequalities between Māori and other New Zealanders. |
| | Tertiary Care | Highly specialised care often only provided in a smaller number of locations. |

# Appendix 2 Minister's Letter of Expectation 2021/22

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

10 FEB 2021

Hon Rick Barker
Chair
West Coast District Health Board
rick@rbconsulting.nz

Tēnā koe Rick

**Letter of Expectations for district health boards and subsidiary entities for 2021/22**

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2021/22. As a DHB Chair you are accountable to me for meeting these expectations.

This government acknowledges the progress made to rebuild our health system, but there is still more to do. It is clear that COVID-19 will be placing a range of pressures on our health system for some time. We are well placed to continue to respond to resurgence as needed and to lock-in new ways of operating based on our COVID-19 response so that we retain and embed new and innovative approaches where possible.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities, and this will be a key piece of work for the health system during 2021/22. Additional information will be provided when it becomes available.

As you know the Government has accepted the high-level direction of travel of the Health and Disability System Review (HDSR) and during this next phase we will roll out our plan to improve the public health system to ensure it delivers high quality services, improved equity for our vulnerable populations and supports better outcomes for all New Zealanders.

There will be uncertainty ahead, but I expect that this will not stop you from driving forward and continuing to deliver the improvements already underway. It is important that the sector continues to function at its best to provide health and disability services for New Zealanders while system changes are being confirmed and implemented. I also expect that you will begin to work together on further enhancements. The work we do now will ensure we have the right models of care to support longer term sustainability and to maximise outcomes through robust investment in primary and community care.

The priorities this Government has previously outlined to guide DHB planning will remain of critical importance for the coming year. Our wellbeing and equity system priorities together with a focus on giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025 and improvements to DHB sustainability, continue to provide a solid framework for planning and articulating the work DHBs are doing:

- giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025
- improving sustainability
- improving child wellbeing
- improving mental wellbeing including a focus on the transformational direction for our approach to mental health and addiction through the agreed actions from the Mental Health and Addiction Inquiry

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

I would like you to continue to build on these areas of focus, so we improve equity for our vulnerable populations while also ensuring COVID-19 lessons and innovations are captured.

I expect all DHBs to deliver breakeven results by the end of 2021/22 and your annual plan will not be supported without this commitment. Strong fiscal management is critical to support our collective ability to invest more in new models of care and in primary care and population prevention approaches.

It is also imperative that the health system maintains and continues to strengthen our health capital planning, investment and delivery and as Chair you must have clear oversight of the DHB's annual plan to ensure it is sustainable, person centred and reflects Government expectations, including breakeven financial targets.

As you will be aware the Government will be implementing recommendations from the Health and Disability system review. This work will be undertaken alongside the work laid out in this letter. I expect that all DHB's will continue to provide the highest quality services to their populations while any changes are implemented across the system.

A number of DHBs will benefit from expert support across a range of areas and I understand that Chairs are working on an exemplars group. I expect you to seek the support of your colleagues and the Ministry where you need a lift in capability or support to navigate specific challenges.

This Government has provided specific sustainability funding for DHB led improvement projects. I expect to see tangible outcomes being delivered and implemented with this funding and reports on the impact it is having.

You will be aware that pay parity for workforces in the DHB-funded sectors is an issue. This is also an issue in other parts of the State sector, and it is important that a whole-of-Government approach is taken. This Government's position will be developed at a central agency level and I expect you to contribute to and act consistently with this approach. There are complex matters that need careful consideration, including whether DHB funding has flowed equitably to employees in the past and how this would be protected in the future.

I expect all DHBs to increase the pace and scale of implementation of the Care Capacity Demand Management Programme (CCDM) in 2021 to meet the expectations outlined in the 2018 NZNO DHB MECA. I want to be clear that full implementation of CCDM includes annual FTE calculations and ensuring agreed budgeted nursing and midwifery FTE are in place.

DHBs are responsible for the health outcomes for your population and it is important that DHBs and the Ministry continue to work together, and with primary and community providers, to ensure we have a strong and equitable public health system delivering better health outcomes for our most vulnerable populations who have long-standing health inequities.

Please ensure any approaches to a service reconfiguration support improved access to care and equity, and are financially sound. As you are aware any shifts or additions in workforce / FTE must be considered as a service change and follow service change processes. DHBs

must remain focused and prepared for increased pressure and ensure systems are in place to ensure COVID-19 innovations are used to avoid pressure building up on existing services.

DHBs are expected to support and contribute to the Ministry's National Asset Management Programme (NAMP), which will be used to assist the Capital Investment Committee and Ministers to make more informed decision on DHB capital expenditure. I expect DHBs to develop their own Asset Management Policy and Strategy and align their asset management practices with the Ministry of Health district health board sector Asset Management

Unlike previous years I have strong expectations that the annual planning process will be completed on time and as Chair it is your responsibility to meet all deadlines for this process. I expect a strong first draft annual plan will be provided to the Ministry for review in early March so that a robust final plan that meets all expectations will be able to be agreed with me as early as possible post Budget 21. If timelines are not met and robust and appropriate plans are not delivered I will not be able to sign them off for the year.

Please note that I do not require you to refresh your Statement of Intent for 2021/22.

We face complex challenges that require collective approaches and I am looking forward to working with you as we continue our efforts to improve outcomes for New Zealanders.

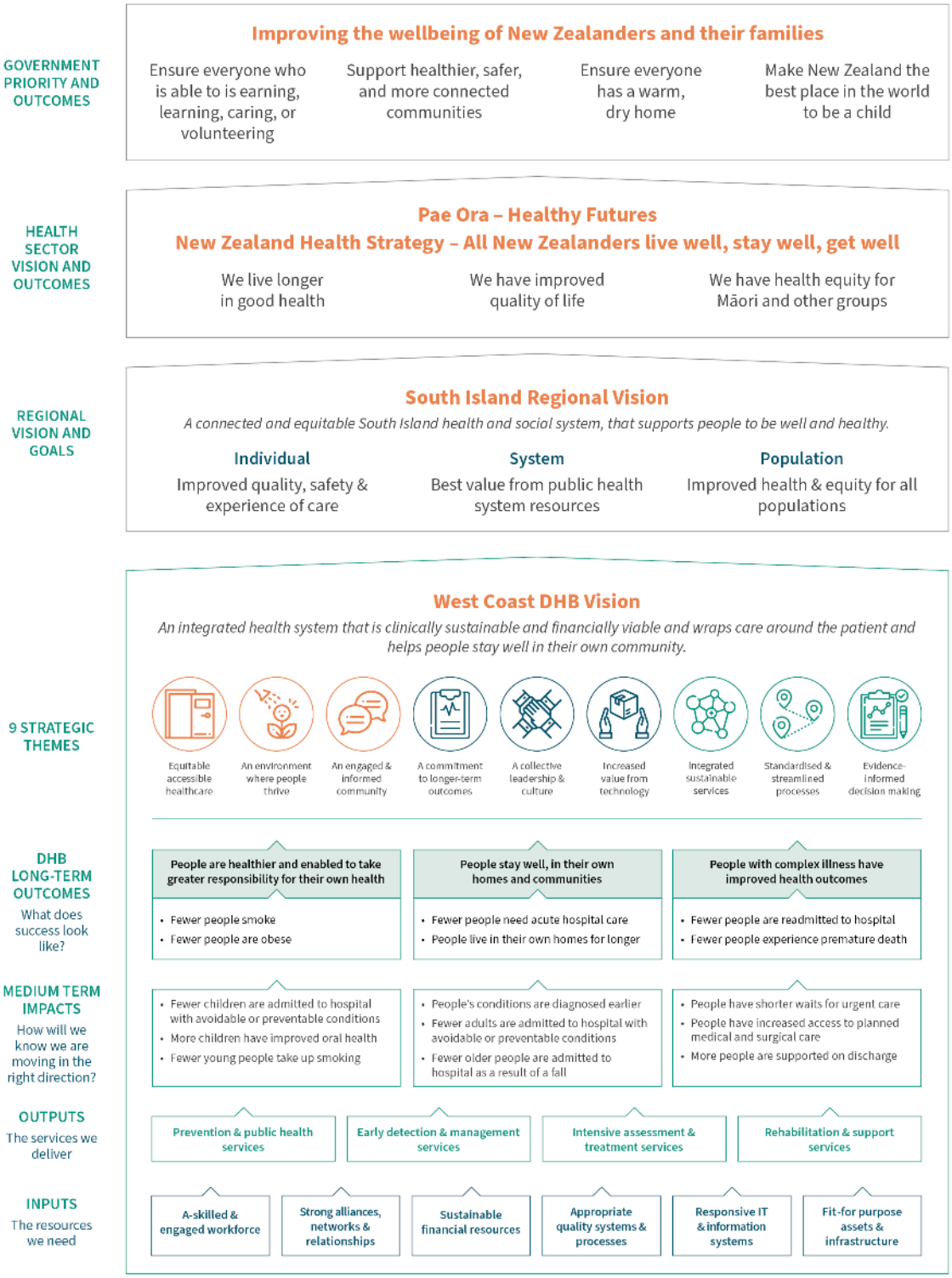
Thank you for the work you have been doing to provide strong governance within our health system. I remind you that in everything you do you are part of the system.

Ngā mihi nui

Hon Andrew Little
**Minister of Health**

Cc Dr Andrew Brant
Chief Executive
West Coast District Health Board

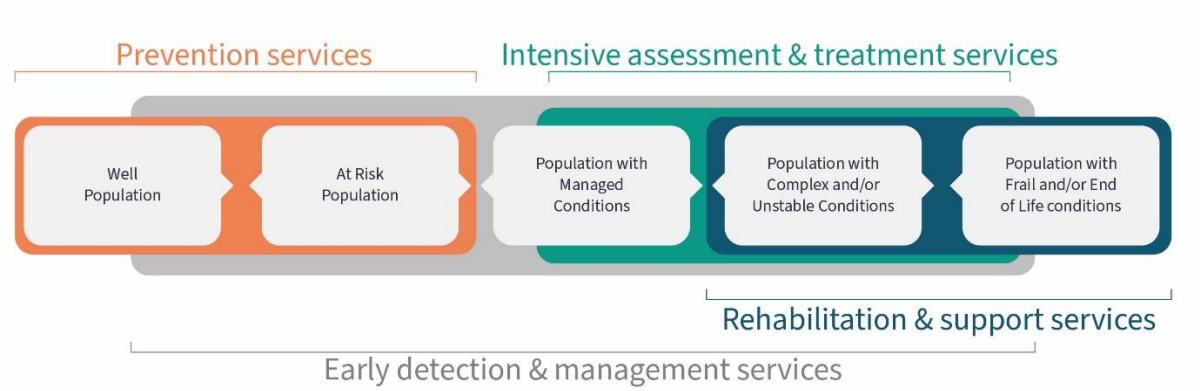
# Appendix 3 Overarching Intervention Logic Diagram




## Te Tiriti O Waitangi

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

# Appendix 4 Statement of Performance Expectations




## Evaluating our performance

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

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

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes. These longer-term outcomes are highlighted in the DHB's Statement of Intent.

On an annual basis, we track our performance against an annual Statement of Performance Expectations, our forecast of the services we plan to deliver and the standards we expect to meet. The results are presented in our Annual Report at the end of the year and are available on the DHB's website.

The following section presents the West Coast DHB's Statement of Performance Expectations for 2021/22.

### IDENTIFYING PERFORMANCE MEASURES

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

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

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

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

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

Access (A)
Are services accessible, is access equitable, are we engaging with all of our population?

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

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

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

### SETTING STANDARDS

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

Targets reflect the strategic objectives of the DHB: increasing the reach of prevention programmes, reducing acute or avoidable hospital admissions and maintaining access to services while reducing waiting times and delays in treatment. We also seek to improve the experience of people in our care, increase equity of access and health outcomes and increase public confidence in our health system.

In considering our drive towards equity, performance targets are universal, set with the aim of reducing disparities between population groups. Key focus areas have been identified to improve Māori health and breakdowns by ethnicity are aligned to each measure.

While targeted interventions can reduce service demand in many areas, there will always be some

demand the DHB cannot influence, such as demand for maternity, dementia or palliative care services.

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

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

### PERFORMANCE EXPECTATIONS

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

The pressures on our system in 2021/22 will be compounded by the unknown impact of the COVID-19 pandemic. Our future environment may be quite different, depending on how the pandemic plays out in New Zealand and around the world. While many of the longer-term population goals and service level expectations (outlined in our Statement of Intent) are unlikely to change, our ability to deliver against them may be compromised by changes in people's environments and economic situations.

### NOTES FOR THE READER

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

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

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

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

## Where does the money go?

In 2021/22 the DHB will receive approximately $188m million dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2021/22, by service class.

| | 2021/22 |
|---|---|
| Revenue | |
| Prevention | 3,698 |
| Early detection & management | 33,778 |
| Intensive assessment & treatment | 122,329 |
| Rehabilitation & support | 28,231 |
| Total Revenue - $'000 | 188,036 |
| Expenditure | |
| Prevention | 3,888 |
| Early detection & management | 35,629 |
| Intensive assessment & treatment | 130,270 |
| Rehabilitation & support | 29,932 |
| Total Expenditure - $'000 | 199,719 |
| Surplus/(Deficit) - $'000 | (11,683) |

## Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

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

By supporting people to make healthier choices, we can reduce the major risk factors that contribute to poor health such as smoking, poor diet, obesity, lack of physical exercise and hazardous drinking. High-need population groups are more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are also designed to spread consistent messages to large numbers of people and can therefore also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| Population Health Services – Healthy Environments | | | | | |
|---|---|---|---|---|---|
| These services address aspects of the physical, social and built environment to protect health and improve health outcomes. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally | Q[10] | Total | 14 | 15 | E.15 |
| Licensed alcohol premises identified as compliant with legislation | Q[11] | Total | 96% | 100% | >90% |
| Tobacco retailers identified as compliant with legislation | Q [11] | Total | 100% | 100% | >90% |

| Health Promotion and Education Services | | | | | |
|---|---|---|---|---|---|
| These services inform people about risk factors and support them to make healthy choices. Success is evident through high levels of engagement. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Mothers receiving breastfeeding and lactation support in community settings | A | Total | 193 | 228 | E>150 |
| Babies exclusively/fully breastfed at LMC discharge (six weeks) | Q[12] | Māori | 67% | n.a | 75% |
| | | Total | 76% | n.a | |
| Babies exclusively/fully breastfed at three months | Q | Māori | 64% | 55% | 70% |
| | | Total | 61% | 64% | |
| People provided with Green Prescriptions for physical activity support | A | Total | 458 | 450 | E>400 |
| Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC) | Q[13] | Māori | 96% | 92% | 90% |
| | | Total | 96% | 93% | |
| Smokers identified in hospital, receiving advice and support to quit smoking (ABC) | Q | Māori | 92% | 89% | 95% |
| | | Total | 91% | 91% | |
| Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC) | Q[14] | Māori | 100% | 100% | 90% |
| | | Total | 100% | 100% | |

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

[11] New Zealand law prevents retailers selling alcohol or tobacco to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years of age) into licensed premises or tobacco retailers. Compliance is seen as a proxy measure of the success of education and training for retailers and reflects a culture that encourages a responsible approach to alcohol and tobacco.

[12] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. These measures are part of the national Well Child/Tamariki Ora Quality Framework and data from providers is not able to be combined so performance from the largest provider (Plunket) is presented. The 2018/19 baseline differs to the previous year's reported result due to a transcribing error it was reported as 76% and should have been 67%.

[13] The ABC programme has a cessation focus and refers to health professionals Asking about smoking status, providing Brief advice and providing Cessation support. The provision of professional advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts.

[14] This data is sourced from the national Maternity Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance. Standards have been set nationally in line with other ABC programme smoking targets.

| Population-Based Screening Services | | | | | |
|---|---|---|---|---|---|
| These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Four-year-olds provided with a B4 School Check (B4SC) | A[15] | Māori | 98% | 97% | 90% |
| | | Total | 93% | 94% | |
| Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention | Q | Māori | 83% | 100% | 95% |
| | | Total | 94% | 100% | |
| Women aged 25-69 having a cervical cancer screen in the last 3 years | A[16] | Māori | 68% | 68% | 80% |
| | | Total | 72% | 72% | |
| Women aged 45-69 having a breast cancer screen in the last 2 years | A[16] | Māori | 68% | 66% | 70% |
| | | Total | 76% | 69% | |
| People aged 60-74 participating in the national bowel screening programme | A | Māori | new | new | 60% |
| | | Total | new | new | |

| Immunisation Services | | | | | |
|---|---|---|---|---|---|
| These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates indicate a well-coordinated, successful service. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Children fully immunised at eight months of age | A[17] | Māori | 83% | 81% | 95% |
| | | Total | 79% | 78% | |
| Proportion of eight-month-olds 'reached' by immunisation services | Q | Total | 96% | 95% | 95% |
| Children fully immunised at two years | A | Māori | 94% | 90% | 95% |
| | | Total | 83% | 82% | |
| Young people (Year 8) completing the HPV vaccination programme | A[18]❖ | Māori | 30% | 47% | 75% |
| | | Total | 30% | 53% | |
| Older people (65+) receiving a free influenza ('flu') vaccination | A[19]❖ | Māori | 50% | 44% | 75% |
| | | Total | 55% | 58% | |

[15] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing health concerns to be identified and addressed early. Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational attainment and quality of life. A referral for children identified with weight concerns allows families to access support to maintain healthier lifestyles.

[16] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment. The measures refer to national screening programme results and standards. From July 2021 the national expectation for Breast Screening was extended to include women 45 to 69 years. Reported baseline results have been updated from previous years. Results are no longer comparable with previously published results.

[17] The West Coast has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. The DHB's focus is to immunise all those who opt-in to the immunisation programme. 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided with advice to enable them to make informed choices for their children - but may have chosen to decline immunisations or opt off the NIR.

[18] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme consists of two vaccinations and is free to young people under 26 years of age. Baseline results refer to young women only, the programme was widened to include boys in 2020/21. The 2018/19 HPV result is subject to data quality issues and we believe is under-reflecting performance.

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

## Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

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

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

The DHB is introducing new technologies and developing a workforce with the skills to provide a wider range of preventative treatment and services, closer to people's homes. Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with local primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and helps to improve their quality of life by reducing complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| General Practice Services | | | | | |
|---|---|---|---|---|---|
| These services support people to maintain their health and wellbeing. High levels of engagement are indicative of an accessible, responsive service. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Newborns enrolled with a PHO by three months of age | A | Māori | 88% | 74% | 85% |
| | | Total | 95% | 90% | |
| Proportion of the population enrolled with a Primary Health Organisation | A | Māori | 86% | 90% | 95% |
| | | Total | 94% | 96% | |
| Youth (12-19) accessing brief intervention/counselling in primary care | A[20Δ] | Total | 159 | 90 | E>150 |
| Adults (20+) accessing brief intervention/counselling in primary care | A[Δ] | Total | 498 | 427 | E>450 |
| Number of integrated HealthPathways in place across the health system | Q[21] | Total | 683 | 677 | E 600 |

| Long-Term Condition Services | | | | | |
|---|---|---|---|---|---|
| These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme | A[22] | Māori | 266 | 266 | E. >200 |
| | | Total | 4,045 | 3,959 | E>3,500 |
| Enrolled population (15-74), identified with diabetes, having an annual diabetes review | A | Māori | 81% | 84% | >85% |
| | | Total | 85% | 61% | |
| Population with diabetes, having an annual review and HbA1c test, demonstrating acceptable glycaemic control (HbA1c <64 mmol/mol) | Q[23] | Māori | 42% | 50% | 60% |
| | | Total | 53% | 56% | |

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

[21] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The pathways support consistent access to treatment and care no matter where in the health system people present.

[22] This measure refers to the primary care programme where enrolled patients are provided with an annual review, targeted care plan and self-management advice to help change their lifestyle, improve their health and reduce the negative impacts of their long-term condition.

[23] Diabetes is a leading long-term condition and a contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.

| Oral Health Services | | | | | |
|---|---|---|---|---|---|
| These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Children (0-4) enrolled in school and community oral health services | A[24]❖ | Māori | 90% | 77% | 95% |
| | | Total | 101% | 88% | |
| Enrolled children (0-12) receiving their oral health exam according to planned recall | T❖ | Māori | 93% | 97% | 90% |
| | | Total | 96% | 98% | |
| Adolescents (13-17) accessing DHB-funded oral health services | A[25]❖ | Total | 76% | 73% | 85% |

| Pharmacy and Referred Services | | | | | |
|---|---|---|---|---|---|
| These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of subsidised pharmaceutical items dispensed in the community | AΔ | Total | 471k | 498k | E<500K |
| People receiving their urgent diagnostic colonoscopy within two weeks | T[26] | Total | 88% | 95% | 90% |
| Number of community-referred radiological tests delivered | A | Total | 6,035 | 5,570 | E>5,500 |
| People receiving Magnetic Resonance Imagining (MRI) scans within six weeks | T | Total | 82% | 91% | 90% |
| People receiving Computed Tomography (CT) scans within six weeks | T | Total | 99.7% | 95% | 95% |

[24] Oral health is an integral component of lifelong health and wellbeing. Early and continued contact with oral health services helps to set life-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[25] Adolescent oral health data is provided by the Ministry of Health. No data is available for Māori utilisation.

[26] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and, by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). The radiology measures refer to non-urgent scans.

## Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| Quality and Patient Safety | | | | | |
|---|---|---|---|---|---|
| These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Staff compliance with good hand hygiene practice | Q[27] | Total | 84% | 81% | 80% |
| Inpatients (aged 75+) receiving a risk assessment to reduce serious harm from falls | Q | Total | 68% | 71% | 90% |
| Patients responding to the national inpatient patient experience survey | P[28] | Total | 28% | 35% | >30% |
| Proportion of patients who responded in the survey that 'hospital staff included their family/whānau or someone close to them in discussions about their care' | P | Total | 55% | 64% | 65% |

| Specialist Mental Health and Alcohol and Other Drug (AOD) Services | | | | | |
|---|---|---|---|---|---|
| These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting growing demand for services, is indicative of a responsive and efficient service. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Proportion of the population (0-19) accessing specialist mental health services | A[29Δ] | Māori | 6.2% | 5.6% | >3.8% |
| | | Total | 5.3% | 5.5% | |
| Proportion of the population (20-64) accessing specialist mental health services | A[Δ] | Māori | 9.7% | 9.6% | >3.8% |
| | | Total | 5.6% | 6.0% | |
| People referred for non-urgent mental health and AOD services seen within 3 weeks | T[30] | Total | 81% | n.a | 80% |
| People referred for non-urgent mental health and AOD services seen within 8 weeks | T | Total | 92% | n.a | 95% |

[27] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. In line with national reporting results refer to the final quarter of each year (April-June). Further detail and quarterly results for the past several years can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[28] There is growing evidence that patient experience is a good indicator of the quality of health services and stronger partnerships and family-centred care have been linked to improved health outcomes. The national DHB inpatient experience survey covers four patient experience domains: communication, partnership, co-ordination and physical and emotional needs.

[29] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. West Coast rates are high, and it is expected they will come down as the DHB implements its strategy to better support people earlier and closer to home. Data is sourced from the national Mental Health dataset (PRIMHD) and results are three months in arrears.

[30] Coding inconsistencies were identified with regards to the mental health wait time data for 2019/20, for both the three and eight-week wait time measures. The DHB was unable to undertake a reconciliation process in time to confirm the results for the year prior to the publishing of this report. Work is ongoing to review the data collection and coding processes to ensure the accuracy of results going forward.

| Maternity Services | | | | | |
|---|---|---|---|---|---|
| While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of maternity deliveries in West Coast DHB facilities | A | Total | 241 | 246 | E.250 |
| Women registered with a Lead Maternity Carer by 12 weeks of pregnancy | A[31]❖† | Māori | 81% | n.a | 80% |
| | | Total | 81% | n.a | |
| Baby Friendly Hospital accreditation achieved in DHB facilities | Q | Total | Yes | Yes | Yes |

| Acute and Unplanned Services | | | | | |
|---|---|---|---|---|---|
| Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of unplanned presentations at the Emergency Department (ED) | A | Total | 11,829 | 11,043 | E<13,000 |
| People admitted, discharged or transferred from ED within 6 hours of presentation | T | Māori | 98% | 99% | 95% |
| | | Total | 98% | 98% | |
| Proportion of people presenting in ED (in triage 1-3), seen within clinical guidelines | T[32] | Total | 77% | 83% | 85% |
| Proportion of people presenting at ED triaged in category 4 or 5 | A | Total | 54% | 54% | <60% |
| Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral. | T | Total | 72% | 83% | 90% |

| Elective and Arranged Services | | | | | |
|---|---|---|---|---|---|
| Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of First Specialist Assessments provided | A | Total | 6,240 | 5,258 | E>6,000 |
| Proportion of patients waiting less than four months for their first specialist assessment | T | Total | 97.0% | 88% | 100% |
| Number of planned care interventions delivered | A[33] | Total | new | 3,220 | TBC |
| Proportion of patients given a commitment to treat and treated within four months | T | Total | 89.0% | 83% | 100% |
| Number of outpatient consultations provided | A | Total | 13,663 | 12,075 | E>13,000 |
| Proportion of outpatient appointments provided by telemedicine | Q[34] | Total | 5.1% | 5.2% | >5% |
| Outpatient appointments where the patient was booked but did not attend | Q[35]Δ | Māori | 15% | 16% | <6% |
| | | Total | 7.7% | 7.2% | |

[31] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report – data is a year in arrears and the 2019 data is yet to be released.

[32] This measure demonstrates whether people presenting in ED are seen in order of clinical need and reflects national triage standards: Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation; Triage 4: seen within 60 minutes; Triage 5: seen within 120 minutes.

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

[34] Increasing value from technology is a key strategic focus for the DHB and the use of telehealth or videoconferencing technology helps to reduce unnecessary travel for patients, their families and clinical staff – particularly when specialists are based in other DHBs.

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

## Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services are those that provide people with the support they need to continue to live safely and independently in their own homes, or regain functional ability, after a health-related event. Services are mostly provided to older people, or people with mental health or complex personal health conditions, following a clinical assessment of need.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

| Assessment, Treatment and Rehabilitation (AT&R) Services | | | | | |
|---|---|---|---|---|---|
| These services restore or maximise people's health. Service utilisation is monitored to ensure people are appropriately supported. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| People (65+) supported by the community In-Home Falls Prevention Service | A[36] | Total | 143 | 84 | >120 |
| Proportion of stroke patients admitted to an organised stroke service (with a demonstrated stroke pathway) after an acute event | Q | Total | 94% | 95% | 80% |
| Proportion of AT&R inpatients discharged home rather than into ARC | Q[37Δ] | Total | 85% | 93% | 80% |

| Home-Based Support Services | | | | | |
|---|---|---|---|---|---|
| These services support people to maintain functional independence. Clinical assessment ensures access is appropriate and equitable. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Number of Meals on Wheels provided | A[Δ] | Total | 36,511 | 41,966 | E>35,000 |
| People supported by district nursing services | A[Δ] | Total | 1,797 | 1,803 | E>1,600 |
| People supported by long-term home-based support services | A[Δ] | Total | 1,100 | 1,041 | E>1,000 |
| Proportion of people supported by long-term home-based support services who have had a clinical assessment of need (using InterRAI) in the last year | Q[38] | Total | 75% | 77% | 95% |

| Aged Residential Care Services | | | | | |
|---|---|---|---|---|---|
| While demand will increase as our population ages, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer. | Notes | Target Group | 2018/19 Results | 2019/20 Results | 2021/22 Target |
| Proportion of the population (75+) accessing rest home level services in ARC | A[39Δ] | Total | 3.8% | 3.4% | E<4.5% |
| Proportion of the population (75+) accessing hospital level services in ARC | A[Δ] | Total | 6.4% | 5.1% | E.<6.0% |
| Proportion of the population (75+) accessing dementia services in ARC | A[Δ] | Total | 1.1% | 0.7% | E.1.0% |
| Proportion of the population (75+) accessing psychogeriatric services in ARC | A[Δ] | Total | 0.3% | 0.3% | E.<0.4% |
| People entering ARC having had a clinical assessment of need using InterRAI | Q | Total | 88% | 91% | 95% |

[36] Falls are one of the leading causes of hospital admission for people aged over 65. The community-based Falls Prevention Service provides care for people 'at-risk' of a fall or following a fall and supports people to stay safe and well in their own homes.

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

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

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

# Appendix 5 Statement of Financial Expectations

## West Coast's financial outlook

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

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

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

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

Facilities pressures: Several of our smaller facilities are outdated, expensive to maintain, poorly located or seismically compromised. The level of remediation required to attain moderate compliance with current building codes is significant. However, the completion of the Te Nīkau facility and the progress on the Buller Health rebuild will significantly improve the quality of our facilities and the efficiencies that can be obtained from these modern facilities.

Financial Viability: Each DHB is funded to cover the cost of services provided to their resident population. Because of our small size, we rely on larger DHBs to provide more complex specialist services for our population and must pay for those services. While the service prices are set nationally, cost increases have historically exceeded annual funding increases. Multi-Employer Collective Agreements (MECA) settled in the past have also significantly exceeded the affordability parameters of the DHB. The flow-on effects of these settlements, to other staff groups and external provider organisations will put immense pressure on the financial sustainability of our health system.

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

## Forecast financial results

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $188m to meet the needs of our population in 2021/22.

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

This represents a $9m increase in funding, however it also includes revenue for pay equity settlements and capital charge relief funding on new facilities, which come with associated expenditure.

The West Coast DHB is predicting a $11.7m deficit result for the 2021/22 year.

## Closing the gap

While health continues to receive a large share of government funding, if we are to be sustainable, we must rethink how we will meet increasing demand for health care within a more moderate growth platform.

There is no easy solution. Savings will be made, not in dollar terms, but in costs avoided through more effective use of available resources and improvements in the health of our population. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system.

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

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

- Streamlining and standardising processes to remove variation, duplication and waste.
- Empowering clinical decision making to reduce delays and improve the quality of care.

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

## Major assumptions

Revenue and expenditure estimates in this document have been based on current government policy settings, service delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results.

In preparing our financial forecasts, we have made the following assumptions:

- Population-based funding levels for 2021/22 are based on the funding advice received from the Ministry.
- Out-years population funding is assumed at an average increase of circa 3.3% per annum.
- The West Coast DHB will continue to receive Crown funding on an early payment basis.
- Costs of compliance with any new national expectations or policy will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Funding for all aspects of pay equity settlement is included in the DHB's population-based funding.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluations. External provider increases will also be settled within available funding levels.
- The approved forecasted deficit will be funded via Crown deficit support (equity injections).
- Work will continue on the facilities redevelopment for Buller Integrated Family Health Centre project, managed by West Coast DHB and governed by West Coast Partnership Group
- Revaluations of land and buildings will continue and will impact on asset values. In addition to periodic revaluations, further impairment in relation to redevelopment and remediation of our facilities may be necessary.
- Treatment related costs will increase in line with known inflation factors, reasonable price impacts on providers and foreseen adjustments for the impact of growth within services.
- National and regional initiative savings and benefits will be achieved as planned.
- Transformation will not be delayed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- There will be no further disruptions associated with pandemics or natural disasters.

## Capital investment

### GREYMOUTH REDEVELOPMENT

Completion of the new Te Nīkau facility occurred early in 2020/21.

The Grey Base redevelopment includes a second tranche upgrade/replacement of other aspects of the Grey Base site. The Board has approved the preliminary site masterplan for the Grey Base campus and the DHB is working with the Ministry on finalising the business case for replacement of the Mental Health Inpatient Unit.

### BULLER REDEVELOPMENT

In December 2018 the Buller IFHC project was approved, with the ongoing project management moving to West Coast DHB. The planned cost of this redevelopment, excluding asbestos remediation, is $21m.

The Buller facilities design has been approved and services have been decanted to allow for construction of the new facility. The IFHC is expected to be completed in May 2023.

### CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $17.5m for the 2021/22 year, of which approximately $11.5m relates to Crown funded Buller IFHC.

Strategic capital for 2021/22-2022/23 comprises of:

- Mental Health & further Grey Base redevelopment.
- Reefton IFHC redevelopment.
- Phased upgrade of clinics outside Westport and Greymouth.
- Move to the South Island Patient Information Care System.
- Investment in other strategic IT/integration systems, including regional IT systems.
- Investments in clinical equipment, including a CT scanner, motor vehicles and general equipment.

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

## Debt and equity

The $21m Buller IFHC project is being funded with equity drawdowns as the project progresses.

The DHB will require deficit funding (equity) to offset the 2020/21 deficit, as well as 2021/22 and outlying years.

The DHB is also repaying $68K equity annually as part of an agreed FRS-3 funding repayment programme with the Ministry of Health.

## Additional considerations

### SUBSIDIARY COMPANY AND PARTNERSHIPS

The South Island Alliance Programme Office is jointly funded by the five South Island DHBs to provide audit, project management and regional service development services.

New Zealand Health Partnerships Limited is jointly funded by all 20 DHBs to enable DHBs to collectively maximise and benefit from shared service opportunities.

### DISPOSAL OF LAND

The West Coast DHB has land and building assets located right across the West Coast, some of which are subject to leasehold interests and arrangements. The DHB is engaged in a process of considering the future of these assets based on our new locality model and future facilities requirements. It is anticipated that recommendations for the disposal of some of the DHB assets will be made in 2021/22.

Necessary approvals will be sought to dispose of any DHB land identified as surplus to requirements. This includes first undertaking the required consultation and obtaining the consent of the responsible Minister. Land would also be valued and offered to parties with the statutory right to receive an offer under the Public Works Act and Ngāi Tahu Claims Settlement Act (and any other relevant legislation), before being made available for public sale.

### ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

### ACQUISITION OF SHARES

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

### ACCOUNTING POLICIES

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

## Statement of Comprehensive Income

Years ending 30 June 2019/20 to 2024/25

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|
| | Audited Actual $'000 | Unaudited Actual $'000 | Plan $'000 | Plan $'000 | Plan $'000 | Plan $'000 |
| **Income** | | | | | | |
| Ministry of Health revenue | 149,769 | 166,369 | 175,784 | 181,224 | 187,188 | 193,215 |
| Patient related revenue | 8,009 | 7,796 | 7,860 | 7,872 | 8,112 | 8,352 |
| Other operating income | 4,525 | 4,894 | 4,392 | 4,529 | 4,602 | 4,712 |
| **Total Income** | **162,303** | **179,059** | **188,036** | **193,625** | **199,902** | **206,279** |
| | | | | | | |
| **Operating Expenses** | | | | | | |
| Personnel (excl Holidays Act Remediation) | 67,535 | 71,265 | 74,667 | 75,358 | 76,460 | 78,099 |
| Outsourced services (clinical and non clinical) | 10,893 | 10,398 | 9,866 | 9,881 | 10,063 | 10,258 |
| Treatment related costs | 9,503 | 9,804 | 10,229 | 10,536 | 10,884 | 11,232 |
| External service providers (include Inter-district outflow) | 66,954 | 73,708 | 78,808 | 80,312 | 82,129 | 83,988 |
| Depreciation & amortisation | 2,733 | 5,382 | 6,354 | 6,552 | 6,744 | 6,948 |
| Interest expenses | - | - | - | - | - | - |
| Other expenses | 11,663 | 10,469 | 11,008 | 11,286 | 11,717 | 11,986 |
| **Total Operating Expenses** | **169,281** | **181,026** | **190,932** | **193,925** | **197,997** | **202,511** |
| | | | | | | |
| **Operating result before capital charge** | **(6,978)** | **(1,967)** | **(2,896)** | **(300)** | **1,905** | **3,768** |
| Capital charge expense | 690 | 3,102 | 6,204 | 6,504 | 6,504 | 6,504 |
| **Surplus / (Deficit) before Holidays Act Remediation** | **(7,668)** | **(5,069)** | **(9,100)** | **(6,804)** | **(4,599)** | **(2,736)** |
| Holidays Act Remediation expense | 11,300 | 2,747 | 2,583 | 2,635 | 2,687 | 2,741 |
| **Surplus / (Deficit)** | **(18,968)** | **(7,816)** | **(11,683)** | **(9,439)** | **(7,286)** | **(5,477)** |
| **Other comprehensive income** | | | | | | |
| Revaluation of land and Buildings | - | (5,518) | - | - | - | - |
| **Total Comprehensive Income** | **(18,968)** | **(2,298)** | **(11,683)** | **(9,439)** | **(7,286)** | **(5,477)** |

## Statement of Financial Position

As at 30 June 2019/20 to 2024/25

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|
| | Audited Actual $'000 | Unaudited Actual $'000 | Plan $'000 | Plan $'000 | Plan $'000 | Plan $'000 |
| **CROWN EQUITY** | | | | | | |
| General funds | 93,858 | 216,678 | 230,910 | 247,542 | 256,915 | 264,136 |
| Revaluation reserve | 25,100 | 28,956 | 28,956 | 28,956 | 28,956 | 28,956 |
| Retained earnings | (115,908) | (122,061) | (133,744) | (143,183) | (150,470) | (155,946) |
| **TOTAL EQUITY** | **3,050** | **123,573** | **126,122** | **133,315** | **135,401** | **137,146** |
| | | | | | | |
| **REPRESENTED BY:** | | | | | | |
| **CURRENT ASSETS** | | | | | | |
| Cash & cash equivalents | 6,153 | 3,415 | (5,259) | (3,483) | 2,195 | 7,158 |
| Trade & other receivables | 4,484 | 5,865 | 5,865 | 5,865 | 5,865 | 5,865 |
| Inventories | 1,044 | 1,097 | 1,097 | 1,097 | 1,097 | 1,097 |
| Assets classified as held for sale | | | | | | |
| Investments (3 to 12 months) | | | | | | |
| Restricted assets | 47 | - | - | - | - | - |
| **TOTAL CURRENT ASSETS** | **11,728** | **10,377** | **1,703** | **3,479** | **9,157** | **14,120** |
| | | | | | | |
| **CURRENT LIABILITIES** | | | | | | |
| Trade & other payables | 15,730 | 17,549 | 17,549 | 17,549 | 17,548 | 17,550 |
| Capital charge payable | - | - | - | - | - | - |
| Employee benefits | 26,755 | 30,422 | 30,422 | 30,422 | 30,422 | 30,422 |
| Restricted funds | 83 | 63 | 63 | 63 | 62 | 62 |
| Borrowings | - | - | - | - | - | - |
| **TOTAL CURRENT LIABILITIES** | **42,568** | **48,034** | **48,034** | **48,034** | **48,032** | **48,034** |
| | | | | | | |
| **NET WORKING CAPITAL** | **(30,840)** | **(37,657)** | **(46,331)** | **(44,555)** | **(38,875)** | **(33,914)** |
| | | | | | | |
| **NON CURRENT ASSETS** | | | | | | |
| Investments (greater than 12 months) | 320 | 231 | 320 | 320 | 320 | 320 |
| Property, plant, & equipment | 35,326 | 162,115 | 171,827 | 176,668 | 173,052 | 169,284 |
| Intangible assets | 497 | 741 | 2,163 | 2,739 | 3,303 | 3,855 |
| **TOTAL NON CURRENT ASSETS** | **36,143** | **163,087** | **174,310** | **179,727** | **176,675** | **173,459** |
| | | | | | | |
| **NON CURRENT LIABILITIES** | | | | | | |
| Employee benefits | 2,253 | 1,857 | 1,857 | 1,857 | 2,399 | 2,399 |
| Borrowings | - | - | - | - | - | - |
| **TOTAL NON CURRENT LIABILITIES** | **2,253** | **1,857** | **1,857** | **1,857** | **2,399** | **2,399** |
| | | | | | | |
| **NET ASSETS** | **3,050** | **123,573** | **126,122** | **133,315** | **135,401** | **137,146** |

Note: The cash position assumes WCDHB receives full equity deficit support indicative funding

## Statement of Movement in Equity

As at 30 June for the years ending 2019/20 to 2024/25

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|
| | Audited Actual $'000 | Unaudited Actual $'000 | Plan $'000 | Plan $'000 | Plan $'000 | Plan $'000 |
| Total Equity at Beginning of the Period | 14,086 | 3,050 | 123,573 | 126,122 | 133,315 | 135,401 |
| Total Comprehensive Income | (18,968) | (2,298) | (11,683) | (9,439) | (7,286) | (5,477) |
| **Other Movements** | | | | | | |
| Contribution back to Crown - FRS3 | (68) | (68) | (68) | (68) | (68) | (68) |
| Contribution from Crown - Capital | 2,000 | 122,889 | 12,000 | 5,000 | - | - |
| Contribution from Crown - Operating Deficit Support | 6,000 | - | 2,300 | 11,700 | 9,440 | 7,290 |
| Other Movements | - | - | - | - | - | - |
| **Total Equity at End of the Period** | **3,050** | **123,573** | **126,122** | **133,315** | **135,401** | **137,146** |

## Statement of Cashflow

As at 30 June for the years ending 2019/20 to 2024/25

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|
| | Audited Actual $'000 | Unaudited Actual $'000 | Plan $'000 | Plan $'000 | Plan $'000 | Plan $'000 |
| **CASH FLOW FROM OPERATING ACTIVITIES** | | | | | | |
| Cash provided from: | | | | | | |
| Receipts from Ministry of Health | 149,689 | 179,705 | 175,784 | 181,224 | 187,188 | 193,215 |
| Other receipts | 12,366 | 523 | 12,240 | 12,401 | 12,714 | 13,064 |
| Interest received | 81 | 52 | - | - | - | - |
| | **162,136** | **180,280** | 188,023 | 193,625 | 199,902 | 206,280 |
| Cash was applied to: | | | | | | |
| Payments to employees | 75,347 | 79,396 | 77,250 | 77,993 | 79,147 | 80,840 |
| Payments to suppliers | 87,649 | 97,324 | 109,989 | 112,015 | 114,212 | 117,463 |
| Interest paid | 3 | - | - | - | - | - |
| Capital charge | 690 | 3,170 | 6,204 | 6,504 | 6,504 | 6,504 |
| GST - net | (532) | 99 | - | - | - | - |
| | **163,157** | **179,988** | 193,443 | 196,512 | 199,863 | 204,807 |
| **Net Cashflow from Operating Activities** | **(1,021)** | **292** | **(5,420)** | **(2,887)** | **39** | **1,472** |
| | | | | | | |
| **CASH FLOW FROM INVESTING ACTIVITIES** | | | | | | |
| Cash was provided from: | | | | | | |
| Sale of property, plant, & equipment | - | - | - | - | - | - |
| Receipt from sale of investments | - | - | - | - | - | - |
| | - | - | - | - | - | - |
| Cash was applied to: | | | | | | |
| Purchase of investments & restricted assets | - | - | - | - | - | - |
| Purchase of property, plant, & equipment | 7,116 | 5,038 | 17,487 | 11,969 | 3,732 | 3,732 |
| | **7,116** | **5,038** | **17,487** | **11,969** | **3,732** | **3,732** |
| **Net Cashflow from Investing Activities** | **(7,116)** | **(5,038)** | **(17,487)** | **(11,969)** | **(3,732)** | **(3,732)** |
| | | | | | | |
| **CASH FLOW FROM FINANCING ACTIVITIES** | | | | | | |
| Cash provide from: | | | | | | |
| Equity Injection - Capital & Other | 2,000 | 2,076 | 12,000 | 5,000 | - | - |
| Equity Injection - Deficit Support | 6,000 | - | 2,300 | 11,700 | 9,440 | 7,290 |
| Loans Raised | - | - | - | - | - | - |
| | **8,000** | **2,076** | **14,300** | **16,700** | **9,440** | **7,290** |
| Cash applied to: | | | | | | |
| Equity Repayment | 68 | 68 | **68** | **68** | **68** | **68** |
| Other | - | - | - | - | - | |
| | **68** | **68** | **68** | **68** | **68** | **68** |
| **Net Cashflow from Financing Activities** | **7,932** | **2,008** | **14,232** | **16,632** | **9,372** | **7,222** |
| | | | | | | |
| Overall Increase/(Decrease) in Cash Held | (205) | (2,738) | (8,675) | 1,776 | 5,679 | 4,962 |
| Add Opening Cash Balance | 6,358 | 6,153 | 3,415 | (5,259) | (3,483) | 2,195 |
| **Closing Cash Balance** | **6,153** | **3,415** | **(5,259)** | **(3,483)** | **2,195** | **7,158** |

Note: The planned cash closing balances assumes WCDHB receives full equity deficit support indicative funding

## Summary of Revenue and Expenses by Arm

As at 30 June for the years ending 2019/20 to 2024/25

| Funding Arm | 2019/20 Audited Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| **Revenue** | | | | | | |
| Ministry of Health revenue | 148,419 | 164,690 | 174,259 | 180,012 | 185,952 | 192,096 |
| Patient related revenue | - | - | - | - | - | - |
| Other operating income | 2,380 | 2,297 | 1,956 | 2,002 | 2,050 | 2,099 |
| **Total Revenue** | **150,799** | **166,987** | **176,215** | **182,014** | **188,002** | **194,195** |
| **Expenditure** | | | | | | |
| Personal Health | 105,807 | 115,544 | 123,758 | 126,005 | 128,708 | 131,447 |
| Mental Health | 15,807 | 16,807 | 18,182 | 18,541 | 18,924 | 19,320 |
| Disability Support | 22,206 | 25,427 | 26,252 | 26,846 | 27,376 | 27,922 |
| Public Health | 1,097 | 787 | 576 | 576 | 576 | 576 |
| Maori Health | 808 | 867 | 927 | 1,021 | 1,045 | 1,072 |
| Governance & Admin | 840 | 893 | 953 | 972 | 996 | 1,020 |
| **Total Expenditure** | **146,565** | **160,325** | **170,647** | **173,960** | **177,625** | **181,356** |
| **Surplus / (Deficit)** | **4,234** | **6,662** | **5,568** | **8,054** | **10,377** | **12,839** |
| Other Comprehensive Income | - | - | - | - | - | - |
| **Total Comprehensive Income** | **4,234** | **6,662** | **5,568** | **8,054** | **10,377** | **12,839** |

| Governance Arm | 2019/20 Audited Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| **Revenue** | | | | | | |
| Ministry of Health revenue | - | - | - | - | - | - |
| Patient related revenue | - | - | - | - | - | - |
| Other operating income | 846 | 918 | 1,003 | 1,020 | 1,045 | 1,075 |
| **Total Revenue** | **846** | **918** | **1,003** | **1,020** | **1,045** | **1,075** |
| **Expenditure** | | | | | | |
| Personnel (excl Holidays Act Remediation) | 1,204 | 1,244 | 1,368 | 1,344 | 1,384 | 1,266 |
| Outsourced services | 907 | 935 | 960 | 936 | 950 | 977 |
| Treatment related costs | 1 | 5 | 3 | - | - | - |
| Depreciation | - | 0 | 1 | - | - | - |
| Interest & Capital Charge | - | - | - | - | - | - |
| Other expenses | 565 | 443 | 442 | 276 | 277 | 290 |
| **Total Expenditure** | **2,677** | **2,627** | **2,774** | **2,556** | **2,611** | **2,533** |
| **Surplus/(Deficit)** | **(1,831)** | **(1,709)** | **(1,771)** | **(1,536)** | **(1,566)** | **(1,458)** |
| Other Comprehensive Income | - | - | - | - | - | - |
| **Total Comprehensive Income** | **(1,831)** | **(1,709)** | **(1,771)** | **(1,536)** | **(1,566)** | **(1,458)** |

## Summary of Revenue and Expenses by Arm (continued)

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|
| Provider Arm | Audited Actual $'000 | Unaudited Actual $'000 | Plan $'000 | Plan $'000 | Plan $'000 | Plan $'000 |
| **Revenue** | | | | | | |
| Ministry of Health revenue | 1,350 | 1,680 | 1,525 | 1,212 | 1,236 | 1,119 |
| Patient related revenue | 8,009 | 7,796 | 7,860 | 7,872 | 8,112 | 8,352 |
| Other operating income | 80,910 | 88,295 | 93,272 | 95,155 | 97,003 | 98,906 |
| **Total Revenue** | **90,269** | **97,771** | **102,657** | **104,239** | **106,351** | **108,377** |
| **Expenditure** | | | | | | |
| Personnel (excl Holidays Act Remediation) | 66,331 | 70,021 | 73,299 | 74,014 | 75,075 | 76,833 |
| Outsourced services | 9,986 | 9,463 | 8,906 | 8,945 | 9,113 | 9,281 |
| Treatment related costs | 9,502 | 9,799 | 10,226 | 10,536 | 10,884 | 11,232 |
| Depreciation | 2,733 | 5,381 | 6,354 | 6,552 | 6,744 | 6,948 |
| Interest & Capital Charge | 690 | 3,102 | 6,204 | 6,504 | 6,504 | 6,504 |
| Other expenses | 11,098 | 10,027 | 10,565 | 11,010 | 11,440 | 11,696 |
| **Total Expenditure** | **100,340** | **107,793** | **115,554** | **117,561** | **119,760** | **122,494** |
| **Surplus / (Deficit)** | **(10,071)** | **(10,022)** | **(12,897)** | **(13,322)** | **(13,409)** | **(14,117)** |
| Holidays Act Remediation expense | 11,300 | 2,747 | 2,583 | 2,635 | 2,687 | 2,741 |
| **Surplus / (Deficit)** | **(21,371)** | **(12,769)** | **(15,480)** | **(15,957)** | **(16,097)** | **(16,858)** |
| Other Comprehensive Income | - | (5,518) | - | - | - | - |
| **Total Comprehensive Income** | **(10,071)** | **(4,504)** | **(12,897)** | **(13,322)** | **(13,409)** | **(14,117)** |

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|---|
| In House Elimination | Audited Actual $'000 | Audited Actual $'000 | Audited Actual $'000 | Audited Actual $'000 | Audited Actual $'000 | Audited Actual $'000 |
| **Revenue** | | | | | | |
| MoH Revenue | - | - | - | - | - | - |
| Patient Related Revenue | - | - | - | - | - | - |
| Other | (79,611) | (86,617) | (91,839) | (93,648) | (95,496) | (97,368) |
| **Total Revenue** | **(79,611)** | **(86,617)** | **(91,839)** | **(93,648)** | **(95,496)** | **(97,368)** |
| **Expenditure** | | | | | | |
| Personnel | - | - | - | - | - | - |
| Depreciation | - | - | - | - | - | - |
| Interest & Capital Charge | - | - | - | - | - | - |
| Other expenses | (79,611) | (86,617) | (91,839) | (93,648) | (95,496) | (97,368) |
| **Total Expenditure** | **(79,611)** | **(86,617)** | **(91,839)** | **(93,648)** | **(95,496)** | **(97,368)** |
| **Surplus/(Deficit)** | **-** | **-** | **-** | **-** | **-** | **-** |
| Other Comprehensive Income | **-** | **-** | **-** | **-** | **-** | **-** |
| **Total Comprehensive Income** | **-** | **-** | **-** | **-** | **-** | **-** |

## Summary of Revenue and Expenses by Arm (continued)

| CONSOLIDATED | 2019/20 Audited Actual $'000 | 2020/21 Unaudited Actual $'000 | 2021/22 Plan $'000 | 2022/23 Plan $'000 | 2023/24 Plan $'000 | 2024/25 Plan $'000 |
|---|---|---|---|---|---|---|
| **Revenue** | | | | | | |
| Ministry of Health revenue | 149,769 | 166,370 | 175,784 | 181,224 | 187,188 | 193,215 |
| Patient related revenue | 8,009 | 7,796 | 7,860 | 7,872 | 8,112 | 8,352 |
| Other operating income | 4,525 | 4,893 | 4,392 | 4,529 | 4,602 | 4,712 |
| **Total Revenue** | **162,303** | **179,059** | **188,036** | **193,625** | **199,902** | **206,279** |
| **Expenditure** | | | | | | |
| Personnel (excl Holidays Act Remediation) | 67,535 | 71,265 | 74,667 | 75,358 | 76,460 | 78,099 |
| Outsourced services | 10,893 | 10,398 | 9,866 | 9,881 | 10,063 | 10,258 |
| Treatment related costs | 9,503 | 9,804 | 10,229 | 10,536 | 10,884 | 11,232 |
| External service providers (incl Inter-district outflow) | 66,954 | 73,708 | 78,808 | 80,312 | 82,129 | 83,988 |
| Depreciation | 2,733 | 5,382 | 6,354 | 6,552 | 6,744 | 6,948 |
| Interest & Capital Charge | 690 | 3,102 | 6,204 | 6,504 | 6,504 | 6,504 |
| Other expenses | 11,663 | 10,469 | 11,008 | 11,286 | 11,717 | 11,987 |
| **Total Expenditure** | **169,971** | **184,128** | **197,136** | **200,429** | **204,501** | **209,015** |
| **Surplus / (Deficit) before Holidays Act Remediation** | **(7,668)** | **(5,069)** | **(9,100)** | **(6,804)** | **(4,599)** | **(2,736)** |
| Holidays Act Remediation expense | 11,300 | 2,747 | **2,583** | **2,635** | **2,687** | **2,741** |
| **Surplus / (Deficit)** | **(18,968)** | **(7,816)** | **(11,683)** | **(9,439)** | **(7,286)** | **(5,477)** |
| Other Comprehensive Income | - | (5,518) | - | - | - | - |
| **Total Comprehensive Income** | **(18,968)** | **(2,298)** | **(11,683)** | **(9,439)** | **(7,286)** | **(5,477)** |

# Appendix 6 System Level Measures Improvement Plan

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

## West Coast DHB 2021/22 Annual Plan

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