

# 2018/19-2021/22

## STATEMENT OF INTENT

Incorporating the 2018/19 Statement of Performance Expectations



*Photo courtesy of Wendy Elwood*



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



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# Statement of Joint Responsibility

**32,410**

reasons to make  
a difference



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

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

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

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

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

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

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

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

**Jenny Black**  
CHAIR | WEST COAST DHB

**Chris Mackenzie**  
DEPUTY CHAIR | WEST COAST DHB

**David Meates**  
CHIEF EXECUTIVE | WEST COAST DHB

November 2018

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Part I

# Overview

Who are we and what do we do?

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## Foreword from the Chair and Chief Executive

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

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

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

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

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

### *Moving forward*

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

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

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

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

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

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

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

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

### *The year ahead*

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

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



Jenny Black  
CHAIR



David Meates  
CHIEF EXECUTIVE



# Introducing the West Coast DHB

## 1.1 Who are we?

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

The West Coast DHB has the smallest population of any DHB in New Zealand. We are responsible for 32,410 people, 0.7% of the total New Zealand population.

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

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

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

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

Our district extends from Karamea in the north, to Jackson Bay in the south and Otira in the east. It comprises three Territorial Local Authorities: Buller, Grey and Westland districts.

### We're very rural

Driving from Karamea to Haast is the same distance as Palmerston North to Auckland.

### Our population's spread out

With more than 0.7 square kilometers per person, our DHB is the most rural by almost 12 times the NZ average.

### Our population's isolated

Not only are they sparsely populated, but 3.4% of households have no access to telecommunication systems. This is the highest proportion in New Zealand.



## 1.2 What do we do?

Like all DHBs, we receive funding from Government with which to purchase and provide the services required to meet the needs of our population, with the expectation of operating within allocated funding.

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

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

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

**Provide** the majority of the health services delivered to our population, through our hospital and specialist services and our DHB owned general practices.

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

## 1.3 Our transalpine service model

Like many small DHBs, population numbers on the West Coast cannot support provision of a full range of specialist services. In some instances, we must refer patients to larger centres with more specialised capacity.

Since 2010, West Coast DHB has shared executive and clinical services with the Canterbury DHB. This includes a joint chief executive, joint executive directors and clinical leads, and shared public health and corporate service teams.

While the West Coast has always had informal clinical arrangements with the Canterbury DHB, the shared model has allowed these to be formalised through clinically-led transalpine service pathways. This formal arrangement enables the West Coast DHB to develop the workforce and infrastructure needed to ensure we can meet the needs of our population, in a clinically and financially sustainable way.

Canterbury specialists now provide regular outpatient clinics and surgical lists on the West Coast. Deliberate investment in telemedicine technology is also improving access to specialist advice, while saving families the inconvenience of travelling long distances for assessment and treatment.

## 1.4 Our population profile

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

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

This is one of the biggest challenges for our health system. Many conditions become more common with age, including heart disease, stroke, cancer, and dementia. As the average age of our population increases, more people are likely to need treatment, care and long-term support, putting increasing pressure on our health system resources.

Deprivation is an indicator of the need for health services and the West Coast has a lower mean personal annual income (\$20,400) compared to the rest of New Zealand (\$24,400). Higher proportions of our population are receiving unemployment or invalid benefits, have no educational qualifications and lack access to a motor vehicle or telephone.

Ethnicity, like age and deprivation, is also a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others. There are currently 3,900 Māori living on the West Coast (12% of our population) and by 2026 that proportion will increase to 13%.

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

## 1.5 Our population's health profile

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

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

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

A reduction in known risk factors such as poor diet, lack of physical activity, tobacco smoking, and hazardous drinking could dramatically reduce the impact of these conditions for our population and reduce the load on our health system.

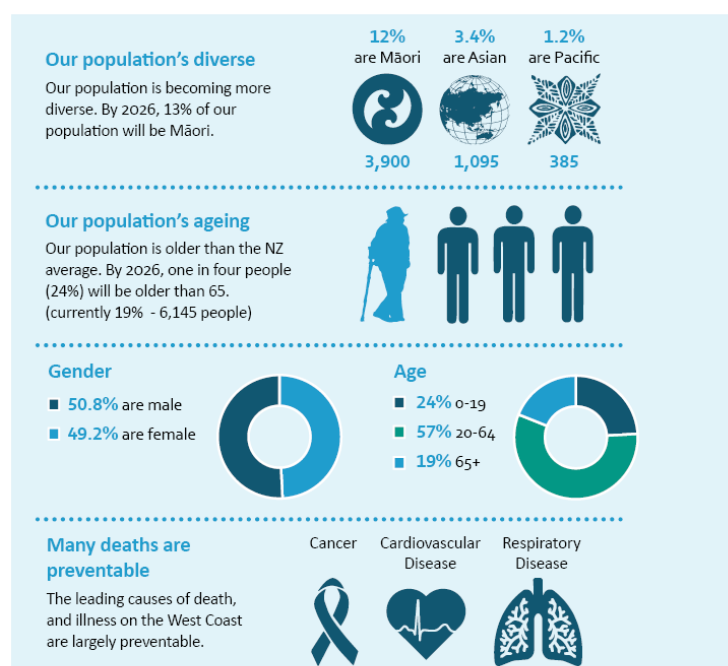
All four major risk factors also have strong socio-economic gradients, so a healthier population focus would contribute greatly to reducing health inequalities between population groups.

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

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

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

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



Based on the Stats NZ Dec 2017 Population Projections

<sup>1</sup> Results from the NZ Health Survey should be interpreted with caution, particularly for Māori. Small population numbers can impact significantly on results. Refer to [www.health.govt.nz](http://www.health.govt.nz).



## Our Operating Challenges

Like health systems world-wide, the shared challenges DHBs are facing are well understood. Populations are ageing, service demand is increasing, treatment costs are rising, and workforce shortages are ever-present. Increasing pressure on government funding also means we are having to do more with less.

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

### 1.6 Geographical pressures

Our biggest challenge is our rurality.

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

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

### 1.7 Workforce pressures

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

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

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

### 1.8 Fiscal pressures

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

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

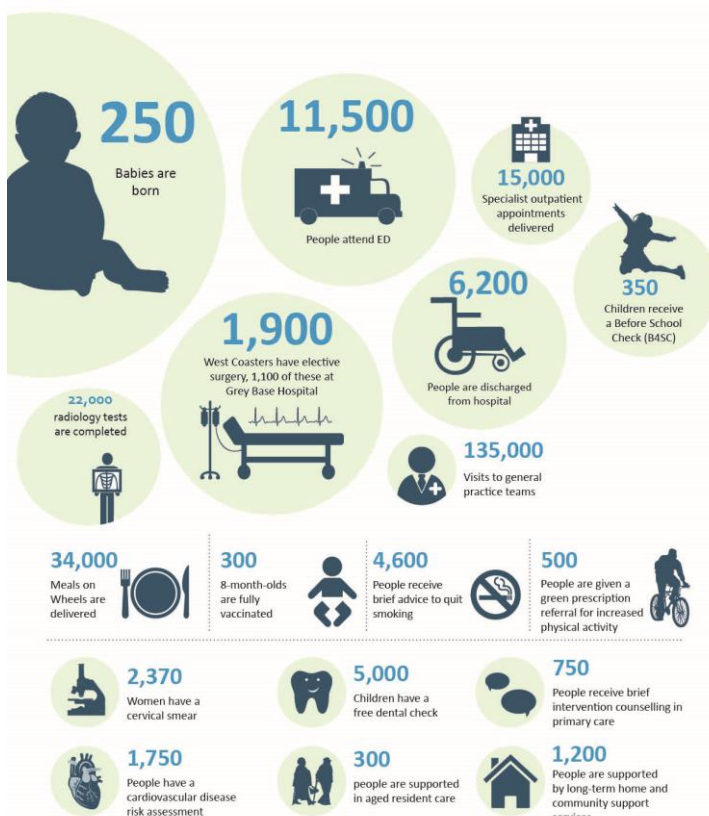
### 1.9 Facilities pressures

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

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

At the same time, a number of our other health facilities are outdated, inefficient and expensive to maintain. Many are seismically compromised or poorly located and do not support the model of care needed to deliver our vision. Careful consideration must be given to the long-term future of all the facilities we own and operate across the West Coast.

## In an average year on the West Coast



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

Part II

# Long-Term Outlook

What are we trying to achieve?

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# Our Strategic Direction

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

## 2.1 Nationally consistent

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

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

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

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

There is increased emphasis on:

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

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

## 2.2 Regionally responsive

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Regional Alliance to address our shared challenges and develop more responsive and effective health services.

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

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

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

The Regional Health Services Plan can be found on the Alliance website: [www.sialliance.health.nz](http://www.sialliance.health.nz).

## 2.3 Locally driven

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

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

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

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

**Clinically and financially viable** - This means our health system will achieve levels of efficiency that will allow an appropriate range of services to be sustainably maintained. There will also be a stable workforce of health professionals in place to provide these services.

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

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

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

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

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

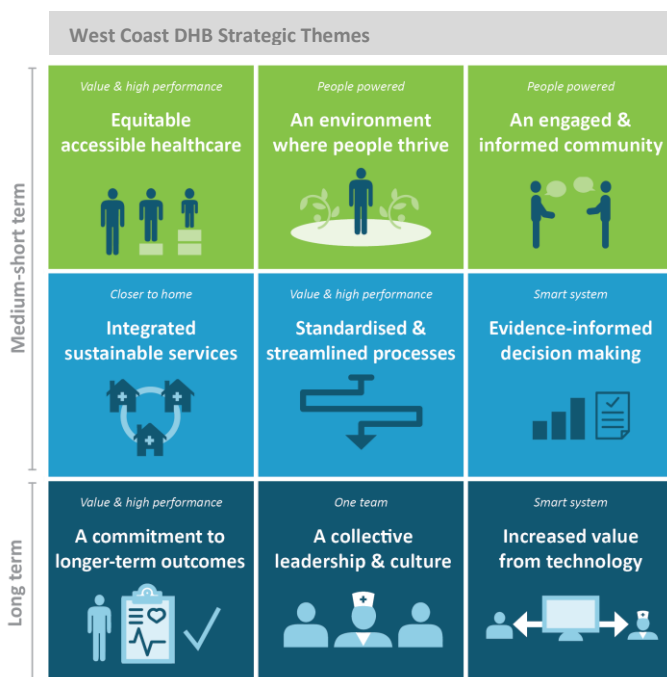
Telemedicine has been embraced by many of our services and in 2016/17, 512 West Coast people had their specialist appointments using telehealth technology, saving patients more than 18,000km of travel and many hours away from work and home.

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

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

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

Operating intentions to support progress in these areas are highlighted in our Statement of Performance Expectations and in our 2018/19 Annual Plan, available on our website: [www.westcoastdhb.health.nz](http://www.westcoastdhb.health.nz).



Part III

# Medium-Term Outlook

How are we going to get there?

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## Managing Our Business

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

This section highlights how we will organise and manage our business in order to support our vision and enable the successful delivery of more integrated health services across our community.

### 3.1 Patient-focused culture

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

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

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

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

### 3.2 Effective leadership

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

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

Strategic and operational decisions are further informed through the following formal mechanisms:

**The Clinical Board:** Where members support and influence the DHB's vision and play an important role in raising the standard of patient care.

**The Consumer Council:** Where members ensure a strong and viable voice for consumers in health service planning and service redesign.

### 3.3 Collective impact

Our vision is based on bringing to life a truly integrated health and social sector. To complete our transformation, the whole system needs to be working together to do the right thing for our patients and our population. Working collaboratively will enable us to respond to the changing needs of our population, and is a critical factor in achieving our goals and objectives. The DHB's major strategic partnerships include:

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

**Tatau Pounamu:** Where, under a shared memorandum of understanding, the DHB actively engages with Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Members of Tatau Pounamu also bring a Māori perspective to the redesign of services across a number of the West Coast Alliance workstreams.

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

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

### 3.4 Commitment to quality

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

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

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

reporting now well established, safety issues are becoming more transparent and empowering the organisation to respond to needed improvement.

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

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

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

### 3.5 Performance management

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

The West Coast DHB has invested in the development of 'live data' systems where real time information on the day-to-day operations within our hospitals enables more responsive decision-making and planning.

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

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

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

### 3.6 Asset management

Having the right assets in the right place and managing them well is critical to the ongoing provision of high-quality and cost-effective health services.

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

Our capital intentions are updated annually to reflect known changes in asset states and intentions in line with our Grey Base Hospital and Integrated Family Health Centre redevelopments.

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

As at 30 June 2017, the West Coast DHB had \$44.387M worth of assets on its books. Refer to the Financial Performance section (page 38) for a breakdown of the DHB's major capital investments to 2021.

### 3.7 Ownership interests

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

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

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

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

## Investing in Our Future

### 3.8 Investing in our people

To meet the needs of our population, and achieve our vision, we need a motivated workforce committed to doing their best for the patient and the system.

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

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

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

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

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

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

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

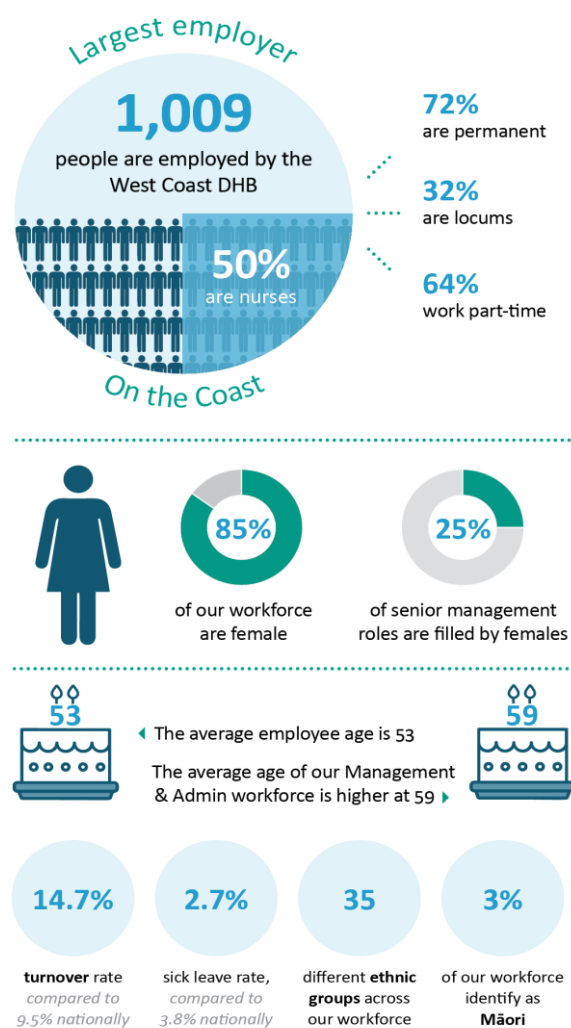
A range of initiatives will be developed and rolled out over the next few years to deliver on the priorities in our People Strategy. We will be measuring the impact we make and using what we learn to inform our next steps. We will also involve our people every step of the way to ensure we are focused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

Alongside our People Strategy, we also identify available talent and expand workforce capability through: participation in the regional Workforce Development Hub; links with the education sector; sharing training resources; and support for internships and clinical placements in our hospitals.<sup>2</sup>

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

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

<sup>2</sup> Refer to the South Island Regional Health Services Plan for regional workforce actions for 2018/19.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

With the onset of increased retirements, and difficulties attracting talent to the Coast, leadership development for those who are managing others will

help improve levels of employee satisfaction and reduce turn-over levels. Training also serves to improve levels of engagement amongst older workers who might otherwise enter into retirement earlier than if they were still learning and developing.

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

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

### 3.9 Investing in health literacy

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

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

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

Areas of investment for the period of this Plan include:

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

### 3.10 Investing in information systems

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

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

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

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

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

Telehealth, videoconferencing and mobile technology, that support staff working remotely, are an important factor in addressing our rurality and isolation challenges. Investment to date has already saved patient and clinical time by reducing the need to travel for assessments. We will continue to expand the use of telemedicine and connect up the system electronically with the digitalisation of our new hospital.

Areas for investment for the period of this Plan include:

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

the technology across the wider health system, with 90% of telehealth moved to the new solution by the end of 2018/19.

- Development and approval of a business case for e-Pharmacy completed by the third quarter 2018/19, with implementation beginning in the fourth quarter of 2018/19.

### 3.11 Investing in facilities

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

The West Coast is in the midst of significantly transforming the way health services are delivered to our community. The new Grey Base Hospital and Integrated Family Health Centre (IFHC) will underpin this transformation by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service delivery.

Unfortunately, ongoing delays with the building programme mean that the DHB has so far been unable to realise anticipated efficiency savings. Increased construction and fixtures and fitting costs are also creating significant pressure.

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

Areas of investment for the period of this Plan include:

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

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

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

### 3.12 Cross-sector investment

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

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



and physical environments that improve population health.

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

Areas of investment for the period of this Plan include:

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

**The Buller Interagency Forum:** The forum involves a number of local and central government agencies and community organisations including the DHB. Providing an opportunity to share information about service provision and projects, the forum promotes community wellbeing across the Buller community.

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

### 3.13 Investing in service redesign

#### SERVICE COVERAGE

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

DHBs are responsible for ensuring that service coverage is maintained for their population. The DHB works to identify service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways.

At this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2018/19.

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

#### SERVICE REDESIGN

We work in partnership with our primary and community partners to redesign the way we deliver health services, to better meet the needs of our population and ensure the future sustainability of our health system. We anticipate that new models of care and service delivery will continue to emerge through this collaborative work.

Consistent with our shared decision-making principles, we look to our clinically-led alliance work streams and leadership groups for advice on the development of new service models. We also endeavour to keep a steady stream of information flowing across our system and our community with regards to service changes and the transformation of services.

In the coming year, the DHB will review capacity and costs across all service areas and look to prioritise resources into areas of most immediate or greatest need. This includes aligning practice and intervention rates with national service specifications or accepted practice in other DHBs, and may impact on the configuration, scope and location of some services.

At times, we may wish to negotiate, enter into or amend service agreements or arrangements to assist in meeting our objectives and delivering the goals outlined in this document. In doing so (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000), we will seek to ensure that any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations in respect to our agreements with the Crown.

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

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

# Monitoring Our Performance

## 3.11 Improving health outcomes

DHBs have a number of different roles and associated responsibilities. In our governance role, we strive to improve health equity and health outcomes for our population. As a funder, we are concerned with the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver and the efficiency with which it is delivered.

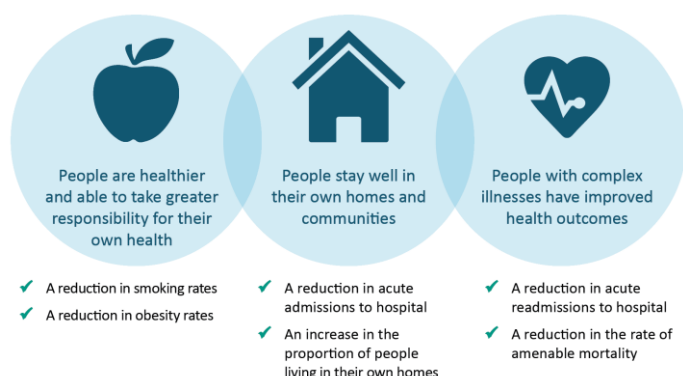
As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

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

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

Our population health approach is inherent in our outcomes framework. At the highest level the framework reflects our three strategic objectives or goals, where we believe success will have a positive impact on the health of our population.

Under each goal we have identified a number of population health outcomes indicators which will provide insight into how well our health system is performing over time.



The nature of population health is such that it may take a number of years to see marked improvements. Our focus is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

### MAIN MEASURES OF PERFORMANCE

To evaluate our performance over the shorter-term, we have identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been selected as our main measures of performance.

We have set performance standards for these contributory measures in order to evaluate our performance and determine if we are moving in the right direction. Tracking our performance against these indicators helps us to evaluate our success in areas that are important to our community, our Board and Government. They form an essential part of the way in which we hold ourselves to account.

These contributory measures sit alongside our annual Statement of Performance Expectations, outlining the service we plan to deliver and the standards we expect to meet in the coming year. They are also reflected in our System Level Measures Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

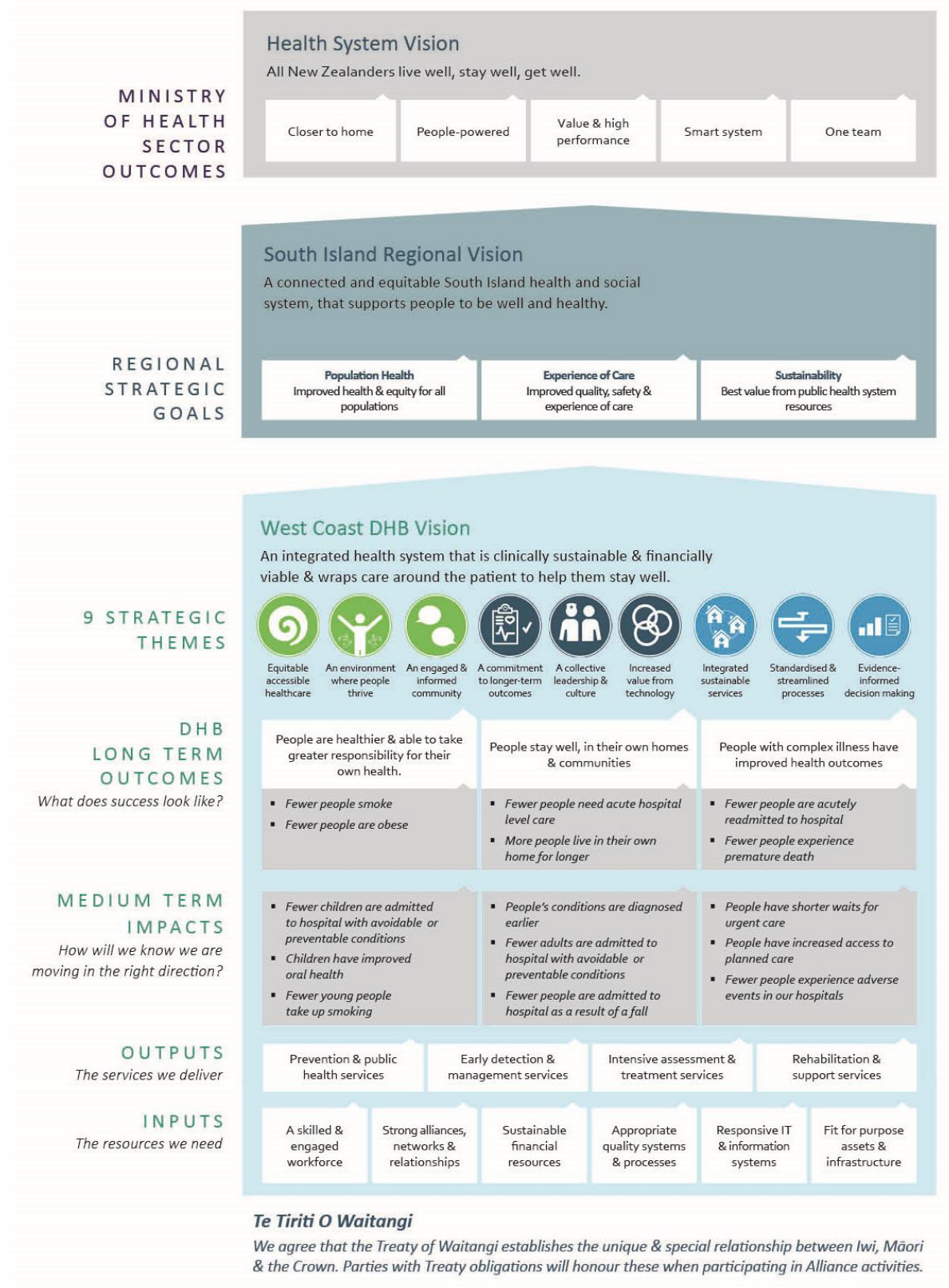
The intervention logic diagram on the following page demonstrates the anticipated value chain, by illustrating how the services the DHB funds or provides will impact on the health of our population, contribute to the goals of the wider South Island region and deliver on the expectations of Government.

Our year-end service performance results are reported to our community in our Annual Report, alongside our year-end financial results.

Our Statement of Performance Expectations for 2018/19 can be found in the Annual Operating Intentions section of this document (page 26).

As a Crown entity, responsible for Crown assets, the DHB also provides regular financial and non-financial performance reporting to the Ministry of Health. The DHB's obligations under the Ministry's monitoring framework are highlighted in the DHB's Annual Plan.

# Overarching Intervention Logic



# System Outcomes

## 3.12 People are healthier and able to take greater responsibility for their own health



### WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions such as cancer, heart disease, respiratory disease, diabetes and depression. These conditions are major drivers of poor health and premature mortality (death) and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates more than 70% of health funding is spent on managing long-term conditions.

Tobacco smoking, inactivity and poor nutrition are major risk factors for a number of the most prevalent of these long-term conditions. These are modifiable risk factors and can be reduced through supportive environments and improved awareness and personal responsibility for health and wellbeing. Public health services, by supporting people to make healthier lifestyle choices, will improve the quality of people's lives and reduce the burden on our health system.

Because the major risk factors also have strong socio-economic gradients, this focus will contribute to reducing inequities in health outcomes between population groups. To support this outcome, we are investing in smoking cessation, exercise and nutrition programmes and the creation of health-promoting and supportive environments.

### HOW WILL WE DEMONSTRATE OUR SUCCESS?

#### A REDUCTION IN SMOKING RATES

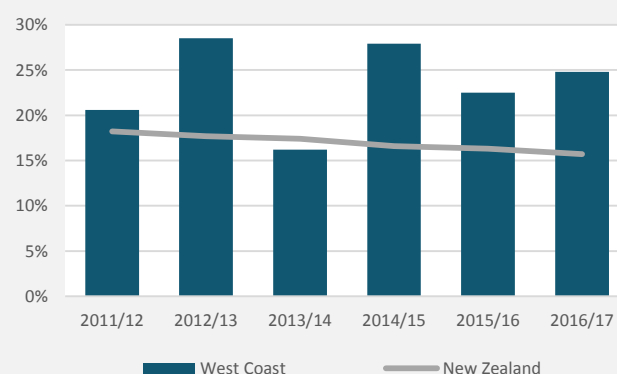
Smoking and exposure to second-hand smoke causes an estimated 5,000 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequalities in health status between population groups.

Data Source: National NZ Health Survey <sup>3</sup>

#### Measure: proportion of the population (15+) who smoke



#### A REDUCTION IN OBESITY RATES

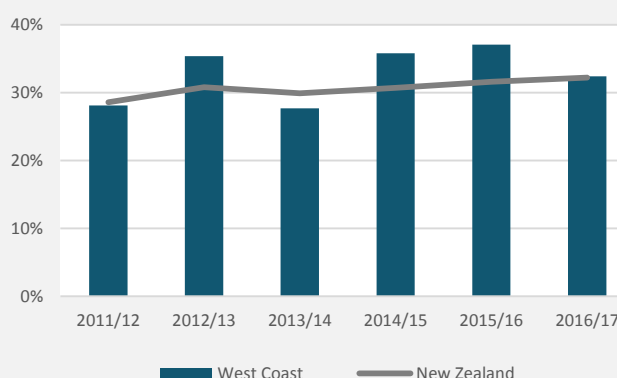
There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicities. Obesity is set to overtake tobacco as the leading risk to health and the most recent (2016/17) NZ Health Survey found 32% of adults and 12% of children were obese.

Not only does obesity impact on the quality of people's lives, but it is a significant risk factor for many of the leading long-term conditions on the West Coast including heart disease, respiratory disease, diabetes and stroke.

Supporting people to achieve a healthier body weight is fundamental to improving people's wellbeing and to preventing poor health and disability at all ages.

Data Source: National NZ Health Survey <sup>4</sup>

#### Measure: proportion of the population (15+) who have obesity



<sup>3</sup> The New Zealand Health Survey is commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. Every year about 14,000 households take part in the survey with total population results presented annually and ethnicity breakdowns over combined time periods (due to small population numbers). West Coast results should be interpreted with caution, particularly for Māori, due to the small survey numbers. For the combined period 2014-2017 – 25.5% of the total West Coast population are current smokers, compared to 44.1% of our Māori population.

<sup>4</sup> The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people. Rates are available by ethnicity over the combined period 2014-2017 – 35.2% of the total population are obese, compared to 55.5% of the Māori population.



## IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

### FEWER AVOIDABLE HOSPITAL ADMISSIONS

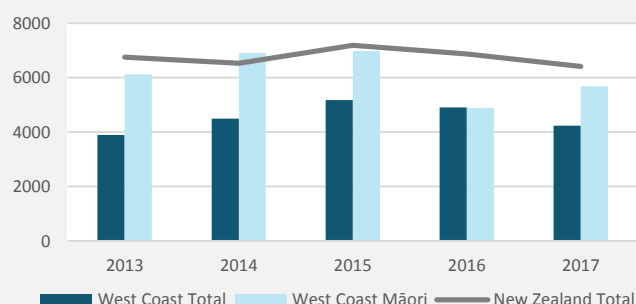
An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, a reduction in risk factors, earlier intervention and the effective management of long-term conditions.

Ensuring children have the best start to life is a crucial component in the long-term health and wellbeing of our population. A reduction in these admissions will also free up hospital and specialist resources to respond to more complex and urgent cases and reduce delays in treatment.

This measure is seen as an indicator of the accessibility and effectiveness of health care and a marker of increased integration between health and social services.

Data Source: Ministry of Health Performance Reporting <sup>5</sup>

Measure: Rate of ambulatory sensitive hospital admission for children (0-4)	Base	Target			
	16/17	18/19	19/20	20/21	21/22
	4,242	<6,416	<6,416	<6,416	<6,416



### CHILDREN HAVE IMPROVED ORAL HEALTH

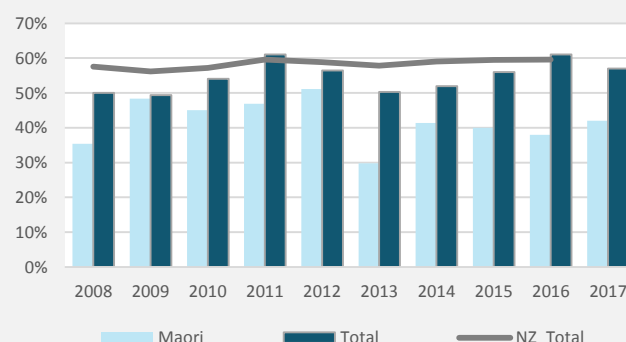
Oral health is an integral component of lifelong health and contributes to a person's self-esteem and quality of life.

Good oral health not only reduces unnecessary hospital admission, but also signals a reduction in risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improvements in the proportion of children caries-free (no holes or fillings) is also seen as a proxy indicator of the effectiveness of mainstream services in reaching those most at risk.

Data Source: School and Community Oral Health Services Patient Management System and Statistics NZ Population Projections <sup>6</sup>

Measure: children caries-free at age five	Base	Target			
	2017	2018	2019	2020	2021
	57%	58%	>58%	>58%	>58%



### FEWER YOUNG PEOPLE TAKE UP SMOKING

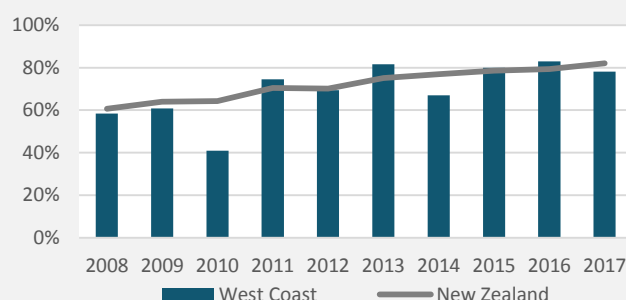
The highest prevalence of smoking is amongst younger people, and preventing young people from taking up smoking is a key contributor to reducing smoking rates across our total population.

Because Māori and Pacific people have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles.

Data Source: National ASH Year 10 Survey <sup>7</sup>

Measure: 'never smokers' amongst Year 10 students	Base	Target			
	2016	2018	2019	2020	2021
	78%	>79%	>79%	>79%	>79%



<sup>5</sup> This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a (non-standardised) rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2017. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations, the December 2017 rate was slightly higher (5,290) but still relatively stable and below the national average.

<sup>6</sup> This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.

<sup>7</sup> The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. Run by Action on Smoking & Health, the survey has been used to monitor student smoking since 1999 and provides valuable insights into tobacco use trends amongst young people. For more detail see [www.ash.org.nz](http://www.ash.org.nz).

### 3.13 People stay well in their own homes and communities



#### WHY IS THIS A PRIORITY?

When people are supported to stay well and can access the care they need closer to home and in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital-level intervention or residential care. This is not only better in terms of people's health outcomes and quality of life, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital level response.

Health services also play an important role in supporting people to regain functionality after illness and supporting people to remain independent for longer. Even where returning to full health is not possible, access to responsive, needs-based rehabilitation, pain management and palliative care services can help to improve the quality of people's lives.

The general practice team is a vital point of ongoing continuity, particularly in terms of improving care for people with long-term conditions and supporting people to stay well as they age. We are investing in general practice services, community-based allied health services, diagnostic services and home based support services with the aim of improving access to services closer to people's homes and enabling earlier intervention, diagnosis and treatment.

#### HOW WILL WE DEMONSTRATE OUR SUCCESS?

##### A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

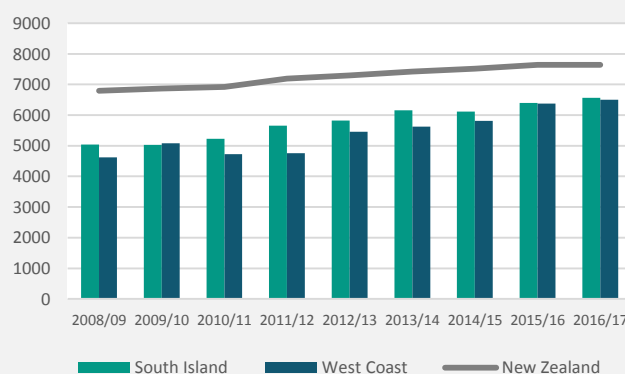
Acute (unplanned) hospital admissions account for almost one third of all admissions in New Zealand. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and even death.

Reducing acute hospital admissions and the length of time people spend in our hospitals also has a positive effect on the health system, enabling more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care.

Acute hospital admissions are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatment in the community.

*Data Source: National Minimum Data Set*

Measure: rate of acute medical admissions to hospital (age standardised, per 100,000)



##### MORE PEOPLE LIVING IN THEIR OWN HOME

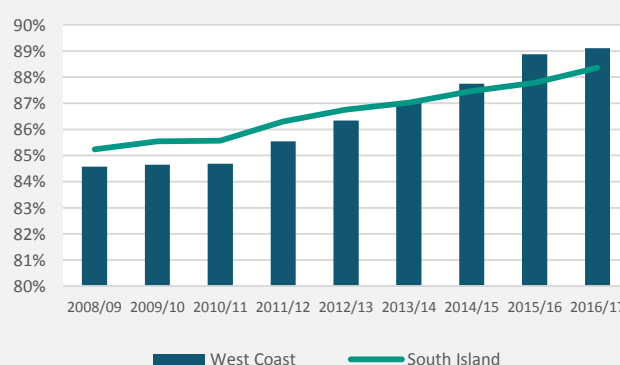
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes when people remain in their own homes and positively connected to their local communities.

Living in residential care is also a more expensive option and resources could be better spent providing home-based support and packages of care to help people stay well in their own homes.

An increase in the proportion of older people living in their own homes is seen as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

*Data Source: SIAPO Client Claims Payment System*

Measure: proportion of the population (75+) living in their own home



## IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

### PEOPLE'S CONDITIONS ARE DIAGNOSED EARLIER

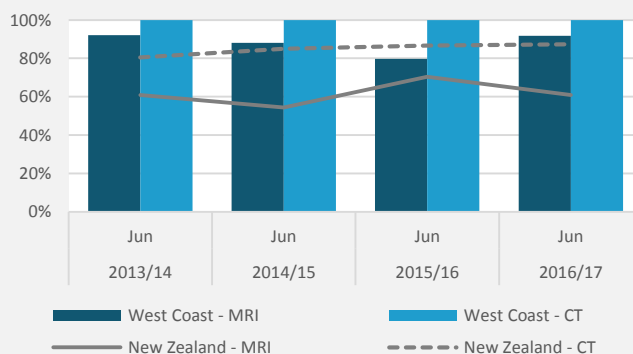
Timely access to diagnostics, by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes.

People also want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

Wait times for diagnostics therefore can be seen as a proxy indicator of the effectiveness of our health system and our ability to match capacity with demand, particularly when we are seeking to minimise wait times and operating within a constrained environment.

Data Source: DHB Patient Management System

Measure: people receiving their non-urgent MRI or CT scan within six weeks	Base	Target			
	16/17	18/19	19/20	20/21	21/22
MRI	92%	90%	90%	90%	90%
CT	100%	95%	95%	95%	95%



### FEWER AVOIDABLE HOSPITAL ADMISSIONS

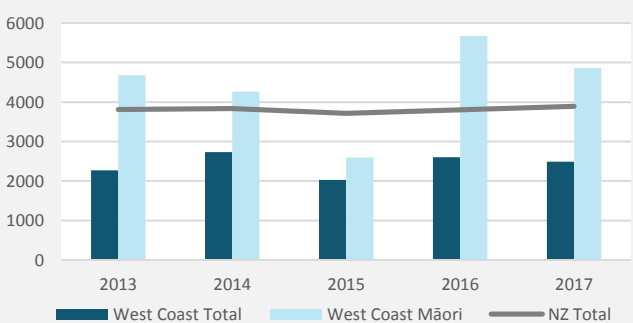
An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, risk factor reduction, earlier intervention and the effective management of long-term conditions.

Not only will a reduction in avoidable admissions contribute to improved health outcomes for our population, but it will also reduce pressure on hospital and specialist services.

A key factor in reducing avoidable hospital admissions is improved coordination between primary and secondary services. As such, this measure is seen as an indicator of the accessibility and effectiveness of primary care and a marker of a more integrated health system.

Data Source: Ministry of Health Performance Reporting <sup>8</sup>

Measure: Rate of ambulatory sensitive hospital admission for adults (45-64)	Base	Target			
	16/17	18/19	19/20	20/21	21/22
	2,487	<3,892	<3,892	<3,892	<3,892



### FEWER FALLS-RELATED HOSPITAL ADMISSIONS

Compared to older people who do not fall, those who do experience prolonged hospital stays, loss of confidence and independence and an increased risk of institutional care.

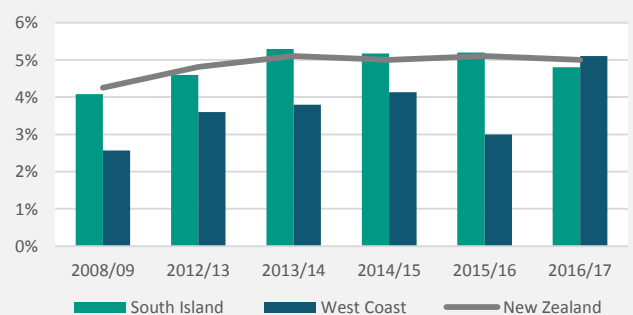
With an ageing population, our focus on reducing harm from falls will help people to stay well and independent and reduce the demand for hospital and residential services.

Solutions to preventing falls include appropriate medications use, improved physical activity and nutrition, access to restorative support and rehabilitation and a reduction in personal and environmental hazards.

This measure is seen as an indicator of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the services being provided.

Data Source: National Minimum Data Set <sup>9</sup>

Measure: population (75+) admitted to hospital as a result of a fall	Base	Target			
	16/17	18/19	19/20	20/21	21/22
	5.1%	<5.0%	<5.0%	<5.0%	<5.0%



<sup>8</sup> This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a (standardised) rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2017. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations, the December 2017 rate for the total population was slightly higher (3,135) but relatively stable and below the national rate.

<sup>9</sup> Small numbers have a disproportionate impact on these results, the difference between 2015/16 and 2016/17 results was 52 people. The target has therefore been set with the aim of maintaining West Coast rates below the national average. From 2013/14 results reflect the updated population in line with the 2013 Census.

### 3.14 People with complex illness have improved health outcomes



#### WHY IS THIS A PRIORITY?

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it.

As the primary provider of hospital and specialist services on the West Coast, this goal also considers the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population, people's experience of care and their confidence in the health system. Ineffective or poor-quality treatment and long waits for treatment also waste resources and add unnecessary cost.

We are in the midst of a significant facilities redevelopment and remediation programme and seeking to transform the way we deliver services to increase capacity with the resources we have available. In order to make the most of our limited clinical workforce we are focusing on improving the flow of patients across our system and reducing duplication of effort to maintain service access and reduce waiting times for treatment. We are also seeking to increase the value from our investment in technology to support clinical decision making and improve the quality of the care we provide.

#### HOW WILL WE DEMONSTRATE OUR SUCCESS?

##### A REDUCTION IN ACUTE READMISSIONS

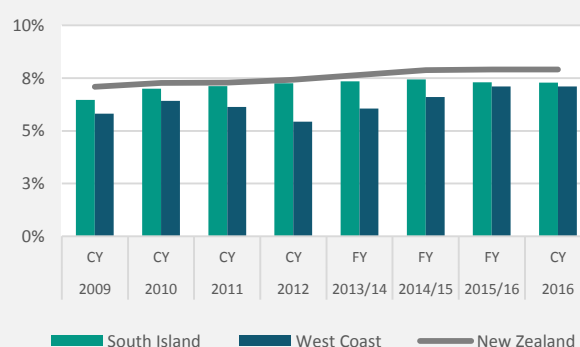
As well as reducing public confidence and driving unnecessary costs - patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

Key factors in reducing acute readmissions include patient safety and quality standards, discharge planning and transition processes and care coordination at the interface between services. Ensuring people receive effective treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided, and the integration between service providers. These rates are also a good counter-measure to productivity measures such as reductions in lengths of stay.

Data Source: Ministry of Health Performance Reporting <sup>10</sup>

Measure: rate of acute readmissions to hospital within 28 days of discharge (unstandardised)



##### A REDUCTION IN AMENABLE MORTALITY

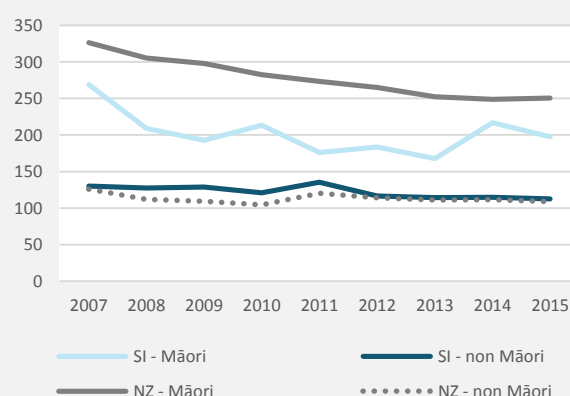
Amenable mortality is defined as premature death (before age 65) from conditions that could have been avoided through lifestyle change, earlier intervention and effective management and treatment.

There are many economic, social and environmental factors that have an influence on people's life expectancy. However, timely diagnosis and access to safe and effective treatment are crucial factors in improving survival rates for complex illnesses such as heart disease and cancer.

A reduction in the rate of amenable mortality can be used to reflect the responsiveness of the health system to the needs of people with complex illness, and as an indicator of access to timely and effective care and treatment.

Data Source: National Mortality Collection <sup>11</sup>

Measure: rate of all-cause mortality for people aged under 65 (age standardised, per 100,000 people)



<sup>10</sup> This measure is a national DHB performance indicator (OS8) and is undergoing review by the Ministry of Health. Due to ongoing refinement of the definition, results differ to previous years. The DHB has also chosen to present unstandardised rate as this enables closer analysis of performance while the definition is confirmed. Data is three months in arrears, with results being the year to March.

<sup>11</sup> The performance data for this measure is sourced from the national mortality collection which classifies the underlying cause of all deaths registered in New Zealand. Data is released three years in arrears and the 2015 results are provisional.

## IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

### SHORTER WAITS FOR URGENT CARE

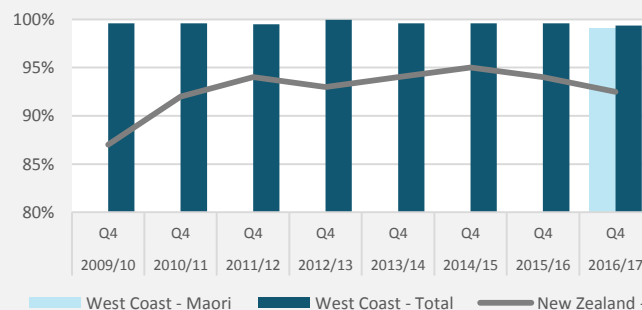
Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.

Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improved patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health services.

Solutions to reducing ED wait times address the underlying causes of delay and span not only our hospital services but the wider health system. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Data Source: DHB Patient Management System <sup>12</sup>

Measure: people admitted, discharged or transferred from ED within 6 hours	Base	Target				
	16/17	18/19	19/20	20/21	21/22	
	99.4%	95%	95%	95%	95%	



### SHORTER WAITS FOR PLANNED CARE

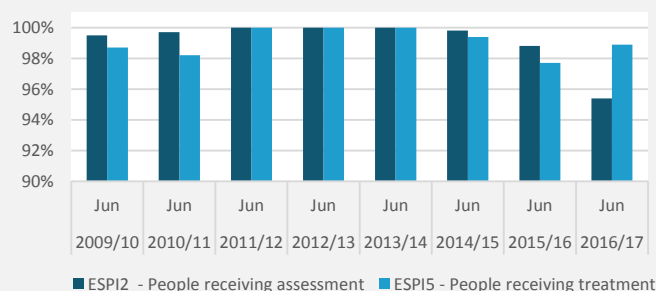
Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort, slowing the progression of disease and helping to restore independence and wellbeing.

Improved performance against these measures requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our system, a proxy for how well we are managing the flow of patients across our services.

Data Source: Ministry of Health Elective Services Website <sup>13</sup>

Measure: people receiving specialist assessment and treatment within set time frames	Base	Target				
	16/17	18/19	19/20	20/21	21/22	
ESPI2	95.4%	100%	100%	100%	100%	
ESPI5	98.9%	100%	100%	100%	100%	



### FEWER ADVERSE EVENTS IN OUR HOSPITALS

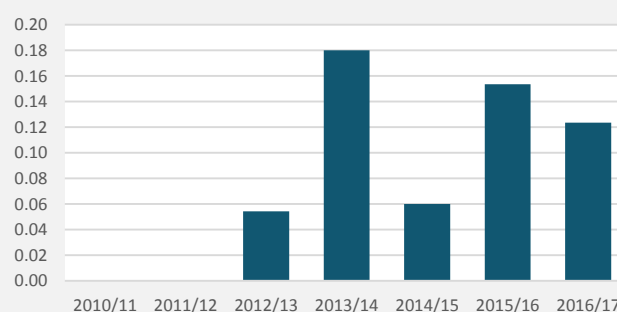
Adverse events, as well as causing avoidable harm to patients, reduce public confidence and contribute unnecessary costs into the system. Improving patient safety and quality standards in our hospitals will greatly improve outcomes for patients.

Patient falls are particularly important, as patients who experience a serious fall are more likely to have prolonged hospital stays, loss of confidence, conditioning and independence and an increased risk of institutional care.

Achievement against this measure provides an indication of the quality of our services. This indicator is also seen as a marker of the engagement of staff and clinical leaders in improving processes and patient safety.

Data Source: DHB Incident Reporting System <sup>14</sup>

Measure: rate of falls with a severity assessment code (SAC) of level 1 & 2	Base	Target				
	16/17	18/19	19/20	20/21	21/22	
	0.12	0.09	0.09	0.09	0.09	



<sup>12</sup> This measure is a national performance measure (Shorter Stays in ED). Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final quarter of each year (April – June).

<sup>13</sup> These measures are part of the national Elective Services Patient Flow Indicators (ESPIs) set and are a measure of whether DHBs are meeting expectations at key point in a patient's journey. ESPI 2 refers to the wait from referral to a person's first specialist assessment. ESPI 5 refers to the wait from the point from when treatment was agreed until treatment is delivered. Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final month of each year (June).

<sup>14</sup> The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest likelihood and consequence. The rate is per 1,000 inpatient beds and small population numbers have a disproportionate impact on these results – there were two incidents in 2014/15 and four in 2016/17.



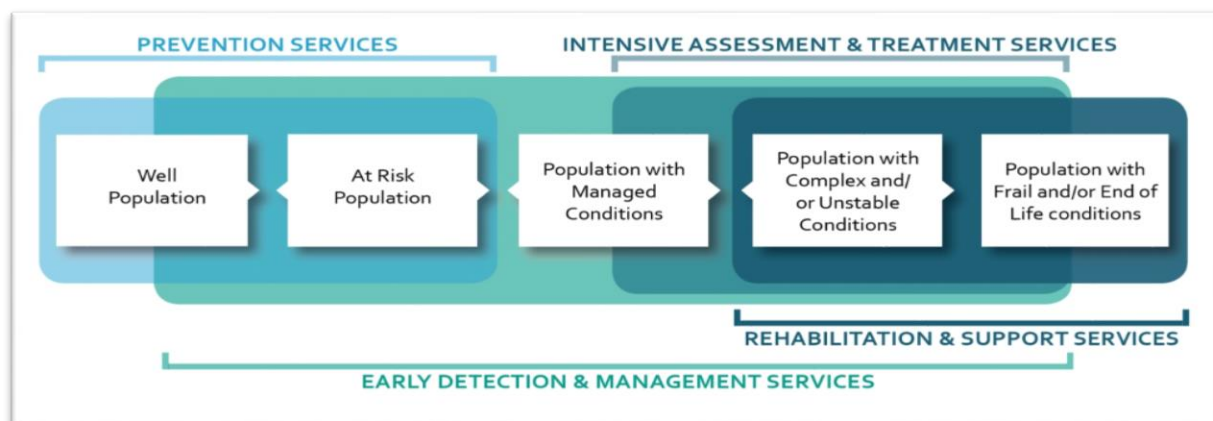
Part IV

# Annual Operating Intentions

What can you expect from us?

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# Service Performance Expectations



## 4.1 Evaluating our performance

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

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

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes. These longer-term health outcomes are highlighted in the Monitoring Our Performance section.

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

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

### IDENTIFYING PERFORMANCE MEASURES

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

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

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

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

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



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



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



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



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

### SETTING STANDARDS

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

Targets reflect the strategic objectives of the DHB increasing the reach of prevention programmes, reducing acute or avoidable hospital admissions and maintaining access to services while reducing waiting times and delays in treatment.

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

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

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

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

#### UNDERSTANDING PERFORMANCE EXPECTATIONS

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

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

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

#### NOTES FOR THE READER

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

- △ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.
- † Performance data relates to the calendar year rather than the financial year.
- ◇ Many national targets and performance measures are set to be achieved by the final quarter of any given year. In line with national expectations, baselines refer to the final quarter.
- E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources.
- ◆ This measure has been identified as a key focus area for Māori. Progress by ethnicity will be reported in our Annual Report.

## 4.2 Where does the money go?

In 2018/19 the DHB will receive approximately \$153 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 2018/19, by service class.

	2018/19
Revenue	Total \$'000
Prevention	6,055
Early detection & management	73,508
Intensive assessment & treatment	66,109
Rehabilitation & support	6,884
Total Revenue - \$'000	152,556
Expenditure	Total \$'000
Prevention	6,296
Early detection & management	76,443
Intensive assessment & treatment	68,745
Rehabilitation & support	7,159
Total Expenditure - \$'000	158,643
Surplus/(Deficit) - \$'000	(6,087)

## 4.3 Prevention services

### WHY ARE THESE SERVICES SIGNIFICANT?

Prevention services are publicly funded services that promote and protect the health of the whole population or targeted sub-groups. These services seek to address individual behaviours by targeting physical and social environments and norms that can influence and support people to make healthier choices and are therefore distinct from treatment services

The four leading long-term conditions - cancer, cardiovascular disease, diabetes, and respiratory disease, make up 80% of the disease burden for our population. By supporting people to make healthier choices, we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequalities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore also be a very cost-effective health intervention.

### HOW WILL WE DEMONSTRATE OUR SUCCESS?

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

Population-Based Screening Services				
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Four-year-olds provided with a B4 School Check (B4SC)	A <sup>18</sup> ♦	74%	90%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q <sup>19</sup> ♦ ♦	new	81%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A <sup>20</sup> ♦	75%	75%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A <sup>20</sup> ♦	76%	77%	70%

<sup>15</sup> The expected number of submissions varies in a given year - it may be higher, for example, when Territorial Authorities are consulting on their draft long-term plans or less if the DHB is involved in the planning or pre-consultation phase. This measure includes submissions on national policy documents or legislation and local and regional council annual and long-term plans, by-laws and policies (excluding submissions on specific resource consents). It includes joint submissions made with Active West Coast, West Coast Tobacco Free Coalition and Healthy West Coast.

<sup>16</sup> New Zealand law prevents retailers from selling alcohol to young people aged under 18 years, with the aim of reducing alcohol-related harm for this age group. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. If the volunteer is refused alcohol the licensed premise is said to have complied with the Sale and Supply of Alcohol Act. Compliance can be seen as a proxy measure of the success of education and training and reflects a culture that encourages a responsible approach to alcohol.

<sup>17</sup> This measure relates to the percent of network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies (large, medium, minor, small and rural agricultural).

<sup>18</sup> 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.

<sup>19</sup> This measure is a national performance measure (Raising Healthy Kids). Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational attainment and quality of life. The referral allows families to access support to maintain healthier lifestyles.

<sup>20</sup> The cervical and breast screening measures refer to participation in national screening programmes and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment.

Health Promotion and Education Services				
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A <sup>21</sup>	200	208	>100
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q <sup>22</sup> ◆	83%	82%	75%
Babies exclusively/fully breastfed at three months	Q <sup>22</sup> ◆	58%	61%	70%
People provided with Green Prescriptions for additional physical activity support	A <sup>23</sup>	543	558	>500
Green Prescription participants more active six to eight months after referral	Q <sup>23</sup>	58%	-	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q <sup>24</sup> ◆◆	79%	91%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q <sup>24</sup> ◆◆	97%	87%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q <sup>25</sup> ◆◆	100%	89%	90%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Children fully immunised at eight months of age	A <sup>26</sup> ◆◆	78%	80%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q <sup>27</sup> ◇	100%	95%	95%
Young women (Year 8) completing the HPV vaccination programme	A <sup>28</sup> +◆	43%	39%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A <sup>29</sup> +◆	61%	55%	75%

<sup>21</sup> This programme aims to improve breastfeeding rates and to create a supportive breastfeeding environment. Evidence shows that infants who are not breastfed have a higher risk of developing chronic illnesses during their lifetimes. The percentage of babies being breastfed can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period.

<sup>22</sup> These breastfeeding measures are part of the national Well Child/Tamariki Ora (WCTO) Quality Framework and standards are set nationally. The results are from the most recent Well Child Performance Report. The three-month breastfeeding baseline relates to the six months to December 2017 and the LMC breastfeeding baseline relates to the six months to June 2017. Three-month breastfeeding data from Well Child providers is currently not able to be combined so performance from the largest provider (Plunket) is presented.

<sup>23</sup> A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a national patient survey completed by Research NZ on behalf of the Ministry of Health. In 2016/17, a decision was made nationally to shift to bi-annual surveys. The next surveys will be in 2017/18 and 2019/20.

<sup>24</sup> Evidence shows that the majority of smokers want to quit and need help to do so. The ABC programme has a cessation focus and refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support. The provision of profession advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts.

<sup>25</sup> This measure is part of the national measures set (Better Help for Smokers). Data is sourced from the Ministry of Health's national Maternity Dataset which covers approximately 80% of pregnancies nationally. As such, the measure is seen as developmental and results are used to indicate trends rather than absolute performance. Standards have been set nationally in line with other smoking targets.

<sup>26</sup> This measure is a national performance measure (Increased Immunisation) and standards are set nationally. The West Coast DHB has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. The DHB's focus is to immunise all those who opt-in to the immunisation programme.

<sup>27</sup> '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.

<sup>28</sup> The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme consists of two vaccinations and is free to young women (and men) under 26 years of age. The target for 2018/19 is the proportion of young women born in 2005 completing the programme.

<sup>29</sup> Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including pregnant women, people aged over 65 and people with long-term or chronic conditions. The population data sources for this measure changed in 2016/17, from PHO enrolment registers to 2013 Census population projections. Results from previous years are not directly comparable.



## 4.4 Early detection and management services

### WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

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

Our vision of an integrated system presents a unique opportunity. For most people, their general practice team is their first point of contact with health services and is a vital point of continuity and in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services, we are better able to support people to stay well, identify issues earlier and reduce complications, acute illness or unnecessary hospital admissions. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or coordinated support.

### HOW WILL WE DEMONSTRATE OUR SUCCESS?

General Practice Services				
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible, responsive service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A <sup>30</sup> ♦	89%	90%	95%
Newborns enrolled with a PHO by three months of age	A <sup>30</sup> ♦	77%	77%	85%
Young people (0-19) accessing brief intervention counselling in primary care	A <sup>31A</sup>	219	200	>150
Adults (20+) accessing brief intervention counselling in primary care	A <sup>31A</sup>	558	548	>450
Number of integrated HealthPathways in place across the health system	Q <sup>32</sup>	654	655	E. 600
Proportion of general practices offering the primary care patient experience survey	E <sup>33</sup>	new	new	85%

Long-Term Condition Services				
These services are targeted at people with high health needs with the aim of reducing complications and crisis through earlier intervention and treatment and by supporting people to better manage and control their conditions.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A <sup>34</sup> ♦	3,793	3,860	>3,000
Population identified with diabetes having an annual LTCM review	A <sup>35</sup> ♦	91%	74%	90%
Population with diabetes having an HbA1c test at their LTCM review showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q <sup>35</sup> ♦	63%	54%	80%
Eligible population having a cardiovascular disease risk assessment in the last 5 years	A <sup>36</sup> ♦	91%	91%	90%

<sup>30</sup> This measure is part of the national Well Child/Tamariki Ora (WCTO) Quality Framework and standards are set nationally. The results have been updated to reflect results from the September 2016 and September 2017 Well Child Framework Reports.

<sup>31</sup> The Brief Intervention Counselling service aims to support people with mild to moderate mental health concerns to improve their health outcomes and quality of life. The service includes the provision of free counselling sessions and extended GP consultations.

<sup>32</sup> Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The pathways support consistent access to treatment and care no matter where people present.

<sup>33</sup> The Patient Experience Survey is a national online survey used to determine patients' experience in primary care and how well they perceive their care is managed. The survey has been piloted in a small number of DHB regions and is now being rolled-out across the country. The information will be used to improve the quality of service delivery and patient safety.

<sup>34</sup> This measure refers to the primary care run programme where enrolled patients are provided with an annual review, targeted care plan and self-management advice to help change their lifestyle, improve their health and reduce the negative impacts of their condition.

<sup>35</sup> 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.

<sup>36</sup> Cardiovascular disease is a leading cause of death on the West Coast. By identifying those at risk of cardiovascular disease early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious event. Targets and eligible population is set nationally: Māori, Pacific or Indian: males 35-74, females 45-74; and all other males 45-74 all other females 55-74.

Oral Health Services				
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Children (0-4) enrolled in DHB funded oral health services	A <sup>37</sup> †◆	87%	97%	95%
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T †◆	78%	93%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A †	75%	75%	85%

Pharmacy and Referred Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of subsidised pharmaceutical items dispensed in the community	A <sup>38A</sup>	455k	466k	E.<500K
People (65+) being dispensed 11 or more long-term medications (rate per 1,000)	Q <sup>39</sup>	4.4	4.2	E. 4.4
Number of community-referred radiological tests delivered at Grey Base Hospital	A	5,504	5,817	E.>5,000
People receiving their urgent diagnostic colonoscopy within two weeks	T <sup>40</sup> ◇	100%	100%	90%
People receiving their Magnetic Resonance Imaging (MRI) scans within six weeks	T <sup>40</sup> ◇	80%	92%	90%
People receiving their Computed Tomography (CT) scan within six weeks	T <sup>40</sup> ◇	100%	100%	95%

<sup>37</sup>These oral health measures are national DHB performance measures (PP12 and 13) and standards are set nationally. Oral health is an integral component of lifelong health and wellbeing. Early and continued contact with oral health services helps to set life-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

<sup>38</sup>This measure relates to pharmaceutical items dispensed by community pharmacies to people living in the community. Hospital dispensed items are excluded. This may still include some non-West Coast residents who had prescriptions filled while on the Coast.

<sup>39</sup>The use of multiple medications is most common in the elderly and can lead to reduced drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and high costs for the system with little health benefit. Multiple medication use requires monitoring and review to validate whether all of the medications are complementary and necessary.

<sup>40</sup>These measures are national DHB performance measures (PP29) and refer to non-urgent scans. By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and by reducing long waits for diagnosis or treatment improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). Standards are set nationally and in line with national reporting the results presented refer to the final month of each year (June).

## 4.5 Intensive assessment and treatment services

### WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events. Others are planned, where access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements.

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

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

### HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Staff compliant with good hand hygiene practice	Q <sup>41</sup> ◇	81%	80%	80%
Hip and knee replacement patients receiving routine antibiotics before surgery	Q <sup>42</sup> ◇	95%	96%	95%
Inpatients (aged 75+) receiving a falls risk assessment	Q <sup>43</sup> ◇	88%	91%	90%
Response rate to the national inpatient patient experience survey	E <sup>44</sup>	35%	28%	>30%
Proportion of patients who felt 'hospital staff included their family/whānau or someone close to them in discussions about their care'	E	54%	76%	65%

Maternity Services				
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A <sup>45</sup> †◆	54%	79%	80%
Number of maternity deliveries in West Coast DHB facilities	A	246	250	E. 300
Baby friendly hospital accreditation achieved in DHB facilities	Q <sup>46</sup>	Yes	Yes	Yes

<sup>41</sup> The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. Standards are set nationally and results refer to the final quarter (April-June).

<sup>42</sup> Cefazolin and cefuroxime are antibiotics recommended as routine for patients receiving surgical hip and knee replacements to prevent infection complications. Skin preparation with antiseptic is also recommended to prevent infection.

<sup>43</sup> While there is no single solution to reducing falls, an essential first step is to assess an individual's risk of falling and act accordingly.

<sup>44</sup> There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. The inpatient patient experience survey runs quarterly in all District Health Board hospitals and covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs.

<sup>45</sup> Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report.

<sup>46</sup> The Baby Friendly Initiative is a worldwide programme led by the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises the standard.

Acute and Urgent Services				
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of presentations at the Grey Base Hospital Emergency Department (ED)	A <sup>47</sup>	11,742	11,382	E.<13,000
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T <sup>48</sup>	80%	79%	85%
Proportion of the population presenting at ED (per 1,000 people)	Q	349	342	<356
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T <sup>49</sup> ◇	80%	56%	90%
Average acute inpatient length of stay (bed days per 1,000 people)	Q <sup>50</sup>	2.40	2.36	2.30

Elective and Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment. Their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service. The West Coast DHB is also striving to reduce travel time for patients.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of First Specialist Assessments provided	A <sup>51</sup>	6,591	7,232	E.>6,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q <sup>52</sup>	12.5%	16%	>10%
Number of elective/arranged surgical discharges (surgeries provided)	A ◇	1,942	1,979	1,916
Average elective inpatient length of stay (bed days per 1,000 people)	Q <sup>50</sup>	1.55	1.34	1.45
Number of outpatient consultations provided	A	15,257	15,479	E. >13k
Proportion of outpatient appointments provided by telemedicine	Q <sup>53</sup>	2.3%	3.3%	>5%
Outpatient appointments where the patient was booked but did not attend (DNA)	Q <sup>54</sup> ◆	5.9%	5.6%	<6%

<sup>47</sup> This measure is aligned to the national Shorter Stays in ED performance measures and counts presentations to the ED in line with the national measure definition. This measure excludes those who do not wait and those with pre-arranged appointments.

<sup>48</sup> 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.

<sup>49</sup> This measure is the national performance measure (Faster Cancer Treatment). Standards are set nationally.

<sup>50</sup> This measure is a national DHB performance measure (OS3). By shortening the average length of a hospital stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective (planned) surgery. Importantly, addressing the factors that influence a patient's length of stay includes: reducing the rate of patient complications and infection, better use of the time clinical staff spent with patients and integration activity to support patients to return home sooner. Performance is balanced against readmission rates to ensure earlier discharge is appropriate and service quality remains high.

<sup>51</sup> This measure counts both medical and surgical assessments but only the first specialist assessments (where the specialist determines treatment), not follow-up assessments after treatment has occurred. This measure is aligned to the national elective services reporting definitions which are DHB of domicile and track assessments provided for West Coast residents no matter where they are delivered.

<sup>52</sup> Non-contact assessments are those where advice or assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients.

<sup>53</sup> Increasing value from technology is a key strategic focus for the DHB and the use of telehealth or videoconferencing technology helps to reduce unnecessary travel for patients, their families and clinical staff – particularly when specialists are based in other DHBs. This measure has been updated to reflect the proportion of total outpatient appointments delivered using telehealth.

<sup>54</sup> When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes, and it is costly in terms of wasted resources for the DHB. This measure is calculated as the proportion of all medical and surgical outpatient appointments where the patient was expected to attend on the day but did not.

Specialist Mental Health and Alcohol and Other Drug (AOD) Services				
These are services for those most severely affected by mental illness and/or addictions, who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population (0-19) accessing specialist mental health services	A <sup>55A</sup>	5.5%	5.3%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	A <sup>A</sup>	5.2%	5.7%	>3.8%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T <sup>56</sup>	81%	76%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	94%	89%	95%
Adult inpatients accessing community services within 7 days of discharge	Q <sup>57</sup>	70%	71%	80%

<sup>55</sup> The access measures are national DHB performance measures (PP6). Standards are set based on expectations that at least 3% of the population will need access to specialist mental health services during their lifetime. West Coast rates are high and with part of the DHB's strategy being to better support people earlier and closer to home, it is expected that rates will come down over time. Data is sourced from the Ministry's national PRIMHD dataset and results are provided three months in arrears. Providers include non-government service providers who provide specialised mental health services and submit records to the national dataset.

<sup>56</sup> The wait time measures are national DHB performance measures (PP8). Standards are set nationally. Data is sourced from the Ministry's national PRIMHD database and results are provided three months in arrears.

<sup>57</sup> This measure is seen as an indicator of suicide prevention activity and patient safety, reflecting continued support for people who have experienced an acute psychiatric episode requiring hospitalisation. Research indicates that people have increased vulnerability immediately following discharge, including higher risk for suicide, while those leaving hospital with a formal discharge plan and links with community services and supports are less likely to experience early readmission. Data is sourced from the NZ Mental Health and Addictions KPI Programme reports (indicator KPI 19) and standards are set nationally.



## 4.6 Rehabilitation and support services

### WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes, or regain functional ability after a health-related event. These services are considered to provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evident by less dependence on hospital and residential care services and a reduction in acute illness, crisis or deterioration leading to acute admission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness or crisis, these services have a major impact on the sustainability of our health system by reducing acute demand, unnecessary ED presentations and the need for more complex interventions. These services also support patient flow by enabling people to go home from hospital earlier.

Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

### HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services aim to restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of AT&R inpatients discharged home rather than into residential care	Q <sup>58A</sup>	88%	91%	80%
Proportion of inpatients referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	Q	31%	91%	80%
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A <sup>59</sup>	new	yes	3
People (65+) supported by the community-based Falls Prevention Service	A <sup>60</sup>	16	117	>120

Home-Based Support Services				
These are services designed to support people to continue living in their own homes and to maintain their functional independence. Largely-demand driven, clinical assessment ensures access to services is appropriate and equitable.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of Meals on Wheels provided	A <sup>61A</sup>	33,561	33,772	E. 35,000
People supported by district nursing services	A <sup>62</sup>	1,071	1,628	E. >1,000
People supported by long-term home-based support services	A <sup>Δ</sup>	786	1,079	E. >1,000
Proportion of people supported by long-term home-based support services who have had a clinical assessment of need using the InterRAI assessment tool	Q <sup>63A</sup>	93%	93%	95%

<sup>58</sup> A discharge from AT&R services to home, rather than into aged residential care, is seen as reflective of the quality and effectiveness of services in assisting that person to regain their functional independence. With appropriate community supports, people who are able to remain safely in their own homes and communities and to 'age in place' report higher levels of satisfaction and quality of life.

<sup>59</sup> The Flexible Integrated Rehabilitation Support Team (FIRST) provides a range of home-based rehabilitation services to facilitate people's early discharge from hospital. The service is a comprehensive part of the broader continuum of care for older people, ensuring a seamless transfer of care between hospital and community settings.

<sup>60</sup> Falls are one the leading causes of hospital admission for people aged over 65. The Falls Prevention Service provides care for people 'at-risk' of a fall or following a fall, and supports people to stay safe and well in their own homes.

<sup>61</sup> Meals on Wheels is a subsidised service available for people who can't prepare a hot meal without help because of a medical condition or a disability, who have no family or whānau help readily available and need the meal to maintain good nutrition and independence. This may be a short intervention or a longer-term solution to support people to stay well in their own homes.

<sup>62</sup> This measure previously counted district nursing visits and has been updated to reflect the people supported by our system. The initial baseline for 2015/16 reflect seven months to June 2016. The previous counts reflected 3,830 visits in 2016/17.

<sup>63</sup> The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning by using evidence-based practice guidelines to ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live.

Respite and Day Support Services				
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need addressed, or to give carers a break. Largely demand-driven, access to services is expected to increase over time, as more people are supported to remain safe and well in their own homes.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of mental health planned and crisis respite service bed-days accessed	A <sup>Δ</sup>	365	482	E. 500
Older people supported by aged care respite services	A <sup>Δ</sup>	61	45	E. 70

Aged Residential Care Services				
With an ageing population, demand for aged residential care (ARC) is expected to increase. However, a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population (75+) accessing rest home level services in ARC	A <sup>64Δ</sup>	5.47%	4.64%	E.<6.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A <sup>Δ</sup>	6.05%	6.21%	E.<6.5%
Proportion of the population (75+) accessing dementia services in ARC	A <sup>Δ</sup>	0.84%	0.85%	E. 0.85%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A <sup>Δ</sup>	0.44%	0.47%	E. 0.45%
People entering ARC having had a clinical assessment of need using InterRAI	Q <sup>Δ</sup>	90%	100%	95%

<sup>64</sup> These Aged Residential Care (ARC) measures refer to people accessing DHB funded ARC services and excludes people choosing to enter ARC and pay privately and people living independently in a retirement village. The South Island has historically had higher ARC rates than national levels. Access rates for more complex care such as dementia and psychogeriatric care are driven by the age of our population and less amendable. However, by providing high quality health services for older people to help them maintain health and remain in their own homes for longer, we expect to see a reduction in demand for rest home level care relative to the more complex care interventions.

# Financial Performance Expectations

## West Coast's financial outlook

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

While health continues to receive a large share of government funding, if we are to be sustainable, we must rethink how we will meet our population's need within a more moderate growth platform.

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

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

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

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

**The costs of seismic remediation:** The level of remediation required to attain moderate compliance with current building codes will put significant financial pressure on the DHB. While some of the more immediate repairs have been completed, the remainder form part of the future facilities build.

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

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

## Planned results

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

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

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

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

### MAJOR ASSUMPTIONS

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

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

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

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

The net operating result, for 2018/19 and out-years, reflects the modelling as per the detailed business case approved by cabinet in 2014 (adjusted for the 2014/15 transitional funding repayment as well as known changes such as capital charge changes).

Given the recent changes to debt and equity, the project will be 100% equity funded by the Crown. As a consequence, future operating costs associated with financing the development will increase significantly after the interim funding arrangements in relation to this change cease (anticipated after year two).

- Revaluations of land and building will continue and will impact on asset values. In addition to periodic revaluations, further impairment in relation to redevelopment and remediation of our facilities may be necessary.
- Treatment related costs will increase in line with known inflation factors, reasonable price impacts on providers and foreseen adjustments for the impact of growth within services.
- National and regional initiative savings and benefits will be achieved as planned.
- Transformation will not be delayed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- There will be no further disruptions associated with pandemics or natural disasters.

While the West Coast DHB is still working through options in relation to funding for the Buller redevelopment (as approved in April 2014), the total associated development costs and any capital or lease expenditure have not been included in forecasts.

## Closing the gap

Alongside the transformation of our health services we are focused on efficiency improvements that will take the wait and waste out of our system.

The DHB will carefully consider all opportunities and options to ensure the most effective use of all available resources including:

- Integrating systems and services and improving production planning to ensure we use our resources in the most effective way.

- Streamlining and standardising processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.
- Prioritising services that deliver maximum health benefit and are sustainable long-term.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Tightening cost growth including moderating treatment, back office, support and FTE costs.

Service changes proposed for the coming year are outlined in the Managing Our Business section of this document.

## Capital investment

### GREYMOUTH REDEVELOPMENT

In December 2012, the Minister of Health appointed the Hospital Redevelopment Partnership Group (HRPG) to govern the West Coast DHB's facility redevelopment. The West Coast HRPG provides project governance, which includes oversight of the project programme and budget.

In 2014, approval was given for a new Grey Base Hospital and IFHC redevelopment. Construction commenced on the combined project in May 2016 with completion originally scheduled for June 2018. Completion is now scheduled for the second quarter of 2019. The revised budget for this development is currently \$77.8m and it is expected that there will be additional costs. At this stage we anticipate an additional \$10-13m. These additional costs will be finalised in due course.

The redevelopment includes a second tranche which will include the upgrade/replacement of the energy centre on the Grey Base Hospital site.

Planning for redevelopment of the mental health facility is also expected to start in 2018/19.

### BULLER REDEVELOPMENT

In Buller, the DHB and clinical teams have worked together with an appointed design team to develop a full concept design for the IFHC development.

An Implementation Business Case has been progressed and options submitted to the HRPG, as we move closer to bringing this facility to life. The notional cost for the development is yet to be confirmed.

### CAPITAL EXPENDITURE

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

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

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

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

## Debt and equity

### MINISTRY OF HEALTH

The Ministry of Health (formerly the Crown Health Financing Agency) agreed, with Cabinet approval, to convert all outstanding DHB debt funding into equity funding. The total term West Coast DHB debt outstanding on 15 February 2017 (\$14.445m) was swapped for the equivalent amount of equity.

The higher equity balance will result in an increase in the amount of capital charge payable to the Crown. The gap between debt (interest) and equity (capital charge) financing at that time was 3.75% (2.25% versus 6.00%).

### EQUITY

The Grey Base Hospital and IFHC redevelopment is now expected to be completed in the second quarter of 2019 at which time the asset will be transferred from the Ministry of Health to the DHB. Following the asset transfer, the Ministry will simultaneously increase the equity of the DHB for the value of the build.

The West Coast DHB will require deficit funding (equity) in order to offset the deficits signalled in outlying years. The DHB is also repaying \$68K equity annually as part of an agreed FRS-3 funding repayment programme with the Ministry of Health.

## Additional considerations

### SUBSIDIARY COMPANY AND PARTNERSHIPS

With an annual budget of just over \$5m, the South Island Alliance Programme Office is jointly funded by the five South Island DHBs to provide audit, project management and regional service development services. West Coast's contribution for 2018/19 will be approximately \$0.170m.

With an annual budget of over \$9.3m, the New Zealand Health Partnership Limited is jointly funded by all 20 DHBs to enable DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB's contribution to the running of the Health Partnership for 2018/19 will be approximately \$0.082m.

### DISPOSAL OF LAND

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

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

### ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

### ACQUISITION OF SHARES

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

### ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. These are attached to this document as Appendix 3.



## Statement of comprehensive income – year ending 30 June

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

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

## Statement of financial position – year ending 30 June

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

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

## Statement of movement in equity – year ending 30 June

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

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

## Statement of cashflow – year ending 30 June

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

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

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

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

	30/06/17 Actual \$'000	30/06/18 Forecast \$'000	30/06/19 Plan \$'000	30/06/20 Plan \$'000	30/06/21 Plan \$'000	30/6/22 Plan \$'000
<b>Funding Arm</b>						
<b>Revenue</b>						
MoH Revenue	130,368	135,636	140,275	143,112	145,758	148,649
Patient Related Revenue	-	-	-	-	-	-
Other	1,661	1,789	1,887	1,913	1,939	1,966
<b>Total Revenue</b>	<b>132,029</b>	<b>137,426</b>	<b>142,162</b>	<b>145,025</b>	<b>147,697</b>	<b>150,615</b>
<b>Expenditure</b>						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	91,354	95,415	102,133	103,729	105,359	106,994
Mental Health	14,192	14,549	14,818	15,047	15,278	15,516
Disability Support	18,063	21,590	21,804	21,982	22,160	22,343
Public Health	599	642	619	624	630	634
Maori Health	811	814	824	826	829	831
Governance & Admin	826	826	828	844	860	878
<b>Total Expenditure</b>	<b>125,846</b>	<b>133,836</b>	<b>141,026</b>	<b>143,052</b>	<b>145,116</b>	<b>147,196</b>
<b>Net Surplus/(Deficit)</b>	<b>6,183</b>	<b>3,589</b>	<b>1,136</b>	<b>1,973</b>	<b>2,581</b>	<b>3,419</b>
Other Comprehensive Income	-	-	-	-	-	-
<b>Total Comprehensive Income</b>	<b>6,183</b>	<b>3,589</b>	<b>1,136</b>	<b>1,973</b>	<b>2,581</b>	<b>3,419</b>
	30/06/17 Actual \$'000	30/06/18 Forecast \$'000	30/06/19 Plan \$'000	30/06/20 Plan \$'000	30/06/21 Plan \$'000	30/6/22 Plan \$'000
<b>Governance Arm</b>						
<b>Revenue</b>						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	2,462	2,829	873	890	905	925
<b>Total Revenue</b>	<b>2,462</b>	<b>2,829</b>	<b>873</b>	<b>890</b>	<b>905</b>	<b>925</b>
<b>Expenditure</b>						
Personnel	994	1,167	1,211	1,241	1,340	1,363
Outsourced services	705	943	994	997	1,007	1,017
Depreciation	-	1	-	1	1	1
Interest & Capital Charge	-	-	-	-	-	-
Other	761	717	427	474	434	436
<b>Total Expenditure</b>	<b>2,460</b>	<b>2,828</b>	<b>2,632</b>	<b>2,713</b>	<b>2,782</b>	<b>2,817</b>
<b>Net Surplus/(Deficit)</b>	<b>2</b>	<b>2</b>	<b>(1,759)</b>	<b>(1,823)</b>	<b>(1,877)</b>	<b>(1,892)</b>
Other Comprehensive Income	-	-	-	-	-	-
<b>Total Comprehensive Income</b>	<b>2</b>	<b>2</b>	<b>(1,759)</b>	<b>(1,823)</b>	<b>(1,877)</b>	<b>(1,892)</b>



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

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

	30/06/17 Actual \$'000	30/06/18 Forecast \$'000	30/06/19 Plan \$'000	30/06/20 Plan \$'000	30/06/21 Plan \$'000	30/6/22 Plan \$'000
<b>Provider Arm</b>						
<b>Revenue</b>						
MoH Revenue	1,190	1,153	973	992	973	991
Patient Related Revenue	2,666	7,187	6,860	6,634	6,634	6,634
Other	78,802	77,746	79,733	81,241	82,774	84,343
<b>Total Revenue</b>	<b>82,658</b>	<b>86,086</b>	<b>87,566</b>	<b>88,867</b>	<b>90,381</b>	<b>91,968</b>
<b>Expenditure</b>						
Personnel	56,489	58,965	60,766	62,733	64,126	65,719
Outsourced services	7,987	7,720	7,486	7,440	7,513	7,590
Depreciation	3,373	2,910	4,110	4,938	5,304	5,350
Interest & Capital Charge	739	1,387	1,524	5,748	5,749	6,349
Other	21,054	21,624	19,143	19,461	19,764	19,923
<b>Total Expenditure</b>	<b>89,641</b>	<b>92,606</b>	<b>93,029</b>	<b>100,320</b>	<b>102,456</b>	<b>104,931</b>
<b>Net Surplus/(Deficit)</b>	<b>(6,983)</b>	<b>(6,520)</b>	<b>(5,463)</b>	<b>(11,453)</b>	<b>(12,075)</b>	<b>(12,963)</b>
Other Comprehensive Income	-	(3,599)	-	-	-	-
<b>Total Comprehensive Income</b>	<b>(6,983)</b>	<b>(2,921)</b>	<b>(5,463)</b>	<b>(11,453)</b>	<b>(12,075)</b>	<b>(12,963)</b>
	30/06/17 Actual \$'000	30/06/18 Forecast \$'000	30/06/19 Plan \$'000	30/06/20 Plan \$'000	30/06/21 Plan \$'000	30/6/22 Plan \$'000
<b>In House Elimination</b>						
<b>Revenue</b>						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(74,377)	(77,171)	(78,048)	(79,571)	(81,121)	(82,704)
<b>Total Revenue</b>	<b>(74,377)</b>	<b>(77,171)</b>	<b>(78,048)</b>	<b>(79,571)</b>	<b>(81,121)</b>	<b>(82,704)</b>
<b>Expenditure</b>						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(74,377)	(77,170)	(78,048)	(79,571)	(81,121)	(82,704)
<b>Total Expenditure</b>	<b>(74,377)</b>	<b>(77,170)</b>	<b>(78,048)</b>	<b>(79,571)</b>	<b>(81,121)</b>	<b>(82,704)</b>
<b>Net Surplus/(Deficit)</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
Other Comprehensive Income	-	-	-	-	-	-
<b>Total Comprehensive Income</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

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

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

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

Part V

# Further Information for the Reader

## Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Minister's Letter of Expectations 2018/19
Appendix 3	Statement of Accounting Policies

## Documents of interest

The following documents can be found on the West Coast DHB's website ([www.westcoastdhb.health.nz](http://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 Annual Plan
- West Coast System Level Measures Improvement Plan
- West Coast DHB Public Health Action Plan
- West Coast DHB Disability Action Plan
- West Coast DHB Quality Accounts
- South Island Regional Health Services Plan

## References

Unless specifically stated, all West Coast DHB documents referenced in this document are available on the West Coast DHB website, [www.westcoastdhb.health.nz](http://www.westcoastdhb.health.nz). Referenced regional document are available from the South Island Alliance Programme Office website: [www.siaapo.health.nz](http://www.siaapo.health.nz). Referenced Ministry of Health documents are available on the Ministry's website: [www.health.govt.nz](http://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](http://www.treasury.govt.nz).

## Appendix 1 Glossary of Terms

Alliance	The West Coast District Alliance	The Alliance is a collective alliance of healthcare leaders, professionals and providers from across the West Coast providing leadership to enable the transformation of our health system in collaboration with system partners and on behalf of the population.
CCCN	Complex Clinical Care Network	The Complex Clinical Care Network is a multidisciplinary team providing a single point of referral for patients from general practice, ambulance and inpatient services. Under the restorative delivery model, clients are assessed using comprehensive assessment tools and an individual goal-based care plan is developed with them.
	Crown Entity	Crown Entity is a generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister but are included in the financial statements of the Government.
ERMS	Electronic Referral Management System	ERMS is a system available from the GP desktop which enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including: wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in West Coast, Canterbury and South Canterbury and rolling out across the remainder of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring that needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in New Zealand.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs in New Zealand with a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them. PHOs provide these services either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Secondary Care	Specialist or complex care that is typically provided in a hospital setting.
	Primary Care	Professional health care provided in the community, usually from a general practice, covering a broad range of health and preventative services and often a person's first level of contact with the health system.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Highly specialised care often only provided in a smaller number of locations.

## Appendix 2 Minister's Letter of Expectations 2018/19

**Hon Dr David Clark**

MP for Dunedin North

Minister of Health

Associate Minister of Finance



Ms Jenny Black  
Chair  
West Coast District Health Board  
PO Box 387  
GREYMOUTH 7840

Dear Ms Black

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

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

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

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

### **Our Approach**

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

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

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

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

### **Funding**

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

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

### **Capital Planning**

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

### **Accountability for Improved Performance**

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

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

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

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

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

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

### **Workforce**

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

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

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

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

### **Expansion of PHARMAC model to manage hospital medicines**

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

### **National Patient Flow**

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

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

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

#### **Planning for 2018/19 and the future**

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

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

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

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

Yours sincerely



Hon Dr David Clark  
**Minister of Health**



## Appendix 3 Statement of Accounting Policies

The prospective financial statements in this Statement of Intent and in the DHB's Annual Plan for the year ended 30 June 2017 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ GAAP, as appropriate for public benefit entities. PBE FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

### *(i) Cautionary Note*

The financial information is prospective. Actual results are likely to vary from the information presented, and the variations may be material.

### *(ii) Nature of Prospective Information*

The financial information presented consists of forecasts that have been prepared on the basis of best estimates and assumptions on future events that West Coast DHB expects to take place.

### *(iii) Assumptions*

The main assumptions underlying the forecast are noted in Section 8 of the Annual Plan.

### **REPORTING ENTITY AND STATUTORY BASE**

West Coast District Health Board ("West Coast DHB") was established by the NZ Public Health and Disability Act 2000. The DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

West Coast DHB has designated itself and its subsidiaries, as public benefit entities (PBEs) for financial reporting purposes.

The DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the West Coast community. The DHB does not operate to make a financial return.

West Coast DHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts.

### **BASIS OF PREPARATION**

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

#### *Statement of compliance*

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 public sector PBE accounting standards.

#### *Measurement basis*

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: land and buildings.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value.

#### *Functional and presentation currency*

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand dollars. The functional currency of West Coast DHB is NZD.

#### *Changes in accounting policies*

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

### **SIGNIFICANT ACCOUNTING POLICIES**

#### *Basis for Consolidation*

The purchase method is used to prepare the consolidated financial statements, which involves adding together like items of assets, liabilities, equity, income and expenses on a line-by-line basis. All significant intragroup balances, transactions, income and expenses are eliminated on consolidation.

West Coast DHB's investments in its subsidiaries are carried at cost in West Coast DHB's own "parent entity" financial statements.

#### *Subsidiaries*

Subsidiaries are entities controlled by West Coast DHB. Control exists when West Coast DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

West Coast DHB measures the cost of a business combination as the aggregate of the fair values, at the date of exchange, of assets given, liabilities incurred or assumed, in exchange for control of subsidiary plus any costs directly attributable to the business combination.

#### *Associates*

Associates are those entities in which West Coast DHB has significant influence, but not control, over the financial and operating policies.

The consolidated financial statements include West Coast DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When West Coast DHB's share of losses exceeds its interest in an associate, West Coast DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that West Coast DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

West Coast DHB's investments in associates are carried at cost in West Coast DHB's own "parent entity" financial statements.

#### *Transactions eliminated on consolidation*

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates are eliminated to the extent of West Coast DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

#### *Foreign currency*

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus /deficit.

#### *Budget figures*

The budget figures are those approved by West Coast DHB in its Annual Plan (incorporating the Statement of Intent) which is tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by West Coast DHB for the preparation of these financial statements.

## Property, plant and equipment

### Classes of property, plant and equipment

The major classes of property, plant and equipment are:

- freehold land
- freehold buildings and building fitout
- leasehold buildings
- plant, equipment and vehicles
- work in progress

### Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

### Revaluations

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expense. Any decreases in value relating to land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in other comprehensive revenue. Additions to land and buildings between valuations are recorded at cost.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

### Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to West Coast DHB and the cost of the item can be measured reliably.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Work in progress is recognised at cost less impairment and is not depreciated.

### Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to West Coast DHB. All other costs are recognised in the surplus or deficit when incurred.

### Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss is recognised in the surplus or deficit. It is calculated as the difference between the net sales price and the carrying amount of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

### Depreciation

Depreciation is charged to the surplus or deficit using the straight line method so as to write off the cost or valuation of fixed assets above \$2,000 to their estimated residual value over their expected economic life. Assets below \$2,000 are written off in the month of purchase. Land is not depreciated.

The estimated useful lives of major classes of assets and resulting rates are:

Class of Asset	Year	Dep Rate
Freehold Buildings & Fitout	10 – 80	1.25 -10%
Leasehold Buildings	3 - 20	5 - 33%
Plant, Equipment and Vehicles	3 - 12	8.3 - 33%

The residual value of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

### Intangible assets

#### Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and West Coast DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Staff training and other costs associated with maintaining computer software are recognised as an expense when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

#### Amortisation

Amortisation is charged to the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are:

Type of asset	Estimated life	Amortisation rate
Software	2-10 years	10 - 50%

### Investments

#### Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

#### Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified.

A receivable is considered impaired when there is evidence that West Coast DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

### Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Other inventories are stated at cost (calculated using the weighted average method).

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

### Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

### Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

## Impairment

The carrying amounts of West Coast DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset, at which point it is recognised in the surplus or deficit.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in other comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in other comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in other comprehensive income.

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where West Coast DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in other comprehensive income, a reversal of the impairment loss is also recognised in other comprehensive income.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

## Impairment of property, plant, equipment and intangible assets

West Coast DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

## Non-cash-generating assets

Property, plant and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

## Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless West Coast DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

## Employee entitlements

### Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

### Defined benefit plans

West Coast DHB makes contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus or deficit will affect future contributions by individual employers, as there is no prescribed basis for allocations. The scheme is therefore accounted for as a defined contribution scheme.

### Long service leave, sabbatical leave, retirement gratuities and sick leave

West Coast DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the year-end date. West Coast DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. The sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent West Coast DHB anticipates it will be used by staff to cover those future absences.

### Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

### Presentation of employee entitlements

Non vested long service leave and retirement gratuities are classified as non-current liabilities; all other employee entitlements are classified as current liabilities.

## Provisions

A provision is recognised when West Coast DHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

### ACC WSMP (Work Place Safety Management Programme)

West Coast DHB currently belongs to the ACC WSMP programme whereby the DHB receives a discount on levies by maintaining the appropriate audit standards on a bi-annual basis. West Coast DHB estimates the unpaid ACC levy and recognises a provision for this estimate.

### Trade and other payables

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate.

### Income tax

West Coast DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

## Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Contributed capital;



- Revaluation reserve; and
- Accumulated surpluses/deficits.

#### *Revaluation reserve*

This reserve relates to the revaluation of property, plant and equipment to fair value.

#### *Goods and services tax*

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

The net GST paid to, or received from Inland Revenue, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed as exclusive of GST.

#### *Revenue*

The specific accounting policies for significant revenue items are explained below.

#### *Ministry of Health population-based revenue*

West Coast DHB receives annual funding from the Ministry of Health, which is based on population levels within the West Coast DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

#### *Ministry of Health contract revenue*

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as West Coast DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the Ministry of Health to receive or retain funding.

Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the Ministry of Health. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

#### *Inter-district flows*

Inter-district patient inflow revenue occurs when a patient treated within West Coast DHB's district is domiciled outside of the district. Inter-district patient inflow revenue is recognised when eligible services are provided.

#### *ACC contract revenue*

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

#### *Interest revenue*

Interest revenue is recognised using the effective interest method.

#### *Rental revenue*

Lease revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

#### *Provision of other services*

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion at the balance date, based on the actual service provided as a percentage of the total services to be provided.

#### *Donations and bequests*

Donations and bequests received with restrictive conditions are treated as a liability until the specific terms from which the funds were derived are

fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

#### *Vested or donated physical assets*

For assets received for no or nominal consideration, the asset is recognised at its fair value when the group obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

#### *Donated services*

Volunteer services received are not recognised as revenue or expenses by the group.

#### *Operating lease payments*

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

#### *Non-current assets held for sale*

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of disposal group) are not depreciated or amortised while they are classified as held for sale.

#### *Borrowing costs*

Borrowing costs are recognised as an expense in the period in which they are incurred.

#### *Critical accounting estimates and assumptions*

The preparation of financial statements in conformity with NZ GAAP requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. These estimates and assumptions may differ from the actual results. The estimates and underlying assumptions are reviewed on an ongoing basis.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

#### *Property, plant and equipment useful lives and residual value*

At each balance date West Coast DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires West Coast DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by West Coast DHB, advance in medical technology, and expected disposal proceeds from the future sale of the assets.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. West Coast DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets
- Asset replacement programs
- Review of second hand market prices for similar assets
- Analysis of prior asset sales.

In light of the Canterbury earthquakes, West Coast DHB has reviewed the carrying value of land and buildings, resulting in an impairment. Other than this review, West Coast DHB has not made any other significant changes to past assumptions concerning useful lives and residual values.

#### *Retirement and long service leave*

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any change in these assumptions will impact on the carrying amount of the liability.

#### *Leases classification*

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to West Coast DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease

term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

West Coast DHB has exercised its judgement on the appropriate classification of its leases and, has determined all lease arrangements are operating leases.

#### *Non-government grants*

West Coast DHB must exercise judgement when recognising grant income to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

## Statement of Intent

Published November 2018  
Pursuant to Section 149 of the Crown Entities Act 2004

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ISSN: 2324-3872 (Print)  
ISSN: 2324-3880 (Online)

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