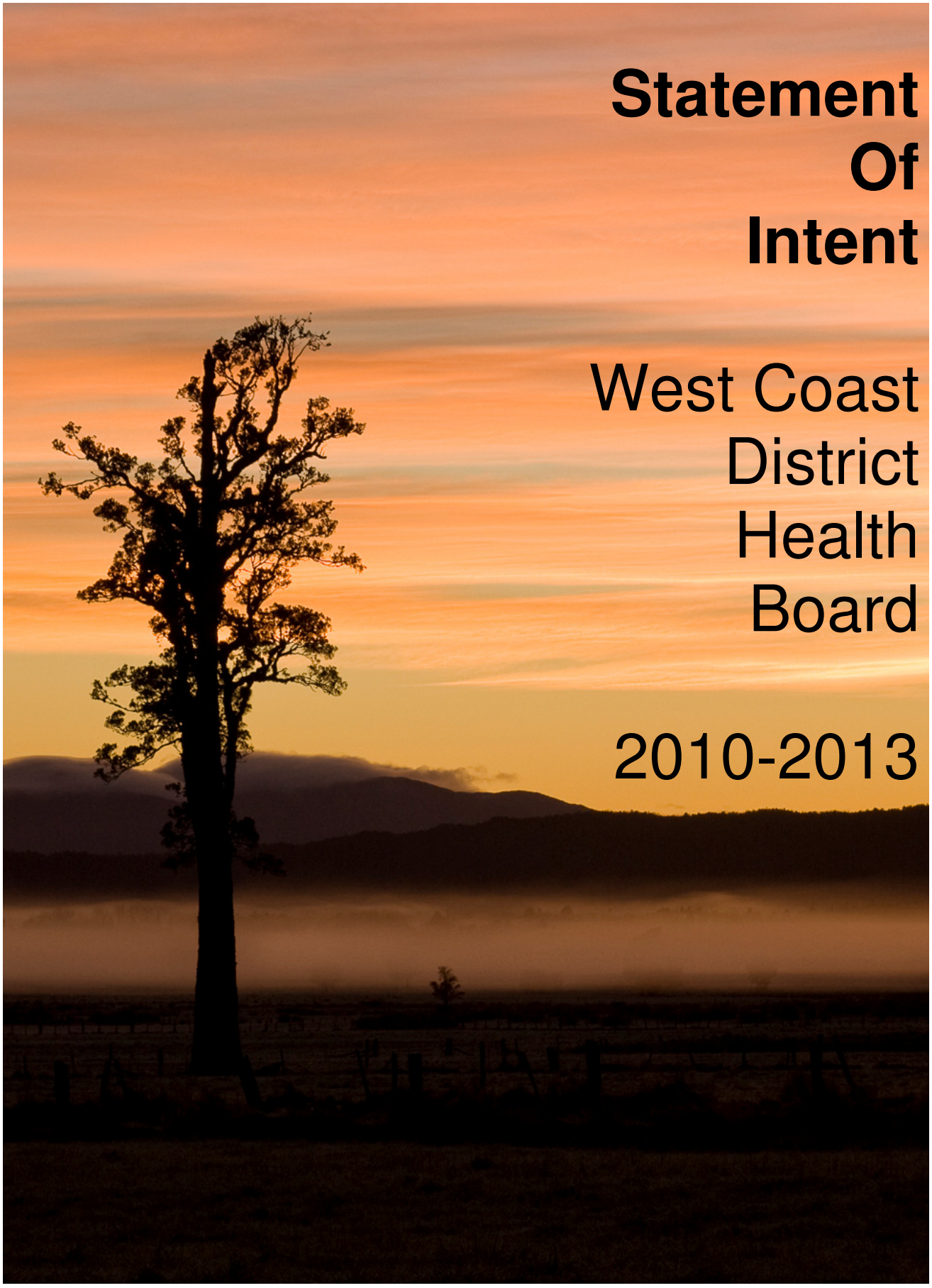


Statement Of Intent

West Coast District Health Board

2010-2013

STATEMENT FROM THE CHAIR AND EXECUTIVE SUMMARY

The forthcoming year will be one of some transformation for the West Coast District Health Board as it strives to meet the healthcare requirements of the West Coast population in a better, faster and more convenient way, both in the next year and into the future.

Greater clinical involvement in all aspects of planning and decision making throughout all areas will ensure that the focus for all services in health continues to be the patient.

There are several key strategic priorities within the District Annual Plan that the District Health Board intends to implement during the 2010/2011 year.

The West Coast District Health Board will maintain its focus on achieving national priorities. The Board recognises the strategic direction of Government targets and will undertake all practicable steps to ensure that the District Health Board performs well in these areas.

Achieving ongoing financial and clinical sustainability is a major priority for the West Coast District Health Board. The Board recognises the significant task it has in endeavoring to reduce its deficit. Many strategies are being implemented to assist the Board to live within its means while still maintaining safe and sustainable services for the West Coast population.

2010/2011 will be a year when there is a clear change from developing to implementing many of the innovative ideas and models of care developed by the sustainability project. The recommendations of the Law and Economic Consulting Group report, "Analysis of Options: Models of care for West Coast District Health Board", provide a pathway for this.

One of the key features of the recommendations is a much higher level of collaboration with the neighbouring Canterbury District Health Board in both clinical and non-clinical areas of service. The appointment of Mr David Meates, Canterbury District Health Board, Chief Executive to also fill the same role for the West Coast District Health Board will enhance this collaboration.

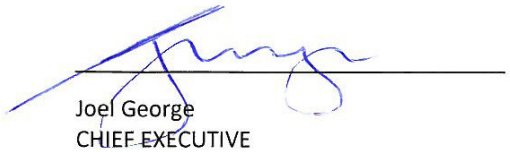
Complementing the Law and Economic Consulting Group recommendations for secondary health services, the West Coast District Health Board will progress the implementation of the West Coast Primary Health Organisation business case for Better, Sooner, More Convenient primary health services.

The Board sees progressing and further integration of the two initiatives as being key to the future shape of health service delivery throughout the West Coast.

Addressing transport issues for patients on the West Coast is a significant challenge. Patient movement, both on the West Coast and to and from other districts, can be problematic given the vagaries of the weather, distances involved, availability of staff, lack of public transport options and costs in both time and money.

The West Coast District Health Board recognises the importance of collaboration with other District Health Boards and other healthcare providers nationally, regionally and locally. A significant focus in 2010/2011 will be furthering the existing extensive relationship with the Canterbury District Health Board. The West Coast will continue its participation in regional service planning and the development of the South Island Health Services Plan to ensure equity of health service to the South Island population.

Dr Paul McCormack
DEPUTY CHAIR



Joel George
CHIEF EXECUTIVE

1. OPERATING ENVIRONMENT

Our District, Our Vision

The West Coast District Health Board is one of twenty one District Health Boards in New Zealand. The West Coast District Health Board district covers the area between Karamea in the north and Haast in the south and extends east to Springs Junction. The landmass length is approximately equal to the distance between Auckland and Wellington; a land area of 2.3 million hectares, much of which is rugged with scattered small and isolated pockets of population.

Functions of District Health Boards

The objectives of District Health Boards are covered by the New Zealand Public Health and Disability Act (2000), as follows:

"Objectives of District Health Boards"

1) Every District Health Board has the following objectives:

   a) to improve, promote, and protect the health of people and communities;
   b) to promote the integration of health services, especially primary and secondary health services;
   c) to promote effective care or support for those in need of personal health services or disability support services;
   d) to promote the inclusion and participation in society and independence of people with disabilities;
   e) to reduce health disparities by improving health outcomes for Māori and other population groups;
   f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
   g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services;
   h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
   i) to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
   j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations;
   k) to be a good employer in accordance with section 118 of the Crown Entities Act 2004.

2) Each District Health Board must pursue its objectives in accordance with its district strategic plan, its annual plan, its statement of intent and any directions or requirements given to it by the Minister under section 33 of this Act or section 103 of the Crown Entities Act 2004, or under section 107 of the Crown Entities Act 2004.

Our District Health Board:

- **PLANS** in consultation with key stakeholders (Iwi, Primary Health Organisations and Non Government Organisations) and our community, the strategic direction for health and disability services within our district[1]. Our District Health Board also plans in collaboration with other District Health Boards, regional and national work.
- **FUNDS** health and disability services through the contracts we have with providers.

[1] For more information on our strategic direction, you can view our District Strategic Plan (DSP) on our website www.westcoastdhb.health.nz

- **PROVIDES** hospital and specialist services that covers medical and surgical services, mental health, older person's health.
- **PROMOTES** community health and wellbeing through health promotion, health education and population health programmes.

Our Vision

"To be the New Zealand centre of excellence for rural health services"

He Mihi

E ngā mana

E ngā reo

E ngā iwi o te motu

Tēnei te mihi ki a koutou katoa

He Whakatauki

"Ko tau rourou, ko taku rourou, ka ora ai te iwi"

With your contribution and my contribution we will be better able to serve the people

Principles

Improved health for the people of the West Coast through better:

- ***Access*** **-** Provide the people of the West Coast with equitable access to a comprehensive range of primary and secondary health services in the most appropriate location
- ***Integration*** **-** Establish closer working relationships between all health care professionals to provide more comprehensive and coordinated person-centred health care services and to ensure seamless continuity of care for patients
- ***Quality*** **-** The degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge
- ***Equity*** **-** Increase understanding of the cause of health inequalities and the action required to reduce these inequalities through funding and service provision at a local level
- ***Values*** **-** All activities of the West Coast District Health Board will reflect the values of:
    - Manaakitanga - caring for others
    - Whakapapa - identity
    - Integrity
    - Respect
    - Accountability
    - Valuing people
    - Whānaungatanga – family and relationships

The Minister's expectation of better, sooner and more convenient health care for all New Zealanders and an integrated health care system overarches these values.

1.1 POPULATION ENVIRONMENT AND HEALTH PROFILE

OUR ENVIRONMENT

The West Coast is a region of contrasts; on one hand it is a region of great natural beauty but on the other hand is home to one of the most socio-economically deprived populations in New Zealand. The geographic nature of the region, being bordered by the Southern Alps on the east and the Tasman Sea on the west, leads to the West Coast being the most rural and isolated region in New Zealand. The total land area covered by the West Coast District Health Board is 23,283 square kilometres and great distances separate many towns, with the distance between Karamea in the north and Haast in the south being 516 kilometres.

The West Coast occupies 8.5% of New Zealand's total landmass and is home to a growing population of 32,200 people[2]. The population is distributed across three Territorial Local Authority areas: Buller, Grey and Westland Districts. The West Coast District Health Board is the most sparsely populated District Health Board in the country with a population density of 1.3 people per square kilometre, less than 10% of the New Zealand average.

OUR POPULATION

The West Coast is home to a growing population of 32,200 people[3]. Population estimates suggest that the child and youth populations decreased slightly between 2001 and 2006 but during the same time period there was significant growth among the older adult population (40-64) and older people (65+). The West Coast District Health Board population has a slightly older age structure compared with New Zealand as a whole, with a higher proportion of people aged 65 years or more compared with the national average. The Māori population on the Coast shows a different age structure and growth pattern however; nearly one in ten of the West Coast population is Māori and there are more Māori aged under 45 years..

More detailed ethnicity data analysis of the West Coast population shows that over 300 people identified as being of Asian ethnicity, nearly 200 were Pacific Island people and nearly 70 identified as Middle Eastern/Latin American/African (MELAA). Overall 9.3% of the population identify as Māori , Pacific people make up less than 1% (0.9%) of the regions population, with the balance falling into other ethnicity groups.

Analysis of socio-demographic data shows that compared with New Zealand as a whole, the West Coast District Health Board has a:

- lower proportion of the population born overseas;
- lower proportion of the population who have never been married or joined a civil union;
- higher proportion of the population who have been separated, divorced, widowed or bereaved;
- higher proportion of the population with no educational qualifications;
- higher proportion of one person households;
- lower proportion of the population with access to a cell phone or mobile phone;
- similar proportion of the population with no access to a motor vehicle;
- slightly higher proportion of the population receiving unemployment benefits;
- higher proportion of families receiving invalids benefit;
- higher proportion of the population who are regular smokers;

[2] Statistics NZ Quarterly Regional Updates, March 2008. This number indicates a growth of 0.5% since the 2006 census count.
[3] Statistics NZ Quarterly Regional Updates, March 2008. This number indicates a growth of 0.5% since the 2006 census count.

OUR HEALTH

Consistent with the above demographic and socio-economic issues is the picture of higher morbidity and mortality rates and lower life expectancy on the West Coast compared with the New Zealand average. The overall rate of hospitalisation is also high. In 2007 there were nearly 7,500 discharges of West Coast District Health Board residents from publicly funded hospitals in 2007. Some of the leading causes of hospitalisation were diseases of the digestive system (13.3%), diseases of the circulatory system (8.8%), injury, poisoning and certain other consequences of external causes (8.8%), and pregnancy, childbirth and the puerperium (7.8%).

The West Coast Māori Health Profile 2008[4] revealed that West Coast Māori have a similar social profile to the West Coast non-Māori but in terms of health, West Coast Māori have a poorer overall health status than the non-Māori in the region. This is demonstrated by a range of indicators, including cardiovascular disease, cancer, diabetes and respiratory disease indicators. Māori are under-represented among primary care utilisation data and have higher rates of smoking. Discrepancies between hospitalisation and mortality rates for cardiovascular disease, and registration and mortality rates for cancer, point to these being additional important areas of unmet need for West Coast Māori.

West Coast children and youth continue to have poorer health outcomes than their counterparts in other parts of the country. The leading causes of mortality, morbidity, and hospitalisations amongst children and youth on the West Coast are preventable. In particular, children have among the worst oral health status in the country, only 50% of five year olds seen by the School Dental Service in 2008 were dental caries free; the figure was just 35% for Tamariki Māori.

West Coast residents have higher smoking rates compared with other areas in New Zealand. The 2006 Census showed that a higher proportion of West Coast District Health Board residents (23.4%) were regular smokers compared with New Zealand as a whole (18.9%), with Buller District home to the highest proportion of smokers (25.7%). The recent New Zealand Health Survey 2006/2007 showed that 28.2% of West Coast residents are current daily smokers compared to 19.1% of New Zealand as a whole. Amongst West Coast Māori, 43.3% of women and 39.6% of men smoke.

1.2 DISTRICT HEALTH BOARDS OPERATING ENVIRONMENT

These functions are taken from section 23 of the New Zealand Public Health and Disability Act.

"Functions of District Health Boards"

1) For the purpose of pursuing its objectives, each District Health Board has the following functions:

   a) to ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement;

   b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities;

   c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b);

   d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement;

   e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori;

   f) to provide relevant information to Māori for the purposes of paragraphs (d) and (e);

[4] West Coast 'Te Tai O Poutini' Māori Health Profile 2008, prepared by Community and Public Health West Coast

g) to regularly investigate, assess, and monitor the health status of its resident population, any factors that the District Health Board believes may adversely affect the health status of that population, and the needs of that population for services;

h) to promote the reduction of adverse social and environmental effects on the health of people and communities;

i) to monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services;

j) to participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector;

k) to provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the District Health Board and to the health and disability support needs of New Zealanders;

l) to provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Crown Entities Act 2004;

m) to collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes;

n) to perform any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minister by written notice to the board of the District Health Board after consultation with it.

2) The Minister must, as soon as practicable after giving a notice to a District Health Board under subsection (1)(n), publish in the *Gazette*, and present to the House of Representatives, a copy of the notice.

3) Subsection (1)(c), (f), and (k) is subject to the Privacy Act 1993.

4) Subsection (1)(c) and (f) does not require a District Health Board to provide any information that could properly be withheld under the Official Information Act 1982, if a request for that information were made under that Act.

5) A District Health Board that, in reliance on subsection (4), decides not to provide relevant information must advise the persons concerned of that decision.

6) To avoid any doubt, subsection (1)(d) does not limit the capacity of a District Health Board to establish and maintain processes to enable other population groups to participate in, and contribute to, strategies for the improvement of the health of those groups.

7) In performing any of its functions in relation to the supply of pharmaceuticals, a District Health Board must not act inconsistently with the pharmaceutical schedule."

Provider Profile

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health and to reducing health inequalities between different groups. New Zealand is experiencing a much higher prevalence of long term chronic conditions such as diabetes and cardiovascular disease. Some groups of New Zealanders suffer from these conditions more than others, for example, Māori, Pacific peoples and low-income New Zealanders. Chronic disease requires increased focus to ensure that it is recognised and managed effectively.

The three national goals from the Primary Health Care Strategy are transparent national priorities, collective stewardship and governance, and enhanced delivery. The goal of transparent national priorities relates to the collaborative work of District Health Boards, Primary Health Organisations and the Ministry of Health to improve sector performance, and their focus on national health priorities. Collective stewardship and governance focuses on the engagement of the community and Primary Health Organisations to identify population needs and target responses consistent with national priorities. Enhanced delivery aims to ensure a continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

The West Coast District Health Board aims to become recognised as a lead District Health Board, and centre of excellence, in rural health. The adverse circumstances in which primary care providers work on the West Coast require the development of innovative solutions, which are likely to have general applicability to other rural areas.

Access to primary health care services is a significant issue for the West Coast population for a number of reasons, one of which is a lack of Primary Care Providers.

The West Coast District Health Board is working in partnership with key stakeholders including the West Coast Primary Health Organisation, Community and Public Health (CPH), Māori health provider, community pharmacies and other primary health care providers to ensure:

- Improved access to better, sooner, more convenient primary health services.
- A greater emphasis on delivering care in the primary setting, through the development of integrated family centres to improve pathways of care for patients.
- Greater integration of primary, community and secondary services to improve the primary / secondary interface.
- Greater emphasis on keeping people healthy through prevention and health promotion, and early diagnosis and treatment.
- A detailed strategy for the active management of chronic conditions.
- A proactive and innovative approach to workforce issues, including partnership with training organisations.
- A reduction of inequalities in health for Māori and for disadvantaged communities, particularly by finding ways to improve uptake of screening and preventive care and early treatment, in collaboration with Maori to find partnerships solutions.
- Collaboration with the community to find joint intersectoral solutions.
- The breaking down of professional silos, with further development of generalist roles such as neighbourhood nurse.
- Stronger specialist support and training for primary and community-based services and further development of innovative information technology solutions to support these changes.
- Greater emphasis of allied health services in the community.
- The development of a strong partnership between the District Health Boards and our partners to work collaboratively to be responsive to emergent plans to refocus funding to optimise outcomes.

District Health Board Provider Arm (i.e. Hospital and Specialist Services)

The District Health Board's hospitals and health centres provide a range of inpatient and outpatient services to the people of the West Coast.

The West Coast District Health Board provider arm currently has hospital and specialist services located at four sites:

Grey Base Hospital, Greymouth

- General Medical, Surgical and Paediatric Inpatient and Outpatient Services
- Allied Health Outpatient and Community Services
- District and Public Health Nursing
- Mental Health Acute Inpatient Service / Psychiatric Emergency Service
- Community Mental Health Service
- Emergency Department
- Maternity Services
- Assessment Treatment and Rehabilitation Services
- Geriatric Long Stay Hospital
- Diagnostic Laboratory, X-ray and Pharmacy Services
- Dementia Unit (Psycho-geriatric and Dementia Care Inpatient Services)

Hokitika Health Centre, Hokitika

- Visiting Specialist Medical and Surgical Outpatients
- Community Mental Health Services
- District and Public Health Nursing
- Allied Health Outpatient and Community Services

Buller Medical Services, Westport

- General Practitioner Medical Inpatient Services
- Visiting Specialist Medical Surgical and Paediatric Outpatient Services

- Allied Health Outpatient and Community Services
- District and Public Health Nursing
- Community Mental Health Services
- Geriatric Long Stay Hospital and Rest Home Elder Care Services
- Maternity Services

Reefton Health Services

- General Practitioner Medical Inpatient Services
- Visiting Specialist Medical Surgical Outpatients
- Geriatric Long Stay Hospital and Rest Home Elder Care Services
- District and Public Health Nursing

The West Coast District Health Board Provider Arm also operates a range of primary care service through 11 sites throughout the West Coast. Services include General Practitioner clinics, Practice, Rural Specialist, District, Well Child and Public Health Nursing Services and Community Mental Health Services throughout the West Coast.

Services are located at Karamea, Ngakawau, Westport, Reefton, Moana, Greymouth, Hari Hari, Whataroa, Franz Josef, Fox Glacier and Haast.

Elective Services (Booked Surgery)

The West Coast District Health Board is committed to meeting the government's expectations to improve access to elective surgery this will focus on three key policy areas of patient flow management, level of service and order of service. To ensure that expected standards around patient flow management are met, the District Health Board will comply with all Elective Services Patient Flow Indicators. The target around 'level of services' looks at volumes of operations, case weighted discharges and standardised intervention rates / standardised discharge ratios. The District Health Board will deliver on its commitments in respect of the Orthopaedic and Cataract initiatives and review the key operations it performs to ensure it is delivering the right level of service for the people of the West Coast. Furthermore the District Health Board is committed to making sure that patients are assessed and prioritised for surgery on a consistent basis and that they then receive surgery according to the priority they were given.

While the West Coast District Health Board will benefit positively from the increase in funding to boost elective surgery volumes over the next few years this does present an element of risk. As such a small District Health Board, the West Coast is more exposed than others to the impact of variations in demand and capacity that occur from time to time.

Mental Health Services

The West Coast District Health Board provides services on the basis of the written strategy Te Tāhuhu: Improving Mental Health 2005-2015. Te Tāhuhu builds on the current mental health strategies and draws together government interest in mental health and addiction, and sets out desired government outcomes for the same. Specifically, Te Tāhuhu broadens the government's interest in mental health from people who are severely affected by mental illness to include all New Zealanders – while continuing to place emphasis on ensuring that people with the highest needs can access specialist services. Therefore, Te Tāhuhu builds on past successes, establishes a platform to maintain momentum and provides a mandate for leadership.

The ten leading challenges or action priorities that the West Coast District Health Board is endeavouring to achieve for mental health and addiction outcomes are promotion and prevention, building mental health services, responsiveness, workforces and culture for recovery, Māori mental health, primary health care, addiction, funding mechanisms for recovery, transparency and trust and working together.

'Blueprint'[21] Funding

The West Coast District Health Board provides the following mental health services with 'Blueprint' Funding:

- Acute and sub-acute inpatient services
- Regional specialist services for:
  - Forensics

21 Mental Health Commission. 1998. Hyperlink to: *Blueprint for Mental Health Services in New Zealand: How things need to be. Wellington: Mental Health Commission.*

- Alcohol and other Drugs
- Mother and Babies
- Eating disorders
- Child inpatient
- Youth inpatient
- Youth Alcohol and other Drugs

- Community mental health services:
  - Adult Community mental health teams (Westport, Greymouth and Hokitika)
  - Child and adolescent services
  - Triage Assessment and Crisis Team (TACT) – mental health crisis response team
  - Crisis and planned respite
  - Community support work
  - Education and employment support
  - Activity and living skills support
  - Kaupapa Māori mental health
  - Alcohol and Other Drug
  - Youth Alcohol and Other Drug
  - Methadone services
  - Advocacy / peer support
  - Supported accommodation (Hokitika and Greymouth)
  - Consumer and family advisory services

1.3 FUTURE SUSTAINABILITY OF OUR HEALTH SERVICE

1.3.1 Primary Health Services

On 10th September 2009, the Chair of the West Coast District Health Board wrote to the Minister of Health as follows:

> The West Coast District Health Board sees two strategic pathways for the future sustainable delivery of health and disability services on the West Coast.
>
> The first is for the West Coast District Health Board to accelerate collaborative work with the Canterbury District Health Board to provide more fully integrated hospital services. We are making excellent progress on this and will report further in the near future.
>
> The second strategic pathway is in respect of non-hospital health and disability services, where the Board sees the most sustainable future as being a more complete integration of the Board's non-hospital services with the other services provided on the West Coast, particularly by the West Coast Primary Health Organisation and other private and non-government providers, to provide services of a sustainable scale within the Integrated Family Health Centre framework. The Board will be enthusiastically seeking the opportunity to pilot this arrangement.

The report by Law and Economic Consulting Group, *Analysis of options: Models of care for West Coast District Health Board*, (November 2009) identifies key components of the first suggestion - closer working relationships with Canterbury District Health Board in the provision of secondary hospital services, which are increasingly likely to be concentrated in Greymouth

The Primary Health Business case articulates the second of the two strategic options identified in the above letter to the Minister. It describes the sector's aspirations for better, sooner and more convenient primary care services for the residents of the West Coast. It explores how the medical centres on the West Coast and the various community delivered services of the District Health Board might be better integrated so that patients' experience of the health care they receive on the West Coast is significantly improved. It explores how primary and community care together, might make a greater contribution to improving the quality and timeliness of health care, while helping save scarce resources. It outlines how a different mix of clinical skills will be aligned in a service delivery model to more efficiently and effectively match a variety of patient needs for care.

What will be different as a result of implementing this business case?

- Three Integrated Family Health Centres will be established based in Westport, Greymouth and Hokitika with associated clinics in rural areas. Each of these will become a one-stop-shop in terms of accessing primary and community health services.
- The establishment of a team-based partnership model for core general practice care so that the majority of first contact care and long-term condition care is provided by appropriately skilled nurses supported closely by General Practitioners and, in time, Nurse Practitioners. This is likely to mean resident (non locum) general practitioner: patient ratios of 1:2000 and increased practice/rural nurse: patient ratios from 1:1180 to 1:900 (with additional general practitioner and nurse time for more rural areas and to reflect teaching commitments).
- The development of a Māori team within each of the three Integrated Family Health Centres. The team will focus on improving access and health outcomes for Māori.
- Devolution of community nursing, allied health and mental health services into the Integrated Family Health Centres, or the Integrated Family Health system. This will include: integration of reception, appointments, electronic clinical records, care pathways and discharge planning, and will consequently reduce duplication of services across the West Coast.
- Full implementation of a best practice, proactive approach to the management of long term conditions including mental health.
- Development of a strong primary care/community care organisation able to lead and manage the Integrated Family Health System within the available budget.

Both the District Health Board and Primary Health Organisation for the West Coast are committed to achieving important changes in health care, as reflected in the targets set out below.

Element	2010/2011	2011/2012	2012/2013
Integrating Primary and community services	Integrated management and delivery of primary and community services through a single management structure and Integrated Family Health Centre teams	Bedding in of new Integrated Family Health Centre teams. Implement new policies and procedures across primary/community	Integration of mental health services with primary and community health services
Team based primary care	Refinement of team based primary care at Buller – move to 1:2000 General Practitioner ratio and 1:900 practice nurse ratio Cross District Health Board standardisation of standing orders, use of Home Care Limited triage and service pathways	Introduction of team based care at Grey practices	Refinement of team based care at Grey practices - move to 1:2000 General Practitioner ratio and 1:900 practice nurse ratio
Affordability	Implementation of year 1 savings initiatives, transitional funding of $5.5million. Consultation on service relocations and reductions and decisions taken	Implementation of year 1 savings initiatives – transitional funding of $3.5million	Implementation of year 1 savings initiatives – transitional funding of $1.5million
Facilities and co-location		Co-location of services at Buller	Co-location of services at Greymouth
Information systems	Move allied health and district nurses to MedTech. Allow access to primary and hospital records to all authorized District Health Board and Primary Health Organisation practitioners Implement privacy audit arrangements.	Full implementation of InteRai. Review possibilities for integrated health record in conjunction with Canterbury.	

1.3.2 Secondary Health Services

In 2007/2008 the West Coast District Health Board initiated a project in partnership with the Ministry of Health to address the issue of clinical and financial sustainability of health services on the West Coast.

During 2008/2009, the project focused on developing models of care appropriate to the needs of the West Coast District Health Board and its population. There was widespread collaboration and consultation between management, clinicians, other healthcare providers and service users. After the unsuccessful submission of business cases for the redevelopment of facilities at Buller Health and Grey Base Hospital in 2009, the West Coast District Health Board and the Ministry of Health commissioned a review to evaluate the work of the sustainability project to date and to recommend preferred future medium and long-term options.

The ensuing report: *"Analysis of options: Models of Care for West Coast District Health Board*" (Law and Economic Consulting Group, December 2009) identified a number of key issues, these include:

- That all rural District Health Boards are finding that lifestyle is no longer a sufficient incentive to attract enough staff to operate a provincial hospital resulting in too much time spent on recruitment to the detriment of time required to manage and deliver health services.
- The costs of delivering care in the current way are unaffordable and recruiting staff is difficult. We need to find new ways to provide healthcare to West Coasters.
- The West Coast has too few patients in many medical specialties to warrant the number of specialist doctors required to maintain a working roster, resulting in the situation where specialist doctors and staff are in danger of seeing too few patients needing the same type of care to allow them to remain experts in their chosen field.
- To provide a safe, modern and high quality service the smaller West Coast hospital services need to be an integrated part of a much larger regional service.
- Modern medical care requires sophisticated support services, many of which are not able to be routinely provided on the West Coast. There are some medical conditions where patients are required to travel to Canterbury for more specialised care. This situation will not change.
- The Canterbury and West Coast District Health Boards have had a long history of working together. A closer collaboration through improved engagement and clinical linkages will better support sustainable health services on the West Coast. A significant outcome from this arrangement will be a greater certainty for the people of the West Coast in the availability of healthcare services and a more appropriate workforce to work in both locations.

It then went on to recommend the following changes to enable the West Coast District Health to deliver effective, safe and affordable services to people living on the West Coast:

- That Grey Base Hospital becomes a centre of excellence for rural health rather than a general acute hospital.
- That there be an immediate move towards a formal clinical partnership arrangement with Canterbury District Health Board.
- The adoption, over time, of a model of care where Grey Base Hospital is led by a core medical team of specifically trained rural hospital specialists.
- The realignment of medical and surgical specialist numbers to those required by clinical workload and service coverage requirements.
- A review of new hospital plans for greater flexibility in providing medical care.
- Continued development of nurse led services and nurse and allied health practitioner roles.
- The development of a pool of skilled medical, nursing and allied health staff who have a broad range of skills and experience in the rural setting to further primary and secondary care integration.
- Ongoing investment in clinical skills development to cover life threatening emergencies.
- A review of the options for improving the reliability of urgent patient transport.
- Continued shared planning and integration with other South Island District Health Boards .

Following extensive consultation between the Board, clinical staff and other staff of both the West Coast and Canterbury District Health Board, there is joint agreement, in principle, on the implementation of all or some of the

Law and Economic Consulting Group report recommendations. While a number of these may proceed immediately, others will require formal public consultation before they can go ahead.(refer to section 1.5)

1.4 REDUCING INEQUALITIES IN MAORI AND PACIFIC HEALTH

Māori Health

Whakatātaka sets out to achieve change within the District Health Boards. District Health Board activities are directed at improving Māori health rather than efforts being concentrated on ad hoc programmes and initiatives. It seeks to build on the strengths and assets within whānau and Māori communities.

There are four pathways for action:

Te Ara Whakahaere: Pathway Ahead – Implementing Whakatātaka

- Te Ara Tuatahi: Pathway 1 - Developing whānau, hapū, iwi and Māori communities
- Te Ara Tuarua: Pathway 2 - Increasing Māori participation throughout the health and disability sector
- Te Ara Tuatoru: Pathway 3 - Creating effective health and disability services
- Te Ara Tuawhā: Pathway 4 - Working across sectors

The pathways for action in Whakatātaka 2006-2011 continue and are integral to the West Coast District Health Board. The four priority areas that have been identified are building quality data and monitoring Māori health, developing whānau ora-based models, improving Māori participation at all levels of the health and disability sector, particularly workforce development and governance, and improving primary health care.

The West Coast District Health Board has set the long-term health outcome for Māori to benefit from the same high health status as non-Māori. Accordingly, the District Health Board has selected priority areas and set goals around these to work towards improving Māori health in the region. The keys areas of focus for investing in Māori health are: implementation of the Cancer Control Strategy; improvement of chronic conditions (cardiovascular disease, diabetes, respiratory illnesses and cancer); healthy lifestyles in Māori communities; Māori workforce development; building capacity and capability of service providers to deliver effective health and disability to Maori.

Pacific Health

The Pacific Health and Disability Action Plan (2002) sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples.

The West Coast has a relatively small Pacific Island population but it is acknowledged that this community is increasing in size each year. The West Coast District Health Board takes the view that specific initiatives for Pacific people are not realistic at this time and it is intended that the needs of this group will be accommodated through quality and equity requirements in contracts that the District Health Board holds concerning the need for cultural responsiveness.

1.5 REGIONAL COLLABORATION

During 2009 the Chief Executives and Chairs of the South Island District Health Boards approved a framework to support planning for clinically and fiscally sustainable health and disability services for the future in the South Island. This framework provides direction for the type and level of health services that will be required to best meet the needs of the South Island population, while allowing discussion and debate about how services can be configured and organised.

The goal is to have a regionally coordinated system of health service planning and delivery of health services that will see lasting improvements in the sustainability, quality and accessibility of clinical services. Initially this will be largely focused on hospital services however over time it must incorporate the development of primary and community based health care to provide the essential base for any changes to hospital services. These collaboration strategies are outlined in Appendix 5. West Coast District Health Board is actively engaged in this collaborative process.

In addition to regional collaboration, the West Coast had engaged in an inter-district partnership with Canterbury District Health Board. Canterbury District Health Board and West Coast District Health Board have mutually agreed to formalise long-standing clinical partnership agreement and work together to plan effective service in our districts.

As part of our active engagement, Canterbury will provide chief executive services to the West Coast for the next five years, and our Chief Executive Officer will lead both the Canterbury and West Coast management teams effective from 1 July 2010. Formalising our clinical arrangements will also mean future specialist clinical staff appointments, such as the recent appointment of a Director of Allied Health, will now be joint appointments between both District Health Boards.

1.6 CURRENT BUSINESS CASES

Introduction

The following business cases are due for development and consideration during 2010/2011:

Grey Base Hospital

The West Coast District Health Board is planning to reconfigure the Grey Base Hospital facilities in order to better suit changing models of care and the changing health needs of the West Coast population whilst also addressing structural (seismic) issues with the current facility. A business case and options analysis were prepared and submitted to the National Capital Committee for approval in 2008. This business case was not approved. During 2010/11 additional planning work will be undertaken in order to explore future options with the intention of submitting a revised business case on completion of models of care planning process.

Buller Health

The West Coast District Health Board has been working in partnership with the West Coast Primary Health Organisation to develop a response to an expression of interest for the development of Integrated Family Health Centres. This includes, the previously District Health Board led, Buller Health proposal. The District Health Board will reconsider re-submission of a business case for capital funding as the implantation of Better Sooner More Convenient Primary Business Case occurs.

2 OUTCOMES AND PRIORITIES

2.1 KEY OUTCOMES AND PRIORITIES FOR OUR DISTRICT HEALTH BOARD

The West Coast District Health Board takes its priorities from the National Outcomes for District Health Boards from the New Zealand Public Health and Disability Act 2000 and from the government's health priorities. In addition to these the Board's expectations also influences the District Health Board's planning and prioritisation. Specific expectations for 2010-2013 include:

Clinical sustainability

- Continued work on models of care/patient pathways to ensure effective and efficient patient care at all times.
- Increased clinical leadership and collaboration between primary and secondary clinicians in implementation of the primary health care business case.
- Development and implementation of improved secondary models of care in partnership with Canterbury District Health Board.
- Prioritisation of identified health needs and the reconfiguration of service delivery to meet those needs, including more inter-district and regional service delivery where appropriate.

Regional Collaboration

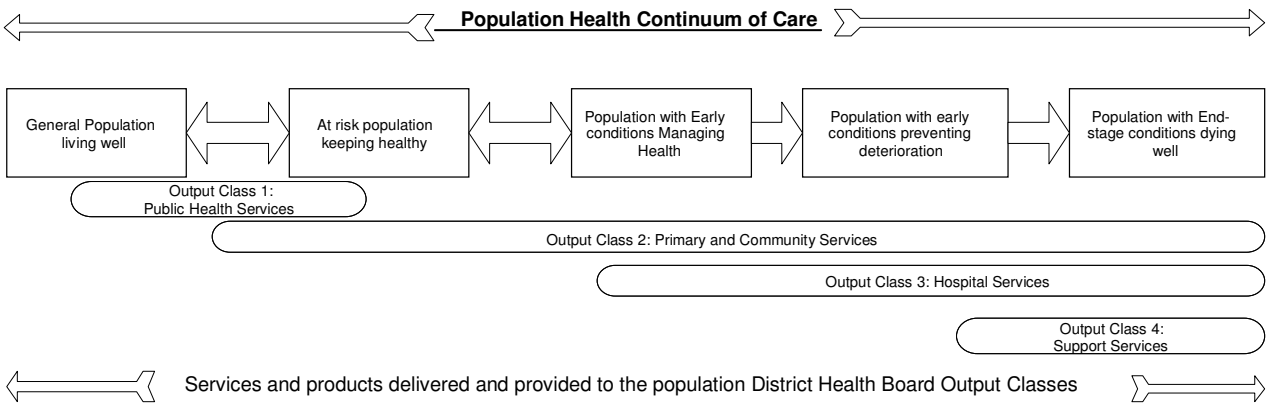
- Participation in the development and implementation of the regional clinical services (South Island Health Services Plan).

- Closer collaboration between District Health Boards on the integration or shared delivery of administrative and technical support services.

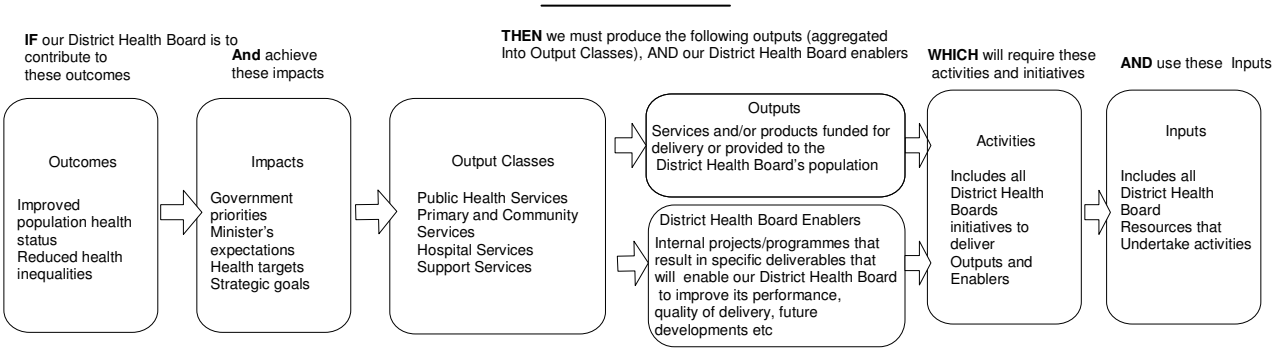
Financial sustainability

- To find ways of 'living within our means' with regard to allocation of funding for the delivery of primary and secondary services with diminishing the quality or quantity of services.
- To reduce the approved budget deficit by 50% over the next three years.
- Streamlined process management that achieves agreed targets within timeframe and within budget.

2.2 KEY MECHANISMS FOR INTERVENTION



2.3 OUTPUT CLASSES



2.3.1 Public Health Services

Public health services are the domain of many organisations across the West Coast including:

- Ministry of Health: principally as a funder of public health services and also a regulator and planner Regional Public Health. The Ministry of Health is also a provider of services.
- District Health Board: in both funding and provision.
- Primary Health Organisation: mainly in the area of provision of primary health care services, but with some public health functions.
- Community and Public Health: in the provision of health promotion and health protection services.

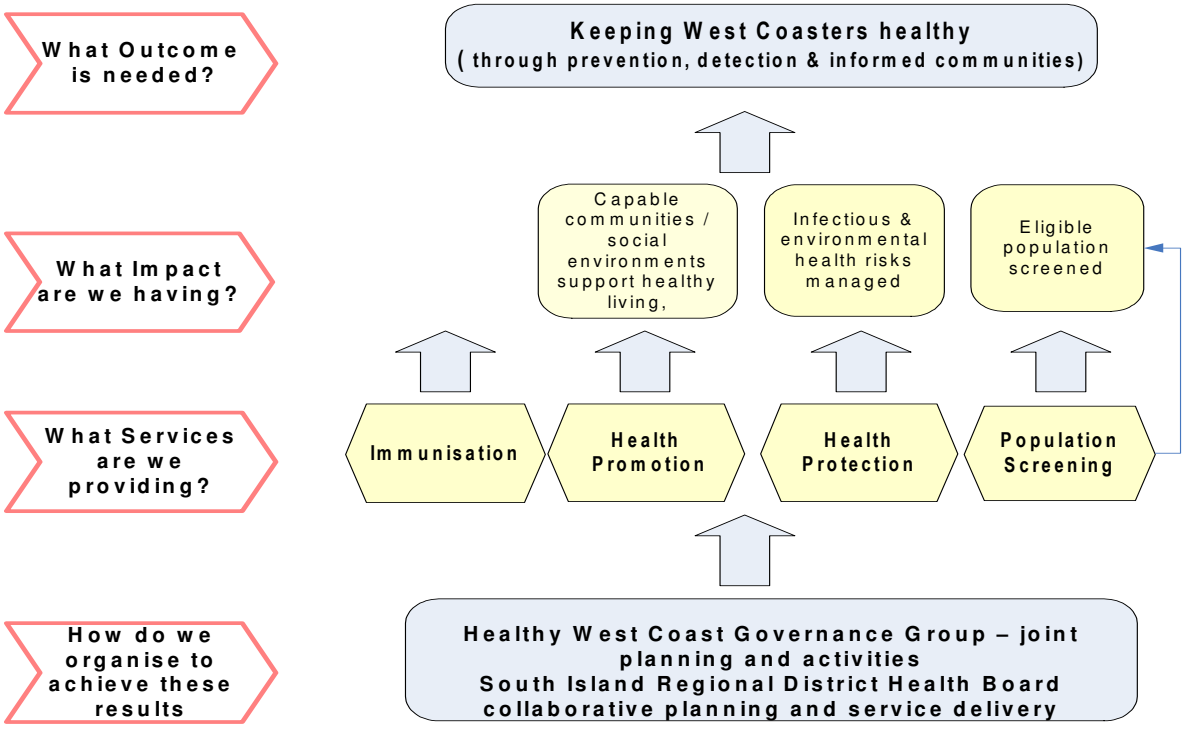
- A significant array of private and non-government organisations, including Maori providers, Regional Sports Trusts.
- Local and regional government.

District Health Boards plan, fund and ensure the provision of health and disability services to their populations. They are required to assess the health and disability support needs of the people in their regions, and to manage their resources appropriately in addressing those needs. Funding is allocated to District Health Boards using a weighted population-based funding formula. The district public health priorities are determined by the District Health Board in response to the community need.

A proportion of the public health services provided on the West Coast are funded and provided by Community and Public Health through the Canterbury District Health Board. The West Coast District Health Board is working collaboratively with both the Primary Health Organisation and Community and Public Health under the banner of Healthy West Coast. The Healthy West Coast Governance Group consists of senior level representatives from the three organisations and is focused on joint planning and delivery for public health services. In 2010/11 this joint planning focuses on tobacco control/smokefree, increased immunisation and nutrition and physical activity. This joint planning and implementation assists in avoiding duplication and providing value for money for West Coast residents.

The Healthy West Coast Governance Group has clear lines of communication to the operational health promotion network 'Active West Coast' which is co-ordinated by Community and Public Health. Membership of this network includes the West Coast District Health Board, Primary Health Organisation, Community and Public Health, Territorial Local Authorities, the Disability Information Service and a range of Non-Government Organisations.

Outcomes for Public Health Services



This will be measured using the following population measures:

Outcome	**Keeping West Coasters Healthy; through prevention detection and informed communities.**				
Actions/ Services	To achieve this Outcome the West Coast District Health Board will look to Improve Nutrition, Reduce harm caused by Tobacco, and increased Immunisation by providing Health promotion , Immunisation, Health Protection, Population Screening services.				
Measure	**Main measures of performance**	**Volumes**			
		Baseline 2008/2009	**2009/2010**	**2010/2011**	**2011/2012**
Full and exclusive breastfeeding at six months	Maori	25%	35%	36%	37%
	Total	35%	27%	29%	37%
% of year 10 students living in a smokefree home	Total	55%	60%	65%	70%
Children fully immunised at age two	Maori	70%	75%	80%	85%
	Total	80%	83%	86%	89%

2.3.2 Primary and Community Services

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health and to reducing health inequalities between different groups. New Zealand is experiencing an increasing prevalence rate of long-term chronic conditions including diabetes and cardiovascular disease. Some groups of New Zealanders suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. Long-term conditions require an increased focus across the primary/secondary interface to ensure that people at risk are recognised early and conditions managed effectively.

The three key goals from the national Primary Health Care Strategy are:

- **Transparent national priorities –** District Health Boards, Primary Health Organisations and the Ministry focused on national health priorities and working collaboratively to improve sector performance.
- **Collective stewardship and governance –** Communities and Primary Health Organisations engaged to identify population needs and target responses consistent with national priorities.
- **Enhanced delivery –** A continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

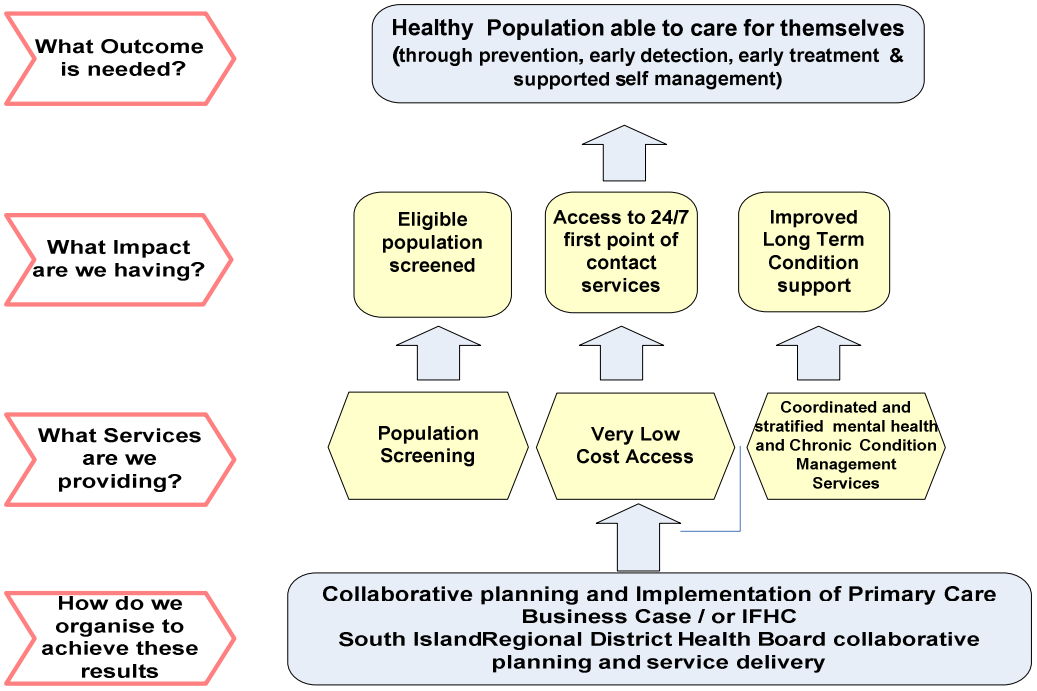
Access to primary health care services is a significant issue for the West Coast population for a number of reasons, including population density, geographic spread and a shortage of primary care providers. The ongoing General Practitioner shortage creates an environment in which it can take up to 20 days for a routine appointment and at times practices have closed their books to new enrolments. The shortage also limits the development of a range of integrated primary/secondary care arrangements such as shared care, as primary practitioners have limited time to participate.

Health outcomes on the West Coast compare unfavourably across a number of health measures with those of other New Zealanders. Considerable inequalities remain in enrolment, access and participation in clinical programs, particularly for Māori. The majority of mortality, morbidity and hospitalisations on the West Coast are preventable and an increasing focus on prevention and early detection, treatment in primary care, improving integration of clinical care across primary, community and secondary services, will address these inequalities.

In order to maximise both clinical and financial resources, the West Coast District Health Board provides a range of primary and community services including physiotherapy, occupational therapy, speech therapy, social work, district nursing, public health well child services, nurse specialists (in diabetes, respiratory and cardiovascular disease), Lead Maternity Care Services, personal care, home based support, sexual health services and so on as close to areas of population in our district as possible. It also operates General Practitioner practices in Greymouth, Reefton, Westport and South Westland.

Non-Government Organisation providers form a critical core of the primary and community services delivered on the West Coast. St John provides emergency first response and retrieval services across the region, and private pharmacies operate in Hokitika, Greymouth and Westport. Primary general practice services, chronic conditions management programmes, navigator and primary mental health services are provided across the West Coast region through the West Coast Primary Health Organisation, with disease state management and whānau ora health services targeted at Māori provided through Maori Health Provider Services. Voluntary sector organisations, such as the Cancer Society, Home Hospice Trust, Arthritis Foundation and a host of similar organisations also play a pivotal role in the delivery of health care services and support within our community.

Outcomes for Primary and Community Services



This will be monitored using the following indicative population measures:

Outcome	Healthy population able to care for themselves through prevention, early detection, early treatment and supported self management
Actions/Services	To achieve this Outcome the West Coast District Health Board will look to increase the use of three-tiered treatment and self-management under the West Coast Chronic Conditions Management programme. It will look at reducing financial barriers to people accessing primary general care through the provision of very low cost access fees; and early screening and ongoing support for people with raised risk profiles for developing chronic and long term conditions.

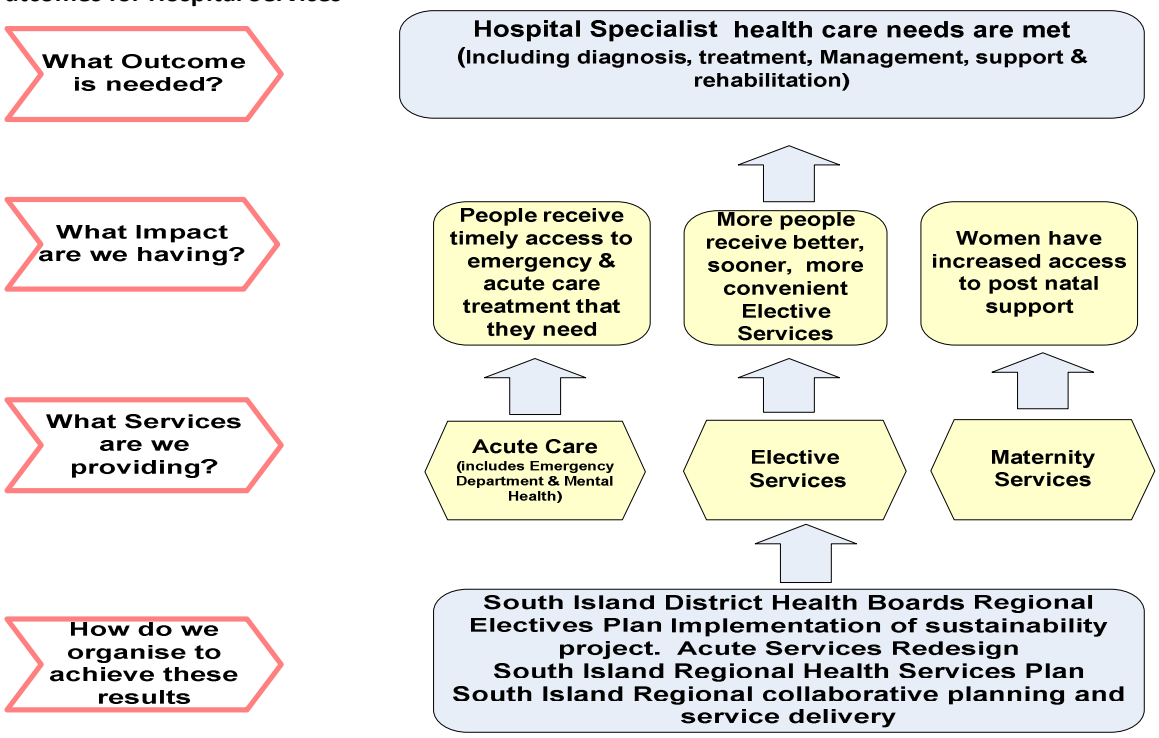
Outcome	**Healthy populations able to care for themselves through prevention, early detection, early treatment and supported self management.**				
Measure	**Main measures of performance**	**Volumes**			
Measure	Main measures of performance (includes quantity, quality, timeliness and effectiveness of outputs)	**Target 2009/ 2010**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**
Reduction in indirectly standardised Ambulatory Sensitive admissions to hospitals over time, by age and population cohort.	Age 0 -74 Maori Other Age 0 – 4 Maori Other Age 45-64 Maori Other*	60.8 92.7 50. 102.24 35.1 90.4	95 <95 95 ≤100 95 <95	To be advised annually by the Ministry of Health	To be advised annually by the Ministry of Health
Percentage of population with access to Very Low Cost Access fees in primary care	West Coast population enrolled with the West Coast Primary health Organisation who have access to Very Low Cost Access fees as percentage of total West Coast population. **	97.3%	>95%	>95%	>95%

2.3.3 Hospital Services

Our hospitals provide a range of inpatient and outpatient services to the people of our region. The West Coast District Health Board has primary level care hospitals at Westport and Reefton, and its base secondary care level hospital at Greymouth. All three sites have an Emergency Department as well as inpatient beds. Core services provided at the Base Hospital include inpatient and outpatient general medical, paediatric medical, surgical, orthopaedic, gynaecology, obstetric, mental health and geriatric Assessment Treatment and Rehabilitation services, as well as elective surgery in the fields of urology, child dental and plastic surgery and a range of visiting specialist medical and surgical sub-specialty outpatient services. These are supported by allied health services including physiotherapy, occupational therapy, speech therapy, social work, podiatry, district nursing, nurse specialists (in diabetes, respiratory, and cardiovascular disease), orthotics, Lead Maternity Care Services, personal care, home-based support, hospital pharmacy, laboratory and radiology diagnostic services. Tertiary level services are funded for our population via inter-district flows to other District Health Boards.

The key contracted service outputs delivered by the West Coast District Health Board are based on a contract made between the Planning and Funding department of the District Health Board and the hospital services (provider role of District Health Board) for the year.

Outcomes for Hospital Services



This will be monitored using the following indicative measures:

Outcome	**Hospital specialist care needs are met**				
Actions/Services	To achieve this outcome the West Coast District Health Board will look to deliver services that are timely and safe.				
Measure	Main measures of performance (includes quantity, quality, timeliness and effectiveness of outputs).	**Target 2009/ 2010**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**
Acute inpatient length of stay (days) [OS4]	Average length of stay for acute patients with a length of stay of one night or more. The measure is indirectly standardised for Diagnostic Related Group cluster and co-morbidities.	3.99	3.93 days	<3.7 days	<3.5 days
Standardised acute readmissions to hospital [OS8]	The rate of unplanned acute readmissions within 28 days of original discharge from hospital. The rate is indirectly standardised for a range of factors using regression methods.	8.21	<8.21%	<8.21%	<8.21 %
Elective and arranged inpatient length of stay (days) [OS3]	Average length of stay for elective and arranged patients with a length of stay of more than one night. The measure is indirectly standardised for Diagnostic Related Group cluster and co-morbidities.	3.92	<3.9 days	<3.9 days	<3.9 days

Outcome	Hospital specialist care needs are met				
30 Day Mortality Rate **[OS9]**	The mortality rate within 30 days of admission for patients in hospital. The rate is indirectly standardised for a range of factors using regression methods.	1.95%	<1.95%	<1.95%	<1.95%
Assessment, Treatment and Rehabilitation Services	Number of patients through Provider Arm inpatient Services. Number of patient falls as a percentage of bed days for Assessment, Treatment and Rehabilitation service. Number of patient falls as a percentage of bed days for Dementia and Psychogeriatric Assessment, Treatment and Rehabilitation service.	122 1.53% 1.23%	130 <1.5% <1.5%	150 <1.5% <1.5%	150 <1.5% <1.5%
Post-natal Stay	Percentage of women with identified risk profiles offered extended lengths of post-natal stay.	New measure – no base data.	100%	100%	100%
Mental Health: **Provider Arm Acute Mental Health patients**	Unplanned readmissions within one month of discharge.	<5	<5	<5	<5
Provider Arm Elective Mental Health patients	Percentage of people in contact with mental health services for two or more years with Relapse prevention plans.	98% target	98%	98%	98%

2.3.4 Support Services

The West Coast District Health Board provider arm offers inpatient and outpatient specialist assessment, treatment and rehabilitation services for older people at Grey Hospital, as well as a community-based Needs Assessment and Service Co-ordination service, Carelink, which works out of Greymouth and Westport. The West Coast District Health Board provider arm also supplies long-term aged residential care facilities at Grey Hospital, Buller Health and Reefton Health, including a specialist dementia unit at Grey Hospital. The West Coast District Health Board funder arm also funds a range of other providers to deliver long-term aged residential care as well as respite care and day-care at Westport, Reefton, Greymouth and Hokitika. Access Homehealth and West Coast District Health Board provider arm are funded to provide long-term home support services throughout the Coast. Presbyterian Support Services (Upper South Island) is funded to provide HomeShare, a home-based day care service for older people that is opening in early 2010.

Concerns about the quality and sustainability of residential aged care services are being met through greater collaboration between the West Coast District Health Board and the residential sector on workforce issues and increased investment in dementia care.

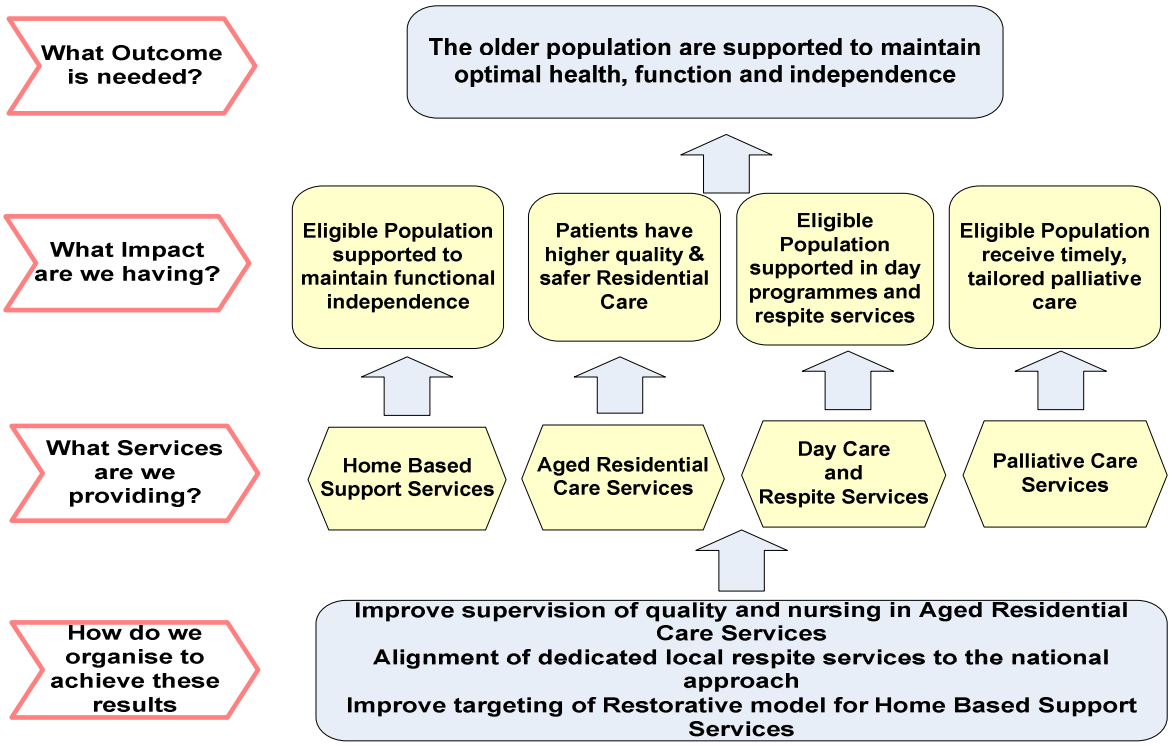
Provision of disability support services for people aged less than 65 years are funded and contracted directly by the Ministry. Our District Health Board provider arm delivers a range of these services for our population under direct contract.

2.3.5 Other Support Services

The services provided for people with disabilities are designed around the New Zealand Disability Strategy. The West Coast District Health Board's vision is to have a fully inclusive community, where people with disabilities can live in a society that highly values them and continually enhances their full participation.

In 2010/2011 the West Coast District Health Board intends to implement its Disability Strategic Action Plan. In doing so it will advance the objectives of the New Zealand Disability Strategy, including fostering an aware and responsive public service, collecting and using relevant information about disabled people and disability issues and encouraging and educating for a non-disabling society.

Outcomes for Support Services



Outcome	The older population are supported to maintain optimal health, function and independence
Actions/Services	To achieve this outcome the West Coast District Health Board will work to maintain function and independence through the provision of an increasing range of support services including, home based support services, aged residential care, day care and respite care services.

Outcome	The older population are supported to maintain optimal health, function and independence				
Measure	Main measures of performance (includes quantity, quality, timeliness and effectiveness of outputs)	Volumes			
		Baseline 2009 calendar year actual	**Target 2010/ 2011**	**Target 2011/2012**	**Target 2012/2013**
Proportion of older population in rest home level care	75+ year olds	6.2%	6.0%	5.6%	5.5%
Proportion of older population in specialist dementia care	75+ year olds	0.7%	0.8%	1.5%	2%

2.4 HOW WE AIM TO MEET THE GOVERNMENT PRIORITIES

The Minister of Health's annual 'Letter of Expectations' is sent to all District Health Boards and identifies the Minister's specific expectations and priorities for the coming year. These expectations, in addition to national health and disability strategies[5] and our strategic priorities (set out in the District Strategic Plan, enables our District Health Board to plan and prioritise activity for 2010/2011.

A set of national Health Targets have been identified to focus the efforts of District Health Boards and make more rapid progress against key national priorities. These Health Targets are included within the selection of performance measures and are also clearly identified in our District Annual Plan 2010/2011.

Health Targets
MOVING TOWARDS HEALTHIER FUTURES
Shorter stays in Emergency Departments
Improved access to elective surgery
Shorter waits for cancer treatment
Increased immunisation
Better help for smokers to quit
Better diabetes and cardiovascular services

In summary the District Health Board has committed to the following measures:

- 95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.
- An additional 22 elective surgery procedures will be carried out over and above the projected volumes for 2010/2011.
- Patients requiring radiation treatment will wait no longer than four weeks by December 2010.
- 90% of two year olds of all (total) ethnicities will be fully immunised.
- 80% of hospitalised smokers will be provided with help and advice to quit.

[5] Available from the Ministry of Health website, www.moh.govt.nz

- An increased percentage of people with diabetes will attend free annual checks and have at least satisfactory diabetes management.
- An increased percentage of the eligible adult population will undergo a cardiovascular disease risk assessment.

Our Statement of Intent aligns with national and Government priorities. These priorities are closely aligned with our vision and long term strategy to improve the health and well-being of the West Coast communities.

3 OUTPUT CLASS AREAS AND STATEMENT OF FORECAST SERVICE PERFORMANCE

Statement of Forecast Service Performance

One of the functions of this Statement of Intent is to show how the West Coast District Health Board will evaluate and assess what services and products we deliver to others in 2010/2011. There are four output classes: public health, primary and community, hospital and support services. For each output class there are agreed national performance measures and targets for the desired outcomes and objectives[6]. These measures and targets will be subject to an annual audit by auditors appointed by the Office of the Auditor General. The performance measures indicated below are not a comprehensive list and do not cover all of the activity of the West Coast District Health Board. These measures highlight our activity towards achieving local and national strategies, priorities and targets. Where possible, we have included past performance (baseline data) along with each performance target to give context of what we are trying to achieve and to better evaluate our performance.

3.1 OUTPUT CLASS ONE – PUBLIC HEALTH

The West Coast District Health Board, West Coast Primary Health Organisation and Community and Public Health jointly plan and deliver various public health services and activities, particularly health promotion, under the 'Healthy West Coast' banner. The joint planning and delivery of these services assists in avoiding duplication of resources and ensures value for money in health promotion services. The focus of joint planning for public health activity is on the following areas in 2010/2011:

- Increased Immunisation
- Tobacco control / smokefree
- Physical activity and nutrition

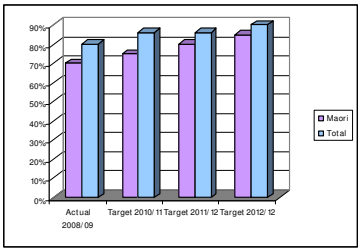
Whilst these are the areas of joint focus between the three health organisations, other areas of public health such as health protection, oral health, breast and cervical screening, and other aspects of health promotion such as youth health, alcohol and healthy homes are retained as organisational priorities. Underpinning this public health approach is a focus on improving the health and wellbeing of Maori communities and reducing inequalities.

[6] As stated in the Crown Entity Act 2004 (s 142 (1))

Health Target 5: Increased Immunisation

Long Term Objective: The West Coast has a high opt-off rate for childhood immunisations. It is the long-term objective of the West Coast District Health Board to achieve the health target of 90% of West Coast children fully immunised by aged two.

Reduce the impact of infectious diseases among local populations by increasing immunisation coverage of West Coast children	Given the impact that socio-economic determinants have on health outcomes it is not surprising that children and youth on the West Coast have worse health outcomes than children in other parts of New Zealand. The West Coast District Health Board believes that 'children are the future' and remains committed to promoting and protecting the health of West Coast children 2010/2011 and beyond to ensure that strong foundations are built for future generations. The West Coast District Health Board Child Health Plan and Healthy West Coast Plan identifies increased immunisation as a priority for improving child health.

Impact		**Actual 2008/ 2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**	
An increase in the number of children fully immunised at age two, across all populations.	Māori	70%	80%	80%	85%	
	Total	80%	86%	86%	90%	

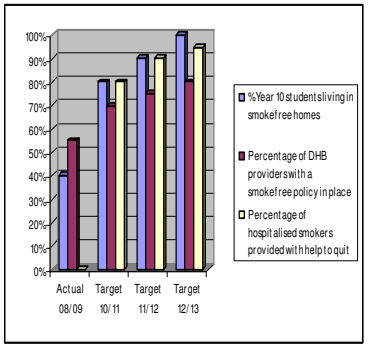
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Continue to provide Outreach Immunisation Services with a focus on reducing inequalities in coverage for tamariki Māori and children in New Zealand Deprivation Index 9 and 10 areas.	Provider	West Coast District Health Board Child Health Plan
Implement the joint West Coast District Health Board/ Primary Health Organisation /Community and Public Health's Healthy West Coast Plan	Provider Funder West Coast Primary Health Organisation	West Coast District Health Board Child Health Plan
Improve practice process for immunisation, particularly relating to providing timely recall information (using the long term conditions model of engagement and collaboration) and offering flexibility around clinic times.	Provider West Coast Primary Health Organisation	West Coast District Health Board Child Health Plan
Ongoing provision of practice nurse training by the Immunisation Coordinator	Provider	West Coast District Health Board Child Health Plan Health West Coast Plan.

Health Target 5: Better Help for Smokers to Quit

Long Term Objective: To reduce the smoking rate on the West Coast by five years over the next three years.

Better help for smokers to quit	Smoking is one of the leading causes of mortality and morbidity for the West Coast population. 2006 census data reports that 25.7% of the West Coast population are regular smokers, compared to 20.7% nationally. Prevalence smoking rates were higher among Māori (41%) and Pacific peoples (36%) than for European. The District Health Board has identified pregnant women, long-term mental health service users, people with chronic conditions, Māori, parents and low socio-economic groups as priority populations for improving access to smoking cessation services.

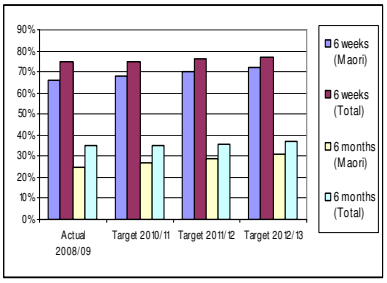
Impact	**Actual 2008/ 2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**
Year 10 students that smoke on a daily basis.	3.2%	3%	2%	2%
District Health Board funded providers with smokefree policies in place.	40%	80%	90%	100%
Year 10 students living in smokefree homes.	55%	70%	75%	80%
Clients accessing smoking cessation services.	520	585	650	700
Hospitalised smokers provided with smoking cessation advice and help to quit.	New measure baseline data not available	80%	90%	95%



The West Coast District Health Board has a strategic vision for its people to be non-smokers by 2015. The District health Board Tobacco Control Plan aims to reduce the harm caused by tobacco through a coordinated approach on smokefree environments, routine screening of clients' smoking status and brief advice, and accessible and acceptable specialist smoking cessation services. The District Health Board will work collaboratively with the West Coast Primary Health Organisation, Community and Public Health and the Cancer Society on planned smokefree health promotion activities.

Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Continued implementation of the Ask, Brief Advice and Cessation strategy to ensure patients across community, primary and secondary services are provided with advice and support to quit.	Smokefree Coordinator	Healthy West Coast Plan
Implement the joint West Coast Smokefree plan in conjunction with key stakeholders.	Smokefree Coordinator	Healthy West Coast Plan
Smokefree environment – increase the number of smokefree homes and workplaces on the West Coast.	Smokefree Coordinator	Healthy West Coast Plan

Implementation of specific programmes including pregnant women, youth and Maori.	Smokefree Coordinator	Healthy West Coast Plan

Improve Nutrition, Increase Physical Activity and Reduce Obesity					
Long Term Objective: The West Coast District Health Board will support the Healthy Eating Healthy Action Strategy and reflect the priority population health objective to improve nutrition, increase physical activity and reduce obesity.					
Increase breastfeeding rates among women living in New Zealand Deprivation Index 8, 9 and 10 areas, young women and Māori women	The primary goals of the Healthy Eating Healthy Action framework (increasing physical activity, improving nutrition and decreasing obesity) are key priorities of the West Coast District Health Board and supported in the 2005-2015 District Strategic Plan.				
Impact	**Actual 2008/ 2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**	
Breastfeeding at 6 weeks (Māori)	66%	68%	70%	72%	
Breastfeeding at 6 weeks (Total)	75%	76%	76%	77%	
Breastfeeding at 6 months (Māori)	25%	27%	29%	31%	
Breastfeeding at 6 months (Total)	35%	35%	36%	37%	

The 2010/2011 Breastfeeding Action Plan is a key component of the nutrition and physical activity section of the Healthy West Coast Plan and 'Keeping People Healthy' section of the Primary Care Business Case. Breastfeeding action focuses on the provision of free community-based lactation consultation, professional development opportunities for clinicians (both primary and secondary care), the extension and augmentation of the Mum4Mum Peer Support counselling programme and breastfeeding antenatal education.

The establishment and maintenance of environments that support breastfeeding will continue to be a priority focus for breastfeeding action.

Improve Nutrition, Increase Physical Activity and Reduce Obesity		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Implement the West Coast Breastfeeding Action Plan in conjunction with the West Coast Primary Health Organisation.	Healthy Eating Healthy Action Manager	Healthy West Coast Plan West Coast District Health Board Child Health Plan
Continue to implement the breastfeeding initiative for Tai Poutini (with a focus on increasing rates among women living in New Zealand Deprivation Index 8, 9 and 10 areas, young women and Māori women.	West Coast Primary Health Organisation Healthy Eating Healthy Action Manager	Healthy West Coast Plan West Coast District Health Board Māori Health Plan West Coast District Health Board Child Health Plan

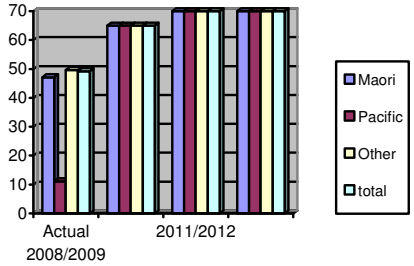
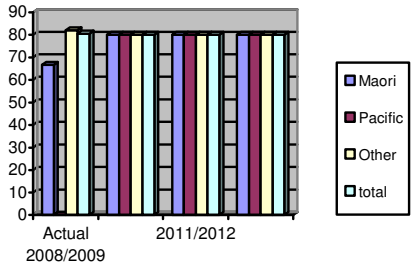
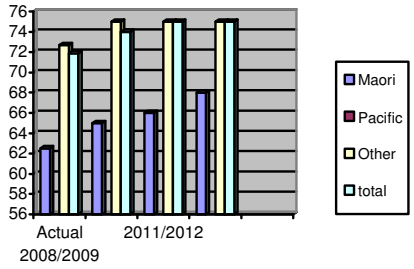
Improve Nutrition, Increase Physical Activity and Reduce Obesity		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Establish environments (such as workplaces, cafes and community facilities) that support breastfeeding.	Healthy Eating Healthy Action Manager	Healthy West Coast Plan West Coast District Health Board Child Health Plan

3.2 OUTPUT CLASS TWO – PRIMARY AND COMMUNITY SERVICES

Over the next three years the District Health Board will focus on integrating primary, community and health services in a way that will result in better, sooner and more convenient services for patients, delivered from integrated family health centres. Changes in current service configurations will include:

- Extensive shift in doctor nurse ratios.
- Advancing development of Nurse Practitioners with prescribing authority.
- Increasing nurse and allied health led services.
- Development of primary mental health coordinators.
- Increasing co-location of a range of primary, community and secondary services.
- Implement Maori nursing positions within each integrated family health centre.
- Implement navigator/kaiawhina positions to provide practical assistance to access services District wide implementation of a three level stratified care approach for long term conditions.
- Implement Shared Care arrangement's in primary/secondary mental health services.
- Improved discharge planning processes.
- Delivery of secondary services within Integrated Family Health Centres.

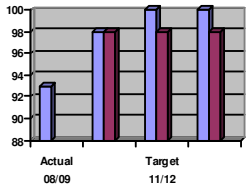
Health Target 6: Better Diabetes and Cardiovascular Services	
Long Term Objective: Improving local responsiveness to reduce the impact and incidence of diabetes and cardiovascular disease, as shown through key indicators of performance in terms of access to free annual diabetes checks, better diabetes management, and cardiovascular risk assessment monitoring.	
Increase the number of patients with diabetes accessing free annual checks; having good diabetes management; and five-year Cardio Vascular Disease risk assessments undertaken.	There will be an increase in the percentage of people estimated to have diabetes accessing free annual checks; an increase in the percentage of people on the diabetes register having good diabetes management; and an increase in the percentage of the eligible adult population who have had their cardiovascular risk assessment in the last five years. The Local Diabetes Team has set targets for the West Coast District Health Board in key performance indicators for 2010/2011 for diabetes detection and management rates. The District Health Board will work with primary health providers to achieve these targets and other aims, including improvement in education on improved nutrition, physical exercise and smoking reduction, and monitoring the use of statin and ACE inhibitors among Māori with diabetes.

Health Target 6: Better Diabetes and Cardiovascular Services					
Impact	**Actual 2008/2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2011/ 2013**	
Percentage of the population estimated to have diabetes* accessing free annual checks.	Maori: 47.1% Pacific: 11.1% Other: 49.7% Total: 49.2%	65% 65% 65% 65%	70% 70% 70% 70%	70% 70% 70% 70%	
Percentage of people with diabetes having satisfactory or better diabetes management.	Maori: 66.7% Pacific: 0% Other : 82.0% Total : 80.6%	80% 80% 80% 80%	80% 80% 80% 80%	80% 80% 80% 80%	
Better Diabetes and Cardiovascular Services (Health Target 6)					
Increased percentage of eligible adult population having Cardiovascular risk assessed in the last 5 years.	Maori: 62.5% Pacific: n/a Other : 72.7% Total : 71.9% *(Actual rates for this measure as at 30 June 2009)*	>65% n/a >75% >74%	>66% n/a >75% >75%	>68% n/a >75% >75%	

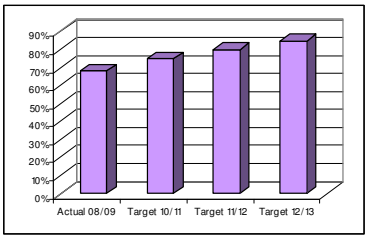
* (based on annually renewed population denominator calculations issued by the Ministry of Health)

Health Target 6: Better Diabetes and Cardiovascular Services		
The West Coast Primary Health Organisation, West Coast District Health Board and other core service providers are continuing to strive to meet the targets for these three national diabetes and cardiovascular responsiveness health targets for the respective population groups. (Note: the diabetes targets are measured on a calendar year, rather than financial year). The Local Diabetes Team has set stretch targets for diabetes into the out-years, with the same performance for all population groups.		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Continued promotion and implementation of the West Coast Primary Health Organisation's Long term Condition Management programme to encourage uptake of diabetes annual reviews and cardiovascular risk assessment through the West Coast Primary Health Organisation and education within the community; with support from services in secondary care	West Coast Primary Health Organisation West Coast District Health Board Provider Funder	West Coast District Health Board Long Term Conditions Management Plan West Coast District Health Board Integrated Diabetes Service Plan
Improved Information Technology interface and two-way data sharing between primary and secondary services, through progressive implementation of inter-active Information Technology. data sharing systems between West Coast District Health Board provider arm service and primary General Practitioner practices.	West Coast Primary Health Organisation West Coast District Health Board Provider	West Coast District Health Board Long Term Conditions Management Plan West Coast District Health Board Integrated Diabetes Service Plan
Formation of a multidisciplinary Local Cardiovascular Team to inform future direction of care and service improvement (along similar lines to the West Coast District Health Board's Local Diabetes Team and Local Cancer Team).	West Coast Primary Health Organisation West Coast District Health Board Provider Funder	West Coast District Health Board Long Term Conditions Management Plan West Coast District Health Board Integrated Diabetes Service Plan

Improving Mental Health Services	
Long Term Objective: The West Coast District Health Board will ensure that 100% of long-term clients have up to date relapse prevention plans (**National Mental Health Sector Standard** criteria 16.4).	
Ensure that 100% of long-term clients have up to date relapse prevention plans (National Mental Health Sector Standard criteria 16.4)	The West Coast District Health Board continues to offer mental health services with high rates of access. Services offered include specialist mental health and alcohol and other drug addiction services for children, youth and adults as well as kaupapa Maori Mental Health Services. The District Health Board has a particular focus on improving the quality of service for long-term mental health users.

Improving Mental Health Services					
Impact	**Actual 2008/ 2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**	
Number of long term clients with an up to date relapse prevention plan – Adult. Number of long term clients with an up to date relapse prevention plan – Children and Youth.	93% New measure baseline data not available	98% 98%	100% 98%	100% 98%	
In 2008/2009 93% of people who have used mental health services for more than two years have an up to date relapse prevention plan. Through the Knowing the People planning project, an individual's physical health, housing, education, employment and family situations are also identified and used to improve the individual's quality of life, and as planning tools for working across agencies to address wider issues.					

Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Continue the Knowing the People planning project. Utilise information gathered to four services on improving the quality of life of patients.	Provider	West Coast District Health Board Strategic Plan 2005
Continue to implement the West Coast District Health Board Mental Health Service Quality Improvement Programme through internal review, evaluation and audit.	Provider	West Coast District Health Board Mental Health Service Quality Improvement Programme
Reconfigure Community Rehabilitation Service, from secondary care to non government organisation	Planner Funder	West Coast District Health Board Mental Health Rehabilitation Review
The quality improvement initiatives for 2010/2011 will fours on integrating primary and secondary services, including single entry povit for patients, packages of care, shared cared arrangement and other initiatives	Planner Funder Provider	Primary Care Business case
Delivery of secondary mental health and addiction services within Integrated Family health Centres.	Planner Funder Provider	Primary Care Business case

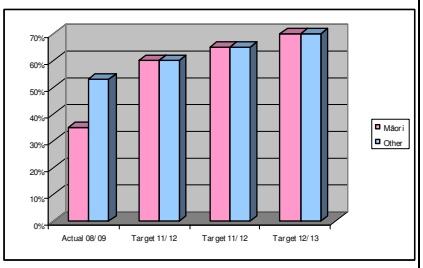
Improving Oral Health					
Long Term Objective: The West Coast District Health Board will work towards 85% adolescent oral health utilisation					
Increase utilisation of oral health services among adolescents	The West Coast has some of the worst oral health in New Zealand, with no fluoridated water supplies and the lowest number of dentists per capita in the country. The ratio of dentists to population impacts on access rates for adolescents, and the District Health Board School Dental Service is continuing to increase the number of adolescents residing rurally and out-of-school youth enrolled in the service. Access rates for adolescents have increased 8% from 55% in 2006, 63% in 2008 to 68% in 2008. The District Health Board has set a target of 75% of the total eligible adolescent population utilising the free oral health service in 2010.				
Impact	**Actual 2008/ 2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**	
An increase in the number of adolescents accessing oral health services	68%	75%	80%	85%	

Implementation of a preventative model of oral health care will continue in 2010/2011. The service will drop the age of eligibility for service from two years to one which will maximize the benefit of this service for preschool children at risk of at risk of dental caries. Education for parents and children will be enhanced with the utilisation of national resources as they become available and expansion of education in early childhood education settings. The service will continue to expand the provision of services to adolescents by increasing the services currently provided to adolescents in rural areas and to out-of -school and un-enrolled adolescents in Greymouth, Westport and Hokitika.

Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Complete implementation of the preventative model of service delivery for oral health	Planner Provider	West Coast District Health Board Youth Health Plan
Continue to provide a dental service for school-aged children throughout the West Coast during the implementation of the Oral Health Business Case	Funder	West Coast District Health Board Youth Health Plan
Increase adolescent enrolments in the School Dental Service with a particular focus on out of school youth and adolescents not accessing with a private dental provide	Provider	West Coast District Health Board Youth Health Plan

Improving Oral Health		
Maintain contracts with local dentists for the provision of child and adolescent oral health services	Funder	West Coast District Health Board Youth Health Plan

Improving Oral Health					
Long Term Objective: The West Coast District Health Board has set a target to increase the number of five year olds dental caries-free to 70%					
Increase the number of five year olds dental caries-free	Decayed, missing and filled teeth (DMFT) rates in both five and twelve year old West Coaster children are higher than the New Zealand average. During 2010/2011 the District Health Board will continue to work towards improving the percentage of West Coast Children dental caries free at age of five years through a range of initiatives. A specific focus is on reducing the current disparity between tamariki Māori and children of other ethnicities, which is particularly noticeable at age five The West Coast District Health Board target for children dental caries free at age of five years is 70% across all ethnic groups by 2012/2013.				
Impact	**Actual 2008/ 2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**	
Number of caries-free 5 year olds					
Māori	35%	40%	65%	70%	
Other	53%	56%	65%	70%	



Improving Oral Health		
Implementation of the West Coast Oral Health Business Case has begun with the procurement of two mobile dental facilities and progress on upgrading three fixed facilities. An increase in dental assistant full time equivalent and the introduction of the preschool topical fluoride service will lead to reducing dental caries rates among five year olds		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Continue to implementation of the District Health Board's Oral Health Business Case	Planner and Funder Provider	West Coast District Health Board Child Health Plan
Complete implementation of the preschool topical fluoride services and health education for preschoolers most at risk of decay	Provider	West Coast District Health Board Child Health Plan
Work collaboratively to cross reference preschool enrolments in primary care with enrolments in dental service	Provider	West Coast District Health Board Child Health Plan

3.3 OUTPUT CLASS THREE – HOSPITAL SERVICES

Secondary Health Services at the West Coast District Health Board covers the provision of both medical and surgical services from locations at Westport, Reefton, Greymouth and Hokitika. Inpatient services are principally provided from Grey Base Hospital, with outpatient services provided in all locations. The recommendations contained in the 2009 Law and Economic Consulting Group report on the sustainability project include strategies that will help address the needs of the West Coast into the future. These will inevitably shape the future delivery of both acute and elective secondary hospital services within our district. West Coast District Health Board is looking to develop Integrated Family Health services and alternative delivery options aimed at ensuring elective capacity, including initiatives across the primary/ secondary interface and closer clinical collaboration with other District Health Boards.

While the West Coast District Health Board continues to experience difficulty with recruitment and retention of clinical staff West Coast District Health Board is working collaboratively with other District Health Boards to share resources to help mitigate these risks. Throughout this process, it will continue to be West Coast District Health Board's goal to maintain an excellent standard of elective medical and surgical care for the resident population.

Acute and Emergency Department Services

Emergency Department services are provided at Grey Base, Buller and Reefton Hospitals. Acute inpatient services provided at the Base Hospital include general medical, paediatric medical, surgical, orthopaedic, gynaecology, obstetric and mental health beds. In addition, acute General Practice-level medical beds are provided at Buller and at Reefton hospitals.

The West Coast District Health Board has developed and is the process of implementing an Emergency Department After-Hours Services Plan to help take pressure off our services and to improve responsiveness to patients seeking emergency care. This includes implementation of an after-hours telephone triage service; increasing nurse participation in after-hours care; increasing nurse Primary Response In Medical Emergency training and assessment; and at Grey Base Hospital – the establishment of an academic practice which will run After Hours services three nights per week. These steps are designed to help mitigate the large number of inappropriate triage level five

attendances currently experienced at Emergency Departments by 35% in three years and to help reduce call requirements on other primary practices.

The West Coast District Health Board is committed to achieve emergency department maximum waiting times of no more that six hours, and better, for all categories of presentation.

Acute mental health services are provided in the community through the West Coast District Health Board's Triage Assessment Crisis Team. Preventative primary mental health services also provided through the West Coast Primary Health Organisation, in order to help manage the number of patients requiring acute assessment through early intervention.

Elective Services

Elective services (booked surgery) are non-acute for patients who do not require immediate hospital treatment and who can be booked for services. The West Coast District Health Board is committed to meeting the government's expectations around elective services, particularly the key principles underlying the electives system:

- Clarity – where patients know whether or not they will receive publicly funded services;
- Timeliness – where services can be delivered within the available capacity, patients receive them in a timely manner; and;
- Fairness – ensuring that the resources available are directed to those most in need.

In managing Elective Services our District Health Board will focus on the following areas:

Patient Flow management: Our District Health Board will comply with required standards on Elective Services Patient Flow Indicators, which demonstrate that the District Health Board is managing patients in accordance with the three principles (clarity, timeliness and fairness), matching their commitments to capacity, and meeting the six month timeframe for provision of assessment and treatment.

Level of Service: The West Coast District Health Board remains committed to the 2009/2010 Collective South Island Elective Services Plan to have a shared responsibility to maintain effective and efficient elective services across the South Island, with regard to the particular needs of all South Islanders. As part of this commitment too, West Coast District Health Board will look to maintain provision of 1592 elective operations in 2010/2011 as our proportional share of delivering the Minister's expectations of an overall 4000 procedures per annum increase in elective discharges across the country, and in keeping with our longer-term goal of moving toward greater national equity of access.

Order of Service: Our District Health Board is committed to making sure that patients are assessed and prioritised for surgery on a consistent basis, and that they then receive surgery according to the priority they were given. The priorities for Secondary Health Services are thus to maintain compliance with Elective Service Patient Flow Indicators and to ensure that the overall delivery of elective services to the West Coast population to meet the Minister's expectations in terms of both inpatient and outpatient waiting times and volume delivery. Furthermore, to deliver key elective procedures at a nationally appropriate Standardised Intervention Rates (SIR) and delivery level; and to continue to identify ways of improving the patient flow for those accessing those services.

Having only a restricted capacity to undertake surgical procedures at Grey Base Hospital due to limited numbers of key specialist and operating theatre staff, acute surgery will always take precedence and may impact on the flow of elective work that can be undertaken on the West Coast.

Non-Admitted Services

The West Coast District Health Board provides a range of elective outpatient medical and surgical outpatient services, as well as non-admitted minor operation, colonoscopy, gastroscopy, urological cystoscopy, and gynaecology services. These volumes are outlined in our District Annual Plan price volume schedules.

Mental Health Services

The West Coast District Health Board continues to provide mental health services with higher rates of access than the Mental Health Commission's benchmark indicators. This includes access to specialist mental health, alcohol and

other drug addiction services and services for children and youth. The District Health Board works collaboratively with regional speciality services to provide community-based services for eating disorders, forensic, and alcohol and other drug specialities. Inpatient services for these specialities along with mothers and babies, and child and adolescent specialities are also provided regionally.

Consequently, the District Health Board has a particular focus on improving the quality of services and quality of life for long-term mental health users, which may result in a reduction in access rates with the increasing focus on recovery and strengths based service delivery. In 2009/2010 this included reconfiguration of community based rehabilitation services, Community Support Work Services and Alcohol and Other Drug Services, as well as the development of consult liaison services, it is expected that this will continue to reduce the need for hospital services.

The quality improvement initiatives in 2010/2011 will focus on integrating primary and secondary mental health services in a way that will result in better, sooner and more convenient services for patients, delivered from integrated family health centres. Changes in current service configurations will include:

- A single entry point for patients who need mental health services.
- Packages of care for those currently falling between primary and secondary services.
- Shared care arrangements.
- Improved discharge planning processes.
- Delivery of Secondary Mental Health and addiction services within Integrated Family Health Centres.

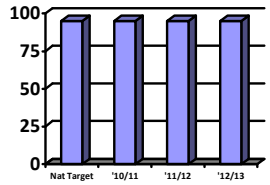
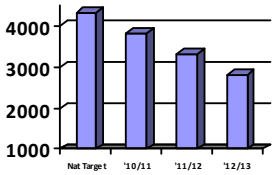
Postnatal Stays

The West Coast District Health Board neither operates nor places any time restriction on the length of stay for mothers or their babies in any of its maternity services. The District Health Board currently encourages mothers to stay for whatever duration they may reasonably wish; or as may be required for clinical need or to establish feeding, to develop parenting skills, or to ensure that mothers and their new-born babies are able to travel home with family at a safe and reasonable time upon discharge.

Continuous Quality Improvement

In 2008 the West Coast District Health Board instigated a systematic patient pathway planning process as part of the Sustainability Project. This planning involves multidisciplinary groups matching service delivery to changing models of care for the West Coast's local population and exploring innovative ways of delivering patient care being piloted nationally. Work on these will continue, ensuring that that the pathway for patients through elective services is as safe and efficient as possible and provided as close to home as possible.

Health Target 1: Shorter Stays in Emergency Department	Shorter stays in Emergency Departments
Long Term Objective: Shorter lengths of stay for patients in Emergency Department services.	
Maintain compliance with national targets for patient lengths of stay in our Emergency Department services	The West Coast District Health Board already consistently achieves emergency department response and waiting times for triage one and two admissions. As part of the Models of Care – Patient Pathways initiative, the West Coast District Health Board will work during 2010/2011 to achieve emergency department waiting times of no more than six hours for all categories of admission. The District Health Board is committed to ensuring continued improvement in waiting times in its three Emergency Department services in all triage categories; particularly in triage category 3 (urgent category). A particular bottle-neck for West Coast services is noted in the after hours period, when staffing by Emergency Doctors is at a reduced threshold. As part of its strategy to improve performance in this area, the West Coast District Health Board has developed an After Hours Plan with initiatives to further assist in improving Emergency Department waiting times.

Health Target 1: Shorter Stays in Emergency Department					
Impact	**National Target**	**Target 2010/2011**	**Target 2011/202**	**Target 2012/2013**	
More than 95 percent of patients will be admitted, discharged or transferred from an Emergency Department within six hours.	>95%	>95%	>95%	>95%	
Reduction of inappropriate triage level 5 attendances (Target: 35% in three years)	4326	3821	3316	2812	
The West Coast District Health Board acknowledges the Health Target that more than 95% of patients presenting for treatment to Emergency Department services will be either admitted, discharged or transferred in less than six hours as a maximum waiting time. Key outputs will be achieved through several priority projects including (amongst others); resource management, review of discharge processes and General Practitioner training. West Coast District Health Board is already maintaining a level at or close to 100% for this measure; and will aim to continue to perform at this higher level of the national target into the future.					

Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Close monitoring of Emergency Department service provision to ensure people are treated within the national waiting times guidelines.	Provider Funder	West Coast District Health Board Secondary Care Plan
Reduction in inappropriate triage level 5 attendance	Provider Funder	West Coast District Health Board Secondary Care Plan

Health Target 2: Improved Access to Elective Services

Long Term Objective: The West Coast District Health Board will maintain compliance in all Elective Services Patient Flow Indicators.

Maintain compliance in all Elective Services Patient Flow Indicators and monitor Standardised Intervention Rates of the target elective procedures	The West Coast District Health Board remains committed to working closely with other South Island District Health Boards to meet our proportional share of delivering the Minister's expectations of an overall aggregate increase in elective discharges across the country, and in keeping with our longer-term goal of moving toward greater national equity of access.
	The priorities for Secondary Health Services elective services in the 2010/2011 year and out years are to: ▪ Continue to maintain compliance with Elective Service Patient Flow Indicators. ▪ To ensure that the overall volume of elective services to the West Coast population is delivered as agreed in the Collective South Island Elective Services Plan. ▪ To deliver key elective procedures at a nationally appropriate Standardised Intervention Rates. ▪ To identify ways of improving the patient flow for those accessing those services through continuous quality improvement and ongoing patient pathway mapping. Having a restricted capacity at times to undertake surgical procedures at Grey Base Hospital due to limited numbers of key specialist and theatre staff; acute surgery will always take precedence and may impact on the flow of elective work that can be undertaken.

Health Target 2: Improved Access to Elective Services

Impact	National Target	Target 2010/2011	Target 2011/2012	Target 2012/2013
Compliance with all Elective Services Patient Flow Indicators (ESPI) for Indicators 1-8 (see below for definitions for Elective Services Patient Flow Indicators)	ESPI 1: >90% ESPI 2: <2% ESPI 3: <5% ESPI 4: <5% ESPI 5: <5% ESPI 6: <15% ESPI 7: <5% ESPI 8: >90%	92.0% 1.6% 4.0% 0.0% 4.0% 12.0% 4.0% 92%	92.0% 1.6% 4.0% 0.0% 4.0% 12.0% 4.0% 92%	92.0% 1.6% 4.0% 0.0% 4.0% 12.0% 4.0% 92%

Health Target 2: Improved Access to Elective Services				
Impact	**National Target**	**Target 2010/2011**	**Target 2011/2012**	**Target 2012/2013**
	Elective Surgical Discharges (per 10,000 population)	292	292	292
Appropriate standardised intervention rates in the key procedures	Major Joint Replacement – including Hip and Knee replacement (per 10,000 population)	21.0	21.0	21.0
	Cataracts (per 10,000 population)	27.0	27.0	27.0
	Cardiac Procedures – including coronary artery bypass graft , valve replacement and repair for people aged 15+ (per 10,000 population)	6.23	6.23	6.23

Health Target 2: Improved Access to Elective Services		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Maintain compliance with Elective Service Patient Flow Indicators 1-8	Provider	West Coast District Health Board Secondary Care Plan
Ensure that the West Coast District Health Board delivers 1592 elective discharges per year as required by the Ministry of Health as our proportional share of delivering the Minister's expectations of an overall aggregate increase in elective discharges across the country, and in keeping with our longer-term goal of moving toward greater national equity of access.	Provider Funder	West Coast District Health Board Secondary Care Plan
Use the Continuous Quality Improvement process to identify productivity and efficiency improvements in patient flow processes.	Provider	West Coast District Health Board Secondary Care Plan
Monitor Standardised Intervention Rates (SIRs) of the target elective procedures to ensure that these are being delivered at national appropriate levels.	Provider Funder	West Coast District Health Board Secondary Care Plan

Health Target 2: Improved Access to Elective Services		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Maintain compliance with Elective Service Patient Flow Indicators 1-8	Provider	West Coast District Health Board Secondary Care Plan
Ensure that the West Coast District Health Board delivers 1592 elective discharges per year as required by the Ministry of Health as our proportional share of delivering the Minister's expectations of an overall aggregate increase in elective discharges across the country, and in keeping with our longer-term goal of moving toward greater national equity of access.	Provider Funder	West Coast District Health Board Secondary Care Plan
Use the Continuous Quality Improvement process to identify productivity and efficiency improvements in patient flow processes.	Provider	West Coast District Health Board Secondary Care Plan
Monitor Standardised Intervention Rates (SIRs) of the target elective procedures to ensure that these are being delivered at national appropriate levels.	Provider Funder	West Coast District Health Board Secondary Care Plan

ESPI (Elective Services Patient Flow Indicator) Definitions:

ESPI 1 – District Health Board services appropriately acknowledge and process referrals within ten working days.

ESPI 2 – Patients waiting longer than six months for their first specialist assessment (FSA).

EPSI 3 – Patients without a commitment to treatment whose priorities are higher than the actual treatment threshold.

ESPI 4 – Clarity of treatment status.

EPSI 5 – Patients given a commitment to treatment but not treated within six months.

ESPI 6 – Patients in active review who have not received a clinical assessment within the last six months.

EPSI 7 – Patients who have not been managed according to their assigned status and who should have received treatment.

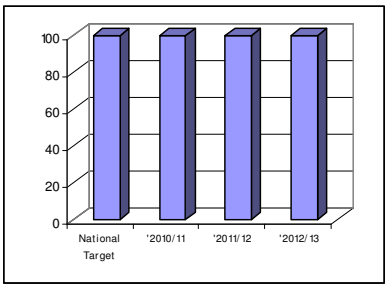
ESPI 8 – Proportion of patients treated who were prioritized using nationally recognized processes or tools.

Health Target 3: Shorter Waits for Cancer Treatment

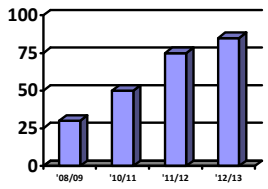
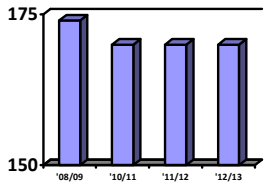
Long Term Objective: Shorter waits for cancer treatment.

Ensure effective diagnosis and treatment of cancer to reduce morbidity and mortality	As part of its cancer control strategy, the West Coast District Health Board funds radiotherapy oncology treatment services for its resident population through services provided by Canterbury District Health Board. Extended waiting times and long-term access to receive radiation oncology treatment have been an issue for patients in recent years. To this end, the West Coast District Health Board has an active interest in and monitors waiting times for radiation oncology treatment in the Christchurch radiation laboratory to ensure that appropriate access is delivered for the West Coast population. Furthermore, waiting times for the population are being appropriately managed and that these services are delivered according to nationally agreed standards.

The West Coast District Health Board acknowledges the Health Target that 100% of patients in Radiation Treatment categories A, B, and C are to wait less than six weeks by 31 July 2010, and four weeks by December 2010 between first specialist assessment and the start of radiation oncology treatment (excluding category D patients), and will work with the provider District Health Board to ensure this target is met. Where the target is in danger of not being met, the West Coast District Health Board will continue to raise the issue with the provider District Health Board as early as possible in order to work with them to address the issue.

Impact	National Target	Target 2010/2011	Target 2011/2012	Target 2012/2013	
All patients receive radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D) by July 2010 and within four weeks by December 2010	100%	100%	100%	100%	

Key Outputs for 2010/2011 (from the District Annual Plan)	Responsibility	Strategic Links
Close monitoring of radiotherapy service provision to ensure people are treated according to their need within the national waiting times guidelines.	Funder	West Coast District Health Board Secondary Care Plan Southern Cancer Network

Improve Hospital Responsiveness to Family Violence, Child Abuse and Neglect					
Long Term Objective: Routine family violence screening is implemented across West Coast District Health Board hospital services.					
All women aged 15 years and over are screened for family violence	The West Coast District Health Board recognises family violence, child abuse and neglect as important personal and public health issues. Improving responsiveness to Family Violence, Child Abuse and Neglect is recognised as one of six priority areas for West Coast children. The District Health Board continues to prioritise collaborating across agencies and improving hospital responsiveness to family violence, child abuse and neglect. In August 2007 the District Health Board began screening in the Emergency Department with a 35.6% screening rate over the year, 4.6% of women screened positive for family violence. During 2008/09 the District Health Board extended screening into the Mental Health and Public Health Nursing Service.				
Impact	**Actual 2008/2009**	**Target 2010/2011**	**Target 2011/2012**	**Target 2012/2013**	
Women aged 15 years and over are routinely screened for family violence	30%	50%	75%	85%	
Child abuse and partner abuse combined external audit score for hospital responsiveness.	174	170 or above	170 or above	170 or above	

Improve Hospital Responsiveness to Family Violence, Child Abuse and Neglect		
The West Coast District Health Board is working collaboratively with community organisations, New Zealand Police, Child Youth and Family and Work and Income to improve responsiveness Family Violence. Hospital responsiveness to family violence is a component of a wider goal to improve community awareness and response to Family Violence on the West Coast.		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Continue to employ a family violence response co-ordinator and a Child Protection co-ordinator	Provider	West Coast District Health Board Child Health Plan
Co-ordinate an intersectoral steering group to plan, assist in implementation and monitor the development of the hospital response to family violence	Planner Provider	West Coast District Health Board Child Health Plan
Continue to provide mandatory training on family violence, child abuse and neglect to all District Health Board staff	Provider	West Coast District Health Board Child Health Plan
Continue to implement routine family violence screening in child health and community nursing services.	Provider	West Coast District Health Board Child Health Plan
Continue to support District Health Board employees by promoting the Employee Assistance Programme as a means for offering support for victims of violence and abuse and work towards implementing further support for staff.	Provider	West Coast District Health Board Child Health Plan

3.4 OUTPUT CLASS FOUR – SUPPORT SERVICES

Health of Older Persons

The West Coast District Health Board is progressively implementing its Health of Older People Strategy 2006-2016 , the 'West Coast Improving Services to the Elderly' (WISE) plan, to develop more integrated health and disability services that are responsive to older people's varied and changing needs.

The WISE plan outlines a comprehensive and innovative change in focus in older people's services, towards a new model of care that is health-focused and preventive, restorative, flexible, collaborative and centred around the older person.

The goals of the WISE plan are to protect older people's health, independence and interdependence, deal with illnesses and disability before they worsen, ensure a smooth path into and out of specialist services and put in place a strong organisational infrastructure for older people's services.

The West Coast District Health Board is moving from a traditional dependency model of aged care, with high volumes of simple home help and rest home entry, to the restorative and proactive model of aged care required by the national Ageing in Place Strategy. This includes more complex and flexible packages of home care, a wider range of services to support people living at home and their carers, and the availability of alternatives to rest home entry. The West Coast District Health Board is implementing this model of care through redeveloping the Needs Assessment and Coordination Service (Carelink) for older people and others with chronic and disabling conditions, introducing the InterRAI assessment tool and investing in the up- skilling of homecare workers.

Support Services Output Class

This section outlines the support services we intend to deliver to our population. Each aggregate includes people with long-term disabilities, people with mental health problems and people who have age-related disabilities.

These outputs are aggregated into: Home-based support services, Residential Care support services, Day Services, and Palliative Care services.

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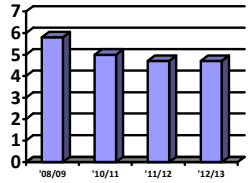
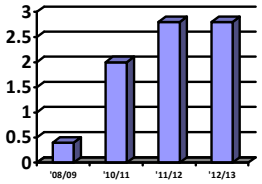
Improving the Health of Older People	
Long Term Objective: The West Coast District Health Board will progressively implement the Health of Older People Strategy to develop more integrated health and disability services that are responsive to older peoples' varied and changing needs	
Protect older peoples' health, independence and interdependence, deal with illness and disability before they worsen, ensure a smooth path into and out of specialist services and put in place a strong organisational infrastructure for older people's services.	The West Coast District Health Board is moving from a traditional dependency model of aged care, with high volumes of simple home help and rest home entry, to the restorative and proactive model of aged care as required by the national Ageing in Place Strategy. This includes more complex and flexible packages of home care, a wider range of services to support people living at home and their carers, and the availability of alternatives to rest home entry. The West Coast District Health Board is implementing this model of care through redeveloping the Needs Assessment and Coordination Service (Carelink) for older people and others with chronic and disabling conditions, introducing the InterRAI assessment tool and investing in the up-skilling of homecare workers.

Improving the Health of Older People					
Impact	**Actual 2008/ 2009**	**Target 2010/ 2011**	**Target 2011/ 2012**	**Target 2012/ 2013**	
Proportion of 75+ population in rest home level care	5.8%	5.0.%	4.7%	4.7%	
Proportion of 75+ population in specialist dementia care	0.4.%	2%	2.8%	2.8%	

Improving the Health of Older People		
Key Outputs for 2010/2011 (from the District Annual Plan)	**Responsibility**	**Strategic Links**
Extending the use of InteRAI assessment tool for older people and others with chronic and disabling conditions.	Planner Provider	West Coast District Health Older Persons Health Plan
Complete the reconfiguration and up-skilling of home-based support service staff.	Planner Providers	West Coast District Health Older Persons Health Plan
Continue to increase the availability of community-based support services, including day care, planned respite, falls prevention and support for carers.	Planner Funder Provider	West Coast District Health Older Persons Health Plan
Improve quality of aged residential care through collaboration on staffing, training and quality issues, and the establishment of dementia rest home level beds.	Planner Funder Provider	West Coast District Health Older Persons Health Plan
Integrate primary, secondary, community and residential services through the Integrated Family Health Centres project, with a focus on the pathway for frail older people.	Planner Provider	Integrated Family Health Centre Business Case

3.5 STATEMENT OF FORECAST PERFORMANCE BASED BY OUTPUT CLASSES

The Statement of Forecast Performance based on Output classes has been prepared using the following four output classes:

- Public Health services
- Primary and community healthcare services
- Hospital services
- Support services.

Cost Allocation

The West Coast District Health Board has arrived at the net result for each output class using a fully absorbed costing model outlined below.

Revenue

Revenue have been directly allocated to output classes where the contract or service level agreement between the provider arm and funder arm can be clearly mapped to an output class based on the service be delivered.

Revenue received that makes a contribution towards the overhead costs have been allocated across the four output classes on an appropriate basis.

Expenditure

Direct costs have been directly allocated to the output class where the input can be clearly mapped to the output class. These costs include direct personnel costs, outsourced services costs, clinical supply costs and other costs of delivering the service.

Shared clinical services costs are those costs that are shared across different output classes and include such costs as the laboratory services or physiotherapy services. There are a number of shared services within the West Coast

District Health Board. These costs have been allocated to the different output classes on an activity measure best suited for the nature of service being delivered. If there is no clearly defined activity measure for allocating the costs an acceptable proxy has been used. Examples of this may be the apportionment of staff time (full time equivalent) or revenue.

Indirect costs are those costs that are not directly attributable to a clinical area or service and include such costs as corporate services, infrastructure costs and governance costs. These costs have been charged to the output classes on a fully absorbed costing basis and different types of expenditure allocated on an appropriate basis. An example of this would be that the cost of payroll would be allocated on number of employees across the output classes.

Eliminations of revenue and expenditure within the West Coast District Health Board

Both revenue and expenditure transactions between the different arms of the West Coast District Health Board have been eliminated on consolidation.

Allocation of funder arm surplus

A surplus is planned for the funder arm. It has been assumed that the funder arm will be able to contribute its surplus as deficit funding to the West Coast District Health Board provider arm. The surplus has been allocated to the different output classes based on the fully absorbed cost of each output class.

Statement of forecasted financial performance by output class

in thousands of New Zealand dollars

For the period 01 July 2010 to 30 June 2011

	Hospital services	Primary & community healthcare services	Public health services	Support services	Total
Revenue					
Crown sourced funding - devolved	57,568	34,564	2,450	20,059	114,642
Crown sourced funding - non devolved contracts	1,289	578	317	307	2,490
Other revenue	545	7,998	467	561	9,571
IDF Inflow	1,562	20	-	36	1,618
Interest	39	24	2	14	78
Total Revenue	**61,004**	**43,183**	**3,235**	**20,977**	**128,399**
Expenditure					
Payments to external providers	2,039	19,575	986	8,095	30,695
IDF Outflows	14,305	1,667	-	999	16,971
Direct cost of clinical services	30,168	14,998	892	7,026	53,083
Cost of shared clinical services	11,911	7,073	800	2,432	22,214
Indirect costs	7,633	2,615	178	2,210	12,635
Total Expenditure	**66,055**	**45,927**	**2,855**	**20,761**	**135,599**
Surplus / (deficit) FY 2010/11 by output class	**(5,052)**	**(2,744)**	**380**	**216**	**(7,200)**

3.6 WEST COAST DISTRICT HEALTH BOARD PERFORMANCE IMPROVEMENT ACTIONS

Benefits from Performance Improvement Actions are potentially realised in three ways: as direct financial benefits to the patients or health service agencies involved; as indirect financial benefits, in terms of avoided costs; and as health improvements for patients and populations. The ability to improve performance is reliant on sector-wide strategies that aim to provide services in a timely manner in the most appropriate location. The net costs avoided within the West Coast District Health Board are projected to be $2.3m in the financial year 2010/2011.

The Performance Improvement Actions are to be reported under the following three categories:

1) Achieve Financial Stability

The Performance Improvement Actions under this category include active revenue optimisation and cost management that will result in delivering health services within budget. The financial benefits falling under this category are projected to be $ 1.8m in the 2010/2011 year.

2) Improve productivity and quality

The Performance Improvement Actions under this category include the improvement of productivity and quality within the District Health Board. Examples include improving theatre and ward utilisation, improved waiting times in primary care and increasing day surgery. The financial benefits falling under this category are projected to be $0.5m in the 2010/2011 year.

3) Enhanced regional cooperation

The Performance Improvement Actions under this category include clinical regional plans and greater regionalisation of shared services and back–office functions. No direct financial benefit has been placed against this category for the 2010/2011 year. The main benefit for the West Coast District Health Board will be enhanced clinical sustainability and potentially financial viability in the provision of health services for the population.

The magnitude of benefits is a combination of estimated direct financial benefits and from a counterfactual perspective representing avoided cost growth rather than savings realised.

The Business Case for Better Sooner More Convenient primary care will result in benefits which will largely be realised as a number of direct financial benefits, in terms of reduced costs through improved productivity and effectiveness. Estimates of the magnitude of this benefit must consider the existing state of forecasts for increased activity, and looking at existing cost data for activities (i.e. counterfactual arguments). The financial benefits have only partly been included above.

4 ORGANISATIONAL CAPABILITY

LEGISLATIVE FRAMEWORK AND GOVERNANCE

Each District Health Board is categorised as a Crown Entity under section (s) 7 of the Crown Entities Act 2004 and, as such, is required by legislation to produce an Statement of Intent to meet the requirements of s 42 and s 39(8) of the New Zealand Public Health and Disability Act 2000 as well as s 139 (1) of the Crown Entities Act 2004. The Statement of Intent, as a public accountability document, is used at the end of the year by auditors working on behalf of the Office of the Auditor-General to compare our planned performance with the actual performance described in our District Health Board's Annual Report.

The West Coast District Health Board will provide the regular reporting outlined below to the Minister and the Ministry of Health. In accordance with s 141 (1) (g) Crown Entities Act 2004 we will consult with the Minister via the Ministry of Health on any significant developments that are not covered in our District Health Board's District Annual Plan, and any changes that deviate from the content of the District Annual Plan will be taken out for public consultation. Regular reporting includes:

- Annually - annual reports and audited statements;
- Quarterly - risk reporting, Crown Funding Agreement non-financial reporting;
- Indicators of District Health Board performance, and Hospital Benchmark Information7;
- Monthly - national data collections, financials;
- Ad hoc - information requests.

The West Coast District Health Board has an established governance and organisational structure that enables us to carry out our responsibilities effectively. Our governance structure is based on the requirements of the New Zealand Public Health and Disability Act 2000. The Board consists of eleven members and has overall responsibility

[7] The Indicators of District Health Board performance are reported quarterly through the Quarterly Reporting process and published by the Ministry of Health, http://www.moh.govt.nz/moh.nsf/indexmh/dhb-nonfinancialreports. The Hospital benchmark Information is also collected quarterly and published by the Ministry of Health, http://www.moh.govt.nz/moh.nsf/indexmh/dhb-hospital-benchmark.

for the operation of The West Coast District Health Board. Seven of the members are elected as part of the three-yearly local body election process (last held in October 2007) and up to four are appointed by the Minister of Health. The Board can delegate matters to the Chief Executive Officer of our District Health Board if this is appropriate. There are also three sub committees to the Board and these are made up of Board members, District Health Board staff, and community representatives. These committees are requirements of the New Zealand Public Health and Disability Act 2000 and are statutory committees:

Hospital Advisory Committee - The Hospital Advisory Committee monitors the financial and operational performance of the hospital/s and assesses strategic issues relating to the provision of hospital services.

Community and Public Health Advisory Committee - The Community Public Health Advisory Committee provides the Board with advice on the health and disability needs of our region's population. The Community Public Health Advisory Committee reports on issues considered as having a significant affect our population's health and it advises the board on those issues of highest importance. The Community Public Health Advisory Committee advises the Board on District Health Board funded or provided services and District Health Board's policies, and how they will impact on our population. The Community Public Health Advisory Committee also analyses relevant reports and makes recommendations to the Board ensuring that any advice it provides is consistent with national strategies and government policy.

Disability Support Advisory Committee – Disability Support Advisory Committee informs the Board about the needs of people with disabilities in our region and prioritise the use of the funds provided for those with a disability. The committee makes sure that the services provided or funded, and the policies adopted, promote the inclusion and participation of people with disabilities in our society, to maximise their independence.

During 2010/2011, Community and Public health and Disability Advisory Committees will be working as a combined entity in order to improve the cohesion and effectiveness of the needs analysis and consequent recommendations for service provision across the entre range of health needs of the West Coast population.

Audit, Risk and Finance Committee - This committee is established pursuant to Clause 38 of Schedule 3 of the New Zealand Public Health and Disability Act (2000).

The functions of the Audit, Risk and Finance Committee are:

- To receive the reports of the internal and external auditors and monitor the progress made by management in implementing recommendations arising from these reports
- To provide a reporting line for the internal auditor independent of the Chief Executive
- To review and advise the Board on its approval of:
  - the District Health Board's financial statements and disclosures; and;
  - the draft District Annual Plan; and;
  - those financial policies and procedures which require Board approval, including delegation policies.
- To assist the Board in the discharge of its responsibilities relative to legal, statutory and regulatory performance to monitor other responsibilities that may be delegated to the committee by the full Board.

The public are welcome to observe the meetings of the board and statutory committees. The meetings are usually held every six weeks and details of the meetings (such as agendas, minutes, membership of the committee, people who attended a meeting) are publicly available on our website www.westcoastdhb.health.nz. at the public library. Occasionally these groups have discussions where it is best if the public does not attend, and this is allowed for in the New Zealand Public Health and Disability Act 2000

Tatau Pounamu Advisory Committee - Tatau Pounamu is the Māori Health Advisory Committee, which is working with the West Coast District Health Board over District Health Board Treaty-based relationships. The West Coast District Health Board expects that Tatau Pounamu will continue to maintain effective iwi involvement (both Mana Whenua and Mata Waka) in service monitoring and evaluation generally. It will also be an appropriate forum for monitoring progress towards the implementation of He Korowai Oranga.

4.1 WORKFORCE DEVELOPMENT PLAN

This is an opportunity to raise the profile of the work that is coordinated nationally, regionally and locally around the development of the workforce. District Health Boards are highly committed to the plans, which are extensive and cover the complete health sector workforce.

The vision of the national workforce group is "To progress development of a health and disability workforce across District Health Boards and involving other stakeholders, so that current and future workforce needs are more likely to be met."

The West Coast vision of rural excellence is directly aligned to this vision as the District Health Board strives to increase the capacity and capability of its own workforce. It also aims to be an Employer of Choice, and meet the elements of a "good employer".

There are three main strands of work to the Future Development Plan. The Models of Care module aims to ensure that workforce development is aligned to service priorities, existing models of care and able to meet the needs of new models of care. The ongoing work associated with sustainability on the West Coast requires re-evaluation of workforce needs into the future. Workforce Environment is the provision of systems that enable workforce development, such as ensuring the education sector is responsive to the workforce needs, and that the organisation develops leaders not only now but in the future. The final aspect, key workforces, relates to the work that is being progressed by six workforce strategy groups that are aligned to District Health Board service direction and inclusive of the employment relations strategy.

Future Workforce Strategy Groups

These are groups that devise the strategy for the various aspects of the workforce, example Nursing, Medical, Technical, Allied Health, Non-Regulated Workforce and Management / Corporate. These strategies and the resultant work plans inform various other aspects of the Future Workforce plan, for example what models of care need to be developed, what training may be required in the future, and how a collective agreement needs to be structured so that the workforce is best able to meet the health needs of the communities.

The West Coast will support the work of these groups and in collaboration with the Canterbury District Health Board attend national meetings, teleconference calls, and by responding to District Health Board New Zealand requests and meeting any set deadlines. The intention of the collaborative Human Resource service is to reduce duplication of resources where possible.

Workforce Activity

There are various projects and programmes focused on different aspects of workforce activity. Much of this work is collaborative and seeks to gain the best information from a wide variety of people both in the health sector and in other sectors, example education.

Specific areas that deserve mention are the Health Workforce Information Programme and Employment Relations. The Health Workforce Information Programme is a central source of quality workforce information for the purpose of analysing the workforce and for planning and developing both now and in the future. The data that is fed into the system needs to be of high quality to ensure that the analysis output is informative. The first baseline report was delivered in December 2006. It noted that the West Coast District Health Board has the oldest average workforce age of all District Health Boards at 47.9 years, well above the 43.6 years average District Health Board age. Allied Health employees are the youngest workforce, and midwives are the oldest.

This data will enable District Health Boards to forecast for the future workforce. The highly specialised nature of the workforce means that it is particularly inflexible in that it takes so long to train and develop the skills required to provide high quality health care. In addition District Health Boards will be better able to understand the changing dynamics of the labour market and plan the supply of skilled health professionals once those factors that alter the various workforce groups' composition are understood – that is, the "who is being recruited and who is leaving the workforce", whether internally (in New Zealand and within the District Health Boards) or externally (emigration or to the private sector within New Zealand).

The West Coast District Health Board is committed to supporting the improvement of this data and ensuring that timeframes are met. Various activities will be undertaken to achieve this, including the provision of resources to carry out the data requests on a quarterly basis, the collection of base data as required by District Health Board New

Zealand in a timely manner and the validation of data as requested by District Health Board New Zealand. Furthermore, the District Health Board will ensure that data quality improvement standards are adhered to, engage with Health Workforce Information Programme before embarking on developing local workforce information analysis and provide Health Workforce Information Programme with access to West Coast District Health Board data on contracted Non Government Organisations. The move towards a Shared Payroll service with the Canterbury District Health Board is supporting this process

Develop the Māori Health and Disability Workforce on the West Coast

Māori development and action on reducing health inequalities requires the West Coast District Health Board to develop the Māori workforce according to the recommendations of the long-term development plan. This will be achieved in close conjunction with the South Island initiatives discussed within the Te Waipounamu (South Island) Māori Workforce Plan and Raranga Tupuake (National) Māori Workforce Plan.

In 2010/11 it is envisaged that there will be an increase in the Māori workforce, particularly in priority health areas, driven partly by local initiatives to attract Māori to opportunities in the health sector. Increased support will be offered for Māori to access networking opportunities.

Employment Relations

The sector has a high level of collaboration at regional and national level for bargaining activity to ensure that agreed objectives are met. The Future Workforce plan is quite explicit in that workforce development informs the Employment Relations policy and strategy. This needs to be appropriately resourced at all levels to ensure a measured and structured approach to each set of negotiations for gaining the best outcomes for all parties. This is the benchmark for ongoing development and the ultimate success of the collaborative bargaining strategy.

The West Coast is committed to supporting the District Health Board New Zealand Employment Relations strategic plan and will demonstrate this by ensuring a consistent approach to bargaining processes and adhering to a consistent position when managing employment relations. Industrial Relations support is now provided through the Canterbury District Health Board Human Resource team. There will be a commitment to improving the performance of the sector on employment and industrial relations, and training will be made available for those involved in the negotiation process to increase capacity and capability. The District Health Board will respond to requests by the regional Employment Relations specialists around Employment Relations strategy and costing claims, and support the centralised model to ensure that the West Coast plays its part in co-ordinating its activity consistently with other District Health Boards.

The wider employment relations arena does not only encompass the industrial relations aspects of bargaining; it is far wider reaching than just negotiating employment agreements. The Employment Relations spectrum also covers the benefits and rewards of working in the health sector, such as the non-cash benefits, developing a career, in-service training, flexible work conditions, “Good Employer” aspects and the health work environment

The West Coast District Health Board will continue to support all the national initiatives and develop a West Coast District Health Board-wide workforce strategy in 2010/2011 that supports the Government direction and shift towards regionalisation.

Recruitment, Organisational Development, Learning and Development and Retention Strategies

Today’s staffing challenges faced by the health sector have been well documented. Labour shortages, competition for talent and ever-increasing budget pressures currently plague today’s health sector. As previously stated, labour market predictions and health sector demographic analysis suggest that the real staffing challenge is yet to come.

It can be argued that one of the greatest challenges the health sector faces is improving processes and systems that will enable it to strategically and proactively implement key workforce management initiatives.

Over the coming year the District Health Board plans to recruit sufficient qualified staff, with a particular aim of the recruitment of permanent staff, thereby reducing the use of and reliance on expensive external agencies and / or temporary labour. Consideration of joint appointments and other flexible resourcing options will remain high on the agenda. A Human Resource Information System will also be implemented as part of a collaborative project with Canterbury District Health Board to facilitate effective workforce management.

Health, Safety and Wellbeing

Senior management is committed to the health and safety policy and procedures in place. The executive management team is regularly updated on the progress of the health and safety business plan.

Union representatives are involved in the regular occupational health and safety committees that occur at four sites across the District Health Board. The meetings are attended by the Health and Safety Advisor and run by a manager from the relevant site; each meeting includes a training component.

The District Health Board will continue to work towards best practice and the Health and Safety Service as a whole for the West Coast District Health Board will be managed from the Canterbury District Health Board thereby reducing the risk of sole practitioners in the Health and Safety roles.

4.2 BUILDING CAPABILITY

Governance Capability

Newly appointed members of the Board are orientated through a planned induction programme in governance to ensure they understand their responsibilities and duties and the West Coast District Health Board's services, including the requirement to keep information about clients confidential.

The Board operates according to a deed, constitution, bylaws, legislation or articles of association, and the corporate policies that it sets, this includes:

- The Board regularly reviews its governance documents and corporate policies to make sure they are current and appropriate
- The Board makes sure the West Coast District Health Board complies with relevant legal requirements
- The West Coast District Health Board receives, reviews and acts on reports on compliance with legislation and legislative updates

The need for the Board to keep up to date is seen as essential and regular training for all Board members will continue. The Board regularly reviews its governance documents and corporate policies to make sure they are current and appropriate

Planning and Funding Capability

The planning and funding arm of the West Coast District Health Board is responsible for meeting the objectives of the New Zealand Public Health and Disability Act 2000 by developing and implementing plans for the procurement of health and disability services for the people of the West Coast. Its functions include the monitoring of performance of providers against funding agreements and managing external relationships, consultation and communication processes, undertaking health needs analyses and applying prioritisation principles to new funding decisions.

Planning and Funding capability will be enhanced through convergence of the West Coast and Canterbury District Health Boards planning and funding decisions during 2010/2011.

Provider Arm Capability

Clinical Viability

The maintenance of clinical viability continues to be a key issue for the West Coast District Health Board. In particular, senior medical specialist numbers are low and at a minimum required to deliver the service. As a consequence on - call rosters and cover are often demanding. The West Coast District Health Board also has significant recruitment problems with allied health staff and other clinical and non-clinical trained staff, which all contributes towards significant locums costs and costs in recruitment and retaining skilled staff.

Large distances and obstructive geographical features (as was identified by the Rural Expert Advisory Group) experienced on the West Coast affect the ease of access to health services. This is exacerbated by the lack of public transport, lack of telephones, geographical isolation, poverty and low numbers of General Practitioners. The small isolated populations of the West Coast suffer diseconomies of scale where health services are concerned. The significant transient and seasonal population and high tourist numbers (more than 6,500 per day on average) compounds access difficulties.

Māori Health

The District Health Board is continuing to invest in improved Māori health, particularly in preventing avoidable illness, which will reduce demand for some hospital and disability services in the longer term, as well as reducing the overall cost to whānau and the wider society.

In the short-term however, this is a challenge for the West Coast District Health Board, which is experiencing continued financial difficulties and scarce resources. The District Health Board will continue to actively seek any additional funding to improve Māori health and reduce Māori health and disability inequalities as it becomes available and will work collaboratively with its iwi partners and other government agencies to achieve this.

Wider Health Sector Capability

As previously reference in the Statement Of Intent the South Island Health Service Planning framework is providing an opportunity for all South Island District Health Boards to work together to develop a model to support the health needs of the South Island into the future.

The South Island Health Service Plan aims to reduce inequalities in access to services, engage key stakeholders to ensure understanding and acceptance and enhance the quality and sustainability of clinical services. To achieve this, the Plan encompasses a range of activities that will help to build the capability of the South Island District Health Boards to meet the needs of their populations into the future. The activities include enabler projects that consider options to support the delivery of services within and across District Health Board boundaries. These include transport and accommodation, technology, human resources and capacity modelling for facilities. In addition there are service-based projects that focus on safe, quality services that are financially and clinically sustainable.

The project teams for the South Island Health Services Plan are drawn from key stakeholders predominantly from within the District Health Boards. All service-based and many of the enabler projects have clinicians appointed to chair the working parties; this supports the South Island Health Service Plan principle of clinical engagement, which states that clinician input, through active clinical leadership into the planning and decision making process, is recognised as a critical component of the success of the South Island Healthy Service Plan.

In addition to this South Island wide initiative, the engagement with the West Coast Primary Health Organisation an the Canterbury District Health Board in the implementation of the primary health business case and recommendations of the Law and Economic Consulting Group models of care review includes both intra-district and inter-district capability building components.

4.3 INFORMATION SERVICES

The West Coast District Health Board's information infrastructure is centered on two core health information systems, iSOFT (for secondary care) and Medtech (for primary care). Both of these systems are relatively modern and able to integrate with other health systems through standard messaging formats . West Coast District Health Board also has a number of other more specialised systems that sit along side these two including the Intelerad PACS (Picture Archiving and Communication System) for digital radiology, the Comrad radiology reporting system, the Détente laboratory system, the Windose pharmacy system and so on. Each of these serves a specific function relating to a specialist area within the hospital.

Current Strategies

One of the District Health Board's key strategies has been to continue the integration of data from various health systems (our own systems, systems run by other District Health Boards and systems run by other providers) into Health Views and Medtech so as to eventually create a completely integrated electronic health record.

Two of the key integration points between primary health and secondary care are the referral and discharge processes. Firstly, in order to support common clinical information systems, West Coast District Health Board will investigate whether to continue investing in the current CIS and develop an improved integration solution, or invest in replacing the existing CIS with a Concerto based solution

The second key of objective is to enable a single source of patient information regionally for improved information sharing. This is aimed to ensure that all relevant information is made available to the receiving provider when there is a transfer of a patient's care (either a referral to a provider or a discharge back to the original referrer).

West Coast District Health Board plans to make its systems available to other providers, so that all relevant health information can be available when and where it is required for a patients care. With the distances, small population and relative isolation, West Coast District Health Board is well placed to benefit from new telecommunications technologies.

The following areas will progressed during 2010/2011:

- An integrated electronic health record (available to other health providers)
- Patient access to the integrated electronic health record
- Continuing to improve data quality to ensure the risk of error is minimised
- Replacement of the West Coast District Health Board financial system to support improved administration processes and shared procurement between the West Coast and Canterbury District Health Boards
- Upgrading office systems
- Upgrading to High Definition and expanding the use of Telemedicine
- Trialling Health Presence

4.4 QUALITY AND SAFETY

The West Coast District Health Board is committed to ensuring that all the health services that it provides funds are of the highest quality. To achieve this, the West Coast District Health Board operates a quality audit and monitoring function, and actively encourages an organisational culture that is supportive of continuous quality improvement and quality initiatives through a systems approach. This focus on continuous improvement is leading to the formation of a culture that fosters learning and change within the organisation, and also places emphasis on developing the capacity to measure performance. It will also ensure that deficiencies are identified, performance measured and processes improved. This is supported through its contracting process, by the inclusion of commitments for all providers to deliver services against national standards and service frameworks, and the maintenance of certification of services where required by the Health and Disability Services (Safety) Act 2001.

Through regular audit and monitoring, the West Coast District Health Board aims to continue to build a culture of quality assurance and quality improvement. The longer term goal of this is to support improved performance via the shared information between providers about new initiatives and their impact on the quality of services provided and the care received by consumers.

The West Coast District Health Board will continue to refine its Emergency Management Plan, including the Influenza Pandemic Management Plan, in conjunction with other healthcare providers, Local Authorities and non-healthcare providers. This will use a collaborative and inter-sectoral approach, using Ministry of Health planning guidelines and recommendations.

4.5 SUBSIDIARIES

The West Coast District Health Board has a joint controlling interest in the South Island Shared Services Agency Limited which is a multi-parent subsidiary of the South Island District Health Boards. The agency provides a planning and funding advisory role to the District Health Board.

5 FINANCIAL PERFORMANCE

The small population and relative isolation of the West Coast make the delivery of health services in the region more expensive to deliver per capita of population than in other areas of New Zealand. This impacts particularly on workforce stability and staffing costs - clinical staff working on the West Coast can feel professionally isolated and the call requirements to maintain 24 hour hospital services can be onerous. The cost of engaging locums to provide cover for vacancies or call relief has led to the West Coast District Health Boards financial performance worsening since the 2005/06 breakeven situation. The move to population-based funding has also contributed to this situation, as has the revaluation of the Property and Plant, which has increased the District Health Boards cost of capital expense.

The West Coast District Health Board believes that the move to population-based funding without addressing the West Coast's unique situation has been one of the most significant issues that it has faced. The continued commitment and support of the Ministry of Health is critical to resolving the funding issues created by factors outlined above and by the unique demographic situation faced by the District Health Board.

Failure to Achieve Breakeven

There are a number of other key challenges that have affected the West Coast District Health Board's ability to achieve breakeven, most of which have been highlighted as risks in past District Annual Plans.

West Coast District Health Board effectively achieved a breakeven year in 2005/2006 financial year (deficit of just $157K) and would still be able to achieve breakeven if it were not for the following factors.

- Initial negotiations around the introduction of the "West Coast Adjuster" led the West Coast District Health Board to understand that its adjusted level of funding (its previous total funding, plus the West Coast Adjuster) would be treated as its new Population Base Funding equity level and that it would therefore receive Future Funding Track on its funding as though it was at Population Base Funding equity. However, this has proved not to be the case, and the District Health Board funding has again been eroded by the fact that it is not funded for Future Funding Track on its $18 million transition Pool and because its funding is systematically reduced by the Population Base Funding transition process, except in those years where changes to its demographic funding are insufficient to allow this transition process to occur. The West Coast District Health Board is often in a situation where its demographic funding is insufficient to allow the Population Base Funding transition process to occur; however, either way, it receives a smaller percentage funding increase than most other District Health Boards and so can't afford the same level wage and salary growth or the same level of investment in new initiatives as is can be afforded (on average) by other District Health Board.
- Over the past four years, the New Zealand health sector has agreed to a number of unaffordable changes for the West Coast District Health in employment conditions during sector wide Multi-Employer Collective Agreement negotiations. West Coast District Health Board is often one of the District Health Boards that is least able to afford these agreements and so is often one of the last District Health Boards to agree to sign them, sometimes under considerable duress from other District Health Boards or from other levels of Government.
- The West Coast District Health Board provides a 24/7 service (cover) in a number of medical and surgical specialties in order to be able to meet unpredictable demand for acute health services. This requires at least a 1:3 roster. Loosely translated this means that a full complement of senior medical officers for each speciality requires approximately 3.5 full time equivalents. Staffing for this requirement has proved difficult, resulting in employing locums services at a premium.
- The West Coast District Health Board owns four of the seven primary practices on the West Coast. These practices are currently not covering their costs. The main reason is the cost of recruiting and retaining general practitioners, who fall under the Association of Salaried Medical Specialist settlement.
- Due to this the West Coast District Health Board has had to rely heavily on locum services.
- Senior medical officers and general practitioners fall under the Association of Salaried Medical Specialist settlement. The conditions such as six weeks annual leave, two weeks per annum accumulated for up to three years continuing medical education and 30% of their time spent on non-clinical activities results in employing of locums to cover these periods of absence as the small staff compliment by speciality cannot absorb prolonged absences.

- Asset Revaluation: in line with Generally Accepted Accounting Policies land and buildings are re-valued every three years or sooner if required. The assets were revalued as at 30 June 2009 and a significant increase in the value was brought into account. This resulted in an increased capital charge of approximately $1.6million.

Budget Deficit - 2010/2011

The $7.2 million deficit submitted in the 2010/2011 West Coast District Health Board District Annual Plan has been prepared after taking the following factors into account:

- That the West Coast District Health Board has assumed that it will continue to receive the $2.8 million "West Coast Adjuster" as additional revenue to reflect the unique circumstances that the West Coast District Health Board faces.
- The West Coast District Health Board will continue to receive Crown Funding on the early payment basis.
- The West Coast District Health Board has based its forecasts on current service delivery, volumes and staff numbers. Staffing has been based on a mix of employed staff and locum staff which may change depending on recruitment and retention of staff.
- That conditions of Multi-Employer Collective Agreements that have already been settled will be implemented as agreed without any unplanned impacts from second tier bargaining or debate over interpretation and translation issues.
- For the 2010/2011 financial year a number of Multi-Employer Collective Agreements are due to expire. The West Coast District Health Board has applied the new terms and conditions of the expiring agreements where ratification has been achieved, for Multi-Employer Collective Agreements where ratification has not been achieved a rate increase of 2% has been applied and not budgeted for any changes in the conditions of employment. The risk exists that these Multi-Employer Collective Agreements may be settled at rates greater than 2% or the terms and conditions may change that has a unfavourable financial effect on the cost of settlement.
- A surplus is planned for the funder arm. It has been assumed that the funder arm will be able to contribute its surplus as deficit funding to the District Health Board provider arm in each of the years covered by the 2010/2011 West Coast District Health Board District Annual Plan. Most of this surplus relates to the removal of historical adjuster payments to the West Coast District Health Board provider arm performance.
- The budgeted deficit will be funded via an equity injection by the Crown.

Other key assumptions are listed earlier in the financial section of the 2010/2011 District Annual Plan.

Information Flows

In line with legislation, the West Coast District Health Board will make available to the responsible Ministers and their agents the following documents and information that is necessary to enable an informed assessment of the entity including a comparison of the performance of the entity with the 2010/2011 District Annual Plan:

- Provision of performance measures required by Ministry of Health as part of its performance-monitoring regime.
- Monthly reporting of financial information to Ministry of Health as part of their performance-monitoring regime.
- Any other information that would normally be requested by an owner or funder of services provided by the West Coast District Health Board.

Activities for Which Compensation Is Sought

No compensation is sought for activities sought by the Crown in accordance with Section 41D of the Public Finance Act.

Disposal of Land

The West Coast District Health Board's policy is that it will not dispose of any estate or interest in any land without having first obtained the consent of the responsible Minister and completed the required consultation. Once approval has been gained, land will then be valued and will be offered to any parties that have a statutory right to

receive an offer under the Public Works Act and Ngāi Tahu Settlement Act (and any other relevant legislation) before then being made available for public sale.

Acquisition of Shares

Before the West Coast District Health Board or any associate or subsidiary subscribes for, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister and obtain approval.

Statement of Accounting Policies

The West Coast District Health Board will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts. In accordance with the Institute of Chartered Accountants of New Zealand Financial Reporting Standard 29, the following information is provided in respect of the District Annual Plan:

(i) Cautionary Note

The District Annual Plan 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 which have been prepared on the basis of best estimate assumptions as to future events that the West Coast District Health Board expects to take place.

(iii) Assumptions

The principal assumptions underlying the forecast are noted in earlier in this section. These assumptions were valid as at March 2010, the date this document was drafted.

Reporting Entity

The West Coast District Health Board is a Health Board established by the New Zealand Public Health and Disability Act 2000. The West Coast District Health Board is a Crown Entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

The West Coast District Health Board is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993; and the Crown Entities Act 2004.

The West Coast District Health Board is a public benefit entity, as defined under New Zealand International Accounts Standards 1.

The West Coast District Health Board's activities involve the funding, planning and delivering of health and disability services and mental health services in a variety of ways to the community.

The financial statements of the West Coast District Health Board have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000, Public Finance Act 1989 and Crown Entities Act 2004.

The financial statements for the West Coast District Health Board are for the year ended 30 June 2009/2010, and were approved by the Board on 30 October 2009/2010.

Statement of Compliance

The financial statements of the West Coast District Health Board have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Basis of Preparation

The financial statements are presented in New Zealand dollars, rounded to the nearest thousand. The financial statements have been prepared on the historical cost basis, modified by the revaluation of land, buildings, fixtures and fittings.

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

Critical accounting estimates and assumptions

In preparing these financial statements, the West Coast District Health Board has made estimates and assumptions concerning the future. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts 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 the West Coast District Health Board 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 the West Coast District Health Board to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the West Coast District Health Board, and expected disposal proceeds from the future sale of the asset. An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. The West Coast District Health Board minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

Critical Judgements in Applying the West Coast District Health Board's Accounting Policies.

Management has exercised the following critical judgements in applying the West Coast District Health Board's accounting policies for the period ended 30 June 2011.

Leases classifications

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 the West Coast District Health Board.

Judgement is required on various aspects that include, but 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.

The West Coast District Health Board has exercised its judgement on the appropriate classification of leases and, has determined that all its leases are operating leases.

Budget Figures

The budget figures are those approved by the Board and published in its District Annual Plan and Statement of Intent. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of these financial statements. They comply with the New Zealand International Funding Resource Standards and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by the West Coast District Health Board for the preparation of these financial statements.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Revenue from the Crown

The West Coast District Health Board is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the West Coast District Health Board meeting its objectives as specified in the statement of intent.

Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates. Where there are explicit conditions attached to the revenue requiring surplus funds to be repaid, revenue is carried forward as a liability in the statement of financial position and allocated to the period in which the revenue is earned.

Other grants

Non-government grants are recognised as revenue when they become receivable unless there is an obligation to return the funds if conditions of the grant are not met. If there is such an obligation the grants are initially recorded as grants received in advance, and recognised as revenue when conditions of the grant are satisfied.

Goods and Services Tax

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Taxation

The West Coast District Health Board is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under the Income Tax Act 2007.

Trust and Bequest Funds

Donations and bequests to the West Coast District Health Board are recognised as revenue when control over assets is obtained. A liability, rather than revenue, is recognised where fulfilment of any restrictions is not probable. Those donations and bequests with restrictive conditions are appropriated from retained earnings to the trust funds component of equity.

When expenditure is subsequently incurred in respect of these funds it is recognised in the statement of financial performance and an equivalent amount is transferred from the trust funds component of equity to retained earnings.

Trade and other receivables

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

Investments

At each balance sheet date the West Coast District Health Board assesses whether there is any objective evidence that an investment is impaired.

Bank deposits

Investments in bank deposits are measured at fair value.

For bank deposits, impairment is established when there is objective evidence that the West Coast District Health Board will not be able to collect amounts due according to the original terms of the deposits. Significant financial difficulties of the bank, probability that the bank will enter into bankruptcy, and default in payments are considered indicators that the deposit is impaired.

Equity investments

The West Coast District Health Board designates equity investments at fair value through equity, which are initially measured at cost.

After initial recognition these investments are measured at their fair value with gains and losses recognised directly in equity, except for impairment losses which are recognised in the statement of financial performance.

On derecognition the cumulative gain or loss previously recognised in equity is recognised in the statement of financial performance.

For equity investments classified as fair value through equity, a significant or prolonged decline in fair value of the investment below its cost is considered an indication of impairment. If such evidence exists for investments

through equity, the cumulative loss (measured as the difference between acquisition cost and the current value, less any impairment loss on that financial asset previously recognised in the statement of financial performance) is removed from equity and recognised in the statement of financial performance. Impairment losses recognised in the statement of financial performance on equity on investments are not reversed through the statement of financial performance.

Inventories

Inventories are held primarily for consumption in the provision of services, and are stated and the lower of cost and current replacement cost. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

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 date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of the West Coast District Health Board's cash management are included as a component of cash and cash equivalents for the purposes of the statement of cash flows.

Impairment

The carrying amounts in the West Coast District Health Board'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 an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the statement of financial performance.

For assets not carried at a revalued amount, the total impairment loss is recognised in the statement of financial performance.

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 the statement of financial performance, a reversal of the impairment loss is also recognised in the statement of financial performance.

For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the statement of financial performance.

Financial Instruments

Financial instruments held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the statement of financial performance.

Financial instruments held as being available-for-sale are stated at fair value, with any resultant gain or loss recognised directly in equity.

Loans and receivables are stated at fair value, using the effective interest method. Any gains or losses are recognised in the statement of financial performance.

Assets Classified as Held for Sale

Non current assets classified as held for sale are measured at the lower of cost and fair value, less cost to sell, and are not amortised or depreciated.

Property, Plant and Equipment

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Coast Health Care Limited (a Hospital and Health Service) were vested in the West Coast District Health Board on 1 January 2001. Accordingly, assets were transferred to the West Coast District Health Board at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost (or, in the case of land and buildings, the valuation) and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Property, Plant and Equipment Acquired Since the Establishment of the District Health Board

Assets, other than land and buildings, acquired by the Board since its establishment, and other than those vested from the Hospital and Health Service, are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisitions and installation including materials, labour, direct overheads, financing and transport costs.

Revaluation of Property, Plant and Equipment.

Land, buildings, fixtures and fittings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value and at least every three years. Fair value is determined from market based evidence by an independent registered valuer.

Additions between revaluations are recorded at cost. The results of revaluing land, buildings, fixtures and fittings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

Assets subject to a revaluation cycle are reviewed with sufficient regularity to ensure that the carrying amount does not differ significantly from fair value at the balance sheet date.

Disposal of Property, Plant and Equipment

When an item of property, plant and equipment is disposed of, any gain or loss is recognised in the statement of financial performance and is calculated at the difference between the net sale price and the carrying value of the asset.

Depreciation

Depreciation is provided on a straight-line basis on all assets with a cost or valuation above $2,000, at rates which will write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives. Assets below $2,000 are written off in the month of purchase. The estimated useful lives of major classes of assets are as follows:

	Years
Freehold Buildings	3 – 50
Fit Out Plant and Equipment	3 – 50
Plant and Equipment	2 – 20
Motor Vehicles	3 – 5

Capital work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

Intangible Assets

Intangible assets that are acquired by the West Coast District Health Board are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each period is recognised in statement of financial performance.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

	Years
Acquired computer software	2 - 10

Trade and other payables

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

Employee Entitlements

Short-term employee entitlements

Employee entitlements that the West Coast District Health Board expects to settle within twelve months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, retiring and long service leave entitlements expected to be settled within 12 months, medical education leave, and sick leave.

Sick leave

The West Coast District Health Board recognises a liability for sick leave to the extent that the compensated expect absences expect to be paid out in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance sheet; to the extent the West Coast District Health Board anticipates it will be used by staff to cover those future absences.

Bonuses

The West Coast District Health Board recognises a liability and an expense for bonuses where it is contractually obliged to pay them, or where there is a past practice that has created a constructive obligation.

Long -term employee entitlements

Employee entitlements that are payable beyond 12 months.

Long Service Leave and Retirement Gratuities

Entitlements that are payable beyond twelve months, have been calculated on an actuarial basis. The calculations are based on likely future entitlements accruing to staff, based on years of service, year's entitlement, the likelihood that staff will reach a point of entitlement and contractual entitlement information. The obligation is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at balance sheet date.

Sabbatical Leave

The West Coast District Health Board's obligation payable beyond 12 months has been calculated on entitlements accruing to staff, based on years of service, years of entitlement and the likelihood that staff will reach the point of entitlement and contractual obligations.

Superannuation Schemes

Defined Contribution Schemes

Obligations for contributions to defined contribution schemes are recognised as an expense in the statement of financial performance as incurred.

Defined Benefit Schemes

The West Coast District Health Board belongs to the National Provident Fund, which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefits 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 a surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is accounted for as a defined contribution scheme. Further information on this scheme is disclosed in note 15.

Leased Assets

Finance Leases

Leases which effectively transfer to the West Coast District Health Board substantially all the risks and benefits incident to ownership of the leased items are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments.

The assets' corresponding lease liabilities are recognised in the statement of financial position. The leased assets are depreciated over the period the West Coast District Health Board is expected to benefit from their use.

The Public Finance Act requires District Health Boards to obtain approval from the Minister of Health prior to entering a finance lease arrangement.

Operating Leases

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Operating lease expenses are recognised in the statement of performance on a systematic basis over the period of the lease.

Interest-bearing Borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised costs with any difference between cost and redemption value recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

Capital Charge

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

Borrowing Costs

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

Cost of Service Statements

The cost of service statements presented in the statement of objectives and service performance report the net cost of services for the outputs of the West Coast District Health Board and represent the cost of providing the output less all the revenue that can be directly attributed to these activities.

Cost Allocation

The West Coast District Health Board has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to each output class.

All indirect costs are charged to the output class on an appropriate basis, as they mostly relate to the costs of providing health services.

An estimation of the proportion of governance activities that is attributed to the provider is charged to the provider output class.

Changes in accounting policy

There have been no change in accounting policy and the accounting policies applied in preparing this forecast are on a basis consistent with the prior year.

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the West Coast District Health Board include:

- New Zealand Institute of Chartered Accountant 1 Presentation of Financial Statements (revised 2007) replaces New Zealand Institute of Chartered Accountant 1 Presentation of Financial Statements (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009.
- New Zealand Institute of Chartered Accountant 23 Borrowing Costs (revised 2007) replaces New Zealand Institute of Chartered Accountant 23 Borrowing Costs (issued 2004) and is effective for reporting periods commencing on or after 1 January 2009.
- NZ specific amendment to New Zealand Institute of Chartered Accountant 2 Inventories. In November 2007 the New Zealand Accounting Standards Review Board approved an amendment to New Zealand Institute of Chartered Accountant 2 Inventories, which requires public benefit entities to measure inventory held for distribution at cost, adjusted when applicable for any loss of service potential.

The West Coast District Health Board has not yet assessed the impact these statements and amendments will have on its financial statements, but does not believe any adjustment will be significant.

10.1 Disposal of Surplus Assets

In the past, the West Coast District Health Board has disposed of a number of major surplus assets. The District Health Board's current stock of surplus assets consists mainly of small parcels of land, often with pre-existing leasehold arrangements. The cost of disposing of these small parcels of land is such that it is currently uneconomic to do so, with the exception of one site.

The West Coast District Health Board owns a considerable amount of land that is adjacent to the Greymouth Hospital site. Some of this has been declared surplus in the past and it is the District Health Board's intention to sell this surplus land in order to help fund the proposed reconfiguration or reconstruction of Greymouth Hospital. In order to dispose of surplus land, the West Coast District Health Board must first obtain approval from the Minister of Health. Once approval has been gained, land will then be valued and will be offered to any parties that have a statutory right to receive an offer under the Public Works Act and Ngāi Tahu Settlement Act (and any other relevant legislation) before then being made available for public sale.

10.2 Debt and Equity

The West Coast District Health Board will require deficit funding (equity) in order to offset the deficit signalled in the West Coast District Health Boards 2010/2011 to 2012/2013 District Annual Plans.

The proposed redevelopment or reconstruction of Greymouth Hospital will be funded by a mix of debt (ex Crown Health Funding Agency) and equity, along with some internal funding from disposal of surplus assets. The $87million option proposed in the unapproved business case is to be funded by; Asset Sales $1 million, Crown Health Funding Authority Debt $51million and Crown Equity $35 million. The cost and therefore the final mix of debt and equity won't be known until a revised business case has been completed.

The proposed redevelopment of Buller Hospital will be funded by a mix of debt (ex CHFA) and equity. The $11.9 million option proposed in the unapproved business case is to be funded by; CHFA Debt $7.0 million and Crown Equity $4.9 million. The cost and therefore the final mix of debt and equity won't be known until a revised business case has been completed.

Debt Facilities

The West Coast District Health Board has a working capital (overdraft) facility of $6.310 million which is to be used as an undrawn facility to cover the amount of early payment.

Bank of New Zealand (BNZ)

The West Coast District Health Board has a working capital (overdraft) facility of $6.310 million which is to be used as an undrawn facility to cover the amount of early payment.

Covenant	Requirement	Planned Compliance*
Gearing Ratio	**Less than or equal to 80%**	**Yes**
Net Operating Deficit	**The Net Operating Deficit for each period from the first day of each financial year of the Borrower to the last day of each successive month of that financial year shall not exceed the budgeted Net Operating Deficit for that month or period by more than the greater of 10% or $2M.**	**Yes**

Details of Loan Financing Facilities

West Coast District Health Board Debt Register

As at April 2010

Lender's name	**CHFA**	**CHFA**	**CHFA**	**BNZ**
Loan Identified As	Renewal	Renewal	Dementia Unit	Overdraft
Debt Amount - face value	$7,695,000	$3,500,000	$2,500,000	$6,310,000
Instrument type	Term Loan	Term Loan	Amortising Loan	Overdraft
Fixed / Floating interest rate	Fixed	Fixed	Fixed	Floating
Fixed rate	6.11%	6.58%	7.42%	
Floating rate base and margin				BKBM+0.35%
Interest payment frequency	Quarterly	Semi-annually	Semi-annually	Daily
Covenants (Debt to Debt + Equity ratio)				80%
Next Payment Due				
When	31/10/2010	31/12/2015	30/06/2010	any time
How much	$7,695,000	$3,500,000	$250,000	any amount
Next Rollover / Refinance Due				
When	31/10/2010	31/12/2015	30/06/2012	
How much	$7,695,000	$3,500,000	$1,500,000	
Plan	Refinance CHFA	Continuation of lending subject to review by CHFA	Continuation of lending subject to review by CHFA	
	5 year renewal	N/A	N/A	

Upcoming Loan Repayments

Dementia Unit	30/06/2010	$ 250,000

FORECAST FINANCIAL STATEMENTS FOR THE 3 YEARS ENDING 30 JUNE 2011, 2012 AND 2013 (CONSOLIDATED)

DHB Consolidated
Statement of Comprehensive Income

REVENUE	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
PBF Vote Health - Mental Health Ringfence	(13,121)	(13,409)	(13,439)	(13,708)	(13,982)
PBF Vote Health - Funding Package (excluding Mental Health)	(90,113)	(96,143)	(95,829)	(97,206)	(99,150)
MOH - Funding Subcontracts	(2,783)	(2,424)	(5,373)	(5,480)	(5,590)
MOH Devolved Funding	(106,017)	(111,976)	(114,641)	(116,394)	(118,722)
MoH - Personal Health	(795)	(1,446)	(1,150)	(1,173)	(1,197)
MoH - Public Health	-	-	(144)	(147)	(150)
MoH - Disability Support Services	(550)	-	(207)	(211)	(215)
Clinical Training Agency	(293)	(443)	(555)	(566)	(578)
MOH Non-Devolved Contracts (provider arm side contracts)	(1,638)	(1,889)	(2,057)	(2,098)	(2,140)
Accident Insurance	(2,196)	(1,814)	(1,894)	(1,932)	(1,971)
Other Government	(3,558)	(4,038)	(4,273)	(4,359)	(4,446)
Other Government (not MoH or other DHBs)	(5,754)	(5,852)	(6,167)	(6,291)	(6,416)
Government & Crown Agency Sourced	(113,409)	(119,717)	(122,865)	(124,782)	(127,278)
Patient / Consumer sourced	(2,575)	(2,648)	(2,792)	(2,848)	(2,905)
Other Income	(1,538)	(1,501)	(1,047)	(1,067)	(1,086)
Non-Government & Crown Agency Sourced	(4,113)	(4,149)	(3,839)	(3,915)	(3,991)
IDFs - All Other (excluding Mental Health)	(1,503)	(1,563)	(1,618)	(1,667)	(1,717)
InterProvider Revenue (Other DHBs)	(78)	-	(77)	(79)	(80)
Inter-DHB & Internal Revenue	(1,581)	(1,563)	(1,695)	(1,745)	(1,797)
REVENUE TOTAL	(119,103)	(125,429)	(128,399)	(130,443)	(133,065)

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
EXPENSES					
Personnel costs					
Medical Personnel	7,997	9,745	10,437	10,646	10,859
Nursing Personnel	19,876	22,631	23,155	23,458	24,137
Allied Health Personnel	10,156	9,106	8,871	8,936	9,114
Support Personnel	1,779	2,032	1,939	1,978	2,017
Management/Administration Personnel	8,437	8,064	7,791	7,847	8,004
Personnel costs Total	48,245	51,578	52,193	52,864	54,131
Outsourced Services					
Medical Personnel	9,136	7,069	6,873	6,841	6,478
Nursing Personnel	219	280	-	-	-
Allied Health Personnel	246	214	49	50	51
Support Personnel	78	51	33	34	34
Management/Administration Personnel	48	37	239	244	249
Outsourced Clinical Services	3,701	3,126	3,102	3,030	3,090
Outsourced Corporate/Governance Services	189	462	830	847	864
DHB Governance & Administration	(52)	-	-	-	-
Outsourced Services Total	13,565	11,239	11,126	11,046	10,767
Clinical Supplies					
Treatment Disposables	1,161	1,176	1,227	1,252	1,277
Diagnostic Supplies & Other Clinical Supplies	54	80	80	82	83
Instruments & Equipment	1,486	1,692	1,617	1,649	1,682
Patient Appliances	374	337	330	337	344
Implants and Prostheses	733	897	936	955	974
Pharmaceuticals	1,586	1,783	1,744	1,779	1,814
Other Clinical & Client Costs	1,112	1,175	1,186	1,210	1,234
Clinical Supplies Total	6,506	7,140	7,120	7,263	7,408
Infrastructure & Non-Clinical Supplies					
Hotel Services, Laundry & Cleaning	3,429	3,565	3,539	3,610	3,682
Facilities	5,521	5,128	4,611	4,657	4,704
Transport	1,571	1,381	1,412	1,380	1,407
IT Systems & Telecommunications	2,110	2,061	2,105	2,126	2,169
Interest & Financing Charges	1,159	2,553	2,261	2,239	2,229
Professional Fees & Expenses	1,045	841	646	655	665
Other Operating Expenses	2,227	2,255	2,552	2,601	2,652
Democracy	278	296	367	308	311
Infrastructure & Non-Clinical Supplies Total	17,340	18,080	17,493	17,576	17,819
Personal Health					
EXPENSES (Payments to Providers)					
Child and Youth	157	162	162	165	169
Laboratory	484	570	505	422	382
Maternity	-	0	10	10	10
Maternity (Tertiary and Secondary)	-	55	-	-	-
Pregnancy and Parenting Education	61	0	8	8	8
Maternity Payment Schedule	-	-	40	41	42
Sexual Health	54	14	-	-	-
Adolescent Dental Benefit	298	384	412	420	429
Child (School) Dental Services	22	(18)	20	20	21
Pharmaceuticals	7,760	7,030	8,303	8,469	8,415
Pharmacy Services	-	313	-	-	-
Management Referred Services	23	-	-	-	-
General Medical Subsidy	56	47	52	53	54
Primary Practice Services – Capitated	5,303	5,811	5,441	5,550	5,661
Primary Health Care Strategy - Other	10	-	-	-	-
Practice Nurse Subsidy	32	-	-	-	-
Rural Support for Primary Health Providers	745	1,223	888	906	924
Immunisation	196	111	95	97	99
Palliative Care	57	277	104	106	108
Chronic Disease Management and Education	163	69	200	204	208
Medical Inpatients	45	(3)	63	64	66
Medical Outpatients	2	-	-	-	-
Surgical Inpatients	84	(303)	834	851	868
Surgical Outpatients	(1)	-	-	-	-
Emergency Services	-	5	-	-	-
Minor Personal Health Expenditure	243	322	224	228	233
Travel & Accommodation	881	1,091	1,142	1,165	1,188
IDF Personal Health - Own DHB Population	13,063	14,449	15,075	15,678	16,305
Total Personal Health	29,738	31,608	33,578	34,458	35,189

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
Mental Health					
EXPENSES (Payments to Providers)					
Crisis Respite	1	-	-	-	-
Child & Youth Mental Health Services	155	36	-	-	-
Mental Health Community Services	-	118	1,238	1,263	1,288
Mental Health Workforce Development	11	9	8	8	8
Day Activity & Work Rehab Services	439	678	569	580	592
Advocacy/Peer Support - Consumer	180	124	122	124	127
Advocacy/Peer Support - Families and Whanau	69	64	64	65	67
Community Residential Beds & Services	954	1,203	1,349	1,376	1,403
Minor Mental Health Expenditure	238	-	-	-	-
Other Mental Health Expenditure	-	56	-	-	-
IDF Mental Health - Own DHB Population	770	789	812	844	878
Total Mental Health	2,817	3,943	4,162	4,261	4,364
Disability Support Services (HOPS)					
EXPENSES (Payments to Providers)					
Home Support	525	749	673	686	700
Personal Care	181	-	-	-	-
Carer Support	1	123	96	98	100
Supported Living	2,296	-	-	-	-
Residential Care: Rest Homes	(40)	2,766	2,555	2,606	2,658
Residential Care: Loans Adjustment	121	(12)	-	-	-
Residential Care: Community	3,545	119	120	122	125
Residential Care: Hospitals	59	3,806	4,218	4,302	4,388
Ageing in Place	-	(125)	65	66	68
Environmental Support Services	-	3	43	44	45
Day Programmes	2	59	81	83	84
Expenditure to Attend Treatment - ETAT	15	-	-	-	-
Respite Care	75	116	140	143	146
Community Health Services & Support	294	1	-	-	-
IDF Disability Support - Own DHB Poplulation	1,060	1,337	1,084	1,127	1,172
Total Disability Support Services	8,134	8,944	9,075	9,278	9,486
Public Health					
EXPENSES (Payments to Providers)					
Nutrition & Physical Activity	256	326	211	215	220
Public Health Infrastructure	52	104	95	97	99
Social Environments	62	28	-	-	-
Tobacco Control	69	9	8	8	8
Human Papillomarus Virus	-	-	1	1	1
Total Public Health	439	547	315	321	328
Maori Health					
EXPENSES (Payments to Providers)					
Maori Service Development	-	162	162	165	169
Whanau Ora Services	-	307	374	381	389
Total Maori Health	-	469	536	547	558
EXPENSES TOTAL	126,784	133,548	135,599	137,615	140,049
NET OPERATING (SURPLUS) / DEFICIT	**7,681**	**8,119**	**7,200**	**7,172**	**6,983**
OTHER COMPREHENSIVE INCOME					
(Gain) / Loss on property revaluations	(19,918)	2,079			
TOTAL COMPREHENSIVE INCOME (SURPLUS) / DEFICIT	**(12,237)**	**10,198**	**7,200**	**7,172**	**6,983**
Supplementary Information					
Depreciation	4,736	4,844	4,583	4,579	4,579

DHB Governance & Funding Administration Arm

Statement of Comprehensive Income

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
REVENUE					
Government and Crown Agency sourced					
Internal revenue (DHB Fund to DHB Governance & Funding Administration)	(1,138)	(1,174)	(1,174)	(1,197)	(1,221)
InterProvider Revenue (Other DHBs)	(27)	-	-	-	-
Government & Crown Agency Sourced	(1,165)	(1,174)	(1,174)	(1,197)	(1,221)
Other Income	(136)	(146)	(40)	(40)	(40)
Non-Government & Crown Agency Sourced	(136)	(146)	(40)	(40)	(40)
REVENUE TOTAL	(1,301)	(1,320)	(1,214)	(1,237)	(1,261)
EXPENSES					
Personnel costs					
Management/Administration Personnel	1,463	1,418	1,043	1,064	1,085
Personnel costs Total	1,463	1,418	1,043	1,064	1,085
Outsourced Services					
Management/Administration Personnel	3	-	-	-	-
Outsourced Corporate/Governance Services	189	181	444	453	462
Outsourced Services Total	192	181	444	453	462
Infrastructure & Non-Clinical Supplies					
Hotel Services, Laundry & Cleaning	4	-	4	4	4
Facilities	3	-	3	3	3
Transport	73	61	45	45	46
IT Systems & Telecommunications	11	25	12	12	12
Interest & Financing Charges	9	-	9	9	9
Professional Fees & Expenses	453	366	365	369	372
Other Operating Expenses	112	130	106	106	107
Democracy	232	254	338	278	281
Infrastructure & Non-Clinical Supplies Total	897	836	882	827	835
Internal Allocations					
Internal Allocation from/to DHB Provider	(960)	(980)	(980)	(1,000)	(1,000)
Internal Allocations Total	(960)	(980)	(980)	(1,000)	(1,000)
EXPENSES TOTAL	1,592	1,455	1,389	1,344	1,382
NET OPERATING (SURPLUS) / DEFICIT AND TOTAL COMPREHENSIVE (INCOME) / DEFICIT	**291**	**135**	**176**	**106**	**121**

DHB Provider Arm

Statement of Comprehensive Income

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
REVENUE					
MoH - Personal Health	(795)	(1,446)	(1,150)	(1,173)	(1,197)
MoH - Public Health	-	-	(144)	(147)	(150)
MoH - Disability Support Services	(550)	-	(207)	(211)	(215)
Clinical Training Agency	(293)	(443)	(555)	(566)	(578)
MOH Non-Devolved Contracts (provider arm side contracts)	(1,638)	(1,889)	(2,057)	(2,098)	(2,140)
Accident Insurance	(2,196)	(1,814)	(1,894)	(1,932)	(1,971)
Other Government	(3,558)	(4,038)	(4,273)	(4,359)	(4,446)
Other Government (not MoH or other DHBs)	(5,754)	(5,852)	(6,167)	(6,291)	(6,416)
Government & Crown Agency Sourced	(7,392)	(7,741)	(8,224)	(8,388)	(8,556)
Patient / Consumer sourced	(2,575)	(2,648)	(2,792)	(2,848)	(2,905)
Other Income	(830)	(1,038)	(929)	(947)	(966)
Non-Government & Crown Agency Sourced	(3,405)	(3,686)	(3,721)	(3,795)	(3,871)
InterProvider Revenue (Other DHBs)	(51)	-	(77)	(79)	(80)
Internal Revenue (DHB Fund to DHB Provider)	(57,140)	(61,161)	(61,814)	(63,050)	(64,311)
Inter-DHB & Internal Revenue	(57,191)	(61,161)	(61,891)	(63,128)	(64,391)
REVENUE TOTAL	(67,988)	(72,588)	(73,836)	(75,312)	(76,818)

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
EXPENDITURE					
Personnel costs					
Medical Personnel	7,997	9,745	10,437	10,646	10,859
Nursing Personnel	19,876	22,631	23,155	23,458	24,137
Allied Health Personnel	10,156	9,106	8,871	8,936	9,114
Support Personnel	1,779	2,032	1,939	1,978	2,017
Management/Administration Personnel	6,974	6,646	6,748	6,783	6,918
Personnel costs Total	46,782	50,160	51,150	51,800	53,046
Outsourced Services					
Medical Personnel	9,136	7,069	6,873	6,841	6,478
Nursing Personnel	219	280	-	-	-
Allied Health Personnel	246	214	49	50	51
Support Personnel	78	51	33	34	34
Management/Administration Personnel	45	37	239	244	249
Outsourced Clinical Services	3,701	3,126	3,102	3,030	3,090
Outsourced Corporate/Governance Services	-	281	386	394	402
Outsourced Services Total	13,425	11,058	10,682	10,593	10,305
Clinical Supplies					
Treatment Disposables	1,161	1,176	1,227	1,252	1,277
Diagnostic Supplies & Other Clinical Supplies	54	80	80	82	83
Instruments & Equipment	1,486	1,692	1,617	1,649	1,682
Patient Appliances	374	337	330	337	344
Implants and Prostheses	733	897	936	955	974
Pharmaceuticals	1,586	1,783	1,744	1,779	1,814
Other Clinical & Client Costs	1,112	1,175	1,186	1,210	1,234
Clinical Supplies Total	6,506	7,140	7,120	7,263	7,408
Infrastructure & Non-Clinical Supplies					
Hotel Services, Laundry & Cleaning	3,425	3,565	3,535	3,606	3,678
Facilities	5,518	5,128	4,608	4,654	4,701
Transport	1,498	1,320	1,367	1,335	1,361
IT Systems & Telecommunications	2,099	2,036	2,094	2,114	2,157
Interest & Financing Charges	1,150	2,553	2,252	2,230	2,220
Professional Fees & Expenses	592	475	281	286	292
Other Operating Expenses	2,115	2,125	2,446	2,495	2,545
Democracy	46	42	29	30	30
Infrastructure & Non-Clinical Supplies Total	16,443	17,244	16,611	16,750	16,984
Internal Allocations					
Internal Allocation from/to DHB Governance & Administration	960	980	980	1,000	1,000
Internal Allocations Total	960	980	980	1,000	1,000
EXPENSES TOTAL	84,116	86,582	86,544	87,405	88,742
NET OPERATING (SURPLUS) / DEFICIT	**16,128**	**13,994**	**12,708**	**12,093**	**11,924**
OTHER COMPREHENSIVE INCOME					
(Gain) / Loss on property revaluations	(19,918)	2,079			
TOTAL COMPREHENSIVE INCOME (SURPLUS) / DEFICIT	**(3,790)**	**16,073**	**12,708**	**12,093**	**11,924**
Supplementary Information					
Depreciation	4,732	4,844	4,579	4,579	4,579

DHB Funds Arm

Statement of Comprehensive Income

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
REVENUE					
PBF Vote Health - Mental Health Ringfence	(13,121)	(13,409)	(13,439)	(13,708)	(13,982)
PBF Vote Health - Funding Package (excluding Mental Health)	(90,113)	(96,143)	(95,829)	(97,206)	(99,150)
MOH - Funding Subcontracts	(2,783)	(2,424)	(5,373)	(5,480)	(5,590)
MOH Devolved Funding	(106,017)	(111,976)	(114,641)	(116,394)	(118,722)
Other Income	(572)	(317)	(78)	(80)	(80)
Non Government & Crown Agency Revenue	(572)	(317)	(78)	(80)	(80)
Interest	(572)	(317)	(78)	(80)	(80)
Total Other Income	(572)	(317)	(78)	(80)	(80)
IDFs - All Other	(1,503)	(1,563)	(1,618)	(1,667)	(1,717)
Inter-DHB and Internal Revenue	(1,503)	(1,563)	(1,618)	(1,667)	(1,717)
REVENUE TOTAL	(108,092)	(113,856)	(116,337)	(118,140)	(120,518)
EXPENDITURE					
Personal Health					
EXPENSES (Payments to Providers)					
Personal Health (to allocate)	-	5,223	5,189	5,293	5,399
Child and Youth	469	676	661	675	688
Laboratory	1,482	1,580	1,722	1,663	1,648
Maternity	660	84	94	95	97
Maternity (Tertiary and Secondary)	1,008	2,010	2,082	2,124	2,167
Pregnancy and Parenting Education	709	19	31	32	32
Maternity Payment Schedule	-	-	40	41	42
Neo Natal	408	259	265	270	275
Sexual Health	258	131	122	124	126
Adolescent Dental Benefit	298	384	412	420	429
Child (School) Dental Services	526	545	535	546	557
Secondary/Tertiary Dental	132	136	138	141	144
Pharmaceuticals	7,999	7,393	8,454	8,623	8,573
PCT Drugs	-	313	237	242	247
Management Referred Services	23	-	-	-	-
General Medical Subsidy	56	47	52	53	54
Primary Practice Services – Capitated	5,602	5,830	5,460	5,569	5,681
Primary Health Care Strategy - Other	10	-	-	-	-
Practice Nurse Subsidy	32	-	-	-	-
Rural Support for Primary Health Providers	745	1,223	968	987	1,007
Immunisation	483	411	180	184	187
Radiology	252	-	-	-	-
Palliative Care	189	425	441	450	459
Meals on Wheels	192	166	163	166	169
Domicilary & District Nursing	1,884	2,731	2,860	2,917	2,975
Community based Allied Health	1,476	2,061	2,248	2,293	2,339
Chronic Disease Management and Education	710	410	549	560	571
Medical Inpatients	165	5,415	5,619	5,731	5,846
Medical Outpatients	9,818	1,425	1,483	1,513	1,543
Surgical Inpatients	5,530	5,898	7,043	7,184	7,328
Surgical Outpatients	6,851	7,523	7,637	7,790	7,945
Paediatric Inpatients	300	434	444	452	461
Paediatric Outpatients	252	320	329	336	342
Emergency Services	336	4,064	3,790	3,865	3,943
Minor Personal Health Expenditure	675	746	696	710	724
Price Adjusters and Premium	5,676	1,159	1,159	1,182	1,206
Travel & Accommodation	881	1,091	1,142	1,165	1,188
IDF Personal Health - Own DHB Population	13,063	14,449	15,075	15,678	16,305
TOTAL PAYMENTS TO PERSONAL HEALTH PROVIDERS	69,150	74,581	77,321	79,075	80,699

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
Mental Health					
EXPENSES (Payments to Providers)					
Mental Health (to allocate)	-	1,090	1,603	1,635	1,668
Acute Mental Health Inpatients	40	2,551	1,442	1,471	1,500
Sub-Acute & Long Term Mental Health Inpatients	3,353	554	564	575	586
Crisis Respite	25	-	-	-	-
Alcohol & Other Drugs - General	1,020	584	594	606	618
Alcohol & Other Drugs – Child & Youth Specific	12	138	177	180	184
Methadone	120	162	162	166	169
Child & Youth Mental Health Services	1,058	725	700	714	728
Kaupapa Maori Mental Health Services - Community	384	368	370	377	385
Mental Health Community Services	4,311	4,521	4,763	4,859	4,956
Mental Health Workforce Development	11	9	8	8	8
Day Activity & Work Rehab Services	439	678	569	580	592
Advocacy/Peer Support - Consumer	180	124	122	124	127
Advocacy/Peer Support - Families and Whanau	153	152	153	156	160
Community Residential Beds & Services	954	1,203	1,349	1,376	1,403
Minor Mental Health Expenditure	264	51	51	52	53
Other Mental Health Expenditure	-	56	-	-	-
IDF Mental Health - Own DHB Population	770	789	812	844	878
TOTAL PAYMENTS TO MENTAL HEALTH PROVIDERS	13,094	13,755	13,439	13,724	14,015
Disability Support Services					
EXPENSES (Payments to Providers)					
AT & R (Assessment, Treatment and Rehabilitation)	2,498	3,069	3,121	3,183	3,247
Needs Assessment	48	50	50	51	52
Service Co-ordination	53	55	55	56	57
Home Support	1,759	2,006	1,981	2,021	2,061
Personal Care	181	-	-	-	-
Carer Support	61	157	130	133	135
Supported Living	3,197	65	65	66	68
Residential Care: Rest Homes	(40)	3,373	3,223	3,287	3,353
Residential Care: Loans Adjustment	121	(12)	-	-	-
Residential Care: Community	5,329	119	120	122	125
Residential Care: Hospitals	135	5,778	6,419	6,547	6,678
Ageing in Place	-	85	128	131	133
Environmental Support Services	-	146	236	241	245
Day Programmes	87	62	90	92	94
Expenditure to Attend Treatment - ETAT	15	-	-	-	-
Respite Care	75	119	160	163	166
Community Health Services & Support	456	168	167	170	173
IDF Disability Support - Own DHB Poplulation	1,060	1,337	1,084	1,127	1,172
TOTAL PAYMENTS TO DSS PROVIDERS	15,035	16,575	17,028	17,390	17,760
Public Health					
EXPENSES (Payments to Providers)					
Screening Programmes	-	81	39	40	41
Nutrition & Physical Activity	508	691	464	473	483
Public Health Infrastructure	103	194	185	189	192
Social Environments	62	28	-	-	-
Tobacco Control	236	175	174	177	181
Human Papillomarus Virus	-	-	170	173	177
TOTAL PAYMENTS TO PUBLIC HEALTH PROVIDERS	909	1,169	1,032	1,053	1,074
Maori Health					
EXPENSES (Payments to Providers)					
Maori Service Development	132	286	286	292	298
Whanau Ora Services	-	307	374	381	389
TOTAL PAYMENTS TO MAORI HEALTH PROVIDERS	132	593	660	674	687
Governance & Administration					
DHB Governance & Administration	1,138	1,174	1,174	1,197	1,221
EXPENSES TOTAL	99,458	107,846	110,653	113,113	115,456
Summary of Results (showing IDFs)					
Subtotal IDF Revenue	(1,503)	(1,563)	(1,618)	(1,667)	(1,717)
Subtotal all other Revenue	(106,589)	(112,293)	(114,719)	(116,474)	(118,802)
REVENUE TOTAL	(108,092)	(113,856)	(116,337)	(118,140)	(120,518)
Subtotal IDF Expenditure	14,893	16,575	16,971	17,650	18,356
Subtotal all other Expenditure	84,565	91,271	93,682	95,463	97,100
EXPENSES TOTAL	99,458	107,846	110,653	113,113	115,456
NET OPERATING (SURPLUS) / DEFICIT AND TOTAL COMPREHENSIVE (INCOME) / DEFICIT	**(8,634)**	**(6,010)**	**(5,684)**	**(5,028)**	**(5,062)**

DHB Consolidated

Statement of Financial Position

	01-Jul-08 Opening Balance	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	201/12 Budget	2012/13 Budget
Current Assets						
Petty Cash	4	8	8	8	8	8
Bank Account	4,078	2,367	2,463	4,050	3,308	3,486
Short Term Investments less than 3 months	3,500	13	51	51	51	51
Short Term Investments – Trusts less than 3 months	6	-	-	-	-	-
Short Term Investments (3 > 12 Months)	-	-	1,589	-	-	-
Short Term Investments Trusts (3 > 12 Months)	-	64	64	64	64	64
Prepayments	253	268	268	268	268	268
Accounts Receivable – Control Account	993	1,114	1,114	1,114	1,114	1,114
Provision for Doubtful Debts	(54)	(31)	(31)	(31)	(31)	(31)
Accrued Debtors	1,776	2,151	2,151	1,599	1,597	1,593
Inventory / Stock	663	718	718	718	718	718
Assets Held for Sale	246	246	246	246	246	246
Current Assets Total	11,465	6,918	8,641	8,087	7,343	7,517
Non Current Assets						
Land - Owned	3,725	6,005	6,005	6,005	6,005	6,005
Non Residential Buildings, Improvements & Plant -Owned	17,478	29,355	24,480	26,480	26,930	26,930
Non Residential Buildings, Improvements & Plant - Leased	253	253	253	253	253	253
Residential Buildings, Improvements & Plant - Owned	1,324	1,583	1,583	1,583	1,583	1,583
Other Equipment - Owned	13,285	14,211	15,611	17,411	19,261	21,361
Information Technology - Owned	4,112	4,119	4,639	4,939	5,239	5,539
Intangible Assets (Software) Owned	1,851	2,068	2,318	2,938	3,038	3,158
Motor Vehicles - Owned	348	420	896	996	1,126	1,206
Provision Depreciation - Owned Non Residential Buildings, Improvements & Plant	(3,151)	(48)	-	(2,214)	(4,428)	(6,643)
Provision Depreciation - Owned Residential Buildings, Improvements and Plant	(99)	-	(72)	(143)	(215)	(286)
Provision Depreciation - Owned Other Equipment	(7,584)	(7,925)	(9,166)	(10,654)	(12,138)	(13,623)
Provision Depreciation - Owned Information Technology	(2,467)	(2,677)	(3,120)	(3,556)	(3,993)	(4,429)
Provision Depreciation - Owned Intangibles (Software)	(808)	(974)	(1,238)	(1,552)	(1,866)	(2,180)
Provision Depreciation - Owned Motor Vehicles	(222)	(233)	(273)	(332)	(391)	(449)
Provision Depreciation - Leased Non Residential Buildings, Improvements & Plant	(99)	(208)	(208)	(208)	(208)	(208)
Work in Progress	204	261	261	261	261	261
Long Term Investments (> 12 months)	1,589	1,589	-	-	-	-
Non Current Assets Total	29,739	47,799	41,969	42,206	40,457	38,478

	01-Jul-08 Opening Balance	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	201/12 Budget	2012/13 Budget
Current Liabilities						
Bank Overdraft	(1,267)	-	-	-	-	-
Accounts Payable Control Account	(1,935)	(2,020)	(2,020)	(2,019)	(2,017)	(2,013)
Risk Sharing Pool	-	-	-	-	-	-
Accrued Creditors	(5,446)	(5,333)	(5,333)	(5,333)	(5,333)	(5,333)
Income Received in Advance	(669)	(578)	(578)	(578)	(578)	(578)
Capital Charge Payable	(67)	(200)	(133)	(133)	(133)	(133)
GST Input Tax	(1,782)	(1,799)	(1,799)	(1,799)	(1,799)	(1,799)
GST Output Tax	1,245	1,409	1,409	1,409	1,409	1,409
GST Adjustments	1	-	-	-	-	-
FBT Expense Accrual	(18)	(20)	(20)	(20)	(20)	(20)
Unclaimed Creditors Monies	-	(15)	(15)	(15)	(15)	(15)
Term Loans - Crown (current portion)	(250)	(250)	(250)	(250)	(250)	(250)
Payroll Clearing Account	-	1	1	-	-	-
PAYE	(341)	(303)	(303)	(303)	(303)	(303)
Sundry Payroll Deductions	(6)	-	-	-	-	-
Employee Superannuation Contributions	(1)	(16)	(16)	(16)	(16)	(16)
Employer Superannuation Contributions	(1)	(16)	(16)	(16)	(16)	(16)
Salaries & Wages - Accrued	(2,565)	(1,609)	(1,609)	(1,609)	(1,609)	(1,609)
ACC Levy Provisions	(345)	(417)	(417)	(417)	(417)	(417)
Accrued Annual Leave Provision	(2,915)	(3,319)	(3,319)	(3,319)	(3,319)	(3,319)
Accrued Other Leave Provision	(1,409)	(1,459)	(1,459)	(1,459)	(1,459)	(1,459)
Long Service Leave Provision - current portion	(261)	(356)	(356)	(356)	(356)	(356)
Retirement Gratuities Provision - current portion	(451)	(404)	(404)	(404)	(404)	(404)
Current Liabilities Total	(18,483)	(16,704)	(16,637)	(16,637)	(16,635)	(16,631)
WORKING CAPITAL	(7,018)	(9,786)	(7,996)	(8,550)	(9,292)	(9,114)
NET FUNDS EMPLOYED	22,721	38,013	33,973	33,655	31,165	29,364
Non-Current Liabilities						
Long Service Leave – Non-current portion	(286)	(340)	(340)	(340)	(340)	(340)
Retirement Gratuities – Non-current portion	(2,160)	(2,203)	(2,203)	(2,203)	(2,203)	(2,203)
Employee - Other Entitlements – Non-current portion	-	(82)	(82)	(82)	(82)	(82)
Term Loans – Crown - Non-current portion	(13,195)	(12,945)	(12,695)	(12,445)	(12,195)	(11,945)
Restricted Trusts and Special Funds	(6)	(64)	(64)	(64)	(64)	(64)
Non-Current Liabilities Total	(15,647)	(15,634)	(15,384)	(15,134)	(14,884)	(14,634)
Crown Equity						
Crown Equity	(45,060)	(45,173)	(48,128)	(54,536)	(61,668)	(66,600)
Capital Injections	-	(3,000)	(6,476)	(7,200)	(5,000)	(5,500)
Capital Repaid	-	68	68	68	68	68
Other Movements	-	(23)	-	-	-	-
Trust and Special Funds (no restricted use)	(41)	(39)	(39)	(39)	(39)	(39)
Revaluation Reserve	(10,333)	(30,251)	(28,172)	(28,172)	(28,172)	(28,172)
Revaluation Reserve - Land	(2,390)	(4,670)	(4,670)	(4,670)	(4,670)	(4,670)
Revaluation Reserve - Non Residential Buildings	(7,943)	(25,072)	(22,993)	(22,993)	(22,993)	(22,993)
Revaluation Reserve - Residential Buildings	-	(509)	(509)	(509)	(509)	(509)
Retained Earnings - DHB Provider	72,798	88,924	102,918	117,039	130,574	143,968
Retained Earnings - DHB Governance & Funding Administration	(236)	3	138	314	420	541
Retained Earnings - DHB Funds	(24,202)	(32,888)	(38,898)	(45,995)	(52,464)	(58,996)
Crown Equity Total	(7,074)	(22,379)	(18,589)	(18,521)	(16,281)	(14,730)
NET FUNDS EMPLOYED	(22,721)	(38,013)	(33,973)	(33,655)	(31,165)	(29,364)

Statement of Movement in Equity

Total equity at beginning of the period	(7,074)	(22,379)	(18,589)	(18,521)	(16,281)
Net Results for the period - DHB Governance & Funding Administration	239	135	176	106	121
Net Results for the period - DHB Provider	16,128	13,994	14,121	13,535	13,395
Net Results for the period - DHB Funds	(8,686)	(6,010)	(7,097)	(6,469)	(6,532)
Total recognised revenue and expenses for the period	7,681	8,119	7,200	7,172	6,983
Movement in Revaluation Reserve	(19,918)	2,079	-	-	-
Equity Injections - Capital	(136)	(476)	(1,100)	-	-
Equity Injections - Deficit Support	(3,000)	(6,000)	(6,100)	(5,000)	(5,500)
Capital Repaid	68	68	68	68	68
Total Equity at end of the period	(22,379)	(18,589)	(18,521)	(16,281)	(14,730)

DHB Consolidated
Statement of Cashflows

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	201/12 Budget	2012/13 Budget
Operating Activities					
Government and Crown Agency Revenue Received	108,567	115,428	118,868	120,159	122,582
Receipts from Other DHBs	-	-	77	79	80
Receipts from Other Government Sources	5,754	5,852	6,167	6,291	6,416
Rental Income Other	154	143	155	158	161
Other Revenue Received	3,144	3,640	3,586	3,657	3,729
Total Receipts	117,619	125,063	128,853	130,344	132,969
Payments for Personnel	(48,387)	(51,578)	(52,192)	(52,864)	(54,131)
Payments for Supplies	(32,782)	(29,389)	(28,928)	(29,055)	(29,190)
Interest Paid	217	(1,448)	(1,396)	(1,438)	(1,433)
Capital Charge Paid	17	-	-	-	-
GST Input Tax	(164)	-	-	-	-
GST Output Tax	1	-	-	-	-
Payments to other DHB's	(16,585)	(16,240)	(17,775)	(18,131)	(18,493)
Payments to Providers	(23,386)	(29,271)	(29,890)	(30,735)	(31,430)
Total Payments	(121,069)	(127,926)	(130,182)	(132,222)	(134,677)
Net Cashflow from Operating	(3,450)	(2,863)	(1,329)	(1,879)	(1,708)
Investing Activities					
Interest receipts 3rd Party	573	366	98	100	100
Dividends	573	366	98	100	100
	573	366	98	100	100
Buildings & Plant	(572)	(36)	(2,000)	(450)	-
Other Equipment	(1,796)	(1,400)	(1,800)	(1,850)	(2,100)
Information Technology	(509)	(520)	(300)	(300)	(300)
Motor Vehicles	(106)	(476)	(120)	(130)	(80)
Purchase of software	-	(250)	(600)	(100)	(120)
Total Capital Expenditure	(2,983)	(2,682)	(4,820)	(2,830)	(2,600)
Increase in Investments and Restricted & Trust Funds Assets	-	-	1,589	-	-
Net Cashflow from Investing	(2,410)	(2,316)	(3,133)	(2,730)	(2,500)
Financing Activities					
Equity Injections - Capital	136	476	1,100	-	-
Equity Injections - Deficit Support	3,000	6,000	6,100	5,000	5,500
Interest Paid	(885)	(845)	(833)	(815)	(796)
New Debt					
CHFA	(250)	(250)	(250)	(250)	(250)
Other Equity Movement	(68)	(68)	(68)	(68)	(68)
Net Cashflow from Financing	1,933	5,314	6,049	3,867	4,386
Total Cash In	121,078	131,655	135,901	135,194	138,319
Total Cash Out	(125,005)	(131,521)	(134,314)	(135,935)	(138,141)
Net Cashflow					
Plus: Cash (Opening)	6,315	2,388	2,522	4,109	3,367
Net cash movements	(3,927)	134	1,587	(742)	178
Cash (Closing)	2,388	2,522	4,109	3,367	3,545

Appendices :

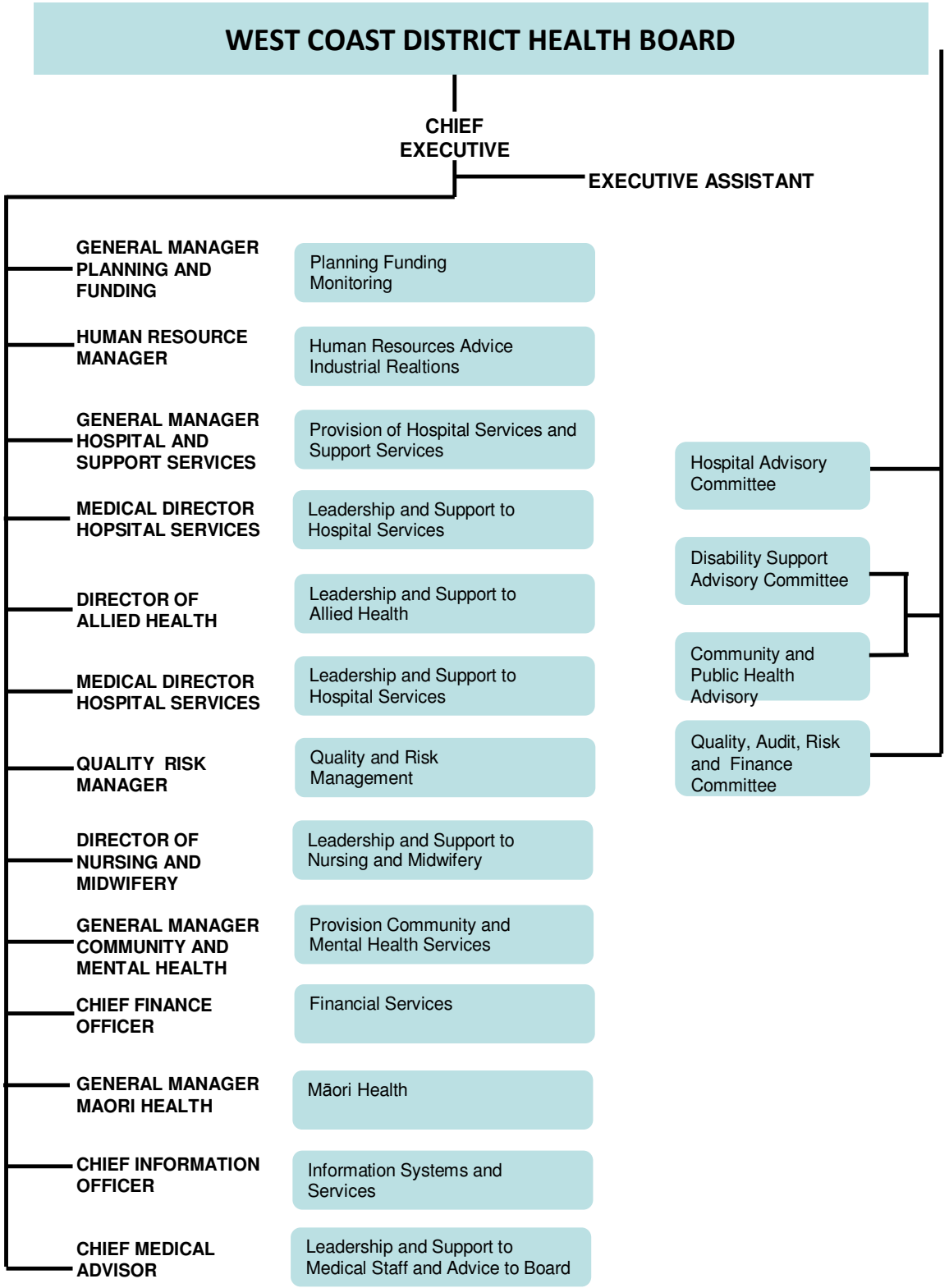
Appendix 1: West Coast District Health Board Organisational Chart

Appendix 2: Geographical Map of West Coast

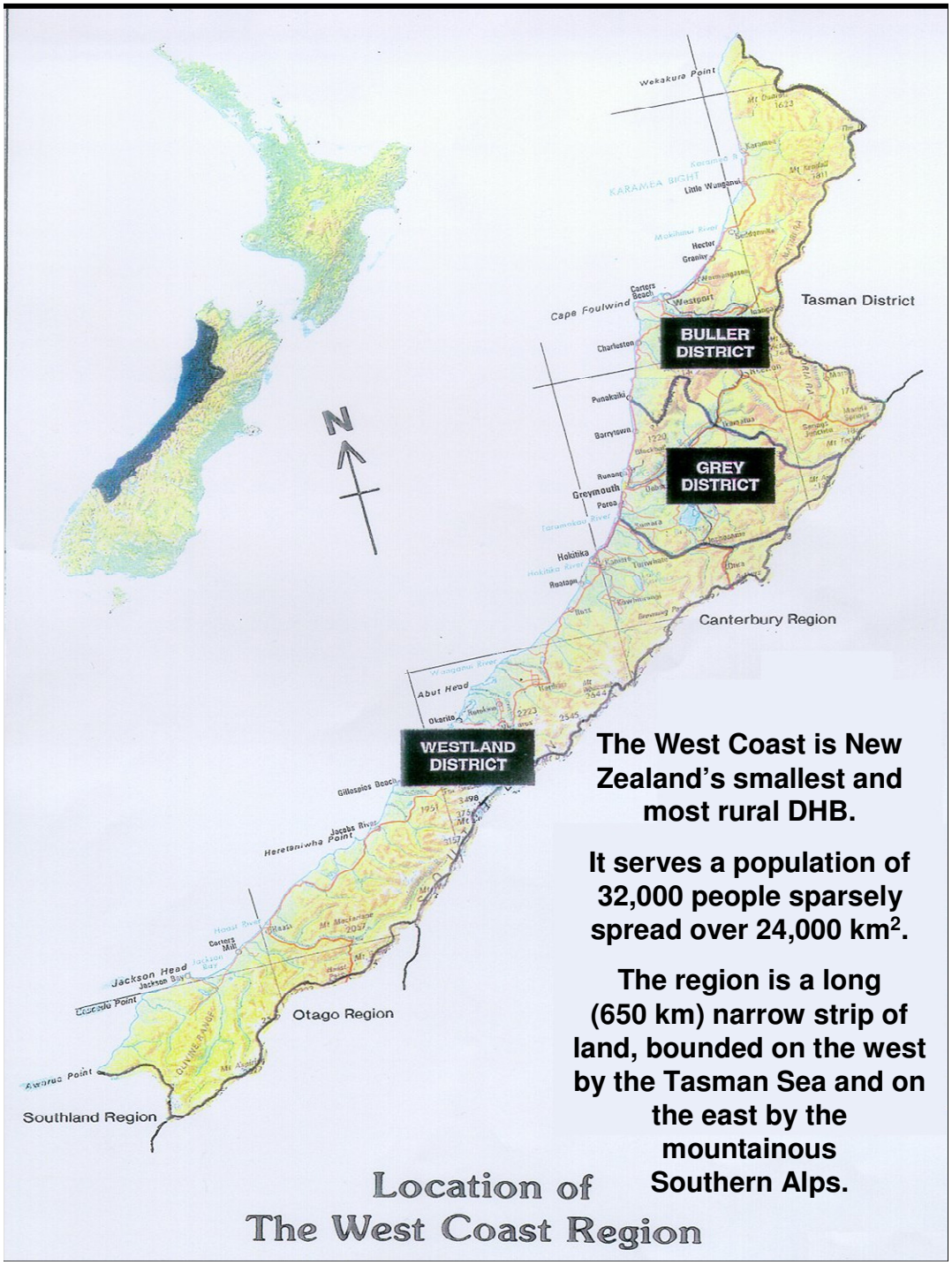
Appendix 3: Definitions

Appendix 4: Glossary of Terms

APPENDIX 1. WEST COAST DISTRICT HEALTH BOARD ORGANISATIONAL CHART



APPENDIX 2: MAP OF WEST COAST



APPENDIX 3: DEFINITIONS

Activity	What an agency does to convert inputs to Outputs.
Capability	What an organization needs (in terms of access to people, resources, systems, structures, culture and relationship), to efficiently deliver the outputs required to achieve the Government's goals.
Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity).
Crown Entity	A generic term for a diverse range of entities within 1 of the 5 categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Hospital Services	Comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialized equipment. These services are generally complex and provided by health care professionals that work closely together. They include: • Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services • Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services Emergency Department services including triage, diagnostic, therapeutic and disposition services
Impact	The contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. For example The change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations (Public Finance Act 1989)

Impact measures	Impact measures are attributed to agency (District Health Boards) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls. (http://www.ssc.govt.nz/upload/downloadable_files/performance-measurement.pdf)
Inputs	The resources used to produce the goods and services (outputs) of the District Health Board. They include personnel, travel, motor vehicles, and land and buildings. Input information provides information about what the District Health Board has spent money on but not what the entity has produced. (Controller and Auditor-General – Statements of intent: Examples of reporting practice, June 2009
Internal outputs	Also referred to as intermediate or management outputs) are: Goods or services processed by one part of the District Health Board and delivered to another part of the same District Health Board; or Steps along the way in the District Health Board's processes which contribute directly to the delivery of another output.
	Management systems, internal outputs and processes are needed to support the delivery of outputs to external parties. Although they are not outputs, information on them is needed for internal management purposes and may be useful for readers of general purpose financial statements.
Intervention logic model	A framework for describing the relationships between resources, activities and results (refer to www.ssc.govt.nz)
Management systems	The supporting systems and policies used by the District Health Board in conducting its business.
Objectives	Is not defined in the legislation but use recognises that not all outputs and activities are intended to achieve "outcomes". Example. *Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving relationships; improving Governance…etc are 'internal to the organisation and enable the achievement of 'outputs*
Outcome	A state or condition of society, the economy or the environment and includes a change in that state or condition. It normally describes a state or condition that is influenced by many different factors which may operate independently and where attributing change to the activities of one agency is very difficult. Example The life expectancy of infants at birth and at age one (Public Finance Act 1989)

Output agreement	An output agreement is to assist a Minister and a Crown entity (District Health Board) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) Crown Entities Act 2004
Output classes	An aggregation of outputs (Public Finance Act 1989) Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) Crown Entities Act 2004). are groups of similar outputs (Public Finance Act 1989)
Outputs	Final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the District Health Board group
Ownership	The Crown's core interests as 'owner' can be thought of as: **Strategy** - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown; **Capability** - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future; **Performance** - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively. (refer to http://www.ssc.govt.nz/glossary/)
Performance measures	Selected measures must align with the District Health Board's District Strategic Plan and District Annual Plan. The use of four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2010/2011) and show intended results for the two subsequent financial years refer to www.ssc.govt.nz/performance-info-measures)
Primary and Community Healthcare Services	Comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. This include general practice, community and Maori

	health services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the District Health Board.
Public Health Services	Publicly funded services that protect and promote health in the whole population or identifiable sub-populations and comprises services that are designed to enhance the health status of the population as distinct from the curative services which repair/support health and disability dysfunction. Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public Health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protections services such as immunisation and screening services.
Purchase agreement	A documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements (refer http://www.ssc.govt.nz/glossary/).
Processes	The way the District Health Board converts inputs into outputs.
Results	Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once. (http://www.ssc.govt.nz/glossary/)
SMART	The acronym that describes the key characteristics of meaningful objectives, which are **S**pecific (concrete, detailed, well defined), **M**easureable (numbers, quantity, comparison), **A**chievable (feasible, actionable), **R**ealistic (considering resources) and **T**ime-Bound (a defined time line).
Standards of Service Measures	Measures of the quality of service to clients focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.
Statement of Intent	A document that identifies, for the medium term, the main features of intentions regarding strategy, capability and performance. Statements of Intent are developed after discussion between an entity and its

	Minister(s). Crown entities on the Sixth Schedule to the Public Finance Act prepare an Statements of Intent that covers medium term financial and performance intentions. After being finalised, the Statements of Intent is tabled in Parliament (http://www.ssc.govt.nz/glossary/)
Statement of service performance (SSP)	Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year (http://www.ssc.govt.nz/glossary/)
Strategy	See Ownership (http://www.ssc.govt.nz/glossary/)
Support Services	Comprise services that are delivered following a 'needs assessment' process and coordination input by Needs Assessment Service Coordinator Services for a range of services including palliative care services, home-based support services and residential care services.
Targets	Agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.
Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos (http://www.ssc.govt.nz/glossary/)

APPENDIX 4: GLOSSARY OF TERMS

ATandR	Assessment, Treatment and Rehabilitation Unit
Au Turoa	Environmental
BNZ	Bank of New Zealand
Capex	Capital Expenditure
CE Act	Crown Entities Act
CEO	Chief Executive Officer
CHFA	Crown Health Financing Agency – a division of the Residual Health Management Unit (RHMU) that acts as a lending bank to District Health Boards.
CFA	Crown Funding Agreement – the main contractual arrangement through which the Ministry of Health Funds the District Health Board.
CPH	Community and Public Health
DAP	District Annual Plan
DHB	District Health Board
DHBNZ	District Health Boards, New Zealand
DSD	Disability Support Directorate
DSP	District Annual Plan
DSS	Disability Support Services
EMT	Executive Management Team
FFT	A percentage increase in District Health Board funding designed to include the cost of inflation for District Health Boards
FSA	First Specialist Attendance (outpatient clinic)
FTE	Full Time Equivalent
GAAP	Generally Accepted Accounting Principles
GP	General Practitioner
HNA	Health Needs Assessment
He Korowai Oranga	Māori Health Strategy
HPAC	HealthPAC (Health Payments, Agreements and Compliance)
HRIS	Human Resources Information System

IDP	Indicator of District Health Board Performance
IFRS	International Financial Reporting Standards
IPA	Independent Practitioners Association
IQ	Improving Quality
IT	Information Technology
Kaiarahi	Māori Health Manager (The word Kaiarahi is Māori for "Guide").
LAN	Local Area (Computer) Network
LTSF	Long Term System Framework
MAGPIE	The Mental health and General Practice Investigation (MaGPIe) a New Zealand study investigating the mental health of patients presenting at GP practices.
MHINC	Mental Health Information National Collection
MoH	Ministry of Health
NASC	Needs Assessment and Service Co-ordination
NDPG	National Data Policy Group
NGO	Non Government Organisation
NHI	National Health Index
NMDS	National Minimum Data Set
NZHIS	New Zealand Health Information Service
NZPHD	New Zealand Public health and Disability Act
OAG	Office of the Auditor General
OCP	Output Collections Programme
OPF	Operating Policy Framework
PBF	Population Based Funding
PC	Personal Computer
PHI	Public Health Intelligence Unit
PHO	Primary Health Organisation
QIC	Quality Improvement Committee
RFI	Request for Information
RFP	Request for Proposal

RHMU	Residual Health Management Unit
RIF	Regional Intersectoral Forum
R and M	Repairs and Maintenance
SAMO	Special Area Medical Officers
SCS	Service Cover Schedule
SFSP	Statement of Forecast Service Provider
SIMHN	South Island Mental Health Network
SISSAL	South Island Shared Services Agency
SMO	Senior Medical Officer
SOI	Statement of Intent
SSC	State Services Commission
SWOT	A strategic planning tool that involves analysing internal factors (Strengths, Weaknesses) and external factors (Opportunities, Threats).
TA	Territorial Authorities
Tai Poutini	The West Coast
Tiakitanga	Guardianship
Tangata Whenua	"People of the land", most commonly referring to traditional Māori Iwi occupants of a region or district
Tatau Pounamu	Māori Advisory Group to West Coast District Health Board
Waka	Mobile health service provided by local Māori Health providers
WAVE	Working to Add Value through E- information
Whakatataka	Māori Health Action Plan
WCDHB	West Coast District Health Board