Statement of Intent 2014-2018

Incorporating the Statement of Performance Expectations 2014/15

THE WEST COAST HEALTH SYSTEM

– supporting you to be well

STATEMENT OF INTENT

Produced July 2014
Pursuant to Section 149 of the Crown Entities Act 2004

West Coast District Health Board
P O Box 387, Greymouth
www.westcoastdhb.health.nz

Statement of Responsibility

The West Coast District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2011. Each DHB is designated as a Crown Agent under the Crown Entities Act 2004 and is responsible to the Minister of Health for a geographically defined population.

This Statement of Intent (incorporating the Statement of Performance Expectations) has been prepared to meet the requirements of both governing Acts and the relevant sections of the Public Finance Act. It sets out the DHB's long-term goals and objectives and describes what the DHB intends to achieve in 2014/15 in terms of improving the health of its population and delivering on the expectations of the Ministry of Health.

The Statement of Intent also contains financial forecast information for the current and three subsequent years: 2015/16, 2016/17 and 2017/18.

The Statement of Intent is extracted from the DHB's Annual Plan and presented to Parliament as a separate public accountability document. It is used at the end of every year to compare the DHB's planned performance with actual performance. The audited results are then presented in the DHB's Annual Report.

The West Coast DHB has made a strong commitment to an integrated health system with joint planning and service delivery. Clinically led local and regional alliances are redesigning the way we provide health services, implementing system change and improving health outcomes. These collaborative partnerships include the West Coast Alliance, the South Island Regional Alliance and transalpine arrangements with the Canterbury DHB.

In line with this approach, the goals outlined in this document present a picture of the joint commitment between the West Coast DHB and the West Coast Primary Health Organisation (as partners in the West Coast Alliance), along with the contribution of other local healthcare partners and the Canterbury DHB, to improve the health of our community and deliver the expectations of Government.

The West Coast DHB also has Māori Health and Public Health Action Plans for 2014/15, both of which (along with this Statement of Intent) are companion documents to the Annual Plan. All of these documents are available on the West Coast DHB website: www.wcdhb.org.nz.

In signing this Statement of Intent, we are satisfied that it represents the intentions and commitments of the West Coast DHB and West Coast Health Alliance for the period 1 July 2014 to 30 June 2018.

Together, we will continue to demonstrate real gains and improvements in the health of the West Coast population.

Peter Ballantyne
Chair West Coast DHB

Susan Wallace
Board Member
West Coast DHB

Date: November 2014

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Part I – Overview

Message from the Chairman and Chief Executive

A Journey Well Underway

The West Coast is one of the most externally reviewed health systems in the country. In the period since 1993, no fewer than 13 reviews of West Coast health services have been undertaken. They have focused on models of care, service options, the economics of healthcare provision, workforce and facilities.

These various reviews all pointed to the same systemic challenges: a small population spread over a large geographic area; longstanding workforce shortages and a prevalence of locums leading to a loss of continuity of care; over-reliance on hospital-level services as a result of fragmented and unsustainable primary services; outdated and inefficient hospital facilities; underdeveloped transport infrastructure; poorly integrated information technology systems; and increasing service provision costs.

Importantly, the reviews all pointed to a common set of whole-of-system priorities for resolving these issues, with the patient and their journey at the centre. They included the re-energising of general practice; the systemic integration of primary care with hospital-level services; more comprehensive long-term conditions management; a strong core workforce with specialist and generalist skills; closer collaboration with the Canterbury health system; joined up transport and information systems; and fit for purpose facilities.

Extensive engagement with our community and clinicians two years ago saw us develop a comprehensive plan for systematically confronting and delivering the transformational change that was needed. During the 2013/2014 year, we have further developed and brought to life the change that this plan sets out.

Specifically, we have redesigned the way in which care is provided, integrating services that have historically been fragmented and refocusing investment on care as close to people's homes as possible. We have agree a programme of change for a number of our services - including maternity and mental health - and we have further improved the way we deliver others, including orthopaedics and older person's health.

We have reinvigorated our recruitment strategy, the results of which are already delivering new clinical capability to the West Coast. We have further connected our information systems, including the implementation of the mental health solution shared between the West Coast, Canterbury, and South Canterbury on the *Health Connect South* platform.

We have also secured the commitment of the Government to new purpose-built healthcare facilities in both Greymouth and Westport.

In summary, we are addressing the underlying causes of unsustainable health service provision on the West Coast. We remain confident that the tangible solutions we are implementing will meet the needs of our community and enable us to provide safe and more sustainable health services for West Coasters now and into the future.

Integrating Care: A health care home and a single point of referral for complex care

The West Coast Health Alliance is now well established, and the Alliance's Grey and Buller Integrated Family Health Centre (IFHC) workstreams are leading the integration of primary care services on the West Coast. In the year ahead, the integration agenda will continue to be pursued alongside planning for the Grey and Westport IFHC facilities. The integration of primary care services is central to realising more effective, efficient and accessible care, together with the ongoing work to improve the performance of DHB-owned general practices, the further development of *HealthPathways,* and the improvements in linkages across the system.

The Complex Clinical Care Network (CCCN) has also now been established. Working alongside general practice and with the West Coast Health Alliance's Health of Older Persons Workstream, the CCCN is better supporting people with complex conditions to remain safe and well in the community and closer to their own homes, rather than in hospital settings. Ongoing commitment to the development of the CCCN and the Coast's Long-Term Conditions Management Programme are essential foundations for preventing deterioration, improving the quality of people's lives and reducing unnecessary demand on the health system.

Sustaining Care: Transalpine services and supporting health professionals

Collaboration with Canterbury continues to be a cornerstone strategy for securing reliable access to a full range of specialist services, for the most part delivered locally on the Coast and with some services delivered in Christchurch.

In 2014/2015, we will deliver on our commitment to regional collaboration and further build on the longstanding partnership between the West Coast and Canterbury health systems to ensure the future sustainability of locally delivered services. Focus services include obstetrics and gynaecology, general medicine, general surgery and anaesthesia. We will also continue to enhance the more than 20 transalpine services that are successfully delivered between the West Coast and Canterbury.

Workforce stability and capability remains another essential enabler for improving the continuity of care we provide and for reducing our historical over-reliance on locums. While we yet have some distance to travel, we have invested in new approaches to medical recruitment including the recruitment of Rural Hospital Medicine doctors, the results of which are already delivering new capability to the West Coast. Joint appointments between the West Coast and Canterbury health systems continue to ensure access to specialist care on the Coast, including in paediatrics, anaesthesia, and gerontology. Our collaboration with Canterbury on a highly successful Nursing Entry to Practice programme is ongoing, and our Rural Learning Centre will continue to work to reduce workforce isolation factors through collaboration, peer support and mentoring.

Connecting Care: Integrated information systems

Integrated information systems are critical to the delivery of joined-up care. Over the past year, we have implemented a regional e-referrals solution that better enables clinicians to provide access to the right service. Our innovative approach to the Health Connect South platform is being considered for wider regional roll-out.

In the year ahead, we will continue to support the implementation of new clinical information systems, including the Electronic Shared Care Record View (eSCRV). This will revolutionise the delivery of clinical care by ensuring that clinicians across the whole of the health system have access to the patient information they need to make the best possible decisions.

Additionally, our ongoing investment in telehealth is improving access to specialist care and reducing associated delays and costs for patients.

Joined-up Care: Settings and fit-for-purpose facilities

The announcement by government of new purpose-built healthcare facilities in both Greymouth and Westport confirms the future of healthcare services for people on the West Coast.

In the last twelve months, significant effort was invested by clinical teams who shaped the development of facility solutions for Greymouth and Westport. In the year ahead, clinicians will be at the forefront of developing the detailed design and plans for the new Grey Base Hospital and IFHC in Greymouth and the IFHC in Westport.

The go-ahead for these new facilities will enable us to plan and take the next steps in the journey that we are on with confidence.

Health targets: Commitments to the Crown

We continue to deliver on Government health targets, leading the country in driving down wait times in Emergency Departments, where we consistently achieve above 99% of people attending ED being admitted, discharged or transferred within 6 hours.

Nine months into 2013/14:

- We are on track to achieve our electives target.
- 100% of people needing radiation or chemotherapy treatment received treatment within 4 weeks.
- 92.5% of hospitalised smokers and 55.4% of smokers in primary care were provided with advice and support to quit (up from 89% and 44% respectively last year).
- 89% of all eight-month-olds on the West Coast were fully immunised, (up 5%).
- 69.6% of eligible people on the Coast had received a cardiovascular risk assessment in the past five years (up from 58% last year).

Clinically and financially sustainable care: A clear plan and commitment

Our vision is for an integrated health system that is clinically sustainable, financially viable and wraps care around a person to help them stay well as close to home as possible. At the heart of this vision is a fundamental re-orientation of our current service model to an integrated home and community-centric system that has the patient firmly at the centre.

As we reflect on the last twelve months, we would like to acknowledge all those across the West Coast health system who continue to travel with us on this journey of transformation. There are many people working hard to deliver a future of sustainable healthcare services for the West Coast.

In year ahead, we remain determined to continue delivering on our commitments, meet national targets, and live within our means. What this means is that we will continue our journey of transformation that is delivering - 21 years on from the first review of Coast health services in 1993 - the kind of health system which Coasters deserve and in which they can be proud.

Peter Ballantyne
Chairman West Coast DHB

David Meates
Chief Executive West Coast DHB

Date: November 2014

Introducing the West Coast DHB

The West Coast DHB has the smallest population of all of New Zealand's 20 District Health Boards, serving at total resident population of 32,145 people.

The West Coast has the third largest geographical area, making it the most sparsely populated DHB. Our district extends from Karamea in the north to Jackson Bay in the south and Otira in the east, and comprises three Territorial Local Authorities: the Buller, Grey and Westland districts.

The West Coast DHB is also a major employer in the West Coast district, employing over 1,000 people.

1.1 Our role and function

The West Coast DHB receives funding from Government with which to fund and provide health and disability services for the West Coast population. In accordance with legislation and the objectives of the DHB, we use this funding to:

Plan the strategic direction of health and disability services on the West Coast and determine the services required to meet the needs of the population, in partnership with primary care, clinical leaders and key stakeholders and in consultation with our community.

Fund the majority of health and disability services provided on the Coast and, through our collaborative relationships with service providers, ensure services are responsive, coordinated, and focused on what is best for the patient and the health system.

Provide health and disability services for the population of the West Coast, through our hospital and specialist services and our DHB-owned general practices.

Promote and protect population health and wellbeing through health promotion, health education and the provision of evidence-based public health initiatives.

1.2 Our operating structure

Governing the DHB

Our Board is responsible to the Minister of Health for the overall performance of the DHB and delivers against this responsibility by setting strategic direction and policy that is consistent with Government objectives, improves health outcomes and ensures sustainable service provision. The Board also ensures compliance with legal requirements and maintains relationships with the Minister of Health and the West Coast community.

Five advisory committees assist the Board to meet its responsibilities. These committees are comprised of a mix of Board members and community representatives.

As part of our commitment to shared decision-making, external providers and clinical leaders also regularly present to the Board and its sub-committees.

While responsibility for the DHB's overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive. The Chief Executive is supported by an Executive Management Team, which provides clinical, strategic, financial and cultural input into decision-making and has oversight of patient safety and quality.

Since July 2010, executive services for the West Coast DHB have been shared with the Canterbury DHB, with one Chief Executive, a growing number of joint appointments and shared corporate divisions including: finance, human resources, information technology, public health and planning and funding services. These joint arrangements promote a better understanding of individual DHB issues on both sides and a closer working relationship between the two DHBs. [1]

Planning and funding health services

The DHB's role includes determining how best to use the funding we receive from Government to improve the health, wellbeing and independence of our population. We work with other providers, agencies, consumers and our community to understand our population's health need.

Through this collaboration, we ensure that services are people-centred, integrated and viable. Our collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the West Coast health system to achieve the best possible health outcomes for our community.

Our Planning and Funding Division holds and monitors alliance agreements and service contracts with the organisations and individuals that provide health services to the West Coast population. This includes an internal service agreement with our Hospital and Specialist Services Division and more than 40 service agreements with external providers – including primary care agreements with the West Coast Primary Health Organisation (PHO), residential mental health service agreements, Māori health service agreements and transalpine service agreements with Canterbury.

[1] *Refer to Appendix 2 for the legislative objectives of a DHB and Appendix 4 for the DHB's organisation structure.*

Providing health and disability services

The West Coast DHB owns Grey Base Hospital, Reefton Hospital and Buller Health and provides a range of hospital-based services on these sites. We also provide specialist outpatient and allied health services on an outreach/extension basis via the Reefton Health, Hokitika Health and Buller Health Centres. The DHB owns Ziman House and Kynnersley Home, which provide rest home level residential care. The DHB also owns five of the eight primary health centres on the West Coast and a number of associated health clinics in remote rural areas including Ngakawau, Karamea and Moana.

This is no small responsibility – in an average week on the West Coast: 230 people go through our Grey Base Emergency Department; 118 people are admitted to our hospitals; 34 people have elective surgery; 297 people have a specialist outpatient appointment and 2,530 general practice appointments are provided.

Promoting community health and wellbeing

The Community and Public Health Division of the Canterbury DHB provides population health and promotion services on behalf of the West Coast DHB. Working with the West Coast PHO, the DHB supports collaborative initiatives that focus on the reduction of negative behaviours and risk factors. This includes improving nutrition and physical activity and reducing tobacco smoking and alcohol consumption under the collective banner of 'Healthy West Coast'.

Community and Public Health also provides health protection services and assists in safeguarding water quality, bio-security (protecting people from disease carrying insects and other pests), the control of communicable diseases and emergency planning to prepare for a natural or biological emergency.

However, good health is determined by many factors and social determinants that sit outside the direct control of the health system. Our partnerships with other agencies (including local and regional councils, Housing NZ, Accident Compensation Corporation and the Ministries of Justice, Education and Social Development) are also vital in influencing and supporting the creation of social and physical environments that reduce the risk of ill health.

1.3 Our transalpine service model

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

While the West Coast has had informal arrangements with the Canterbury DHB, these are now being formalised through the establishment of clinically led transalpine service pathways.

This approach is not about reducing services. Formal arrangements enable both DHBs to proactively develop the most appropriate workforce and service infrastructure, to ensure future services meet the needs of both populations and are both clinically and financially sustainable.

These arrangements include joint clinical appointments and shared services that have enabled specialists to visit the West Coast and provide outpatient clinics to save patients from having to travel. Deliberate investment in telemedicine technology such as videoconferencing is also allowing clinical teams to provide better support to their patients and reducing long waits and travel for treatment.

Since 2010, more than 800 telehealth consultations have taken place in a variety of specialties, including oncology, paediatrics, general medicine, plastics, orthopaedics and general surgery – providing access to specialist advice while saving many families the inconvenience of travelling long distances for treatment.

1.4 Our accountability to the Minister

As a Crown entity, the DHB must have regard for Government legislation and policy as directed by the Minister of Health. As appropriate, and required by legislation, we will engage with the Minister and seek prior approval before making any significant service change, capital investment or disposal of Crown land. We will also comply with specific consultation expectations that the Minister communicates to us.

The Crown Entities Act requires DHBs to report annually to Parliament on their performance, as judged against our Statement of Performance Expectations. We publish this account as our Annual Report, available on our website.

In addition, DHBs have a number of other reporting obligations under the Crown Entities Act and Operational Policy Framework. These include financial and non-financial service performance reporting provided to the National Health Board including:

- Annual Reports and Audited Financial Statements;
- Quarterly non-financial performance reports;
- Quarterly health target reports;
- Quarterly reports on service delivery against plan;
- Bi-annual risk reports;
- Monthly financial reports; and
- Monthly wait time and Elective Services Performance Indicator (ESPI) compliance reporting.

We will also meet our requirements with respect to national data collection, including: national health index, national minimum dataset, national booking reporting system, national immunisation register, national non-admitted patient collection and ethnicity reporting.

Identifying Our Challenges

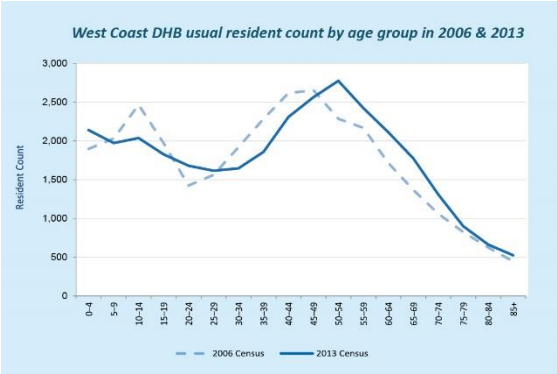
Analysing the demographics and health profile of our population helps us to predict the demand for services and influences the choices we make when prioritising and allocating resources. This information also helps us to understand the factors affecting our performance and identify areas for focus and improvement.

2.1 Population profile

West Coast was home to a resident population of 32,145 people at the 2013 Census, an increase of 2.6% on 2006. This is a slower rate of growth than between the 2001 and 2006 censuses. Grey district has the largest population, with a resident population of 13,371 people.[2]

The West Coast DHB population has an older age structure compared with New Zealand as a whole, with a higher proportion of people aged over 65 (16.1%) compared with the national rate (14.3%).

While our younger populations decreased slightly between 2006 and 2013, there was significant growth in our older population groups. 5,181 people on the Coast are aged 65 or older and 2,088 (6.5% of our total population) are aged 75 or older.



As we age, we develop more complicated health needs and multiple health conditions, meaning we consume more health resources and are more likely to need specialised services. There are a number of long-term conditions that become more common with age, including heart disease, stroke, cancer and dementia. The ageing of our population will put significant pressure on our workforce, infrastructure and finances.

Our Māori population has a different age structure and growth pattern, with 42.4% of the West Coast Māori population under 20 years of age compared to 24.8% of the total population. However, ethnicity is a strong indicator of need for health services and must be considered when planning services for the future. One in ten West Coasters identifies as Māori (10.5% up from 9.7% in 2006). Westland district has the largest Māori population in the region, at 13.4%.

Deprivation is another indicator of the need for health services. Analysis of socio-demographic data in 2006 showed that compared with New Zealand as a whole, the West Coast DHB had a lower mean personal income ($20,400 per year compared to $24,400 nationally). Higher proportions of our population are receiving unemployment or invalid benefits, have no educational qualifications and lack access to a motor vehicle.

2.2 Health profile

West Coasters have higher overall morbidity and mortality rates and lower life expectancy when compared with the New Zealand average. The overall rate of hospitalisation is also high.

While gains have been made, West Coast Māori continue to have a poorer overall health status than others in the region. This is demonstrated by a range of indicators, including rates of cardiovascular disease, cancer, diabetes and respiratory disease. Māori are also under-represented among primary care utilisation data.

West Coast children and young people have poorer health outcomes than their counterparts in other parts of the country. The leading causes of mortality, morbidity and hospitalisations for young people on the West Coast are preventable.

West Coast residents also have higher smoking rates compared with other areas in New Zealand. The 2013 Census showed that 19.6% of West Coast residents were regular smokers, compared to 14.4% of New Zealand as a whole. Amongst West Coast Māori, 32.4% of the population were regular smokers. The negative health outcomes associated with risk factors such as tobacco smoking place considerable pressure on our health system. Smoking is also a substantial contributor to socio-economically based health inequalities.

2.3 Operating environment

Geographical pressures

Meeting our population's health need is a highly complex business that is further complicated by the challenges of delivering health services to a relatively small population over a large geographic area.

Bordered by the Southern Alps on the east and the Tasman Sea on the west, the West Coast is the most rural

[2] *Unless otherwise referenced, data is based on Statistics NZ 2013 Census and Ministry of Health mortality data. See Appendix 3 for a summary of the 2013 Census.*

and isolated DHB in New Zealand. It is also the most sparsely populated, with a population density of 1.4 people per square kilometre.

While our population is just 0.76% of New Zealand's estimated resident population, the total land area covered by the West Coast DHB is 23,283 square kilometres, with great distances between towns. The distance between Karamea in the north and Haast in the south is 516 kilometres, almost the same as from Auckland to Palmerston North. This creates significant challenges, often requiring patients or health professionals to travel long distances to receive or deliver health services. 30.7% of households on the West Coast have only one resident.

This is further complicated by the fact that fewer West Coasters have access to a motor vehicle or telephone than other New Zealanders. 3.4% of West Coast households have no telecommunication systems; this is the highest proportion of any region in New Zealand.

Workforce pressures

Our ability to meet future demand for services relies heavily on having the right people, with the right skills, in the right place. As a major employer in our district, we employ over 1,000 people in our services and almost the same number in the community through service contracts for health and disability services with public, private and charitable organisations.

Like many DHBs, as a greater proportion of our population reaches traditional retirement age, there are concerns over the availability of a sufficient workforce to meet increasing demand for health services. However, as a result of our geographical isolation, it can be especially difficult to recruit and retain health staff to work on the West Coast. Our past reliance on temporary and locum staff has made it difficult to maintain consistency of care and is financially unsustainable.

Our ability to safely provide complex and specialised services is also challenged by the relatively small number of Senior Medical Officers and specialist clinicians in our services. While we are addressing this as part of our transalpine collaboration with the Canterbury DHB, we also need to focus on the recruitment of permanent staff with more generalist skills and the creation of new roles with wider scopes to give stability to our services.

Facility pressures

In their current configuration, our facilities limit the development of new models of service delivery, are outdated and inefficient, and are expensive to maintain. In addition, some of our primary and community facilities are not appropriately located or configured to support an integrated service model or clinical team.

Following seismic assessments of buildings located on the Grey Base Hospital site, a number were identified as earthquake-prone, requiring immediate remediation to bring them above 33% of the current building code. Two were closed because the facilities were deemed unsafe to occupy. This has required services to move into temporary or crowded spaces – putting further pressure on our capacity and on our workforce.

In May 2014 approval was given for the redevelopment of the Grey Hospital and Integrated Family Health Centre. A joint Partnership Group, appointed by the Ministry of Health, is charged with delivering the facilities redevelopment. The DHB is also moving forward in addressing the need for viable health services in Buller. It is imperative that the new facilities are fit-for-purpose and designed to support rather than hinder our more responsive and integrated health system model.

While the redevelopment process is underway, it is important that we make carefully considered decisions on the repair of current facilities to ensure safety and service continuity – without over-investing in facilities that do not have a future role.

Fiscal pressures

Government has given clear signals that DHBs need to live within their means and rethink how we deliver improved health outcomes in more cost-effective ways.

Numerous factors contribute to fiscal pressures: the costs of meeting wage and salary increases; increasing demand for services including diagnostics and residential care; and rising treatment related and infrastructure costs.

Our ability to contain cost growth within affordable levels is made more difficult by rising public and cross-government expectations, an ageing population and the increasing costs of new technology.

While fiscal pressures will be an increasing challenge, there are opportunities to add value to the activities we undertake, reduce duplication across our system and direct funding into services that will provide the greatest return in terms of improved health outcomes.

The DHB will need to successfully implement a number of strategies to minimise cost growth and achieve long-term financial sustainability including: the development of integrated models of care in Grey/Westland and Buller, improved management of DHB-owned general practice, increased transalpine collaboration with the Canterbury DHB, clinically led service transformation of local services and the improved use of technology and workforce.

2.4 Critical success factors

The following areas are where the greatest gains can be made in improving health outcomes for our population and the viability of our health system. They also represent the major factors critical to our success, where failure would significantly threaten the achievement of the strategies and goals outlined in this plan.

CRITICAL SUCCESS FACTORS	KEY STRATEGIES
Integrating fragmented health services A legacy of unsustainable DHB-owned general practices with financial, access and continuity of care issues has led to fragmentation amongst general practices and secondary services and a number of inefficient, isolated services struggling to deliver in appropriate settings.	Complete the remediation of DHB-owned general practice underway with Better Health, with a focus on clinical recruitment and improved service delivery. Expand the focus of the West Coast Alliance and deliver against key projects. Support more flexible service delivery models including: mobile, in-reach and afterhours services and direct access to diagnostics and specialist advice for GPs. Continue to invest in the development of HealthPathways. Support the major design and development phases of the hospital and Integrated Family Health Centre developments on the Grey and Buller Hospital sites. Invest in the Health Care Home Strategy to increase the use of multidisciplinary teams and improve linkages across the system, particularly as the IFHCs develop.
Connecting the system Unreliable paper-based information systems and poorly performing information technology platforms have led to ineffective and inefficient service delivery, wasting time and reducing the continuity and safety of care.	Support implementation of new clinical information systems, Health Connect South and the Electronic Shared Care Record View (eSCRV). Implement eReferrals and eSign-Off systems to reduce duplication and delays. Expand the use of telemedicine technology to improve the continuity of care and reduce the associated delays and costs of patient and clinician travel. Implement national information collection systems.
Reducing reliance on secondary care High surgical intervention rates and overinvestment in secondary services (at the expense of community alternatives) has led to a reliance and demand for hospital services that far outweighs capacity and is financially unsustainable.	Implement a community-based rapid response and supported discharge service and introduce a stepped care model for Mental Health Services to support people in the community and closer to their own homes, rather than in hospital settings. Enhance the single point of referral through the Complex Clinical Care Network and introduce a casemix model to provide a more timely and flexible response. Expand the transalpine model to provide more certainty of care for West Coast residents where highly specialised services are not sustainable.
Assuring patient safety With a series of recent sentinel events, assurances are needed about the quality of services being delivered and the safety of patients in our care.	Support the rollout the national patient safety project 'Open for Better Care'. Complete implementation of the Maternity Review recommendations. Implement the recommendations of the Mental Health Service Review. Continue to review all serious events to identify issues that need resolution.
Building a sustainable workforce Longstanding clinical recruitment and retention issues have led to high use of locums and temporary staff. This not only reduces continuity of care and operational leadership capability, but is also financially unsustainable.	Seek clinicians with a wider range of generalist skills and introduce models of care that enable staff to work to the greatest extent of their scope. Implement a new general practice recruitment strategy through Better Health. Invest in the development of our rural clinical workforce through the Rural Learning Centre in Greymouth, including mentoring, training and supervision. Develop a transalpine recruitment strategy and support joint senior appointments between the West Coast and the Canterbury DHB. Invest in telemedicine systems and outreach clinics that will allow specialists to provide advice and supervision to colleagues in more remote areas.
Meeting community expectations Longstanding community frustration, has eroded confidence and trust in the West Coast health system.	Establish a Consumer Council to formalise consumer engagement. Invest in a grassroots community engagement strategy to increase transparency around imperatives for change. Engage in a proactive media campaign to better inform the community of what is happening across the health system.
Meeting Government expectations It is important that the West Coast DHB delivers against national expectations in order to maintain the confidence of Government – particularly in light of the investment being made in our health system over the next five years.	Deliver against the six national health targets. Work regionally and nationally to support tighter, collaborative purchasing and procurement processes that reduce avoidable cost growth. Through the West Coast Alliance and Hospital Redevelopment Partnership Group, accelerate implementation of the Integrated Family Health Service model. Reduce the West Coast DHB deficit and manage within future forecast budgets.

Part II – Long-Term Outlook

Our Strategic Direction

What are we trying to achieve?

3.1 Our strategic context

Although we may differ in size, structure and approach, DHBs have a common goal: to improve the health of their populations by delivering high quality, accessible health care. However, with increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and the whole of the New Zealand health system faces an unsustainable future.

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHB service planning.[3]

International direction emphasises that an aligned, 'whole of system' approach is required to ensure service sustainability, quality and safety while making the best use of limited resources. This entails four major shifts in service delivery:

1. Early intervention, targeted prevention and self-management and a shift to more home-based care.
2. A more connected system and integrated services, with more services provided in community settings.
3. Regional collaboration clusters and clinical networks, with more regional service provision.
4. Managed specialisation, with a shift to consolidate the number of tertiary centres/hubs.

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely and accessible care being paramount. However, less-complex care (traditionally provided in hospital settings) is increasingly being provided in the community.

To ensure the sustainability of the health system, DHBs need to shift their population's health needs away from the complex end of the continuum of care and support more people to manage their own health and stay well.

These shifts can only be achieved with the support of connected and integrated clinical networks and multidisciplinary teams and are consistent with the changes being driven across the West Coast health system to meet the needs of our population.

3.2 The West Coast vision

"An integrated West Coast health system that is clinically sustainable, financially viable and wraps care around the patient to help them stay well".

In the drive to secure a stable and sustainable future for health services on the West Coast, the DHB has worked through a series of internal and organisational reviews – consulting with partner organisations, clinical staff and the West Coast community about a range of initiatives and changes that will improve access to services.

From this consultation, we have developed a vision for the future of the West Coast health system: an integrated health system that is clinically sustainable, financially viable and wraps care around the patient to help them stay well.

At the heart of this vision is a fundamental reorientation of our current service model to an integrated, home and community-centric model, with the retention of a full range of hospital-level services, but delivered in more efficient and effective ways.

New services will be offered close to home that focus on prevention, early intervention and increased responsiveness. From a service delivery perspective, healthcare providers are being brought together to work as teams. There is a plan underway to implement common assessment tools and pathways that will ensure the right person or team is able to provide the right care and support at the right time and in the right place.

Future health services on the West Coast will be:

People-centred: Services will be focused on meeting people's needs and will value their time as an important resource. Services will minimise waiting times and avoid the need for people to attend services at multiple locations or times unless there are good clinical reasons to do so.

Based on a single system: Services and providers will work in a mutually supportive way for the same purpose – to support people to stay well. Resources will be flexible across services and across the system.

Integrated: The most appropriate health professional will be available and able to provide care where and when it is needed. Services will be supported by timely information flow to support clinical decision-making at the point of care.

Viable: The West Coast health system will achieve levels of efficiency and productivity that allow an appropriate range of services to be sustainably maintained in the long term. There will be a stable workforce of health professionals in place to provide these services.

[3] *Trends in Service Design and New Models of Care: A Review, 2010, Ministry of Health, www.nationalhealthboard.govt.nz.*

Implementation of our new model of care is underway on all fronts. Access to specialist health care has improved, and the time West Coasters spend travelling to access care has been reduced. New telemedicine services and outreach clinics now regularly save patients from needing to travel for specialist treatment and follow-up consultations.

Important steps have already been taken towards achieving a more integrated health system, including improving clinical information systems, commencing the development of Integrated Family Health Services within the Grey/Westland and Buller communities, and setting in place a new transalpine health service for specialist services between the West Coast and Canterbury DHBs.

Recognising that clinical leadership is crucial to the successful integration of services, we are engaging health professionals from across the West Coast in all stages of service design and in the development of integrated patient pathways across the health system. Empowered health professionals are taking a lead in setting strategic direction, developing alternative models of care, reducing duplication and waste and improving patient care on the West Coast.

While many of the challenges we face are the same as other DHBs, the difference for the West Coast is our geographic isolation and the complicating factors that come with delivering services to such a small population over such a large area. There is no 'quick fix' – we must develop tailored solutions that enable us to do more (for more people) with the resources we have available.

Partnerships and alliances are also critical – not only in improving outcomes for our population, but in ensuring our health system is clinically and financially sustainable. The West Coast Alliance will take the lead in accelerating the implementation of the model of care for Grey/Westland and Buller, in order to support wrap-around care for our population and the provision of services closer to people's own homes.

The redevelopment of health facilities is also a critical factor in the future sustainability of health services on the West Coast. Approval for the redevelopment of the Grey Hospital and Integrated Family Health Centre was granted in May 2014 and consultation on the redesign of services in Buller is underway.

The DHB will continue to work closely with the Ministerial appointed Hospital Redevelopment Partnership Group to ensure that the new facilities development will enable our redesigned model of care to be delivered, the health needs of our community to be met and our vision for the West Coast health system to be realised.

Achieving our vision requires the transformation of our entire health system. Balancing what *must* be done with what *can* be done will be an ongoing struggle. We will not be able to make lasting change without the support and engagement of our workforce, our community and primary care partners and our neighbouring DHBs.

Our West Coast Alliance and the continued engagement of stakeholders and our community in the future of our health systems is critical to our success. The development of our new model of care includes nine key components, and this is where our focus will be over the next three years:

A healthcare home, with emphasis on primary care as the point of continuity, multi-disciplinary teams working in the community to wrap care around the patient and a more integrated response to acute demand.

A single point of referral for complex care, with the introduction of a rapid response and supported discharge service to better support people at home and in community settings.

Locally delivered hospital-level services using both specialists and rural hospital medicine doctors, in closer transalpine collaboration with Canterbury.

Healthy environments and lifestyles, with emphasis on early intervention and reducing risk factors and a commitment to Smokefree Aotearoa 2025.

Strengthened mainstream service responsiveness to Māori needs, alongside supporting Kaupapa Māori service developments and Whānau Ora.

Integrated information systems, with a focus on clinical information systems that support decision-making at the point of care and extended use of telemedicine.

Maintenance and deliberate development of a local workforce of resident specialists and generalists supported by clinicians from Canterbury.

Improved transport solutions and patient transport infrastructure.

The development of modern, fit-for-purpose facilities and integrated family health services closer to people's homes that support closer alignment and integration of health teams.

3.3 National direction

At the highest level, DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga) and by the requirements of the New Zealand Public Health and Disability Act.

The ultimate health sector outcomes are that all New Zealanders lead longer, healthier and more independent lives; and the health system is cost-effective and supports a productive economy.

DHBs are expected to contribute to meeting the national health sector outcomes and Government commitments to provide *'better, sooner, more convenient health services'* by: increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money.

Alongside these longer-term national strategies and commitments, the Minister of Health's annual 'Letter of Expectations' also signals priorities for the health sector – most specifically with regards to the delivery of better public services and the six national health targets.[4]

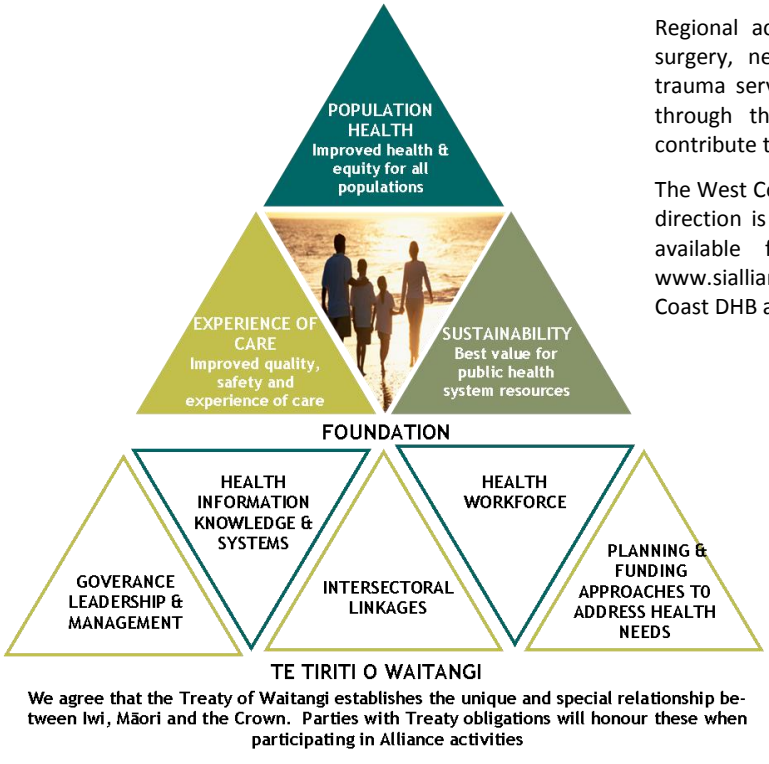
The West Coast DHB is committed to making continued progress against national priorities and health targets. Activity planned over the coming year to deliver on national expectations is part of the focus of the West Coast Alliance and prioritised by the Alliance Workstreams and the DHB's Service Divisions. Key actions for the coming years are outlined in the DHBs Annual Plan.

3.4 Regional direction

In delivering its commitment to '*better, sooner, more convenient health services*', the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The South Island Alliance was established in 2011 to formalise the partnership between the five South Island DHBs. In 2013, the region's DHBs agreed to further develop this approach with a framework that aligns all regional activity to agreed goals. The '*best for patients, best for system*' framework has become '*Best for People, Best for System',* supporting a focus on the whole population. The shared vision has also been revised to include disability to ensure key population groups are identified within the framework:

A sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible.



While each DHB is individually responsible for the provision of services to its own population, working regionally enables us to better address our shared challenges and support improved patient care and more efficient use of resources. The South Island DHBs are committed, through the Alliance, to making the best use of all available resources, strengthening clinical and financial sustainability and increasing access to services for the South Island population.

The Canterbury, Nelson Marlborough, West Coast, South Canterbury and Southern DHBs form the South Island Alliance – together providing services for 1,004,380 people (23.7% of the total NZ population).

The success of the Alliance relies on improving patient flow and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to better connect the services and clinical teams involved in a patient's care

Closely aligned to the national direction, the shared outcomes goals of the South Island Alliance are:

- Improved health and equity for all populations.
- Improved quality, safety and experience of care.
- Best value for public health system resources.

To help ensure success, regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multidisciplinary representation from community and primary care, hospital and specialist services and consumers.

There are seven priority areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity will also focus on: cardiology, elective surgery, neurosurgery, public health, stroke and major trauma services. Regional asset and workforce planning, through the South Island Regional Training Hub, will contribute to improved delivery in all service areas.

The West Coast DHB's commitment in terms of the regional direction is outlined in the Regional Health Services Plan, available from the South Island Alliance website: www.sialliance.health.nz. Key deliverables for the West Coast DHB are also highlighted the DHB's Annual Plan.

[4] *Refer to Appendix 6 for the Minister's Letter for 2014/15 and Appendix 7 for the DHB's commitment to the Health Targets.*

Measuring Our Progress

How will we know we are making a difference?

DHBs are expected to deliver against the national health sector outcomes: '*All New Zealanders lead longer, healthier and more independent lives'* and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in meeting those commitments and in improving the health and wellbeing of their populations. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service access indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing a strategic framework, the South Island DHBs identified three high-level strategic regional goals. To achieve these goals, we have agreed a number of key strategies which will be achieved through the delivery of regional initiatives and the collective activity of all five South Island DHBs. A comprehensive indicator set is currently under development, to sit alongside the regional strategic framework and enable evaluation of regional activity.

While the regional framework is developed, the South Island DHBs have identified four collective DHB outcome goals where individual DHB performance will contribute to regional success – along with a core set of associated outcomes indicators, which will demonstrate whether we are making a positive change in the health of our populations. These are long-term outcome indicators (up to 10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target.

- *Outcome 1: People are healthier and take greater responsibility for their own health.*

  A reduction in smoking rates.

  A reduction in obesity rates.

- *Outcome 2: People stay well in their own homes and communities.*

  A reduction in acute medical admission rates.

- *Outcome 3: People with complex illnesses have improved health outcomes.*

  A reduction in avoidable mortality rates.

  A reduction in acute readmission rates.

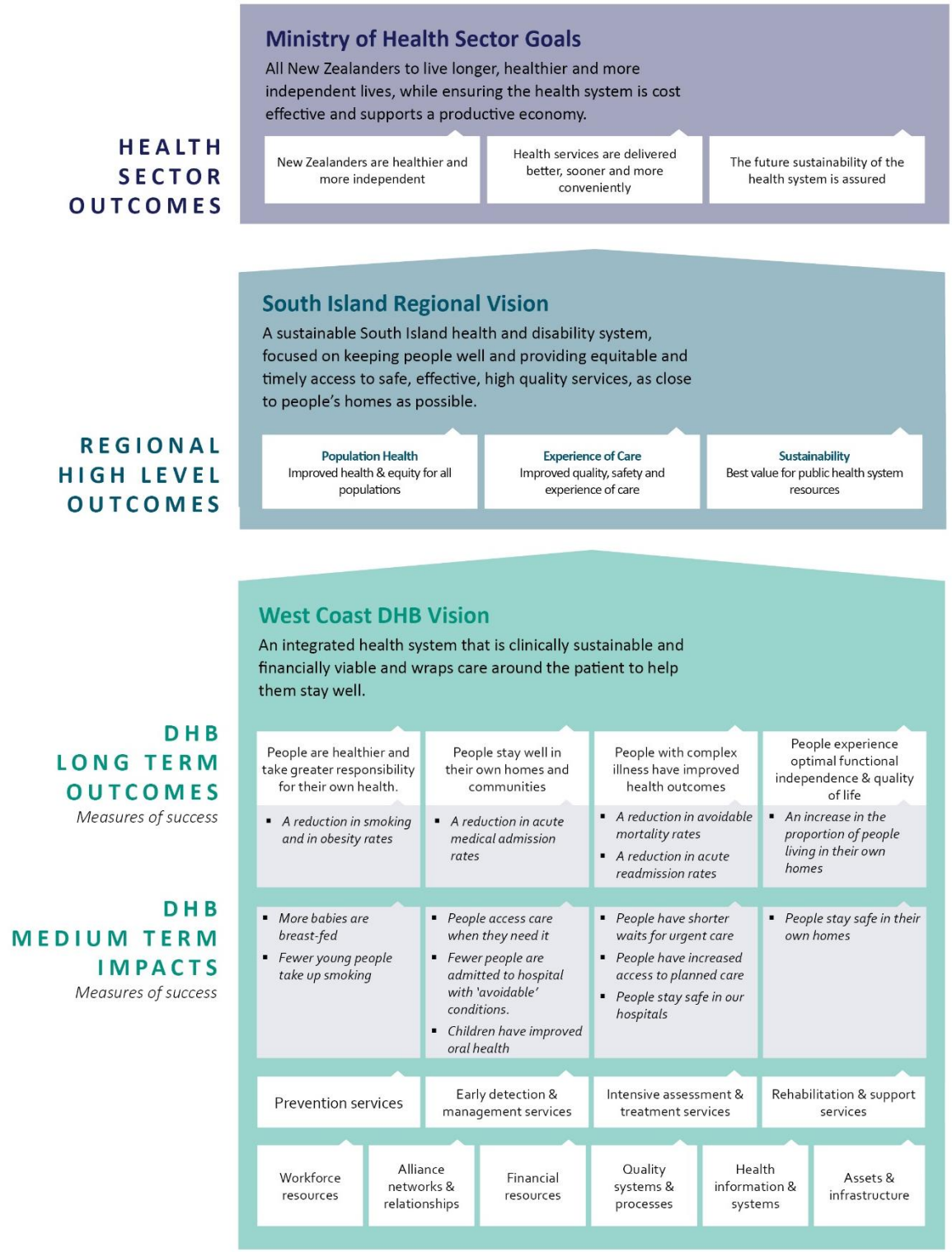
- *Outcome 4: People experience optimal functional independence and quality of life.*

  An increase in the proportion of the population living in their own homes.

Each of the South Island DHBs has also identified a set of associated medium-term indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance, and each DHB has set local targets to evaluate their performance over the next four years. These indicators will sit alongside the DHB's Statement of Performance Expectations and be reported against in the DHB's Annual Report at the end of every year.

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (*outputs*) will have an *impact* on the health of their population and result in the achievement of desired longer-term regional *outcomes* and the expectations and priorities of Government.

Overarching intervention logic



STRATEGIC OUTCOME GOAL 1

4.1 People are healthier and take greater responsibility for their own health

Why is this outcome a priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and hospital and specialist services. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions. Long-term conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOME MEASURES LONG TERM

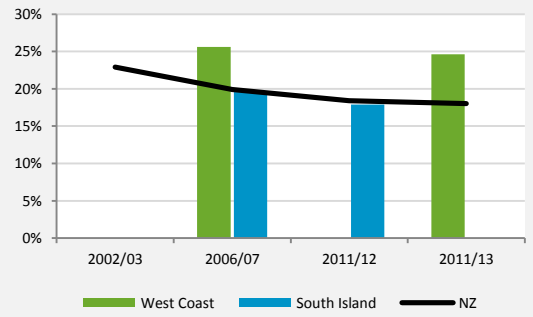
We will know we are succeeding when there is:

A reduction in smoking rates.

- *Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money is available for necessities such as nutrition, education and health. Supporting our population to say 'no' to tobacco smoking is our foremost opportunity to reduce inequalities and target improvements in the health of our population.*

Data sourced from national NZ Health Survey.[5][6]

Outcome Measure: The percentage of the population (15+) who smoke.

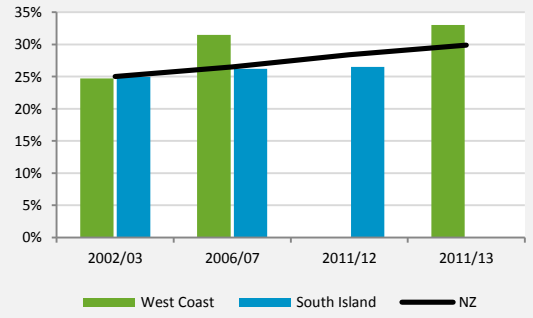


A reduction in obesity rates.

- *There has been a rise in obesity rates in New Zealand in recent decades. The 2011/13 NZ Health Survey found that 30% of adults and 10% of children are now obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing of long-term conditions and disability at all ages.*

Data sourced from national NZ Health Survey.[7]

Outcome Measure: The percentage of the population (15+) who are obese.



[5] *The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. Results by region and DHB are subject to availability and results for 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs hence the different time periods presented. Ethnicity breakdowns are not provided.*

[6] The 2013 Census results for smoking (while not directly *comparable*) demonstrated greater improvements, with 20.5% of those aged 15+ smoking regularly, down from 25.7% in 2006. Rates for Māori, while improving, are still high, with 34.3% of West Coast Māori (15+) being regular smokers, down from 41.4% in 2006.

[7] *'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.*

IMPACT MEASURES MEDIUM TERM

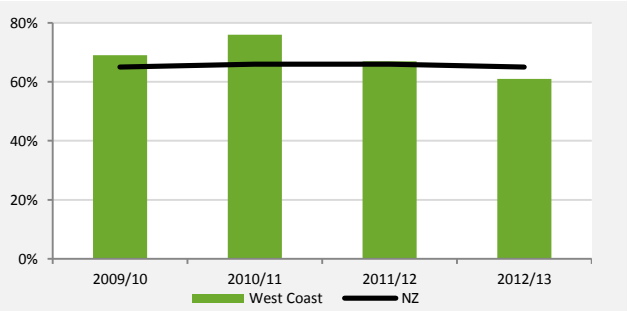
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the prevention services the DHB funds and provides:

More babies are breastfed.

- *Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life. Breastfeeding also contributes to the wider wellbeing of mothers.*
- *An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.*

Data sourced from Plunket via the Ministry of Health.[8]

The percentage of babies exclusively or fully breastfed at 6 weeks.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	61%	74%	>74%	>74%	>74%

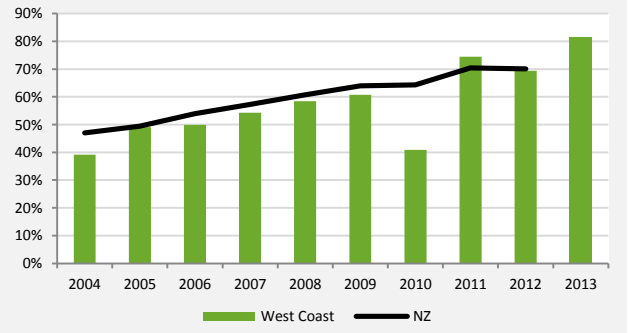


Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up smoking.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

Data sourced from national Year 10 ASH Survey.[9]

The percentage of 'never smokers' among Year 10 students.	Actual 2013	Target 2014	Target 2015	Target 2016	Target 2017
	82%	75%	>75%	>75%	>75%



[8] *This data is provided nationally by the Ministry of Health for Plunket only. It does not include local WellChild/Tamariki Ora breastfeeding results. The target is based on national Well Child standards for breastfeeding at 6 weeks.*

[9] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz. A national result for 2013 was not available at the time of publication.*

STRATEGIC OUTCOME GOAL 2

4.2 People stay well in their own homes and communities

Why is this outcome a priority?

When people are supported to stay well in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection, diagnosis and timely provision of treatment. The general practice team is also vital as a point of continuity and effective coordination across the continuum of care, particularly in terms of improving the management of care for people with long-term conditions and reducing the exacerbations of those conditions and the complications of injury and illness.

For most people, their general practice team is their first point of contact with health services; however, supporting general practice are a range of other health professionals including midwives, community nurses, social workers, personal health providers and pharmacists. These providers also have prevention and early intervention perspectives that link people with other health and social services and support them to stay well and out of hospital.

OUTCOME MEASURES LONG TERM

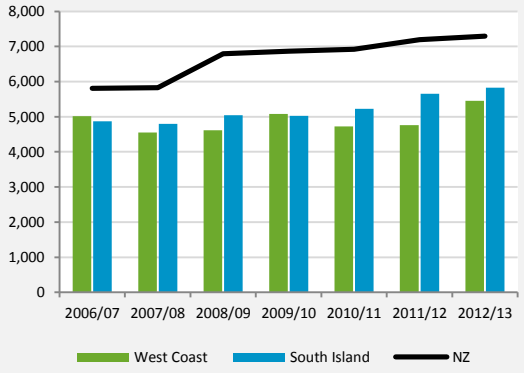
We will know we are succeeding when there is:

A reduction in acute medical admission rates.

- *The impact long-term conditions have on quality of life and demand growth is significant. By improving the management of long-term conditions, people can live more stable, healthier lives and avoid deterioration that leads to acute illness, hospital admission, complications and death.*
- *Acute medical admissions can be used as a proxy measure of improved conditions management by indicating that fewer people are experiencing an escalation of their condition leading to an urgent (acute) or complex intervention. They can also be used to indicate access to appropriate and effective care and treatment in the community.*
- *Reducing acute hospital admissions also has a positive effect on productivity in hospital and specialist services – enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.*

Data sourced from National Minimum Data Set.

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



IMPACT MEASURES MEDIUM TERM

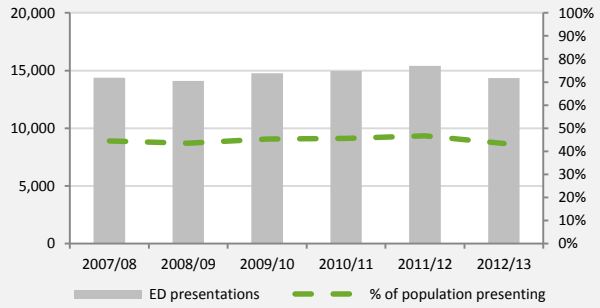
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the early detection and management services the DHB funds and provides:

People access care when they need it.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, which is not necessarily in hospital Emergency Departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the proportion of the population presenting to the Emergency Department (ED) can be seen as a proxy measure of the availability and uptake of alternative community options to more appropriately manage and support people.*

Data sourced from individual DHBs.

The percentage of the population presenting at ED.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	43%	<45%	<45%	<45%	<45%

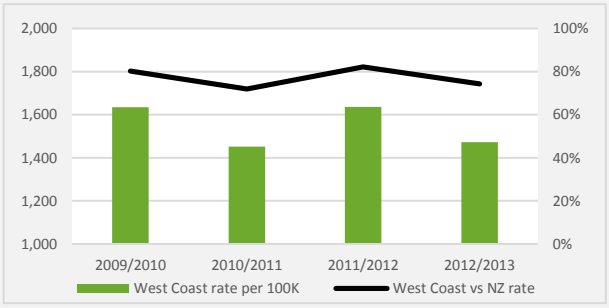


Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *A number of admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.*
- *These admissions provide an indication of the quality of early detection, intervention and disease management. A reduction indicates improvements in care and frees up hospital resources for more complex and urgent cases.*
- *The key factors in reducing avoidable admissions are access to diagnostics and treatment, integration between services and the systems approach to long-term conditions. Achievement against this measure is therefore seen as a proxy measure of a more unified health system as well as a measure of the quality of services being provided.*

Data sourced from the Ministry of Health. [10]

The ratio of actual to expected avoidable hospital population for our population (<75).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	74%	≤95%	≤95%	≤95%	≤95%

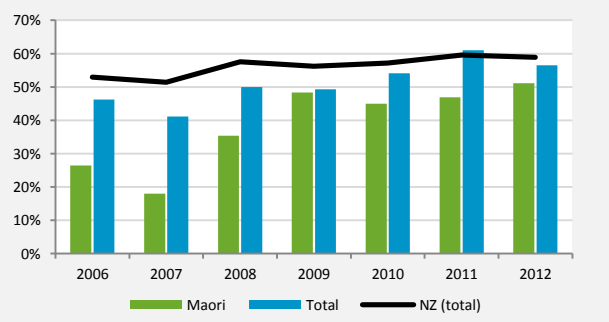


Children have improved oral health.

- *Oral health is an integral component of lifelong health and affects a person's comfort in eating, ability to maintain good nutrition, self-esteem and quality of life.*
- *Good oral health not only reduces unnecessary complications and hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition.*
- *Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy measure of equity of access and the effectiveness of services in targeting those at risk.*
- *The target for this measure have been set to hold the total population rate steady while placing particular emphasis on bring the rates for Māori and Pacific children up.*

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).	Actual 2012	Target 2014	Target 2015	Target 2016	Target 2017
	56%	≥54%	≥56%	>56%	>56%



[10] *This measure is based on the national DHB performance indicator (SI1) and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity, while this has little impact on total population results it is having a significant impact on Māori results against this measure. The DHB is working with the Ministry to resolve this issue.*

STRATEGIC OUTCOME GOAL 3

4.3 People with complex illness have improved health outcomes

Why is this outcome a priority?

For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures. At the same time, the Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reduces demand by moving the point of intervention earlier in the path of illness.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that have a negative impact on the health of our population.

OUTCOME MEASURES LONG TERM

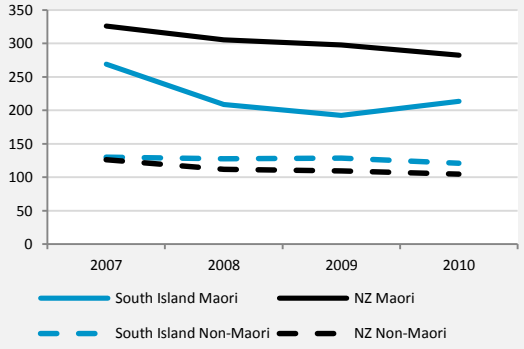
We will know we are succeeding when there is:

A reduction in avoidable mortality rates.

- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases the options for treatment and the chances of survival.*
- *Premature mortality (death before age 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the more harmful impacts and complications of a number of complex illnesses can be reduced.*
- *A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.*

Data sourced from MoH mortality collection 2010 update.

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

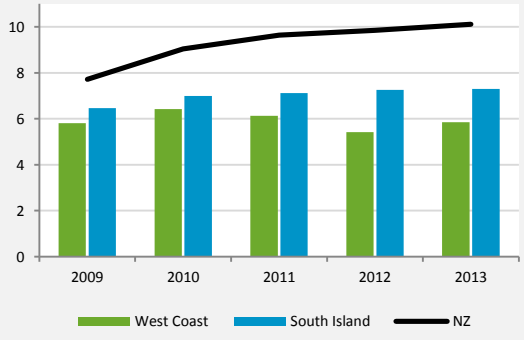


A reduction in acute readmission rates.

- *An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.*
- *Some acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration - ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.*
- *Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.*
- *Acute readmissions also serve as a counter-measure to balance improvements in productivity and reductions in the length of stay and provide an indication of the integration of services and appropriate supports for people on discharge.*

Data sourced from Ministry of Health (raw rates, unstandardised).

Outcome Measure: The rate of acute readmissions to hospital within 28 days of discharge.



IMPACT MEASURES MEDIUM TERM

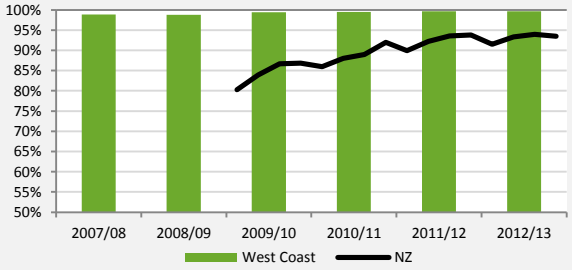
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the intensive assessment and treatment services the DHB funds and provides:

People have shorter waits for acute (urgent) care.

- *Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.*
- *Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Timely ED performance signals not only good outcomes through early intervention and treatment but also fosters public confidence and trust in health services.*
- *Strategies to maintain short waits span not only the hospital but the whole health system. In this sense, this indicator reflects how responsive the whole system is to the urgent care needs of the population.*

Data sourced from individual DHBs.[11]

The percentage of people presenting at ED - admitted, discharged or transferred within six hours.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	99.7%	>95%	>95%	>95%	>95%

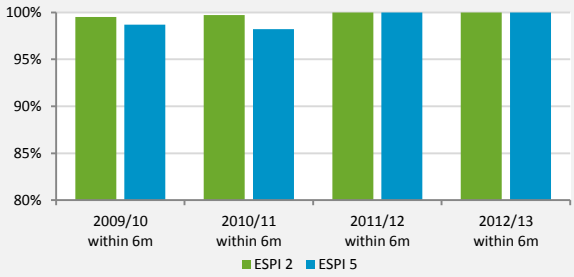


People have increased access to planned care.

- *Elective (planned) services are an important part of the healthcare system: these services improve the patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *Timely access to services and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.*
- *Improved performance against this measure requires effective use of resources so that wait times are minimised while a year-on-year increase in volumes is delivered. In this sense, this indicator is indicative of how responsive the system is to the needs of the population.*

Data sourced from Ministry of Health.[12]

Wait time (months) from referral to First Specialist Assessment (ESPI 2).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/16
	<6	<4	<4	<4	<4
Wait time (months) commitment to treatment (ESPI 5).	<6	<4	<4	<4	<4

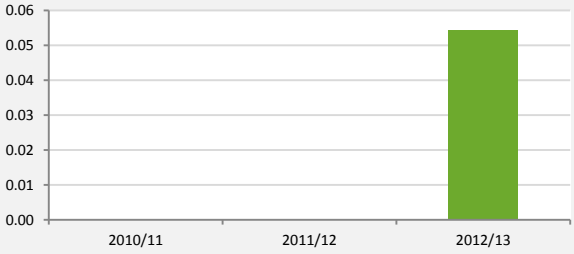


People stay safe in our hospitals.

- *Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.*
- *The rate of falls is particularly important, as patients are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence and an increased risk of institutional care.*
- *Achievement against this measure is also seen as a proxy indicator of the engagement of staff and clinical leaders in improving processes and championing quality.*

Data sourced from individual DHBs.[13]

The rate of SAC level 1 and 2 falls in West Coast Hospitals.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	0.05	<0.05	<0.05	<0.05	<0.05



[11] *This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10.*

[12] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance, and DHBs receive individual performance reports from the Ministry of Health on a monthly basis. National performance data is not made available. The wait time target for 2014/15 is mixed - being a maximum of 5 months for Q1 and Q2 and a maximum of 4 months from January 2015.*

[13] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days. This measure differs to that used in previous report as it refers to the total population rather than just events for those aged 65+.*

STRATEGIC OUTCOME GOAL 4

4.4 People experience optimal functional independence and quality of life

Why is this outcome a priority?

As well as providing early intervention and treatment, health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on improving quality of life, such as pain management or palliative services.

With an ageing population, the South Island will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence. This is not only a better health outcome for our population, but reduces the rate of acute hospital admissions and frees up health resources across the system.

OUTCOME MEASURES LONG TERM

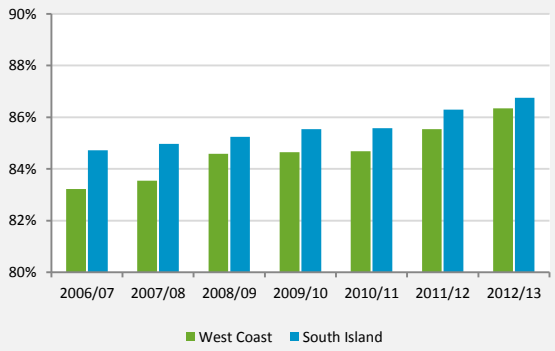
We will know we are succeeding when there is:

An increase in the proportion of the population living in their own home.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, evaluation of older people's services have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.*
- *Living in ARC facilities is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.*
- *An increase in the proportion of people supported in their own homes can be used as a proxy measure of how well the health system is managing age-related long-term conditions and responding to the needs of our older population.*

Data sourced from Client Claims Payments provided by SIAPO.

Outcome Measure: The percentage of the population (75+) living in their own homes.



IMPACT MEASURES MEDIUM TERM

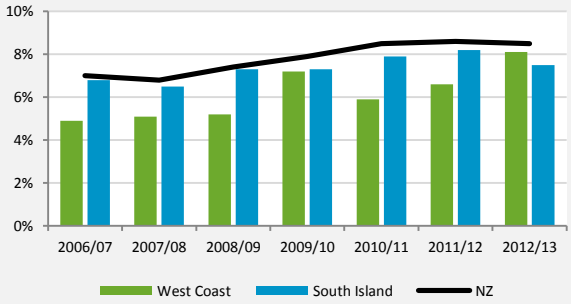
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the rehabilitation and support services the DHB funds and provides:

People stay safe in their own homes.

- *Around 22,000 New Zealanders aged 75+ are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, those who do experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the demand on acute and aged residential care services.*
- *The solutions to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*
- *A reduction in falls can thus be seen as a proxy measure for improved health service provision for older people.*

Data sourced from National Minimum Data Set.

The percentage of the population (75+) admitted to hospital as a result of a fall.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	8.2%	7.8%	7.4%	7%	6.6%



Our Organisational Capacity and Capability

What do we need to deliver our vision?

Having already identified the challenges we face and set a collective vision for the West Coast health system, this section highlights the strengths that we have, or will have to develop, over the next several years to support our transformation and deliver on our goals.

5.1 A patient-focused culture

Our culture is an important element in transforming and integrating our health system. To meet the needs of our population and fully achieve our vision, we need an engaged and motivated workforce committed to doing the best for the patient and for the health system. We also need buy-in and support from our community.

Part of our focus is on increased transparency and engagement with our workforce and our community. Longstanding frustrations have eroded confidence and trust in the West Coast health system.

Our weekly Chief Executive updates and quarterly 'Report to the Community' newsletters keep people informed of developments across the West Coast health system and provide opportunities for feedback and engagement. Clinically led community road shows are also held annually to provide updates on progress in transforming the West Coast health system and opportunities for us to hear the views and concerns of our community.

Over the last two years, the West Coast DHB has invested in leadership and engagement programmes that encourage our workforce to ask '*What is best for the patient?*' and empower them to make change to improve the effectiveness and efficiency of our health system. The '*Xcelr8*', '*Collabor8*', and '*Making Time for Caring*' programmes promote lean thinking approaches to service and system design and support the development of a culture that prioritises patients' needs.

This approach, of engaging our workforce in determining the future direction of our health system, is fostering stronger cross-system partnerships and alliances that are improving the continuity of care for patients.

We also expect that a patient-focused and empowering culture will help attract and retain staff by promoting workforce satisfaction and engagement.

5.2 Effective governance & leadership

To support good governance across our health system, we need a clear accountability and decision-making framework that enables our leaders and community to provide direction and monitor performance.

We are fortunate to have Board members who contribute a wide range of expertise to their governance role. Their governance capability is supported by a mix of experts, professionals and consumers on the Board's advisory committees, and clinical and cultural leads attend Board and committee meetings to provide advice and consultation as required.

Our Board and Chief Executive further ensure that their strategic and operational decisions are fully informed with support at all levels of the decision-making process, including the following formal advisory mechanisms.

Clinical participation in decision-making

Recognising that clinical leadership is crucial to the successful integration of services, we engage health professionals from across the West Coast in all stages of service design and in the development of integrated patient pathways across the health system.

The DHB's Chief Medical Officer, Director of Nursing and Midwifery and Executive Director of Allied Health provide clinical leadership and input into DHB decision-making at the executive level.

In addition, the West Coast has a Clinical Board: a multidisciplinary clinical forum that oversees the DHB's clinical activity. The Clinical Board advises the Chief Executive on clinical issues and takes an active role in setting clinical standards and encouraging best practice and innovation. Members support and influence the transformation of our health system and play an important role in raising the standard of patient care.

The West Coast Alliance Leadership Team is also a clinically led governance group, and the associated alliance workstreams include clinicians and health professionals from across the health system.

Consumer participation in decision-making

There are a number of consumer and community reference groups, advisory groups and working parties in place across the West Coast health system. Their advice and input assists in the development of new models of care and individual service improvements.

The DHB has recently established a 10-member Consumer Council to formally embrace the inclusion of those who use health and disability services in their design and development. The Council focuses on projects that: enhance the collection and use of consumer feedback; reduce barriers to access and waiting times; and improve the quality of the patient journey and the engagement of consumers and their families.

Māori participation in decision-making

Through its partnership with Tatau Pounamu, the Board is able to actively engage Poutini Ngāi Tahu, in particular Te Rūnanga o Ngāti Waewae and Te Rūnanga o Makaawhio, in the planning and design of health services and strategies to improve Māori health outcomes.

The DHB works closely with Poutini Waiora (previously Rata Te Awhina Trust), the West Coast's Māori health services provider, to improve the delivery of services to Māori, and also supports Kia Ora Hauora (the national Māori Health workforce development programme) to build Māori capacity across our health system.

The DHB's General Manager of Māori Health provides further cultural leadership and input into decision-making at the executive level of the DHB.

As part of our commitment to the principle that Māori enjoy at least the same level of health as non-Māori (and the safeguarding of cultural concepts, values and practices), the DHB produces an annual Māori Health Action Plan that sits alongside the DHB's Annual Plan but specifically identifies where and how improvements will be made for Māori in the coming year.

Decision-making principles

The advice and input of these groups supports good decision-making, but the environment in which we operate still requires the DHB to make hard decisions about which competing services or interventions to fund with the limited resources available.

The DHB has a prioritisation framework and set of principles based on best practice and consistent with our strategic direction. These principles assist us in making final decisions on whether to develop or implement new services. They are also applied when we review existing services or investments and support reallocation of funding to services that are more effective in improving health outcomes and reducing inequalities.

Effectiveness: Services should produce more of the outcomes desired, such as a reduction in pain, greater independence and improved quality of life.

Equity: Services should reduce inequalities in the health and independence of our population.

Value for money: Our population should receive the greatest possible value from public spending.

Whānau ora: Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau.

Acceptability: Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.

Ability to implement: Implementation of the service is carefully considered, including the impact on the whole health system, workforce considerations and any risk and change management requirements.

5.3 Alliances & partnerships

Our vision is wider than just the DHB. We need to adopt a partnership approach that recognises our relationships with the organisations we fund are more than contractual.

Following the lead of Canterbury, we have established the West Coast Alliance, a partnership of health professionals and providers, to enable collaborative service planning and design, and to determine the appropriate models of care for our health system. [14]

Through the West Coast Alliance, we are working to embed a view of our health system as one system with one budget and to support the transformation and integration of our health system.

The Alliance has recently been cemented with the signing of a nationally developed District Alliance Agreement between the DHB and the West Coast PHO.

Six alliance workstreams are in place where members work collaboratively to develop more integrated models of service delivery to ensure people get the right care and support at the right time, in the right place. The alliance workstreams also support the delivery of national expectations and health targets. The activity prioritised under the Alliance workstreams informs the direction of the DHB's annual work plans every year and is reflected throughout the DHB's Annual Plan.

The current workstreams are: Grey/Westland IFHS; Buller IFHS; Pharmacy; Healthy West Coast; Child & Youth Health; and Health of Older People. In 2014/15 a seventh will be established – focused on Mental Health.

Partnerships with other agencies

At a local level, we also work with the education, social development and justice ministries, local trusts, charities and social service agencies to improve outcomes for our population – integrating services to meet shared goals through health promotion, screening, nutrition, physical activity and mental health and addictions initiatives.

Commitment to national programmes

At a national level, we work with the education, social development and justice sectors to improve outcomes for our population and achieve shared goals. From this perspective we are committed to implementing national cross-agency programmes including: the Prime Minister's Youth Mental Health Project, the Children's Action Plan and the Whānau Ora programme.

The West Coast will continue to actively participate in the development and delivery of national programmes led by the National Health IT Board, Health Quality & Safety Commission, Health Workforce NZ, the National Health Committee, Health Promotion Agency, PHARMAC and Health Benefits Limited - for the benefit of our population and the wider health system.

[14] *Refer to Appendix 5 for structural diagram of the Alliance.*

5.4 Subsidiaries

The South Island Shared Services Agency Limited is wholly owned by the five South Island DHBs and the West Coast DHB is a joint shareholder. While the company remains in existence, following the move to a regional alliance framework, the staff now operate as a service to the South Island DHBs from under the employment and ownership of Canterbury DHB referred to as the *South Island Alliance Programme Office*.[15]

The Programme Office is funded jointly by the South Island DHBs to provide services such as audit, regional service development and project management with an annual budget of just over $4m.

5.5 Investment in information systems

Information systems are a national priority, and DHBs are taking a collective approach to implementing the Government's *National Health Information Technology Plan*. The South Island DHBs have collectively determined the strategic actions to deliver on the national plan and we are committed to this approach.

Our major priority is to enable seamless and transparent access to clinical patient information across geographic boundaries. This will benefit patients by enabling more effective clinical decision-making, improving the standards of care and reducing risks associated with missing important information.

The West Coast DHB has already adopted several key regional information systems, such as Health Connect South and the Electronic Referral Management System and will, in the next few years, replace its old hospital based patient administration system with a new supported system in line with the rest of the country.

We will continue to work closely with clinicians and stakeholders across the West Coast, to ensure that the right clinical information is available to the right people, at the right time and in the right place. Full details of the regional investment in information systems can be found in the South Island Regional Health Services Plan including the following major initiatives:

Telehealth enables sustainable health care by removing the need for clinicians or patients to travel and providing patients with timely access to care. We are continuing to expand telehealth clinics and improve the network infrastructure of outlying clinics across the Coast.

HealthPathways provides assessment, management and referral information to support health professionals to better manage the care of their patients. Over 600 clinically-designed pathways and GP resource pages are already available and we will continue to localise and refining pathways to complement our model of care.

Health Connect South (HCS) is a clinical workstation and data repository (portal) that brings a patients clinical information into one view, providing timely information at the point of care and supporting clinical decision making. A single HCS record now exists between Canterbury, West Coast and South Canterbury and will be fully implemented regionally in 2015.

WEST COAST DHB WORKFORCE		
DHB Total Headcount	*Turnover*	*Sick Leave*
1,078	0.9%	2.95%
86% female	8.4% nationally	3.6% nationally
Average Age	*Largest Ethnic Group*	*Diversity*
52 years	NZ European	37 nationalities
Oldest Workforce	*Largest Workforce*	*FTE Terms*
SMOs	Nursing	66% part time
Avg. Age 55	49% of DHB workforce	66% permanent

The Electronic Referral Management System (ERMS) enables general practices to send referrals electronically from their desktops. ERMS is being rolled out regionally by the South Island IT Alliance (led by Canterbury), and the West Coast was the first DHB other than Canterbury to introduce this system into their district.

The Electronic Shared Care Record View (eSCRV) is a secure system that enables the sharing of core health information (i.e. allergies, medications and test results) between the health professionals involved in a person's care no matter where they are based. West Coast will implement the regional system in 2014/15.

The South Island Patient Information Care System (PICS) will be the new regional patient administration system, which will further integrate systems throughout the South Island. The West Coast will begin to upgrade its old legacy system alongside Canterbury DHB in 2014/15.

E-medications is a foundation system which promotes patient safety by improving medications management. The system has three components and is being rolled out regionally. West Coast will implement ePharmacy in 2014/15 and eMedications Reconciliation in 2015/16.

The National Patient Flow Project will create a new national view of wait times, health events and outcomes across the patient journey. The Coast will implement Phase I (collection of referrals to specialists) in 2014/15 and Phase II (non-admitted and associated referral information including diagnostic tests) from 2015/16.

The Self-Care Patient Portal – enables patients to be involved in their care and is an essential part of the national vision. West Coast DHB is working with the PHO to develop and implement a Patient Portal available to West Coast patients in the coming year

[15] *Legal transfer of the employees and assets has taken place. The company will be retained as a shell, pending dissolution.*

Transalpine collaboration with Canterbury makes it increasingly important to allow seamless integration between the two DHBs. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs and will also develop a unified virtual IT team spread between the two DHBs to make better use of resources in both organisations.

5.6 Investment in people

Our ability to meet current and future demand for health services relies on having the right people, with the right skills, working in the right place in our health system.

Like all DHBs, our workforce is ageing and we face shortages and difficulties in recruiting to some professional areas. However, the West Coast has the added challenge of attracting staff to a remote location that has suffered from major job losses due to industry closures and community disasters in recent years.

The West Coast DHB is committed to being a good employer, and we are aware of our legal and ethical obligations in this regard. We continue to promote equity, fairness and a safe and healthy workplace, underpinned by a clear set of organisational values, including a code of conduct and commitment to continuous quality improvement and patient safety.

In conjunction with the Canterbury DHB, the DHB will also review current policy and agree a phased implementation plan to meet the new Vulnerable Children's Legislation requirements for worker safety checks as this comes into effect.

However, in the West Coast's context, with financial constraints and growing demand for services, it is not sufficient to just be a good employer.

In 2011, we undertook an employee engagement survey of our staff which demonstrated positive levels of engagement. Results showed 72% of our workforce was 'engaged' with only 3% disengaged.

We need to ensure the sustainability of our services and improve the continuity of care for our population. To do this, we must reduce our use of locums, recruit to key positions, make the best possible use of our available workforce and cultivate an environment that enables people to work to the greatest extent of their scope.

Expanding our workforce capacity

From a recruitment perspective, there are a number of areas where workforce shortages affect our system's capacity. These include rural general practitioners, nurse practitioners, general surgeons and a number of specialist and allied health positions. The DHB is also looking to increase its Māori health workforce.

In response, we are strengthening our recruitment strategies and working closely with Canterbury DHB to supplement West Coast-based clinical support and services in some key areas with joint appointments.

We are supporting local scholarships to encourage Māori students into health careers and will continue to tap into available talent through links with the education sector and regional training hub and increased internships and clinical placements in our hospitals and primary care.

We will also continue to expand capacity through investment in telemedicine and electronic systems which support the provision of specialist services without a significant increase in workforce numbers.

Supported by the use of technology, Canterbury Clinical Nurse Specialists in paediatrics and oncology are supporting generalist nurses on the West Coast to care for patients, while Respiratory Clinical Nurse Specialists on the West Coast provide case management with support from Canterbury medical specialists.

Enhancing our workforce capability

Developing our existing staff is a key strategy in enhancing the capability of our health system. We have recently strengthened our core development training calendar, which can be accessed by health professionals working anywhere in the West Coast health system.

We have also stepped up our participation in the Health Workforce NZ sponsored Regional Training Hubs to support critical role identification and expand workforce capability through sharing of training resources. The focus over the coming years will be on Diabetes Nurse Prescribers, Sonographers, GPEP2 training for general practice registrars and implementation of the new 70/20/10 training in medical disciplines. E-learning packages will be progressively rolled-out regionally and a full suite of packages will be available on-line 2015/16.

In addition to aligning workforce development with Health Workforce NZ funding, we have developed a set of standing orders and associated training practices that support the development of a 'generalist/specialist' nursing workforce on the West Coast. Our participation in the regional Allied Health Assistant Training Programme is also helping to expand the scope of existing allied health roles and establish new ones.

Locally we are supporting the development of our rural medical workforce with investment in a Rural Learning Centre in Greymouth. The aim is to encourage people to work in rural locations by reducing isolation factors through collaboration, peer support and mentoring.

We are also supporting development of our local Māori health workforce through the national Kia Ora Hauora training programme and the Ngā Manukura ō Āpōpō Leadership Programme.

5.7 Investment in quality and safety

Over the last two years we have made considerable changes to sharpen our focus on improving the quality and safety of the services provided at the West Coast DHB. The formation of an organisational quality team is helping us to share expertise, concentrate effort and reduce duplication and the establishment of a Clinical Board has introduced a new level of leadership with a system-wide approach to quality improvement. Opportunities to work across organisations for patient safety improvements are also beginning to be realised.

Much of our current quality activity focuses on strengthening our reporting systems. With a culture of reporting well established safety issues are transparent and staff are confident the organisation will respond to needed improvement. The implementation of the South Island Incident and Risk Management system (ICNet) in 2015 will assist in identifying trends and real time tracking of events.

The priorities of the Health Quality & Safety Commission (HQSC) and the National Patient Safety Campaign have been incorporated into our quality programme. Stronger collaboration with our Canterbury neighbours and with the wider South Island will also help us to continue to build clinical capacity and quality improvement expertise.

Over the next few years key focus areas for our Clinical Board and quality team will be aligned to the following national priorities.

Consumer engagement

The West Coast DHB is exploring new relationships with those who use our services to find ways of hearing patient stories, understanding what matters to them, and incorporating their experience into the redesign and evaluation of services. A Consumer Council has been established and priority will be given to supporting the development of a work plan and participation in improvement teams.

The West Coast DHB also produced its first set of Quality Accounts in 2013 as a means of answering the questions that consumers consider important and identifying whether the DHB is providing a safe and high quality service. Future accounts will see wider consumer consultation to identify key areas of importance.

Preventing healthcare-associated infection

Admission to hospital exposes patients to potential harm through healthcare-associated infection, and the West Coast DHB is committed to minimising this risk through three specific projects, in line with the HQSC.

Safe hand hygiene practices significantly reduce the risk of infection. Our Gold Auditors undertake frequent hand hygiene observation and audit, and we are implementing our hand hygiene quality plan, with charge nurse managers championing hand hygiene. Strengthening the ability for patients to provide feedback about this aspect of care is an important concurrent activity.

Patients are also at risk through the use of a central line, which introduces a potential track for infection: central-line-associated bacteraemia (CLAB). Processes are in place to minimise this risk both at insertion and during ongoing use, with processes audited continuously. As at 14 April 2014 we have been CLAB free for 629 days.

Patients also have a risk of infection following a surgical procedure. To address this, we continuously undertake surgical site surveillance with all patients who have had 'clean surgery' by way of a patient survey. We will continue to align this practice to the National Surgical Site Surveillance Programme and increase the scope of ICNet in surveillance activities.

Reducing falls in healthcare settings

Falls resulting in harm are known to significantly reduce the ongoing quality of life and function for patients, particularly those over the age of 75, and add considerable healthcare and lifestyle costs for both patients and health providers.

In line with the HQSC's National Patient Safety Campaign, the West Coast DHB has re-established a Falls Prevention Team - bolstered with increased membership to fortify a culture of 'zero harm' from falls across the organisation. Again, it is imperative that patient and family experience is heard and incorporated into system design. Reviewing risk assessment and management tools is also a key focus, and we are implementing strategies to visually identify those at risk of falling.

Medication and surgical safety

The West Coast DHB is committed to reducing the incidence of medication errors and the risk of resultant patient harm. Our Medication Safety Committee is leading the development of a culture of safety and 'zero harm' in medication-related practice. The National Medication Chart has been adopted by all acute clinical areas in the West Coast DHB and we are participating in an HQSC-led medicine reconciliation programme.

The West Coast DHB has also adopted the surgical safety checklist, which is used in all surgical procedures to minimise the risk of harm. Documentation audits are in place to ensure that usage meets the 100% target. We will also consider observational audit to identify how the checklist is used, with outcomes communicated to all staff associated with the operating theatres.

5.8 Investment in facilities

The West Coast is in the midst of significantly transforming the way we deliver health services in order to improve the quality and sustainability of our system. It is imperative that this transformation is underpinned by modern, fit-for-purpose infrastructure that supports more responsive and integrated service provision.

Our current facilities are expensive to maintain, their geographical and physical configuration is outdated and inefficient, and they are hampering the introduction of more integrated service models that would improve the quality of care we deliver. Under-investment in facilities maintenance over the past decade, to minimise operating deficits, has resulted in significant infrastructure degradation and associated risk.

Seismic assessments of buildings located on the Grey Base Hospital site identified a number of buildings as earthquake-prone and non-compliant with modern seismic standards. A number of buildings were closed, deemed unsafe to occupy and some services are now crowded into temporary spaces.

Some of our primary and community facilities are also not appropriately located or configured to best contribute to our future integrated service model.

Considerable clinical engagement went into the preparation of a business care to upgrade our facilities, with over 50 hours of workshops with design teams in 2014 alone. Over 70 clinicians and staff from the West Coast DHB and PHO, general practice teams, community pharmacy, Poutini Waiora and specialist service contractors came together to ensure we could provide the best care possible for people living on the Coast.

At the end of 2012, the Government established a West Coast Hospital Redevelopment Partnership Group to confirm and fast-track plans to redevelop the Grey Base Hospital and associated Integrated Family Health Centre and address the need for viable health services and complementary infrastructure in Buller.

The Partnership Group submitted a detailed business case to the National Capital Investment Committee (CIC) in April 2014 and in May the business case was given sign-off by Cabinet allowing the project to move into the final design phase.

The approved Grey Base Hospital redevelopment is virtually a greenfield development plan. An Integrated Family Health Centre will be developed on the Grey Base Hospital site. Almost all of the Hospital will be rebuilt. A committed budget of $68 million will mean new wards, a bigger maternity unit, four older person's health cottages, an emergency department, intensive care unit and three modern state-of-the-art operating theatres.

Development of a mental health inpatient facility and energy centre will also be included.

The redevelopment of the Greymouth site provides a once-in-a-lifetime opportunity to capture the transformation already underway and bring integrated service provision to life. With a clear decision on the way forward the West Coast health system will be able to cement a more certain and sustainable future.

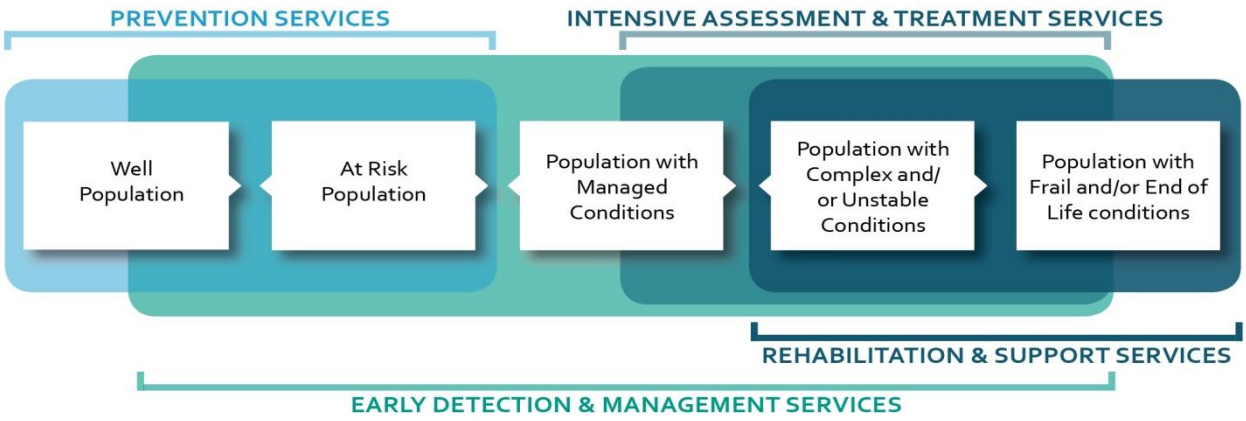
Site work will begin at Grey Base in 2014 and detailed planning will be a major focus for the next year. A strong clinical voice will continue to be essential in ensuring the final result is reflective of the needs of our population.

Focus will also be on Buller and the facilities required to support more integrated health services here as well. The DHB will engage with the Buller community in 2014/15 to talk about a new Integrated Family Health Centre and how this will function. The DHB will also be looking at how aged care services, maternity services and transport will be organised in the future.

Part III - Annual Outlook

Statement of Performance Expectations

What services will we deliver in the coming year?



Evaluating our performance

As the major funder and provider of health and disability services on the West Coast, we are strongly motivated to ensure our population gets the most efficient and effective services possible.

Understanding the dynamics of our population and the drivers of demand are fundamental when determining which services to fund and at what level. Just as fundamental is our ability to evaluate whether the services we are purchasing and providing are making a measureable difference in the health and wellbeing of our population.

One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make. Over the longer term, we do this by measuring our performance against a set of desired population outcomes (Section 4).

In the more immediate term, we evaluate our performance by providing a forecast of what services we will fund and provide in the coming year and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report.[16]

Achieving equity of outcomes is an overarching priority for the West Coast health system and reflects our commitment to ensuring that our population should enjoy the best possible health status.

With a growing Māori population and persistent inequalities amongst our population, this goal pervades everything we do. All of the West Coast targets and standards are therefore set the same for all population groups, with the aim of improving performance up for all.

Specific actions with respect to improving Māori health are outlined in our Māori Health Action Plan, along with performance against key indicators by ethnicity.

Choosing performance measures

In order to present a fair picture of performance, the services we deliver have been grouped into four 'output classes' that are a logical fit with the stages of the continuum care and are applicable to all DHBs:

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

Identifying a set of appropriate measures for each output class is difficult. We cannot simply measure 'volumes'. The number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'.

We have therefore chosen to present a mix of measures demonstrating: Timeliness (T), Coverage (C), Volume (V) and Quality (Q) - all of which help us to evaluate different aspects of our performance. Against each we have set targets to demonstrate the standard expected.

The measures chosen cover those activities we believe have the potential to make the greatest contribution to the wellbeing of our population. Others are more relevant in that they represent areas where we are developing new services or expect to see a change in activity levels or settings in the coming year.

[16] *Annual Reports can be found at www.westcoastdhb.org.nz.*

Setting standards

Wherever possible, we have included a past year's baseline and national results to give context in terms of what we are trying to achieve and to support evaluation of our performance. However, measures that relate to new services have no baselines, and some measures relate to West Coast-specific services for which there is no national comparison available.

In setting performance targets, we have considered the changing demographics of our population, increasing demand and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining service access while reducing waiting times and delays in treatment to demonstrate increased productivity and capacity.

To ensure the quality of services provided, the DHB invests in programmes that are evidence-based or evidence-informed, where research shows definite gains and positive outcomes. This provides greater assurance that these are quality services, allowing the DHB to focus on monitoring implementation and timely and appropriate access.

It is important to note that a significant proportion of the services funded by the DHB are demand driven – such as laboratory tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided, not as targets to be achieved, but to give the reader context in terms of the use of resource across the West Coast health system.

Notation

Some data is provided to the DHB by external parties and can be affected by a delay in invoicing. Rather than footnote every instance, symbols are used to indicate where this is the case: Δ indicates data that could be affected by invoicing delay and is subject to change (data for these measures was pulled or before 22 May 2014).

A † symbol also indicates where data relates to the calendar year rather than financial year.

There are also a number of national health targets where performance is tracked and reported nationally on a quarterly basis rather than annually. A ◇ symbol indicates that the baseline, national average and target refer to the fourth quarter result of that year.

Where does the money go?

The table below presents a summary of the 2014/15 budgeted financial expectations by output class.

Over time, we anticipate it will be possible to use this output class framework to demonstrate changes in allocation of resources and activity from one end of the continuum of care to the other.

REVENUE	TOTAL $'000
Prevention	3,261
Early detection and management	36,504
Intensive assessment & treatment	78,080
Support & rehabilitation	22,332
Grand Total	**140,177**

EXPENDITURE	TOTAL $'000
Prevention	2,997
Early detection and management	36,496
Intensive assessment & treatment	78,306
Support & rehabilitation	22,377
Grand Total	140,177

Surplus/(Deficit)	**0**

OUTPUT CLASS

6.1 Prevention services

Preventative health services promote and protect the health of the population and address individual behaviours by targeting changes to physical and social environments that engage, influence and support people to make healthier choices. These services include: promotion and education programmes to raise awareness of risk behaviours and healthy choices; the use of legislation and policy to protect the public from environmental risks and communicable diseases; and individual health protection services (such as immunisation and screening programmes) that support early intervention to modify lifestyles and maintain good health.

Why is this output class significant for the DHB?

By improving environments and raising awareness, these services support people to make healthier choices – reducing major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. High-needs and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore our foremost opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of babies exclusively breastfeeding on hospital discharge	Q [17]	92%	>75%	-
Lactation support and specialist advice consults provided in community settings	V	149	>100	-
Nutrition and Activity courses provided in the community	V	6	≥10	-
People referred to Green Prescriptions for additional physical activity support	V [18]	374	≥500	-
% of Green Prescription participants more active 6-8 months after referral	Q [19]	43%	50%	63%
% of smokers identified in primary care receiving advice and help to quit (ABC)	C	55%	90%	57%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C◇	95%	95%	96%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	124	>100	-
% of priority schools supported by the Health Promoting Schools framework	C [20]	100%	>70%	-

Population-Based Screening Services *These services help to identify people at risk of illness and pick up conditions earlier. Many are funded and provided through the National Screening Unit. The DHB's role is to encourage uptake, as indicated by high coverage rates.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of four-year-olds receive a B4 School Check (B4SC)	C [21]	81%	90%	80%
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C† [22]	55%	100%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [23]	78%	80%	77%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [23]	81%	>70%	72%

[17] The percentage of babies' breastfeeding demonstrates the effectiveness of consistent health promotion messages delivered during the antenatal, birthing and early postnatal period. Standards are based on national targets.

[18] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.

[19] Results taken from national patient survey competed by Research NZ on behalf of the Ministry of Health.

[20] The Health Promoting Schools Framework addresses health issues through activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated and/or have a high proportion of Māori and/or Pacific children.

[21] The B4 School Check is the final core WellChild/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.

[22] A HEEADSSS assessment is provided to Year 9 students in low decile schools. It is free and covers: Home; Education; Employment; Eating; Exercise; Activities; Drugs; Sexuality; Suicide; Safety; and Spirituality and allows health concerns to be identified and addressed early.

[23] These are national screening programmes, and standards are based on national targets.

Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of newborns enrolled on the National Immunisation Register at birth	C	100%	≥95%	-
% of children fully immunised at eight months of age	C◇	93%	95%	90%
% of eight-month-olds 'reached' by immunisation services	Q [24]	98%	95%	95%
% of Year 8 girls completing their HPV vaccinations (i.e. receiving Dose 3)	C† [25]	44%	60%	52%
% of older people (65+) receiving a free influenza ('flu') vaccination	C†	55%	75%	65%

[24] 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children but have chosen to decline immunisations or opt off the NIR.
[25] The baseline is the percentage of girls born in 1999 receiving Dose 3 by the end of 2012, and the target is for 2014 for girls born in 2001.

OUTPUT CLASS

6.2 Early detection and management services

Early detection and management services maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated - particularly where people have multiple conditions requiring ongoing interventions or support.

Why is this output class significant for the DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age. By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. These services also support people to better manage their long-term conditions and avoid complications, acute illness and crises. Our current move to better integrate services presents a unique opportunity. Providing flexible and responsive services in the community, without the need for a hospital appointment, will support people to stay well and reduce the overall rate of hospital admissions, particularly acute and avoidable admissions. Reducing the diversion of critical resources into managing acute demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Primary Health Care (GP) Services *These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake of services are indicative of engagement, accessibility and responsiveness of primary care services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of the total DHB population enrolled with a Primary Health Organisation	C	94%	95%	96%
Avoidable hospital admission rate for children aged 0-4	Q [26]	102%	<101%	100%
Young people (0-19) accessing Brief Intervention Counselling	VΔ [27]	59	80	-
Adults (20+) accessing Brief Intervention Counselling	VΔ	301	>300	-
Number of HealthPathways in place across the West Coast health system	V [28]	308	>600	-

Oral Health Services *These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.*	Notes	2012 DHB Result	2014 Target	2012 National Average
% of pre-schools children (0-4) enrolled in DHB-funded oral health services	C†	85%	90%	70%
% of enrolled children (0-12) examined according to planned recall	T†	72%	90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C†[29]	77%	85%	73%

[26] Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The measure is based on the national DHB performance indicator SI1 and is defined as the standardised rate per 100,000 population.

[27] The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. The adult results differ slightly to that previously published (298) due to the addition of late claims.

[28] The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.

[29] The 2012/13 result differs slightly from that previously published (77%) due to population adjustments.

Long-term Conditions Management (LTCM) Programmes *These services are targeted at people with high health need due to having a long-term condition (such as CVD or Diabetes) and aim to reduce deterioration, crises and complications through good management and control of that condition. Success is demonstrated through early intervention, monitoring and management strategies which reduce the negative impact and the need for hospital admission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
People identified with a long-term condition enrolled in the PHO LTCM programme	V	2,552	>2,000	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C [30]	58%	90%	67%
% of people with diagnosed diabetes having an annual LTCM review	C	70%	>70%	-
% of people with satisfactory diabetes management	Q	78%	80%	-

Pharmacy and Referred Services *These are services which a health professional may prescribe or refer a person to help diagnose a health condition, or as part of treatment. They are provided by allied health personnel such as laboratory technicians, medical radiation technologists and pharmacists. While pharmaceuticals are largely demand driven to improve performance, we will target primary care access to diagnostics and shorter wait times to aid decision-making and improve referral processes.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Subsidised pharmaceutical items dispensed in the community	VΔ [31]	479,972	est. <600K	-
Laboratory tests completed for the West Coast population	VΔ[32]	na	est. <150K	-
Number of community requested radiological tests delivered by Grey Hospital	V	5,721	est. >5,000	-
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T [33]	53%	75%	56%
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T	100%	≥90%	79%
% of people receiving their Magnetic Resonance Imagining (MRI) within 6 weeks	T	91%	≥80%	52%

[30] This measure refers to CVDRAs undertaken in primary care in line with the national 'More heart and diabetes checks' health target.
[31] This measure covers all items dispensed in the community rather than hospital; however, it may still include some non-West Coast residents who had prescriptions filled while on the Coast.
[32] This result was not available at the time of printing due to a change in processing process.
[33] All diagnostic result baselines are the June 2013 month final result published by the Ministry of Health, and targets are set to match national standards set for all DHBs.

OUTPUT CLASS

6.3 Intensive assessment and treatment services

Intensive assessment and treatment services are usually complex services provided by specialists and other healthcare professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services and emergency or urgent care services. A proportion of these services are driven by demand that the DHB must meet, such as acute and maternity services, while others are planned, with provision and access determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Why is this output class significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life through appropriate corrective action. Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system. As an owner of these services, the DHB is also committed to providing high quality services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Quality improvement in service delivery, systems and processes will increase patient safety, reduce the number of events causing injury or harm and improve health outcomes. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in West Coast DHB hospitals and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Rate of compliance with good hand hygiene practice	Q [34]	73%	80%	71%
% of hip and knee replacement patients receiving cefazolin ≥2g	Q [35]	new	95%	-
% of hip and knee replacement patients who have appropriate skin preparation	Q	new	100%	-
% of time all three parts of the surgical safety checklist are used	Q [36]	84%	90%	71%
% of inpatients (aged 75+) who received a falls assessment	Q [37]	53%	90%	77%
Maternity Services *These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided in home, community and hospital settings by a range of health professionals, including lead maternity carers, GPs and obstetricians. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C	62.5%	80%	63%
% of new mothers attending DHB-funded parenting and pregnancy courses	C	new	>30%	-
Maternity deliveries in West Coast DHB facilities	V	325	est. 300	-
Baby friendly hospital accreditation of DHB facilities	Q [38]	Yes	Yes	-

[34] This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. The baseline result is taken from national Health Quality & Safety Commission (HQSC) reporting for Quarter 4 2012/13.
[35] Cefazolin ≥2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.
[36] The surgical safety checklist, developed by the World Health Organisation, is a common sense approach to ensuring the correct surgical procedures are carried out on the correct patient. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.
[37] While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and acting accordingly. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.
[38] The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises achievement of the standard.

Acute/Urgent Services *These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly (they may or may not lead to hospital admission). Hospital-based services include emergency services, short-stay acute assessment, acute medical and surgical services and intensive care services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of children under six with access to free primary care outside business hours	C	100%	100%	-
% of general practices providing telephone triage outside business hours	C	100%	100%	-
Attendances at West Coast emergency departments (EDs)	V [39]	14,359	≤15,000	-
% of people (Triage 1-3) presenting in ED seen within clinical guidelines	Q [40]	87%	>85%	-
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T◇ [41]	100%	100%	100%
Acute inpatient average length of hospital stay (standardised)	Q [42]	3.27	≤3.27	3.99

Elective/Arranged Services *These are 'booked' or 'arranged' services for people who do not need immediate hospital treatment. They include elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
First Specialist Assessments provided (medical and surgical)	V [43]	6,724	est. >6,500	-
% of First Specialist Assessments that were non-contact	Q [44]	5%	>5%	-
Elective surgical discharges delivered (surgeries provided)	V [45]	1,686	1,592	-
Elective inpatient average length of hospital stay (standardised)	Q [42]	3.30	≤3.18	3.36
Outpatient attendances	V	15,428	est. >14,500	-
Outpatient 'Did not Attend' rates (total population)	Q	8.2%	<6%	-
Outpatient 'Did not Attend' rates (Māori)	Q	14%	<6%	-
% of outpatient appointments/consultations provided by telemedicine	Q	1.57%	>1.57%	-

Specialist Mental Health Services *These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of young people (0-19) accessing specialist mental health services	CΔ [46]	6.1%	>3.8%	2.8%
% of adults (20-64) accessing to specialist mental health services	CΔ	4.9%	>3.8%	3.4%
% of people referred for non-urgent MH/AOD services seen within 3 weeks	T [47]	72%	80%	76%
% of people referred for non-urgent MH/AOD services seen within 8 weeks	T	91%	95%	91%

[39] This measure is based on the national ED health target. It counts Grey Hospital ED and Buller Emergency Departments.
[40] Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.
[41] This measure is a national performance measure (PP30) and refers to all people 'ready for treatment'. It excludes Category D patients, whose treatment is scheduled with other treatments or as part of a trial.
[42] This measure is a national performance measure (OS3). When seeking to reduce average length of hospital stay, performance should be balanced against readmissions rates to ensure earlier discharge is appropriate and service quality remains high.
[43] This measure counts both medical and surgical assessments but counts only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred.
[44] Non-contact FSAs are those where specialist advice and assessment are provided without the need for a hospital appointment.
[45] This measure is a national performance measures (the electives health target) and excludes 'arranged' cardiology and dental volumes.
[46] This measure is based on the previous national performance measure (PP6) dropped in 2014/15 and expectations that 3% of the population will need access to specialist level mental health services.
[47] This measure is a national performance measure (PP8) and results are provided three months in arrears to March 2013.

Assessment, Treatment and Rehabilitation Services (AT&R) *These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Admissions into inpatient AT&R services	V	125	est. >150	-
Consultations provided by outpatient and domiciliary AT&R services	V	1,601	est. >1,700	-
% of AT&R inpatients discharged to their own home rather than into ARC	QΔ [48]	90%	≥90%	-

[48] *While living in ARC is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. Discharge from AT&R to home (rather than ARC) reflects the quality of services in terms of assisting that person to regain their functional independence. The measure excludes those who were ARC residents prior to AT&R admission.*

OUTPUT CLASS

6.4 Rehabilitation and support services

Rehabilitation and support services provide people with the assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered after a clinical 'needs assessment' process and include: domestic support, personal care, community nursing, services provided in people's own homes and places of residence, day care, respite care and residential care. Services are mostly for older people, mental health clients and personal health clients with complex conditions. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering.

Why is this output class significant for the DHB?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into hospital services.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence. In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system by reducing acute demand, unnecessary ED presentation and the need for more complex intervention. These services also support the flow of patients and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and/or maximise their quality of life.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupation therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to these services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	39%	80%	-
People supported by the rapid response/supported discharge service	V	new	50	-
People (65+) access community-based falls prevention services	V [49]	new	yes	-

Home-Based Support Services *These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	QΔ [50]	83%	>95%	-
People supported by long-term home and community support services	VΔ	736	est. >740	-
Community-based district nursing visits provided (long-term clients only)	VΔ	4,913	est. >5000	-
Meals on Wheels provided	V	35,234	est. >37,000	-

[49] *The aim for the coming year is to establish a Falls Prevention Service on the West Coast as a means of providing better care for people 'at-risk' or following a fall - supporting people to stay safe and well in their own homes and communities.*

[50] *InterRAI is an evidence-based geriatric assessment tool, the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care.*

Respite and Day Services *These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Mental health planned and crisis respite service bed days used	CΔ	483	est. >500	-
Occupancy rate of mental health planned and crisis respite beds	CΔ [51]	71%	85%	-
People supported by aged care respite services	V	58	est. 70	-
Palliative Care Services *These are services that improve the quality of life of patients and their families facing terminal illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
ARC facilities trained to provide the Liverpool Care Pathway option to residents	V [52]	3	4	-
People in ARC services supported by the Liverpool Care Pathway	V	31	>30	-
Residential Care Services *These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days for lower-level care is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people entering ARC having had a clinical assessment of need using InterRAI	QΔ [50]	99%	95%	-
% of ARC residents receiving vitamin D supplements	C	57%	75%	-
Subsidised ARC rest home beds provided (days)	VΔ	43,573	est. <50,000	-
Subsidised ARC hospital beds provided (days)	VΔ	40,821	est. <40,000	-
Subsidised ARC dementia beds provided (days)	VΔ	2,805	est. >3,000	-
Subsidised ARC psycho-geriatric beds provided (days)	VΔ	3,729	est. >4,000	-

[51] Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directed to other areas.
[52] The Liverpool Care Pathway is an international palliative care programme adopted nationally and reflects best-practice care.

Meeting Our Financial Challenges

While health continues to receive a large share of national funding, clear signals have been given that Government is looking to the whole of the health sector to rethink how we will meet the needs of our populations with a more moderate growth platform. The Minister of Health has made it clear that DHBs are expected to operate within existing resources and approved financial budgets and to ensure services and service delivery models are financially sustainable.

7.1 West Coast's financial outlook

Funding from the Government, via the Ministry of Health, is the main source of DHB funding. This is supplemented by revenue agreements from organisations such as the ACC and patient co-payments.

Like the rest of the health sector the West Coast DHB faces significant financial pressures from increasing service demand, rising treatment costs, wage expectations and increased public expectations – all of which must be managed within allocated funding. While these are the most significant pressures, there are a number of locally specific pressures that also need to be managed by the West Coast DHB:

Seismic remediation costs: The level of facilities repair required to attain moderate compliance with current building codes will exert significant financial pressure on the DHB. While some of the more immediate repairs have been completed, the remainder form part of the Detailed Business Case for future facilities.

Over-reliance on locum and temporary staff: While the use of locums and temporary staff allows for services to be maintained, the DHB is currently filling a significant number of full-time positions with locums. This not only reduces continuity of care but is an expensive and unsustainable option.

Increasing expectations from the public, clinical staff and government: Changes in clinical practice and the availability of more advanced treatments and technology drive increased cost within the system. With a smaller population base, these new technologies are not always affordable and must therefore be prioritised.

Inter-District Flows (IDFs): The West Coast DHB relies heavily on larger DHBs to provide complex specialist procedures for its population. A new capacity agreement with Canterbury DHB has removed some of the variability and risk associated with spend on ID. However, it is difficult to predict the volume of services required and, while the service prices are set nationally, costs have historically exceeded funding increases.

7.2 Achieving financial sustainability

The West Coast DHB is committed to reducing its current deficit and achieving a breakeven position for 2014/15 despite these pressures – however there is no 'quick fix'.

To ensure our health system is clinically and financially sustainable, we must provide the right care and support, at the right time and in the right place.

Savings will be made not in dollars terms, but in terms of costs avoided through more effective utilisation of the resources available and reduced demand for services.

The following factors are critical to the West Coast DHB's success in achieving financial sustainability:

Constraining cost growth: It is critical that costs are constrained. If an increasing share of funding continues to be directed into meeting cost growth our ability to maintain current service delivery levels will be at risk. The DHB will also be further restricted in terms of our ability to invest in new equipment, technology and initiatives.

Renegotiating transitional funding: The West Coast DHB currently receives $17.794m additional transitional funding which is vital to the fiscal sustainability of our health system. It is imperative that in future treatment of this funding it forms part of our base and is no longer at risk - as assumed in the financial modelling performed to evaluate the Grey redevelopment approved by Cabinet.

Rebalancing the system: It is crucial that we continue to develop more integrated models of care to make the most effective use of available resources. This will support earlier intervention strategies that help people stay well and reduce the demand for hospital services.

Rebuilding general practice: The West Coast has a legacy of unsustainable DHB-owned general practice with financial, access and workforce issues. It is crucial that we complete the remediation of its general practices to ensure the financial sustainability of general practice on the Coast.

Developing the transalpine approach: Our well established partnership with the Canterbury DHB needs to continue to address the delivery of some clinical services to ensure a model that is not only financially sustainable but also clinically safe.

Investing in clinical leadership: Enabling clinical input into operational and strategic decision-making is critical in achieving not only clinically acceptable and sustainable change but in supporting the development of a stable and motivated workforce.

Reducing duplication and waste: Removing unnecessary duplication and delay will improve patient flow and free up resources across our system. Investing in initiatives and information technology that achieve these goals is therefore critical in constraining cost growth and improving productivity.

The West Coast DHB is also committed to actively supporting national entities' initiatives to achieve mutual benefits and cost savings across the sector. The table (below) indicates the level of inclusion in 2014/15 financial projections.

7.3 Assumptions

The financial forecasts in this plan are based on a number of key assumptions. The following are those that have a degree of risk associated with them:

- Current Government policy settings and known health service initiatives will continue. It is assumed that we will receive fair prices for services provided on behalf of other DHBs and the Crown.
- Normal operations, volumes and service delivery will continue in 2014/15, with no disruptions associated with pandemic or natural disaster.
- Population-based funding levels will remain the same, as indicated in the funding envelope received in December 2013, and transitional funding will be maintained at 2013/14 levels.
- The West Coast DHB will continue to receive Crown Funding on an early payment basis.
- Any additional compliance costs, legislative changes, sector reorganisation or service devolvement will be cost-neutral or fully funded.
- Conditions of collective employment agreements that have already been settled will be implemented as agreed, with no unplanned impacts from second tier bargaining or debate over interpretation and translation issues. Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation.
- External provider increases will be made within available funding levels, after allowance for committed and demand-driven funding.
- Transformation strategies and programmes will not be delayed due to sector or legislative changes. It is assumed that investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- The approved forecasted deficit will be funded via deficit support (equity injections) by the Crown.
- In line with Generally Accepted Accounting Policies, land and buildings will be re-valued every three years or sooner if required. The land and buildings were re-valued/impaired 30 June 2012. The forecast for 2014/15 and the budgets for this and outlying years have been based on this revaluation. It has been assumed that there will be minimal change from this valuation for the 2014/15 year; however, there may be further impairments necessary dependent on the outcome of engineering assessments.
- Work will continue on the facilities redevelopment plans for Greymouth and Buller under the nationally directed Partnership Group. As the Grey redevelopment has been approved, the costs and capital expenditure associated have been included in the capital budget with the operating net result reflecting the modelling per the detailed business case approved by cabinet in April 2014. As agreed in the business case the funding will be a mix of debt and equity.

  However, although the Buller facility development has also been approved (April 2014), the DHB has not had the opportunity to fully explore procurement options and their financial impacts. Development costs and any capital or lease expenditure associated with Buller have therefore not been included.

West Coast commitment to National Initiatives

2014/15	CAPITAL COSTS	OPERATING COSTS		OPERATING BENEFITS	NET OPERATING
		ONE-OFF	ONGOING		
	$'000s	$'000s	$'000s	$'000s	$'000s
Health Benefits Limited					
Finance, Procurement and Supply Chain	(402)	(70)		(42)	(112)
Human Resource Management Information Systems		(14)			(14)
National Health IT Board					
eMedicines / eDischarge	(27)				0
National Patient Flow		(104)			(104)
Self-Care Portal		(45)			(45)
Health Quality & Safety Commission					
Patient experience indicators			(15)		(15)
Total impact for WCDHB	(429)	(233)	(15)	(42)	(290)

7.4 Asset planning & investment

Greymouth and Buller Redevelopment

The detailed business case for the redevelopment of Greymouth Hospital and Integrated Family Health Centre (including the energy centre) was approved by Cabinet and the national Capital Investment Committee in April 2014. Construction will begin at Grey Hospital in 2015.

A secondary tranche of redevelopment has been identified for a later stage – this includes demolition and Furniture, Fittings, and Equipment.

Approval was also obtained to rectify some urgent issues in relation to severe seismic and electrical problems facing the Greymouth campus, and these were completed in the 2013/14 year.

Capital expenditure

The business as usual capital expenditure budget for the 2014/15 year is $3.4M (excluding capital expenditure committed in previous years) and subject to approval. This capital budget will cover the replacement of clinical and other operational capital requirements and will focus on standardisation of equipment between the West Coast and Canterbury DHBs and strategic IT projects.

With a tight capital expenditure budget, the West Coast DHB will continue to be disciplined and focus on the key priorities in determining capital expenditure.

Disposal of surplus assets

The West Coast DHB currently has a stock of surplus assets, consisting of parcels of land within Greymouth and Westport, a number of which have existing leasehold arrangements.

The West Coast DHB will assess the need to retain ownership of these properties based on future models of care and facilities requirements. Those no longer required will be deemed properties intended for sale and necessary approvals sought to dispose of them.

In order to dispose of surplus land, the West Coast DHB 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 being made available for public sale.

7.5 Debt and equity

Ministry of Health

The West Coast DHB currently has debt facilities with the Ministry of Health (formerly the Crown Health Financing Agency), totalling $14.445M. The West Coast DHB's total term debt is currently $14.445M and is expected to remain at this amount as at June 2014.

The current debt with the Ministry of Health consists of several loans, and current interest rates range from 2.30% to 6.58%.

The West Coast DHB's current debt profile is:

PRINCIPAL	INTEREST RATE	MATURITY DATE
$250,000	2.31%	28-Jun-14
$3,500,000	6.58%	15-Apr-15
$250,000	2.30%	28-Jun-15
$3,000,000	4.75%	15-Apr-16
$250,000	2.50%	28-Jun-16
$250,000	2.69%	28-Jun-17
$4,695,000	5.22%	15-Dec-19
$2,000,000	4.92%	15-Apr-23
$250,000	4.30%	15-Apr-23

The West Coast DHB term liabilities are secured by a negative pledge. Without the Ministry of Health's prior written consent, the DHB cannot:

- Create any security over its assets, except in certain circumstances;
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- Make a substantial change in the nature or scope of its business as presently conducted, or undertake any business or activity unrelated to health; or
- Dispose of any of its assets except disposals at full value in the ordinary course of business.

Westpac Banking Corporation

In November 2012, the West Coast DHB changed its main bankers to Westpac Banking Corporation as part of the national health sector banking facility arranged through Health Benefits Limited.

Equity

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

Statement of Financial Expectations

Where will our funding go?

8.1 Statement of comprehensive income

For the years ending 2012/13 to 2017/18

in thousands of New Zealand dollars

	2012/13 Actual	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Operating Revenue						
Crown and Government sourced	128,941	130,848	134,509	137,117	139,966	142,823
Inter-DHB Revenue	36	34	34	35	36	37
Inter-District Flows Revenue	1,656	1,625	1,551	1,584	1,617	1,650
Patient-Related Revenue	3,112	2,936	2,760	3,064	3,128	3,192
Other Revenue	1,088	1,323	1,323	1,351	1,379	1,407
Total Operating Revenue	134,833	136,766	140,177	143,151	146,126	149,109
Operating Expenditure						
Employee benefit costs	55,688	55,081	55,613	56,790	57,967	58,651
Outsourced Clinical Services	9,119	4,395	4,520	2,719	2,716	2,313
Treatment-Related Costs	7,369	7,261	7,342	7,498	7,654	7,810
External Providers	29,844	35,712	35,182	35,928	36,676	37,424
Inter-District Flows Expense	16,675	17,947	20,040	20,465	20,890	21,316
Outsourced Services - non-clinical	1,443	1,647	1,548	1,581	1,614	1,647
Infrastructure Costs and Non-Clinical Supplies	12,790	10,390	9,491	9,722	9,645	9,168
Total Operating Expenditure	132,928	132,433	133,736	134,703	137,162	138,329
Result before Interest, Depn & Cap Charge	1,905	4,333	6,441	8,448	8,964	10,780
Interest, Depreciation & Capital Charge						
Interest Expense	650	684	1,364	2,388	2,550	2,565
Depreciation	4,156	3,937	3,937	4,700	5,464	5,548
Capital Charge Expenditure	675	812	1,140	2,460	2,650	2,667
Total Interest, Depreciation & Capital Charge	5,481	5,433	6,441	9,548	10,664	10,780
Net Surplus/(deficit)	(3,576)	(1,100)	-	(1,100)	(1,700)	-
Other comprehensive income						
Gain/(losses) on revaluation of property	-	-	-	-	-	-
Total comprehensive income	(3,576)	(1,100)	-	(1,100)	(1,700)	-

8.2 Statement of financial position

As at 30 June for years ending 2012/13 to 2017/18

in thousands of New Zealand dollars

	30/06/2013 Actual	30/06/2014 Forecast	30/06/2015 Plan	30/06/2016 Plan	30/06/2017 Plan	30/06/2018 Plan
Assets						
Non-current assets						
Property, plant and equipment	28,826	27,102	72,325	94,067	92,398	90,564
Intangible assets	1,812	1,631	1,211	791	371	49
Other investments	0	165	567	567	567	567
Total non-current assets	30,638	28,898	74,103	95,425	93 ,336	91,180
Current assets						
Cash and cash equivalents	6,172	9,341	10,068	10,678	12,699	14,787
Other investments	60	60	60	60	60	60
Inventories	1,124	1,100	1,100	1,100	1,100	1,100
Debtors and other receivables	3,968	4,218	4,218	4,218	4,218	4,218
Assets classified as held for sale	136	136	136	136	136	136
Total current assets	11,460	14,855	15,582	16,192	18,213	20,301
Total assets	**42,098**	**43,753**	**89,685**	**111,617**	**111,549**	**111,481**
Liabilities						
Non-current liabilities						
Interest-bearing loans and borrowings	12,195	10,695	39,195	54,995	55,245	50,550
Employee entitlements and benefits	2,927	2,835	2,835	2,835	2,835	2,835
Total non-current liabilities	15,122	13,530	42,030	57,830	58,080	53,385
Current liabilities						
Interest-bearing loans and borrowings	250	3,750	3,250	250	-	4,695
Creditors and other payables	7,239	7,248	7,248	7,248	7,248	7,248
Employee entitlements and benefits	9,275	9,081	9,081	9,081	9,081	9,081
Patient and restricted trust funds	60	60	60	60	60	60
Total current liabilities	16,824	20,139	19,639	16,639	16,389	21,084
Total liabilities	31,946	33,669	61,669	74,469	74,469	74,469
Equity						
Crown equity	69,729	70,761	88,693	98,925	100,557	100,489
Other reserves	19,569	19,569	19,569	19,569	19,569	19,569
Retained earnings/(losses)	(79,185)	(80,285)	(80,285)	(81,385)	(83,085)	(83,085)
Trust funds	39	39	39	39	39	39
Total equity	10,152	10,084	28,016	37,148	37,080	37,012
Total equity and liabilities	**42,098**	**43,753**	**89,685**	**111,617**	**111,549**	**111,481**

8.3 Statement of movements in equity

For the years ending 2012/13 to 2017/18

in thousands of New Zealand dollars

	2012/13 Actual	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Balance at 1 July	10,196	10,152	10,084	28,016	37,148	37,080
Contributions from the Crown	3,600	1,100	18,000	10,300	1,700	-
Contributions repaid to the Crown	(68)	(68)	(68)	(68)	(68)	(68)
Total comprehensive income	(3,576)	(1,100)	-	(1,100)	(1,700)	-
Balance at 30 June	**10,152**	**10,084**	**28,016**	**37,148**	**37,080**	**37,012**

8.4 Statement of cashflow

For the years ending 2012/13 to 2017/18
in thousands of New Zealand dollars

	2012/13 Actual	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Cash flows from operating activities						
Cash receipts from Ministry of Health, patients and other revenue	135,453	136,174	139,589	142,563	145,538	148,521
Cash paid to employees	(55,710)	(60,142)	(60,505)	(59,888)	(61,069)	(61,357)
Cash paid to suppliers	(31,794)	(20,968)	(18,009)	(18,422)	(18,527)	(18,232)
Cash paid to external providers	(31,499)	(35,712)	(35,182)	(35,928)	(36,676)	(37,424)
Cash paid to other District Health Boards	(15,020)	(17,947)	(20,040)	(20,465)	(20,890)	(21,316)
Cash generated from operations	1,430	1,405	5,853	7,860	8,376	10,192
Interest paid	(648)	(684)	(1,364)	(2,388)	(2,550)	(2,565)
Goods and services tax (net)	50	120	-	-	-	-
Capital charge paid	(677)	(812)	(1,140)	(2,460)	(2,650)	(2,667)
Net cash flows from operating activities	155	29	3,349	3,012	3,176	4,960
Cash flows from investing activities						
Interest received	229	588	588	588	588	588
Purchase of intangible	-	(165)	(402)	-	-	-
Acquisition of property, plant and equipment	(3,436)	(315)	(48,740)	(26,022)	(3,375)	(3,392)
Acquisition of intangible assets	(1,706)	-	-	-	-	-
Net cash flows from investing activities	(4,913)	108	(48,554)	(25,434)	(2,787)	(2,804)
Cash flows from financing activities						
Proceeds from equity injections	3,600	1,100	18,000	10,300	1,700	-
Repayment of equity	(68)	(68)	(68)	(68)	(68)	(68)
Cash generated from equity transactions	3,532	1,032	17,932	10,232	1,632	(68)
Borrowings raised	-	2,000	28,000	12,800	-	-
Repayment of borrowings	-	-	-	-	-	-
Net cash flows from financing activities	3,532	3,032	45,932	23,032	1,632	(68)
Net increase in cash and cash equivalents	(1,226)	3,169	727	610	2,021	2,088
Cash and cash equivalents at beginning of year	7,398	6,172	9,341	10,068	10,678	12,699
Cash and cash equivalents at end of year	**6,172**	**9,341**	**10,068**	**10,678**	**12,699**	**14,787**

8.5 Summary of revenue and expenses by arm

Governance Arm: Forecast Operating Statement for the years ending 2012/13 to 2017/18

in thousands of New Zealand dollars

	2012/13 Actual	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Income						
Internal Revenue	828	826	827	827	827	827
Other income	66	-	-	-	-	-
Internal allocation from Provider Arm	1,320	1,031	1,424	1,464	1,495	1,530
Total income	2,214	1,857	2,251	2,291	2,322	2,357
Expenditure						
Personnel	531	578	1,123	1,139	1,146	1,157
Outsourced services	369	462	300	306	312	318
Other operating expenses	411	464	468	478	488	498
Democracy	194	353	360	368	376	384
Total expenses	1505	1,857	2,251	2,291	2,322	2,357
Net Surplus / (Deficit)	**709**	-	-	-	-	-

Funder Arm: Forecast Operating Statement for the years ending 2012/13 to 2017/18

in thousands of New Zealand dollars

	2012/13 Actual	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Income						
PBF Vote Health-funding package (excluding Mental Health)	104,975	106,332	105,927	108,122	110,317	112,519
PBF Vote Health-Mental Health Ring fence	13,884	14,071	14,195	14,548	14,902	15,257
MOH-funding side contracts	2,308	2,312	5,888	6,013	6,138	6,263
Inter District Flow's	1,656	1,625	1,551	1,584	1,617	1,650
Other income	278	-	-	-	-	-
Total income	123,101	124,340	127,561	130,267	132,974	135,689
Expenditure						
Personal Health	76,174	87,264	92,429	94,389	96,351	98,315
Mental Health	13,888	14,358	14,606	14,915	15,224	15,533
Disability Support	17,864	17,703	17,566	17,938	18,311	18,685
Public Health	739	684	704	719	734	749
Māori Health	609	851	818	835	852	869
Governance	828	826	827	827	827	827
Total expenses	110,102	121,686	126,950	129,623	132,299	134,978
Net Surplus / (Deficit)	**12,999**	**2,654**	**611**	**644**	**675**	**711**

Provider Arm: Forecast Operating Statement for the years ending 2012/13 to 2017/18

in thousands of New Zealand dollars

	2012/13 Actual	2013/14 Forecast	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan
Income						
Internal revenue-Funder to Provider	62,792	67,235	70,935	72,438	73,942	75,448
Ministry of Health side contracts and Other Government	7,774	8,133	8,499	8,434	8,609	8,784
Patient and consumer sourced	3,112	2,936	2,760	3,064	3,128	3,192
Other income	744	1,323	1,323	1,351	1,379	1,407
Total income	74,422	79,627	83,517	85,287	87,058	88,831
Expenditure						
Employee benefit costs	55,158	54,503	54,490	55,651	56,821	57,494
Outsourced Clinical Services	9,119	4,395	4,520	2,719	2,716	2,313
Treatment Related Costs	7,368	7,261	7,342	7,498	7,654	7,810
Outsourced Services - non clinical	1,076	1,185	1,248	1,275	1,302	1,329
Infrastructure Costs and Non Clinical Supplies	12,182	9,573	8,663	8,876	8,781	8,286
Internal allocation	1,320	1,031	1,424	1,464	1,495	1,530
Total Operating Expenditure	86,223	77,948	77,687	77,483	78,769	78,762
Result before Interest, Depn & Cap Charge	(11,801)	1,679	5,830	7,804	8,289	10,069
Interest, Depreciation & Capital Charge						
Interest Expense	650	684	1,364	2,388	2,550	2,565
Depreciation	4,156	3,937	3,937	4,700	5,464	5,548
Capital Charge Expenditure	677	812	1,140	2,460	2,650	2,667
Total Interest, Depreciation & Capital Charge	5,483	5,433	6,441	9,548	10,664	10,780
Net Surplus/(deficit)	(17,284)	(3,754)	(611)	(1,744)	(2,375)	(711)
Other comprehensive income						
Gain/(losses) on revaluation of property	-	-	-	-	-	-
Total comprehensive income	**(17,284)**	**(3,754)**	**(611)**	**(1,744)**	**(2,375)**	**(711)**

Summary of Forecasted Revenue and Expenditure for the year ending 30 June 2015

in thousands of New Zealand dollars

	Governance	Funder	Provider	Eliminations	Result
Revenue	827	127,561	83,517	71,728	140,177
Expenditure	827	126,950	84,128	71,728	140,177
Net Surplus (Deficit)	-	611	(611)	-	-

Part IV - Appendices

Appendices

Further information for the reader:

Appendix 1	Glossary of terms
Appendix 2	Objectives of a DHB – New Zealand Public Health and Disability Act (2000)
Appendix 3	2013 Census summary for the West Coast
Appendix 4	West Coast DHB organisational structure
Appendix 5	West Coast Alliance Structure
Appendix 6	Minister of Health's letter of expectations for 2013/14
Appendix 7	West Coast's commitment to the national health targets
Appendix 8	Statement of accounting policies

References

Unless specifically stated, all West Coast DHB documents referenced in this document are available on the West Coast DHB website (www.wcdhb.govt.nz).

All Ministry of Health or National Health Board documents referenced in this document are available either on the Ministry's website (www.health.govt.nz) or the National Health Board's website (www.nationalhealthboard.govt.nz).

The Crown Entities Act 2004 and the Public Finance Act 1989, both referenced in this document are available on the Treasury website (www.treasury.govt.nz).

9.1 Glossary of terms

ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	Management of conditions with sudden onset and rapid progression.
ALT	Alliance Leadership Team	The team leading the West Coast Alliance.
ARC	Aged Residential Care	Residential care for older people, including rest home, hospital, dementia and psycho-geriatric level care.
B4SC	B4 School Check	The final core WCTO check, which children receive at age four. The free check allows health concerns to be identified and addressed early in a child's development for the best possible start for school and later life.
CCCN	Complex Clinical Care Network	A single point of referral for patients from general practice, ambulance and inpatient services. Under the restorative CCCN delivery model, clients are assessed using comprehensive assessment tools and an individual goal-based care plan is developed with them.
CPH	Community and Public Health	The division of the DHB that provides public health services.
CVD	Cardiovascular Disease	Diseases affecting the heart and circulatory system, including: ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
	Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entity	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the annual financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
	Effectiveness	The extent to which objectives are being achieved. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
ERMS	Electronic Referral Management System	A system available from the GP desktop enabling referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide.
ESPIs	Elective Services Patient flow Indicators	A set of indicators developed by the Ministry of Health to monitor how patients are managed while waiting for elective (non-urgent) services.
FSA	First Specialist Assessment	(Outpatients only) The first time a patient is seen by a doctor for a consultation in that speciality. This does not include procedures, nurse or diagnostic appointments or pre-admission visits.
HbA1c	Haemoglobin A1c	Also known as glycated haemoglobin, HbA1c reflects average blood glucose level over the past 3 months.
HCS	Health Connect South	A shared regional clinical information system that will provide a single repository for clinical records across the South Island. Already implemented in West Coast, Canterbury and South Canterbury.
HEEADSSS		An assessment provided to students attending teen parent units, alternative education facilities and deciles 1 to 3 high schools that covers Home environment; Education/employment; Eating/exercise; Activities and peer relationships; Drugs/cigarettes/alcohol; Sexuality; Suicide/depression/mood; Safety; and Spirituality.
	Impact	The contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. Normally describes results that are directly attributable to the activity of an agency. Impact measures should be attributed to DHB outputs in a credible way and represent near-term results expected from the outputs delivered.
	Input	The resources (e.g. labour, materials, money, people, technology) an organisation uses to produce outputs.
IDFs	Inter-District Flows	Services (outputs) provided by a DHB to a patient whose place of residence is in another DHB's region. Under PBF, each DHB is funded on the basis of its resident population; therefore, the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	A comprehensive geriatric assessment tool.

	Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
	Intervention logic model	A framework for describing the relationships between resources, activities and results, which provides a common approach for planning, implementation and evaluation. Intervention logic focuses on being accountable for what matters: impacts and outcomes.
LMC	Lead Maternity Carer	The health professional a woman chooses to provide and coordinate the majority of her maternity care. Most LMCs are midwives, though GPs and obstetricians may also be LMCs.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ. A person's NHI number is stored on the NHI along with their demographic details. The NHI is used to help with the planning, coordination and provision of health and disability services across NZ.
NGO	Non-Government Organisations	In the context of the relationship between Health and Disability NGOs and the West Coast DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market.
OPF	Operational Policy Framework	An annual document endorsed by the Minister of Health that sets out the operational-level accountabilities all DHBs must comply with, given effect through the CFA between the Minister and the DHB.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
	Output Class	An aggregation of outputs of a similar nature.
	Outputs	Final goods and services delivered to a third party outside of the DHB. Not to be confused with goods and services produced entirely for consumption within the DHB (internal outputs or inputs).
PBF	Population-Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Professional health care received in the community, usually from a general practice, covering a broad range of health and preventative services. The first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care practitioners and are funded by DHBs to provide of a set of essential primary healthcare services to the people enrolled with that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Purchase agreement	A documented arrangement between a Minister and a department/organisation for the supply of outputs.
	Regional collaboration	Refers to DHBs across geographical 'regions' planning and delivering services (clinical and non-clinical) together. Four regions exist: Northern, Midland, Central and Southern. The Southern region includes all five South Island DHBs (Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs). Regional collaboration sometimes involves multiple regions, or may be 'sub-regional collaboration' (DHBs working together in a smaller grouping of two or three DHBs, e.g. Canterbury and West Coast).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIA(PO)	South Island Alliance (Programme Office)	A partnership between the five South Island DHBs working to support a clinically and financially sustainable South Island health system where services are as close as possible to people's homes.
SSP	Statement of Service Performance	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
WCTO	WellChild/Tamariki Ora	A free service offering screening, education and support to all New Zealand children from birth to age five.

9.2 Objectives of a DHB – New Zealand Public Health and Disability Act (2000)

Part 3: Section 22:

The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

- To reduce health disparities by improving health outcomes for Māori and other population groups;
- To reduce, with a view to eliminating, health outcome disparities between various population groups, 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;
- To improve, promote, and protect the health of people and communities;
- To improve integration of health services, especially primary and secondary health services;
- To promote effective care or support for those in need of personal health or disability support services;
- To promote the inclusion and participation in society and independence of people with disabilities;
- To exhibit a sense of social responsibility by having regard to the interests of people to whom we provide, or for whom we arranges the provision of services;
- To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
- To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
- To exhibit a sense of environmental responsibility by having regard to the environmental implications of our operations; and
- To be a good employer.

9.3 2013 Census summary for the West Coast

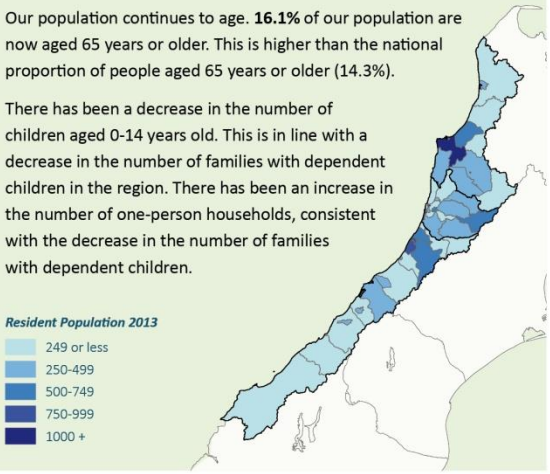
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Our resident population has increased by **2.6%** since 2006, to 32,150. This is a slower rate of growth than at the last census. However, the rate of population growth has also slowed nationally.

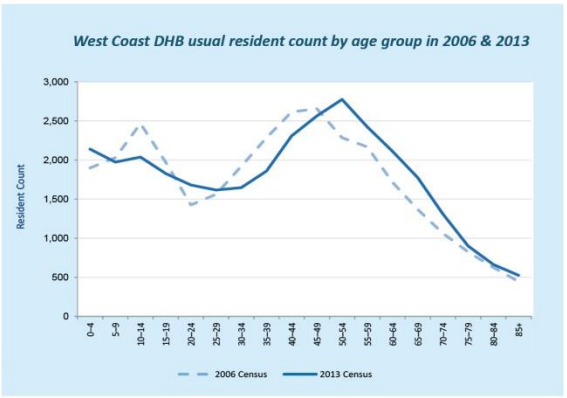
The Grey District has the largest population in the region, with a resident population of **13,370**. The Buller District has a population of 10,470 residents. The Westland District has a population of 8,300 residents.

Our population continues to age. **16.1%** of our population are now aged 65 years or older. This is higher than the national proportion of people aged 65 years or older (14.3%).

There has been a decrease in the number of children aged 0-14 years old. This is in line with a decrease in the number of families with dependent children in the region. There has been an increase in the number of one-person households, consistent with the decrease in the number of families with dependent children.



Our population is also becoming more ethnically diverse. We now have greater proportions of Māori, Pacific and Asian ethnicities than in 2006. The percentage of Māori has increased from 9.7% to **10.5%**. Our Māori population are younger, with **42.4%** aged 0-19 years-old (compared to 24.8% of the total West Coast population).



What We Don't Know

Updated population projections and estimates

The current Statistics New Zealand population projections are still based on the 2006 Census results. Projections based on the 2013 Census results will not be available until December 2014. Updated population estimates will be made available in August 2014.

WHAT THE 2013 CENSUS TELLS US

16.1% 65+

16.1% of our population are aged 65 or older, up from 13.8% in 2006.

2.6% **increase** in the number of residents on the West Coast since 2006.

32,150 People

10.5% of our population are **Māori**

30.7% of households only have one resident.

20.5% of those aged 15 years or older **smoke regularly,** down from 25.7% in 2006.

20.5%

0.8% of the total New Zealand resident population live in the West Coast. However, the West Coast is one of the **largest DHBs** by geographic region.

4.7% decrease in the number of **families** with dependent children.

15% decrease in the number of **single parent** families with dependent children.

3.4% of households have no access to telecommunication systems. This is the **highest** proportion of any region **in New Zealand**.

What Does This Mean?

Our aging population

The West Coast DHB has an increasing elderly population. While progress has been made to address the needs of older people, new service models will need to continue to be developed.

Our population distribution

We have a population that is spread over a vast geographic distance. We also have households that are hard to contact, with 3.4% without access to any telecommunications. This presents a challenge in the delivery of health services within the West Coast and demonstrates the importance of mobile delivery of services to the community.

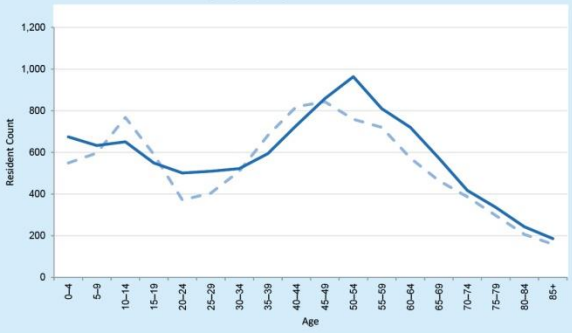
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

CENSUS Demographic Changes by DISTRICT

Please note: Due to the difference in resident populations the scale of each graph varies. — 2006 Census — 2013 Census

Buller District

usual resident count by age group in 2006 and 2013



770 more residents living in Buller than in 2006.

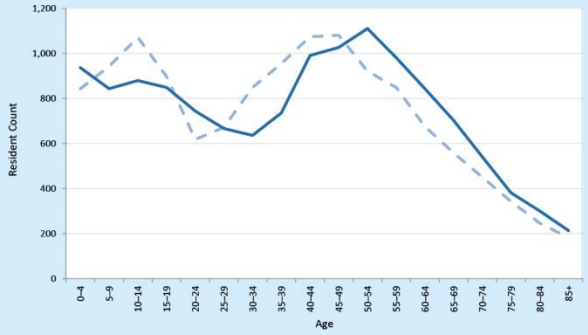
No change in the number of **families** with dependent children. The other districts have both had a decrease.

16.7%

16.7% of Buller residents are aged 65 years or older, up from 15.7% in 2006. This is the highest proportion on the Coast.

Grey District

usual resident count by age group in 2006 and 2013



150 more residents living in Grey than in 2006.

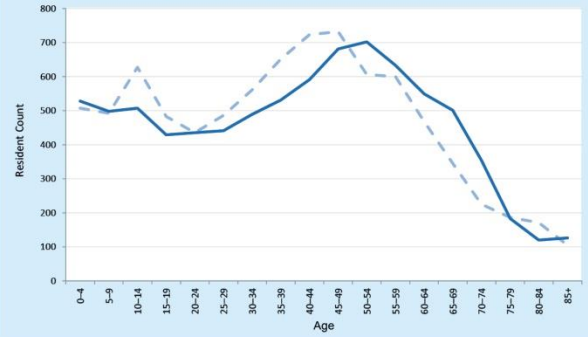
19.9% of Grey residents are aged under 15. This is the highest proportion on the Coast.

16%

16% of Grey residents are aged 65 years or older, up from 13.5% in 2006.

Westland District

usual resident count by age group in 2006 and 2013



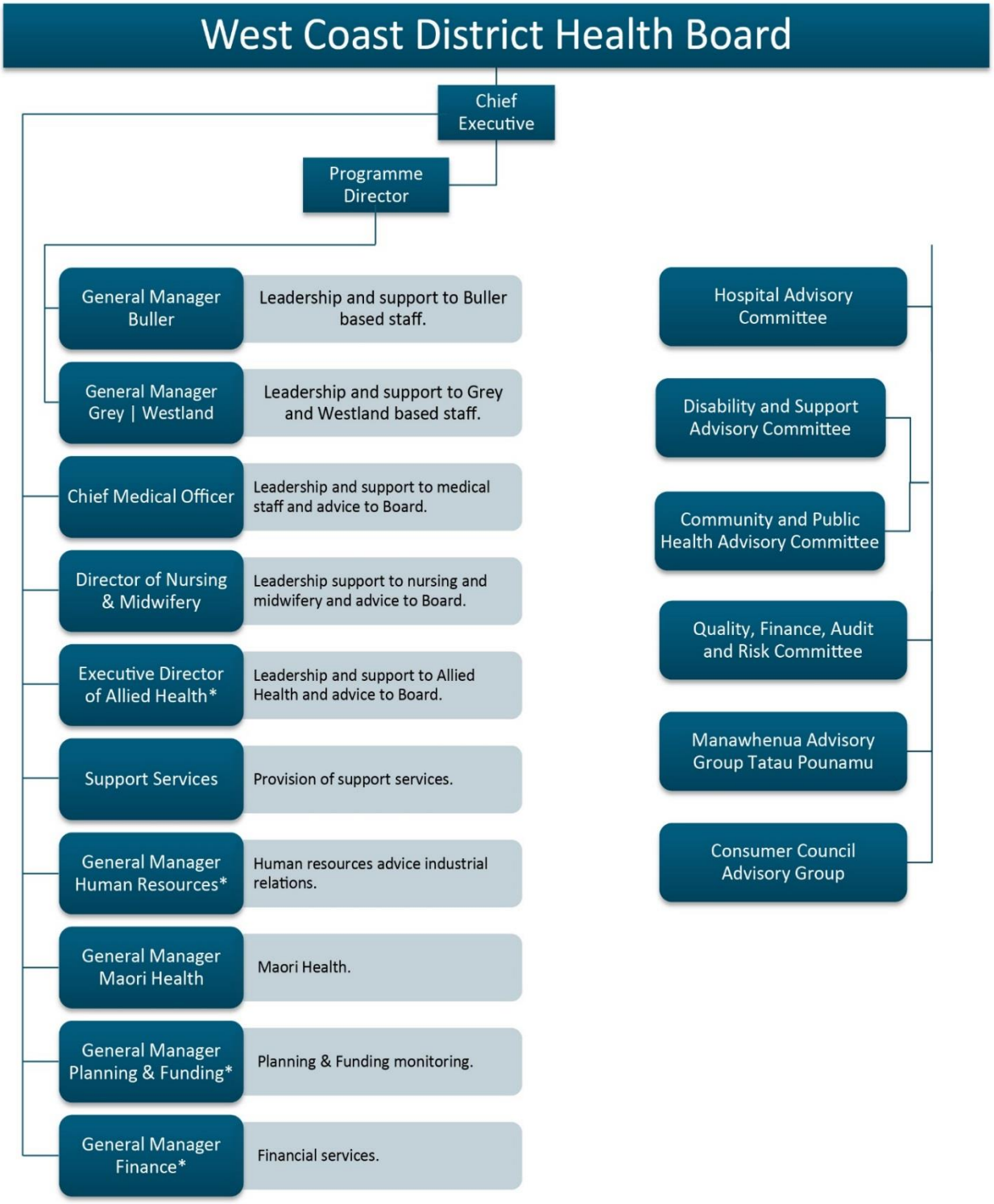
4.1% of Westland households have **no access** to telecommunication systems.

100 **fewer** residents living in Westland than in 2006.

13.4% of the population are **Māori**

This is the **highest proportion** on the Coast.

9.4 West Coast DHB organisational structure



*Joint appointments with CDHB

9.5 West Coast Alliance Structure

9.6 Minister of Health's letter of expectations for 2014/15

4/2/14

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

30 JAN 2014

Dr Paul McCormack
Chair
West Coast District Health Board
PO Box 387
GREYMOUTH 7840

Dear Dr McCormack

Letter of Expectations for DHBs and subsidiary entities 2014/15

Public and patient confidence in the health service continues to grow strongly. Thank you to your team. This achievement is built on the four objectives of the Government's health plan*: helping families stay healthy, better performance, best use of every dollar, and a strong and trusted workforce*. In the next year we expect continued strong focus on successful implementation.

New Zealand has come through the global financial crisis in much better shape than most other countries. That's because of this government's careful and prudent financial management. Our approach has been to protect the most vulnerable in our society, and rebuild the economy's capacity to create jobs, higher incomes and security.

Despite the toughest of times, we are providing better public services within careful funding increases. This government now invests an extra $2.5 billion a year more into the public health service. And this year's budget will again see more investment in Health.

Better Public Services: Results for New Zealanders

Of the Prime Minister's ten whole-of-government key result areas, DHBs are expected to actively engage and invest in increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children.

It is important Boards work closely with other social sector organisations and initiatives including Whanau Ora, Children's Action Plan and Youth Mental Health. The government values the contribution of NGOs and DHBs must work with them.

National Health Targets

The national health targets have proven very successful at driving major improvements for patients: more elective surgery, faster access to emergency and cancer care, and better prevention. DHBs will provide clear and specific plans for achieving all national health targets in their Annual Plans.

In particular further work is required to achieve the three preventive targets. You must demonstrate appropriate performance management arrangements for PHOs. Poor performance must be rectified and not ignored. You should again show your local primary care networks are involved in and explicitly endorse your target achievement plans.

Your DHB is expected to help patients by meeting our objectives of shorter waiting times for surgery, diagnostics, cardiac and cancer care.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Care Closer to Home

New Zealanders are living longer, more sedentary lives. This means more of us have chronic conditions like diabetes, asthma, dementia, cancer and mental health disorders. The sooner doctors and nurses can detect, treat or prevent these conditions, the better they can reduce the significant burden these conditions put on both patients and the health system.

A major strategy to do this is *clinical integration* – providing joined-up care across primary and secondary services. With resources and interventions flowing to where they are most effective. So patients get their care sooner and closer to home.

DHBs must focus strongly on service integration across the health system, including integrated family health centres, primary care direct referral for diagnostics, clinical pathways and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home; particularly important are avoiding a hospital admission and care after a hospital discharge. You should continue working with the Ministry to implement our commitments to improving home care, stroke services and dementia care pathways.

Regional and National Collaboration

DHBs are expected to make further progress on implementing Regional Service Plans including workforce, IT and capital objectives. DHBs are expected to strongly support the implementation of the key Health Benefits Ltd savings programmes. Further gains in quality, efficiency and cost control will also come from your work with Pharmac, Health Workforce NZ and the Health Quality and Safety Commission. The new patient satisfaction survey is one example.

Strong clinical leadership and engagement is important and remains essential.

Living Within Our Means

To support New Zealand's recovery your DHB must keep to budget. Your DHB must have detailed and effective plans to improve financial performance year on year. Equity and capital remain constrained. As agents of the Crown you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership to deliver on the government's objectives. You and your Board must monitor and hold your CEO accountable against these expectations.

Appreciation

Again, thank you for the considerable effort you and your team are making. This makes a real difference to the quality of life of many thousands of New Zealanders. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

Attached: PM's Key Result Areas and National Health Targets

Appendix 1: Prime Minister's Key Result Areas and DHB Health Targets for 2014/15

Prime Minister's Key Result Areas – Supporting Vulnerable Children

Increase immunisation rates

Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017.

Rheumatic Fever

Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017.

Assist to reduce the number of assaults on children

By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5%.

National Health Targets for 2014/15

Shorter stays in Emergency Departments

95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Improved access to elective surgery

The volume of elective surgery will be increased by at least 4,000 discharges per year.

Shorter waits for cancer treatment / transitioning to Faster Cancer Treatment

All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.

Faster cancer treatment.

The 62-day faster cancer treatment indicator that is currently a developmental measure, will transition into a full policy priority accountability measure, and will become the next cancer health target during 2014/15. Further details including the health target definition, DHB performance expectations for 2014/15, and the process for transition will be provided at the end of February 2014.

Increased immunisation

90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Within the target a specialised identified group will include:

- progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

9.7 West Coast's commitment to the national health targets

Shorter Stays in Emergency Departments

Government expectation

95% of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

West Coast contribution – see page *Error! Bookmark not defined.*

95% of people presenting at ED will be admitted, discharged or transferred within six hours.

Improved Access to Elective Surgery

Government expectation

More New Zealanders have access to elective surgical services, with at least 4,000 additional discharges nationally every year.[53]

West Coast contribution – see page *Error! Bookmark not defined.*

1,592 elective surgical discharges will be delivered in 2014/15.

Shorter Waits for Cancer Treatment

Government expectation [54]

All people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.[55]

West Coast contribution – see page *Error! Bookmark not defined.*

100% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.

Increased Immunisation

Government expectation

95% of all eight-month-olds are fully vaccinated against vaccine preventable diseases.

West Coast contribution – see page *Error! Bookmark not defined.*

95% of all eight-month-olds will be fully vaccinated.

Better Help for Smokers to Quit

Government expectation

90% of smokers seen in primary care, 95% of hospitalised smokers and 90% of women at confirmation of pregnancy are offered brief advice and support to quit smoking.

West Coast contribution – see page *Error! Bookmark not defined.*

95% hospitalised smokers, **90%** of primary care smokers and **90%** of pregnant smokers will receive advice and help to quit smoking.

More Heart and Diabetes Checks

Government expectation

90% of the eligible population have their cardiovascular risk assessed once every five years.

West Coast contribution – see page *Error! Bookmark not defined.*

90% of the eligible population will have had CVD risk assessment once in the past five years.

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[53] *The national health target definition of elective surgery excludes dental and cardiology services.*
[54] *This national health target will change in Quarter 2 2014/15 to the Faster Cancer Treatment Health Target.*
[55] *The national health target definition excludes Category D patients, whose treatment is scheduled with other treatments or part of a trial.*

9.8 Statement of accounting policies

The prospective financial statements in this Statement of Intent for the year ended 30 June 2015 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year. The following information is provided in respect of this Statement of Intent:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 7 of the Statement of Intent.

REPORTING ENTITY AND STATUTORY BASE

The West Coast District Health Board ("West Coast DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. West Coast DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. West Coast DHB is a Reporting Entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, Public Finance Act 1989, and the Crown Entities Act 2004.

West Coast DHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

West Coast DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the West Coast community.

The consolidated financial statements of West Coast DHB consist of West Coast DHB and the West Coast DHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts.

BASIS OF PREPARATION

Statement of compliance

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Section 154 of the Crown Entity Act 2004, which includes the requirement to comply with New Zealand Generally Accepted Accounting Practice (NZ GAAP). In accordance with NZ GAAP, the consolidated financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, and land and buildings.

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

Functional and presentation currency

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

Changes in accounting policies

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

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 West Coast DHB include:

- NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

- The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, West Coast DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means West Coast DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, West Coast DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

- Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

Subsidiaries

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

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

Owned assets

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

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

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

Additions

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

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

Donated assets are recorded at the best estimate of fair value and recognised as income. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

Depreciation

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

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

Class of Asset	Years	Depreciation Rate
Freehold Buildings & Fit Out	10 – 50	2 - 10%
Leasehold Building	3 – 20	5 - 33%
Plant, Equipment & Vehicles	3 – 12	8.3 - 33%

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and West Coast DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the surplus or deficit when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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

Amortisation

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

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

Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in other comprehensive income.

Other financial assets held are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains

and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the surplus or deficit. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the surplus or deficit.

Financial assets classified as held for trading or available-for-sale are recognised/derecognised on the date West Coast DHB commits to purchase/sell the investments.

Trade and other receivables

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

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

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

Cash and cash equivalents

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

Impairment

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

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

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

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

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

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

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

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

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

Restricted assets and liabilities

Donations and bequests received with restrictive conditions are treated as liabilities until the specific terms from which the funds were derived are fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Provisions

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

ACC Partnership Programme

West Coast DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme the DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Trade and other payables

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

Derivative financial instruments

West Coast DHB uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational and financing activities. West Coast DHB does not hold these financial instruments for trading purposes and has not adopted hedge accounting.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are remeasured to fair value at each balance date. The gain or loss on remeasured to fair value is recognised immediately in the surplus or deficit.

Income tax

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

Goods and services tax

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

Revenue

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

Revenue relating to service contracts

West Coast DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or West Coast DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Services rendered

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to West Coast DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by West Coast DHB.

Interest income

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

Critical judgements in applying West Coast DHB's accounting policies

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

Property, plant and equipment useful lives and residual value

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

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

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

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

Retirement and long service leave

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

Leases classification

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

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

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

Non-government grants

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

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