West Coast DHB

STATEMENT OF INTENT 2015-2018

& Statement of Performance Expectations 2015/2016

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 2015/16 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: 2016/17, 2017/18 and 2018/19.

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.

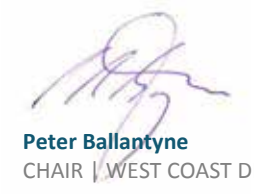
The West Coast DHB has made a strong commitment to an integrated health system with joint planning and service delivery. Clinically led local and regional alliances are redesigning the way we provide health services, implementing system change and improving health outcomes. These collaborative partnerships 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.[1]

The West Coast DHB also has Māori Health and Public Health Action Plans for 2015/16, 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 2015 to 30 June 2019.

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



Peter Ballantyne
CHAIR | WEST COAST DHB

Helen Gillespie

CHAIR | QUALITY, FINANCE, AUDIT & RISK COMMITTEE, WEST COAST DHB

October 2015

[1] *The South Island Regional Health Services Plan can be found on the South Island Alliance website:www.sialliance.health.nz.*

Table of Contents

Part I – Overview

Foreword from the Chairman and Chief Executive

FOCUSING ON PEOPLE FIRST

The West Coast District Health Board has an important opportunity over the coming year to consolidate the transformation that has been taking place and make a real difference in outcomes for communities on the West Coast.

At the centre of our vision are West Coast people receiving the right care at the right time, closer to home. Our vision is about an integrated system where our communities see only one health system that doesn't require navigation or create unnecessary delays. It is about our staff who are supported with the same up-to-date information no matter where they work. It is about a strong, sustainable primary care system that is proactive in the care it provides. It is about community care that is enabled to care for more people in their own homes. It is about a seamless service between Canterbury and the West Coast that means our communities receive quality care at all levels.

We know that at some point in people's lives they may receive care from a self-employed midwife, have a Before School Check, get immunised, receive messages about giving up smoking, see nurses, doctors, need care in their home or even need hospital-level care. Whether we call these services primary or secondary care is neither here nor there for the people of the West Coast. What we are trying to deliver to them is the health advice, support and services that they will need to enable them to live healthy West Coast lives.

We continue to live with the system challenges that dictate a different way of doing things including: a small population spread over a large geographic area; a prevalence of locums which can contribute to a loss of continuity of care; outdated and inefficient hospital facilities; underdeveloped transport infrastructure; and increasing service provision costs.

Working collaboratively the West Coast health system has become far more joined up as together we put in the effort required to tackle the big health issues on the Coast. It is exciting to begin to see the fruits of all the hard work.

INTEGRATING CARE: HEALTH CARE HOME AND A SINGLE POINT OF REFERRAL FOR COMPLEX CARE

The work already undertaken in primary care by the West Coast Alliance and clinicians within general practice has delivered some significant improvements. Access to primary care for planned appointments has improved with shorter waiting times and services are working closer to provide joined up services to patients.

In looking ahead there continues to be significant work that needs to be done. The West Coast Health Alliance's Integrated Family Health Centre (IFHC) Workstreams are leading the integration of primary care services on the West Coast - preparing for the new facilities in Grey and Buller. In the year ahead, the integration agenda will look at further implementing new ways of working in preparation for the move into the new facilities. This will include improving linkages across the system with HealthPathways, providing increased services in a primary and community setting, implement new ways of providing for unplanned care and further improving the performance of the DHB owned general practices.

The Complex Clinical Care Network (CCCN) is an important component in looking after the health of patients with complex needs up and down the Coast. Working alongside general practice and with the West Coast Health Alliance's Health of Older Persons Workstream, the CCCN is supporting older people with complex conditions to remain safe and well in the community and closer to their own homes. Further investment in the CCCN over the coming year will see the establishment of the Flexible Integrated Rehabilitation Service Team (FIRST) and the establishment of a Falls Champion and Fracture Liaison service.

SUSTAINING CARE: TRANSALPINE SERVICES AND SUPPORTING HEALTH PROFESSIONALS

Our transalpine collaboration with Canterbury continues to provide the West Coast with reliable access to a full range of specialist services, for the most part delivered locally, with some services delivered in Christchurch.

In late 2014 we brought together senior clinicians from Canterbury and the West Coast to review the transalpine approach. This planted the seed for a number of services progressing this approach to support high quality, sustainable services on the Coast. In the coming year we will see more departments bringing this to life with general medicine, anaesthesia and mental health among the services that will build on this collaborative approach.

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 still have some distance to travel, we continue to invest 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 in paediatrics, anaesthesia, and gerontology. There is also significant work underway around developing a flexible workforce that can move around the health system to where the demand is. This will further reduce our reliance on locums and support an integrated way of working.

CONNECTING CARE: INTEGRATED INFORMATION SYSTEMS

Integrated information systems remain critical to the delivery of joined-up care. We have introduced an electronic signoff system for receiving laboratory results, enabling clinicians to view the results from anywhere and brings the West Coast DHB into line with the electronic processes used by Canterbury colleagues.

HealthOne has improved 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. This includes general practitioners, pharmacists, radiographers, specialists and surgeons – every part of the clinical care team who are dealing with individual patients.

More resources are being put into the transalpine telehealth system, to improve access to specialist care and reduce associated delays and costs for patients. This is a great relief physically and financially for patients who live in outlying areas when they have no need to be physically present in a room with their specialist – but can be supported by local clinicians in their local areas.

JOINED-UP CARE: SETTINGS AND FIT-FOR-PURPOSE FACILITIES

Planning is well underway for our new purpose-built healthcare facilities in both Greymouth and Buller – the physical surroundings to enable us to deliver our seamless model of care services when people cannot receive services in their homes.

Clinical teams have continued to lead the discussions about the services contained in the new facilities, sitting alongside architects and other key design planners. In Greymouth we have been able to show people early designs as we get one step closer to putting that first spade in the ground. In Buller a design team has been appointed and will soon re-engage with clinicians to work on the master plan and concept design.

HEALTH TARGETS: COMMITMENTS TO THE CROWN

Every quarter the Crown asks us to report back against a series of health targets. Together, the West Coast health system has been working hard to improve our performance against these important measures.

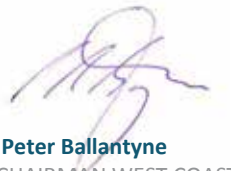
We are now meeting targets around: provision of smoking cessation messages in primary and secondary care; delivering shorter stays for patients in our emergency department; ensuring the people who need them have heart and diabetes checks; and meeting our targets for elective surgery.

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.

Over the last twelve months we have seen significant progress in bringing this vision to life. We would like to acknowledge all those across the West Coast health system who continue to travel with us on this journey of transformation with many people working hard to deliver a future of sustainable healthcare services for the West Coast population.

As we look to the year ahead, we remain determined to continue delivering on our commitments, meet national targets, and live within our means. We will continue our journey of transformation and deliver 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

October 2015

Introducing the West Coast DHB

1.1 Who are we

The West Coast DHB has the smallest population of all of New Zealand's 20 District Health Boards, serving a total resident population of 33,685 people (0.73% of the New Zealand population).

On behalf of our population, we manage a budget of almost $141M—which includes $101M (0.89%) of the population based funding provided to DHBs.

While the West Coast has the smallest population we also have the third largest geographical area, making the West Coast DHB the most sparsely populated DHB in New Zealand. 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 a major employer in the West Coast district, employing over 1,000 people. The DHB also owns and manages three major facilities in Greymouth, Westport and Reefton, five general practices across the West Coast and both Kynnersley Home in Westport and Ziman in Reefton, which provide rest home level care.

1.2 What do we do

The West Coast DHB is charged by Government with improving, promoting and protecting the health and independence of the West Coast population. Like all DHBs, we receive funding from Government with which to purchase and provide services to meet the needs of our population and are expected to operate within allocated funding. In accordance with legislation we:

Plan the strategic direction of the West Coast health system and determine the services required to meet the needs of our population in partnership with clinical leaders and alliance partners and in consultation with other DHBs, service providers and our community.

Fund the majority of the health services provided on the West Coast, and through our collaborative partnerships with other service providers, ensure services are responsive, coordinated and effective. The DHB holds and monitors more than 40 service contracts and agreements with the organisations and individuals that provide health services to our population, including: the West Coast Primary Health Organisation (PHO), residential mental health services and aged care service providers.

Provide the majority of specialist health and disability services for our population, through our hospital and specialist services and our DHB owned general practices. This is no small responsibility – in an average week: 191 people go through our Grey Base Emergency Department; 132 people are admitted to our hospitals; 35 people have elective surgery; 345 people have a specialist outpatient appointment and 2,601 general practice appointments are provided.

Promote and protect our population's health and wellbeing through investment in health promotion, education and evidence-based public health initiatives. 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 Alliance and the West Coast PHO the focus of these initiatives is on the reduction of negative behaviours and risk factors. This includes improving nutrition and physical activity and reducing tobacco smoking and alcohol consumption.

1.3 Our operating structure

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, meets the needs of our population and ensures sustainable service provision. As an owner of Crown assets, the DHB is also accountable to Government for the financial and operational management of those assets.

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 jointly provided by the Canterbury DHB. The two DHBs now share senior clinical and management expertise including: a joint Chief Executive, Executive Directors, Clinical Directors and Senior Medical Officers, as well as joint planning and funding, finance, public health,

human resources, information support and corporate services teams.

The West Coast also has in place a formal Health Alliance, a partnership of health professionals and providers, who work together to enable collaborative service planning and design and to determine the appropriate models of care for our health system. Through the Alliance, we embedding a view of our health system as one system with one budget and supporting the transformation and integration of our health system. The annual work programme of the West Coast Alliance forms the basis of the DHB's Annual Plan.

1.4 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 always had informal arrangements with the Canterbury DHB, these are progressively being formalised through the establishment of clinically led transalpine service pathways. This approach is not about reducing services. Instead, formal arrangements enable both DHBs to proactively develop the workforce and service infrastructure needed to ensure future services meet the needs of both populations in a clinically and financially sustainable way.

These arrangements include joint clinical appointments and shared service models that enable specialists to provide regular outpatient clinics and surgical lists on the West Coast and save patients from having to travel. Deliberate investment in telemedicine technology such as videoconferencing is providing further access to specialist advice while also saving families the inconvenience of travelling long distances for treatment.

Since 2010 more than 1,200 video and telemedicine consultations have taken place across oncology, paediatrics, general medicine, plastics, orthopaedics and general surgery. In the coming year more departments will bring the transalpine model to life with general medicine, anaesthesia and mental health among the services that will build on this collaborative approach.

1.5 Our accountability to the Minister

As a Crown entity and responsible for Crown assets, the DHB observes Government legislation and policy as directed by the Minister of Health. As required by legislation, we engage with the Minister and seek prior approval before making any significant service change or capital investment or disposing of any Crown land.

The West Coast DHB also strives to maintain open communication with the Minister and the Ministry of Health. This includes regular financial and performance reporting and a policy where early communication is provided with regard to any material or significant service change or issue of public interest.

The DHB's reporting obligations include:

- Annual Reports and Audited Financial Statements
- Quarterly non-financial performance reports and health target reports
- Quarterly service delivery reports against plan
- Bi-annual risk reports
- Monthly financial reports and monthly wait time and ESPI compliance reporting.

The Crown Entities Act also requires DHBs to report annually to Parliament on their performance, as judged against our Statement of Intent. We publish this account as our Annual Report and also publish annual Quality Accounts, highlighting innovations and improvements in service delivery. Both are available on our website.

In an average week on the West Coast

5 babies are born

275 people attend ED

268 people attend specialist outpatient appointments

8 children receive a Before School Check (B4SC)

137 people are discharged from hospital

36 West Coasters have elective surgery, 23 of these at Grey Base Hospital

114 radiology tests are completed

2,696 people visit their general practice team

717 Meals on Wheels are delivered

6 8-month-olds are fully vaccinated

23 people receive support and advice to quit smoking

9 people are given a green prescription referral for increased physical activity

123 women have a cervical smear

75 children have a free dental check+

10 people receive brief intervention counselling in primary care*

68 people have a cardiovascular disease risk assessment

232 people are supported in aged resident care

1,773 hours of home-based support are provided to long-term clients

+ represents the 2014 calendar year. All other figures are for the 2014/15 financial year and are based on the DHB's Annual Report.
** includes telephone consultations.*

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

Based on the Census 2013 results and projections, West Coast is home to a usually resident population of 32,145 people, an increase of 2.6% on 2006. Grey district has the largest population, with an estimated resident population of 13,371 people.

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%).

Projections for 2015/16 indicate that 5,181 people on the Coast are aged 65 or over and 2,088 are 75 or over (6.5% of our total population). By 2026 more than one in every five people on the West Coast will be over 65 years of age (23.1%). This presents one of the biggest challenges to our health system.

As we age, we develop more complicated health needs and are more likely to need specialised services and more health resources. Long-term conditions become more common with age, including heart disease, stroke, cancer, respiratory disease and dementia. While more people living longer is a successful outcome in itself – the ageing of our population will put significant pressure on our workforce, infrastructure and finances. To ensure the long-term sustainability of our health system, we need to support our older population to remain healthy and well for as long as possible.

We must also consider the unique needs of other population groups in our planning for the future. Like age, ethnicity is a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others. In 2013, 10.5% of our population identified as Māori. By 2026 this percentage will have reached 12.5%.

Deprivation is another indicator of the need for health services. The West Coast has a lower mean personal income in New Zealand ($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 also 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 all largely preventable.

The most recent results from the combined 2011-2013 New Zealand Health Survey found that:

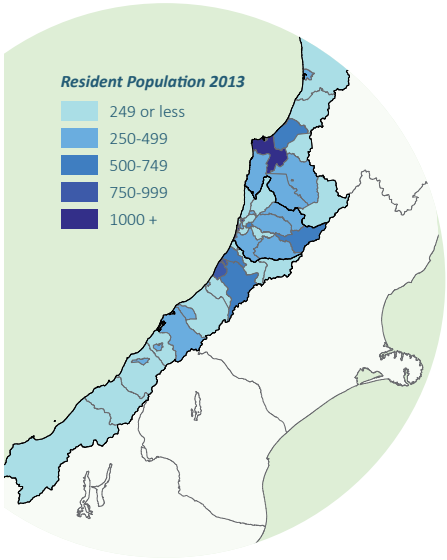
- 24.6% of our population are current smokers compared to the national average of 18% and smoking rates amongst our Māori and Pacific populations are significantly higher.
- 33% of our adult population are classified as obese 3% higher the national average.
- 14.9% of our population is likely to drink in a hazardous manner. While this rate is on a par with the national average (15%), it still amounts to more than one in every 10 adults surveyed.

As our population ages and becomes more ethnically diverse, the number of people living with long-term and complex conditions will increase. This means more demand on primary care, hospital care and residential care unless we step up our efforts to keep people healthy.

Many of the leading causes of death are conditions for which a reduction of risk factors, earlier identification and improved management and treatment can significantly improve outcomes.

Providing people with the knowledge, motivation and skills to avoid or improve their condition provides huge opportunity to improve the overall wellbeing of our population and ease the demand on our health system.

2.3 Operating environment



GEOGRAPHICAL PRESSURES

Meeting our population's health need is a 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 one of the most rural and isolated DHB in New Zealand. It is also the most sparsely populated, with a population density of just 1.4 people per km^2.

While our population is just 1.2% of New Zealand's estimated resident population, the total land area covered by the West Coast DHB is 23,283 square kilometres. Geographically we are one of the largest DHBs in New Zealand.

What this means is great distances between towns. The distance between Karamea and Haast 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.

This is further complicated by the fact that over 30% of households on the Coast have only one resident, and fewer 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. Like many DHBs, there are growing concerns over the availability of a sufficient workforce to meet increasing demand for health services as a greater proportion of our population reaches traditional retirement age.

As a result of our geographical isolation, it can be especially difficult to recruit and retain a health workforce 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 and while this will be required to some extent in the future we need to reduce our reliance on a temporary workforce.

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 these gaps as part of our transalpine collaboration with the Canterbury DHB, we will also focus on the recruitment of permanent staff with more generalist skills and the creation of new roles with wider professional 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, inefficient, and expensive to maintain. Some of our primary and community facilities are not appropriately located or configured to support an integrated service model or clinical team.

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 and considerable staff and public engagement is helping to determine our future facilities requirements.

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 deemed unsafe to occupy. It is important that the redevelopment progresses on schedule to ensure safety and service continuity and to avoid the DHB having to over-invest in facilities that do not have a future.

FISCAL PRESSURES

Government has given clear signals that DHBs need to operate within allocated funding and rethink how they deliver improved health outcomes in more cost-effective ways.

Numerous factors contribute to fiscal pressures: the increasing demand for services including diagnostics and aged residential care; rising treatment related and infrastructure costs and the rising costs of wages and salaries. Our ability to contain cost growth within affordable levels is made more difficult by increasing public and government expectations and the costs of new technology.

Fiscal pressures will be an increasing challenge, however with the transformation of our service models 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.

To achieve this, the DHB needs to successfully implement strategies alongside the development of integrated models of care in Grey and Buller, including:

- improved management of DHB-owned general practice;
- increased transalpine collaboration with the Canterbury DHB;
- increased integration and alignment of services;
- clinically led service transformation of local service models;
- the improved use of technology; and,
- better use of the health workforce across the West Coast health system.

2.4 Critical success factors

While significant progress is being made across a number of areas, the following still represent those areas where the greatest gains can be made in terms of improving health outcomes for our population. They also represent factors critical to our success, where failure would threaten the achievement of the strategic objectives outlined in this plan and the future viability of our health system.

Integrating fragmented health services: A legacy of unsustainable DHB-owned services with financial, access and continuity of care issues has led to fragmentation across the system and left a number of inefficient, isolated services struggling to deliver in appropriate settings.

Connecting the system electronically: Unreliable paper-based information systems and poorly performing information technology platforms have led to inefficient service delivery, wasting of clinical and patient time and reducing the continuity and safety of care.

Reducing over-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.

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.

Building a sustainable workforce: Longstanding clinical recruitment and retention issues have led to high use of locums and temporary staff reducing both continuity of care and clinical and operational leadership capability.

Restoring community confidence: Longstanding community frustration has eroded public confidence and trust. It is critical that promises made to our community about the transformation of our system are kept.

Meeting Government expectations: It is important that the West Coast health system 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.

Part II – Long-Term Outlook

Setting Our Strategic Direction

What are we trying to achieve?

Although they differ in size, structure and approach, DHBs have a common goal: to improve the health and wellbeing of their populations by delivering high quality and accessible health care. A growing prevalence of long-term conditions, increasing demand for services, workforce shortages, rising treatment costs and tighter financial constraints make this increasingly challenging.

3.1 Strategic context

In 2010, the National Health Board released Trends in Service Design & New Models of Care. [2] This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHBs in their service planning.

International direction emphasises that a 'whole of system' approach is required to improve health outcomes and ensure the sustainability of high quality health services. This approach entails four major service shifts:

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

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely access to care being paramount. However, the prevalence of long-term conditions and the ageing of our population means we need to move away from the traditional health model in order to support our population to maintain good health for longer.

Rather than wait for people to become acutely unwell or require institutionalised care, the whole of the health system needs to work in partnership to deliver accessible and effective services that support people to stay well and in their own homes for as long as possible.

3.2 The West Coast vision

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 service changes that will improve access to services and health outcomes for our population.

From this consultation, we have developed a vision for the future of the West Coast health system—at the heart of which is a fundamental reorientation of our current service model that puts the patient and their needs at the centre and reduces unnecessary delays in their care and treatment.

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

In line with our vision – the future model for 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.

[2] *Ministry of Health. 2010. Trends in Service Design and New Models of Care. Wellington: Ministry of Health*

Implementation of our new model of care is underway on all fronts. Access to specialist health care has improved, and the time people spend travelling to access care has been reduced. New telemedicine services and outreach clinics regularly save patients having to travel for specialist treatment and follow-up. The introduction of our Complex Clinical Care Network (CCCN) is supporting older people to stay well and in their own homes for longer and aged residential care bed utilisation is dropping.

From a service delivery perspective, healthcare providers are being brought together to work as multi-disciplinary teams. Working with the West Coast PHO we are building a strong and sustainable primary care model.

Important steps have been taken towards achieving a more integrated health system, including improving clinical information systems, commencing the development of Integrated Family Health Services across the West Coast, and establishing transalpine service arrangements with the Canterbury DHB.

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 easy answer – we must develop tailored solutions that enable us to do more (for more people) with the resources we have available.

Recognising that clinical leadership is crucial to the successful integration of services, health professionals from across the West Coast are engaged through the West Coast Alliance in all stages of service design and in the development of patient pathways across our health system. Empowered health professionals are taking a lead in setting strategic direction, and accelerating the implementation of the new model of care.

Achieving our vision requires the transformation of our entire health system. The redevelopment of our health facilities is also a critical factor in the future sustainability of West Coast health services.

Timeframes for the redevelopment of the Grey Hospital and Integrated Family Health Centre (IFHC) and the Buller IFHC will see the new facilities completed by the end of 2017.

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

The development of our new model of care includes nine key strategic components, and this is where our focus will continue to 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 (FIRST) 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, reducing risk factors and a commitment to Smokefree Aotearoa 2025.

Strengthened mainstream service responsiveness to Māori needs with a focus on 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 the closer alignment and integration of health teams.

3.3 National alignment

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

The ultimate high-level health system 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 these system outcomes and the commitments of

Government to provide 'better public services' and 'better, sooner, more convenient health services' by: increasing access to services; improving quality and patient safety; supporting the health of children, older people and those with mental illness; making the best use of information technology; and strengthening our health workforce. [3]

Alongside these longer-term goals and commitments, the Minister of Health's 'Letter of Expectations' signals annual priorities for the health sector. The 2015/16 focus is on: clinical leadership; integration; tackling the key drivers of morbidity; delivery of national health targets; fiscal discipline and performance management.

The West Coast DHB is committed to playing its part in the delivery of longer-term health system outcomes and progress against national goals. Activity planned and prioritised in the coming year is in line with our strategic direction and goals and the priorities expressed by the Minister of Health and is highlighted in Part III of our Annual Plan - Delivering our Service Priorities.

3.5 Regional commitment

In setting its expectations for better public services and better, sooner, more convenient health services the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance—together providing services for 1,081,953 people or 23.5% of the total NZ population. [4]

While each DHB is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. Together we are committed to delivering a sustainable South Island health 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.

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

Closely aligned to the national direction, and operating under a 'Best for People, Best for System' framework, 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 from public health system resources

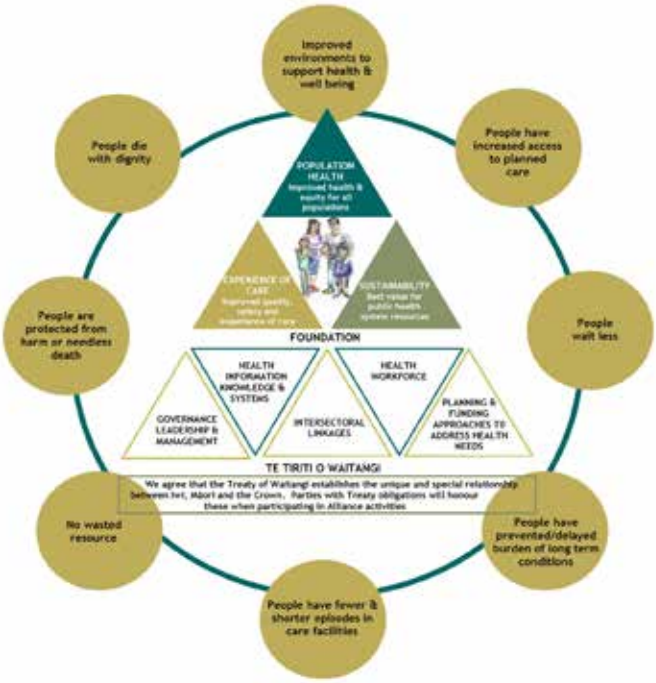
A set of high level outcomes sit alongside the 'Best for People, Best for System' framework and enable evaluation of regional activity at a population level. These are highlighted in the outer circles in Figure 1.

The South Island Health Services Plan highlights the agreed regional activity to be implemented through our service level alliances and work streams in seven priority service areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity in the coming year will also focus on: cardiac services, elective surgery, palliative care, public health, stroke and major trauma services. Workforce planning, through the South Island Regional Training Hub and regional asset planning, will contribute to improved delivery in all service areas.

West Coast's commitment in terms of the regional direction is outlined in the South Island Health Services Plan, and key deliverables are also highlighted in Part III of our Annual Plan. [5]

Figure 1. South Island Best for People, Best for System Framework.



[3] *Ministry of Health's Statement of Intent 2014-2018 available on their website – www.health.govt.nz.*
[4] *2015/16 Population Based Funding Projection provided to the Ministry of Health by Stats NZ, based off the 2013 Census.*
[5] *For further detail refer to the Regional Health Services Plan available on the South Island Alliance website: www.sialliance.health.nz.*

Measuring Our Progress

How will we know we are making a difference?

DHBs are expected to deliver against the national health system 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 their objectives under the New Zealand Public Health and Disability Act to 'improve, promote and protect the health of people and communities'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in achieving these goals and improving the health and wellbeing of their populations. There is no single indicator that can demonstrate the impact of the work DHBs do. Instead, the South Island DHBs have collectively chosen a mix of population health and service performance indicators that we believe are important to our stakeholders and that together, provide an insight into how well the health system and DHBs are performing.

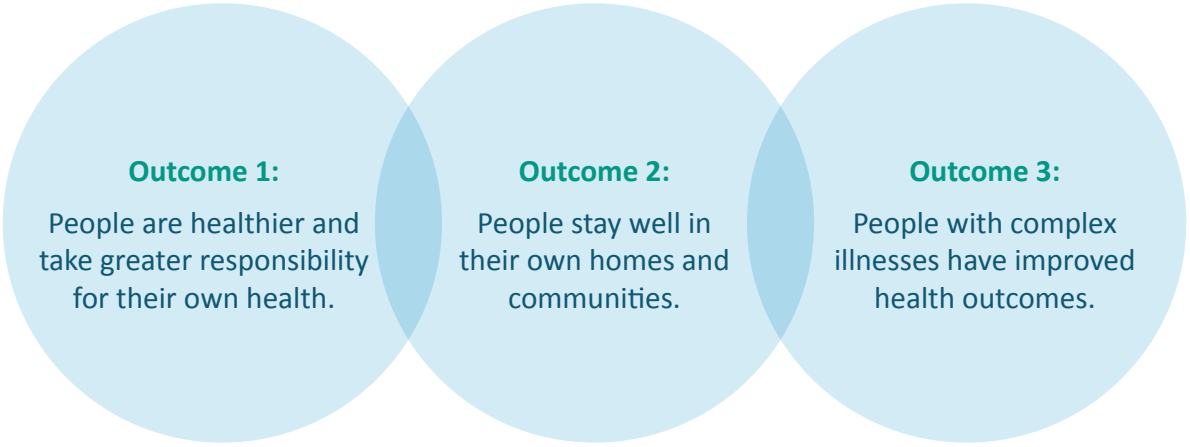
In developing our strategic framework, the South Island DHBs identified three shared high-level strategic objectives where collectively we can influence change and deliver on the expectations of Government, our communities and our patients by making a positive change in the health of our populations.

Alongside these strategic objectives (or goals) are a number of associated outcomes indicators, which will demonstrate success over time. These are long-term indicators and, as such, the aim is for a measurable change in health status over time, rather than a fixed target.

The South Island DHBs have also identified a core set of associated medium-term indicators. Because change will be evident over a shorter period of time, these indicators have been identified as the headline or main measures of performance. Each DHB has set local targets in order to evaluate their performance over the next four years and determine whether they are moving in the right direction. These impact indicators will sit alongside each DHB's Statement of Service 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.

The outcome and impact indicators were specifically chosen from existing data sources and reporting frameworks. This approach enables regular monitoring and comparison, without placing additional reporting burden on the DHBs or other providers. As part of their obligations DHBs must also work towards achieving equity and to promote this, the targets for each of the impact indicators are the same across all ethnic groups.



- ✓ A reduction in smoking rates.
- ✓ A reduction in obesity rates.

- ✓ A reduction in acute admissions to hospital
- ✓ An increase in the proportion of people living in their own homes

- ✓ A reduction in acute readmissions to hospital
- ✓ A reduction in the rate of avoidable mortality

Overarching Intervention Logic

MINISTRY OF HEALTH HIGH LEVEL OUTCOMES

Health System Vision

All New Zealanders to live longer, healthier & more independent lives, & the health system is cost effective & supports a productive economy.

New Zealanders are healthier & more independent	High-quality health & disability services are delivered in a timely & accessible manner	The future sustainability of the health system is assured

REGIONAL HIGH LEVEL OUTCOMES

South Island Regional Vision

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

Population Health Improved health & equity for all populations	**Experience of Care** Improved quality, safety & experience of care	**Sustainability** Best value from public health system resources

West Coast DHB Vision

An integrated health system that is clinically sustainable & financially viable & wraps care around the patient to help them stay well.

DHB STRATEGIC OBJECTIVES

What does success look like?

People are healthier & take greater responsibility for their own health.	People stay well, in their own homes & communities	People with complex illness have improved health outcomes
▪ *A reduction in smoking rates* ▪ *A reduction in obesity rates*	▪ *A reduction in the rate of acute admissions to hospital* ▪ *An increase in the proportion of people living in their own home*	▪ *A reduction in the rate of acute readmissions to hospital* ▪ *A reduction in the rate of avoidable mortality*

IMPACT MEASURES

How will we know we are moving in the right direction?

▪ *More babies are breastfed* ▪ *Children have improved oral health* ▪ *Fewer young people take up smoking*	▪ *People's conditions are diagnosed earlier* ▪ *Fewer people are admitted to hospital with avoidable or preventable conditions.* ▪ *Fewer people are admitted to hospital as a result of a fall*	▪ *People have shorter waits for urgent care* ▪ *People have increased access to planned specialist care* ▪ *Fewer people experience adverse events in our hospitals*

OUTPUTS

The services we deliver

Prevention & public health services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services

INPUTS

The resources we need

A skilled & engaged workforce	Strong alliances, networks & relationships	Sustainable financial resources	Appropriate quality systems & processes	Responsive IT & information systems	Fit for purpose assets & infrastructure

Strategic Outcome Goal 1

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

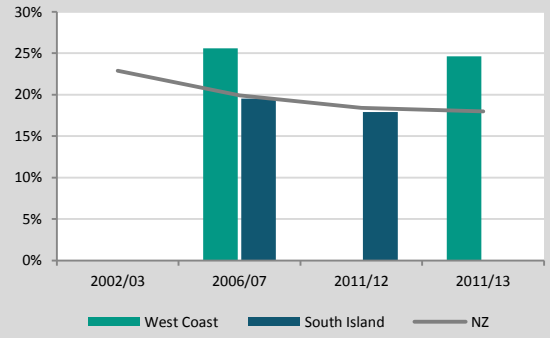
WHY IS THIS OUTCOME A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major drivers of poor health and account for a significant number of presentations across primary care and hospital and specialist services. The likelihood of developing long-term conditions increases with age, and with an ageing population, the burden of long-term conditions will grow. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on managing long-term conditions. These 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 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. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our population.

OVERARCHING OUTCOMES INDICATORS

MEASURE: THE PERCENTAGE OF THE POPULATION (15+) WHO SMOKE



Outcome: A reduction in smoking rates

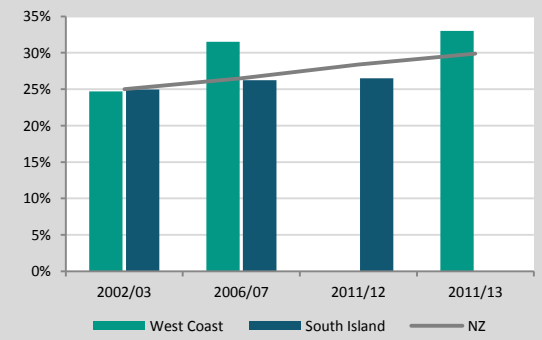
Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.

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 source: National NZ Health Survey[6]

MEASURE: THE PERCENTAGE OF THE POPULATION (15+) WHO ARE OBESE



Outcome: A reduction in obesity rates

There has been a rise in obesity rates in New Zealand in recent decades. The most recent NZ Health Survey found that 30% of adults and 10% of children are now obese.

This has significant implications for rates of cardiovascular and respiratory disease, diabetes and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

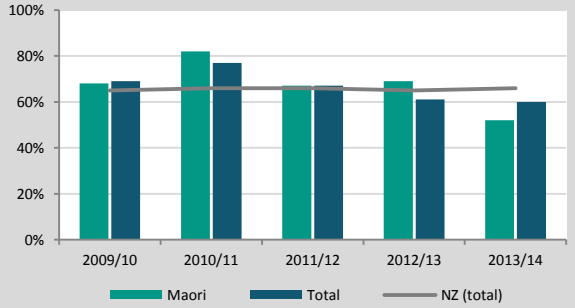
Supporting our population to achieve healthier body weights through improved nutrition and physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.

Data source: National NZ Health Survey[7]

[6] *The NZ Health Survey is completed by the Ministry of Health and results are subject to availability. From 2011, survey results were combined year-on-year in order to provide more robust results for smaller DHBs—hence the different time periods presented. Results are currently unavailable by ethnicity or region. The 2013 Census results for smoking (while not directly comparable) demonstrates that 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] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.*

MEASURE: % OF BABIES EXCLUSIVELY OR FULLY BREASTFED AT SIX WEEKS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 60%	Target: 74%	>74%	>74%	>74%

Impact: More babies are breastfed

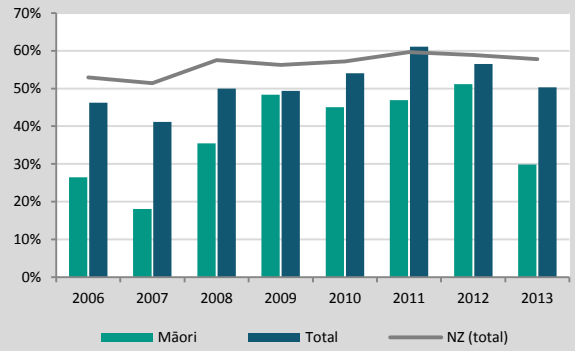
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

Breastfeeding also contributes to the wider wellbeing of mothers as well as bonding between mother and baby.

An increase in breastfeeding rates is seen as a proxy indicator of the success of health promotion and engagement activity, appropriate access to support services and a change in both social and environmental factors influencing behaviour and support healthier lifestyle choices.

Data source: Plunket via the Ministry of Health[8]

MEASURE: % OF FIVE-YEAR-OLDS CARIES FREE (NO HOLES OR FILLINGS)



2013	2015	2016	2017	2018
Actual: 50%	Target: 56%	>56%	>56%	>56%

Impact: More children have improved oral health

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

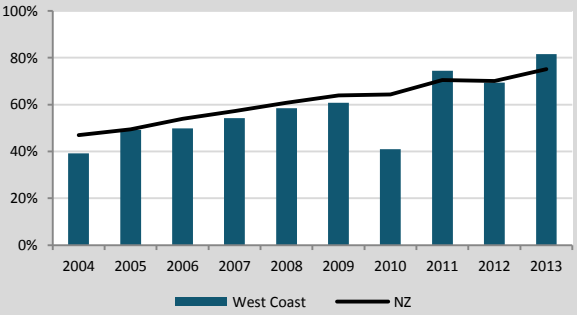
Good oral health not only reduces unnecessary hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and health outcomes.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy indicator of equity of access and the effectiveness of services in targeting those most at risk.

The target for this measure has been set to maintain the total population rate while placing particular emphasis on improving the rates for Māori and Pacific children.

Data Source: Plunket via the Ministry of Health

MEASURE: % OF 'NEVER SMOKERS' AMONG YEAR 10 STUDENTS



Actual 12/13	Target 14/15	15/16	16/17	17/18
82%	>75%	>75%	>75%	>75%

Fewer young people take up tobacco smoking.

The highest prevalence of smoking amongst younger people and reducing smoking prevalence across the total population is largely dependent on preventing young people from taking up smoking.

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

Because Māori and Pacific have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides significant opportunities to improve long-term health outcomes for these populations.

Data source: National Year 10 ASH Survey[9]

[8] *Provider data for breastfeeding is currently unable to be combined so performance data from Plunket (as the largest provider) is presented. While this covers the majority of babies, because the smaller local WellChild/Tamariki Ora providers target Māori and Pacific mothers—results for Māori are likely to be understated. The target is based on national Well Child standards for breastfeeding at 6 weeks.*

[9] *The ASH survey is a national survey used to monitor student smoking since 1999. Run by Action on Smoking and Health, it provides an annual point prevalence snapshot of students aged 14 or 15 years. The average number of West Coast students participating in the annual survey is around 200-220 and these small numbers can lead to fluctuations between years —for more detail see www.ash.org.nz.*

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, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes at a lower cost than countries with systems that focus on specialist level care.

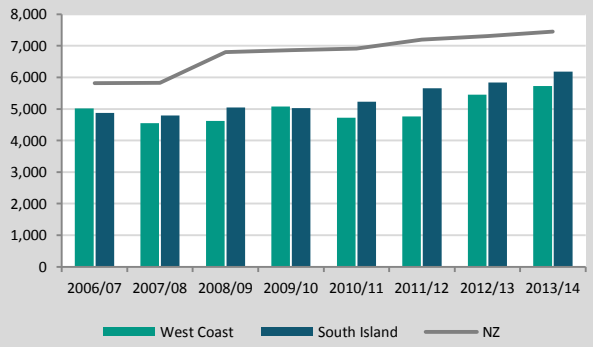
General practice can deliver services sooner and closer to home and through early detection, diagnosis and treatment, deliver improved health outcomes. The general practice team is also vital as a point of continuity, particularly in terms of improving the management of care for people with long-term conditions and reducing the likelihood of acute exacerbations of those conditions resulting in complications of injury and illness.

Health services also play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, allied and personal health providers and pharmacists. These providers also have prevention, early intervention and restorative perspectives and link people with other social services that can further support them to stay well and out of hospital.

Even where returning to full health is not possible, access to responsive, needs-based pain management and palliative services (closer to home and families) can help to improve the quality of people's lives.

OVERARCHING OUTCOMES INDICATORS

MEASURE: THE RATE OF ACUTE MEDICAL ADMISSIONS TO HOSPITAL *(AGE-STANDARDISED, PER 100,000)*



Outcome: A reduction in acute medical admission rates.

Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and premature death.

Lower acute admission rates can be used as a proxy indicator of improved management and to indicate the accessibility of timely and effective care and treatment in the community.

Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources otherwise taken up by the demand for urgent care.

Data source: National Minimum Data Set

MEASURE: THE % OF THE POPULATION (75+) LIVING IN THEIR OWN HOMES

Outcome: More people living in their own homes

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes.

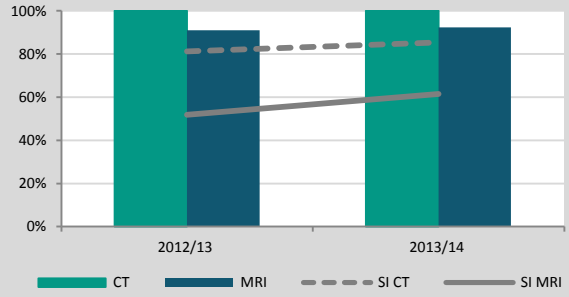
Living in ARC is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.

An increase in the proportion of older people supported in their own homes is a proxy indicator of how well the health system is responding to the needs of our older population.

Data Source: SIAPO Client Claims Payment System[10]

[10] *Updated Census population estimates used for 2013/14 have had a noticeable impact on the results for this measure with the total 75+ populations previously over counted.*

MEASURE: % OF PEOPLE WAITING LESS THAN SIX WEEKS FOR CT/MRI SCANS



2013/14	2015/16	2016/17	2017/18	2018/19
CT Actual 100%	Target: 95%	95%	95%	95%
MRI Actual 92%	Target: 85%	85%	85%	85%

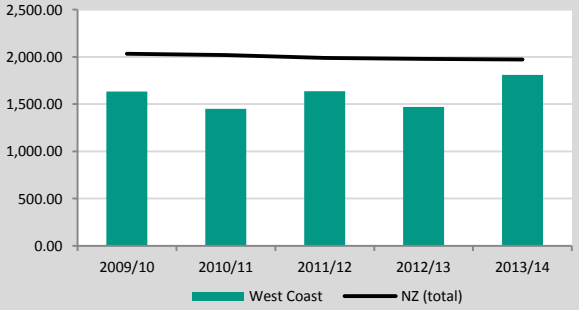
Impact: People's conditions are diagnosed earlier

Diagnostics are an important part of the healthcare system and timely access to diagnostics, by improving clinical decision-making, enables early and appropriate intervention and helps to improve the quality of care and outcomes for our population.

Timely access to diagnostics can be seen as a proxy indicator of system effectiveness where effective use of resources is needed to minimise wait times while meeting increasing demand.

Data source: Individual DHB Patient Management Systems

MEASURE: RATIO OF ACTUAL VS. EXPECTED AVOIDABLE HOSPITAL ADMISSIONS FOR THOSE AGED UNDER 75



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 82%	Target: TBC	TBC	TBC	TBC

Impact: Fewer avoidable hospital admissions

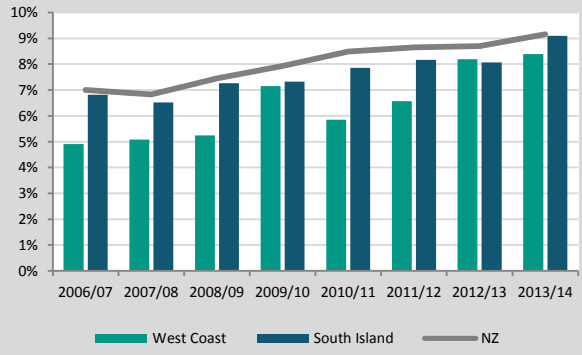
Given the increasing prevalence of chronic conditions effective primary care provision is central to ensuring the long-term sustainability of our health system.

Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions—not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

Lower avoidable admission rates are therefore seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

Data Source: Ministry of Health Performance Reporting SI1[11]

MEASURE: % OF THE POPULATION (75+) ADMITTED TO HOSPITAL AS A RESULT OF A FALL



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 8.4%	Target: 7.8%	7.4%	7%	<7%

Impact: Fewer people admitted to hospital after falls

Compared to people who do not fall, these people 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.

Solutions to reducing falls span both the health and social service sectors and include appropriate medications use, improved physical activity and nutrition, appropriate support and a reduction in personal and environmental hazards.

Lower falls rates can be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided.

Data Source: National Minimum Data Set[12]

[11] *This measure is a 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 a rate per 100,000 people and the target is set to maintain performance below the national rate—which reflects less people presenting to hospital. The Ministry is working to resolve a definition issue with this measures and target setting for 2015/16 has been postponed while the definitions are reset.*

[12] *Updated Census population estimates used for 2013/14 have had a noticeable impact on the results for this measure with the total 75+ populations previously over counted – the actual number of people admitted as a result of a fall has dropped from 184 (2012/13) to 179.*

Strategic Outcome Goal 3

4.3 People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

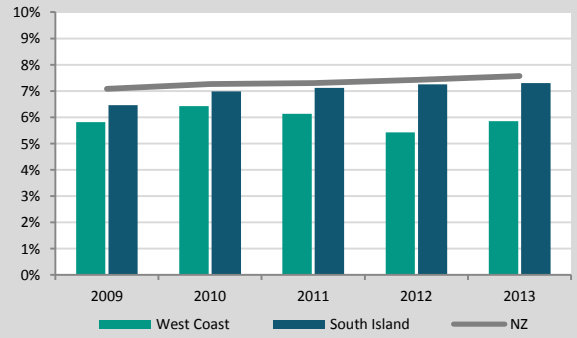
For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

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.

OVERARCHING OUTCOMES INDICATORS

MEASURE: RATE OF ACUTE READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE



Outcome: A Reduction in acute readmissions

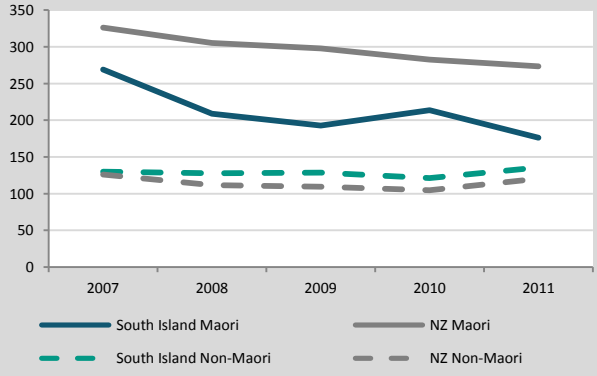
Unplanned hospital readmissions are largely (though not always) related to the care provided to the patient.

As well as reducing public confidence and driving unnecessary costs, patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

Because the key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge – they are a useful maker of the quality of care being provided and the level of integration between services.

Data Source: Ministry of Health Performance Data OS8[13]

MEASURE: RATE OF ALL-CAUSE MORTALITY FOR PEOPLE AGED UNDER 65 *(AGE STANDARDISED, PER 100,000 PEOPLE)*



Outcome: A reduction in avoidable mortality

Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

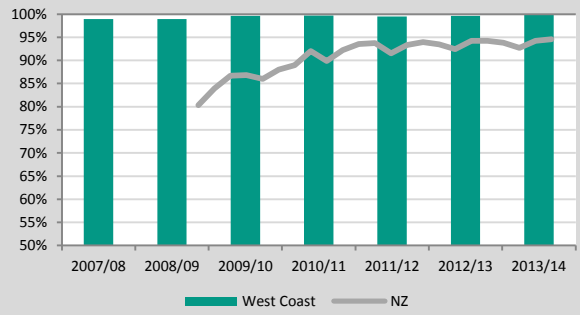
A reduction in avoidable mortality rates can be used as a proxy indicator of responsive specialist care & improved access to treatment for people with complex illness.

Data Source: National Mortality Collection[14]

[13] *This measure is a national performance indicator (OS8). The Ministry of Health is reviewing the definition for this measure and target setting has been delayed for 2015/16 while the definition is reset. The DHB has elected to present the unstandardised or 'raw' rates as these are easier to replicate and match against admissions internally and therefore enable closer analysis of performance.*

[14] *Mortality data is sourced from the national mortality collection which is three years in arrears, the data presented was released in 2014.*

MEASURE: % OF PEOPLE PRESENTING IN ED WHO ARE ADMITTED, DISCHARGED OR TRANSFERRED WITHIN SIX HOURS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 100%	Target: 95%	95%	95%	95%

Impact: People have shorter waits for urgent care

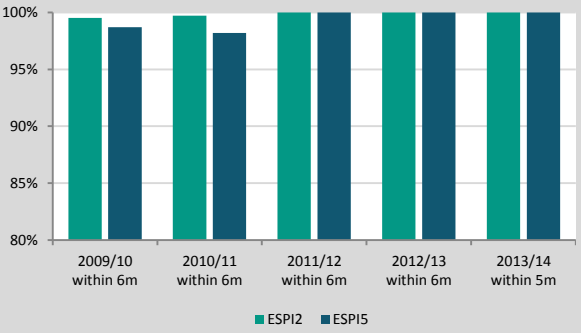
Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

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

Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Data Source: Individual DHB Patient Management Systems[15]

MEASURE: % OF PEOPLE RECEIVING THEIR SPECIALIST ASSESSMENT (ESPI 2) OR TREATMENT (ESPI 5) IN <4 MONTHS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 100%	Target: 100%	100%	100%	100%

Impact: People have increased access to planned care

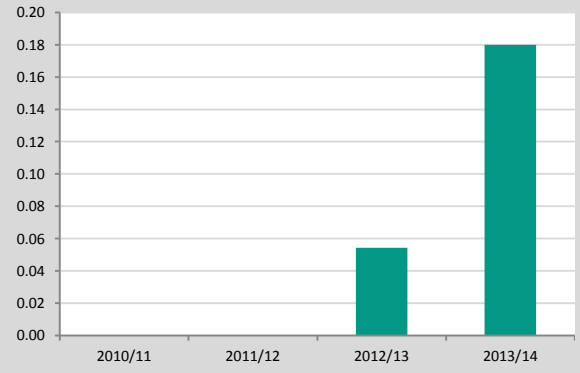
Planned services (including specialist assessment and elective surgery) are an important part of the healthcare system and improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing.

Timely access to assessment 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 wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is a marker of how responsive the system is to the needs of the population.

Data Source: Ministry of Health Quickplace Data Warehouse[16]

MEASURE: RATE OF SAC LEVEL 1 & 2 FALLS IN WEST COAST HOSPITALS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 0.18	Target: 0.05	0.05	0.05	0.05

Impact: People experience fewer adverse events

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.

An initial jump in results is expected as people are encouraged to report falls.

Data Source: Individual DHB Quality Systems[17]

[15] *This measure is the national DHB Health Target 'Shorter Stays in ED'. In alignment with the health target reporting, the year-end result is from the final quarter of the year (April-June) and relates to presentations to the Greymouth Hospital Emergency Department.*

[16] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance. In line with the ESPI target reporting the annual results presented are those from the final quarter of the year.*

[17] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood. Data reported is per 1,000 inpatient bed days. Small numbers have a significant impact on these results — the 2013/14 result relates to 6 incidents.*

Managing Our Business

The manner in which we work, the way we interact with each other and the values of our organisation are key factors in our success. Having already identified the challenges we face and set a collective vision for the West Coast health system, this section highlights our organisational strengths and the way in which we will manage our business 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 where longstanding frustrations have eroded confidence and trust. Our 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 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 DHB has invested in leadership and workforce engagement programmes that encourage people to ask 'What is best for the patient?' and 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'.

This approach, is fostering stronger cross-system partnerships and alliances that are improving the continuity of care for patients. Our patient-focused culture is also help attract and retain staff by promoting workforce satisfaction and engagement.

5.2 Effective governance and leadership

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 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.

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 service improvements.

The DHB has formally established a 10-member Consumer Council to 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.

CLINICAL PARTICIPATION IN DECISION-MAKING

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

The West Coast has a Clinical Board that oversees the DHB's clinical activity, 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 our health systems transformation 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 its associated workstreams and service level alliances include both clinicians and health professionals from across the West Coast health system.

Clinical leadership is further facilitated by the DHB's Chief Medical Officer and Executive Directors of Midwifery and Allied Health, who provide clinical leadership and input into DHB decision making at the executive level.

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, 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.

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 a Māori Health Action Plan that sits alongside the Annual Plan and identifies where and how improvements will be made for Māori in the coming year.

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

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.

5.2 Successful alliances & partnerships

Our vision is wider than just the DHB and as such we are adopting partnership and alliance based approaches that recognise our relationships with the organisations we fund are more than just contractual.

WEST COAST ALLIANCE

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. Through the 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.

Seven clinically-led Alliance Workstreams are in place and 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 support the delivery of the West Coast health system vision as well as the delivery of national expectations and achievement of the national health targets. The work programme of the West Coast Alliance forms the basis of the DHB's Annual Plan.

PARTNERSHIPS WITH OTHER AGENCIES

Because good health is also determined by factors and social determinants outside the direct control of the health system, maintaining active partnerships with other agencies is vital. We work closely with other agencies (including local and regional councils, Housing NZ, ACC and the Ministries of Justice, Education and Social Development) to influence and support the creation of social and physical environments that reduce the risk of ill health.

Regionally we support development of our Māori health workforce through the Kia Ora Hauora training programme and the Ngā Manukura ō Āpōpō Leadership Programme.

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 also continues 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 Shared Services (Health Benefits Limited)—for the benefit of our population and wider health system.

5.3 Subsidiary companies

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 — the South Island Alliance Programme Office.

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 $6m. The West Coast DHB's contribution to the Regional Office for 2015/16 will be $120,512.

5.4 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.

The West Coast DHB has faced a number of long-term challenges to achieving clinical and financial viability. 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.

In response to these longstanding challenges, we have worked with our communities and clinical teams to develop a clear vision for a single, integrated health system that keeps people as well as possible for as long as possible, in or close to their own homes. Bringing this to life requires systematic efforts to address underlying workforce challenges.

Of significance for the coming year is the ongoing implementation of Transalpine clinical services in collaboration with the Canterbury health system and the ongoing efforts to develop and stabilise the local resident workforce. This work will build on the Transalpine Review and Planning Workshop held in October 2014 which involved 70 clinical leaders from across the Coast and Canterbury health systems. Together they agreed plans for the ongoing evolution of transalpine collaboration over the coming two years to ensure the sustainability of our services and improve the continuity of care for our population.

In conjunction with the Canterbury DHB, the West Coast DHB has reviewed its current Child Protection Policy against recent changes to Vulnerable Children's legislation and agree a phased implementation plan to meet the new requirements for worker safety checks as this comes into effect. Alongside the other 20 DHBs, West Coast will implement safety checking requirements for recruiting workers in the children's workforce and ensure this information is available to the Director General of Health to meet the requirements in the Vulnerable Children's legislation. The DHB is also reviewing relevant contracts to ensure a clause relating to the need for contracted service providers to have a Child Protection Policy is included.

At a broader level, 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.

EXPANDING OUR WORKFORCE CAPACITY

From a recruitment perspective, there are a number of areas where workforce shortages affect our system's capacity. Rural general practitioners, nurse practitioners, general surgeons and a number of specialist and allied health positions remain vulnerable to supply shortages.

In response, we are strengthening recruitment strategies, targeting programme to attract rural hospital medical specialists, working closely with Canterbury DHB and continuing to supplement West Coast-based clinical support and services with joint appointments.

Growing our rural hospital medical specialist workforce will be key to our ongoing transformation. The DHB is also looking to increase Māori participation in the health workforce through the national Kia Ora Hauora training programme and the Ngā Manukura ō Āpōpō Leadership Programme.

We are supporting local scholarships to encourage 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 integrated electronic systems, which support the provision of specialist services without a significant increase in workforce numbers.

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 pre-vocational curriculum which requires PGY2s to have a three month community placement. E-learning packages will be progressively rolled-out regionally and a full suite of packages will be available online 2015/16.

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

Online Learning modules are available to staff via the health Learner Management System (LMS), providing the right training and development for staff regardless of their location on the Coast. Modules continue to be developed for the LMS and a significant amount of development and assessment can be completed from the Coast, without the need to travel to Canterbury, or attend a face-to-face training session.

The West Coast is an active participant in the South Island Regional Training Hub Nurse Practitioner working group. This group is developing pathways within South Island health services to increase the number of nurse practitioner roles to better meet the health needs of the South Island Community.

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. Further development now includes a regional project to develop a West Coast and Canterbury standing orders process which will be integrated into HealthPathways and align within the Transalpine model. 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.

5.5 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. 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 have been 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 (Safety 1st) 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. We continue to develop and further strengthen our partnership ties with our Canterbury neighbours and with the wider South Island that will help us to continue to build sustainable 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. We will also work with

neighbouring DHBs and the HQSC to implement new Quality and Safety Markers over the coming year.

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 our 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 DHB also produced its second set of Quality Accounts in 2014 as a means of answering the questions that consumers consider important and identifying whether the DHB is providing a safe and high quality services. Future accounts will see wider consumer consultation to identify key areas of importance.

Preventing healthcare-associated infection (HAIs): Admission to hospital exposes patients to potential harm through healthcare-associated infection, and the 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 will maintain the appropriate number of trained hand hygiene auditors and implement our hand hygiene quality plan, with charge nurse managers also 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). Systems and audits are in place to minimise this risk and we have recently achieved 1000 CLAB free 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 the infection prevention and control platform (ICNet) in surveillance activities.

Reducing falls in healthcare settings: Falls resulting in harm are known to significantly reduce the 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. The introduction of Safety1st has enabled us to analyse incidents and contributing factors more easily, with all senior staff being able to access their own results in real time. We are now integrating the use of this information into related project areas.

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.

In collaboration with Canterbury we are committed to implementing an online patient vital signs observation system to enhance early detection of the deteriorating patient. The first ward will be online by mid-2016.

Medication and surgical safety: We are committed to reducing 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 quality improvement project results of our efforts to reduce adverse effects of opiates will be consolidated this year.

The National Medication Chart has been adopted in all acute clinical areas and we are participating in an HQSC-led medicine reconciliation programme with all patients' medicine reviewed at admission, discharges and transfer.

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 consider observational audit to identify how the checklist is used, with outcomes communicated to all staff associated with the operating theatres and will look to reinforce the importance of the checklist as a teamwork and communication tool. We will participate with our South Island colleagues in the introduction of the brief debrief approach and utilise the appropriate measures for improvement.

We also have active mortality and morbidity review meetings across all services with each case reviewed and link into regional forums and encourage dissemination of learnings.

5.6 Investment in information systems

Information systems are a national priority, and DHBs are taking a collective approach to implementing the National Health Information Technology Plan. The South Island DHBs have collectively determined 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 information.

The West Coast DHB has already adopted several key regional information systems, such as Health Connect South, Health One (formally eSCRV) 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:

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, referrals and management 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 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 DHBs.

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 and the West Coast was the first DHB other than Canterbury to introduce this system.

Electronic Sign Off enables clinicians to sign off their results electronically. We implemented electronic sign off of laboratory results in 2014.

HealthOne 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.

The South Island Patient Information Care System will be the new regional patient administration system, which will further integrate systems throughout the South Island. The West Coast will be moving to the new system in 2016/17.

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 2015/16 and eMedications Reconciliation in 2016/17.

National Infrastructure Platform (NIP) is a platform for improving the security, reliability and service levels of the Information Technology infrastructure that supports health services.

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

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.

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 develop a unified virtual IT team spread between the two DHBs to make better use of resources in both organisations.

5.7 Investment in facilities

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

The West Coast is in the midst of significantly transforming the way 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, to minimise operating deficits, has resulted in significant infrastructure degradation and associated risk.

At the end of 2012, the Government established a 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.

An Integrated Family Health Centre is being developed on the Grey Hospital site. 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. Redevelopment of our 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 service transformation underway and bring integrated service provision to life. With a clear decision on the way forward our health system will be able to cement a more certain and sustainable future.

Focus in the coming year will also be on Buller and the development of facilities required to support more integrated health service here as well. The DHB undertook significant engagement with the Buller community in 2014/15 to talk about a new Integrated Family Health Centre and how this will function. We are now looking at how aged care services, mental health services, after hour services and transport will be organised in the future and will be making some significant steps forward in these areas.

In order to avoid costly and wasteful investment, close alignment and careful timing of the redevelopment is essential. The DHB is working with the Ministry of Health, through the nationally appointed Hospital Redevelopment Partnership Group, to ensure that delays are minimised.

5.8 Service reconfiguration

The service coverage schedule between the DHB and the Ministry is the translation of government policy into the minimum level and standard of service to be made available to the public.

The West Coast DHB seeks to identify service coverage gaps and risk through the monitoring of performance indicators, risk reporting, formal audits and complaints mechanism and ongoing review of patient pathways. We are committed to continuing to manage and resolve any issues we encounter and at this stage are not seeking any formal exemptions to the Service Coverage Schedule for 2015/16.

In the first instance we would anticipate that any services not able to be provided locally will be contracted through the Canterbury DHB.

SERVICE REDESIGN AND RECONFIGURATION

In line with our vision we are engaged in a continual transformation of the way we deliver health services in order to better meet the needs of our population, improve the quality of services delivery and ensure the sustainability of our health system. We anticipate that new models of care and service delivery will continue to emerge as we respond to the changing needs of our population and in line with the development of the new model of care and our IFHC and facilities redevelopment in Grey and Buller.

We recognise our obligations (under the Operational Policy Framework) to notify the Minister of Health with respect to plans for any significant service change and will continue to do so. In line with our shared decision-making principles, decisions regarding how a service is best delivered are made collectively and wherever possible under the leadership of clinical leaders and health professionals delivering the service.

The West Coast DHB also has a policy of ongoing community engagement, and will keep a steady stream of information flowing across the sector on the planned transformation of any services. Any service changes will be carefully considered so as not to destabilise or negatively affect other providers or our neighbouring DHBs.

Activity for the period of this plan includes:

Service Integration: In line with the redevelopment of facilities in Grey and Buller and the corresponding redesign of service models for primary and secondary care supporting this. Alliance workstreams are in place to support the development of these new models including the redesign of pathways for planned, unplanned and acute care under the IFHC model and the introduction of more flexible workforce models.

Older People's Health Services: We will continue to implement the new service model for older people's health (driven through the CCCN) and to strengthen and enhance home based support for older people. In the coming year, there will be closer integration of nursing and home-based support services, and the development of the 'FIRST' rapid response and supported discharge service and the Falls and Fracture Liaison Service. We will also implement the direction of travel with regards to the aged care on the Coast including a shift away from the provision of aged residential care by the DHB.

Mental Health Services: We will continue to implement service model redesign and reconfiguration of resources in line with the clinically-led service review of our Mental Health Services undertaken in 2013/14. These changes will be led by the Mental Health Workstream under the West Coast Alliance and will involve the introduction of locality based care and an expanded role for primary and community service providers.

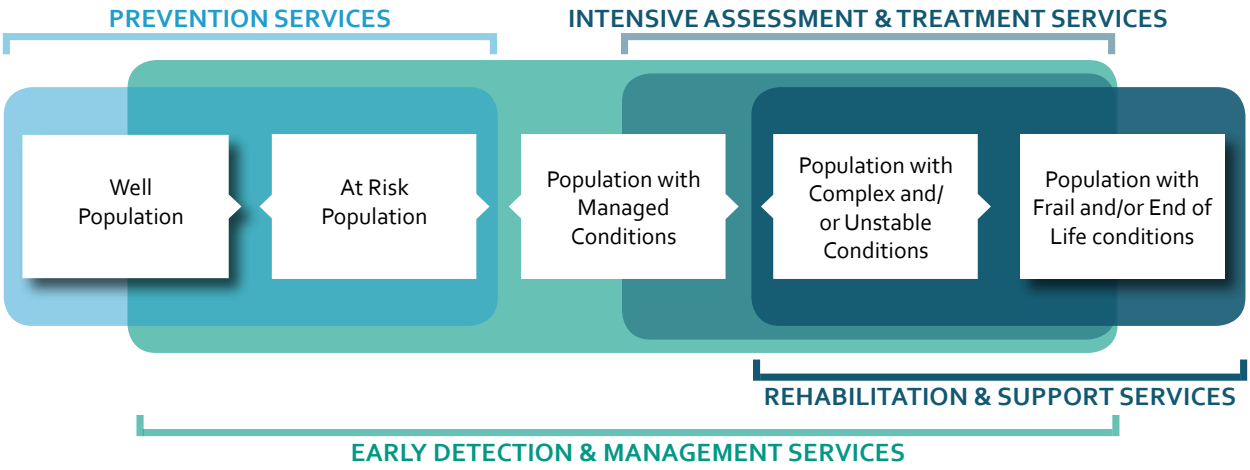
Regional and Transalpine Services: We will continue to adopt consistent, regionally developed pathways for access to specialist services – particularly across cancer, cardiac and orthopaedic services, delivery of fertility and ENT services and service development identified in the Regional Health Services Plan.

National Direction: We will continue to work with the Ministry of Health to align policy and service coverage arrangements nationally. This will include implementing changes in line with the national pharmacy and PHO agreements and the Vulnerable Children's Legislation.

At times, we may wish to enter into cooperative agreements and arrangements to assist in meeting our objectives to enhance health outcomes for our population and efficiencies in the health sector. In doing so (in accordance with Section 24(1) of the NZPHD Act 2000), we will ensure that any arrangements do not jeopardise our ability to deliver the services required under our statutory obligations in respect of our accountability and funding agreements with the Crown.

Part III – Annual Operating Intentions

Statement of Service Performance Expectations



EVALUATING OUR PERFORMANCE

We aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services on the West Coast, the decisions we make about which services will be delivered will have a significant impact on people's health and wellbeing.

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.

Over the longer term we evaluate the effectiveness of the decisions we make by tracking performance against a set of desired population outcomes which are outlined in the strategic direction section of this document and highlighted in the overarching intervention logic diagram on page 14.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver 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. [18]

When evaluating our performance, we have chosen a mixture of indicators that we believe are most important to our patients, community and stakeholders. We have also chosen a mix of indicators that together provide a measure of how well the DHB is meeting the challenges confronting the West Coast Health System.

The DHB has a separate Māori Health Action Plan and where the performance indicators align they have been included in the forecast to highlight the areas of particular priority in terms of improving health outcomes for Māori on the West Coast. [19]

Because our aim is to give a fair and accurate insight into how our health system is performing, we cannot simply measure what we delivered in terms of '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 indicators that address four key aspects of performance: Volume (V); Timeliness (T); Coverage (C); and Quality (Q).

Wherever possible, past year's baselines and national results have been included to give context in terms of what we are trying to achieve and to support evaluation of our performance. Service indicators have also been grouped into four 'output classes' that are a logical fit with the continuum care and are applicable to all DHBs. Those are: prevention services; early detection and management services; intensive assessment and treatment services; and rehabilitation and support services.

[18] *The Annual Report is tabled in Parliament and is available on the DHB's website: www.westcoastdhb.health.nz.*

[19] *Specific actions to improve Māori health are outlined in our Māori Health Action Plan, available on our website.*

SETTING STANDARDS

In setting performance standards, we have considered the changing demographics of our population, increasing areas of demand and the assumption that resources and funding growth will be limited. Targets tend to reflect the objective of increasing the coverage of prevention programmes, reducing acute or avoidable demand and maintaining service access while reducing waiting times and delays in treatment.

While a healthier population and earlier intervention can reduce avoidable demand over time – there will always be a certain level of need for some services. These services include: diagnostic tests and assessments, emergency care, maternity services, rehabilitation and respite services, aged residential care and palliative care. Estimated service volumes have been provided against these services, not as targets to be achieved, but to give context in terms of the use of resources across our health system.

With a growing Māori population and persistent inequalities amongst our population achieving equity of outcomes is an overarching priority for our health system. All of our targets are universal with the aim of bringing performance for all population groups to the same level, rather than accepting different standards for different populations.

A number of the standards set against the indicators presented are based on national expectations and may be particularly difficult for the West Coast DHB to meet as our small population number mean a small number of people can have a big impact on results. However it is important that we strive to ensure our population has equity access to services and that we monitor these indicators in order to make appropriate funding decisions as we move forward.

WHERE DOES THE MONEY GO?

The following table presents a summary of the budgeted financial expectations for 2015/16, by output class. Over time, we anticipate it will be possible to use this framework to demonstrate changes in the allocation of resources and funding from one end of the continuum of care to the other.

2015/16

REVENUE	TOTAL $'000
Prevention	2,588
Early detection and management	26,554
Intensive assessment & treatment	92,164
Support & rehabilitation	20,169
Grand Total	141,925

EXPENDITURE	TOTAL $'000
Prevention	2,392
Early detection and management	26,290
Intensive assessment & treatment	93,381
Support & rehabilitation	20,740
Grand Total	142,803

Surplus/(Deficit) - $'000	(878)

NOTE:

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

E Some service are demand driven and it is not appropriate to set targets, instead estimated volumes are provided to give context as to the use of resource across our system.

Δ Performance data provided by external parties can be affected by a delay in invoicing and results are subject to change.

† Performance data for some programmes relates to the calendar rather than financial year.

◇ National Health Targets are set for DHBs to achieve by the final quarter of the year. Performance data therefore refers to the fourth quarter result for any given year.

◆ This measure also appears in West Coast's Māori Health Action Plan for 2015-16.

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: education programmes that 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 that support early intervention that support people to modify lifestyles and maintain good health.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

By supporting people to make healthier choices we can reduce the risk factors that contribute to long-term conditions and prevent or minimise the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. At-risk and high-need population groups are also more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes.

SERVICE PERFORMANCE INDICATORS (2015/16)

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of babies exclusive/fully breastfed at LMC discharge	Q [20]	80%	>75%	75%
% of Māori babies exclusive/fully breastfed at LMC discharge	Q ◆	42%	75%	71%
Lactation support and specialist advice consults provided in community settings	V	117	>100	-
% of priority schools supported by the Health Promoting Schools framework	C [21]	100%	>70%	-
Nutrition and Activity courses provided in the community	V	7	>5	-
People referred to Green Prescriptions for additional physical activity support	V [22]	474	500	-
% of Green Prescription participants more active 6-8 months after referral	Q [23]	80%	>50%	62%
% of smokers enrolled with a PHO receiving advice and help to quit (ABC)	C [24]	62%	90%	86%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	95%	95%	95%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	129	>100	-
% of women smokefree at two weeks postnatal	Q [25]	88%	95%	87%
% of Māori women smokefree at two weeks postnatal	Q ◆	90%	95%	65%

[20] *Standards are based on national WellChild Quality Framework targets and baseline is to December 2013.*
[21] *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.*
[22] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.*
[23] *Results taken from national patient survey competed by Research NZ on behalf of the Ministry of Health. Target is set nationally.*
[24] *This is the national health target measure – for 2015/16 the time period of the measure has changed from offered ABC within 12 months to within 15 months. Past results are against the previous target.*
[25] *Standards are based on national WellChild Quality Framework targets and baseline is to December 2013.*

Population-Based Screening Services These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of four-year-olds receiving a B4 School Check (B4SC)	C [26]	90%	90%	91%
% of Year 9 students in decile 1-3 schools receiving a HEEADSSS assessment	C † [27]	55%	95%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [28]	79%	80%	77%
% of Māori women aged 25-69 having a cervical cancer screen in the last 3 years	C ◆	73%	80%	63%
% of women aged 50-69 having a breast cancer screen in the last 2 years	C [29]	76%	>70%	73%
% of Māori women aged 50-69 having a breast cancer screen in the last 2 years	C ◆	77%	>70%	65%

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	2013/14 Result	2015/16 Target	2013/14 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 ◇	81%	95%	92%
% of Māori children fully immunised at eight months of age	C ◆	94%	95%	88%
% of eight-month-olds 'reached' by immunisation services	Q [30]	96%	95%	-
% of Year 8 girls completing their HPV vaccinations (i.e. receiving Dose 3)	C † [31]	54%	65%	53%
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	63%	75%	69%
% of older Māori (65+) receiving a free influenza ('flu') vaccination	C † ◆	72%	75%	-

[26] 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.
[27] A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.
[28] This is a national screening programme with standards based on the national targets.
[29] This is a national screening programme with standards based on the national targets. The baseline results differ to previous years due to a change in age bands (from women aged 45-69 to women aged 50-69). The 2013/14 baseline is for the two years to March 2014.
[30] '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.
[31] The baseline is the percentage of girls born in 2000 receiving Dose 3 by the end of 2013, and the target for 2015 for girls born in 2002.

Output Class

6.2 Early detection and management services

Early detection and management services are services which help to maintain, improve and restore people's health by ensuring that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. These services are particularly important where people have multiple conditions requiring ongoing interventions or coordinated 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 can support people to maintain good health and, through earlier diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes.

Our vision of a connected system presents a unique opportunity. Providing flexible and responsive services in the community, without the need for a hospital appointment, better supports people to stay well and stabilise or manage their condition—reducing complications, acute illness or crises and therefore acute and avoidable hospital admissions. Reducing avoidable demand will have a major impact in freeing up hospital and specialist services to allow for more complex and planned interventions.

SERVICE PERFORMANCE INDICATORS (2015/16)

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of the total DHB population enrolled with a Primary Health Organisation	C	92%	95%	-
% of the Māori DHB population enrolled with a Primary Health Organisation	C ◆	92%	95%	-
Avoidable hospital admission rate for children aged 0-4	Q [32]	96%	TBC	100%
Avoidable hospital admission rate for Māori children aged 0-4	Q ◆	183%	TBC	100%
Young people (0-19) accessing Brief Intervention Counselling	V Δ [33]	65	80	-
Adults (20+) accessing Brief Intervention Counselling	V Δ	374	>300	-
Number of HealthPathways in place across the West Coast health system	V [34]	434	650	-

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	2013 Result	2015 Target	2013 National Average
% of pre-schools children (0-4) enrolled in DHB-funded oral health services	C †	75%	90%	73%
% of pre-schools Māori children (0-4) enrolled in DHB-funded oral health services	C † ◆	66%	90%	59%
% of enrolled children (0-12) examined according to planned recall	T †	78%	90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C †	72%	85%	70%

[32] *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. The definition for this measure is being revised nationally and was not available at the time of printing – targets will be confirmed once the definition is set.*

[33] *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.*

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

Long-Term Conditions Management (LTCM) Programmes These services are targeted at people with high health needs due to a long-term condition 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	2013/14 DHB Result	2015/16 Target	2013/14 National Average
People identified with a long-term condition enrolled in the LTCM programme	V	2,767	>2,000	-
% of people with diagnosed diabetes having an annual LTMC review	C	99%	>90%	-
% of people with diabetes with satisfactory or better diabetes management (Hba1c ≤ 64mmol/mol) at their annual review	Q	78%	80%	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇ [35]	77%	90%	84%
% of the eligible Māori population having a CVD Risk Assessment in the last 5 years	C ◇ ◆	77%	90%	80%

Pharmacy and Referred Services These are services which a health professional may use 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 services are largely demand driven; faster and more direct access aids clinical decision-making, improves referral processes and reduces the wait for treatment.	Notes	2013/14 DHB Result	2015/16 Target	2013/14 National Average
Subsidised pharmaceutical items dispensed in the community	V Δ [36]	445k	E.<600K	-
Number of community requested radiological tests delivered by Grey Hospital	V	5,590	E.>5,000	-
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T ◇ [37]	33%	75%	55%
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T ◇	100%	>95%	80%
% of people receiving their Magnetic Resonance Imagining (MRI) within 6 weeks	T ◇	92%	85%	60%

[35] This measure is the national 'More heart and diabetes checks' health target and refers to Cardiovascular Risk Assessments undertaken in primary care in line with the definitions.
[36] 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.
[37] The diagnostic measures are national performance measures (PP29) and baselines are as at the final quarter (to June) in line with national results published by the Ministry of Health. 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 more complex services provided by specialists and health professionals working closely together and are usually provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. A proportion of these services are in response to an acute event and others are planned where access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

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

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

SERVICE PERFORMANCE INDICATORS (2015/16)

Quality & Patient Safety Measures These quality and patient safety measures apply across all hospital services and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
Rate of compliance with good hand hygiene practice	Q ◇ [38]	77%	80%	75%
% of hip and knee replacement patients receiving cefazolin >2g	Q ◇ [39]	89%	95%	85%
% of hip and knee replacement patients who have appropriate skin preparation	Q ◇	100%	100%	97%
% of time all three parts of the surgical safety checklist are used	Q ◇ [40]	96%	≥90%	94%
% of inpatients (aged 75+) who received a falls assessment	Q ◇ [41]	89%	90%	89%

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	2013/14 DHB Result	2015/16 Target	2013/14 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C	62%	80%	59%
% of new mothers attending DHB-funded parenting and pregnancy courses	C	N/A	>30%	-
Maternity deliveries in West Coast DHB facilities	V	279	Est. 300	-
Baby friendly hospital accreditation of DHB facilities	Q [42]	Yes	Yes	-

[38] *This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards.*
[39] *Cefazolin >2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.*
[40] *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.*
[41] *While there is no single solution to reducing falls, an essential first step is to assess an individual's risk of falling, and acting accordingly.*
[42] *The Baby Friendly Initiative is a worldwide programme lead by the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises the standard.*

Acute/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). Services include accident & emergency responses, short-stay acute assessment and observation, acute care packages, acute medical and surgical services and intensive care services.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of children <13 with access to free primary care outside business hours	C [43]	new	100%	-
% of general practices providing telephone triage outside business hours	C	100%	100%	-
Attendances at the Grey Base Hospital Emergency Department	V [44]	11,043	Est.<13,000	-
% of people (Triage 1-3) presenting in ED seen within clinical guidelines	Q [45]	87%	>85%	-
% of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receive their first treatment within 62 days of referral.	T ◇ [46]	New	85%	New
% of people waiting less than 4 weeks to start radiotherapy or chemotherapy	T ◇ [47]	100%	100%	100%
Acute inpatient average length of hospital stay (standardised)	Q [48]	2.45	≤2.45	2.64

Elective/Arranged Services These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. 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	2013/14 Result	2015/16 Target	2013/14 National Average
First Specialist Assessments provided (medical and surgical)	V [49]	6,864	E.>6,000	-
% of First Specialist Assessments that were non-contact (virtual)	Q [50]	4.2%	>5%	-
Elective surgical discharges delivered (surgeries provided)	V [51]	1,695	1,889	-
Elective inpatient average length of hospital stay (standardised)	Q [48]	1.59	≤1.59	1.67
Outpatient attendances	V [52]	15,565	Est. >13k	-
% of outpatient appointments/consultations provided by telemedicine	Q	2.1%	>1.5%	-
Outpatient 'Did not Attend' rates (total population)	Q [53]	8.5%	6%	-
Outpatient 'Did not Attend' rates (Māori)	Q	18.0%	6%	-

[43] *This measure was previously '100% children under six with access to free primary care after hours'.*
[44] *This measure is based off the national ED Health Target, but the result are for a full year.*
[45] *Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.*
[46] *This measure is the national Faster Cancer Track Health Target which was introduced in Q2 of 2014/15.*
[47] *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.*
[48] *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. The baseline differs to that previously published due to a change in the national definition for this measure – day stays are now included in the count.*
[49] *This measure counts both medical and surgical assessments but only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred. The measure is aligned to the national elective services reporting definitions which are DHB of domicile—covering all FSAs provided for West Coast residents no matter where they are delivered.*
[50] *Non-contact FSAs are those where specialist advice and assessment are provided without the need for a hospital appointment.*
[51] *This measure is the national Elective Surgery Health Target. The measure was redefined in 2015/16 and now includes inpatient surgical discharges, regardless of whether the discharge is from a surgical or non-surgical speciality and both 'elective' and 'arranged' admissions.*
[52] *The DNA presentations relate to medical and surgical specialist outpatient appointments only and do not cover either mental health or AT&R services. Baselines differ slightly to previous years due to an alignment of definitions, data sources and inclusion of late coding.*
[53] *The DNA results differ slightly to those previously published due to clarification and alignment of data definitions and timeframes and the inclusion of late coding for previous years. These DNA presentations relate to medical and surgical specialist outpatient appointments and do not include DNAs for mental health or AT&R services.*

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of young people (0-19) accessing specialist mental health services	C Δ [54]	6.1%	>3.8%	3.4%
% of adults (20-64) accessing to specialist mental health services	C Δ	5.4%	>3.8%	3.8%
% of people referred for non-urgent MH/AOD services seen within 3 weeks	T [55]	76%	80%	79%
% of people referred for non-urgent MH/AOD services seen within 8 weeks	T	93%	95%	93%

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	2013/14 Result	2015/16 Target	2013/14 National Average
Admissions into inpatient AT&R services	V	131	E.>150	-
Consultations provided by outpatient and domiciliary AT&R services	V	2,060	E.>1,700	-
% of AT&R inpatients discharged to their own home rather than into ARC	Q Δ [56]	89%	90%	-

[54] *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.*

[55] *This measure is a national performance measures (PP6) and targets are based on the assumption that 3% of the population will need access to specialist mental health services. Results are three months in arrears and reflect specialist services (DHB and NGO) reporting through to the national PRIMHD database so may undercount service provision if providers are not reporting to the national system.*

[56] *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 often after illness or disability. These services are delivered after a clinical 'needs' assessment and include: domestic support, personal care, community nursing, respite and residential care. Services are mostly for older people, mental health clients and people with complex conditions.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Services that support people to live 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 support enables people to maximise their function and independence. In preventing deterioration and crisis, these services have a major impact on the sustainability of the health system by reducing acute demand, avoidable hospital admissions and the need for more complex intervention. These services also support the flow of patients by enabling them to go home earlier and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

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.

SERVICE PERFORMANCE INDICATORS 2015/16

Rehabilitation Services These services restore or maximise people's health or functional ability following a health-related event and success is often measured through increased referral to appropriate services following an acute event such as a heart attack or stroke.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	55%	80%	-
People supported by the FIRST service	V	New	25	-
People (65+) access the community-based falls/fracture liaison service	V [57]	New	25	-

Home and Community-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 the capacity in the system, and success is measured against delayed entry into residential or hospital services with more people supported to live longer in their own homes.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of older people (65+) receiving long-term home and community support services who have had a clinical assessment using InterRAI	Q Δ [58]	94%	95%	-
People supported by long-term home and community support services	V Δ	751	Est. >740	-
Community-based district nursing visits provided (long-term clients only)	V Δ	4,364	Est. >4,000	-
Meals on Wheels provided	V Δ	33,082	Est. >35k	-

[57] *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.*
[58] *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. Access to services are expected to increase over time, as more people are supported to remain in their own homes.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
Mental health planned and crisis respite service bed days used	C Δ	379	Est. 500	-
People supported by aged care respite services	V	64	Est. 70	-

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 and community-based support.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of people entering ARC having had a clinical assessment using InterRAI	Q Δ [58]	97%	>95%	-
% of ARC residents receiving vitamin D supplements	C	59%	75%	-
Subsidised ARC rest home beds provided (days)	V Δ [59]	44,438	Est. <50k	-
Subsidised ARC hospital beds provided (days)	V Δ	41,352	Est. <40k	-
Subsidised ARC dementia beds provided (days)	V Δ	4,551	Est. >4,000	-
Subsidised ARC psycho-geriatric beds provided (days)	V Δ	2,394	Est. >2,000	-

[59] *All of the ARC bed baselines differ from those published in the 2014 Annual Report due to the addition of late claims.*

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 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; supplemented by revenue agreements from 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 planned 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 still filling a significant number of full-time positions with locums. This not only reduces continuity of care but is an expensive and unsustainable option, which needs to be addressed.

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. We know that affordability of the Greymouth hospital and IFHC was predicated on this basis and it is clear that the achievement of living within our means requires a number of significant actions and service redesign — it will not be a '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. We need to ensure that cost growth is minimised, through the development of our news models of care and other efficiencies, so that more of our total funding can be directed into improving services and service delivery.

Transitional funding: The West Coast DHB receives around $18m of additional transitional funding which is vital to the fiscal sustainability of our health system. Although this was reduced in the 2014/15 year, current advice sees this funding rising back to previous levels for 2015/16.

It is imperative that future treatment of this funding is resolved to be no longer at risk. The continuation of this funding would be consistent with the assumptions used in the financial modelling performed to evaluate the Grey redevelopment which was approved by Cabinet. If for some reasons this treatment is not achieved the impact on the ongoing affordability of the West Coast Hospital Development is significant, and impacts on the ability of the DHB to operate sustainably.

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 higher-end and more resource intensive 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 our general practices to ensure the financial sustainability of general practice on the West 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 DHB is also committed to actively supporting national initiatives to achieve mutual benefits and cost savings across the sector. Our level of inclusion in 2015/16 financial projections is provided in the table at the end of this financial section.

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 and 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 2015/16, with no disruptions associated with pandemic or natural disaster.
- Population-based funding levels for 2015/16 will remain at the level indicated by the Ministry in the funding envelope received December 2014.
- 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 and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- National and regional initiative savings and benefits will be achieved as per planning assumptions provided to the DHB, with no requirement to impair associated investments.
- 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, with forecasts for 2014/15 and budgets for 2015-2016 and beyond based on this revaluation. However, further impairments may be necessary dependent on the outcome of engineering assessments.
- Work will continue on the facilities redevelopment plans for Grey and Buller under the nationally directed Partnership Group.

The associated costs and capital expenditure for the Grey redevelopment 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 (adjusted for the 2014/15 transitional funding repayment advice). As agreed in the business case the funding will be a mix of debt and equity.

The DHB has not had the opportunity to fully explore the financial impacts of the procurement options responded to by the market for the Buller redevelopment (approved April 2014). Associated development costs and any capital or lease expenditure have therefore not been included in this Plan.

7.4 Asset planning and investment

GREY RE-DEVELOPMENT

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 late 2015.

Current fiscal modelling in relation to this facility has made some assumptions in regard to building importance level and similar aspects which, if proved to be incorrect, will create significant cost pressure, and may impede the ability to complete the facility project within its approved budget. In this instance the affordability of the project, both in terms of completion, or if additional funding is permitted the ongoing affordability for the West Coast DHB will be compromised.

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

In Buller, a design team has been appointed and will soon re-engage with clinicians to work on the master plan and concept design for the redevelopment. The outcome of this process will help guide the impending business case.

CAPITAL EXPENDITURE

The business as usual capital expenditure budget for the 2015/16 year is $3.8M; 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 DHB will continue to be disciplined and focus on the key priorities in determining capital expenditure.

Over the next six years, the key strategic capital intentions above business as usual capital expenditure include:

- Buller IFHC (notionally $8.1M)
- Mental health facility refurbishment (notionally $5M)
- Phased upgrade of rural health clinics outside of Greymouth and Westport (notionally $0.5M per clinic)
- Secondary tranche Grey Hospital redevelopment (notionally $5M)
- Move to the South Island Patient Information Care System (notionally $2.5M)
- Investment in other strategic IT / integration systems (notionally $1.8M-$2.2M p.a.)

We anticipate that the above capital intentions will be funded by internal cash except for the Buller IFHC, mental health facility refurbishment and secondary tranche Grey Hospital redevelopment projects, whereby 40-45% Crown capital support would likely be required.

We will continue to manage our cash flow effectively and any significant change to Crown support will be signaled to the respective agencies as required.

Exploratory work with regards to the Buller IFHC has started while planning for the mental health facility project is expected to start in 2016 with the business case submission anticipated in 2017.

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 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 DHBs 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 total term debt is currently $14.445M and is expected to remain at this amount as at June 2016.

THE WEST COAST DHB'S CURRENT DEBT PROFILE

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

Grey Hospital redeveloped facility is expected to be completed in the first quarter of 2017 at which time the asset will be transferred from the Ministry of Health to the DHB. Following the asset transfer, term debt will increase by $40.8M to $55.245M, based on a 60% debt and 40% equity funding ratio for this new asset, as per the detailed business case model.

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

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 Shared Services (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.

COMMITMENT TO NATIONAL INITIATIVES

2014/15 (in $'000S)	CAPITAL COSTS	OPERATING COSTS		OPERATING BENEFITS	NET OPERATING
		ONE-OFF	ONGOING		
NHITB - eMedicines Reconciliation (eMR) with eDischarge Summary	-	-	(6)	-	(6)
NHITB - Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)	-	-	-	-	-
NHITB - Replacement of legacy Patient Administration Systems	-	-	-	-	-
NHITB - National Patient Flow	-	(104)	-	-	
NHITB - MoH contribution to National Patient Flow	-	(104)	-	-	(104)
NHITB - Provider & Patient Portal	(50)	-	-	-	-
Data warehouse	-	-	(3)	-	(3)
HQSC - SSIP DHB Infections Management systems (ICNet NG system)	(55)	-	(50)	-	(50)
HQSC - Patient experience indicators	-	-	-	-	-
HBL (Health Benefits ltd)					
Core Funding	-	-	(55)	-	(55)
FPSC Integrator	-	-	(3)	-	(3)
NIP Integrator	-	-	(9)	-	(9)
FPSC (existing oracle licenses)	-	-	(18)	-	(18)
FPSC (gap funding)	-	-	(22)	-	(22)
FPSC (technology)	-	-	-	-	-
FPSC (investment)	-	-	(47)	-	(47)
FPSC (hA costs)	-	-	(90)	-	(90)
FPSC (benefits)	-	-	-	253	253
Food	-	-	(63)	-	(63)
Linen & Laundry	-	-	(7)	-	(7)
National Infrastructure Platform	-	-	-	-	-
IT Procurement	-	-	-	-	-
Human Resource Management Information System	-	-	-	-	-
Banking and insurance	-	-	(16)	-	(16)
TOTAL	(105)	(208)	(388)	253	(343)

Statement of Financial Expectations

Where will our funding go?

8.1 Statement of comprehensive income

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
INCOME						
Ministry of Health revenue	126,385	129,885	130,009	131,373	132,873	134,492
Patient related revenue	9,409	10,274	10,668	10,856	11,172	11,494
Other operating income	629	635	720	732	745	758
Interest income	608	530	528	528	528	528
Total Income	137,031	141,324	141,925	143,489	145,318	147,272
OPERATING EXPENSES						
Personnel	55,477	56,680	57,212	58,269	59,207	61,181
Outsourced services (clinical and non-clinical)	7,981	7,264	5,112	4,792	4,172	4,152
Treatment related costs	7,727	7,510	7,404	7,478	7,553	7,630
External service providers (include Inter-district outflow)	48,869	52,822	55,558	56,034	53,702	55,411
Depreciation & amortisation	4,373	4,686	4,740	5,327	5,907	5,907
Interest expenses	713	750	720	1,740	2,760	2,760
Other expenses	12,225	11,822	11,265	11,143	10,825	10,834
Total Operating Expenses	137,365	141,534	142,011	144,783	144,126	147,875
Operating surplus before capital charge	(334)	(210)	(86)	(1,294)	1,192	(603)
Capital charge expense	753	790	792	792	2,968	2,968
Surplus/(deficit)	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)
Other comprehensive income	-	-	-	-	-	-
Total comprehensive income	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)

8.2 Statement of financial position

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
CROWN EQUITY						
General funds	(89,744)	(91,812)	(92,636)	(68,798)	(70,332)	(75,766)
Revaluation reserve	19,569	19,569	19,569	19,569	19,569	19,569
Retained earnings	80,272	81,272	82,150	84,236	86,012	89,583
Total Equity	10,097	9,029	9,083	35,007	35,249	33,386
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	7,483	9,265	10,201	11,752	15,401	16,945
Trade & other receivables	8,786	4,218	4,218	4,218	4,218	4,218
Inventories	1,010	1,100	1,100	1,100	1,100	1,100
Assets classified as held for sale	136	136	136	136	136	136
Investments (3 to 12 months)	80	-	-	-	-	-
Restricted assets	61	60	60	60	60	60
Total Current Assets	17,556	14,779	15,715	17,266	20,915	22,459
CURRENT LIABILITIES						
Trade & other payables	8,751	5,448	5,448	5,448	5,448	5,448
Capital charge payable	1,836	1,800	1,800	1,800	1,800	1,800
Employee benefits	8,468	9,081	9,081	9,081	9,081	9,081
Restricted funds	61	60	60	60	60	60
Borrowings	3,750	3,250	3,250	3,250	3,250	3,250
Total Current Liabilities	22,866	19,639	19,639	19,639	19,639	19,639
Net Working Capital	(5,310)	(4,860)	(3,924)	(2,373)	1,276	2,820
NON-CURRENT ASSETS						
Investments (greater than 12 months)	-	-	-	-	-	-
Property, plant, & equipment	27,069	26,697	25,831	91,020	87,629	84,238
Intangible assets	1,681	1,222	1,206	1,190	1,174	1,158
Total Non-Current Assets	28,750	27,919	27,037	92,210	88,803	85,396
NON-CURRENT LIABILITIES						
Employee benefits	2,648	2,835	2,835	2,835	2,835	2,835
Borrowings	10,695	11,195	11,195	51,995	51,995	51,995
Total Non-Current Liabilities	13,343	14,030	14,030	54,830	54,830	54,830
Net Assets	10,097	9,029	9,083	35,007	35,249	33,386

8.3 Statement of movements in equity

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
Total Equity at Beginning of the Period	10,152	10,097	9,029	9,083	35,007	35,249
Total Comprehensive Income	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)
OTHER MOVEMENTS:						
Contribution back to Crown - FRS3	(68)	(68)	(68)	(68)	(68)	(68)
Contribution from Crown - Capital	-	-	-	27,200	-	-
Contribution from Crown - Operating Deficit Support	1,100	-	1,000	878	2,086	1,776
Total Equity at End of the Period	10,097	9,029	9,083	35,007	35,249	33,386

8.4 Statement of cashflow

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
CASH FLOW FROM **OPERATING** ACTIVITIES						
CASH WAS PROVIDED FROM:						
Receipts from Ministry of Health	123,439	128,334	128,509	129,843	131,313	132,900
Other receipts	9,648	15,890	12,888	13,118	13,477	13,844
Interest received	608	530	528	528	528	528
	133,695	144,754	141,925	143,489	145,318	147,272
CASH WAS APPLIED TO:						
Payments to employees	61,534	62,917	61,352	62,209	62,647	64,621
Payments to suppliers	68,937	77,606	75,199	75,507	72,812	74,587
Interest paid	781	713	720	1,740	2,760	2,760
Capital charge	897	826	792	792	2,968	2,968
GST - net	238	(394)	-	-	-	-
	132,387	141,668	138,063	140,248	141,187	144,936
Net Cashflow from Operating Activities	1,308	3,086	3,862	3,241	4,131	2,336
CASH FLOW FROM **INVESTING** ACTIVITIES						
CASH PROVIDED FROM:						
Sale of property, plant, & equipment	53	-	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	53	-	-	-	-	-
CASH WAS APPLIED TO:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	1,982	2,336	3,858	70,500	2,500	2,500
	1,982	2,336	3,858	70,500	2,500	2,500
Net Cashflow from Investing Activities	(1,929)	(2,336)	(3,858)	(70,500)	(2,500)	(2,500)
CASH FLOW FROM **FINANCING** ACTIVITIES						
CASH PROVIDED FROM:						
Equity Injection - Capital	-	-	-	27,200	-	-
Equity Injection - Deficit Support	-	1,100	1,000	878	2,086	1,776
Loans Raised	2,000	-	-	40,800	-	-
	2,000	1,100	1,000	68,878	2,086	1,776
CASH APPLIED TO:						
Loan Repayment	-	-	-	-	-	-
Equity Repayment	68	68	68	68	68	68
	68	68	68	68	68	68
Net Cashflow from Financing Activities	1,932	1,032	932	68,810	2,018	1,708
Overall Increase/(Decrease) in Cash Held	1,311	1,782	936	1,551	3,649	1,544
Add Opening Cash Balance	6,172	7,483	9,265	10,201	11,752	15,401
Closing Cash Balance	7,483	9,265	10,201	11,752	15,401	16,945

8.5 Summary of revenue and expenses by arm

FUNDER, GOVERNANCE & FUNDER ADMIN: FORECAST OPERATING STATEMENT YEARS ENDING 2013/14 TO 2018/19

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 Actual	30/06/15 Forecast	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
FUNDING ARM						
REVENUE						
MoH Revenue	125,344	128,694	128,797	130,137	131,613	133,208
Total Revenue	125,412	128,694	128,797	130,137	131,613	133,208
EXPENDITURE						
Personal Health	84,749	89,579	92,079	93,461	92,059	94,362
Mental Health	14,018	14,056	14,080	14,293	14,508	14,870
Disability Support	18,317	18,566	18,950	19,233	19,520	20,007
Public Health	673	704	683	692	701	719
Māori Health	817	818	809	821	833	853
Governance & Admin	705	827	827	827	827	827
Total Expenditure	119,279	124,550	127,428	129,327	128,448	131,638
Net Surplus/(Deficit)	6,133	4,144	1,369	810	3,165	1,570
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	6,133	4,144	1,369	810	3,165	1,570
GOVERNANCE & FUNDER ADMIN						
REVENUE						
Other	705	827	827	827	827	827
Total Revenue	705	827	827	827	827	827
EXPENDITURE						
Personnel	598	1,123	1,292	1,308	1,324	1,340
Outsourced services	594	450	396	376	356	336
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(487)	(746)	(861)	(857)	(853)	(849)
Total Expenditure	705	827	827	827	827	827
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-

PROVIDER ARM: FORECAST OPERATING STATEMENT YEARS ENDING 2013/14 TO 2018/19

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 Actual	30/06/15 Forecast	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
PROVIDER ARM						
REVENUE						
MoH Revenue	70,746	72,092	72,255	73,702	75,179	76,684
Patient Related Revenue	9,409	10,274	10,668	10,856	11,172	11,494
Other	1,169	1,165	1,248	1,260	1,273	1,286
Total Revenue	81,324	83,531	84,171	85,818	87,624	89,464
EXPENDITURE						
Personnel	54,879	55,557	55,920	56,961	57,883	59,841
Outsourced services	7,387	6,814	4,716	4,416	3,816	3,816
Depreciation	4,373	4,686	4,740	5,327	5,907	5,907
Interest & Capital Charge	1,466	1,540	1,512	2,532	5,728	5,728
Other	20,439	20,078	19,530	19,478	19,231	19,313
Total Expenditure	88,544	88,675	86,418	88,714	92,565	94,605
Net Surplus/(Deficit)	(7,220)	(5,144)	(2,247)	(2,896)	(4,941)	(5,141)
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	(7,220)	(5,144)	(2,247)	(2,896)	(4,941)	(5,141)
IN HOUSE ELIMINATION						
REVENUE						
MoH Revenue	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
Total Revenue	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
EXPENDITURE						
Other	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
Total Expenditure	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income						
CONSOLIDATED						
REVENUE						
MoH Revenue	125,680	129,058	129,182	130,546	132,046	133,665
Patient Related Revenue	9,409	10,274	10,668	10,856	11,172	11,494
Other	1,942	1,992	2,075	2,087	2,100	2,113
Total Revenue	137,031	141,324	141,925	143,489	145,318	147,272
EXPENDITURE						
Personnel	55,477	56,680	57,212	58,269	59,207	61,181
Outsourced services	7,981	7,264	5,112	4,792	4,172	4,152
Depreciation	4,373	4,686	4,740	5,327	5,907	5,907
Interest & Capital Charge	1,466	1,540	1,512	2,532	5,728	5,728
Other	68,821	72,154	74,227	74,655	72,080	73,875
Total Expenditure	138,118	142,324	142,803	145,575	147,094	150,843
Net Surplus/(Deficit)	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)

Part IV – Further Information for the Reader

Appendices

Appendix 9.1	Glossary of terms
Appendix 9.2	Objectives of a DHB
Appendix 9.3	Organisational chart
Appendix 9.4	West Coast Alliance Structure
Appendix 9.5	West Coast's commitment to National Health Targets
Appendix 9.6	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.westcoastdhb.health.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).

Appendix 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 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 it is free and allows health concerns to be identified and addressed early 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.
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		A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early and the assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.
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.
IPIF	Integrated Performance and Incentive Framework	IPIF has been established to support the health system to address equity, safety, quality, access and cost of services. It is a quality and performance improvement programme that will reward good performance and will be developed and implemented over several years.
	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.
SPE	Statement of Performance Expectations	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of performance expectations 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.
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.

Appendix 2

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

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

PART 3: SECTION 22:

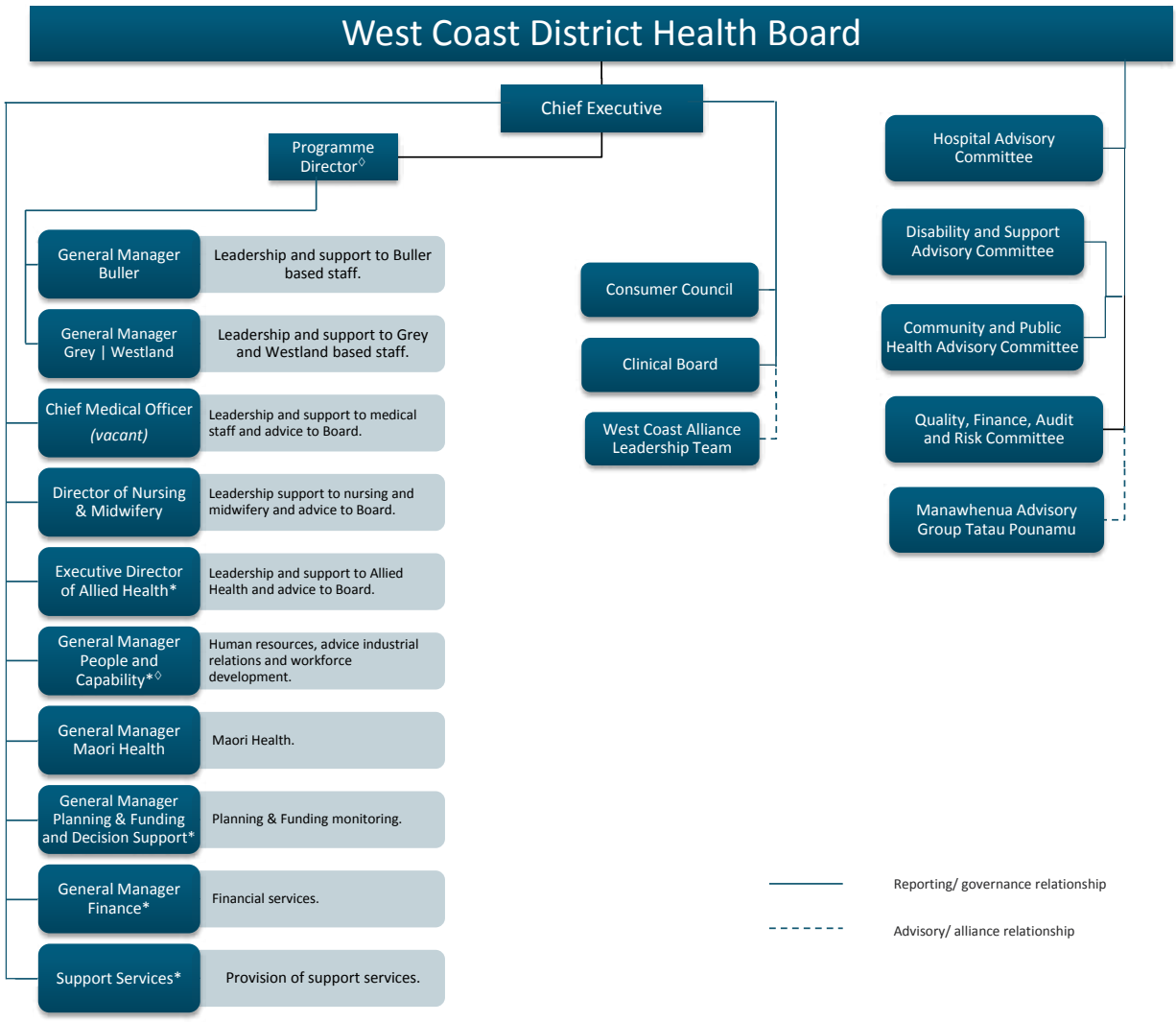
The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

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.

Appendix 3

West Coast DHB organisational structure



*Joint appointments with CDHB
◊Position filled by one individual

Appendix 4

West Coast Alliance Structure

Appendix 5

West Coast's commitment to the national health targets

SHORTER STAYS IN EMERGENCY DEPARTMENTS

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

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

West Coast contribution – see section 6.9

IMPROVED ACCESS TO ELECTIVE SURGERY

Expectation: More New Zealanders have access to elective surgical services. Nationally, DHBs will deliver an increase in the volume of elective surgery by an average of 4000 per year.

Target: 1,889 elective surgical discharges will be delivered in 2014/15.

West Coast contribution – see section 6.10

FASTER CANCER TREATMENT

Expectation: 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016

Target: 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

West Coast contribution – see section 6.12

INCREASED IMMUNISATION

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

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

West Coast contribution – see section 6.13

BETTER HELP FOR SMOKERS TO QUIT

Expectation: 90% of smokers seen in primary care, 95% of hospitalised smokers and 90% of women at confirmation of pregnancy with general practice or a Lead Maternity Carer (LMC) are offered brief advice and support to quit smoking.

Target: 90% of smokers seen in primary care and 95% hospitalised smokers will receive advice and help to quit, 90% of pregnant smokers being offered advice and help to quit smoking.

West Coast contribution – see section 6.3

MORE HEART AND DIABETES CHECKS

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

Target: 90% of the eligible population will have had CVD risk assessment within the past five years.

West Coast contribution – see section 6.4

Appendix 6

Statement of accounting policies

The prospective financial statements in this Annual Plan for the year ended 30 June 2016 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 Annual Plan:

(i) Cautionary Note

The Annual Plan'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 West Coast DHB expects to take place.

(iii) Assumptions

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

REPORTING ENTITY AND STATUTORY BASE

West Coast DHB ("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 has designated itself as a public benefit entity (PBEs) for financial reporting purposes.

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. West Coast DHB does not operate to make a financial return.

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

BASIS OF PREPARATION

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

Statement of compliance

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

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards. These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new PBE accounting standards.

Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: 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 Canterbury DHB is NZD.

Changes in accounting policies

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

Standards, issued but not yet effective and not early adopted.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. West Coast DHB will apply these updated standards in preparing its 30 June 2016 financial statements and expects there will be minimal or no change in applying these updated accounting standards.

SIGNIFICANT ACCOUNTING POLICIES

Foreign currency

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

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

Budget figures

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

PROPERTY, PLANT AND EQUIPMENT

Classes of property, plant and equipment:

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

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

Owned assets

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

Revaluations

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is

recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expense. Any decreases in value relating to land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in other comprehensive revenue. Additions to land and buildings between valuations are recorded at cost.

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

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

Additions

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

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

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

Where a physical asset is gifted to or acquired for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue.

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*
Freehold Buildings	3 - 50
Fit Out Plant & Equipment	3 - 50
Plant and Equipment	2 - 20
Vehicles	3 - 5

The residual value of assets is reassessed annually.

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

INTANGIBLE ASSETS

Software development and acquisition

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

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

Amortisation

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

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

INVESTMENTS

Bank term deposits

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

Equity 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 Canterbury 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.

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

INVENTORIES

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

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

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

CASH AND CASH EQUIVALENTS

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

IMPAIRMENT OF PROPERTY, PLANT, AND EQUIPMENT AND INTANGIBLE ASSETS

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

Non-cash-generating assets

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

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

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

RESTRICTED ASSETS AND LIABILITIES

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

BORROWINGS

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

EMPLOYEE ENTITLEMENTS

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

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

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

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

Annual leave, conference leave and medical education leave - 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 West Coast 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, West Coast 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 a re-measurement to fair value is recognised immediately in the surplus or deficit.

The full fair value of a forward foreign exchange derivative is classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, foreign exchange derivatives are classified as non-current.

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 revenue

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

OPERATING LEASE PAYMENTS

Payments 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 previously recognised.

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

BORROWING COSTS

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

The preparation of financial statements in conformity with NZ 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 programs;
- Review of second hand market prices for similar assets; and,
- Analysis of prior asset sales.

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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

STATEMENT OF INTENT

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