West Coast DHB

STATEMENT OF INTENT 2016/2020

& Statement of Performance Expectations 2016/2017

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 categorised as a Crown Agent under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services.

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

The document sets out our goals and objectives and describes what we intend to achieve, in terms of improving the health of our population and ensuring the sustainability of the West Coast health system. The Statement of Intent also contains service and financial forecast information for the current and three subsequent out-years: 2016/17, 2017/18, 2018/19 and 2019/20.

This 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 the year to compare planned and actual performance. Audited results are published in the DHB's year-end Annual Report.

The Minister of Health has been very clear in setting his annual expectations for 2016/17 that DHBs must focus on integration and strong clinical leadership.

The West Coast DHB has made a clear commitment to whole of system planning and service delivery. Clinically-led local and regional alliances have been established as vehicles for implementing system change and improving health outcomes. This includes our West Coast Health Alliance and the South Island Regional Alliance.

In line with this approach and commitment, the direction and deliverables outlined in this Statement of Intent present a picture of the collaborative activity that will be delivered by the West Coast DHB and our Alliance partners to improve the health of the West Coast community.

The West Coast DHB also has a Māori Health Action Plan and a Public Health Action Plan, both of which are companion documents to our Annual Plan. These Plans set out further actions and activity to improve population health and reduce inequalities in health status and outcomes. Both of these companion documents are available on the DHB website: www.westcoastdhb.health.nz.

In signing this Statement of Intent, we are satisfied that it accurately represents our joint intentions and commitments. Together, we will continue to strive to deliver real gains and improvements in the health of our population.

Peter Ballantyne
CHAIR | WEST COAST DHB

Joseph Thomas
DEPUTY CHAIR | WEST COAST DHB

Stella Ward
CHAIR | WEST COAST HEALTH ALLIANCE

August 2016

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Part I

Overview

Foreword from the Chairman and Chief Executive

This Statement of Intent along with our Annual Plan sets out our objectives for the coming year and the key actions we will take to address the pressures and demands on our health system and improve health outcomes for our population.

33,190
reasons to make a difference

TURNING OUR CHALLENGES INTO STRENGTHS

On the West Coast we often talk about the challenges we face. Particularly the unique challenge of providing services to our small population of 33,190 spread across a region that spans 516kms from Karamea in the north to Haast in the south.

How do we maintain a sustainable health system in this environment and at the same time achieve our goal of a people centred, integrated service?

It is the very nature of this challenge that presents us with an opportunity to become a leader in providing health care in a rural environment. We should not look at this challenge as an immovable barrier to achieving our goals and delivering services that our community can be proud of.

This is an opportunity to develop a health system that is flexible, sustainable and provides the right care, in the right place at the right time. One that centres care around the individual, reducing the need for multiple visits, increasing access to care through the use of technology and wrapping services around the patient through a single integrated service model.

This is not discounting the challenges we face or pretending that what we strive for will be easy to achieve, as this is not the case.

This is about taking on this challenge, working with our health teams and our communities across the Coast to achieve something that is truly innovative and sustainable. It is about enabling our staff and our colleagues to take on these challenges and supporting them to develop and use their strengths to develop services that are truly centred around the person in order that we can achieve our goals, not just now but into the future.

ONE TEAM, CLOSER TO HOME: INTEGRATING OUR PRIMARY AND COMMUNITY SERVICES

What we look to achieve in 2016/17 will build on the hard work of our staff, partners and communities over the last several years.

We have come together through the West Coast Health Alliance to develop some of the key foundations needed to bring an integrated service to life.

This includes the development of HealthPathways, the primary care long term conditions management programme, the complex clinical care network and the pharmacy to GP programme. We have also improved communication between secondary and primary care with the implementation of HealthOne, the ERMS electronic referral management system and the expansion of telehealth services.

These foundations or building blocks are enabling us to take the next step in integrating our primary and community services across the Coast. In 2016/17 this will include:

- Looking at our primary and community services as a single, integrated service.
- Expanding the use of tools such as HealthPathways and new case mix models to provide a consistent approach to care across the West Coast.
- Continuing to enable and expand transalpine services and telehealth clinics to support complex care being delivered closer to home.
- Continue to enable and explore a more rapid move towards community and primary care based mental health and wellbeing services.
- Continuing to build on services that enable people to stay well in their homes for longer.
- Improved access to primary care with longer opening hours and the implementation of a patient portal.
- Working with our Māori health provider to reach those in our Māori communities that have difficulty accessing health care.

JOINED UP SETTINGS: FIT FOR PURPOSE FACILITIES

Our integrated approach to health service design and delivery also means that our facilities redevelopment is an integral part of the plan for the future of health care on the West Coast. The new Grey Hospital and Grey

and Buller Integrated Family Health Centres (IFHCs) are key enablers for moving our health system to a more productive and sustainable configuration and bringing a range of services closer to people's homes.

We look forward to working with the nationally appointed Hospital Redevelopment Partnership Group to ensure our new facilities will meet the health needs of our community and enable the vision for the West Coast health system to be realised. Completion of the Grey Hospital and IFHC is anticipated in 2018.

HIGH PERFORMING, SMARTER SYSTEMS: INTEGRATING OUR INFORMATION SYSTEMS

The health system is a complex environment with many different parts so connected information systems are key to working in an integrated way.

We have come a long way over the last few years with tools now including HealthOne, Health Connect South, HealthPathways, and the electronic referral management system (ERMS).

We will continue this progress in 2016/17 with the implementation of ePharmacy and eMedications to support informed clinical-decision making and improve the quality of the care we deliver. We will also implement a patient portal system to enable greater access for patients to primary care and to support people to take more responsibly for managing their own health and wellbeing.

We have looked at how we can make information more visible to people through better reporting. Our Alliance reporting provides visibility of the progress we are making across our Alliance workstreams. We have also implemented live, interactive reporting tools to enable better decision making.

In the coming year this work will support the availability of more live and interactive reporting, improved visibility of ethnicity in reporting and greater visibility of patient travel times to assist in identifying opportunities such as telehealth.

PEOPLE POWERED: ENGAGING WITH OUR COMMUNITY

To be person centred we need to ensure we are engaging and listening to our communities. We are doing this through a number of avenues including our Consumer Council, an advisory group to the DHB, the inclusion of community members on our Alliance workstreams and regular interaction with communities through community meetings.

As we progress down the path towards a person centred health system, and as we support greater integration of our services, it will be increasingly important to engage with our communities to ensure the outcomes we are looking to achieve are coming to fruition.

Are we increasing access to primary and community services, are we reducing the number of visits needed to get the right care, are we reducing wait times, are we wrapping services around individuals to get the best health benefits and are we reducing travel requirements for our patients, providing care closer to where they live?

This is what patient centred care is about and it's important that we continue, not only to measure and report on the actions we take to get there but also the outcomes we are trying to achieve.

WEST COAST ALLIANCE: PARTNERING FOR SUCCESS

The actions and goals contained in our Statement of Intent and Annual Plan are an integral part of describing what we are doing and wanting to achieve on the Coast. However it is important to note that it is a reflection of a much larger programme of work.

Our staff and partners in the health system from right across the Coast have put a significant amount of time and energy into bringing us closer to realising our ultimate vision.

A significant proportion of this work is driven through the West Coast Health Alliance which brings together the DHB and its partners to redesign and transform health care on the Coast via a clinically-led process.

The Alliance work plan helps to form the foundation of this document and our Annual Plan. We would like to acknowledge our staff and our partners across the health system.

They continue to do so much to bring to life a health service that our communities can be proud of, we look forward to working with them for another year.

Peter Ballantyne
CHAIRMAN WEST COAST DHB

David Meates
CHIEF EXECUTIVE WEST COAST DHB

August 2016

Introducing the West Coast DHB

1.1 Who are we?

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

The West Coast DHB has the smallest population of all of twenty DHBs. We are responsible for 33,190 people, 0.7% of the total New Zealand population.

We own and manage three major facilities in Greymouth, Westport and Reefton and five general practices across the West Coast.

In the past year (2014/15): 140,200 general practice appointments and 13,972 specialist outpatient appointments were provided, there were 11,370 attendances at the Grey Emergency Department; 7,750 admissions to our hospitals; 2,053 elective surgeries delivered; and 256 babies delivered.

While we are the smallest DHB by population we have the third largest geographical area, making the West Coast DHB the most sparsely populated DHB in the country.

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 DHB is a major employer on the West Coast, employing over 1,000 people across our hospital and primary care services.

The DHB also holds and monitors more than 40 service contracts with other organisations and individuals who provide health services to our population. This includes the West Coast Primary Health Organisation (PHO).

1.2 What do we do?

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

In 2016/17 we will have approximately $145m to meet the needs of our population, which includes $123.362m of population based funding provided to DHBs by the Ministry of Health.

In line with legislation we use our funding to:

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

Purchase the health services provided to our population, and through our collaborative partnerships with other service providers, ensure services are responsive, coordinated and effective.

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

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

1.3 Our operating structure

Our Board is responsible to the Minister of Health for the overall performance of the DHB. As an owner of Crown assets, the DHB is also accountable to Government for the financial and operational management of those assets.

The Board delivers against this responsibility by setting strategic direction and policy that is consistent with Government objectives, meets the needs of our population and ensures sustainable service provision.

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, service providers and clinical leaders also regularly present to the Board and its sub-committees.

Operational management has been delegated to the Chief Executive. The Chief Executive is supported by an Executive Management Team, who provide clinical, strategic, financial and cultural input into decision-making and have oversight of patient safety and service quality (refer to Appendix 2 for the organisational chart of the West Coast DHB).

Since 2010, West Coast DHB has shared executive and clinical services with the Canterbury DHB. This includes: senior clinical and management expertise, a joint Chief Executive, Executive and Clinical Directors, as well as joint planning and funding, finance, public

health, people and capability, information services and corporate services teams.

Since 2011 the West Coast has had a formal Health Alliance in place. The West Coast Health Alliance is a partnership of health professionals and providers, from across the West Coast health system.

Health resources are increasingly limited. We have to be focused and smart to achieve and sustain improved outcomes for our population. There are many service providers, organisations, and agencies who have a shared interest in improving the health of our population — it makes sense to work collectively.

Through our partnerships and Alliance, we work together to determine and design the most appropriate and effective service delivery models for our health system. The collective work programme of the West Coast Alliance is much wider than the activity reflected in this Statement of Intent and in our Annual Plan but activity across priority areas is strongly reflected throughout this document.

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 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 Canterbury specialists to provide regular outpatient clinics and surgical lists on the West Coast. 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 1,700 video and telemedicine consultations have taken place across oncology, paediatrics, plastics, orthopaedics, geriatrics, palliative care 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. This includes engaging with the Minister and seeking approval before making any significant service change, or capital investment, or disposing of Crown land.

The West Coast DHB also strives to maintain open communication with the Ministry of Health. This includes regular financial and performance reporting and a no surprises policy with regard to any significant service change or issue of public interest – positive or negative.

The DHB's reporting obligations include:

- Monthly financial reports
- Monthly wait time and elective services compliance reporting
- Quarterly service performance and health target performance reports
- Quarterly quality and adverse event reporting
- Quarterly updates on service delivery to plan
- Bi-annual risk reports
- Annual Quality Accounts.

The Crown Entities Act also requires DHBs to report annually to Parliament on their financial and service performance. We publish these audited financial and service performance accounts as our Annual Report. The Annual Report is available on the DHB's website www.westcoastdhb.health.nz.

Refer to Appendix 3 for DHB's legislative objectives.

In an average week on the West Coast

5 babies are born

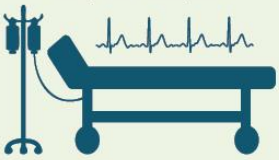
219 people attend ED

269 people attend specialist outpatient appointments

8 children receive a Before School Check (B4SC)

149 people are discharged from hospital

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



420 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

106 people receive brief advice to quit smoking

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

41 women have a cervical smear

94 children have a free dental check*

11 people receive brief intervention counselling in primary care*

68 people have a cardiovascular disease risk assessment

328 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

2.1 Population profile

The West Coast has the smallest population of any DHB in New Zealand and in 2016/17 will be home to 33,190 people, an increase of just 2.8% since 2006. Grey district has the largest population, with an estimated resident population of 13,371 people.

Our ageing population

Our population is older than the NZ average. By 2026, one in four people (23.5%) will be older than 65.

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 (17.7%) compared with the national rate (15%).

Many conditions become more common with age, including heart disease, stroke, cancer, and dementia. More people living longer is a successful outcome. However as we age we develop more complicated health needs, meaning we are more likely to need specialist services. The increasing average age of our population will put significant pressure on our workforce and infrastructure.

Projections for 2016/17 indicate that 5,860 people on the Coast are aged 65 or over and 2,350 are 75 or over. By 2026 one in every four people on the West Coast will be over 65 years of age (23.5%).

Ethnicity, like age, is also a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others.

There are currently 3,890 Māori living on the West Coast (11.7% of our population) and by 2026 Māori will represent 13.6% of our total population. We need to carefully consider the needs of our growing Māori population in our future planning.

Our population diversity

Our population is becoming more diverse. By 2026, 13.6% of our population will be Māori.

Deprivation is another indicator of the need for health services. The West Coast has a lower mean personal income compared to the rest of 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.

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 in primary care utilisation data.

The leading causes of mortality, morbidity and hospitalisations are all largely preventable.

A reduction in known risk factors, such as tobacco smoking, hazardous drinking, poor diet and lack of physical activity, could dramatically reduce the impact of many diseases, and prevent hospital admission or even premature death.

All four major risk factors also have strong socio-economic gradients, contributing greatly to health equalities between population groups.

The most recent results from the combined 2011-2014 New Zealand Health Survey found that:

- 22% 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.
- 31.8% of our adult population are classified as obese, 2% higher the national average.
- 16% of our population are likely to drink in a hazardous manner. While this rate is on a par with the national average (15.5%), it still amounts to more than one in every 10 adults.

As our population ages and becomes more ethnically diverse, the number of people living with long-term and complex conditions will increase.

By providing people with the knowledge, motivation and skills to avoid or improve their health and better manage their long-term conditions we will create opportunities to improve the overall wellbeing of our population and ease the demand on our health system.

2.3 Operating environment

GEOGRAPHICAL PRESSURES

Meeting the health needs of the West Coast population is a complex business, complicated by the challenges of delivering health services to a relatively small population over a large geographic area.

While our population is just 0.7% of New Zealand's estimated population, the total land area we cover is 23,283 square kilometres. Geographically we are the third largest DHB in the country.

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 DHBs. We are also the most sparsely populated, with a population density of just 1.4 people per km^2.

Our geography 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. 3.4% of West Coast households have no telecommunication systems (telephone or internet); this is the highest proportion of any region in New Zealand.

We're rural

From Karamea to Haast, West Coast DHB covers the same distance as Palmeston North to Auckland.

WORKFORCE PRESSURES

Our ability to meet future demand for services also relies heavily on having the right number of people, with the right skills. Like other DHBs, we have growing concerns over the availability of a sufficient workforce to meet the 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 suitable 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. While locums 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 also need to focus on the recruitment of senior staff with more generalist skills and the creation of roles with wider professional scopes to give stability to our services.

FACILITY PRESSURES

In their current configuration, our facilities are outdated, inefficient, and expensive to maintain. A number have been identified as earthquake-prone and require remediation to bring them above 33% of the current building code. In addition a number of our primary and community facilities are not appropriately located or configured to support an integrated service model or clinical team.

In 2014 approval was given for a new Grey Base Hospital and Integrated Family Health Centre (IFHC). The $77.8m redevelopment (originally $68m) is currently scheduled to be completed in 2018, under the governance of the Ministry appointed Hospital Redevelopment Partnership Group.

The new facilities will enable the delivery of more responsive and integrated health service models. Continued progress of the redevelopments is critical not only to ensure safety and service continuity, but to avoid the DHB having to over-invest in facilities that do not have a long-term future.

The development of the Buller IFHC is also a key priority and enabler of the full realisation of safe and sustainable service provision on the Coast. The DHB continues to work in collaboration with the Ministry of Health to bring to life the IFHC in Buller.

FISCAL PRESSURES

Numerous factors contribute to the fiscal pressure on the DHB including: the increasing demand for services, rising treatment and infrastructure costs, and wages and salary increases. Our ability to contain cost growth within affordable levels is made more difficult by increasing public expectations, the costs of new technology and demand for seven-day-a-week service.

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. 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 health gain.

2.4 Critical success factors

The following are areas where the greatest gains can be made in terms of improving both health and system outcomes. They also represent factors critical to our success, where failure would threaten the achievement of the objectives outlined in this plan and the future viability of our health system.

DOING THE RIGHT THINGS

Integrating services: High surgical intervention rates and overinvestment in secondary services have led to an over reliance on hospital-level services. Combined with a legacy of access and continuity issues across DHB-owned primary care services, this has created fragmentation across the system. Addressing the health and wellbeing of our population across the full continuum of care is the only way to get ahead of the demand curve, and is the foundation from which we will build a more effective and sustainable system.

Prioritising resources for greater impact: Because our resources are increasingly limited, we need to focus our efforts in a way that will have the biggest impact. It is critical that we continue to target and support our most vulnerable population groups. We also need to actively evaluate our performance and use data and evidence to ensure the initiatives we have in place are making a real difference in the health and wellbeing of our population.

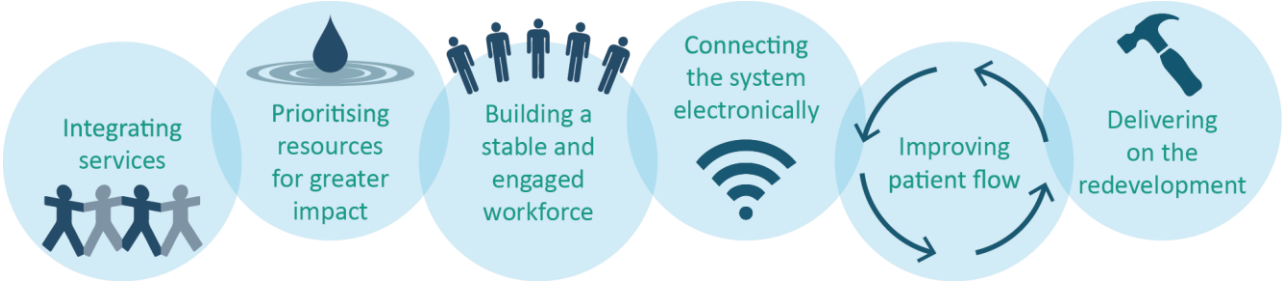
Building a stable and engaged workforce: Longstanding clinical recruitment and retention issues have led to high use of locums and temporary staff, reducing continuity and diminishing clinical and operational leadership capability. We need the right people, with the right skills, in the right place in order to move forward and adopt more integrated and effective models of care. We also need these people to be motivated and engaged to support genuine and lasting transformation. It is critical that we expand the capacity and capability of our workforce and ensure that our health system is a place people want to work.

DOING THINGS RIGHT

Connecting the system electronically: Unreliable paper-based information systems and poorly performing information technology platforms have led to inefficient service delivery, wasting clinical and patient time and reducing the continuity and safety of care. It is critical that we improve access to information that supports clinical decision-making and reduce waste and rework across our system. By providing the right care the first time, not only will we avoid unnecessary expenditure but people's experience and outcomes will be improved.

Improving patient flow: With a series of recent adverse events, assurances are needed about the quality of services being delivered and the safety of patients in our care. Long waits and long hospitals stays are linked to negative outcomes for patients. By improving the flow of patients through our system we can facilitate earlier diagnosis, provide faster access to treatment, and reduce the length of stays. Health outcomes will be better and public confidence and trust in the health system will grow.

Delivering on the redevelopment: Any delays in the construction of the Grey and Buller facilities will create additional financial and operational pressures, and waste resources that could be better invested into patient services. Careful consideration must also be given to choices made during the rebuild that will have future operational cost impacts for the DHB. The safety of our staff and patients and the transformation of our health system depends on the redevelopments being delivered within agreed timeframes and budgets.



Part II

Long-Term Outlook

Setting Our Strategic Direction

3.1 Strategic context

New Zealand's health system is generally performing well against international benchmarks. However, an ageing population and the growing prevalence of long-term conditions is increasing demand. At the same time financial and workforce constraints limit our capacity.

Alongside these health sector challenges, there is growing acknowledgement of the social determinants of health and conversely, the role good health plays in social outcomes. Health outcomes for our communities are interlinked with issues of education, employment, housing and justice, and we are increasingly being asked to take a broader view of wellbeing.

These pressures mean health services cannot continue to be provided in the same way. While hospitals will continue as settings for highly specialised care, we need to move away from traditional hospital-based models.

There are clear opportunities that are supporting the transformation of our health system: shifts towards earlier intervention, and investment in home and community based care, new technology and more connected information systems.

If we are to continue to improve health outcomes within current resources we need to further integrate and connect services, not only across the health system, but across all public services.

3.2 National direction

Acknowledging these challenges and opportunities, the long term vision for NZ 's health service is articulated through the NZ Health Strategy which intends to support all New Zealander's to 'live well, stay well, get well' and sets out five themes to give focus for change:

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

In supporting people closer to home, DHBs are expected to commit to Government priorities to provide better public services. In particular, 'better, sooner, more convenient health services', better public service results, and the building of a more productive economy.

DHBs are also guided by a range of population or condition specific strategies, including: He Korowai Oranga (Māori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Health of Older People Strategy, Primary Care Health Strategy, Mental Health and Addiction Service Development Plan (Rising to the Challenge), Cancer Strategy and Diabetes Strategy.

Alongside these longer-term directions, the Minister of Health's annual Letter of Expectations signals annual priorities for the health sector. In 2016/17 the focus is on:

- Implementing the NZ Health Strategy: DHBs need to be focused on the critical areas to drive changes that are identified in the Strategy
- Living within our means: DHBs must continue to consider where efficiency gains can be made and look to improvements through national, regional and sub-regional initiatives
- Working across government: Supporting vulnerable families and improving outcomes for children and young people is a priority, along with health's contribution to Better Public Service Results
- Delivering national health targets: while health target performance has improved, this needs to remain a focus for DHBs, particularly the Faster Cancer Treatment target
- Tackling obesity: DHBs are expected to deliver on the new health target to address childhood obesity and show leadership in working to reduce the incidence of obesity
- Shifting and integrating services: DHBs need to continue to work with primary care to move services closer to home and achieve better co-ordinated health and social services
- Improving health information systems: DHBs need to complete current national and regional IT investments and support the co-design process of the Health IT Programme 2015-2020.

The West Coast DHB is committed to the delivery of health sector goals and making progress against national targets. Activity prioritised in the coming year is highlighted in Part III of this Plan.

Our key deliverables have also been mapped onto the New Zealand Health Strategy Roadmap to highlight the alignment between the local and national direction.

Refer to the appendices for the Letter of Expectations, West Coast DHB's commitment to the Health Targets and key deliverables against the NZ Health Strategy.

3.3 Regional commitment

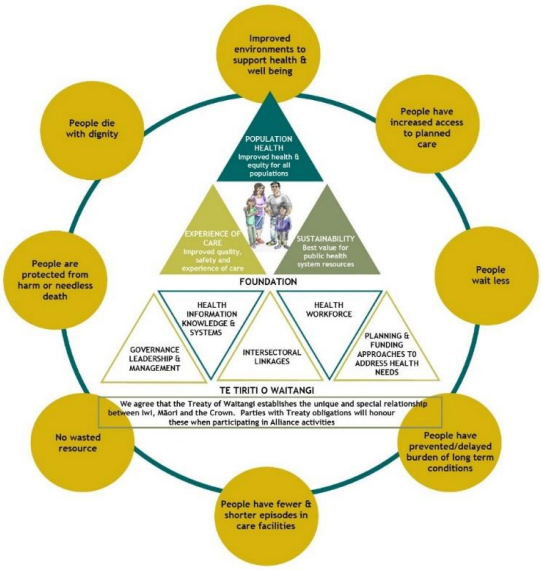
In delivering its commitment to better public services and better, sooner, more convenient health services the Government also has clear expectations of increased regional collaboration between DHBs.

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for over one million people, or 24% of the NZ population.

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.

With an annual budget of just over $6.2m, the Alliance is jointly funded by the South Island DHBs to provide services such as audit, regional service development and project management. West Coast's contribution for 2016/17 is $165,023.

The South Island Alliance helps to improve the system within which health services are delivered and the alignment between the individual South Island DHBs. Now entering its sixth year, the Alliance has proven itself as a successful model, bringing clinicians, managers, service providers, and consumers together to work towards the shared regional vision of *best for people, best for system.*



The Alliance outcomes framework defines what success looks like for South Island health services, and outcomes measures will be implemented this year, to track if we are heading in the right direction.

The *South Island Regional Health Services Plan* outlines the agreed regional activity for the next three years across seven priority service areas: cancer, child health, health of older people, mental health and addictions, information services, support services, and quality and safety.

In addition, regional workstreams will focus on: cardiac services, elective surgery, palliative care, public health, stroke, major trauma and hepatitis c pathways. Workforce planning, through the Regional Workforce Development Hub and regional asset planning, contribute to improved delivery in all service areas.

The West Coast DHB is involved in the regional Service level alliances and workstreams. The DHB's commitment in terms of the regional direction is outlined in Part III of this Plan.[1]

3.4 The West Coast vision

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.

The DHB has worked through a series of organisational reviews in the drive to secure a stable and sustainable future for health services on the West Coast. We have consulted 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 this vision is a fundamental reorientation of our current service model to put the patient and their needs at the centre and reduce unnecessary delays in their care and treatment.

Our vision is for an integrated West Coast health system that is clinically sustainable and financially viable, a health system that wraps care around the patient to help them stay well.

[1] *The South Island Regional Health Services Plan can be found at www.sialliance.health.nz.*

In line with our vision – the future model of care 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 both across services and across the wider West Coast health 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: Our 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.

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 already 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 is supporting more people to stay safe and well in their own homes.

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 services with Canterbury.

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.

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.

The redevelopment of our health facilities is also a critical factor in the future sustainability of West Coast health services. The DHB is working closely with the nationally 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 rapid response and supported discharge services to better support people at home and in community settings.

Locally delivered hospital-level services using both specialists and rural hospital medicine doctors, but 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 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.

Managing Our Business

We are required to deliver on a broad mandate to a diverse range of stakeholders. The values of our organisation, the manner in which we interact with others, and the investment choices we make are key factors in our success.

This section highlights our organisational strengths and the way in which we will manage our business to support our transformation and deliver on the collective goals of our health system.

4.1 A patient-focused culture

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

Part of our focus is on increased transparency and engagement, where longstanding frustrations have eroded confidence and trust. Our Chief Executive updates and 'Report to the Community' newsletters keep people informed of developments and provide opportunities for feedback and engagement.

Forums and community meetings have been held to provide updates on the transformation of our health system and enable us to hear and respond to the views and concerns of our community.

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

Canterbury DHB's award winning staff leadership programmes: 'Xcelr8', 'Particip8' and 'Collabor8' have been adopted to promote lean thinking approaches to service and system redesign and support the development of a culture that focuses on the patient.

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 helping to attract and retain staff by promoting workforce satisfaction and engagement.

4.2 Effective 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 leader's attendance at Board and committee meetings to provide advice and input as required.

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

CONSUMER PARTICIPATION IN DECISION-MAKING

There are a number of consumer 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. As an advisory group to the DHB, the Council supports a partnership model that ensures a strong and viable voice for consumers.

The DHB is also increasing consumer engagement across the West Coast Health Alliance. Both Reefton and Buller Workstreams have consumer representatives and the Grey Workstream will be next to seek consumer input.

CLINICAL PARTICIPATION IN DECISION-MAKING

Viewing clinical leadership as intrinsic to our success, we engage health professionals from across our system in service redesign and the development of new models and integrated patient pathways.

The DHB has a Clinical Board that advises the Chief Executive on clinical issues and takes an active role in setting clinical standards and encouraging best practice and innovation. Members support and influence the DHB's vision and play an important role in raising the standard of patient care.

The West Coast Health Alliance Leadership Team is also a clinically-led governance group, and clinical leadership is established across all of its associated workstreams and service level alliances.

Clinical leadership is further facilitated by the DHB's three Medical Directors, the Director of Nursing and Midwifery and Executive Director of 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. We also support 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 delivers a Māori Health Action Plan. This Māori Health Action Plan sits alongside our Annual Plan and identifies how improvements will be made in Māori health 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.

4.3 Successful partnerships

Our vision is wider than just the DHB. Working collaboratively is enabling us to respond to the changing needs of our population and is a critical factor in achieving the objectives set out in this plan

WEST COAST ALLIANCE

In 2011 we established the West Coast Health Alliance. The Alliance brings together health professionals and providers from across the West Coast to enable collaborative service planning and design, and to determine the appropriate models of care for our health system. Together, we are working to improve the delivery of health service on the West Coast and to realise opportunities to transform and integrate our health system.

The overarching purpose of the Alliance is to provide people with quality care, closer to their own homes, in a way that allows them to play an active role in managing their health. This includes the establishment of Integrated Family Health Services (IFHS) and Community Hubs, the development of integrated patient pathways and the strengthening of clinical leadership as a fundamental driver of improved patient care.

Central to our Alliance are a number of clinically-led workstreams and service level alliances that identify and recommend new models of care and service improvements. The Alliance workstreams also support the delivery of national expectations including achievement of the national health targets. The Alliance work programme for 2016/17 is reflected throughout this Plan.

For a summary of the priority areas of focus for the Alliance refer to Appendix 10.6.

CROSS SECTORAL COLLABORATION

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 local and regional councils, Housing New Zealand, ACC, Police 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, Health Promotion Agency, PHARMAC and NZ Health Partnership Limited for the benefit of our population and the wider health system.

4.4 Commitment to quality

Over the last several years, we have sharpened our focus on improving the quality and safety of the services provided by the West Coast DHB.

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.

With a culture of reporting well established, safety issues are becoming more 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) is assisting in identifying trends and real time tracking of events, allowing us to examine incidents as they happen and take action to improve quality and safety.

The national HQSC Quality and Safety markers continue to be part of the set of measures used by our governance groups to monitor the effectiveness of our improvement activity. Performance against the HQSC markers is reported to the West Coast DHB's Clinical Board and to the Board's Quality, Finance, Audit and Risk Committee. They are also reported annually in the DHB's Quality Accounts.

In the coming year, in line with the national HQSC direction, our Clinical Board will champion quality and safety projects focused in the following areas:

Consumer engagement: By working in partnership with consumers we gain insight from their experience. The DHB is gathering patient stories and surveying patients using the national survey and we plan to further increase participation rates this year. This information is reported at department level and used to direct quality improvement activities.

Preventing healthcare-associated infection: Hospital admissions expose patients to potential harm through healthcare-associated infection. The DHB is committed to minimising this risk in three particular areas of focus (in line with the HQSC priorities): Hand Hygiene, Line-Associated Bacteraemia and Surgical Site Infections.

Reducing falls: Reducing the harm caused by falls is a key component of our strategy for improving the health of older people. In our hospitals, we pay close attention to fall prevention and the specific falls risk for each patient in our care. We have standardised falls alert visual cues and Safe Mobility Plans for each patient and will soon introduce an electronic nursing patient observation system to record falls risks and assist with adherence to protocol and prevention activity. In the coming year we will also introduce a Fracture Liaison Service and community-based Falls Prevention Programme to better support those at risk of falling.

Medication safety: The use of medications always carries the risk of a side effects or adverse outcome. We are participating in the national medicine reconciliation, electronic medicines management and the opioid campaign initiatives being driven through the HQSC. The national Medication Chart has been adopted in all acute clinical areas and we are participating in the HQSC-led medicine reconciliation programme with patients' medicine reviewed at admission, discharges and transfer.

Surgical safety The West Coast DHB has also adopted the Surgical Safety Checklist, which is used in surgical procedures to minimise the risk of harm. A surgical working group will be established to lead and promote surgical teamwork and communication using the Checklist. We will collaborate with our South Island colleagues in the introduction of the brief-debrief approach and utilise the performance measures to drive improvement.

4.5 Investment in people

The delivery of our vision relies heavily on having the right people, with the right skills, in place right across our health system. We also need those people to be aligned with a common purpose, and well supported to make the most of their skills and talents.

WELLBEING, RESILIENCE AND SAFETY

Workforce wellbeing and resilience has emerged, alongside leadership capability, as both our biggest challenge and our biggest opportunity.

Changes to the Health and Safety in Employment Act also came into effect April 2016, materially extending organisational accountability and liability in relation to workplace safety.

We have responded to these challenges by creating a Wellbeing, Health and Safety Team. The Team will focus on the development and implementation of a Wellbeing Strategy to support our staff and health and safety policy, strategy and resources to support the business.

It is intended that through these changes we will better support existing wellbeing initiatives within a broader Wellbeing Strategy for the organisation over the longer-term. We also aim to provide clarity in relation to accountability and responsibility for strategic and operational wellbeing and health and safety and support the business with appropriate policy, strategy and resources.

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

The DHB has reviewed its Child Protection Policy against changes to Vulnerable Children's Legislation and will implement appropriate safety checking requirements in line with the Legislation.

We are supportive of national employment engagement process and meet regularly with unions to discuss issues of mutual interest. Active participation in the national Employment Relations Strategy Group helps to establish parameters to ensure bargaining will deliver on both sector and organisational expectations.

LEADERSHIP CAPABILITY

Leadership capability exists within the system, and has supported some stunning successes in patient care and system integration. As we continue to do more and strive to continuously improve, we will work with our people to further enhance their leadership and capability.

Our programmes include:

- 2020 leaders – a peer support leadership model
- Xcelr8 – a programme that enhances the ability of established leaders to pick up the pace of change, excel in leadership and management, and to do more with what we already have
- Particip8 – a programme that empowers emerging leaders and innovators to influence others, and learn to work together to make an effective difference
- Collabora8 – a programme that introduces frontline staff to Lean Thinking.

We have stepped up our participation in the Health Workforce NZ sponsored South Island Workforce Development Hub to support critical role identification and expand workforce capability through sharing of training resources right across the health sector.

E-Learning is also incorporated into our developmental approach to building capability. We will continue to develop HealthLearn, a standardised online learning platform that can be customised to the different development needs of our workforce.

ENABLEMENT OF LINE MANAGEMENT AND STAFF

Continuing to build the capability of line managers and staff is necessary to support the next stages in our transformation journey.

We have increased senior people and capability leadership resources in the business by assigning operational responsibilities to three newly created People and Capability Managers.

These roles will work with line managers and staff within the business, to enable and support the management of operational employment matters.

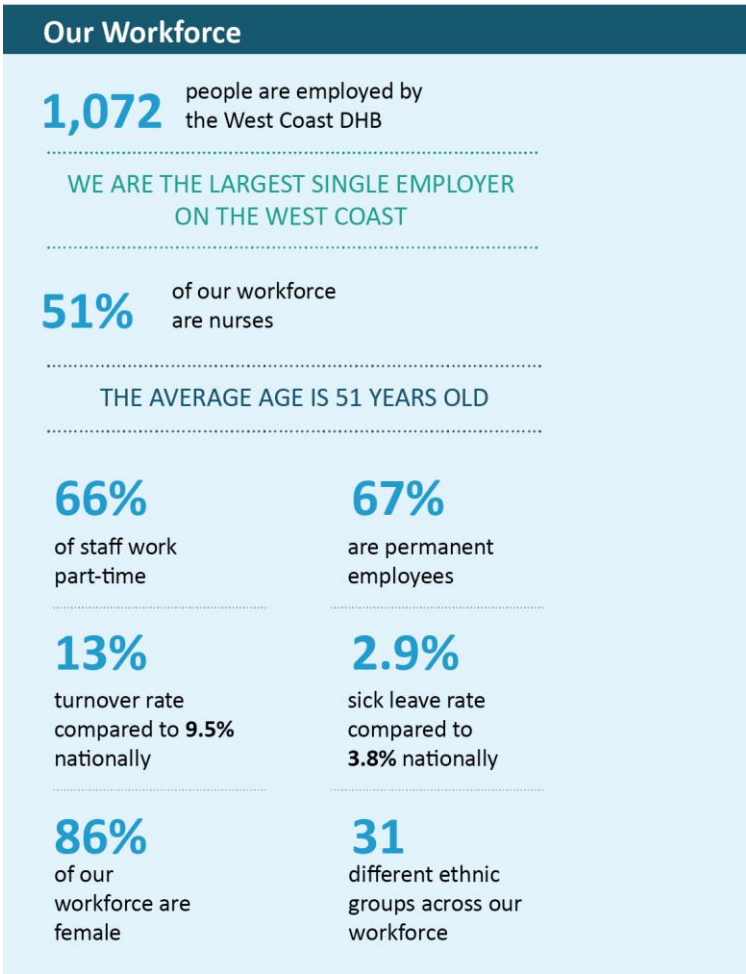
EXPANDING OUR WORKFORCE CAPACITY

We continue to strengthen our interactive and targeted recruitment strategies, including branding, profiling and Facebook to keep people connected. We also identify available talent through national and regional initiatives, links with the education sector, and support for internships and increased clinical placements in our hospitals.

We recognise that growing our rural clinical workforce is key to our ongoing transformation. We continue to invest in the Rural Learning Centre in Greymouth. The aim is to encourage people to work in rural locations by reducing isolation factors through peer support and mentoring.

We seek to increase the number of Māori in our health workforce by engaging in Kia Ora Hauora, a national initiative aimed at increasing the number of Māori working in health fields.

We also continue to work closely with Canterbury DHB and the Workforce Development Hub to supplement West Coast-based clinical support and services with joint appointments.



4.6 Information solutions

Connecting our health system electronically is central to our vision. Improved access to patient information at the point of care enables more effective clinical decision-making, improves standards of care and reduces the time people spend waiting.

Information systems are a national priority, and DHBs are taking a collective approach to implementing the national Health Information Technology (IT) Plan. The South Island DHBs have collectively determined strategic actions to deliver on the Plan and we are committed to this approach.

The West Coast DHB has already adopted several key regional information systems, such as Health Connect South, HealthOne and the Electronic Referral Management System (ERMS). Over the next four years we will replace our old hospital-based patient administration system with a new supported system in line with the rest of the South Island.

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.

Our transalpine collaboration with Canterbury also makes it increasingly important to enable seamless integration. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs and by the end of the year will have a unified IT team across both DHBs.

Further detail on the regional direction can be found in the South Island Regional Health Services Plan but investment for 2016-2019 includes:

The South Island Patient Information Care System (PICS) will replace the isolated legacy systems. This new regional patient administration system will further integrate systems throughout the South Island. The West Coast will be moving to the new system in 2016/17 following Canterbury going live.

The Electronic Referral Management System (ERMS) enables general practices to send referrals electronically from their desktops. West Coast was the first DHB other than Canterbury to introduce this system and in the coming year will look to support e-triaging.

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 deploy ePharmacy and eMedications Reconciliation in the coming year.

The National Maternity Clinical Information System is an information system for maternity that will link relevant information collected about a woman and her baby from pregnancy until her baby is 4-6 weeks old. In accessing the system all relevant health care providers including midwives, GPs, hospital based doctors, specialists and nurses can work together effectively. The DHB will implement the Maternity Information System in the first half of this year.

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), and Phase II (non-admitted and associated referral information including diagnostic tests) and will begin Phase III this year.

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 West Coast Primary Health Organisation (PHO) to develop and implement a Patient Portal which will be available to West Coast patients.

4.7 Facilities Redevelopment

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 health services are delivered in order to improve both the clinical and financial 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. There are also a number of seismic issues that need to be addressed.

In December 2012 the Minister of Health appointed the Hospital Redevelopment Partnership Group to govern the West Coast facility redevelopment and provide oversight of the programme and budget.

The, Government has an approved budget of $77.8m (originally $68m) for the new Grey Base Hospital and IFHC, including $4.6m for a new energy centre and $1m to cover demolition costs.

Led by clinicians, the facility design will enable the delivery of modern integrated health care on the West Coast. The new facilities will support the new model of care ensuring people living on the Coast have access to the right services, in the right place and at the right time, to enable them to stay well and in their own homes and communities for longer.

When completed the Grey Base Hospital facility will incorporate:

- Integrated inpatient ward
- Pharmacy
- New operating theatres
- A critical care unit
- New radiology department
- Maternity services with 24/7 obstetric cover
- Emergency department
- Acute observation area
- Paediatric in-patient area
- Allied health
- 24 hour urgent care.

The facility also includes an Integrated Family Health Centre (IFHC), which will collocate primary care and outpatient services as well as an infusion service.

In order to avoid costly and wasteful investment, continued progress and careful consideration of the operational impacts of the redevelopment is essential. The DHB is working with the Ministry of Health, and the Partnership Group, to ensure that delays and cost impacts are minimised.

Anticipated activity for 2016-2019 includes:

Grey Base Hospital and IFHC: The design of the facility is now complete and site works for the new Grey Base Hospital and IFHC began in May 2016, with a planned completion date for in the second quarter of 2018.

Buller IFHC: Focus in next few years will also be on the development of facilities required to support more integrated health service in Buller. The DHB undertook significant engagement with the Buller community in 2015 to talk about a new IFHC and how this will function. The DHB and clinical teams have worked together with an appointed design team to develop a full concept design and an implementation business case has been developed to bring this facility to life.

4.8 Service reconfiguration

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

The West Coast DHB works to identify service coverage gaps and risk through the monitoring of performance indicators, risk reporting, formal audits and complaint 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 2016/17.

SERVICE REDESIGN AND RECONFIGURATION

In line with our vision, we are engaged in continual improvement and transformation.

We are working with our primary and community partners to redesign the way we deliver health services to better meet the needs of our population, improve the quality of service delivery, and ensure the sustainability of our health system.

We anticipate that new models of care and service delivery will emerge as we respond to the changing needs of our population and in line with the development of our new integrated models of care in Greymouth and Buller.

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

The DHB recognises its obligations under the national operational policy framework to notify the Minister of Health with respect to any significant service change and will continue to do so.

At times, we may wish to enter into cooperative arrangements or service agreements to assist in meeting our objectives and goals as outlined in this document. In doing so (in accordance with Section 24(1) and Section 25 of the NZPHD Act 2000), we will ensure that any arrangements or agreements 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.

ANTICIPATED SERVICE CHANGE FOR 2016-2017 INCLUDES:

TYPE OF SERVICE CHANGE	DESCRIPTION OF SERVICE CHANGE	AREA IMPACTED BY SERVICE CHANGE
Internal service reconfiguration	Reconfiguration of organisational structures to support new ways of working in the new facilities and to support greater integration across hospital and general practice services. This includes service shifts and relocations following the completion of the Buller and Grey IFHC and hospital redevelopments.	▪ Services on the Buller and Grey campuses and three DHB-owned general practices.
Internal service redesign	Internal service redesign to improve capacity, safety or access including the redesign of service models and patient pathways. This includes service changes in line with the clinically-led service review recommendations for maternity, mental health and older person's health services.	▪ Older person's health and aged care services ▪ Specialist mental health services
System-wide service redesign and integration	System-wide service integration and the redesign of models of care to ensure we have the capacity to sustainably meet service demand and improve individual and population health outcomes. This includes primary/secondary pathways for planned, unplanned and acute care in line with the redevelopment of facilities in Grey and Buller, under the guidance of the Alliance IFHC Workstreams.	▪ Primary and community NGO mental health services ▪ Home and community-based support services ▪ Primary and community acute services and the ED service interface
Regionally-driven change to service delivery model or service location	Regionally-driven service redesign or reconfiguration to support equity of access, sustainability of vulnerable services and the adoption of consistent regional pathways in line with the South Island Regional Health Services Plan. This includes the redesign of service models to support the adoption of collaborative transalpine pathways between West Coast and Canterbury DHBs.	▪ Hepatitis C services ▪ Cancer services ▪ General medicine ▪ Anaesthesia services ▪ Mental health services ▪ Child and youth services
Nationally driven service change	Nationally driven service redesign or reconfiguration to align with national policy or legislation changes, a change in national service specifications or a refocus of national funding.	▪ Pharmacy services ▪ Obesity-related services ▪ Smoking cessation services

Monitoring Our Performance

HOW WE KNOW WE ARE MAKING A DIFFERENCE

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

Together with the other four South Island DHBs, we have identified three high-level strategic objectives where we can influence change and where success will have a positive impact on the health of our community and the effectiveness of our health system.

- People are healthier and take greater responsibility for their own health
- People stay well in the own homes and communities
- People with complex illnesses have improved health outcomes.

Because there is no single measure that will demonstrate the impact of the work we do, we have identified a core set population health and service performance measures that will provide an insight into how well our health system is performing. Tracking our performance against these indicators will help us to evaluate our success.

Six of the identified measures are outcomes indicators where success will be evident over the longer-term. As such, the aim is for a measurable change in health status over time, rather than a fixed target.

The remainder are seen as contributory measures, where our performance will have a measurable impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been identified as the main measures of performance.

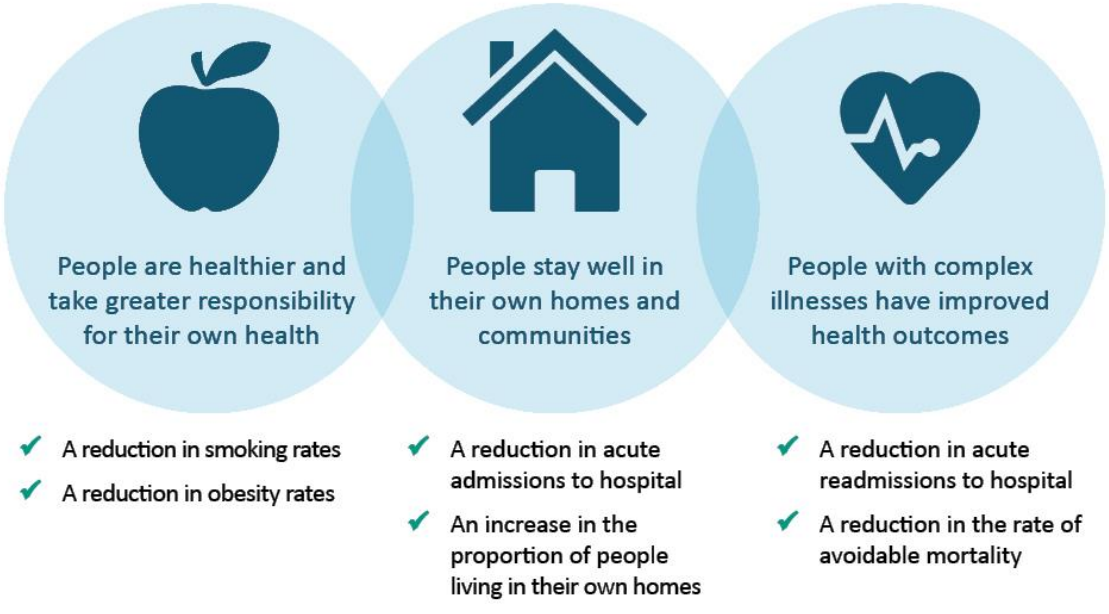
We have set standards (or targets) against the contributory measures in order to evaluate our performance and determine whether we are moving in the right direction.

All of the indicators will be monitored alongside our forecast of service performance, and reported in our Annual Report at the end of the year.

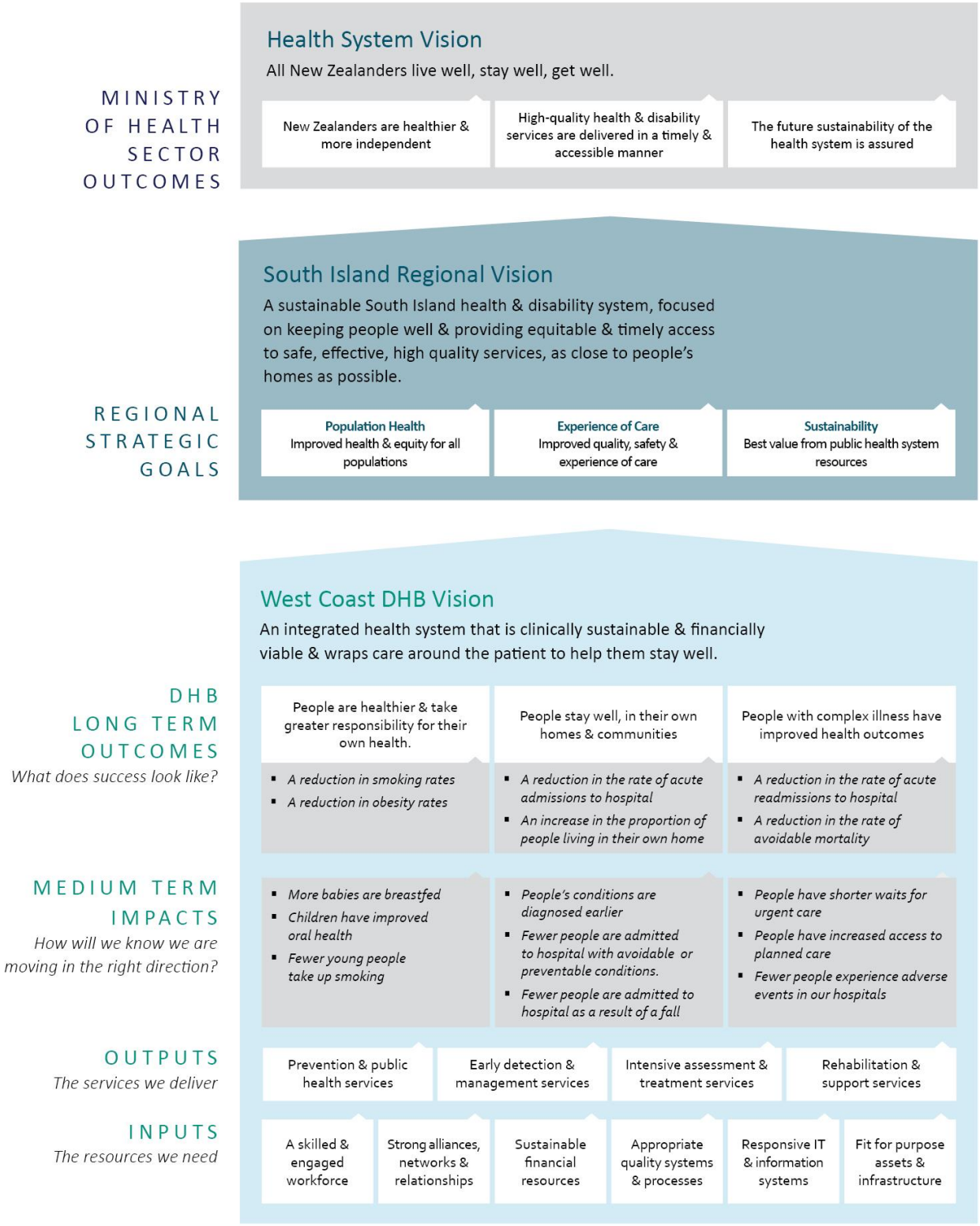
The fifteen performance measures selected were deliberately chosen from existing national reporting frameworks and data sources to enable regular monitoring and comparison with other DHBs to give context to our performance.

The intervention logic on the following page illustrates how the services that we fund or provide (outputs) will have an impact on the health of our population, result in the longer-term outcomes desired, and deliver the expectations and priorities of Government.

As part of our obligations under legislation DHBs must also work towards achieving equity. To promote this goal, the targets set against each of the performance indicators are the same across all population groups.



Overarching Intervention Logic



Te Tiriti O Waitangi

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

Strategic Outcome Goals

5.1 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 cardiovascular disease, diabetes, and cancer. These conditions are major drivers of poor health and account for a significant proportion of presentations across primary and hospital 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. Long-term conditions are also more prevalent amongst Māori and Pacific people and closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major risk factors for a number of the most prevalent long-term conditions. These are avoidable risk factors and investment in public health, promotion and prevention services will support and encourage people to make healthy choices and help drive down rates of heart disease, diabetes and cancer.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

LONG-TERM OUTCOMES INDICATORS

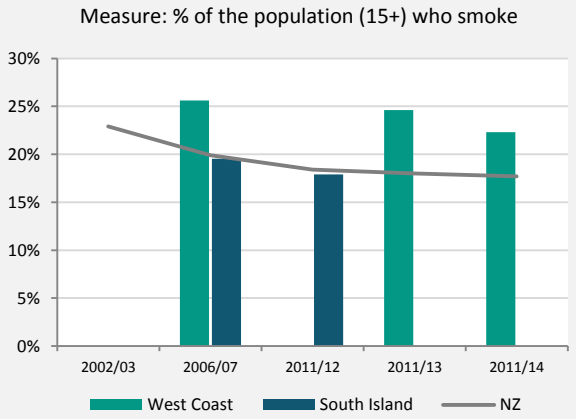
Outcome: A reduction in smoking rates

Tobacco smoking kills an estimated 5,000 people in NZ every year and is a major risk factor for the leading causes of death worldwide. Smoking is also a major contributor to preventable illness and long-term conditions, such as heart and respiratory disease and cancer.

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

Supporting people to say 'no' to smoking is our foremost opportunity not only to improve overall health outcomes but also to reduce inequalities in the health of our population.

Data source: National NZ Health Survey [2]



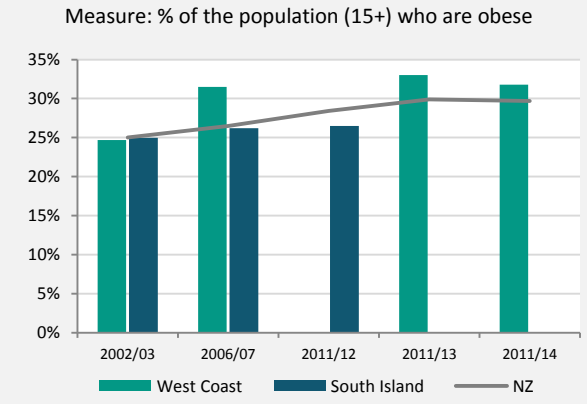
Outcome: A reduction in obesity rates

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

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

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

Data source: National NZ Health Survey [3]



[2] *The NZ Health Survey is completed by the Ministry of Health, surveys are combined year-on-year in order to provide more robust results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity. The 2013 Census results (while not directly comparable) demonstrates smoking rates amongst Māori are dropping but remain significantly higher than other population groups — 34.3% of West Coast Māori (15+) identified as regular smokers compared to 20.5% of the total population.*

[3] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.*

INTERMEDIATE IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

Impact: More babies are breastfed

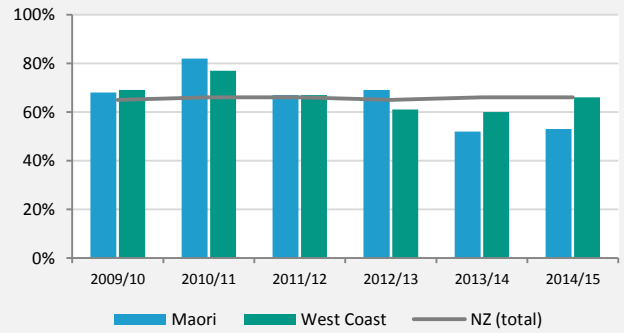
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

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

Appropriate access to support services and a change in both social and environmental factors influence breastfeeding behaviour and support healthier lifestyle choices. An increase in breastfeeding rates can therefore be seen as a proxy indicator of the success of our health promotion and engagement activities.

Data source: Plunket [4]

Measure: % of babies exclusively or fully breastfed at 6 weeks	Base	Target			
	14/15	16/17	17/18	18/19	19/20
	66%	75%	>75%	>75%	>75%



Impact: 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.

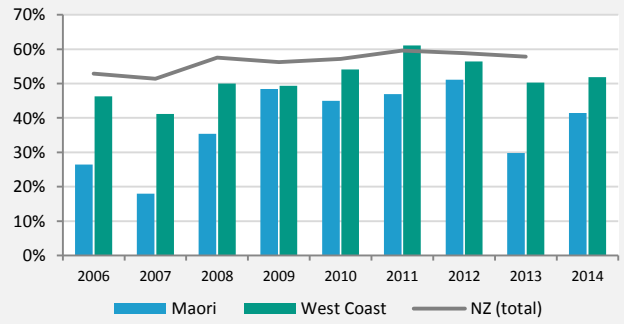
Good oral health not only reduces unnecessary hospital admissions but also signals a reduction in risk factors, such as poor diet, which have lasting benefits in terms of improved nutrition and health outcomes.

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

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

Data Source: School and Community Oral Health Services [5]

Measure: % of five-year-olds caries free (no holes or fillings)	Base	Target			
	2014	2016	2017	2018	2019
	52%	57%	58%	>58%	>58%



Impact: Fewer young people take up smoking

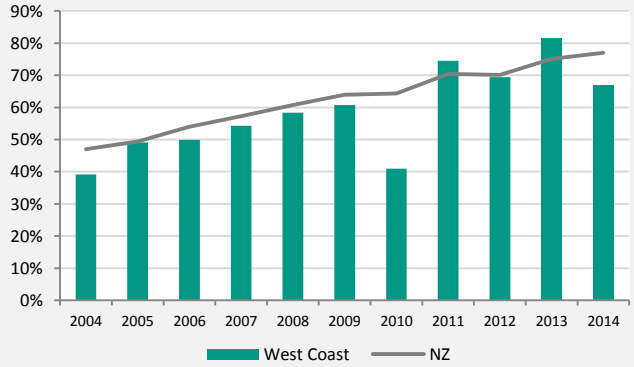
The highest prevalence of smoking is amongst younger people and reducing smoking rates across the total population is largely dependent on preventing young people from taking up smoking.

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

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

Data Source: National Year 10 ASH Snapshot Survey [6]

Measure: % of Year 10 students who have never smoked	Base	Target			
	2014	2016	2017	2018	2019
	67%	75%	>75%	>75%	>75%



[4] *Well-Child/Tamariki Ora breastfeeding data is currently not able to be combined so performance data from the largest provider (Plunket) is presented. While this covers the majority of mothers, because the smaller Well-Child/Tamariki Ora providers primarily target Māori and Pacific mothers - results for these ethnicities are likely to be under-stated. The target is based on national standards for breastfeeding at 6 weeks.*

[5] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.*

[6] *The ASH Survey is a national survey used to monitor student smoking since 1999. Run by Action on Smoking & Health it provides an annual point preference snapshot of students aged 14 or 15 years at the time of the survey – see www.ash.org.nz.*

5.2 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 achieve better health outcomes at a lower cost than countries with systems that focus on specialist level care.

Our investment in general practice is enabling the DHB to deliver services faster and closer to home, with improved access leading to early detection, diagnosis and treatment. The general practice team is also a vital point of ongoing continuity, particularly in terms of improving care for people with long-term conditions.

Health services also play an important role in supporting people to regain functionality after illness and to remain healthy and independent in their own homes. 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 service agencies that can further support them to stay well, out of hospital, and in own homes.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

LONG-TERM OUTCOMES INDICATORS

Outcome: A reduction in acute hospital admissions

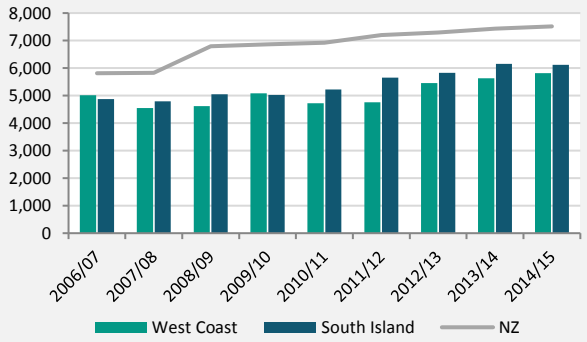
Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and premature death.

Reducing acute admissions also has a positive effect on the health system, enabling more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care.

Lower acute admission rates are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatment in the community.

Data Source: National Minimum Data Set

Measure: Rate of acute medical admissions into hospital (age standardised, per 100,000)



Outcome: More people living in their own home

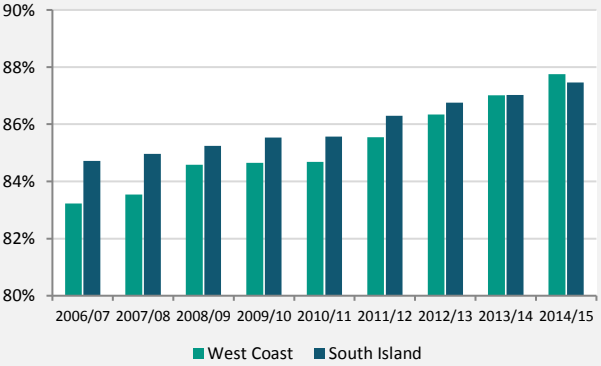
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes when people remain in their own homes and positively connected to their local communities.

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

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

Data Source: SIAPO Client Claims Payment System [7]

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



[7] *The 2013/14 and 2014/15 results for this measure differ from those previously published following a reset of population numbers in December 2014 to align with the 2013 Census results rather than the 2006 Census predictions.*

INTERMEDIATE IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

Impact: Conditions are diagnosed earlier

By improving clinical decision-making, timely access to diagnostics enables early and appropriate intervention improving both the quality of care and outcomes for our population.

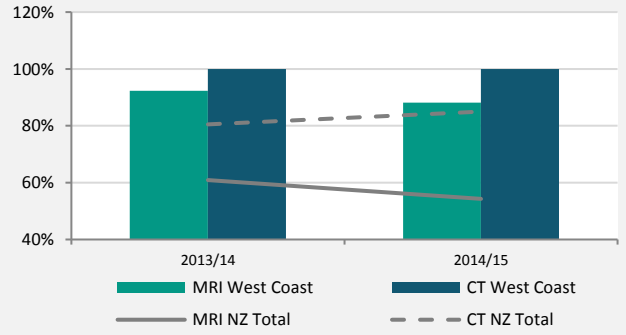
People also want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

Wait times for diagnostics therefore can be seen as a proxy indicator of the effectiveness of our health system, particularly when we are seeking to minimise wait times while meeting increasing demand.

Data Source: Individual DHB Patient Management Systems

Measure: % of people waiting less than 6 weeks for CT/MRI scans

	Base	Target			
	14/15	16/17	17/18	18/19	19/20
MRI	88%	85%	85%	85%	85%
CT	100%	95%	95%	95%	95%



Impact: Fewer avoidable hospitalisations

A number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, early intervention and the effective management of long-term conditions - including improved coordination of care across primary and secondary services.

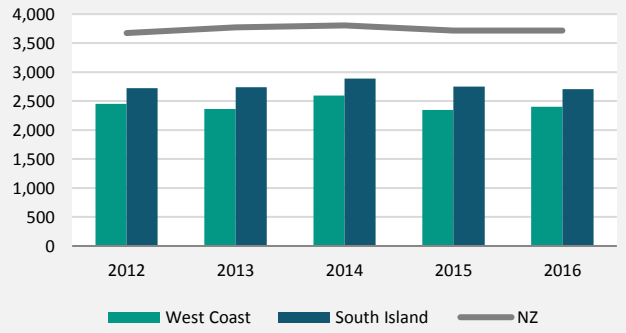
Not only will a reduction in avoidable admissions demonstrate improved health outcomes for our population but it will also reduce unnecessary pressure on our hospital services.

This indicator is seen as both a proxy measure of the accessibility and quality of primary care services and a marker of a more integrated and connected health system.

Data Source: Ministry of Health Performance Reporting [8]

Measure: Rate of avoidable hospital admission for adults (45-64)

Base	Target			
14/15	16/17	17/18	18/19	19/20
2,401	<2,401	<2,401	<2,401	<2,401



Impact: Fewer falls-related hospitalisations

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

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

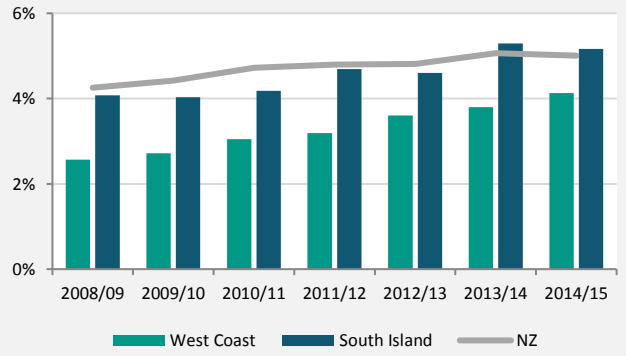
Solutions to preventing falls include: appropriate medications use, improved physical activity and nutrition, restorative support and a reduction in personal and environmental hazards.

Lower fall rates are used as a proxy indicator of the responsiveness of our 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 [9]

Measure: % of the population (75+) admitted to hospital as a result of a fall

Base	Target			
14/15	16/17	17/18	18/19	19/20
4.1%	<4.9%	<4.9%	<4.9%	<4.9%



[8] This measure is a national DHB performance indicator (SI1) and covers hospitalisations for conditions considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the target is set to reduce equity between population groups. Results differ to those previously published, following a reset of the definition by the Ministry of Health in 2016. Performance data was provided nationally to all DHBs and the baselines are to March.

[9] This measure has been reset to reflect updated national ICD code definitions, so results differ to those previously published. From 2013/14 results also reflect the updated 75+ population in line with the 2013 Census. The target has been set to remain below the national average.

5.3 People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in supporting recovery or slowing the progression of illness. This leads to improved health outcomes with restored functionality and a better quality of life.

As providers of hospital and specialist services, DHBs are operating under growing demand and workforce pressures. At the same time, Government is concerned that patients wait too long for specialist assessments, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity to demand by managing the flow of patients through its 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 we have capacity to provide for the complex needs of our population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, ineffective treatment or unnecessary waits can cause harm, resulting in longer hospital stays, readmissions and complications that have a negative impact on the health of our population.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

LONG-TERM OUTCOMES INDICATORS

Outcome: A reduction in acute readmissions

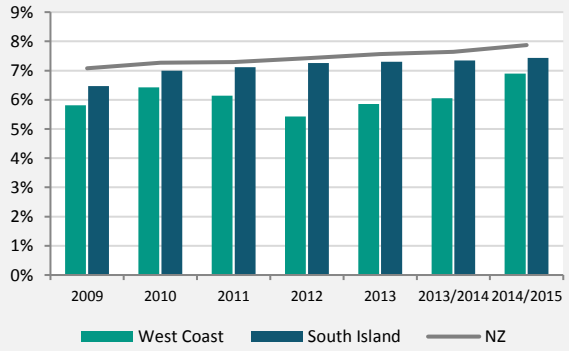
As well as reducing public confidence and driving unnecessary costs - patients who are readmitted to hospital are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

The key factors in reducing acute readmissions include improved patient safety and quality processes, and improved patient flow and service integration. Ensuring people receive effective (and safe) treatment in our hospitals, as well as appropriate support and care on discharge.

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

Data Source: Ministry of Health Performance Reporting [10]

Measure: Rate of acute readmissions to hospital within 28 days of discharge



Outcome: A reduction in avoidable mortality rates

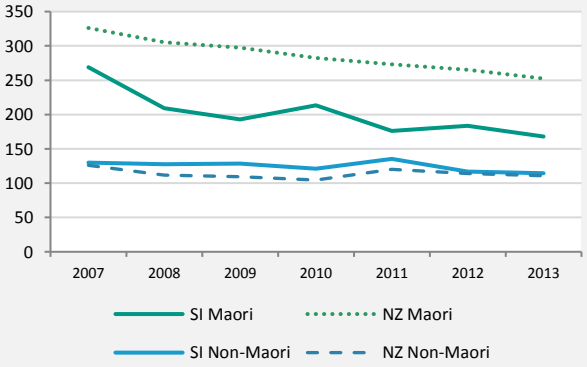
Upstream determinants of population health, such economic, social and environmental conditions have an influence on premature mortality rates (death before age 65). However premature mortality is partly preventable through lifestyle change, earlier intervention and the effective management of long-term conditions.

Timely and effective diagnosis and access to safe and effective treatment are also crucial factors in improving survival rates for complex illnesses such as health disease and cancer.

A reduction in avoidable mortality rates can therefore be used as a proxy indicator of the responsiveness of the whole of our health system to the needs of people with complex illness, and a measure of access to timely and effective care and treatment.

Data Source: National Mortality Collection [11]

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



[10] This measure is a national DHB performance indicator (OS8), results differ to those previously published following a reset of the definition by the Ministry of Health in 2016. Because the definition is still undergoing further review the DHB has elected to present the 'raw' or unstandardised rate as this is easier to replicate and match against local admissions and therefore enables closer analysis of performance.

[11] The performance data presented is the most current available, sourced from the national mortality collection which is three years in arrears.

INTERMEDIATE IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

Impact: Shorter waits for urgent care

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

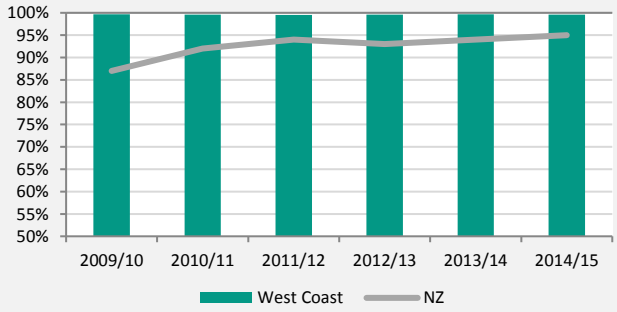
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by enabling early intervention and treatment but will improve public confidence and trust in our health services.

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

Data Source: DHB Patient Management System [12]

Measure: % of people admitted, discharged or transferred from ED within 6 hours

Base	Target			
14/15	16/17	17/18	18/19	19/20
100%	95%	95%	95%	95%



Impact: Shorter waits for specialist care

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

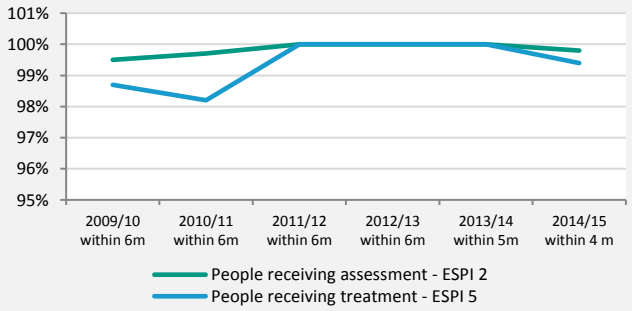
Improved performance against this measure requires us to make the most effective use of our resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

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

Data Source: Ministry of Health Elective Services Website [13]

Measure: % of people receiving assessment and treatment within 4 months

Base	Target			
14/15	16/17	17/18	18/19	19/20
ESPI2 99.8%	100%	100%	100%	100%
ESPI5 99.4%	100%	100%	100%	100%



Impact: Fewer adverse events

Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs.

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

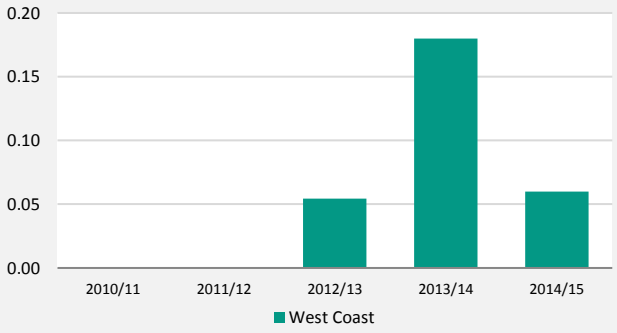
Improving patient safety and quality standards in our hospitals will greatly improve outcomes for our patients.

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

Data Source: DHB Incident Reporting System [14]

Measure: Rate of SAC level 1 & 2 falls

Base	Target			
14/15	16/17	17/18	18/19	19/20
0.11	0.05	0.05	0.05	0.05



[12] This indicator is the national DHB 'Shorter Stays in ED' health target and results differ slightly from previous results to align with national reporting which presents the final quarter (Q4) as the year-end result. The previously published result (99.5%) was across the full year and also included urgent presentations in Buller.

[13] The Elective Services Patient Flow Indicators (ESPIs) are nationally DHB performance measures. Monthly performance reports are provided by the Ministry of Health. In line with ESPIs target reporting the results presented are those from the final month of the year.

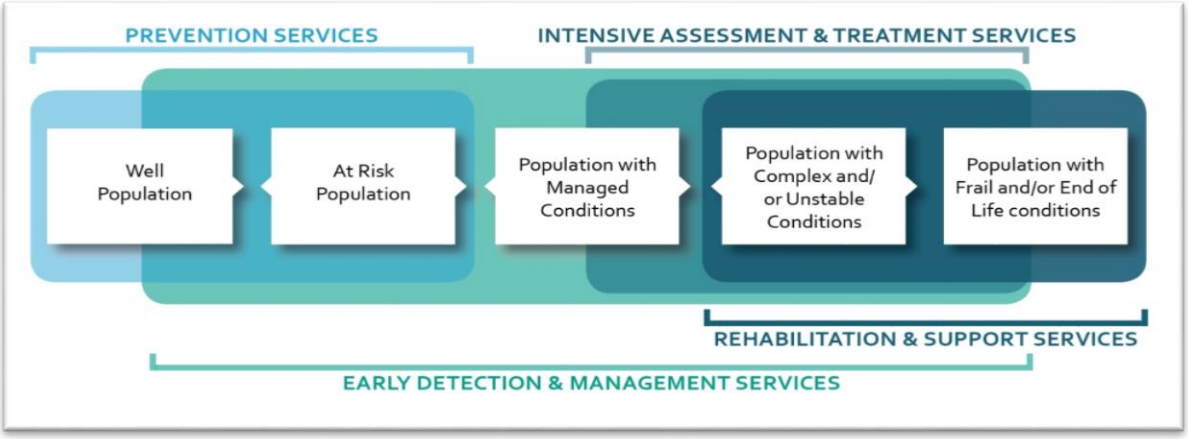
[14] The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest likelihood and consequence. The rate is per 1,000 inpatient beds and small numbers on the West Coast have a disproportionate impact on results. The 2013/14 result relates to 6 incidents and the 2014/15 result to 2.

Part III

Annual Operating Intentions

Statement of Service Performance Expectations

How will we demonstrate success?



EVALUATING OUR PERFORMANCE

As the both the major funder and provider of health services on the West Coast, the decisions the DHB makes about which services will be funded, and at what level, have a significant impact on people's health and wellbeing.

Understanding the dynamics of our population and the drivers of demand are key when making these decisions. Just as fundamental is our ability to evaluate whether the services we are purchasing and providing are making a measureable difference.

Over the medium and longer term we evaluate the effectiveness of the decisions we make by tracking our performance against a set of desired population health outcomes, highlighted earlier in this document.

We also evaluate our service performance by providing an annual forecast of the services we plan to deliver and the standards we expect to meet. The following service statement presents our anticipated delivery for the 2016/17 year. We will report actual performance against this forecast in our year-end Annual Report.[15]

Services have been grouped into four service (or output) classes that are a logical fit with the continuum care. These are: prevention services; early detection and management services; intensive assessment and treatment services; and rehabilitation and support services (illustrated above).

Because it would be overwhelming to measure every service delivered, for each service class we have chosen a set of indicators which we believe are important to our community and stakeholders and that provide a fair representation of how well the DHB is performing.

In presenting our performance picture, we do not simply measure volumes of services delivered. 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, or whether the service was delivered at the right time. We have therefore chosen a mix of indicators that address four key aspects of our performance: Volume (V), Timeliness (T), Coverage (C) and Quality (Q).

The DHB has a separate Māori Health Action Plan. Where the performance indicators align, these have been included in the forecast of service performance to highlight areas of particular priority in terms of improving health outcomes for Māori on the Coast.

Wherever possible, past year's baselines and national results are included to give context in terms of what we are trying to achieve, and to support evaluation of our performance.

SETTING STANDARDS

In setting performance standards, we have considered the changing demographics of our population,

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

increasing areas of demand and the assumption that resources and funding growth will be limited.

Targets reflect the strategic direction and goals of our health system: increasing coverage of prevention programmes, reducing acute or avoidable demand for our hospital services and maintaining service access while reducing waiting times for treatment.

While a healthier population and earlier intervention can reduce avoidable demand over time, there will always be some 'demand driven' services. These services where the DHB must respond to population demand include: diagnostic tests, emergency care, maternity services, rehabilitation, respite services, dementia and palliative services.

It is not appropriate to set targets for these services. Instead, previous years' volumes and estimates for the coming year have been provided against these services lines to give context in terms of the use of resources across our health system.

EXPECTATIONS

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 are based on national expectations and may be particularly difficult for the West Coast DHB to meet. Our small population numbers mean a few 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 2016/17, by output class.

2016/17

REVENUE	TOTAL $'000
Prevention	2,784
Early detection and management	26,931
Intensive assessment & treatment	94,707
Support & rehabilitation	20,593
Grand Total	145,015

EXPENDITURE	TOTAL $'000
Prevention	2,433
Early detection and management	26,354
Intensive assessment & treatment	95,733
Support & rehabilitation	21,049
Grand Total	145,569

Surplus/(Deficit) - $'000	(554)

NOTES

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

E Services are demand driven and no targets have been set for these service lines.

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

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

◇ Targets are set for DHBs to achieve by the final quarter of the year and performance data refers to the fourth quarter or June result.

◆ This measure appears in the DHB's Māori Health Action Plan for 2016-17.

Output Class

6.1 Prevention services

Preventative health services promote and protect the health of the population. They address individual behaviours by targeting changes to physical and social environments that influence and support people to make healthier choices and are, in this way, distinct from treatment services. They include: health promotion and 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 and good health.

WHY IS THIS OUTPUT CLASS SIGNIFICANT?

The four leading long-term conditions, cancer, cardiovascular disease, diabetes and respiratory disease make up 80% of the disease burden for the total population.[16] These diseases are largely preventable and by supporting people to make healthier choices we can reduce the risk factors that contribute to these conditions. Prevention services are designed to spread consistent messages to large numbers of people, and can be cost-effective. 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-need populations and to reduce inequalities in health status and health outcomes.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Health Promotion and Education Services These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, followed by positive behaviour choices.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of babies exclusively breastfeeding on hospital discharge	Q [17]	84%	≥75%	-
% of babies exclusive/fully breastfed at LMC discharge	Q [18]	75%	75%	74%
% of Māori babies exclusive/fully breastfed at LMC discharge	Q ◆	59%	75%	68%
Lactation support and specialist advice consults provided in community settings	A	172	>100	-
% of priority schools supported by the Health Promoting Schools framework	C [19]	100%	>70%	-
Nutrition and Activity courses provided in the community	A	9	>5	-
People referred to Green Prescriptions for additional physical activity support	A [20]	478	500	-
% of Green Prescription participants more active 6-8 months after referral	Q [21]	86%	>50%	-
% of women smokefree at two weeks postnatal	Q [18]	81%	95%	78%
% of Māori women smokefree at two weeks postnatal	Q ◆	65%	95%	62%
% of smokers enrolled with a PHO receiving advice and help to quit (ABC)	C	90%	90%	90%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	98%	95%	96%
% of Māori smokers identified in hospital receiving advice and help to quit (ABC)	C ◆	100%	95%	-

[16] *World Health Organisation identifies the main non-communicable diseases are cancer, diabetes, cardiovascular and respiratory disease.*
[17] *The percentage of babies' breastfeeding can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period. Standards are set in alignment with World Health Organisation recommendations.*
[18] *These measures are part of the national Well-Child/Tamariki Ora Quality Framework, standards are set nationally. 2014/15 numbers have been updated to reflect the full year results published by the Ministry of Health.*
[19] *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.*
[20] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.*
[21] *Results are taken from national patient survey competed by Research NZ on behalf of the Ministry of Health. Targets are set nationally.*

Population-Based Screening Services These services help to identify people at risk of illness and pick up long-term conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of four-year-olds provided with a B4 School Check (B4SC)	C [22]	92%	>90%	92%
% of 'high needs' four-year-olds provided with a B4 School Check	C ◆ [23]	118%	>90%	92%
% of four-year-olds (identified as obese at B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q [24]	new	95%	new
% of Year 9 students in decile 1-3 schools receiving a HEEADSSS assessment	C † [25]	46%	95%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [26]	74%	80%	77%
% of Māori women aged 25-69 having a cervical cancer screen in the last 3 years	C ◆	62%	80%	63%
% of women aged 50-69 having a breast cancer screen in the last 2 years	C [26]	75%	>70%	72%
% of Māori women aged 50-69 having a breast cancer screen in the last 2 years	C ◆	76%	>70%	64%

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	2014/15 Result	2016/17 Target	2014/15 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 ◇	85%	95%	93%
% of Māori children fully immunised at eight months of age	C ◆	80%	95%	90%
% of eight-month-olds 'reached' by immunisation services	Q [27]	98%	95%	97%
% of Year 8 girls completing the HPV vaccination programme	C † [28]	53%	70%	61%
% of eligible Māori girls completing the HPV vaccination programme	C ◆	28%	70%	64%
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	64%	75%	63%
% of older Māori (65+) receiving a free influenza ('flu') vaccination	C † ◆	69%	75%	-

[22] The B4 School Check is the final core Well-Child/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.
[23] The high needs grouping includes Māori, Pacific and children living in High Deprivation areas.
[24] This measure is the newly introduced national Raising Healthy Kids health target.
[25] 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.
[26] The cervical and breast screening measures refer to national screening programmes and standards as set to align to the national targets. Results differ (1%) from those previously published having been updated to reflect the now available result at June 2015.
[27] '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.
[28] The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme currently consists of three vaccinations and is free to young women under 20 years of age. Around 150 women are diagnosed with cervical cancer and 50 women die from it each year in New Zealand. The baseline is the percentage of girls born in 2001 receiving Dose 3 and the target for 2016/17 is for girls born in 2003 completing the programme.

Output Class

6.2 Early detection and management services

Early detection and management services help to maintain, improve and restore people's health by ensuring that those at risk, or with disease onset, are identified 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?

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 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. By providing flexible and responsive services in the community, without the need for a hospital appointment, we are better supporting people to stay well and to manage their long-term conditions - reducing complications, acute illness or crises and avoiding hospital admissions. Reducing avoidable and acute demand for hospital services frees up our hospital and specialist services capacity to enable the provision of more complex and planned interventions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Primary Health Care (GP) Services These services are offered in local community settings by general practice teams and other primary health professionals and are aimed at improving, maintaining or restoring people's health. Coverage rates or uptake of services are indicative of the accessibility and responsiveness of primary care services	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of the total DHB population enrolled with a Primary Health Organisation	C	91%	95%	-
% of the Māori DHB population enrolled with a Primary Health Organisation	C ◆	94%	95%	-
Number of HealthPathways in place across the West Coast health system	Q [29]	614	650	-
Avoidable hospital admission rate for children aged 0-4 per 100,000 people	Q [30]	5,388	TBC	6,789
Avoidable hospital admission rate for Māori children aged 0-4 per 100,000	Q ◆	6,136	TBC	7,631
Young people (0-19) referred to Brief Intervention Counselling	A Δ [31]	126	>80	-
Adults (20+) referred to Brief Intervention Counselling	A Δ	413	>300	-

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	2014 Result	2016 Target	2014 National Average
% of children (0-4) enrolled in DHB-funded oral health services	C †	100%	95%	76%
% of Māori children (0-4) enrolled in DHB-funded oral health services	C † ◆	88%	95%	61%
% of enrolled children (0-12) examined according to planned recall	T †	89%	90%	-
% of enrolled Māori children (0-12) examined according to planned recall	C ◆	88%	90%	-
% of adolescents (13-17) accessing DHB-funded oral health services	C †	70%	85%	-

[29] The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.
[30] 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. Results differ to those previously published following an update of the definition by the Ministry of Health – baselines are to March 2016. Targets will be set and agreed as part of the delivery of the West Coast's System Level Improvement Plan due with the Ministry in October 2016.
[31] 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.

Long-Term Conditions Management (LTCM) Programmes These services are targeted at people with high health need due to having a long-term condition. The aim is to reduce deterioration, crises and complications of those conditions through earlier identification, monitoring and effective management of people's conditions.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
People identified with a long-term condition enrolled in the LTCM programme	A	3,666	>2,000	-
% of people with diagnosed diabetes having an annual LTMC review	C	96%	>90%	-
% of people with diabetes with satisfactory or better diabetes management (Hba1c ≤ 64mmol/mol) at their annual review	Q	69%	80%	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇ [32]	91%	90%	89%
% of the eligible Māori population having a CVD Risk Assessment in the last 5 years	C ◆	87%	90%	85%

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 professionals such as laboratory technicians, medical radiation technologists and pharmacists. While services are largely demand driven, access to these services improves clinical decision-making and reduces unnecessary delays in treatment.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Subsidised pharmaceutical items dispensed in the community	A Δ [33]	443k	E.<600K	-
Number of community requested radiological tests delivered by Grey Hospital	A	5,935	E.>5,000	-
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T ◇ [34]	83%	85%	75%
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T ◇	100%	95%	85%
% of people receiving their Magnetic Resonance Imagining (MRI) within 6 weeks	T ◇	88%	85%	54%

[32] This measure refers to cardiovascular disease (CVD) risk assessments undertaken in primary care and was previously the national 'More heart and diabetes checks' health target. By identifying those at risk of CVD early, we can help them to change their lifestyle, improve their health and reduce the chance that they develop a serious health condition. This intervention is expected to reduce the rate of avoidable CVD-related hospitalisation for our population.

[33] 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.

[34] The diagnostic measures are national performance measures (PP29) and baselines are as at the final month of the year (June) in line with national results published by the Ministry of Health. Targets are set to match national standards set for all DHBs. The result differ from that previously published (92%) due to a transcription error.

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. They are usually provided in hospital settings, which enables the collocation of expertise and specialist equipment. A proportion of these services are delivered in response to acute events 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?

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality & Patient Safety Measures These quality and patient safety measures are national quality and safety markers championed and monitored by the NZ HQSC. High compliance levels indicate robust quality processes and strong clinical engagement.[35]	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Rate of compliance with good hand hygiene practice	Q ◇ [36]	83%	80%	80%
% of hip and knee replacement patients receiving cefazolin >2g	Q ◇ [37]	100%	95%	96%
% of hip and knee replacement patients who have appropriate skin preparation	Q ◇	100%	100%	99%
% of inpatients (aged 75+) who received a falls assessment	Q ◇ [38]	88%	90%	93%

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 by a range of health professionals, including lead maternity carers, general practice teams and obstetricians. Utilisation is monitored to ensure service levels are maintained and to demonstrate capacity to respond to need.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C [39]	56%	80%	-
% of new mothers attending DHB-funded parenting and pregnancy courses	C	69%	30%	-
Maternity deliveries in West Coast DHB facilities	A	256	Est. 300	-
Baby friendly hospital accreditation of DHB facilities	Q [40]	Yes	Yes	-

[35] *All of the HQSC quality measures have been updated in line with new national reporting timeframes and definitions, baselines results differ slightly from those previous published having been updated to the final 2014/15 quarter.*
[36] *This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards.*
[37] *Cefazolin >2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.*
[38] *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.*
[39] *This measure is part of the national Well-Child/Tamariki Ora Quality Framework, standards are set nationally. 2014/15 numbers have been updated to reflect the full year results published by the Ministry of Health.*
[40] *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 and emergency responses, short-stay observation, acute care packages, acute medical and surgical treatment and intensive care services. While largely demand driven, earlier intervention and shorter wait times are indicative of an effective system.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of children under thirteen with access to free primary care after hours	C [41]	new	100%	-
% of general practices providing telephone triage outside business hours	C	88%	100%	-
Attendances at the Grey Base Hospital Emergency Department	A [42]	11,376	Est.<13,000	-
% of people (Triage 1-3) presenting in ED seen within clinical guidelines	Q [43]	85%	>85%	-
% of people waiting less than 4 weeks to start radiotherapy or chemotherapy	T ◇ [44]	100%	100%	-
% 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 ◇ [45]	50%	85%	68%
Acute inpatient average length of hospital stay (standardised)	Q [46]	2.35	≤2.35	2.60

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). Improved access is seen as indicative of an effective system.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
First Specialist Assessments provided (medical and surgical)	A [47]	6,663	E.>6,000	-
% of First Specialist Assessments that were non-contact (virtual)	Q [48]	4.2%	>5%	-
Elective/arranged surgical discharges (surgeries provided)	A [49]	2,053	1,906	-
Elective inpatient average length of hospital stay (standardised)	Q [46]	1.63	≤1.55	1.64
Outpatient attendances	A	13,972	Est. >13k	-
% of outpatient follow-up appointments provided by telemedicine	Q[50]	8.6%	>5%	-
Outpatient 'Did not Attend' rates (total population)	Q [51]	7.8%	6%	-
Outpatient 'Did not Attend' rates (Māori)	Q	16.2%	6%	-

[41] This measure was previously '100% children under six with access to free primary care after hours'.
[42] This measure is based off the national ED Health Target. The national definition was redefined by the Ministry of Health in 2016 and results differ to those previously published having been aligned to the new definition and referring only to Grey Hospital ED.
[43] Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.
[44] 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.
[45] This measure is the national Faster Cancer Track Health Target which was introduced in Q2 of 2014/15.
[46] 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 measure was redefined in 2015/16 – day stays are now included in the count and results therefore differ to those previously published.
[47] 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.
[48] Non-contact FSAs are those where specialist advice and assessment are provided without the need for a hospital appointment.
[49] 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.
[50] This measure relates to the proportion of total follow-ups outside of Greymouth seen by telehealth.
[51] These DNA rates relate to medical and surgical specialist outpatient appointments and do not include 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 services. Improved access and shorter wait times are indicative of the systems positive response to demand.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of young people (0-19) accessing specialist mental health services	C Δ [52]	6.1%	>3.8%	3.5%
% of adults (20-64) accessing to specialist mental health services	C Δ	5.0%	>3.8%	3.8%
% of people referred for non-urgent MH/AOD services seen within 3 weeks	T [53]	77%	80%	80%
% 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 and outpatient clinics. An increase in the proportion of older people discharged home, rather than into residential care or hospital environments reflects a successful outcome for the patient and the service.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Admissions into inpatient AT&R services	A	124	E.>150	-
Consultations provided by outpatient and domiciliary AT&R services	A	3,194	E.>2,500	-
% of AT&R inpatients discharged to their own home rather than into ARC	Q Δ [54]	83%	90%	-

[52] This measure is based on the national performance measure (PP6) and expectations that 3% of the population will need access to specialist level mental health services. Data is provided nationally and is produced a quarter in arrears.
[53] This is a national performance measure (PP8). Results are three months in arrears.
[54] 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 assessment of people's needs and include: domestic support, personal care, community nursing, respite and residential care. Services are primarily for older people, mental health clients and people with complex conditions.

WHY IS THIS OUTPUT CLASS SIGNIFICANT?

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 assessment, advice and 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.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Rehabilitation Services These are services that help to restore or maximise people's health or functional ability following a health-related event such as a heart attack or stroke. Increased referral and access to services following an acute event is indicative of a responsive restorative focused service.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	41%	80%	-
People are being supported by the FIRST service	V	new	yes	-
People (65+) access the community-based falls/fracture liaison service	V [55]	new	25	-

Home and Community-Based Support Services These are services that help to restore functional independence and support people to continue living in their own homes. Largely demand driven, clinical assessment ensures appropriate and equitable access to services and success is determined as more people supported to live longer in their own homes.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of older people (65+) receiving long-term home and community support services who have had a clinical assessment using InterRAI	Q Δ [56]	93%	95%	-
People supported by long-term home and community support services	V Δ	792	Est. >740	-
Community-based district nursing visits provided (long-term clients only)	V Δ	4,171	Est. >4,000	-
Meals on Wheels provided	V Δ	37,306	Est. >35k	-

[55] *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.*
[56] *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 is expected to increase over time, as more people are supported to remain in their own homes.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Mental health planned and crisis respite service bed days used	C Δ	457	Est. 500	-
People supported by aged care respite services	V	56	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. With an ageing population, demand is expected to increase, but a reduction in demand for lower-level residential care (rest homes) is seen as indicative of more people being successfully supported to remain in their own homes.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of people entering ARC having had a InterRAI assessment	Q Δ [56]	97%	>95%	-
Subsidised ARC rest home beds provided (days)	V Δ [57]	40,488	Est. <50k	-
Subsidised ARC hospital beds provided (days)	V Δ	37,537	Est. <40k	-
Subsidised ARC dementia beds provided (days)	V Δ	5,399	Est. >4,000	-
Subsidised ARC psycho-geriatric beds provided (days)	V Δ	2,167	Est. >2,000	-

[57] *All of the ARC bed baselines differ from those published in the 2015 Annual Report due to an updating of claiming data and definitions.*

Meeting Our Financial Challenges

7.1 West Coast's financial outlook

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

While health continues to receive a large share of government funding, clear signals have been given that the health sector must rethink how it will meet the needs of the population 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.

Like the rest of the health sector, the West Coast DHB is experiencing growing financial pressure from increasing demand and treatment costs, rising wage expectations and heightened public expectations.

We are also facing a number of unique challenges due to our size and geographic isolation. We are also in the midst of a significant redevelopment, remediation and repair programme.

Over-reliance on locum staff: Difficulties recruiting staff to the West Coast means the DHB is still filling a number of permanent positions with locum staff. While the use of locums allows services to be maintained, this reduces the continuity of care and is an expensive and unsustainable option.

Inter-district flow (IDF) costs: Because of our small size we rely heavily on larger DHBs to provide more complex specialist services for our population. While the service prices are set nationally, cost increases have historically exceeded funding increases.

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

There is no easy solution to ensuring the long-term clinical and financial sustainability of our health system. Truly improving the health of our population is the only way to get ahead of the demand curve.

This means realigning services to 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 a reduced demand for urgent and acute care services.

While these gains may be slow, they are the foundation from which we will build our more effective and sustainable health system. The DHB is committed to continuing its deliberate strategy in this regard.

7.2 Planned results

In 2016/17 the West Coast DHB will have a total of $145m to meet the needs of our population.

This includes $123.362m of population based funding provided to DHBs from the Ministry. A 1.7% increase on the previous year, plus an additional $0.898m population share of additional funding ($0.354m of which is pharmaceutical investment funding that comes with additional costs of the same amount). Whilst this change in funding equates to a $2.96m increase (2.14%), it is the minimum percentage funding increase available to DHBs in 2016/17.

As part of its package the DHB receives $16.16m (2015/16 $18.88m) of transitional funding which is vital to the fiscal sustainability of our health system.

The West Coast DHB is predicting a $0.554m deficit result for the 2016/17 year.

7.3 Major assumptions

Revenue and expenditure estimates in this Plan have been based on current government policy settings, services delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results. In preparing our financial forecasts, we have made the following assumptions:

- Out-years funding is assumed at the minimum rate increase per annum.
- The West Coast DHB will continue to receive Crown Funding on an early payment basis.
- Costs of compliance with new national expectations will be cost neutral or fully funded as will any legislative changes, sector reorganisation or service devolvement.
- The approved forecasted deficit will be funded via Crown deficit support (equity injections).

- Work will continue on the facilities redevelopment plans for Grey and Buller under the nationally appointed Partnership Group.
- The associated costs and capital expenditure for the Grey redevelopment have been included in the capital budget with an estimated completion date of May 2018. The net operating result reflects the modelling as per the detailed business case approved by cabinet in 2014 (adjusted for the increase in the capital cost from $68m to $77.8m and its associated IDCC impact as well as changes in transitional funding repayments). As agreed, the funding will be a mix of debt and equity.
- Revaluations of land and building will continue and will impact on asset values. In addition to periodic revaluations, further impairment in relation to re-development facilities repair may be necessary.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and accumulated leave revaluations. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors, reasonable price impacts on providers and foreseen adjustments for the impact of growth within services.
- National and regional initiative savings and benefits will be achieved as planned.
- Transformation will not be delayed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- There will be no further disruptions associated with pandemics or natural disasters.

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 not been included in this Plan.

7.4 Closing the gap

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

The DHB will carefully consider all opportunities and options over the coming year including:

- Integrating systems, services and process to remove variation, duplication and waste.
- Improving production planning to ensure we use our resources in the most effective way.
- Empowering clinical decision-making to reduce delays and improve the quality of care.
- Prioritising services that deliver maximum health benefits and are sustainable long-term.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Tightening cost growth including moderating treatment, back office, support and FTE costs.

Service changes already identified for 2016/17 are outlined in service reconfiguration section of this Plan (Section 5.8).

7.5 Asset planning and investment

GREY REDEVELOPMENT

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

In 2014 approval was given for a new Grey Base Hospital IFHC. The currently estimated $77.8m redevelopment is provisional scheduled to be completed in May 2018 and construction commenced in May 2016.

A secondary tranche of redevelopment has been identified for a later stage including additional demolition costs. Planning for the mental health facility project is expected to start in 2016 with the business case submission anticipated in 2017.

BULLER REDEVELOPMENT

In Buller, the DHB and clinical teams have worked together with an appointed design team to develop a full concept design for the IFHC development. An Implementation Business Case has been progressed and submitted to the Capital Investment Committee as we move closer to bringing this facility to life.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget is $2.5m for 2016/17. Strategic capital for 2016/17-2019/20 is comprised of:

- Buller IFHC (notionally $8.76m)
- Mental health refurbishment (notionally $5m)
- Phased upgrade of five clinics outside Westport and Greymouth (notionally $0.5m per clinic)

- Secondary tranche Grey Hospital redevelopment (notionally $5m)
- Move to the South Island Patient Information Care System (notionally $2.4m)
- 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.

7.6 Debt and equity

The West Coast DHB currently has debt facilities with the Ministry of Health (formerly the Crown Health Financing Agency). 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	2.50%	30/06/2016
3,000,000	2.21%	15/10/2016
250,000	2.69%	30/06/2017
4,695,000	5.22%	15/12/2019
250,000	4.30%	15/04/2023
250,000	4.61%	15/04/2023
2,000,000	4.92%	15/04/2023
3,500,000	3.40%	15/04/2025
250,000	3.67%	15/04/2025

The Grey redevelopment is expected to be completed in the second quarter of 2018 at which time the asset will be transferred from the Ministry to the DHB. Following the asset transfer on the currently estimated $77.8m cost, term debt will increase by $46.68m to $61.125m, based on a 60% debt and 40% equity funding ratio for this new asset, as per the Detailed Business Case.

The current debt with the Ministry of Health consists of several loans, current interest rates range from 2.21% to 5.22% and are secured by negative pledge.

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 NZ Health Partnership 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.

7.7 Additional considerations

SUBSIDIARY COMPANIES

The South Island Shared Services Agency Limited established in 2000, is a shelf company owned by the South Island DHBs. Following a move to an alliance model, staff are now employed by the Canterbury DHB and operate as the South Island Alliance Programme Office.

With an annual budget of just over $6.2m, the Alliance is jointly funded by the South Island DHBs to provide services such as audit, regional service development and project management. West Coast's contribution for 2016/17 is $165,023.

DISPOSAL OF LAND

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.

Normal policy is that DHBs will not dispose of any estate or interest in any land without having first obtained the consent of the responsible Minister, and completed required public consultation.

Once approval has been gained, land will then be valued and will be offered to any parties that have a statutory right to receive an offer under the Public Works Act and Ngāi Tahu Settlement Act (and any other relevant legislation) before being made available for public sale.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

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

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 10.7.

Statement of Financial Performance Expectations

Where will our funding go?

8.1 Statement of comprehensive income

For the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	30/06/15 Actual $'000	30/06/16 Actual $'000	30/06/17 Plan $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
Income						
Ministry of Health revenue	128,735	130,399	133,516	135,884	138,294	140,748
Patient related revenue	9,964	9,906	10,303	10,633	10,972	11,402
Other operating income	645	657	726	746	766	836
Interest income	517	327	470	534	584	584
Total Income	139,861	141,289	145,015	147,797	150,616	153,570
Operating Expenses						
Personnel	57,840	57,143	58,062	59,278	59,746	60,124
Outsourced services (clinical and non clinical)	7,255	7,284	6,638	6,693	4,961	4,414
Treatment related costs	7,736	7,781	7,858	7,936	8,015	8,095
External service providers (include Inter-district outflow)	49,985	52,649	56,084	57,567	58,557	59,820
Depreciation & amortisation	4,238	4,572	4,572	4,874	6,985	6,985
Interest expenses	732	651	648	944	2,726	2,726
Other expenses	12,350	11,128	10,723	10,497	9,844	10,005
Total Operating Expenses	140,136	141,208	144,585	147,789	150,834	152,169
Operating surplus before loss on sale	(275)	81	430	8	(218)	1,401
Loss on sale (Grey Base Hospital)					-	
Operating surplus before capital charge	(275)	81	430	8	(218)	1,401
Capital charge expense	772	978	984	984	3,754	3,754
Surplus / (Deficit)	(1,047)	(897)	(554)	(976)	(3,972)	(2,353)
Other comprehensive income	(2,513)	-	-	-	-	-
Total Comprehensive Income	**1,466**	**(897)**	**(554)**	**(976)**	**(3,972)**	**(2,353)**

8.2 Statement of financial position

As at 30 June for the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	30/06/15 Actual $'000	30/06/16 Actual $'000	30/06/17 Plan $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
CROWN EQUITY						
General funds	(90,905)	(91,889)	(92,511)	(62,435)	(66,475)	(68,896)
Revaluation reserve	22,082	22,082	22,082	22,082	22,082	22,082
Retained earnings	81,319	82,216	82,770	83,746	87,718	90,071
TOTAL EQUITY	**12,496**	**12,409**	**12,341**	**43,393**	**43,325**	**43,257**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	5,648	11,867	14,195	16,079	17,500	23,036
Trade & other receivables	11,099	5,924	5,600	6,022	9,018	7,399
Inventories	984	986	986	986	986	986
Assets classified as held for sale	136	-	-	-	-	-
Investments (3 to 12 months)	-	-	-	-	-	-
Restricted assets	70	74	74	74	74	74
TOTAL CURRENT ASSETS	17,937	18,851	20,855	23,161	27,578	31,495
CURRENT LIABILITIES						
Trade & other payables	8,174	8,161	8,161	8,161	8,161	8,161
Capital charge payable	-	-	-	-	-	-
Employee benefits	10,056	9,313	9,313	9,313	9,313	9,313
Borrowings	3,250	3,500	3,500	3,500	8,195	3,500
TOTAL CURRENT LIABILITIES	21,480	20,974	20,974	20,974	25,669	20,974
NET WORKING CAPITAL	(3,543)	(2,123)	(119)	2,187	1,909	10,521
NON CURRENT ASSETS						
Investments (greater than 12 months)	573	567	567	567	567	567
Property, plant, & equipment	27,747	26,291	24,706	100,619	96,621	93,123
Intangible assets	1,575	1,248	761	274	(213)	(700)
TOTAL NON CURRENT ASSETS	29,895	28,106	26,034	101,460	96,975	92,990
NON CURRENT LIABILITIES						
Restricted funds	63	66	66	66	66	66
Employee benefits	2,598	2,563	2,563	2,563	2,563	2,563
Borrowings	11,195	10,945	10,945	57,625	52,930	57,625
TOTAL NON CURRENT LIABILITIES	13,856	13,574	13,574	60,254	55,559	60,254
NET ASSETS	**12,496**	**12,409**	**12,341**	**43,393**	**43,325**	**43,257**

8.3 Statement of movements in equity

For the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	30/06/15 Actual $'000	30/06/16 Actual $'000	30/06/17 Plan $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
Total Equity at Beginning of the Period	10,096	12,496	12,409	12,341	43,393	43,325
Total Comprehensive Income	1,466	(897)	(554)	(976)	(3,972)	(2,353)
Other Movements						
Contribution back to Crown - FRS3	(67)	(68)	(68)	(68)	(68)	(68)
Contribution from Crown - Capital	-	-	-	31,120	-	-
Contribution from Crown - Operating Deficit Support	1,000	878	554	976	3,972	2,353
Other Movements	-	-	-	-	-	-
Total Equity at End of the Period	**12,496**	**12,409**	**12,341**	**43,393**	**43,325**	**43,257**

Note: Forecast and Plan Operating Deficit Support is assumed to be confirmed post balance date.

8.4 Statement of cashflow

For the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	30/06/15 Actual $'000	30/06/16 Actual $'000	30/06/17 Plan $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	128,170	127,546	131,856	134,191	136,567	138,987
Other receipts	(2,417)	18,530	12,689	13,072	13,465	13,999
Interest received	517	327	470	534	584	584
	126,270	146,403	145,015	147,797	150,616	153,570
Cash was applied to:						
Payments to employees	64,214	65,175	64,670	65,940	64,676	64,506
Payments to suppliers	60,581	72,306	74,695	76,031	76,447	77,952
Interest paid	668	651	648	944	2,726	2,726
Capital charge	772	978	984	984	3,754	3,754
GST - net	(210)	(767)	-	-	-	-
	126,025	138,343	140,997	143,899	147,603	148,938
Net Cashflow from Operating Activities	**245**	**8,060**	**4,018**	**3,898**	**3,013**	**4,632**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	11	-	-	-	-
Receipt from sale of investments	-	75	-	-	-	-
	-	86	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	3,137	2,859	2,500	80,300	2,500	3,000
	3,137	2,859	2,500	80,300	2,500	3,000
Net Cashflow from Investing Activities	**(3,137)**	**(2,773)**	**(2,500)**	**(80,300)**	**(2,500)**	**(3,000)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	-	-	-	31,120	-	-
Equity Injection - Deficit Support	1,100	1,000	878	554	976	3,972
Loans Raised	(500)	-	-	46,680	-	-
	600	1,000	878	78,354	976	3,972
Cash applied to:						
Other	(525)	-	-	-	-	-
Equity Repayment	68	68	68	68	68	68
	(457)	68	68	68	68	68
Net Cashflow from Financing Activities	**1,057**	**932**	**810**	**78,286**	**908**	**3,904**
Overall Increase/(Decrease) in Cash Held	(1,835)	6,219	2,328	1,884	1,421	5,536
Add Opening Cash Balance	7,483	5,648	11,867	14,195	16,079	17,500
Closing Cash Balance	**5,648**	**11,867**	**14,195**	**16,079**	**17,500**	**23,036**

Note: Cash associated with deficit support funding is assumed to be received in the following year.

8.5 Summary of revenue and expenses by arm

Funder, Governance & Funder Admin: Forecast Operating Statement Years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	30/06/15 Actual $'000	30/06/16 Actual $'000	30/06/17 Plan $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
Funding Arm						
Revenue						
MoH Revenue	127,555	129,270	132,307	134,638	137,011	139,427
Total Revenue	127,555	129,270	132,307	134,638	137,011	139,427
Expenditure						
Personal Health	87,163	89,913	93,453	95,308	96,673	98,315
Mental Health	14,387	14,340	14,194	14,335	14,478	14,621
Disability Support	17,183	18,045	18,355	18,539	18,725	18,913
Public Health	623	637	676	683	690	697
Maori Health	810	625	727	735	743	751
Governance & Admin	827	826	827	827	827	827
Total Expenditure	120,993	124,386	128,232	130,427	132,136	134,124
Net Surplus/(Deficit)	**6,562**	**4,884**	**4,075**	**4,211**	**4,875**	**5,303**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**6,562**	**4,884**	**4,075**	**4,211**	**4,875**	**5,303**
Governance & Funder Admin						
Revenue						
Other	885	900	907	907	907	907
Total Revenue	885	900	907	907	907	907
Expenditure						
Personnel	1,285	1,401	1,416	1,509	1,531	1,553
Outsourced services	517	400	380	360	340	320
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(917)	(901)	(889)	(962)	(964)	(966)
Total Expenditure	885	900	907	907	907	907
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-

Provider Arm: Forecast Operating Statement Years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	30/06/15 Actual $'000	30/06/16 Forecast $'000	30/06/17 Plan $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
Provider Arm						
Revenue						
MoH Revenue	71,361	72,040	72,530	73,279	74,035	74,798
Patient Related Revenue	9,964	9,906	10,303	10,633	10,972	11,402
Other	1,103	910	1,116	1,200	1,270	1,340
Total Revenue	82,428	82,856	83,949	85,112	86,277	87,540
Expenditure						
Personnel	56,555	55,741	56,646	57,769	58,215	58,571
Outsourced services	6,737	6,884	6,258	6,333	4,621	4,094
Depreciation	4,238	4,572	4,572	4,874	6,985	6,985
Interest & Capital Charge	1,504	1,629	1,632	1,928	6,480	6,480
Other	21,002	19,811	19,470	19,395	18,823	19,066
Total Expenditure	90,036	88,637	88,578	90,299	95,124	95,196
Net Surplus/(Deficit)	**(7,608)**	**(5,781)**	**(4,629)**	**(5,187)**	**(8,847)**	**(7,656)**
Other Comprehensive Income	2,513	-	-	-	-	-
Total Comprehensive Income	**(5,095)**	**(5,781)**	**(4,629)**	**(5,187)**	**(8,847)**	**(7,656)**
In House Elimination						
Revenue						
MoH Revenue	(71,007)	(71,737)	(72,148)	(72,860)	(73,579)	(74,304)
Total Revenue	(71,007)	(71,737)	(72,148)	(72,860)	(73,579)	(74,304)
Expenditure						
Other	(71,007)	(71,737)	(72,148)	(72,860)	(73,579)	(74,304)
Total Expenditure	(71,007)	(71,737)	(72,148)	(72,860)	(73,579)	(74,304)
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-
CONSOLIDATED						
Revenue						
MoH Revenue	127,909	129,573	132,689	135,057	137,467	139,921
Patient Related Revenue	9,964	9,906	10,303	10,633	10,972	11,402
Other	1,988	1,810	2,023	2,107	2,177	2,247
Total Revenue	139,861	141,289	145,015	147,797	150,616	153,570
Expenditure						
Personnel	57,840	57,143	58,062	59,278	59,746	60,124
Outsourced services	7,255	7,284	6,638	6,693	4,961	4,414
Depreciation	4,238	4,572	4,572	4,874	6,985	6,985
Interest & Capital Charge	1,504	1,629	1,632	1,928	6,480	6,480
Other	70,071	71,558	74,665	76,000	76,416	77,920
Total Expenditure	140,908	142,186	145,569	148,773	154,588	155,923
Net Surplus/(Deficit)	**(1,047)**	**(897)**	**(554)**	**(976)**	**(3,972)**	**(2,353)**
Other Comprehensive Income	2,513	-	-	-	-	-
Total Comprehensive Income	**1,466**	**(897)**	**(554)**	**(976)**	**(3,972)**	**(2,353)**

Part IV

Further Information for the Reader

Appendices

Appendix 9.1	Glossary of Terms
Appendix 9.2	West Coast DHB Organisational Chart
Appendix 9.3	Legislative Objectives of a DHB: New Zealand Public Health and Disability Act (2000)
Appendix 9.4	West Coast's commitment to National Health Targets
Appendix 9.5	NZ Health Survey – West Coast's Roadmap of Actions 2016/17
Appendix 9.6	West Coast Health Alliance Priorities 2016/17
Appendix 9.7	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 referenced Ministry of Health documents are available on the Ministry's website (www.health.govt.nz).

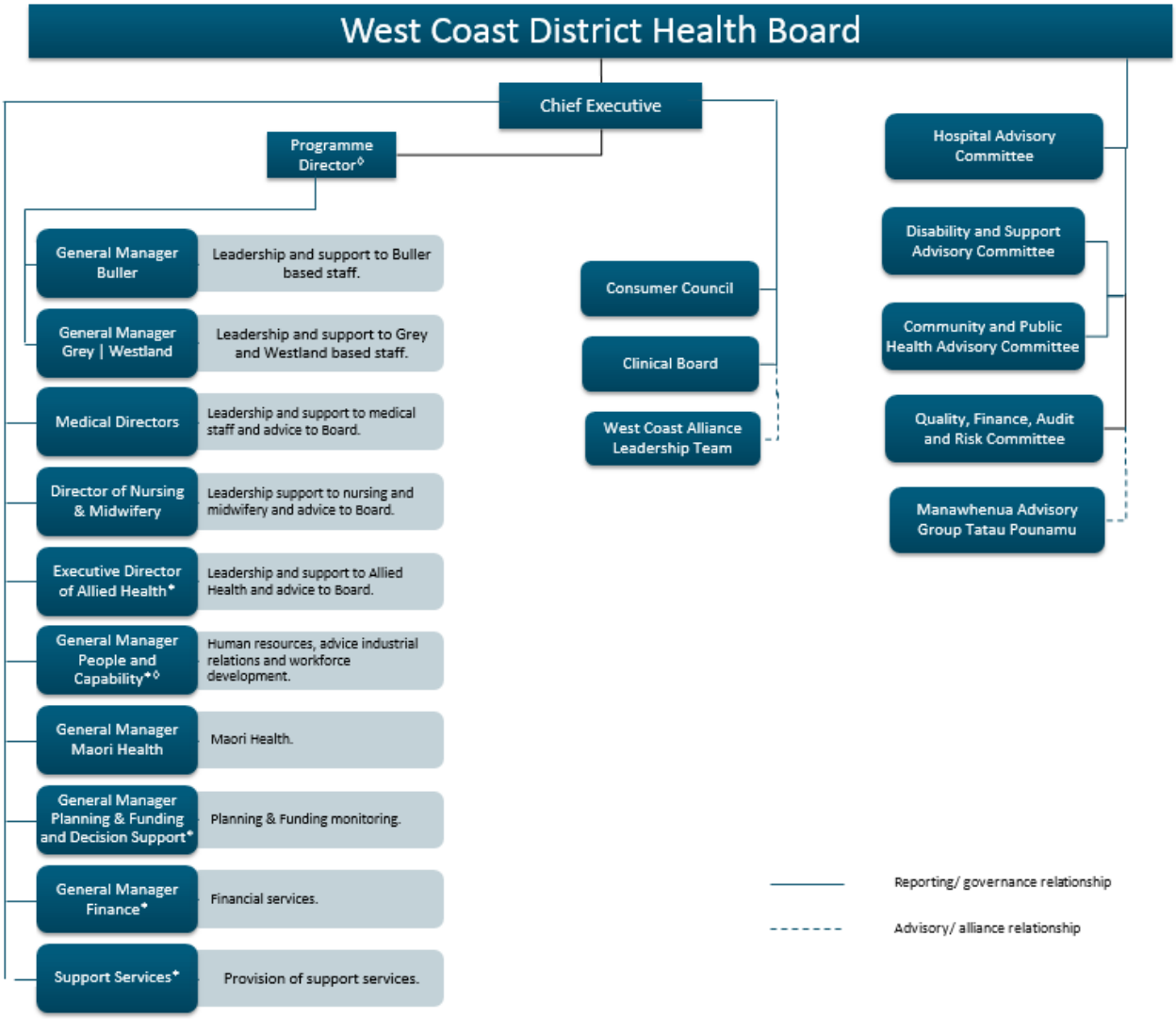
The Crown Entities Act 2004 and the Public Finance Act 1989, both referenced in this document, are available on the Treasury website (www.treasury.govt.nz).

9.1 Glossary of terms

ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	Management of conditions with sudden onset and rapid progression.
Alliance	The West Coast District Alliance	The (West Coast District) Alliance is a collective alliance of healthcare leaders, professionals and providers from across the West Coast. The Alliance provides leadership to the transformation of the West Coast health system in collaboration with system partners and on behalf of the population.
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 is delivered to children at age four (prior to starting school) it is free and allows health concerns to be identified and addressed early to ensure 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.
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 Entity	A generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the financial statements of the Government.
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	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 free assessment provided to Year 9 students to allow health concerns to be identified and addressed early 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 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.
	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.
NGO	Non-Government Organisations	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.
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 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.
	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 the five South Island DHBs (Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIAPO	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 Service	A free service offering screening, education and support to all New Zealand children from birth to age five.

9.2 West Coast DHB organisational structure



* Joint appointments with CDHB

** Position filled by three individuals to replace the previous Chief Medical Officer role

◊ Position filled by one individual

9.3 Legislative objectives of a DHB

NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT (AMENDED 2012) - PART 3: SECTION 22

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

- To improve, promote, and protect the health of people and communities
- To promote the integration of health services, especially primary and secondary health services
- To seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- To promote effective care or support for those in need of personal health services or disability support services
- To promote the inclusion and participation in society and independence of people with disabilities
- 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 within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders
- To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services
- 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 its operations
- To be a good employer in accordance with section 118 of the Crown Entities Act 2004.

9.4 West Coast's commitment to the national health targets

BETTER HELP FOR SMOKERS TO QUIT

Expectation: PHO enrolled smokers and women at confirmation of pregnancy with general practice or a Lead Maternity Carer will be offered brief advice and support to quit smoking.

Target: 90% of PHO enrolled smokers and 90% of pregnant smokers will be offered advice and help to quit smoking.[58]

INCREASED IMMUNISATION

Expectation: Eight-month-olds will have their full primary course of immunisation (six weeks, three months and five months immunisation events) on time.

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

RAISING HEALTH KIDS

Expectation: Obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Commitment: 95% of obese children will be offered a referral to a health professional for clinical assessment and family-based intervention.

SHORTER STAYS IN EMERGENCY DEPARTMENTS

Expectation: 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.

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: 1,906 elective surgical discharges will be delivered in 2016/17.

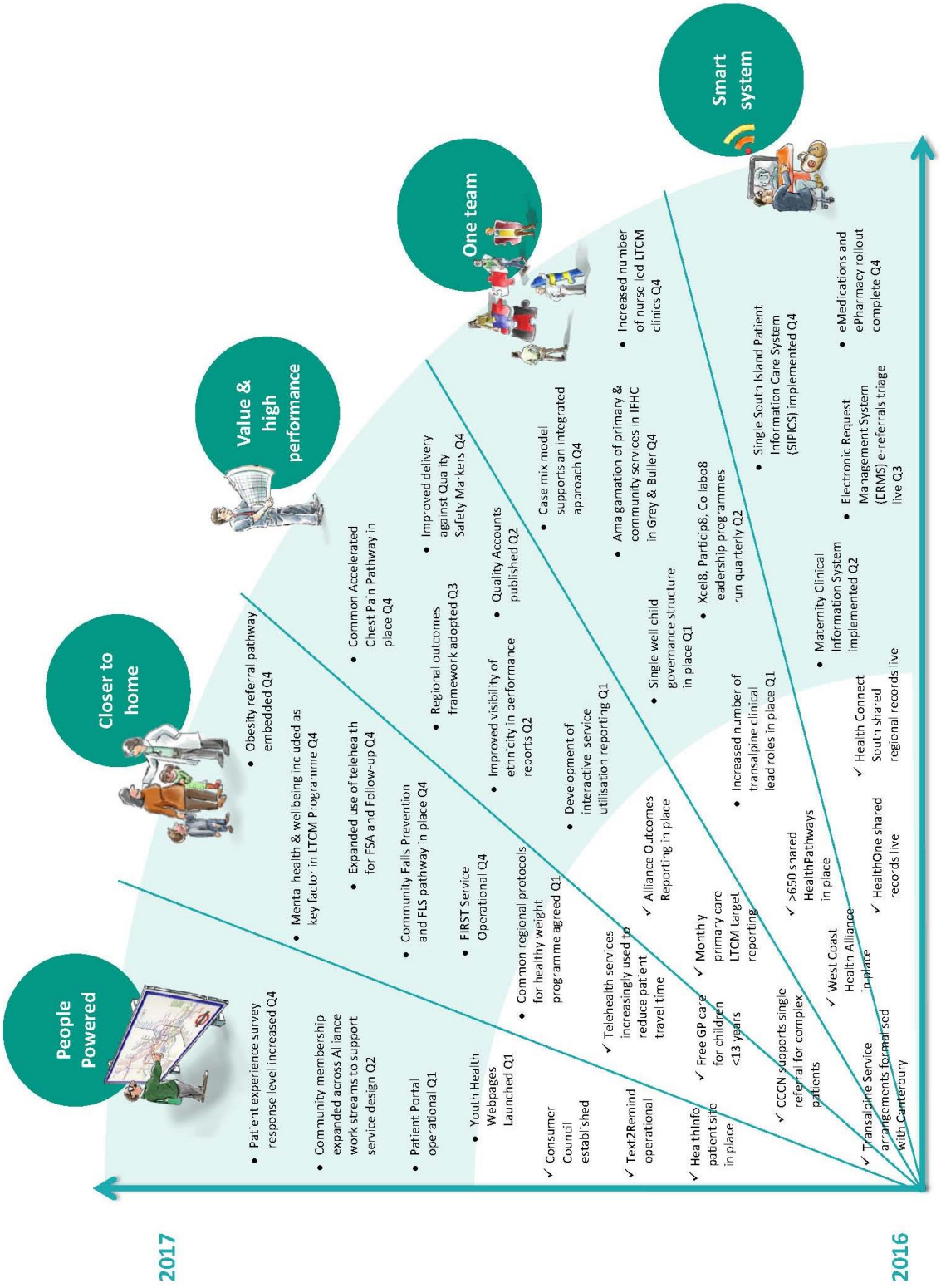
FASTER CANCER TREATMENT

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

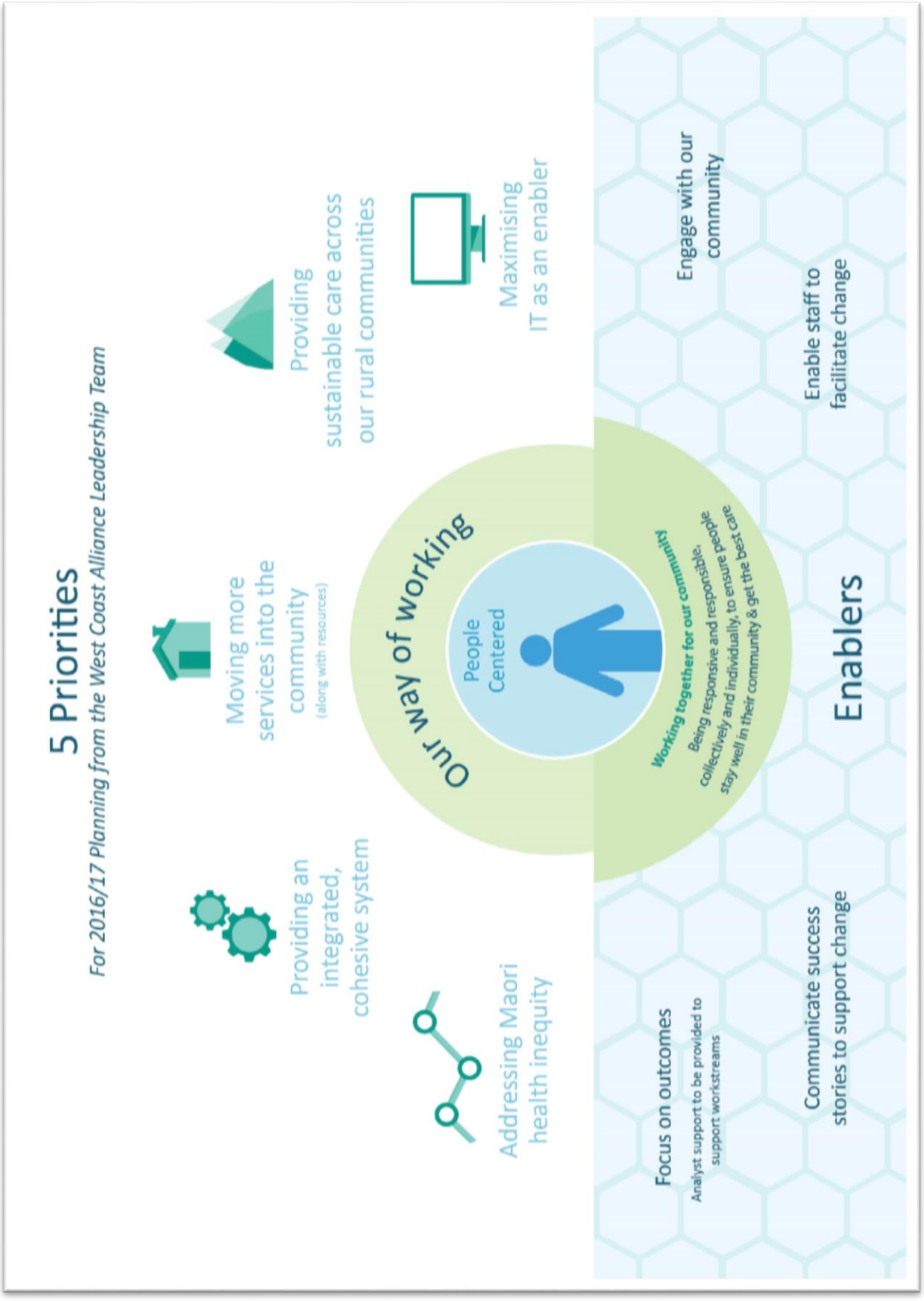
Target: 85% of patients will receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by June 2017.

[58] *Note the Maternity Smoking Target is currently a developmental measure and is monitored for information only.*

9.5 NZ Health Strategy – West Coast's roadmap of actions 2016/17



9.6 West Coast Health Alliance priorities 2016/17



9.7 Statement of accounting policies

The prospective financial statements in this Statement of Intent (SOI) for the year ended 30 June 2017 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ 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 document:

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

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

(iii) Assumptions
The main assumptions underlying the forecast are noted in Section 7 of this document.

REPORTING ENTITY AND STATUTORY BASE

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

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

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

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

BASIS OF PREPARATION

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

Statement of compliance

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

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

Measurement basis

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

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

Functional and presentation currency

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

Changes in accounting policies

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

Transition to PBE accounting standards.

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. West Coast DHB has applied these standards in preparing the 30 June 2015 financial statements.

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 has applied these updated standards in preparing these prospective financial statements. West Coast DHB expects there will be minimal or no change in applying these updated accounting standards.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

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

Subsidiaries

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

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

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are:

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

Owned assets

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

Revaluations

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

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

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

Additions

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

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Depreciation

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

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

Class of Asset	**Year**	**Dep Rate**
Freehold Buildings & Fitout 10 – 50	2 -10%	
Leasehold Buildings	3 - 20	5 - 33%
Plant, Equipment and Vehicles	3 - 12	8.3 - 33%

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

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

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

Amortisation

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

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

Investments

Bank term deposits

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

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

Trade and other receivables

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

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

Inventories

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

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

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

Cash and cash equivalents

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

Capital charge

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

Impairment

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

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

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

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

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

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

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

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

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

Impairment of property, plant, equipment and intangible assets

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

Non-cash-generating assets

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

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

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

Borrowings

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

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

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

Provisions

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

ACC 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.

Income tax

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

Equity

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

- Contributed capital;
- Revaluation reserve; and
- Accumulated surpluses/deficits.

Revaluation reserve

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

Goods and services tax

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

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

Revenue

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

Ministry of Health population-based revenue

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of other services

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

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with NZ 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
- Analysis of prior asset sales.

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

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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

STATEMENT OF INTENT

Published August 2016
Pursuant to Section 149 of the Crown Entities Act 2004

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