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2017/21 STATEMENT OF INTENT

Incorporating the 2017/18
Statement of Performance Expectations &
Statement of Financial Expectations

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004.

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

Statement of Joint 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 for their resident population.

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 set out our goals and objectives for the coming year 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 over the longer-term. It also contains the DHB's Statement of Performance Expectations and Statement of Financial Expectations.

The Statement of Intent is extracted from the DHB's Annual Plan and presented to Parliament, as a separate public accountability document. It is used at the end of the year to compare the planned and actual performance of the DHB. Audited results will be presented in the DHB's Annual Report for 2017/18.

The West Coast DHB has made a strong commitment to 'whole of system' service planning. We are working in partnership with other service providers and engaging with individuals, their families and the West Coast community to design and deliver service solutions to better meet the needs of our population.

In keeping with this commitment, the actions in this Statement of Intent present a picture of the collective activity that will be delivered by the West Coast DHB and our alliance partners.

This includes activity delivered through our local West Coast Alliance with the West Coast Primary Health Organisation (PHO), the South Island Regional Alliance with our partner South Island DHBs, and our transalpine agreements with the Canterbury DHB.

We also recognise our role in actively addressing disparities in health outcomes for our Māori population and are committed to making a real difference in the future of our tamariki. While the total number of Māori on the West Coast is small, Māori make up 12% of our total population. We work closely with Tatau Pounamu and Poutini Waiora, both directly and through the West Coast Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of the Treaty of Waitangi.

In signing this Statement of Intent, we are satisfied that it fairly represents our joint intentions and activity and is in line with Government expectations for 2017/18.

Jenny Black
CHAIR | WEST COAST DHB

Chris Mackenzie
DEPUTY CHAIR | WEST COAST DHB

Stella Ward
CHAIR | WEST COAST HEALTH ALLIANCE

David Meates
CHIEF EXECUTIVE | WEST COAST DHB

October 2017

Table of Contents

Part I

Overview

Foreword from the Chair and Chief Executive

32,600
reasons to make
a difference

The West Coast DHB aspires to support our people to achieve the health outcomes they want for themselves and their family and whānau.

Our vision is a health system with the patient and their needs at the centre, and this means we have to be creative at times in order to find ways that our health system can be flexible and sustainable.

We aim to enable our system to provide the right care, in the right place, at the right time, reducing the need for patients to make multiple visits, increasing access to care through the use of technology and wrapping services around the people we care for.

Like all DHBs, we face the challenges of an ageing population, increasing service demand and treatment costs, and workforce shortages. However, delivering a high quality, sustainable health service in a rural area is particularly challenging, and we are the most rural region in the country by far. Our rurality magnifies the operating pressures we face and we must consider all our challenges with this overarching factor in mind.

LEADING IN RURAL HEALTH

For the West Coast to achieve its vision there is no option but to lead the way in modelling rural health service delivery and develop a single, truly integrated, service model. The West Coast is already leading in many aspects of rural health care:

- The use of telehealth provides our communities the opportunity to see specialists without leaving their local area.
- Our Rural Nurse Specialists provide local health care to our most rural locations along the Coast.
- Reefton has local community members working together with our health care team identifying initiatives to improve health and wellbeing.
- Westport mental health and primary care teams are trialling an integrated approach to mental and physical health services for long-term mental health clients.
- Our Rural Hospital Medicine Specialists work in our Emergency Department, our wards and in our general practices, including travelling to our most remote places such as Karamea.

Significant work will be undertaken in the coming year to further develop our integrated approach to community health care services. This will include progressing our vision through locality-based integrated health services focused on the needs of local populations.

JOINED-UP OLDER PERSONS' HEALTH SERVICES

We often hear how wonderful staff have been in our older persons' health services, how caring and compassionate, how attentive and inquiring. Even so, there are also areas where we can do better. There will be a greater focus on improved access to supports and timeliness in gaining those supports in 2017/18. This will include respite services, home-based support services, community rehabilitation services and improved community dementia services.

NEW FACILITIES

This year we will be finalising our plans to transition to the new Grey Base health facilities—Including what we need to take with us, what needs to be replaced, and where people will work in the new or existing facilities.

There's also other planning going on. We've already merged our two general practices in Greymouth to iron out any inconsistent systems before operating from the new Integrated Family Health Centre (IFHC). In Buller, we are finalising site details for another purpose-built IFHC and determining how we will work within it.

A DIALOGUE WITH OUR DISTRICT

We have focused on listening to our communities better, with several grass-roots community meetings over the past year, and we plan to continue this open dialogue as we move forward. While our Board sets our strategic direction, we will seek input from our communities to ensure we are travelling along the right path, and we will communicate widely to ensure our people understand the choices we are making.

We look forward to continuing our journey with you all.

Jenny Black
CHAIR

David Meates
CHIEF EXECUTIVE

October 2017

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 any DHB in New Zealand. We are responsible for 32,600 people, 0.7% of the total New Zealand population.

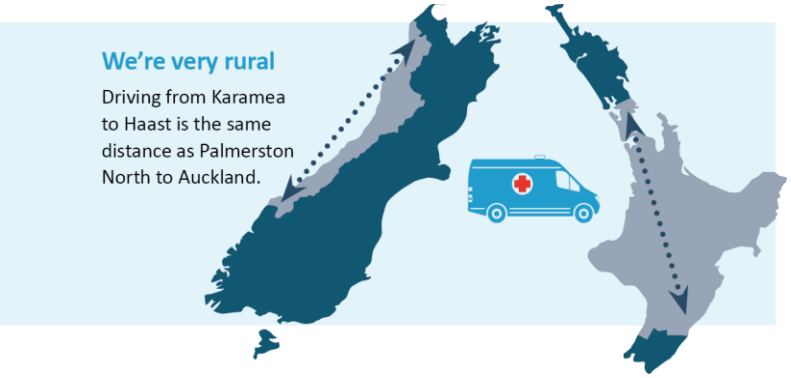
We own and manage three major health facilities in Greymouth, Westport, and Reefton and five general practices across the West Coast.

We are a major employer, with over 1,000 people employed across our hospital and primary care services. We also hold and monitor more than 40 service contracts with other organisations and individuals, who provide health and disability services to our population. This includes the West Coast PHO.

In 2015/16 there were over 11,000 presentations at the Grey Hospital Emergency Department, 21,000 specialist appointments and 140,000 general practice consultations. We also delivered 246 babies, provided 1,942 elective surgeries, 5,504 radiology tests and over 93,000 hours of home based support.

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 with only 1.4 people per square kilometre.

Our district extends from Karamea in the north, to Jackson Bay in the south, and Otira in the east. It comprises three Territorial Local Authorities: Buller, Grey, and Westland districts. Grey district has the largest population, with an estimated resident population of 13,550 people.



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 we are expected to operate within allocated funding.

In 2017/18 we will receive approximately $148 million dollars to meet the needs of our population. In line with legislation we use our funding to:

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

Fund the health services needed for our population, and, through our collaborative partnerships with other service providers, ensure services are responsive, coordinated and effective.

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

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

1.3 Our transalpine service model

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

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

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

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

542 West Coast patients had their specialist appointments using telehealth technology in 2016, saving patients more than 18,000km of travel.

1.4 Our population profile

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 (18%), compared with the national average (15%).

Many conditions become more common with age, including heart disease, stroke, cancer, and dementia. As the average age of our population increases, more people are likely to need treatment and support, putting further pressure on our health system.

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

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

There are currently 3,920 Māori living on the West Coast (12% of our population) and by 2026 Māori will represent 14.4% of our total population. While gains have been made, West Coast Māori continue to have poorer overall health status than other ethnicities in the region. We need to carefully consider the needs of our growing Māori population in our future planning.

1.5 Our health profile

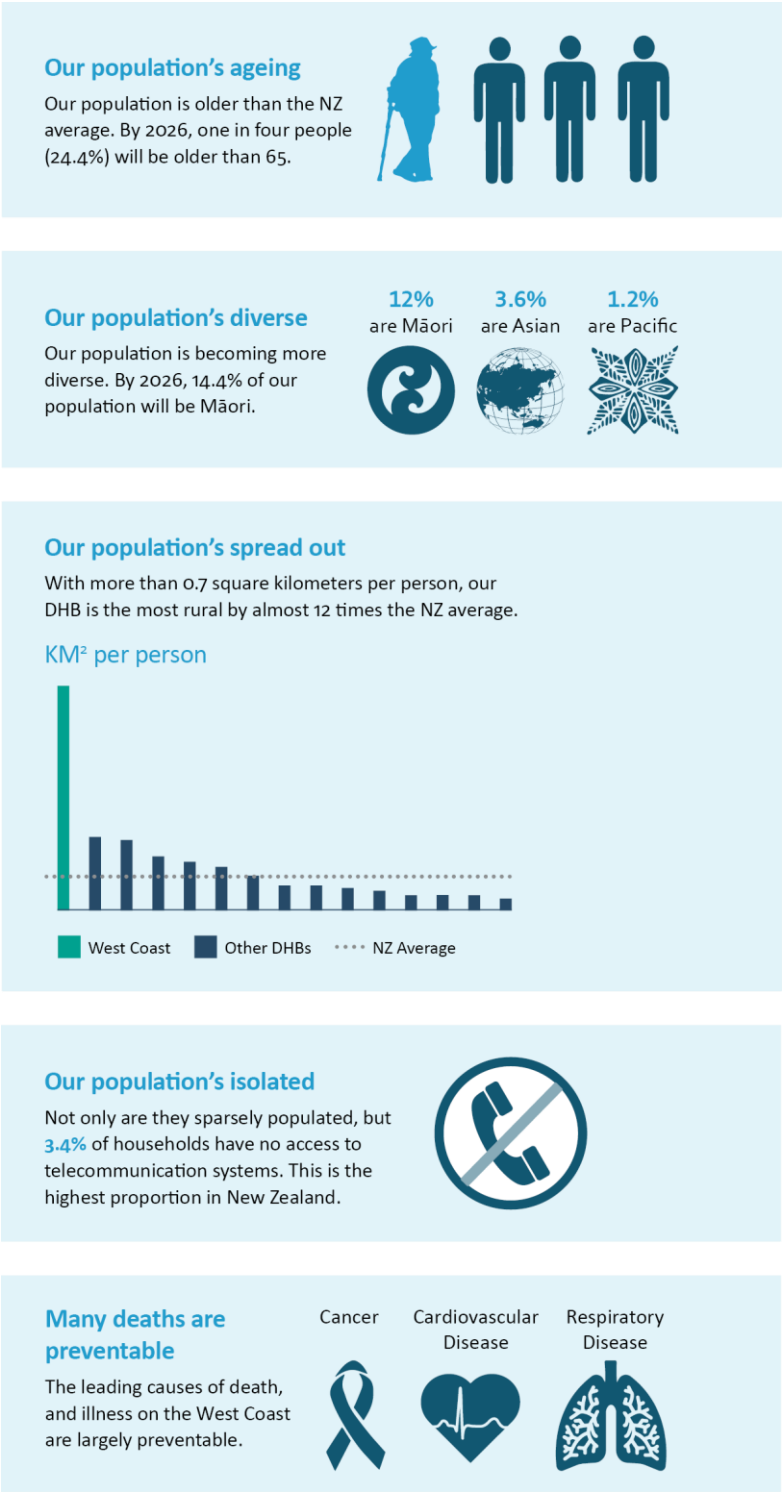
West Coasters have higher overall morbidity and mortality rates and a lower life expectancy compared with the New Zealand average.

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

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

- Almost a third (31.8%) of our total adult population are classified as obese.
- 22% of our population are current smokers (higher than the national average) and smoking rates amongst Māori are even higher.
- 16% of our population are likely to drink in a hazardous manner. While this rate is on a par with the national average, it still amounts to more than one in every eight adults on the Coast.

This presents an opportunity for our health system to work collaboratively with other sectors to improve health outcomes for our population.



Part II

Long-Term Outlook

Setting Strategic Direction

2.1 National context

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

There is a clear understanding that these pressures mean that health services cannot continue to be provided in the same way they always have.

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

The long-term vision for New Zealand's health service is articulated through the New Zealand Health Strategy. The overarching intent is to support all New Zealanders to 'live well, stay well, get well'.

The Strategy identifies five key themes to give the health sector a focus for change:

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

Our direction is further 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), Healthy Ageing Strategy, Rising to the Challenge (Mental Health and Addiction Service Development Plan), the Disability Strategy and the United Nations Convention on the Rights of People with Disabilities.

DHBs are also expected to commit to government priorities and provide 'better, sooner, more convenient health services', and 'better public services'. The Minister of Health's letter of expectations signals annual expectations and priorities for DHBs. The DHB's Annual Plan for 2017/18 outlines how the West Coast DHB will meet those expectations.[1]

In 2017/18 the focus is on:

- Delivering against the NZ Health Strategy
- Living within our means
- Working across government
- Delivering on national health targets
- Streamlining of planning including developing a longer-term outlook and increasing regional alignment.

2.2 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.

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23.3%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Alliance to better address our shared challenges.

Our jointly developed South Island Regional Health Services Plan outlines the agreed regional activity for the next three years. West Coast has made a strong regional commitment and is engaged in a number of regional workstreams including: cancer, child health, information services, electives and stroke services.

Our regional commitment is outlined in the South Island Regional Health Services Plan.[2]

2.3 The West Coast vision

The vision for the West Coast health system is one born out of past experience and collective clarity around the future challenges we face. Developed with input from our partner organisations, staff and community – our vision is already guiding the decisions we make and the actions we take as an organisation.

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

At the centre of this vision is our community; our whānau; our patients. The foundational goal is that future health services on the West Coast will be:

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

While this provides our foundation, further clarity is required to guide our decisions and actions and ensure success in developing a truly person-centred service. To this end, our vision also provides us with clarity in how we will achieve this. This clarity will be critical as

[1] *The Minister of Health's Letter of Expectations for 2017/18 is attached as Appendix 2.*

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

our teams and our people face complex decisions on determining the future of our health system.

Future health services on the West Coast will be:

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

Based on a single system: This means 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.

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

Identifying Our Challenges

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

While many of the challenges we face are the same as other DHBs, our biggest challenge is our rurality.

The total land area we cover is 23,283 square kilometres but our population is just 0.7% of New Zealand's total population. Geographically we are the third largest DHB in the country but the most sparsely populated, with a population density of just 1.4 people per square kilometre.

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

Workforce challenges: Our workforce is relatively small, but must provide a broad range of complex services at a consistently high standard. In our rurally isolated environment we face significant difficulties in recruiting and retaining a suitable health workforce.

Facility pressures: A number of our current health facilities are outdated, inefficient and expensive to maintain. Many are poorly located and do not support the model of care needed to deliver our vision. Careful consideration must be given to the long-term future of all the facilities we own and operate.

Fiscal pressures: Meeting growing service demand, increasing treatment and infrastructure costs, and expectations around wages and salary increases is an ongoing challenge. We are also balancing community expectations regarding access to new and complex services in a small rural environment.

In meeting these challenges the West Coast will become a leader in the provision of rural health services: identifying opportunities to add value, reducing duplication across our system, and redirecting funding into services that will provide the greatest return in terms of health gain.

Important steps have been taken towards enabling our vision including connecting clinical information systems, establishing shared transalpine pathways with the Canterbury DHB, introducing the Complex Clinical Care Network and commencing the development of Integrated Family Health Services.

In the next few years we will deliver new health facilities that will support our vision by allowing us to further integrate primary and community services and improve the experience of people in our health system.

The following critical success factors are the strategic components needed for us to achieve our vision and become a leader in the provision of rural health services.

The integration of services to improve patient flow:

A healthcare home and point of continuity with general practice

A single point of referral for complex care

Locally delivered hospital-level services backed by closer transalpine collaboration

The prioritisation of resources for greater effect:

Support for healthier environments and lifestyles

Strengthened responsiveness to Māori

Connected information systems and extended use of telemedicine

Improved transport solutions

A strong, stable and engaged workforce

Modern, fit-for-purpose facilities and integrated family health services

Managing Our Business

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

2.4 Organisational culture

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

CLINICAL AND CONSUMER LEADERSHIP

Clinical leadership is intrinsic to our success. Through our shared clinical/management model, clinical input is embedded at all levels of the decision-making process, across operational services and alliance workstreams. Strategic and operational decisions are further informed through the following formal mechanisms:

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

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

PARTNERSHIPS

We are also aware that our vision is wider than just the DHB. Working collaboratively has enabled us to respond to the changing needs of our population and is a critical factor in achieving our goals and objectives. The DHB's strategic partnerships include:

The West Coast District Alliance: where the DHB and the PHO come together with other local service providers to improve the delivery of healthcare and realise opportunities to better integrate our system. This includes the development of the West Coast's System Level Improvement Plan for 2017/18 which is incorporated in the DHB's Annual Plan.

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

Our Transalpine Partnership: where the Canterbury and West Coast DHBs work together to provide sustainable access to specialist services for our population. The partnership includes shared clinical pathways, information systems, corporate services, and joint clinical and management positions.

2.5 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.

With a culture of reporting well established, safety issues are becoming more transparent and are empowering the organisation to 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 Health Quality and Safety Commission (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 DHB's Clinical Board and to the Board's Quality, Finance, Audit and Risk Committee. They are also reported annually to our community in our Quality Accounts which can be found on the DHB's website.

Contracted services are also aligned with national quality standards and auditing of contracted providers includes quality audits.

2.6 Performance management

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

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

On an annual basis, our financial and non-financial performance is audited against our Statements of Service and Financial Performance Expectations (refer to pages 22 and 36 of this document). The results are published annually as the DHB's Annual Report.

At a broader level, we monitor our performance over the longer-term against a core set of desired population outcomes, to evaluate the effectiveness of our strategies and investments decisions.

Further reference to the DHB's outcome goals can be found further in this document, page 13.

2.7 Asset management

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

Our capital intentions are updated annually to reflect known changes in asset states and intentions in line with our Grey Base Hospital and Integrated Family Health Centre redevelopment. Refer to the financial section of this document for our major capital investments for the coming year.

The DHB is also developing a Long Term Investment Plan, looking at where we need to invest to support the delivery of our vision over the next ten years. It is anticipated that this Investment Plan will be completed in 2018/19, in alignment with the timeframes for the Treasury-led Investor Confidence Rating Programme.

2.8 Ownership interests

The West Coast DHB has an interest in the South Island Shared Service Agency Limited, now functioning as the South Island Alliance Programme Office.

Jointly funded by the five South Island DHBs, the regional Programme Office provides audit and project management services and drives regional service development on behalf of the South Island DHBs. Further detail on the activity of the regional Alliance can be found at www.sialliance.health.nz.

The West Coast DHB also has an ownership interest in the New Zealand Health Partnership Limited (NZHPL).

A limited liability company owned and jointly funded by all 20 DHBs, the Partnership enables DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB is participating in the Finance, Procurement and Supply Chain programme, with NZHPL facilitating the move of all 20 DHBs to a shared services model for these services.

We do not intend to acquire shares or interests in any other companies, trust or partnerships in 2017/18.

2.9 Investing in our people

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

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

In our rurally isolated environment we face significant difficulties in recruiting and retaining a suitable health workforce. This has led to an-over reliance on locum and contract staff, the cost of which is unsustainable long-term. Recruiting and retaining a capable health workforce is one of our critical success factors.

We identify available talent and expand workforce capability through: participation in the regional Workforce Development Hub; links with the education sector; sharing training resources; and support for internships and clinical placements in our hospitals.

We invest in a Rural Learning Centre in Greymouth, to encourage people to work rurally by reducing isolation factors and providing peer support and mentoring. We are also engaged in the South Island Kia Ora Hauora Programme, aimed at increasing the number of Māori working in our health system.

While our aim is to support service delivery as close to home as possible, in some areas our rurality and small size means that we cannot sustainably meet all the needs of our population without assistance.

Over the past several years, we have deliberately established a number of joint clinical and executive roles as part of our transalpine partnership with the Canterbury DHB. Shared corporate services teams including Finance, Planning & Funding, Information Services, and People and Capability also provide considerable support to our service teams.

As part of our commitment to our workforce we are reviewing our HR processes and systems and engaging in a number of conversations about how we continue to put people at the heart of all that we do.

2.10 Investing in information systems

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

Information management is a national priority, and DHBs are expected to implement the national Health Information Technology Plan.

The South Island DHBs have determined collective actions to deliver on the national plan and the West Coast DHB is committed to this approach. We have already adopted several major regional systems, including: Health Connect South (award winning), HealthOne, and the Electronic Referral Management System (ERMS).

Our transalpine partnership with Canterbury makes shared information systems increasingly important. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs and replacing our old hospital-based patient administration system with the new single South Island Patient Information Care System (PICS).

Telehealth, videoconferencing and mobile technology is also an important factor in addressing our rurality and isolation challenges. This investment has both saved patient and clinical time by reducing the need to travel for assessments. We will continue to expand the use of telemedicine and connect up the system electronically with the roll-out of the shared mental health portal over the next two years.

2.11 Investing in facilities

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

The West Coast is in the midst of significantly transforming the way health services are delivered to our community, in order to improve the clinical and financial sustainability of our system.

The new $77.8m Grey Based Hospital and Integrated Family Health Centre (IFHC) will underpin this transformation by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service provision.

Anticipated activity for the next several years includes:

Grey Base Hospital and IFHC: Construction is underway and completion of the Hospital and IFHC is anticipated in the second quarter of 2018.

Grey Base Energy Centre: The replacement Energy Centre is part of the Grey Base Hospital redevelopment and is planned for completion in 2018.

Buller IFHC: The DHB engaged with the Buller community in 2015 on the development of a future service model for the district. DHB staff and clinical teams have since worked with an appointed design team to develop a full concept design and implementation business case for an IFHC in Buller.

Options have been considered by the Ministry appointed Hospital Redevelopment Partnership Group and we expect to move forward with the development of the service models and facility in 2018.

2.12 Cross-sector investment

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

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.

At a national level, 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, for the benefit of our population and the wider health system.

Our cross-sector work includes:

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

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

2.13 Service Configuration

SERVICE COVERAGE

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

DHBs are responsible for ensuring that service coverage is maintained for their population. The West Coast DHB works to identify service coverage risk through the monitoring of performance indicators, risk

reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways.

At this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2017/18. However, we are mindful of continuity risks while we decant and transfer services into the new Grey Base Hospital, particularly with regards to radiology services and operating theatres. We are working with neighbouring DHBs and the Ministry of Health to assess and alleviate these risks, but anticipate that meeting diagnostic and elective surgery wait time targets will be a significant challenge during this period.

SERVICE REDESIGN

Through the West Coast Alliance, 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 and ensure the future sustainability of our health system. We anticipate that new models of care and service delivery will continue to emerge with the development of more integrated family health services on the West Coast.

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.

At times, we may wish to negotiate, enter into or amend current service agreements or arrangements to assist in meeting our objectives and delivering against the vision and goals outlined in this document and in the DHB's Annual Plan for 2017/18. In doing so (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000), we will seek to ensure that any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations in respect to our agreements with the Crown.

Listed below are the anticipated service changes for the coming year.

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
Location and configuration of services	Services on the Grey Base Hospital Campus	Relocation of services in line with the completion of the new Grey Base Hospital and IFHC.	Increased integration of services and sustainable service delivery.	Local
Location and configuration of services	Rural Academic General Practice and Grey Medical	Relocation and merger of rural academic and general practice services in line with the completion of the IFHC on the Grey Base site.		Local
Location and redesign of service model	Nortern locality: Westport, Buller and Reefton	The DHB is working in the northern locality to redesign models of care, including the development of integrated family health services and a sustainable after-hours model.	Increased integration and sustainable service delivery.	Local
Location, configuration and redesign of service model	Coordination, assessment and management services	The DHB will look to bring assessment, coordination, and management services together into one integrated HUB. This is likely to include: phone services and rostering, needs assessment, and home and community service coordination.	Increased integration and sustainable service delivery.	Local
Redesign of service model	Home and Community Based Support Services	Working under the guidance of the West Coast Alliance, the DHB will complete the redesign of the model of care for home and community based support services. This will include consideration of the future of DHB aged residential care services.	Increased service capacity and integration, and improved patient outcomes.	Local
Redesign of service model, reconfiguration of services and location	Primary and Community Services	Working under the guidance of the West Coast Alliance, the DHB will complete the redesign of the model of care for primary and community services. This will include reviewing our approach to the provision of planned/unplanned care and extending general practice hours to support a new primary acute care service model.	Increased service capacity and integration, and improved patient outcomes.	Local
Reconfiguration of services	Dementia Services	The DHB will look to reconfigure dementia services currently under hospital management to sit alongside primary and community services as part of the wider integrated service model.	Increased service integration and improved patient outcomes.	Local
Reconfiguration of services	Infusion Services	The DHB will look to reconfigure infusion services currently under hospital management to sit	Increased service integration and	Local

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
		alongside primary and community services as part of the wider integrated service model.	improved patient outcomes.	
Reconfiguration of services	Orthotics Services	The DHB will look to reconfigure orthotics services currently under hospital management to sit alongside primary and community services as part of the wider integrated service model.	Increased service integration and improved patient outcomes.	Local
Change of provider	Podiatry Services	The DHB will look to outsource these services in response to workforce sustainability issues.	Sustained service delivery.	Local
Redesign of service model, reconfiguration of services and change of location	Mental Health Services	Under the guidance of the Mental Health Leadership Team, the DHB is working to complete the transformation of the model of care for mental health services. This will include a shift of some secondary based services into the community and increased transalpine support from Canterbury.	Increased service capacity and integration, and improved patient outcomes.	Local
Redesign of service models	General Surgery, Cancer and Anaesthesia services	The DHB will continue to redesign service models to support the adoption of collaborative transalpine pathways between West Coast and Canterbury DHBs.	Increased service capacity and equity of access to services.	Local Regional
Redesign of service model and contracting arrangements	Community Pharmacy and Pharmacist Services	Under the guidance of the West Coast Alliance, the DHB will work with Pharmacy providers to implement the national pharmacy contracting arrangements and develop local services in alignment with the direction of the national Pharmacy Action Plan.	Increased service integration, improved service quality and improved patient outcomes.	Local National
Reconfiguration of services	Corporate and Management Services	The DHB will complete the reconfiguration of its management structure to better align responsibilities with the new integrated service models.	Increased integration and sustainability of service provision	Local
Potential redesign of service models, change of provider and/or location of service	Secondary and Care Services	The DHB will continue to review capacity and costs across all service areas, and look to prioritise resources onto areas of the most immediate or greatest need. This includes aligning practice and intervention rates with national service specifications or accepted practice in other DHBs, and may impact on the configuration and scope of some services.	Reduction in operating costs, increased capacity and greater patient and system returns.	Local Regional

Monitoring Our Performance

IMPROVING HEALTH OUTCOMES

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

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

However, there is no single performance measure that can easily reflect the impact of the work we do.

We have a clear vision for the West Coast health system and in working to achieve this vision, we have developed an outcomes framework that enables us to evaluate whether we are achieving our purpose and delivering the best possible outcomes for our population.

In line with our vision we have established three high-level strategic objectives, or goals, where we can influence change, and where success will have a positive impact on the health of our population.

Alongside each goal we identified a number of long-term population health outcomes that are important to our stakeholders and will provide an insight into how well our health system is performing.

Tracking our performance against these outcomes will help us to evaluate our success. The nature of health is such that it may take a number of years to see marked improvements against some of these outcome measures. Our focus for the long-term outcomes is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

Working with the rest of the South Island DHBs, we have also collectively identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change in this space will be evident over a shorter period of time, these contributory measures have been selected as our main measures of performance.

We have set local standards against these contributory measures in order to determine if we are moving in the right direction and to evaluate our performance. These measures sit alongside our annual statement of performance expectations, outlining the service we plan to deliver and the standards we expect to meet in the coming year.

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

The performance standards (or targets) set across all these measures reflect the strategic objectives of our health system: increasing the coverage of prevention programmes; reducing acute or avoidable demand for hospital services; and maintaining access to services - while reducing waiting times and delays in treatment.

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 measures are the same across all population groups.

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

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

Overarching Intervention Logic

MINISTRY OF HEALTH SECTOR OUTCOMES

Health System Vision

All New Zealanders live well, stay well, get well.

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

REGIONAL STRATEGIC GOALS

South Island Regional Vision

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

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

West Coast DHB Vision

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

9 STRATEGIC THEMES

DHB LONG TERM OUTCOMES

What does success look like?

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

MEDIUM TERM IMPACTS

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

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

OUTPUTS

The services we deliver

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

INPUTS

The resources we need

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

Te Tiriti O Waitangi

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

Outcomes Goals

People are healthier and take greater responsibility for their own health

WHY IS THIS A PRIORITY?

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

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

Because the major risk factors also have strong socio-economic gradients, this focus will contribute greatly to reducing health inequalities between population groups. As such, we are focusing on smoking and nutrition programmes and the engagement of people, particularly children, with preventative and behavioural setting programmes.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN SMOKING RATES

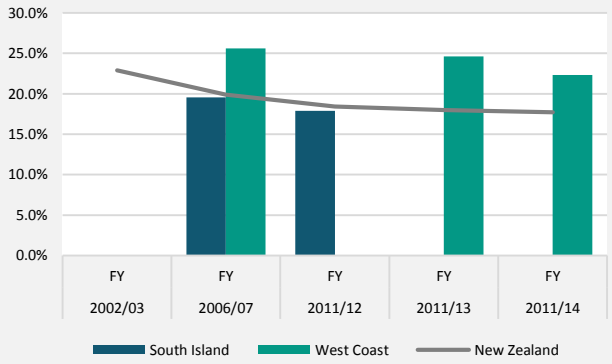
Tobacco smoking kills an estimated 5,000 people in New Zealand every year and is a major modifiable risk factor for many diseases and long-term conditions including heart disease, respiratory disease and cancer.

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 to improve health outcomes and to reduce inequalities in health status between population groups.

Data source: National NZ Health Survey [3]

Outcome measure: proportion of the population (15+) who smoke



A REDUCTION IN OBESITY RATES

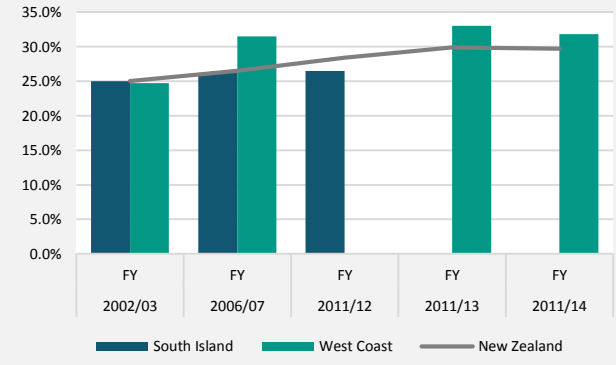
There has been a steady rise in obesity rates in New Zealand. The most recent NZ Health Survey found that 30% of adults and 10% of children are obese.

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

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

Data source: National NZ Health Survey [4]

Outcome measure: proportion of the population (15+) who are obese



[3] *The NZ Health Survey is commissioned nationally by the Ministry of Health and since 2011 results have been combined year-on-year (hence the different time periods presented). Results are currently unavailable by ethnicity, however the 2013 Census (while not directly comparable) demonstrate that Māori smoking rates are improving but are still high compared to the rest of the population: 34.3% of Māori (15+) on the West Coast identified as regular smokers compared to 20.5% of the total population.*

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

IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

MORE BABIES ARE BREASTFED

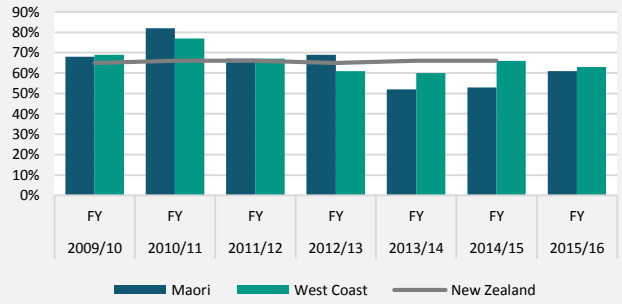
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

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

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

Data source: Plunket [5]

Measure: babies exclusively or fully breastfed at six weeks	Base	Target			
	15/16	17/18	18/19	19/20	20/21
	63%	75%	>75%	>75%	>75%



CHILDREN HAVE IMPROVED ORAL HEALTH

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

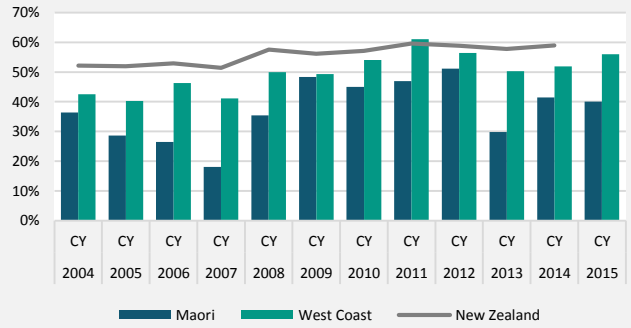
Good oral health not only reduces unnecessary hospital admission, but also signals a reduction in risk factors, such as poor diet, which have lasting benefits in terms of improved nutrition and health outcomes.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also 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 [6]

Measure: children caries-free (no holes or fillings) at age five	Base	Target			
	2015	2017	2018	2019	2020
	56%	63%	>63%	>63%	>63%



FEWER YOUNG PEOPLE TAKE UP SMOKING

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

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

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

Data Source: National Year 10 ASH Snapshot Survey [7]

Measure: 'never smokers' amongst Year 10 students	Base	Target			
	2015	2017	2018	2019	2020
	80%	>75%	>75%	>75%	>75%

[5] This measure is part of the national Well Child/Tamariki Ora (WCTO) Framework and 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 providers primarily target Māori and Pacific mothers, results for these ethnicities are likely to be under-stated. The performance standards for the WCTO Framework measures are set nationally.

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

[7] 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. For more detail see www.ash.org.nz.

People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

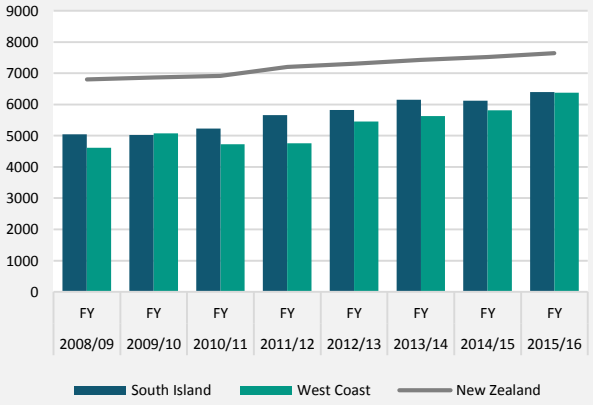
Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and even premature death.

Reducing acute hospital 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

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



MORE PEOPLE LIVING IN THEIR OWN HOME

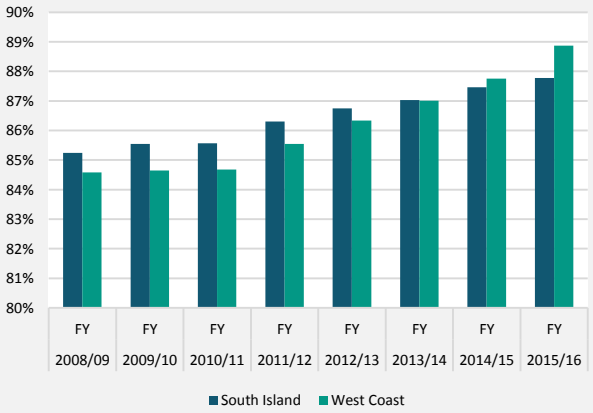
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes, when people remain in their own homes and positively connected to their local communities.

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

An increase in the proportion of older people 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 our older population.

Data Source: SIAPO Client Claims Payment System

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



IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

PEOPLES CONDITIONS ARE DIAGNOSED EARLIER

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

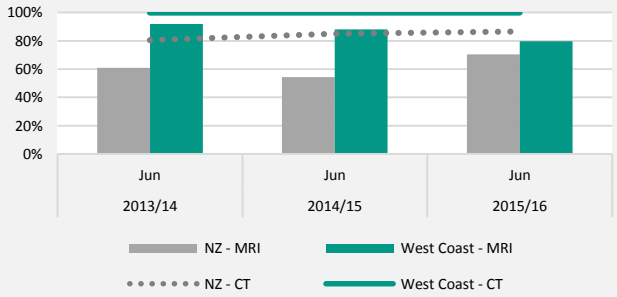
People also want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

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

Data Source: DHB Patient Management System

Measure: people waiting less than 6 weeks for their non –urgent MRI or CT scan

	Base	Target			
	15/16	17/18	18/19	19/20	20/21
MRI	80%	90%	90%	90%	90%
CT	100%	95%	95%	95%	95%



FEWER AVOIDABLE HOSPITAL ADMISSIONS

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

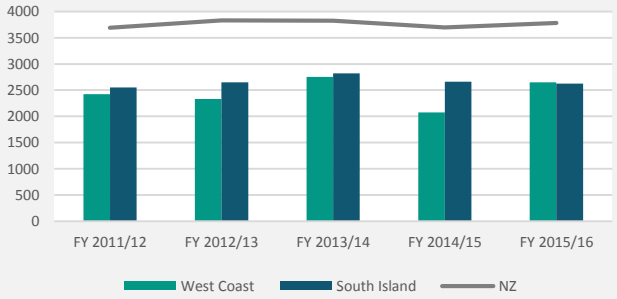
Not only will a reduction in avoidable admissions contribute to improved health outcomes for our population, but it will also reduce pressure on hospital and specialist services.

This indicator is seen as 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 ambulatory sensitive hospital admission for adults (45-64)

Base	Target			
15/16	17/18	18/19	19/20	20/21
2,652	<2,652	<2,652	<2,652	<2,652



FEWER FALLS-RELATED HOSPITAL ADMISSIONS

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 harm from falls will help people to stay well and independent and reduce the demand for hospital and residential services.

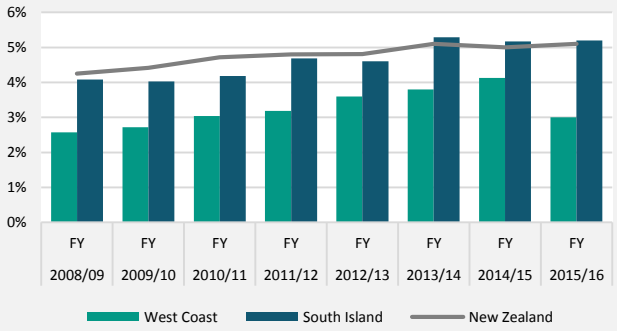
Solutions to preventing falls include: appropriate medications use, improved physical activity and nutrition, restorative support and a reduction in personal and environmental hazards.

This indicator is seen 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: population (75+) admitted to hospital as a result of a fall

Base	Target			
15/16	17/18	18/19	19/20	20/21
3.0%	<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 DHB's aim is to maintain current performance below the national rate (which reflects fewer people presenting to hospital) and to reduce the equity gap between population groups. Results differ to those previously presented, being based off the national June 2017 series provided by the Ministry of Health. All baselines have been reset to reflect the current series.

[9] From 2013/14 results reflect the updated 75+ population in line with the 2013 Census. The target has been set with the aim of maintaining West Coast rates below the national average.

People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

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

We are in midst of a significant facilitates redevelopment, remediation and repair programme and capacity within our hospital services is currently severely limited. In order to meet both the physical and emotional needs of our growing population, we are focusing on improving the flow of patients across our system and reducing duplication of effort in order to maintain service access while reducing waiting times for treatment.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE READMISSIONS

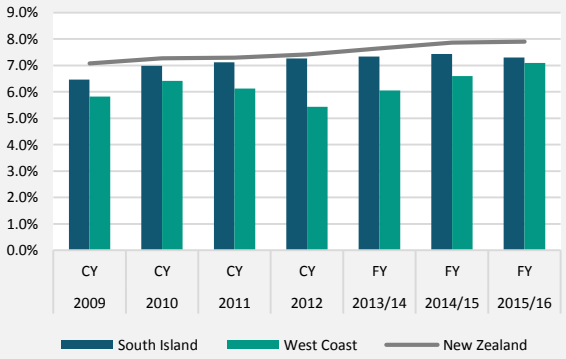
As well as reducing public confidence and driving unnecessary costs - patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

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

Readmission rates are therefore a useful marker of the quality of care being provided, and the 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]

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



A REDUCTION IN AVOIDABLE MORTALITY

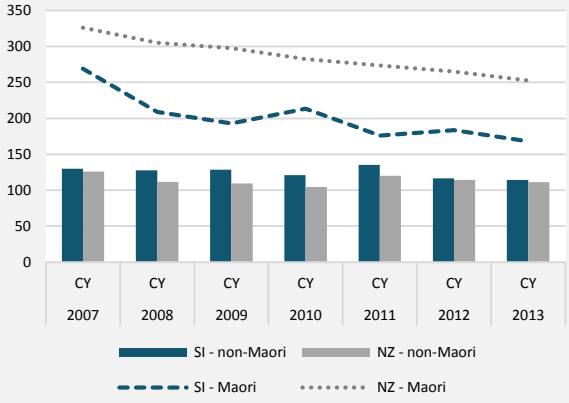
There are many upstream determinants of health, such economic, social and environmental factors that have an influence on people's life expectancy. However premature of mortality (death before are 65) is partly preventable through lifestyle change, earlier intervention and the effective management of long-term conditions.

Timely diagnosis and access to safe and effective treatment are 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 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]

Outcome 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). The 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 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. Data is three months in arrears, being the twelve months to March of each year.*

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

IMPACT MEASURES - CONTRIBUTING TOWARDS OUR STRATEGIC OBJECTIVES

SHORTER WAITS FOR URGENT CARE

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

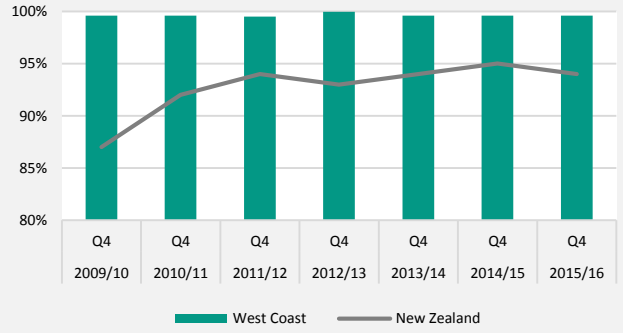
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improve patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health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

Solutions to reducing ED wait times 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: people admitted, discharged or transferred from ED within 6 hours

Base	Target			
15/16	17/18	18/19	19/20	20/21
99%	95%	95%	95%	95%



SHORTER WAITS FOR PLANNED CARE

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

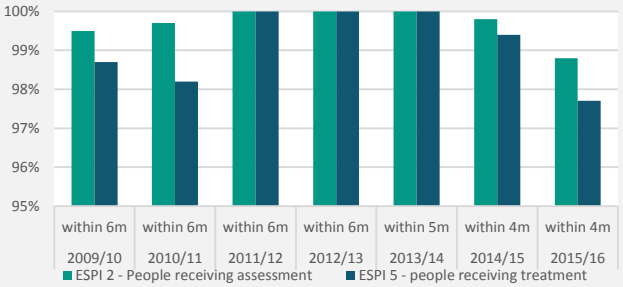
Improved performance against this measure requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our 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: people receiving specialist assessment (ESPI2) and treatment (ESPI5) within 4 months

Base	Target			
15/16	17/18	18/19	19/20	20/21
ESPI2 98.8%	100%	100%	100%	100%
ESPI5 97.7%	100%	100%	100%	100%



FEWER ADVERSE EVENTS IN OUR HOSPITALS

Adverse events, as well as causing avoidable harm to patients, reduce public confidence and contribute unnecessary costs into the system.

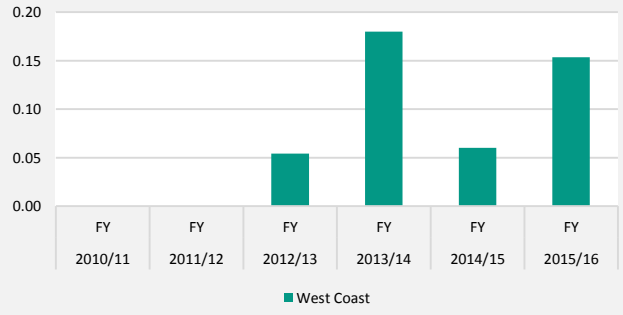
Patient falls are particularly important, as patients who experience a serious fall are more likely to have prolonged hospital stays, loss of confidence, conditioning and independence and an increased risk of institutional care.

Improving patient safety and quality standards in our hospitals will greatly improve outcomes for patients and achievement against this measure provides an indication of the quality of our services. This indicator is also seen as a proxy measure for the engagement of staff and clinical leaders in improving processes and patient safety.

Data Source: DHB Incident Reporting System [14]

Measure: Rate of falls with a severity assessment code (SAC) of level 1 & 2

Base	Target			
15/16	17/18	18/19	19/20	20/21
0.15	0.05	0.05	0.05	0.05



[12] *This measure is the national 'Shorter Stays in ED' health target. In line with national health target expectations and reporting, the result presented refer to the final quarter of each year (01 April – 30 June).*

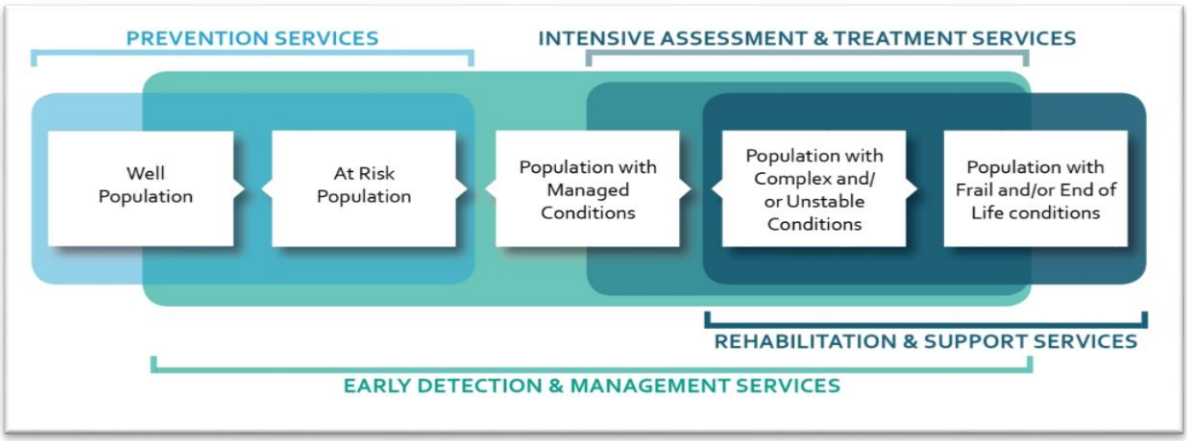
[13] *These measures are part of the national DHB Elective Services Patient Flow Indicators (ESPIs) set. In line with national ESPIs performance expectations and reporting the results presented refer to the final month (June) of each year.*

[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 – there were two incidents in 2014/15 and five in 2015/16.*

Part III

Annual Operating Intentions

Statement of Performance Expectations



3.1 Evaluating our service performance

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

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

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes. These longer term health outcomes are highlighted in our Statement of Intent which can be found on our website, www.westcoastdhb.health.nz.

Over the shorter term, we evaluate our performance on an annual basis by providing a forecast of the services we plan to deliver and the service standards we expect to meet. The results are then presented in our Annual Report.[15]

The following section presents the West Coast DHB's statement of performance expectations for 2017/18.

Because it would be overwhelming to measure every service we deliver, services have been grouped into four service classes. These reflect the full health and wellbeing continuum (illustrated above): from keeping people healthy and well, through identifying and treating illness, to supporting people to age well.

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

In presenting our performance picture, we have not simply presented the volume of services delivered. The number of people who receive a service is often less important than whether enough of the right people received the service, or whether the service was delivered at the right time. We have therefore presented a mix of measures that address four key aspects of performance: Access (A); Timeliness (T); Coverage (C); and Quality (Q).

SETTING STANDARDS

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

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

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

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

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

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

PERFORMANCE EXPECTATIONS

Like all DHBs, with a growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority on the West Coast.

All of our targets are universal and have been set with the aim of bringing performance for all population groups to the same level. Working with local stakeholders, the DHB has identified a number of particular areas for improving Māori health. These indicators are identified in this forecast (◆) and will be reported by ethnicity in our year-end Annual Report to highlight progress in reducing equity gaps for Māori.

Many of the performance standards presented in our forecast for 2017/18 are national expectations set for all DHBs, including the six national health targets. The DHB is committed to maintaining high standards of service delivery, however our small population size can make some of these expectations particularly challenging for the West Coast DHB to meet.

WHERE DOES THE MONEY GO?

The table below presents a summary of the budgeted financial expectations for 2017/18, by output class.

Prospective Summary of Revenue & Expenses by Output Class	2017/18 Plan $'000
Early Detection	
Total Revenue	23,678
Total Expenditure	42,639
Net Surplus / (Deficit)	**(18,961)**
Rehabilitation & Support	
Total Revenue	22,445
Total Expenditure	32,395
Net Surplus / (Deficit)	**(9,949)**
Prevention	
Total Revenue	2,082
Total Expenditure	2,409
Net Surplus / (Deficit)	**(327)**
Intensive Assessment & Treatment	
Total Revenue	100,047
Total Expenditure	72,851
Net Surplus / (Deficit)	**27,196**
Consolidated Surplus / (Deficit)	**(2,041)**

NOTES

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

Δ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.

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

◇ National Health Targets are set to be achieved by the final quarter of any given year. In line with national performance reporting, baselines refer to the final quarter (April-June) result.

◆ This measure has been identified as a key priority area for Māori, and progress by ethnicity will be reported in the Annual Report.

E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources.

3.2 Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Health Promotion and Education Services				
These services inform people about risk and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A [16]	172	200	>100
Babies exclusive/fully breastfed at LMC discharge (4-6 weeks)	Q [17] ◆	75%	n.a	75%
Babies exclusive/fully breastfed at 3 months	Q [17] ◆	59%	54%	60%
People provided with Green Prescriptions for additional physical activity support	A [18]	478	543	>500
Green Prescription participants more active 6-8 months after referral	Q [18]	86%	58%	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	C [19] ◇◆	90%	79%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	C ◇◆	98%	97%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	C [20]◇◆	100%	100%	90%
Mothers smokefree at two weeks postnatal	Q [21] ◆	81%	76%	95%

[16] This programme aims to improve breastfeeding rates and to create a supportive breastfeeding environment. Evidence shows that infants who are not breastfed have a higher risk of developing chronic illnesses during their lifetimes.
[17] These measures are part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The Framework covers health promotion, education, screening and support and checks are provided free to all children from birth to five years. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available at the time of printing.
[18] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a national patient survey competed by Research NZ on behalf of the Ministry of Health. In 2017 a decision was made nationally to shift to bi-annual surveys. The next survey will be in 2017/18.
[19] Professionals providing brief advice to smokers is shown to increase the chances of smokers making quit attempts. The ABC programme refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support.
[20] This measure is collected via the National Maternity Dataset which covers approximately 80% of pregnancies nationally. The measure is a developmental measure and results are used to indicate trends rather than absolute performance. Targets are set nationally.
[21] This measure is part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available at the time of printing.

Population-Based Screening Services				
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Four-year-olds provided with a B4 School Check (B4SC)	C [22] ◆	92%	74%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q [23] ◇◆	new	new	95%
Young people (Year 9) in decile 1-3 schools receiving a HEEADSSS assessment	C [24] †	46%	68%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	C [25] ◆	74%	75%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	C [25] ◆	75%	76%	70%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Children fully immunised at eight months of age	C [26] ◇◆	85%	78%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q [27] ◇	98%	100%	95%
Young women (Year 8) completing the HPV vaccination programme	C [28] †◆	53%	43%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	C [29] †◆	64%	61%	75%

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

[23] This measure is the new national Raising Healthy Kids health target, introduced in Q1 of 2016/17.

[24] 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.

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

[26] The West Coast DHB has a large community within its population who decline immunisations or opt off the National Immunisation Register (NIR) and this makes delivering all of the national immunisation targets extremely challenging. The DHB strives to offer and encourage immunisation to all the eligible population and to immunise all those who opt-in to the programmes.

[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 may 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 consists of two vaccinations and is free to young women and men under 26 years of age. The target for 2017/18 is the proportion of young women born in 2004 completing the programme.

[29] The denominator for this measure changed in 2016/17, from the number of people enrolled with a PHO, to the population according to the 2013 Census projections. Results from previous years will not be directly comparable.

3.3 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Primary Care (General Practice) Services				
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible, responsive service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Proportion of the population enrolled with the Primary Health Organisation (PHO)	C ◆	91%	89%	95%
Number of integrated HealthPathways in place across the West Coast health system	Q [30]	614	654	650
Young people (0-19) accessing brief intervention counselling in primary care	A [31] Δ	126	219	>80
Adults (20+) accessing brief intervention counselling in primary care	A [32] Δ	413	558	>300
General practices offering the primary care patient experience survey	Q [32]	-	new	85%
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Q [33] ◆	5,144	4,757	<4,757

Long-Term Conditions Management (LTCM) Services				
These services are targeted at people with high health needs due to having a long-term or chronic condition. High levels of enrolment and engagement with the general practice LTCM programme are indicative of success.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-Term Conditions Management (LTCM) programme	A [34] ◆	3,666	3,793	>2,000
Population identified with diabetes having an annual LTCM review	C	96%	91%	90%
Population with diabetes having an HbA1c test at their LTCM review showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q	69%	63%	80%
Eligible population having a cardiovascular disease risk assessment in the last 5 years	C [35] ◆	91%	91%	90%

[30] The HealthPathways website helps ensure a consistent approach to care and equitable access to services, by providing general practice with online access to clinically designed pathways that guide patient care and provide advice on treatment.
[31] The Brief Intervention Counselling service aims to support people with mild to moderate mental health concerns to improve their health outcomes and quality of life. The service includes the provision of free counselling sessions and extended GP consultations.
[32] The Patient Experience Survey is a national online survey used to determine patients' experience in primary care and how well they perceive their care is managed. The survey has been piloted in a small number of DHB regions and is now being rolled-out across the country. The information will be used to improve the quality of service delivery and patient safety.
[33] Some hospital admissions are seen as avoidable through early intervention and treatment, and the rate of these admissions provides an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. The DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based off the latest national series provided by the Ministry of Health being to June 2016. Baselines have been reset to reflect the current series and results are as at June of each year.
[34] This measure refers to the primary care run LTCM programme where patients who are enrolled with the PHO are provided with an annual review, targeted care plan and packages of care, appropriate referrals and self-management advice to help change their lifestyle, improve their health and reduce the negative impacts of their condition. Cardiovascular disease and diabetes are two of the four leading long-term conditions on the Coast and are targeted by the programme, along with chronic obstructive pulmonary disease.
[35] The eligible population is set nationally: Māori, Pacific or Indian, males 35-74, females 45-74 all other males 45-74 and females 55-74.

Oral Health Services				
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Children (0-4) enrolled in DHB oral health services	C † ◆	100%	87%	95%
Children (0-12) enrolled in DHB oral health services, being examined according to planned recall	T † ◆	89%	78%	90%
Adolescents (13-17) accessing DHB-funded oral health services	C †	70%	75%	85%

Pharmacy and Referred Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment and is therefore indicative of a successful service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Number of subsidised pharmaceutical items dispensed in the community	A [36] Δ	443k	455k	E.<600K
Number of community-requested radiological tests delivered by Grey Hospital	A	5,289	5,504	E. >5,000
People receiving their urgent diagnostic colonoscopy within 2 weeks	T [37] ◇	83%	100%	90%
People receiving their Magnetic Resonance Imagining (MRI) scans within 6 weeks	T [37]◇	88%	80%	90%
People receiving their Computed Tomography (CT) scan within 6 weeks	T [37]◇	100%	100%	95%

[36] This measure covers pharmaceutical items dispensed by community pharmacies to people living in the community. Hospital dispensed items are excluded. This may still include some non-West Coast residents who had prescriptions filled while on the Coast.

[37] 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 aligned to national standards set for all DHBs. Small population numbers on the West Coast can distort performance against these measures. For example, the total number of people seen outside the target time for MRIs scans in 2015/16 was 12 people. These wait times refer to non-urgent scans.

3.4 Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These quality and patient safety measures are national markers, championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement. [38]	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Rate of staff compliance with good hand hygiene practice	Q [39] ◇	83%	81%	80%
Hip and knee replacement patients receiving routine antibiotics before surgery	Q [40] ◇	100%	95%	95%
Hip and knee replacement patients receiving antiseptic skin preparation in surgery	Q [40] ◇	100%	100%	100%
Response rate to the national inpatient patient experience survey	Q [41]	27%	35%	>30%
Response to the communications domain in the inpatient patient experience survey – 'rate your experience of communications out of 10'.	Q	8.8	9.3	>8.0

Maternity Services				
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Women registered with a Lead Maternity Carer (LMC) by 12 weeks of pregnancy	C [42] †◆	56%	54%	80%
New mothers attending DHB-funded parenting/pregnancy courses	C	69%	100%	>30%
Number of maternity deliveries in West Coast DHB facilities	A	256	246	E. 300
Baby friendly hospital accreditation achieved in DHB facilities	Q [43]	Yes	Yes	Yes

[38] These quality measures are national markers monitored by the NZ Health Quality & Safety Commission. Performance reporting is aligned to the HQSC reports (being the quarter to June of each year) and standards are set nationally.

[39] This measure is based on ward audits of medical and surgical wards conducted according to Hand Hygiene NZ standards. The 2015/16 result has been updated from that previously published in the Annual Report, to reflect the full year rather than the Q3 result available which was the most recent available at the time of printing.

[40] Cefazolin and cefuroxime are antibiotics recommended as routine for patients receiving surgical hip and knee replacements to prevent infection complications. Skin preparation with antiseptic is also recommended to prevent infection.

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

[42] This measure comes from the national Maternity Collection and is provided by calendar year – the 2015/16 result being 12 months to December 2015. Updated data was provided by the Ministry. In line with the adoption of this measure, the new national Better Public Services measures and baselines where provided to all DHBs. The aim is to engage mothers with the health system early in their pregnancy to promote good health and wellbeing of both mother and baby.

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

Acute and Urgent Services				
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times seen as indicative of a responsive system.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
General practices providing telephone triage outside business hours	C	88%	88%	100%
Presentations at the Grey Base Hospital Emergency Department (ED)	A	11,376	11,742	E.<13,000
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T [44]	85%	80%	85%
Proportion of the population presenting at Grey Base Hospital ED (per 1,000 people)	Q	354	349	<342
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T ◇	50%	80%	90%
Acute inpatient average length of hospital stay (standardised)	Q [45]	2.35	2.40	2.30

Elective and Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service. The West Coast DHB is also striving to reduce travel time for patients.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
First Specialist Assessments provided	A [46]	6,663	6,591	E.>6,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [47]	5.5%	12.5%	>10%
Elective/arranged surgical discharges (surgeries provided)	A ◇	2,053	1,942	1,905
Elective inpatient average length of hospital stay (standardised)	Q [45]	1.63	1.55	1.40
Outpatient consultations provided	A	16,903	15,257	E. >13k
Proportion of outpatient appointments provided by telemedicine	Q [48]	1.9%	2.3%	>5%
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [49] Δ ◆	6.9%	5.9%	<6%

[44] This measure demonstrates whether people presenting in ED are seen in order of clinical need and reflects national triage standards: Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.

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

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

[47] Non-contact assessments are those provided without the need for a hospital appointment. This aligns to the West Coast DHB's vision of reducing waiting times and unnecessary travel for patients and their families.

[48] This measure has been updated to reflect the proportion of total outpatient appointments delivered using telehealth or videoconferencing technology—reducing unnecessary travel for patients and their families.

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

Specialist Mental Health Services				
These are services for those most severely affected by mental illness and/or addictions, who require specialist intervention and treatment. Reducing waiting times, while meeting increasing demand for services, is indicative of a responsive service.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Proportion of the population (0-19) accessing specialist mental health services	C [50] Δ	6.1%	5.5%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	C Δ	5.0%	5.2%	>3.8%
People referred for non-urgent mental health and alcohol and other drug services seen within 3 weeks	T [51]	77%	81%	80%
People referred for non-urgent mental health and alcohol and other drug services seen within 8 weeks	T	93%	94%	95%

Specialist Assessment, Treatment and Rehabilitation (AT&R) Services				
These are services provided to restore functional ability and enable people to live as independently as possible. An increased proportion of people discharged home, rather than into aged residential care (ARC), reflects a successful outcome.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Admissions into inpatient AT&R services	A [52]	124	91	E.<150
Inpatients (aged 75+) receiving a falls assessment	Q [53] ◇	88%	88%	90%
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q [54] Δ	83%	82%	80%

[50] These measures are national performance measures (PP6), and standards are set based on national expectations that at least 3% of the population will need access to specialist mental health services during their lifetime. West Coast rates are high and with the DHB vision being to better support people earlier and closer to home, it is expected that current rates will come down over time, as more people are appropriately seen and supported in primary and community settings. Results are provided nationally using data submitted by providers to the national PRIMHD database and produced a quarter in arrears.

[51] These are national DHB performance measures (PP8). Performance results are provided nationally and are three months in arrears.

[52] An increasing focus on restorative care being delivered in people's own homes (via the DHB's Complex Clinical Care Network) will result in fewer people needing to be admitted into our hospitals in order to access assessment, treatment and rehabilitation services.

[53] 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. In line with national expectations, the DHB aims to assess all the falls risk of all older inpatients and develop a falls plan to reduce risk.

[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. A 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 and the DHB has identified this measure from this perspective. However, the DHB notes the impact of very small numbers on this measure and the understanding that as more rehabilitation services are made available in people's homes and communities, only the most complex patients will need to access AT&R in hospital. A higher proportion of these people are likely to need ongoing support and care. The measure excludes those who were ARC residents prior to AT&R admission.

3.5 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Rehabilitation Services				
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A [55]	-	new	yes
People (65+) supported by the community-based Falls Prevention Service	A [56]	-	16	>25
People referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	C [57]	41%	31%	80%

Home and Community-Based Support Services				
These are services designed to support people to continue living in their own homes and to maintain their independence. Largely demand driven, clinical assessment ensures access to services is appropriate and equitable.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Meals on Wheels provided	A [58] Δ	37,306	33,561	E. 35,000
Number of home and community district nursing visits provided to long-term clients	A Δ	4,171	4,246	E. >4,000
Number of people supported by long-term home and community support services	A Δ	792	786	E. >740
Proportion of people receiving long-term home and community support services who have had a clinical assessment of need using the interRAI assessment tool	Q [59] Δ	93%	93%	95%

[55] Flexible Integrated Rehabilitation Support Team (FIRST) is a new service that will work with clients in their own homes to enable them to remain as independent as possible. It will be part of the broader continuum of care for adults, ensuring a seamless transfer of services between the hospital and the community. The target has been set to ensure that the service is established and available for our population.
[56] Falls are one the leading causes of hospital admission for people aged over 65. The Falls Prevention Service provides care for people 'at-risk' of a fall, or following a fall, and supports people to stay safe and well in their own homes. The service was introduced in 2015/16.
[57] The New Zealand Clinical Guidelines for Stroke Management set out expectations around the provision of stroke services where services are provided by a coordinated interdisciplinary team with expertise in stroke and rehabilitation, across a pathway that consists of early and ongoing comprehensive assessment and treatment, proven to support improved outcomes for stroke patients.
[58] Meals on Wheels is a subsidised service available for people who can't prepare a hot meal without help because of a medical condition or a disability, who have no family or whānau help readily available, and need the meal to maintain good nutrition and independence. This may be a short intervention or a longer-term solution to support people to stay well in their own homes.
[59] The International Residential Assessment Instrument (interRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning by using evidence based practice guidelines to ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live.

Respite and Day Services				
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need addressed. Largely demand-driven, access to services is expected to increase over time, as more people are supported to remain safe and well in their own homes.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
People supported by aged care respite services	A Δ	56	61	E. 70
Number of mental health planned and crisis respite service bed-days accessed	A Δ	457	365	E. 500

Aged Residential Care Services				
With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Notes	2014/15 Result	2015/16 Result	2017/18 Target
Number of ARC rest home bed-days provided	A Δ	40,488	35,363	E. <50,000
Number of ARC hospital bed-days provided	A Δ	37,537	37,843	E. <40,000
Number of ARC dementia bed-days provided	A Δ	5,399	5,439	E. >4,000
Number of ARC psychogeriatric bed-days provided	A Δ	2,167	3,314	E. >2,000
People entering ARC having had a clinical assessment of need using interRAI	Q Δ	97%	90%	95%

Meeting Our Financial Challenges

3.6 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 to the health sector that we must rethink how we will meet our population's need within a more moderate growth platform.

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

We are also facing a number of unique challenges due to our size and geographic isolation and are in the midst of a significant redevelopment, remediation and repair programme. Additional fiscal challenges for the West Coast include:

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

The costs of inter-district flow: 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.

The costs of seismic remediation: 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. Truly improving the health of our population is the only way to get ahead of the demand curve. This means redesigning services to provide people with the right care and support, at the right time and in the right place. Savings will be made, not in dollar terms, but in terms of costs avoided through more effective utilisation of the resources available and a reduced demand for services.

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

3.6 Planned results

The West Coast DHB is predicting a $2.041m deficit result for the 2017/18 year.

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $148m to meet the needs of our population in 2017/18.

This represents a 3.9% increase on the previous year and whilst this equates to a $5m increase in funding, this includes revenue for pay equity settlements, which come with associated expenditure. This forecast is based on receiving the minimum percentage funding increase available to DHBs in 2017/18.

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

MAJOR ASSUMPTIONS

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

- Population-based funding levels for 2017/18 are based on the funding advice received by the Ministry in June 2017
- Out-years funding is assumed at an average of 2.5% increase per annum.
- The West Coast DHB will continue to receive Crown Funding on an early payment basis
- Costs of compliance with a 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 for Grey and Buller under the nationally appointed Hospital Redevelopment Partnership Group
- Funding for all aspects of pay equity settlements will be cost neutral as they will be fully funded.
- Work will continue on the facilities redevelopment for Grey and Buller under the nationally appointed Hospital Redevelopment 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 June 2018. The net operating result, for 2017/18 and out-years, reflects the modelling as

per the detailed business case approved by cabinet in 2014 (adjusted for the 2014/15 transitional funding repayment as well as known changes such as capital charge changes).

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

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

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

3.8 Closing the gap

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

The DHB will carefully consider all opportunities and options to ensure the most effective use of our collective resources 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 benefit and are sustainable long-term
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services
- Tightening cost growth including moderating treatment, back office, support and FTE costs.

Service changes proposed for the coming year are outlined in the managing our business section of this document.

3.9 Asset planning and investment

GREYMOUTH REDEVELOPMENT

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

In 2014 approval was given for a new Grey Base Hospital and IFHC redevelopment. Construction commenced on the combined project in May 2016 with completion scheduled for June 2018. The revised budget for this development is $77.8m.

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

Planning for redevelopment of the mental health facility is also expected to start in 2017/18.

BULLER REDEVELOPMENT

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

An Implementation Business Case has been progressed and options submitted to the HRPG as we move closer to bringing this facility to life. The notional cost for the development of the Buller IFHC is $12m.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $2.5m for the 2017/18 year. In addition to the normal capital requirements, the Grey redevelopment requires further investment in capital equipment than would normally be afforded, such as Information Technology infrastructure.

Strategic capital for 2017/18-2020/21 comprises of:

- Mental health redevelopment (notionally $5m)
- Phased upgrade of clinics outside Westport and Greymouth (notionally $0.5m per clinic)
- Secondary tranche Grey Base Hospital redevelopment (notionally $5m)
- Move to the South Island Patient Information Care System (notionally $2.5m)

- Investment in other strategic IT / integration systems, including regional IT 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 Base Hospital redevelopment projects, whereby 40-45% Crown capital support would likely be required.

3.10 Debt and equity

MINISTRY OF HEALTH

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

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

EQUITY

The Grey Base Hospital and IFHC redevelopment is expected to be completed in the second quarter of 2018 at which time the asset will be transferred from the Ministry of Health to the DHB. Following the asset transfer, the Ministry will simultaneously increase the equity of the DHB estimated at $77.8 million.

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

3.11 Additional considerations

SUBSIDIARY COMPANY AND PARTNERSHIPS

With an annual budget of just over $6m, the South Island Alliance Programme Office is jointly funded by the five South Island DHBs to provide audit, project management and regional service development services. West Coast DHB's contribution for 2017/18 will be approximately $0.148m.

With an annual budget of over $54m, the New Zealand Health Partnership Limited is jointly funded by all 20 DHBs to enable DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB's contribution to the running of the Health Partnership for 2017/18 will be approximately $0.567m.

DISPOSAL OF LAND

The West Coast DHB currently has a stock of assets, consisting of parcels of land within Greymouth and Westport, a number of which have existing leasehold arrangements. The DHB will assess the future of these properties based on future models of care and facilities requirements.

Necessary approvals will be sought to dispose of any of the DHB's properties identified as surplus to requirements. Normal policy is that DHBs will not dispose of any estate or interest in any land without having first undertaken required consultation and obtained the consent of the responsible Minister. With approval, land would be valued and offered to parties with the statutory right to receive an offer under the Public Works Act and Ngāi Tahu Settlement Act (and any other relevant legislation), before being made available for public sale.

In the coming year this is likely to include the disposal of land to accommodate the development of an Integrated Family Health Centre in Buller.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

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

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. These are presented as Appendix 3.

Statement of Financial Expectations

3.12 Statement of comprehensive income – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Income						
Ministry of Health revenue	128,912	131,477	136,234	141,223	145,839	148,319
Patient related revenue	2,884	2,666	7,017	6,747	6,747	6,747
Other operating income	9,166	8,220	4,581	4,225	4,276	4,332
Interest income	327	408	420	420	420	424
Total Income	141,289	142,771	148,252	152,615	157,282	159,822
Operating Expenses						
Personnel	57,142	57,416	59,796	59,790	60,865	63,065
Outsourced services (clinical and non clinical)	7,284	8,692	7,487	7,851	7,168	7,242
Treatment related costs	7,781	8,402	8,288	8,100	8,182	8,264
External service providers (include Inter-district outflow)	52,649	53,161	58,419	59,979	61,258	61,874
Depreciation & amortisation	4,572	3,373	3,400	5,326	5,217	5,490
Interest expenses	651	343	-	-	-	-
Other expenses	11,129	11,446	11,416	9,940	9,422	9,293
Total Operating Expenses	141,208	142,833	148,806	150,986	152,112	155,228
Operating surplus before capital charge	81	(61)	(553)	1,629	5,170	4,594
Capital charge expense	978	739	1,488	6,234	6,225	6,865
Surplus / (Deficit)	(897)	(800)	(2,041)	(4,605)	(1,055)	(2,271)
Other comprehensive income	-	-	-	-	-	-
Total Comprehensive Income	**(897)**	**(800)**	**(2,041)**	**(4,605)**	**(1,055)**	**(2,271)**

3.13 Statement of financial position – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
CROWN EQUITY						
General funds	72,563	86,062	167,267	171,803	172,789	174,992
Revaluation reserve	22,082	22,082	22,082	22,082	22,082	22,082
Retained earnings	(82,236)	(83,036)	(85,077)	(89,681)	(90,736)	(93,006)
TOTAL EQUITY	**12,409**	**25,108**	**104,272**	**104,204**	**104,136**	**104,068**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	11,850	10,811	12,687	11,563	10,262	12,234
Trade & other receivables	5,941	4,685	5,123	6,555	6,555	6,555
Inventories	986	1,060	1,007	1,007	1,007	1,007
Assets classified as held for sale						
Investments (3 to 12 months)						
Restricted assets	74	72	74	74	74	74
TOTAL CURRENT ASSETS	18,851	16,628	18,891	19,199	17,898	19,870
CURRENT LIABILITIES						
Trade & other payables	10,411	9,249	9,249	9,249	9,249	9,249
Capital charge payable	-	-	-	-	-	-
Employee benefits	6,975	7,201	7,201	7,201	7,201	7,201
Restricted funds	74	70	70	70	70	70
Borrowings	3,500	-	-	-	-	-
TOTAL CURRENT LIABILITIES	20,960	16,519	16,519	16,519	16,519	16,519
NET WORKING CAPITAL	(2,109)	108	2,372	2,680	1,379	3,351
NON CURRENT ASSETS						
Investments (greater than 12 months)	567	567	567	567	567	567
Property, plant, & equipment	26,858	26,500	103,730	103,851	105,574	104,012
Intangible assets	681	636	306	(191)	(681)	(1,159)
TOTAL NON CURRENT ASSETS	28,106	27,703	104,603	104,227	105,460	103,420
NON CURRENT LIABILITIES						
Employee benefits	2,643	2,703	2,703	2,703	2,703	2,703
Borrowings	10,945	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	13,588	2,703	2,703	2,703	2,703	2,703
NET ASSETS	**12,409**	**25,108**	**104,271**	**104,203**	**104,135**	**104,067**

Statement of movement in equity – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Total Equity at Beginning of the Period	12,496	12,409	25,108	104,272	104,204	104,136
Total Comprehensive Income	(897)	(800)	(2,042)	(4,605)	(1,055)	(2,271)
Other Movements						
Contribution back to Crown - FRS3	-	-	-	-	-	-
Contribution from Crown - Capital	-	13,499	77,800	-	-	-
Contribution from Crown - Operating Deficit Support	878	-	3,474	4,605	1,055	2,271
Other Movements	(68)	-	(68)	(68)	(68)	(68)
Total Equity at End of the Period	**12,409**	**25,108**	**104,272**	**104,204**	**104,136**	**104,068**

3.14 Statement of cashflow – year ending 30 June

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	127,546	132,551	136,683	141,223	145,839	148,319
Other receipts	18,530	12,995	11,115	11,042	10,391	10,511
Interest received	327	408	416	420	420	424
	146,403	145,954	148,214	152,685	156,650	159,254
Cash was applied to:						
Payments to employees	65,175	65,782	67,906	69,849	67,335	69,672
Payments to suppliers	72,237	75,515	77,848	77,312	78,927	79,498
Interest paid	651	343	-	-	-	-
Capital charge	978	739	1,488	6,234	6,225	6,865
GST - net	(767)	706	-	-	-	-
	138,274	143,085	147,242	153,395	152,487	156,035
Net Cashflow from Operating Activities	**8,129**	**2,869**	**972**	**(710)**	**4,163**	**3,219**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	12	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	-	12	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	2	-	-	-
Purchase of property, plant, & equipment	2,859	2,970	2,500	4,950	6,450	3,450
	2,859	2,970	2,502	4,950	6,450	3,450
Net Cashflow from Investing Activities	**(2,859)**	**(2,958)**	**(2,502)**	**(4,950)**	**(6,450)**	**(3,450)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	-	(946)	-	-	-	-
Equity Injection - Deficit Support	1,000	-	3,473	4,604	1,054	2,271
Loans Raised	-	-	-	-	-	-
	1,000	(946)	3,473	4,604	1,054	2,271
Cash applied to:						
Other	68	4	68	68	68	68
Equity Repayment	-	-	-	-	-	-
	68	4	68	68	68	68
Net Cashflow from Financing Activities	**932**	**(950)**	**3,405**	**4,536**	**986**	**2,203**
Overall Increase/(Decrease) in Cash Held	6,202	(1,039)	1,875	(1,124)	(1,301)	1,972
Add Opening Cash Balance	5,648	11,850	10,811	12,687	11,563	10,262
Closing Cash Balance	**11,850**	**10,811**	**12,687**	**11,563**	**10,262**	**12,234**

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

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Funding Arm						
Revenue						
MoH Revenue	127,783	130,287	135,470	139,989	144,584	147,042
Patient Related Revenue	-	-	-	-	-	-
Other	1,487	1,661	1,705	1,740	1,775	1,810
Total Revenue	129,270	131,948	137,175	141,729	146,359	148,852
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	89,913	91,421	94,694	96,616	98,259	99,241
Mental Health	14,340	14,192	14,504	14,649	14,794	14,941
Disability Support	18,045	18,063	20,873	21,080	21,293	21,507
Public Health	637	599	560	565	571	577
Maori Health	625	811	818	826	835	844
Governance & Admin	826	826	827	827	827	827
Total Expenditure	124,386	125,913	132,276	134,563	136,579	137,937
Net Surplus/(Deficit)	**4,884**	**6,035**	**4,899**	**7,166**	**9,780**	**10,915**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**4,884**	**6,035**	**4,899**	**7,166**	**9,780**	**10,915**

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Governance & Funder Admin						
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	2,596	2,462	2,805	2,481	2,515	2,549
Total Revenue	2,596	2,462	2,805	2,481	2,515	2,549
Expenditure						
Personnel	1,401	994	1,189	1,040	1,055	1,070
Outsourced services	400	705	870	712	719	726
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	795	762	746	599	605	611
Total Expenditure	2,596	2,462	2,805	2,351	2,379	2,407
Net Surplus/(Deficit)	**-**	**0**	**0**	**130**	**136**	**142**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**0**	**0**	**130**	**136**	**142**

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

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
Provider Arm						
Revenue						
MoH Revenue	1,129	1,190	764	1,234	1,255	1,277
Patient Related Revenue	2,884	2,666	7,017	6,747	6,747	6,747
Other	78,843	78,893	76,327	76,662	77,415	78,182
Total Revenue	82,856	82,750	84,108	84,643	85,417	86,206
Expenditure						
Personnel	55,741	56,421	58,607	58,750	59,810	61,995
Outsourced services	6,884	7,987	6,617	7,139	6,449	6,516
Depreciation	4,572	3,373	3,400	5,326	5,217	5,490
Interest & Capital Charge	1,629	1,082	1,488	6,234	6,225	6,865
Other	19,811	20,722	20,936	19,095	18,687	18,668
Total Expenditure	88,637	89,584	91,048	96,544	96,388	99,534
Net Surplus/(Deficit)	**(5,781)**	**(6,835)**	**(6,940)**	**(11,901)**	**(10,971)**	**(13,328)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(5,781)**	**(6,835)**	**(6,940)**	**(11,901)**	**(10,971)**	**(13,328)**

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
In House Elimination						
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Total Revenue	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Total Expenditure	(73,433)	(74,388)	(75,835)	(76,238)	(77,009)	(77,785)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-

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

	30/06/16 Actual $'000	30/06/17 Forecast $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
CONSOLIDATED						
Revenue						
MoH Revenue	128,912	131,477	136,234	141,223	145,839	148,319
Patient Related Revenue	2,884	2,666	7,017	6,747	6,747	6,747
Other	9,493	8,628	5,001	4,645	4,696	4,756
Total Revenue	141,289	142,771	148,252	152,615	157,282	159,822
Expenditure						
Personnel	57,142	57,416	59,796	59,790	60,865	63,065
Outsourced services	7,284	8,692	7,487	7,851	7,168	7,242
Depreciation	4,572	3,373	3,400	5,326	5,217	5,490
Interest & Capital Charge	1,629	1,082	1,488	6,234	6,225	6,865
Other	71,559	73,009	78,123	78,019	78,862	79,431
Total Expenditure	142,186	143,571	150,294	157,220	158,337	162,093
Net Surplus/(Deficit)	**(897)**	**(800)**	**(2,041)**	**(4,605)**	**(1,055)**	**(2,271)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(897)**	**(800)**	**(2,041)**	**(4,605)**	**(1,055)**	**(2,271)**

Part V

Further Information for the Reader

Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Minister's Letter of Expectations 2017/18
Appendix 3	Statement of Accounting Policies

Documents of interest

The following documents can be found on the West Coast DHB's website (www.westcoastdhb.org.nz/publications) and read in conjunction with this document. They provide additional parts of the picture on health service delivery and transformation across our health system.

- West Coast DHB Annual Plan 2017/2018
- West Coast DHB Public Health Action Plan 2017/18
- West Coast DHB Quality Accounts 2017/18
- South Island Regional Health Services Plan 2016-2019

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, referenced in this document, are available on the Treasury website, www.treasury.govt.nz.

Appendix 1 Glossary of Terms

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

Appendix 2 Minister's Letter of Expectations 2017/18

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

Ms Jenny Black
Chairperson
West Coast District Health Board
PO Box 387
Greymouth 7840

16 DEC 2016

black-white@clear.net.nz

Dear Ms Black

Letter of Expectations for DHBs and Subsidiary Entities 2017/18
The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2016 Vote Health received an additional $568 million, the largest increase in seven years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy
The refreshed New Zealand Health Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to ensure that all New Zealanders live well, stay well and get well.

The DHB annual plans are the primary document for demonstrating DHB delivery of the Strategy, and your 2017/18 annual plan is expected to clearly demonstrate the linkages between the five themes of the Strategy and your DHB's performance story, activities and outcomes, while also maintaining a focus on Māori health outcomes and health equity.

In particular I want to see a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions.

Finally, I want your Board to very carefully consider how any new local initiatives fit within the context of the Strategy.

Living Within our Means
While the global economic environment continues to be challenging, DHB funding has continued to be increased year on year. DHBs need to budget and operate within allocated funding and must have clear plans to improve year-on-year financial performance. Your DHB's financial performance is currently tracking to plan for 2016/17, and I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. In particular your Board must work closely with NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services.

Working Across Government
I expect DHBs to continue supporting cross-agency work to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki once this has been established.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

All DHBs must continue to work closely with other social sector organisations to achieve cross-sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as the Prime Minister's Youth Mental Health Project, the Childhood Obesity Plan and the *Living Well with Diabetes* Plan.

Locally, I expect West Coast DHB will ensure systems are in place to effectively follow-up rheumatic fever cases, continue current activity to maintain high coverage rates for those children who are not opted off or declined, and reduce the use of seclusion in inpatient mental health services.

National Health Targets
All of the national health targets are very important for driving overall performance, and have resulted in major improvements in the health outcomes of New Zealanders. I expect DHBs to remain focussed on achieving and improving performance against all six health targets. The *faster cancer treatment* target remains a top priority for service delivery for DHBs and further progress is expected during 2017/18.

The first national result for the *raising healthy kids* health target is 49 percent. I expect results for all DHBs to improve considerably each quarter as referral processes and clinical pathways are fully implemented.

Locally, West Coast DHB has shown good performance in relation to the *improved access to elective surgery* and *shorter stays in emergency departments* health targets. However, performance in relation to the other health targets can be improved. Please ensure delivery of these health targets is a priority for your DHB.

Streamlining of DHB Annual Planning
In order to ensure that the Health Strategy is informing DHB planning, DHB annual plans will be streamlined in 2017/18 so that they are focussed on my key expectations for your DHB. Your DHB should also be considering longer-term strategic planning (ten-year horizon) as a way to deliver on the vision of the Health Strategy, and I expect that in the future you will be able to demonstrate this planning.

Working regionally also continues to be important, and I expect that when you are considering your long-term strategic planning you are also considering this in a regional context.

There are a number of key planning priorities for 2017/18 that DHBs will need to clearly respond to in their annual plans. These planning priorities have been selected in order to progress the key Government expectations outlined above, and also to progress other key health initiatives, such as Bowel Screening, implementation of the Healthy Ageing Strategy and continued integration of health care in order to better prevent and manage long term conditions, and provide services and care in the best ways to meet local needs. This will require ongoing engagement with your primary and community partners, including implementation of the System Level Measures.

The full list of my planning priorities for 2017/18 is attached for your information. I have asked the Ministry to provide separate advice about how each of these should be reflected in your plan.

Concluding comments
In implementing your annual plan it is important that clinicians are engaged and involved throughout; clinical leadership is fundamental in delivering high-quality health services.

Please note that I am not requiring DHBs to refresh their statements of intent (SOIs) for tabling in 2017/18. However, please ensure you review your SOI produced in 2016/17 to confirm that there are no significant changes. The statements of performance expectations will still need to be produced and tabled.

Keep in mind that the Budget 2017 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available, including information on planning priorities.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2017/18.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

2017/18 DHB Annual Planning Priorities

Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
Supporting Vulnerable Children Better Public Service Target
Reducing Rheumatic Fever Better Public Service Target
Increased Immunisation Better Public Service and Health Target
Shorter Stays in Emergency Departments Health Target
Improved Access to Elective Surgery Health Target
Faster Cancer Treatment Health Target
Better Help for Smokers to Quit Health Target
Raising Healthy Kids Health Target
Bowel Screening
Mental Health
Healthy Ageing
Living Well with Diabetes
Childhood Obesity Plan
Child Health
Disability Support Services
Primary Care Integration
Pharmacy Action Plan
Improving Quality
Living Within our Means
Information Technology
Workforce.

Appendix 3 Statement of Accounting Policies

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

The following information is provided in respect of this Plan:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

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

REPORTING ENTITY AND STATUTORY BASE

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

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

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

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

BASIS OF PREPARATION

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

Statement of compliance

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

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

Measurement basis

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

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

Functional and presentation currency

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

Changes in accounting policies

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

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

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

Subsidiaries

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

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

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are:

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

Owned assets

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

Revaluations

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

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

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

Additions

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

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Depreciation

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

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

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

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

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

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

Amortisation

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

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

Investments

Bank term deposits

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

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

Trade and other receivables

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

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

Inventories

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

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

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

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of

acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

Capital charge

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

Impairment

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

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

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

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

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

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

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

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

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

Impairment of property, plant, equipment and intangible assets

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

Non-cash-generating assets

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

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

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

Borrowings

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

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

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

Provisions

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

ACC WSMP (Work Place Safety Management Programme)

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

Trade and other payables

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

Income tax

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

Equity

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

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

Revaluation reserve

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

Goods and services tax

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

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

Revenue

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

Ministry of Health population-based revenue

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

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

Provision of other services

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

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

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

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

Critical accounting estimates and assumptions

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

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

Property, plant and equipment useful lives and residual value

At each balance date West Coast DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the

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

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

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

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

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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

Statement of Intent

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