Office of Hon Tony Ryall

Minister of Health
Minister of State Services

17 AUG 2010

Mr Rex Williams
Chair
West Coast District Health Board
PO Box 387
GREYMOUTH 7840

Dear Mr Williams

West Coast District Health Board: 2010/11 District Annual Plan

This letter advises that together with the Minister of Finance, I have signed West Coast District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for one year and that the Board has my support for implementing this one year plan.

Clinical and financial sustainability

In approving your DAP for only one year, the Minister of Finance and I are concerned about the deficit of $7.2M the DHB is forecasting for 2010/11, with this deficit position unchanged in out years. The DHB is not demonstrating how it plans to work its deficit out of the system. The rate of transformational change and in particular, the efficiencies and cost savings that the DHB is planning, do not provide a clear pathway to financial sustainability.

My DAP approval is conditional upon the DHB demonstrating an improved financial pathway in its 2011/12 DAP, with a significantly advanced level of thinking evident in the DAP. This will require the DHB to make good progress on transforming models of care, both at a local level as it develops primary care consistent with the approved Better, Sooner, More Convenient business case, and at a sub-regional level as it develops stronger clinical service and management collaboration with Canterbury DHB.

I expect the Board and your incoming CEO to advance the work reflected in your 2010/11 DAP with regard to the two significant streams of work related to long term sustainability. My understanding is that the incoming CEO is comfortable with the broad direction of travel of the DHB, but that his approach to the delivery of this vision and his analysis of priorities involves a stronger focus on community engagement and providing safe clinical services. I expect the Board to enable and support the new CEO's vision and leadership as he takes significant steps to build integrated services, re-engage stakeholders and move the DHB towards clinical and financial sustainability. I require a report on overall progress and future planning by 29 October 2010 with clear timelines, actions and planned outcomes.

Mental health ring fence

Your DHB has signalled plans to allocate less than the expected mental health ring fence allocation by $0.3M in 2010/11. While I am not viewing allocations below the ring-fence as an impediment to the overall approval of your DAP, I expect the DHB to work with the Ministry during 2010/11 to ensure my expectations regarding the mental health ring-fence are met. This includes ensuring that funding not allocated in accordance with ringfence expectations is tagged for mental health and addiction services, to be allocated in outyears.

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This should include your DHB working with the Ministry's Mental Health Group to determine the appropriate level of service delivery for the DHB's population; and in 2011/12 and out-years, allocating sufficient funding to support this. The NHB will ensure that this work is undertaken as it forms part of my agreement to your 2010/11 DAP.

As part of this discussion, it will be important to establish whether any proposed changes to mental health service models, including integrating primary and secondary mental health services, should be considered under the service change protocols outlined in the 2010/11 Operational Policy Framework (OPF).

Health targets and priorities
I appreciate the DHB's emphasis on the Government's health targets and priority areas. The Ministry of Health has advised that it considers there are heightened risks associated with your achievement of the agreed health targets for Improved Access to Elective Surgery, Shorter Waits for Cancer Treatment and Immunisation. I expect that your DHB remains focused on improving performance in these and other health target areas, and that it will work closely with the Ministry, and in particular, the Health Target Champions, to ensure good progress is made.

With regard to South Island-wide regional planning, I expect greater levels of collaboration and evidence of effective decision making across the South Island DHBs, focused on planning for vulnerable services and a shared approach to future capital planning.

The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

I note the risks outlined in your DAP and the mitigation strategies you have identified. I expect robust financial performance and that you continue to keep the Ministry informed of emerging risks. My approval of your DAP does not mean acceptance of your assumptions in the out years.

My approval of your DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the National Capital Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

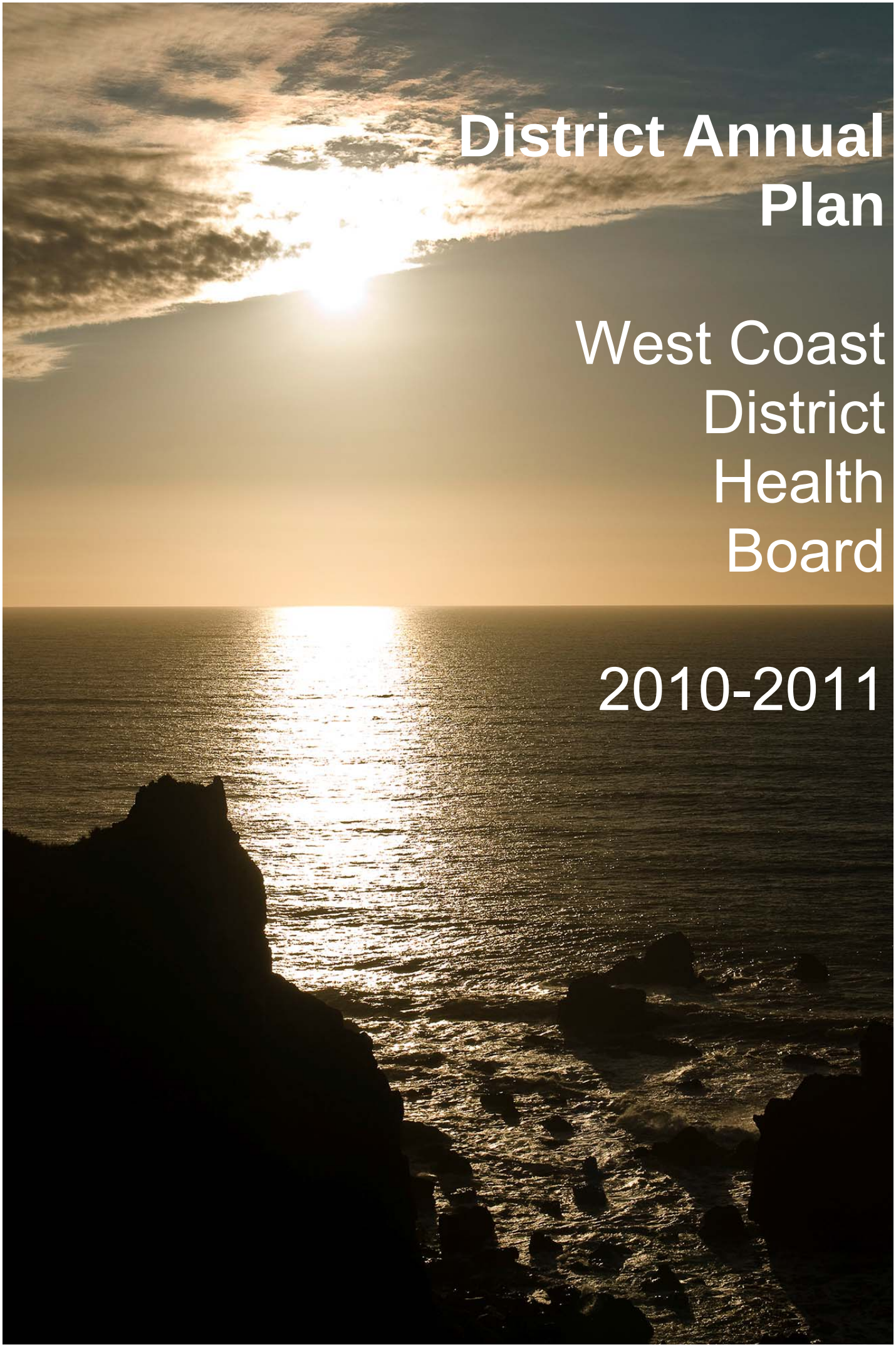
I wish you, your Board and management every success with the implementation of your 2010/11 DAP, and thank you for your contribution and efforts to improve the health of New Zealanders.

Finally, please ensure that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance



District Annual Plan

West Coast District Health Board

2010-2011

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Statement from the Chairman and Chief Executive

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

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

There are several key strategic priorities within the District Annual Plan that the District Health Board intends to implement during the 2010/2011 year.
The West Coast District Health Board will maintain its focus on achieving national priorities. The Board recognises the strategic direction of Government targets and will undertake all practicable steps to ensure that the District Health Board performs well in these areas.

Achieving ongoing financial and clinical sustainability is a major priority for the West Coast District Health Board. The Board recognises the significant task it has in endeavouring to reduce its deficit. West Coast District Health Board is firmly committed to reducing the 2010/2011 deficit to zero deficit over the next five years. Many strategies are being implemented to assist the Board to live within its means while still maintaining safe and sustainable services for the West Coast population.

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

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

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

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

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

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

Dr Paul McCormack
DEPUTY CHAIR

Joel George
CHIEF EXECUTIVE OFFICER

Hon Tony Ryall
MINISTER OF HEALTH

Bill English
MINISTER OF FINANCE

1.0 Introduction

This District Annual Plan has two key objectives, the first of which is to detail how the West Coast District Health Board plans to progress its strategic objectives from the 2006 - 2015 District Strategic Plan, the 2010 - 2013 Statement of Intent, the Minister's Health Targets and the Minister's and District Health Board Chair's Letters of Expectation. These include the services to be funded and provided to best meet the health needs of the West Coast, within the available funds. The second purpose of the document is to ensure compliance with legislative requirements for the receipt of funding through the Ministry of Health. It is used as a means by which to manage performance against stated goals and objectives, both internal and as laid out by the Ministry of Health.

1.1 The West Coast District Health Board

GOVERNANCE AND ADMINISTRATION FUNCTIONS

The West Coast District Health Board

The West Coast District Health Board provides leadership and is responsible for:

- Monitoring and evaluating the achievement of strategic and operational results and quality, both clinical and non-clinical
- Establishing and reviewing the mission, values, vision and strategic directions of the West Coast District Health Board
- Facilitating the appropriate involvement of clients in service development, delivery and review
- Ensuring the West Coast District Health Board is adequately resourced to meet its objectives
- Developing and monitoring governance policies that provide an adequate risk management framework and clear delegations to the Chief Executive

The Board clearly defines, documents and works within its scope of authority, roles and responsibilities, regularly reviewing them and making changes as necessary. The Board operates according to a deed, constitution, bylaws, legislation or articles of association, and the corporate policies that it sets.

The West Coast District Health Board has Treaty-based relationships with Te Runanga o Ngati Waewae and Te Runanga o Makaawhio. The Board encourages, supports and regularly consults with Tangata Whenua and the Māori community both directly and through Tatau Pounamu, its Māori Health Consultative Group.

The Board regularly receives useful, timely and accurate information so that it can:

- Identify issues before they become problems
- Monitor the quality of services provided
- Anticipate community issues and new opportunities for the West Coast District Health Board
- Make informed decisions
- Act in a timely way

The Provider Arm

The West Coast District Health Board through its provider arm supplies a range of secondary level medical and surgical services, emergency, hospital maternity, district nursing, community health, mental health and primary health services.

The Executive Management Team

The West Coast District Health Board Executive Management Team ensures expert direction and oversight to the operational activity of the organisation as a whole.

Clinical Quality Improvement Team and Clinical Governance

Professional advice on clinical and ethical issues around secondary service from the West Coast Clinical Quality Improvement Team fosters continuous quality improvement and accountability between health professionals and managers. This model of continuous quality improvement has been applied in mental health and is under development within primary care services. Further development of the clinical governance processes will occur as the relationship with West Coast Primary Health Organisation and Canterbury District Health Board evolves during the year.

Planning and Funding

The planning and funding arm of the West Coast District Health Board is responsible for meeting the objectives of the New Zealand Public Health and Disability Act 2000 by developing and implementing plans for the procurement of health and disability services for the people of the West Coast.

Functions include monitoring of the performance of providers against funding agreements and managing external relationships, consultation and communication processes, undertaking health needs analyses and applying prioritisation principles to all funding decisions.

OUR VISION

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

He Mihi

E ngā mana

E ngā reo

E ngā iwi o te motu

Tēnei te mihi ki a koutou katoa

He Whakatauki

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

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

PRINCIPLES

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

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

- Valuing people
- Whānaungatanga – family and relationships

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

RELATIONSHIP WITH MAORI

As an agent of the Crown, the West Coast District Health Board accepts its responsibilities and obligations to Māori as set out under the New Zealand Public Health and Disability Act 2000. In fact, it welcomes the opportunity to work with Māori to actively address the disparities in health provision.

The District Health Board is working in partnership with Poutini Ngāi Tahu, in particular Te Runanga o Ngati Waewae and Te Runanga o Makaawhio, as well as Māori communities throughout the West Coast region, in a spirit of co-operation that encompasses the principles of the Treaty of Waitangi, i.e.

- ***Partnership*** **-** Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- ***Participation*** **-** Involving Māori at all levels of the sector in planning, development and delivery of health and disability services
- ***Protection*** **-** Commitment to the goal that Māori enjoy at least the same level of health as non-Māori and the safeguarding of Māori cultural concepts, values and practices

MEETING THE NEEDS OF OUR POPULATION

The New Zealand Public Health and Disability Act 2000 requires the West Coast District Health Board to improve, promote and protect the health of the population of the West Coast, promote the integration of services, and promote effective care or support for those in need of personal health or disability support services. It must ensure the provision of services for its resident population and for other people as specified in the Crown Funding Agreement (CFA)[1]. In accordance with Section 25 of the New Zealand Public Health and Disability Act, the West Coast District Health Board intends to ensure the provision of health and disability support services in some cases through provision itself, and in others by agreement with other organisations and individuals.

1.2 Our Environment – Our Community

OUR ENVIRONMENT

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

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

[1] The CFA is agreed annually between the DISTRICT HEALTH BOARD and the Minister of Health and outlines the funding to be provided by the Crown in return for the provision, or arranging for the provision, of specific services

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

OUR POPULATION

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

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

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

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

OUR HEALTH

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

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

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

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

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

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

2.0 Achieving Government Health Targets

2.1 Shorter stays in Emergency Departments

Long-Term Objectives – What do we want to achieve?

The West Coast District Health Board already consistently achieves emergency department response and waiting times for triage one and two admissions. As part of the Models of Care – Patient Pathways initiative, the West Coast District Health Board will work during 2010/2011 to achieve emergency department waiting times of no more than six hours for all categories of admission.

The District Health Board is committed to ensuring continued improvement in waiting times in its three Emergency Department services in all triage categories; particularly in triage category 3 (urgent category). The District Health Board is also committed to remaining at or preferably below the Ministry of Health's targets for maximum patient lengths of stay in Emergency Department. A particular bottle-neck for West Coast services is noted in the after hours period, when staffing by Emergency Department Medical Staff at a reduced threshold.

Why is this important?

West Coast District Health Board recognizes the importance of patients receiving acute emergency assessment and care as rapidly as possible after presentation at the emergency department operated by provider arm. This has been particularly problematic for emergency services provided after hours. As part of its strategy to improve performance in this area, the West Coast District Health Board has developed an After Hours Plan with initiatives to assist in improving Emergency Department waiting times. These include:

- Implement an enhanced Nurse Triage by phone service (which will include a transfer to primary after-hours services for those callers requiring care within 24 hours)
- Undertake a community education campaign to enhance West Coast community's knowledge and understanding of after-hours care arrangements and utilisation of the Emergency Department
- Provide advanced training for nurses working to triage after-hours patients or participating in after-hours rosters.
- Improving responsiveness to patients in this area will be a priority for the Board in 2010/2011.

West Coast District Health Board projects to reduce Emergency Department waiting times

There are a number of other areas where the West Coast District Health Board can also further improve service efficiency and reduce the risk of backlogs and bottlenecks which might affect the waiting time for patients to be seen in the Emergency Departments.

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Safe Staffing Healthy Workplace Demonstration Site	As part of the Safe Staffing project, West Coast District Health Board is undertaking three subprojects aimed at improving the way resources are deployed.	Capacity Planning / Matching Resources to Capacity: ▪ The establishment of demand modeling systems to predict both acute and elective demand and then the flexing of both elective demand (to smooth overall demand) and our staffing levels in order to cope with anticipated demand. Variance	A reduction in the risk of blockages and bottlenecks occurring in wards (so that they can take patients that need to be admitted from the Emergency Department) and also in the Emergency Department itself The West Coast District Health Board is prepared to handle unplanned

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
		Management ▪ The refinement of processes and procedures for handing situations where staffing numbers (nursing full time equivalents vary from the number and skill mix required for the mix of patients presenting on a particular day	fluctuations in staffing mix or patient demand
Implement the discharge project	Continue to implement a process on our medical and surgical wards whereby patients have their date of discharge estimated on admission	This means that support services can be put in place in advance for when a patient is discharged Models of care and patient treatment pathways for urgent transferred to tertiary services.	It is estimated this project will save 30 bed days per month, freeing bottlenecks in the wards in order to streamline whole of hospital processes
Rural General Practitioner raining programme for the West Coast	Continuation of the rural General Practice training programme	Train two doctors in rural general practice programme. Providing an after hours General Practitioner service adjacent to the Emergency Department at grey base Hospital.	A reduction in Emergency Department waiting times It is anticipated that an increased number of triage give patients will visit a General Practitioner or registrar rather than the Emergency Department.
Staff education	Education and training for Emergency Department nurses to ensure better, sooner and more convenient care is provided	Providing training in advance triage.	Patients are now directed to the appropriate place for care or they are seen and discharged by the nurse under the supervision of the Emergency Department doctor, thereby reducing waiting times
Management of pharmaceuticals and general stock	Redesigned workflow in the Emergency Department	Store rooms were redesigned with lambert bins in a consistent colour scheme	Staff are able to locate stock at a glance. This is a saving of nursing time and there by contributing to reduced waiting times
Traffic Management within the Emergency Department	Implement the traffic management plan with the Emergency Department	Alter the flow of patients within the Emergency Department (blocking access to treatment areas for the general public). Review of patient pathways through the whole of the system.	Less clutter and confusion and streaming acute care. This allows clinical staff to focus on triaged patients without interruptions form patients who have not yet been triage Better utilization of staff time Shorter wait between presentation and assessment for patients.
OUTCOMES			
How will we measure our success (associated measures of performance)?			
HT3 – Shorter stays in the Emergency Department			

2.2 Improve Access to Elective Surgery

Long-Term Objectives – What do we want to achieve?

The West Coast District Health Board is currently over-intervening in terms of elective surgical interventions for its population compared to other districts. The West Coast District Health Board will continue to review intervention rates for our population and adjust purchasing decisions accordingly to improve the level of service where required. So not to disadvantage our population in moving towards greater equity however, any changes we effect will closely consider issues of clinical sustainability; equitable access between District Health Board's populations regionally within the South Island; and improving efficiency to ensure better, sooner, more convenient services within the available resources.

Why is this important?

Timely access to elective surgery is important to ensure reduction of pain and discomfort to patients and to reduce the risk of patient's conditions deteriorating due to prolonged waiting times. This is particularly important our population ages over time, which will increase the demand for elective surgical procedures. Any changes that we introduce will need to be balanced with these considerations in view.

How will we seek to improve outcomes for our population in the year ahead?

The West Coast District Health Board remains committed to the 2009 Collective South Island Elective Services Plan to have a shared responsibility to maintain effective and efficient elective services across the South Island. As part of this commitment too the West Coast District Health Board will look to provide 1592 elective operations in 2010/2011 as our proportional share of delivering the Minister's expectations of an overall 3.28% per annum increase in elective discharges across the country, and in keeping with our longer-term goal of moving toward greater national equity of access.

The priorities for Secondary Health elective services in the 2010/2011 year are to:

- continue to maintain compliance with Elective Service Patient Flow Indicators (ESPIs);
- to ensure that the overall volume of elective services to the West Coast population is delivered as agreed in the Collective South Island Elective Services Plan;
- to deliver key elective procedures at a nationally appropriate Standardised Intervention Rates (SIR);
- and to identify ways of improving the patient flow for accessing those services through continuous quality improvement and ongoing patient pathway mapping.

Grey Base Hospital has a restricted capacity at times to undertake surgical procedures due to limited numbers of key specialist and theatre staff.

As part of our ability to deliver elective services as efficiently as possible, West Coast District Health Board is looking to improve theatre capacity and efficiency, and outpatient scheduling. This will be undertaken through capacity planning to better match medical staff rostering, staff planned leave, allied health and ward capacities to improve theatre utilisation and volume production. A theatre project will be undertaken to review start and finish times, as well as turnaround times for cases. Through closer clinical links with Canterbury District Health Board, we will also look to improve rostering and delivery of those outpatient and surgery services currently reliant on private visiting specialists to help provide a greater certainty of regularised clinical support and availability. This will assist in reducing both outpatient clinic and theatre cancellation rates, which will in turn assist reduction of the waiting time for those patients on waiting lists.

In addition, we will look to improve elective inpatient day of surgery rates towards the current 76% national average or better (West Coast District Health Board currently sits at 54%), and rising toward the desired target level of 90% during 2011/2012. It is noted that the 90% target may not be achievable for our district given its geography; with patients coming from far away places who cannot otherwise be accommodated in nearby motels the night before surgery being admitted for pre-operative preparation where they are particularly elderly or when admission is required for clinical safety considerations. A project to review this element of the patient pathway is expected to be complete by the end of October 2010. As part of this priority we will include a process to review admission practices and to support same day admission through policy development to prevent unnecessary admission and subsequent

leave; improve facilitation of pre-assessment attendance rather than admission; and increased use of motels the night before to accommodate patients who need early morning admission where appropriate.

Acute surgery will always take precedence and may impact on the flow of elective work that can be undertaken. We will continue to work closely with other South Island District Health Boards to ensure that elective volumes for our population will be delivered in aggregate.

Standardised Intervention Rates

The Ministry of Health introduced Standardised Intervention Rates in 2010/2011 to monitor level of service delivery in key procedures across District Health Boards. The Standardised Intervention Rates are published on the New Zealand Health Information Service website: http://www.electiveservices.govt.nz. The West Coast District Health Board will aim to maintain an SIR over the expected level in all areas for the following key indicators in 2010/2011:

- Elective/surgical discharges 292 per 10,000 population
- Major joint replacement procedures 21.0 per 10,000 population (10.5 Hip replacements/10.5 knee replacements)
- Cataract procedures 27.0 per 10,000 population
- Cardiac procedures 6.23 per 10,000 population (includes coronary artery bypass graft, valve replacements and repair for people aged 15+)

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Maintain compliance with Elective Service Patient Flow Indicators 1 to 8	West Coast District Health Board is compliant with Elective Services Patient Flow Indicators 1 to 8 throughout 2010/2011	Active monitoring of the West Coast District Health Board's Provider Arm outpatient and inpatient waiting lists at Grey Base Hospital Monthly monitoring of progress for a "whole of population" view of all elective volumes delivered for West Coast residents, in concert with Elective Service Team of the Ministry of Health Improved theatre efficiency and capacity , and outpatient scheduling (as outcome above) Review ward configurations with the aim of optimising staff rostering. To optimise patient throughput and journey Reduce "do not attends" rate through proactive confirmation of attendance with patients Review admission process (as outlined above) to improve day of surgery admission rates	Patients will be seen and treated within referral and management waiting time guidelines Day of surgery admission rates improve from current rate (54%) to 76% in 2010/2011. Theatre utilisation rate at Grey Base Hospital improved to 65% (measured as % used time of available minutes) 80% of First Specialist Assessment outpatients in resident specialist clinics seen within four months of referral (excluding appointments deferred at patient request)
Ensure that the West Coast District Health Board delivers on the	West Coast District Board will undertake at least the minimum volumes of elective	Greater collaboration and cooperation of regional clinical networks Create value by developing processes	At least 1592 elective surgical discharges will be delivered for the resident West Coast population in 2010/2011

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
overall level of elective services funded in 2010/2011, and as agreed in the Collective South Island Elective Services Plan.	discharges for 2010/2011 for its population, to contribute to the delivery the overall planned increases in elective surgical discharges for the year as part of a regional collective approach	and incentives to ensure more effective, efficient and equitable use of resources Change driven forward by clinician and management engagement and partnerships Better use of clinical staff resources (including anaesthetics) to ensure theatres time is maximised. Increased number of day surgery procedures and increased percentage of patients for day of surgery admissions. Improved discharge planning resulting in shorter stays.	Reduction in unmet surgical health needs across the population
Monitor Standardised Intervention Rates of the target elective surgery and key marker procedures to ensure that these are being delivered at national appropriate levels	Ensuring that West Coast residents have at least equitable access to elective services as people in other districts	Adjustment of investment in specific elective service specialties over time, in partnership with other District Health Board providers	Reduction in unmet surgical health needs across the population
OUTCOMES			
How will we measure our success (associated measures of performance)?			
At least 1592 elective surgical discharges will be delivered for the resident West Coast population in 2010/2011.			
West Coast residents are provided with appropriate access to elective surgical procedures. HT2 – Improved Access to elective Surgery			
Standardised Intervention Rates (SIR) of target key indicator elective services are provided in line with national levels			
Day of surgery admission rates improve from current rate (54%) to 76% in 2010/2011.			
Theatre utilisation rate at Grey Base Hospital improved to 65% (measured as % used time of available minutes)			

2.3 Shorter Waits for Cancer Treatment

Long-Term Objectives – What do we want to achieve?

With high rates of cancer of various forms West Coast District Health Board aims to ensure that our population has access to diagnostic and treatment services as soon and conveniently as possible in order to reduce the impact and incidence of cancers as well as the social and emotional burden on patients and their families/whanau.

Why is this important?

Cancer remains a leading cause of death in New Zealand. Approximately one third of all cancers are preventable, and early diagnosis and early intervention have a significant impact on outcomes for the remainder. In particular, effective and timely quality screening programmes create opportunities for early diagnosis and intervention.

The West Coast District Health Board is the principal provider of secondary cancer care services on the West Coast, with support from tertiary level services provided through Canterbury District Health Board. Oncology chemotherapy services and visiting specialist oncology outpatient services are provided locally by West Coast District Health Board; along with resident Oncology Nurse and Palliative Care Nurse Specialist services. Primary cancer care services on the Coast are provided through local general practices; the West Coast Primary Health Organisation and its pilot Cancer Navigator service; and key non-government organisations - particularly the West Coast Cancer Society and the Buller-West Coast Home Hospice Trust. In addition, two national cancer screening programmes operate locally on the West Coast and are supported by the West Coast District Health Board. The National Cervical Screening Programme and the Breast Screen Aotearoa through a permanent screening facility at Grey Base Hospital. With a high incidence of bowel cancer on the Coast, there is also a local initiative of early surveillance screening for bowel cancer among high risk groups and families via surgical endoscopy at Grey Base Hospital, based on national guidelines. The West Coast District Health Board operates a whānau facility, with accommodation while they receive inpatient treatment services onsite at Grey Base Hospital to assist patients, their families and supporters who have to travel to Greymouth .

As part of our cancer control strategy, the West Coast District Health Board funds radiotherapy oncology treatment services for its resident population through services provided by Canterbury District Health Board. To this end, the West Coast District Health Board has an active interest in and monitors waiting times and access for radiation oncology treatment in Christchurch, to ensure that appropriate access is delivered for the West Coast population and that waiting times for the population are being appropriately managed and that these services are delivered according to nationally agreed standards. The Health Target for shorter waits for cancer times are that everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.

How will we seek to improve outcomes for our population in the year ahead?

During 2010/2011, the West Coast District Health Board will continue implementation of the mid and longer-term goals outlined in our local Cancer Action Plan that have been evolved out of the report: "The journey of treatment and care for people with cancer on the West Coast" (November 2006). This work will continue to be driven through the Local Cancer Team of key stakeholder organisations in the community. The work will also continue to be underpinned through regional collaboration and service coordination via the Southern Cancer Network; and by the standardisation of models of care and patient treatment pathways currently being developed, with lung and bowel cancer being the priorities.

West Coast District Health Board's Local Cancer Team has also taken on the task of developing and implementing a comprehensive integrated model for palliative care for our district, in lieu of there having never been a formal hospice service here on the West Coast. This work was given further impetus with the "Boosting Hospice Initiative" funding in July 2009. The West Coast District Health Board's Local Cancer Team identified needs for development in the following areas in addition to current palliative care service provision arrangements:

- formalised arrangements to support improved access to after-hours care and advice for General Practitioners, District and Rural Nurses, etc – with both West Coast District Health Board services and Hospice New Zealand and/or Nurse Maude;
- formalised payment for after-hours nursing care provision (which may reduce over time as additional palliative care nurse specialist FTE and education are developed)
- formal adoption of the West Coast District Health Board palliative care guidelines for the West Coast District Health Board district (especially in regard to medication delivery);
- increased use of flexible funding packages for patients;
- wider use of night-sitter and carer support services for palliative patients;
- additional palliative care coordinator full time equivalent roles, that would help to link the introduction and ongoing delivery of the Liverpool Care Pathway for the Dying programme; improve access to people living in

rural areas and the Buller area; as well as an educational function to help maintain skills and practices of clinical staff in the community, hospital and rest home settings;

- over-arching standard contracts for the provision of palliative care services for individual patients in rest homes and private long stay hospitals;
- support for diploma training in palliative care for at least two general practitioners and for nurses;
- improved psycho-social support for patients and their families (including linkages with other agencies);
- progressive implementation of the Liverpool Care Pathway for the Dying.

The plan to increase palliative care nurse specialist resource and a dedicated Coordinator role was competed with the employment of an additional 1.5 full time equivalent to these roles in January 2010; with one nurse based in Greymouth and the other in Westport. These positions are integral to assisting the implementation of the other elements of the Palliative Care pathway programme from February 2010 onward, and during the year ahead.

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Continued participation in national, regional and local cancer prevention initiatives.	Early detection and response to cancers Closer regional collaboration and service coordination via the Southern Cancer Network, with input and support from our own Local Cancer Team	Active promotion and support given to help reduce the contributory risk factors to cancers, including improved nutrition, increased physical exercise, smoking reduction, skin care, and the like Active screening for cervical, breast, colon and skin cancers (which have a high incidence on the West Coast), as well as participation in the national HPV vaccination programme Close monitoring of oncology, chemotherapy and radiotherapy service provision to ensure people are treated according to their need within the national waiting times guidelines	Reducing the incidence and impact of cancers over time – particularly of those ambulatory sensitive cancers Early detection and treatment will create opportunities for better early diagnosis, intervention and outcome at an individual patient level Standardisation of models of care and patient treatment pathways currently being developed (with lung and bowel cancer being the priorities) Maximum wait time for radiotherapy treatment reduced to four weeks by December 2010
Formal adoption of the West Coast District Health Board cancer and palliative care guidelines.	Closer alignment of medication treatment protocols with those of West Coast District Health Board – particularly in regard to medical oncology and to palliative care.	Formal adoption of oncology and palliative care services guidelines. In line with regional support and tertiary services	Standardisation of models of care and patient treatment pathways currently being developed Ability to improve continuity of care for patients, and reduce duplication and possible complications
Improving both "working hours" and after hours support for cancer and palliative care	To improve quality of life for cancer patients and other end-stage of life patients needing palliate care, and their whānau	Formalise after-hours support arrangements with West Coast District Health Board and with Hospice New Zealand and/or Nurse Maude Formalise after-hour nursing care provision arrangements, night-sitter services, and payments at local areas Greater use of the Oncology Nurse and Palliative Care Nurse Specialists' expertise in the community in close alignment with primary and non government organisation providers	Better direct support to patients and their families / whānau Improved co-ordination of services and reduction of duplication and/or gaps in service Increased opportunity for educational training and development for personnel involved in the delivery of cancer and palliative care services – across the primary, secondary and rest home sectors

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Progressive implementation of the Liverpool Care Pathway for the Dying Programme	Standardisation of care for palliative patients in line with international best practice guidelines Improved integration between District Health Board palliative care services and community and on government organisation services	Progressive implementation of the defined steps and timetable of the programme	Improved standardised and consistent care to limit pain and distress for all patients during the end stages of their life Improved understanding, training and knowledge of all aspects of care protocols and international best practice by those delivering palliative care in all environments over time Improved back-up and support for palliative care providers

OUTCOMES
How will we measure our success (associated measures of performance)?
HT3 – Shorter Waits for Cancer Treatment *Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010*
Over time, a reduction in cervical, breast, bowel, and skin cancer rates
PP5 – Waiting times for chemotherapy treatment
Over time, a reduction in cancer mortality rates for all cancer types.

2.4 Increasing the percentage of two-year-olds fully immunised

Long-Term Objectives – What do we want to achieve?

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

Why is this important?

West Coast children and youth continue to have poorer health outcomes than their counterparts in other parts of the country. Given the impact that socio-economic determinants have on health outcomes this is not surprising as almost 50% of children and youth on the West Coast reside in NZDep 8, 9 and 10 areas. The leading causes of morbidity and hospitalisation are preventable. The West Coast Child Health Plan identifies immunisation coverage as a priority for improving child health.

How will we seek to improve outcomes for our population in the year ahead?

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Immunisation	Improved	Implement the joint West Coast District	Coordinated approach to increasing

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
coverage	immunisation coverage on the West Coast	Health Board/ Primary Health Organisation /Community and Public Health's Healthy West Coast Plan	immunisation coverage
		Improve practice process for immunisation, particularly relating to providing timely recall information (using the long term conditions model of engagement and collaboration) and offering flexibility around clinic times.	Increase the number of children fully vaccinated by age 2
		Provide Outreach Immunisation Services with a focus on reducing inequalities in coverage for tamariki Māori and children in NZDep 9 and 10 areas	Reduction in inequalities in coverage for tamariki Māori, children in NZDep 9 and 10 areas
		Ongoing provision of practice nurse training by the Immunisation Coordinator	Increased access to information on childhood vaccinations
OUTCOMES			
How will we measure our success (associated measures of performance)?			
HT-4Increased Immunisation - 86% of children fully immunised at aged two (by ethnicity)in 2010/2011			

2.5 Better Help for Smokers to Quit

Long term objective:

To reduce the smoking rate on the West Coast region by 5 % over the next three years.

Why it is important:

The 2006 census data reports that 25.7% of the West Coast population are regular smokers compared with 20.7 % nationally and that smoking prevalence rates are higher among Māori (41%). Smoking is one of the leading causes of mortality and morbidity for the West Coast population.

How do we seek to make these changes?

The West Coast District Health Board aims to reduce harm caused by tobacco by joint planning and implementation with Community and Public Health and the West Coast Primary Health Organisation. Smokefree plans will include programmes that have proven to be successful such as smokefree environments, a comprehensive smoking cessation service and the implementation of the Ask, Brief advice and Cessation strategy across both primary and secondary care services.

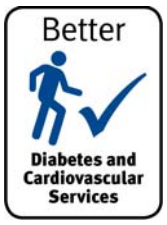
NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Smokefree Planning	Joint planning of all	All plans will be developed across key	West Coast District Health

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
	programmes will occur between key stakeholders who provide smokefree services on the West Coast	stakeholders, with joint goals and outcomes The key stakeholders will be part of the smokefree coalition group and smokefree governance which will direct, coordinate and review progress against the smokefree plan The smokefree plan will be reviewed for progress and a new plan will be developed for the next three years	Board's Smokefree Plan will be a guiding document for all stakeholders Seamless interface between primary and secondary care
ABC Strategy	Key organisations will implement the Ask, Brief advice and Cessation strategy across appropriate services	Smokefree pathway will be used within the West Coast District Health Board Secondary Care services by all clinical staff. ABC model will be used within primary care by all clinical staff The Smokefree coordinator will work with the Primary Health Organisation to support Primary Care reaching Health Target 5 Non government organisations and Workplaces' involvement in Ask, Brief advice and Cessation will be reviewed and included in 3 year plan. Expectation of an ABC process will be included in all relevant non government organisations contracts.	The West Coast District Health Board will achieve the national health target where 80% or more of hospitalized smokers are provided with advice and help to quit. 80% of smoking patients attending general practices are provided with advice and help to quit by July 2011. NGOS will have capacity to reach more smokers in the community, supporting the Ask, Brief advice and Cessation message and reducing the smoking rate on the West Coast
Smokefree Policy	Smokefree policy will outline each organisation's commitment to smokefree	The District Health Board Smokefree policy will be reviewed annually for compliance All services that have contracts with the West Coast District Health Board will have a smokefree policy Workplaces will be supported to have smokefree policies that support their staff to quit smoking	Increase in the number of related organisations active in smokefree
Smokefree Environments	To increase the number of smokefree environments on the West Coast	The Smokefree Coalition group will continue to advocate to appropriate bodies such as TLAs and sports groups to adopt smokefree environments The Smokefree Coalition will include increasing the number of smokefree homes on the West Coast in other programmes where appropriate Some workplaces will be encouraged to become totally smokefree	Five new smokefree environments in the West Coast community Two non-health related workplaces will become smokefree A reduction in the prevalence of exposure of non-smokers to second hand smoke inside the home to less than 5% (baseline 2006 12.55%, 2007 7.5%) A reduction in the prevalence of exposure of non-smokers to second hand smoke inside the home for Māori (baseline 2007 16.1%) and for Pacific people (baseline 2007 16.4%)

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Reducing disparity in health	To reduce the smoking rate within specific target groups on the West Coast	A specific programme targeting each group will be developed and implemented Smokefree activities in workplaces will encourage higher quitting rates in the 20 to 50 year age group A joint Māori Smokefree Plan will be developed and implemented by Healthy West Coast (West Coast District Health Board, West Coast Primary Health Organisation and Community and Public Health) Support any national strategies to reduce smoking initiation in youth	A reduction in the number of pregnant women and their partners who smoke At least 15% of Māori smokers accessing cessation services every year An increase in the proportion of 'never smoked' year 10 students of at least 3 % (absolute increase) over 2007/08 (baseline 57%) An increase for both Māori Year 10 'never smokers' and Pacific Year 10 'never smokers'
OUTCOMES			
10 % of the West Coast smoking population will access all smoking cessation services			
15 % of the West Coast Māori population who smoke will access smoking cessation services			
The West Coast District Health Board will meet the Health Target of 90% by July 2011			
Data will be collected from Primary Health Organisation performance programme that shows: *% of eligible population who have ever had a smoking status recorded; and* *% of eligible population whose current smoking status is recorded as current smoker*			
Increase in the number of 15-19 year olds who have never smoked			
Increase in the number of homes that are smokefree			

2.6 Better Diabetes and Cardiovascular Services

Long-Term Objectives – What do we want to achieve?



2010/2011 will see the completion of implementation of much of the Chronic Conditions Management Strategy Plan adopted in December 2006 (now known as the Long Term Conditions Management Strategy) to overarch our strategies for improved management and best practice principles for chronic condition services. There are still some elements of the plan that will need to be completed in 2010/2011, along with the improved realignment of some services as the implementation of the Integrated Family Health Centre environment is progressively adopted by the Board. The initial focus of the Long Term Conditions Management Strategy was on diabetes, cancer, cardiovascular disease and stroke management. Over time the District Health Board aims to extend this focus progressively to other chronic conditions that affect the West Coast community, including disabling and resource-intensive conditions such as respiratory conditions (including chronic obstructive pulmonary disease) and arthritis.

Why is this important?

The Long Term Conditions Management Strategy recognises the commonality and many inter-related issues that cut across these various chronic conditions. A holistic and comprehensive approach to planning service improvement and integration for the region is more likely to produce better outcomes than looking at the individual conditions in greater isolation. It also aims to allow for progressive implementation of change and additional close-patient management in a way that might minimise the burden upon already resource-stretched and busy providers of

primary care and secondary care alike. Whilst recognising the value of the generic approach to chronic or long-term conditions, the value of the focused interdisciplinary team, with consumer and Māori representation, has been seen in the success of the local diabetes team. In light of this, the West Coast District Health Board introduced a similar model for its Cancer Control Steering Group during 2008/2009. Plans to launch similar local teams for Cardiovascular and Stroke (LCT) and Respiratory (LRT) diseases did not materialise as hoped due to staff changes – but this is an area that we will look to pursue in 2010/2011. These teams will continue to promote service improvement under the umbrella of the West Coast Chronic Conditions Management Steering Group.

Key priorities in chronic and long term condition management to be addressed as a whole in 2010/2011 by the West Coast District Health Board are:

- Increase implementation of the West Coast Long Term Conditions Management programme so that over time, 70% of all patients with Chronic Obstructive Pulmonary Disease, Cardiovascular disease, and/or diabetes, have an annual review followed by a package of care appropriate for their level of need
- Improve self-management and health literacy capacities for patients with long term conditions
- Linking of the West Coast Long Term Conditions Management programme with relevant West Coast District Health Board's "Health Pathways" programmes
- IT support for integration and information sharing between primary and secondary care
- Undertake medication use reviews through community pharmacies (within available financial resources).
- Seamless discharge planning
- Review the management of Level three long term conditions patients and enhance the integration between general practice care and Assessment Treatment and Rehabilitation services, Carelink, and nurse specialist care
- Development of the Health Navigators / Kaiawhina roles, to change the cancer navigator process and criteria to provide health navigator services for Level three long term condition patients who have difficulty accessing health care and social services
- Better integration of the support provided to patients by Clinical Nurse Specialists and medical centres – including integrated community nursing and allied health in the Integrated Family Health Centres model as per the implementation timetable, subject to approval of the Business Case for this being accepted by the Minister of Health
- Links with local iwi and Māori community networks are strengthened and enhanced to encourage greater Māori participation in accessing health services on the West Coast
- Continue to involve West Coast Māori in decision-making around implementing chronic and long term conditions management and achieving equity in health outcomes
- Continued implementation of the Cancer Action Plan and Palliative Care Strategy
- Implement the District Health Board's Healthy Eating Healthy Action Plan in conjunction with other agencies

Reducing the Impact and Incidence of Diabetes

The key objectives in helping to reduce the impact and incidence of diabetes within our community are:

- Reducing diabetes contributory factors - modification of lifestyle factors such as obesity and smoking reduction and increasing physical activity are crucial components to the prevention of diabetes
- Diabetes recognition and follow-up: increase early recognition and response to individuals with diabetes
- Effective diabetes management – to slow the rate of diabetes progression; reduce incidence of avoidable diabetes related complications; and to strengthen self-management capability of individuals, family and Whānau
- Improve access to retinopathy screening to prevent the development and progression of avoidable diabetic eye disease

These goals will be achieved through the continuance of a series of measures to reduce the impact and incidence of diabetes in our population that are already in train.

Health promotion activities and collaborative projects between providers such as the West Coast District Health Board provider arm services, West Coast Primary Health Organisation, Healthy Eating Healthy Action, Community and

Public Health and others that incorporate physical activity, nutrition improvement, smoking cessation, obesity reduction, and diabetes awareness are delivered to individuals, schools, businesses, and the wider community, will be key to reducing contributory risk factors.

The West Coast Primary Health Organisation and other primary care providers will also be instrumental in increasing the proportion of people with diagnosed diabetes who receive free annual checks and consequently, a greater focus on those with greatest risk factors, and an ability to improve responsiveness to the follow-up and self-management aspects of individual patient care. This has been strengthened with the refocus of the West Coast Primary Health Organisation's Long Term Conditions programme in 2009, which included the redesign of the Primary Health Organisation's diabetes screening and cardiovascular risk assessment programme. Reciprocal links with local iwi and Māori community networks are to be further strengthened and enhanced to encourage enrolment in the West Coast Primary Health Organisation to access diabetes free annual checks, and to promote health messages to Māori as well as the wider population on the West Coast. This will continue to be supported through patient pathways within the hospital system to ensure people admitted who have cardiovascular system and diabetic risk factors receive advice about reducing risk factors, self-management support, and referral on to other appropriate health professionals for further follow-up and intervention. These intervention and support streams will be further strengthened by the development of the Integrated Family Health Centre models on the West Coast during 2010/201, in providing closer effective liaison, clinical support and electronic information sharing between traditional primary and secondary care services. Timely patient and clinician access to diabetes support services, including referral to a diabetes nurse educator, dietician, podiatry, retinal screening, and specialist physician support will occur as appropriate.

The local diabetes team set targets for the West Coast District Health Board in key performance indicators for detection, management and retinal screening rates in 2008. The local diabetes team will continue to monitor progress against meeting the targets in 2010/2011, as well as the combined diabetes and cardiovascular diseases performance indicator measures.

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Closer alignment of primary and secondary services involved in the provision of diabetes detection, follow-up and management.	Better integration of the support provided to patients by Clinical Nurse Specialists and medical centres.	Integration of specialist secondary and community nursing, and of allied health and support services involved in diabetes care, into the Integrated Family Health Centres model as per the implementation timetable	Closer alignment of services to actively help and support people with diabetes to be diagnosed and provided with appropriate care and self-management support to match their individual needs A smooth pathway of care and advice for patients Better utilisation and sharing of available resources to avoid service duplication
Continued promotion and implementation of the West Coast Primary Health Organisation's Long -term Condition Management programme.	Greater uptake of free annual diabetes checks	West Coast Primary Health Organisation to continue to actively roll out the programme through all practices to maximise the number of people have established diabetes or are at risk of developing the disease having annual checks and being provided with quarterly follow-up to support self management of the disease and associated risk factors Local diabetes team to support the endeavours of the West Coast Primary Health Organisation through its annual promotional activities	Better outcomes for treatment Higher needs populations are screened and provided with timely interventions to help manage and mitigate the risks associated with diabetes Outcomes targets (as set by the local diabetes team for our population below) are met
Improved Information Technology	Faster and more convenient access to patient information –	Progressive implementation of inter-active IT. data sharing systems between West Coast District Health Board provider arm	Speedy access for clinicians to latest patient records and relevant test results to best inform patient care

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Interface and two-way data sharing between primary and secondary services	particularly to inpatient episode information, patient risk alert updates, and to laboratory test results Avoidance of unnecessary duplication in diagnostic testing	service and primary General Practitioner practices	Reductions of costs from unnecessary duplication and ordering of diagnostic tests
OUTCOMES			
How will we measure our success (associated measures of performance)			
65% percent of people with diagnosed diabetes will attend free annual checks, rising to 70% by 2011/2012. *HT6 – Better Diabetes and cardiovascular services*			
80% percent of people with diabetes will have satisfactory or better diabetes management (defined by having HBA1c level of equal to or less than 8% at their free annual check. *HT6 – Better Diabetes and cardiovascular services*			
90% of people who have had their free annual diabetes check have had retinal screening or an ophthalmologist examination within the last two years of the check.			

Cardiovascular Disease and Stroke

Cardiovascular diseases include ischemic heart failure, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Stroke refers to the sudden onset of neurological deficit caused by an interruption of the brain's blood supply. As with diabetes, reduction of the incidence and impact of cardiovascular diseases and stroke in the West Coast region is reliant on a population health focus, with close linkage and liaison between the public, primary and secondary health sectors to make best use of limited financial and human resources available on the West Coast. Service changes and improvements in this regard will continue to be overarched by the West Coast Long Term Conditions Management Strategy and be an evolving process over time.

As with diabetes, the key objectives in helping to reduce the impact and incidence of cardiovascular diseases and stroke within our community focus on risk reduction; recognition and follow-up; and effective cardiovascular diseases and stroke management. Under the three tiers of the Long Term Condition Management programme, many of the same techniques and strategies are being applied for cardiovascular diseases and stroke as for diabetes. This will continue to be a key focus of service delivery in 2010/2011 and beyond. Health promotion and information messages delivered in appropriate ways and settings are critical to encourage individuals and whānau to take-up healthy lifestyles (including the importance of physical activity, improved nutrition, reducing obesity, smoking reduction and cessation and the like) to reduce cardiovascular risk. Recorded five-year absolute cardiovascular diseases risk is actively monitored, with information regularly shared and used to inform planning initiatives and targeting of service provider activities to best effect cardiovascular diseases detection and follow-up, and to help ensure that patients receive comprehensive individualised advice, care regimes, self-management support, and onward referral they may require for their condition. These initiatives are occurring in both primary and secondary service environments. Through these approaches, the West Coast District Health Board aims to increase early recognition and response to individuals with cardiovascular diseases and stroke, slow rates of cardiovascular diseases and stroke progression, and reduce the incidence of avoidable cardiovascular diseases and stroke-related complications. Cardiac rehabilitation and follow-up programmes are also now in place to ensure the greatest possible gains for the individual and reduce their risk of follow on cardiovascular diseases and stroke events.

Further work will be undertaken to strengthen cardiovascular diseases and stroke patient pathways during 2010/2011 to ensure smooth interface between primary and secondary services and avoidance of service duplications. As identified in the priorities for Long Term Conditions, further Information Technology work will also be undertaken to assist integration and information sharing between primary and secondary care. Monitoring of ambulatory sensitive admission rates five-year absolute cardiovascular diseases risk care plan datasets will also continue to be undertaken in 2010/2011 to monitor trends in order to prioritise areas of greatest need. The West Coast District Health Board will continue to look to establish a centre of excellence in cardiovascular diseases and stroke rehabilitation within local capacities and capabilities, as part of implementation during the year of the Integrated Family Health Centre.

NEXT STEPS IN 2010/2011			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	What is the District Health Board trying to achieve?	What action will we take to make this happen?	What impacts will this have?
Formation of a Local Cardiovascular Diseases Team	Improved planning for future directions in service delivery for cardiovascular diseases and stroke services; particularly in regard to being able to provide a cardiovascular diseases and stroke centres of excellence within the local context.	Establishment of a multi-disciplinary team of key clinical service providers and patient and community stakeholders, to inform future direction of care and service improvement (along similar lines to the West Coast District Health Board's Local Diabetes Team and Local Cancer Team)	Development of specific mid- to longer-term plans and goals for further service improvement for cardiovascular diseases and stroke service within the overarching Long Term Conditions Management Strategy Seamless service provision and greater interaction between primary and secondary services as part of the Integrated Family Health Centre model
Development of Cardiovascular diseases and stroke pathways	To improve outcomes for people who have heightened risk and/or who suffer Cardiovascular diseases or stoke by providing intervention and treatment within clinically appropriate timeframes	Development of formal clinical best practice and intervention pathways of care for cardiovascular diseases and stroke, in line with the West Coast District Health Board's Long Term Conditions Strategy Establish audit of processes and outcomes of acute care and initial management phase (first six months) of conditions – particularly those with heart attacks to ensure equitable care is provided	Better outcomes for treatment and rehabilitation for individual patients
Improved Information Technology interface and two-way data sharing between primary and secondary services	Faster and more convenient access to patient information – particularly to inpatient episode information, patient risk alert updates, and to laboratory and x-ray test results Avoidance of unnecessary duplication in diagnostic testing	Progressive implementation of inter-active Information Technology data sharing systems between West Coast District Health Board provider arm service and primary General Practitioner practices	Speedy access for clinicians to latest patient records and relevant test results to best inform patient care Reductions of costs from unnecessary duplication and ordering of diagnostic tests
OUTCOMES			
How will we measure our success (associated measures of performance)?			
Over time, an increase in the percentage of the eligible adult population will have had their ccardiovascular diseases risk assessed in the last five years groups (as defined and monitored quarterly by the Ministry of Health).			

NEXT STEPS IN 2010/2011			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	What is the District Health Board trying to achieve?	What action will we take to make this happen?	What impacts will this have?
HT6 – Better Diabetes and cardiovascular services			
Formal development of a plan for further improving upon service delivery and responsiveness for cardiovascular diseases and stroke patients, above those service models that have already been developed and established during the last three years.			

3.0 Better Sooner More Convenient Primary Care Services – Integrated Family Health Services

Long-Term Objectives – What do we want to achieve?

Improve access to better sooner more convenient primary health services that are integrated with community and secondary service providers improving pathways through primary-community-secondary health services.

Why is this important?

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

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

How will we seek to improve outcomes for our population in the year ahead?

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Better Sooner More Convenient Health Service	Improve access to general practice	Reopen opportunity for people to enrol in all areas	Reduced waiting time for non urgent appointments Increase Māori enrolments
		Implement navigator/kaiawhina positions to provide practical assistance to access services	Increase Māori enrolment s Improve utilisation of primary services
		Implement Māori nursing positions within each integrated family health centre	Increase Māori enrolment s Improve Māori utilisation of primary services
	Implement integrated family health centres	Develop integrated health services Increasing integration between primary, secondary and community based services , with a focus on Greymouth in 2010/2011	Increase Multidisciplinary working Increased service co-ordination improved pathways through care
		Increasing nurse/allied health led services	Increased access to a range of services Improving pathways through care

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Better Sooner More Convenient Health Service		Increasing co-location of a range of primary, community and secondary services	Improved access to services Improved co-ordination and multidisciplinary working
	Implementation of health pathways:	Adaptation of the Canterbury primary / secondary pathway work	Defined community based access to diagnostics, treatments and specialist advice. Community based delivery of non inpatient secondary care services
	Enhanced after hours care reducing Emergency Department attendance	Telephone triage provided across the district	Enhanced understanding of how to access after-hours services Improved sustainability of afterhours rosters, particularly in rural areas Reduction in Emergency Department attendance
	Enhanced after hours care reducing Emergency Department attendance	Community education campaign undertaken	Enhanced understanding of how to access after-hours services Reduction in triage 5 Emergency Department attendance
		Fund advance nurse training in PRIME, Advance Health Assessment, Post Graduate Certified papers.	Increase participation of Nurses in after hours rosters Improved sustainability of afterhours rosters
	Greater use of frontline nursing	A shift in doctor v nurse: ratios and increased use of nursing clinics	Increased primary service capacity Reduce waiting time for non urgent appointment
		Advancing the development of nurse practitioners with prescribing authority	Increased access to a range of services Reduce waiting time for non urgent appointments Increased primary service capacity and capability to meet the populations health needs
		Implementation of standing orders district wide and the further development of nursing leadership and specialisation	Reduce waiting time for non urgent appointments Increased primary service capacity and capability to meet the populations health needs
	Coordinated and stratified response to mental health and long term conditions	Increase clinical co-ordination services across all three districts	Increased range of primary mental health services Improved collaboration between primary and secondary collaboration
		Implement Shared Care arrangement's in primary/secondary mental health services	Improved services for long term mental health service users
		District-wide implementation of a three level stratified care approach for long term	Improved co-ordination of chronic conditions

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
		conditions	Improved health outcomes
OUTCOMES			
How we will measure our success (associated measures of performance)			
% of Māori enrolled in primary practice			
Ratio of visits by Māori compared with other populations			
HT1 Shorter stays in emergency departments			
HT4 'Increased immunisation'			
HT6 'Better diabetes and Cardiovascular diseases services'			
PP6 Improving the health status of people with severe mental illness			
SI1 Ambulatory sensitive (avoidable) hospital admissions			

3.1 Key Milestones for Better Sooner More Convenient Primary Care Services

The table below shows the important milestones associated with the integration of primary and community services as indicated in the Business Case for Better, Sooner, More Convenient Primary Care.

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

4.0 Clinical Leadership

The West Coast District Health Board acknowledges the Minister of Health's document "In Good Hands" and is committed to achieving the broad objectives of this document. The District Health Board is in the process of establishing more effective clinical leadership processes through the Clinical Quality Improvement Team.

West Coast District Health Board clinicians also participate in the Primary Health Organisation clinical governance group and contribute to a range of local and national technical advisory groups. These activities will be enhanced to provide the basis for further development of clinical leadership and clinical involvement in the planning, design and evaluation of health services across the district.

In 2010/2011 the West Coast District health Board will continue to focus on clinical leadership throughout the District Health Board structure. This includes ensuring clinician participation and input into all West Coast Health Board and advisory group meetings, Executive Management Team meetings and all other projects and processes as we move towards primary and secondary integration and integration with Canterbury District Health Board.

The Canterbury and West Coast District Health Boards have agreed on the establishment of a combined clinical governance framework to oversee and develop good clinical practice.

5.0 National and Regional Coordination

The West Coast District Health Board has a strong history of collaborative working both within and between districts. In particular, there have been long -standing collaborative arrangements with West Coast over a range of clinical and technical supports. In addition to these, there are other significant collaborative arrangements as follows:

NATIONAL

20 District Health Boards New Zealand (DHBNZ)

All District Health Board's support District Health Board's New Zealand (District Health Board New Zealand) and the West Coast District Health Board will continue to actively participate in District Health Board New Zealand activities. District Health Board New Zealand's purpose is to support District Health Board's and provide co-ordination of activity at the national level. District Health Board New Zealand maintains links with central shared support agencies and works to confirm sector priorities through the Health Sector work plan and the District Health Board New Zealand Annual Plan. District Health Board New Zealand is active in a range of areas including primary health, workforce development, industrial relations, funding and accountability, public health, service frameworks, pricing and prioritisation tools.

Accident Compensation Commission (ACC)

West Coast District Health Boards is committed to working within the national agreement on Accident Compensation Commission and District Health Boards ensuring that their relationship is effective and delivers best value for money. The proposed addition to the relationship agreement (Statement of Collaboration) already in place aims to ensure that there are arrangements at strategic and operational levels that attend to risks and opportunities, manage business relationships, and ensure efficient contractual arrangements.

Both Accident Compensation Commission and District Health Boards are under financial pressure, and facing increased deficit. Accident Compensation Commission has reviewed its activity and has identified a number of initiatives required to restore sustainability. These include new approaches to some services, tightened approvals processes, and proposals to recalculate levies to reflect cost patterns and risk rating.

The District Health Boards have collectively identified concerns from some of these changes:

- Elective Surgery – new approach to elective surgery;
- Accident Compensation Commission approval criteria – tighter criteria resulting in increased decline rates at District Health Boards;
- Accident Compensation Commission Levy – changes and impact on risk rating;
- Physiotherapy – changes to service contracts, and District Health Boards position on provision and charging co-payments (Minister has prevented this);
- Boundary between health, disability and Accident Compensation Commission, including how to operationalise cost sharing approaches;
- High-tech imaging – new Accident Compensation Commission contract with staged price reduction;
- Treatment injury – how to improve management of treatment injury;
- Inter-hospital transfers – Accident Compensation Commission proposed changes to contracts;
- Laboratory testing – Accident Compensation Commission proposed changes to contracts;
- ACC development of their procurement strategy – opportunity to align approach with Health;
- Membership of The Australasian Rehabilitation Outcomes Centre and participation in benchmarking;
- What is the potential for health to manage services on behalf of Accident Compensation Commission , or Accident Compensation Commission on behalf of health.

The strategic Accident Compensation Commission - District Health Boards relationship is being re-established focusing on system performance, improvement initiatives and joint management of risk. The West Coast District Health Board is committed to the re-establishment process and anticipates participating in the national process during 210/2011.

Tertiary Education Providers

The University of Otago and the West Coast District Health Board work together to provide a range of training opportunities for medical students, and services for the people of the West Coast.

The University of Otago's School of Medicine trains about two hundred medical students in each year. The Undergraduate Medical Training is a six year programme. The first three of which are spent in Dunedin, and the final three years in one of the three medical schools attached to the University. There are approx seventy students per year at the Dunedin, Christchurch and Wellington Medical Schools. The West Coast District Health Board hosts three separate groups of medical students:

- a group of twenty Third Year Medical Students annually for a week, as part of their public health rotation.
- Four groups of three Fifth Year Medical Students, from the Dunedin Medical School, for their Rural General Practitioner Rotation. These students are on the Coast for five weeks. This is our sixth year of being involved in this programme.
- a group of three Fifth Year Rural Medical Immersion Programme Students. These students are here for their entire year. This is our fourth year of being involved in this programme.
- There are also opportunities for Sixth Year students to undertake rural rotation and registrar opportunities.

The West Coast District Health Board and the University of Otago also collaborate in the training of and service provision by physiotherapy, occupational therapy, and speech and language therapy students and pharmacy interns, as well as with the Nelson Marlborough Institute of Technology and Christchurch Polytechnic Institute of Technology in relation to nursing and radiography students.

REGIONAL SERVICES

During 2009 the Chief Executives and Chairs of the South Island District Health Boards approved a framework to support planning for clinically and fiscally sustainable health and disability services for the future in the South Island.

This framework provides direction for the type and level of health services that will be required to best meet the needs of the South Island population, while allowing discussion and debate about how services can be configured and organised.

In considering the future there are concepts that must be agreed to enable individual District Health Board and providers to plan and move forward without waiting for the South Island Health Services Planning process to be sufficiently advanced to provide detail for each service and related activity including service delivery specifics required for facility developments.

The goal is to have a regionally coordinated system of health service planning and delivery of health services that will see lasting improvements in the sustainability, quality and accessibility of clinical services. Initially this will be largely focused on hospital services however over time it must incorporate the development of primary and community based health care to provide the essential base for any changes to hospital services.

What the future may look like

The challenge for health professionals is that they will need to work differently, in different settings, across different sectors to coordinate patient care and ensure smooth transition for patients to appropriate levels of care. Secondary and tertiary services in the future need to exist within District Health Board structures but be provided across a number of District Health Boards. Most health professionals do not work in a linear structure they work in professional teams, collegial networks, across teams and in the future this will be the way that secondary and tertiary services will need to operate in particular across District Health Board boundaries providing services to local, sub-regional and regional populations.

A strong and highly developed primary care infrastructure is the required foundation for all South Island District Health Boards. More health care will be provided at home and in the community for long term conditions and rehabilitation. A highly developed primary care sector is fundamental to meeting the future demands on health services. Without this fundamental, it is unlikely that secondary and tertiary services will be able to be sustainable. This is supported by World Health Organisation's annual report 2008.

Clinical networks will provide a forum for clinical leadership, and a partnership between management and clinicians across the service continuum to support delivery of a quality health service. For this reason networks are likely to have a more formal place in the health system and be accountable for agreed outcomes.

The traditional labels for facilities that align with the levels of service delivered i.e. primary, secondary and tertiary, are now and will continue to blur as services are delivered in a variety of places, including the home. Models of care, clinical networks and new technologies are changing to support service delivery in different environments to those traditionally recognised. However, there will always be a need for facilities where specialised services will be delivered and coordinated from. The labels primary, secondary and tertiary are used in this document to reflect the core level of services delivered from the facility.

With these changes the current configuration of facilities across the South Island will need to evolve. The traditional District Health Board boundaries and patient flows across the South Island will need to be challenged to ensure the services across the South Island are supported in a sustainable manner.

Without working through the more detailed planning to address the above issues, it is impossible to accurately predict or determine facility configuration and planning. There are also political and broader economic implications which need to be tested which reach far wider than the health sector. Examples of these policy settings include the impact that any changes to the configuration of tertiary services in Dunedin Hospital may have on the Education sector and in particular the University of Otago, and any broader economic impact on the wider community. The same would apply to populations such as Greymouth, and to a lesser extent Timaru on the consequential economic impact of any changes. These issues need to be addressed at a political level as they run the risk of derailing robust health service planning, or result in the focus of health service planning being centred around immovable assumptions / paradigms.

This being said a structure of facilities across the South Island is likely to be:

1. Integrated Family Health Centres – These centres will be primary led services providing a full range of multi disciplinary primary care services, including some services that have traditionally been provided through hospitals or District Health Board settings. These may include some outpatient activity; community based and district nursing, and needs assessment. These will be provided in numerous settings and will be sized to take account of the population mass and distribution. Integrated Family Health Centres will be aligned with designated 'Base Hospitals', not necessarily along existing referral lines.

2. Community Hospitals – These centres may include services provided in other areas through Primary led Integrated Family Health Centres, however they will also provide acute stabilisation and transfer services, visiting secondary outpatient services, primary maternity care, sub acute care, rehabilitation for patients transferred from secondary and tertiary hospitals and appropriate day patient services including low level surgical activity.

3. Secondary Hospitals – will provide core Secondary Services for sustainable catchment populations. A number of these services will be provided in these facilities via In Reach Services from larger regionally based services. These facilities may develop areas of special interest but will be undertaken through regional planning rather than individual District Health Board generated initiatives. Some tertiary services will be provided in secondary hospitals through integrated service planning and delivery on behalf of the region.

4. Tertiary Centre – Tertiary services will include robust outreach services, both from an outpatient, day patient, and where appropriate inpatient services, provided across the region.

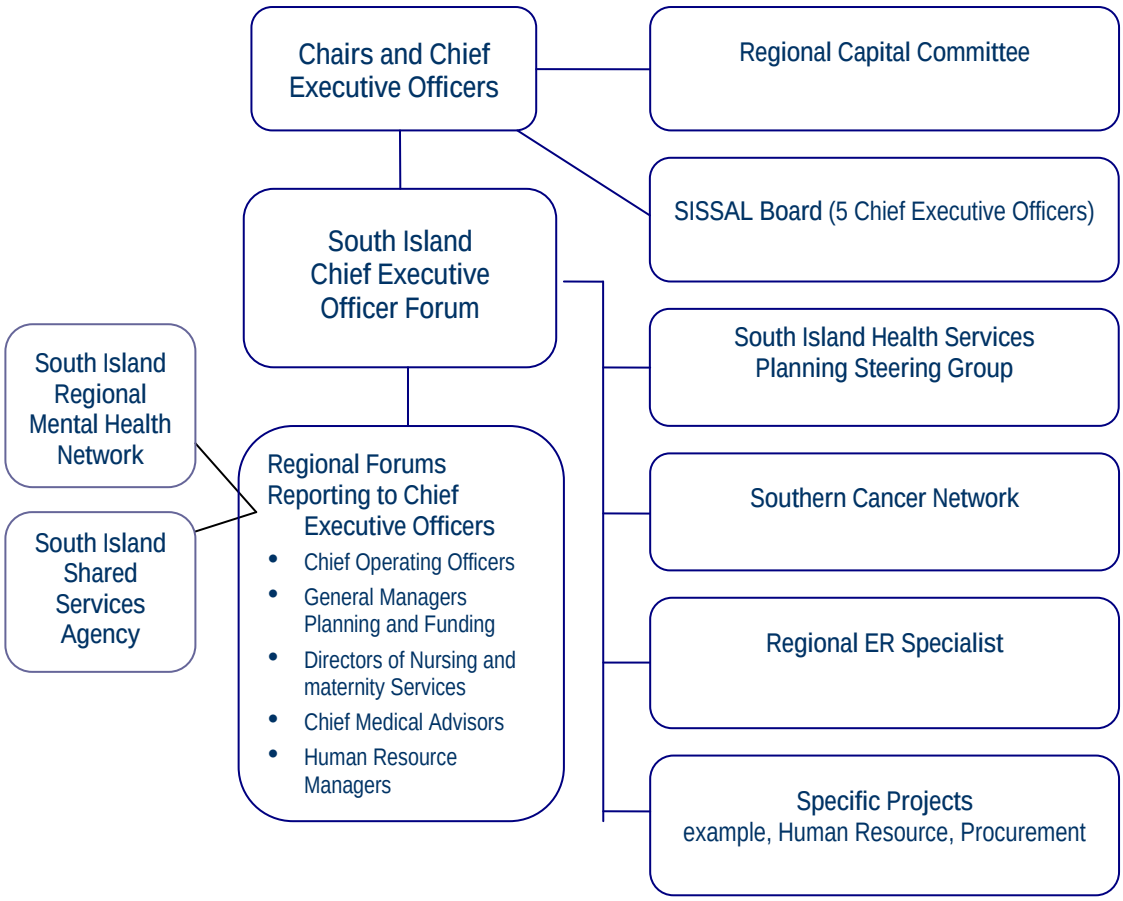
Decision Making

To support the South Island District Health Boards collective process of health service planning and delivery all District Health Boards in the South Island have agreed a process to gain collective decisions making. This process includes clearly define principles together with an escalation pathway where consensus cannot be reached.

Mechanisms

There are a number of forums across the South Island that meet on a regular basis and provide support and a regional infrastructure for undertaking regional planning and decision making. The networks within and across these forums will support moving towards the framework described above.

The diagram below provides an indication of the regional forums and the reporting relationships. This is not intended to represent every South Island group as it is acknowledged that a number of others exist.



Principles and Assumptions

The regional groups work agreed terms of reference that focus of decision making for the good of the South Island population as a whole.

Some of the work undertaken regionally relates to greater sharing and maximization of resources and flexibility in approach. Other collaborative approaches look to planning and aligning resources that meet the needs of the population into the future.

All service planning is based on the South Island Health Services Planning principles:

- Equity of Access
- Maori Health Service Needs
- Clinical engagement
- Patient centred consumer involvement
- Community acceptance
- Quality and safety
- Continuum of care
- Fiscal Sustainability
- Clinical sustainability

Networks

Formal networks currently operating in the South Island include the Southern Cancer Network and the South Island Regional Mental Health Network. In addition there are an number of service related project groups established under the South Island Health Services Planning group that have the potential to be Clinical Networks to support regional delivery services. These groups include neurosurgery, child health and ophthalmology, together with the surgical service clusters that are forming as part of the elective services initiative.

Priorities

The South Island District Health Board will continue to collaborate to support services that are identified as being potentially at risk of service failure, whether short to medium term or through an unexpected event.

The Elective Services initiative looks to a three year view to:

1. improve equity of, and access to, surgical services that contribute to the health outcomes for the people of the South Island
2. ensure southern region District Health Board have the capacity to deliver the required levels of service to deliver increasing elective volumes (meeting the Ministers expectations) and equitable access to services:
3. ensure southern region District Health Board provide efficient and effective delivery of services
4. monitor and evaluate the delivery of elective surgical services and establish region wide mechanisms to manage variance from expected performance

The South Island District Health Board will also work towards a South Island Regional Clinical Service Plan that includes the following scope and content:

1. 10-year focus within a 20-year horizon
2. Financial impact analysis on global operational and capital cost changes from current to proposed service configuration
3. Comprehensive and cover the continuum of care
4. Consistent scope of content
5. Basis for District Strategic Plan
6. Basis for Asset Management Plans (district, regional and national) and capital investment strategy

Monitoring and Evaluation

The South Island District Health Boards recognise the need to evaluate both process and outcome for changes implemented.

The evaluation process includes the following components:

1. Why we did it?
2. What we did?
3. What was achieved
   - for the systems?
   - for the patients?
   - for the clinicians?
4. How transferable are the changes? (where appropriate – generally for major change)

South Island Health Services Planning – Whole of Health Service Planning

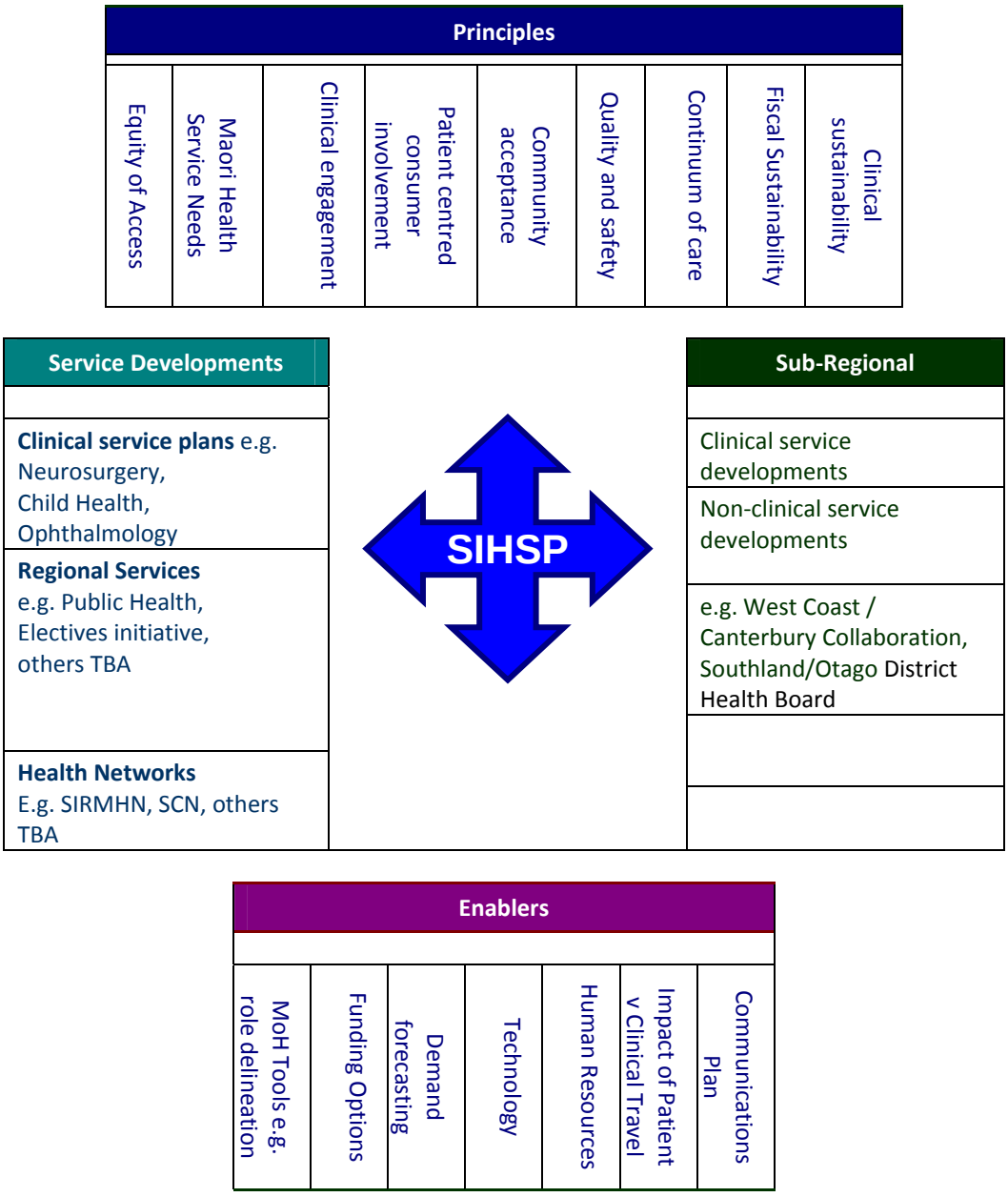
The South Island District Health Boards have agreed to the development of a South Island Health Services Plan which links to the Health Futures Framework goals of improving system performance and strengthening clinical and fiscal sustainability. The concept of provision as close to the patient / clients home as possible is an underlying principle to be aspired to in undertaking South Island Health Service Planning, while recognising that some services, particularly lower volume and more specialised levels of care, will not be able to be undertaken at all locations.

The vision of the South Island Health Services Plan (SIHSP) is to:

- reduce inequalities in access to health services across the South Island
- enhance the quality of health services across the South Island

- enhance the sustainability of all health services for the South Island population that are appropriately delivered in the South Island
- engage with key stakeholders to ensure understanding and acceptability of South Island Health Services

South Island Health Services Planning – Whole of Health Service Planning



District Health Board Participation

Each South Island District Health Board has committed to the development of the South Island Health Services Plan. The Steering Group has a member from each District Health Board who provides a linkage to the local District Health Board and to their professional group across the South Island. The South Island Health Services Plan Steering Group does not have decision making responsibility. Recommendations on South Island health services plans will be referred to the South Island Chief Executive Group for decision and adoption. The South Island District Health Boards Chief Executive Group are the Programme Executive as such act as champions for the Programme, and are accountable for the delivery of planned benefits associated with the Programme. The Steering Group includes other key stakeholders including Ministry of Health and Union representation.

The South Island Health Services Plan provides a framework for regional and sub-regional, clinical and non-clinical developments, each of which forms part of the programme of work. Workstreams are based around clinical services, e.g. developing long-term viable services and chronic care, while others consider enablers that will support different models of care and ways of delivering services. Each workstream includes participation from relevant stakeholders including District Health Board clinicians and managers. SISSAL provides administrative, project and programme management resource.

The South Island Health Services Plan programme includes a Communication Plan that supports keeping stakeholders informed and involved in the process.

2010 -2011 Priorities

Aim	Develop a stage one South Island Regional Clinical Services Plan
Actions	Develop a stage one Regional Clinical Services Plan that identifies: ▪ the regional and sub regional work undertaken in 2009-10. ▪ the regional and sub-regional activities for 2010-11 ▪ identify gaps and potential future collaborative workstreams and activities to meet these This plan will include the minimum content as required by the Ministry of Health: - vulnerable services - services related to capital investment proposals that are expected in the next three years - configuration changes that will contribute to financial viability
Outputs	Development of stage one Regional Clinical Services Plan
Measure	South Island Regional Clinical Service Plan completed by 30 September 2010

Aim	Develop regional service plans for identified services to support viable health and disability services for the South Island population
Actions	Regional service planning of prioritised services as identified in stocktake undertaken in 2008-09 or subsequently, including neurosurgery, child health, ophthalmology and public health. Establish working groups of stakeholders from relevant South Island District Health Boards and across the continuum. These groups will be clinically led and involve management and key stakeholders
Outputs	Business case development to support service delivery changes as appropriate Ongoing review and support of regional service developments Health networks established where appropriate to support ongoing service delivery
Measure	A reduction in service failure across the South Island through or sub-regional approaches Regional collaboration to support equitable access to services

Aim	Develop a plan from each enabler workstream that will support viable service delivery within the South Island
Actions	Develop workstreams to consider opportunities within technology, employment and transport and accommodation that will support alternative service delivery models across the continuum of care Involve stakeholders from across the South Island District Health Boards
Outputs	Workstream plans Business case development to support recommendations as appropriate.

Aim	Develop a plan from each enabler workstream that will support viable service delivery within the South Island
Measure	Implementation of changed models of service delivery supported by changes through enabler workstreams

Aim	Implement a South Island Elective Services Plan that supports efficient, effective and sustainable management of elective surgical services for the future, in compliance with national policy and standards
Actions	Over the next three years the South Island will: Provide a framework for the development and implementation of a collective approach for the delivery of elective surgical services across the South Island to ensure equitable access for all population groups Improve equity of, and access to, surgical services that contribute to the health outcomes for the people of the South Island Ensure southern region District Health Boards have the capacity to deliver the required levels of service to deliver increasing elective volumes Ensure southern region District Health Boards provide efficient and effective delivery of services
Outputs	Elective service outputs delivered as required by Ministry of Health meeting elective services targets, Elective Services Performance Indictors compliance, case weighted discharge volumes and discharge targets Clinical leaders supporting and involved with changing Elective Services approach The development of agreed patient focused outcome measurements Improved understanding of need (including unmet need) Development of a regional production / action plan based on capacity available within the region by August 2010Regional employment of medical staff (surgeons and anaesthetists etc), registered nurses, anaesthetic technicians and other identified health professionals Shared SI accommodation and travel policy for patients and /or staff being transported out of their deciled district for treatment Regional planning for establishment of new theatre facilities Establishment of outcome measurements to monitor and evaluate the benefits of the regional elective surgical service delivery Monitoring and evaluation of the delivery of elective surgical services and establish region wide mechanisms to manage variance from expected performance.
Measure	A regional production / action plan based on capacity available within the region is delivered by August 2010 Elective service outputs delivered with SI collective responsibility Decrease in variance across SI service Standardised Discharge Ratios Increased utilisation of public resources

- To date most of the regional work has been within District Health Boards in order to better understand and where possible increase internal elective capacity. The areas of focussed attention have been similar to that outlined in the *Delivery Plan for shorter stays in Emergency Departments* produced by all District Health Boards in 2009 without the condensed time frames for systems response that generally apply in coordinating quality acute care and in this case that of quality elective patient flow i.e. pre load or outpatients capacity; contractility or theatre utilisation; and after load or resourced bed capacity along with outpatient capacity repeated at the close of the patient journey.
- This work has achieved success in that theatre capacity is improving, resourced bed numbers and utilisation have expanded and all/ most District Health Boards are meeting the current elective services targets that have the ongoing Elective Service Performance Indicator compliance requirement, case weighted volumes and now discharge targets to meet. Noting that this achievement has also relied upon accessing local private capacity where possible too.
- In 2010/2011 active clinical leadership is the goal to achieving the next phase of achievement such as a robust regional plan that details who, when, where, how publically funded provider arm services may share their electives patient

groups with a regional and / or neighbour District Health Boards so that improved / timely access to elective services is achieved either procedure by procedure or by specialty if agreed.

- The South Island Chief Operating Officers and General Managers Planning and Funding have developed a regional Elective Services Plan, which includes development of a regional production plan based on capacity available within the region, and that an action plan to implement this will be confirmed by August 2010.
- There are a numbers of questions that remain unanswered or have not been adequately explored in order to understand what options the South Island District Health Boards have to maximise regional collaboration they may share to achieve the forecasted elective service demand in the coming years. A subject of topical discussion is the patient willingness to travel to another centre not traditionally named as their secondary care facility.

The increase in discharge and CWD targets for 2010/11 are identified to be in Canterbury District Health Board volumes only with the remaining five South Island District Health Boards maintaining the 2009/10 status quo as shown in Table One.

Table One: District Health Board elective services base increases

	Surgical Discharges				
District Health Board	2009/2010 health target	2010/2011 health target	Variation from 2009/2010	Equitable share of health target	Variation from equitable share
Canterbury	14,369	15,225	856	15,491	-266
Nelson Marlborough	5,968	6,029	61	4,716	1,313
South Canterbury	2,597	2,622	25	2,060	562
Southern	9,630	9,955	325	9,409	546
West Coast	1,571	1,592	21	1,254	338
Total	**34,135**	**35,423**	**1,288**	**32,930**	**2,493**

Note: caseweights are in WIES NZ09. Base case weighted discharge (cwd) will be adjusted in accordance with any change resulting under WIES NZ10.

Joints, Cataracts and Cardiac

The targeted funding increases for joints, cataracts and cardiac procedures for the South Island District Health Boards are shown in Table Two.

Table Two: targeted funding increases

District Health Boards	**Joints**		**Cataract**		**Cardiac**		
	Total required	Minimum to be Funded under Expression of Interest	Total required	Minimum to be Funded under Expression of Interest	Total required	Minimum to be Funded under Expression of Interest	Minimum total Case Weight Discharge required for cardiac
Canterbury	920	470	1305	528	312	40	2652
Nelson Marlborough	346	69	413	25	111	24	944
Otago	425	117	499	0	127	0	1080
South Canterbury	148	38	168	0	44	22	374
Southland	246	65	305	116	62	0	527
West Coast	79	0	94	26	24	5	204
Total	**2164**	**759**	**2784**	**695**	**680**	**91**	5780
Southern	671	182	804	116	189	0	1606.5

Canterbury and the West Coast District Health Board - Regional Partnerships

As part of our focus on integrated service delivery and a seamless transition between services for patients, our Board has a commitment to the development of formal clinical networks and to regional health services planning. Through this commitment, the collective South Island District Health Boards will implement solutions that will improve the patient experience and the health of our wider populations and reduce and control costs, while ensuring that patient care is not compromised.

In line with this commitment, and after a recent report into the future provision of health services by the West Coast District Health Board, Canterbury and the West Coast have mutually agreed to formalise long-standing clinical partnership arrangements and work together to plan sustainable and effective services for our regions.[5] This collaboration is a natural progression of the long-standing links that we have had with each other. However, formalising our partnership will allow us to more actively plan the assistance we provide, help to build a more appropriate workforce in both locations and improve patient safety; without having any detrimental affect on services provided to our own population.

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

This approach allows us to share 'back office' services, workforce resources, experience, knowledge and understanding without increasing wage and salary costs and will reduce duplication and waste between the two District Health Boards.

Human Resources and Payroll functions are amongst the functions where considerable progress has already been made, and this work is being undertaken with little additional resources. Both District Health Boards are also committed to working closely on the implementation of our *Better, Sooner, More Convenient* Business Cases, particular the rural health components, to ensure a consistency of approach across the wider region and alignment between our services.

The following table outlines the agreed timeframes for progression of our active partnership with the West Coast District Health Board.

Area of Activity	Action	Timeframe
Governance Arrangements	West Coast District Health Board to adopt Canterbury standing orders, committee structure and terms of reference to harmonise governance practice and reduce administration cost	Effective from March 2010
	Chief Executive Officer to assume joint responsibility for Canterbury and West Coast District Health Boards	Effective from 1 July 2010
	Formal integration of the Planning and Funding teams of both District Health Boards with focus on joint appointments, service planning and work plans, sharing data sets and introducing common process and tools	Effective 1 July 2010
Clinical Partnership Arrangements *Including: joint appointments of clinical staff and clinically led work streams at speciality and service levels to develop models of care, standard protocols, patient pathways and shared education*	Agreement by both Boards to formalise clinical partnership arrangements and move to joint clinical governance framework	Effective from March 2010
	Joint Paediatrician Senior Medical Officer appointment to improve functional linkages between nursing and midwifery services on West Coast and neonatal and paediatric service in Canterbury	Commenced Feb 2010.
	Joint Director of Allied Health appointment to improve professional input, leadership and direction for both District Health Boards	Commenced April 2010.
	Obstetric and Gynaecology work stream to ensure 24/7 senior medical cover for West Coast women	Commenced December 2009
	Urgent Care (Emergency Department) work stream established to improve functional linkages and support West Coast clinical teams	Commencing 1 July 2010

[5] *Analysis of options: Models of Care for West Coast District Health Board, by Law and Economic Consulting Group (LECG).*

Area of Activity	Action	Timeframe
programmes.	Mental Health work stream focused on joint appointments, workforce planning, sharing data sets and common processes for serious incidents	Commenced April 2010
	Canterbury Initiative work stream to support the development of clinically led patient pathways and HealthPathways site for West Coast	Commenced May 2010
	Better, Sooner, More Convenient Business Case work stream focused on coherent strategy for rural services development including clinical and financial sustainability	Effective September 2010
Back Office Service Arrangements	Occupational Health and Safety - single safety team with focus on standardising processes and systems for workplace safety	Effective 1 July 2010
	Human Resources - single team with focus on standard processes, joint appointments and digital recruitment processes to reduce time and costs.	Commenced September 2009
	Payroll System - Alignment of systems and joint appointments	Commenced September 2009 Effective April 2010
	Finance Systems - Implementation of the Convergence Project R12 upgrade for the Oracle finance system to enable sharing of procurement policies, ordering of supplies and financial functions	Commenced February 2010
	Information Systems – Investigate integration of laboratory information systems as a first step in a common information systems environment	Commenced September 2009

6.0 Wider Challenges Facing our District Health Board

6.1 Workforce Pressures

6.1.1 Workforce Development and Organisational Health

Workforce development will continue to be a major focus for the West Coast District Health Board: The District Health Board's Future Development Plan ensures that workforce development is aligned to service priorities and that adequate systems are in place for its support. The recent collaboration and progressive shift towards a full shared HR service with the Canterbury District Health Board increases the accessibility of the West Coast District Health Board to more advanced systems and resources to support this development.

Increasing emphasis is being placed upon the importance of clinical leadership and also the need to provide an explicit leadership framework and the management tools and development to support clinicians in leadership positions. This work will be managed collaboratively with the Canterbury District Health Board as clinical collaboration evolves.

The development of the Māori health and disability workforce will continue in a bid to further reduce health inequalities between population groups in the region. This will be achieved through following initiatives from the South Island and National Māori Workforce Plans.

Recruitment of sufficient numbers of qualified staff of all ethnicities is a priority for the District Health Board. Strategic recruitment initiatives such as the local scholarship programme continue to show benefits for both the West Coast District Health Board and the wider community.

6.1.2 Workforce Development Plan

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

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

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

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

6.1.3 Future Workforce Strategy Groups

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

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

6.1.4 Workforce Activity

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

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

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

The West Coast District Health Board is committed to supporting the improvement of this data and ensuring that timeframes are met. Various activities will be undertaken to achieve this, including the provision of resources to carry out the data requests on a quarterly basis, the collection of base data as required by District Health New Zealand in a timely manner and the validation of data as requested by District Health Board New Zealand. Furthermore, the District Health Board will ensure that data quality improvement standards are adhered to, engage with Health Workforce Information Programme before embarking on developing local workforce information analysis and provide Health Workforce Information Programme with access to West Coast District Health Board data on contracted Non Government Organisations. The move towards a shared Payroll service with the Canterbury District Health Board is supporting this process.

6.1.5 Develop the Māori Health and Disability Workforce on the West Coast

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

In 2010/2011 it is envisaged that there will be an increase in the Māori workforce, particularly in priority health areas, driven partly by local initiatives to attract Māori to opportunities in the health sector. Increased support will be offered for Māori to access networking opportunities.

6.1.6 Employment Relations

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

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

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

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

6.1.7 Recruitment, Organisational Development, Learning and Development and Retention Strategies

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

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

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

6.1.8 Health, Safety and Wellbeing

Senior management continues to show high levels of commitment to the Health and Safety Policy and procedures in place. The executive management team is regularly updated on the progress of the Health and Safety business plan.

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

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

6.2 Transport

The issue of transport to enable access to health services is a serious and ongoing concern to our community. Success in the implementation of better sooner more convenient models of primary care and sustainable secondary services depends on improved transport within and between districts. Approximately 1,155 West Coast District Health Board's residents received inpatient services from other District Health Boards (Inter District Flows) in 2007. The cost to the District Health Board for those patients that needed to be transferred from the West Coast district to another District Health Boards that year was $889,642. In addition there are unmeasured costs to the community itself in gaining access to services on an equitable basis. Resolution of the issue of patient travel for treatment is a priority area of work to support other key initiatives during 2010/2011. As we move towards more reliance on collaboration both between and within the Districts, the issue of improving patient transport needs addressing at three quite separate and distinct levels. The issue of transport within the District is crucial to the establishment of the proposed integrated primary health system. Secondly, transport between the West Coast and Canterbury is a core component of the inter-district activity on providing sustainable secondary care. Finally there is a need to work on transport on a whole of South Island basis as the South Island Clinical Services plan is developed and implemented. Consequently there are three specific areas of activity planned for 2010/2011 in respect of maintaining and improving access to treatment through effective transport mechanisms:

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Improving patient transport	Maintain or improve access to primary health and secondary health services as new models of care are developed and implemented both within the West Coast and between South Island District Health Boards	Investigation into patient transport systems to and between hospital and community health services as part of the better sooner more convenient primary health business case.	Progress towards addressing the long standing issue of improved patient access between urban and rural areas of health service delivery
		Further investigation into patient transport issues highlighted in the Law and Economic Consulting Group report on future models of care	Development of transport solutions which are critical to enabling implementation of preferred models of care for secondary health service delivery
		South Island Clinical Services Plan work stream to develop, evaluate and present a model which best accommodates the economic and social impact of patients travelling versus clinician travel on a regional basis	West Coast will be better positioned to participate in regional service delivery system.

7.0 Performance Improvement Actions

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

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

1) Achieve Financial Stability

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

2) Improve Productivity and Quality

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

3) Enhanced Regional Cooperation

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

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

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

7.1 Rural Health Learning Centre

The West Coast aspires to be a Centre of Academic Excellence in rural health. We hold a unique position within the national health care provision framework with regard to rural health and we are weaving this concept into the fabric of our facilities and systems.

We intend to have a fully developed learning centre in place by 2012 by consolidating current learning activities and actively promoting the learning experiences available to health professionals on the West Coast.

Goals include:

- To produce professionally and academically successful graduates, supported by a competent qualified teaching faculty and suitably resourced education facility
- To develop a cohort of appropriately trained staff for rural New Zealand

- To support and develop educational and career pathways in rural health

We work in partnership with a number of academic institutions and are actively seeking to increase those linkages.

The District Health Board is running a pilot programme for training rural General Practitioners, developing a post graduate training programme for rural nurses and establishing an academic primary practice in which to base these programmes. It is considering linking existing new graduate programmes for a range of health professionals to emphasise core common curriculum components and to encourage professionals to work as a multi disciplinary team. There are linkages with other related activities such as scholarship programmes and encouraging young people to consider health careers. Training has been provided for health professionals to become teachers. We have an active under graduate placement programme in place for medical students [including the rural immersion programme] nursing and allied health students and provide new graduate programmes

Coordinating and providing the myriad of under graduate and post graduate placements and programmes gives us the educational base to further develop programmes to attract, train and retain health professionals to the West Coast.

7.2 Inpatient Services

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

During 2008/2009, the project focused on developing models of care appropriate to the needs of the West Coast District Health Board and its population. There was widespread collaboration and consultation between management, clinicians, other healthcare providers and service users.

After the unsuccessful submission of business cases for the redevelopment of facilities at Buller Health and Grey Base Hospital in 2009, the West Coast District Health Board and the Ministry of Health commissioned a review to evaluate the work of the sustainability project to date and to recommend preferred future medium and long-term options.

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

All rural District Health Boards are finding that lifestyle is no longer a sufficient incentive to attract enough staff to operate a provincial hospital resulting in too much time spent on recruitment to the detriment of time required to manage and deliver health services.

The costs of delivering care in the current way are unaffordable and recruiting staff is difficult. New ways need to be found to provide healthcare to West Coasters.

The West Coast has too few patients in many medical specialties to warrant the number of specialist doctors required to maintain a working roster, resulting in the situation where specialist doctors and staff are in danger of seeing too few patients needing the same type of care to allow them to remain experts in their chosen field.

To provide a safe, modern and high quality service the smaller West Coast hospital services need to be an integrated part of a much larger regional service.

Modern medical care requires sophisticated support services, many of which are not able to be routinely provided on the West Coast. There are some medical conditions where patients are required to travel to Canterbury for more specialised care. This situation will not change.

The Canterbury and West Coast District Health Boards have had a long history of working together. A closer collaboration through improved engagement and clinical linkages will better support sustainable health services on the West Coast. A significant outcome from this arrangement will be a greater certainty for the people of the West Coast in the availability of healthcare services and a more appropriate workforce to work in both locations.

The Law and Economic Consulting Group went on to recommend the following changes to enable the West Coast District Health to deliver effective, safe and affordable services to people living on the West Coast:

- That Grey Base Hospital becomes a centre of excellence for rural health rather than a general acute hospital
- That there be an immediate move towards a formal clinical partnership arrangement with Canterbury District Health Board

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

Following extensive consultation between the Board, Clinical and other staff of both West Coast and Canterbury District Health Board, there is joint agreement, in principle, on the implementation of all or some of the Law and Economic Consulting Group report recommendations. While a number of these may proceed immediately, others will require formal public consultation before they can go ahead.

7.3 Quality and Safety

Long-Term Objectives – What do we want to achieve?

The West Coast District Health Board is committed to ensuring all the health services that it provides and funds are of the highest quality

Why is this important?

To ensure value-for-money and patient safety

How will we seek to improve outcomes for our population in the year ahead?

The West Coast District Health Board operates a quality audit and monitoring function, and actively encourages an organisational culture that is supportive of continuous quality improvement and quality initiatives through a systems approach. Implicit in this approach is measuring the effectiveness of these systems against agreed best practice standards. The outcome of this measurement will provide the basis for system improvements (developed as part of the West Coast District Health Board Quality Improvement Programme).

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Implementation of the West Coast District Health Board Quality Improvement Programme	Ensure services provided are people-centred	Continue to operate the West Coast District Health Board complaints procedure and management system, consumer satisfaction surveys, informed consent procedure, consultation procedure and community forums	A reduction in the occurrence of dissatisfied consumers
	Ensure access and equity to services	Health needs and access issues are identified for all consumer groups including Maori, consumers with disabilities, the elderly, children and adolescents, rural consumers	Improved access to identified groups
	Ensure safety of services	Maintain involvement in various certification and accreditation programmes, insurance programme and risk mitigation strategies	Identified deficiencies are addressed
Development of a Quality Plan and Risk Plan	Ensure effectiveness of services	Develop and implement a West Coast District Health Board Quality Plan and Risk Plan that: ▪ Specifies accountabilities for quality, risk and patient safety at all organisational levels ▪ Ensures better leadership of quality improvement and risk management processes ▪ Provides quality and risk reporting to senior management and the Board ▪ Monitors quality indicators ▪ Maintains data integrity mechanisms ▪ Develops new and revised policies and procedures ▪ Provide staff education and training programmes	Reduce delays in the provision of care and treatment to consumers Improved clinical leadership Policies and procedures are updated and maintained as required
Implement the West Coast District Health Board Health Emergency Plan	Ensure readiness for a Health Emergency Response	Ensure that the Emergency Response Plan is exercised annually through a tabletop exercise, annual review of the plan, internal audits, and coordination of a multi-agency pandemic planning working group	The West Coast District Health Board is prepared to effectively handle emergencies

OUTCOMES
How we will measure our success (associated measures of performance)?
• *Appropriate levels of certification / accreditation / insurance programme is maintained*
• *Risks are monitored and mitigated*

7.4 Workforce Planning and Development

Long-Term Objectives – What do we want to achieve?

Models of health care delivery where professionals work across District Health Board boundaries and provide services to local, sub-regional and regional populations. The West Coast District Health Board will work collaboratively with other District Health Boards in the Region (and in particular with Canterbury District Health Board) to achieve this workforce model.

Why is this important?

Workforce planning and development will contribute to an improvement in patient outcomes and over time in health professional's employment satisfaction .

How will we seek to improve outcomes for our population in the year ahead?

Through increasing clinical leadership in the delivery of health care services on the West Coast and collaboration with other District Health Boards in working towards consistent employment practices.

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
Workforce Planning and Development	Increasing clinical leadership and involvement in decision making	In collaboration with Canterbury District Health Board ensuring that key clinical leaders attend leadership training to support their involvement	Improved understanding of leadership and ability to lead and participate in decision making and leadership roles
	Collaborative employment practices	Where possible the consideration of joint appointments and shared employment policies and procedures	Reduction in locum cover and consistency of employment practices
OUTCOMES			
How we will measure our success (associated measures of performance)?			
Improvement in patient outcome Keep Performance Indicators. OS1 – Staff turnover by major professional group			

7.5 Information technology

Long-Term Objectives – What do we want to achieve?

One of the District Health Board's key strategies has focused on the integration of data from various health systems into Health Views and Medtech to eventually create a completely integrated electronic health record. Two of the key integration points between primary health and secondary care are the referral and discharge processes. The objective is to ensure that all relevant information is made available to the receiving provider when there is a transfer of a patient's care (either a referral to a provider or a discharge back to the original referrer).

How will we seek to improve outcomes for our population in the year ahead?

NEXT STEPS IN 2010/2011			
PRIORITY PROJECT	**OBJECTIVE**	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is District Health Board trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
A common clinical information system	Investigate whether to continue investing in the current CIS and develop an improved integration solution, or invest in replacing the existing CIS with a Concerto based solution	To ensure that all relevant information is made available to the receiving provider when there is a transfer of a patient's care (either a referral to a provider or a discharge back to the original referrer)	Adoption of single information technology system
	To enable a single source of patient information regionally for improved information sharing	To provide easy movement of clinicians from one District Health Board to another, without having to relearn systems. One central view of information regionally to enable better sharing of results	Enhanced sharing of results regionally
OUTCOMES			
How we will measure our success (associated measures of performance).			
Reduced requests for training in clinical information systems			
Reduces risk through improved information handover and sharing of information			

Refer to Appendix 8 for the Information System Strategic Plan (ISSP).

CURRENT STRATEGIES

The following areas will progressed during 2010/2011:

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

8.0 Service Change, Service Coverage and Regional Services Planning

8.1 Service Change

Older Persons Health Services

The West Coast District Health Board will continue implementing its Older Persons Strategy during 2010/2011. This includes expanding residential respite services and setting up a booking system for respite care, aided by an increase in funding made available by the Minister (approximately $50,000 a year).

In aged residential care, the West Coast District Health Board will continue to participate in the national Aged Residential Care contract negotiations and support the national Aged Residential Care review. The West Coast District Health Board has been strongly encouraging providers to set up dementia rest home level beds on the West Coast and it is hoped that these will be established before the end of 2010/11.

This, as well as the recent expansion of the dementia outreach team, will markedly improve the quality of care for people with dementia. The West Coast District Health Board will continue to work with aged residential care providers to explore ways of collaborating on common issues of concern such as staff recruitment.

The West Coast District Health Board will apply a 1.73% increase to price in the Aged Residential Care Contract. The 1.73% increase to price will include any cost implications (if any) on providers from changes to the new audit regime and any funding implications that may arise out of the A21 Review for 2010/2011.

With the implementation of unannounced spot audits from 1 January 2010 the pilot evaluation report indicates there may be a cost increase to providers for such audits due to increased time taken to conduct the audits. Any increased cost to providers that may accrue from the changes to the audit regime is included in the increase to prices that the District Health Board will pass through to aged residential care for 2010/2011.

During 2010/2011 the West Coast District Health Board will complete a reconfiguration of home support services on a restorative package model. This will enable more cost-effective allocation of long-term support services, a more skilled carer workforce and a mechanism for providing step-down beds and will contribute to a more streamlined transfer of care between hospital and community.

Moves to expand community-based support services will continue, including planned respite care, day-care, dementia day-care and services to support carers. Falls prevention programmes will be expanded to cover the whole West Coast.

Carelink, the Needs Assessment and Service Coordination service, will continue to develop strongly, using InterRAI to guide allocation of needs-based packages of care, working in much more closely with primary health teams in an Integrated Family Health Care model, and working with the primary care long-term conditions programme to provide case management for frail older people.

The feasibility of Carelink managing the short-term home support budget through assessment by Carelink staff will be explored and implemented if feasible, to create a single point of entry to home support services. The information generated by InterRAI will be available to other health and support services Carelink will explore the use of InterRAI as a shared electronic client record. Data from InterRAI will be used to inform planning and funding decisions.

Work started in 2009/2010 on a strategy for the support of carers will continue, setting up a more flexible and sustainable process for supporting carers and the Non Government Organisations that provide information and advocacy to people and their carers.

Oral Health

Implementation of a preventative model of oral health care will continue in 2010/2011 that will build on the implementation of topical fluoride services in 2009/2010. The service will drop the age of eligibility for service from two years to one, to maximize the benefit of this service for preschool children at risk of dental caries and education for parents and children will be enhanced with the utilisation of national resources as they become available and expansion of education in early childhood education settings.

The service will continue to expand the provision of services to adolescents by increasing the services currently provided to adolescents in rural areas and to out-of-school and unenrolled adolescents in Greymouth, Westport and Hokitika. The service volume target is 500 adolescents.

Facilities changes will continue with the closure of fixed clinics in rural areas in 2010/2011. Planning for the Westport and Greymouth facilities to become included in the Integrated Family Health Centre will eventually result in the closure of the Grey Main, Westport North and Westport South school dental clinics.

Mental Health

The West Coast District Health Board will continue to implement the Mental Health Rehabilitation Services Review during 2010/2011. With an tender process for the provision of Community Support Work Services currently underway, the devolvement of services from the District Health Board provider arm services to a Non Government Organisation provider from 1 July 2010 is likely.

Implementation of Integrated Family Health Services will also lead to service changes in mental health, with an increased number of mental health assessments undertaken in primary care, introduction of packages of care for those currently falling between primary and secondary services, shared care arrangements and the delivery of secondary mental health and addiction services within Integrated Family Health Centres.

Devolvement of Community Support Services and improving primary mental health services will lead to a reduction in access rates for specialist services, particularly as Community Support Work services are devolved from the provider arm. Mental health clients who are currently enrolled in secondary services because of their ongoing need for support services will be transferred to their primary health provider.

Māori Health

There will be changes to Kaupapa Māori Health Services during 2010/2011, following a tender process currently being undertaken for the provision of Kaupapa Māori Health Services. This will provide a range of whānau ora nursing and whānau ora support services to Māori throughout the West Coast. Future focus will be on the service needs identified in the District Health Board's Māori Health Needs Assessment, including access to primary care services, smoking rates, chronic conditions management/education and prevention, child health and mainstream service/treatment effectiveness

8.2 Business Cases

Introduction

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

Grey Base Hospital

The West Coast District Health Board is planning to reconfigure the Grey Base Hospital facilities in order to better suit changing models of care and the changing health needs of the West Coast population whilst also addressing structural (seismic) issues with the current facility. A business case and options analysis were prepared and submitted to the National Capital Committee for approval in 2008.

This business case was not approved. During 2010/2011 additional planning work will be undertaken in order to explore future options with the intention of submitting a revised business case on completion of models of care planning process.

Buller Health

As stated elsewhere in this District Annual Plan, the West Coast District Health Board has been working in partnership with the West Coast Primary Health Organisation to develop a response to an expression of interest for the development of Integrated Family Health Centres. This includes, the previously District Health Board led, Buller Health proposal.

The District Health Board will reconsider re-submission of a business case for capital funding as the implementation of Better Sooner More Convenient Primary Business Case occurs.

8.3 Service Coverage

The West Coast District Health Board will work to ensure that national consistency across services is achieved through compliance with the Service Coverage Schedule and Operating Policy Framework requirements.

The West Coast District Health Board will work to identify service coverage gaps through monitoring and review of all services on a continuous basis.

The West Coast District Health Board will provide regular reports and updates on service continuity service gaps if any, throughout the quarterly reporting process.

8.4 Service Delivery

Please refer to Appendix 2, the Price Volume Schedules

9.0 Local Priorities

The West Coast District Health Board has identified seven local priorities that align with the District Strategic Plan and the health needs of West Coast residents. Below is a brief synopsis of these local priorities. The annual work plans have been produced and are available on request.

Local Priority	Focus for 2010/2011
Improving Maori Health and Implementing He Korowai Oranga	The West Coast District Health Board has identified priority areas for implementation: ▪ Improving Māori Health and Implementing He Korowai Oranga ▪ Encourage initiatives across sectors that positively affect Whānau Ora ▪ Strengthen Māori health governance ▪ Maintain access and utilisation of health services for Māori ▪ Enhance mainstream service effectiveness ▪ Increase the capacity and capability of service providers to deliver effective health and disability services for Māori ▪ Develop the West Coast Māori health and disability workforce ▪ Build quality data and monitor Māori health
Reducing Inequalities	Inequalities in health are clearly evident on the West Coast particularly for Māori, children (0-14), youth (12-24), older people (55+), long-term mental health service users and those with chronic conditions. The District Health Board is committed to reducing inequalities in health outcome and delivery, and reductions in inequalities are evident in a number of areas including a reduction in the difference in immunisation rates between Māori and non-Māori, and an increase in Māori enrolments and access to primary care services. During 2010/2010 the District Health Board will continue to work to reduce inequalities for these priority populations through the following activities. ▪ Inequality and cultural training for staff ▪ Provision of Kaiawhina and Maori nursing positions to improve access and utilisation of primary care services ▪ Targets projects for children, youth, older people and mental health services users
Child and Youth Health Services	The West Coast Youth Health plan identifies sexual health, mental health, alcohol, tobacco and other drugs, nutrition and physical activity as priority areas for youth health. These areas remain priorities in 2010/2011, with the addition of adolescent oral health services and the development of alternative education based health services
Improving Mental Health	2010/11 will focus on: ▪ The quality improvement initiatives in 2010/2011 will focus on integrating primary and secondary mental health services. Changes in current service configurations will include: ▪ a single entry point for patients who need mental health services, ▪ packages of care for those currently falling between primary and secondary services, ▪ shared care arrangements, ▪ improved discharge planning processes ▪ delivery of secondary mental health and addiction services within Integrated Family Health Centres

Local Priority	Focus for 2010/2011
Improving the Health of Older People	We plan to maintain the momentum of change in each of these areas, including: ▪ Completing the reconfiguration and up skilling of home-based support services that was started in 2010/2011 ▪ Improving the cost-effectiveness of all long-term support services by tying service allocation more closely to assessed need (this will be enabled by the home care changes) ▪ Strengthening assessment and coordination of services through extending the end-use of InterRAI as a form of shared client record, aligning Carelink staff with individual primary health centres, expanding Carelink's service to include assessment for short-term and post discharge home support (if feasible), and establishing a system for routinely providing community pharmacy medication reviews for the frail elderly ▪ Integrating primary, secondary, community and residential services through the Integrated Family Health Centres project, with a focus on the pathway for frail older people ▪ Continuing to increase the availability of community-based support services, including day care, planned respite, falls prevention and support for carers. ▪ Supporting quality of aged residential care through collaboration on staffing, training and quality issues and the establishment of dementia rest home level beds.
Minimise Family Violence, Child Abuse and Neglect	Improving hospital responsiveness to Family Violence, Child Abuse and Neglect is the current focus of the health sector with mental health, alcohol and drug, emergency department, child health (school, home visiting and paediatric), maternity and sexual health services identified by the Ministry of Health as priority areas
Nutrition and Physical Activity	The West Coast District Health Board will continue to work collaboratively with Canterbury District Health Board support and empower communities to take action, work intersectorally to plan and implement nutrition and physical activity-related projects and assisting the implementation of the 'Keeping People Healthy' section of the primary care business case. Nutrition and physical activity is a priority focus for the Healthy West Coast joint planning and implementation in 2010 and 2011

10.0 Managing Financial Resources

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

Strategies have been put in place to attract staff but these are long-term plans and so the West Coast District Health Board still suffers the effects of short-term workforce fluctuations.

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

Failure to Achieve Breakeven

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

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

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

locums to cover these periods of absence as the small staff compliment by speciality cannot absorb prolonged absences.

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

Budget Deficit - 2010/2011

The $7.2million deficit submitted in this district annual plan has been prepared after taking the following factors into account:

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

Other key assumptions are listed earlier in the financial section of this district annual plan.

Information Flows

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

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

Activities for Which Compensation Is Sought

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

Disposal of Land

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

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

Acquisition of Shares

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

Statement of Accounting Policies

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

(i) Cautionary Note

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

(ii) Nature of Prospective Information

The financial information presented consists of forecasts which have been prepared on the basis of best estimate assumptions as to future events that the West Coast District Health Board expects to take place.

(iii) Assumptions

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

Reporting Entity

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

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

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

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

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

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

Statement of Compliance

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

Basis of Preparation

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

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

Critical accounting estimates and assumptions

In preparing these financial statements, the West Coast District Health Board has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Property, plant and equipment useful lives and residual value

At each balance date the West Coast District Health Board reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires the West Coast District Health Board to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the West Coast District Health Board, and expected disposal proceeds from the future sale of the asset. An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. The West Coast District Health Board minimises the risk of this estimation uncertainty by:

- physical inspection of assets;

- asset replacement programs;

- review of second hand market prices for similar assets; and

- analysis of prior asset sales.

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

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

Leases classifications

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

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

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

Budget Figures

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

Revenue

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

Revenue from the Crown

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

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

Other grants

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

Goods and Services Tax

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

Taxation

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

Trust and Bequest Funds

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

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

Trade and other receivables

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

Investments

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

Bank deposits

Investments in bank deposits are measured at fair value.

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

Equity investments

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

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

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

For equity investments classified as fair value through equity, a significant or prolonged decline in fair value of the investment below its cost is considered an indication of impairment. If such evidence exists for investments through equity, the cumulative loss (measured as the difference between acquisition cost and the current value, less any impairment loss on that financial asset previously recognised in the statement of financial performance) is removed

from equity and recognised in the statement of financial performance. Impairment losses recognised in the statement of financial performance on equity on investments are not reversed through the statement of financial performance.

Inventories

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

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of the West Coast District Health Board's cash management are included as a component of cash and cash equivalents for the purposes of the statement of cash flows.

Impairment

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

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

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

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

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

Financial Instruments

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

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

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

Assets Classified as Held for Sale

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

Property, Plant and Equipment

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

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

Assets, other than land and buildings, acquired by the Board since its establishment, and other than those vested from the Hospital and Health Service, are recorded at cost less accumulated depreciation. Cost includes all

appropriate costs of acquisitions and installation including materials, labour, direct overheads, financing and transport costs.

Revaluation of Property, Plant and Equipment.

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

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

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

Disposal of Property, Plant and Equipment

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

Depreciation

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

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

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

Intangible Assets

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

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

Amortisation

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

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

	Years
Acquired computer software	2 - 10

Trade and other payables

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

Employee Entitlements

Short-term employee entitlements

Employee entitlements that the West Coast District Health Board expects to settle within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

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

Sick leave

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

Bonuses

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

Long -term employee entitlements

Employee entitlements that are payable beyond 12 months.

Long Service Leave and Retirement Gratuities

Entitlements that are payable beyond 12 months, have been calculated on an actuarial basis. The calculations are based on likely future entitlements accruing to staff, based on years of service, year's entitlement, the likelihood that staff will reach a point of entitlement and contractual entitlement information. The obligation is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at balance sheet date.

Sabbatical Leave

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

Superannuation Schemes

Defined Contribution Schemes

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

Defined Benefit Schemes

The West Coast District Health Board belongs to the National Provident Fund, which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefits scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which a surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is accounted for as a defined contribution scheme. Further information on this scheme is disclosed in note 15.

Leased Assets

Finance Leases

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

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

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

Operating Leases

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

Interest-bearing Borrowings

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

Capital Charge

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

Borrowing Costs

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

Cost of Service Statements

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

Cost Allocation

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

Cost Allocation Policy

Direct costs are charged directly to each output class.

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

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

Changes in accounting policy

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

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

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

- New Zealand Institute of Chartered Accountant 1 Presentation of Financial Statements (revised 2007) replaces New Zealand Institute of Chartered Accountant 1 Presentation of Financial Statements (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009.
- New Zealand Institute of Chartered Accountant 23 Borrowing Costs (revised 2007) replaces New Zealand Institute of Chartered Accountant 23 Borrowing Costs (issued 2004) and is effective for reporting periods commencing on or after 1 January 2009.

- NZ specific amendment to New Zealand Institute of Chartered Accountant 2 Inventories. In November 2007 the New Zealand Accounting Standards Review Board approved an amendment to New Zealand Institute of Chartered Accountant 2 Inventories, which requires public benefit entities to measure inventory held for distribution at cost, adjusted when applicable for any loss of service potential.

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

10.1 Disposal of Surplus Assets

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

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

10.2 Debt and Equity

The West Coast District Health Board will require deficit funding (equity) in order to offset the deficit signalled in this District Annual Plan.

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

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

Debt Facilities

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

Bank of New Zealand (BNZ)

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

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

Details of Loan Financing Facilities

West Coast District Health Board Debt Register

As at April 2010

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

Upcoming Loan Repayments

Dementia Unit	30/06/2010	$ 250,000

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

DHB Consolidated

Statement of Comprehensive Income

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

	2008/09 Audited Actual	2009/10 Forecast	**2010/11 Budget**	2011/12 Budget	2012/13 Budget
EXPENSES					
Personnel costs					
Medical Personnel	7,997	9,745	10,437	10,646	10,859
Nursing Personnel	19,876	22,631	23,155	23,458	24,137
Allied Health Personnel	10,156	9,106	8,871	8,936	9,114
Support Personnel	1,779	2,032	1,939	1,978	2,017
Management/Administration Personnel	8,437	8,064	7,791	7,847	8,004
Personnel costs Total	48,245	51,578	52,193	52,864	54,131
Outsourced Services					
Medical Personnel	9,136	7,069	6,873	6,841	6,478
Nursing Personnel	219	280	-	-	-
Allied Health Personnel	246	214	49	50	51
Support Personnel	78	51	33	34	34
Management/Administration Personnel	48	37	239	244	249
Outsourced Clinical Services	3,701	3,126	3,102	3,030	3,090
Outsourced Corporate/Governance Services	189	462	830	847	864
DHB Governance & Administration	(52)	-	-	-	-
Outsourced Services Total	13,565	11,239	11,126	11,046	10,767
Clinical Supplies					
Treatment Disposables	1,161	1,176	1,227	1,252	1,277
Diagnostic Supplies & Other Clinical Supplies	54	80	80	82	83
Instruments & Equipment	1,486	1,692	1,617	1,649	1,682
Patient Appliances	374	337	330	337	344
Implants and Prostheses	733	897	936	955	974
Pharmaceuticals	1,586	1,783	1,744	1,779	1,814
Other Clinical & Client Costs	1,112	1,175	1,186	1,210	1,234
Clinical Supplies Total	6,506	7,140	7,120	7,263	7,408
Infrastructure & Non-Clinical Supplies					
Hotel Services, Laundry & Cleaning	3,429	3,565	3,539	3,610	3,682
Facilities	5,521	5,128	4,611	4,657	4,704
Transport	1,571	1,381	1,412	1,380	1,407
IT Systems & Telecommunications	2,110	2,061	2,105	2,126	2,169
Interest & Financing Charges	1,159	2,553	2,261	2,239	2,229
Professional Fees & Expenses	1,045	841	646	655	665
Other Operating Expenses	2,227	2,255	2,552	2,601	2,652
Democracy	278	296	367	308	311
Infrastructure & Non-Clinical Supplies Total	17,340	18,080	17,493	17,576	17,819

Personal Health

EXPENSES (Payments to Providers)					
Child and Youth	157	162	162	165	169
Laboratory	484	570	505	422	382
Maternity	-	0	10	10	10
Maternity (Tertiary and Secondary)	-	55	-	-	-
Pregnancy and Parenting Education	61	0	8	8	8
Maternity Payment Schedule	-	-	40	41	42
Sexual Health	54	14	-	-	-
Adolescent Dental Benefit	298	384	412	420	429
Child (School) Dental Services	22	(18)	20	20	21
Pharmaceuticals	7,760	7,030	8,303	8,469	8,415
Pharmacy Services	-	313	-	-	-
Management Referred Services	23	-	-	-	-
General Medical Subsidy	56	47	52	53	54
Primary Practice Services – Capitated	5,303	5,811	5,441	5,550	5,661
Primary Health Care Strategy - Other	10	-	-	-	-
Practice Nurse Subsidy	32	-	-	-	-
Rural Support for Primary Health Providers	745	1,223	888	906	924
Immunisation	196	111	95	97	99
Palliative Care	57	277	104	106	108
Chronic Disease Management and Education	163	69	200	204	208
Medical Inpatients	45	(3)	63	64	66
Medical Outpatients	2	-	-	-	-
Surgical Inpatients	84	(303)	834	851	868
Surgical Outpatients	(1)	-	-	-	-
Emergency Services	-	5	-	-	-
Minor Personal Health Expenditure	243	322	224	228	233
Travel & Accommodation	881	1,091	1,142	1,165	1,188
IDF Personal Health - Own DHB Population	13,063	14,449	15,075	15,678	16,305
Total Personal Health	29,738	31,608	33,578	34,458	35,189

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

DHB Governance & Funding Administration Arm

Statement of Comprehensive Income

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

DHB Provider Arm

Statement of Comprehensive Income

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

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

DHB Funds Arm

Statement of Comprehensive Income

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

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

DHB Consolidated

Statement of Financial Position

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

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

Statement of Movement in Equity

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

DHB Consolidated
Statement of Cashflows

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

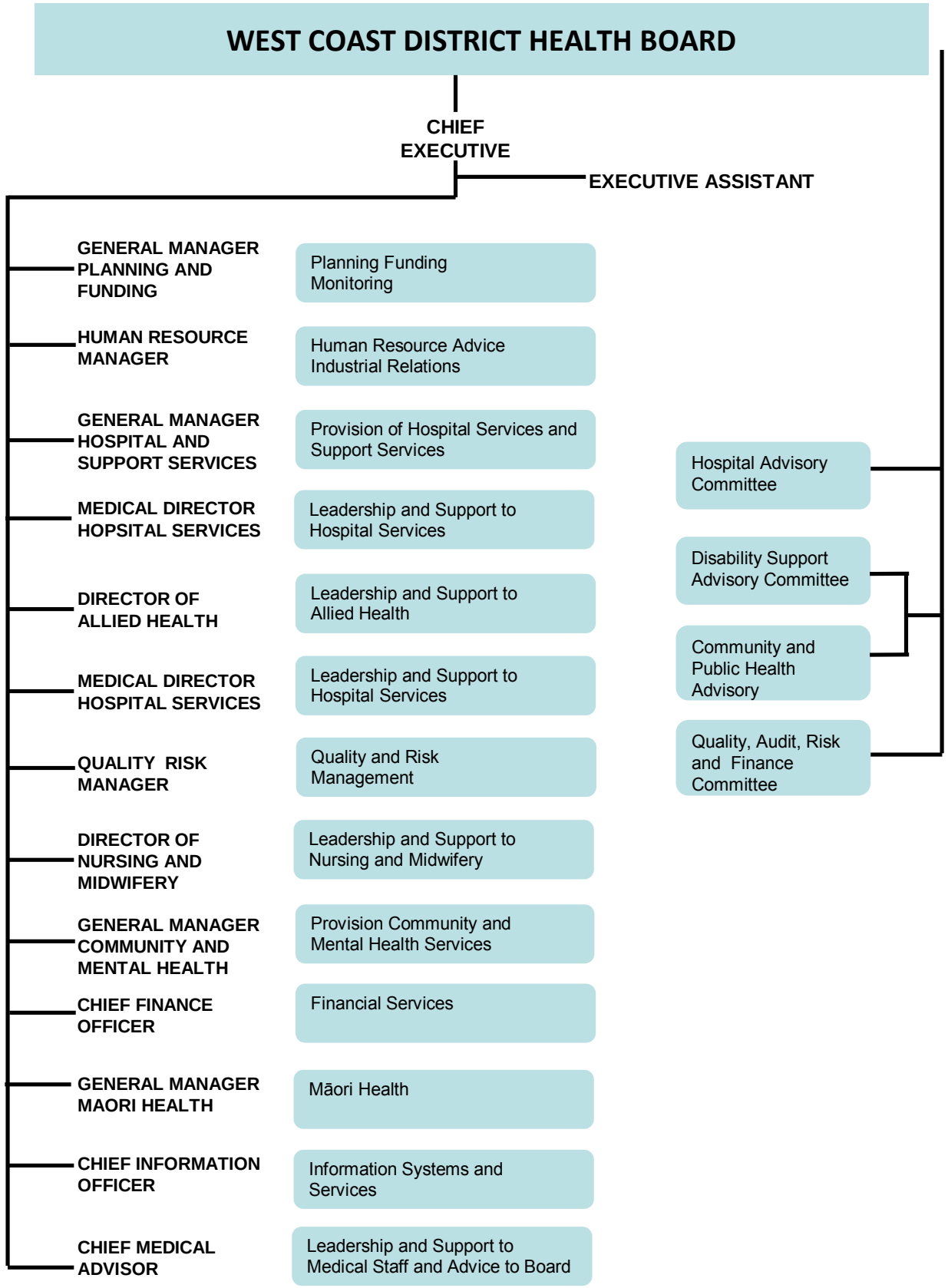
Appendices

Appendices

- Appendix 1. West Coast District Health Board Organisational Chart.
- Appendix 2. Price Volumes Schedules.
- Appendix 3. Summary of District Health Board Plans and Strategies.
- Appendix 4. District Health Board Summary of Outcomes.
- Appendix 5. West Coast District Health Board Performance Targets Measures for 2010/2011.
- Appendix 6. Information Systems Strategic Plan.
- Appendix 7. Regional Priority Areas.
- Appendix 8. Glossary of Terms

- **Appendix 1.**

1 West Coast District Health Board Organisational Chart



Appendix 2.

2 Price Volume Schedules

The West Coast District Health Board expenditure profiles are represented by the following price volume schedules and templates.

- 2010/2011 Provider Arm Price Volume Schedule
- 2010/2011 District Annual Plan Financial Template
- 2010/2011 Elective Services Price Volume Schedule
- 2010/2011 Funder Arm Price Volume template
- 2010/2011 Mental Health Financial Plan
- 2010/2011 Revenue Reconciliation

Appendix 3.

3 Summary of District Health Board Plans and Strategies

- **District After Hours Plan**

  The West Coast Primary Health Organisation and West Coast District Health Board envisage a strong after hours primary care service which is clinically and financially sustainable and which meets the needs of the enrolled population and visitors. The plan will reflect the differing needs of all regions of the Coast. This plan is not static but through collaborative implementation will support the vision of "the centre of rural excellence" for the West Coast. The Primary Health Organisation believes that sustainable after hours care must stand up to the test of time, five years and beyond. This will include changes as better technologies or service models surface which optimise access to quality timely care.

- **The West Coast District Health Board Child Health Plan**

  The development of a West Coast Child Health Plan is an important step towards achieving the District Health Board vision of 'children are the future'. Through the identification of the key issues affecting West Coast children's health, the areas with the poor health outcomes, key indicators of child health and the development and implementation of strategies that address these issues, the health of West Coast children can be improved and inequalities in health outcomes reduced.

- **The West Coast District Health Board Chronic Conditions Management Plan**

  This strategy has been developed collaboratively with the West Coast Primary Health Organisation and Community and Public Health, with input from Non Government Organisations on the West Coast. Actions are contained in this strategy that require work from, and collaboration with, these partners in health care provision on the West Coast. This strategy focuses on cardiovascular disease and diabetes. It is expected that other chronic conditions will be added to the focus of the strategy as time goes on.

- **West Coast District Health Board three year Smokefree Plan**

  The West Coast District Health Board Smokefree Plan was developed in partnership with the West Coast Primary Health Organisation and Community and Public Health. The plan outlines the initiatives planned to achieve our collective goal of reducing the burden smoking on the West Coast over the next three years. These initiatives are focused on reducing initiation, increasing smokefree environments, promoting cessation and providing acceptable accessible cessation services.

- **The West Coast District Health Board Disability Action Plan**

  In 2001, the Ministry of Health released the New Zealand Disability Strategy . The New Zealand Disability Strategy recognises that we live in a disabling society and has a vision for "a fully inclusive society". New Zealand will be inclusive when people with impairments can say they live in "a society that highly values our lives and continually enhances our full participation".

  The West Coast District Health Board has developed this plan in response to the New Zealand Disability Strategy. It presents a strategy to assist with the implementation of the New Zealand Disability Strategy on the West Coast. Accordingly, each action point in this plan has a link to the relevant objective of the New Zealand Disability Strategy and this Plan is deliberately focused around the practicalities of ensuring that successful implementation is achieved. This includes having regard for the diversity of residents of, and visitors to, the West Coast. This also requires the District Health Board to have particular regard for Māori as tangata whenua. Under te Tiriti o Waitangi (1840) and the New Zealand Health and Disability Act (2000) the West Coast District Health Board must ensure that Māori achieve equity of outcome, therefore it has included specific initiatives for, or acknowledgement of, Māori to improve outcomes for this priority population group.

- **The West Coast District Health Board Māori Health Plan**

  It is the intention of this plan to map clear and defined pathways that enable the utilisation of accessible and appropriate health services by all Māori who live on Te Tai Poutini. Furthermore this plan will continue to build on the progress made relating to objectives within the last Māori Health Plan 2003-2006, and to set the direction that Māori health will follow in 2007-2011.

  This plan incorporates national and local strategic directions, adopting the key principles of He Korowai Oranga: New Zealand Māori Health Strategy 2002, and Whakatātaka Tuarua; the national strategies that outline Māori health priorities and directions for Māori health. Whānau ora is the theme of the West Coast District Health Board Māori Health Plan / Te Kaupapa Hauora Māori o Te Poari Hauora a Rohe o Tai Poutini.

- **The West Coast District Health Board Primary Health Care Plan**

  This plan is intended as an initial overall framework for West Coast District Health Board to guide the development of primary and community services over the period 2007-2012.

  Over the next two years the District Health Board will develop this plan further into a comprehensive strategy for the full range of primary and community-based services, to complement the current reconfiguration of specialist and hospital services (the Grey Base 2020 project).

- **The West Coast District Health Board Primary Mental Health Plan**

  The purpose of the primary mental health project was to ascertain the mental health needs of the West Coast population, and to develop a strategic plan, with the view to implementation over five years, which addresses the needs of the population and meets the aims of the Primary Mental Health Strategy. In addition the plan looks specifically at meeting the previously identified objectives required / outlined in the earlier District Annual Plans, namely to:

  - Meet the needs of the 17% of the population with diagnosable (mild to moderate) mental disorder
  - Improve access for people with mild to moderate mental health issues to primary mental health care on the West Coast
  - Improve access to primary health care for people with severe and enduring mental illness (3%) treated by the West Coast District Health Board mental health service

  The scope of the Primary Mental Health Strategic Plan is to make recommendations to the West Coast District Health Board in regard to addressing the physical and mental health needs of the West Coast population who experience mental illness. It is part of the development of both the overall Primary Health and Mental Health Plan for the West Coast.

- **The West Coast District Health Board Secondary Care Plan**

  The intent of this document is to plan out the specialised health services that will be needed for West Coasters in 10 – 15 years time, and to set out a work programme for the next three years to prepare for these developments.

  The scope of the plan is limited to hospital-based services. While some inpatient care and outpatient clinics and procedures are provided in Westport and Reefton, these are effectively 'super-primary' services. Secondary services are currently only provided from Grey Base Hospital, and it is not envisaged that this will change in the timeframe envisaged by this plan, although it is expected that some services currently provided from Grey Base Hospital will, in future, be provided as community-based services.

- **The West Coast District Health Board WISE (West Coast Improving Services for the Elderly) Plan**

  This plan describes the West Coast District Health Board's action plan for developing health and disability support services for older West Coast residents over the next six years to 2016.

The plan takes account of the West Coast District Health Board's Strategic Plan 2002-2021, Te Poari Hauora a Rohe a Tai Poutini / Māori Health Plan 2003-2006, Long term Conditions Management Project and the Better Sooner More Convenient Project for Integrated Family Health Centres, as well as the New Zealand Health Strategy, New Zealand Health of Older People's Strategy, New Zealand Disability Strategy, He Korowai Oranga / Māori Health Strategy and New Zealand Primary Health Care Strategy.

The plan describes how the West Coast District Health Board will improve services for older people along the continuum of care, and enable a greater number of older people to 'age in place', as required by the New Zealand Health of Older People Strategy.

- **The West Coast District Health Board Youth Health Plan**

Improving child and youth health is one of the West Coast District Health Board's six priorities in its District Strategic Plan 2005 – 2015. This reflects a wider national initiative to address the health and development issues faced by young people in New Zealand.

This document outlines the West Coast District Health Board's Youth Rangatahi Health Plan. The West Coast Youth Rangatahi Health Profile is the background document to this plan, and draws on national and local youth health data. The plan sets out specific action for improving youth health in the following priority areas: injury, sexual health, mental health, alcohol, tobacco and other drugs.

- **The West Coast Cancer Control Strategy (Cancer Action Plan)**

West Coast District Health Board has a goal of becoming a centre of rural excellence in healthcare delivered to the community it serves. The West Coast District Health Board acknowledges the impact the burden of cancer and other chronic conditions will have on the provision of health services in the coming years, as the population ages. A paradigm shift is required to cope with this. The need for proactive, co-ordinated services across the health sector is acknowledged as being necessary to provide high quality health care for chronic conditions.

As part of this vision, the West Coast District Health Board has adopted a strategy of leading for outcomes in respect of the management and control of chronic conditions – with an initial focus upon diabetes, cancer, cardiovascular disease and stroke management, and respiratory disease. The West Coast Chronic Conditions Management Strategy 2006-2009 has been developed, and was adopted (subject to some modifications being incorporated) by the West Coast District Health Board in December 2006. This plan will overarch and inform future planning and directions for service delivery in relation to cancer control initiatives and strategies for the West Coast District Health Board. In addition, the future range, nature, and mode of delivery of secondary services provided locally are being reviewed as part of the West Coast District Health Board's Draft Secondary Care Plan.

- **The West Coast District Health Board Integrated Diabetes Service Plan**

This plan, which aims to co-ordinate diabetes services throughout the West Coast region and maximise the use of resources, has been partially superseded by the Chronic Conditions Management Plan

- **Health of Older Persons**

The West Coast District Health Board is collaborating with other South Island District Health Boards on a joint workplan for the development of health and support services for older people. The health of older people is a priority area for all South Island District Health Boards. Our ageing population necessitates new paradigms to address increasing demand, current and evolving service gaps, financial sustainability of the health sector and current issues with quality and workforce.

The South Island Chief Executive Officers have requested that their Planning and Funding teams work regionally to align services for older people across the South Island to ensure consistent service responses and equity of access for South Island residents. This is expected to maximise returns through combined effort and the sharing of personnel and expertise to champion and address areas of common interest. The regional work plan aligns the work being done by each of the South Island District Health Boards on developing services for older people and aims to meet the following priorities: (Examples of activities within each priority are given)

(iv) Maximise financial sustainability and cost-effectiveness (e.g. rolling out InterRAI; regionally consistent implementation of a restorative model of home support; regional dataset to allow effective monitoring and benchmarking of expenditure and utilisation on residential care and other high-cost services; consistent regional response to common providers)

(v) Ensure fairness and equity of access to services (e.g. consistent Needs Assessment and Service Coordination processes and access criteria; regional booking system for planned respite care)

(vi) Maintain clinical quality of care (e.g. regional adoption of quality improvement initiatives piloted by individual District Health Boards such as medication management in aged residential care; dementia regional service and other formal linkages between secondary and tertiary services)

The work plan builds on the work that South Island District Health Boards each have underway to implement the national Ageing in Place Strategy as outlined in each District Health Board's District Annual Plan. The work plan gives both short-term and longer-term actions to meet the objectives, and will also be aligned with the national workplan for older people's services being developed by the Ministry of Health.

The work plan will demonstrate measurable results and will be reviewed by the General Managers Planning and Funding and Chief Executive Officers quarterly. It will include strategic and operational issues and ensure convergence of District Health Board activity and alignment with the Minister's priority to reduce duplication.

Appendix 4.

4 District Health Board Summary of Outcomes

West Coast District Health Board Summary of Outcomes							
Long-term outcomes **District Strategic Plan**	**Outcome 1** West Coasters will be as healthy as possible... Physically active non smokers Abstain from recreational drugs and gambling Eat a balanced diet Consume alcohol only in moderation	**Outcome 2** Māori will enjoy the same high health status as non-Māori	**Outcome 3** West Coasters will have affordable and equitable access to services	**Outcome 4** West Coasters will have at least equal access to specialised medical and surgical services as other New Zealanders with similar need	**Outcome 5** There will be a meaningful commitment to the idea 'Children are the future'	**Outcome 6** Collaborate to ensure the physical, social and cultural environments West Coasters live in promote health, inclusion and participation in society and maximise independence of people living with disabilities	**Outcome 7** As West Coasters become older they will have access to services that will help them remain in their own homes for as long as possible, and then to continue to live in or near their communities
Medium-term outcomes	Reduce inequalities	Increase relative investment in Māori health	Closer collaboration between District Health Board and primary health organisation over primary health services delivery	Improve the Primary/secondary interface	Improve oral health	Improving levels of awareness of the difficulties for people with disabilities	To protect health, independence and interdependence of older people
	Reduce the incidence and impact of chronic conditions	Foster development of whānau, hapū, iwi and Māori communities	Improving the primary / secondary interface	Retain medical and surgical services	Improve nutrition	Improve the ability of the District Health Board to respond to the needs of employees and patients with disabilities	Identify illness and disability before they worsen

West Coast District Health Board Summary of Outcomes							
Long-term outcomes **District Strategic Plan**	**Outcome 1** West Coasters will be as healthy as possible... Physically active non smokers Abstain from recreational drugs and gambling Eat a balanced diet Consume alcohol only in moderation	**Outcome 2** Māori will enjoy the same high health status as non-Māori	**Outcome 3** West Coasters will have affordable and equitable access to services	**Outcome 4** West Coasters will have at least equal access to specialised medical and surgical services as other New Zealanders with similar need	**Outcome 5** There will be a meaningful commitment to the idea 'Children are the future'	**Outcome 6** Collaborate to ensure the physical, social and cultural environments West Coasters live in promote health, inclusion and participation in society and maximise independence of people living with disabilities	**Outcome 7** As West Coasters become older they will have access to services that will help them remain in their own homes for as long as possible, and then to continue to live in or near their communities
	Improve health outcomes for youth	Increase Māori participation in the health and disability sector	Improve integration between primary and secondary mental health care	Increase clinical and financial viability of secondary services	Improve access to primary mental health services for children	Enhance the ability of the sector to respond to and meet the needs of people with disabilities	Ensure that older people have a smooth path into and back from specialist services
	Increase physical activity and healthy eating	Encourage initiatives with other sectors that positively affect Whānau Ora	Improve access to a range of quality mental health services		Improve immunisation coverage	Prevent disabilities caused by disease, illness, accident or injury	
Health sector strategic inputs – existing / draft detailed plans	Chronic Conditions Management Strategy Cancer Control Strategy Primary Health Care Plan Māori Health Plan Child Health Plan Youth Health Plan WISE Plan Disability Action Plan Primary Mental Health Plan	Māori Health Plan	Primary Health Care Plan Secondary Services Plan Primary Mental Health Plan	Secondary Services Plan Chronic Conitions Management Strategy Cancer Control Strategy WISE Plan	Child Health Plan Primary Health Care Plan Secondary Services Plan	Disability Action Plan Primary Health Care Plan Secondary Services Plan Primary Mental Health Plan	WISE Plan Primary Health Care Plan Secondary Services Plan

Appendix 5.

5 West Coast District Health Board Performance Targets Measures for 2010/2011

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
HT1	Shorter stays in emergency departments		Total	>95%	% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	**95%**	Quarterly
HT2	Improved access to elective surgery		Total	1592	The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1400 per year)	**4,000**	Quarterly
HT3	Shorter waits for cancer treatment		Total	100%	% of patients in category A, B and C wait less than **four** weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).	**100%**	Quarterly
HT4	Increased Immunisation		Māori	80%	% of two year olds are fully immunised by July 2011	**90%**	Quarterly
			Pacific	N/A			
			Total	86%			
HT5	Better help for smokers to quit	1. Hospitalised smokers	Total	80%	% of hospitalised smokers will be provided with advice and help to quit by July 2011	**90%**	Quarterly
		2. Primary Care	Total	80%	% of patients attending primary care will be provided with advice and help to quit by July 2011	**80%**	Quarterly
HT6	Better diabetes and cardiovascular services	1. Diabetes Management	Māori	80%	Increased percent of people with diabetes have satisfactory or better diabetes management		Quarterly
			Pacific	80%			
			Other	80%			
			Total	80%			

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
		2. Diabetes Checks	Māori	65%	Increased percent of people with diabetes attend free annual checks		
			Pacific	65%			
			Other	65%			
			Total	65%			
		3. Cardiovascular diseases Lipids	Māori	>65%	Increased percent of the eligible adult population have had their Cardiovascular diseases risk assessed in the last five years		
			Pacific	Not applicable			
			Other	>75%			
			Total	>74%			
PP1	Clinical leadership self assessment		Total	The District Health Board provides a qualitative report in the form of a self assessment identifying progress achieved; What's worked; what hasn't; Planned actions - for each of the following areas of focus: • whether managers and clinical leaders feel valued and recognised for their leadership capability • whether joint management and clinical relationships are effective • whether strong and effective engagement is in place at all levels, across management and clinicians, and across disciplines • whether there is shared ownership of organisational outcomes across management and clinical leadership, and across disciplines.			

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
PP2	Implementation of Better, Sooner, More Convenient primary health care		Total	The District Health Board is to supply a report confirming it has implemented the changes to primary care service delivery models agreed in its DAP **OR** a report identifying why changes to primary care service delivery models agreed in its DAP have not been implemented, with an associated resolution plan.	Those District Health Board's involved in the development of business cases with successful Expression of Interest providers are required to report on progress of the implementation of those changes as agreed to in their DAP. Those District Health Board's not involved in the development of business cases are required to report on the implementation of changes to primary health care that deliver on the core elements outlined in Chapter 3 of Better, Sooner, More Convenient and agreed to in its DAP.		Annual
PP3	Local Iwi/Māori engagement and participation in District Health Board decision making, development of strategies and plans for Māori health gain	Measure 1	Total	100%	% of Primary Health Organisations with Māori Health Plans (MHPs) that have been agreed to by the District Health Board		Six-monthly
		Measure 2	Total	100%	% of District Health Board members that have undertaken Treaty of Waitangi training		
		Measure 3	Total	Provide a report demonstrating: • Achievements against the Memorandum of Understanding (MoU) between a District Health Board and its local Iwi/Māori health relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties during the reporting period. • Provide a copy of the Memorandum of Understanding (MoU).			

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
		Measure 4	Total	Report on how (mechanisms and frequency of engagement) local Iwi/Māori are supported by the District Health Board to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on Primary Health Organisation).			
		Measure 5	Total	Report on how MHPs are being implemented by the Primary Health Organisations and monitored by the District Health Board (include a list of the names of the Primary Health Organisations with MHPs)			
		Measure 6	Total	Describe when Treaty of Waitangi training (including any facilitated by the Ministry) has, or will, take place for Board members.			
		Measure 7	Total	Two Key Milestones from your Māori Health Plan: Milestone 1: Improve information on Maori health service utilization and outcomes in secondary and primary care, as identified in the Maori Health Needs Assessment.	Identify at least two key milestones from your Māori Health Plan to be achieved in 2010/2011. For reporting in Quarter 2, provide a progress report on the milestones, and for reporting in Quarter 4, provide a report against achievement of those milestones during the current year.		

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
				Milestone 2: Implementation of workplace development programme to increase Maori health career path opportunities, including involvement of local secondary and tertiary education services.			
PP4	Improving mainstream effectiveness District Health Board provider arms pathways of care of Māori	Measure 1	Total	Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Māori.			Six-monthly
		Measure 2	Total	Report on an example(s) of actions taken to address issues identified in the reviews.			
PP5	Waiting times for chemotherapy treatment		Total	100%	% of patients wait less than six weeks between first specialist assessment and the start of chemotherapy treatment. Wait times templates are to be supplied each quarter, The templates should display results for each month within the quarter. Qualitative comment on reasons (and management plans) for people with chemotherapy waits longer than six weeks is to be supplied in quarterly reports.	**100%**	Quarterly
PP6	Improving the health status of people with severe mental illness	Age 0-19	Māori	6%	% of people domiciled in the District Health Board region, seen per year.		Six-monthly
			Other	4%			

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
			Total	4%	N.B. adjustment of these figures access over previous years does not represent an reduction in overall services as we are intentionally shifting pattern of service utilisation in favour of people accessing primary mental health services. When this is possible and appropriate.		
		Age 20-64	Māori	6%			
			Other	4%			
			Total	4%			
		Age 65+	Total	2.5%			
PP7	Improving mental health services using crisis intervention planning		Total	95%	% of long-term clients (in contact for two years or more) who have relapse prevention plans.	**90%**	Six-monthly

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
PP8	District Health Board's report alcohol and drug service waiting times and waiting lists		Total	Waiting times and waiting lists are to be measured, for one month, every six months, to inform Ministry policy and, to determine the variation and extent of waiting times and waiting lists to determine if targets will be required to be set in the future. District Health Board's will report their longest waiting time, in days, for each service type for one month prior to the reporting period. A narrative is also required to: 1. identify the name and location of service(s) with the longest waiting time and waiting list 2. explain variances of more than 10% in waiting times or waiting lists 3. explain/identify targets that the District Health Board may have for reducing waiting times and or waiting lists	Service type: Inpatient Detoxification, Specialist Prescribing, Structured Counselling, Day Programmes and Residential Rehabilitation. District Health Board's will report waiting times by Māori and Other ethnicities.		Six-monthly
PP9	Delivery of Te Kokiri: the mental health and addiction action plan		Total	District Health Board's are to provide a summary report on progress made towards Implementation of Te Kokiri: the Mental Health and Addiction Action Plan.			Annual
PP10	Oral Health DMFT Score at year 8		Māori	2	Mean decayed, missing or filled permanent teeth at year eight per child		Annual
			Pacific	1.1			

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
			Other	1.3			
			Total	1.4			
PP11	Children caries free at 5 years of aged	*The baseline for Pacific children in 2008/09 was based on seven children.	Māori	40%	% of children carries free at 5 years of age		Annual
			Pacific	33%*			
			Other	56%			
			Total	53%			
PP12	Utilisation of District Health Board funded dental services by adolescents		Total	75%	% of adolescent utilisation of District Health Board funded dental services		Annual
PP13	Improving the number of children enrolled in District Health Board funded dental services	Measure 1	Total	66%	% of children under five enrolled in District Health Board funded dental services		Annual
		Measure 2	Total	5%	% of preschool and primary enrolled with District Health Board funded dental services who have not been examined according to there planned recall.		
PP14	Family violence prevention		Total	180/200	Combined audit score	**140/200**	Annual
SI1	Ambulatory sensitive (avoidable) hospital admissions	1. Age 0-74	Māori	95	Each District Health Board is expected to provide a commentary on their latest 12 month Ambulatory sensitive hospital data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce Ambulatory sensitive hospital District Health Board should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds.		Six-monthly
			Pacific	n/a			
			Other	<95			
		2. Age 0-4	Māori	95			
			Pacific	n/a			
			Other	≤100			
		3. Age 45-64	Māori	95			
			Pacific	n/a			
			Other	<95			

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
SI2	Regional service planning		Total	District Health Board's are to report confirming: • The District Health Board has progressed the RCSP according to plan submitted to Ministry of Health District Health Board cannot provide the confirmation report outlined above, it is expected that the District Health Board will transition to compliance no later than six months after the non-compliance is first reported. A planned pathway to full compliance, including key milestones and timelines, should be formalised and provided to the Ministry no later than three months after the non-compliance is first reported.			Six-monthly

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
SI3	Service coverage		Total	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the District Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage identified by the District Health Board or Ministry through: • analysis of explanatory indicators • media reporting • risk reporting • formal audit outcomes • complaints mechanisms • sector intelligence.			Six-monthly
SI4	Elective services standardised intervention rates	1. Intervention rate	Total	292 per 10,000	Intervention rates not significantly below the expected level. for any procedure where the standardised intervention rate in the 2009/2010 financial year or 2010 calendar year is significantly below the target level a report demonstrating: 1. what analysis the District Health Board has done to review the appropriateness of its rate **AND** 2. whether the District Health Board considers the rate to be appropriate for its population **OR** 3. a description of the reasons for its relative under-delivery of that procedure; and 4. the actions being undertaken in the current year (2010/2011) that will ensure the target rate is achieved.	**At least 292 per 10,000**	Six-monthly
		2. Major joint procedures intervention rate for Hip and Knee	Total	21.0 per 10,000		**21.0 per 10,000 (10.5 each for knee and hip)**	
		3. Cataract procedures intervention rate	Total	27.0 per 10,000		**27.0 per 10,000**	
		4. Cardiac procedures intervention rate	Total	6.23 per 10,000		**At least 6.23 per 10,000**	

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
SI5	Agreed Funding for Māori Health and disability initiatives	Measure 1	Total	It is expected that setting expectations in District Annual Plans and monitoring District Health Board performance against this indicator HKO-04 will ensure increased funding for Māori health and disability initiatives Please complete the following measures in the Template provided: **Measure 1** District Health Board to report actual expenditure on Māori Health Providers by General Ledger code. **Measure 2** District Health Board's to report actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit (PU). **Measure 3** Where information is available, District Health Board's to provide a table that reflects the District Health Board predicted expenditure for Māori health in the District Health Board 2009/2010 DAP in comparison to actual expenditure, with explanation of variances.			Annual
		Measure 2	Total				
		Measure 3	Total				
SI6	Risk Reporting		Total	District Health Board's are to report confirming: • the District Health Board			Six-monthly

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
				uses a formal risk management and reporting system to manage District Health Board and report them to its Board • the system meets current Australia / New Zealand Standard requirements relating to risk management • how frequently the District Health Board submits formal risk report updates to its Board (or a Board approved sub-committee). If the District Health Board cannot provide the confirmation report outlined above, it is expected that the District Health Board will transition to compliance no later than six months after the non-compliance is first reported. A planned pathway to full compliance, including key milestones and timelines, should be formalised and provided to the Ministry no later than three months after the non-compliance is first reported.			
SI7	Improving breast-feeding rates	6 Weeks	Māori	68%	% of infants exclusively and fully breastfed at six weeks	**74%**	Annual
			Pacific	NA*			
			Other	76%			

Policy Priorities Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
			Total	76%			
		3 Months	Māori	52%	% of infants exclusively and fully breastfed at three months	**57%**	
			Pacific	NA*			
			Other	60%			
			Total	60%			
		6 Months	Māori	27%	% of infants exclusively and fully breastfed at six months	**27%**	
			Pacific	NA*			
			Other	35%			
			Total	35%			

Ownership Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
OS1	Staff turnover by major professional group		Total	The District Health Board provides a qualitative report in the form of a self assessment identifying progress achieved; What's worked; what hasn't; Planned actions - for each of the following areas of focus: Whether •managers and clinical leaders feel valued and recognised for their leadership capability • joint management and clinical relationships are effective • strong and effective engagement is in place at all levels, across management and clinicians, and across disciplines • there is shared ownership of organisational outcomes across management and clinical leadership, and across disciplines.			Quarterly
OS2	Capital expenditure in line with plan	deviation from plan in the YTD	Total	4.820$ million----	above or below plan as set out in District Annual Plan financial templates. Expenditure should not be materially greater than set out in plan.		Quarterly
OS3	Elective and arranged inpatient length of stay	average length of stay for elective and arranged patients with a length of stay of one night or more. The measure is indirectly standardised for DRG cluster and comorbidities.	Total	<3.9 days	District Health Board's will have individual targets towards shorter length of stay. The		Quarterly

Ownership Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
					suggested benchmark is the average length of stay of the 'fifth-District Health Board in the 2008/09 financial year.		
OS4	Acute inpatient length of stay	Average length of stay for acute patients with a length of stay of one night or more. The measure is indirectly standardised for DRG cluster and co-morbidities.	Total	3.93 days	District Health Board's will have individual targets towards shorter length of stay. The suggested benchmark is the average length of stay of the 'fifth-best' District Health Board in the 2008/2009 financial year.		Quarterly
OS5	Theatre productivity	The District Health Board is expected to reduce the number of theatre sessions that start late, finish early, or are cancelled.	Total	Local theatre productivity Target for West Coast District Health Board utilisation rate 65%. [measure: used theatre time as percentage of available theatre minutes]	Note: national definition for this measure is yet to be defined. Originally described as : Each quarter, the District Health Board is required to submit the following data elements for each theatre in each Provider Arm facility: • number of scheduled theatre sessions in the quarter (may be		Quarterly

Ownership Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
					zero if the theatre is not in use) • number of cancelled theatre sessions in the quarter • number theatre sessions that start late (and do not finish early) • number of theatre sessions that finish early (and started on time) • number of theatre sessions that start late and finish early		
OS6	Elective and arranged day surgery	the rate of day surgery for elective and arranged surgical patients (operating room and non-operating room). The rate is indirectly standardised for DRG.	Total	59 % (raw rate)	District Health Board's will have individual targets towards higher rates of day surgery. The suggested benchmark is the rate of the 'fifth-best' District Health Board in the 2008/09 financial year.		Quarterly
OS7	Elective and arranged day of surgery admissions	the rate of day of surgery admissions for elective and arranged surgical patients.	Total	76 %	of surgery on a day of surgery admission basis (with some room for flexibility). This benchmark is based on Australian	90%	Quarterly

Ownership Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
					experience.		
OS8	Acute readmissions to hospital	the rate of unplanned acute readmissions within 28 days of original discharge from hospital. The rate is indirectly standardised for a range of factors using regression methods.	Total	< 8.21 %	District Health Board's will set individual targets for improvement of acute readmission rates. The suggested benchmark is the national average acute readmission rate during 2008/09.		Quarterly
OS9	30 Day mortality	The mortality rate within 30 days of admission for patients in hospital. The rate is indirectly standardised for a range of factors using regression methods.	Total	<1.95 %	District Health Board will set individual targets. The suggested benchmark is that District Health Board's aim to maintain mortality at least at the 2008/09 level for the District Health Board, or improve it, during the year.		Annual
OS10	Improving the quality of data provided to national collection systems	Measure 1 Timeliness of National Minimum Data Set Data	Total	≤5%		>3% and ≤5%	Quarterly
		Measure 2 National health Index Duplications	Total	≤3%		**>2% and ≤3%**	
		Measure 3 Ethnicity not stated in National health Index	Total	≤4%		**>2% and ≤4%**	
		Measure 4 Start versus specific descriptors in	Total	≤59%		>51% and ≤59%	

Ownership Dimension							
Code	**Performance measure title**	**Measures**	**Area**	**2010/2011 Target/deliverable**	**Further information**	**National Target**	**Frequency of reporting**
		the National Minimum Data Set Data					
OS11	Hospital outputs are delivered to plan	The delivery of hospital outputs is measured against planned delivery as stated in the Provider Arm Price Volume Schedule, and expressed as a ratio of (actual/planned).	Total	<5 %	District Health Board's are expected to deliver total outputs for the year with a variance of less than three percent from plan overall, and a variance less than five percent in sub-groups of outputs.	National Expectation of: <3% variance overall <5% variance in sub-group outputs	Quarterly- for three quarters
OS12	National patient satisfaction survey		Total	This measure is a place holder for a patient satisfaction survey or similar tool. Currently there is no detailed measure in this ownership dictionary as a piece of work on the future of the current survey and consideration of alternative models is yet to take place. A place holder measure is included in the summary tables and diagrams so that the measure is captured in the analysis of reporting burden, but the shape of future surveys and associated measures is yet to be confirmed.			Quarterly

Appendix 6.

6 Information System Strategic Plan

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/ priority**	**District Health Board Project Reference #**	**Planned Start (Month/ Year)**	**Expected Completion (Month/ Year)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in District Annual Plan. State how project aligns to specific ear Objectives**	**Brief Project Description: include comment on: 1) effect of change on District Health Board operation 2) the measures of District Health Board, Regional or National Benefit to be achieved**
Servers Replace-ments	1		Oct 2010	Jan 2011		R	L	125	I	Section: 7.4 Quality and Safety: Required to supply a reliable computer system at an acceptable performance level.	Replace aged core PMS servers, Citrix and Exchange Servers struggling with performance, cost savings with removal of legacy SAN
Laboratory Upgrade to CHL Delphi	1		Sep 2010	Mar 2011	5	R	R	100	I	Section 5.0 National and Regional. Regionally aligns systems	Align laboratory systems with Canterbury District Health Board Multi-Lab for regional convergence
Tele-medicine Ex-pansions	1		Aug 2010	Nov 2010		R	L	100	I	Section 5.0 National and Regional. Enable improved clinical collaboration with Canterbury District Health Board	Replaced aged vivid systems with HD capable ones
Tape Library Capacity	1		Nov 2010	Feb 2011		R	L	80	I	Section: 7.4 Quality and Safety: Required to supply a reliable computer system at an acceptable performance level.	Current library is at capacity in terms of backup window.
Colpscopy	1		Aug 2010	Dec 2010		N	R	35	I	Section 5.0 National	Will enable improved

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/ priority**	**District Health Board Project Referenc e #**	**Planned Start (Month/ Year)**	**Expected Completion (Month/ Year)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in District Annual Plan. State how project aligns to specific ear Objectives**	**Brief Project Description: include comment on: 1) effect of change on District Health Board operation 2) the measures of District Health Board, Regional or National Benefit to be achieved**
System										and Regional. Regionally aligns systems	transfer of care for Colpscopy patients with Canterbury District Health Board, reduce clinical time spent on administration functions
Finance System	1		Feb2010	Dec 2011		R	N	500	I	Section 5.0 National and Regional. Regionally aligns systems	Finance Systems - Implementation of the Convergence Project R12 upgrade for the Oracle finance system to enable both District Health Boards to share procurement policies, ordering of supplies and shared financial functions
Replacing Health-Views with Canter-bury District Health Board's Concerto	2		Feb 2011	Dec 2011		R	R	450	I	Section 5.0 National and Regional. Regionally aligns systems	Align clinical information systems with Canterbury District Health Board for regional convergence
Prism for Non District Health Board GPs	2		Aug2010	Mar 2011	2	N	L	125	I	Section 3.0 Better Sooner More Convenient Primary Care Services – Integrated Family Health Services	Requirement for IFHC and Better Sooner More Convenient
Dental PrISM	2		Sept 2010	Dec 2010	2	N	R	60	N	Section 5.0 National and Regional.	Leverage off Canterbury District Health Board's

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/ priority**	**District Health Board Project Referenc e #**	**Planned Start (Month/ Year)**	**Expected Completion (Month/ Year)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in District Annual Plan. State how project aligns to specific ear Objectives**	**Brief Project Description: include comment on: 1) effect of change on District Health Board operation 2) the measures of District Health Board, Regional or National Benefit to be achieved**
										Regionally aligns systems	Titanium system to enable removal of legacy paper bases systems
e-Referrals			Deferred with con-certo							Deferred with aligning clinical information systems with Canterbury District Health Board	
e-Pharmacy			Deferred with con-certo							Deferred with aligning clinical information systems with Canterbury District Health Board	

Column 2: Project Ranking	Column 6: HISAC Action Zone	Column 7: Project type	Column 8: Project significance	Column 10: Project Funding Source
1: Must Do in 2010/2011	1: National Network Strategy	N: New	N: National	I: Internal (in approved DAP)
2: Should Do in 2010/2011 - Probable Do in 2011/2012	2: NHI Promotion	U: Upgrade	R: Regional	M: MoH New Funding
3: Nice to Do in 2010/2011 - Should Do in 2011/2012	3: HPI Implementation	R: Replacement	L: Local	P: Third Party
4: Non-urgent-Requested by Clinicians	4: ePharmacy			N: Not yet determined
5: Non-urgent-Requested by Board/Staff	5: eLabs			
6: Non-urgent-Requested by Ministry	6: Discharge Summaries			
7: Early Warning-upcoming work- probable future Rank 1	7: Clinical Care and Disease Management'			
8: Early Warning-upcoming work- probable future Rank 2	8: Electronic Referrals			
9: Early Warning-upcoming work- probable future Rank 3	9: National Outpatient Collection			
	10: National Primary Care Collection			
	11: National Systems Access			
	12: Anchoring Framework			

Appendix 7.

7 Regional Priority Areas

Southern Cancer Network- DAP Statement

Background

The Cancer Control Strategy Action Plan 2005-2010 identified a number of priorities, including the continued development of regional cancer networks to enhance co-operation and collaboration of organisations involved with / or contributing to cancer control. The structures, scope and functions of regional networks in New Zealand are evolving.

The Southern Cancer Network (SCN) brings together key stakeholders in the South Island (SI) to support the planning and delivery of comprehensive and integrated cancer services. These services are co-ordinated across patient care pathways through a multidisciplinary team approach, for the given population area (region). The SCN aims to increase access to comprehensive cancer services by promoting a collaborative approach to cancer care planning and delivery.

The SCN was formed in September 2007 and the present management infrastructure established in March 2008. A steering group was elected in March 09 to provide advice and direction to the Management Team and associated groups. The steering group is representative of the SI cancer continuum with members selected from each region and professional grouping.

The SCN Strategic Plan was completed in August 2009 and each South Island District Health Board is working towards achieving or has developed a Local Cancer Plan.

2010/2011 Priorities

Aim	Promote service improvements for lung and bowel cancer
Actions	Collaborate with regional networks and the Ministry of Health in the development of national standards and patient management frameworks. Establish Regional South Island multi-disciplinary work groups for the management of lung and bowel cancer Liaise with South Island Local Cancer Networks
Outputs	Establishment of a National Working Group for the Lung and Bowel Cancer Tumour Stream Development of National Standards for lung cancer Development of Patient Management Framework for lung cancer and bowel
Measure	Standards and Patient Management Frameworks are adopted by cancer service providers

Aim	Develop a co-ordinated and seamless cancer journey for the patient.
Actions	Work with the MOH, other Cancer networks and all relevant groups to explore the national adoption of Patient Management Frameworks for lung and bowel cancer Work with multidisciplinary teams across the region to maximise the timeliness of the lung and bowel cancer patient's access to referral, diagnosis, treatment, follow-up, surveillance and/or end of life care
Outputs	The patient journey is 'mapped' for lung and bowel cancer in the South Island
Measure	Reports with recommendations are produced

Aim	Determine South Island Inequalities for Cancer patients
Actions	Collaborate with South Island Manawhenua Groups, Iwi and other Maori Health groups to identify and address issues relating to inequalities Promote the adoption of strategies known to reduce inequalities with respect to cancer and cancer services
Outputs	Establishment of a SCN South Island Maori Advisory Group Inequalities are identified with recommendations.
Measure	Action plan developed for implementing recommendations.

Aim	SCN maintains an informed position with respect to cancer service provision across the region and works with stakeholders to address issues
Actions	Work with Local Cancer Networks Groups to monitor, co-ordinate and identify local issues and to oversee development and implementation of Local Cancer Plans. Develop data collection, monitoring systems and a range of indicators. Understand the South Island Cancer burden at a regional and district level
Outputs	All 6 South Island District Health Boards have a Local Cancer Plan that is reviewed annually Data collection to enable the network to monitor progress against strategies over time South Island Health Needs Assessment for Cancer
Measure	Data and information ensures local, regional and national cancer strategies align

South Island Health of Older People - DAP Statement

Health of Older People (HOP) is a service development priority area for all South Island District Health Boards. It is also an area of high clinical and financial risk. The rapidly increasing numbers of those aged over 65 years in the region necessitates new paradigms to address the following.

- The associated increase in health service demand;
- Current and evolving service gaps;
- Financial sustainability of the health sector and current issues with quality and workforce.

The South Island Regional Health of Older People Network (SIRHOPN) was formally established in October 2009, in response to the demands and issues identified above. Its purpose is:

- to provide effective regional Health of Older People service planning and funding advice and recommendations to the South Island Regional General Managers Network;
- to promote effective and appropriate sharing of information that supports a regional perspective on Health of Older People services; and
- to develop, prioritise, implement and monitor regional activities which contain prioritised goals and allocated resources for each financial year, that deliver outputs which will have an overall strategic aim for regional development.

South Island Health of Older People teams are now working regionally in order to ensure consistent service responses and equity of access for South Island residents. It is anticipated that this will maximise returns through combined effort and the sharing of personnel and expertise to champion and address areas of common interest. A draft regional work plan has been established that builds on the work that South Island District Health Boards already have underway. Current and future work as identified in the work plan, supports the national Ageing in Place Strategy.

Aim	Maximise financial sustainability and cost-effectiveness
Actions	▪ Standardise the eligibility criteria and processes for entry to HOP services. ▪ Work collaboratively to roll out InterRAI. ▪ Develop a common service specification and contracting/pricing mechanism for a restorative package of care model for Home Based Support Services. ▪ Build and maintain a regional dataset.
Outputs	▪ Reliable detailed data for funding and planning decisions. ▪ Purchasing of cost-effective service mix and configuration. ▪ Consistent approach to service allocation to ensure services are targeted appropriately to needs. ▪ Reduced demand on residential services over time.
Measure	▪ InterRAI has been implemented in all South Island District health Board. ▪ A common service specification for Home Based Support Services is in place for all South Island District Health Boards. ▪ A break-even result for HOP budgets at year-end.

Aim	Ensure fairness and equity of access
Actions	▪ Document a consistent framework for referral, assessment and care co-ordination across the HOP continuum. ▪ Work collaboratively to roll out InterRAI. ▪ A common process for reconfiguring Home Based Support Services into a restorative approach. ▪ Develop a regional booking system for respite care. ▪ Build and maintain a regional dataset.
Outputs	▪ Standard and objective access criteria for HOP services. ▪ A restorative focus for Home based support services. ▪ Effective allocation of respite care. ▪ Reliable detailed data for funding and planning decisions. ▪ Communicate South Island access criteria to all District Health Boards nationally.
Measure	▪ Agreed access criteria implemented across District Health Boards.

Aim	Maintain quality of care
Actions	▪ Identify initiatives for improving quality and cost-effectiveness. ▪ Identify the workforce capability and capacity needs for the HOP continuum. ▪ Improve referral, assessment and coordination services to ensure service type and level are targeted to need (right person, right skill, right place, right time). ▪ Collaborative relationships fostered among primary, secondary and tertiary HOP. ▪ Develop a regional approach to supporting carers. ▪ Enhance primary care interface for older people. ▪ Ensure monitoring of quality is effective. ▪ Maintain a restorative focus for home based support services.
Outputs	▪ More predictable access to specialist services and better use of scarce resources. ▪ Better linkage of HOP and support services to primary health care – more proactive care of frail older people. ▪ Reliable insight into quality of services.
Measure	▪ Reduction in issues related to quality of care for users.

South Island Regional Mental Health - DAP Statement

The South Island Regional Mental Health Network has developed the second South Island Regional Mental Health strategic plan (2009 – 2012). It builds on key national policies and emulates Te Tahuhu: Improving Mental Health 2005 – 2015 and Te Kokiri: The Mental Health and Addiction Action Plan 2006 – 2015.

The strategic plan outlines the ten strategic challenges identified in Te Kokiri and provides the proposed South Island District Health Board's strategic activities, for which a regional approach is most appropriate, to achieve these challenges. The strategic activities have informed the development of the annual work plan for last year and will continue to do so for the next two years. Within the context of a dynamic and evolving health environment, wider societal changes and expectations of Government, the strategic plan activities will be reviewed annually and an annual work plan developed to meet these changing demands.

Aim	To promote effective and appropriate sharing of information that supports a regional perspective on Mental Health Planning and Funding, influences changes, and progresses the implementation of National Mental Health Strategy.
Actions	The South Island Regional Mental Health Network continues to share information and collaborate regionally.
Outcomes	A regional perspective on mental health planning and funding improves effectiveness and reduces duplication.
Measure	Regional collaboration occurs, influences change and progresses the implementation of National Mental Health Strategy.

Aim	To implement the regional activities as defined in the second South Island Regional Mental Health strategic plan (2009 – 2012), that support the development of South Island mental health services.
Actions	An annual work plan is developed with key projects that meet the objectives defined in the second South Island Regional Mental Health strategic plan (2009 – 2012).
Outcomes	There is an improvement in mental health outcomes for the South Island population.
Measure	Annual work plan activities are regularly monitored and reported and are achieved by the end of June 2010.

Aim	To support national workforce and service development initiatives and guidelines.
Actions	Regional plans are developed that support national guidelines.
Outcomes	There is an improvement in mental health outcomes for the South Island population.
Measure	South Island mental health services reflect national guidelines.

Appendix 8.

8 Glossary and Abbreviations

AT&R	Assessment, Treatment and Rehabilitation
Au Turoa	Environmental
BNZ	Bank of New Zealand
Capex	Capital Expenditure
CEO	Chief Executive Officer
CHFA	Crown Health Financing Agency – a division of the Residual Health Management Unit (RHMU) that acts as a lending bank to District Health Board's.
CFA	Crown Funding Agreement – the main contractual arrangement through which the Ministry of Health Funds the District Health Board.
DHB	District Health Board
DHBNZ	District Health Board's, New Zealand
DSD	Disability Support Directorate
DSS	Disability Support Services
EMT	Executive Management Team
FFT	A percentage increase in District Health Board funding designed to include the cost of inflation for District Health Boards
FSA	First Specialist Attendance (outpatient clinic)
GAAP	Generally Accepted Accounting Standards
GP	General Practitioner
FTE	Full Time Equivalent
HEAT	Health Equity Assessment Tool
He Korowai Oranga	Māori Health Strategy
HPAC	HealthPAC (Health Payments, Agreements and Compliance)
HRIS	Human Resources Information System
IDP	Indicator of District Health Board Performance
IFRS	International Financial Reporting Standards
IPA	Independent Practitioners Association
ISSP	Information System Strategic Plan
IT	Information Technology
Kaiarahi	Māori Health Manager (The word Kaiarahi is Māori for "Guide").
LAN	Local Area (Computer) Network
MAGPIE	The Mental Health and General Practice Investigation (MaGPIe) a NZ study investigating the mental health of patients presenting at General Practitioner practices.
MHINC	Mental Health Information National Collection

MoH	Ministry of Health
NASC	Needs Assessment and Service Co-ordination
NDPG	National Data Policy Group
NGO	Non Government Organisation
NHI	National Health Index
NMDS	National Minimum Data Set
NZHIS	New Zealand Health Information Service
OPF	Operating Policy Framework
PBF	Population Based Funding
PC	Personal Computer
PHI	Public Health Intelligence Unit
PHO	Primary Health Organisation
QIC	Quality Improvement Committee
RFI	Request for Information
RFP	Request for Proposal
RHMU	Residual Health Management Unit
RIF	Regional Intersectoral Forum
R & M	Repairs and Maintenance
SAMO	Special Area Medical Officers
SCS	Service Cover Schedule
SIMHN	South Island Mental Health Network
SISSAL	South Island Shared Services Agency
SMO	Senior Medical Officer
SWOT	A strategic planning tool that involves analysing internal factors (Strengths, Weaknesses) and external factors (Opportunities, Threats).
TLA	Territorial Local Authorities
Tai Poutini	The West Coast
Tiakitanga	Guardianship
Tangata Whenua	“People of the land”, most commonly referring to traditional Māori Iwi occupants of a region or district
Tatau Pounamu	Māori Advisory Group to West Coast District Health Board
Waka	Mobile health service provided by local Māori Health providers
WAVE	Working to Add Value through E- information
Whakatataka	Māori Health Action Plan
WCDHB	West Coast District Health Board