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Office of Hon Tony Ryall

Minister of Health
Minister of State Services

11 JUL 2011

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

Dear Dr ~~McCormack~~ Paul and team

West Coast District Health Board 2011/12 Annual Plan

This letter advises that together with the Minister of Finance, I have approved and signed West Coast District Health Board's (DHB) 2011/12 Annual Plan for three years.

This year has seen significant change to the accountability framework for all DHBs with the introduction of annual Regional Service Plans to replace District Strategic Plans and one Annual Plan that incorporates the Statement of Intent. These changes are designed to help improve the way we plan service delivery by setting a long term direction and clear pathways to get there, through an integrated approach linking the different levels of health care.

I want to thank you for your cooperation as we transition to this new way of thinking and look forward to your continued support as we strive for improved health services for all New Zealanders.

Clinical and financial sustainability

All DHBs are expected to budget and operate within allocated funding and identify specific actions to improve financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery.

Your DHB's financial position is of significant concern and as a result your Annual Plan is subject to joint Ministerial approval. I acknowledge that your DHB is planning to reach breakeven in 2013/14 and that you have identified a number of actions to achieve efficiencies and improve financial performance.

I am however concerned that the planned results are very dependent on all of these actions being achieved, including an assumption of full employment and reduced outsourcing, although this has not been the trend to date. I expect the National Health Board to actively monitor your DHB's financial performance in 2011/12, and in particular, the speed with which permanent staff are recruited.

Primary Care

Delivering better, sooner and more convenient services closer to home has been a priority for the Government and DHBs for a number of years. Closer integration of services across primary and secondary care and a greater range of services being delivered in the community should not only reduce pressure on hospitals but also improve the patient experience.

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

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan including more tangible actions and deliverables to show how you will achieve the objectives of your business case. I expect you to be active in advancing these improvements to the way primary care services are delivered in the community.

Regional Collaboration

Greater regional collaboration is a key aspect of the new accountability arrangements and supports more effective use of clinical and financial resources. Better collaboration amongst DHBs is essential to address priority vulnerable services and has the potential to maximise efficiencies through shared back office functions, as well as IT, workforce support and development and capital investment. As core elements of the National Health Board's work, I look forward to seeing the benefits of collaborative partnership with your fellow DHBs as these important regional initiatives are implemented.

Your Annual Plan incorporates a strong regional flavour. It is evident that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning.

I expect to see delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan and look forward to seeing greater ongoing support for the work of Health Benefits Limited in developing shared back office functions where appropriate. I also thank you for your continued commitment to work with the Health Quality and Safety Commission.

Health of Older People

The prioritisation of investment in services to ensure the health and support needs of older people are met is important. An ongoing programme will be required to manage the impact of our ageing population on health services and support the provision of high quality and sustainable services in this area.

I am pleased to see more detail in your Annual Plan on how you are planning to deliver health services for older people. I am especially interested to follow your progress in relation to addressing the respite care needs of your community and the effective use of recent additional funding for this service.

How you will provide new and expanded services for people with dementia is of importance to me as is your DHB's continued application of the comprehensive clinical assessment tool (interRAI) currently being rolled out nationally. Better articulation of how improvements are being sought in this priority area will be expected from all DHBs in next year's Annual Plan.

Clinical Leadership

Clinical leadership is fundamental to improving patient care and has an important role in supporting overall service delivery in a number of ways. Engagement with clinical leaders aids job satisfaction for health care professionals and improves delivery of workforce initiatives. The success of clinical networks is based on clinical input working across regions and nationally to assist with overall service delivery. Clinical leadership also plays an important part in the integration of service delivery closer to home.

I expect to see clinical leadership embedded as a way of working within your DHB and the ways in which you seek engagement with your clinicians continue to expand over coming years.

Health Targets

New Zealanders have high expectations that they will have access to quality health care services when they need them. The Government's Health Targets are selected to drive ongoing improvements in specific priority areas in order to meet the growing expectations of the public.

I appreciate West Coast DHBs efforts to deliver on the Health Targets and your progress in delivering on these. It is good to see that you have identified more specific actions within your Annual Plan that you will take to ensure you achieve your planned performance on the six Health Targets.

Mental Health Ringfence

I am approving your plan with the expectation that your DHB will work closely with the National Health Board to agree and ensure appropriate use of any currently unallocated mental health ringfence funding in line with policy.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service change or service reconfigurations must comply with the requirements of the Operational Policy Framework and you will need to advise the National Health Board of any proposals that may require my approval.

Additionally, my acceptance of your Annual Plan does not indicate support for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment 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 acknowledge that the impacts for DHBs of the earthquakes in Christchurch over the last year are difficult to determine and that these have not been taken into account in producing Annual Plans. The impacts of these events are ongoing for the health sector and will need to be managed beyond what is included in your Annual Plan.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2011/12 Annual Plan.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance

Annual Plan with Statement of Intent

West Coast District Health Board 2011/2012

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

ANNUAL PLAN

1 July 2011 – 30 June 2012

Produced in 2011 by the

West Coast District Health Board

P O Box 387, Greymouth

www.westcoastdhb.health.nz

Picture courtesy from West Coast Tourism

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Message from the Chairman and Chief Executive

It is with pleasure that we present our Annual Plan for the 2011/12 financial year. This plan reflects our commitment to providing a sustainable and effective health service for people living on the West Coast within our resources.

For the West Coast, a sustainable and effective health service will require a unified approach to health service delivery across the system. This will not only include the connection and integration of community, primary and secondary health services that are directly delivered on the West Coast, but also a stronger alignment of our systems and workforce with the Canterbury DHB.

Our health priorities for the 2011/12 year have been identified by the people working in the West Coast health system, our clinical leaders, community leaders and consumers. The priorities focus on improving the clinical, financial and social sustainability of the West Coast health system. Emphasis is on delivering the right care, at the right place and at the right time within the funding available.

We understand that building better relationships at all levels is a priority for us this year. The importance of creating an environment of confidence and trust through open and transparent relationships with our community who become patients from time to time, clinical leaders and our people working in our health system, intersectoral agencies and with our community leaders is critical to us achieving our health priorities and strategic imperatives.
The strategic imperatives for 2011/2012 are:

- **Achieving the Government's health targets**

This is a key imperative for the West Coast DHB. We want to achieve a high level of performance against the targets leading to timely, quality and accessible services across our population.

- **Managing our financial performance to achieve financial sustainability**

To become more sustainable our focus is on reducing and eliminating waste, changing models of care to deliver services more efficiently and working more collaboratively with other health organisations.

- **Delivering Better, Sooner, More Convenient health care**

Our focus this year is on transforming models of care to improve the level of care we provide across our entire system. Greater use of telehealth technology will enable patients and staff to access specialist expertise in rural clinics, where previously it had only been available in secondary or tertiary hospital settings.

- **Collaboration with the Canterbury DHB**

Working more closely with the Canterbury DHB is already impacting positively on the sustainability of service provision across the West Coast. Closer collaboration with the Canterbury DHB is providing greater certainty for both the planning and delivery of our health services.

- **Facilities planning**

As part of our commitment to Better, Sooner, More Convenient health care we are delivering services closer to people's homes. The focus this year is on changing our models of care and developing Integrated Family Health Centres in the Buller and Grey districts, as well as developing a sustainable model of care for Grey Hospital Services.

- **Recruitment and Retention**

People are an integral part of the future of this DHB. We have a focus on ensuring that the best possible clinicians and others are engaged by the health system and choose to stay on the West Coast. This is vital for financial, clinical and social sustainability with a stable workforce giving confidence both to the community and also to those within our organisation.

Improving outcomes for our population is another key area of emphasis. Our aim is to improve the availability, quality and timeliness of services. This will allow people to make healthier choices and enhance their quality of life. We are working with the other South Island DHBs to develop services that enable people to:

- Take greater responsibility for their own health
- Stay well in their own homes and communities
- Receive timely and appropriate complex care.

Outlined in this Annual Plan are comprehensive programmes that aim to prevent disease and manage people with long-term health conditions; support older people to stay healthy and well in their own homes; provide an integrated responsive system of mental health care; promote and improve the health of children and young people; and work closely with iwi hapu me whanau o Te Tai o Poutini and stakeholders to ensure our Maori whanau receive and have access to services that will improve whanau ora.

We have a big job ahead of us. We have the foundations in place to deliver sustainable health services within our community. By working more collaboratively, not only with other DHBs, but also with all health providers on the West Coast we can do an even better job.

Thank you to the many people who make up the health sector on the West Coast – you do an outstanding job. We look forward to delivering on the programmes within this plan to further improve health services on the West Coast.

Signatories

Paul McCormack

Chairman West Coast District Health Board

David Meates

Chief Executive West Coast District Health Board

Honourable Tony Ryall

Minister of Health

Approval of the Minister of Health

CONTEXT – IDENTIFYING THE CHALLENGES

Module 1

The West Coast District Health Board is pleased to present the Annual Plan with Statement of Intent for 2011/12. This document includes the DHB Annual Plan that details how the West Coast DHB plans to progress its strategic objectives, the Minister's Health Targets and the District Health Board Chair's Letter of Expectation and the Statement of Intent that outlines our longer term accountability requirements to Parliament and the public.

1.1 What We Do – the nature and scope of a District Health Board's functions

The West Coast DHB has the smallest population of the twenty DHBs established under the New Zealand Public Health and Disability Act (NZPHD Act), and is the most sparsely populated District Health Board in the country. Our District extends from Karamea in the North, to Jacksons Bay in the South and Otira in the East and comprises three Territorial Local Authorities the Buller, Grey and Westland districts.

We collaborate with other health and disability organisations, stakeholders and our community to decide what health and disability services are needed and how to best use the funding we receive from Government to improve, promote and protect the health, wellbeing and independence of our population.

Through this collaboration, we ensure that services are well coordinated and cover the full continuum of care, with the patient at the centre. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the health system to achieve the best health outcomes for our community.

As the West Coast DHB we:

- ***Plan*** the strategic direction for health and disability services on the West Coast, in partnership with clinical leaders, stakeholders and our community and in consultation with other DHBs, especially Canterbury DHB;
- ***Fund*** the majority of health and disability services provided on the West Coast, through relationship and service contracts with other health and disability service providers;
- ***Provide*** health and disability services for the population of the West Coast in a collaboration with Canterbury DHB; and
- ***Promote***, protect and improve our population's health and wellbeing through health promotion, health education and the provision of evidence-based public health initiatives in collaboration with Community and Public Health (C&PH) and the West Coast Primary Health Organisation (WCPHO)

Governance of the DHB

The Board assumes the Governance role and is responsible to the Minister of Health for the overall performance and management of the DHB. Its core responsibilities are to set the strategic direction for the DHB and to develop policy that is consistent with Government objectives and improves health outcomes for our population. The Board also ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and the West Coast community.

Three statutory (mandatory) advisory committees and one non-statutory committee have been established to assist the Board to meet its responsibilities. The membership of these committees is comprised of a mix of Board members and community representatives who meet regularly throughout the year. As part of West Coast's commitment to shared decision making, front-line staff and clinical leaders also regularly present to the Board and Committees to provide a working perspective and technical advice to members.

- *The Hospital Advisory Committee* - monitors the financial and operational performance of our hospital and specialist services, assessing strategic issues relating to those services and providing advice to the Board.
- *The Community and Public Health Advisory Committee* and *the Disability Support Advisory Committee* (delivered through the same body of membership) - provide the Board with advice on the health and disability needs of our population, assess how the services we fund or provide are delivered and the policies we adopt will impact on our population and promote the inclusion, participation and independence of people with disabilities.
- *The Audit, Risk and Finance Committee* - enhances the Board's governance function by monitoring and providing advice on the financial operation of the DHB and monitoring quality and clinical risk issues.
- *Tatau Pounamu* - enables local Maori participation and involvement in the strategic planning processes and the development of Maori capacity in the health and disability sector to improve Maori health on the West Coast.

Management of the DHB

While responsibility for the DHB's overall performance rests with the Board, it has a delegation policy assigning operational and management matters to the Chief Executive. The Chief Executive is supported by an Executive Management Team, which includes Chief Medical Advisor, Director of Nursing, Director of Allied Health, General Managers of Planning and Funding, Primary, Community and Mental Health Services, Maori Health, Hospital Services, Human Resources, the Chief Financial Officer, and the Quality and Risk Manager, who provide clinical, financial and cultural leadership, input into Board and Committee decision making and oversight of patient safety and quality.

Planning and Funding

The core responsibilities of the Planning and Funding Team are:

- Assessing our population's current and future health needs;
- Determining the best mix and range of services to be purchased;
- Building partnerships with service providers, Government agencies and other DHBs;
- Engaging with our stakeholders and community through participatory consultation;
- Leading the development of new service plans and strategies in health priority areas;
- Prioritising and implementing national health and disability policies and strategies in relation to local need;
- Undertaking and managing contractual agreements with service providers; and
- Monitoring, auditing and evaluating service delivery.

Providing Health and Disability Services

As well as being responsible for planning and funding the health and disability services that will be delivered, we also provide a significant share of those services as the current '*owner*' of West Coast hospitals. The West Coast DHB owns Grey Base Hospital, plus a range of hospital based services provided on an outreach/extension basis via Reefton Health and Buller Health.

The West Coast DHB also owns four primary health centres including Greymouth Health Centre (this is provided across two sites including Grey Medical Centre and RAGP), Reefton Medical, Buller Health and South Westland Medical Practice (made up of rural clinics in Whataroa, Franz Joseph, Fox Glacier, Haast and Hari Hari) plus associated medical clinics in remote rural areas including Ngakawau, Karamea, Moana[1]. The DHB is currently reviewing its ownership of these practices as part of examining options to achieve a clinically and financially sustainable primary care on the West Coast. There are also two privately own primary health centres on the West Coast.

On the principles of a 'whole system' approach, West Coast DHB works closely with West Coast Primary Health Organisation and other health and disability services that are funded directly form other sources such as community pharmacies, Plunket and disability support Services

Promoting Community Health and Wellbeing

Good health is determined by many factors, or social determinants of health, which sit outside of the traditional health system (e.g. education, housing and income). Our partnerships with other agencies – including local and regional councils, Child Youth and Family, Police, Housing NZ, the Ministries of Education and Social Development and ACC – are vital in creating and supporting social and physical environments that prevent illness and reduce the risk of ill health.

Community and Public Health provides regional public and population health services on behalf of the West Coast, Canterbury and South Canterbury District Health Boards, and covers the largest geographic area of any public health service in the country. We also share Healthy Eating, Healthy Action (HEHA) resources between the West Coast and Canterbury with joint service development management in place.

Through Community and Public Health, West Coast PHO and our Healthy Eating Healthy Action (HEHA) and Smokefree/Tobacco control contracts we support collaborative ventures and initiatives that focus on the reduction

[1] *The business models and ownership of District Health Board primary health practices is currently under review as part of our drive towards achieving clinical and financial sustainability.*

of behavioural and environmental risk factors to reduce long-term conditions and injury. This includes improving nutrition, increasing physical activity and reducing tobacco smoking, alcohol consumption and other risk behaviours under the joint banner of Healthy West Coast.

Community and Public Health also provide health protection service and leads collaboration on safeguarding water quality, bio security (protecting people from disease-carrying insects and other pests) and the control of communicable diseases and emergency planning to ensure preparedness for a natural or biological emergency.

1.2 West Coast Environment, Population and Health

Our Environment

The geographic nature of the district, 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 DHB 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 population is distributed across three Territorial Local Authority (TLA) areas: Buller, Grey and Westland Districts. The West Coast DHB is the most sparsely populated DHB in the country with a population density of 1.3 people per square kilometre, less than 10% of the New Zealand average.

Our Population

The West Coast is home to a population of 32,200 people. 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 DHB 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 West 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 less than 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 Maori, Pacific people make up less than 1% (0.9%) of the regions population.

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

- lower proportion of the population born overseas;
- lower proportion of the population who have never been married or joined a civil union;
- lower mean annual personal income of $20,400 compared to the national average of $24,400;
- 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

West Coasters have a higher overall morbidity and mortality rates and lower life expectancy 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 DHB residents from publicly funded hospitals.

The West Coast Māori Health Profile 2008[2] revealed that West Coast Māori have a similar social profile to the rest of the West Coast population but in terms of health, West Coast Māori have a poorer overall health status than others in the district. This is demonstrated by a range of indicators, including cardiovascular disease, cancer, diabetes and respiratory disease indicators. Māori are under-represented among primary care

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

utilisation data and have higher rates of smoking. A much higher proportion of West Coast Māori (55%) die before the age of 65 compared with other West Coasters (20%).

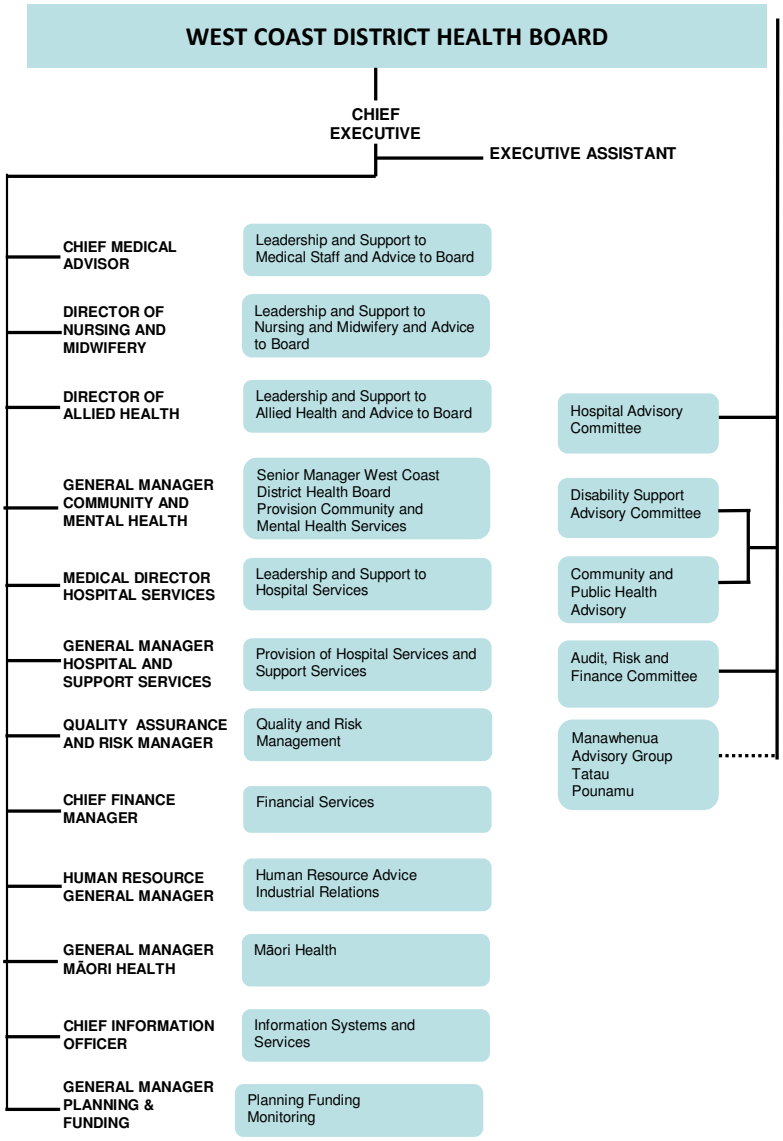
West Coast children and youth continue to have poorer health outcomes than their counterparts in other parts of the country. The leading causes of mortality, morbidity, and hospitalisations amongst children and youth on the West Coast are preventable. In particular, children have among the worst oral health status in the country, only 52% of five year olds seen by the School Dental Service in 2010 were dental caries free; the figure was just 38% for Tamariki Māori.

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 DHB 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 most 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.

1.3 Operating Environment

Organisational Structure

We have an established governance and organisational structure, based on the requirements of the NZPHD Act, through which the DHB functions.



Operating Pressures

Demographics Pressures

Whilst our population is likely to remain static the proportion of people aged 65 years and over is expected to increase by over 50% by 2020.

Workforce Pressures

Our people are our key asset as a health system, although we have not yet learnt how to effectively recruit and retain key health professionals so that we have a full establishment of motivated and stable health personnel in place across the coast. There are strategic challenges associated with strong competition for skills, expectations of younger employees, implementation of new technology and shifting workforce demographics will be exacerbated with changes in global dynamics, and as people regain confidence following a range of significant local disasters – but we will manage these.

Fiscal Pressures

There is a requirement from government for the West Coast Health System to live within it means. The West Coast currently receives $120 m to provide health and disability services across our district, and this funding equates to 50% more funding per head of population than the New Zealand average. Despite this, in the year ending June 2011 we are forecast to operate to a deficit of $7.2M. There is a commitment by the West Coast DHB board and the wider Health System to make rapid progress in decreasing our deficit in 2011/12 and will achieve breakeven by the end of 2013/14.

Other Operating Pressures:

- Access to primary care – the West Coast have a higher than average utilisation of primary health care services in some parts of the district (in particular the Buller community) and in main population centres there are long waiting lists for access to primary care services.
- Ability to maintain acute demand care on a 24/7 basis – this issue stems from the challenges associated with providing acute demand services across in both hospital and community settings, especially in the more remote areas.
- Increasing burden of long-term conditions
- Provision of complex and specialised services – our ability to provide complex and specialised services is a challenge because of the relatively small number of Senior Medical Officers within our hospital and community service. We are addressing this in our fundamental collaboration with Canterbury DHB.

1.4 Risk Factors

Alongside the identified pressures above, the most immediate risks are:

Risk	Mitigation Strategies
Gaining Support for Transformation There is an element of 'health review fatigue' in both the West Coast community as a whole and by health professionals working within the system. It is essential that our West Coast community and health professionals become engaged in leading and supporting the changes required to ensure our long term sustainability.	Locally – Successful engagement with our local community and health professionals in order to build the trust and confidence required. Enabling clinical leaders to have direct input and influence into the transformation of our health system.
Integration of Primary and Secondary Services In line with our vision and with Government expectations, we are investing in the development of primary/secondary	Locally – Continue to support clinical leaders in the implementation of Better, Sooner, More Convenient

Risk	Mitigation Strategies
patient pathways and closer integration of services through Better Sooner More Convenient Primary Health Care. There are a number of barriers to successful and sustainable integration, such as the sharing of patient information which sits with various providers rather than the patient.	Business Case with an increase focus on new patient centred models of care (as opposed to the provider). Develop a shared Electronic Referral Management System as a base for primary/secondary activity to improve clinical decision making and better identify unmet need. Engage clinical professional and provider groups in a new shared decision making approach to prioritisation and service management decisions to support shared accountability in a complex environment.
Creating a Momentum for Efficiencies and Change Ongoing management of resources and a continuing passion for improving outcomes is essential to ensure that we can deliver services effectively and efficiently now and in the future. Our future sustainability is dependent on us making continuous improvements and organisational culture, behaviour and capability.	Locally - Clinical/management partnerships, clinical leadership and ongoing staff training and engagement in the future vision. Introduction of lean thinking principles for process improvements, embedding this way of working in internal training programmes and project methodologies, including the Improving the Patient Journey Programme and Xcelr8 and Collabor8 programmes.
The Needs of Our Ageing Population Aged Residential Care and Home Bases Support services on the West Coast are vulnerable due to their inability to recruit and retain appropriately skilled care workforce within the funding that is available to them. The West Coast currently has a higher proportion of people in ARC than the national average.	Locally – Continue to work with ARC and HBS service providers to find effective solutions and support quality improvements. Regionally - Work with other DHBs to address wider aspects of demand related to our ageing populations and the cost of ARC services.
Sustained Capacity to Deliver Elective Services In 2009/10 we delivered 1578 elective surgical services to our population, and we will deliver the 1592 in 2011/12. We need to ensure service access levels for our population are equitable to those of those of other DHBs.	Locally - Emphasis on internal production planning, reducing duplication and waste in our system and enhancing public/private partnerships to increase elective surgical volumes for our population. Continued development of clinically led primary/secondary patient pathways to improve our capacity to deliver the right services to the right people. Regionally - Formal partnership with the Canterbury DHB to better plan the assistance they provide us, help to build a more appropriate workforce in both locations and improve continuums of care for the benefit of both populations. Progress of the Regional Electives Plan to improve South Island elective services delivery and make the best use of capacity and capability across the region as a whole.
Managing the Costs of Wages and Salaries While our people are our greatest asset, wage and salary settlement costs are a significant national challenge. A number of wage negotiations will be completed in the next year, and the flow-on effect of DHB agreements into the primary and community sector is also a risk in terms of price increase expectations and the longer-term sustainability of smaller providers faced with similar wage expectations.	Locally - Working smarter and supporting clinical governance and clinical leadership models to drive technical efficiencies and release clinical staff to provide more direct patient care. Nationally – Supporting a strategic approach to remuneration, working collectively on sector-wide negotiations with different workforce groups and maintaining close communication with sector and clinical leaders.
Maintaining Patient Safety and Clinical Quality Patient safety is a significant issue for all modern health services. Adverse events occur at an unacceptable level which, as well as causing avoidable harm to patients, drives	Locally – A genuine commitment to patient safety within services delivery and strengthening clinical governance and leadership to ensure a safe patient journey through the

Risk	Mitigation Strategies
unnecessary costs.	whole health system.
Clinical Workforce The ability to recruit and retain an appropriate clinical workforce is critical to the performance of our DHB. This is a significant issue for the whole of the health sector as national and international competition for scarce workforce resources in some clinical specialities, nursing and allied health areas is increasing.	Nationally - Targeted participation in national initiatives such as health specific job portals that leverage the strong NZ brand as well as collective participation at international career forums will increase our effectiveness in specific job markets and employee groups. Locally - Our recruitment efforts will become increasingly more targeted to markets and occupational groupings where we are most at risk clinically. Employee engagement practices will be introduced that will target areas that will improve what our clinical workforces will say about working for us; whether they are prepared to stay working for us; and determine how much discretionary effort they are prepared to give us.

1.5 Critical Success Factors

In order for us to be successful in our drive towards achieving clinical and financial sustainability, the following critical success factors have been identified.

- Establishing effective clinical governance and clinical leadership, and associated clinical management partnerships
- Developing a whole of west coast health system – delivering the right care in the right place
- Reducing the reliance on locums in both primary and community services;
- Maintaining clinical safety;
- Meeting the objective of a $2.7m reduction on the operating deficit within the provider arm by June 2012;
- Implementation of the final elements of our year one and the year two deliverables of the Better Sooner More Convenient Primary Care Business Case;
- Achieving confidence and trust from our community as we go forward;
- Maintaining a successful partnership in clinical service delivery with the Canterbury DHB.

The subsequent sections of this annual plan and statement of intent have been developed taking these critical success factors into account.

STRATEGIC DIRECTION

Module 2

What will a sustainable and effective Health System look like?

Along with all NZ DHBs, we face some pressures of rising costs, increasing demand for services, an ageing population and international clinical workforce shortages make it clear that the whole of the health system faces an unsustainable future in its current configuration. In response to these challenges, significant changes are being made to the way in which we design, fund and deliver health services.

These changes are being driven at all levels through the New Zealand health system in line with the wider strategic context for health outlined in the New Zealand Health Strategy, the New Zealand Disability Strategy and the New Zealand Maori Health Strategy (He Korowai Oranga).These national strategies, combined with the Minister's of Health annual letter of expectations (refer to Appendix 1) and the New Zealand Public Health and Disability Act, provide the guidance for policy and planning at national, regional and local levels. The New Zealand Health Strategy in particular outlines objectives for the health of the New Zealand population and focuses on the role of DHBs in tackling inequalities in health.

For the West Coast, a sustainable and effective health system will require a unified approach to health service delivery across the system. This will not only include the connection and integration of community, primary, secondary health services that are directly delivered on the West Coast, but also a strong alignment of our systems and our workforces with Canterbury DHB.

2.1 National direction - *Better, sooner, more convenient* health care

The current NZ health direction is described in the document '*Better Sooner More Convenient*', which clearly describes the expectations of the government of the health system. Implicit in this policy is a promise of people receiving a better experience of the New Zealand health system characterised by less waiting and more health services being delivered in the local communities.

Alongside the overarching national health strategies the National Health Board has recently released the strategic directional document '*Trends in Service Design and New Models of Care: A Review*'.[3] This document provides a high-level summary of emerging worldwide trends and international responses to the pressures and challenges facing the health sector, which will help guide DHBs.

These trends emphasise shifts within the health system as a whole, rather than its constituent parts. The underlying premise is that an aligned, system-wide approach, focused on patient rather than disease, is required to transform the health system, make health delivery more equitable and more inclusive and enable us to meet increasing demand within a constrained environment.

The diagram below **(Figure 1)** is adapted from the national document and describes a whole of system shift in the way health services are delivered – with the solid line representing current service configuration and the dotted line representing future service configuration. These follow a general theme of '*localise where possible, centralise where necessary*' and present four major service shifts:

- Targeted prevention, self management and home-based services;
- Integrated family health centres, partnerships and teams;
- Hospital clusters with regional service provision; and
- Managed specialisation and consolidation into a smaller number of centres/hubs.

NATIONAL SHIFTS

Targeted prevention, self management and home-based services.

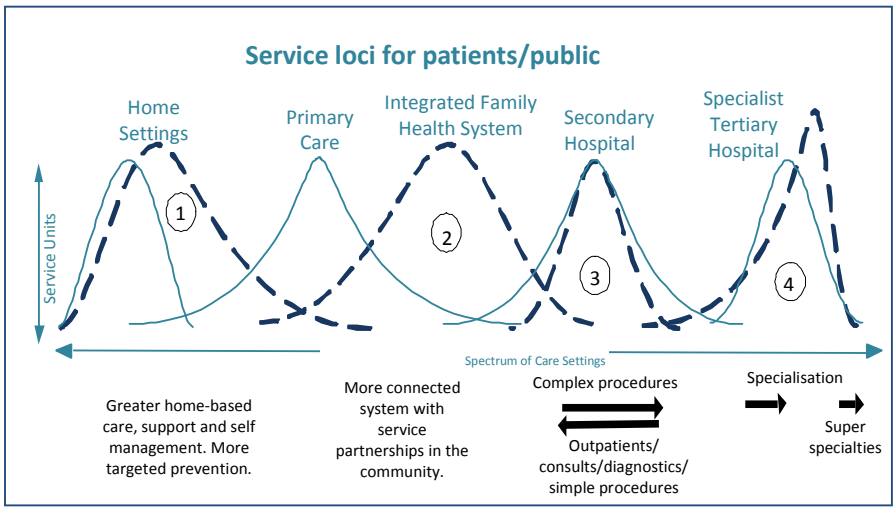
Integrated family health centres, partnerships and clusters.

Hospital clusters with regional service provision.

Managed specialisation and consolidation into a smaller

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

Figure 1: Pictorial representation of shifts in service trends



NATIONAL SHIFTS…

Targeted prevention, self management and home based services.

Integrated family health centres, partnerships and clusters.

Hospital clusters with regional service provision.

Managed specialisation and consolidation into a smaller number of centres/hubs.

This re-orientation is consistent with the expectations of Government, particularly the commitment to better, sooner, more convenient healthcare for all New Zealanders and the provision of services closer to people's own homes. There is a clear focus on greater regional collaboration between DHBs.

Hospitals are recognised as an important back-up and a setting for highly specialised care, with the importance of timely and accessible complex care being paramount. However, more of the less-complex services (traditionally provided in hospital settings) will be provided in the community. Supported by clinical networks and multidisciplinary teams the focus will shift to enhancing people's ability to manage their own health and to stay well - reducing long waiting times and the current unsustainable growth in demand for hospital and specialist services.

These national policy shifts are already being reflected with improved primary care access to diagnostics, the development of integrated patient pathways and the provision of procedures, such as skin lesion removals, in general practice – without the need for a hospital appointment. These changes enable more effective delivery of services by supporting people to get the care they need quickly, from the most appropriate provider.

The development of integrated family health systems and more collaborative partnerships between health professionals (e.g. general practitioners, pharmacists, nurses, dieticians and physiotherapists) will further support enhanced primary and community services and allow hospital and specialist services to meet its specific function of providing intensive treatment and complex care.

National direction also includes accelerated collaboration between DHBs to reduce duplication and waste, maximise clinical and financial resources and ensure the ongoing sustainability of health services. This includes clear expectations that alongside the blurring of traditional primary and secondary roles, the role of hospitals and the provision of specialised (tertiary) services will be critically reviewed and consolidated across regions.

The National Health Board has identified five 'vulnerable' services that will become national services in the next year: Clinical Genetics, Paediatric Pathology, Paediatric Metabolic Services, Paediatric Cardiology and Paediatric Cardiac Surgery. These services will be planned and funded centrally instead of by individual DHBs. They were chosen because issues around their small size, specialist retention or critical mass make them vulnerable if they are not managed in a coordinated way across the country.

A second set of services have been identified for national service improvement: Cardiac Surgery, Paediatric Oncology, Paediatric Gastroenterology, Neurosurgery and Major Trauma. National service improvement programmes and associated clinical networks will be established in each of these service areas, but services will still be funded and provided by individual DHBs.

2.2 Regional direction - Equity, quality, sustainability, engagement

All five South Island DHBs face similar pressures to ensure the future sustainability of health services, achieve the priorities of Government and continue to deliver high quality, responsive health services.

Like the West Coast, other South Island DHBs are changing the way they work within their local districts to alleviate these pressures. However, as individual DHBs we cannot make a large enough impact to ensure the future sustainability of services, particularly more highly specialised and complex services.

With a relatively small total South Island population and limited health resources, we must be more focused on how we respond regionally to deliver the best outcomes for our populations. Implementing diverse but similar individual responses to our collective challenges duplicates effort and investment and leads to further service inequality between DHBs.

The collective vision is a clinically and fiscally sustainable South Island health system - focused on keeping people well and providing equitable and timely access to safe, effective and high quality health and disability services, as close to people's homes as possible.

The South Island DHBs are each committed to the national direction. The provision of services closer to people's own homes, the transformation of primary care and the integration of service are already happening. Our regional direction aligns with national policy and international trends, and has been articulated in the South Island's Regional Health Services Plan. [4]

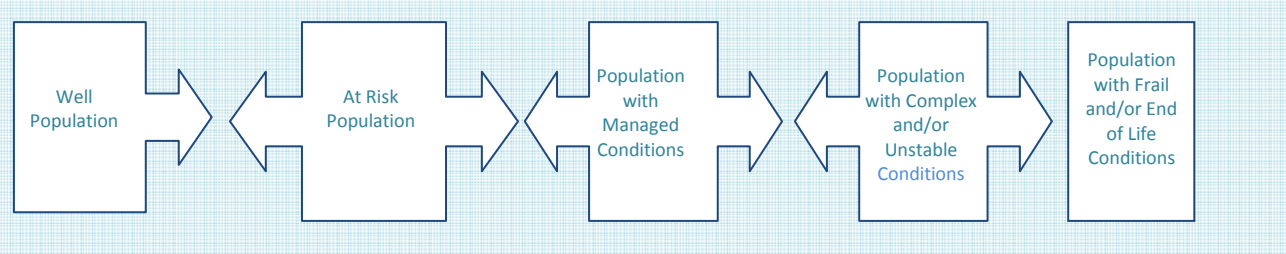
The regional direction is based around the following concepts:

- More health care will be provided at home and in the community to support long term conditions and rehabilitation;
- Secondary and tertiary services will be provided across DHB boundaries, providing services to local, sub-regional and regional populations;
- Flexible models of care and new technologies will support service delivery in different environments from those traditionally recognised;
- Health professionals will work differently, to coordinate patient care and ensure a smooth transition for patients between appropriate levels of care and providers;
- Clinical networks and partnerships between clinicians and management will support the delivery of quality health services across the health continuum.

These concepts emphasise the significant step change needed in the way in which we design and deliver services to meet the changing needs of our population. Traditional DHB boundaries and patient flows across the South Island will be challenged to ensure that service delivery is sustainable and focused on the patient.

A generic model of care has also been supported, that ensures a consistent approach to understanding the full range of health needs a person may have over their lifetime. The model (illustrated below in Figure 2) is based on similar national and international models and focuses health planning on the patient's need and the provision of the right service (or treatment), at the right time and in the most appropriate place - at each stage of the continuum of care from 'wellness' to 'end of life'.

Figure 2 - Generic (patient centred) Continuum of Care



[4] South Island Regional Health Services Plan 2010, South Island Shared Services Agency Limited

This way of working prompts the development of integrated patient pathways across the system and supports service redesign and improvements to the patient journey by questioning the gaps and blockages. In this sense, the model supports quality clinical outcomes by identifying with the needs of the patient. It also encompasses a Whānau Ora approach by taking a holistic view of the person (or population) and the determinants of health that influence people's wellbeing.

The model triggers the following questions:

- What do we need to do to keep people well in the community?
- What do we need to do to ensure early detection and early intervention?
- What do we need to do to support people to better self-manage in a community setting, avoid unnecessary hospital admissions and slow the progression or deterioration of their condition?
- What do we need to do to ensure that when people require complex interventions, hospital care, specialist advice or diagnostics that they are available at the right time and to a high quality standard?
- What do we need to do to provide appropriate and restorative support services so that people can regain their functional independence after injury or illness and avoid further complications?
- What do we need to do to support and respect people dying with dignity and to meet their needs?

Supported by analysis of populations, this approach will facilitate and support discussion around the most appropriate service and facility configurations across the South Island and challenge the current boundaries between providers. In doing this we will make improvements in patient flow by introducing more flexible workforce models, improving the sharing of patient information and connecting formerly disparate services across service levels and across DHB regions.

Regional service planning in the South Island is implemented through active work streams based around priority service areas. These are service areas that have been identified nationally, regionally or locally as 'vulnerable' clinical areas, areas of high demand, or key enablers to support change.

Six service areas have been prioritised: Cancer; Child Health; Health of Older People; Mental Health; Procurement; and Information Technology.[5]

In order to better support and drive regional planning and delivery, the South Island DHBs have adopted a modified Alliance Framework. An Alliance Framework was chosen because it is uniquely suited to enable the rapid implementation of complex and evolving service models, without the need to disrupt current organisational structures. More importantly, an Alliance takes relationship contracting to a higher level where the participants take the ultimate step in 'removing barriers' to getting the right thing done, by eliminating misalignment of organisational interests for the good of the system.

The South Island Chief Executives have formed an Alliance Leadership Team and will have responsibility for coordination of regional health service planning under an Alliance Governance Board consisting of the Chairs of the five South Island DHBs. The Alliance Charter and implementation framework are outlined in the South Island Health Services Plan.

Formal service level Alliances will be constituted and resourced for each of the priority service areas to support the South Island to respond to immediate challenges and pressures in the coming year. Under Lead Chief Executives and a South Island Alliance Management Team; each service level Alliance will be responsible for establishing its long term strategic objectives and plan of action.

The South Island Health Services Plan and the service plans for the priority work streams have been approved by the regional Chief Executives and each of the South Island DHB Boards. Appendix 2 outlines the specific 2011/12 action plans for each of these services areas.

One of the South Island's major strengths is the collegial relationships that exist between clinical teams and support the development of sub-regional and regional quality improvement strategies, patient pathways and service models. Each service level Alliance will be clinically led and have active clinical input, with multidisciplinary representation from primary care as well as from hospital and specialist services.

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[5] The existing Southern Cancer Network is captured under the Alliance Framework as a principle work stream and some of its processes will be adjusted over time to broaden clinical input and ensure an integrated approach to health service delivery.

A Long Term Health Sector Plan (LTHSP) is currently being drafted by the National Health Board (with expected delivery of the final plan in June 2011). The LTHSP will outline the future direction for public health services, focusing on service planning and new models of care. It will provide high-level direction over the next 20 years and describe the challenges the sector faces and options for models of care that offer solutions and implications for the way services are configured in the future.

After the LTHSP is finalised by the NHB, it will guide future decisions about service configuration and investment at all levels of the system and support the DHB in their long term local and regional planning. The NHB will use the LTHSP to inform their review of national, regional, and district plans.

2.3 Local direction - bringing it all together

The West Coast DHB is aligned to the regional and national approach for the provision of consistently high quality and responsive health services. At the same time the West Coast health system will provide the services that can only be achieved through local provision or those services that we can provide better than elsewhere.

Members of the West Coast health system, clinical leaders, service stakeholders and consumers have identified priorities for the coming year that focus on improving the clinical financial and social sustainability of the West Coast Health System and delivering the right care, at the right place and the right time within the funding available. The strategic imperatives of our health system for 2011/12 are:

- ***Achieving the Minister's Health Targets*** – A high level of performance against the Minister's Health Targets and the provision of timely, quality and accessible services across our population is a key imperative for the West Coast DHB.
- ***Managing our financial performance to achieve financial sustainability*** – To deliver within existing resources the focus for the West Coast health system is on reducing and eliminating waste, changing models of care to delivery services more efficiently and alignment to an inter-district and regional approach to health service delivery.
- ***Delivering better, sooner, more convenient primary care*** – The patient experience within the health system is at the centre of the implementation of the BSMC business case. This year the focus will be on transforming models of care to enhance the patient journey and flow throughout the entire system.
- ***Collaboration with the Canterbury DHB*** – The planning and delivery of health services on the West Coast and for our population is inextricably intertwined with the Canterbury DHB. The evolution of our relationship with Canterbury DHB includes the alignment and integration of our workforces and systems and will impact positively on the sustainability of service provision across the districts.
- ***Facilities planning*** – The planning of facility design for the coming year will predominately focus on changing models of care and the opportunity for an Integrated Family Health Centre's in the Buller and Grey districts, as well as developing a sustainable model of care for Grey Hospital Services

The importance of creating an environment of confidence and trust through open and transparent relationships with our community, clinical leaders, intersectoral agencies and with our patients is critical to us achieving our priorities and being seen as a high performing DHB.

IMPROVING OUTCOMES FOR OUR POPULATION

2.4 What are we trying to achieve?

This section presents an overview of how we will demonstrate whether we are making a positive change in health outcomes for our population and the population of the wider South Island. Our aim is to improve the availability (access and equity), quality and timeliness of services and to enable people to make healthier choices and enhance their quality of life. This section explains how we will measure this improvement and change over time.

In line with the functions and responsibilities of a DHB, we will deliver on the priorities and expectations of the Minister and Ministry of Health in order to achieve the Government's long-term vision: *"All New Zealanders lead longer, healthier and more independent lives*".

At a regional level, in support of the national vision, the South Island DHBs are working collectively to deliver "*A clinically and fiscally sustainable South Island Health System where services are provided as close to people's homes as possible*." In order to contribute to this regional vision and improve health outcomes for our individual populations, the South Island DHBs are making associated shifts in the way they work and interact regionally. These shifts are focused on the achievement of three key strategic goals or regional outcomes:

- The development of services that support people to stay well and take increased responsibility for maintaining their own health and wellbeing.

  Strategic Goal: People take greater responsibility for their own health.

- The development of primary and community services that support people in community-based settings and provide a point of ongoing continuity of care.

  Strategic Goal: People stay well in their own homes and communities.

- The freeing-up of secondary care services and specialist resources to ensure timely and appropriate responses to episodic events and the provision of support and specialist advice as part of a person's wider journey through the system.

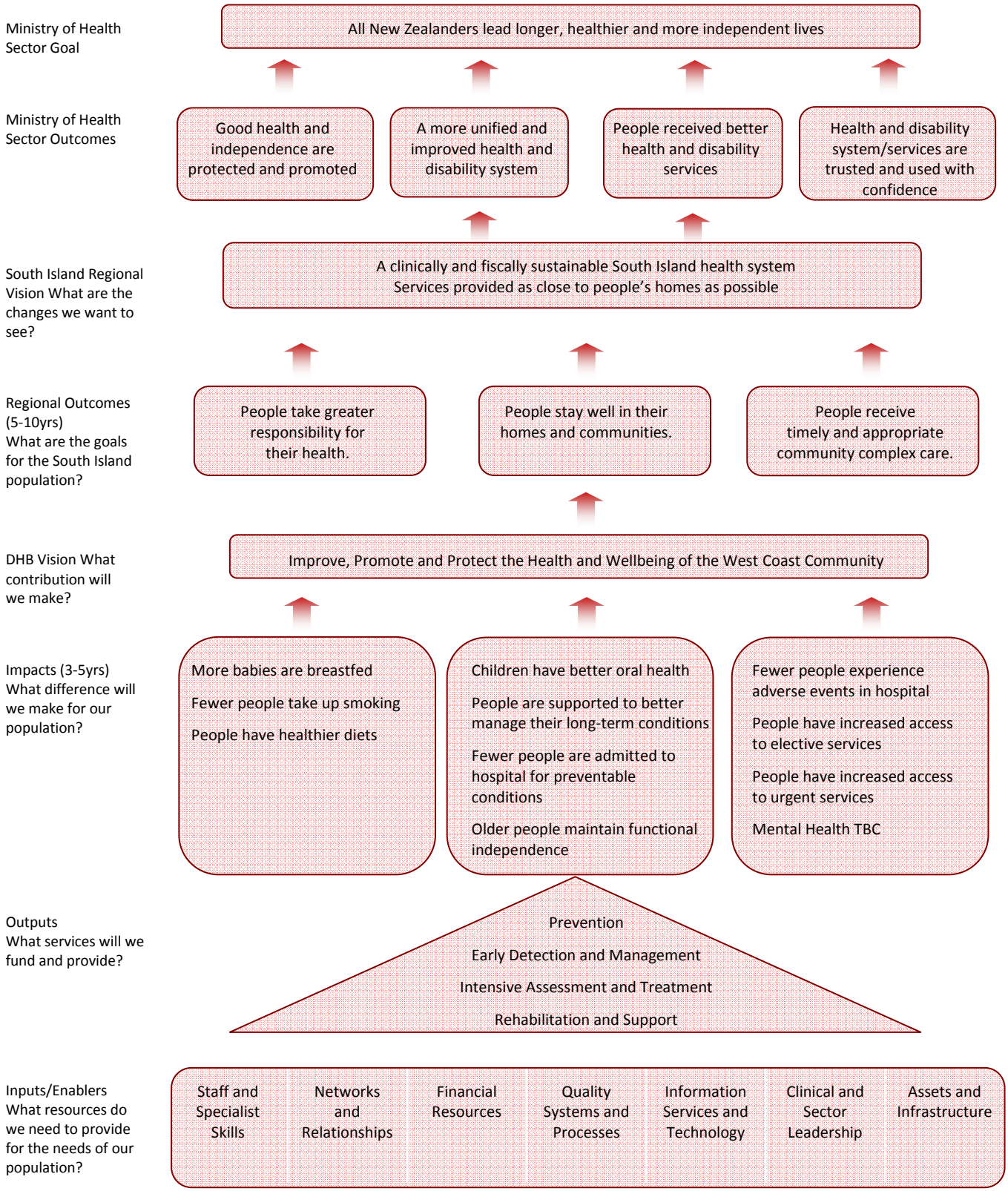
  Strategic Goal: People receive timely and appropriate complex care.

For each strategic goal the five South Island DHBs have identified a core set of regional performance measures, at a population outcome level, which will demonstrate whether we are achieving these goals and thus making a positive change in the health of our collective population. These are long-term outcome measures (5-10 years in the life of the health system) and as such, we are aiming for a measurable change in the health status of the South Island population over time, rather than a fixed target.

In order to contribute to these outcomes, the South Island DHBs have considered what impact the outputs we fund and provide will have on the health of our populations. We have identified areas where individual DHB performance will have an impact on achievement of regional outcomes and collectively agreed a core set of related medium-term (3-5 years) impact performance measures or 'main measures'. Each DHB has set local targets against these main measures to evaluate the impact service delivery will have over the next three years.

The logic intervention diagram below visually demonstrates the value chain of how the outputs individual DHBs fund or provide have an impact on the health of their population and result in the achievement of long-term regional outcome goals and the expectations and priorities of Government.

Figure 3: Logic intervention diagram



STRATEGIC GOAL

2.5 People Take Greater Responsibility for their Own Health

Expectation

Population health and prevention programmes, through enhanced education and support, ensure people are better protected from harm, are more informed of the signs and symptoms of ill health and are supported to reduce risk behaviours and modify lifestyles in order to maintain good health. They create health-promoting physical and social environments which support people to take more responsibility for their own health and improve individual and community capability to make healthier choices.

Why is this Outcome a Priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of health funding is spent on long-term conditions.

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

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

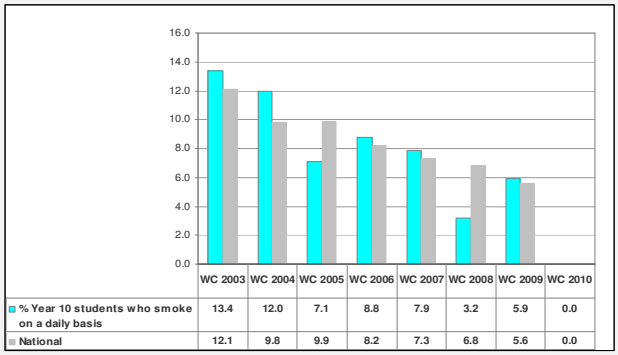
Associated Regional Outcome Measures - We will know we are succeeding when there is:

A reduction in smoking rates.

- *Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is a major contributor to preventable illness and long-term conditions such as lung and a variety of other cancers, chronic obstructive pulmonary disease, heart disease and strokes.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say no to tobacco smoking is our foremost opportunity to target improvements in the health of populations with high need and to reduce inequalities.*

Data sourced from national NZ Health Survey.[6]

Long-term Outcome Measure: The percentage of the population year 10 students (14+) who smoke.



	WC 2003	WC 2004	WC 2005	WC 2006	WC 2007	WC 2008	WC 2009	WC 2010
% Year 10 students who smoke on a daily basis	13.4	12.0	7.1	8.8	7.9	3.2	5.9	0.0
National	12.1	9.8	9.9	8.2	7.3	6.8	5.6	0.0

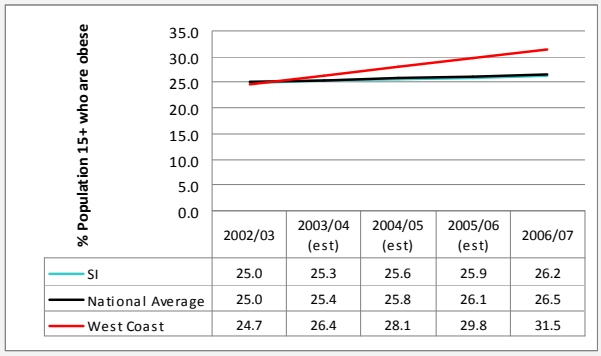
A reduction in obesity rates.

- *There has been a rise in obesity in New Zealand in recent decades and the 2006/07 NZ Health Survey found that one in four adults (26.5%) and one in twelve children (8.3%) were obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving the health and wellbeing of our population and to the prevention and management of long-term conditions and disability at all ages.*

Data sourced from national NZ Health Survey.[6]

Long-term Outcome Measure: The percentage of the population (15+) who are obese.[7]

[6] *The data for these measures comes from the national NZ Health Survey collected by the Ministry of Health. The survey was undertaken in 2003/04 and 2006/07; figures for the intervening years are estimated. 2006/07 data is pulled from PHIOnline. The next survey is currently underway.*



	2002/03	2003/04 (est)	2004/05 (est)	2005/06 (est)	2006/07
SI	25.0	25.3	25.6	25.9	26.2
National Average	25.0	25.4	25.8	26.1	26.5
West Coast	24.7	26.4	28.1	29.8	31.5

IMPACT MEASURES MEDIUM TERM (3-5 YRS) ASSOCIATED WITH ACHIEVING REGIONAL OUTCOMES

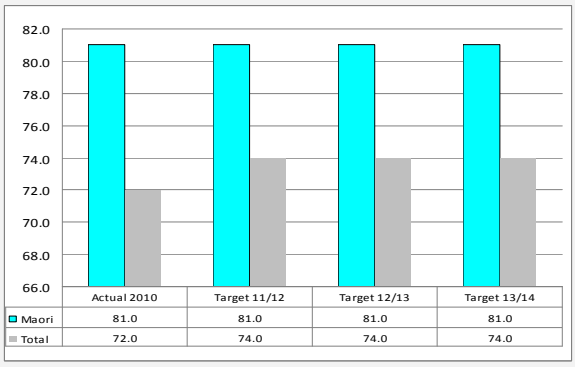
Over the next three years the West Coast DHB will seek to make a positive difference (impact) on the health and wellbeing of the West Coast population and to contribute to longer-term regional outcomes. The effectiveness of the services the DHB funds and provides, and the contribution it makes, will be evaluated using the following impact measures:

An increase in the proportion of babies fully and exclusively breastfed.

- *Breastfeeding helps lay the foundations of a healthy life for a baby, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life. This in turn contributes to the health and wider wellbeing of mothers.*
- *Although breastfeeding is natural, it sometimes doesn't come naturally so it's important that mothers have access to appropriate support and advice. Successful health promotion and engagement, access to services and a change in social and environmental factors, influence and support breastfeeding.*

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

The percentage of West Coast children fully/exclusive breastfed at 6 weeks.	Actual 2010	Target 11/12	Target 12/13	Target 13/14
Māori	81%	81%	>81%	>81%
Total	72%	74%	>74%	>74%

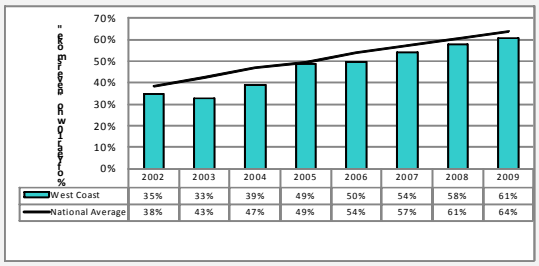


	Actual 2010	Target 11/12	Target 12/13	Target 13/14
Maori	81.0	81.0	81.0	81.0
Total	72.0	74.0	74.0	74.0

A reduction in the proportion of young people who take up tobacco smoking.

- *Reducing smoking prevalence is dependant on increasing smoking cessation and preventing young people from taking up smoking. Over 90% of smokers have started smoking by 18 years of age, and the highest prevalence of smoking is amongst young people.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviours.*
- *Data sourced from national Year 10 ASH Survey.*[9]

The percentage of 'never smokers' among Year 10 West Coast students.	Actual 2009	Target 11/12	Target 12/13	Target 13/14



	2002	2003	2004	2005	2006	2007	2008	2009
West Coast	35%	33%	39%	49%	50%	54%	58%	61%
National Average	38%	43%	47%	49%	54%	57%	61%	64%

[7] *Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Māori or Pacific people.*
[8] *Breastfeeding data is reported annual on calendar rather than financial years, and is based on the national DHB performance indicator S17.*
[9] The ASH survey provides a point prevalence data set and is based on calendar years.

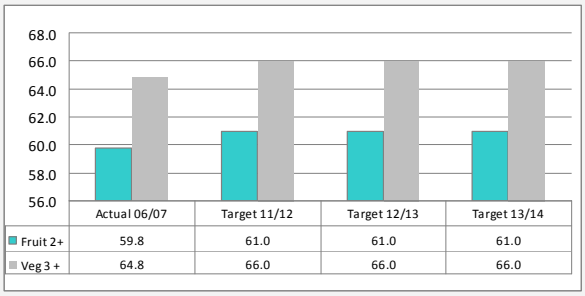
An increase in the proportion of adults who have healthier diets.

- *Good nutrition is fundamental to health and the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths in NZ each year (approximately 11,000).*[10]
- *Appropriate fruit and vegetable consumption helps to protect our population against obesity, cardiovascular disease, diabetes and some common cancers and contributes to maintaining a healthy body weight.*
- *An increase in fruit and vegetable consumption is seen as a proxy measure of successful engagement and a change in the social and environmental factors that influence people to make healthier choices.*

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

The percentage of the West Coast population (15+) having the recommended servings of fruit and vegetables.

	Actual 06/07	Target 11/12	Target 12/13	Target 13/14
Fruit 2+	59.8%	61%	>61%	>61%
Veg 3+	64.8%	66%	>66%	>66%



STRATEGIC GOAL

2.6 People are supported to Stay Well in their Own Homes and Communities

Expectation

Primary and community services support people to access intervention, diagnostics and treatment and to better manage their illness or long-term conditions. These services assist people to detect health conditions earlier, making treatment and interventions easier and reducing the complications of injury and illness.

Why is this Outcome a Priority?

For most people, their General Practice Team (GPT) is their first point of contact with health services. Primary care can deliver services sooner and closer to home and is one of the most effective ways to prevent disease through screening, early detection and timely provision of treatment. Primary care is also vital as a point of continuity and effective coordination across the continuum of care and for improving the management of care for people with long-term conditions.

Supporting primary care are a range of health professionals including midwives, community nurses, social workers, aged residential care providers, Maori health providers', pharmacists, community mental health workers and community allied health professional who work in the community, often with the neediest families. These providers have prevention and early intervention perspectives that link people with other services and community agencies and further support them to stay well and manage long-term conditions. Studies show that countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and that they achieve better health outcomes for lower cost, than those countries with systems that focus on specialist care.

With an ageing population, the South Island will require strong primary care and community support, including residential care, respite and responsive short-term and home-based support. If long-term conditions are managed effectively, crises and deterioration can be reduced and health outcomes improved. Even where returning to full health is not possible, access to flexible, responsive, needs-based services can support people to maximise function with the least restriction and dependence.

This means fewer people need hospital-level or long-stay interventions, and those who do have a greater chance of returning to a state of good health and slowing the progression of disease. This is not only a better health outcome for our population, but it reduces the rate of acute and unplanned hospital admissions and frees up health resources, allowing them to be directed to other priority areas.

[10] *Niki Stefanogiannis (2004) Nutrition and the burden of disease in New Zealand; 1997–2011, Wellington: Public Health Intelligence.*

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

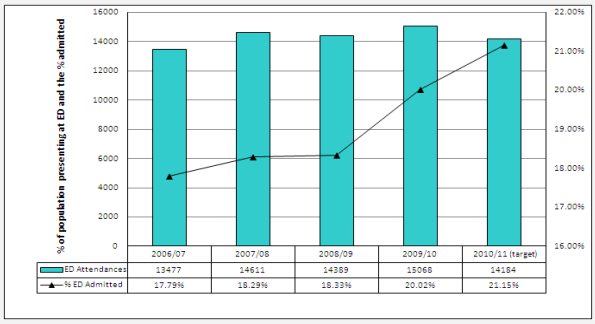
Associated Regional Outcome Measures - We will know we are succeeding when there is:

A reduction in 'avoidable' presentations to hospital Emergency Departments (EDs).

- *Supporting people to seek early intervention and providing access to alternative urgent care pathways will ensure people are being given the right treatment in the right place - reducing unnecessary presentations to emergency departments. Early intervention will not only improve health outcomes for our population, but also reduce avoidable pressure on hospital resources and enable investment in other priority areas.*
- *An increase in the ratio between the number of people presented at ED and those being admitted is seen as a proxy measures of whether people are appropriately presenting at ED and are being better managed in more appropriate locations.*

Data Sourced from National Minimum Data Set and individual DHBs.

Long-Term Outcome Measure – The percentage of the population presenting at ED and the percentage admitted.[11]

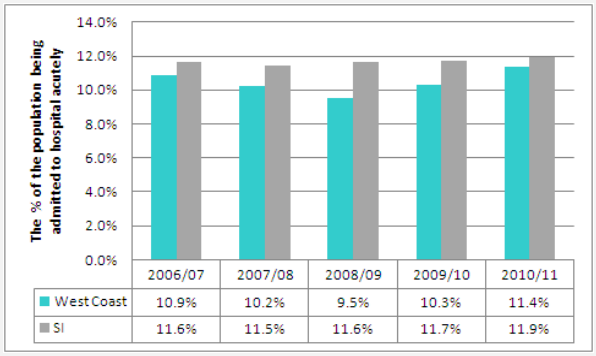


An increase in the proportion of the population supported to manage their long-term conditions.

- *The impact of long-term conditions in terms of quality of life and cost to the health system is significant. By improving the management of these conditions, people are supported to live more stable healthier lives, without the deterioration that leads to acute illness and crisis.*
- *Acute admissions can be used as a proxy measure of the improved management of long-term conditions by indicating that they are being better managed earlier, without escalation to an event needing urgent and complex intervention.*
- *Reducing acute admissions also has a significant effect on productivity in hospital and specialist services - enabling more efficient use of health resources that would otherwise be taken up by demand for urgent and acute care.*

Data sourced from SISSAL [12]

Long-term Outcome Measure – The percentage of the population being admitted to hospital acutely.



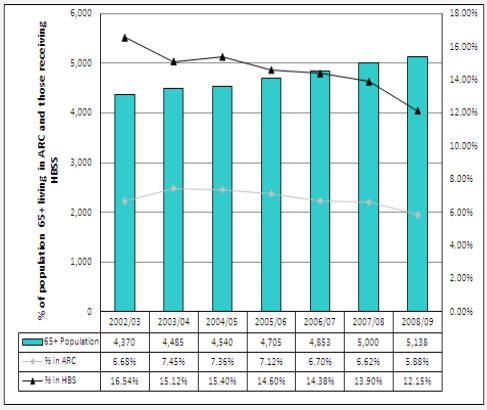
Note: Parameters around "acute" still need to be confirmed.

An increase in the proportion of the population aged over 65 supported to live well, in their own homes.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, when people receive adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life as a result of staying active and positively connected to their communities.*
- *Living in ARC facilities can be associated with a more rapid functional decline than 'ageing in place'. It is also a more expensive option, and resources could be better spent providing appropriate levels of support to people in their own homes. The aim is to support older people to stay well as long as possible rather than entering ARC facilities.*

Data sourced from SISSAL Client Claims Payment System.

Long-term Outcome Measure – The percentage of the population 75+ living in ARC and those receiving Home Based Support Services.



[11] *Presentations by West Coast resident only- excludes visitors to the region. 'Admitted' is defined as in the Ministry of Health national ED Health Target.*

[12] *This data is provided at an Age Standardised Rate (ASR) per 100,000 people.*

IMPACT MEASURES MEDIUM TERM (3-5 YRS) ASSOCIATED WITH ACHIEVING REGIONAL OUTCOMES

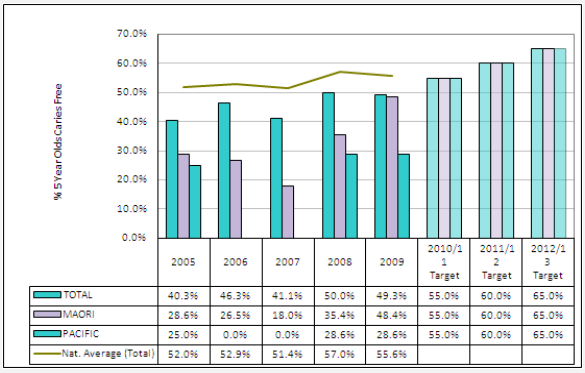
Over the next three years the West Coast DHB will seek to make a positive difference (impact) on the health and wellbeing of the West Coast population and to contribute to longer-term Regional Outcomes. The effectiveness of the services the DHB funds and provides, and the contribution it makes, will be evaluated using the following impact measures:

An increase in the proportion of children with good oral health.

- *Regular dental care has lasting benefits for improved health and wellbeing, demonstrating early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition), self esteem and quality of life.*
- *Māori children are three times more likely to have decayed, missing or filled teeth, and improved oral health is a proxy measure of equity of access and the effectiveness of mainstream services in targeting those most in need.*
- *While water fluoridation can significantly reduce tooth decay across all population groups, no West Coast children have access to fluoridated water.*

Data sourced from Ministry of Health.[13]

The percentage of West Coast children who are caries free (have no holes or fillings) at age 5.		Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	Māori	48.4%	55%	60%	65%
	Pacific	28.6%	55%	60%	65%
	Total	49.3%	55%	60%	65%

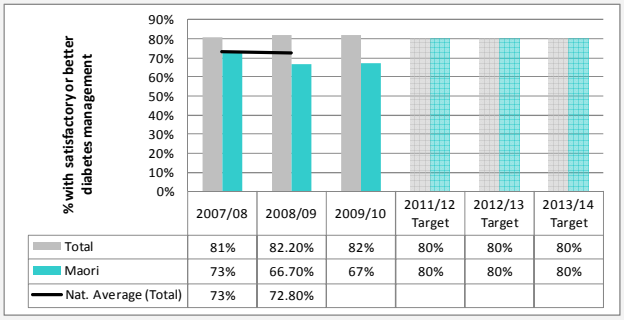


An increase in the proportion of people identified with diabetes having 'satisfactory' management of their diabetes.

- *Diabetes is a significant cause of ill health and premature death, and prevalence is increasing at an estimated 4-5% a year.*
- *Improving the management of diabetes will reduce avoidable complications that require hospital-level intervention, such as amputation, kidney failure and blindness, and will improve people's quality of life.*
- *Diabetes is also strongly associated with cardiovascular diseases (heart attacks and stroke) and respiratory disease. As such it contributes significantly to the top causes of death.*

Data sourced from Ministry of Health and Individual DHBs.[14]

The percentage of people receiving diabetes annual reviews who have satisfactory or better diabetes management (HbA1c<8%).		Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	Māori	67.0%	80%	80%	80%
	Pacific	n/a	n/a	n/a	n/a
	Total	82.0%	80%	80%	80%



[13] *Oral health data is reported annually for the school year (i.e. calendar year) and is based on the national DHB performance indicator PP11.*

[14] *Diabetes data is reported on a quarterly basis, one quarter in arrears, and is based on the national DHB Health Target 'Better diabetes and CVD services'. Prior to 2007/08 diabetes data was reported by calendar year. 2007/08 results are financial year estimates provided by the MoH.* Satisfactory diabetes management is defined as having HbA1c≤8%.

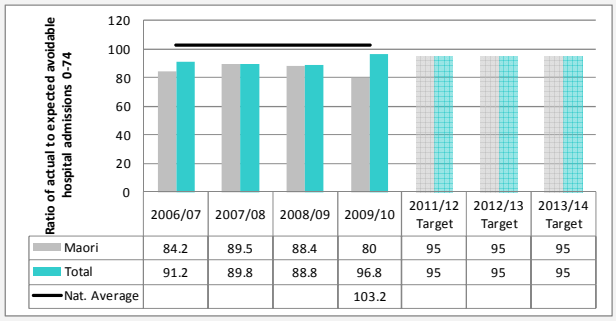
A reduction in the proportion of the population admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *There are a number of admissions to hospital for conditions which are seen as preventable through appropriate early intervention. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention and community-based care.*
- *A reduction in these admissions will reflect better management of and treatment of people across the whole system and will free up hospital resources for more complex and urgent cases.*
- *The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services. Achievement against this measure therefore is seen as a proxy indicator of a more unified health system.*

Data sourced from the Ministry of Health. [15]

The ratio of actual to expected avoidable hospital admissions for the West Coast population aged 0-74.

	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
Māori	80.0	<95%	<95%	<95%
Pacific	n/a	n/a	n/a	n/a
Total	96.8	<95%	<95%	<95%



An increase in the proportion of people aged over 75 who are supported to maintain functional independence.

- *Around 12,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to elderly people who do not fall, those who fall experience prolonged hospital stay, loss of confidence, restriction of social activities, loss of independence and an increased risk of institutional care.*
- *With a significantly increasing older population, a focus on reducing falls will help to reduce the relative demand on acute and residential services. Reducing the average hospitalisation rate for falls by 1% would mean over 500 fewer hospitalisations (people 75+) across the country.*
- *Achievement against this measure will indicate improved health service provision for older people, as the initiatives used to reduce falls will address various health issues and risk factors associated with falls including: medication use, osteoporosis, lack of physical activity, poor nutrition, impaired vision and environmental hazards.*

Data sourced from Ministry of Health.

The percentage of the population in West Coast aged over 75, admitted to hospital as a result of a fall.

Actual 09/10	Target 11/12	Target 12/13	Target 13/14

NOTE: The intention is to use the national Ministry Indicator (PP15) which has been introduced for all DHBs from 2011/12. The data and definitions are currently being finalised, and the South Island DHBs will begin to report against this measure as soon as it is agreed.

[15] Avoidable or 'Ambulatory Sensitive' hospital admissions are based on admissions for 26 conditions including: asthma, diabetes, angina and chest pain, vaccine-preventable diseases, dental conditions and gastroenteritis. Prior to 2009/10 the definition included 37 conditions. The expected rate is the national average, and a ratio greater than 100 indicates performance worse than the national average and is based on the national DHB performance indicator SI1.

STRATEGIC OBJECTIVE

2.7 People Receive Timely and Appropriate Community and Complex Care

Expectation

Most people will receive effective acute care in the community so that only the most ill people will require hospital admission.

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, health outcomes and quality of life are improved and untimely deaths reduced.

Why is this Outcome a Priority?

Timely access to high quality hospital and specialist services improves health outcomes, and shorter waiting lists and wait times are indicative of a well functioning system matching capacity with demand - managing the flow of patients through its services and addressing the needs of its population.

Our Government is concerned that patients wait too long for hospital diagnostic tests, for cancer treatment and for elective surgery. The expectation around reducing waiting times, coupled with the current fiscal situation, means DHBs need to develop innovative ways of assisting more people and reducing waiting times with limited resources.

This outcome reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future. Typically, an organisation's capacity is considered to be the means through which an outcome is achieved and not an outcome itself. However, as providers of hospital and specialist services who are operating under increasing demand and workforce pressures, the South Island DHBs have included the provision of timely and appropriate complex care as a Strategic Goal.

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

Associated Regional Outcome Measures - We will know we are succeeding when there is:

A reduction in unplanned acute readmissions to hospital and specialist services. ▪ *Unplanned acute readmission rates are a measure of quality of care, efficiency and appropriateness of discharge for hospital patients. They are also a quality counter-measure to balance improvements in productivity and reduced lengths of stay, at the same time as our population is ageing and people are presenting with more complex conditions.* ▪ *Improved patient-focused and clinically driven pathways will support early intervention and planned readmission where clinically appropriate, and deliver improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to maintain more stable lives.* *Data sourced from Ministry of Health.*[16]	Long-term Outcome Measure – The rate of acute readmissions to HSS (unplanned and within 28 days). *NOTE: The intention is to use the national Ministry Indicator (OS8) which was introduced for all DHBs in 2010/11. The data and definitions are still being tested, and the South Island DHBs will use this measure once data is stabilised.*
A reduction in the rate of mortality within 30 days of discharge from hospital and specialist services. ▪ *Mortality rates are a measure of clinical outcomes for hospital patients and are related to the safety and efficacy of treatment. Maintaining or reducing our current mortality rates will demonstrate maintenance of clinical quality standards and a balance against productivity gains such as reduced length of stay.*	Long-term Outcome Measure – The rate of mortality within 30 days of discharge from hospital. *NOTE: The intention is to use the national Ministry Indicator (OS9) which was introduced for all DHBs in 2010/11. The data and definitions are still being tested, and the South Island DHBs will use this measure once data is stabilised.*

[16] The unplanned acute readmissions measure is based on the national DHB performance indicator OS8.
[17] The 30 day mortality rate measure is based on the national DHB performance indicator OS9.

- *System and process changes being made to the way we deliver services to patients, such as changes intended to reduce the incidence of falls, pressure ulcers, pneumonia and hospital-acquired infections, will lead to a measurable change in patient mortality.*

Data sourced from Ministry of Health.[17]

IMPACT MEASURES MEDIUM TERM (3-5 YRS) ASSOCIATED WITH ACHIEVING REGIONAL OUTCOMES

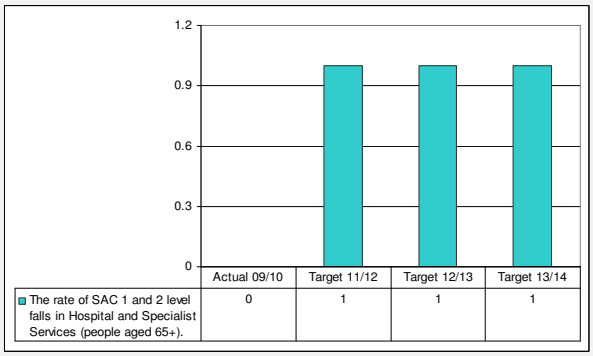
Over the next three years the West Coast DHB will seek to make a positive difference (impact) on the health and wellbeing of the West Coast population and to contribute to longer-term Regional Outcomes. The effectiveness of the services the DHB funds and provides, and the contribution it makes, will be evaluated using the following impact measures:

A reduction in serious incidents (adverse events) causing harm to patients in Hospital and Specialist Services.

- *Adverse events in hospital, as well as causing avoidable harm to patients, also drive unnecessary costs for DHBs.*
- *Quality improvements in service delivery, systems and processes will improve patient safety and reduce the number of serious incidents causing injury - providing better outcomes for patients in our services and reducing readmission and mortality rates.*
- *Compared to elderly people who do not fall, those who fall experience prolonged hospital stay, loss of confidence, restriction of social activities, loss of independence and an increased risk of institutional care.*
- *Achievement against this measure will indicate improved quality processes and a reduction of harm in our hospital and specialist services.*

Data sourced from Individual DHBs.

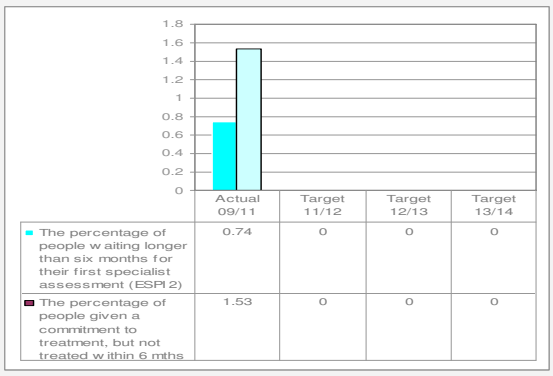
	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
The rate of SAC 1 and 2 level falls in Hospital and Specialist Services (people aged 65+).[18]	0	1	1	1



Improving outcomes for our population in the provision of elective services

- *West Coast DHB is committed to manage all elective patients consistently and to provide treatment within six months of referral.*

	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
The percentage of people waiting longer than six months for their first specialist assessment (ESPI 2)	0.74	0	0	0
The percentage of people given a commitment to treatment, but not treated within 6 months (ESPI 5).	1.53	0	0	0



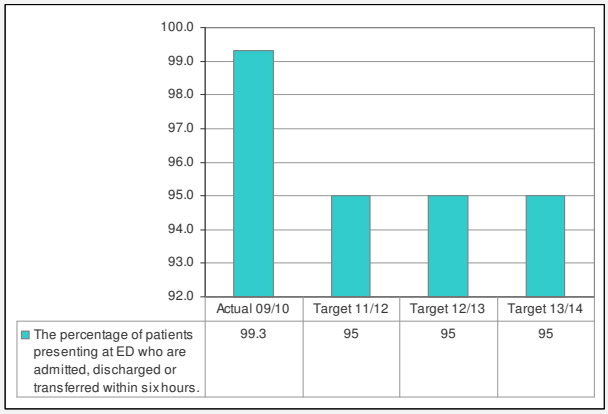
[18] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the consequence or outcome of the incident and the likelihood that it will recur. A matrix is used to stratify the actual and/or potential risk associated with the incident. Level 1 and 2 incidents are those with highest consequence and likelihood.*

An increase in timely access to Urgent Care services

- *Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients.*
- *The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentation, the effectiveness of the services provided in ED, and the hospital and community services provided following exit from ED. Therefore, reducing waiting times in ED is indicative of a coordinated 'whole of system' response to the urgent care needs of the population.*
- *Improved performance against this measure will not only improve outcomes for our population, but will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services.*

Data sourced from the Ministry of Health.[19]

The percentage of patients presenting at ED who are admitted, discharged or transferred within six hours.	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	99.3%	<95	<95	<95



[19] This measure is based on the national DHB Health Target 'Shorter stays in Emergency Departments'.

GOVERNMENT EXPECTATIONS

Module 2

Health targets - How will we contribute?

When planning investment and activity within the health sector, DHBs must consider their contribution and role in the achievement of the vision and goals of Government reflected through the expectations of the Minister of Health, the National Health Board and the Ministry of Health.

In setting expectations for 2011/12, a clear signal has been given that the Government wants better, sooner, more convenient health care for all New Zealanders. A strong priority has been given to improving frontline services within available resources and DHB are expected to focus on strengthening clinical leadership, improving the health of older people and ensure greater regional collaboration between DHBs.

The Minister's specific priorities for DHBs in 2011/12 are:

- Improved service delivery and reducing waiting times – achievement of the national health targets and continued improvement in reducing waiting times;
- Strengthened clinical leadership – support for clinical networks and clinicians leading development in identified priority services and the integration of services closer to home;
- Services closer to home – refocusing resources on delivering services in local community settings, closer to patients, and enabling community and hospital-based clinicians to provide services more effectively.
- Improving the health of older people - with a focus on improving older people's underlying health and wellbeing and preparing to meet the impact of our ageing population;
- Regional cooperation – greater regional collaboration between DHBs to maximise clinical and financial resources and evidence of real gains from these endeavours;
- More unified systems - working constructively with the National Health Board, Health Benefits Ltd, the National Health IT Board, Health Workforce NZ and Health Quality and Safety Commission; and
- Improved financial performance – taking ownership of financial performance and implementing specific actions to operating within budget. [20]

To measure progress against the national priorities, a set of national health targets has been established by the Ministry of Health, with the anticipation that a collaborative DHB focus will drive performance improvement across the sector. The health targets are monitored quarterly by the National Health Board.

While the health targets capture only a small part of what is necessary and important to our community's health, they do provide a focus for action and improved performance across the continuum, from prevention and early intervention through to improved access to intensive assessment, treatment and support services. There is also clear alignment between regional and local priorities and the national health targets. In this sense, achievement of the national health targets is a reflection of how well the health system is impacting on the lives of our populations.[21]

The West Coast DHB is committed to making continued progress towards achieving the national health targets, and our contribution (in terms of local targets) is set out in the following two pages. The activity planned to deliver on these health targets is summarised in the Annual Activity and Forecast of Service Performance sections of this document.

[20] The Minister's letter of expectations is attached as Appendix 1

[21] *Information regarding the Health Targets can be found on the Ministry's website www.moh.govt.nz*

Shorter Stays in EDs

Government Expectation

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

Why is this target area important:

This target is reflective of a 'whole of system' approach to managing acute demand, strong clinical leadership and a commitment to improving the quality of care for patients across the whole continuum.

ED length of stay is also seen by the Government as an important measure of the quality of acute care in our public hospitals. Long stays in ED are reflective of overcrowding, which can lead to compromised standards of privacy and dignity for patients and are linked to negative clinical outcomes for patients, such as increased mortality and longer inpatient lengths of stay. The target is also reflective of the flow of patients through the hospital and how well different departments interact.

Our contribution:

>95% of people presenting to a West Coast ED will be admitted, discharged or transferred within six hours.

Improved Access to Elective Surgery

Government Expectation

More New Zealanders have access to elective surgical services with an average of 4,000 additional discharges nationally every year.[22]

Why is this target area important:

The Government wants the public health system to deliver better, sooner, more convenient health care for all New Zealanders. In order to achieve this, the growth in elective surgical discharges must keep up with population growth. This in turn will increase access and achieve genuine reductions in waiting times for patients.

All patients also have the right to clarity about whether they will receive publicly funded treatment, timeliness in terms of those who are given a commitment to treatment receiving that treatment in a timely manner (a maximum of six months) and fairness in ensuring that prioritisation status is based on a patient's level of health need compared to other patients.

Our contribution:

1592 elective surgical discharges will be delivered in 2011/12.

Shorter Waits for Cancer Treatment

Government Expectation

All New Zealanders requiring cancer radiation oncology treatment receive it within four weeks of their first specialist assessment.[23]

Why is this target area important:

Cancer is the leading cause of death and a major cause of hospitalisation in New Zealand. Timely cancer treatment is important to improve patient outcomes and provide a better quality of life. The target measures one part of a patient's journey with cancer and provides an indicator of how well the system is working.

Māori and Pacific populations have proportionately higher cancer incidence compared to other populations. Providing support to improve access to treatment and ensure sufficient treatment capacity are both important factors in ensuring Māori and Pacific people have equitable outcomes.

Our contribution:

100% of people who need radiation oncology treatment will receive it within four weeks of the decision to treat.

[22] *The national health target definition of elective surgery excludes dental and cardiology services.*
[23] *The national health target definition excludes Category D patients, whose treatment is scheduled to ensure effective sequence of radiation treatment with chemotherapy or other anti-cancer drugs.*

Increased Immunisation Rates

Government Expectation

95% of two years olds in New Zealand are fully vaccinated against vaccine preventable diseases by July 2012.

Why is this target area important:

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and not sufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). Coverage for two year olds demonstrates whether children have received the full series of infant immunisations, when they are most vulnerable.

Our contribution:

88% of two year olds fully vaccinated by July 2012.

Better Help For Smokers to Quit

Government Expectation

95% of all smokers presenting to ED, day stay and other hospital services are provided with help and advice to quit by July 2012.

Why is this target area important:

Smoking kills an estimated 5,000 people in New Zealand every year, and smoking-related diseases are a significant cost to the health sector. Smoking is also a major contributor to inequalities in health and to a number of long-term conditions, including heart disease, cancers and respiratory disease.

Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care. This target is designed to prompt health professionals to routinely ask about smoking status and provide smokers with brief advice and support to prompt quit attempts and quit success.

Our contribution:

95% of hospitalised smokers will be provided with advice and help to quit by July 2012.

90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit smoking by July 2012.

Improved Diabetes and CVD Services

Government Expectation

People are supported to understand and identify the symptoms of long-term conditions and to better manage their condition.[24]

Why is this target area important:

Long-term conditions comprise the major health burden for New Zealand now and in the foreseeable future. These conditions are the leading cause of morbidity and disproportionately affect Māori and Pacific people. As the population ages and lifestyles change, these conditions are likely to increase significantly.

Improving outcomes for people with diabetes and CVD will take a 'whole of system' approach that encourages healthier lifestyles and supports early diagnosis, management plans and access to treatment. These targets measure one part of the journey and can provide an indication of how well long-term conditions are being identified and managed in primary care.

Our contribution:

90% of the eligible adult population as measured in each of the population groups Maori, Other and total population will have their CVD risk assessed once every five years.

70% of the expected population with diabetes as measured in each of the population groups Maori, Other and total population, will receive a free diabetes annual review.

80% of those receiving a free annual diabetes review as measured in each of the population groups Maori, Other and total population, will have satisfactory or better diabetes management (HbA1c≤8%).

[24] *The Diabetes and CVD service health target incorporates three target indicators, and there is no overall national goal.*

DELIVERING ON PRIORITIES AND TARGETS

Module 3

As part of our commitment to providing Better, Sooner More Convenient health care to our population, a key focus for 2011/12 is on delivering services closer to home. Wherever possible we are aiming to deliver services either in the client's home or in local community settings. As part of this commitment we will be redistributing resources and reconfiguring services in the following areas:

- Integrated Family Health Systems;
- Disease Prevention and Managing Long-Term Conditions;
- Older Persons' Health Services;
- Mental Health Services;
- Child and Youth Health Services;
- Maori Health Services;
- Cancer;
- Diabetes and Cardiovascular Disease;
- Elective Services;
- Making the System More Efficient - In each of the areas above we are committed to living within our means and as such will remove variation, reduce duplication and eliminate waste. A subsection of making the system more efficient is ensuring effective clinical leadership. For each of the above sections to be implemented effectively we will need to ensure proper engagement with doctors, nurses, pharmacists and other allied health professionals. A number of systems to ensure effective clinical leadership already exist (such as clinical leaders on the Executive Management Team of the West Coast DHB, Clinical Governance Group of the West Coast PHO and the Better Sooner More Convenient Alliance Leadership Team). As we move forward, we will take every opportunity to further ensure more effective clinical leadership in all areas of day-to-day service delivery of the West Coast health system;
- Regional collaboration – we are committed to working collaboratively with the four South Island DHBs to achieve the objectives outlined in South Island Health Services Plan. Specific actions are outlined in Appendix 3.

3.1 Integrated Family Health Systems

We will ensure the people of the West Coast have access to Better, Sooner, More Convenient health care. This includes improved access to a wider range of integrated services, in more convenient locations, to further improve the overall health status of our population.

How are we improving outcomes for our population?

In line with the Government's strategy for Better, Sooner More Convenient (BSMC) health care, the West Coast DHB recognises the value of taking a whole of system approach to the delivery of health care. The implementation of BSMC will be patient-centric and focus on the delivery of health services to the right people, in the right place and at the right time.

We expect that implementation of the West Coast Business Case for Better, Sooner, More Convenient Primary Care will allow health professionals (doctors, nurses, pharmacist and allied health professionals) to work outside of the constraints and boundaries which have up until now inhibited patient access to the appropriate level of acute and planned care. The West Coast DHB is committed to supporting the implementation of 2011/12 deliverables in the Better, Sooner, More convenient business case in partnership with the West Coast PHO and other West Coast health care providers.

The second year of delivery of the Better Sooner More Convenient business case is focused on the implementation for a sustainable and fully Integrated Family Health Centre (IFHC) in the Buller district as well as the development of a model of care for an IFHC in Greymouth. In the case of Greymouth IFHC there is an opportunity for this to be developed alongside a refurbished hospital.

Why is this important?

It is accepted that the current models of care provided in the Buller and Grey districts are not clinically or financially sustainable. There is a shortage of general practitioners in the Buller and Grey districts. We have not

yet learnt how to recruit and retain a skilled primary care workforce. Resolution of this deficit is a key expectation of the Board. The proposed model of care for integrated health services is designed to reduce waste and provide more convenient, effective, and clinically safe local services that can be sustained into the future as well as putting the patient at the centre of the system.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Establishment of an IFHC in the Buller community. *A financially sustainable 'one stop shop' for primary health care in the Buller district.*	Development of a model of care for integrated family health services in the Buller district. Complete the IFHC design for full integration of hospital, community and primary health care services. Commence building of the Buller IFHC (*subject to acceptable capital funding being obtained*).	A detailed model of care plan is developed by October 2011. Key aspects of the model of care implementation plan commenced by November 2011. The Buller IFHC build commenced by March 2012 (*with a view to complete construction by early 2013*).
Development of an IFHC in the Greymouth community. *An integrated model of care for primary and community health care in the Grey district.*	Development of a model of care for integrated family health services in the Grey district. Substantially progress the development work on an IFHC in Greymouth as part of the re-development and refurbishment of Grey Base Hospital.[25]	Community engagement and support for a proposed new Grey IFHC/hospital model of care is achieved by December 2011. Agreement is obtained for the Grey district whole of system model of care by December 2011. Key aspects of the model of care implementation commenced by January 2012.
Development of the ownership, governance and management arrangements for IFHC on the West Coast. *Financially sustainable and effective IFHCs on the West Coast.*	Review current and determine future ownership and governance arrangements for Integrated Family Health facilities and services. Progress the development of a whole of system focus on the right model of ownership and governance for the West Coast health system.	Ownership, governance and management arrangements for Integrated Family Health centres and services are agreed and applied by 30 June 2012.
Implementation of the core general practice work stream, including Maori health, acute care and workforce. *To improve safety, continuity and coordination of general practice care, reduce waiting times for our patients and improve the financial viability of West Coast practices.* *To develop a robust system for acute care after hours.* *To improve access and healthy outcomes for patients, particularly Maori.*	Monitor standing orders use in each practice and adapt standard processes as required by October 2011.	Safe practice and clinical consistency across the West Coast Health System is achieved. The content of standing orders is updated by May 2012.
	Evaluate and update the After Hours Plan to further improve out-of-hours cover. Develop and implement an action plan to address the appropriateness of ED presentations.	A reduction in the number of acute primary care presentations (triage 5 patients) in ED during week days to <35. A reduction in the number of inappropriate ED presentations and improved access to primary care services. >95% of patients are discharged or transferred from ED within six hours.
	Develop and implement a safe and sustainable model	A safe and sustainable model of

[25] *Development of the IFHC in the Grey District is aligned and inter-related to progress on the Grey Base Hospital refurbishment project.*

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
	of care for general practice staffing in the Buller and Grey districts. Work with Canterbury/West Coast DHB Human Resources recruitment and retention team to meet West Coast primary care recruitment and retention needs. Establish a new organisational key performance indicators based on a full establishment of key clinical staff being recruited and retained across the West Coast health system. Develop a report on potential alternative workforces in primary care.	care for staffing is developed in the Buller and Grey districts by October 2011 and December 2011 respectively and implementation commenced by November 2011 in Buller and January 2012 in Grey. All seven practices are Cornerstone accredited by June 2012 (*five a currently accredited*). Board decisions to ensure a clinically and financially sustainable model of general practice on the West Coast will be made by December 2011.
	Māori health care plans developed for each general practice/IFHC service as appropriate.	Maori Health care plans for general practices are available from December 2011. Kaiawhina positions established in Buller Integrated Family Health Centre by December 2011 and Grey Integrated Family Health Centre by June 2012. Appointment of a dedicated Maori clinical position to each of the Integrated Family Health Centres by December 2011 in Buller and June 2012 in the Grey district.
Implementation of the IT workstream *To achieve common patient management systems across primary and community services that achieve patient confidence and protection of privacy, improves patient safety and increases the effectiveness of clinical care.* *Integration of primary and secondary information systems.*	Extend access to MedTech across all health centres, community nursing and allied health. Develop a link into MedTech for community pharmacy.	MedTech extension across health centres (if accepted) achieved by March 2012. The mechanisms for enabling community nursing and allied health are analysed by December 2011, with agreement and implementation by May 2012. Access is provided to relevant pharmacy staff and training provided by June 2012.
	Establish the fundamental elements of a safe and appropriate sharing of confidential patient's information. Ensure an appropriate patient and clinical framework is developed to ensure all patient information sharing systems adequately protect patient privacy. Provide effective clinical governance and stewardship of the systems and data through the establishment of a clinical governance group. Establish rules for management of confidential clinical patient data, monitoring and access.	West Coast health system agreement as to the fundamental elements of a safe shared record for patient information and implement in line with IT Health Board direction. A process to provide clinical governance and stewardship is determined and a clinical governance group is established by September 2011.
	Develop mechanisms to enable lab results to be provided to one database and accessed by relevant staff.	Coast lab results are able to be accessed through one central database by 30 June 2012.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Integration of the West Coast DHB's community nursing, allied health and mental health services with medical centres. *To provide more coordinated care for patients across primary care and community nursing services.* *To reduce barriers in access to mental health support and provide seamless care through the development of a model of care that integrates primary and secondary mental health.*	Develop an integrated model of care for community nursing, allied health and mental health with general practice. Develop a shared information system that facilitates collaborative care. Shift key aspects of service provision from a hospital-based to community-based to provide a coordinated and integrated model of care.	Integrated model of care for community nursing, allied health and mental health is developed by September 2011 (in Buller) and implemented from January 2012. More patients are able to access these services through primary care by June 2012. Patients experience a seamless and coordinated approach to services that are provided by the integrated family health system.
	Develop a fully integrated primary and secondary mental health and addiction service in each of the IFHCs as they develop. Review, refine and roll out a mental health shared care system across the district.	Integrated mental health system in Buller commenced in November 2011 and in Grey in December 2011. The patient pathway for alcohol, drug and other addictions is in place by June 2012.
Effective leadership towards the implementation of better, sooner, more convenient primary care across the West Coast.	DHB and West Coast PHO Leadership that includes forums that enable joint primary and secondary clinical leadership and decision making, planning and implementation. Provide senior executive constructive and good faith leadership and participation in these forums through the Alliance Leadership Team (ALT). Continue the development pf effective working partnerships between the West Coast PHO and WCDHB to ensure appropriate levels of stewardship. Application of the use of PHO cash reserves according to the 2011/12 operating framework and in accordance with governance best practice.	The West Coast health system clinical governance responsibility will include clinical oversight over the implementation of BSMC by September 2011. West Coast DHB and PHO display effective ownership and stewardship of BSMC through the ALT. Plan developed, in consultation and agreement with the PHO, for the use of PHO cash reserves during 2011/12 and beyond.
Improve referral and assessment services for older people and implement models of care that support people to live independently in their own homes. *To provide more timely and targeted responses to the needs of older people and enable them to maintain independence.*	Implement access to InterRAI for primary and community health and support services. Establish Carelink as the single point of entry for all assessments for support services, including long-term, short-term and mental health. Complete implementation of restorative model of home-based support services, including training for all relevant services and greater availability of allied health and rehabilitative services in the community.	Reduced unplanned acute admissions for people aged over 65. Reduction in waiting time for support services and for community allied health services. Delayed entry to ARC and extension of independent living.

3.2 Disease Prevention and Managing Long-term Conditions

Through promoting healthy lifestyles and providing people with the tools to help them improve their quality of life, we will improve the health status of our population at risk of developing long-term conditions and reduce the prevalence and impact of these conditions.

How are we improving outcomes for our population?

Smoking, inactivity, poor nutrition and rising obesity rates are also major contributors to an increase in long-term conditions. Our Tobacco Control/Smokefree Plan, Canterbury & West Coast Nutrition and Physical Activity Plan 2010-2012 and public health promotion programmes are our approach to reducing these risk factors and are focused on population and personal health initiatives that target improved nutrition and physical activity.

The Healthy West Coast Governance Group is committed to working collaboratively to implement the year two deliverables of the Keeping People Healthy work stream for the Better Sooner More Convenient Primary Care Business Case. This collective public health Group is focused on joint planning, funding and delivery of public health and health promotion services throughout the West Coast.

Why is this important?

The World Health Organisation estimated that more than 70% of health care funds are spent on long-term conditions. Reducing risk factors will assist in mitigating the predicted increase in rates of long-term conditions, and effective management of long-term conditions can make a real difference by helping to prevent crises and deterioration and enabling people to attain the highest possible quality of life.

Many long-term conditions share common risk factors and are preventable. Trends indicate the increasing rates of overweight and obesity in the West Coast population. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

Providing better help for smokers to quit is a national health target for DHBs. Both hospital and primary care services are expected to identify current smokers and then offer brief intervention advice and support for smokers to quit. The ABC programme is now embedded in our hospital and specialist service divisions and we are committed to achieving the 95% target by the end of the 2011/12 year. We will also support primary care in their efforts to develop systems to record the identification and provision of advice and support in order to meet the primary care target by the end of the same year.

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Implement smokefree programmes *To decrease tobacco use.*	Provide smokefree environments to support those making cessation attempts. Ensure tobacco retailers comply with legislation. Provide Māori smoking cessation services. Identify people's smoking status and provide smokers with brief advice on quitting smoking and the resources to support cessation using the ABC Strategy. Support secondary services to provide ABC through staff training and education and the enhanced availability of NRT for patients on the wards. Support primary care to establish systems which will allow collection of baseline data and record the provision of smoking cessation advice.	70% of year 10 students have *never* smoked. 95% of tobacco retailers identified from controlled purchase operations are complaint with legislation. 95% of hospitalised smokers will be provided with advice and help to quite by July 2012. 90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2012.

	Carry out evidenced based promotional activities to encourage the people to carry out quit attempts.	10% of the West Coast smoking population will access smoking cessation services. Aukati Kai Paipa will be provided to >65 Maori clients.
Implement the Canterbury & West Coast Nutrition & Physical Activity Plan 2010-2012 in conjunction with other agencies. *To create environments that support healthy eating, physical activity and weight reduction and empower communities to take positive action.*	Facilitate community action to empower and enable Māori and Pacific people to achieve Healthy Eating Healthy Action (HEHA) goals and increase HEHA capability. Coordinate the delivery of Māori Community Action projects and provide HEHA workforce development opportunities to Māori communities. Support joint planning and programme delivery through the Healthy West Coast Governance Group and Active West Coast Network. Develop and implement targeted communications initiatives with an overarching theme of chronic disease prevention. Support the provision of the Healthy Eating Active Living Programme for West Coast DHB staff. Provide programmes that enable older people to improve their cooking skills, nutrition knowledge and physical activity behaviours with a focus on supporting the Healthy Eating Healthy Aging programme. Develop and implement an integrated community falls prevention programme for older people.	The available funding for 2011/12 is effectively utilised via the delivery of community projects, professional development training, linkages and communication strategies as per the deliverables outlined in the NPA plan. Key health messages are provided consistently to West Coast communities with an emphasis on targeted, appropriate communications for specific populations. The number of participants in the Senior Chef nutrition and cooking skills programme. The number of people aged 75 years and over hospitalised for falls related injuries.
Reduce the harm caused by alcohol	Ensure licensed premises comply with legislation. Deliver Host Responsibility training to duty manager's courses. Carry out evidenced based promotional activities to improve people's drinking behaviour and reduce the amount of alcohol related harm. Investigate ways to reduce the harm caused by alcohol through hospital and community health settings. Investigate ways in which to reduce the harm caused in hospital and community settings through alcohol consumption by pregnant women. Investigate alcohol screening and intervention programme through hospital and community health systems.	95% of alcohol retailers are identified from controlled purchase operations as compliant with legislation. 95% of duty managers trained completes the Host Responsibility course. Programmes to reduce the harm caused by alcohol are identified in the hospital and community health settings.

3.3 Older Persons' Health Services

We will support older people to stay healthy and well and in their own homes for as long as possible, and establish a sustainable level of service provision for the future.

How are we improving outcomes for our population?

The West Coast DHB continues to work in collaboration with Canterbury DHB and the West Coast Primary Health Organisation to improve the pathways of care for older people, from primary health, to specialist secondary care, to long-stay services. Improving pathways of care helps ensure that older people get the services they need at the right time, to prevent illness and injury (e.g. falls prevention), regain functioning (e.g. inpatient and community rehabilitation) and delay the need for long-term residential care (e.g. restorative homecare and support for carers).

The priority focus for 2011/12 includes:

- Improving our services to support ageing in place;
- Developing intervention to avoid unplanned admissions to hospitals or rest homes;
- Implementing a model of home-based support services that focuses on adequately supporting older people in their own homes and preventing admission to hospital and aged residential care and that is tailored to individual need;
- Consolidating and integrating assessment processes across primary and secondary care;
- Improving access to both residential and home-based care for people with dementia;
- Improving access to a range of support services in the community, including day care and respite care; and
- More proactively managing care for older people with complex needs.

Why is this important?

West Coast's population is ageing, which is driving an increasing demand for health and support services, including residential care. Approximately half of our resources are engaged in providing health services for people over 65 years of age.

The demand placed on aged residential care (ARC) services continues to be a challenge. Our DHB has one of the highest age-standardised per capita utilisation of ARC services, due in part to the under-development of home and community based support services. West Coast DHB spends more per resident, due to a much lower proportion of people paying privately for aged care. Additionally, our aged care facilities struggle to recruit and retain adequate skilled nursing workforce.

The West Coast health system understands the value of improving our services to support aging in place and is focused on developing interventions to avoid unplanned admissions to hospitals or to rest homes.

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Improve the quality of aged residential care (ARC) services. *To ensure residents receive consistent and high quality health services.*	Support the improvement of quality of nursing and supervision in rest homes. Improve access to specialist dementia long-stay care. Improve access to supported living options.	Reduced acute admissions to rest homes. Fewer rest homes not meeting audit standards. More supported housing options and a reduction in rest home entry. The rate of older people receiving specialist dementia residential care is closer to the national average.
Improve referral and assessment services for older people and simplify referral pathways.	Implement access to InterRAI for primary and community health and support services. Establish Carelink as the single point of entry for all	Reduced unplanned acute admissions for people aged over 65.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
To provide more timely and targeted responses to the needs of older people and enable them to maintain independence.	assessments for support services, including long-term, short-term and mental health. Establish strong links between Canterbury and West Coast AT&R and Psychogeriatric services and identify patient pathways and protocols for frail older people, including stroke patients. Strengthen the links between Carelink, AT&R and primary health and set up case management for frail older people.	Reduction in waiting time for support services and for community allied health services. Greater consistency in the availability and quality of care over Canterbury and the West Coast Health of Older People services.
Improve proactive care management for older people with complex needs. *To ensure older people with complex needs and their families are actively supported and enable older people to live well at home and in their community.*	Complete implementation of restorative model of home-based support services, including training for all relevant services and greater availability of allied health and rehabilitative services in the community. Expand respite and day care services, including services for people with dementia and their carers. Strengthen services to support family and other unpaid carers, including dementia education and support. Maintain and extend illness/injury prevention initiatives such as falls prevention, nutrition and physical activity, befriending and home insulation. Maintain medication reviews for older people.	Delayed entry to ARC and extension of independent living. Unplanned acute admissions and readmissions for older people are reduced. Reduced proportion of the population aged over 75 admitted to hospital as a result of a fall. 50 pharmacist medication reviews completed for older people with complex medication and support needs. Reduced acute and avoidable admissions and likely reduced length of stay Increased use of respite care.
Improve services on discharge from hospital for older people. *To enable people to return home with the necessary treatment and support to restore functioning and maintain independence.*	Provide a broader range of appropriate multidisciplinary services to support discharge, including community allied health and step-down beds. Provide a broader range of restorative support packages to support people to regain their independence.	Reduced hospital re-admission rates for people 65+.
Development of a 65+ capability across the region	Introduce a Nurse Practitioner (NP) role for Older Persons Health/Mental Health to address needs across both older persons and mental health services	Reduction of acute and avoidable admission and facilitate reduced Length of stay. Early intervention and appropriate treatment of emerging health issues related to the older person.

3.4 Mental Health Services

We will provide an integrated, responsive system of mental health care that provides timely access to services for people with mental illness and alcohol and other drug problems.

How are we improving outcomes for our population?

Achieving the vision for meeting our community's mental health need requires mental health services to be fully integrated under a whole of system approach Consistent with our Better Sooner More Convenient Business Case we are working to integrate mental health services alongside primary care teams within Integrate Family Health Centres. This will enable teams will provide a range of services to meet the mental and physical health needs of individuals along the continuum from 'mild' to 'severe and enduring' mental illness.

Individuals with enduring illness will receive the majority of their treatment within their general practice, thereby improving continuity of care for patients. Increased coordination with specialist services, including inpatient and Psychiatric Emergency Services will support the provision of services for those with severe illness.

Why is this important?

It is estimated that 20% of the New Zealand population have a mental illness or addiction and 3% are severely affected by mental illness. It is forecast that depression will be the second leading cause of disability in New Zealand by 2020.

High access rates to specialist mental health services accompanied by clear gap in service provision for those requiring more than brief intervention counselling, but not requiring specialist services, indicates a need for a greater range of primary and community mental health services for our population.

Our ageing population continues to place an increasing demand on mental health services for people aged 65 years and over. The likelihood of mental illness (predominantly depression and anxiety disorders) increases with age, and older people have different patterns of mental illness, often accompanied by loneliness, physical frailty and co-morbid physical illness.

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Integrate primary and secondary mental health services. *To improve service responsiveness and ensure individuals have access to integrated services across the continuum of care.*	Further develop the psychiatric consultant liaison role in supporting primary practice. Review shared care pilot, refine model and processes and roll out across the West Coast. Develop closer links between mental health clinicians and mental health promoters to enhance health promotion activities.	Number of patients in shared care. Number of patients accessing extended GP consultations. Number of patients receiving community based packages of care.
Increase treatment capacity for Community specialist Youth Alcohol and Other Drugs (AOD) services. *To prevent a lifetime of adverse experiences for the individual and avoid substantial costs to the state.*	Provide early detection and treatment for alcohol and other drug problems for children and young people. Support the implementation of the Fresh Start programme (a programme led by the Ministry of Social Development that includes the ability for courts to refer youth to community based AOD services).	Number of children and youth accessing early detection and treatment for alcohol and other drug problems.
Implement National Coexisting Problems Guidelines. *To improve service responsiveness to individuals with coexisting mental health and alcohol and other drug problems.*	Implement the West Coast DHB component of the Regional Coexisting Mental Health and Addiction Problems plan.	Clinical pathways defined.

3.5 Child and Youth Health Services

We will promote and improve the health of children and young people to enable them to make healthier choices and become healthier adults.

Effective child and youth health service delivery requires close connection and coordination between all of the child-related primary, community and hospital services. There are a variety of DHB and non-DHB responsible for provide child and youth services on the West Coast and it is our intention is that a whole of system approach ensures active participation by all of these.

How are we improving outcomes for our population?

Action that reduce risky behaviours and increase protective behaviours that impact on health during infancy, childhood, adolescence and into adulthood will continue. In 2011/12 we will focus on strengthening the relationship between high need families and their general practice team and reducing the number of preventable hospital admissions for our young population.

Infants, children and young people continue to have good access to Specialist Mental Health Services and adolescents with mild to moderate mental health and alcohol and drug issues will continue to benefit from our brief intervention services. Increasing coordination between these services and increasing the treatment capacity for Community Specialist Youth AOD services are priorities for 2011/12.

Paediatric services will continue to be provided in a safe environment for children that require either hospital or community care. Increasing coordination and cooperation with Child Health Services in Canterbury DHB is a priority for the year ahead.

Why is this important?

Children and youth on the West Coast have poorer health outcomes than children and youth in other parts of New Zealand, particularly in terms of oral health. It follows that sub-optimal health in childhood can lead to poorer health outcomes in adult life and behavioural patterns established in adolescence have a significant impact on an individual's health in the long-term.

We believe that 'children are the future' and that a focus on protecting the health of West Coast children and youth and providing responsive child and youth health services will build strong foundations for future generations.

Improving utilisation of health and disability services by children and young people helps to improve long-term health and wellbeing, and diseases of the gums and teeth are amongst the most common health problems experienced by New Zealanders. West Coast children and adolescents do not have access to optimally fluoridated water and preventative dental programmes remain a key focus. We are continuing to reorient our dental services to focus on education and preventative measures, reducing the age of enrolment to the service from 24 months to 12 months, implementing topical fluoride services with a focus on those at high risk of decay, and providing individualised education to parents during their child's dental visit. The Minister has indicated an expectation that regionally the five South Island DHBs will ensure 90% of all two year olds are fully vaccinated. We support this regional target and have set a local West Coast target of 86%, which we will work closely with primary care to achieve over the coming year.[26]

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Increase coordination across child and youth health services. *To improve access and service responsiveness for children and young people*	Coordination of Specialist Child Health Services (Child Development, Paediatric and Child and Adolescent Mental Health Services) for children and young people across a range of referrals areas.	Number of children jointly assessed by the Specialist Child Health Services. Smooth transition and

[26] The 2010/11 target has been agreed on the assumption that the Ministry's assistance will help to resolve identified data and system issues which will ensure all 'fully immunised' children are counted as completed immunisations.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Ensure Children and Adolescents, transition to Adult services when Paediatric services are no longer appropriate	Continue multidisciplinary working to triage referrals and provide joint assessments and interventions. Strengthen the speciality in health services coordination function for children with developmental/behavioural concerns both pre and post diagnosis. Increase coordination with Child Health Services in Canterbury DHB.	appropriate services /supports for adolescents and young adults with Health and DSS needs. Processes are established to ensure effective transition from paediatric and youth to adult services.
Implement our Breastfeeding Action Plan. *To improve breastfeeding confidence and support mothers to care for themselves and their babies.*	Invest in services to support mothers to breastfeed, particularly in rural areas, including peer support programmes and lactation services. Support increased Lead Maternity Carer and Tamariki Ora input into educating, encouraging and supporting women to breastfeed. Strengthen stakeholder alliances and joint planning and coordination via the Breastfeeding Interest Group and through joint strategies, projects and promotion of available services. Provide and promote supportive environments that encourage women to breastfeed.	>96% of new mothers have established breastfeeding on hospital discharge. 17 volunteer mothers are engaged in Mum 4 Mum peer support training. 74% of all infants and 81% of Māori are fully or exclusively breastfed at 6 weeks. 39% of all infants and 32% of Māori infants are still fully or exclusively breastfed at 6 months.
Improved immunisation coverage *To improve immunisation coverage and reduce vaccine preventable disease on the West Coast*	Improve practice processes for immunisation, including timely recall and flexible clinic times. Provide Outreach Immunisation Services with a focus on increasing immunisation coverage by age 2 and reducing inequalities in coverage for tamariki Maori and children in NZDep 9 and 10 areas. Ensure information for parents is widely available thorough antenatal education.	88% of all West Coast Children fully vaccinated at aged two. Decreased number of cases of vaccine-preventable diseases in the community. Number of LMC, well child, and practice nurses provided with ongoing immunisation education.
Complete the implementation of the West Coast Oral Health Business Case. *To increase service delivery, reduce inequalities and prevent hospitalisations.*	Provide topical fluoride services and education for parents of preschoolers and school children most at risk of decay. Increase coordination between the Dental Service, Well Child and other health providers. Increase coordination between the dental service and local dentists treating adolescents. Implement a project focused on engaging out-of-school youth and rural schools to encourage adolescent dental treatment. Upgrade dental facilities in Greymouth include dental facilities in the development of Integrated Family Health Centre in Westport.	55% of West Coast children are caries-free (no holes or fillings) at aged five. Reduction in inequalities in between tamariki Maori and the total population dental caries free at age 5. Increase adolescent's enrolments in the Dental Services with a particular focus on out of school youth and adolescents not accessing local dentists. 80% of adolescents access oral health services.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Complete Implementation of Alternative Education Based Health Services. *To identify unmet health need and ensure that at risk adolescents receive the support and treatment they need.*	Provide regular physical health clinics in Alternative Education Facilities. Provide HEADSS[27] Assessments for adolescents enrolled in Alternative Education. Ensure coordinated follow-up of referrals resulting from the provision of health clinics and HEADSS assessment.	Percentage of adolescents enrolled in Alternative Education receiving a HEADSS Assessments. Percentage of HEADSS Assessments resulting in referral to health or support services. Percentage of referrals seen.
Improve health professional responsiveness to family violence child abuse and neglect. *To identify and reduce violence against children and young people.*	Improve coordination of response to child abuse and neglect across and between health services, Child Youth and Family and the Police. Identification, risk assessments and intervention for suspected child abuse and neglect. Provide training for health professionals in the identification of child abuse, neglect, harm and impacts of family violence. Routinely screen women aged 15+ for family violence.	Number of 'issues of concern' reported to Child Youth and Family. 50% of women accessing hospital services aged 15+ are routinely screened for family violence.

3.6 Maori Health Services

We will work closely with iwi hapu me whanau o Te Tai o Poutini and stakeholders and providers to ensure that Māori whānau receive and have access to services that will improve whānau ora

How are we improving outcomes for our population?

Increased participation of Māori in service development will further improve the cultural and clinical responsiveness of mainstream services. This includes active participation at governance and advisory levels and a focus on Māori-led service provision Maori workforce development and service development.

Our ongoing work in establishing good foundations for our younger populations will assist in improving Māori health and reducing inequalities in health outcomes. The focus will be on increasing Maori uptake of services such as breastfeeding support, immunisation programmes, Well Child/Tamariki Ora and B4 School Checks and oral health services.

Whilst it is expected that Maori will benefit from the establishment of clear patient pathways and improving the effectiveness of mainstream services, we recognise the need to target programmes and initiatives in key areas to reduce specific health inequalities.

We will have a continued commitment to the initiatives within the regional Māori Health Workforce Plan, with a particular focus on improving the capacity and capability of Maori services providers and responsiveness of mainstream services within the West Coast health system.

In addition to these objectives DHB will be work towards achieving the national Māori health objectives.

Why is this important?

Although progress has been made, Māori still, on average, have the poorest health status of any population group in New Zealand and are less likely to access mainstream health and disability services.

Consistent with national trends the Maori population on the West Coast is increasing, particularly in the Westland district. West Coast Maori have a similar deprivation profile to non-Maori on the West Coast; although West Coast Māori have overall worse health status and significantly higher all cause mortality rates. A much higher proportion of Maori on the West Coast die before the age of 65 (55%) compared with non-

[27] *Assessment of Home, Education, Activities, Drugs and Alcohol, Sexuality and Alcohol, Sexuality, Suicide*

Māori (20%). Data also indicates that West Coast Māori not only have poorer access to health services, but they have poorer outcomes following intervention.

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Improve access to care for Maori on the West Coast	Implement the Better Sooner More Convenient plan including Kaiawhina working across all health services to increase enrolments and access. Maori Health Plans are developed with each General Practice.	Kawiawhina and Kaupapa Maori Nurse job descriptions developed. Business case for the implementation of these positions developed. Pilot Kaiawhina position established in the Buller Increasing number of Māori enrolled in LTC management programme. GP Maori Health plans implemented within the practices.
Improve the effectiveness and responsiveness of mainstream services *To improve the capability of all staff to deliver appropriate health services for Māori and support Māori health as a career path*	Māori patients are considered across all patient pathways. Support mainstream staff to understand culturally appropriate approaches through the provision of Te Pikorua and Tikanga recommended Best Practice training. Work with general practice staff to develop methodologies from the Maori health plan 2011-2012 to achieve positive Maori health outcomes.	Percentage of patient pathways considering Māori patients. Number of DHB staff who have completed Te Pikorua and Tikanga recommended Best Practice training.
Reorient Māori Health Services to support mainstream services achieve national targets	Work with Māori health providers to implement a whanau-centred system based on individuals, whanau and community empowerment. Increase collaboration between Māori and mainstream providers to implement the *Better Sooner More Convenient Business case* and better meet the needs of Māori and improve Māori health.	Maori Health Provider service specifications clearly align with Better Sooner More Convenient business case and identified needs within the Maori Health Profile. Collaborative initiatives aimed at improving Maori health are initiated by the Maori Health Provider.
Improve access to care for Māori with disabilities	Improve access for Māori to the West Coast Disability Support Services. Work with the Māori health provider to improve access to services for Māori with disabilities.	Māori accessing West Coast Disability Support Services increased by 10%.
Support Māori workforce development to improve the capability of services to appropriately provide health services to Māori	Support the implementation of Kia Ora Hauora. Support Māori staff to access further training through Hauora Maori training.	Number of Māori staff accessing training through Hauora Māori training.

3.7 Cancer and Palliative Care

By working collectively to reduce risk behaviours and improving consistent access to quality services across the whole system, we can reduce the impact of cancer and improve outcomes for our population.

How are we improving outcomes for our population?

We are committed to working in a whole of system approach with the range of primary care and community providers including Non Government Organisations (NGO) to provide a seamless approach to cancer across the continuum of care. Key activities for the year ahead in reducing the incidence and impact of cancer and responding to people requiring palliative care are outlined in the table below.

Why is this important?

Cancer is the highest cause of death and a major cause of hospitalisation in New Zealand. While cancers attributable to tobacco smoking are expected to decline (with declining tobacco consumption), cancers related to poor diet, lack of physical activity and rising obesity levels are on the increase. At least one third of cancers are preventable, and the impact and death rate of cancer can be reduced through early diagnosis and treatment.

Primary cancer care services on the West Coast are provided through local general practices; the West Coast Primary Health Organisation and its 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 supported by the West Coast DHB: the National Cervical Screening Programme (NCSP) and the Breast Screen Aotearoa (BSA) through a permanent screening facility at Grey Base Hospital. With a high incidence of bowel cancer on the West 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 healthy system is keen to support these services, particularly in recognising that effective and timely quality screening programmes create improved opportunities for early diagnosis, intervention and effective treatment.

The delivery of cancer treatment and palliative care services is unlike those in more densely populated areas of New Zealand. The West Coast DHB is the principal provider of secondary cancer care services on the West Coast, with support from tertiary level services provided through Canterbury DHB. Oncology chemotherapy services and visiting specialist oncology outpatient services are provided locally by West Coast DHB; along with resident Oncology Nurse and Palliative Care Nurse Specialist services; and specialist community palliative care services provided in our region through Nurse Maude Association. For those West Coast residents who find themselves requiring end-of-life care, the West Coast is continuing development of the Liverpool Pathway of Care for the Dying within our region with support from Nurse Maude, as well as the use of individual placement programmes to best provide for the needs of the patients and their family/whanau as may be possible.

As part of our Cancer Control Strategy, the West Coast DHB funds radiotherapy oncology treatment services for its resident population through services provided by Canterbury DHB. To this end, the West Coast DHB 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 is that everyone needing radiation treatment will have this within four weeks of referral.

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Support cancer prevention and screening programmes. *To reduce the incidence and impact of cancer over time*	Provide ongoing support for the national HPV Vaccination Programme, national breast and cervical screening programmes on the West Coast. Continue local initiative of surveillance for bowel cancer among high risk groups and families via	Improved response time for those identified as having cervical, breast, bowel, and skin cancer rates. Early detection and treatment will create opportunities for

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Early detection and response to cancers.	surgical endoscopy, based on national guidelines. Implementation of the Healthy West Coast Plan (as per the Disease Prevention section).	better early diagnosis, intervention and outcome at an individual patient level. West Coast screening rates remain consistent with or above the national average. Over time, reduced cancer mortality rates.
Improve the patient pathways. *To further improve response time and reduce treatment delays.* *Better direct support to patients and their families / whānau.* *Reduce variation in the patient journey, information given and support services available, to sustain performance in a changing demand environment.*	Formally link into Canterbury DHB's value stream mapping and principles of lean thinking, to determine patient flow through Oncology Services at all points in the pathway; primary, secondary and tertiary. As part of the Better Sooner More Convenient Primary Care Business Case ensure enhanced utilisation of the Oncology Nurse and Palliative Care Nurse Specialists expertise in the community. Improve patient linkage to providers and NGO support services (as appropriate) from first contact with Oncology Services. Increased use of high-definition video-conferencing links between West Coast DHB facilities, tertiary centre specialists to support multi-disciplinary meetings, clinical reviews for cancer patients, and increased staff education opportunities to improve knowledge and assist better outcomes for patients with cancer and their families/whanau. Close monitoring of oncology, chemotherapy and radiotherapy service provision to ensure people are treated according to their need within the national waiting times guidelines.	Standardisation of models of care and patient treatment pathways. Improved continuity of care for patients, and reduce duplication and possible complications. Reduced wait times for cancer treatments in line with clinical guidelines. Patients requiring priority radiation treatment will have this within four weeks. Formal adoption of the Canterbury DHB oncology and palliative care services guidelines and medication treatment protocols.
Support palliative care services. *To improve quality of life for cancer patients needing palliative care and their families/whānau.* *Standardisation of care for palliative patients in line with international best practice guidelines.* *Improved integration between DHB palliative care services and community and NGO services*	Complete implementation of the Liverpool Care Pathway (LCP) pilot project across the West Coast and completion of the rollout by June 2012. Introduction of high-definition video-conferencing links between West Coast DHB facilities, tertiary centre specialists and Nurse Maude services in Canterbury, to support ongoing development of the specialist community palliative physician support network; to improve clinical assessment options; and to improve educational training and development opportunities for personnel involved in the delivery of cancer and palliative care services across the system.	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. Improved back-up and support for palliative care.
Align strategic activity across the South Island region. *To make the most effective use of resources and workforce and ensure equity of access.*	Support SCN to develop consistent standards and documented referral pathways for major tumour streams. Support SCN in conjunction with our Local Cancer Team to identify local and regional issues and solutions, to reduce inequalities in service delivery for our populations.	Standardisation of models of care and patient treatment pathways. Reduced variation in treatment between South Island DHBs.

3.8 Diabetes & Cardiovascular Disease

We will deliver responsive diabetes and Cardiovascular Disease (CVD) services for West Coast residents as part of a seamless, integrated service that provides expertise supported by clinical governance and evidence-based best practice. Through a collaborative, integrated and consistent approach to prevention, early intervention and management, we will reduce the onset and impact of these diseases.

How are we improving outcomes for our population?

Improving diabetes and cardiovascular services is a national health target, with the aims being to increase the number of people who have diabetes being detected and followed up to have their diabetes well managed; and an increase the percentage of the eligible adult population having their CVD risk assessed in primary care (currently measured by the number of people having had a fasting lipid/glucose test in the past five years).

We are committed to working in a whole of system approach with the range of health promotion services, primary care and community providers – as this is where the greatest gains in reducing the impact and incidence of diabetes and CVD will be achieved. Key activities for the year ahead in meeting these objectives for our population are outlined in the table below

Why is this important?

Diabetes is estimated to cause around 1,200 deaths per year in New Zealand and can lead to blindness, amputation, heart disease and kidney failure. The impact of diabetes in terms of illness and the cost to the health sector is significant, and the prevalence of diabetes is increasing at an estimated 4-5% a year, particularly among Māori and Pacific people, who are disproportionately represented in diabetes statistics with rates around three times higher than other New Zealanders. On the West Coast, there is also a sizable disparity between Maori and non-Maori populations in key statistical indicators of diabetes. Type II diabetes, most frequently diagnosed in adults and now being diagnosed in children and young people, is strongly linked to poor nutrition and other lifestyle factors and is therefore amenable to prevention.

CVD includes coronary heart disease, circulation, stroke and other diseases of the heart. It is a leading cause of death of hospitalisation for West Coast (excluding pregnancy and childbirth). Older people, Māori and Pacific people have higher rates of CVD, which is expected to increase as our population ages. As with diabetes, CVD is also strongly influenced by environmental and lifestyle influences and by risk behaviours such as poor nutrition, lack of physical activity and tobacco smoking. Increasing rates of CVD will result in greater demand for more specialised care and treatment for heart attack, stroke, heart failure and other circulatory diseases.

The West Coast DHB has in place a Long-Term Conditions Management Strategy to overarch our strategies of leading for outcomes for improved management and best practice principles for chronic condition services, including diabetes and CVD. The Strategy recognises the commonality and many inter-related issues that cut across these various chronic conditions, and that 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 (LDT) and the Local Heart and Respiratory Team. This work will continue and will be further built upon during 2011/12 through the implementation of *Better Sooner More Convenient* programme strategies under the clinical guidance of the West Coast Alliance Leadership Team

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Improve the identification and clinical management of people 'at risk' of CVD and diabetes *To improve access to appropriate intervention and support improved self*	Ongoing support for the West Coast Long Term Conditions Management Strategy Programme. Implementation of the Healthy West Coast Plan (as per the Disease Prevention section) with a	90% of the eligible population as measured in each of the population groups Maori, Other and Total Population will have had their CVD risk assessed in

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
management of CVD and diabetes *Increase uptake of free annual diabetes checks* *Over time, an increase in the percentage of the eligible adult population will have had their CVD risk assessed in the last five years groups (as defined and monitored quarterly by the Ministry of Health).* *Over time, 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.*	focus on smoking reduction, improved nutrition and increased physical activity. Key diabetes and CVD target indicator data is actively monitored, with information regularly shared and used to inform planning initiatives and targeting of service provider activities to best effect. Diabetes Health promotion campaign during the month of November 2011 involving Primary practices, Pharmacies and DHB clinical nurse specialist. Delivery of Men's Health forums with the focus on cardiovascular risk screening during the year.	the last five years – via lipid/fasting glucose test. 70% percent of all people with diagnosed diabetes as measured in each of the population groups Maori, Other and Total Population, will attend free annual checks 80% percent of all people with diabetes as measured in each of the population groups Maori, Other and Total Population will have satisfactory or better diabetes management (defined by having HBA1c level of equal to or less than 8% at their free annual diabetes check. 90% of all people as measured in each of the population groups Maori, Other and Total Population, who have had their free annual diabetes check have had retinal screening or an ophthalmologist examination within the last two years of the check.
Ensure people receive the right care in the right setting. *To support improved access to resources, information and support to enable people to modify lifestyles, self manage their condition and stay well.* *Closer alignment and integration of primary and secondary services involved in the detection, follow-up and management of diabetes, CVD, and other long term conditions.* *Improved Information Technology interface and two-way data sharing between primary and secondary services*	Continued design and implementation of the clinical/patient education and tools for self management of long-term conditions. Provide general practitioners with direct access to specialist advice, clinical nurse specialists, other appropriate health professionals and diagnostic test results. Alignment of diabetes nurse educator and cardiac nurse specialist resources with West Coast PHO and general practice services through the Better Sooner More Convenient programme by 30 June 2012. Kaupapa Maori Nurses work collaboratively with general practice and secondary care services to help improve outcomes for Māori with diabetes and CVD. Priority focus on high needs patients by general practice through the PHO long term conditions programme.	Reduction in CVD readmission rates over time. Better utilisation and sharing of available resources to reduce costs from unnecessary duplication and ordering of diagnostic tests. A smooth pathway of care and advice for patients. Faster and more convenient access for clinicians to latest patient records and relevant test results to best inform patient care.
Support Rehabilitation Programmes. *To reduce the likelihood of a subsequent CVD event and to support people to optimise recovery.* *Better outcomes for treatment and*	Referral of people to local cardiac and stroke follow-up and rehabilitation programmes after acute events. Closer collaboration with Canterbury DHB services to improve support and access to a range of specialised rehabilitation and support services for people who need more advanced care.	100% of people are offered access to cardiac rehabilitation programmes after an acute event. Development of specific mid-to longer-term plan for further service improvement for CVD and stroke services within the

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
rehabilitation for individual patients.	Completion of an 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. Complete planning for future directions in service delivery for CVD and Stroke services; particularly in regard to being able to provide a CVD and Stroke centres of excellence within the local context.	overarching West Coast Long Term Conditions Management Strategy is completed.

3.9 Elective Services

Elective Services are non-urgent procedures and operations that improve people's quality of life. We will make the best use of the resources we have available, provide equity of access and certainty of care and keep waiting times under six months.

How are we improving outcomes for our population?

West Coast retains an active commitment to the Collective South Island Elective Services Plan with regards to maintaining effective and efficient elective services to meet the needs of all South Islanders. As part of this commitment, the West Coast DHB will deliver 1592 elective operations in 2011/12.

Our priorities for elective services in the 2011/12 year are:

- Maintain compliance with Elective Service Patient Flow Indicators (ESPIs) which measure clarity, timeliness and fairness, and a commitment to manage all elective patients consistently and to provide treatment within six months of referral
- 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;
- Deliver key elective procedures at a nationally appropriate Standardised Intervention Rates (SIR); and
- Identify ways of improving the patient flow for those accessing those services through continuous quality improvement and ongoing patient pathway mapping.

Why is this important?

Timely access to elective surgery is important to reduce pain and discomfort to patients, and to reduce the risk of patient's condition deteriorating due to prolonged waiting times. This is particularly important for our population as it ages over time, which will increase the demand for elective surgical procedures.

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

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Meet national elective service priority targets *To deliver the elective surgical*	Active monitoring of the West Coast DHB's Provider Arm outpatient and inpatient waiting lists.	1592 elective surgical services discharges are delivered for our resident population.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
discharges planned in 2011/12. *Ensure that West Coast residents have at least equitable access to elective services as people in other districts.* *Ensure all elective patients are managed consistently and provided treatment within six months of referral.* *Maintain compliance with Elective Service Patient Flow Indicators (ESPIs) 1 to 8.*	Monthly monitoring of progress for a "whole of population" view of all elective surgery and ambulatory initiative funding and volumes delivered for West Coast residents, in concert with Elective Service Team of the Ministry of Health. Monitor Standardised Intervention Rates of the target elective surgery and key marker procedures to ensure that these are being delivered at national appropriate levels.	Standardised Intervention Rates (SIR) of target key indicator elective surgical services are provided in line with national levels. Patients will be seen and treated within referral and management waiting time guidelines. Decisions to treat patients are made on the basis of assigned priority. Reduced waiting times for people requiring surgery and first specialist assessment at outpatients.
Maintain and improving current production capability. *To assist delivery of the elective surgical discharges planned in 2011/12.*	Process improvement through clinical leadership in a review of service provision to identify "how we can best take care of the patients here locally on the West Coast",Explore options to increase use of non-contact First Specialist Assessments in concert with primary care to assist rapid assessment and referral of patients to treatment lists. Partnering with General Practitioners in Westport and Reefton, as well as with tertiary specialists in Canterbury DHB, to help reduce the need for patient transfers between hospital facilities. Utilise other DHB and private resources if needed to deliver care to our residents where this is the best option for the patient's care.	Hospital outputs are delivered to within 5% of overall plan. Improved utilisation of theatre sessions and outpatient clinics. Continued compliance with ESPI and surgical delivery targets. Increased volume of elective services delivered in aggregate across the South Island. Over time, improving efficiency to ensure better, sooner, more convenient services within the available resources.
Identify additional and future service capacity required. *To enable the DHB to meet future needs within available resources.*	Clinical involvement in theatre management, booking and production planning process. Clinical sustainability and equitable access between DHB populations reviewed regionally.	Actual elective surgical and outpatient volumes are delivered to within 5% of overall plan.
Continually Improve Performance. *To improve service quality and capacity within our hospital and specialist services and reduce waiting times for our population.*	Implement lean thinking principles and processes to improve patient flow and reduce waiting times. Establish results-based performance information and benchmarks to monitor improvements in patient outcomes. Adopt a suite of nationally agreed theatre and ward utilisation measures to monitor and improve overall performance. Ensure, wherever clinically appropriate, day surgery and day of surgery admissions are normal practice.	More than 60% of elective and arranged surgeries (raw rate) are day surgeries. More than 64% of elective and arranged surgeries are day of surgery admissions. Improved utilisation of theatre sessions to greater than 75%. Elective and arranged inpatient average length of stay maintained at <3.9 days. Acute inpatient length of stay maintained at 3.93 days. 30 day mortality rates maintained at <1.95%.

3.10 Making the System More Efficient

We will reduce variation, duplication and waste from the system to improve service quality, increase capacity and delivery timely interventions that will improve the health of our population.

How are we improving outcomes for our population?

We recognise that clinical leadership is central to improving service quality and patient safety. We have adopted the *Improving the Patient Journey Programme* pioneered by Canterbury DHB. Improving the Patient Journey is a continuous quality improvement programme underpinned by our Quality Strategic Plan and an investment in constraint theory, 'lean thinking', variation management and production planning processes.

Improving the Patient Journey needs to work at two levels through our organisation:

- Strategic operational level changes focused on identifying system-wide constraints to achieving outcomes such as: variation in clinical practice and variation of patient flow caused by individual behaviours, and increasing or shifting capacity to the most appropriate location or the most appropriate provider; and
- Worksite change (frontline staff driven), focused on standardising worksites to reduce clinical risk and reducing wasted staff time to increase direct care time with patients.

We are engaging with our clinical workforce to identifying improvement opportunities and driving more effective use of resources by reducing waste and variation in our system. Through this we intend to shift the focus from financial discussions to understanding the blockages in the system and improving capacity without additional investment.

During 2011/12 the focus making the system more efficient for:

- ***The patient*** – including clinical leadership, seamless transition through comprehensive pathways of care, keeping people well to keep them out of the health system, right care, at the right place, at the right time;
- ***The health workforce*** – including develop a workforce that is fit for task and purpose and making the West Coast an attractive place to work;
- ***Financial sustainability*** – including living within our means, performance improvement actions; and
- ***The system*** – including doing the basics well with a focus on all decisions and activity adding value, procurement and support services (e.g. facilities maintenance); the importance of relationships within a whole of system approach (private and public providers and the impact of non-health services agencies e.g. territorial local authorities, Air New Zealand and Telecom).

Over the next year we will work closely to improve the way we measure service delivery across the whole of the West Coast to support momentum and ensure that improved outcomes for our population are recognised.

The tools of lean thinking are being introduced in our new way of working, and place greater emphasis on patient 'value-streams' - looking at the shared services within the system (such as radiology, laboratories, e.g. mental health, older persons health, paediatrics) and how these can better support clinical services and improve the patient journey. Through this work, we intend to identify opportunities to improve clinical and financial sustainability.

Clinical Leadership, by clinicians and others, is a central component of that system, characterised by the ability to implement, and followership.

Clinical governance is the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. Clinical leadership is a central component of that system. The following areas will be developed by the nursing, allied health and medical senior clinical leadership during the 2011-12 year:

- Clinical Governance: Lead the development of an integrated whole of system clinical governance framework for the West Coast that collaborates with Canterbury DHB clinical governance
- Good clinical leadership:

- Develops staff competency
- Supports services to achieve best practice
- Leads staff in reflecting the West Coast DHB vision and values
- Influences and interprets regional and national strategy/trends in good health care
- Strengthens clinical input in West Coast DHB Board and Advisory Committees in their decision making processes
- Strengthens clinical input into the planning and funding of future service provision within the West Coast health system, between Canterbury and West Coast DHBs and into the South Island as a whole.
- Support s professional accountability
- Helps to align clinical and financial incentives
- Ensures quality improvement and safe patient care
- Accepts accountability for the successful delivery of the West Coast DHBs strategic objectives
- Supports the development and maintenance of a proactive research culture.

- Workforce development and utilisation
  - Lead the development of the West Coast as a Rural Learning Centre
  - Facilitate professional development
  - Facilitate Recruitment and Retention of appropriately skilled clinical staff
- Quality Improvement and Safe Patient Care
  - Lead activities to promote and maintain clinical quality and safety
  - Monitor clinical and professional standards and the completion of actions from audits
  - Support the development of a Quality Team within the West Coast Health system
- Accept responsibility for delivery of West Coast DHB strategic goals
- Develop/maintain a proactive research culture

Why is this important?

The increasing burden of long-term conditions, the changing demographics of our population and increase in the population of older people requires a completely different approach to health care intervention.

To ensure we achieve clinical and financial sustainable, and continue to provide good quality health care to our population, we need to make significant changes to the way we work.

Our significant challenges are integrating services across the whole system to share capacity and capability and reducing variation, duplication and waste across the whole system. Variation in the patient care has a major impact on quality, time and satisfaction both for patients and for our health workforce. Our emphasis needs to be on improving quality by reducing variation in service, practice and process to achieve a more focused approach to managing patient outcomes in an efficient and effective manner.

The West Coast health system recognises that 90% of patient care happens on a daily basis in primary and community settings. We believe that there are considerable opportunities for improving patient pathways in primary and community settings and we expect that the implementation of Better Sooner More Convenient Primary Care will address many of these. In addition we are focusing on key aspects of patient care in secondary settings that will create better linkages between primary and secondary settings and improve patient pathways.

OBJECTIVE	**ACTION**	**EVIDENCE**
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Communicate our vision. *To engage our workforce and whole community in the challenges and in supporting the transformation of our health system.*	Complete public consultation and community engagement in the planning and delivery of Integrated Family Health Systems across the district as a whole. Share our achievements and transformations with interest groups and our community and other stakeholders to provide a greater understanding of the challenges in delivering effective rural health	Stakeholders are engaged and supported with balanced and objective information to assist them in understanding the opportunities, problems, alternatives and solutions. Increased response rate to DHB consultation processes.

	care and how we can meet these challenges. Increase opportunities across the health system to actively engage in the challenges and participate in 'making it better'.	Increased participation in Xcelr8 and Collabor8 programmes.
Improve capacity to deliver within our means. *To improve access, quality and service responsiveness and to enable the DHB to meet future needs within available resources.*	Engage services in production planning and the development of whole of DHB plans and volume schedules. Support weekly production planning to deliver to capacity and to proactively respond to changes in demand. Utilise valumetric principles to apply lean thinking to the theatre environment and support surgical teams to establish performance benchmarks to improve start times and patient turnaround and increase available theatre time for additional elective procedures. Standardise theatre equipment sets to reduce theatre delays, decrease clinical risk and streamline sterile service processes.	Hospital outputs are delivered within 5% of overall plan. 1,592 elective services discharges delivered. Improved Elective Services Standardised Intervention Rates. Improved utilisation of theatres.
Improve patient pathways. *To reduce waste and variation in service delivery and improve the quality of patient care by adopting a clinically led and standardised approach.*	Review the referral process for First Clinical Assessment (FSA) with a view to reducing obstacles to specialist assessment, diagnosis and treatment. Support a culture that ensures, where clinically appropriate, day surgery and day of surgery admissions (DOSA) are normal practice.	Improved coordination and follow up between primary and secondary service referrals. Increase in day of surgery admissions.
Doing the basics well.	Implement the Trendcare nurse rostering system to enable the effective allocation of nursing resource to meet ward occupancy/patient demand. Develop a locum management plan to reduce the West Coast health system reliance on locums.	Trendcare nursing roster system is in place. Reduction in locum use.
Workforce	Implement effective performance management systems. Develop and implement organisational culture surveys. Continue to collaborate with Canterbury DHB around shared models of service delivery, including joint clinical appointments in key areas across the districts.	Performance management systems are in place for *all* clinical staff. Baseline organisational culture information is established. Increase in the number of joint clinical appointments between Canterbury and West Coast DHBs.
Finance To ensure that the West Coast DHB operates in a strong financial control environment. That the West Coast DHB operates within the agreed funding levels for 2011/12.	Maintain and improve where necessary the appropriate internal controls. A risk based internal audit approach with vigorous follow-up audit recommendations. Develop a culture based on good financial management principles and value for money decisions. To implement a sustainable pathways to a break-even position.	Compliance to policy and procedures. Reduction in identified financial risk. A reduction in operating deficit by $7.2M to $4.5M in 2011/12 (as part of movement towards zero deficit by 2013/14.

Achieving Effective Clinical Leadership

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident?*
Strong clinical governance in the planning and delivery of services across the West Coast DHB	Develop an integrated whole of system clinical governance framework for the West Coast.	A documented clinical governance framework for the West Coast Health system will be in place by December 2011. Staff survey results indicate improved participation in decision making; clinical leadership and clinical quality initiatives.
Provision of clinical leadership across nursing, allied health and medical staff	Strengthen senior clinical contribution into the West Coast DHB and Advisory committees. Strengthen clinical inputs into the planning of future services provision across the West Coast health system.	Regular attendance and reporting from Clinical Leaders group to Board and Advisory Committee meetings. Future health service models of care are developed by the doctors, nurses and allied health professionals who provide the service.
Increased professional development opportunities for clinical staff to increase staff retention	Develop the West Coast as a Rural Learning Centre. Facilitate increased opportunities for the professional development of clinical staff. Work with Human Resources and Primary Care recruitment and retention coordinator to focus on activities that enhance recruitment and retention.	Rural learning centre meets its work plan. Number of professional development workshops/ sessions provided. Increased staff retention. Workforce plan developed that will outline actions to retain and attract clinical staff and report against these – reduced staff turnover and reduced time to recruit into vacancies.
Quality improvement and safe patient care	Lead activities to promote and maintain clinical quality and safety, including supporting the development of the Xcelr8 Alumni. Monitor clinical and professional standards and ensure actions from audits are completed. Develop a Quality Team for the West Coast Healthy System.	Quarterly meetings of Xcelr8 alumni. 95% of audit actions completed. Reduced mortality as measured by standardised mortality ratio. Quality team established by September 2011.

FORECAST SERVICE PERFORMANCE

Module 4

Measuring Our Performance

Over the long term a key role of the health sector is to make positive changes in the health status of the population. Many of the determinants of health are beyond the DHB's influence– Government priorities and national policy and decision-making have a part to play in making health gains. However, as the major funder and provider of the majority of health and disability services delivered on the West Coast, the decisions we make have a significant impact on our population, and, if coordinated and planned correctly, will improve the efficiency and effectiveness of the whole West Coast health system.

Understanding the dynamics of our population and the drivers of demand is fundamental when determining which services will be delivered to our population and at which level. Just as fundamental is our ability to demonstrate and assess whether the services we are purchasing and providing are making a measurable difference in the health and wellbeing of our population.

One of the functions of this document is to show how the DHB will evaluate the effectiveness of the decisions we make on behalf of our population. We do this is by providing a forecast of the services (outputs) that we will fund and provide in 2011/12 (using associated performance measures and targets) and then reporting against these in our end-of-year Annual Report.[28]

In order to present a representative picture of performance, our outputs have been aggregated into four '*output* classes' that are applicable to all DHBs, and are a logical fit with the specific stages of the continuum care. The four output classes are:

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

Identifying appropriate output measures in each output class is difficult. There are more services being delivered across the health system than can be reasonably addressed in one document. The DHB also cannot not simply measure the pure outputs '*volumes*'; the number of services delivered or the number of people who receive a service is often less important than whether '*the right person*' or '*enough*' of the right people received the service, or whether the service was delivered '*at the right time*'.

We have chosen to present a mix of measures focused on four key elements of performance: *Quantity or 'Volume'* (to demonstrate capacity), *Quality* (to demonstrate effectiveness) and *Timeliness* and *Coverage* (to demonstrate reach and access). Wherever possible, we have included past years' baseline data to support evaluation of our performance at the end of the year, and national averages to give context in terms of what we are trying to achieve. [29]

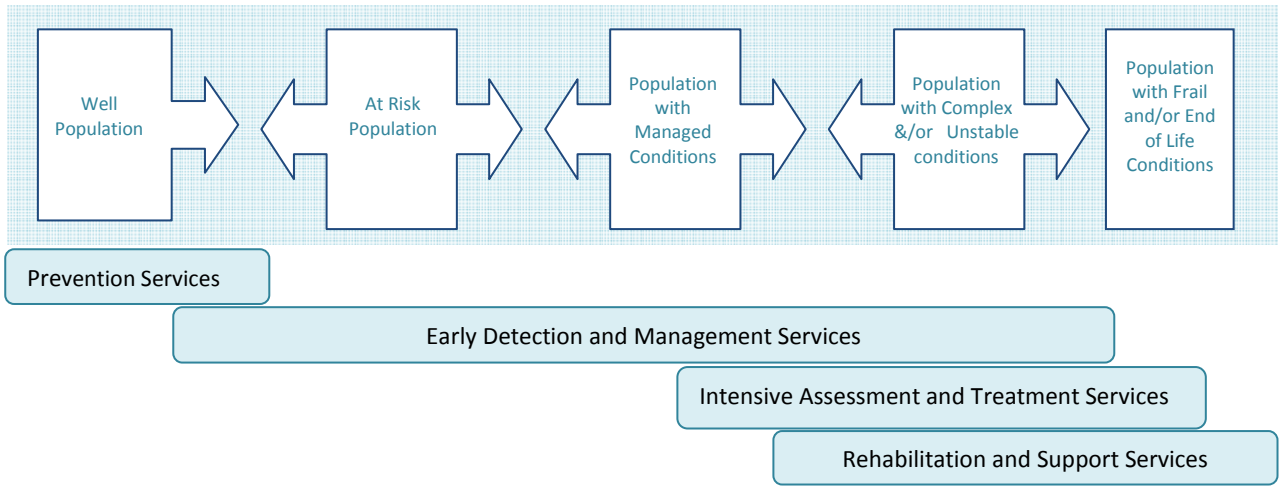
The output measures used reflect a reasonable picture of activity throughout the whole system. They measure those activities with the potential to make the greatest contribution to health and wellbeing in the shorter term, and to the health outcomes we are seeking over the longer term.

Over time, we anticipate it will be possible to use this output class framework to demonstrate changes in allocation of resources and activity from one end of the continuum of care to the other, and our progress in achieving the desired health outcomes for our populations.

[28] *DHB performance is also measured by the Ministry of Health through quarterly reporting against the Performance Monitoring Framework (refer to Appendix 4). A copy of previous years' Annual Reports can be found on the DHB website www.westcoastdhb.health.nz..*

[29] *Some measures being developed relate to new services for which there is no baseline data. A number also relate to West Coast-specific services for which there is no national comparison or national average available. These instances have been noted.*

Figure 4: Scope of DHB Operations – Output Classes against the Continuum of Care



In setting performance targets we have considered the changing demographics within our population, increasing demand for health services and the assumption that increases in funding growth will be limited.

West Coast's focus is on the development of innovative service delivery models that enable us to treat more people within the constraints of current resources. Targets tend to reflect the objective of maintaining performance levels against changing population demographics including an increasingly ageing population and to demonstrate increased productivity and capacity.

We are also focused on the provision of services closer to people's own homes. Performance targets that demonstrate growth in service activity or the establishment of new services therefore tend to be based in primary and community settings, or support increased integration of services.

The targets also reflect our commitment to reducing inequalities between population groups and hence some measures appropriately reflect a specific focus on high need groups.

4.1 Prevention Services

Output Class Description

Prevention health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and population-based immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

These services are the domain of many organisations across the region including: the Ministry of Health; Community and Public Health (the public health unit of the Canterbury DHB, which also provides services for the West Coast and South Canterbury districts); primary care and general practice; as well as private and non-government organisations; and local and regional government. Services are provided with a mix of public and private funding.

Why is this Output Class significant for the DHB?

By improving environments and raising awareness, these services support people to reduce the major risk factors that contribute to the most prevalent long-term conditions and enable people to avoid, delay or reduce the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effectiveness when the aims are achieved.

High need and at risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

These services also ensure that threats to the health of the community are prevented from developing or spreading and that services are prepared for emergency events – such as pandemics or earthquakes.

Description of the sub-sets of services that make up this output class

- *Health Promotion and Education Services* – are services delivered so that people are more informed about health matters and are supported to be healthy. Success begins with awareness and engagement and may be reinforced by programmes that support people to maintain wellness or assist them to change behaviours, indicated by rates of positive or negative behaviours (such as smoking rates).
- *Statutory and Regulatory Services* – are services which sustainably manage environmental elements in a way that supports people and communities to make healthier choices and maintain their health and safety. These services are frequently delivered by public health units and include effective quarantine and bio-security procedures, proper management of hazardous substances, assurance of safe drinking water, and compliance monitoring with liquor licensing and smoke environment legislation.
- *Population Based Screening Services* – are services mostly funded and provided through the National Screening Unit that help to identify people at risk of illness and pick up conditions earlier including breast screening, cervical cancer screening, newborn hearing testing, antenatal HIV screening, etc. The DHB's role is to encourage uptake, as indicated by high coverage rates. [30]
- *Immunisation Services* – are services, which prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated and successful service.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years the West Coast DHB will seek to fund or provide outputs which will make a positive impact on the health and wellbeing of the West Coast population. The Quantity, Quality, Timeliness and Coverage of those outputs will be measured using the following output performance measures:

Performance Measure	Notes	Actual 2009/10	Target 2011/12	Current National Average
Health Promotion and Education Services				
The provision of Mum 4 Mum peer support training to volunteer mothers	V [31]	17	17	-
The proportion of women breastfeeding on discharge from hospital	Q [32]	96%	96%	-
Lactation support and specialist advice consults provided in community settings	V	152	152	-
The proportion of Maori infants exclusively and fully breastfed at 6 weeks	Q [32]	75%	81%	59.2
Help and smoking cessation advice provided to hospitalised smokers	C	55%	Reach 95%	25%
Help and smoking cessation advice provided to smokers identified in primary care	C	Not available	90%	-
Enrolments in the Aukati Kai Paipa smoking cessation programme	V	119	100	-
The percentage of year 10 students who have never smoked	Q	61%	70%	61%
Total West Coast population enrolments to all smoking cessation services	Q[33]	1282	1200	-
The provision of community-based Cooking Skills to Life Skills and Senior Chef courses	C[30]	4	5	-

[30] The purpose of screening and immunisation services is to maximise the reach to the greatest proportion of the identified population. Hence coverage (both in volume and proportion) provide a proxy measure of the quality of the service but increased the numbers engaged and reached by the programmes.

[31] *Mum4Mum training supports social change by allowing the DHB to significantly increase its capacity to deliver key messages through informal contact facilitated by appropriately trained volunteer mothers. The measure is the number of Mothers trained.*

[32] *The proportion of women/children breastfeeding is seen as a measure of service quality – demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period.*

[33] *The HPS framework is based on activities within the school setting that can impact on health; the definition includes Active Schools and National Health Foundation Schools. Priority schools are low decile, rural and/or have a high proportion of Maori and/or Pacific children.*

The number of people provided with Green Prescriptions	V	243	250	-
The percentage of women accessing hospital services 15+ screened for family violence	C	30%	50%	
Statutory and Regulatory Services				
Compliant tobacco retailers identified from controlled purchase operations	Q	New	95%	
Compliant alcohol retailers identified from controlled purchase operations	Q	56.5%[34]	95%	
Population Based Screening Services				
Women screened for HIV as part of routine antenatal blood tests	C	67%	75%	-
Infants screened for neonatal hearing loss	V	93%	95%	-
Children provided with a B4 School Screening Health Check	C[35]	120%	85%	%
Young people in alternative education provided with a HEADSSS assessment	C [36]	n/a	75%	n/a
Eligible population (20-69) provided with cervical cancer screens	C [37]	76%	75%	75%
Eligible population (45-69) provided with breast screen examinations	C [37]	76%	75%	58%
Immunisation Services				
Children fully immunised at age two	C	85%	88%	87%
Eligible young women engaged in the HPV vaccination programme.	C [38]			36.5%
Flu vaccinations provided to people aged over 65.	V [39]	56%	65%	66
The proportion of the population, deemed high need, under 65+ receiving a flu vaccination.	C	60%	65%	64%
Reduction in the number of cases of (per 1000,000) pertusis diseases in the community	Q	89	85	31.7

4.2 Early Detection and Management Services

Output Class Description

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

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori and Pacific health services, pharmacy services, community radiology and diagnostic services and child oral health and dental services.

A proportion of these services are demand driven, such as pharmaceuticals and diagnostics, and services are provided with a mix of public and private funding and may include co-payments for general practice services and some high-cost drugs.

Why is this Output Class significant for the DHB?

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular

[34] *This figure is low due to the CPO carried out at the Wildfoods 2010 Festival 9 out of 11 attempts*
[35] *More checks were completed on 4 year olds than were expected to be in the 4 year old population.*
[36] *A HEADSSS assessment covers Home environment, Education/employment; eating and exercise, Activities and peer relationships; Drugs, cigarettes and alcohol; Sexuality; Suicide, depression, mood screen; Safety; and Spirituality – provided to year nine students attending decile 1 or 2 secondary schools, students attending teen parent units; and students attending alternative education facilities.*
[37] *The breast and cervical screening standards are based on national targets set for DHBs. Canterbury aims to continue to successfully deliver at a level above these national targets and the national average.*
[38] *The population engaged measures eligible young women who have been provided with Dose 1. The national average based on the 'major' six DHBs.*
[39] *This volume target is based on the number of vaccination required to achieve 75% coverage of the population and assumes an enrolled population of 68,000. The volume is important for this age group as the population growth means an increased volume must be delivered year on year to maintain the same percentage coverage for the over 65 population.*

disease, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, for example, Māori and Pacific people and those on lower incomes. The prevalence of long-term conditions also increases with age. The increased in demand for services that comes with the increased prevalence of long-term conditions is coupled with an increasing demand for acute and urgent care services that in general, is growing at a faster rate than the growth in our population.

Early detection and management services result in earlier identification of risk and health issues, providing an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. They also help to reduce the burden of long-term conditions by supporting people to better manage their conditions and avoid complications, acute illness and crises. These services also promote regular connection with health services, supporting people to maintain good health through earlier diagnosis and treatment and reducing complex intervention and unnecessary hospital admissions.

Providing flexible, responsive and needs-based services in the community, without the need for a hospital appointment, will reduce the overall rate of hospital admissions, particularly acute and unplanned admissions and will have a major impact on the sustainability of hospital and specialist services by freeing up specialist services for more complex and planned interventions and reducing the diversion of critical resources into managing acute demand.

Government expects that primary care will make a larger contribution to the health system as a point of continuity and improve access to a wider range of publicly funded services closer to home. The integration of services to meet Government expectations for '*better, sooner, more convenient health services*' provides a unique opportunity to reduce duplication, waste and inefficiencies across the health system by ensuring the right person has access to the right services, in the right place and at the right time – irrespective of provider.

This output class includes the following sub-set

- *Primary and Community Health Care Services* – are services offered in local community settings by primary care team including general practitioners (GPs), registered nurses, nurse practitioners and allied health practitioners and other primary health care professionals aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.
- *Pharmacy Services* – are services aligned to requirements of the Pharmaceutical Schedule including provision and dispensing of medicines. Pharmaceuticals are demand driven, and we are likely to see an increased dispensing of pharmaceutical items as more people engage with health services.
- *Community Referred Tests and Diagnostic Services* – are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. These services are demand driven and are likely to increase as more people engage with health services and respond to health promotion messages about early diagnosis. To improve performance, we will target an increase in the number of community referred radiological images as an indication of improved primary care access to diagnostics, without the need for a hospital appointment.
- *Long-term Conditions Programmes* – are services, initiated and managed in primary care, and targeted at people with high health need due to long-term conditions such as diabetes, CVD or mental illness and provide identification, intervention and management to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring for improvement or deterioration and clinical outcomes that demonstrate successful management of conditions. A focus on early intervention strategies and delivery of services closer to home will mean additional services will be available in the community and without the need for a specialist or hospital appointment.
- *Oral Health Services* – are services provided to assist people in maintaining healthy teeth and oral tissues and are provided by approved registered oral health professionals. High enrolments are indicative of engagement, while more timely examination and treatment of children indicates a well functioning and efficient service.

Quality improvement initiatives in 2011/12 will continue to focus on the implementation work of integrating primary and secondary community health services in a way that will result in better, sooner and more convenient services for patients, delivered from integrated family health centre models.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years the West Coast DHB will seek to fund or provide outputs which will make a positive impact on the health and wellbeing of the West Coast population. The Quantity, Quality, Timeliness and Coverage of those outputs will be measured using the following output performance measures:

Performance Measure	Notes	Actual 2009/10	Target 2011/12	Current National Average
Primary and Community Health Care Services				
Population enrolled with the West Coast Primary Health Organisation	C [40]	97%	>95%	
Proportion of the Maori population enrolled with the West Coast Primary Health Organisation	C	89%	>95%	-
Number of patients receiving extended primary care consultations for mental health conditions	V	237	300	-
Provision of brief intervention counselling provided in Primary Care				
- ages 0-19 years	V	59	80	-
- ages 20+ years		234	200	-
Number of District Nursing visit (personal care services)	V	20346	23000	-
Reduction in rate of preventable (ambulatory sensitive) hospital admissions for Māori across all ages.	0-74 years	80	<95	-
Oral Health Services				
Percentage of preschool children enrolled in DHB funded dental service	C	71%	75%	-
Children enrolled in dental services, examined according to planned recall	T	96%	98%	-
Decayed, missing or filled permanent teeth rate at Year 8	V	1.32	1.12	1.36
Increase adolescent enrolments in the community dental services	V	29	250	-
The percentage of adolescents accessing oral health services	C[41]	76%	80%	-
Long-term Conditions Programmes				
Eligible population (35-74) provided with CVD risk assessments	C[42]	71.8%	90%	75.3%
Provision of diabetes annual reviews (in all population groups)	C[43]	49.2%	70%	n/a
People with diagnosed diabetes (in all population groups) who have satisfactory or better diabetes management	C[44]	80.6%	80%	n/a
Proportion of people (in all population groups) with diabetes accessing biennial retinal screening.	C[45]	72.6%	90%	n/a
Pharmacy Services				
Dispensed pharmaceutical items per enrolled population	C[46]	86%	100%	88%
Number of Pharmacist Medication review s completed for older people with complex needs	V[47]	New measure	50	-

[40] The national target for PHO enrolments is 95%, and the aim is to continue to achieve above this level.
[41] Half of 14 years olds and 18 year olds
[42] Percentage of eligible people aged 35 – 74 years (in all populations groups) who have had their CVD risk assessed via lipid/fasting glucose test.
[43] Percentage of people with diagnosed diabetes (in all population groups) who have had their free annual checks [Note actual 2009/10 for Maori 47.1%; Other 49.7%]
[44] Percentage of people with diagnosed diabetes (in all population groups) who have satisfactory or better diabetes management (defined by having HBA1c level of equal to or less than 8% at their free annual diabetes check) [Note Actual for 2009/10 for Maori 67.0%; Other 82.0%]
[45] Percentages of all 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. [Note Actual for 2009/10 Maori 66.7%; Other 73.2%]
[46] This indicator measurers how actual pharmaceutical test expenditure for a DHB region relates to 'expected expenditure', this is based on historical utilization and national average expenditure.
[47] This measure refers to programmes, which began in hospital settings in 2009 and primary settings in 2010; no baseline data prior to 2009/10.

Community Referred Tests and Diagnostic Services

Number of community referred Radiological tests to Grey Hospital	V	5232	5000	n/a
Percentage of GP referred laboratory expenditure (actual against expected)	C [48]	44%	100%	80%
Percentage of referred pharmacy expenditure (actual against expected)	C[47]	86%	100%	88%

4.3 Intensive Assessment and Treatment Services

Output Class Description

Intensive assessment and treatment services are services that are usually complex and provided by specialists and other health care professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services and emergency or urgent care services.

An owner of hospital and specialist services the DHB provides an extensive range of intensive treatment and specialist services to its population. The DHB also funds some intensive assessment and treatment services for its population that are provided by other DHBs, private hospitals or private providers. A proportion of these services are driven by demand, such as acute and maternity services. However, others are planned services for which provision is determined by capacity and resource; clinical triage, national service coverage agreements and treatment thresholds determine access to these services.

Why is this Output Class significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (i.e. removal of an obstructed gallbladder so that the patients does not have repeat attacks of abdominal pain/colic, increased risk of cancer and/or infection) or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services can also support improvements across the whole system, enabling people to be supported in the community with confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury and provide improved outcomes for people in our services.

Government has set clear expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care being delivered. The changes being made to meet Government expectations are providing unique opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Description of the sub-sets of services that make up this output class

Specialist Mental Health Services - are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation as well as crisis response when needed, as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness. The West Coast DHB continues to provide mental health services to more than 3% of the West Coast population. This includes access to specialist mental health, alcohol and other drug addiction services and services for children and youth and Kaupapa Maori Mental Health Services. West Coast DHB works collaboratively with regional speciality services to provide community-based services for eating disorders, forensic and AOD specialities. Inpatient services for these specialities along with mothers and babies, and child and adolescent specialities are also provided regionally. Acute mental health services are provided in the community through the West Coast DHB's TACT team, with preventative primary mental health services provided through the West Coast Primary Health Organisation, in order to help manage the number of patients requiring acute assessment through early intervention

Elective Services – are services for people who do not need immediate hospital treatment and are 'booked' services. This

[48] *These indicators respectively measure how actual pharmaceutical and laboratory expenditure for a DHB region relates to 'expected expenditure' as part of the PHO performance programme, This is based on historical utilisation and national tests. It is expected that these are matched.*

includes elective surgery, but also non-medical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing increasing needs and matching commitments to capacity. Secondary Health Services at the West Coast DHB covers the provision of both medical and surgical services from locations at Westport, Reefton, Greymouth and Hokitika. Inpatient services are principally provided from Grey Base Hospital, with outpatient services provided in all locations. The West Coast DHB provides a range of elective outpatient medical and surgical outpatient services, as well as non-admitted minor operation, colonoscopy, gastroscopy, urological cystoscopy, and gynaecology services.

The West Coast DHB is committed to meeting the government's expectations around elective services, particularly the key principles underlying the electives system:

- **clarity** – where patients know whether or not they will receive publicly funded services
- **timeliness** – where services can be delivered within the available capacity, patients receive them in a timely manner; and
- **fairness** – ensuring that the resources available are directed to those most in need

In managing Elective Services, our DHB is committed to ensuring compliance with required standards on ESPIs timeframes for provision of assessment and treatment; ensuring that the hospital(s) provide the amount of elective operations, procedures, assessments and interventions rate agreed to by this Annual Plan; ensure that patients are assessed and prioritised for surgery on a consistent basis, and that they then receive surgery according to the priority they were given. West Coast DHB is committed to manage all elective patients consistently and to provide treatment within six months of referral. As part of our commitment too, West Coast DHB will look to maintain provision of 1592 elective operations in 2011/12 as our proportional share of delivering the Minister's expectations of an overall 4000 procedures 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.

Having only a restricted capacity to undertake surgical procedures at Grey Base Hospital due to limited numbers of key specialist and operating theatre staff, acute surgery will always take precedence and may impact on the flow of elective work that can be undertaken on the West Coast.

Acute Services – are services for illnesses that have an abrupt onset, are often of short duration and rapidly progressive, for which the need for care is urgent (they may or may not lead to a hospital admission). Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Performance against clinical triage guidelines is used to demonstrate the capacity and responsiveness of the system. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of service provision. Acute inpatient services provided at Grey Base Hospital include general medical, paediatric medical, surgical, orthopaedic, gynaecology, obstetric and mental health beds. In addition, acute General Practice-level medical beds are provided at Buller and at Reefton hospitals. Emergency Department (ED) services are provided at Grey Base Hospital, Buller and Reefton Health Services.

Shorter stays in ED - Shorter Stays in ED is one of six national health targets. West Coast DHB is committed to maintaining achievement of the Shorter Stays in ED target and has a number of strategies in place to ensure current systems can cope within increasing demand of patients presenting to ED. These include assessment of triage 5 patients and making appointments to GPs for these lower needs presentations; regular weekly Monday meetings with practice managers to discuss individual management plans for patients who repeatedly present at ED; close collaboration with the wards to avoid bottle-neck of patients requiring further secondary level care; and the engagement of additional doctors at the ED in Greymouth.

Maternity Services – are services provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.

Specialist Assessment, Treatment and Rehabilitation Services – are services provided to people who experience disability or age-related disorders to restore people's functional ability and enable them to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. An increase in the rate of people discharged home with support, rather than to residential care or hospital environment (where appropriate) will be indicative of success and of the responsiveness of services.

What change will we make in the coming year?

Among the key areas of focus in the coming year that will help drive continuity and our goals for service improvement in these intensive assessment and treatment services will be:

- The implementation of the integrated family health centre model of service delivery to develop alternative delivery options and closer linkages across the primary/ secondary interface and
- Ongoing implementation of the recommendations contained in the 2009 LECG report on long term sustainability
- Closer clinical collaboration with other DHBs – particularly Canterbury DHB
- Working collaboratively with other DHBs to share resources to help mitigate risks to continuity of services.

- Ongoing commitment to identify ways of improving the patient flow for those accessing those services
- Throughout this process, continue to maintain an excellent standard of specialist assessment, treatment and rehabilitation care for the resident population

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years the West Coast DHB will seek to fund or provide outputs which will make a positive impact on the health and wellbeing of the West Coast population. The Quantity, Quality, Timeliness and Coverage of those outputs will be measured using the following output performance measures:

Performance Measure	Notes	Actual 2009/10	Target 2011/12	Current National Average
Specialist Services Mental Health Services				
Acute inpatient mental health services provided (bed days)	V [49]	1704	1700	
Mental health inpatient services for people aged over 65 (bed days)	mhis02	823	800	
Young people (0-19) accessing specialist mental health services	C	4.8%	3.8%	2.42%
Adults (20-64) accessing specialist mental health services	C	4.9%	3.4%	3.07%
Older adults (65+) accessing specialist mental health services	C[50]	2.56%	2.5%	2%
Long-term mental health clients (20-64) with current Relapse Prevention Plans	Q	97%	98%	89%
Average length of acute inpatient stay (KPI 8)	Q[51]	13 days	<15 days-	-
Performance Measure	Notes	Actual 2009/10	Target 2011/12	Current National Average
28-day acute inpatient readmission rate (KPI 12)	C[52]	8%	<5	17%
Pre-admission community care (KPI 18)	C[53]	74%	75%	64%
Post-discharge community care (KPI 19)	C[54]	84%	90%	54%

[49] *Purchase Unit Code MHC29.*

[50] *PP6 The average number of people domiciled in the DHB region seen per year aged 65+*

[51] *The total number of in-scope acute inpatient bed nights for referral closures in the reference period. Number of in-scope overnight referral closures from the mental health service organisations acute mental health and addiction service inpatient unit occurring during the reference period. Excludes transfers, deaths etc. Excludes leave days*

[52] *Total Number of in-scope overnight referral closures by the participants acute mental health and addiction services in patient unit during the reference period that are followed by a re-admission within 28 days to the organisations acute metal health and addiction services in patient units. Total of number in-scope overnight referral closures by the participants acute mental health and addiction services in patient unit during the reference period excludes transfers, deaths etc. Re admission from same day events excluded*

[53] *Number of in-scope acute inpatient referrals to the mental health and addiction service organisation's acute inpatient teams, occurring during the reference period for which a face to face community mental health contact was recorded in the seven days immediately preceding that admission by community care services managed by the organisation. Total number of in-scope acute inpatient referrals.*[53] *The total number of in-scope acute inpatient bed nights for referral closures in the reference period. Number of in-scope overnight referral closures from the mental health service organisations acute mental health and addiction service inpatient unit occurring during the reference period. Service user participation in contact is required. Contact must occur in the seven days prior to admission but not on the day of admission Excludes transfers, deaths etc. Excludes leave days*

[54] *The number of overnight referral closures from Acute in-scope acute inpatient units referrals to the organisations community catchment the mental health and addiction service organisation's acute inpatient teams, occurring during the reference period for which a face to face community mental health contact with client participation was recorded in the seven days immediately following preceding that discharge admission by community care services managed by the organisation. Total number of overnight acute in patient referral closures to the organisations community catchment area in-scope acute inpatient referrals occurring during the reference period. Service user participation in the contact is required. Contact must occur in the seven days post discharge prior to admission but not on the same day of discharge admission*

Elective Services

Elective surgical discharges (raw volume)	V [55]	1,578	1,592	-
Other Elective surgical service discharges provided	V [56]	90	158	-
Surgical electives as a percentage of national case-weight delivery.	Q	1.14%	1.1%	-
Standardised intervention rates per 10,000 for key indicator elective services are provided in line with national levels (* Targets are subject to annual review and update by the Ministry of Health)				
1. Overall Intervention	C	378.57	308	301.36
2. Major Joints	C	28.84	21.0	20.02
3. Cataracts	C	38.1	27.0	30.9
4. Cardiac Procedures	C	2.72	6.5	6.1
Maintain compliance with Elective Service Patient Flow Indicators (ESPIs) 1 to 8 (national targets indicated below)				
ESPI 1 – >90%	V	100%	92.0%	-
ESPI 2 – <1.5%	V	0.74%	0%	-
ESPI 3 – <5%	V	0.01%	4.0%	-
ESPI 4 – <5%	V	0.0%	0.0%	-
ESPI 5 – <4%	V	1.53%	0%	-
ESPI 6 – <15%	V	0.%	12.0%	-
ESPI 7 – <5%	V	1.73%	4.0%	-
ESPI 8 – >90%	V	100%	92%	-
Elective and arranged inpatient indirectly standardised length of stay (days) [OS3]	Q [38]	3.68	< 3.9	4.09
Theatre utilisation (OS5)	Q	83.9%	85%	-
Elective and Arranged indirectly standardised day of surgery rate [OS6]	Q [57]	60%	64%	62%
Elective and arranged day of surgery admission rates for case mix included discharges [OS7]	Q [58]	68.8%	75%	79.7%
Specialist Medical and Surgical outpatient "Patient did not attend" Rates	Q	9.9%	< 6%	n/a
First Specialist Assessments (FSA) provided on the West Coast	V	5357	5663	n/a
Acute Services				
Acute inpatient indirectly standardised length of stay (days) [OS4]	Q [59]	3.67	< 3.9	4.09
Standardised acute readmission rate [OS8]	Q [54]	7.64	< 8.21	9.95
Total presentations at Emergency Departments [Buller, Reefton and Grey]	V [60]	15,068	15,376	-
Proportion of people assessed, treated or discharged from ED in under six hours	T [61]	99.3%	>95%	86.8%
Proportion of people triaged in ED and seen within clinical guidelines	Q [62]	80.5%	>85%	-

[55] The elective surgical discharge volumes exclude elective cardiology and dental and are based on the national health target.
[56] This represents elective surgical discharges [Cardiology and dental] that are not included as part of the heal target volumes.
[57] The definitions for the OS3, OS6 and OS7 measures are based on national indicators of performance set for DHBs. Data for 2009/10 Actual is given is per results for the 12 months ending 30 September 2010. This has been updated and recommended for use by the Ministry of health for Target setting for 2011.2012.
[58] The definitions for the OS3, OS6 and OS7 measures are based on national indicators of performance set for DHBs. Data for 2009/10 Actual is given is per results for the 12 months ending 30 September 2010. This has been updated and recommended for use by the Ministry of health for Target setting for 2011.2012.
[59] The definitions for the OS4 and OS8 measures are based on national indicators of performance set for DHBs. Data for 2009/10 Actual is given is per results for the 12 months ending 30 September 2010. This has been updated and recommended for use by the Ministry of health for Target setting for 2011.2012
[60] Baseline 2009/10: 14,390
[61] This measure is based on the national health target of 95% and is based on a sub-set of the total population - young people 0-15 years of age. The aim is to maintain performance above the health target in Canterbury.

Reduction in inappropriate triage level five presentations at Emergency Department at Grey Base Hospital [over three years]	V[63]	3938	2943	-
GP practices utilising telephone triage systems outside of business hours	C	BSMC	100%	-
Percentage of patients waiting less than 4 weeks between FSA and start of radiation oncology treatment	T[64]	NA	100%	n/a
Provision of chemotherapy treatment within 4 weeks of decision to treat	T	100%	100%	-
Maternity Services				
Deliveries in West Coast DHB facilities	V	307	350	-
Proportion of total deliveries, made in Primary Birthing Units	Q	8.8%	10%	%
Specialist obstetric consultations provided	V	492	560	-
Assessment, Treatment and Rehabilitation Services				
Provision of inpatient AT&R services [bed days]	V	2753	2152	-
Provision of outpatient and domiciliary AT&R services	V	2009	1900	-
Proportion of AT&R inpatients discharged home (as opposed to residential care or other inpatient services)	Q	61.7%	>60%	-
Number of inpatient falls causing serious harm for people in AT&R service as a percentage of bed days	Q [65]	0.12%	<,0.5%	-
Number of inpatient falls (all falls) for people in AT&R service as a percentage of bed days	Q	0.81%	<1.0%	-
Number of patient falls as a percentage of bed days for Dementia and Psychogeriatric AT&R service	Q	1.61%	<1.5%	

4.4 Rehabilitation and Support Services

Output Class Description

Rehabilitation and support services provide people with the support and assistance they need to maintain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered following a 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) Services and include: domestic support, personal care, community nursing and community services provided in people's own homes and places of residence and also long and short-term residential care, respite and day services. Services are provided mostly for older people, mental health clients and for personal health clients with complex health conditions.

Respite care, carer support, day care and information services are essential supports for families and others who care for those with long-term disabling conditions, and help to reduce or delay entry to long-term residential care.

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

Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

Why is this Output Class significant for the DHB?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered

[62] *This measures percentage of people presenting at emergency departments in triage categories 1-3 who are seen within Triage time-guidelines [Triage 1 - seen immediately on presentation; Triage 2 - seen within ten minutes; Triage 3 – seen within thirty minutes of presentation]*

[63] *Target for 2009/10 had been 3312*

[64] *Target for this measure was 6-weeks in 2009/2010. The Actual result for the year was 93%. The new four week target commenced with effect from 1 December 2010; hence no comparative percentage is available for the 2009/10 year, nor for current national average.*

[65] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the consequence or outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood and this measure cover SAC 1&2.*

to provide a much higher quality of life, as a result of staying active and positively connected to their communities. People whose needs are adequately met will also be less dependent on hospital and residential services and less likely to experience acute illness, crisis or deterioration of their conditions. Even when returning to, or maintaining, full health is not possible, timely access to responsive support services enables people to maximise function with the greatest independence.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. Effective and responsive delivery of support services will help to reduce demand for acute services and improve access to other services and interventions. It will also free up resources for investment into early intervention, health promotion and prevention services that will help people stay healthier for longer.

While living in Aged Residential Care is appropriate for a small proportion of our population, West Coast rates are above national averages. Living in Aged Residential Care has also been associated with a more rapid functional decline than 'ageing in place' and is a more expensive option. Resources could be better spent providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

West Coast is planning the introduction of a 'restorative' approach to home support and will implement the regional service specification for home-based support services by introducing individual packages of care that better meet people's needs. This may include complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area. West Coast already uses the InterRAI standard assessment tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Description of the sub-sets of services that make up this output class

Needs Assessment and Services Coordination Services – are services that determine a person's eligibility and need for publicly funded support services and then assist the person to determine the best mix of supports based on their strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The number of assessments completed is indicative of access and responsiveness.

Palliative Care Services – are services that improve the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports. The DHB will target an increase in the number of sites that support the "Liverpool Care of the Dying" pathway as this reflects best-practice care.

Rehabilitation Services – are services that restore or maximise people's health or functional ability following a health related event such as: mental health community support, physical or occupation therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral to these services.

Home-Based Support Services – are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. Examples include domestic support, personal care and community nursing services. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against a decreased or delayed entry into residential or hospital services.

Residential Care Services – are services provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised rest home-level bed days alongside an increase in the number of home-based support service hours is seen as indicative of more people being successfully supported to continue living at home.

Respite Day and Carer Support Services – are services providing people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health needs can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature and may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.

Key focus in the coming year

- Implementation of the restorative model of homecare during 2011/12
- Extension of existing day care services to include services for people with dementia
- The development and implementation of a planned respite care service (including dementia respite) that is sustainable for a small dispersed population.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years we will fund and provide the following outputs which will make a positive impact on the health and

wellbeing of the Canterbury population. The Quantity (Volume), Timeliness, Coverage and Service Quality of those outputs will be measured using the following output performance measures:

Performance Measure	Notes	Actual 2009/10	Target 2011/12	Current National Average
Needs Assessment and Services Coordination Services				
Needs assessments provided to people with age related disability	V	313	500	-
Proportion of needs assessments completed using InterRAI assessment tool	Q	100%	100%	-
Mental heath needs assessments provided	V	102	150	n/a
Palliative Care Services				
Palliative packages of care in place provide appropriate care to meet individual clinical needs	C	100%	100%	-
ARC facilities trained to provide the Liverpool Care Pathway option to residents	Q [66]	Starts 2010/11	Phase 1 complete	-
People in ARC services being supported by the Liverpool Care Pathway	V	New service	No base as to set target at this stage	-
Rehabilitation Services				
People having had an acute event referred to stroke rehabilitation services	C [67]	Unknown	At least 69%	-
People having had an acute event referred to cardiac rehabilitation services	C [67]	unknown	At least 30%	-
Provision of integrated falls prevention services for older people in community	V [68]	unknown	50 available	-
Provision of Mental Health Activity and Living skills and Education and Employment Support services	V	70	150	- -
Clients accessing Education and Employment support services supported into full or part time employment	Q	57%	65%	-
Home-Based Support Services				
Provision of home help services (hours) – long term only	V	64170	65000	-
Provision of home-based personal care services (hours) – long term only	V	22950	23000	-
Provision of community-based district nursing services (contacts) – long term only	V	4590	4000	-
Meals on wheels services provided	V	43763	40500	-
Provision of Mental Health Support Work Services (clients)	V	96	100	-
Residential Care Services				
Unplanned (issues-based) audits undertaken on ARC facilities	Q	0	0	
Provision of (subsidised) long-term residential mental health services (bed days)	V	6935	8030	-
Number of people residing in permanent rest home level care as a % of the 75+ population	Q	6.1%	5.6% (regional average)	-
Respite and Day Services				
Provision of mental health respite beds for planned respite -(bed days)	V	280 bed days	365 bed days	-
Provision of aged care respite beds	V	1068 bed days	1500 bed days	
Provision of day services	V	410 days	500 days	

[66] *The Liverpool Care Pathway is an international programme adopted nationally, and is currently being implemented on the West Coast from February 2010. The programme begins with case ovulation and training and is planned to be implemented in all aged residential care facilities over time.*

4.5 Summary of Revenue and Expenses by Output Classes

This table summarises the revenue and expenditure for the four output classes listed above.

Statement of budgeted financial performance by output class

For the period 01 July 2011 to 30 June 2012

	Prevention	Early Detection and Management	Intensive Assessment & Treatment	Support & Rehabilitation	Total
Revenue					
Crown sourced funding - devolved	3,128	37,177	58,407	19,798	**118,510**
Crown sourced funding - non devolved contracts	439	493	512	286	**1,730**
Other Revenue	134	6,656	2,343	1,504	**10,637**
IDF Inflow	-	-	1,884	-	**1,884**
Interest	5	60	86	29	**180**
Total Revenue	**3,705**	**44,387**	**63,231**	**21,617**	**132,941**
Expenditure					
Payment to External Providers	818	20,135	1,861	8,161	**30,975**
IDF Outflows	-	-	16,210	1,300	**17,510**
Cost of Clinical Services	1,207	22,372	39,043	12,193	**74,815**
Allocated non-health related costs	167	3,319	8,577	2,079	**14,141**
Total Expenditure	**2,192**	**45,826**	**65,690**	**23,732**	**137,441**
Surplus/ (deficit) by output class	**1,513**	**(1,439)**	**(2,460)**	**(2,114)**	**(4,500)**

STEWARDSHIP

Module 5

5.1 Organisational Strength

Decision Making Principles

The DHB has an established prioritisation framework and a set of prioritisation principles. Based on best practice and consistent with our strategic direction, these principles assist us in making decisions about which competing services or interventions to fund, with the limited resources available.

The prioritisation principles that guide our decision making are:

- *Effectiveness:* Services should be effective, producing more of the outcomes desired, such as a reduction in pain, maintenance of daily activity, greater independence and the prevention of premature death.
- *Equity:* Services should reduce significant inequalities in the health and independence of our population.
- *Value for Money:* Our population should receive the greatest possible value (in terms of effectiveness and equity) from public spending on health and disability services.
- *Whānau Ora:* Services should have a positive impact on the holistic health and wellbeing of the person and their family and whānau. This has particular significance for Māori, but relevance for all cultures.
- *Acceptability:* Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.
- *Ability to implement:* Our ability to implement the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

The prioritisation principles are also applied when we review existing health investments and provide the opportunity to reallocate funding, on the basis of evidence, to services that are more effective in improving health outcomes and reducing inequalities. We do not see these prioritisation principles as the only criteria in the decision making process; however, starting with a base of analysis against the principles improves the quality of decision making.

Māori Participation in Decision Making

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

The DHB 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

Consumer and Community Input

The West Coast health system has links with a number of consumer and community reference groups, advisory groups and working parties. Their advice and input assists in developing DHB plans and strategies to improve the delivery of health and disability services and to reduce inequalities in health status within our population.

Equal Employment Opportunities

We support the principles of equal employment opportunity as outlined in West Coast DHB's Equal Employment Opportunity Procedure whereby staff are employed or promoted on the basis of merit, all staff

are valued for their different skills and experiences and to maintain client centred focus diversity amongst staff is encouraged.

5.2 Our Collaborative Approach

Working collaboratively with others, both across the sector and with other health and social services providers is integral to increasing our capacity and capability to respond to the changing needs of our population and to achieving the goals set out in this Plan.

We are committed to sharing resources with regional DHBs as well as collaborating with the Ministry, DHBNZ, and other health and social service providers to build capacity in the health sector. We are also committed to working with external agencies and providers of other types of services to influence the social determinants that are external to the health system but contribute to improving health outcomes for our population.

NATIONAL COLLABORATION

At a national level we work with the education, social development and justice sectors to improve outcomes for the West Coast population through training, health, nutrition, physical activity, alcohol and other drug and mental health initiatives; crossing sectors in an effort to meet shared goals.

Similarly we are committed to a number of national programmes which will improve the health of the community, including B4 School Checks, Newborn Hearing Screening, the Human Papillomo A Virus Immunisation Programme.

The DHB will also participate in the national work streams being developed and lead by the National Health Board, National Health IT Board, Health Quality and Safety Commission and Health Workforce New Zealand. By clearly articulating strategic direction, these work streams will support common platforms, reduce duplication and variation and minimise inequalities between DHBs- all of which will free-up resources and create additional capacity in the health sector.

The West Coast specific actions in relation to national work streams can be found earlier in this Stewardship Section or through the Actions and Activity sections of this document.

REGIONAL COLLABORATION

The five South Island DHBs have an agreed process for collective decision making to support regional health service planning. The framework provides direction for the type and level of service 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. Through our joint South Island Shared Services Agency, the South Island DHBs have produced a South Island Health Services Plan and commenced the development of an alliance with clear governance, decision-making processes and accountabilities.

Regional clinical networks are helping to drive regional planning and secure the clinical sustainability of South Island services these include the: Southern Cancer Network, Regional Mental Health Network, Regional Health of Older Persons Network, Paediatric Surgery, Paediatric Oncology, Paediatric Neurology and Neonatal Services Networks, Brain Injury Rehab Networks, Neurosurgeon Network and Anaesthesia Networks. We already recognise the importance of clinical leadership in the transformation of Canterbury's health system and recognise the increase capacity that can be gained with the support of those on the front-line of service delivery. A number of these clinical networks will be supported to move to alliance models in the coming year and extend membership across the sector, bringing in colleagues from primary and community services to further expand their experience and expertise.

This step-up to regional alliance models will better support clinical networks, provide clear long-term signals around regional service planning and capital investment and improve the use of shared resources - increasing service capacity and sustainability across the South Island.

5.3 Workforce Development

Over the next twelve months we will invest in targeted health specific people practices that include work to improve our leadership and management capability, and the implementation of core systems in performance management and recruitment as well as learning and development. The support, expertise and know-how for this work will be supported through the collaborative human resource arrangement with Canterbury DHB. It is expected that these initiatives when combined with other planned initiatives will have a profound effect on how we perform.

Recruitment and Retention

Our plan to strategically address recruitment is one that we are confident will be beneficial as we continue in our efforts to make our DHB an attractive one to locate to professionally and personally. The following are the key elements of that plan:

- **Technology** – the development of a database to attract and retain talent that focuses on current vacancies and future workforce trends and developments;
- **Strategic Sourcing** – the implementation of a centralised and specialised recruitment team that is based in Christchurch for both West Coast and Canterbury DHBs that will allow us to focus on strategic recruitment, rolling campaigns and so on;
- **Candidate Care Programme** – this programme focuses on the candidate experience, putting this first; as well as being clear about our employee value proposition and our employer branding;
- **Settlement Programme** – this programme focuses on how we introduce new employees to the organisation and the region, takes into account personal and family life as well as work life;
- **Employee Referral Programme** – this programme utilises the power of personal networks that may include a structured reward programme;
- **Alumni** – the development and implementation of a structured programme that allows us to keep track of our staff and a means for attracting back in the future;
- **Collaboration** – a strategic approach to recruitment aligned with work that is occurring within the West Coast Health System (and Canterbury Health System), South Island and nationally.

Learning and Development

We will continue to invest in the development of our staff but in addition will align our work, in partnership with HWFNZ, through the rural learning centre with national and regional initiatives that will be available to us through the proposed South Island Regional Training Hub. Besides participating in our own right through our expertise in rural health development we will leverage clinical skill development opportunities and management/leadership development that will become available to us.

Over- reliance on temporary/locum cover

We have an over-reliance on locum cover that has a significant impact on costs and continuity of care. Our plan is to reduce these costs by addressing terms and conditions of locum employment through national forums and to work with the Canterbury DHB to have more senior medical staff working on the West Coast regularly. We believe that care will be improved and costs reduced through these initiatives.

5.4 Quality Improvement and Patient Safety

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

The West Coast DHB 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 DHB Quality Improvement Programme).

The West Coast DHB will work constructively with the National Health Board and the Healthy Quality and Safety Commission to make purchasing, productivity and quality improvements.

5.5 Information Services and Technology

To provide accurate and timely patient-focused information to better inform clinical decision-making.

Why is this important?

The ability to provide a smooth patient journey through the health system requires integrated information systems and the sharing of patient-focused information between primary and secondary providers. This

information also needs to be accurate, timely and available at the point of care, to allow the best decisions to be made about patient care.

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

The National Health IT Board has highlighted five priorities within phase one of the National Health IT Plan. The South Island Regional IT Plan addresses all five priorities and a governance model is being setup to enable implementation of the various aspects of the plan. The most important aspect for the West Coast DHB is to enable seamless regional collaboration and transparent access to patient clinical notes. This will benefit patients by enabling better utilisation of clinical staff time, improved standardisation of care, and reduced risk of missing important information that is siloed in other systems. West Coast DHB will achieve these benefits when it moves to a regional Clinical Information System that is hosted by Canterbury DHB using the Orion product called Concerto. Part of this change will also enable a sub-regional laboratory and PACS repository which will ultimately provide one source for all diagnostic tests and clinical information within the region.

The West Coast DHB will establish the necessary fundamentals to build individual and community for a shared confidential patient information system.

West Coast DHB is also working with Canterbury DHB and Pegasus health around the Electronic Referrals Management System that was developed as part of the Canterbury Clinical Initiative. This will enable an e-Referral solution for West Coast primary health care, by providing a streamlined referral process that is aligned to the Health Pathways developed by Canterbury DHB. The secondary care part of the solution for West Coast DHB will be part of a wider rollout when a solution is implemented within the Concerto product hosted by Canterbury DHB. Similarly with discharge Summaries, as updates to the standards are applied to the Concerto system, West Coast DHB will also benefit from these. Both of these solutions will benefit patient care by providing more timely and accurate access to information between primary and secondary care, allowing clinical staff to make better decisions on treatment options.

Alignment and centralisation of Patient Administration Systems is part of the Regional Health IT Plan. By aligning administration processes it will reduce overheads and allow more consistent processes within the region. This alignment will occur at other DHB's initially as West Coast DHB already has an implementation of the preferred Patient Administration System, which will be moved to a regional implementation in the future.

West Coast DHB and the West Coast PHO are working collaboratively on a number of primary care initiatives as part of the Better Sooner More Convenient business case. One aspect of this is implementing a shared care portal that will allow clinical staff to access certain parts of the primary care record. For instance this will allow emergency staff when presented with an unconscious patient to determine what medications they are on and provide appropriate treatment. Likewise the same portal will be expanded to allow patients to access their own patient record from home via the internet and potentially book into clinics remotely. Another key focus is standardising Medtech32 as the primary care system for the West Coast area by working with the only independent practice not on Medtech and enabling them to migrate. This is key foundation to achieving a number of other primary care initiatives across the West Coast, such as e-Referrals, clinician portal, patient portal and global medications list for hospital and community pharmacy.

Other more sub-regional priorities are the increased demand for clinical networking, education, support, more timely patient care and reduced travel time. West Coast DHB is deploying a number of video conferencing devices throughout the West Coast to meet these needs, including a mobile clinical cart for paediatric and maternity services. In addition, West Coast DHB is using Telehealth to conduct remote outpatient clinics at Buller hospital on a separate video conferencing system. This system will merged to the dominant system in use by the DHB which will allow further use of Telehealth clinics to be run between DHBs.

West Coast DHB has two legacy systems which will no longer be supported as of July 2011 including the pharmacy and financial based systems. West Coast will be moving to a regional or nationally hosted finance system and will work with Canterbury DHB on a regional implementation of a pharmacy system. The changes with the finance systems are expected to bring process efficiencies to West Coast DHB, and the new pharmacy system will provide a platform capable of an ePrescribing in the future.

There are a number of office systems which need updating at West Coast DHB which is causing collaborative issues with other DHB's and the Ministry of Health. These systems such as email, office and desktop functions will be aligned on a regional basis as appropriate either by hosting arrangement, leveraged licensing deals or standardisation of systems. A key enabler for this to occur is the newly formed regional infrastructure team led by Otago DHB.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
Regional Clinical Information System *To provide improved clinical access to patient information, lower clinical risk, improve efficiency and* patient *outcomes.*	Migrate from iSOFT HealthViews onto Orion Concerto hosted by Canterbury DHB. Migrate from Integrated Software Solutions Omniclient to Delphic Multi-lab, hosted by Canterbury Health Laboratories. Realign existing Intelerad PACS and Comrad Radiology Information System to regional implementations hosted by Canterbury DHB.	Reduction in the number of silos containing patient information. Reduced number of logins for clinical staff.
eReferrals system for primary care *To provide streamlined referral process aligned with health pathways, reduction in rejected referrals and improved quality of information enabling better patient outcomes.*	Implement the Electronic Referrals Management System developed by Pegasus Health and Canterbury Clinical Initiative for West Coast primary care.	Number of electronic referrals. Reduction in number of rejected referrals due to incomplete information.
Regional pharmacy system *To provide a supported system after June 2012, and one that allows West Coast DHB to meet the ePharmacy standard in the future.*	Migrate legacy iSOFT Windose system to ePharmacy system hosted by Canterbury DHB.	By having a supported system after June 2012.
Regional (or national) Finance system *To provide a supported system after June 2012, and enable efficiency gains by reducing unnecessary duplication in processes.*	Migrate legacy IBA Financial system to Oracle hosted either national or regionally.	By having a supported system after June 2012.
Telehealth *To improve clinical networking, education, support, more timely patient care and reduced travel time.*	Implement more Video Conferencing equipment in the West Coast. Integrate or replace the Cisco Health Presence system so it is compatible with the Vivid videoconferencing network. Integrate the Mobile Surgical Services video conferencing system so it is on the same network as Vivid.	Number of video conferencing systems. Number of separate video conferencing networks. Number of outpatient clinics and patients seen via Telehealth. Number of hours spent on video conferencing.
Regional email system *To enable improved collaboration between DHB's by using a single email/calendaring system and mail gateway.*	Migrate to a regional Exchange implementation Migrate to a regional mail gateway	Number of users on a regional exchange system. Number of mail gateways in region.
Shared Care Portal *To improve secure access to vital clinical information for clinical staff and empower patients by providing access to their own health information.*	Implement the Medtech Manage My Health clinical and patient portal. Migrate the remaining Macintosh based Profile practice onto Medtech32.	Number of times ED staff access medications list. Number of patients accessing portal remotely. Number of on-line bookings. Number of practices on Medtech32.
Update basic infrastructure to improve collaboration	Update to Microsoft office 2007.	Number of Microsoft Office 2007 users.

OBJECTIVE	ACTION	EVIDENCE
What are we trying to achieve?	*What action will we take to make this happen?*	*How will change be evident/measured?*
To reduce incompatibles between organisations, maintain systems and regionalise licensing arrangements.	Update to Windows 2008 active directory. Update to XenApp 5. Update to Windows Server 2008 for Citrix Farm.	Number of Windows 2008 CALS. Number of XenApp5 servers. Number of Windows 2008 servers.

5.6 Accountability and Consultation with the Minister

As a Crown entity the DHB must have regard to Government legislation and to Government policy as directed by the Minister of Health.

In accordance with Section 141 (1) (g) of the Crown Entities Act and the New Zealand Public Health and Disability Act 2000, the DHB will inform the Minister of Health about any proposals to significantly change the way we invest in, or deliver, health services throughout the West Coast. The DHB will also inform the Minister of any proposals for significant capital investment or the disposal of crown land. As appropriate, and required by legislation, we will engage the Minister in discussion of those proposals and seek approval prior to making any significant change, investment or disposal. We will also comply with requirements in relation to any specific consultation expectations that the Minister communicates to us.

The Minister contributes to the setting of the DHB's strategic direction through the annual Letter of Expectations and setting of Health Targets and through the approval of Regional Health Services Plans and Annual Plans (including the Statement of Intent). The Crown Entities Act requires the DHB to report annually to Parliament on out performance as judged against our Statement of Intent and to publish this account as our Annual Report.

We must comply with reporting requirements and obligations in the Crown Entitles Act and Operational Policy Framework and with specific expectations that the Minister communicates to us. This includes ad-hoc information reports as requested by the Minister, service agreement reporting (as per service contracts) and the following regular formal reporting provided to the Ministry of Health:

- Annual Reports and Audited Financial Statements
- Quarterly non-financial performance reports and health target reports
- Quarterly hospital benchmark information reports
- Quarterly reports on service delivery against plan
- Bi-annual risk reports
- Monthly financial reports
- Monthly waiting time and ESPI compliance reporting

The DHB also meets reporting requirements in respect of national health information systems including: ethnicity reporting, national health index (NHI), national minimum dataset (NMDS), national booking reporting system (NBRS), mental health information national collection (MHINC), national immunisation register (NIR) and national non-admitted patient collection (NNPAC).

Alongside this reporting we compare our performance with that of other DHBs to ensure we are providing our population with the most effective services and returning improved health outcomes. Quality benchmark reporting and standardised intervention rates are indications of performance, and we also monitor and assess the quality of services provided by our hospital and specialist services and external providers, through service agreements, reporting of adverse incidents, routine quality audits, consumer surveys, service reviews and issues-based audits.

For our Board we provide monthly and quarterly performance monitoring against a mix of financial and non-financial indicators and targets. We provide and discuss this performance at public meetings and make this information available to the public on our website. We also support the Minister of Health's expectation that the public should be provided with better information on health system performance by publishing on our website and in local newspapers our quarterly performance against the national health targets.

SERVICE CONFIGURATION

Module 6

6.1 Service Coverage

Service coverage information demonstrates how government policy is translated into the required minimum level and standard of services to be made available to the public. The West Coast DHB does not seek exceptions to the Service Coverage Schedule. Services not provided locally for the resident population are provided by other DHBs.

The West Coast DHB 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 DHB will work to identify Service Coverage gaps through:

- Analysis of explanatory indicators
- Media reporting
- Risk reporting
- Formal audit outcomes
- Complaints mechanisms, managing and resolving any service coverage issues in a timely and transparent manner

The West Coast DHB will report on a quarterly basis on resolution of any new or existing Service Coverage gaps and issues that arise that are not identified in the Annual Plan with Statement of Intent and not approved as long-term exceptions. Additionally, such reporting may assist more efficient resolution when similar issues arise, as well as to inform policy review processes.

6.2 Service Redesign and Reconfiguration

It is expected that all potential service redesigned and reconfiguration activities during 2011/2012 will be determined through the implementation of Better Sooner More Convenient Primary Health Care and the associated development of model of care in both Primary (community) and Secondary (hospital) setting on a case by case basis. It is anticipated that during 2011-12 there will be business cases developed for the establishment of Integrated Family Health Centres in both Westport and Greymouth and that a business case will be submitted for the refurbishment/upgrading of Grey Base Hospital (see section 8.3 'Asset Planning and Sustainable Investment', page 85) . These and any other proposals for change will be subject to and will conform with the change notification process as determined by the Crown Funding Agreement.

6.3 Service Issues

Risks and opportunities

Our workforce direction and plan needs to be applicable at a primary, secondary and community care level across the whole of the West Coast health system whilst being aligned to (sub) regional and national initiatives.

It is clear that health is a large systems business, by inference small system changes can make a significant difference to the care that is provided to our community. That said, if we are to deliver on expectations the status quo is not sustainable and small scale change will not in our case make much difference. Moving forward requires a major foundational shift at a core systems level, so that fundamental changes can be made and workforce strategy can be aligned to our vision.

Over the next twelve months we will invest in targeted health specific people practices including work to improve our leadership and management capability, and the implementation of core systems in performance management, recruitment as well as learning and development. The support, expertise and know how for this work will be made available through the collaborative human resource arrangement with CDHB who will supply much needed technology and expertise that will be supplemented with local expertise. It is expected

that these initiatives when combined with other planned initiatives will have a profound effect on how we perform

- *Recruitment and retention*

  Despite the fact that our DHB is both rural and geographically remote our plan to strategically address recruitment is one that we are confident will be beneficial as we continue in our efforts to make our DHB an attractive one to locate to professionally and personally. The following are the key elements of that plan.

  - **Technology** – allow us to develop a database to attract and retain talent, focusing not on the roles that are currently vacant but on future workforce trends and developments.
  - **Strategic Sourcing** – the implementation of a centralised specialised recruitment team based at CDHB will allow us to focus on strategic recruitment, rolling campaigns etc.
  - **Candidate Care Program** – focusing on the candidate experience, putting this first; as well as being clear about our employee value proposition and our employer branding.
  - **Settlement Program** – how we introduce new employees to the organisation and the region, takes into account personal and family life as well as work life.
  - **Employee Referral Program** – utilising the power of personal networks that might include a structured reward program.
  - **Alumni** – a structured program allowing us to keep track of our staff and a means for attracting back in the future.
  - **Collaboration** – a strategic approach to recruitment aligned with work that is occurring within the Canterbury Health System, South Island, Nationally.

  Recruitment and retention continues to be difficult A world wide shortage of medical practitioners compounds our problems.

- *Establish a full complement of key health professionals to reduce our over-reliance of temporary/locum cover*

  We have an over-reliance on locum cover that has a significant impact on costs and continuity of care. Our plan is to reduce these costs by addressing terms and conditions of locum employment through national forums and to work with the CDHB to have more senior medical staff working on the Coast regularly. We believe that care will be improved and costs reduced through these initiatives.

- *Learning and Development*

  We will continue to invest in the development of our staff but in addition will align our work, in partnership with HWFNZ, through the rural learning centre with national and regional initiatives that will be available to us through the proposed South Island Regional Training Hub. Besides participating in our own right through our expertise in rural health development we will leverage clinical skill development opportunities and management/leadership development that will become available to us.

- *Financial viability and service affordability*

  Financially we are viable within the budget guidelines set for us as long as we can work out contractual relationships with Canterbury to supply senior medical staff. Failure to do this will lead us to look wider for other contractual relationships within the South Island.

- *Clinical safety (without immediate support and working in isolation)*

  We have safe emergency services and safe primary and secondary services. These are available on a 24/7 basis and one of our main concerns is to maintain this degree of coverage. These are backed by adequate emergency transport arrangements.

Nursing staff who work in isolation are prioritised in receiving HWNZ funding for Post Graduate education. This ongoing clinically based education ensures best practice, evidence based care and clinical safety. A robust set of Standing Orders, process of accreditation and audit also supports nurses working in isolation and who are responsible for providing primary care. Nurses are also supported to receive professional supervision for reflective practice and undertake regular peer review and case presentation. Regular contact with nursing line management ensures problem identification and quick resolution, as well as appropriate resource allocation for isolated areas. Within the Rural Nurse Specialist team advanced skill levels of individuals are identified and best utilised within the team. Ongoing regular training in skills such as PRIME (Pre hospital emergency care), cervical screening and vaccination ensures these nurses maintain competency and clinical safety.

- *Trust and confidence in the future of health service delivery of the West Coast*

  With good will from Canterbury DHB and in particular the senior medical workforce there is a high degree of confidence in the delivery of high class care on the West Coast.

  Health care services on the West Coast are continually reviewed and the model of care adjusted or developed accordingly in response to community health care needs. A multidisciplinary approach to care delivery ensures a 24/7 service to the entire district, and the proposed hospital reconfiguration signals a commitment to the ongoing delivery of appropriate hospital based health services. The Better Sooner More Convenient initiative demonstrates this commitment for community based services and efficient links through to these hospital based services.

PRODUCTION PLANNING

Module 7

7.1 2011/12 Production Plan Summary

Annual Plan View

WEST COAST DHB

RAW GROWTH BY OUTPUT CLASS [1]

	2009/10 actuals	2010/11 forecast		2011/12 planned	
Prevention	394	643	1 ▲	613	0 ▼
Early detection and treatment	-	-	▲	-	▲
Intensive assessment & treatment	46,415	48,442	0 ▲	49,719	0 ▲
Rehabilitation & support	-	-	▲	-	▲

[1] Doesn't include outputs not allocated to any output class.

HOSPITAL OUTPUTS GROWTH

Inpatients	2009/10 actuals	2010/11 forecast		2011/12 planned	
Medical	1,298	1,309	0 ▲	1,319	0 ▲
Maternity	254	273	0 ▲	300	0 ▲
Surgical	2,446	2,248	0 ▼	2,459	0 ▲
Total Inpatient (CWDs)	*3,998*	*3,830*	▼	*4,078*	▲

Outpatients (expressed as cost weights)	2009/10 actuals	2010/11 forecast		2011/12 planned	
Emergency Department	890	912	0 ▲	908	0 ▼
medical first	145	161	0 ▲	177	0 ▲
Medical follow up	219	283	0 ▲	278	0 ▼
Oncology chemotherapy	-	-	▲	-	▲
Oncology radiotherapy	-	-	▲	-	▲
Renal	-	-	▲	-	▲
Scope	101	96	0 ▼	150	1 ▲
Surgical first	240	240	0 ▲	268	0 ▲
Surgical follow up	316	327	0 ▲	319	0 ▼
Other med / surg	-	-	▲	-	▲
Maternity	70	77	0 ▲	75	0 ▼
Total Outpatient events	*1,980*	*2,095*	▲	*2,175*	▲
Total Additional Volumes	*2,584*	*2,632*	▲	*3,247*	▲
TOTAL ACTIVITY EXPRESSED AS COST WEIGHTS	***8,562***	***8,556***	**0** ▼	***9,500***	**0** ▲

Annual Plan view

- Raw growth by output class: This is a raw grouping of outputs by output class. Its value is on highlighting significant increases and decreases, and it doesn't represent anything at an aggregate level. This analysis doesn't include those outputs not allocated to any output class.
  This section is under development. After discussion in CFO forum 17/12/10, work is to be done with DHBs to show output variance in a more accurate way.

- Hospital outputs growth: Similar summary to the one used last year, the information used to build this table has been drawn from volumes data in the 2011/12 Provider Arm section across actual (2009/10), forecast (2010/11), and planned (2011/12) years, and includes both internal and non-internal revenue. The emphasis in this table is to show the total volume growth, which gives the percentage change in outputs across two sets of years: forecast growth from 2009/10 to 2010/11; and planned growth from 2010/11 to 2011/12.

In order to measure output growth across a set of years, the price (value) is fixed at the value for the latter year, and CWOs counted across both years using these price values.

This summary information is indicative only. It will be included in the Annual Plan to formalise the link between the Production Plan and the planning documents, but it is by no means 'written in stone'

FINANCIAL PERFORMANCE

Module 8

8.1 Overview

Over the past ten years an increasing share of national expenditure has been devoted to health. While the health sector continues to receive a large share of Government funding, clear signals have been given that Government is looking to DHBs and the whole of the health sector to rethink how we will meet the needs of our populations with a more moderate growth platform now and into the future.

In setting expectations for 2011/12, the Minister expects DHB to operate within existing resources and approved financial budgets and to work collaboratively to meet fiscal challenges and ensure services and service delivery models are clinically and financially sustainable.

The West Coast DHB has an approved budgeted deficit of $7.200M for the 2010/11 year. The operating result for 2011/12 is a deficit of $4.500M, reducing to a break-even position by 2013/2014. The West Coast DHB, like the rest of the health sector, faces significant financial pressure from demand-driven services, availability of a skilled clinical workforce and cost increases, which must be managed within allocated funding. While the most significant pressure comes from increasing demand and associated spend on health services, there are a number of other expenditure expectations that place financial pressures on the West Coast health system.

Excluding increasing demand, the most significant fiscal pressures are:

- Increasing wage and salary expectations.

  Wages are the health sector's largest expense. 92 % of West Coast DHB's workforce are on Employer Collective Agreement (MECA) awards, many of which have automatic step (pay) increases already built in, where even a small percentage cost of living increase will create significant fiscal pressure.

  Multi-Employer Collective Agreement (MECA) awards also raise expectations in the community and place additional pressure on community-based providers to match wages.

  The West Coast DHB relies heavily on the use of locum services to cover medical vacancies across a number of service areas. There is a financial premium attached to the using of locum services and any increases in the benefits of employed medical staff has the effect of locums increasing there charges over time.

  Despite international competition for specialised staff, it is important that employment award settlements are made at levels that are fiscally sustainable for the whole health system.

- Increasing treatment related costs.

  As activity increases so does consumption of treatment-related items such as implants, instruments, food products and referred services such as pharmaceuticals, laboratory and diagnostic services. In a number of areas, the costs of these treatment-related items are growing faster than our funding levels.

- Increasing expectations from the Government, clinical staff and the public.

  Changes in clinical practice and the availability of more technically advanced (and more expensive) treatments and technology drive increased cost within the system. An increased national focus on population screening is a recent but significant driver of costs, as are public expectations around the local available of primary and hospital health services. The West Coast DHB must support robust and transparent prioritisation around the health care systems, programmes and initiatives.

- Inter District Flows (IDF's)

  The West Coast DHB relies heavily on Canterbury DHB and to a lesser extent other DHBs to provide complex secondary and tertiary procedures for its funded population. It is difficult to predict and manage the changing volume of services that might be required. The price of IDF's is set nationally and has historically exceeded the funding increases. This trend will in all likelihood continue for the periods covered by this Annual Plan and places additional financial pressures on existing resources.

- Population Based Funding

  The West Coast DHB receives a higher level of funding for its population than any other area within New Zealand. This is made up of our share of Population Based Funding a special West Coast Adjuster and a Transitional Funding element. Within total funding, the component which forms the transitional funding

pool is systematically reduced by the Population Based Funding Formula transition process. The transitional funding for 2011/12 is $17.794m (2010/11 - $17.528m and 2009/10 - $18.376m).

8.2 Meeting Our Financial Challenges

The financial pressures facing the West Coast DHB are not short-term pressures to which there is a 'quick-fix' solution. For long term financial sustainability of the West Coast health system the focus needs to be on making the system work, seamless integration across the continuums of care and to develop a workforce that can support this model. Success is achieving the best possible outcomes for our investment.

This means providing the right care and support, to the right person, at the right time, in the right place. Savings will not only be made in dollars terms, but also in terms of costs avoided through more effective use of the resources available. Improving the effectiveness and quality of service has been proven to improve patient outcomes and reduce costs, through fewer treatment-related incidents and less rework and duplication. Ineffective systems lead to delays in patient care which also create risk and provide poorer health outcomes, in addition to higher costs. Delays also reduce public confidence in the West Coast DHB system and negatively affect the ability to engage with the West Coast population.

By being more effective and improving the quality of the care the West Coast DHB provides will enable the Board to both improve health care to the West Coast population and achieve long term financial wellbeing.

There are six major factors that are critical to the West Coast DHB's success:

- Constraining Cost Growth.

  It is critical that costs are constrained in delivery of services. If an increasing share of funding continues to be directed into meeting cost growth, the ability to maintain current service delivery will be at risk. The West Coast DHB will be severely restricted in terms of its ability to invest in new equipment, technology and new initiatives that allow us to meet future demand levels if costs are not constrained.

- Rebalancing the System.

  It is critical that the West Coast DHB continues to reorient and rebalance the West Coast health system to make the most effective use of available resources and build capacity across the system. If traditional boundaries and barriers remain, it will restrict the ability to introduce more effective service delivery models.

- Integration of Health Services.

  It is critical that health services on the West Coast follow an integrated approach across primary, hospital and community services with strong links into Canterbury DHB for speciality services.

- Stable Work force availability.

  It is critical that the West Coast District Health develop a model of care that can be supported by a stable and available clinical workforce, especially in the primary (rural) setting.

- Transitional Funding.

  The West Coast DHB intends to re-negotiate the future treatment of the Transitional Funding Pool so that the transitional funding forms part of the base funding.

- Collaboration with Canterbury DHB.

  It is critical that the West Coast District Health and Canterbury Health Board develop collaborative models of service across clinical and support functions that will reduce risk and have financial benefits.

Living within our means

The West Coast DHB is submitting a deficit budget of $4.500m (2010/11 - $7.200m) for the 2011/12 year. This is the first year of a three year deficit reduction plan which will result in the West Coast DHB operating within its funding parameters (break-even) by 2013/14.

In achieving a break-even position by year 2013/14 and future years the West Coast DHB has a number of specific initiatives that will be implemented over the next three years.

These initiatives will be underpinned by the following principals:

- Reducing Variation, Duplication and Waste.

  Removing unnecessary duplication and delay will result in an improved patient flow and will free up resources. Programmes that achieve these goals are vital in constraining cost growth and improving productivity. They include our clinically led 'Improving the Patient Journey' Programme and interactive staff engagement programmes such as XcelR8. All support LEAN Thinking and empower front-line staff and health professionals to take a lead in removing delay and waste from the system.

- Doing the Basics Well.

  Better understanding of the West Coast DHB's core business will allow services to be delivered more effectively and efficiently and better anticipate future demand. Improvements in the way activity is captured and recorded will not only improve clinical decision making, but help to ensure that the West Coast DHB is fairly remunerated for services provided and reducing overall cost growth.

- Return on investment over time (value for money).

  Investment decisions will need to have a positive impact on the financial position and health system over time.

- Whole of System Approach to Health Delivery.

  All changes to the West Coast health system needs to take a whole of system approach, taking into consideration the integration of primary, hospital and community based services as well as regional health strategies.

- Investing in Clinical Leadership.

  Seeking and enabling clinical input and leadership in operational processes and decision making, will result in clinically acceptable efficiencies across the whole system. Clinical leaders and providers in the front line of health care are in the best position to decide 'how' services should be delivered in order to improve quality and technical efficiency, and it is only with their support that change will be long-lasting.

- Shifting of hospital services into primary and community based services (Realigning Service Expenditure).

  The West Coast DHB is intending to deliver on Government policy by shifting services from hospital based services into primary and community based services. This will enable the West Coast DHB to better manage the pressure of demand growth and achieve further productivity gains from integrating services. This move is being actively pursued through the Integrated Family Health Centres Business Cases. In future years this will be reflected by applying funding at a proportionally greater rate to primary and community services.

Initiatives to reduce the deficit

- Achieve full key health professional complement thus reducing reliance on locum services.

  Over the past few years the West Coast DHB has been unable to recruit and retain medical personnel on an ongoing basis. This has resulted in an increasing reliance on locum services for the provision of acute cover across hospital based services. This is an extremely expensive model, does not benefit the patient or easily allow for consistency of practice.

  The global economic crisis has alleviated this situation slightly (by making New Zealand more attractive to international medical graduates than some competing countries), however there are still significant barriers to entry to new staff in the form of registration and immigration processes.

  Improving how locum doctors are rostered for hospital services has also been identified an area to where savings can be made and so work is under way to improve these processes.

  The ability to make Grey Hospital available for private surgery will also be explored as a number of clinicians have commented that the ability to work in private, as well as in the public system would be an important aspect affecting their interest as potential employees.

  A renewed drive to attract doctors to work in our region will be undertaken, both within the hospital setting and general practice. Doctor to doctor recruitment and a revitalised work role, with closer links professionally with Canterbury colleagues will be presented. A primary care recruitment and retention coordinator will work with existing processes to improve stability in the primary care workforce.

- Primary Practices.

  The West Coast DHB owns four of the six general practices on the West Coast. The West Coast owned general practices have traditionally operated at a loss, due to a number of factors.

  A review has been undertaken to look at the current primary care practice models. On completion of the review the West Coast DHB will then take the appropriate actions within the recommendations of the review to achieve a clinically sound and financially sustainable primary care practice model.

- Developing Workforce Capacity.

  The West Coast DHB is actively promoting and training clinical staff that will be able to support a generalist approach to patient care rather than a narrow specialised clinical scope of practice that currently exists. This will result in a workforce of rural medical generalists that will be able to cover a number of specialities with the support of the traditional medical specialist role, with the object of treating the majority of patients locally, and patients with more complex needs being transferred to other centres. Close collaboration with Canterbury DHB clinicians will support the new service delivery model. This will allow our rural hospital to provide acute services across the main specialities. . Telemedicine will be a fundamental enabler in achieving this model. Innovative ways of providing surgical services in a rural setting will also be developed.

  Costs and clinical risk of delivering acute services in the New Zealand rural setting will be greatly reduced if this is achieved. This will require a shift in collective thinking to create a medical and legal environment to support this style of care.

  The development of nurse practitioners also plays a part in the future model of care for the West Coast.

  The West Coast DHB's Rural Learning Centre co-ordinates a number of training programmes that are working towards developing a workforce that will support the rural environment, and includes the training of the Rural Hospital Medicine Specialist, Nurse Practitioners, Rural General Practitioners as well as undergraduate and new graduate programs that focus on producing rural generalists.

  By supporting less traditional workforce models that span across sectors and between DHBs, the West Coast DHB will expand the capacity of the available workforce.

- Capacity planning project.

  This is an ongoing project focussing on quality and productivity improvements within Hospital Services. The main objective of the project is to streamline the patient journey from referral to discharge, ensuring that the resources of the West Coast DHB are efficiently utilised. These include the scheduling of outpatient clinics, theatre and ward utilisation and discharge planning and staff rostering to meet planned demand. This project will have a staged implementation and be fully implemented by the end of December 2011.

- Supporting Unified Systems.

  The West Coast DHB supports the establishment of shared resources and systems that will reduce overall expenditure and variation across the sector. This will be achieved by working in collaboration with Canterbury DHB, the National Health Board, Health Benefits Limited and other DHBs.

  The West Coast DHB and Canterbury DHB have already made progress in this regard with a number of services being shared across the two DHBs.

  Reducing hospital costs

  Corporate and Support Services

  A number of corporate services are being delivered via a shared service model across the West Coast DHB and Canterbury DHB, these include the chief executive services and human resource services. By the 01 July 2010 a number of support services will be shared across the two DHBs with the resultant benefits.

  Supply Chain Management

  The supply chain management system is a shared service across the West Coast DHB and Canterbury DHB. The model will support national procurement initiatives and work closely with the National Health Board and Health Benefits Limited. This shared service will allow the West Coast DHB to be part of procurement initiatives undertaken by Canterbury Health Board, have access to their skill base and align the procurement processes resulting in both reduced risk of supply and financial benefits.

Shared Clinical Information Systems

The development of shared clinical information systems and electronic referrals management will enable the next steps in transformation of the health system. Shared electronic health records with access to information across Canterbury DHB and within the West Coast DHB will make it easier for both patients and staff to mover between locations, improving health delivery across the region.

8.3 Asset Planning and Sustainable Investment

Business Cases

In 2010 the West Coast DHB along with the West Coast Public Health Organisation's (WC PHO) submitted the business case for 'Better, Sooner, More Convenient Health Care' on the West Coast. This business case was approved by the Minister of Health in May 2010, with 2010/11 being the first year of implementation of this plan.

The business case covers the whole of the West Coast and the Buller, Grey and the South Westland area.

The initiatives and programmes planned for year two are outlined in Module 3 of this document.

Business cases planned for 2011/12

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

Buller Hospital/Buller Integrated Family Health Centre

A business case will be submitted in 2011 seeking approval for the facility development of an Integrated Family Health Centre for the Buller region based on the Better, Sooner, More Convenient service model. The facility will also house the Oral Health clinic for the Buller region. Funding of the facility will be via a Public Private Partnership (PPP).

Grey Base Hospital

The West Coast DHB 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. The reconfiguration will make provision for an Integrated Family Health Centre to be included in the final design.

It is expected that this reconfiguration will be funded by a mix of equity, debt and internal sources.

Further information on these projects will become available as it proceeds through the business case development process.

Capital Expenditure

The capital expenditure programme for the West Coast DHB will be focussing on ensuring that a robust replacement programme for clinical equipment exists and that there is standardisation of equipment between the West Coast DHB and Canterbury DHB.

The implementation of a new Financial Management Information System (FMIS) is planned for 2011/2012. The current financial system is an older styled financial system and will be unsupported from 30 June 2013. The implementation of the new system will be done as part of the upgrade planned for Canterbury DHB and will be within the national information technology plans. The West Coast DHB will fund the FMIS implementation from internal resources.

The West Coast DHB capital expenditure budget for 2011/12 will include capital expenditure committed in the 2010/11 financial year and will total $4.00M.

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

Disposal of Surplus Assets

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

The West Coast DHB Board will access the need to retain ownership of these properties based on future models of care and facilities.

In order to dispose of surplus land, the West Coast DHB must first obtain approval from the Minister of Health. Once approval has been gained, land will then be valued and will be offered to any parties that have a statutory right to receive an offer under the Public Works Act and Ngāi Tahu Settlement Act (and any other relevant legislation) before then being made available for public sale.

8.4 Debt and Equity

Debt Facilities

The West Coast DHB currently has debt facilities with the Crown Health Funding Agency (CHFA) and Bank of New Zealand.

Crown Health Funding Agency (CHFA)

The West Coast DHB has a $13.695M total loan facility with the Crown Health Funding Agency. The West Coast DHB's total term debt is expected to be $12.695M as at June 2012.

The current debt with the Crown Health Funding Agency consists of four loans with one of the loans due for repayment at 30 June 2012. The loan repayment is $1.500M and is it proposed that $1.250m of this loan will be "rolled over" with the Crown Health Financing Agency, effectively reducing the debt by $250k.

Current interest rates range 4.75% to 7.42%.

The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent the DHB cannot perform the following actions:

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

West Coast District Health Board Debt Register
As at 28 February 2011

Lender's name	**CHFA**	**CHFA**	**CHFA**	**CHFA**	**BNZ**
Loan Identified As	Renewal	Renewal	Renewal	Dementia Unit	Overdraft
Debt Amount - face value	$3,000,000	$4,695,000	$3,500,000	$2,500,000	$6,310,000
Instrument type	Term Loan	Term Loan	Term Loan	Amortising Loan	Overdraft
Fixed / Floating interest rate	Fixed	Fixed	Fixed	Fixed	Floating
Fixed rate	4.75%	5.22%	6.58%	7.42%	
Floating rate base and margin					BKBM+0.35%
Interest payment frequency	Semi-annually	Semi-annually	Semi-annually	Semi-annually	Daily
Covenants (Debt to Debt + Equity ratio)					80%
Next Payment Due					
When	15/04/2016	15/12/2019	31/12/2015	30/06/2011	any time
How much	$3,000,000	$4,695,000	$3,500,000	$250,000	any amount
Next Rollover / Refinance Due					
When	15/04/2016	15/12/2019	31/12/2015	30/06/2012	
How much	$3,000,000	$4,695,000	$3,500,000	$1,500,000	
Plan	Refinance CHFA	Refinance CHFA	Continuation of lending subject to review by CHFA	Continuation of lending subject to review by CHFA	

Upcoming Loan Repayments

Dementia Unit	30/06/2011	$	250,000

Bank of New Zealand (BNZ)

The West Coast DHB 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 either, 10% or $2M.	Yes

Equity

The West Coast DHB will require deficit funding (equity) in order to offset the deficit signalled in this Annual Plan and outlying years. The West Coast District Health Bard is also repaying $68K equity annually as part of the agreed FRS-3 funding.

Future funding of proposed facility developments

The proposed development of Buller Integrated Family Health Centre facility will be funded on a Private and Community based funding model. The cost and final funding arrangements won't be known until the business case has been completed.

The proposed reconfiguration of Grey Base Hospital facility will include elements of the Integrated Family Health Centre. The funding for this development will be a combination of debt and equity introduced by the private sector, community based organisations and the Crown. The final cost and therefore mix of debt and equity won't be known until the business case has been completed.

8.5 Assumptions

Key Assumptions

The financial forecasts in this District Annual Plan are based on many assumptions. The following assumptions are those that have a degree of risk associated with them:

- Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives. It is assumed that we will receive fair prices for services provided on behalf of other DHB s and the Crown.
- Revenue and expenditure have been budgeted on normal operations, current volumes and service delivery with no assumption for costs or disruptions associated with pandemic or natural disaster.
- That the West Coast DHB has assumed that it will continue to receive the $2.8M "West Coast Adjuster" as additional funding to reflect the unique circumstances that the West Coast DHB faces.
- No change from 2011/12 Transitional Funding Pool has been budgeted for in 2012/13 and 2013/14.
- The West Coast DHB will continue to receive Crown Funding on the early payment basis.
- No additional compliance costs have been budgeted, as it is assumed these will be cost neutral or fully funded. It is also assumed that the impact of any legislative changes, sector reorganisation or service devolvement (during the term of this Plan) will be cost neutral or fully funded.
- That conditions of Multi-Employer Collective Agreements (MECA) 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. It is assumed that employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation.
- It is assumed that external provider increases will be made within available funding levels, after allowance for committed and demand-driven funding.

- 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 DHB provider arm in each of the years covered by the forecast. Most of this surplus relates to the removal of historical adjuster payments to the West Coast DHB provider arm performance.
- Revenue and expenditure have been budgeted on the basis that transformation strategies and programmes will not be delayed due to sector or legislative changes. It is assumed that investment to meet increased demand will be prioritised and approved by the Executive Management Team in line with Board's strategy.
- The approved budgeted deficit will be funded via deficit support (an equity injection) by the Crown.
- In line with Generally Accepted Accounting Policies (GAAP), Land and Buildings are re-valued every three years or sooner if required. The land and buildings were revalued as at 30 June 2010 and the budget for 2011/2012 and outlying years has been based on this revaluation. It has been assumed that there will be minimal change from this valuation for the 2011/12 year.
- Work will continue on the Facilities Redevelopment Plan for Greymouth Base Hospital and the Buller Integrated Health Centre. No major facilities development costs or capital expenditure associated with the redevelopment has been included in the capital budget as the business cases for these projects still require specific approval by the Minister of Health.

8.6 Statement of Accounting Policies

The West Coast DHB 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 DHB 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 2011, the date this document was drafted.

Reporting Entity

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

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

The West Coast DHB is a public benefit entity, as defined under NZIAS 1.

The West Coast DHB'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 DHB 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 DHB are for the year ended 30 June 2010, and were approved by the Board on 28 October 2010.

Statement Of Compliance

The financial statements of the West Coast DHB have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), 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 financial statements have been prepared on a going concern basis that reflects the formal ongoing support of the Ministry of Health. The West Coast DHB is currently reviewing its service delivery model with the Ministry, with the intention of moving to an economically sustainable status. The board considers the adoption of the going concern assumption to be appropriate on this basis.

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

Changes In Accounting Policy

There have been no changes in accounting policy during the year, which have been applied on a basis consistent with the prior year.

The West Coast DHB has adopted revisions to accounting standards during the year which have only had a presentational or disclosure effect:

NZ IAS 1 *Presentation of Financial Statements (Revised 2007)* replaces NZ IAS 1 *Presentation of Financial Statements (Revised 204)*. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions from owners. The West Coast DHB has decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Those items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.

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 DHB include:

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurements. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets have been completed and has been completed and has been published in the new financial instrument standard NZ IFRS. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39.

The approach in NZ IAS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014.

The West Coast DHB 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.

Significant Accounting Policies

Revenue

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

Revenue from the Crown

The West Coast DHB is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the West Coast DHB 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.

Sale of goods or services

Revenue from sales of goods is recognised when the product is sold to the customer.

Trust and Bequest Funds

Donations and bequests to the West Coast DHB 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.

Goods and Services Tax (GST)

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.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position.

Taxation

The West Coast DHB 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.

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 DHB 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 DHB 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 DHB 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 surplus or deficit.

If on review the cumulative gain or loss is a calculated into the surplus or deficit. 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 surplus or deficit is removed from equity and recognised in the surplus or deficit. Impairment losses recognised in the statement of financial performance on equity on investments are not reversed through the surplus or deficit (see page 28).

Inventories

Inventories are held primarily for consumption in the provision of services, and are stated and the lower of cost or 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 DHB'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 DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If 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 surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

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 surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the surplus or deficit.

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 surplus or deficit.

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 surplus or deficit.

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 DHB on 1 January 2001. Accordingly, assets were transferred to the West Coast DHB 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 DHB

Assets, other than land, buildings and fixtures and fittings, 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 Land, Buildings, fixtures and fittings

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 surplus or deficit.

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 surplus or deficit 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 DHB 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 the surplus or deficit.

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 DHB 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 DHB recognises a liability for sick leave to the extent that the compensated absences are expected 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 date to the extent the West Coast DHB anticipates it will be used by staff to cover those future absences.

Bonuses

The West Coast DHB 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 DHB'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 surplus or deficit as incurred.

Defined Benefit Schemes

The West Coast DHB 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 16.

Leased Assets

Finance Leases

Leases which effectively transfer to the West Coast DHB 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 DHB is expected to benefit from their use.

The Public Finance Act requires DHB 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 surplus or deficit 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 surplus or deficit 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.

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 NZIFRS 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 DHB for the preparation of these financial statements.

Cost Allocation

The West Coast DHB 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 provider, as they mostly relate to the costs of providing hospital and health service infrastructure.

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

Critical Judgements in applying the West Coast DHB's Accounting Policies

Management has exercised the following critical judgements in applying the West Coast DHB's accounting policies for the period ended 30 June 2010.

Leases classifications

Determining whether a lease agreement is 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 DHB.

Judgement is required on various aspects that include, but not limited to, the fair value of the leased 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 DHB has exercised its judgement on the appropriate classification of leases and, has determined that all its leases are operating leases.

Critical Accounting Estimates and Assumptions

In preparing these financial statements, the West Coast DHB 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 DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires the West Coast DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the West Coast DHB, 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 surplus or deficit.

The West Coast DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

The West Coast DHB has made significant changes to past assumptions concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 8.

8.7.1 Group Statement of Comprehensive Income

West Coast District Health Board
Statement of comprehensive income

For the years ending 2009/10 to 2013/14

in thousands of New Zealand dollars

	2009/10 Actual	2010/11 Forecast	2011/12 Budget	2012/13 Budget	2013/14 Budget
Operating Revenue					
Crown and Government sourced	121,331	123,993	126,247	129,227	132,209
Inter DHB Revenue	137	117	127	129	131
Patient Related Revenue	2,687	2,828	2,965	3,017	3,071
Other Revenue	1,631	1,763	1,718	1,715	1,742
Total Operating Revenue	125,786	128,701	131,057	134,088	137,153
Operating Expenditure					
Employee benefit costs	52,189	52,107	53,396	55,795	56,206
Outsourced Clinical Services	11,751	12,550	9,667	6,548	6,089
Treatment Related Costs	7,112	7,210	7,292	7,236	7,307
External Providers	28,710	29,846	30,974	31,337	31,805
Net Inter District Flows	15,094	16,253	15,625	16,167	16,728
Outsourced Services - non clinical	496	1,079	1,508	1,537	1,568
Infrastructure Costs and Non Clinical Supplies	10,780	10,573	10,479	10,510	10,699
Total Operating Expenditure	126,132	129,618	128,941	129,131	130,402
Result before Interest, Depn & Cap Charge	(346)	(917)	2,116	4,957	6,751
Interest, Depreciation & Capital Charge					
Interest Expense	952	780	735	692	677
Depreciation	5,074	4,641	4,801	4,850	4,957
Capital Charge Expenditure	1,331	862	1,080	1,122	1,117
Total Interest, Depreciation & Capital Charge	7,357	6,282	6,617	6,664	6,751
Net Surplus/(deficit)	(7,703)	(7,200)	(4,500)	(1,707)	0
Other comprehensive income					
Gain/(losses) on revaluation of property	(6,363)	0	0	0	0
Total comprehensive income	(14,066)	(7,200)	(4,500)	(1,707)	0

8.7.2 Group Statement of Financial Position

West Coast District Health Board
Statement of financial position

As at 30 June for year endings 2009/10 to 2013/14

in thousands of New Zealand dollars

	30/06/2010 Actual	30/06/2011 Forecast	30/06/2012 Budget	30/06/2013 Budget	30/06/2014 Budget
Assets					
Non-current assets					
Property, plant and equipment	36,433	36,223	35,691	33,592	32,484
Intangible assets	1,094	1,148	1,130	2,080	2,380
Other investments	2	2	2	2	2
Total non-current assets	37,529	37,373	36,823	35,673	34,866
Current assets					
Cash and cash equivalents	3,176	3,125	3,358	4,190	4,679
Other investments	1,642	55	55	55	55
Inventories	761	746	746	746	746
Debtors and other receivables	3,478	4,603	4,603	4,603	4,603
Patient and restricted funds					
Assets classified as held for sale	246	246	246	246	246
Total current assets	9,303	8,775	9,008	9,840	10,329
Total assets	**46,832**	**46,148**	**45,831**	**45,513**	**45,195**
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	5,000	12,445	12,195	11,945	11,695
Employee entitlements and benefits	2,910	3,204	3,204	3,204	3,204
Total non-current liabilities	7,910	15,649	15,399	15,149	14,899
Current liabilities					
Interest-bearing loans and borrowings	7,945	250	250	250	250
Creditors and other payables	8,239	7,520	7,520	7,522	7,521
Employee entitlements and benefits	7,889	7,947	7,949	7,947	7,948
Patient and restricted trust funds	55	55	55	55	55
Total current liabilities	24,128	15,772	15,774	15,774	15,774
Total liabilities	32,038	31,421	31,173	30,923	30,673
Equity					
Crown equity	54,609	61,741	66,173	67,812	67,743
Other reserves	23,888	23,888	23,888	23,888	23,888
Retained earnings/(losses)	(63,742)	(70,941)	(75,442)	(77,148)	(77,148)
Trust funds	39	39	39	39	39
Total equity	14,794	14,727	14,658	14,590	14,522
Total equity and liabilities	46,832	46,148	45,831	45,513	45,195

8.7.3 Group Statement of Movements in Equity

West Coast District Health Board
Statement of changes in equity

For the years ending 2009/10 to 2013/14

in thousands of New Zealand dollars

	30/06/2010 Actual	30/06/2011 Forecast	30/06/2012 Budget	30/06/2013 Budget	30/06/2014 Budget
Balance at 1 July	22,379	14,794	14,727	14,658	14,590
Contributions from the Crown	6,549	7,200	4,500	1,707	(0)
Contributions repaid to the Crown	(68)	(68)	(68)	(68)	(68)
Total comprehensive income	(14,066)	(7,199)	(4,501)	(1,707)	0
Balance at 30 June	14,794	14,727	14,658	14,590	14,522

8.7.4 Group Statement of Cashflow

West Coast District Health Board
Statement of cash flows

For the years ending 2009/10 to 2013/14

in thousands of New Zealand dollars

	2009/10 Actual	2010/11 Forecast	2011/12 Budget	2012/13 Budget	2013/14 Budget
Cash flows from operating activities					
Cash receipts from Ministry of Health, patients and other revenue	126,854	129,082	132,740	135,866	138,999
Cash paid to employees	(52,842)	(51,741)	(53,395)	(55,795)	(56,206)
Cash paid to suppliers	(30,673)	(32,349)	(28,947)	(25,831)	(25,662)
Cash paid to external providers	(28,804)	(29,633)	(30,974)	(31,336)	(31,805)
Cash paid to other District Health Boards	(15,399)	(17,861)	(17,509)	(18,117)	(18,745)
Cash generated from operations	(864)	(2,501)	1,916	4,787	6,581
Interest paid	(848)	(780)	(735)	(692)	(677)
Goods and services tax (net)	152	(120)	0	0	0
Capital charge paid	(1,400)	(873)	(1,080)	(1,122)	(1,117)
Net cash flows from operating activities	(2,960)	(4,274)	100	2,973	4,787
Cash flows from investing activities					
Interest received	172	239	200	170	170
Proceeds from sale of investments	9	1,587	0	0	0
Acquisition of property, plant and equipment	(2,433)	(3,712)	(4,110)	(3,620)	(4,010)
Acquisition of intangible assets	(231)	(773)	(140)	(80)	(140)
Net cash flows from investing activities	(2,483)	(2,659)	(4,050)	(3,530)	(3,980)
Cash flows from financing activities					
Proceeds from equity injections	6,549	7,200	4,500	1,707	(0)
Repayment of equity	(68)	(68)	(68)	(68)	(68)
Cash generated from equity transactions	6,481	7,132	4,432	1,639	(68)
Borrowings raised					
Repayment of borrowings	(250)	(250)	(250)	(250)	(250)
Net cash flows from financing activities	6,231	6,882	4,182	1,389	(318)
Net increase in cash and cash equivalents	788	(51)	233	832	489
Cash and cash equivalents at beginning of year	2,388	3,176	3,125	3,358	4,190
Cash and cash equivalents at end of year	**3,176**	**3,125**	**3,358**	**4,190**	**4,679**

8.7.5 Summary of Revenue and Expenses by Arm

Governance Operating Statement for the years ending 2009/10 to 2013/14

in thousands of New Zealand dollars

	2009/10 Actual	2010/11 Forecast	2011/12 Budget	2012/13 Budget	2013/14 Budget
Income					
Internal Revenue	1,349	1,175	1,174	1,174	1,174
Other income	70	89	50	50	50
Internal allocation from Provider Arm	984	983	1,323	1,290	1,328
Total income	2,403	2,247	2,547	2,514	2,552
Expenditure					
Personnel	1,353	1,055	1,091	1,072	1,055
Outsourced services	160	538	646	650	655
Other operating expenses	560	424	531	512	497
Democracy	249	317	280	280	345
Total expenses	2,322	2,335	2,548	2,514	2,552
Net Surplus / (Deficit)	81	(87)	(0)	(0)	0

Funder Operating Statement for the years ending 2009/10 to 2013/14

in thousands of New Zealand dollars

	2009/10 Actual	2010/11 Forecast	2011/12 Budget	2012/13 Budget	2013/14 Budget
Income					
PBF Vote Health-funding package (excluding Mental Health)	96,967	98,129	97,905	100,325	102,745
PBF Vote Health-Mental Health Ring fence	13,409	13,440	13,884	14,328	14,772
MOH-funding side contracts	2,737	4,418	6,721	6,721	6,721
Inter District Flow's	1,586	1,608	1,884	1,949	2,017
Other income	331	188	180	150	150
Total income	115,030	117,783	120,574	123,473	126,405
Expenditure					
Personal and Maori Health	76,044	78,715	78,016	79,384	80,952
Mental Health	13,707	13,090	13,884	14,228	14,485
Disability Support	16,422	16,266	17,370	17,654	17,978
Public Health	1,125	1,126	1,011	1,026	1,043
Maori Health	592	498	661	671	682
Governance	1,176	1,176	1,174	1,174	1,174
Total expenses	109,066	110,870	112,116	114,138	116,315
Net Surplus	**5,964**	**6,913**	**8,458**	**9,336**	**10,090**

Provider Operating Statement for the years ending 2009/10 to 2013/14

in thousands of New Zealand dollars

	2009/10 Actual	2010/11 Forecast	2011/12 Budget	2012/13 Budget	2013/14 Budget
Income					
Internal revenue-Funder to Provider	62,327	61,987	62,459	63,511	64,590
Ministry of Health side contracts and Other Goverment	8,355	8,123	7,864	7,982	8,102
Patient and consumer sourced	2,687	2,828	2,965	3,017	3,071
Other income	1,230	1,485	1,488	1,515	1,542
Total income	74,599	74,423	74,775	76,025	77,305
Expenditure					
Employee benefit costs	50,836	51,052	52,305	54,723	55,151
Outsourced Clinical Services	11,695	12,493	9,631	6,508	6,049
Treatment Related Costs	7,111	7,209	7,292	7,236	7,307
Outsourced Services - non clinical	392	597	898	928	954
Infrastructure Costs and Non Clinical Supplies	9,972	9,834	9,674	9,722	9,861
Internal allocation	984	983	1,323	1,290	1,328
Total Operating Expenditure	80,990	82,168	81,122	80,407	80,649
Result before Interest, Depn & Cap Charge	(6,391)	(7,744)	(6,347)	(4,383)	(3,344)
Interest, Depreciation & Capital Charge					
Interest Expense	952	780	735	692	677
Depreciation	5,074	4,639	4,797	4,845	4,953
Capital Charge Expenditure	1,331	862	1,080	1,122	1,117
Total Interest, Depreciation & Capital Charge	7,357	6,280	6,612	6,659	6,747
Net Surplus/(deficit)	(13,748)	(14,025)	(12,959)	(11,042)	(10,090)
Other comprehensive income					
Gain/(losses) on revaluation of property	(6,363)	0	0	0	0
Total comprehensive income	**(20,111)**	**(14,025)**	**(12,959)**	**(11,042)**	**(10,090)**

Summary of Budgeted Revenue and Expenditure for the year ending 30 June 2012

in thousands of New Zealand dollars

	Governance	Funder	Provider	Eliminations	Result
Revenue	2,547	120,574	74,775	63,632	134,264
Expenditure	2,548	112,116	87,734	63,632	138,764
Net Surplus (Deficit)	**(0)**	**8,458**	**(12,959)**	**(0)**	**(4,500)**

APPENDICES

1 Minister of Health Letter of Expectations for 2011/2012

2 Implementation – The South Island DHB Alliance

3 Regional Priorities

4 Performance Measure and Description

Appendix 1: Minister of Health Letter of Expectations for 2011/2012

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

Via email.

2 6 JAN 2011

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

Dear Paul

Letter of Expectations for District Health Boards and their subsidiary entities for the 2011/12 year

The Government wants ***better, sooner, more convenient*** health care for all New Zealanders. This means strong priority is given to improving frontline services within available resources.

District Health Boards (DHB) are rising to this challenge, providing New Zealanders with more services from the large sums of money invested in the public health service.

Despite the tight financial times, the Government has increased Vote Health by more than $1.2 billion over two years. In many countries, health budgets have been curtailed or even reduced. We are determined to protect and grow the public health service.

Thank you for the commitment of you and your staff to improving the New Zealand public health service, and providing even more care to patients. We appreciate DHB staff have achieved so much for patients during these difficult economic times.

Expectations for all District Health Boards:

Improving service and reducing waiting times

The six Health Targets provide a clear and specific focus for action to improve patient care. DHBs have done well using these to improve both timely patient access to important services, and disease prevention.

Nationally, an extra 400 patients a week are getting elective surgery; more patients are getting cancer radiation treatment sooner; patients and their families are being seen faster in emergency departments; record levels of child immunisation; fewer smokers; more diabetes support.

While this is real progress for patients, there is still much room for improvement. We expect you to achieve the Health Targets, and continue improving waiting times.

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

Clinical Leadership

Clinical leadership is internationally recognised as a fundamental driver of improved patient care. It is also pivotal to greater job satisfaction for the health workforce.

We expect you to strengthen clinical engagement from bedside to boardroom. We also expect DHBs to work with their neighbours to further encourage and support clinical networks with clinicians leading the development and operation of each of the identified priority services, and the integration of services closer to home.

Services Closer to Home

New Zealanders want better access to a wider range of services closer to home. Closer integration of services across hospitals and the community will improve convenience for patients and reduce pressure on hospitals. We are increasing GP patient subsidies again and investing more in primary care.

We expect all DHBs to refocus more resources toward delivering services in local community settings, closer to patients. This work needs to particularly include attention to the following:

- reducing unplanned admissions through working with community and hospital-based clinicians on: chronic disease management, the frail elderly, after-hours
- ensuring community and hospital-based clinicians at the forefront of development, supported by management, and enabled to provide services more effectively
- developing efficient and effective integrated family health centres
- supporting the Whanau Ora Initiative.

To do this, you will need to engage doctors, nurses, pharmacists and other allied health professionals further into this work.

Health of Older People

As the 'baby boomers' age in larger numbers, the need grows to reorient our investment and service to meet their health and support needs. We are investing more in services for the elderly than ever before.

The recent aged residential care review showed we have a window of opportunity to act now, as demand remains relatively stable over the next few years. As the numbers of New Zealanders living longer increase, the number of people with dementia will also grow.

In preparing to meet the impact of our aging population on health services, we expect you to:

- focus on improving older people's underlying health and wellbeing - particularly in the areas of mental health (dementia) and preventing disease and injury
- build better systems - including using standardised monitoring and audit (InterRAI) as tools to improve quality across home-care and aged residential care
- provide new and expanded services - concentrating on dementia, and primary and community care improvements to avoid hospital admissions
- support family/whanau - in particular provision and access to respite care, day programmes and social supports
- engage in next steps of work on the aged residential care review.

Regional Collaboration

Greater regional collaboration between DHBs is an essential part of our future direction, to maximise clinical and financial resources. Following unanimous Parliamentary support of amending legislation last year, we expect to see regional collaboration develop significantly in the 2011/12 year, including:

- regional plans which focus on a small number of high priorities and the most vulnerable services in each region, with implementation plans to quickly and sustainably secure these services
- development of shared back-office functions across DHBs
- regionalisation of IT platforms, IT support and workforce development.

We expect you to support and advance the associated work of the National Health Board and Health Benefits Ltd both individually and collectively. Equally we thank you for your commitment to work with the Health Quality and Safety Commission.

All DHBs must budget and operate within their allocations and establish specific action plans to improve financial performance. This means your Board should be able to clearly demonstrate how it effectively takes ownership of financial performance and will develop and implement specific actions to live within its means year on year.

This means purchasing, productivity and quality improvements (including removing duplication and eliminating waste) and further reducing administrative overheads.

Along with the Chair of the NHB we look forward to receiving your Annual Plan for 2011/12 showing how you will progress the expectations outlined in this letter. Thank you again for all you and your team are doing.

Yours sincerely

Tony Ryall

Hon Tony Ryall
Minister of Health

cc David Meates, Chief Executive Officer, West Coast District Health Board

Appendix 2: Implementation – The South Island DHB Alliance

"If you want to be incrementally better, be competitive. If you want to be exponentially better, be collaborative".

In order to effect the implementation of regional service planning and delivery the South Island DHBs are establishing a modified alliance framework utilising the learning from the "Better, Sooner, More Convenient" business cases which adopted an alliance approach to enable rapid implementation of complex and evolving services without the need to disrupt current organisational structures . This significantly shortens the timeframe for establishment and implementation and avoids the disruptive debate between current organisations allowing new arrangements to evolve over time in a "form follows function" approach.

The DHBs are adopting this approach to facilitate working together to jointly solve problems by sharing knowledge and resources with a focus on achieving the best outcomes for the region's populations.

An alliance framework has been adopted because it is uniquely suited to:

- Collaborative ventures
- Diverse stakeholder interests
- Complex and evolving service development
- Complex risk situations where traditional "risk transfer" approaches are precluded because the scope is unclear or the circumstances and risks are unpredictable

The Alliance framework takes relationship contracting to a higher level where the participants take the ultimate step in "removing barriers" to getting the right thing done by eliminating misalignment of organisational interests. Alliance contracting recognises that disputes will occur, but provides for most disputes to be resolved using an informal dispute resolution procedure. This usually consists of first, resolution at the operational level then, if need be, senior management level, followed by the alliance board and then, possibly, mediation.

Framework

South Island DHB Alliance Governance Board

Consists of the Chairs of the five DHBs representing the Governance bodies of the five funding organisations and therefore acting as the client/funder of the Alliance and providing monitoring and over-sight on behalf of their Boards.

South Island DHB Alliance Leadership Team (ALT)

The five CEs as the senior management function of the organisations participating in the alliance. The functions of the ALT are defined in Table 1. It is normal practice in an Alliance for the funder to be part of the ALT however in this Alliance the CEs represent both the funder of services and the providers of services.

South Island DHB Alliance Management Team

The Alliance Management Team is an operational group that takes accountability for ensuring that the decisions of the ALT are implemented. For the purposes of this Alliance the management team will be drawn from across the DHBs and have representation from the different skill sets that would normally sit on the SMT/EMT of a DHB. It is intended that the AMT will work through their networks to utilise the skills and capabilities of their colleagues. The functions are defined in Table 1.

Work-streams and Regional Service Level Alliances (SLA)

These are the working groups of the Alliance and will be clinically-led and chaired, representative of the whole health system and supported by strong management and analytical resource as allocated by the AMT. The definitional difference between work-streams and SLAs is out-lined in Table 1. In functioning they are similar with over-lapping responsibilities due to the interdependent nature of health systems. Frequently workstreams identify opportunities for SLAs as opportunities for service development arise.

The South Island DHB ALT will approve the membership, scope, delegation and work plan of the Work-Streams and the Regional SLAs. A member of the South Island DHB ALT will be allocated to each of the principle work streams and/or Regional SLAs to provide a coordinating and linking function which facilitates

smooth processes and maximises the opportunity for shared learning, reduction of duplication and integration.

Planning and Funding

The Planning and Funding functions of the DHBs continue their role as described in Table 1 but report and are guided by the SLAs as appropriate and implement new contractual arrangements as required to support the work of the SLAs and work-streams

Documentation

The implementation of the Alliance is supported by a Charter which outlines the purpose, the principles and the expected behaviour of all of the participants in the Alliance at whichever level they participate. In more formal implementation this would also be supported by a contract but it is assumed that this is not strictly necessary in this context. The work-streams and Regional SLAs will also have a Terms of Reference which will define their activity. The members of the Regional SLAs will also sign the Charter.

The Concept of Good Faith

Alliancing documentation is premised on good faith obligations which are a powerful concept;

1 Alliance principles include obligations requiring the alliance participants to:

a) establish and maintain an environment within the alliance which encourages open, honest and timely sharing of information with respect to alliance activities;

b) act reasonably and do all things reasonably within the power and control of each participant which is necessary to give effect to the spirit and intent of the alliance and the alliance agreement; and

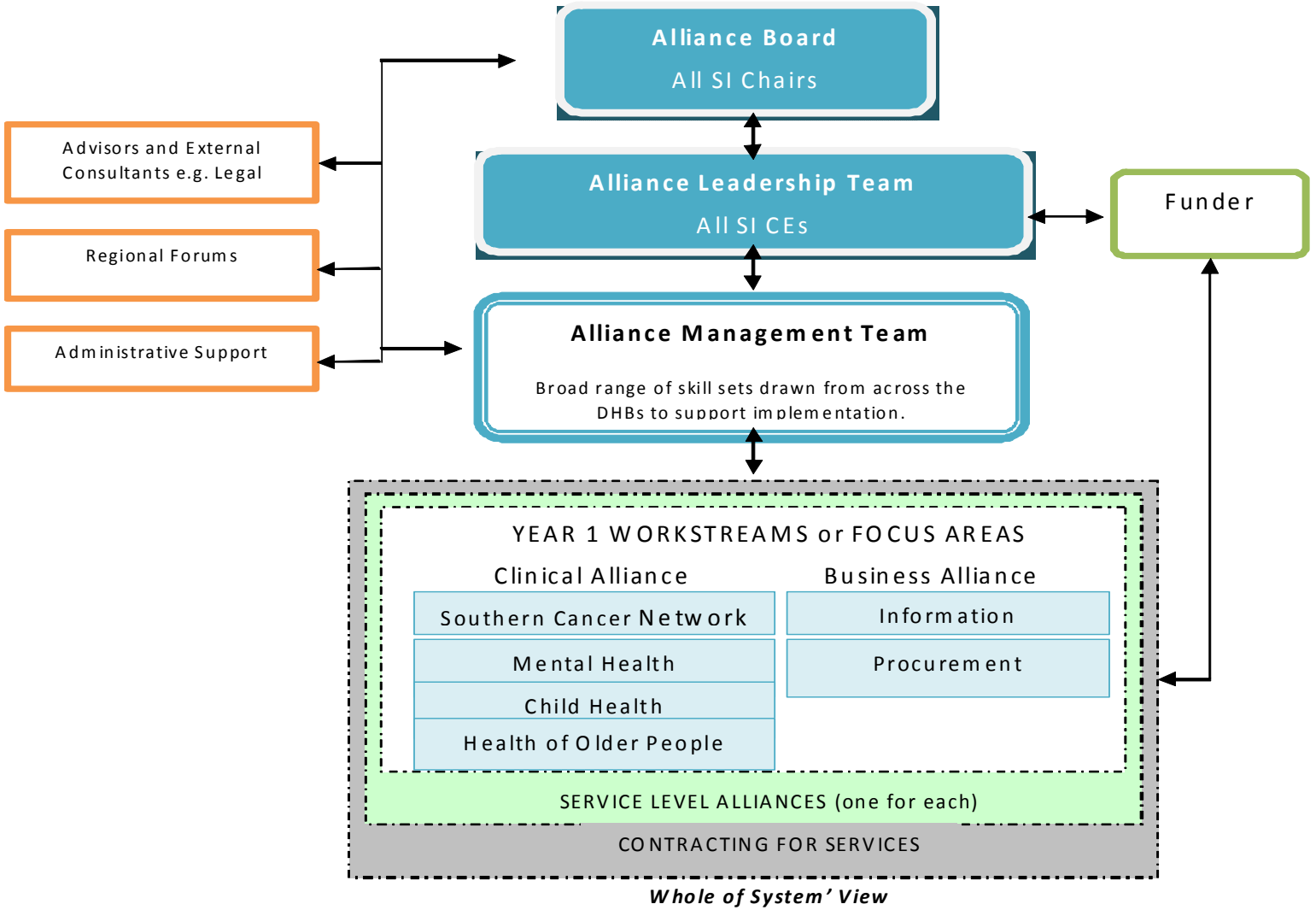
c) act in good faith when conducting all activities arising out of the alliance and the alliance agreement, including:
   (i) being fair, honest and ethical in dealings between the participants;
   (ii) not impeding or restricting the other participants' performance of the alliance activities; and

making all decisions on a best for alliance basis, and when making any such decision, giving predominate weight to the interests of the alliance over the self interest of each participant.

Table 1 Structures to Deliver on the South Island DHB Alliance Work Programme 2011-2013

Workstreams	Service Level Alliance	DHB P&F	Service Providers	ALT
• Strong clinical leadership to provide guidance in an area of health and social services for a population as identified in the Regional Planning. • Bring together data and ideas on the needs of a defined population. • Propose transformational service improvement. Identify areas requiring redesign and innovation. • May or may not lead to service level alliances. • May oversee project work. • Link with other workstreams; undertake joint work with other workstreams as appropriate. • No specified funding accountability.	• Design and plan the delivery of a service or group of services in a specific area of health and social services within a defined scope. • Build on the guidance developed by the work streams. Apply the delegated funding available to lead the required service/service change. • Link with other service level alliance groups and workstreams. • Design evaluation criteria. • Accountability to ensure that monitoring an evaluation is occurring. • Report regularly to ALT on service design, progress and activity, and evaluation • Feed into Annual Planning process around deliverables, targets, etc. • Memberships fulfils a skillset appropriate to the service(s). • Members may also be service providers (but not necessarily) • Members are agreed by ALT and sign Alliance Charter.	• Manage statutory obligations of the DHBs to plan and fund services. • Develop service provision agreements as appropriate to support the work of the SLAs and work-streams. • Support monitoring and reporting requirements of the alliance structure. • Monitor and evaluate according to legislative requirements. • Fund project work as appropriate.	• Delivery service as planned by service level alliance. • Contract holders for service delivery. • Sign Alliance Agreements if appropriate in the context.	• Resolve problems arising. • Prioritise activity and allocating funding within scope of the Regional Planning • Monitor deliverables. • Determine the scope of service level alliances. • Makes decisions within scope delegated. Alliance Management Team Resource allocation and implementation • Who's going to do what, who's the best person for the role? • Where are they going to work from? • How is the required funding going to be sources and the costs managed and the funds sourced? Facilitate linkages with Workstream Groups and ALT.

SOUTH ISLAND DHB ALLIANCE



Appendix 3: Regional Priorities

Regional Priorities – South Island Alliance

The action plans for the six priorities identified by the South Island Alliance are set out below. For further information refer to the 2011-12 South Island Implementation Supplement of the South Island Health Services Plan (SISSAL)[69]

Regional Health of Older People

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Develop a common approach to restorative service delivery of community services 2. Roll out InterRAI across each of the South Island DHBs. 3. Standardize the eligibility criteria and processes for entry to services across the South Island. 4. Implement the South Island Dementia initiative. 5. Health of Older People Alliance developed workplan focussed on priority areas across the continuum of Older People's Services	• Ensure more consistent access to service provision, no matter which District users are domiciled in. • Improve a restorative focus for home-based support services across the region. • Improve the skill sets of those working with older people who have dementia. • Ensure future development of Older People's Services across the South Island is prioritised and focussed on meeting the needs of the Older Person in a sustainable and equitable manner	• Consistent approach to service allocation to ensure services are targeted appropriately to needs. • Coordinated service development and provision across the continuum of services for the Older Person	• Each DHBs service specifications reflect a common restorative approach • All 5 DHBs have incorporated InterRAI into needs assessment processes. • Each DHB has agreed the components and adopted a consistent approach to accessing support services for older people. • Each DHB has run a first round of the regional dementia training programme (Walking in other's shoes).	• Standard & objective access criteria for HOP services. • A restorative focus for Home based support services. • More predictable access to specialist services and better use of scarce resources. • Reduced demand on residential services over time.

[69] Available from the West Coast DHB on request.

Regional - Southern Region Cancer Network

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Development and implementation of a South Island Blood and Cancer Service Plan. 2. Implementation of the South Island Clinical Cancer Information System. 3. Share cancer control knowledge and information to enable informed decision making. 4. Efficiency gains and improvements to the patient journey are identified in the patient mapping reports (lung and bowel tumour streams), implemented and monitored. 5. Development of an (electronic) integrated referral system, South Island Medical Oncology Protocols, e-prescribing and an enhanced system (via SICCIS) for recording the medical oncology prioritisation wait times (pending the outcome of the funding bid for Medical Oncology Prioritisation Wait Time RFP). 6. Develop and support the implementation of a South Island 10-year plan for radiation oncology (including linear accelerator review).	• Facilitate regional collaboration and service quality improvement leading to better, sooner and more convenient cancer services. • Robust cancer data and information sources are developed and shared that describe outcomes, current service provision and enable informed service development & planning decision-making. • To share knowledge and information to inform and enable decision making for consumers and health professionals within the cancer continuum. • Efficiency gains and improvements to the patient journey are identified, implemented and monitored. • Improve access and wait times: for lung and colorectal cancer, to radiotherapy treatment, to medical oncology /chemotherapy, improve access to cancer diagnostics including PET scans.	• The SCN Regional Strategic Plan. • The South Island Blood and Cancer Service Plan. • Cancer patients receive timely, high quality care, are supported across the cancer care continuum and have equitable access to services. • Cancer health targets are achieved in the South Island.	• Progress against the SCN Regional Strategic Plan. • South Island Blood and Cancer Service Plan complete and operational. • South Island Clinical Cancer Information System implemented and reporting South Island cancer information monthly. • SCN website operational, Newsletters published quarterly. • Progress against the recommendations in the South Island Lung and Colorectal reports is monitored and achieved[2]. • Integrated referral system, e-prescribing implemented. South Island medical oncology protocols developed and implemented (pending successful bid)[2]. • South Island DHB's performances meet national cancer health target requirements.	• Regional system and service efficiencies and quality improvement opportunities identified and implemented resulting in the meeting of national health targets, economies of scale, increased consistency of practice and increased equity of access. • Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making. • Innovation and infrastructure planning and development are supported to reduce inequalities and build regional capacity and capability.
7. Implement the South Island Multi-Disciplinary Meeting (MDM) project to improve the supporting infrastructure and increase access and utilisation of MDM. 8. Ongoing support and monitoring of the utilisation of PET Scans and other diagnostics in the South Island	• Improve infrastructure and access to cancer multidisciplinary meetings. • Improve access and reduce inequalities to cancer services. • Workforce innovations are identified and adapted to the South Island setting.	• Cancer patients receive timely, high quality care, are supported across the cancer care continuum and have equitable access to	• 10% increase in the percentage of patients with Lung and Colorectal Cancer are discussed at Multidisciplinary meetings. • 10% increase in the number of patients with Lung or Colorectal cancer domiciled outside of Christchurch and Dunedin are discussed at Multidisciplinary meetings.	• Regional system and service efficiencies and quality improvement opportunities identified and implemented resulting in the meeting of national health targets, economies of scale, increased

[70] See South Island PET Scan utilisation report contained in Appendix 2 of the Southern Cancer Network Six Monthly Report July – December 2010

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
9. Reducing Inequalities projects are supported within the Local Cancer Networks 10. All SCN network groups are provided with ongoing support to progress actions in their respective work plans. 11. The advanced symptom management system (ASyMS©) bid (currently with Health Workforce NZ) will pilot an integrated cross tertiary and community technology based patient management system that will change current workforce and work flow while supporting a greater number of cancer patients self-manage (with support) while receiving chemotherapy in the community.		services. • Cancer health targets are achieved in the South Island.	• South Island PET Scan utilisation (including variant requests) is collected via DHB of domicile and national clinical indication or variant and reported monthly[70]. • SCN work groups progress their respective work plans. • The internationally linked ASYMS pilot is funded and piloted in the South Island.	consistency of practice and increased equity of access. • Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making. • Innovation and infrastructure planning and development are supported to reduce inequalities and build regional capacity and capability.

Regional Mental Health

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability[71][72].

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Mental Health Alliance developed workplan focussed on priority areas across the continuum of Mental Health Services	• Collaborative planning and teamwork will enable the implementation of regional sustainable strategies to improve health outcomes	• Support to enable all people with experience of mental illness and addiction to fully participate in society and in the everyday life of their communities and whānau	Progress against agreed work plan	• Strengthened regional collaboration and integration of health services.

[71] Logan, F (2009), South Island Regional Mental Health Strategic Plan 2008- 2011. SISSAL, Christchurch, January 2009
[72] Minister of Health (2006). Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015, Wellington, Ministry of Health

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
Mothers and babies[73]				• Whole of systems approach to improve quality, access and sustainability of health services thereby increased sharing, reducing duplication and fragmentation of services. • Improved health outcomes for service users, and family/ whānau. • The health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives'. • An intermediate outcome is that people receive better health and disability services.
2. Regional provider expands the scope of regular education sessions beyond secondary care; tailoring specifically for individual districts and the needs of the wider health sector by utilising local/district expertise.	• Support the Better, Sooner, More Convenient philosophy enabling primary care and NGOs to help people earlier rather than waiting to meet secondary service criteria. Education sessions will be tailored to meet the specific needs of the individual DHBs and providers.	• Regional provider delivers education sessions to the DHBs tailored to meet their needs, inclusive of the wider health sector.	• Number of education sessions and number of people attending (primary, NGO, secondary).	
3. Regional service provides clinical supervision to District service staff.	• Individual staff and cases will be supported and receive additional training/education which can then be shared with the local team.	• Clinical supervision provided to District service staff by the regional provider.	• Number of clinical supervision sessions provided.	
4. The regional provider investigates a screening tool (peri natal and post partum) for use by service providers across the sector in the South Island.	• Consistency and quality of care across the South Island.	• Screening tool made available to service providers across the sector in the SI.	• Screening tool (peri natal and post partum) availability.	
Eating Disorders[74757677]				
5. The regional provider engages with DHBs to review the length of the weight recovery programme and trial utilisation of short stays.	• Consumers beginning treatment more quickly.	• Short stays utilised. • Baseline measure: The median wait was 58 days (2009) and 32.5 days (2010).	• Reduction in waiting list to regional weight recovery programme to be determined by the MH Alliance group.	
6. Districts and the regional provider develop guidelines for a local "pre-admission programme", including medical stabilisation. The programme will provide active treatment at a District level for the consumer, while waiting for a tertiary level inpatient bed.	• Consumers beginning treatment more quickly.	• Short stays utilised. • Baseline measure: The median wait was 58 days (2009) and 32.5 days (2010).	• Reduction in waiting list to regional weight recovery programme. • This will be determined by the MH Alliance group.	

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
7. The regional provider to provide education and support for medical detoxification, keeping Districts up-to-date on treatment options.	• Consult liaison is currently provided to the wider health sector (primary, community and secondary services) in direct response to meeting Districts need for this type of service. Districts have identified a need for education and face to face consult liaison as provided by other regional mental health services.	• Regional provider delivers education sessions to the DHBs tailored to meet their needs.	• Number of education sessions and number of people attending.	
8. Each District improves pre-admission medical detoxification support. Districts work closely with consumers to reduce the daily intake to an appropriate level for successful medical detoxification, and promote the use of Nicotine Replacement Therapy before entry to the programme.	• All Districts will provide the intensive outpatient support required to increase the success of the medical detox programme.	• Consumers on Nicotine Replacement Therapy on admission. Seen 48 hours before admission to confirm suitability for treatment and fitness to travel, and daily dosage reduced to required amount.	• Number of people on NRT prior to admission.	
Medical Detoxification				
9. The regional provider to provide education and support for medical detoxification, keeping Districts up-to-date on treatment options.	• Consult liaison is currently provided to the wider health sector (primary, community and secondary services) in direct response to meeting Districts need for this type of service. Districts have identified a need for education and face to face consult liaison as provided by other regional mental health services.	• Regional provider delivers education sessions to the DHBs tailored to meet their needs.	• Number of education sessions and number of people attending.	
10. Each District improves pre-admission medical detoxification support. Districts work closely with consumers to reduce the daily intake to an appropriate level for successful medical detoxification, and promote the use of Nicotine Replacement Therapy before entry to the programme.	• All Districts will provide the intensive outpatient support required to increase the success of the medical detox programme.	• Consumers on Nicotine Replacement Therapy on admission. Seen 48 hours before admission to confirm suitability for treatment and fitness to travel, and daily dosage reduced to required amount.	• Number of people on NRT prior to admission.	

[73] Regional Models of Care Project: Identified Regional Model of Care; Mothers and Babies, SISSAL, Christchurch, December 2010
[74] Regional Models of Care Project: Identified Regional Model of Care; Eating Disorders, SISSAL, Christchurch, December 2010
[75] South Island Regional Eating Disorders Plan, SISSAL, Christchurch, 2009
[76] Regional Models of Care Project: Identified Regional Model of Care; Eating Disorders, SISSAL, Christchurch, December 2010
[77] South Island Regional Eating Disorders Plan, SISSAL, Christchurch, 2009

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
Child and Youth AOD Residential[78]				
11. The regional provider purchase technology (e.g. videoconference equipment) for enabling distance collaboration (co-working with the District service) and ongoing communication.	• Better distance collaboration, family involvement, on-going communication and consult liaison support and advice to improve communication between the Districts and the regional provider.	• Better communication between Districts and the regional provider.	• Technology is made available and communication through this technology is improved.	
12. Odyssey House are supported to undertake a facilitated process to clearly define eligibility criteria and define roles and responsibilities of both the regional provider and the District services.	• Increased engagement of young people in the service resulting in a higher completion rate.	• A regional access SPF is completed.	• Regional access SPF is completed; there is a higher completion rate as young people are more prepared for the programme.	
Inpatient Child and Youth Services[79]				
13. Regional provider improves the routine discharge planning process to facilitate a better transition process.	• Child/Youth and family are able to generalise the strategies learned in the regional service, to the local setting.	• Child/youth and family are more resilient at the vulnerable transition period.	• Child/youth able to generalise strategies	
14. Include District staff as early as possible in discharge planning, enabling District staff to work with the regional service prior to discharge if clinically indicated.				
Forensic[80]				
15. Develop business rules for the consistent and standardised collection of data relating to Forensic services across the SI.	• Consistent understanding of Forensic activity across the SI to better undertake service development and planning.	• Consistent understanding of Forensic activity across the SI	• All activity is collected is consistent and standardised.	

[78] Regional Models of Care Project: Identified Regional Model of Care; Child and Youth Alcohol and Other Drugs - Residential, SISSAL, Christchurch, December 2010
[79] Regional Models of Care Project: Identified Regional Model of Care; Inpatient Child, Adolescent and Family Mental Health Service, SISSAL, Christchurch, December 2010
[80] *South Island Regional Forensic Plan, SISSAL, Christchurch 2007*

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
16. Develop a South Island Forensic Outpatient service provision framework.	• Consistent access to services across the South Island.	• South Island Forensic Outpatient Service Provision Framework completed.	• SI Forensic Outpatient Service Provision Framework completed.	

Regional Children's Health

Four actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Child Health Alliance developed work plan focussed on priority areas across the continuum of Children's Health	• Ensure future development of Child Health Services across the South Island is prioritised and focussed on meeting the needs of Children in a sustainable and equitable manner	• Coordinated service development and provision across the continuum of services for Children	• Progress against agreed work plan	Strengthened regional collaboration and integration of child & youth health services.
2. Develop markers of processes of health care, (performance indicators) benchmark and work collaboratively to understand differences and identify opportunities for improvement.	• Enhance collaboration and communication across SI child health services and enable consistency of clinical practices, efficiencies and improved access across health providers. • Support the implementation of an alliance framework and when appropriate alliance contracting.	• Clinically sustainable and affordable regional SI child health services that support clinicians to generate innovative changes to support holistic approaches across the network.	Process markers (performance indicators) are developed and implemented to measure and compare systems supporting quality improvement and sharing of innovation. For example: • Reduction in did not attend (DNA) rates for outpatient appointments • Reduction in procedural waiting times • First specialist assessment (FSA) per capita for general and sub-specialty outpatient clinics (e.g. General paediatrics orthopaedics, ESPI compliance for paediatric surgery)	Strengthened regional collaboration and integration of child & youth health services.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
3. Monitor and evaluate paediatric epidemiology data to assess the health status of the SI child and youth population	• Provide regional baseline data to improve service planning and reduce inequalities for this population group in the SI	• South Island benchmarking and health status reports providing clarity around differences in care and outcomes with opportunities for improvement.	Use of evidence about health status to focus service improvement and development. For example: • Chronic disease management in childhood and young people • Diabetes management	Improved health outcomes for target groups of children and families.
4. Develop and implement regional clinical pathways for children from secondary to tertiary care providers and where appropriate from secondary/tertiary to primary health care providers.	• Enhance collaboration and communication across SI child health services and enable consistency of clinical practices, efficiencies and improved access across health providers.	• Clinically sustainable and affordable regional SI child health services that supports local child health services to provide safe and quality-focussed care with appropriate support from tertiary services and a multidirectional flow within the network.	Regional clinical pathways for gastroenterology and general surgery: • Are used by paediatricians in the 7 SI paediatric services for referral of children and young people from secondary to tertiary care • 85% gastroenterology and general surgery referrals will be assessed, have diagnostic investigations completed and treated within agreed national guideline timeframes (audit review) • Evaluate referrals to specialist services with a reduction of inappropriate clinical referrals	Whole of systems approach to improve quality, access and sustainability of health services thereby increased sharing, reducing duplication and fragmentation of services.
5. Develop a SI regional paediatric workforce development plan in conjunction with national workforce development and planning, including succession planning for regional paediatric multi-disciplinary teams.	Improve service quality and viability.	Maintenance of skills when workload alone is insufficient. Fewer isolated clinicians with better peer support. Linked services to achieve critical mass for viability	SI regional paediatric workforce plan developed for: • Opportunities for paediatric training rotations across SI paediatric services • Shared clinical training/education opportunities • Shared recruitment and retention policies • Dual clinical appointments within DHB paediatric services	Sustainable workforce to ensure a viable child and youth health services in SI
6. Develop and implement regional early warning score protocol – a quality improvement tool to improve assessment of unwell children and ensure the right care, at the right time, by the right service is provided for all SI children.	Improve clinical assessment and early intervention of appropriate treatment	Best practice clinical assessment and treatment of the unwell child / youth	• Fewer episodes of unexpected clinical deterioration and sentinel events • Improved staff awareness of normal physiological variation across the age span	Improved health outcomes for at risk children and youth

Regional Procurement

The following actions will be implemented in 2011-12 to support financial viability and clinical safety and quality.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
Projects for the Procurement and Supply Chain Alliance have been identified as follows: 1. Processes and Documentation – building on work already done to enable SI DHBs to work together in this area. 2. Savings and general Reporting – a single SI savings report will be developed for DHBs, CEOs and HBL. 3. Planning – based on planning in the previous two years this will include consumables, services, and Capex. 4. Training and Development – to enable and grow the capability of supply and procurement staff in the SI. 5. Supply Chain – this will include warehousing, and place and chase of goods. 6. High Spend Commodity Groups – in the first instance short reports on key high spend groups will be developed to inform future decision making in these areas. These groups are likely to include fleet, vehicles, laundry, food, orderlies, cleaning, locums, temporary labour, radiology, laboratory, and coal. In addition to the above projects this alliance will continue to: 7. align contracts, overcoming the lead-in time to develop new contracts by using the opt-on clause on contracts as they expire. 8. Strengthen relationship with clinical staff, through promoting the work of this group to clinician leaders including goals and processes 9. Take advantage regionally of 'All of Government' contracts via MED.	• Enhance collaboration and communication across SI procurement functions. This will enable greater purchasing power and savings for SI DHBs. • Enable alignment of clinical material between CDHB and WCDHB in order to reduce clinical risk where clinicians are working between the two DHBs. • Provide stability and opportunities for procurement staff to improve and broaden their skill bases, which aid recruitment and retention of skilled staff in this sector. • Improve relationships with clinical staff will improve processes and ensure that the best decisions are made. • Alignment with the target of collective procurement driven by HBL and MED to take advantage of bulk purchasing savings.	• Increased financial sustainability through cost savings in goods and services procured by SI DHBs. • Reduced repetition of competitive tendering' processes across the SI.	Measured by • Increased savings in SI procurement and supply chain to deliver to individual boards • Increased standardisation of processes and range of consumables • Increase in the number of collaborative projects • HBL are in agreement with the work plan • Standard reporting on procurement activity to all SI boards	Achievement of • Timely access to products and services required in the provision of health services • Less clinical variation to achieve safer and easier clinical exchanges

Regional Information Systems

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical / financial viability. These actions are consistent with the roadmap set out in the South Island Regional IT Plan submitted to the National Health IT Board in September 2010 and aligned with the goals and aims set out in the National Health IT plan.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Establishment of a South Island (SI) IT Alliance with agreed Terms of Reference and a clinical component that will enable collaboration. 2. The following deliverables and actions are the focus: • Clinical information systems which includes clinical data repository, clinical workstation • Imaging/picture archive (PACS-Radiology and regional archive) • Clinical Support Systems (Laboratory and Pharmacy) • Patient Administration System (PAS) 3. Implementation of the South Island Clinical Cancer Information System (including ASYMS).	• Ensure IT developments appropriately link the South Island's DHBs and clinical networks. • Develop appropriate clinical pathways and administrative, IT and other support systems. • Enhance collaboration and communication across SI IT services to enable consistency of IT practices and clinical application, efficiencies and improve access across health service providers • Enable greater sharing of information across continuums of care including e-referrals/ e-discharges and clinical pathways • Robust cancer data and information sources are developed and shared that describe outcomes, current service provision and enable informed service development & planning decision-making.	• Sustainable technology and associate infrastructure • Regional access and consistent access to clinical information • Regional access and consistent access to clinical information	• Implementation of the SI Regional IT Plan • South Island Clinical Cancer Information System implemented and reporting South Island cancer information monthly.	• Strengthened regional collaboration and integration of health services across the continuum of care • Whole of systems approach to improve quality, access and sustainability of health services thereby increased sharing, reducing duplication and fragmentation of services. • Enhanced productivity and risk management • Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making.

Appendix 4: Performance Measures and Description

Performance Measure and Description	2011/12 Target	National Target	Frequency
PP1 Clinical leadership self assessment			
The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DBH engagement with it across their region. This will include a summary of the following – how the DHB is: ● Contributing to regional clinical leadership through networks ● Investing in the development of clinical leaders ● Involving the wider health sector (Including primary and community care) in clinical inputs ● Demonstrating clinical influence in service planning ● Investing in professional development ● Influencing clinical input at board level and all levels throughout the District Health Board – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required.	NA	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care			
The DHB is to supply a progress report on the implementation of changes to primary health care services that deliver on the core elements of Better, Sooner, More Convenient primary health care. In particular progress must be described regarding: 1. the shifting of services from secondary care to primary care settings; 2. the development of Integrated Family Health Centres; and 3. any specific reporting requirements that may be identified in the Minister's Letter of Expectations (to be confirmed). **AND (as applicable)** 1. Those District Health Boards involved in Better, Sooner, More Convenient (BSMC) primary health care business case(s) are required to supply a progress report on the implementation of the business case(s) it is involved in. The BSMC Monitoring Framework includes indicators at three levels: 2. Those District Health Boards involved in Better, Sooner, More Convenient primary health care business case(s) are required to supply a progress report on the operation and expenditure of the flexible funding pool, including how pool funding has been prioritised to deliver services to meet the four high-level objectives. Where problems are identified, resolution plans are to be described.	No quantitative target qualitative deliverable required.	NA	Quarterly
PP3 Local Iwi/Māori engagement and participation in DHB decision making, development of strategies and plans for Māori health gain			
Measure 1 - PHO Māori Health Plans Percentage of PHOs with MHPs that have been agreed to by the District Health Board .	100 %	**100%**	Six-Monthly
Measure 2 - PHO Māori Health Plans Report on how MHPs are being implemented by the PHOs and monitored by the District Health Board (include a list of the names of the PHOs with MHPs) **OR** for newly established PHOs, a report on progress in the development of MHPs (include a list of the names of these PHOs).	No quantitative target qualitative deliverable required.	NA	

• **Measure 3 - District Health Board – Iwi/Māori relationships** 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 MoU.			
Measure 4 - District **Health Board – Iwi/Māori relationships** Report on how (mechanisms and frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs).			
Measure 5 - District Health Board Māori Health Plan Provide a report by exception on national level priorities that have not been achieved in the District Health Board Māori Health Plan. The report will say why the priority has not been achieved, what the District Health Board will do to rectify it, and by when.			
PP4 Improving mainstream effectiveness DHB provider arms pathways of care of Māori			
Measure 1 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.	No quantitative target qualitative deliverable required.	NA	Six-Monthly
Measure 2 Report on examples of actions taken to address the issues identified in the reviews. The report should identify:• what issues/ opportunities were brought to your attention as a result of the reviews of pathways of care that you identified in Measure one• the follow up actions you intend to take/ are taking as a result of the issues and opportunities that you identified above.The report should include timeframes for implementing the actions you identify.			
PP5 Waiting times for chemotherapy treatment			
Provide a report confirming the District Health Board has reviewed the monthly wait time templates produced by either the relevant Cancer Centre(s) or its own District Health Board where treatment commenced at that DHB for the quarter . Where the monthly wait time data identifies: • any patients domiciled in the District Health Board waiting more than four weeks, due to capacity issues, and/or • wait time standards were not met, for patients in priority categories A and B District Health Boards must provide a report outlining the resolution path.	100% at four weeks	**100%** **at four weeks**	Quarterly

PP6 Improving the health status of people with severe mental illness					
The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • child and youth aged 0-19, specified for each of the three categories Māori, Other, and in total • adults aged 20-64, specified for each of the three categories Māori, Other, and in total • older people aged 65+, specified for each of the three categories Māori, Other, and in total.	**Age 0-19**	Māori	3.8%	NA	Six-Monthly
		Other	3.8%		
		Total	3.8%		
	Age 20-64	Māori	3.4%		
		Other	3.4%		
		Total	3.4%		
	Age 65+	Total	2.5%		
PP7 Improving mental health services using crisis intervention planning					
Provide a report on: 1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan. 3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDSS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]). 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.	**Adult (20+)**	Māori	98%	**95%**	Six-Monthly
		Non Māori	98%	**95%**	
	Child & Youth	Māori	98%	**95%**	
		Non Māori	98%	**95%**	

PP8 DHBs report alcohol and drug service waiting times and waiting lists					
Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm. Reporting will be on the longest waiting time in days, plus the number of people on the waiting list for treatment at the end of the month, i.e. volume and time. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment. District Health Boards will report their longest waiting time, in days, for each service type for one month prior to the reporting period.			No quantitative target. Supply of quantitative data required.	NA	Six-Monthly
PP9 Delivery of Te Kokiri: the mental health and addiction action plan					
District Health Boards are to provide a summary report on progress made towards implementation of Te Kōkiri: the Mental Health and Addiction Action Plan. A template for this report can be found on the nationwide service framework library web site NSFL homepage: http://nsfl.health.govt.nz.			No quantitative target qualitative deliverable required.	NA	Annual
PP10 Oral Health DMFT Score at year 8					
Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are – • Decayed (D), • Missing (due to caries, M), and • Filled (F); and (ii) children who are caries-free (decay-free).		Māori	2.28 ratio	NA	Annual
		Pacific	1.3 ratio		
		Other	1.0 ratio		
		Total	1.12 ratio		
	Total	***Fluoridated***	-		
		Non Fluoridated	1.12 ratio		
PP11 Children caries free at 5 years of aged					
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are – • Decayed (d), • Missing (due to caries, m), and • Filled (f). Measured by the number of five year olds caries free as a percentage of total five year olds examined at WCDHB School Dental services. Note: there are no fluoridated water supplies on the West Coast.		Māori	55%		Annual
		Pacific	55%		
		Other	55%		
		Total	55%		
	Total	***Fluoridated***	Not applicable		
		Non-Fluoridated	55%		

PP12 Utilisation of DHB funded dental services by adolescents				
In the year to which the reporting relates, the total number of adolescents accessing District Health Board -funded adolescent oral health services, defined as: (i) the unique count of adolescent patients' completions and non-completions under the Combined Dental Agreement; and (ii) the unique count of additional adolescent examinations with other District Health Board -funded dental services (e.g. District Health Board Community Oral Health Services, Māori Oral Health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, the Ministry will organise a data extract from Sector Services for all District Health Boards for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for District Health Boards' use in determining part (i) of the Numerator.	Total	80%	**85%**	Annual
PP13 Improving the number of children enrolled in DHB funded dental services				
Measure 1 - In the year to which the reporting relates, the total number of children under five years of age, i.e. aged 0 to 4 years of age inclusive, who are enrolled with District Health Board -funded oral health services (District Health Board's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers).	Children Enrolled **0-4 years**	75%	NA	Annual
Measure 2 - In the year to which the reporting relates:(i) the total number of pre-school children and primary school children in total and for each school decile who have not been examined according to their planned recall period in District Health Board -funded dental services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers); and(ii) the greatest length of time children has been waiting for their scheduled examination, and the number of children that have been waiting for that period.	Children not examined **0-12 years**	<1%		
PP14 Family violence prevention				
Confirmation report based on audit scores for partner abuse and child abuse and neglect programme components. (Data source: Provided to District Health Boards by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit.)		160/200	**140/200**	Annual
PP15 Improving the safety of elderly: Reducing hospitalisation for falls				
The number of people 75 yrs and older hospitalised for falls domiciled in the District Health Board region, per year.		%	NA	Six-Monthly

PP16 Workforce - Career Planning			
The District Health Board provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with career plan for required categories: ● Medical staff ● Nursing ● Allied technical ● Maori Health ● Pacific ● Pharmacy ● Clinical rehabilitation ● Other	No quantitative target. Supply of quantitative data required.	NA	Annual

System Integration Dimension

Performance Measure and description			2011/12 Target	National Target	Frequency
SI1 Ambulatory sensitive (avoidable) hospital admissions					
Each District Health Board is expected to provide a commentary on their latest 12 month ASH 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 ASH admissions. Each 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.	**Age 0-74**	Māori	<95	NA	Six-Monthly
		Pacific	n/a		
		Other	<95		
	Age 0-4	Māori	<95		
		Pacific	n/a		
		Other	<95		
	Age 45-64	Māori	<108		
		Pacific	n/a		
		Other	<95		

SI2 Regional service planning				
A single progress report on behalf of the region agreed by all District Health Boards within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan. For each action the progress report will identify: • the nominated lead District Health Board /person/position responsible for ensuring the action is delivered • whether actions and milestones are on track to be met or have been met • performance against agreed performance measures and targets • financial performance against budget associated with the action. If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan.		No quantitative target qualitative deliverable required.	NA	Quarterly
SI3 Service coverage				
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.		No quantitative target qualitative deliverable required.	NA	Six-Monthly
SI4 Elective services standardised intervention rates				
For any procedure where the standardised intervention rate in the 2011/12 financial year or 2011 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 (2011/12) that will ensure the target rate is achieved.	**Intervention rate**	308 per 10,000	**308 per 10,000**	Six-Monthly
	Major joint replacement procedures	21 per 10,000	**21 per 10,000**	
	Hip	10.5 per 10,000	**10.5 per 10,000**	
	Knee	10.5 per 10,000	**10.5 per 10,000**	
	Cataract Procedures	27 per 10,000	**27 per 10,000**	
	Cardiac procedures	6.5 per 10,000	**6.5 per 10,000**	

SI5 Expenditure on services provided by Māori Health providers					
Measure 1 DHB to report actual expenditure (GST exclusive) on Māori providers by General Ledger (GL) code. **Measure 2** DHBs to report actual reported expenditure for Māori providers in comparison to estimated expenditure for Māori providers in their Annual Plan for the same reporting period, with explanation of variances.			No quantitative target. Supply of quantitative data required.	NA	Annual
SI7 Improving breast-feeding rates					
District Health Boards are expected to set District Health Board -specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. District Health Boards will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Māori and Pacific communities. The Ministry will provide breastfeeding data sourced from Plunket, and District Health Boards must provide data from non-Plunket Well Child providers. District Health Boards are to report providing the local data from non-Plunket Well Child providers.	**6 weeks**	Māori	81%	**74%**	Annual
		Pacific	70%		
		Other	n/a		
		Total	74%		
	3 Months	Māori	46%	**57%**	
		Pacific	65%		
		Other	n/a		
		Total	60%		
	6 Months	Māori	32%	**27%**	
		Pacific	40%		
		Other	n/a		
		Total	39%		

Ownership Dimension

Performance Measure and description	2011/12 Target	National Target	Frequency
OS3 Elective and arranged inpatient length of stay			
The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The District Health Boards 'actual' ALOS, and the nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nation-wide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents, and summing the result across all discharge groups.	<3.9 Days	NA	Quarterly
OS4 Acute inpatient length of stay			
The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The District Health Board 'actual' ALOS, and nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nationwide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents for the DHB, and summing the result across all discharge groups.	<3.9 Days	NA	Quarterly
OS5 Theatre Utilisation			
Each quarter, the District Health Board is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility. • Actual theatre utilisation, • resourced theatre minutes, • actual minutes used as a percentage of resourced utilisation The expectation is that District Health Boards will supply information on the template quarterly. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following: a. For District Health Boards whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended b. For District Health Boards whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended	85%	**85%**	Quarterly

OS6 Elective and arranged day surgery			
The standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The District Health Boards 'actual' day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). The 'expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the District Health Board, and summing the result across all DRGs.	64%	**62% Standardised**	Quarterly
OS7 Elective and arranged day of surgery admissions			
The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage.	75%	**90% Standardised**	Quarterly
OS8 Acute readmissions to hospital			
The standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB's 'actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The 'expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the District Health Board.	<8.15%	NA	Quarterly
OS9 30 Day mortality			
The measure is for a standardised mortality rate, in order to improve the comparability of the measure across the sector. The standardised mortality rate is the ratio of the 'actual' to 'expected' mortality rates, multiplied by the nationwide mortality rate, expressed as a percentage. The District Health Board's 'actual' mortality rate, and the nationwide mortality rate, are both defined as the number of in-hospital patient deaths within 30 days of admission, as a proportion of all patient discharges, including day cases. The 'expected' mortality rate is derived using regression methods from the DRG and patient population characteristics of the DHB.	<1.9%	NA	Annual

OS10 Improving the quality of data provided to national collection systems			
Measure 1: National Health Index (NHI) duplications Numerator: Number of NHI duplicates that require merging by Data Management per District Health Board per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter. Denominator: Total number of NHI records created per District Health Board per quarter (excluding pre-allocated NHIs and newborns)	<6%	**<6%**	Quarterly
Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per District Health Board per quarter Denominator: Total number of NHI records created per District Health Board per quarter	<2%	**<2%**	
Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS) Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per District Health Board Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per District Health Board	>55%	**>55%**	
Measure 4: Timeliness of NMDS data Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge. Denominator: Total number of publicly funded NMDS events in the NMDS per District Health Board per quarter.	<5%	**<5%**	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event Numerator: Total number of NNPAC Emergency Department admitted events that have a matching NMDS event Denominator: Total number of NNPAC Emergency Department admitted events	>97%	**>97%**	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the District Health Board in the quarterDenominator: Total number of PRIMHD records submitted by the District Health Board in the quarter	>98%	**>97%**	

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