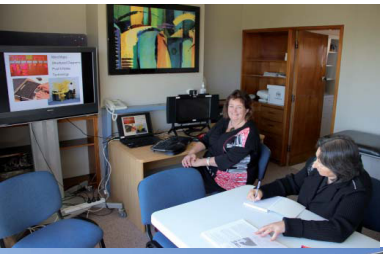

-West Coast-
DISTRICT HEALTH BOARD
TE POARI HAUORA A ROHE O TAI POUTINI

West Coast District Health Board

Annual Plan 2012/2013 and Statement of Intent

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

ANNUAL PLAN

1 July 2012 – 30 June 2013

Produced in 2012 by the

West Coast District Health Board

P O Box 387, Greymouth

www.westcoastdhb.health.nz

Pictures courtesy of WCDHB
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APPROVAL FROM THE MINISTER OF HEALTH

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MESSAGE FROM THE CHAIRMAN AND CHIEF EXECUTIVE

It is with pleasure that we present our Annual Plan for the 2012/13 financial year. This plan reflects our commitment to providing a West Coast health system that supports our community to be well within the allocated resources.

For the West Coast, a sustainable and effective health service will require a unified approach to health service delivery across the system. Our health priorities for the 2012/13 year have been identified at a national, regional and local level. Emphasis is on delivering the right care, at the right place and at the right time within the funding available.

Building better relationships at all levels continues to have high importance. Creating an environment of confidence and trust through open and transparent relationships with our community, people working in our health system, intersectoral agencies and with our community leaders is critical to us achieving our health priorities and strategic imperatives.

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:

- Be healthier and take greater responsibility for their own health
- Stay well and maintain their functional independence
- Recover from complex illness and/or maximise their quality of life.

The West Coast DHB strategic imperatives for 2012/2013 are:

- ***Achieving the Minister's health targets*** – We intend 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*** – 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 implementing locally designed patient pathways that integrate and connect the West Coast health system models of care to improve the level of care we provide across our entire system.
- ***A 'Transalpine approach'*** – The West Coast DHB working in collaboration with the Canterbury DHB is committed to a Transalpine approach to service provision and developing the quality patient pathways that will ensure West Coasters can access the high quality health services they need as close to where they live as possible.
- ***Facility development and refurbishment*** – A single point of entry into the health system that contains both primary health care and acute hospital services is being developed in the Buller to overcome issues with aging buildings. Planning for similar changes at the Grey Base Hospital campus is also progressing.
- ***Provision of wrap around services for older people*** – Support of older West Coasters to live independent and healthy lives will occur through the provision of connected and integrated services provided close to home.

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 whānau o Te Tai o Poutini and stakeholders to ensure our Māori whānau receive and have access to services that will improve whānau ora.

We are developing the tools to deliver sustainable health services within our community. By working smarter and more collaboratively with other DHBs and health providers on the West Coast we are making key steps towards serving our community more effectively.

In pursuit of the above, the West Coast District Board is firmly committed to working in a close collaborative partnership with Canterbury District Health Board at governance, clinical and organisational levels.

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.

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance

Peter Ballantyne
Acting Chair, West Coast DHB

David Meates
Chief Executive, West Coast DHB

Introducing the West Coast DHB

The West Coast District Health Board (West Coast DHB) is pleased to present the Annual Plan with Statement of Intent for 2012/13. 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 Minister of Health's letter of expectation to our Board Chair 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 Quality 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 Māori participation and involvement in the strategic planning processes and the development of Māori capacity in the health and disability sector to improve Māori 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 Officer, Director of Nursing and Midwifery, Executive Director of Allied Health, General Managers of Planning and Funding, Primary, Community and Mental Health Services, Māori Health, Hospital Services, Human Resources, the Chief Financial Officer who provide clinical, financial and cultural leadership, input into Board and Committee decision making and oversight of patient safety and quality. Various management roles at the West Coast DHB, including the Chief Executive, are joint positions across the West Coast and Canterbury DHBs.

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

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: Greymouth Health Centre (provided across two sites: Grey Medical Centre and Rural Academic General Practice [RAGP]), Reefton Medical, Buller Health and South Westland Medical Practice (with rural clinics in Whataroa, Franz Josef, Fox Glacier, Haast and Hari Hari), plus associated medical clinics in remote rural areas including Ngakawau, Karamea, Moana[1]. The DHB is currently reviewing the business management of these practices as it examines options to achieve clinically and financially sustainable primary care on the West Coast. There are also two privately owned 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 from other sources such as community pharmacies, Plunket, Disability Support Services and Rata te Awhina Trust.

Promoting Community Health and Wellbeing

Good health is determined by many factors, or social determinants of health, which sit outside 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 to create and support 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.

Through Community and Public Health, West Coast PHO and our Smokefree/Tobacco control and population health contracts we support collaborative ventures and initiatives that focus on the reduction of behavioural and environmental risk factors to reduce long-term conditions and injury. This includes reducing tobacco smoking, improving nutrition, increasing physical activity, reducing alcohol consumption and other risk behaviours under the joint banner of Healthy West Coast.

[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.*

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 Our Performance Story

The West Coast Health System – Supporting you to be well

The West Coast DHB and alliance partners are working on developing health care services that are:

- ***People centred:*** Services will focus upon meeting people's needs and will value their time as an important resource. Services will minimise requirements for people to wait for care and avoid the need for people to attend services at many different places or times unless there are good clinical reasons to do so.
- ***A single system:*** All elements of health services will work in a mutually supportive way for the same purpose. Resources will be flexible across services.
- ***Integrated:*** The most appropriate health professional will be readily available to provide care where and when it is needed. Services will be supported by good communication and timely information flow throughout the system.
- ***Viable:*** As a whole the health system will live within its means and achieve levels of efficiency and productivity which allow and appropriate range of services to be maintained in the long-term. There will be a stable workforce of health professionals to provide these services.

In the drive to secure a stable future for health services on the West Coast, the West Coast DHB and West Coast PHO have been working with health professionals to develop a model of care that details the approach for future service delivery, the required workforce, and the settings in which care will be delivered. Important steps have already been taken towards achieving a more sustainable future for health services on the West Coast, including improving clinical information systems, commencing the development of the Buller Integrated Family Health Centre and setting in place new cooperative arrangements between specialist services between West Coast and Canterbury DHBs.

During 2011/12 the West Coast DHB has considerably improved access to specialist health care and reduced the time West Coasters spend travelling to access this care. The utilisation of telemedicine on the West Coast has saved the need for over 100 oncology patients to travel to Christchurch for specialist treatment and follow-up consultations. Instead of travelling to Christchurch, West Coast patients are now able to access specialist advice via telemedicine from their local clinic. During the year this service has also been utilised for paediatric, general surgery and nutrition specialist consultations.

The West Coast DHB continues to make progress on each of the Minister's health targets and has far exceeded the elective surgery target. During 2010/11 the West Coast DHB delivered 1,710 elective operations; considerably higher than our target of 1,592. We have continued to lead the country in access to urgent care and in 2011/12 have made considerable progress towards achieving our smoking, diabetes and cardiovascular disease targets.

Our plan for 2012/13 builds on the important steps that have been made to enhance the viability and sustainability of health services on the West Coast and the achievement of the Minister's health targets.

1.3 Our Transalpine Approach

The West Coast has a longstanding relationship with Canterbury DHB, recently cemented by formal arrangements that have enabled closer clinical collaboration and joint 'back office' service provision. Formalising our collaboration has allowed us to actively plan the assistance and services that Canterbury provide to the West Coast and to build the most appropriate workforce and infrastructure in both locations - without any detrimental effect on services to either population.

As part of these formal arrangements, Canterbury and the West Coast now share a Chief Executive and senior clinical and management expertise including: a joint Director of Allied Health, Clinical Director of Mental Health and some Senior Medical Officers, such as a Paediatrician, as well as joint project, human resources and information support. A number of training and secondment opportunities also support the development of an experienced and sustainable workforce in both regions.

Having recognised the value of this close collaboration, clinicians and senior staff from both DHBs met to consider how we can further support the provision of quality clinical services on the West Coast. Key outcomes from this workshop were a commitment to a 'transalpine' approach to service provision and recognition that quality patient pathways are critical in assuring West Coasters can access the services they need as close to where they live as possible.

Clinicians from West Coast and Canterbury DHBs will continue to develop this transalpine approach over the next year.

The initial work has been to plan for and implement the new models of care, including transitional arrangements, now being incorporated into the business case for the redevelopment of the Grey Base Hospital campus. Clinical support networks, referral guidelines and the use of technology such as videoconferencing will enable clinical teams to make the best arrangements for their patients and help to reduce long waits for treatment. We will develop a comprehensive range of patient pathways to improve the quality of the services provided. In the coming year the focus will be on orthopaedic services, paediatrics services, oncology and health services for the elderly.

1.4 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 1.4 people per square kilometre, less than 1% (0.7%) of the New Zealand's total estimated resident population.

Our Population

The West Coast is home to a population of 32,900 people*– an increase of 2% from the 2006 estimated resident population. The child and youth populations decreased slightly between 2006 and 2011 but during the same time period there was slight growth among the older adult population (40-64) and significant growth among 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 with 75% of West Coast Māori population aged less than 45 years. Detailed ethnicity data analysis of the West Coast population shows that nearly 90% of the West Coast population identify as 'Other' (not Māori, or Pacific or Asian), 10% as Māori, just above 1% as Asians and Pacific less than 1%.

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; and
- 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 2010/11, there were over 6600 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 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%).

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

** Estimated Resident Population at June 2011– Source; Statistics New Zealand – Subnational Populations Estimates: At 30 June 2011, accessed 25 October 2011.*

*** Only includes Hospital discharges from Buller, Grey Base, Reefton and Southern Cross Christchurch Hospital – Source: West Coast DHB iPM dataset.*

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 61% of five year olds seen by the School Dental Service in 2011 were dental caries free; the figure was just 47% 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 recently published 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.

1.5 Operating Environment

The West Coast DHB has an established governance and organisational structure, based on the requirements of the NZPHD Act, through which the DHB functions *(see Appendix 5 for the organisational structure).*

Demographic 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. This will result in an increase in demand for health services and the requirement for a flexible and responsive model of care that support older people to stay well. Our ageing population will also create challenges for our workforce with the need for medical, nursing and allied health staff to be competent in a broad range of skills, with the flexibility to shift from one area of service delivery to another.

Fiscal Pressures

The West Coast Health System must live within it means. The West Coast will receive $116M in 2012/13 to provide health and disability services across our district through core population budget funding, including transitional pool funding and this funding equates to 24% more funding per head of population than the population based funding formula. Despite this, in the year ending June 2012 we are forecast to operate to a deficit of $5.1M. The West Coast health system is committed to making rapid progress in further decreasing our deficit in 2012/13 and achieve breakeven by the end of 2014/15.

Workforce Pressures

Our ability to continue to transform our health system and to meet the future demand for services relies heavily on having the right people, with the right skills, in the right place. There are various challenges around recruiting and retaining health professionals on the West Coast and the reliance on temporary and locum staff makes it difficult to maintain consistency of care. Additionally, as a greater proportion of the population reaches traditional retirement age, there is concern over the continued availability of a sufficient workforce pool to meet increases in demand for health services. These challenges are accompanied by changing workforce patterns, the expectations of younger people, new technology and changing delivery models that place pressure on the health workforce to change their working models in response.

Workforce is a critical asset for the DHB. As a major employer in our district we employ just over 1,100 people and indirectly employ people to deliver health and disability services to our population through service contracts with public, private and charitable organisations.

It is essential that we continue to drive to create a professional working environment that will make the West Coast health system an attractive place for young health professionals to come and work. A large focus of our workforce strategy in 2012/13 will be redefining the West Coast 'brand' in order to retain and attract people to the region. We will also focus on expanding and integrating training and professional development programmes and developing core leadership/management curricula to increase capability and capacity across our health system.

We committed to investing in clinical leadership and engaging our health professionals in service level alliances and regional networks to support the accelerated integration of services and enable our health system to respond quickly to immediate issues.

Other Operating Pressures

- ***Access to primary care*** – the West Coast has 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 longer than ideal waiting times 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 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 CDHB.
- ***Aged residential care*** – the West Coast has higher from average utilisation of residential care for the elderly and home based support.

1.6 Key Challenges and Critical Success Factors for the West Coast DHB

Alongside the identified pressures above, the most immediate challenges and critical success factors for the West Coast health system in achieving clinical and financial sustainability are:

CHALLENGES	CRITICAL SUCCESS FACTORS
Gaining Local Trust and Confidence There has been a continuous process of review and change within the West Coast health system over a number of years. It is imperative that we continue to engage our community and health professionals and ensure that progress and positive and tangible changes within the system are evident.	Locally – Our clinical leaders and local community are engaged in designing and modifying our health system. We will continue to support the integration of our health system through ensuring that the right people are getting the support and information required to bring about positive change. IT systems and workforce are recognised as two critical enablers of an integrated and connected West Coast health system. A West Coast Consumer Council comprised of service user representatives from across the system and over a range of services will be in place by December 2012. The West Coast DHB has recently adopted an Open Disclosure Policy for serious and sentinel events, in line with the national trend.
Embedding Clinical Leadership throughout the West Coast Health System Historically, the balance between clinicians and managerial leadership has varied across the West Coast health system. Developing a partnership between clinicians and management, to provide a clinician-led management-enabled system, will allow the best health services to be provided.	Locally - This year we will embed the new clinical governance and support continued clinical leadership throughout the system to ensure that clinical best practice and safety is maintained. There will be clinical input into all key strategic decisions on health service delivery on the West Coast.
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. Applying lean thinking principles for process improvements and continuing to introduce this way of working to our workforce through internal training programmes and project methodologies, including the Improving the Patient Journey Programme and Xcelr8 and Collabor8 programmes will be a focus.
Achieving a Sustainable Workforce Recruitment and retention of clinical staff is difficult, leading to a high use of locums and temporary staff. This reliance on locums is costly and impacts upon patient continuity and consistency of care. The West Coast DHB must also live within our means in relation to wage and salary and the costs of recruiting health professionals to the district.	Nationally and inter-district - Reducing the reliance upon locum cover through addressing the terms and conditions of locum employment via national fora and continued sharing of health professionals through our 'transalpine approach' with CDHB. Locally - Our recruitment efforts will become increasingly more targeted to markets and occupational groupings where we are most at risk clinically. Clinicians that have a wider range of skills will be targeted and specialist skills will be sourced from CDHB and well as provided locally.
Redevelopment of Health Service Infrastructure Hospital services in their current configuration constrain improvements to care, are expensive to maintain, are not compliant with modern seismic standards and Grey Base hospital has numerous issues including leaks and an ageing steam and electrical systems. The West Coast DHB faces challenges around obtaining agreement and approval for a	Locally – Grey Base Hospital will be transformed into a building that contains both primary health care services and hospital services operating within a fully integrated system. Investment will also occur across the West Coast health systems to provide integrated health services that are delivered closer to home and reduce the reliance on hospital based service delivery.

CHALLENGES	CRITICAL SUCCESS FACTORS
capital business case for the redevelopment/refurbishment of Buller Health and of the Grey Base Hospital campus within a fiscally constrained environment. Some primary and community facilities are not adequately fixed or located for the services provided from them.	
Achieving Financial Sustainability Even though we are proportionally the best funded DHB in New Zealand, we struggle to live within our means. There is the requirement to further reduce the operating deficit within the West Coast health system.	Local – reduce the operating deficit within the West Coast health system through changing models of care, integrating the system and reducing variation, duplication and waste. This will include developing a whole of West Coast health system that is well connected and works for the community – delivering the right care in the right place.

What will a sustainable health system look like?

Although they may differ in size, structure and approach, health providers have a common goal: to improve the health of their populations by delivering high quality and accessible health care. With increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and our health system faces an unsustainable future if we continue on the current trajectory. In response, significant changes are being made to the design and delivery of health services at all levels of the New Zealand health system.

2.1 National direction: '*better, sooner, more convenient*' healthcare

The changes being driven across the New Zealand health system are in line with the wider strategic context outlined in the *New Zealand Health Strategy*, *the New Zealand Disability Strategy* and the *New Zealand Māori Health Strategy* (*He Korowai Oranga*).

These national strategies, combined with the Minister of Health's annual letter of expectations and the *New Zealand Public Health and Disability Act,* provide guidance for policy and planning at regional and local levels. The *New Zealand Health Strategy,* in particular, outlines objectives for the health of the New Zealand population and the role of DHBs in delivering the national vision: "*All New Zealanders lead longer, healthier and more independent lives*"

Alongside these overarching strategies, the National Health Board has released *Trends in Service Design and New Models of Care*.[3] This document provides a high-level summary of emerging worldwide trends and international responses to the pressures and challenges facing the health sector.

Hospitals will continue to be a key support and a setting for highly specialised care, with the importance of timely and accessible care being paramount. However, less-complex care (traditionally provided in hospital settings) will be provided in the community.

Supported by clinical networks and multidisciplinary teams, the focus is shifting towards supporting people to better manage their own health and to stay well.

This emerging direction emphasises four major shifts in service delivery, based on the view that an aligned system-wide approach is required to improve health outcomes and reduce the unsustainable growth in demand for health services:

1. Greater support for early intervention, targeted prevention and self-management, with a shift to more home-based care;
2. Greater support for a more connected system and integrated services, with a shift to the provision of more services in community settings;
3. Greater support for regional collaboration clusters and clinical networks, with a shift to more regional service provision; and
4. Managed specialisation, with a shift to consolidate the number of tertiary centres/hubs.

This reorientation is consistent with Government's commitment to *'better, sooner, more convenient'* health care and clear expectations to bring more health services closer to where patients live – accelerating the integration of primary and secondary services.

The development of Integrated Family Health Centres (IFHCs), Community Hubs and collaborative partnerships between health professionals will further enhance primary and community services and free up hospital and specialist services to provide more intensive treatment and complex care.

Increased Regional collaboration

Government also has 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 nationally and across DHB regions. Greater collaboration between DHBs is seen as a means to reduce duplication and waste, maximise clinical and financial resources and ensure the ongoing sustainability of health services.

A work programme to develop National Services and National Service Improvement programmes was introduced by the National Health Board in 2010, aimed at improving equity of access, quality, consistency and sustainability for

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

vulnerable services. This was particularly aimed at high-cost/low-volume specialist services including paediatrics and congenital cardiac services.

Building on the DHB model, lead DHBs were selected to be responsible for the provision and development of national services. DHBs whose populations were recipients of these services were expected to work collaboratively with the national service provider – supporting outreach clinic arrangements to improve access for their populations.

National Service Improvement programmes required the commitment of clinicians and managers within DHBs across a designated service pathway to identify areas of opportunity and work together on interventions to improve equity of access, quality, consistency and sustainability nationwide.

2.2 Regional direction: best for patient, best for system

The West Coast is part of the South Island region along with Nelson Marlborough, Canterbury, South Canterbury and Southern DHBs. Each DHB individually ensures the provision of health and disability services for its population and faces similar challenges in delivering high quality services, ensuring the future sustainability of those services and achieving Government priorities.

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

The South Island total population is 1,038,843 people (24% percent of the total New Zealand population). Implementing diverse but similar individual responses duplicates effort and investment and leads to service and access inequalities. Regional collaboration is an essential part of our future direction.

In agreeing a collaborative regional direction, the South Island DHBS have committed to a 'best for patient, best for system' alliance framework that aligns with national policy. The South Island's Regional Health Services Plan articulates the regional direction and the key principles that will inform regional service development, service configuration and infrastructure requirements over the next several years.

Our 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, high quality services, as close to people's homes as possible.

Closely aligned to the national approach, the regional direction is based on the following concepts:

- More health care will be provided at home and in community and primary care settings;
- Secondary and tertiary services will be provided across DHB boundaries;
- 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 a smooth transition for patients between services and providers; and
- Clinical networks and multidisciplinary alliances will support the delivery of quality health services across the health continuum.

These concepts emphasise the significant step change in the way we design and deliver services. Through regional service planning, traditional DHB boundaries and patient flows are being challenged to ensure that services are supported in a sustainable manner.

An alliance approach

Regional service planning in the South Island is implemented through service level alliances and work streams based around priority service areas. These areas have been identified nationally, regionally or locally as clinically 'vulnerable', under pressure from high demand, or as key enablers to support change.

Each service level alliance and work stream is clinically led and has active clinical input, with multidisciplinary representation from community and primary care as well as from hospital and specialist services.

Six service level alliances have been prioritised to respond to immediate challenges in the coming year: Cancer, Child Health, Health of Older People, Mental Health, Information Services and Support Services.

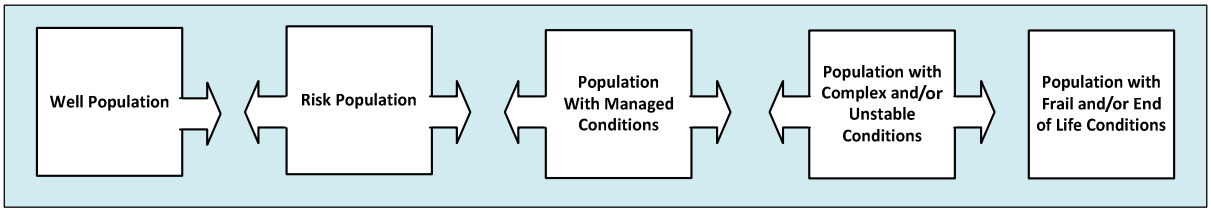
Alongside these service level alliances, collaborative activity is expanding through work streams aligned to a number of other priority areas: cardiac, elective, neurosurgery, ophthalmology, stroke, Māori health and HR services.

The South Island Regional Health Services Plan has been approved by the regional Chief Executives and the Boards of all five South Island DHBs. It is available on the South Island Alliance's website: www.sissal.govt.nz.

A generic model of care

Our success relies on improving patient flow across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to connect services across service levels, providers and regions.

In support of this 'whole of system' approach, the South Island has adopted a generic model of care to ensure a consistent understanding of the range of health needs a person may have over their lifetime.



The model focuses health planning on the patient's needs and the provision of the right service, at the right time and in the right place. It triggers a series of questions by asking what we need to do to:

- keep people well in the community?
- ensure early detection and early intervention?
- support people to self-manage in a community setting, avoid unnecessary hospital admissions and slow the progression or deterioration of their condition?
- ensure that when people require complex interventions, they are available at the right time and to a high quality standard?
- support people to regain their functional independence and avoid further complications?

This approach prompts the development of patient pathways that flow across the continuum of care and supports service redesign by questioning gaps and barriers. 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 wellbeing.

Flexible and non-traditional workforce models are a central part of the future picture. The South Island Regional Training Hub is working to analyse workforce trends and future requirements and to develop plans for specific workforce groups and critical roles.

2.3 Local direction

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

Members of the West Coast health system, including clinical leaders, 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 2012/13 are as follows.

- ***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 deliver services more efficiently and aligning to a transalpine and regional approach to health service delivery.
- ***Delivering better, sooner, more convenient health 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 implementing locally designed patient pathways that increasingly integrate and connect the West Coast health system for planned and unplanned care. The aim will be to expand general practice services as people's 'health care home', increase the autonomy and viability of DHB-owned general practices and provide clinically and financially sustainable hospital services. To enable these improved models of care, there will be a focus on integrating IT systems, developing effective transport systems and empowering the workforce.

- ***A 'transalpine approach'***– 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. This year there will be an increased focus on joint appointments and sharing of clinical staff between the two DHBs, the development of clinical networks and patient-centred health pathways.
- ***Facility development and refurbishment*** – Investment into Grey Base Hospital and Buller Hospital is required to overcome serious issues with ageing buildings. During the course of the year, we will be working towards transforming the Buller Hospital and Buller Medical Centre into a 'one stop shop' as a single point of entry into the health system that contains both primary health care services and acute hospital services. We will be working to develop a similar model for the Grey Base Hospital campus.
- ***Provision of wrap-around services for older people*** – We will support older West Coasters to live independent and healthy lives and avoid admission to hospital and aged residential care through the provision of connected and integrated services that are provided closer to home.

IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

What are we trying to achieve?

DHBs are responsible for supplying health and disability services to meet the needs of their populations; however, resources are limited. To sustainably cope with the increasing demand for services, we must design pathways that influence the flow of people – shifting care to the most appropriate setting and reducing demand by supporting people to stay well and maximise their independence.

We work with our stakeholders to effectively coordinate the way we care for our population and to influence demand. Ultimately this will assist us to achieve our desired outcomes: people will receive the care and support they need, when they need it, in the most appropriate place and manner.

In line with the functions and responsibilities of a DHB, we will deliver on the priorities and expectations of Government. By achieving our goals, we will help to deliver the Government's vision: "*All New Zealanders lead longer, healthier and more independent lives*".

At a regional level, the South Island DHBs are working collectively to deliver "*A clinically and fiscally sustainable South Island health system*." The regional focus on "*providing equitable and timely access to safe, effective, high quality services"* will not only contribute to ensuring health services are sustainable but, by keeping people well, it will also alleviate the increasing demand for services and improve health outcomes.

This will allow us to achieve our vision/goal of providing a viable people centre, integrated single system that supports our community to be well.

This section presents an overview of how we will demonstrate whether we are succeeding in improving the health and wellbeing of our population and that of the wider South Island. There is no single measure for our desired outcomes or for the impact of the work we do. Rather, we use population health indicators as proxies to demonstrate the outcome or impact being sought.

The South Island DHBs have identified three strategic outcomes and a core set of associated performance measures, which will demonstrate whether we are 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 measureable change in the health status of the South Island population over time, rather than a fixed target.

- ***Outcome 1: People are healthier and take greater responsibility for their own health.***

  The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing.

- ***Outcome 2: People stay well and maintain their functional independence.***

  The development of primary and community-based services that provide early diagnosis and treatment and support people to better manage enduring health conditions, reduce the complications of disease and injury and maintain functional independence in their own homes and communities.

- ***Outcome 3: People recover from complex illness and/or maximise their quality of life.***

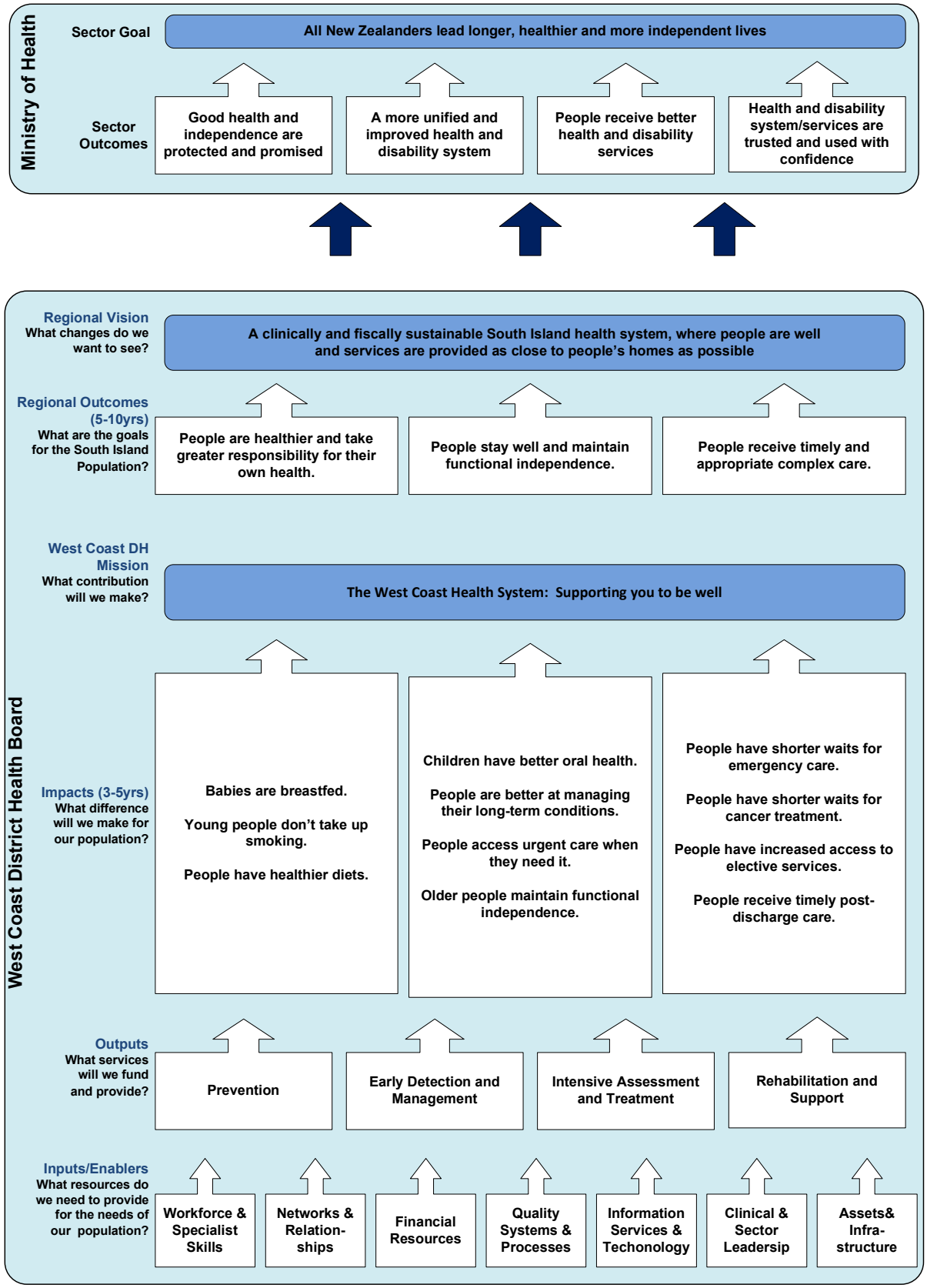
  The development of systems and models of care that free up secondary and specialist services to provide timely and appropriate complex care and advice to reduce the progression of illness, better support people's functional capacity and improve people's quality of life.

Against each of these desired regional outcomes, we have identified areas where individual DHB performance will have an impact on achievement and collectively agreed a core set of related medium-term (3-5 years) performance measures. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'main measures', and each South Island DHB has set local targets to evaluate their performance over the next three years.

The following intervention logic diagram visually demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired regional outcomes and the delivery of the expectations and priorities of Government.[4]

[4] *The DHB also has a Māori Health Action Plan which is a companion document to this Annual Plan and sets out key performance measures specifically to support improvements in Māori health and reduce inequalities. The 2012/13 Māori Health Action Plan is available on the DHB's website.*

Figure 3: Intervention Logic



STRATEGIC GOAL

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

Expectation

Population health and prevention programmes 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. These programmes create health-promoting physical and social environments which support people to take more responsibility for their own health and 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. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all 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 our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

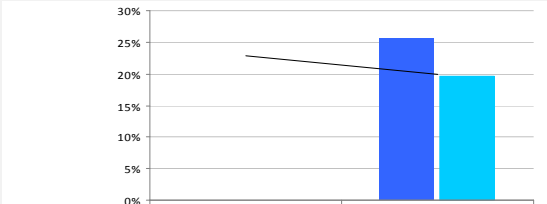
We will know we are succeeding when there is:

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 cancer, respiratory disease, heart disease and stroke.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, 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 reduce inequalities and target improvements in the health of populations with high need.*

Data sourced from national NZ Health Survey via PHI Online.[5]

Long-term Outcome Measure: The percentage of the population (15+) who smoke.



	2002/03	2006/07
West Coast		25.6%
South Island		19.5%
National Average	22.9%	19.9%

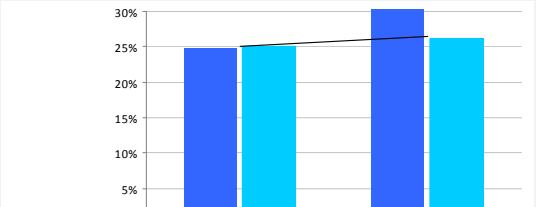
Note: No data available for 2002/03.

A reduction in obesity rates.

- *There has been a rise in obesity rates 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.* [6]
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.*

Data sourced from national NZ Health Survey via PHI Online.

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



	2002/03	2006/07
West Coast	24.7%	31.5%
South Island	25.0%	26.2%
National Average	25.0%	26.5%

[5] *The NZ Health Survey was completed by the Ministry of Health in 2003/04 and 2006/07; the next survey results are expected in 2012.*
[6] *'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.*

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

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

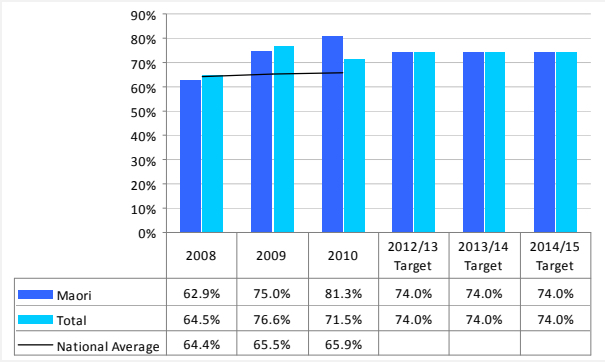
More babies are fully and exclusively breastfed.

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

Data sourced from Plunket via the Ministry of Health.[7]

The percentage of West Coast babies fully/exclusively breastfed at 6 weeks.

	Actual 2010	Target 12/13	Target 13/14	Target 14/15
Māori	81.3%	74%	> 74%	> 74%
Total	71.5%	74%	> 74%	> 74%



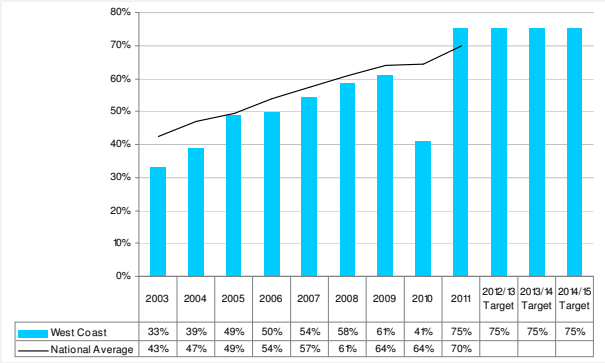
Fewer young people take up tobacco smoking.

- *Reducing smoking prevalence is largely dependent on 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, with approximately one in every four West Coast teenagers (15-19) currently smoking.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

Data sourced from national Year 10 ASH Survey.[8]

The percentage of 'never smokers' among Year 10 West Coast students.

Actual 2011	Target 12/13	Target 13/14	Target 14/15
75%	75%	> 75%	> 75%



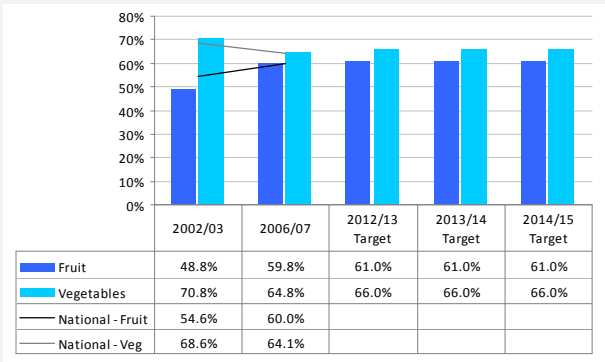
Adults have healthier diets.

- *Good nutrition is fundamental to health and the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in NZ every year.*[9]
- *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 health promotion and engagement leading to a change in the social and environmental factors that influence people to make healthier choices.*

Data sourced from the national NZ Health Survey.

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

	Actual 06/07	Target 12/13	Target 13/14	Target 14/15
Fruit 2+	59.8%	61%	> 61%	> 61%
Veg 3+	64.8%	66%	> 66%	> 66%



[7] *Data is reported annually on calendar years for the national DHB performance indicator S17.*
[8] *The ASH survey (run by Action on Smoking and Health) provides a point prevalence data set and is reported annually on calendar years.*
[9] *Niki Stefanogiannis: Nutrition and the burden of disease in NZ; 1997–2011, Public Health Intelligence, Ministry of Health, Wellington.*

STRATEGIC GOAL

2.5 People stay well and maintain their functional independence

Expectation

Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and supporting them to better manage illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness. They also support people to regain their functionality after illness and to remain healthy and independent.

Why is this outcome a priority?

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and prevent disease through education, 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, particularly in 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, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

With an ageing population, the South Island will require a strong base of primary care and community support, including residential care, respite 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 responsive, needs-based services helps people to maximise function with the least restriction and dependence.

If people are well, they need fewer hospital-level or long-stay interventions, and those who do have a greater chance of returning to a state of good health or 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.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

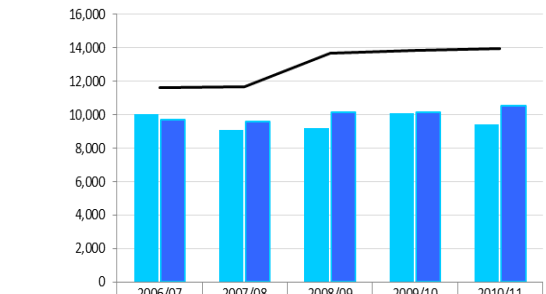
We will know we are succeeding when there is:

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

- *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 medical admissions can be used as a proxy measure of the improved management of long-term conditions by indicating that people are less likely to experience an escalation of their condition leading to an event needing urgent (acute) and complex intervention.*
- *Reducing acute admissions to hospital also has a positive effect on productivity in hospital and specialist services - enabling more efficient use of health resources that would otherwise be taken up by a reactive response to demand for urgent care.*

Data sourced from National Minimum Data Set.

Long-term Outcome Measure – The age-standardised rate of acute medical admissions to hospital (per 100,000 people).



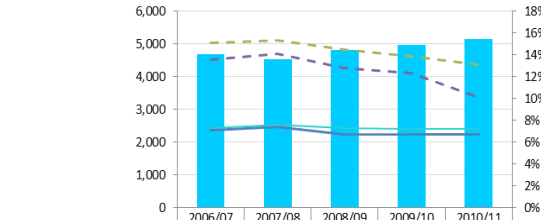
	2006/07	2007/08	2008/09	2009/10	2010/11
West Coast	10,018	9,073	9,208	10,113	9,406
South Island	9,705	9,613	10,151	10,134	10,555
New Zealand	11,607	11,688	13,673	13,845	13,984

An increase in the proportion of the population (65+) supported to maintain functional independence.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, West Coast rates are lower than the South Island average. When people receive adequate support for their needs, remaining in their own homes provides a 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 to stay well in their own homes for as long as possible.*

Data sourced from Client Claims Payment System provided by SIAPO.

Long-term Outcome Measure – The percentage of the population (65+) in ARC and those receiving Home Based Support Services.



	2006/07	2007/08	2008/09	2009/10	2010/11
West Coast Population 65+	4,695	4,540	4,823	4,968	5,140
West Coast % ARC	7.1%	7.4%	6.7%	6.7%	6.7%
South Island % ARC	7.3%	7.6%	7.3%	7.2%	7.2%
West Coast % HBS	15.1%	15.3%	14.5%	13.9%	13.1%
South Island % HBS	13.6%	14.1%	12.8%	12.3%	10.1%

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

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

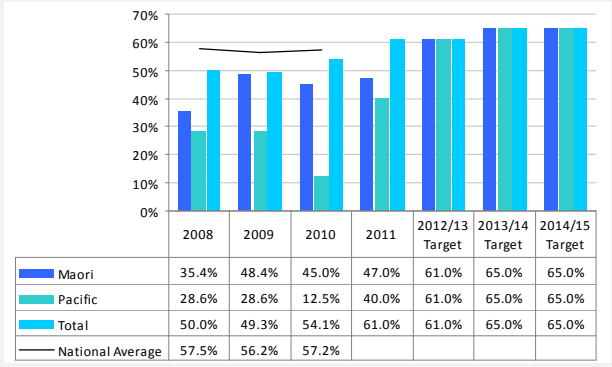
More children have good oral health.

- *Oral health is 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.*
- *Good oral health not only reduces unnecessary complications and hospital admissions for extraction, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights - helping to keep people well.*
- *Māori children are three times more likely to have decayed, missing or filled teeth and as such, improved oral health is also a proxy measure of equity of access and the effectiveness of mainstream services in targeting those most in need.*

Data sourced from Ministry of Health.[10]

The percentage of West Coast children caries free at age 5 (no holes or fillings).

	Actual 2011	Target 12/13	Target 13/14	Target 14/15
Māori	47%	61%	65%	65%
Pacific	40%	61%	65%	65%
Total	61%	61%	65%	65%



	2008	2009	2010	2011	2012/13 Target	2013/14 Target	2014/15 Target
Maori	35.4%	48.4%	45.0%	47.0%	61.0%	65.0%	65.0%
Pacific	28.6%	28.6%	12.5%	40.0%	61.0%	65.0%	65.0%
Total	50.0%	49.3%	54.1%	61.0%	61.0%	65.0%	65.0%
National Average	57.5%	56.2%	57.2%				

People better manage their long-term conditions.

- *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*

The percentage of the West Coast population identified with diabetes with HbA1c≤64mmol/mol.

	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
Māori	71.0%	80%	80%	80%
Pacific	71.0%	80%	80%	80%
Total	71.0%	80%	80%	80%

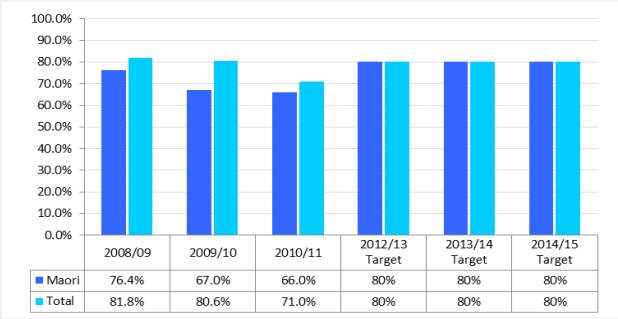
[10] *Oral health data is reported annually for the school year (calendar year) and is based on the national DHB performance indicator PP11.*

[11] *Diabetes data is reported one quarter in arrears via the national PHO Performance - 'satisfactory' is defined as having HbA1c≤64%.*

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, good diabetes management is likely to reflect good management of other long-term conditions as well.*

Data sourced from individual DHBs.[11]



	2008/09	2009/10	2010/11	2012/13 Target	2013/14 Target	2014/15 Target
Maori	76.4%	67.0%	66.0%	80%	80%	80%
Total	81.8%	80.6%	71.0%	80%	80%	80%

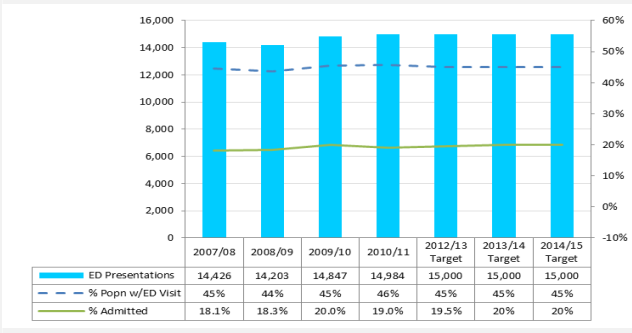
More people access care appropriate to their needs.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are being given the right treatment and support, at the right time and in the right place, which is not necessarily in hospital emergency departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the number of people presenting to the Emergency Department (ED) and an increase in the percentage of people presenting who are admitted are proxy measures of whether people are being more appropriately managed and supported elsewhere.*

Data sourced from individual DHBs.[12]

The percentage of the West Coast population presenting at ED.

Actual 10/11	Target 12/13	Target 13/14	Target 14/15
46%	45%	45%	45%



	2007/08	2008/09	2009/10	2010/11	2012/13 Target	2013/14 Target	2014/15 Target
ED Presentations	14,426	14,203	14,847	14,984	15,000	15,000	15,000
% Popn w/ED Visit	45%	44%	45%	46%	45%	45%	45%
% Admitted	18.1%	18.3%	20.0%	19.0%	19.5%	20%	20%

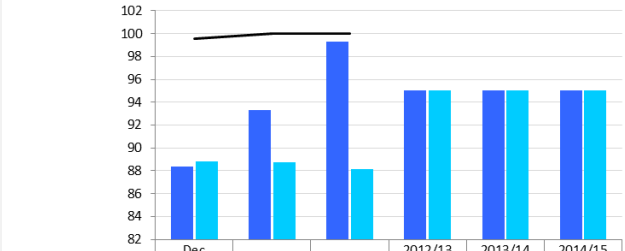
Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *There are a number of admissions to hospital for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the quality of early detection, intervention and disease management services.*
- *A reduction in these admissions will reflect better management and treatment and will free up hospital resources for more complex and urgent cases. The expected rate is the national average - results lower than 100 indicate better than average performance.*
- *The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services, increased access to diagnostics and improved management of long-term conditions. Achievement against this measure is seen as a proxy indicator of a more unified health system, as well as the quality of the services being provided.*

Data sourced from the Ministry of Health. [13]

The ratio of actual to expected avoidable admissions for the West Coast population (<75).

	Actual 2011	Target 12/13	Target 13/14	Target 14/15
Māori	99	95	95	95
Pacific	88	95	95	95
Total	99	95	95	95



	Dec 2008	Sep 2010	Sep 2011	2012/13 Target	2013/14 Target	2014/15 Target
Maori	88	93	99	95	95	95
Total	89	89	88	95	95	95
New Zealand	100	100	100			

More older people maintain functional independence.

- *Around 12,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to*

The percentage of the West Coast population (75+) admitted to hospital as a result of a fall.

Actual 10/11	Target 12/13	Target 13/14	Target 14/15
6%	5%	5%	5%

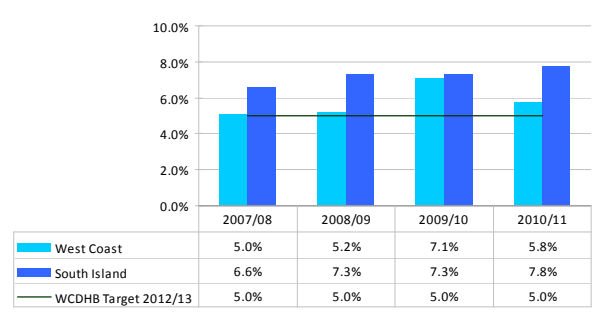
[12] *'Admitted' is defined by the Ministry of Health national ED Health Target.*

[13] *This measure is based on the national DHB performance indicator SI1and covers hospitalisations for 26 identified conditions including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The 10/11 actual is for the 12 months to 30 Sept 2011*

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

- *With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the relative demand on acute and aged residential care services.*
- *A reduction in falls will indicate improved health service provision for older people, as the initiatives used to reduce falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*

Data sourced from SIAPO



	2007/08	2008/09	2009/10	2010/11
West Coast	5.0%	5.2%	7.1%	5.8%
South Island	6.6%	7.3%	7.3%	7.8%
WCDHB Target 2012/13	5.0%	5.0%	5.0%	5.0%

STRATEGIC GOAL

2.6 People recover from complex illness and/or maximise their quality of life

Expectation

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, people's health outcomes and quality of life can be improved.

Why is this outcome a priority?

Clinicians, in collaboration with patients and their families, make decisions with regards to complex treatment and care. Not all decisions result in interventions to prolong life, but may focus on patient care such as pain management or palliative services to improve the quality of life. For those who do need a higher level of intervention, timely access to high quality complex services improves health outcomes by restoring functionality, slowing the progression of illness and disease and improving the quality of life.

The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter waiting lists and wait times are also indicative of a well functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures, and Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. The expectations around reducing waiting times, coupled with the current fiscal situation, mean DHBs need to develop innovative ways of treating more people and reducing waiting times with limited resources.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

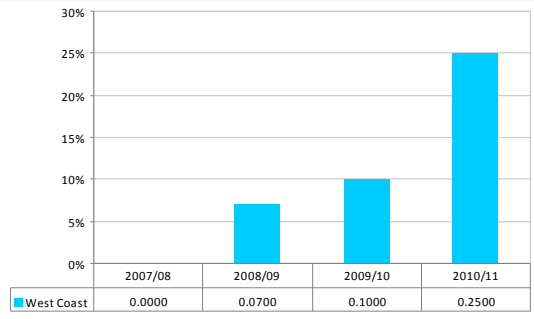
We will know we are succeeding when there is:

A reduction in acute (unplanned) readmissions to hospital and specialist services.

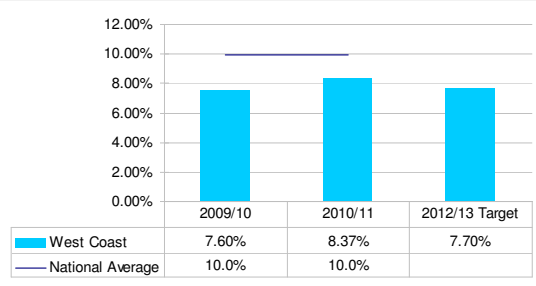
- *Readmission rates are a proxy measure of the quality of care, effectiveness of service provision and appropriateness of discharge from hospital and specialist services.*
- *They serve as a counter-measure to balance improvements in productivity and reduced lengths of stay, at the same time as our population is ageing and people are presenting with more complex conditions. They also provide an indication of the integration between services to appropriately support people on discharge from hospital.*
- *Improved patient safety, quality processes and clinically driven patient pathways will support patients to receive the most appropriate complex care and support whilst in our hospital and specialist services and reduce the likelihood of an adverse event requiring readmission.*
- *A reduction in acute (or unplanned) readmissions will demonstrate improved patient outcomes that enable people, their families and caregivers to maintain more stable lives and improve their quality of life.*
- *A reduction in the inpatient readmissions of people aged 65 years and over is an indicator that the transfer of care for older people between hospital, primary care and residential care is operating effectively.*

Data sourced from Ministry of Health and individual DHBs.

Long-term Outcome Measure – The rate of acute inpatient readmissions to hospital within 28 days of discharge from hospital.



Long-term Outcome Measure –The rate of acute (unplanned) inpatient readmissions to mental health services within 28 days of discharge.



Long-term Outcome Measure – the rate of inpatient readmissions to acute hospital services within 28 days of discharge for people aged 65 or more years.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

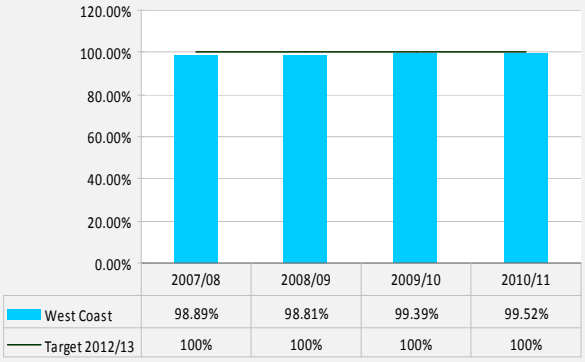
Over the next three years we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

More people receive timely emergency care.

- *Emergency Departments (EDs) are an important component of our health system, treating people who have a serious illness or injury that requires urgent attention and are often a barometer of the health of the hospital.*
- *Long waits in ED are linked to overcrowding, negative clinical outcomes, longer stays in hospital beds and compromised standards of privacy and dignity for patients. Improved performance will not only improve outcomes by providing early intervention and treatment, but being able to access services when they need to will improve the public's confidence and trust in health services.*
- *Solutions to reducing ED wait times need to address the underlying causes of delay, and therefore span not only the ED, but the whole health system from primary care to hospital discharge. In this sense this indicator is also indicative of how the wider system is responding to the urgent care needs of the population.*

Data sourced from individual DHBs.[14]

The percentage of patients presenting at West Coast EDs who are admitted, discharged or transferred within six hours.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	99.5%	100%	100%	100%

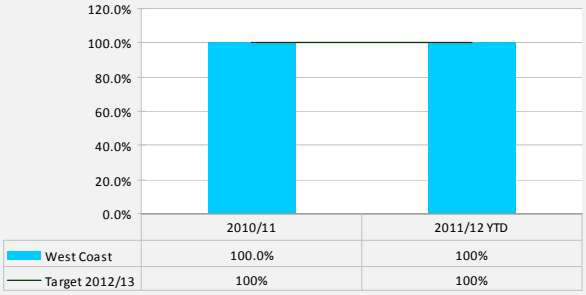


More people receive timely cancer services.

- *Cancer is the leading cause of death and a major cause of hospitalisation in New Zealand. Timely cancer treatment is important to improve outcomes and provide a better quality of life.*
- *This measure, while targeting one part of a patient's journey with cancer, provides a good indicator of how well the system is responding to need.*
- *Māori and Pacific peoples have higher cancer incidence rates compared to other population. Inequalities of access to screening, early diagnosis and treatment contribute to poorer outcomes. Improving access to treatment and ensuring sufficient treatment capacity are both important factors to ensure Māori and Pacific people have the opportunity for equitable outcomes.*

Data sourced from individual DHBs.[15]

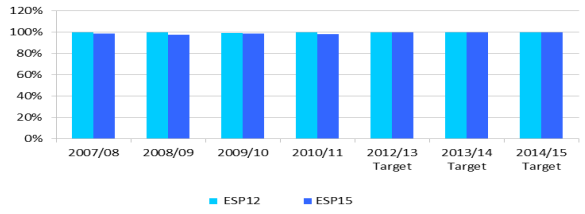
The percentage of patients who receive radiation therapy treatment within four weeks of the decision to treat.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	100%	100%	100%	100%



More people receive timely access to elective services.

- *Elective (non-urgent) services are an important part of the health care system: these services improve a patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *The Government wants more New Zealanders to have access to elective surgical services. Improved performance against this measure requires the most effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered.*
- *Timely access to elective services is considered a measure of the effectiveness of the health system and improves health outcomes for our population by slowing the progression of disease and maximising people's functional capacity.*
- *National expectations have been set for a set of eight Elective Services Patient Flow Indicators (ESPIs), and West Coast aims to meet these expectations.*

The percentage of people in West Coast provided with a FSA within 6 months of referral (ESPI 2) and reducing five months by June 2013 and four months by June 2014.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	99.7%	100%	100%	100%
The percentage of people in West Coast given a commitment to treatment and treated within 6 mths (ESPI 5) and reducing five months by June 2013 and four months by June 2014.	98.1%	100%	100%	100%



[14] *This measure is based on the national DHB Health Target 'Shorter stays in Emergency Departments'.*
[15] *This measure is based on the national DHB Health Target 'Shorter waits for Cancer Treatment'.*
[16] *The Elective Services Patient Flow Indicators (ESPIs) are measures of system performance, for which DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available for these measures.*

Data sourced from individual DHBs.[16]

Fewer people experience adverse events that cause harm in our hospital and specialist services.

- *Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. A reduction in the number of adverse events provides an indication of the quality of services, processes and systems and improves outcomes for patients in our services.*
- *The number of falls resulting in harm is particularly important, as these patients are more likely to experience a prolonged hospital stay and recovery, loss of confidence and independence and an increased risk of institutional care.*
- *A key factor in reducing adverse events is the engagement of staff and clinical leaders in improving processes and championing change. Achievement against this measure is therefore also seen as a proxy indicator of an engaged and capable workforce with the capacity and capability to improve service delivery.*

Data sourced from individual DHBs.[17]

The rate of SAC 1 and 2 falls in West Coast Hospitals (65+).	Actual 2010	Target 12/13	Target 13/14	Target 14/15
	0.05	< 1	< 1	< 1

The rate of SAC 1 and 2 falls in West Coast Hospitals for people aged 65 and over in 2010 is 0.5.

The West Coast DHB plans to ensure the rate is less than 1.0 in 2012/13.

More people receive timely post-discharge care.

- *Research indicates that mental health service users have increased vulnerability immediately following discharge, and those leaving hospital after an admission with a formal discharge plan that has linkages with community services are less likely to experience early readmission.*
- *Responsive intervention and community support post-discharge not only improves health outcomes, but also enables people, their families and caregivers to maintain more stable lives.*
- *A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission.*
- *This measure is therefore a proxy for access to services but also for continuity of services, demonstrating integration and coordination between services to improve the quality of people's lives.*

The percentage of people in West Coast having a post-discharge contact within seven days of discharge from Specialist Mental Health Services.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	See note below			

NOTE: The intention is to use the Key Performance Indicator (KPI) from the national Mental Health and Addictions KPI Framework. This Framework is currently being introduced through a staged process, and the data and definitions are still being tested with clinical teams and providers across the country. The South Island DHBs will use this measure once data is stabilised.

[17] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days.*

2.7 Health targets - How will we contribute?

When planning investment and activity across the health system, DHBs must consider the role they play in the achievement of the vision and goals of Government - reflected in the annual expectations of the Minister of Health.

In setting expectations for 2012/13, Government has been clear that the public health system must deliver '*better, sooner, more convenient*' health care and lift health outcomes for patients within constrained funding increases. The Government has made commitments to New Zealanders to deliver even faster access to elective surgery, diagnostic tests, chemotherapy and youth drug and alcohol services and expects DHBs to meet these commitments.

The Minister of Health continues to advocate for strengthened clinical leadership and engagement, and expects to see improvements in productivity, patient safety and the quality of services.

The Minister also expects DHBs to focus strongly on service integration, particularly with primary care, including the development of integrated family health centres, direct-referral access to diagnostics and clinical pathways involving community and hospital clinicians.

The Minister's priorities for DHBs for 2012/13 are:

- ***Integrated care*** – developing integrated services to drive delivery and improve performance in three priority areas: unplanned and urgent care, long-term conditions and wrap-around services for older people.
- DHBs are also to work across their local networks to implement the Government's commitments to zero-fee after-hours GP visits for children under 6, shorter waits for child and youth drug and alcohol treatment and further integration of child and maternity services.
- ***Shorter waiting times*** – improved access to services including: elective surgery, diagnostics tests, cancer treatments and child and youth drug and alcohol treatment.
- ***Improving health services for older people*** – developing integrated services for older people that support their continued safe, independent living at home, particularly after hospital discharge. DHBs will also work to implement the Government commitments related to dedicated stroke units and dementia pathways.
- ***Regional integration*** – accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains. DHBs are also expected to make significant progress in implementing regional service plans and delivering on regional workforce, IT and capital objectives.
- ***Efficiency and containing costs*** – supporting the work of Health Benefits Ltd, Health Workforce NZ and the Health Quality and Safety Commission. Significant productivity gains are expected to be made across services and organisations.
- ***Achievement of health targets*** – joint planning with primary and community networks to deliver smoking, cardiovascular disease and immunisation targets.

The national health targets measure progress against key national priorities, with the anticipation that a unified collaborative focus will drive performance improvement across the sector. Progress is 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 services through to improved access to intensive assessment, treatment and support.

There is also alignment between regional and local priorities and the national health targets. In this sense, achievement of the national health targets is seen as a reflection of how well every level of the health system is working together to improve the health and wellbeing of our population.[18]

West Coast is committed to making continued progress towards achieving the Minster's expectations and national health targets. Our contribution (in terms of local targets) is set out against the national health targets on the following page. The activity planned to achieve these health targets is outlined in the Service Performance section of this document.

[18] *Further information regarding the health targets can be found on the Ministry's website www.health.govt.nz.*

Shorter Stays in Emergency Departments

Government expectation

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

West Coast contribution

95% of people presenting at 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 at least 4,000 additional discharges nationally every year.[19]

West Coast contribution

1,592 elective surgical discharges will be delivered in 2012/13.

Shorter Waits for Cancer Treatment

Government expectation

Everyone needing radiation or chemotherapy treatment will have this within four weeks[20]

West Coast contribution

100% of people who need radiation or chemotherapy will receive it within four weeks of clinical decision to treat.

Increased Immunisation

Government expectation

85% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 % by July 2014 and 95% by December 2014.

West Coast contribution

85% of all eight-month-olds will be fully vaccinated by 1 July 2013.

Better Help for Smokers to Quit

Government expectation

90% of all smokers seen by a health professional in primary care, and 95% in public hospitals or at confirmation of pregnancy with a Lead Maternity Carer (LMC) are offered brief advice and support to quit smoking.

West Coast contribution

90% of smokers seen in primary care and 95% of those seen in public hospitals will receive advice and help to quit.

Progress towards 90% of pregnant smokers being offered advice and help to quit smoking.

More Heart and Diabetes Checks

Government expectation

90% of the eligible population have their cardiovascular risk assessed once every five years by the end of 2014.

West Coast contribution

75% of the eligible population have had their cardiovascular risk assessed by 1 July 2013, and moving to 90% over 3 years.

The West Coast DHB's contribution to achieving the Minister's priorities can be found in the following sections:

[19] *The national health target definition of elective surgery excludes dental and cardiology services.*
[20] *The national health target definition excludes Category D patients, whose treatment is scheduled with other treatments or part of a trial.*

MOH TEMPLATE	CORRESPONDING WEST COAST DHB SECTION
Emergency Departments	Reducing the Time People Spend Waiting (Emergency Department) Section 3.2
Access to Elective Services	Reducing the Time People Spend Waiting (Electives) Section 3.2
Cancer Services	Reducing the Time People Spend Waiting (Cancer) Section 3.2
Immunisation	Child and Youth Health (Immunisation) Section 3.5
Tobacco	Disease Prevention Section 3.7
CVD / Diabetes	Cardiovascular Disease and Diabetes Section 3.8
Primary Care Development and Delivery	Integrating the Canterbury Health System Section 3.1
Child and Youth Mental Health and Addiction Services	Mental Health Services Section 3.4 Child and Youth Health Section 3.5
Health of Older People	Improving Health Services for Older People Section 3.3
Cardiac Services	Cardiovascular Disease and Diabetes Section 3.8
Whānau ora	Māori Health Services Section 3.6
Living Within Our Means	Financial Performance Section 7
Workforce	Modules 1, 2 and Stewardship Module 4

SERVICE PERFORMANCE PRIORITIES 2012-2013

As part of our commitment to providing Better, Sooner More Convenient healthcare to our population, a key focus for the coming year 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 our service performance priorities in 2012/13 are:

- ***Integrating the West Coast Health System*** - focused on the development of integrated family health centres in the Buller and Grey Districts to achieve more coordinated primary health care and social services, the development of care pathways and the revamp and refurbishment of hospital services.
- ***Achievement of health targets*** - including joint planning with primary and community networks to deliver smoking, cardiovascular disease and immunisation targets.
- ***Reducing the time people spend waiting*** – an improved access to services including: faster access to elective surgery, diagnostics tests, cancer treatments and child and youth drug and alcohol treatment.
- ***Improving health services for older people*** - focused on developing integrated services for older people that support their continued safe, independent living at home, particularly after hospital discharge.
- ***Maintaining and enhancing core services*** – including a focus on disease prevention and healthy lifestyles, mental health services, child and youth health services, Māori health services and Cancer and Palliative Care.

3.1 Integrating the West Coast Health System

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. This whole of system approach focuses on integrating primary care with other parts of the health system, coordinating health and social services and developing and implementing care pathways that are designed and supported by clinicians from across the system. The integration of services on the West Coast will drive improved performance in three key areas – unplanned and urgent care, long-term conditions, and wrap around services for older people.

The West Coast DHB is committed to supporting the implementation of 2012/13 deliverables in the Better, Sooner, More convenient business case in partnership with the West Coast PHO and other West Coast health care providers. The third year of delivery is focused on the continued implementation of Integrated Family Health Centres (IFHC) within the Buller and Grey Districts, the integration of care for the elderly (outlined in the health of older persons section), the on-going design and development of patient-centred models of care and health pathways and the revamp and refurbishment of hospital-based services.

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 and resolution of the West Coast DHBs deficit is a clear 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.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Establishment of an IFHC in the Buller community. *A financially sustainable 'one stop shop' for primary health care in the Buller district.*	Implementation of the new model of care for integrated family health services in the Buller district. Locally designed pathways of care are implemented. Commence integration of hospital, community and primary health care services. Establish clinical governance structure for the Buller IFHC (that is linked to the West Coast Clinical Governance structure). Commission the construction of the Buller IFHC. Commence building of the Buller IFHC (*subject to acceptable capital funding being obtained*) with a view to opening the new facility by the end of 2013. Aggregate aged residential care services in Buller under a single private provider.	The management structure of an integrated health service in Buller is in place by December 2012. Construction of the Buller IFHC commenced by July 2013. Clinical Governance is in place by December 2012.
Development of an IFHC in the Greymouth community *An integrated, financially sustainable and clinically viable hospital system in the Grey district.* *An integrated model of care for primary and community and hospital level health care in the Grey district.*	Commence implementation of a model of care for integrated family health services in the Grey district. Complete and commence implementation of the business case for the Grey Hospital refurbishment/replacement. Implementation of the 'transalpine approach' for all non-clinical hospital services. Liaison doctors appointed and commence in general medicine, surgical O and G anaesthetic, orthopaedic and emergency medicine departments at Christchurch as part of the transalpine service. Reorient RMO positions to a mix of RMO and RHM registrar positions. Develop service towards on call out-of-hours care provided by local generalists and supported by CDHB specialists in medicine, paediatrics and orthopaedics. Support local specialists to maintain skills and expand areas of	Improved access and a reduction in waiting times to primary health care in the Grey District. Better linkage and coordination between primary and secondary healthcare services for those who need it. Better integration and/or coordination of service delivery for those with complex clinical care needs. All non-clinical services are efficiently provided via the 'transalpine model' by December 2012.

	interest through regular visits to CDHB. Establish a 'single' Allied Health service across the West Coast health system that has a generalist workforce and access to specialist support as required. Integration of daytime and after-hours primary health services into the same location.	Transalpine oncology, paediatric, aged care and orthopaedic service is operating on a regular basis by Q2. Full complement of O and G anaesthetic specialists employed by end of Q2 2012/13. A single Allied Health service is in place by December 2012. Reduced clinical risk and improved clinical sustainability.
Financial sustainability, efficiency and autonomy for DHB owned general practice on the West Coast. *Financially sustainable, accessible, high quality general practice that is integrated with the rest of the health system on the West Coast.* *Greater operational autonomy for general practices on the West Coast.*	Development and implementation of an action plan for general practice business operations that focuses on enhanced operational autonomy, workforce retention and financial viability. Enhance business practices through provision of training and enhanced administrative support.	Implementation of an action plan commences Q2 2012/13. Primary care budgets are achieved and the primary care deficit is halved by the end of 2013/14.
The provision of integrated, financially sustainable and clinically safe health services provision in Reefton.	Outline the process for the review of current and future health services in Reefton. Complete the review of current and future health service provision in Reefton.	Process to review the future of Reefton Health Services is determined by Q1 2012/13. Review complete by Q3 2012/13.
The establishment of transport systems that enable better, sooner and more convenient access to health services that West Coast people require.	Complete a review of transport options for health service delivery (both intra-district and inter-district) and implement preferred options.	Transport review completed by December 2012 and preferred options are in place by July 2013.

3.2 Reducing the Time People Spend Waiting

A. 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 for First Specialist Assessment and for Elective surgery under six months – with the aim of reducing this wait to no more than four months by the end of 2014.

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 2012/13.

Our priorities for elective services in the 2012/13 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, or less, from referral;
- Identification of productivity and efficiency gains, as well as changes to processes and systems currently in place, to help effect a shift to a maximum wait of five months in 2013 and a maximum of four months by the end of 2014;
- 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.
- Reporting diagnostic waiting times for Computerised Tomography (CT) scanning; Magnetic Resonance Imaging (MRI); diagnostic colonoscopy and coronary angiography to establish baseline data for monitoring timely access to these services. (Note: West Coast DHB does not deliver MRI or coronary angiography locally, so data for these two will be provided through Canterbury DHB as the primary providers of these services for West Coast residents).

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 clinical assessments and 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.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Meet national elective service priority targets *To deliver the elective surgical discharges planned in 2012/13.* *To ensure that West Coast residents have at least equitable access to elective services as people in other districts.* *To ensure all elective patients are managed consistently and treated within six months of referral and maintain*	Proactive monitoring of the West Coast DHB's Provider Arm outpatient and inpatient waiting lists. 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. By September 2012, patients will be prioritised for treatment on national CPAC tools and treatment will be in accordance with	1592 elective surgical services discharges are delivered for our resident population. 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

compliance with Elective Service Patient Flow Indicators (ESPIs) 1 to 8.	assigned priority, to improve consistency in prioritisation decisions.	guidelines, on the basis of assigned priority using national CPAC tools. Reduced wait times for people requiring surgery and FSA, with maximum waiting times reducing further over time.
Maintain and improve upon current production capability. *To assist delivery of the elective surgical discharges planned in 2012/13 and improve access to diagnostic tests.*	Continue process improvement through ongoing 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. Continue to increase use of non-contact First Specialist Assessment in concert with primary care to assist rapid assessment and referral of patients to treatment lists. Further develop partnering with General Practitioners in Westport and Reefton (as part of our Better, Sooner, More Convenient Healthcare programme plans), as well as with tertiary specialists in CDHB, 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. Promote direct referral from general practice for diagnostic testing for CT scans and colonoscopy using health pathways, where these are delivered locally on the West Coast, by 31 December 2012. From 1 July 2012, implement reporting of diagnostic waiting times for Computerised Tomography (CT) scanning; Magnetic Resonance Imaging (MRI); diagnostic colonoscopy and coronary angiography to establish baseline data for monitoring timely access to these services.	Hospital outputs are delivered to within 5% of overall plan. Maximised 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. Delivery of shorter waiting times for diagnostic tests.
Identify additional and future service capacity required. *To enable the DHB to meet future needs within available resources.*	Continued clinical involvement in theatre management, booking and production planning process. By 31 March 2013, develop combined, single clinical department management structures between services of Canterbury and West Coast District Health Boards where appropriate, to enhance clinical governance and oversight, as well as work-force and service support. Identify, fund and implement increased use to tele-health and non-contact specialist assessments as alternative models of care for delivery of direct clinical and management services to patients where appropriate (especially for clinical follow-up); as well as clinical oversight and support to West Coast inpatient and outpatient services Clinical sustainability and equitable access between DHB populations reviewed regionally.	Actual elective surgical and outpatient volumes are delivered to within 5% of overall plan. Where appropriate, shared clinical governance structures are established between West Coast and Canterbury DHB clinical services. Reduced reliance on locum specialists for delivery of local services Reduction in need for patients to have to travel great distances from their home localities for assessment and ongoing assessment and clinical management in other centres.
Continually Improve Performance. *To improve service quality and capacity within our hospital and specialist services and reduce waiting times for our population.*	Promote greater use of lean thinking principles and processes to improve patient flow and reduce waiting times. Use results-based performance information and benchmarks to monitor improvements in terms of patient outcomes. Use nationally agreed theatre and ward utilisation measures to benchmark, monitor and improve overall service performance. Ensure, wherever clinically appropriate, day surgery and day of surgery admissions are normal practice.	Inpatient average length of stay maintained at 3.43 days. *[National Measure OS3].* Improved utilisation of theatre sessions to greater than 89%. *[National Measure OS5].* More than 59.6% of standardised elective and arranged surgeries undertaken as day surgery. *[National Measure OS6].* 82% of standardised elective and arranged surgeries are day of surgery admissions (i.e.

		operated upon on the same day as admission). *[National Measure OS7].* 28-day acute readmission rates – to be confirmed with Ministry of Health by 31 July 2012. [*National Measure OS8*].

B. Shorter Waits for Cancer Treatment, and Improving 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 division of the 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 and a periodic visiting service to Buller. 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 progressive implementation 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/whānau 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. The majority of chemotherapy treatments are also started under specialist supervision in Christchurch for West Coast residents, with the bulk of the ongoing delivery of chemotherapy infusions delivered locally on the West Coast thereafter. To this end, the West Coast DHB has an active interest in and monitors waiting times and access for radiation oncology and chemotherapy 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 or chemotherapy treatment will have this within four weeks (- calculation of target achievement excludes Category D radiation patients).

West Coast DHB has reallocated $17,000 from savings from the community pharmacy budget to implement the faster cancer treatment initiative in 2012/13 towards funding multi-disciplinary meetings (MDM) for all main cancer tumour types and increasing the number of cases discussed at MDMs. Part of this will include support for the engagement of new technologies to further enhance the use of the dedicated high-definition video-conferencing links between West Coast DHB facilities, tertiary centre specialists to support regional and surpa-regional multi-disciplinary meetings, clinical review of patients, and increased staff education opportunities to improve knowledge and assist better outcomes for patients with cancer and their families/whānau.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Support cancer prevention and screening programmes. *To reduce the incidence and impact of cancer over time through prevention and early detection of cancers.*	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 surgical endoscopy, based on national guidelines and ensure diagnostic colonoscopy (excluding surveillance) are undertaken within maximum waiting time timeframes. Colonoscopy for patients is delivered within the national waiting time targets as follows: ▪ 50% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days) , and ▪ 50% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks. ▪ 50% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date. Continued implementation of the Healthy West Coast Annual Plan (as per the Disease Prevention section). Provide support to West Coast division of the Cancer Society and Southern Cancer Network health promotion and cancer awareness activities as these arise	Improved response time for those identified as having cervical, breast, bowel, and skin cancer rates. Opportunities for better early diagnosis, intervention and outcomes at an individual patient level. West Coast breast and cervical screening rates remain consistent with or above the national average. Over time, reduced cancer mortality rates. National targets for Colonoscopy waiting times are met as follows: ▪ 50% referred for urgent diagnostic colonoscopy treated within 14 days ▪ 50% referred for diagnostic colonoscopy treated within 42 days ▪ 50% of people waiting for surveillance / follow-up colonoscopies will be treated within 84 days of planned date.
Improve patient pathways. *To further improve response time and reduce treatment delays by reducing variation in the patient journey, information given and support services available in order to better direct support to patients and their families / whānau and sustain performance in a changing demand environment.*	Continued link to CDHB's Oncology Services to provide standardisation of models of cancer care and patient treatment pathways. Undertake lean-thinking review to identify areas where the workflow can be streamlined from First Specialist Assessment (FSA) to start of treatment to ensure patients start treatment within four weeks Continued close links with Canterbury DHB Services to ensure timely referral and prioritisation of patients. As part of the *Better, Sooner, More Convenient Healthcare* Business Case ensure enhanced utilisation of the Oncology Nurse and Palliative Care Nurse Specialists expertise in the community. Expand utilisation of inpatient medical ward nursing staff capacities in the delivery of chemotherapy regimes on the West Coast to provide clinical support to the increasing workload in chemotherapy care, as well as case management 'back up' and succession planning options for the small team of oncology nurse providers of this service. Continue to improve appropriate patient links to providers and NGO support services from first contact with Oncology. Support the Southern Cancer Network (SCN) to conduct a regional approach to Multi-Disciplinary Meeting (MDM) Coordination, including the establishment of a MDM coordination model for the South Island and the establishment of a regional MDM Information Technology systems project to support electronic integration of MDM referral processes, agendas, MDM forms and data collection process for audit purposes. Support the Regional Cancer Network to implement the recommended regional Videoconference solution to support regional and supra-regional MDMs. Recommendation includes a three month feasibility study in the South Island to ensure the	Improved continuity of care for patients, and reduce duplication and possible complications. Everyone needing radiation or chemotherapy treatment will have this within four weeks. Expansion of the Canterbury DHB's oncology and palliative care services guidelines and medication treatment protocols across West Coast secondary care for regional consistency and coordination. Information supplied to help establish baseline data for new Ministry of Health national indicators of the proportions of patients referred urgently with a high suspicion of cancer who have their first specialist assessment at the 14, 31 and 62 day intervals from referral. MDM coordination model implemented by 30 June 2013. Regional MDM Information Technology systems project established by 30 June 2013

	vendor meets the required acceptance criteria Support implementation of the South Island Clinical Cancer Information System (SICCIS) to enable close monitoring of oncology, chemotherapy and radiotherapy service provision to ensure people are treated according to their need within the national waiting times guidelines. Work with Canterbury DHB regional cancer service providers to establish and contribute to data collection systems to support service improvements to cancer patient pathways. Work in collaborative partnerships; seek to apply for opportunistic funding for projects in support of the cancer plan, improving cancer patient care delivery, and reducing inequalities, as these periodically arise. Provide support for provision of education packages for professional staff involved in cancer and palliative care, additional to existing training linked to CME and other established training networks.	
Support palliative care services. *To improve quality of life for cancer patients needing palliative care and their families/whānau, ensure standardisation of care for palliative patients in line with international best practice guidelines and improve integration between DHB palliative care services and community and NGO services.*	Collaborate with Nurse Maude in the provision of Liverpool Care Pathway (LCP) service development, delivery and support on the West Coast. Undertake regular education and PEPA (Programme of Experience in Palliative Approach) "staff exchanges" between Nurse Maude and West Coast nursing staff involved in palliative care. Work with Ministry of Health with a view to piloting the United Kingdom Gold Standards Framework in Palliative Care as a New Zealand pilot evaluation site Maintain 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 in conjunction with our Local Cancer Team to identify local and regional issues and solutions, to reduce inequalities in service delivery for our populations. As above, work with Southern Cancer Network to support implementation of regional initiatives identified in the National Cancer Programme Work Plan, including further development of consistent standards and documented referral pathways for major tumour streams; models of care for medical oncology; improving regional multi-disciplinary meeting (MDM) functionality; and implementing the South Island clinical cancer information repository (MOSAIQ).	Standardisation of models of care and patient treatment pathways. Reduced variation in treatment between South Island DHBs. Phase one priorities of the Regional Strategic Plan implemented by June 2013.

C. Shorter Stays in Emergency Department

Emergency Departments are a critical front line service for patients in medical crisis and need for urgent care. As such, it is vital that they are received and treated as rapidly as possible, within terms of priority of their emergency situation and relative need for interventional care.

How are we improving outcomes for our population?

West Coast retains an active commitment to delivering shorter waiting times for triage and treatment at our emergency services by having greater than 95 percent of patients who present to our services being either admitted, discharged or transferred from the Emergency Department within six hours or less. West Coast has consistently maintained this target and is committed to continue to deliver this level of service in 2012/13.

West Coast DHB operates a Level 3-4 Emergency Department at Grey Base Hospital, and Accident and Medical departments at Reefton and at Buller Health that provide acute triage into the Grey Base Emergency department and into the primary care medical beds in Reefton and Westport as appropriate.

West Coast DHB has worked proactively with the West Coast PHO to implement a series of measures designed to help better maintain patients in the community to help avoid the need for presentation to Emergency Departments

and Accident and Medical department services in the first instance, as well as to reduce the number and impact of inappropriate presentation to Emergency Department services; particularly in the lower triage 5 band for those cases that may be appropriately be addressed in primary care or by community nursing services. These include the introduction of after-hours telephone triage for primary practice, as well as wider scope of the continuum of care initiatives commenced and being undertaken through the Long Term Conditions management programme to help improve self-management capacities of those West Coasters with long term conditions and in turn, reduce their need for acute interventions (see also, section 3.8: Cardiovascular Disease and Diabetes - Long Term Conditions Management). We are looking to further support this with the use of nurse treatment of triage level four and five patients under standing orders.

At Grey Base Hospital, several initiatives are being undertaken currently and into 2012/13 to help maintain, and to further streamline, the flow of patients through the Emergency Department itself as well as through to inpatient specialties. Work is to be undertaken to explore options to provide additional flex to nursing hours and rosters to better match patient demand around traditional peak demand flows. A quality team has met to consider the possible introduction of the use of observation transition beds attached to ED for patients who may only need observation rather than acute admission as such, to help reduce the flow of patients into specialist ward services where this may not be necessary. Provisional findings are that this is not able to undertaken within the current physical footprint of the hospital building – but will remain a focus of consideration in planning for the rebuild of Grey Hospital. Work is concurrently being undertaken to improve discharge planning in order to help free up beds in the acute inpatient services and in turn, help pull patients through into the wards from Emergency Department in a more timely fashion.

While still a couple of years off yielding results, the West Coast DHB's rural academic training scheme is also promoting the use of rural hospital medical doctors to work in the Emergency Department; with two trainees currently in this training programme. We will continue to work on refinement of these services to help remove bottle-necks in our Emergency Department settings in 2012/13.

Why is this important?

Timely access to emergency services supports the health and disability strategy outcome of allowing New Zealanders to live longer, healthier and more independent lives; as well as improving patient experience , public confidence in being able to access the services they need; and improving hospital productivity by ensuring resources are used effectively and efficiently.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Deliver shorter stays in emergency departments. *To deliver ED services to patients in a timely manner that respects patients' needs and values their time.*	Maintain primary practice Very Low Cost Access programme, and free After Hours telephone triage services to help support improved management of acutely unwell people and access to the most appropriate urgent care option at any given time Continue zero fees to under six-year olds for after-hours visits to general practice Provision of weekly meetings between Emergency Department charge and managers of GP practices to discuss any issues that may have presented itself through the week, and also those patients who attend the department regularly with GP problems. As part of the developing a new model of care and service delivery for Grey Hospital Clinical services explore the need for additional medical and nursing staff resources to improve management of acute workload flows at peak presentation periods; development of nurse treatment of triage level four and five under standing orders, and further work around improving discharge planning. Explore options for the introduction of observation transition beds unit in plans for redevelopment of Grey Base Hospital.	More than 95% of people admitted, transferred or discharged within 6 hours of ED presentation; and dropping to 5 hours by 30 June 2013. Triage Level 5 presentations at Grey Base Hospital Emergency Department drop by at least 5% per annum from 2010/11 levels (4,110) over the next three years, 2012/13 to 2014/15. Triage Level 5 presentations at the acute triage Accident and Medical services at Reefton and Buller Health drop by at least 5% per annum from 2010/11 levels (745) over the next three years, 2012/13 to 2014/15

3.3 Improved Health Services for Older People

We will develop an integrated clinical network of services, covering primary, community hospital and residential settings, which 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 is actively collaborating with Canterbury DHB and the West Coast Primary Health Organisation to develop an integrated clinical network of services, covering primary, community, hospital and residential settings. Specialist geriatric staff (medical, nursing and allied health) will work more closely with generic staff in primary, community, residential and hospital services to improve the pathways of care for older people. The focus is on ensuring that older people get the services they need at the right time, without duplication, 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 2012/13 includes:

- Putting West Coast DHB's share ($26,000) of the national $3 million savings from the Pharmaceutical budget towards implementing a Complex Clinical Care Network (CCCN) in collaboration with Canterbury DHB. This includes a CDHB geriatrician leading an inter--disciplinary team to provide specialist support for primary health teams, community nurses, homecare agencies and rest homes in managing older clients with complex conditions. Funding for the added geriatrician input has been included in the 2012/13 budget and the service will be set up by December 2012;
- Key to this CCCN is establishing a gerontology nursing team to provide clinical assessment, advice and case management for primary health teams, homecare agencies, rest homes and secondary services who are looking after older people with complex conditions;
- Improving the pro-active case management of people living in the community, particularly those with high and/or complex needs, to support ageing in place and reduce avoidable admissions to acute hospital services and long-stay residential care;
- Ensuring GPs and primary health staff have the specialist support they need to provide interventions that will avoid unplanned admissions to hospitals or rest homes;
- Participating in regional and national initiatives to develop a dementia pathway, and adapting this for the local situation with the involvement of all stakeholders, including primary health teams, homecare agencies, rest homes and relevant NGOs, whilst also supporting these services to deliver improved care to people with dementia. The establishment of the CCCN is an integral part of linking primary health teams to specialist advice and support in this and other areas of health of older people (e.g. stroke management and prevention).
- Using the West Coast DHB's share ($21,000) of the dementia pathways funding to extend the 'Walking in Another's Shoes' dementia training programme to include staff from primary health teams, homecare agencies and relevant community agencies, thereby building capacity within the generic health and support workforce to manage simple cases of dementia
- Implementing the New Zealand Clinical Guidelines for Stroke Management 2010, through greater collaboration between the relevant staff in Canterbury and West Coast DHBs, and supported by the CCCN.
- Implementing a model of home-based support services that focuses on adequately supporting older people in their own homes, that is tailored flexibly to individual need and that has well-trained staff;
- Increasing the targeted efficiency of home support services to meet clients' needs and to be more consistent with the access criteria used elsewhere in the South Island
- Improving the understanding and acceptance of a pro-active restorative model of care by all those working with older people;
- Consolidating and integrating assessment processes across primary, secondary and residential care;
- Improving access to both residential and home-based services for people with dementia,
- Improving access to a range of support services in the community, including day care and respite care, and carer support; and
- Working with other South Island DHBs to align strategic activity and equitable access to older persons' health services, through participating in the South Island Regional Alliance for Older Persons' Health and supporting the Regional Work Plan.

- Monitor unplanned re-admission rates to acute hospital of people aged 65+ and 75+, to compare them to the national and regional averages.

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 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.

There is scope for reducing avoidable admissions to acute hospital and to long-term residential care through setting up a clinical network that links specialist and generic workers.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
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 through greater support from the specialist geriatric team (see below) and inclusion of residential care facilities in the Clinical Network. Ensure the eligibility criteria and processes for entry to long-term care are standardised to be consistent with other South Island DHBs. Improve access to specialist dementia long-stay care. Ensure that all people living in aged residential care have had an InterRAI assessment and care plans are informed by this assessment. Develop a pathway and timeframe for implementing InterRAI within residential care facilities. Establish the 'Walking in Another's Shoes' dementia training initiative for residential care staff, to achieve a culture change in the care of people with dementia.	All rest homes meet audit standards. The rate of older people entering rest home care and specialist dementia residential care is close to the South Island average. All new residents entering aged residential care receive an InterRAI assessment All residents have care plans appropriate to their clinical care assessment A clear pathway and timeframe for InterRAI implementation in residential care facilities is available
Improve referral and assessment services for older people and simplify referral pathways. *To provide more timely and targeted responses to the needs of older people and enable them to maintain independence.*	Make InterRAI available to primary and community health and support services. Establish a Single Point Of Entry for all people needing assessment for long-term support services and/or specialist assessment and case management for complex chronic conditions, provided by an integrated Clinical Network. This is aimed to start by December 2012. Establish strong links between Canterbury and West Coast AT&R and Psychogeriatric services and identify patient pathways and protocols for older persons' health, including stroke patients and people with dementia. Implement the New Zealand Clinical Guidelines for stroke through greater collaboration with relevant staff between Canterbury and West Coast DHBs. Set up a Clinical Network whereby a specialist geriatric medical and nursing team supports staff in primary, secondary, community, secondary and residential settings in their work with older people. This is aimed to start by December 2012. Set up an inter-disciplinary team to provide assessment, treatment and rehabilitation of older people and others with complex chronic conditions in a community setting (home or residential care facility). This is aimed to start by December 2012. Extend and reconfigure allied health services and community nursing services as needed to enable timely responsiveness for patients in community settings. Routinely monitor unplanned readmission rates to benchmark	InterRAI is used for 100% of people receiving long-term support services. Access to InterRAI re cords is available to a wide range of relevant clinical staff. A clear single point of entry for assessment and case management is established. Clear patient pathways are established, particularly for people with complex chronic and disabling conditions. Clear communication and training mechanisms are evident between the specialist and generic staff. Older people receive more timely and appropriate care A drop in avoidable acute hospital admissions, length of hospital stay and rest home entry. Standardized readmission rates to hospital; targets : - people aged 65+ 12.22 - people aged 75+ 12.91

	against regional and national averages.	
Improve proactive care management for older people with complex needs. *To ensure older people with complex needs and their families/whānau 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. Expand respite and day care services, including services for people with dementia and their carers. Strengthen services to support family and other unpaid carers. Maintain and extend the 'Walking in Another's Shoes' dementia training initiative beyond residential care facilities, to home support agencies and relevant NGOs. Participate in regional and national initiatives to develop a standard dementia pathway and once this is available, work with primary health teams and other stakeholders to ensure it is accepted and appropriate for local conditions. Maintain and extend illness/injury prevention initiatives such as falls prevention, nutrition and physical activity, befriending and home insulation. Participate in regional initiatives on advanced care directives. Ensure medication reviews for older people. Encourage development of supportive living options as an alternative to rest home entry.	The proportion of people on high level packages of care is similar to the South Island average – i.e. an increase in the proportion. The entry to rest home care is similar to the South Island average – i.e. a reduction in avoidable entry. Increase in the proportion of carers in long-term care services who have received dementia training. Increased use of respite care, day care and carer support. Reduced proportion of the population aged over 75 admitted to hospital as a result of a fall. 40 pharmacist medication reviews completed for older people and / or others with complex needs. More options for supported living are available for West Coasters.
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 inter-disciplinary services to support discharge, including community allied health and step-down beds, through development of a Clinical Network (see above).	Reduced hospital re-admission rates and length of stay for people 65+.

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 Healthcare* Business Case we are continuing to integrate mental health services alongside primary care teams within Integrated Family Health Centres. This will enable teams to 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?

An estimated 20% of the New Zealand population have a mental illness or addiction and 3% are severely affected by mental illness. Depression is forecast to 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.

An increased focus on early detection and treatment of Alcohol and Other Drug (AOD) issues among adolescents with mild to moderate mental health and alcohol and drug issues will continue to improve outcomes for our young people. Monitoring the treatment capacity of Child and Adolescent Mental Health and Addictions services (CAMHS) to ensure that 80% of non-urgent referrals are seen in three weeks and 95% are seen in eight weeks will help to improve long-term health and wellbeing and build strong foundations for future generations

Our ageing population continues to place an increasing demand on mental health services. 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.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Integrate primary and secondary mental health services. *To improve service responsiveness and ensure individuals have access to integrated services across the continuum of care.*	Implement recommendations from the review of the Buller shared care pilot and refine the model and processes for roll out across the West Coast. Recruit and employ an additional mental health liaison position.	Recommendations from the Buller shared care pilot review are implemented by Q3 2012/13.
Increase early detection and treatment for youth through community specialist Alcohol and Other Drugs 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. Continue the implementation of the Fresh Start programme[21]. Extend the collaborative alcohol and drug school education programme provided by WCDHB and NZ Police into additional schools.	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 addiction problems.*	Implement the West Coast DHB component of the Regional Coexisting Mental Health and Addiction Problems plan. Continue to collaborate with the Ministry of Health to implement the West Coast DHB component of the Regional Coexisting Mental Health and Addiction Problems plan.	Clinical pathways are defined by Q4 2012/13.
Improve access to mental	Monitor the waiting times for children, adolescents and adults	At least 3% of the population

[21] *A programme led by the Ministry of Social Development that includes the ability for courts to refer youth to community-based AOD services.*

health services. *To ensure timely access to support and treatment.*	referred for non-urgent mental health or addiction services. Plan and implement service changes to reduce waiting times as required.	access specialist mental health services. 77% of population referred for non-urgent mental health or addiction services are seen within 3 weeks and 95% within 8 weeks within 3 years. Refer to PP8 in Appendix 4 for specific targets.

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 integration and coordination between all of the child-related primary, community and hospital services. There are a variety of DHB and non-DHB providers responsible for the provision of child and youth services on the West Coast. The provision of seamless and patient-centred care for children and young people requires the active participation and integration of all providers and services.

How are we improving outcomes for our population?

Actions that reduce risky behaviours and increase protective behaviours that support health during infancy, childhood, adolescence and into adulthood will continue. In 2012/13 we will focus on improving the coordination of Well Child/Tamariki Ora (WCTO) Services across providers, increasing the uptake of school-based health assessments, improved coordination of services for children and young people with ASD and continuing collaborative and integrated working across Child Development, CAMHS and Paediatric services. We also plan to work with the Ministry of Health in 2012/13 to implement the WCTO quality review that is currently underway and incorporate any necessary quality improvement framework across WCTO services and Before School Check to improve the health and wellbeing of children on the West Coast. The work on the Maternity Quality and Safety programme's strategic plan is well underway and we plan to have a draft strategic plan in place by the 1 July 2012.

We will ensure that infants, children and young people continue to have good access to Specialist Mental Health Services. An increased focus on early detection and treatment of AOD issues among adolescents with mild to moderate mental health and alcohol and drug issues will continue to improve outcomes for our young people. Increasing the treatment capacity of Child and Adolescent Mental Health and Addictions services to ensure that 80% of non-urgent referrals are seen in three weeks and 95% are seen in eight weeks within three years is also a priority for 2012/13.

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 CDHB continues to be a priority for the year ahead.

The Government has made a commitment of zero fee after-hours primary care visits for children under 6 and the West Coast DHB will work closely with the West Coast PHO and primary practices to achieve this.

Immunisation continues to be a focus for the West Coast DHB and following the West Coast Pertussis epidemic in 2011 there is an increased urgency to ensure vaccinations are on time. The West Coast has historically had a higher than average 'opt-off' and 'decline' rate within its communities. This currently amounts to nearly 14% of the total eligible population, meaning that we routinely achieve 96% coverage for those willing to be immunised. Half of those opting off have strongly held ethical and religious views on this issue and are unlikely to change their view. Notwithstanding this, the West Coast DHB is fully committed to work collaboratively with all child health service providers, and will use our best endeavours to reach the national target of 95% of all two year olds fully immunised by 2013/14. Pending the achievement of the national target, the West Coast DHB will monitor its success in immunising those who have not declined or opted off as an internal performance measure.

The West Coast DHB Immunisation Advisory Group has approved a draft strategic plan to decrease the immunisation decline rates of 2 year olds which it hopes to subsequently improve the childhood immunisation rate in 2012/13. The focus in the first half of 2012/13 is to work in collaboration with all primary care stakeholders to implement the strategies to achieve high immunisation coverage. The Group has also developed actions to be undertaken to achieve the Minister's expectation on the new immunisation target from two year olds to eight months olds. The actions will involve collaborative work with LMCs, medical practices and PHO to establish a robust process to ensure newborns are enrolled with a GP within two weeks of age.

We are committed to meeting the national expectation and achieve the 85% target of all eight months old fully immunised by the end of the coming year.

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.

Improving preventative services and increasing utilisation of health and disability services by children and young people helps to improve long-term health and wellbeing.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improved immunisation coverage. *To improve immunisation coverage and reduce vaccine-preventable disease on the West Coast.*	Develop systems for seamless handover of mother and child as they move from: antenatal care, maternity care, birth, Well Child/Tamariki Ora and primary care. Implement individualised invitation letters for immunisations to parents from West Coast practices. Implement the 'txt to remind' immunisation system across all West Coast practices. Support the robust process for registration of newborns through collaborative work with LMCs, primary care providers, general practice, Well Child Tamariki Ora providers, child and adolescent oral health services and PHO. General practitioner details are recorded on the maternity services birth event booking form. If details are missing the information will be forward to the PHO so a nominated GP can be identified prior to birth. Provide Outreach Immunisation Services with a focus on increasing immunisation coverage and reducing inequalities for tamariki Māori and children in NZ Dep 9 and 10 areas. Ensure immunisation information is widely available for parents thorough antenatal education. Maintain the Immunisation Advisory Group which includes all relevant stakeholders for the DHB's immunisation services, primary care and Community and Public Health. Use our best endeavours to reach the target of 95% of children fully immunised at aged two.	85% of all West Coast children fully immunised at eight months by July 2013 and 95% by December 2014. (National health target) 95% of all West Coast children fully immunised at aged two. (PP21) 90% of newborns enrolled with a GP or WCTO provider by 2 weeks of age. Decreased number of cases of vaccine-preventable diseases in the community.
Increase coordination across child and youth health services. *To improve access and service responsiveness for children and young people and ensure they transition to adult services when paediatric services are no longer appropriate.*	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 referral areas. Continue multidisciplinary working to triage referrals and provide joint assessments and interventions. Improve coordination of services for children and young people with ASD and developmental/behavioural concerns both pre and post diagnosis. Improve coordination between Well Child/Tamariki Ora services providers. Increase coordination across services to identify children/tamariki not enrolled or not accessing a range of preventative and primary care services. Increase coordination with Child Health Services in CDHB.	The number of children jointly assessed by the Specialist Child Health Services. Smooth transition between appropriate services for adolescents and young adults with health and disability support needs. Processes are established to ensure effective transition from paediatric and youth to adult services.
Improve breastfeeding confidence and support mothers to care for themselves and their babies. *To contribute positively to infant health and wellbeing and to lay the foundations for a healthy life.*	Support the Breastfeeding Interest Group to take a lead in strengthening stake holder alliances, identify opportunities to better engage women in breastfeeding strategies and improve integration between providers. Provide access to free lactation consultants across the West Coast District to provide clinical assistance to breastfeeding mothers, particularly Māori, rural, young and mothers living in NZ Dep 8-10. Invest in supplementary services to support mothers to breastfeed, including peer support programmes that are accessible and appropriate for high needs and high risk women. Support the establishment and maintenance of breastfeeding friendly environments on the West Coast.	17 volunteer mothers are engaged in Mum4Mum peer support training. 345 mothers referred to lactation support and specialist advice consults in the community. 96% of mothers are breastfeeding on hospital discharge. 74% of infants are fully or exclusively breastfed at 6 weeks and 40% at 6 months.

Ensure that Well Child / Tamariki Ora (WCTO) services, including the B4SC, are accessible and meet the needs of families, including families with high needs. *To identify unmet health need and ensure that children and adolescents receive the support and treatment they need.*	Provide B4 School Checks to 4-year-old children throughout the West Coast. Ensure coordinated follow-up of referrals resulting from the B4 School Check. Hold one-stop-shop days monthly on the West Coast with WCTO providers. Support the uptake of B4SC by ensuring collaboration between all WCTO providers, including public health nurses, rural nurses, oral health and immunisation outreach. Implement the WCTO Quality Reviews' recommendations. Incorporate a Quality Improvement Framework across all WCTO services, including B4SC. Support quality improvement of the B4SC programme, collect high quality data and meet reporting requirements. Increase the uptake of facility based health assessments and physical health clinics in Alternative Education Facilities. Provide HEADSS[22] Assessments for adolescents enrolled in Alternative Education. Ensure coordinated follow-up of referrals resulting from the provision of health clinics and HEADSS assessment. Implement Gateway Assessments for all children entering Child Youth and Family care. Support the provision of housing insulation through the 'Warm Up West Coast' project to reduce respiratory illness and avoidable hospital admission. Support the Ministry of Health with audit processes to ensure appropriate use of needs assessment tools when allocating additional WCTO visits. Ensure all infants and children identified through WCTO assessment, including B4SC, as needing referral for specialist advice or care receive timely access to appropriate services.	At least 80% of all eligible children receive B4 School Check, including at least 80% of children in most deprived regions. One-stop-shops provided in Greymouth, Hokitika and Westport. Develop a WCTO Quality Improvement Implementation plan within 6 months of receiving the recommendations of the WCTO Quality Reviews and Quality Improvement Framework. Incorporate findings in regular B4SC quality improvement letters. Percentage of adolescents enrolled in Alternative Education receiving a HEADSS Assessments. Number of Gateway Assessments completed. A process is developed to monitor timeliness of access to referred services following WCTO referral by December 2012.
Improve Oral Health Service Delivery. *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. Continue to work collaboratively with Well Child/Tamariki ora, primary practice and other health providers. Increase coordination between the dental service and local dentists treating adolescents. Continue to implement the project focused on engaging out-of-school youth and those attending rural schools to facilitate adolescent dental treatment. Include dental facilities in the development of Integrated Family Health Centre in Westport and Greymouth.	61% of West Coast children are caries-free (no holes or fillings) at aged five in Year 1 and 65% in Year 2.. Reduction in inequalities between tamariki Māori and the total population dental caries free at age 5 85% of adolescents access oral health services. Number of hospitalisations.
Improve health professional responsiveness to family violence, child abuse and neglect. *To identify and reduce family violence.*	Improve coordination of response to child abuse and neglect across 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.
Improve child and youth access to health services *To ensure children and youth receive the support and treatment they need.*	The WCDHB expects that both WCDHB owned and non-WCDHB owned primary practices will provide zero-fee after-hours primary care visits for children under 6. Monitor waiting times for children and adolescents referred for non-urgent mental health or addiction services. Plan and implement changes to reduce waiting times if required.	Zero fee after-hours primary care for under 6's throughout West Coast from July 2012. 80% of children and youth referred for non-urgent MH or addiction services are seen in 3 weeks and 95% in 8 weeks.

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

Maternity Services

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement a collaborative and integrated approach to maternity service *To provide access to an integrated service for mothers, babies and children that meets their needs and expectations through a continuum of care from early pregnancy, through to parenting.* *To identify families with additional or high needs and ensure they receive the support they need.*	Maintain the current process in place where all women are registered with an LMC[23] by week 12 of their pregnancy. Provide high quality parenting and pregnancy education to first time parents. Identify actions to improve the linkage and referral processes between LMCs, primary care providers, general practice, Well Child Tamariki Ora providers, and child and adolescent oral health services to support early interventions. Support a robust process for registration of newborns into general practice through collaborative work with LMCs, primary care providers, general practice, Well Child Tamariki Ora providers and child and adolescent oral health services. Support the Child and Youth Health Advisory Committee to develop an integrated/collaborative network of services to ensure there is continuum of care for mothers and babies. Support the inclusion of Maternity service providers into the Child and Youth Health Advisory Committee to provide a whole of system approach for child, youth and maternity services. Work collaboratively with maternity services, parenting and pregnancy education providers to review and develop courses that are meet the needs of higher risk groups such as teen parents and families where English is their second language. Plan to implement the new national service specifications for parenting and pregnancy education in 2012/13 which is currently under review by the MOH. Implement the national Maternity Quality and Safety programme. Work with general practice and LMCs to identify pregnant women who smoke and ensure they are offered advice and support to quit smoking. Support a joint (Canterbury/West Coast) approach to ensure alignment and improve quality outcomes.	Number of women registered with an LMC by week 12 of their pregnancy. At least 30% of pregnant woman access DHB funded parenting and pregnancy primary education. 90% of all newborns enrolled with a GP or WCTO provider by 2 weeks of age. Maternity service providers part of the Child and Youth Advisory Committee. Aged standardised rate for ASH for 0-4 year olds target <95. Maternity Services and parenting and pregnancy education to address parenting and pregnancy of higher risk groups developed and implemented. West Coast DHB Quality and Safety Strategic Plan approved by Q1, 2012/13. Progress towards 90% of women who identify as smokers at the time of presentation to health services. Confirmation of pregnancy being offered advice and support to quit. First annual Maternity quality and Safety report submitted by 30 June 2013.

[23] *All midwives on the West Coast are Lead Maternity Carers and all pregnant women are assigned an LMC.*

3.6 Māori Health Services

We will work closely with Iwi Hapu me Whānau o Te Tai o Poutini, 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?

This year the focus will be on improving the capacity and capability of the West Coast health system to provide appropriate, accessible and integrated health services for Māori on the West Coast. This includes improving the responsiveness and effectiveness of mainstream service providers, reorienting and integrating Māori health services and delivering on Whānau Ora.

Following the review of mainstream service effectiveness for Māori, our service priorities for 2012/13 include maternal health, chronic conditions, smoking cessation, child health and oral health. We anticipate that Māori will benefit from the establishment of clear patient pathways and targeted initiatives that are aimed specifically at increasing Māori uptake of services such as immunisation programmes, breastfeeding support, and school-based health services and reducing inequalities.

Delivery on Whānau Ora and improving access and health outcomes for our population by supporting interconnectedness and the provision of seamless services between providers and sectors will continue to be a priority. We will work alongside providers to support the organisational transformation required for the delivery of a Whānau Ora Integrated model that is clinically sound, culturally robust and empowers patients and their Whānau to be self-managing.

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 Māori population on the West Coast is increasing, particularly in the Westland district. West Coast Māori have a similar deprivation profile to non-Māori 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 Māori on the West Coast die before the age of 65 (55%) compared with non-Māori (20%). Data also indicates that West Coast Māori not only have poorer access to health services, but they have poorer outcomes following intervention.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve access to healthcare for Māori on the West Coast.	Implement the Better Sooner More Convenient Healthcare plan including Kaiarataki working across all health services to increase enrolments and access. Māori Health Plans are developed and implemented with each General Practice. Māori Health Champions will be identified within each practice to support implementation of the Māori Health Plan.	Kaiarataki and Kaupapa Māori health positions will be established in the Buller and Grey districts by end Q1 and Q2 respectively Increased enrolments and access for Māori to clinical services. Increased number of clinics provided in the community.
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.*	Consider accessibility and the appropriateness of services for Māori patients 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 increase accessibility for Māori and increased uptake of primary care programmes. Implement the recommendations from the Review of Mainstream Service Effectiveness in the areas of cardiovascular disease, diabetes, cancer, smoking cessation services and oral health.	Patient pathways consider the needs of Māori patients and seek to reduce inequalities. An increase in the number of DHB staff who have completed Te Pikorua and Tikanga recommended Best Practice training. Increased uptake of primary care services by Māori.

Transformation of our West Coast health system to create an integrated people-centred family service that effectively meets the needs of whanau using the whanau ora approach	Reconfigure Maori Health Provider/Services to align with Better, Sooner More Convenient Healthcare and Whanau Ora. Support Mainstream services to deliver more effectively to Maori through improved collaboration with the Maori Health Provider Appointment of Maori Advisory Committees in each IFHC district to ensure local Maori engagement in developing services that impact on Maori Kaupapa Maori Nurses in partnership with other providers will work with whanau to develop wrap-around services tailored to their needs.	Existing contracts with Māori Health provider are aligned with the Better Sooner More Convenient Healthcare Business Case by October 2012 in the Buller, December 2012 in the Grey district and June 2013 in the Westland district. Collaborative initiatives aimed at improving Māori health are initiated by the Māori Health Provider and are in place by 30 June 2013.
Support Māori workforce development to improve the capability of services to provide health services to Māori	Support the implementation of Kia Ora Hauora. Facilitate and support Māori staff from across the health system to access further training through Hauora Māori training. Support the Māori Provider to build their capacity and capability to implement their Whānau Ora initiative.	An increase in the number of Māori staff accessing training through Hauora Māori training.
Work together to support the implementation of the national Te Puni Kokiri led Whānau Ora initiative. *To implement Whānau Ora through the provision of integrated services.*	Participate in the assessment of the regional Te Waipounamu Business Case and Programme of Action (Phase 1 of the national initiative). Participate in the Whānau Ora Regional Governance Group to monitor and support the implementation of the collective Plan of Action. Support the Whānau Ora collective to move into Phase 2 of the national programme and develop their Whānau Ora model. Identify opportunities for the introduction of Integrated Contracting across government agencies to support the implementation of the Whānau Ora model.	The Programme of Action is approved by Q1. The Whānau ora model is approved by Q4. Integrated contract is in place with the Māori Provider by June 2013.

3.7 Disease Prevention Services

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. Commitment to the West coast Tobacco Control Plan and public health promotion programmes are our approach to reducing these risk factors, with continued focus on population and personal health initiatives that target improved nutrition and physical activity. The collective public health group, Healthy West Coast Governance Group, is committed to working collaboratively to plan, fund and implement Public Health services throughout the West Coast.

The WCDHB is committed to supporting smokers to quit across primary and secondary care to contribute to achieving in both health target areas.

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 2012/13 Health Target of 95% in public hospitals and 90% in primary care. Progress will also be made towards the target of 90% of pregnant women who identify as smokers are offered advice and support to quit at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Support smokers to make more quit attempts, leading to more successful quit attempts and a reduction in smoking prevalence. *To reduce the major risk factor of long-term conditions and reduce inequalities in health outcomes, particularly for Māori, who have disproportionately higher smoking rates.*	Provide and promote Smokefree environments to support those making cessation attempts and reduced exposure to second-hand smoke. Undertake controlled purchase operations (CPOs) to ensure tobacco retailers comply with existing and new Smokefree legislation. The WCDHB is committed to supporting smokers to quit across primary and secondary care to contribute to achieving in both health target areas. Continue to improve ABC in our hospitals: ▪ Further enhance ABC documentation, data collection and systems to streamline and reduce the burden of reporting; ▪ Provide ongoing training and education for all staff, including mandatory training, e-learning and 'train the trainer' approaches; ▪ Support clinical leadership including the Director of Nursing, Nurse Manager and smokefree ward champions; ▪ Explore ways to support Māori smokers to transition from hospital into a community-based cessation programme; and ▪ Continue to support monitoring and feedback processes including monthly ward-specific feedback reports. Support the implementation of ABC in primary care and ensure systems are in place to allow collection of baseline data and record the provision of smoking cessation advice.	Three CPOs carried out and appropriate enforcement action taken as necessary. 75% of year 10 students have *never* smoked. 95% of hospitalised smokers will be provided with advice and help to quit. Aukati KaiPaipa will be provided to >100 clients 90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit. Progress is made towards providing 90% of women who identify as smokers at the time of confirmation of pregnancy advice and support to quit.

	▪ Work with PHOs to develop resources (such as the 'smoking assessment' advanced forms in Medtech) and provide training for GP teams on documentation of smoking status and the provision and documentation of cessation advice and support; ▪ Regularly meet with WCPHO – including the PHO Clinical Manager – to share target results and agree future actions. Action plans will be continually reviewed by the steering group in regards to effectiveness; ▪ Support the PHO to continue to be informed about the updates of the Health Target, linking into communication channels set up by the Ministry; ▪ Explore and implement the use of monitoring and feedback tools such as monthly practice-specific reports; ▪ Provide targeted community-based cessation support to Māori and whānau via the Aukati Kai Paipa programme. Work with general practice and LMC to ensure processes are in place to systematically provide pregnant women with advice and support to quit smoking. ▪ Identify clinical champions to support and pass on key messages to LMCs; ▪ Ensure that training and resources are available for LMCs to provide brief advice and cessation support to patients; ▪ Ensure LMCs are aware of referral pathways to cessation services including Aukati Kai Paipa and Coast Quit; ▪ Ensure that PHOs implement training, provide resources and communicate key messages about smoking in pregnancy to GPs and their practices. Increase capacity of organisations (especially those with at-risk clients) and people who can provide cessation support.	
Reduce the harm caused by alcohol. *To reduce a major risk factor of harm and long-term conditions.*	Deliver host responsibility training to improve the skills of Duty Managers in reducing alcohol-related harm. Monitor Licensed premises assessed to be of high risk of creating alcohol-related harm. Assist Police with alcohol controlled purchase operations (CPOs) to reduce the supply of liquor to minors. Investigate and report on requests from District Licensing Agencies for new licences and licence renewals within 15 days of request.	3 monitoring visits per year to high-risk premises. 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.
Increase the number of homes insulated on the West Coast.	Identify those homes on the West Coast most at risk due to living in homes with poor home insulation. Prioritise households with children (under two), seniors (over 65) and those that have someone with a housing-related health problem (such as a respiratory illness).	An increase in the number of homes insulated on the West Coast.
Empower people and communities to take positive action to improve health and wellbeing. *To support healthy eating, physical activity and weight reduction and reduce the risk factors of long-term conditions.*	Facilitate community action to enable Māori to continue to achieve healthy and active lifestyles. Support joint planning and delivery through the Healthy West Coast Governance Group and Active West Coast Network and jointly identify and address any issues or gaps. Provide targeted community-based programmes that enable people to improve their cooking skills, enhance nutrition knowledge, increase physical activity and reduce falls.	The Oranga Pai community programme is implemented 5 'Cooking Skills to Life Skills' and 'Senior Chef' courses are delivered. 360 people are provided with Green Prescriptions. The number of people aged 75+ hospitalised for falls-related injuries decreases.

3.8 Cardiovascular Disease and Diabetes: Long Term Conditions Management

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 5-year risk assessed in primary care. This is to be a target of our general practices, as well as our Māori Health service provider that will be linked in closely with the PHO and General Practices, as part of our roll out and delivery of BSMC programme in primary care. This will enhance data collection and information sharing to the benefit of patient care and reduction of duplication.

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 ,and other long term personal health conditions, 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. 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 does not have a separate stroke unit as the minimum viable size required for such a unit is not supported by our population; however, in collaboration with CDHB we will be implementing the 2010 clinical stroke guidelines. The services will be further supported through Functional Independence Measurement (FIM) training and the Australian Rehabilitation Outcomes Centre (AROC) programme covering stroke and other disease state rehabilitation.

The West Coast DHB has in place a Long-Term Conditions Management Strategy (LTC) that overarches our strategies of leading for outcomes for improved patient self-management, clinical management and best practice principles for all long term condition across primary and secondary services, with a primary focus on diabetes, CVD, chronic respiratory disease, and stroke; and intimately linked in with CVD risk assessment and smoking cessation programmes. 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.

The Long Term Conditions Strategy was formally adopted in December 2006. Under the LTC Strategy, primary care services for long term conditions patients are stratified into three tiers in terms designed to help patients self manage their conditions to live independently at home, and where they need hospital intervention, to have reduced stay with packages of care and support already in place when to help facilitate their discharge home. The LTC programme allows for closer monitoring and self-management support for people with long term conditions, e.g. heart disease, diabetes, respiratory disease. Patients with LTCs have at least an annual review and then receive a package of care based on their level of need (level 1, 2 or 3). Level one is for people who are managing well and provides an annual clinical review, a “My Shared Care” health record and referral to either PHO or community support programmes. Level 2 is for people needing help and support to self-manage, and provides quarterly clinical review and additional self-management support based on the Flinders model. Level 3 is for very high need patients with major clinical and/or social issues; and includes Assessment Treatment and Rehabilitation (AT&R) or Need Assessment and Service Coordination (NASC) assessment; full Flinders self-management assessment and follow up

and close clinical monitoring by both nurse specialists and GPs. "Share for Care", a system for sharing an electronic summary of health records held at primary practice and hospital services between health professionals involved in patients care, was introduced on the West Coast from 30 November 2011. This provides members of a consenting patient's health care team - including general practice, hospital, allied health, pharmacy and, for some mental health staff - access to key health record information to help reduce unnecessary duplication and to help keep them up-to-date and fully informed, to ensure they make the best decisions about the patient's care. Information made available through the Share for Care includes summaries of long term health problems; long term medications; recent health issues and medications within the last six months; allergies; hospital records; hospital discharge summaries; and test results. The system is designed to be equally useful to emergency situations as it is to long term conditions management

The number of people that are managed in the community setting under this LTC programme is recalculated annually, based on the PHO enrolled population. Volumes for Level 1 is uncapped, while at present in 2012, the target populations that would be supported under this calculation are 951 for Level 2 and 190 for Level 3. As at the end of March 2012, there were 2052 patients enrolled in the LTC programme (6.6% of the population), including 1576 in Level 1, 424 in Level 2 and 52 in Level 3. Māori enrolments make up 6.3% of all enrolments in the LTC programme to date. In comparison, Māori make up 5.1% of the enrolment population ager 45+ years – the prime age group of people in the LTC programme.

The Long Term Conditions Strategy has a number of clinical pathways developed, including clinical pathways for respiratory disease, cardiovascular disease and diabetes. These are subject to continuous quality improvement and review. We have bridges for this review process through our Local Diabetes Team and Heart and Respiratory Local Team, which are a mechanism by which we look at our current processes and potential process improvements across the long term conditions continuum of prevention, primary and secondary care. Whilst recognising the value of the generic approach to chronic long-term conditions, the value of these specific focused interdisciplinary teams, with consumer and Māori representation, has been seen in the success of sharing information between providers, and in informing and guiding the West Coast DHB in the development of planning initiatives and targeting of services and service delivery improvements, from health promotion, disease prevention and self management, primary and secondary care. This work will continue and will be further built upon during 2012/13 and supported through the *Better Sooner More Convenient Healthcare* programme being progressively implemented on the West Coast.

While universal free access to a GP visit for annual diabetes reviews under the Get Checked programme is no longer available, the West Coast DHB will use the $32,000 funding allocated to the programme to continue funding improvement packages and support the wider West Coast PHO's existing comprehensive Long Term Conditions Programme. In addition to these $32,000 diabetes Get Checked funds, the Long Term Conditions programme is supported by the bulk of $475,000 provided from Care Plus funding, as well as a small portion of the $210,000 provided from Services to Improve Access funding. This will deliver planned, proactive, structured, tiered long term conditions care across several clinical conditions, designed to deliver better access and more individually tailored services - particularly focussing on the high needs populations at the third level of the 3-tiered programme. These stratified programmes have shown to be producing good outcomes for patients over the last few years, in terms of their individual patient self-management capacities and improving health status. For this reason, we plan to continue to provide the delivery of the 3-tier support levels of the Long Term Conditions Programme for people with diabetes, CVD and chronic obstructive pulmonary disease, with no patient co-payment for any of the levels. This has been funded from inception of the programme by a combination of Diabetes Free Annual Review, Care Plus and Services to Improve Access funding. Cardiovascular risk assessments every five years for eligible people come from the same combined funding pool, and are also free to the patient at the moment.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve the identification and clinical management of people 'at risk' of CVD and diabetes *To improve access to appropriate intervention and support improved self-management of CVD and diabetes* *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).*	Ongoing support for the West Coast Long Term Conditions Management Strategy Programme. Continued implementation of the Healthy West Coast Plan (as per the Disease Prevention section) with a focus on smoking reduction, improved nutrition and increased physical activity. Key diabetes and CVD target indicator data is actively monitored through our Local Teams, with information regularly shared and used to inform planning initiatives and targeting of service provider activities to best effect. Comprehensive analysis and review of data from the long term conditions programme is undertaken and additionally used to review the long term conditions programme performance in respect of patient outcomes to inform future directions, at both individual general practice level as well as overall for our population.	75% of the eligible adult population as measured in each of the population groups Māori and Total Population will have had their CVD risk assessed in the last five years by July 2013, with this target rising to 90% over the next three years. 70% of all people with diagnosed diabetes as measured in each of the population groups Māori and Total Population, will attend annual reviews

Over time, all high risk population 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.	Key diabetes and CVD target indicator data is actively Proactive campaign, automatic recall, and direct contact and invitation for people due for risk assessment provided through general practice. Use diabetes free annual check funds to target both new and existing high needs patients with intensive self-management support programmes through the LTC management strategy programme - particularly those patients at Level 3. Ongoing support for continuous quality improvement review of the three clinical pathways for diabetes, CVD and respiratory through the respective Local Teams. Quarterly monitoring of results against service delivery targets for CVD and diabetes by the Local Teams	80% of all people with diabetes as measured in each of the population groups Māori and Total Population will have satisfactory or better diabetes management (defined by having HBA1c level of equal to or less than 64% at their annual diabetes review. 90% of all people as measured in each of the population groups Māori and Total Population, who have had their annual diabetes review 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.* *To more closely align and integrate primary and secondary services involved in the detection, follow-up and management of diabetes, CVD, and other long term conditions.* *To improve the Information Technology interface and two-way data sharing between primary and secondary services*	Review and update design of the clinical/patient education and tools for self-management of long-term conditions as appropriate. General practitioners provided with direct access to specialist advice, clinical nurse specialists, other appropriate health professionals, and to diagnostic test results through information technology. Priority focus on high needs patients by general practice through the PHO long term conditions programme, including tailored, intensive self-management programmes (using former diabetes annual checks funds) Review alignment of diabetes nurse educator and cardiac clinical rehabilitation nurse specialist resources roles in respect of the *Better Sooner More Convenient Healthcare* programme with West Coast PHO and general practice services (including rehabilitation programmes, input into specialist clinics, training and education to practice staff) to better supporting the Long Term Conditions management programme. For people who have an diabetes screening checks each quarter, report on the following: ▪ % with cholesterol ▪ % not smoking ▪ % who have had retinal screening within the last two years ▪ % on kidney protective medications ▪ Narrative of key activities undertaken in primary care to reach the diabetes key indicator outcome targets Annual Report from the Local Diabetes Team or equivalent on key focus areas and outcomes, to help inform the DHB and its providers in service improvement planning and direction. Review cardiac clinical pathway by 31 March 2013, to include: ▪ Promotion of closer involvement of cardiac clinical nurse specialists with general practice teams to provide support for patients with suspected or worsening cardiac disease. ▪ Investigate the role for appropriately skilled /trained nurses to provide exercise ECG tests and cardiac ultrasound/echocardiograph. ▪ Implementation of appropriate technology and equipment to enable nurses to closely liaise with the tertiary provider of cardiac services and specialist doctors, inclusive of clinical data and imaging. Improved access will promote improved referral to the cardiac service. ▪ Implement a telehealth model for Cardiac and Respiratory Clinical Nurse Specialists for follow up clinics and consultation with the tertiary team. Localise and operationalise electronic Health Pathways for cardiac patients, including clear guidelines for when to refer for diagnostic testing for people with suspected or worsening	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 focussed on outcome and self-management improvement. Faster and more convenient access for clinicians to latest patient records and relevant test results to best inform patient care. Improved flow of patients to Christchurch; represented by improved Standardised Intervention Rate for cardiac surgery. Acute Bed reduced by 5% from 2010/11 levels; Target for acute adult medical bed days in DHB Provider Arm services for 2012/13 – 8725 bed days per annum. Acute medical admissions reduced 5% from 2010/11 levels. Target for acute adult medical admissions to DHB Provider Arm services for 2012/13 – 2185 admissions per annum. Annual Report from the Local Diabetes Team or equivalent on key focus areas and outcomes.

	cardiac disease Self-management training and education facilitation is offered to help extend general practice response capabilities for people with diabetes (using former diabetes free annual checks funds) Kaupapa Māori Nurses work collaboratively with general practice and secondary care services to help improve outcomes for Māori with diabetes and CVD.	
Support Rehabilitation Programmes. *To reduce the likelihood of a subsequent CVD event and support people to optimise recovery, achieving better outcomes for treatment and rehabilitation for individual patients.*	Referral of people to local cardiac and stroke follow-up and rehabilitation programmes after acute events. Close collaboration with Canterbury DHB services to continue 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. Implementation of a specific plan for further service improvement for CVD and stroke services within the overarching West Coast Long Term Conditions Management Strategy is undertaken.

Organisational Capability

4.1 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.

4.2 Our people

WEST COAST DHB WORKFORCE 2011		
Total Female Headcount	*Total Male Headcount*	*Total WCDHB Headcount*
954	167	1121
70.8% part time		2% of NZ total
Average Age	*Largest Ethnic Group*	*Average Length of Service*
49.7 years	NZ European	8.07 years
Largest Workforce Group	*Youngest Workforce Group*	*Oldest Workforce Group*
Nursing 500	Management Clerical	Support Workers
44.5% of workforce	Av Age 46.2 years	Av Age 51.1 years

Global competition for skilled people, the expectations of younger generations of employees, the impact of emerging technologies, and rapidly changing demographics in the workplace are all ongoing challenges for the New Zealand health system.

It is widely acknowledged that in order to meet future demand for service we must transform the way we work, and the way we deliver health services to our population. We simply do not have the workforce numbers to continue to provide services the way we have in the past, and we cannot continue to compete for the same skilled staff.

Strategies to address these pressures must be considered and balanced. We need to attract, retain and motivate key performers and those with high potential or scarce skills – while at the same time focusing on cost containment, performance improvement and risk management.

As a good employer, we promote equity, fairness and a safe and healthy workplace. We uphold high standards of governance and ethical business conduct through a clear set of organisational values and policies, including an integrated code of conduct, as well as compliance with legal requirements.

However, in our current context it is not sufficient just to be a good employer. To attract and retain the right people, with the right skills, West Coast DHB aims to be an employer of choice and to make our workplace more attractive by offering challenging work, more patient contact time, ongoing career and leadership development and opportunities to be part of decision-making.

Strategic direction

Over the past several years we have been transforming the way we work to ensure we can meet the needs of our population in the future. We are engaging our workforce in the development of alternative and improved models of care and in training that expands people's capabilities and capacity.

Our progress on integrating models of care has strengthened working partnerships between community, primary and secondary health professionals. This not only increases our health system's capacity, but also improves the continuity of care for patients and helps to attract and retain staff by promoting workforce satisfaction and engagement.

Empowered health professionals are taking a lead in setting strategic direction, developing service models, reducing duplication and waste and improving patient care on the West Coast.

Clinically led *'Making Time for Caring' and 'Lean Thinking'* initiatives will support our desire to increase direct patient care time on our wards, improving both patient outcomes and workforce satisfaction. These strategies will improve capacity, reduced patient wait times and increasing the number of people we can see.

Telemedicine, outreach clinics and connected electronic patient information and referral systems have allowed us to further expand capacity. Health Professionals are now better able to provide services, supervision and advice to colleagues in other parts system or the country without a significant increase in workforce numbers. Videoconferencing and telemedicine smoothes the transfer of patient being treated for medical detoxification between tertiary and secondary services, enables remote supervision of dieticians on the West Coast and supports the provision of specialist advice with Christchurch paediatric specialists able to carry our 'virtual ward rounds' at Grey Base Hospital.

Training and education programmes are expanding capabilities and roles across the health system, empowering health professionals to work to the greatest extent of their scope and helping to support cross-sector partnerships and service delivery models.

We are also supporting the development of our rural clinical workforce both on the West Coast with recent investment in the Rural Learning Centre located in Greymouth.

In collaboration with the Canterbury and Otago Universities and the South Island Polytechnic Network, we have developed a South Island Tertiary Alliance to deliver a single management and leadership curriculum for all health employees in the South Island. This will promote career enhancement, maximise people's potential and help us to retain valuable employees – while also building core capabilities across the wider health system. Health Workforce

NZ (HWNZ) is now an active member of this Alliance, and we hope to give some consideration to a core national curriculum.

We are supporting the development of an appropriately skilled Māori health workforce by taking the South Island lead for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori studying towards health careers and working in health fields. The initiative will support more than 250 Māori regionally.

We have also stepped up our investment in the HWNZ-sponsored South Island Regional Training Hub. These hubs are expected to become centres of excellence for postgraduate clinical training and education, career planning and the administration of activities such as bonding schemes.

Operational direction

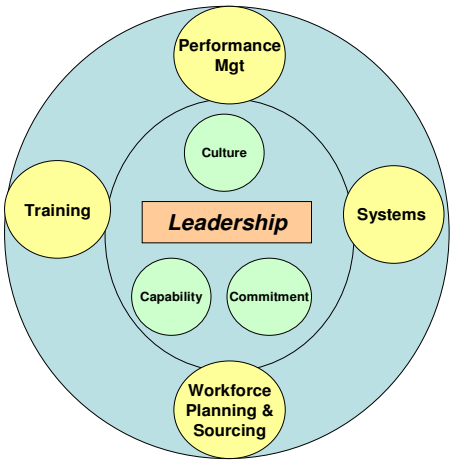
Work to develop an integrated approach to workforce planning in conjunction with the CDHB is underway. Through this engagement we will invest in common HR IT systems, leadership development and workforce training. Our objective is to develop a plan that will guide recruitment and employee development now and into the longer term. This work will factor in projected demand growth, changing demographics, workforce expectations and service models. In time this work will be extended into the community and other health organisations on the West Coast.

We will expand our support for workforce training and development across the system. This will include joint clinical appointments with the University of Otago, our Nursing Entry to Practice programme, clinical placements, joint non-clinical appointments across West Coast and Canterbury DHBs, secondments into and from the primary care sector and an active role in the regional training hubs. The establishment of the Rural Learning Centre will aid in the learning and development activities for staff.

We will also continue to participate in the *'XcelR8'* leadership programme for West Coast DHB staff, supporting an aligned change in our culture and way of working. This programme, together with the new *'Particip8'* programme, fosters innovation and ensures the rapid adoption of staff-led process improvements.

Our internal strategy (Figure 1) continues to support progressive reform of HR practice with promotion of these system elements across the West Coast DHB, regionally through the South Island DHBs, and nationally through HWNZ and the NZ Healthcare Institute for Management and Leadership at the University of Auckland.

Figure 1: Canterbury DHB and West Coast DHB combined HR Strategy



During the coming year, we expect to digitise all HR administration and technology and further integrate West Coast HR systems with Canterbury. This is a significant piece of work that will promote improved efficiencies and support managers to better manage their staff through greater information access. We will embed performance management, recruitment, talent and succession planning approaches in the organisation, as well as commencing work on culture and employee engagement projects.

Creating a fit for purpose future rural workforce

The future direction for workforce development for the West Coast health system focuses on promoting the generalist across professional groupings of allied health, nursing and medicine; assisting professionals to be working at the top of their scope and looking for areas where scopes can be expanded; and taking an inter-professional approach to learning and education.

The role of the generalist within the medical workforce will be developed through the rural hospital medicine doctor role, and greater involvement of general practitioners in roles that have traditionally been hospital-based. These roles will work collaboratively with the traditional hospital-based specialist roles. Developing the role of the rural hospital medicine doctor will be closely linked to expanding the role of nursing within the hospital setting.

The generalist nursing workforce (registered and enrolled) will be supported by nurse practitioners, clinical nurse specialists, registered nurses with a specialist interest and nurses working with an expanded scope. The nursing workforce will be mobile between clinical areas, utilise the generalist skill set, and match capacity to demand to ensure resource meets clinical need.

The allied health workforce will be enhanced and focused on generalist care, with specific input from those with specialist skills, as well as remote connection to rurally focused urban specialists within Canterbury via the enhanced telehealth services. These developments are acknowledged as the way forward for a sustainable workforce for the West Coast.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement leadership development programmes. *To engage key people in the transformation of the West Coast health system and help us to retain our valued workforce.*	Establish champions across the West Coast health system to promote best practice and support transformation based on a 'best for patient, best for system' approach. Support Service Level Alliances, clinical and professional networks and multidisciplinary working groups. Establish talent pools with identification of critical roles. Drive change through the development of clinically led patient pathways that support evidence-informed practice and improve health outcomes for patients. Supporting the adoption of leadership development practices, partnerships and alliances across the South Island.	Establish core curriculum for management and leadership Introduce talent identification programmes Mitigate risk by implementing succession planning
Promote the desired culture of the WCDHB. *To promote desired behavioural norms and influence 'the way we do things in West Coast' to ensure we are better able to deliver on our strategic goals.*	Identify and promote the desired culture of the DHB and promote cultural messages via channels that are valued by the organisation. Invest in programmes that reiterate the desire behaviours and culture, including 'XcelR8' and 'Particip8'. Introduce a diagnostic tool to assess current and ideal culture values and identify opportunities for change. Align systems for goal setting, performance reporting, and communications to reinforce culture messages. Promote inter-professional learning through the Rural Centre.	Cultural diagnostic tool introduced by Q3/Q4 >50 people participate in XcelR8 and Particip8 programmes. Effective interdisciplinary team work in medical nursing and allied health education on the West Coast.
Improve employee engagement and commitment. *To keep our workforce enthusiastic and motivated.*	Use the data gained from the new attachment (first 90 days of employment) and exit technology to identify areas of concern and opportunities for improvement. Run a Staff Engagement Survey to determine priorities.	50% of people leaving have completed an exit interview. >80% would recommend WCDHB as an employer.
Expand workforce capability through core learning and development models. *To support changes in technical skills and behaviours that will increase the capability of our workforce to perform effectively within the West Coast Health system.*	Address barriers that currently limit staff from working to the full extent of their education, skills and experience. Work with undergraduate professions and training agencies to ensure appropriate training spaces are available. Invest in extending primary care education programme coverage and expand the variety of education channels. Support ongoing skills development, building on internal CDHB learning and development plans and the South Island Training Alliance core curriculum. Embed desired capabilities into recruitment processes, position descriptions, development plans, curriculum, performance standards and succession plans.	Moodle technology learner and management systems and organisational training portals established by Q4. West Coast GPs have access to the primary care education programme.
Expand workforce capability through improved performance management. *To provide staff with a greater understanding of how they contribute and the standards required to improve performance levels and the quality of service provision.*	Provide education and training in Sonar 6 performance management to ensure a consistent DHB approach. Introduce online performance management technology to allow more time for quality conversations on performance expectations. Introduce performance measures covering a combination of what (technical) and how (behavioural) to increase engagement in performance management. Supporting the adoption of aligned performance management	>100 people complete Sonar 6 training. >50% of DHB employees use the online performance system by Q4.

	practices (Sonar 6) across the South Island.	
Expand workforce capacity through improved workforce planning, recruitment and retention.	Develop a system-wide view that identifies workforce gaps and opportunities over the next 3, 5 and 15 year periods. Support NetP and Professional Development Programmes. Support scholarships for Māori. Research and redefine West Coast's employee value. Invest in market mapping, profiling of candidates and alternative channels to engage prospective employees. Leverage off the use of shared recruitment and retention technology (Phoenix) to develop a wider talent pool. Promote inter-professional learning through the Rural Learning Centre. Expand rural hospital medicine and rural general practice training on the West Coast. Continue to recruit into Nursing Entry to Practice/Specialty Practice and Midwifery First Year of Practice programmes to grow the future workforce. Continue to develop advanced clinical skill for nursing and explore/implement expanded nursing roles within the West Coast Health System. New roles within Allied Health to be explored including clinical specialist and allied health assistant roles across the allied health disciplines.	12% reduction in time taken to fill vacancies. 1% improvement in retention rates. Effective interdisciplinary teamwork in medical, nursing and allied health education on the West Coast. Clear education and workforce planning informed by service and model of care design across the disciplines. Two Rural Hospital Medicine registrar and two GPEP 1 registrar posts for 2013 academic year. Ongoing support and planning for HWNZ funded Post Graduate nursing education.
Expand workforce capacity through the alignment and reform of HR systems.	Digitise all HR administration and technology and further integrate Canterbury and West Coast HR systems. Implement an integrated HRIS platform across the West Coast health system. Embed performance management, recruitment, talent and succession planning approaches and processes at a DHB and system-wide level.	All WCDHB recruitment undertaken by CDHB by Q1. Hiring manager's time is halved.
Expand regional workforce capacity through improved workforce planning and sourcing.	Regionally identify future workforce requirements and agree a common set of workforce planning tools. Support a SI approach to workforce training for 'vulnerable' workforce areas. Support the development of regional education sessions, forums, peer support and mentoring using innovative approaches including e-learning and video conferencing. Expand the rural hospital medicine and rural GP team on the West Coast.	Agree five core HR policies across all SI DHBs by Q4. Agree common core HR systems across SI DHBs. Two RMH registrars, two GP EPI registrar posts are in place for the 2013 academic year.
Align workforce activity across the South Island. *To make the most effective use of our current workforce and ensure we have the workforce we need to meet the future demand for services across the South Island.*	Support the Regional Training Hub to analyse workforce trends and future requirements and identify appropriate responses to identified workforce gaps. Support the regional coordination of clinical placements to specialist training programmes. Identify opportunities to deliver or connect education to professional groups under South Island Alliance workstreams. Develop a regional programme of peer support/mentoring, education and training that encourages post graduate studies. Review and standardise the career pathways and training opportunities for PGY1 and PGY2 students. Review and standardise career planning for HWNZ-funded trainees. Review and support improvements to regional education sessions, forums, peer support and mentoring using innovative approaches including e-learning and video conferencing. Strengthen the training network within Te Waipounamu and facilitate the coordination and delivery of post-graduate training and education to all workforce groups.	Data analysis for South Island health workforce complete by Q1. Annual Plans by priority workstream agreed by Q2. Peer support/mentoring programme agreed by Q2. Regional programme to promote post graduate studies agreed by Q3. Review on PGY1 and PGY2 training complete by Q3. 100% of HWNZ funded staff have career plans in place by Q4. South Island health workforce plan developed by Q4.

4.3 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 as part of the West Coast DHB Quality Improvement Programme.

Our initiatives are aligned to the national health priority areas, and the Health Quality and Safety Commission work programme.

We are committed to the national quality improvement projects on Medication Safety, Quality Accounts, Mortality Review, Incident Management/Reportable Events, Infection Prevention and Control (including Hand Hygiene and Central Line Associated Bacteraemia), the Surgical Checklist, and implementation of the Maternity Quality and Safety Programme in collaboration with Canterbury DHB.

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.

4.4 Integrated Information Systems

We will provide accurate and timely patient information across the system to better inform clinical decision-making.

Why is this important?

Providing a smooth patient journey through the West Coast health system requires integrated information systems and the sharing of patient information between primary and secondary providers. Integrated systems will give health professionals timely access to the information they need to perform their roles, reducing wasted effort collecting information that is stored in many different places. Patients will not be asked repeatedly for the same information and can have confidence that information will be used appropriately for their care.

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

IT solutions and advances are a critical enabler for the integration of health services on the West Coast. The focus in 2012/13 will include the expansion of a shared care portal to enable clinical staff and patients to access the patient record electronically, expansion of video conferencing throughout the district and Telehealth clinics. Greater efficiencies will also be achieved through the adoption of a regionally hosted finance and pharmacy systems.

In the coming year, the West Coast DHB will merge its clinical systems into regional instances. The first part of this change has already been completed with the merger of the WCDHB PACs system with CDHB's regional archive to provide a single location for radiology imaging. This year we will adopt a regional Clinical Information System that is hosted by Canterbury DHB using Orion's 'Concerto', followed by the merger to a sub-regional laboratory repository. This will ultimately provide one source for all diagnostic tests and clinical information within the region.

West Coast DHB will continue to work with CDHB and Pegasus around the Electronic Referrals Management System that was developed as part of the Canterbury Initiative. This will enable an e-Referral solution for primary health care on the West Coast, by providing a streamlined referral process that is aligned to agreed health pathways.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Regionally integrated information systems *To improve clinical access to patient information, lower clinical risk, and improved patient outcomes, and to enable efficiency gains by reducing unnecessary duplication in processes.*	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. Implement the regional Endoscopy Solution within WCDHB Migrate legacy iSOFT Windose system to ePharmacy system as part of the national roll-out. Migrate legacy IBA Financial system to Oracle hosted either national or regionally.	Reduction in the number of silos containing patient information. Reduced number of logins for clinical staff. Fully supported and integrated financial systems are operational by July 2013. Fully supported and integrated ePharmacy systems are operational by Dec 2014.
An effective eReferrals system for primary care *To provide a streamlined referral process aligned with health pathways, reduce rejected referrals and improve quality of information to enable better patient outcomes.*	Implement the Electronic Referrals Management System developed by Pegasus Health and Canterbury Clinical Initiative for West Coast primary care.	Increase in the number of electronic referrals. Reduction in number of rejected referrals due to incomplete information.
Provision and utilisation of Telehealth throughout the West Coast. *To improve clinical networking, education and support, provide more timely patient care and reduce travel time.*	Provide additional videoconferencing equipment throughout the West Coast. Implement the Southern Cancer Network Multi-Disciplinary meeting solution.	Increased utilisation of videoconferencing throughout the West Coast. An increase in the number of outpatient clinics and patients appointments via Telehealth. An increase in the number of meetings conducted by video conference (>130 hr/mth).

Utilisation of a shared care portal that enables access to clinical information and online bookings. *To improve secure access to vital clinical information for clinical staff and patients*	Implement the Medtech 'Manage My Patient' portal.	Patients are able to access the portal by June 2013.
Extend access to Medtech for nursing and allied health staff working within IFHCs	Increase the Medtech licence to include all clinical that working within IFHCs. Provide training and system support for new users.	All clinicians working in IFHCs are competent to utilise Medtech.
Enhanced collaboration and greater functionality through updating basic IT infrastructure *To reduce incompatibilities between organisations, regionalise licensing arrangements and improve capability to support wireless technologies within health.*	Update to Microsoft office 2010, XenApp 6.5 and Windows Server 2008 for Citrix Farm. Deploy wireless technology to a various sites throughout the West Coast Health System.	Windows 2008, and XenApp6.5 updates are completed by December 2012. Microsoft Office 2010 update completed by June 2013. An additional five wards have wireless access by June 2013.

4.5 System Partnerships and Alliances

The West Coast DHB is committed to sharing resources and knowledge to boost capacity in the health sector. We are also committed to working with external agencies and providers in other sectors to influence the social determinants that strongly contribute to improving longer-term health outcomes for our population.

Alliance Leadership Team

The Alliance Leadership Team (ALT) was formed in response to opportunities presented by the Government to transform and integrate health systems through the Better, Sooner, More Convenient Healthcare Business Case. The ALT provides leadership and guidance to the implementation of BSMC, including the design and implementation of integrated family health centres and models of care in the Buller and Grey districts, patient-centred health pathways that seek to improve access and reduce waiting across the West Coast health system and a specific focus on providing integrated care for older people that is provided closer to home.

Three key work streams have also been generated to support the operational development of new models of care throughout the district. During 2012/2013 the ALT will be responsible for determining the final phase of implementation of the BSMC business case as approved by the Ministry of Health.

West Coast Intersectoral Forum

The West Coast Intersectoral Forum consists of executive level representatives from local government, education, social development, police, economic development, health, non-government sectors and local iwi. The DHB coordinates the West Coast Intersectoral Forum, which supports knowledge sharing, cooperative working and collaborative projects. The West Coast DHB provides a leadership and coordination role for this forum.

Regional collaboration

The five South Island DHBs have adopted a modified Alliance Framework to support accelerated regional planning and service delivery.

The South Island Chief Executives form the Alliance Leadership Team and take responsibility for coordination of regional health service planning under the Alliance Governance Board (the South Island DHB Chairs). This step up to a regional alliance better supports collective decision-making and enables the South Island DHBs to provide clear long-term signals around regional service planning and capital investment – improving the use of shared resources.

South Island regional planning is implemented through service level alliances and work streams. The West Coast is represented across the regional planning streams, and our commitment to specific regionally planned actions has been reflected throughout this document. The full regional work plan can be found in the South Island Regional Health Services Plan at www.sissal.govt.nz.

National collaboration

At a national level, we work with the education, social development and justice sectors to improve outcomes for our population through health promotion, nutrition, physical activity, alcohol and drug and mental health initiatives – integrating services to meet shared goals.

We are committed to implementing a number of national programmes which will improve health outcomes, including B4 School Checks, Immunisation Programmes, Gateway Assessments and the rollout of the InterRAI assessment tool.

The West Coast will continue to participate in the national work streams led by the National Health Board, National Health IT Board, Health Quality and Safety Commission and Health Workforce New Zealand.

4.6 Associate and Subsidiary Companies

The West Coast DHB is also a joint shareholder in the ***South Island Shared Services Agency Limited*** (SISSAL), which is wholly owned by the five South Island DHBs. The company remains in existence; however, the staff will operate as a service to South Island DHBs from within the employment and ownership of the Canterbury DHB – as the ***South Island Alliance Programme Office*** (SIAPO).

Legal transfer of the employees has taken place and transfer of the assets is being progressed. The company will be retained as a shell, pending dissolution. Services are funded jointly by the South Island DHBs to provide services such as contract and provider management, audit, analysis, service development and project management with an annual budget of around $3.4m.

During 2012/13 the West Coast DHB will consider the establishment of a subsidiary company to provide management support for DHB owned primary care practices (*refer to service change – section 6.3*).

4.7 Accountability to the Minister

As a Crown entity, the DHB must have regard for Government legislation and policy as directed by the Minister of Health. As appropriate, and required by legislation, we will engage the Minister in discussion and seek prior approval before making any significant service change. The DHB will also inform the Minister of any proposals for significant capital investment or the disposal of Crown land. We will also comply with requirements in relation to any specific consultation expectations that the Minister communicates to us.

The Crown Entities Act requires the DHB to report annually to Parliament on our performance, as judged against our Statement of Intent, and to publish this account as our Annual Report.

In addition, we will comply with reporting requirements and obligations in the Crown Entities Act and Operational Policy Framework and with specific expectations that the Minister communicates to us. This includes ad-hoc information reports, service agreement reporting and the following regular formal reporting provided to the National Health Board:

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

The DHB also meets requirements with respect to national data collection including: ethnicity reporting, national health index (NHI), national minimum dataset (NMDS), national booking reporting system (NBRS), national immunisation register (NIR) and national non-admitted patient collection (NNPAC).

How will we measure our performance?

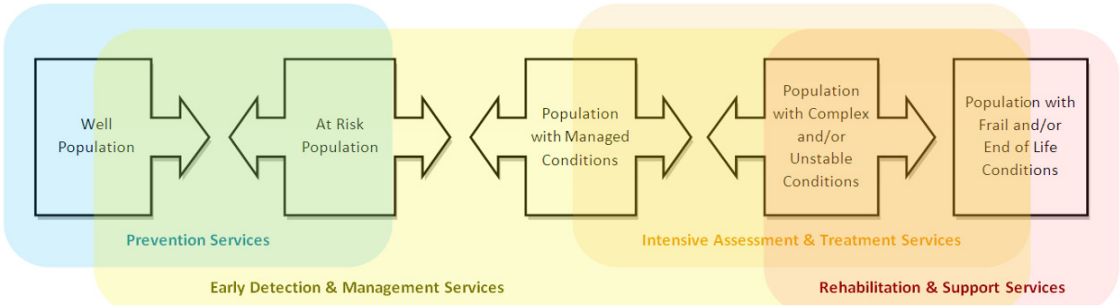
Over the long-term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services on the West Coast, the decisions we make about which services will be delivered have a significant impact on our population and, if coordinated and planned well, 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 to fund for our population and at which level. Just as fundamental is our ability to assess whether the services we are purchasing and providing are making a measureable difference in the health and wellbeing of our population.

One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make on behalf of our population. Over the longer-term we do this by measuring our performance against a set of desired outcomes which are outlined in the strategic direction section of this document and highlighted in the intervention logic diagram in Section 2.4.

Figure 2: Scope of DHB operations – Output classes against the continuum of care

OUR OUTPUTS COVER THE FULL CONTINUUM OF CARE FOR OUR POPULATION.



In the more immediate term, we evaluate our performance by providing a forecast of our planned outputs (what services we will fund and provide in the coming year). We then report against these in our end-of-year Annual Report.[24]

Choosing measures of performance

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

Identifying a set of appropriate measures for each output class is difficult. We cannot simply measure '*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, and whether the service was delivered '*at the right time*'.

In order to best demonstrate this, we have chosen to present our forecast of service performance using a mix of measures of Timeliness, Coverage, Volume and Quality - all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected.[25]

The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year - and therefore reflect a reasonable picture of activity across the whole of the West Coast health system.

To ensure the quality of services provided, the DHB invests in programmes that are evidence-based or evidence-informed such as Green Prescriptions, Appetite for Life, ABC Smoking Cessation, Community Based Falls Prevention

[24] *West Coast DHB Annual Reports can be found at www.westcoastdhb.org.nz*

[25] *Timeliness and Coverage demonstrate increased access, Volume delivered demonstrates increased capacity and Effectiveness demonstrates value for investment.*

and InterRAI – where research shows definite gains and positive outcomes. This provides the DHB with greater assurance that these are 'the right services', allowing us to focus on monitoring implementation and whether the right people have access, at the right time and in the right place.

In some cases the DHB will measure the number of people 'trained' in a particular programme or method, to give further assurance of quality provision and of the capacity of the system to deliver these services.

Setting targets

Wherever possible, we have included a past year's 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.

In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity.

Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care. Our targets also reflect our commitment to reducing inequalities between population groups, and hence some measures appropriately reflect a specific focus on high need groups.

Measures that relate to new services have no baseline data. A number of the output measures also relate to West Coast-specific services for which there is no national comparison or national average available. These instances have been noted.

Some data is provided to the DHB on calendar, not financial, years. Rather than footnote every instance, a symbol has been added to indicate where this is the case (†).

Where does the money go?

The table below presents a summary of the 2012/13 budgeted financial expectations by output class.

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

Statement of budgeted financial performance by output class

For the period 01 July 2012 to 30 June 2013

$000

	Prevention	Early Detection and Management	Intensive Assessment & Treatment	Rehabilitation & Support	Total
Revenue					
Crown sourced funding - devolved	3,447	28,624	68,461	20,116	**120,649**
Crown sourced funding - non devolved contracts	455	361	656	390	**1,863**
Other Revenue	46	7,165	2,559	1,632	**11,402**
IDF Inflow	-	-	1,657	-	**1,657**
Interest	5	48	97	29	**180**
Total Revenue	**3,954**	**36,198**	**73,431**	**22,168**	**135,751**
Expenditure					
Payment to External Providers	986	17,830	3,865	8,784	**31,464**
IDF Outflows	-	-	16,037	1,430	**17,467**
Cost of Clinical Services	1,463	17,507	45,379	10,642	**74,991**
Allocated non-health related costs	262	2,472	9,791	2,904	**15,429**
Total Expenditure	**2,711**	**37,809**	**75,072**	**23,760**	**139,351**
Surplus/ (deficit) FY 2012/13 by output class	**1,243**	**(1,611)**	**(1,641)**	**(1,592)**	**(3,600)**

OUTPUT CLASS

5.1 Prevention services

Output class description

Preventative 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 that engage, 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 individual health protection services such as 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 regions); primary care and general practice; a significant array of 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 make healthier choices, reducing the major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. 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 also our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

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 (Volume – V), Quality (Q), Timeliness (T) and Coverage (C) of those outputs will be measured using the following output performance measures:

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes that support people to maintain wellness or assist them to make healthier choices. Change is indicated by rates of positive or negative behaviours (such as smoking rates).*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
The provision of Mum 4 Mum peer support training to volunteer mothers	V [26]	31	17	-
The proportion of women breastfeeding on discharge from hospital	Q [27]	96%	96%	-
Lactation support and specialist advice consults provided in community settings	V	354	150	-
The proportion of infants exclusively and fully breastfed at 6 wks	Q [27]	72%	74%	59.2
Smoking cessation help and advice provided to hospitalised smokers	C	85%	95%	-
Smoking cessation help and advice provided to smokers identified in primary care	C	28%	90%	-
Enrolments in the Aukati Kai Paipa smoking cessation programme	V	119	100	-
The percentage of year 10 students who have never smoked	Q	75%	75%	64%
Total West Coast enrolments to all smoking cessation services	Q[28]	1282	1300	-

[26] *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.*
[27] *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.*
[28] *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 Māori and/or Pacific children.*

The provision of community-based nutrition courses	C[30]	4	5	-
The number of people provided with Green Prescriptions	V	469	350[29]	-
The percentage of women accessing hospital services 15+ screened for family violence	C	17%	50%	
Statutory and Regulatory Services *These services sustainably manage environments to support people and communities to make healthier choices and maintain health and safety. They include: compliance monitoring with liquor licensing and smoke environment legislation, assurance of safe drinking water, proper management of hazardous substances and effective quarantine and bio-security procedures.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Controlled purchase operations carried out on tobacco retailers	Q	New	3	
Monitoring visits on alcohol retailers identified as high risk premise	Q	New	3	
Population Based Screening Services *These services are mostly funded and provided through the National Screening Unit and help to identify people at risk of illness and pick up conditions earlier. They include breast and cervical cancer screening and antenatal HIV screening. The DHB's role is to encourage uptake, as indicated by high coverage rates*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Women screened for HIV as part of routine antenatal blood tests	C	73%	75%	-
Infants screened for neonatal hearing loss	V	93%	95%	-
All eligible Children provided with a B4 School Screening Health Check	C	70%	85%	72%
Youth in alternative education provided with a HEADSSS assessment	C [30]	50%	75%	-
Eligible population (20-69) provided with cervical cancer screens	C [31]	68%	75%	72%
Eligible population (45-69) provided with breast screen examinations	C [31]	75%	75%	84%
Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations 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*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Children fully immunised at 8 months of age by July 2013	C	New	85%	%
Children fully immunised at aged two	C	84%	95%	90%
Year 8 girls completing HPV vaccinations	C [32]	new	60%	-
Flu vaccinations provided to people aged over 65.	V [33]	58%	65%	65%
The proportion of the population, deemed high need, under 65+ receiving a flu vaccination.	C	61%	65%	64%

[29] *Lower target set due to indication of funding cuts to Green Prescription on time of writing.*

[30] *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.*

[31] *The breast and cervical screening standards are based on national targets set for DHBs. Our aim is to continue to successfully deliver at a level above these national targets and the national average.*

[32] *The population engaged measures eligible young women who have been provided with Dose 3. The national average based on the 'major' six DHBs.*

[33] *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.*

OUTPUT CLASS

5.2 Early detection and management services

Output class description

Early detection and management services 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 services.

Some of these services are demand-driven, such as pharmaceuticals and laboratory tests, and services are provided with a mix of public and private funding and may include co-payments for general practice services and pharmaceuticals.

Why is this output class significant for the DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age. The associated increase in demand for services includes an increasing demand for acute and urgent care services that, in West Coast, is growing at a faster rate than our population.

By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. These services also support people to better manage their long-term conditions and avoid complications, acute illness and crises. The integration of services to meet Government expectations for '*better, sooner, more convenient health services*' presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home.

Providing flexible and responsive services in the community, without the need for a hospital appointment, will support people to stay well and reduce the overall rate of admissions, particularly acute, emergency and avoidable hospital admissions. Reducing the diversion of critical resources into managing acute demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

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 (Volume – V), Quality (Q), Timeliness (T) and Coverage (C) of those outputs will be measured using the following output performance measures:

Primary and Community Health Care Services *These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse 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.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Population enrolled with the West Coast Primary Health Organisation	C [34]	94%	>95%	
Proportion of the Māori population enrolled with the West Coast Primary Health Organisation	C	81%	>95%	-
Number of patients receiving extended primary care consultations for mental health conditions	V	752	300	-
Provision of brief intervention counselling provided in Primary Care - ages 0-19 years	V	73	80	-

[34] *The national target for PHO enrolments is 95%, and the aim is to continue to achieve above this level. The population used to is the Estimated Resident population for the WCDHB as at June 2011 from Statistics New Zealand: Total population - 32900 and Māori population - 3320*

- ages 20+ years		360	250	-
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	88	<95	100
Oral Health Services *These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Percentage of preschool children enrolled in DHB funded dental service	C	71%	77%	-
Children enrolled in dental services, examined according to planned recall	T	96%	98%	-
Decayed, missing or filled permanent teeth rate at Year 8	V	1.39	1.12	
Increase adolescent enrolments in the community dental services	V	49	50	-
The percentage of adolescents accessing oral health services	C[35]	80%	85%	64.1%-
Long-term Conditions Programmes *These services are targeted at people with high health need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Eligible population (35-74) provided with CVD risk assessments	C[36]	76.3%	75%	75.3%
Provision of diabetes annual reviews (in all population groups)	C[37]	66%	70%	n/a
People with diagnosed diabetes (in all population groups) who have satisfactory or better diabetes management	C[38]	71%	80%	n/a
Community Referred and Delivered Services *These 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. To improve performance, we will target improved primary care access to diagnostics to improve clinical referral processes and decision-making.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Number of community referred Radiological tests to Grey Hospital	V	5232	5000	n/a
Percentage of GP referred laboratory expenditure (actual against expected)	C [39]	44%	100%	80%
Percentage of referred pharmacy expenditure (actual against expected)	C[47]	86%	100%	88%

[35] *Half of 14 years olds and 18 year olds*

[36] *Percentage of eligible people aged 35 – 74 years (in all populations groups) who have had their CVD risk assessed via lipid/fasting glucose test.*

[37] *Percentage of people with diagnosed diabetes (in all population groups) who have had their free annual checks*

[38] *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)*

[39] *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.*

OUTPUT CLASS

5.3 Intensive assessment and treatment services

Output class description

Intensive assessment and treatment services are usually complex services 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.

The West Coast DHB provides an extensive range of intensive treatment and complex 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 which the DHB must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

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 (e.g. removal of an obstructed gallbladder so that the patient does not have repeat attacks of abdominal pain) or through corrective action (e.g. major joint replacements). Responsive services and timely treatment support improvements across the whole system and give people 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. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

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. In meeting these expectations, we are introducing innovative clinically led service delivery models and reducing waiting time within our hospital 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.
- Closer clinical collaboration with other DHBs – particularly Canterbury DHB.
- Integrated multi-disciplinary primary/community-focussed Clinical Network for the assessment, treatment, and rehabilitation and case management of frail older people and others with complex long-term conditions in a community setting, with specialist geriatric expertise available to support primary and community-based services.
- 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.

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

Specialist Mental Health Services - 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 Māori 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 – 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 2012/13 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 – 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 - West Coast DHB is committed to maintaining achievement of the Shorter Stays in ED target and has a number of established 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 meetings with practice managers to discuss individual management plans for patients who repeatedly present at ED and close collaboration with the wards to avoid bottle-neck of patients requiring further secondary level care.

Specialist Assessment, Treatment and Rehabilitation Services – A major change to this is planned for 2012-13, in collaboration with Canterbury DHB, whereby specialist geriatrician input will be directly available to support primary and community staff to provide home-based AT&R services for older people and others with complex chronic conditions. 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.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

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 (Volume – V), Quality (Q), Timeliness (T) and Coverage (C) of those outputs will be measured using the following output performance measures:

Specialist Services Mental Health Services *These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation rates are monitored across ethnicities and age groups to ensure service levels are maintained and to demonstrate responsiveness.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Acute inpatient mental health services provided (bed days)	V [40]	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[41]	2.56%	2.5%	2%
Long-term mental health clients (20-64) with current Relapse Prevention Plans	Q	98%	98%	89%
Average length of acute inpatient stay (KPI 8)	Q[42]	13 days	<15 days	-
28-day acute inpatient readmission rate (KPI 12)	C[43]	13.9%	<5	17%
28-day acute inpatient readmission rate for people aged 65 or more years	C	-	<5%	-
Pre-admission community care (KPI 18)	C[44]	74%	75%	64%
Post-discharge community care (KPI 19)	C[45]	84%	117%	54%
Elective Services *These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Elective surgical discharges (raw volume)	V [46]	1,710	1,592	-
Other Elective surgical service discharges provided	V [47]	117	137	-
Surgical electives as a percentage of national case-weight delivery.	Q	1.17%	1.1%	-

[40] *Purchase Unit Code MHC29.*

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

[42] *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*

[43] *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*

[44] *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.*[44] *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*

[45] *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*

[46] *The elective surgical discharge volumes exclude elective cardiology and dental and are based on the national health target.*

[47] *This represents elective surgical discharges [Cardiology and dental] that are not included as part of the heal target volumes.*

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)				
2. Major Joints	C	36.69	21.0	n/a
3. Cataracts	C	73.69.	27.0	n/a
4. Cardiac Procedures	C	5.28	6.2-6.5	n/a
4 (b) Percutaneous Revascularisation		13.65	11.9	
4.(c) Coronary angiography		23.48	32.3	
Maintain compliance with nationally monitored Elective Service Patient Flow Indicators (ESPIs) (national targets indicated below)				
ESPI 1 – >90%	V	100%	92.0%	-
ESPI 2 – <1.5%	V	0.3%	0%	-
ESPI 3 – <5%	V	1.2%	4.0%	-
ESPI 5 – <4%	V	1.9%	0%	-
ESPI 6 – <15%	V	0.%	12.0%	-
ESPI 8 – >90%	V	100%	100%	-
Inpatient indirectly standardised length of stay (days) [OS3]	Q[38]	3.43	3.43	4.02
Theatre utilisation (OS5)	Q	87.49%	89%	-
Elective and arranged day of surgery admission rates for case mix included discharges [OS7]	Q [48]	61.2%	82%	80.9%
Specialist Medical and Surgical outpatient "Patient did not attend" rates at Provider Arm services	Q	8.6%	< 6%	n/a
Specialist Medical and Surgical First Specialist Assessments (FSA) provided to West Coast residents (all providers)	V	5476	7328	n/a
Acute Services *These are services for illnesses that have an abrupt onset, are often of short duration and progress rapidly, for which the need for care is urgent (they may or may not lead to hospital admission). Hospital-based services include emergency departments, short-stay acute assessments and intensive care services. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of services*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Standardised acute readmission rate [OS8]	Q[54]	8.37	< 8.2	10.1
Total presentations at Emergency Departments (Grey Base Hospital) and Accident and Medical Departments[Buller Health and Reefton]	V[49]	15,315[50]	15,376	-
Proportion of people assessed, treated or discharged from ED in under six hours	T [51]	99.5%	>95%	86.8%
Proportion of people triaged in ED and seen within clinical guidelines	Q [52]	88.9%	>85%	-
GP practices utilising telephone triage systems outside of business hours	C	100%	100%	-
Everyone needing radiation treatment will have this within four weeks (-calculation of target achievement excludes Category D radiation patients)	T[53]	88.2	100%	n/a
Everyone needing chemotherapy treatment will have this within four weeks	T	100%	100%	-

[48] *The definitions for the OS3, OS6 and OS7 measures are based on national indicators of performance set for DHBs. Data for 2010/11 Actual is given is per results for the 12 months ending 30 September 2011. This has been updated and recommended for use by the Ministry of health for Target setting for 2012.13*

[49] *Baseline 2009/10: 14,390*

[50] *Of which 14984 stayed to be treated.*

[51] *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.*

[52] *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]*

[53] *The new four week target commenced with effect from 1 December 2010;*

Maternity Services *These services are 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*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Deliveries in West Coast DHB facilities	V	331	350	-
Proportion of total deliveries, made in Primary Birthing Units	Q	7.2%	10%	%
Specialist obstetric consultations provided	V	525	560	-
Assessment, Treatment and Rehabilitation Services *These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. 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 environments, (where appropriate) is indicative of the responsiveness of services.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Number of inpatient AT&R bed days	V	2443	2152	-
Number of outpatient and domiciliary AT&R attendances	V	1523	3000	-
Number of referrals of complex clients to the new Chronic Conditions Clinical Network (expected to start 1 December 2012)	V	Nil	50	n/a
Standardised acute re-admission rates to hospital for 2012/13 - Readmissions for people aged 65 + - Readmissions for people aged 75 +	 V V	 12.22 12.91	 12.22 12.91	 14.26 14.79

OUTPUT CLASS

5.4 Rehabilitation and support services

Output class description

Rehabilitation and support services provide people with the support and assistance they need to maintain or regain 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 clinical 'needs assessment' process and include: domestic support, personal care, community nursing, community services provided in people's own homes and places of residence, day care, respite and residential care services. Services are mostly for older people, mental health clients and for personal health clients with complex health conditions.

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 to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admissions or readmission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and 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 by reducing acute demand, unnecessary ED presentation and the need for more complex intervention. These services also support the flow of patients and improved recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and/or maximise their quality of life.

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, West Coast rates are above national averages. Living in ARC 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 introducing a 'restorative' approach to home support, including 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 improve 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.

Key focus in the coming year

- Implementation of the restorative model of homecare, with integrated case management of complex cases, a higher proportion of people being cared for at home with high packages of care, a higher level of skill among homecare workers, more flexible packages of service available for all clients and a streamlined process for accessing services and managing the homecare budget.
- Increase in the availability of day care and dementia day care services.
- The development of a strong respite care service, in both rest homes and community agencies, to provide planned respite care service (including dementia respite)

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

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 West Coast population. The Quantity (Volume – V), Quality (Q), Timeliness (T) and Coverage (C) of those outputs will be measured using the following output performance measures:

Needs Assessment and Services Coordination Services *These 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*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Needs assessments provided to people with age related and other chronic conditions	V	479	700	-
Proportion of needs assessments completed using InterRAI assessment tool	Q	100%	100%	n/a
The proportion of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan (PP18)	Q	75%	90%	MoH developing
Mental health needs assessments provided	V	102	150	n/a
Palliative Care Services *These are services that improve the quality of life of patients and their families facing 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.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
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 [54]	Starts 2010/11	Phase 1 complete	-
People in ARC services being supported by the Liverpool Care Pathway	V	New service	No base to set target	-
Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. They include 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 of the right people to these services.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Number of people on high/complex packages of care	V [55]	Approx 5	30	-
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 *These services restore or maximise people's health or functional ability following a health-related event. They include 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 of the right people to these services.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Number of hours of long-term home help delivered	V	60163	63000	-
Number of hours of personal care delivered	V	22258	23000	-
Number of Meals on wheels provided	V	38,368	39,000	-
Provision of Mental Health Support Work Services (clients)	V	96	100	-

[54] *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.*

Residential Care Services *These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Unplanned (issues-based) audits undertaken on ARC facilities	Q	0	0	
Number of people residing in permanent rest home level care as a % of the 75+ population	Q	6.28%	5.5% (regional average)	n/a
Number of people residing in permanent specialist dementia residential care as a % of the 75+ population.	Q	0.81%	1.97%	n/a
Provision of (subsidised) long-term residential mental health services (bed days)	V	6935	8030	
Respite and Day Services *These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. They 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.*	**Notes**	**Actual 2010/11**	**Target 2012/13**	**Current National Average**
Provision of mental health respite beds for planned respite (bed days)	V	280 bed days	365 bed days	-
Number of aged care respite bed-days used	V	1073 bed days	1500 bed days	
Number of day-care days provided	V	736 days	800 days	

6.1 A balanced and resilient health system

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, particularly Canterbury DHB.

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

Following the lead of Canterbury DHB, West Coast DHB has subscribed to an 'alliance approach' to decision making whereby a whole of system view is applied on the principle of one unified system and one health budget. In practice this means working in partnership with clinicians and providers to determine appropriate models of care and when it makes sense to do so devolving the decision-making. There remains a clear understanding about the responsibility of the DHB at a clinical and legislative level.

This represents a significant shift at both a community and organisation level so that there can be more effective shared decision-making within a clear set of principles and priorities.

This approach has allowed significant progress in the delivery of the Better, Sooner, More Convenient healthcare strategy.

Over the next twelve months there will be systematic changes in the model of care in primary, community and hospital services as we move towards clinically and financially sustainable healthcare delivery on the West Coast.

During 2012/13 these developments in healthcare delivery will be further enhanced through the proposed development of an Integrated Family Health Centre (IFHC) in the Buller district and the development and submission of a business case for the redevelopment and refurbishment of Grey Hospital in tandem with Integrated Family Health systems for the Grey district.

To support these developments we will work with the National Health Board to identify different ways to fund and contract for a range of primary and community health care services.

6.3 Service Changes

During 2012/13 there will be a continuous process of service transformation as we seek to eliminate duplication and waste and start to 'live within our means' rather than doing this through services reduction or cuts. , We seek to delivery services in more productive and efficient ways – minimising unnecessary administration (especially for clinical staff), making better use of clinical resourcing through effective production planning and schedules of clinics and other direct patient contract systems.

The DHB recognises its obligation to notify the Minister of Health with respect to any significant service changes. While there are clear plans in place for the development of an integrated family health system, efficient and productive primary health centres and a comprehensive redesign of the hospital in Greymouth, we are not yet at the point of seeking any significant service changes according to our obligation under the operational policy framework.

At this stage the changes envisioned involve improvements in the model of care and patient to ensure the right care, in the right place at the right time. In particular we aim to:

- Redesign service delivery across hospital and secondary services through the development of 'transalpine' secondary and specialist service in partnership with Canterbury DHB. In the first instance this will involve orthopaedic surgical, paediatric (child Care), oncology (cancer treatment), health of older persons and some aspects of mental health service delivery.
- Redesign and reconfigure on a whole of system basis to deliver the Better, Sooner More Convenient Health Care Business Case. In particular, this will involve the commissioning of Integrated Family Health Centres or service in the Buller and Grey districts.
- Reconfigure and shift service delivery throughout the region in order to achieve consistency and equity on a South Island wide basis (as outlined in the Regional South Island Health Services Plan).
- Review the governance structures across hospital, primary and community health services with a view to eliminate unnecessary duplication of the oversight and administration of the West Coast health system..

In support of the above we expect to consult with the Minister over capital expenditure for the Buller IFHC and for both the hospital and IFHC in the Grey district.

7.1 Financial sustainability

While health continues to receive a large share of national funding, clear signals have been given that Government is looking to the whole of the health sector to rethink how we will meet the needs of our populations with a more moderate growth platform.

In setting expectations for 2012/13 the Minister expects DHBs to operate within existing resources and approved financial budgets; to work collaboratively to meet fiscal challenges and to ensure services and service delivery models are clinically and financially sustainable.

7.2 Meeting our financial challenges

Like all DHBs the West Coast DHB faces significant fiscal pressures, including: the costs of meeting wage and salary increases; demand for diagnostics and residential care; rising prices; increasing treatment-related costs; and increased public expectations of the availability of new, more technologically advanced treatments. West Coast DHB is committed to reducing its current deficit and achieving a break-even position by 2015/16 despite these pressures.

There is no 'quick-fix' solution and to ensure our health system is clinically and financially sustainable we are focused on making decisions that are 'best for patient and best for system'. This means providing the right care and support, 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 utilisation of the resources available. Improving the effectiveness and quality of services improves patient outcomes and reduces costs, through fewer treatment-related incidents and reduced duplication. By being more effective, reducing waste and duplication and improving models of care the West Coast DHB will not only improve the health status of our community, but we will also achieve long term financial wellbeing.

There are six factors that are critical to the West Coast DHB's being successful in achieving financial sustainability:

1. ***Constraining Cost Growth***- It is critical that costs are constrained in the 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.
2. ***Rebalancing the System***- It is crucial 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.
3. ***Integration of Health Services*** - Health and disability services on the West Coast need to be integrated across primary, hospital and community services with strong links into Canterbury DHB for speciality services.
4. ***Stable Workforce availability***- The West Coast DHB must develop a model of care that can be supported by a stable and available clinical workforce, especially in the rural primary setting.
5. ***Transitional Funding***- The West Coast DHB intends to renegotiate the future treatment of the Transitional Funding Pool so that the transitional funding forms part of the base funding.
6. ***A 'transalpine approach'*** - Our partnership with Canterbury DHB is well established and planned to increase over the following year with a 'transalpine' approach. This service addresses clinical models of care across the hospital based specialities between the two DHBs and will result in a model that will be clinically safe and able to be delivered within the funding available.

These imperatives will be underpinned by the following principals:

- ***Reducing Variation, Duplication and Waste***- Removing unnecessary duplication and delay will result in 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. These programmes support and promote lean thinking and empower all health system employees to take a lead in removing delay and waste from the system.
- ***Doing the Basics Well*** – By better understanding our core business, we are delivering services more effectively and efficiently and better anticipating 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 ensure that both revenue and cost matches appropriately.

- ***Return on investment over time (value for money)*** - Investment decisions need to have a positive impact on patient care and the financial position of the health system over time. The utilisation of our prioritisation framework ensures that value for money is appropriately considered for all investment decisions.
- ***A Whole of System Approach to Health Delivery*** - All changes to the West Coast health system will take a whole of system approach that integrates 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 assist in achieving clinically acceptable efficiencies across the whole system. Clinical leaders and frontline staff are in the best position to decide 'how' services should be delivered in order to improve quality and create technical efficiencies..
- ***Shifting hospital services into primary and community-based services (Realigning Service Expenditure)***- The West Coast DHB is committed to delivering on Government policy by shifting services from hospital-based 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 Integrated Family Health Centre Business Plan. In future years this will be reflected by applying funding at a proportionally greater rate to primary and community services.

7.3 Financial outlook

Funding from the Government, via the Ministry of Health is the main source of DHB funding. This is supplemented by additional revenue agreements from organisations such as the Accident Compensation Corporation (ACC) and co-payments from patients.

For 2012/13 year we are forecasting that the West Coast DHB's funding, including non-Government-related revenue, will increase by approximately $2.1M (2011/12 $2.9M).

The West Coast DHB, like the rest of the health sector, faces significant financial pressures 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:

- ***Over reliance on locum and temporary staff*** - While the judicious use of locum cover and temporary staff allows for greater flexibility and continuity of service, the DHB is currently filling a significant number of full time permanent positions with locums.
- ***Increasing wage and salary expectations*** - Wages are the health sector's largest expense. 92% of the West Coast DHB's workforce is on Employer Collective Agreement (MECA) awards, many with automatic step pay increases already built in. Even a small percentage cost of living increase will create significant fiscal pressure for the DHB. MECA awards also raise expectations in the community and place additional pressure on community-based providers to match wages.

  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 treatment 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 Government, clinical staff and the public*** - Changes in clinical practice and the availability of more 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 availability of primary and hospital health services. The West Coast DHB must support robust and transparent prioritisation for health care systems, programmes and initiatives.
- ***Inter District Flows (IDFs)*** - 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 IDFs is set nationally and has historically exceeded the funding increases.

Living within our means

The West Coast DHB is submitting a deficit forecast of $3.6M for the 2012/13 year. This is a reduction of $900K over the 2011/12 approved deficit. The West Coast DHB is well advanced in developing models of care that aim to achieve both financial and clinical sustainability by 2014/15. IAs indicated earlier, the West Coast DHB is working closely with Canterbury DHB on the 'transalpine approach' to further enhance collaboration and where appropriate integrating services.

7.4 Assumptions

Key Assumptions

The financial forecasts in this plan are based on various 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.
- Population based funding received in 2012/13 will be the same as indicated in the funding envelope received in December 2011 and the 2012/13 Transitional Pool funding will remain at 2011/12 levels.
- 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 MECAs 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.
- 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 forecasted 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 re-valued as at 30 June 2011 and the budget for 2012/13 and outlying years has been based on this revaluation. It has been assumed that there will be minimal change from this valuation for the 2012/13 year.
- Work will continue on the Facilities Redevelopment Plan for Greymouth Regional Medical Centre 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 require specific approval by the Minister of Health.

7.5 Asset Planning and Sustainable Investment

Business Cases

In 2010 the West Coast DHB along with the West Coast PHO submitted the business case for '*Better, Sooner, More Convenient Healthcare'*. This was approved by the Minister of Health in May 2010 and 2012/13 will be year three of implementation. The initiatives and programmes planned for year three are outlined in Module 3 of this document and will be funded within current allocations.

Buller Integrated Family Health Centre and age residential care facility

In March 2012 the West Coast DHB agreed that the proposed Integrated Family Health Centre location would be the current Buller Health site. The centre will also include a facility for aged residential and hospital level care beds established within the integrated service model. The approval of the facility design is expected in the second quarter of 2012/13 with construction commencing in 2013. The funding of the facility will be via private investment through local agencies and corporate bodies.

Greymouth Regional Health Centre Business Case

The Business Case for the Greymouth Regional Health Centre is currently under development with and will be completed for submission to the National Capital Committee in the second quarter of 2012/13. The facility is to be reconfigured using elements of the existing structure and some new build to better suit the changing hospital models of care, whilst also addressing structural (seismic) issues with the current facility. The proposed facility will also include the Integrated Family Health Centre and design will be based on an integrated approach to service delivery across primary, community and hospital services.

The funding of the project will be a mix of equity introduced and debt.

Capital Expenditure

The capital expenditure budget for the 2012/13 year is $2.9m (excluding capital expenditure committed in the 2010/11 year), subject to approval. The capital budget will cover the replacement of clinical and other operational capital requirements and will be focussed on standardisation of equipment between the West Coast and Canterbury DHBs and strategic IT projects.

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 will assess the need to retain ownership of these properties based on future models of care and facilities requirements. Properties that are no longer required will be deemed properties intended for sale and necessary approvals sought to dispose of them.

In order to dispose of surplus land, 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 being made available for public sale.

7.6 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 CHFA. The West Coast DHB's total term debt is expected to be $12.195M as at June 2013.

The current debt with the CHFA 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 CHFA term liabilities are secured by a negative pledge. Without the CHFA'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 March 2012

Lender's name	**CHFA**	**CHFA**	**CHFA**	**CHFA**	**BNZ**
Loan Identified As	WC004	WC004	WC003	WC005	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
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	

Bank of New Zealand (BNZ)

The West Coast DHB has a working capital (overdraft) facility of $6.31M 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 Greymouth Regional Medical Centre 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.

7.7 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 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 earlier in this section. These assumptions were valid as at March 2012, 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.

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.

Standards, Amendments and Interpretations Issued that are Not Yet Effective and Have Not Been Early Adopted

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

- 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.
- NZ IAS 24 Related Party Disclosure. This standard has not yet been adopted by the West Coast District Health Board and will be for the June 2012 year end. The effect of adopting the revised statement NZ IAS 24 will be:
    - More information regarding the transactions between the West Coast DHB and other entities controlled, jointly controlled, or significantly influenced by the Crown.

- Disclosure of any related party transactions with Ministers of the Crown.
- Commitments with related parties will need to be disclosed.

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 (SOI).

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 District Health Board assesses whether there is any objective evidence that an investment is impaired.

Bank deposits

Investments in bank deposits are measured at fair value.

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

Equity investments

The West Coast 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.

On derecognising the cumulative gain or loss previously recognised in equity is recognised in 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.

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 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 re-valued 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 re-valued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a re-valued 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 re-valued 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 District Health Board

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 re-valued 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, except where they form part of a larger asset group 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 that are transferred to the West Coast DHB transfer 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 1989 requires DHBs 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 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 outputs for the four output classes using the cost allocation methodology outlined below.

Cost Allocation Methodology

Direct Costs are those costs directly attributable to an output class. Indirect costs are those costs that cannot be directly attributable to an output class or identified in an economic feasible manner, with a specific output class.

Direct costs are charged directly to each output class.

Indirect costs are allocated to output classes based on costs drivers and related activity.

Depreciation and facility costs are allocated on the basis of floor area occupied by the production of each output.

Indirect personnel costs, including human resource and payroll costs are allocated on the basis of full time equivalent staff numbers within the output class areas and indirect information system costs on the number of work-stations within the output class areas.

Critical Judgments 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 forecasted periods from year ending 2013 to 2015.

Leases classifications

Determining whether a lease agreement is a finance or 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.

West Coast District Health Board
Forecast Statement of comprehensive income
For the years ending 2010/11 to 2014/15

in thousands of New Zealand dollars

	2010/11 Actual	2011/12 Forecast	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast
Operating Revenue					
Crown and Government sourced	124,287	126,618	129,383	131,478	133,556
Inter DHB Revenue	110	79	124	126	129
Inter District Flows Revenue	1,635	1,884	1,657	1,686	1,711
Patient Related Revenue	2,828	3,056	3,391	3,996	4,099
Other Revenue	1,792	1,926	1,488	1,491	1,494
Total Operating Revenue	130,652	133,563	136,044	138,777	140,988
Operating Expenditure					
Employee benefit costs	52,704	52,871	56,499	57,338	59,762
Outsourced Clinical Services	13,287	11,907	8,638	7,431	5,691
Treatment Related Costs	7,707	7,862	7,911	8,116	8,213
External Providers	28,453	30,403	30,952	31,029	31,264
Inter District Flows Expense	17,528	17,682	17,467	17,681	17,897
Outsourced Services - non clinical	1,259	1,287	1,388	1,406	1,418
Infrastructure Costs and Non Clinical Supplies	10,514	10,343	10,669	10,741	10,628
Total Operating Expenditure	131,452	132,354	133,524	133,742	134,874
Result before Interest, Depn & Cap Charge	(800)	1,209	2,519	5,035	6,114
Interest, Depreciation & Capital Charge					
Interest Expense	775	737	735	727	712
Depreciation	4,578	4,799	4,661	4,686	4,698
Capital Charge Expenditure	690	774	723	713	704
Total Interest, Depreciation & Capital Charge	6,043	6,310	6,119	6,126	6,114
Net Surplus/(deficit)	(6,843)	(5,100)	(3,600)	(1,091)	(0)
Other comprehensive income					
Gain/(losses) on revaluation of property	(2,578)	0	0	0	0
Total comprehensive income	(9,421)	(5,100)	(3,600)	(1,091)	(0)

West Coast District Health Board
Forecast Statement of financial position
As at 30 June for year endings 2009/11 to 2013/15

in thousands of New Zealand dollars

	30/06/2011 Actual	30/06/2012 Forecast	30/06/2013 Forecast	30/06/2014 Forecast	30/06/2015 Forecast
Assets					
Non-current assets					
Property, plant and equipment	32,794	31,884	32,474	30,433	29,105
Intangible assets	1,148	940	839	2,844	3,349
Other investments	2	2	2	2	2
Total non-current assets	33,944	32,826	33,315	33,279	32,456
Current assets					
Cash and cash equivalents	2,922	6,584	5,667	5,385	5,890
Other investments	3,556	56	56	56	56
Inventories	791	831	831	831	831
Debtors and other receivables	4,182	4,402	4,452	4,452	4,452
Patient and restricted funds					
Assets classified as held for sale	136	136	136	136	136
Total current assets	11,587	12,009	11,142	10,860	11,365
Total assets	**45,531**	**44,835**	**44,458**	**44,140**	**43,822**
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	11,195	12,195	11,945	11,695	11,445
Employee entitlements and benefits	2,858	3,248	3,248	3,248	3,248
Total non-current liabilities	14,053	15,443	15,193	14,943	14,693
Current liabilities					
Interest-bearing loans and borrowings	1,500	250	250	250	250
Creditors and other payables	9,441	8,593	8,531	8,533	8,533
Employee entitlements and benefits	7,964	8,644	8,645	8,643	8,644
Patient and restricted trust funds	56	56	56	56	56
Total current liabilities	18,961	17,543	17,482	17,482	17,483
Total liabilities	33,014	32,986	32,675	32,425	32,176
Equity					
Crown equity	61,753	66,185	69,717	70,740	70,672
Other reserves	21,310	21,310	21,310	21,310	21,310
Retained earnings/(losses)	(70,585)	(75,684)	(79,284)	(80,374)	(80,374)
Trust funds	39	39	39	39	39
Total equity	12,517	11,850	11,782	11,714	11,646
Total equity and liabilities	45,531	44,836	44,457	44,139	43,822

West Coast District Health Board
Forecast Statement of changes in equity
For the years ending 2010/11 to 2014/15

in thousands of New Zealand dollars

	30/06/2011 Actual	30/06/2012 Forecast	30/06/2013 Forecast	30/06/2014 Forecast	30/06/2015 Forecast
Balance at 1 July	14,794	12,517	11,850	11,782	11,714
Contributions from the Crown	7,212	4,500	3,600	1,091	0
Contributions repaid to the Crown	(68)	(68)	(68)	(68)	(68)
Total comprehensive income	(9,421)	(5,099)	(3,599)	(1,090)	(0)
Balance at 30 June	12,517	11,850	11,782	11,714	11,646

West Coast District Health Board
Forecast Statement of cash flows

For the years ending 2010/11 to 2014/15

in thousands of New Zealand dollars

	2010/11 Actual	2011/12 Forecast	2012/13 Budget	2013/14 Budget	2014/15 Budget
Cash flows from operating activities					
Cash receipts from Ministry of Health, patients and other revenue	129,181	133,057	135,734	138,532	140,758
Cash paid to employees	(52,322)	(51,801)	(56,499)	(57,338)	(59,762)
Cash paid to suppliers	(32,201)	(32,259)	(28,666)	(27,694)	(25,950)
Cash paid to external providers	(28,206)	(30,403)	(30,952)	(31,029)	(31,265)
Cash paid to other District Health Boards	(17,880)	(17,682)	(17,467)	(17,681)	(17,897)
Cash generated from operations	(1,428)	913	2,149	4,791	5,884
Interest paid	(814)	(737)	(735)	(727)	(712)
Goods and services tax (net)	58	58	0	0	0
Capital charge paid	(723)	(873)	(723)	(713)	(704)
Net cash flows from operating activities	(2,907)	(639)	691	3,351	4,468
Cash flows from investing activities					
Interest received	820	286	260	245	230
Proceeds from sale of investments	(1,913)	3,500	0	0	0
Acquisition of property, plant and equipment	(3,053)	(2,935)	(3,745)	(4,590)	(3,775)
Acquisition of intangible assets	(95)	(744)	(1,405)	(60)	(100)
Net cash flows from investing activities	(4,241)	107	(4,890)	(4,405)	(3,645)
Cash flows from financing activities					
Proceeds from equity injections	7,212	4,512	3,600	1,091	0
Repayment of equity	(68)	(68)	(68)	(68)	(68)
Cash generated from equity transactions	7,144	4,444	3,532	1,023	(68)
Borrowings raised					
Repayment of borrowings	(250)	(250)	(250)	(250)	(250)
Net cash flows from financing activities	6,894	4,194	3,282	773	(318)
Net increase in cash and cash equivalents	(254)	3,662	(917)	(282)	505
Cash and cash equivalents at beginning of year	3,176	2,922	6,584	5,667	5,385
Cash and cash equivalents at end of year	**2,922**	**6,584**	**5,667**	**5,385**	**5,890**

West Coast District Health Board
Forecast Operating Statements by Arm

Governance Arm: Forecast Operating Statement for the years ending 2010/11 to 2014/15

in thousands of New Zealand dollars

	2010/11 Actual	2011/12 Forecast	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast
Income					
Internal Revenue	1,176	1,175	827	876	797
Other income	115	38	50	50	50
Internal allocation from Provider Arm	984	1,322	1,322	1,322	1,322
Total income	2,275	2,535	2,199	2,248	2,169
Expenditure					
Personnel	1,060	1,082	620	631	641
Outsourced services	521	523	431	439	447
Other operating expenses	373	540	845	816	791
Democracy	315	284	303	363	290
Total expenses	2,269	2,428	2,199	2,248	2,169
Net Surplus / (Deficit)	6	106	0	(0)	(0)

Funder Arm: Forecast Operating Statement for the years ending 2010/11 to 2014/15

in thousands of New Zealand dollars

	2010/11 Actual	2011/12 Forecast	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast
Income					
PBF Vote Health-funding package (excluding Mental Health)	101,801	100,809	102,764	104,453	106,142
PBF Vote Health-Mental Health Ring fence	13,440	13,884	13,884	13,884	13,884
MOH-funding side contracts	1,028	3,927	4,032	4,101	4,162
Inter District Flow's	1,635	1,884	1,657	1,686	1,711
Other income	216	190	180	165	150
Total income	118,120	120,694	122,518	124,288	126,049
Expenditure					
Personal and Maori Health	78,436	78,087	77,827	78,761	79,706
Mental Health	12,995	13,673	14,039	14,208	14,378
Disability Support	16,542	17,188	18,004	17,958	18,070
Public Health	1,009	862	766	770	774
Maori Health	503	569	787	797	806
Governance	1,176	1,175	827	876	797
Total expenses	110,661	111,554	112,251	113,370	114,531
Net Surplus	**7,459**	**9,140**	**10,267**	**10,919**	**11,518**

Provider Arm: Forecast Operating Statement for the years ending 2010/11 to 2014/15

in thousands of New Zealand dollars

	2010/11 Actual	2011/12 Forecast	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast
Income					
Internal revenue-Funder to Provider	63,504	62,295	63,005	63,784	64,572
Ministry of Health side contracts and Other Goverment	8,128	8,078	8,827	9,167	9,496
Patient and consumer sourced	2,828	3,056	3,391	3,996	4,099
Other income	1,461	1,698	1,258	1,276	1,294
Total income	75,921	75,127	76,481	78,222	79,461
Expenditure					
Employee benefit costs	51,644	51,789	55,879	56,707	59,121
Outsourced Clinical Services	13,301	11,916	8,643	7,443	5,708
Treatment Related Costs	7,706	7,862	7,911	8,116	8,213
Outsourced Services - non clinical	724	755	952	955	954
Infrastructure Costs and Non Clinical Supplies	9,827	9,521	9,521	9,562	9,547
Internal allocation	984	1,322	1,322	1,322	1,322
Total Operating Expenditure	84,186	83,164	84,228	84,105	84,866
Result before Interest, Depn & Cap Charge	(8,265)	(8,038)	(7,747)	(5,883)	(5,405)
Interest, Depreciation & Capital Charge					
Interest Expense	775	737	735	727	712
Depreciation	4,578	4,797	4,661	4,686	4,698
Capital Charge Expenditure	690	774	723	713	704
Total Interest, Depreciation & Capital Charge	6,043	6,308	6,119	6,126	6,114
Net Surplus/(deficit)	(14,308)	(14,345)	(13,866)	(12,009)	(11,519)
Other comprehensive income					
Gain/(losses) on revaluation of property	(2,578)	0	0	0	0
Total comprehensive income	**(16,886)**	**(14,345)**	**(13,866)**	**(12,009)**	**(11,519)**

Summary of Forecasted Revenue and Expenditure for the year ending 30 June 2013

in thousands of New Zealand dollars

	Governance	Funder	Provider	Eliminations	Result
Revenue	2,199	122,518	76,481	63,832	137,366
Expenditure	2,199	112,251	90,347	63,832	140,965
Net Surplus (Deficit)	**0**	**10,267**	**(13,866)**	**0**	**(3,600)**

APPENDICES

1 Minister of Health Letter of Expectations for 2011/2012

2 Implementation – The South Island DHB Alliance and Regional Priorities

3 Performance Measure and Description

4 West Coast District health Board Organisation Structure

5 Objective of a DHB – New Zealand Public Health and Disability Act (2000)

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

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

26 JAN 2012

Mr Peter Ballantyne
Acting Chair
West Coast District Health Board
Grey Base Hospital
PO Box 387
GREYMOUTH 7840

Dear Peter

Letter of Expectations for District Health Boards and their subsidiary entities for the 2012/13 year

Delivering **better, sooner, more convenient care** and lifting health outcomes for patients within constrained funding increases is the Government's key expectation for the public health service in the 2012/13 financial year.

Thank you for the contribution you and your staff have made to improving the New Zealand public health service. The Government greatly appreciates the work of District Health Board (DHB) staff in providing more service for patients in these difficult economic times.

While internationally a number of countries are making significant cuts to health spending, the re-elected National-led Government will continue to increase its investment in Health, but within a necessarily tighter financial framework.

The Government is determined to return to surplus in 2014/15. The public health service can contribute by lifting productivity, and keeping to budget. All DHBs should establish specific plans to improve financial performance year-on-year. The supply of equity and debt will continue to be constrained, so Boards will need to prioritise capital more closely and fund from internal resources.

Integrated Care

International evidence shows that integrating primary care with other parts of the health service is vital to better management of long-term conditions, an ageing population and patients in general. This is achieved through better coordinated health and social services and the development of care pathways designed and supported by community and hospital clinicians.

DHBs must focus more strongly on service integration particularly with primary care; ensuring the scope of activity is broadened and the pace significantly stepped up. Areas include integrated family health centres, primary care direct-referral to diagnostics, and clinical pathway development involving community and hospital clinicians.

The Annual Plan Guidance provides clear expectations on the need and scope for change. We expect your Board's Annual Plan will show how integration between community and hospital services will be used to drive delivery and improve performance in three priority areas: unplanned and urgent care, long-term conditions, and wrap around services for older people.

Your DHB will also work with local primary care networks and the Ministry of Health (the Ministry) to provide zero fee after hours GP visits for children under six, as outlined in the Government's election policy. Over the next year the Ministry will be looking at further integration of child and maternity services. Expectations from the Prime Minister's Youth Mental Health Project will also be advised to you.

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

Shorter Waiting Times

The Government's election policy included ambitious plans to further shorten waiting times in a number of key areas including surgery, diagnostics and cancer care. Specific expectations in this significant area will be covered in a separate letter shortly.

Health Targets

Some changes to the national health targets have already been advised. Your DHB is expected to include specific plans for achieving these priority targets in your Annual Plan. This will include joint plans with primary care networks in your district for at least the smoking, cardiovascular disease (CVD) and immunisation targets.

Health of Older People

Our population continues to age and pose new challenges. DHBs are expected to engage with primary/community care to develop integrated services for older people that support their continued safe, independent living at home, particularly after a hospital discharge. Your DHB will also work with the Ministry to implement the Government's commitments relating to dedicated stroke units and dementia.

Regional Integration

Greater integration between regional DHBs is important for both financial and clinical reasons. We expect DHBs to make significant progress in implementing their Regional Service Plans, and delivering on regional workforce, IT and capital objectives that have been set. We will be monitoring execution against the various dashboards used by the National Health Board (NHB).

We need to see further improvements in efficiency and containing costs. Boards will need to support and advance the work of Health Benefits Ltd, Health Workforce NZ and the Health Quality and Safety Commission.

Significant productivity gains will need to be made across services and organisations, particularly hospitals. This will include making smarter use of your workforce and increasing integration with primary care and services for older people.

Strong clinical leadership remains pivotal to your on-going success.

All DHBs are expected to work co-operatively with the Ministry on implementing the Government's election commitments.

Finally, as agents of the Crown, you must assure yourselves that you have in place the appropriate clinical and executive leadership needed to deliver the Government's objectives. The performance of Chief Executives must be monitored against these expectations and I will be interested to see how they are reflected in your annual performance agreement with your Chief Executive.

Thank you for your work in the past, and I look forward to working with you to deliver more and better access to services in the future. Please share this letter with your local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

Appendix 2: Implementation of the South Island DHB Alliance and Regional Priorities

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

The South Island Alliance Governance and Leadership Team are committed to govern, lead and guide our Alliance as it seeks to improve health outcomes for our populations. This Alliance was formed to enable the District Health Boards (DHBs) in the South Island region to work effectively together, utilising our combined resources to jointly solve problems, develop innovative solutions to health sector challenges and achieve outcomes for the people of the South Island Region.

The South Island Alliance has proven its effectiveness as a collaboration framework as we have delivered against our regional plans during 2011-12. The 2012-13 South Island regional health services plan continues to identify the opportunities that will make a difference for our population and deliver changes that are best for patient, best for system.

West Coast DHB is represented across the regional planning streams, and our commitment to specific regionally planned actions has been reflected throughout this document. The full regional work plan can be found in the South Island Regional Health Services Plan at www.sissal.govt.nz.

The following is a extract of the Executive Summary from the South Island Regional Health Service Plan for 2012/2013

With a relatively small total South Island population (1,038,843 people, 24% percent of the total New Zealand population), implementing diverse but similar individual responses duplicates effort and investment, and leads to service and access inequalities. Regional collaboration is an essential part of our future direction.

By 2025-26, more than one in five people in the South Island will be aged 65 years or over, compared to one in eight in 2010-11. While our older population is living 'well' for longer, older people are more likely to have more complex or multiple long-term conditions, and consequently, are higher users of health services. With the expected increase in the proportion of the population who are aged over 65 and who are Māori or Pacific, the prevalence of long-term conditions is also predicted to increase across the South Island. Both population ageing and increases in long-term conditions across all population groups will drive increases in health expenditure.

In agreeing a collaborative regional direction, the South Island DHBs have committed to a 'best for patient, best for system' alliance framework that aligns with national policy. The South Island Regional Health Services Plan articulates the regional direction and key principles that will inform regional service development, service configuration and infrastructure requirements over the next several years.

Our 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, high-quality services as close to people's homes as possible.

Closely aligned to the national approach, the regional direction is based on the following concepts:

- More health care will be provided at home and in community and primary care settings;
- Secondary and tertiary services will be provided across DHB boundaries;
- 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 a smooth transition for patients between services and providers; and
- Clinical networks and multidisciplinary alliances will support the delivery of quality health services across the health continuum.

Our ability to achieve through this approach has been clearly demonstrated by the outcomes achieved to date. Our Service Level Alliances and regional work activities continue to grow and build on the work undertaken to-date to achieve the vision for the South Island.

The challenges faced by Canterbury DHB during 2011 and ongoing following the Christchurch earthquakes have been significant and are acknowledged by the South Island Alliance. The relationships developed through the South Island Alliance have been key in providing support for the continued delivery of patient care through the challenges.

South Island Alliance Activity

The South Island DHBs are involved in collaborative activity across a large number of regional and sub-regional service areas. The Alliance Leadership Team and South Island Alliance Board recognise the need for focused effort to

gain momentum in achieving collaborative outcomes. The alliance approach will therefore continue to be applied to four priority clinical service areas and two enabling services as the first tranche of a phased approach.

The service level alliances:

1. Cancer
2. Child Health
3. Health of Older People
4. Mental Health
5. Support Services
6. Information Services

In addition to these services, the workstreams established for cardiac, elective and stroke services will gain momentum during 2012-13 to deliver the identified national outcomes. Regional planning also continues to deliver regional outcomes for neurosurgery and ophthalmology services. The Regional Training Hub, Asset Planning, Human Resources, Māori Health and Communication activities feed into the Service Level Alliances and the overarching plan to support the vision of a sustainable South Island health system focused on keeping people well and providing equitable, and timely, access to safe, effective, high-quality services as close to people's homes as possible.

Each priority area, whether supported by a regional Service Level Alliance, workstream or group, is clinically-led, or, as for the Support Services Service Level Alliance, has clinicians involved in the teams and in all key decision making approaches. Members of the Service Level Alliances and other working groups come from each of the DHBs and provide breadth of expertise and ownership for development initiatives. A regional communication strategy and the South Island Alliance Programme Office support the activities across the South Island.

Appendix 3: Performance Measure and Description

Performance Measure and description	2012/13 Target	National Target	Frequency
PP1 Clinical leadership self assessment			
The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB 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 DHB – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required.	n/a	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care			
The DHB provides a qualitative report as follows: 1. Those DHBs with BSMC Alliance are required to submit jointly agreed • Year Two Implementation Plans by 31 December 2011 or earlier. • Quarterly reports outlining progress against the key deliverables in the jointly agreed Year Two Implementation Plans including resolution plans for any areas of slippage against deliverables • Quarterly reports on the operation and expenditure of the Flexible Funding Pool, including how pool funding has been jointly prioritised to deliver services. 2. All DHBs are required to report progress against the deliverables in their jointly agreed approach to meeting the following expected measures: • Description of how all necessary clinicians and managers (primary/community and secondary) will be involved ongoing in the process of development, delivery and review • Activities to integrate community pharmacy • Activities to expand and integrate nursing services • Evidence of health needs analysis of population by localities • Identification of targeted areas/patient groups for improved outcomes as a result of enhanced primary and community service delivery (with a focus on managing long term conditions i.e. CVD / Diabetes) including: ▪ Identification of and achievement against targets for the number of people that are expected to be appropriately managed in a primary/community setting instead of secondary care – Identification of and achievement against targets for growth reduction: – ED attendance (for triage level 5 attendances at Grey) – Acute inpatient admissions – Acute bed days – Identification of and achievement against a target for the prevention of readmissions for the 75+ population (and any other target populations) Targets: standardized acute readmission rates for 65+ and 75+ age groups. – Identification of, and achievement against new service activity in quantified patient terms ▪ Identification of and activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model • Progress against the above infrastructure and revenue stream milestones • Identification of and progress against the activities to ensure free after-hours services to children under six years of age	qualitative deliverable required 3905 2185 8725 Targets: 65+: 12.22 75+: 12.91 qualitative deliverable required		
Additional reporting deliverable required for Quarter 4: Each DHB must provide a report with the following information: • each PHO's working capital requirements • each PHO's total cash balance and total income in advance at the end of the financial year • the PHOs that the DHB has required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in	qualitative deliverable required	n/a	Quarterly

cash balances to the agreed level, and • a copy of the relevant PHO's forecast expenditure plans					
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 categories Māori and in Total • adults aged 20-64, specified for each of the categories Māori and in Total • older people aged 65+, specified for each of the categories Māori and in Total	**% child and youth aged 0 - 19**	Māori	3.8%	n/a	Six-Monthly
		Total	3.8%		
	% adults 20 - 64	Māori	3.8%		
		Total	3.8%		
	% aged 65+	Total	3.4%		
PP7 Improving mental health services using relapse prevention 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	95%	**95%**	Six-Monthly
		Total	95%	**95%**	
	Child and Youth	Māori	95%	**95%**	
		Total	95%	**95%**	

PP8 Shorter waits for non-urgent mental health and addiction services

80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks. *DHBs will be required to meet this target within three years. DHBs will need to set and agree with the Ministry individualised targets (based on data provided by the Ministry) stepped over the three years to ensure the target is met.*

Rolling annual waiting time data will be provided by the Ministry sourced from PRIMHD

A narrative is required to:

1. identify what processes have been put in place to reduce waiting times
2. explain variances of more than 10% waiting times target

Note: The Midland region DHBs will include, as requested, their Child and Youth NGO Mental Health services as part of this performance measure.

%

Mental Health Provider Arm

	<= 3 weeks	<=8 weeks
Age	**Proposed target (%)**	**Proposed target (%)**
0-19	80%	95%
20-64	80%	95%
65+	70%	95%
Total	77%	95%

Addictions (Provider Arm and NGO)

	<= 3 weeks	<=8 weeks
Age	**Proposed target (%)**	**Proposed target (%)**
0-19	80%	95%
20-64	80%	95%
65+	70%	95%
Total	77%	95%

Six-Monthly

PP10 Oral Health DMFT Score at year 8 Transitional measure (not included in performance dashboard reports)					
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	year 1 – 1.35 year 2 – 1.35	n/a	Annual
		Pacific	n/a		
		Total	year 1 – 1.35 year 2 – 1.35		
PP11 Children caries free at 5 years of age Transitional measure (not included in performance dashboard reports)					
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).		Māori	year 1 – 61% year 2 – 65%	n/a	Annual
		Pacific	n/a		
		Total	year 1 – 61% year 2 – 65%		
PP12 Utilisation of DHB funded dental services by adolescents Transitional measure (not included in performance dashboard reports)					
In the year to which the reporting relates, the total number of adolescents accessing DHB-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 DHB-funded dental services (e.g. DHB 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 DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part (i) of the Numerator.		Total	year 1 – 85% year 2 – 85%	**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 DHB-funded oral health services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers).		Children Enrolled **0-4 years**	year 1 – 75% year 2 – 77%	n/a	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 DHB-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**	year 1 – <1% year 2 – <1%		
PP16 Workforce - Career Planning					
The DHB 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 ● Māori Health ● Pacific ● Pharmacy ● Clinical rehabilitation ● Other			Supply of quantitative data required.	n/a	Annual

PP18 Improving community support to maintain the independence of older people				
Numerator: The number of people aged 65 and older who have received long-term home-support services in the last three months who have had a Comprehensive Clinical Assessment and a completed care plan. Denominator: The number of people aged 65 and older who have received long-term home-support services in the last three months.		95%	95%+	Quarterly
PP 20 improved management for long term conditions (CVD, diabetes and Stroke)				
Part 1, Focus area 1: Cardiovascular disease DHBs supply a quarterly narrative report that comments on data supplied by the Ministry, and DHB performance in relation to the number of people diagnosed with ischemic heart disease and on lipid lowering medications, with a view to establishing a formal performance baseline for application in 2013/14.		No quantitative target Progress to be demonstrated via qualitative deliverable .	n/a	Quarterly
Part 1, Focus area 2: Stroke services DHBs are to provide a quarterly narrative report on stroke services delivered including plans and actions to improve services.				
Part 1, Focus area 3: Maintain or Improve access to Diabetes Annual Reviews Numerator - Count of enrolled people in the PHO with a record of a Diabetes Annual Review during the reporting period Denominator - The number of enrolled people in the PHO who would be expected to have diagnosed diabetes, using the Diabetes Prevalence Estimate Data Source: PHO Performance Programme Indicators Definitions 1 July 2011 version 5.3 Sept 11		70%		
Part 2, Focus area 1. Progress in delivery of Diabetes care improvements Provide a quarterly progress report on delivery of actions and volumes agreed for each Improvement area identified in the Annual Plan.		Qualitative deliverable.		
Part 2, Focus area 2 Local Diabetes Team Service (or an equivalent service).. Provide the annual report from the local diabetes team to the Ministry as outlined in the Service Specification for Specialist Medical and Surgical Services – Diabetes Service – Local Diabetes Team Service (or an equivalent service).				Annual
Part 2, Focus area 3. Diabetes Management	Māori	80%		Quarterly
Numerator: (Data source: DHB to provide).	Pacific	n/a		
The number of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64mmol/mol at their free annual check during the reporting period. Denominator: (Data source: DHB to provide. Note that this is the numerator from the Diabetes Free Annual Check indicator). The number of unique individuals with type I or type II diabetes on a diabetes register whose date of their free annual check is during the reporting period.	Total	80%		
PP 21 Ensure Immunisation coverage for two year olds				
Each quarter, DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan. The Ministry will provide summary data for the quarter on the nationwide service framework library web site NSFL homepage: http://www.nsfl.health.govt.nz/.		95%	95%	Quarterly

System Integration Dimension

Performance Measure and description			2012/13 Target	National Target	Frequency
SI1 Ambulatory sensitive (avoidable) hospital admissions					
Each DHB 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 DHB 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	n/a	Six-Monthly
		Pacific	NA		
		Total	<95		
	Age 0-4	Māori	<95		
		Pacific	NA		
		Total	<95		
	Age 45-64	Māori	<95		
		Pacific	NA		
		Total	<95		
SI2 Regional service planning					
A single progress report on behalf of the region agreed by all DHBs 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 DHB/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 Progress to be demonstrated via qualitative deliverable.	n/a	Quarterly
SI3 Ensuing delivery of Service coverage					
Exception report - Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through:• analysis of explanatory indicators• media reporting • risk reporting• formal audit outcomes• complaints mechanisms• sector intelligence.			No quantitative target exception based qualitative deliverable required.	n/a	Six-Monthly
SI4 Elective services standardised intervention rates					
Data sourced from National Minimum Dataset. Exception report - For any procedure where the standardised intervention rate in the 2011/12 financial year is significantly below the target level a report demonstrating: 1. what analysis the DHB has done to review the appropriateness of its rate AND 2. whether the DHB 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 (2012/13) that will ensure the target rate is achieved	**Major joint replacement procedures**		21.0 per 10,000	21.0 per 10,000	Annual quarter 1
	Cataract Procedures		27.0 per 10,000	27.0 per 10,000	

Cardiac Procedures Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating 1. what analysis the DHB has done to review the appropriateness of its rate AND 2. whether the DHB 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 (2012/13) that will ensure the target rate is achieved.			6.2-6.5 per 10,000	For cardiac surgery a target intervention rate of between 6.2 and 6.5 per 10,000	Quarterly
			11.9 per 10,000	For percutaneous revascularization a target rate of at least 11.9 per 10,000	
			32.3 per 10,000	For coronary angiography services a target rate of at least 32.3 per 10,000	
SI5 Delivery of Whānau Ora					
The DHB provides a qualitative report identifying progress within the year that shows the DHB's active engagement with existing and emerging Whānau Ora Provider Collectives, steps towards improving service delivery within these providers, and supporting the building of mature providers. This will include a summary of the following – how the DHB is: • Contributing to the strategic change for Whānau Ora in the district • Contributing information about Whānau Ora within the district at appropriate forums, including nationally. • Investing in Whānau Ora Provider Collectives through deliberate activities • Involving the DHB's governors and management in the Whānau Ora activity in the district • Demonstrating meaningful activity moving towards improved service delivery and building mature providers.			No quantitative target qualitative deliverable required.	n/a	Annual
SI7 Improving breast-feeding rates					
DHBs are expected to set DHB-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. DHBs 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 DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers.	**6 weeks**	Māori	74%	**74%**	Annual
		Pacific	NA		
		Total	74%		
	3 Months	Māori	57%	**57%**	
		Pacific	NA		
		Total	57%		
	6 Months	Māori	40%	**27%**	
		Pacific	NA		
		Total	40%		

Ownership Dimension

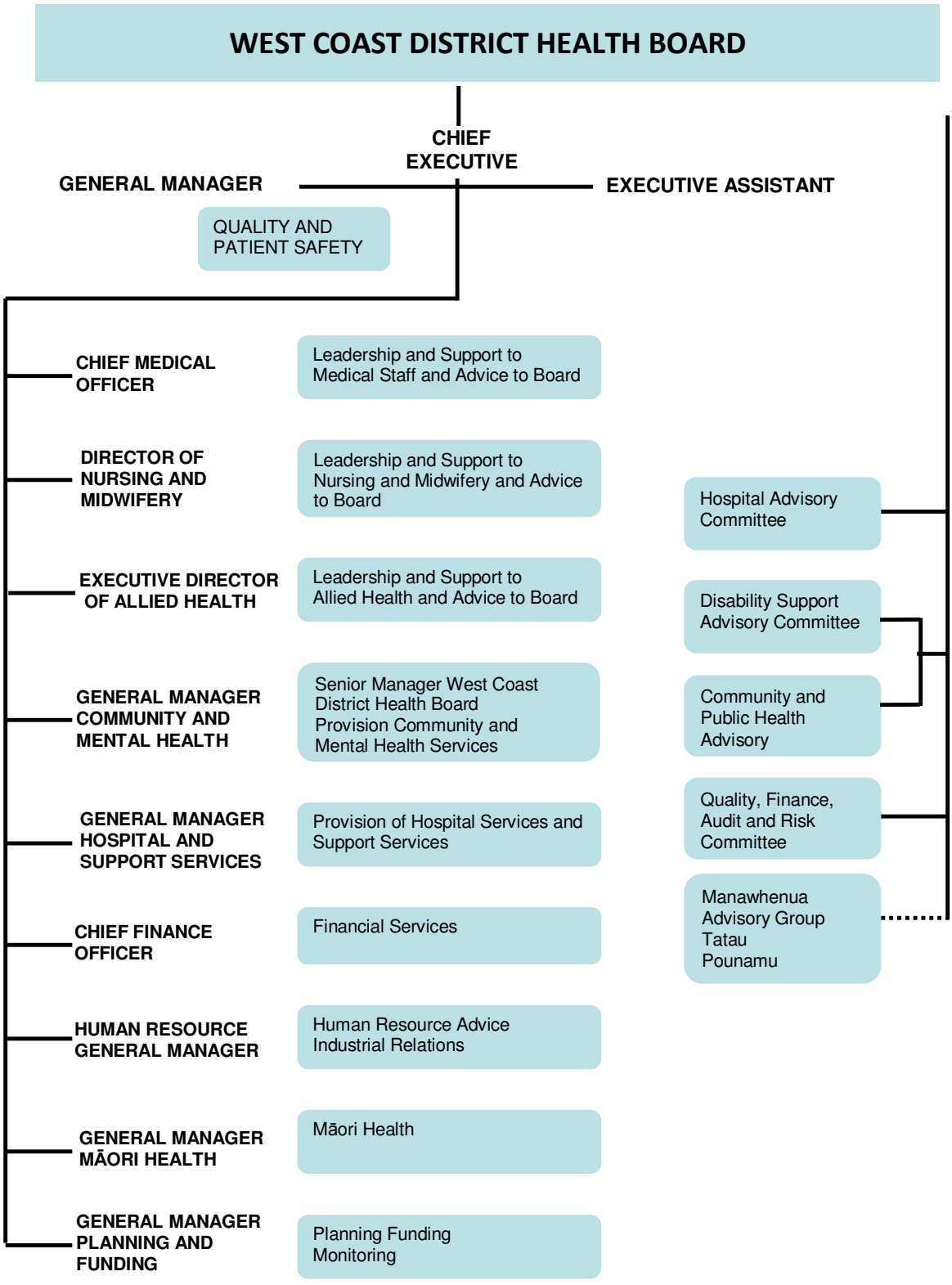
Performance Measure and description	2012/13 Target	National Target	Frequency
OS3 inpatient length of stay			
Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating: 1. what analysis the DHB has done to review the appropriateness of its rate AND 2. whether the DHB 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 (2012/13) that will ensure the target rate is achieved.	3.43 Days	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly
OS5 Theatre Utilisation			
Each quarter, the DHB 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 DHBs 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 DHBs whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended b. For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended	89%	85%	Quarterly
OS6 Elective and arranged day surgery			
Data sourced from National Minimum Dataset. Exception report - 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 DHBs '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 DHB, and summing the result across all DRGs.	59.6%	59.2% 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. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	82%	DHBs will be supplied with comparative data on performance relative to other DHBs. For DHBs with a final 2010/11 result that is below 95 percent, their suggested target is 95 percent. For DHBs with a final 2010/11 result that is above 95 percent, their suggested target will be to maintain current levels.	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 DHB. Readmissions are aggregated by DHB of service. Where an acute readmission occurs within a different DHB to that of the previous inpatient discharge (ie, the first admission), and the previous discharge DHB of Service is consistent with the previous discharge Agency Code, the readmission will be allocated against the DHB of the initial inpatient discharge. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	To Be Confirmed by 31 July 2012 with the Ministry of Health	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly
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 DHB 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 DHB per quarter (excluding pre-allocated NHIs and newborns)	<6%	Greater than 3.00% and less than or equal to 6.00%	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 DHB per quarter Denominator: Total number of NHI records created per DHB per quarter	<2%	Greater than 0.50% and less than or equal to 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 DHB Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB	>55%	Greater than or equal to 55.00% and less than 65.00%	
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 DHB per quarter.	<5%	Greater than 2.00% and less than or equal to 5.00% late	
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%	Greater than or equal to 97.00% and less than 99.50%	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarterDenominator: Total number of PRIMHD records submitted by the DHB in the quarter	>98%	Greater than or equal to 98.0% and less than 99.5%	

Output Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OP1 Output Delivery Against Plan			
Part A: Hospital production. Each DHB is required to submit completed Production Plans as part of the Annual Plan round. From these Production Plans, the Ministry will calculate planned outputs for the following groups of personal health services. 1. Casemix included medical services 2. Casemix included surgical services 3. Casemix included maternity services 4. Non-casemix medical services 5. Non-casemix surgical services 6. ED non-admitted events	Within 3% of plan	Output delivery within three percent of plan	Quarterly
Part B: Monitoring the delivery of personal health services and mental health services For Mental Health Services provided by the DHB's provider arm, the DHB must complete the Mental Health Volumes Reporting template. This will be provided by the Ministry, and included with the main quarterly reporting template.	Within 5% of plan	Volume delivery is within five percent of plan	
DV1: Faster cancer treatment			
Detailed information will be provided in the Ministry of Health's data definitions for the Faster cancer treatment indicators. Please refer to this document for information on the definitions, data collection and exceptions. This information will be available on the NSFL by March 2012.	data is provided to establish baseline		Quarterly
DV2: Improving waiting times for diagnostic services			
• Elective coronary angiogram to be reported to the National Booking Reporting System (NBRS) in accordance with NBRS data dictionary reporting requirements. • CT, MRI and colonoscopy reporting templates to be submitted to the National Health Board within 20 days of the end of the previous month. The reporting template will be located on the NSFL website with other Performance Measure documents.	data is provided to establish baseline		Monthly

Appendix 4: Organisation Structure



Appendix 5: Objective of a DHB – New Zealand Public Health and Disability Act (2000)

Part 3: Section 22:

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

- To reduce health disparities by improving health outcomes for Māori and other population groups;
- To reduce, with a view to eliminating, health outcome disparities between various population groups, by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
- To improve, promote, and protect the health of people and communities;
- To improve integration of health services, especially primary and secondary health services;
- To promote effective care or support for those in need of personal health or disability support services;
- To promote the inclusion and participation in society and independence of people with disabilities;
- To exhibit a sense of social responsibility by having regard to the interests of people to whom we provide, or for whom we arranges the provision of services;
- To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
- To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
- To exhibit a sense of environmental responsibility by having regard to the environmental implications of our operations; and
- To be a good employer.