THE WEST COAST HEALTH SYSTEM
– supporting you to be well

Annual Plan 2013-2014

Incorporating the Statement of Intent

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

ANNUAL PLAN & STATEMENT OF INTENT

Produced July 2013
Pursuant to Section 149 of the Crown Entities Act 2004

West Coast District Health Board
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Signatory Page

The West Coast District Health Board (DHB) is one of 20 DHBs, established under the *New Zealand Public Health and Disability Act in 2011.* Each DHB is categorised as a Crown Agent under the *Crown Entities Act 2004* and is responsible to the Minister of Health for a geographically defined population.

This Annual Plan has been prepared to meet the requirements of both governing Acts and the relevant sections of the Public Finance Act. It sets out the DHB's goals and objectives and describes what the DHB intends to achieve in 2013/14 in terms of improving the health of its population and delivering on the expectations of the Ministry of Health.

The Plan also contains service and financial forecast information for the current and two subsequent years: 2013/14, 2014/15 and 2015/16.

Sections of this Annual Plan are extracted to form a stand-alone Statement of Intent document, which is presented to Parliament. As a public accountability document, the Statement of Intent is used at the end of every year to compare the DHB's planned performance with actual performance. The audited results are then presented in the DHB's Annual Report.

The West Coast DHB has made a strong commitment to one integrated health system with joint planning and service delivery. Clinically led local and regional alliances are in place as vehicles for redesigning the way we provide health services, implementing system change and improving health outcomes. This includes the West Coast Health Alliance, the South Island Regional Health Services Alliance and transalpine arrangements with the Canterbury DHB.

In line with this approach, the actions and activities outlined in this Annual Plan present a picture of the joint commitment between the West Coast DHB and the West Coast PHO (as partners in the West Coast Health Alliance), along with the contribution of other local healthcare partners and the Canterbury DHB, to improving the health of our community and delivering the expectations of Government.

The key actions the DHB will deliver as part of its commitment to the regional alliance are also highlighted throughout this Plan. The full South Island Regional Health Services Plan (of which the West Coast DHB is a signatory) can be found on the South Island Alliance Programme Office website: www.sialliance.health.nz.

The West Coast DHB also has Māori Health and Public Health Action Plans for 2013/14, both of which are companion documents to this Annual Plan. These documents set out key actions and performance measures to improve population health and reduce inequalities. Both of these documents are available on the West Coast DHB website: www.wcdhb.org.nz.

In signing this Annual Plan, we are satisfied that it represents the intentions and commitments of the West Coast DHB and West Coast Health Alliance for the period 1 July 2013 to 30 June 2014.

Together, we will continue to demonstrate real gains and improvements in the health of the West Coast population.

Paul McCormack	Peter Ballantyne	Hon Tony Ryall
Chairman WCDHB	Deputy Chairman WCDHB	Minister of Health

Date: June 2013

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Message from the Chairman and Chief Executive

Transforming our system

In 2012 we undertook a series of community meetings and consultations on the future of health services on the Coast, asking our staff and community: '*If there was one thing you could change about healthcare on the Coast, what would that one thing be?*' The feedback we received from that consultation confirmed for us that there was much that could, and should, be changed.

It is true that none of the challenges the West Coast health system faces are new: a small population spread over a large geographic area; workforce shortages and an over-reliance on locums leading to a loss of continuity of care; outdated and inefficient hospital facilities; and increasing service provision costs. But these are not challenges to which there is a 'quick fix' – we need to develop tailored local solutions that recognise it's not about delivering more of the *same* services, but more of the *right* services.

Over the past year, we have developed and begun to implement a comprehensive plan for systematically confronting and delivering the change that is needed. We are redesigning the way in which care is provided, integrating services that have historically been fragmented and refocusing investment on care as close to people's homes as possible. Most importantly, we are addressing the underlying causes of unsustainable health service provision. We are confident that the tangible solutions that we are implementing will meet the needs of our community and enable us to provide safe and sustainable health services for West Coasters now and into the future.

Integrated care: Health care home and a single point of referral for complex care

Improving primary care on the Coast remains an imperative. Through the West Coast Health Alliance, the DHB is working with general practice to reorient the way we support and deliver primary care services. Through the Complex Clinical Care Network, we are creating a single point of referral that better supports people with complex conditions, and we are working alongside general practice to support older people to remain independent, safe and well in their own homes. Closer working relationships between general practice and community nursing services will also support more multidisciplinary approaches to patient care and less reliance on specialist services.

Sustainable care: Transalpine services and supporting health professionals

Collaboration with Canterbury has seen the development of more than ten 'transalpine' services, giving West Coasters reliable access to specialist services and allowing us to better plan the workforce and infrastructure needed in both locations. Access to specialist health care has improved, and the time West Coasters spend travelling to access care has been reduced. Clinical outreach services now provide regular access to specialist advice in local clinics.

We have placed an increasing focus on securing a permanent workforce to improve the continuity of care we provide and to reduce our historical reliance on locums - an expensive and unsustainable way to run our health system. Through the transalpine model, a number of joint specialist positions are now in place across Canterbury and West Coast services, including joint geriatrician, paediatrician, anaesthetics and allied health positions. We have adopted a joint Nursing Entry to Practice Programme that shares elements of training with Canterbury and brings graduates together in their first year of training. We have also established a Rural Learning Centre to reduce workforce isolation factors through collaboration, peer support and mentoring.

Continuity of care: Connected information systems

Integrated information systems have been a significant part of the transalpine approach. Over the past year we have implemented a new regional clinical information system and a regional laboratory and imaging system, and we are currently implementing regional e-referrals. In addition, our investment in telehealth and videoconferencing services now enables staff in remote areas to consult colleagues or specialists in other DHBs about a patient's condition, and over 300 consultations have already been enabled through our telehealth systems.

The impact of the rollout of these shared information systems is only beginning to be felt, but with shared access to patient records through Health Connect South, health professionals on the Coast will be able to make fully informed decisions about patient care whilst reducing duplicate laboratory tests, imaging and other diagnostics. All this will make care more effective and efficient for West Coasters.

Joined-up care: Settings and fit-for-purpose facilities

With the agreement and implementation of the model of care for the West Coast, we have a clear way forward. Now we need to support this with decisions on our facilities. Seismic assessments have revealed a number of our buildings to be earthquake-prone and below current building and council standards. Temporary relocations and repairs can only go so far, and place pressure on our capacity and our workforce. To truly implement new models, unlock the benefits of our programme of change and transform our health system, we need infrastructure that is fit-for-purpose and supports the delivery of modern health services.

Health targets: Commitments to the Crown

We continue to deliver on Government health targets, leading the country in driving down wait times in Emergency Departments, where we consistently achieve above 99% of people attending ED being admitted, discharged or transferred within 6 hours. Six months into 2012/13:

- We had delivered 103% of our year-to-date elective surgery target.
- 89% of hospitalised smokers and 44% of smokers in primary care were provided with advice and support to quit (up from 86% and 40% respectively on the same time last year.
- 84% of all eight-month-olds on the West Coast were fully immunised, including 100% of Māori eight-month-olds.
- 58% of eligible people on the Coast had received a cardiovascular risk assessment in the past five years – still some way to go against the national target, but already 3% above the national result.

Clinically and financially sustainable care: A clear plan and commitment

All of this is part of the significant and radical transformation of health services on the Coast. Reviews of our maternal and mental health services are underway, and we are transforming primary care and services for older people. Empowered clinical leadership is proving critical in improving the continuum of care for our population and in lifting the quality of the services that we deliver to our population. It is in this context that our newly formed Clinical Board and recently reinvigorated West Coast Health Alliance have key roles to play in making decisions about how we can improve on what we do and where we should be investing our time and resources.

As we look forward to the coming year, we remain firmly focused on improving our performance, meeting national targets, living within our means and, most importantly, ensuring the delivery of effective and sustainable health services for the people of the West Coast. The pressure will be on - change is always difficult - and we need to make sure that we keep people fully informed as we make decisions about the future of our health system.

We would like to thank all those across our health system who have contributed to developing this new direction and those who are working hard to bring it to life. It is hard work, but we have started to put some solid foundations in place. Our community deserves a health system in which they can have trust and confidence. This is what we aim to deliver.

Paul McCormack

Chairman West Coast DHB

David Meates

Chief Executive West Coast DHB

Date: June 2013

Introducing the West Coast DHB

The West Coast DHB has the smallest population of all the DHBs in the country, serving 32,900 people. The West Coast also has the third largest geographical area, making it the most sparsely populated DHB. Our district extends from Karamea in the north to Jackson Bay in the south and Otira in the east, and comprises three Territorial Local Authorities: the Buller, Grey and Westland districts. The West Coast DHB is a major employer in the district, employing over 1,100 people.

1.1 What we do

The West Coast DHB receives funding from Government with which to fund and provide health and disability services for our population. Based on the size and demographic mix of our population (age, ethnicity and deprivation), the West Coast DHB received 0.91% of the total Vote Health funding allocated in 2013/14 - over $112 million.

In accordance with legislation and the objectives of the DHB, we use this funding to:

- *Plan* the strategic direction for health and disability services on the West Coast, through the West Coast Health Alliance and in partnership with clinical leaders, key stakeholders and our community and in consultation with other DHBs and service providers, particularly the Canterbury DHB;
- *Fund* the majority of health and disability services provided on the West Coast, and through our collaborative partnerships and relationships with service providers ensure services are responsive, coordinated, and focused on what is best for the patient and the system;
- *Provide* health and disability services for the population of the West Coast, both through our hospital and specialist services and through our DHB-owned general practices; 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.

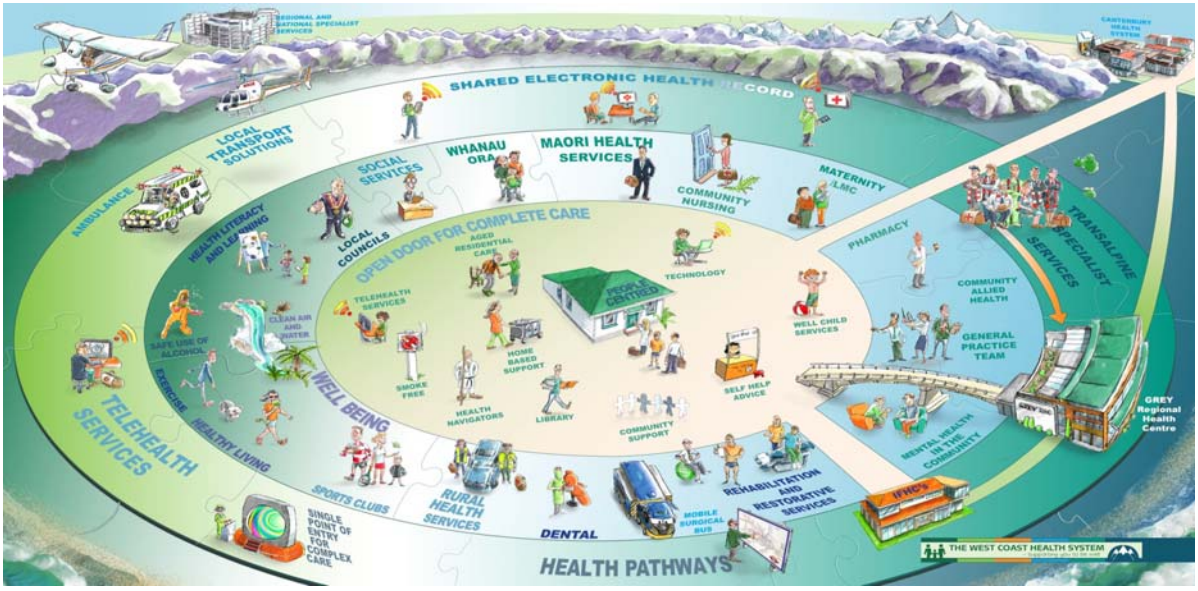
1.2 Our vision

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

The DHB is committed to improving, promoting and protecting the health and wellbeing of our whole population and ensuring that all people on the West Coast enjoy the best possible health. Accelerating the integration of services and the development of services that provide care closer to people's homes will be a key focus for 2013/14 through the West Coast Health Alliance. This will not only increases our health system's capacity, but improves the continuity of care for patients.

Recognising that clinical leadership as crucial to the successful integration of services, we are engaging health professionals from across the West Coast in all stages of service design and in the development of integrated patient pathways across the health system. Empowered health professionals are taking a lead in setting strategic direction, developing alternative models of care, reducing duplication and waste and improving patient care on the West Coast.

Also, while significant improvements have been made for Māori health over the past several years, inequalities still exist and we will not achieve our vision while Māori health lags behind all others. This strategic platform pervades everything we do, but specific actions in respect to improving Māori health are contained in the West Coast's Māori Health Action Plan.



1.3 Our operating structure

Governing the DHB

Our Board assumes the governance role and is responsible to the Minister of Health for the overall performance of the DHB. Its core responsibility is to set strategic direction and policy that is consistent with Government objectives, improves health outcomes and ensures sustainable service provision. The Board also ensures compliance with legal and accountability requirements and maintains relationships with the Minister, Parliament and the West Coast community.

Five advisory committees 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, providers and clinical leaders also regularly present to the Board and its committees to provide a working perspective and technical advice to members. [1]

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 provides clinical, strategic, financial and cultural input into Board and committee decision-making and has oversight of patient safety and quality.

Since July 2010, chief executive services for the West Coast DHB have been shared with Canterbury DHB, with a joint Chief Executive, a growing number of joint clinical and senior management positions and shared corporate services including: finance, human resources, information services, public health services and planning and funding. A number of Board appointments are also shared between the West Coast and Canterbury DHBs. This supports a shared governance viewpoint at the Board table and, like the joint staff appointments, promotes an improved working relationship, a better understanding of individual DHB issues and a closer relationship between the two DHBs.

Planning and funding health services

The DHB works with other health and disability organisations, stakeholders and our community to assess our population's need for health and disability services and determine 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, cover the full continuum of care and keep the patient at the centre. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the West Coast health system to achieve the best health outcomes for our community.

Our Planning and Funding Division holds and monitors alliance agreements and service contracts with the organisations and individuals that provide health services to the West Coast population. This includes an internal service agreement with our Hospital and Specialist Services Division and more than 40 service agreements with external providers – including the West Coast PHO, community-based personal health and disability support service providers and the Canterbury DHB.

Providing health and disability services

The West Coast DHB owns Grey Base Hospital, and also provides a range of hospital-based services on an outreach/extension basis via Reefton Health and Buller Health.

In addition, the DHB owns four of the seven primary health centres on the Coast: Greymouth Health Centre (provided across two sites: Grey Medical Centre and Rural Academic General Practice), Reefton Medical, Buller Health, and South Westland Medical Practice (with rural clinics in Whataroa, Franz Josef, Fox Glacier, Haast and Hari Hari), plus a number of associated medical clinics in remote rural areas including Ngakawau, Karamea, Moana.[2]

This is no small responsibility – in an average week on the West Coast: 2,612 general practice appointments are provided; 330 people have a specialist outpatient appointment; 238 people go through our Grey Base Emergency Department; 101 children have a dental check; 34 people have elective surgery; 29 people have a CVD risk assessment with their GP; 24 young people receive a free sexual health check; 11 people enrol in smoking cessation programmes; and 6 babies are born.

Promoting community health and wellbeing

Good health is determined by many factors and social determinants of health that sit outside the direct control, but not the influence, of the health system. 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.

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[1] *Refer to Appendix 3 for the legislative objectives of a DHB and Appendix 4 for the DHB's organisation structure.*

[2] *The business models and ownership of DHB primary health practices is currently under review as part of our drive towards achieving clinical and financial sustainability and improved health outcomes for our population.*

Canterbury DHB's Community and Public Health Division provides population health services on behalf of the West Coast. Through Community and Public Health, the 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 improving nutrition and physical activity and reducing tobacco smoking and alcohol consumption under the collaborative banner of 'Healthy West Coast'.

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

1.4 Our transalpine partnership

Like many smaller DHBs, population numbers on the West Coast are just too small to allow the DHB to provide a full range of services. When the West Coast cannot provide services locally, we must refer patients to other DHBs and large centres with more specialised capacity.

To support this, the West Coast has formal arrangements in place with the Canterbury DHB for the provision of more specialised services to the West Coast population. Formalising our collaboration and knowing what will be provided by Canterbury enables both DHBs to proactively plan the most appropriate workforce and service infrastructure in both locations. These formal arrangements are not about reducing services, but about ensuring continued access to services that are safe and both clinical and economically sustainable.

The arrangements include joint clinical appointments that have enabled closer clinical collaboration, and the establishment of shared services and clinically designed transalpine pathways, such as those in place for paediatrics, oncology and orthopaedics. Paediatric outpatient clinics are now provided on the West Coast by a jointly appointed paediatrician who travels from Christchurch two days a fortnight.

Clinical networks, referral guidelines and the use of technology such as videoconferencing and telemedicine are also supporting clinical teams to make the best arrangements for their patients and reducing long waits and travel for treatment. Since the introduction of the Transalpine Oncology Service, more than 300 telehealth consultations have taken place – providing access to specialist advice, but saving many families the inconvenience of travelling long distances for treatment.

Ten transalpine services are currently in place – paediatric medicine, surgery and dietician services; vascular, gerontology, oncology; orthopaedics; neurology; cardiology; haematology; respiratory and ECHO services and plastic surgery. In the coming year, the focus will be on accelerating the transalpine approach across all services with a particular focus on general medicine, general surgery, mental health services and older people's health services.

Identifying our challenges

Analysing the demographics and health profile of our population helps us to predict the demand for services and influences the choices we make when prioritising and allocating resources. This information also helps us to understand the factors affecting our performance and identify areas for focus and improvement.

1.5 Population profile

The West Coast is home to a population of 32,900 people, an increase of 2% from 2006, and is expected to grow by only another 1% over the next 13 years. By 2026, the West Coast's population is predicted to be over 33,300 people.[3]

As one might expect from our slower population growth, the West Coast DHB population has an older age structure compared with New Zealand as a whole, with a higher proportion of people aged over 65 compared with the national average. While our younger population decreased slightly between 2006 and 2011, there was slight growth among the population aged 40-64 and significant growth among people aged 65+.

By 2026, the proportion of people aged over 65 will have increased by over 10%, one in every four people on the Coast will be over 65, and the number of people aged over 80 will have doubled.

As we age, we develop more complicated health needs and multiple health conditions, meaning we consume more health resources and are more likely to need specialised services. There are a number of long-term conditions that become more common with age, including heart disease, stroke, cancer and dementia. This will put significant pressure on our workforce, infrastructure and finances. Improving the health of older people is a priority for the West Coast in 2013/14.

Ethnicity is a strong indicator of need for health services, and we must consider the unique health needs of different population groups in our planning for the future. While just over 1% of the West Coast population identifies as Asian and less than 1% as Pacific, one in ten West Coasters identifies as Māori (10%). The Māori population on the West Coast has a different age structure and growth pattern, with 75% of the West Coast Māori population under 45 years of age.

Deprivation is also a strong indicator for the need for health services. Analysis of socio-demographic data shows that compared with New Zealand as a whole, the West Coast DHB has a lower mean personal income (in the 2006 Census, $20,400 per year compared to $24,400 nationally). Higher proportions of our population are also receiving unemployment or invalid benefits, have no educational qualifications and lack access to a mobile phone or motor vehicle.

1.6 Health profile

West Coasters have a higher overall morbidity and mortality rates and lower life expectancy when compared with the New Zealand average. The overall rate of hospitalisation is also high.

While gains have been made, West Coast Māori continue to have a poorer overall health status than others in the district. This is demonstrated by a range of indicators, including rates of cardiovascular disease, cancer, diabetes and respiratory disease. Māori are also 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%).[4]

West Coast children and young people have poorer health outcomes than their counterparts in other parts of the country. The leading causes of mortality, morbidity, and hospitalisations for young people on the West Coast are preventable.

West Coast residents have higher smoking rates compared with other areas in New Zealand. The 2006/07 New Zealand Health Survey showed that 28.2% of West Coast residents were 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. The negative health outcomes associated with risk factors such as tobacco smoking place considerable pressure on our health system. Disproportionately high amongst Māori populations, smoking is also a substantial contributor to socio-economically based health inequalities.

Māori Health, Child and Youth Health, Disease Prevention and Long-Term Conditions are all priority areas for the West Coast DHB in the coming year.

1.7 Operating environment

Planning, funding and delivering health services is a highly complex business and on the West Coast is further complicated by the challenges of delivering quality health services to a relatively small population over a large geographic area.

The geographic nature of the district, being bordered by the Southern Alps on the east and the Tasman Sea on the west, means that the West Coast is the most rural and isolated DHB region in New Zealand. It is also the most sparsely populated, with a population density of 1.4 people per square kilometre. Just 0.7% of New Zealand's total estimated resident population lives on the West Coast.

[3] *Unless otherwise referenced, data is based on Statistics NZ projections and Ministry of Health mortality and demographic data.*
[4] *West Coast 'Te Tai O Poutini' Māori Health Profile 2008, prepared by Community and Public Health West Coast*

While our population may be smaller, the total land area covered by the West Coast DHB is 23,283 square kilometres, and great distances separate many towns. The distance between Karamea in the north and Haast in the south is 516 kilometres, almost the same as the distance from Auckland to Palmerston North, which brings significant challenges in terms of the provision of health and disability services, often requiring either clients or health professionals to travel long distances to receive or deliver health services. Compared to the rest of New Zealand, fewer West Coasters have access to a motor vehicle, and public transport is limited.

Workforce pressures

Workforce is a critical asset for the West Coast DHB. Our ability to continue to transform our health system and meet future demand for services relies heavily on having the right people, with the right skills, in the right place. As a major employer in our district, we employ just over 1,100 people in our services and almost the same number indirectly to deliver health and disability services to our population through service contracts with public, private and charitable organisations.

Like many DHBs, as a greater proportion of the West Coast population reaches traditional retirement age, we have concerns over the continued availability of a sufficient workforce pool to meet increases in demand for health services. However, we also face a number of unique challenges as a result of our geographical isolation. It can be difficult to recruit and retain health professionals to work on the West Coast, and our reliance on temporary and locum staff can make it difficult to maintain consistency of care and is financially unsustainable.

It is essential that we create a working environment that will make the West Coast health system an attractive place for young health professionals to come and work and that encourages people who are already working here to stay. Our ability to provide complex and specialised services is a challenge because of the relatively small number of Senior Medical Officers in our hospitals, and we are addressing this as part of our transalpine collaboration with the Canterbury DHB. We are also focusing on the recruitment of permanent staff, generalist positions and joint appointments with Canterbury to give stability to our services. We are also supporting the development of our rural clinical workforce, with recent investment in a Rural Learning Centre in Greymouth. The aim is to encourage people to work in rural locations by reducing isolation factors through collaboration, peer support and mentoring.

Fiscal pressures

Sitting alongside workforce challenges, the health sector also faces fiscal pressures from both increased demand and increased treatment- and wage-related costs. Government has given clear signals that we need to live within our means and rethink how we deliver improved health outcomes in more cost-effective ways.

In the year ending June 2013, the West Coast DHB is forecasting a deficit of $3.6M. We are committed to making rapid progress in further reducing our deficit in 2013/14 and achieving a breakeven position by the end of 2014/15.

The DHB has implemented a number of strategies to minimise cost growth and achieve long-term financial sustainability. Major projects include the development of the integrated model of care for Grey/Westland and Buller through clinically led service transformation and transalpine collaboration with the Canterbury DHB – focused on clinical pathways, joint clinical positions and improved use of technology.

While fiscal pressures will always be a challenge, there are still opportunities to add value to the activities that we undertake, reduce duplication and waste across our system and direct funding into services that will provide the greatest return in terms of improved health outcomes for our population.

Facility pressures

Our facilities, in their current configuration, limit models of care delivery, are outdated and inefficient, and are expensive to maintain. Some of our primary and community facilities are also not appropriately located or configured to support an integrated service model.

Following seismic assessments of buildings located on the Grey Base Hospital site, a number were identified as earthquake-prone, requiring immediate remediation to bring them above 33% of the current building code. Two were closed because the facilities were deemed unsafe to occupy. This has required services to be moved into temporary or crowded spaces to undertake the necessary repairs, which is putting considerable pressure on our capacity and on our workforce. In addition, Council consents for the urgent work that was required to relocate these services were provided on a temporary basis only.

The DHB must provide the Council with clarity about its future intentions, and with further seismic assessments underway and further repairs likely needed on other sites, there is an urgent need to make firm decisions on the future of all of our health facilities across the West Coast. It is also imperative that the transformation of the model of care on the Coast is underpinned by modern, fit-for-purpose infrastructure that supports responsive and integrated service provision.

A joint Partnership Board, appointed by the Ministry of Health, is charged with delivering a detailed business case for facilities redevelopment at Grey Base Hospital and addressing the need for viable health services in Buller. A clear decision on the way forward for both of these sites is expected in July 2013. In the meantime, it will be important to make carefully considered decisions on the repairs of current facilities to ensure safety and service continuity without over-investing in facilities that do not have a future role in our health system.

1.8 Critical success factors

The following areas represent the four major factors that are critical to our success, where failure would significantly threaten the achievement of the strategies, goals and priorities outlined in this plan.

CRITICAL SUCCESS FACTORS	MITIGATION STRATEGY
Achieving financial sustainability Even allowing for our geographic spread and high health need, the West Coast DHB uses more than its fair share of available health funding compared to other communities in New Zealand. It is critical that we constrain cost growth. If we cannot live within our means and reduce our deficit position, we will severely restrict our ability to maintain services and invest in the new technology and initiatives necessary to meet future demand.	Create a more sustainable platform for the future by maintaining a focus on efficient and effective use of resources and elimination of duplication and waste in every part of our system. Apply scrutiny to contractual arrangements, seek opportunities to generate increased revenue and review transitional funding arrangements. Work regionally and nationally to support tighter, collaborative purchasing and procurement processes that reduce avoidable cost growth. Apply greater controls in relation to locum recruitment and work with Canterbury DHB on joint appointments and the consolidation of corporate and executive management functions across both DHBs. Through our West Coast Health Alliance and Partnership Board, accelerate implementation of the Integrated Family Health Service model.
Rebalancing the System Services are not always provided in the most appropriate community or hospital setting. Services can be isolated or inflexible and not clinically sustainable. In order to ensure that services are sustainable we need to rebalance the system and get ahead of the demand curve – keeping people well and reducing the demand for complex care.	In line with the model of care, reorient and rebalance our health system to make the most effective use of available resources and reduce barriers to accessing appropriate treatment and support. Support the new model by applying new funding at a proportionally greater rate to primary and community services to get ahead of the demand curve and support the delivery of services closer to home. Invest in the development of transalpine services and pathways that will provide our population with sustainable access to specialist services. Support more flexible models of care and service delivery to improve access: mobile services, telemedicine, transport options, multidisciplinary teams and direct GP access to diagnostics and specialist advice to better support people closer to their own homes.
Integrating fragmented health services Service configurations are not always efficient, and there is poor integration between primary (general practice) and secondary care (hospital). There are a number of technical and workforce efficiencies that could be implemented across the system to reduce waste and duplication.	Develop patient-centred and multidisciplinary models of care that focus on primary care as the point of continuity, with direct access to specialist advice and support to provide care closer to people's homes. Engage clinical leaders from across the health system in reviewing and redesigning patient pathways. In doing so identify opportunities to improve and integrate delivery models and support services to work more closely together. Invest in shared IT systems other technology to encourage and enable closer integration of primary and secondary services and timely sharing of accurate information amongst members of the healthcare team.
Building a sustainable and stable workforce Recruitment and retention issues have led to high use of expensive locums and temporary staff, which reduces the continuity and consistency of care and is not a good use of limited funding.	Focus recruitment efforts on occupational groupings most at risk clinically. Reduce reliance on locum cover by working to recruit and retain people in permanent positions and supporting models of care that allow staff to work to the greatest extent of their scope. Seek clinicians that have a wider range of generalist skills, and increasingly source scarce specialist skills from, or with, Canterbury DHB. Invest in telemedicine, outreach clinics, joint DHB appointments and the development of transalpine pathways and services that will allow specialists to provide advice and supervision to colleagues in rural areas.

Setting our strategic direction

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

2.1 Strategic context

Populations are ageing, long-term conditions are becoming more prevalent and the needs of vulnerable populations are escalating. As people's conditions become more complex, the care required is more costly in terms of time, resources and dollars. To ensure the sustainability of our health system, we need to shift our population's health needs away from the complex end of the continuum of care and support more people to stay well.

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international trends and responses to the pressures and challenges facing the health sector, to help guide DHB service planning.[5] International direction emphasises that an aligned, whole-of-system approach is required to ensure service sustainability, quality and safety while making the best use of limited resources.

This entails four major shifts in service delivery:

- Early intervention, targeted prevention and self-management and a shift to more home-based care;
- A more connected system and integrated services, with more services provided in community settings;
- Regional collaboration clusters and clinical networks, with more regional service provision; and
- Managed specialisation, with a shift to consolidate the number of tertiary centres/hubs.

Hospitals 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) is increasingly being provided in the community. The focus is shifting towards supporting people to better manage their own health and to stay well, with the support of clinical networks and multidisciplinary teams.

2.2 National direction

These international shifts are consistent with the longer-term changes being driven across the New Zealand health system to meet the Government's commitment to providing *'better, sooner, more convenient health services'.*

At the highest level, DHBs are guided by the *New Zealand Health Strategy*, *Disability Strategy,* and *Māori Health Strategy (He Korowai Oranga)* and by the requirements of the *New Zealand Public Health and Disability Act.*

Alongside national strategies and commitments, the Minister of Health's 'Letter of Expectations' and the National Health Board's planning guidelines signal annual priorities for the health sector. DHBs are expected to meet Government commitments to: increase access to services and reduce waiting times; improved quality, patient safety and performance; and provide better value for money**.**

In summary, the Minister's 2013/14 priorities are: [6]

Better public services – in particular, supporting vulnerable children and young people; Care closer to home; Improving the health of older people; Regional and national collaboration; and DHBs living within their means.

DHBs are also to commit to achieving the national Health Targets:

- Shorter stays in emergency departments;
- Improved access to elective surgery;
- Shorter waits for cancer treatment;
- Increased immunisation;
- Better help for smokers to quit; and
- More heart and diabetes checks.

West Coast DHB is committed to making continued progress on national priorities and health targets. Activity planned over the coming year to deliver on the Minister's expectations is outlined in the Service Performance section of this document. The DHB will also contribute to delivery of the Budget 2013 initiatives announced by the Minister, and will work with the Ministry of Health to implement these initiatives and develop appropriate performance indicators to monitor progress.

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

[6] *The Minister of Health's Letter of Expectations 2013/14 is included as Appendix 5. A summary tables of the West Coast DHB's commitments towards the six national health targets is includes as Appendix 6.*

2.3 Regional direction

In delivering the goal of '*better, sooner, more convenient health services',* the Government has clear expectations of increased regional collaboration and alignment between DHBs. Significant progress is expected in implementing Regional Health Service Plans and delivering on regional workforce, information services and capital objectives in the coming year.

The West Coast is part of the South Island region along with Nelson Marlborough, Canterbury, South Canterbury and Southern DHBs. Together we provide services for 1,050,571 people, representing 23% percent of the total New Zealand population. While each DHB is individually responsible for the provision of services to its own population, working regionally enables us to better address our shared challenges and support improved patient care and more efficient use of resources.

Together, the South Island DHBs have established the South Island Alliance: a partnership between the five DHBs that is committed to a '*best for patients, best for system*' framework and strong clinical engagement. Regional activity is implemented through service level alliances and clusters based around priority service areas. The workstreams are clinically led, with multidisciplinary representation from community and primary care as well as hospital and specialist services.

Closely aligned to national direction, the regional vision is a clinically and fiscally sustainable South Island health system focused on keeping people well, where services are provided as close as possible to people's homes.

Our success relies on improving patient flow and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to better connect the services and clinical teams involved in a patient's care

We have made good progress in 2012/13 by: establishing a single South Island cancer patient database; launching regional HealthPathways; and introducing the eReferrals Management System. We have extended the shared Health Connect South clinical portal to three DHBs as a single installation, with plans to include all South Island DHBs in 2013/14.

We have implemented the 'Walking in Another's Shoes' training programme across the South Island to improve the care of dementia patients and rolled out a community-based early intervention programme for young people with anorexia nervosa. The South Island Alliance has also collectively delivered 37,616 elective surgical discharges - 2,130 more than the previous year - and delivered close to $15m of savings through regional procurement and supply chain initiatives.

Building on these successes, the South Island Regional Health Services Plan for 2013/14 articulates the agreed direction and prioritised activity for the coming year. The plan has been approved by the Chief Executives and Boards of all five DHBs.

Seven service areas have been prioritised: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety. Regional activity will also focus on: cardiac, elective, neurosurgery, ophthalmology, and stroke services. Regional asset planning and workforce planning, through the South Island Regional Training Hub, will contribute to delivery in all service areas.

The West Coast DHB is contributing to the achievement of the Regional Plan through membership of all of the activity streams. We are committed to the delivery of regional activity including: the continued rollout of South Island HealthPathways, Heath Connect South, the eReferrals Management Solution and supporting the Regional Training Hubs and development of regional clinical pathways to improve access for our population.

The longer-term outcomes we are seeking and the impact we are hoping to make on the health of our collective populations are articulated in the following section of this document. The 2013/14 South Island Regional Health Services Plan is available from the Alliance Programme Office website: www.sialliance.health.nz.

2.4 Local direction

For several years, we have signalled that health services on the West Coast face serious challenges. With an ageing population, increasing demand, workforce shortages and a flatter future funding path, the current models of care on West Coast are not clinically or financially sustainable.

In the drive to secure a stable and sustainable future for health services on the West Coast, the DHB has worked through a series of internal and organisational reviews, the implementation of the Better, Sooner, More Convenient Healthcare Business Case with the West Coast PHO, the transalpine health service model with Canterbury and the establishment of the West Coast Health Alliance to develop a model of care that will support future service delivery on the West Coast.

Over the past year, we have consulted with our partner organisations, staff and the West Coast community about a range of initiatives and changes that, once implemented or approved, will improve access to services. From this consultation, we have developed a vision for the future of the West Coast health system: an integrated health system that is clinically sustainable and financially viable and wraps care around the patient to help them stay well.

Future health services on the West Coast will be:

- *People-centred:* Services will be focused on meeting people's needs and will value their time as an important resource. Services will minimise waiting times and avoid the need for people to attend services at multiple locations or times unless there are good clinical reasons to do so.
- *Based on a single system:* Services and providers will work in a mutually supportive way for the same purpose – to support people to stay well. Resources will be flexible across services and across the system.
- *Integrated:* The most appropriate health professional will be available and able to provide care where and when it is needed. Services will be supported by timely information flow to support clinical decision-making at the point of care.
- *Viable:* The West Coast health system will achieve levels of efficiency and productivity that allow an appropriate range of services to be sustainably maintained in the long term. There will be a stable workforce of health professionals in place to provide these services.

This vision will be supported by a model of care that includes nine key components:

Healthy Environments and Lifestyles.

A Health Care Home with emphasis on primary care as the point of continuity.

A Single Point of Referral for Complex Care.

Improvements in Māori Health.

Reconfiguring Secondary and Transalpine Health Services.

Integrating Information Systems.

Delivering Transport solutions.

Supporting Health Professionals to build a sustainable workforce.

Settings - the development of modern, fit-for-purpose facilities and services closer to people's own homes.

Implementation of this model is underway on all fronts. Important steps have already been taken towards achieving a more sustainable future, including improving clinical information systems, commencing the development of Integrated Family Health Services within the Grey/Westland and Buller communities, and setting in place new transalpine health service for specialist services between the West Coast and Canterbury DHBs. Access to specialist health care has improved, and the time West Coasters spend travelling to access care has been reduced. New telemedicine services and outreach clinics now regularly save patients from needing to travel for specialist treatment and follow-up consultations. Instead, West Coast patients have direct access to specialist advice from their local clinic – with telemedicine already being used for paediatric, general surgery, oncology and nutrition specialist consultations.

Our plan for 2013/14 builds on the important steps that have been made over the past year.

Partnerships and health system alliances are critical – not only improving outcomes for our population, but also ensuring our health system is clinically and financially sustainable. The West Coast health system has a history of working collaboratively through forums and networks such as Healthy West Coast and local Diabetes, Heart, Respiratory and Cancer Networks, as well as in the implementation of locally designed patient pathways.

We will continue this work to improve service delivery for our most vulnerable population groups. The West Coast Health Alliance will take the lead in accelerating the implementation of the model of care for Grey/Westland and Buller, in order to support wrap-around care for our population and the provision of services closer to people's own homes.

We will also continue expanding our transalpine approach to support the delivery of highly specialised services that cannot always be provided locally. Investment in technology that improves access to specialist advice, along with shared patient information systems, will better support our clinical teams and improve the quality of care for our patients.

While the challenges we face are the same as other DHBs, the difference on the West Coast is our geographic isolation and the complicating factors that come with delivering services to such a small population over such a large area. There is no 'quick fix' to our unique challenges. To address our workforce and service delivery challenges, we must develop tailored solutions that ensure our population has equitable access to services – solutions that enable us to do more (and see more people) with the resources we have available.

Achieving our vision requires the transformation of our entire health system, and balancing what *must* be done with what *can* be done will be an ongoing struggle. We will not be able to make lasting change without the support and engagement of our workforce, our community and primary care partners and our neighbouring DHBs. Engagement of the wider sector, joint planning and service integration are therefore a key focus for the coming year.

Improving health outcomes for our population

What are we trying to achieve?

DHBs are responsible for delivering against the health sector goal: "*All New Zealanders lead longer, healthier and more independent lives*" and for meeting Government commitments to deliver '*better, sooner, more convenient health services*'.

This section presents an overview of how we will demonstrate whether we are succeeding in meeting those commitments and improving the health and wellbeing of our population. There is no single measure that can demonstrate the impact of the work we do, so we use a mix of population health and service access indicators as proxies to demonstrate improvements in the health status of our population.

The South Island DHBs have collectively identified four strategic outcomes and a core set of associated indicators, which will demonstrate whether we are making a positive change in the health of our populations. These are long-term outcomes (5-10 years in the life of the health system) and as such, we are aiming for a measurable change in the health status of our populations over time, rather than a fixed target.

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

  A reduction in smoking rates.

  A reduction in obesity rates.

- *Outcome 2: People stay well in their own homes and communities.*

  A reduction in the rate of acute medical admission.

  A reduction in premature ischemic heart disease rates.

- *Outcome 3: People with complex illness have improved health outcomes.*

  A reduction in the rate of acute readmissions.

  A reduction in premature cancer mortality rates.

- *Outcome 4: People experience optimal functional independence and quality of life.*

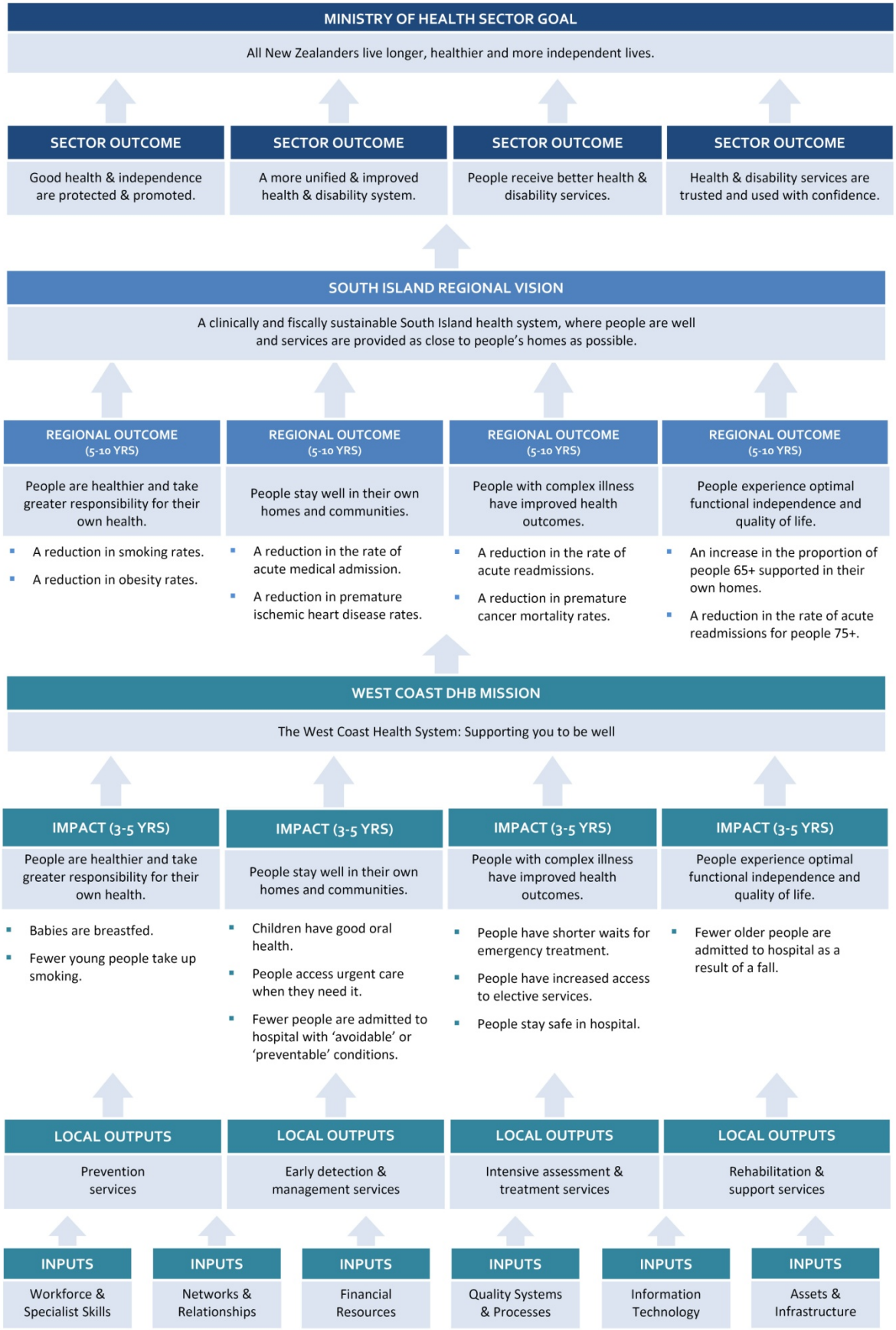
  An increase in the proportion of people over 65 supported in their own homes.

  A reduction in the rate of acute readmissions for people over 75.

For each of these desired outcomes, we have identified areas where individual DHB performance will have an impact on success and collectively agreed a core set of 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' of performance 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 longer-term outcomes and the delivery of the expectations and priorities of Government.

Figure 1: Intervention logic diagram



STRATEGIC OUTCOME GOAL 1

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

Expectation

Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and 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. A substantial portion of this results from 'acute' admissions, which are commonly treated as discrete episodes of care but are in fact exacerbations of a long-term condition.

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)

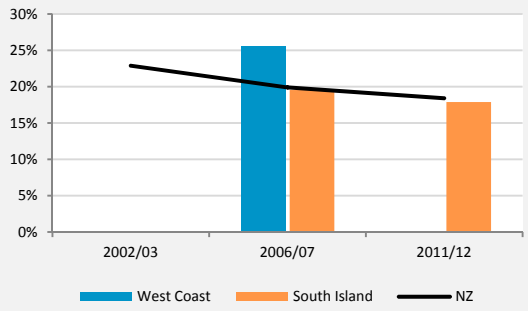
We will know we are succeeding when there is:

A reduction in smoking rates.

- *Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also 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, meaning less money is 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 our population.*

Data sourced from national NZ Health Survey.[7]

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

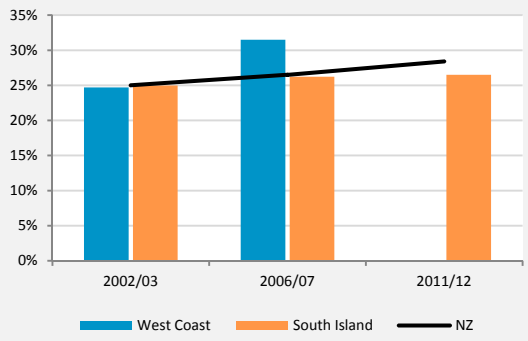


A reduction in obesity rates.

- *There has been a rise in obesity rates in NZ in recent decades, and the 2011/12 NZ Health Survey found that one in ten children (10%) and three in ten adults (28%) are obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving 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.[7]

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



[7] *The NZ Health Survey was completed by the Ministry of Health in 2003/04, 2006/07 and 2011/12. Results by region and district are subject to MoH availability. '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)

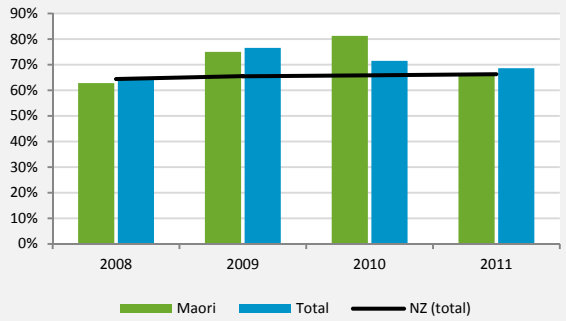
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

More babies are 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's important that mothers have access to appropriate support and advice.*
- *An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.*

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

The percentage of babies fully/exclusively breastfed at 6 weeks.	Actual 2011	Target 2013	Target 2014	Target 2015
	69%	74%	≥74%	≥74%

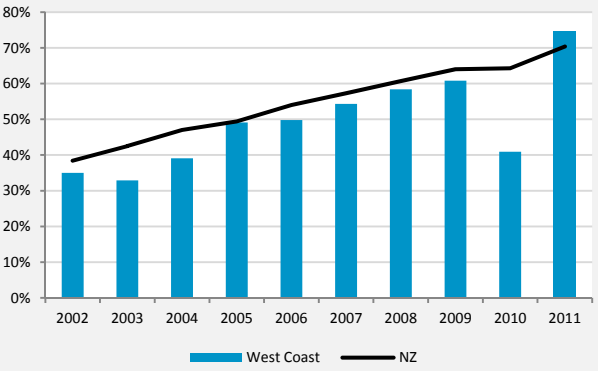


Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up 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.[9]

The percentage of 'never smokers' among Year 10 students.	Actual 2011	Target 2013	Target 2014	Target 2015
	75%	≥75%	≥75%	≥75%



[8] *The 2011 result is only for the second half of the 2011 year (i.e. July to December) due to MoH data availability.*
[9] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz.*

STRATEGIC OUTCOME GOAL 2

2.6 People stay well in their own homes and communities

Expectation

Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better managing their 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.

Why is this outcome a priority?

For most people, their general practice team is their first point of contact with health services. General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection and timely provision of treatment. The general practice team 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 general practice are a range of other health professionals including midwives, community nurses, social workers, 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.

When people are supported to stay well in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

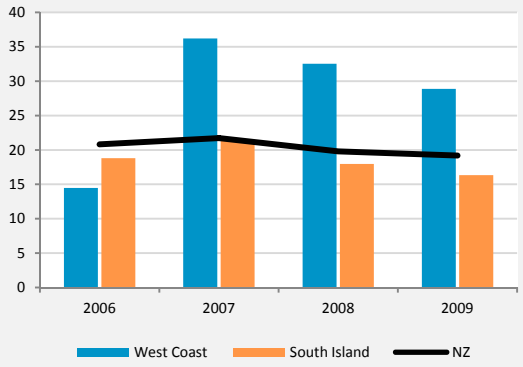
We will know we are succeeding when there is:

A reduction in premature ischemic heart disease mortality rates.

- *Cardiovascular Diseases (CVD) such as heart disease and stroke are the leading cause of death on the Coast.*
- *Premature mortality due to CVD is largely preventable with lifestyle change, early intervention and effective treatment. By detecting people at risk and improving the ongoing management of their condition, the more harmful impacts and complications of CVD can be reduced.*
- *CVD is significantly more prevalent amongst Māori and Pacific groups, so improved CVD outcomes are an opportunity to reduce inequalities and target improvements in the health of our more vulnerable populations.*
- *The rate of premature death due to ischemic heart disease can be used as a proxy measure of improved conditions management and access to effective treatment.*

Data sourced from MoH mortality collection.

Outcome Measure: The rate of death due to ischemic heart disease in people aged under 65 (per 100,000)

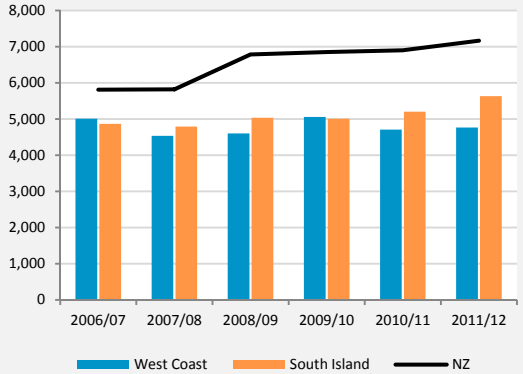


A reduction in acute medical admissions.

- *The impact long-term conditions have on quality of life and demand growth is significant. By improving the management of long-term conditions, people can live more stable, healthier lives, and avoid deterioration that leads to acute illness, hospital admission, complications and death.*
- *Reducing acute hospital admissions also has a positive effect on productivity in hospital and specialist services - enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.*
- *Acute medical admissions can be used as a proxy measure of improved conditions management by indicating that fewer people are experiencing an escalation of their condition leading to an urgent (acute) or complex intervention. They can also be used to indicate access to appropriate and effective care and treatment in the community.*

Data sourced from National Minimum Data Set.

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



IMPACT MEASURES MEDIUM TERM (3-5 YRS)

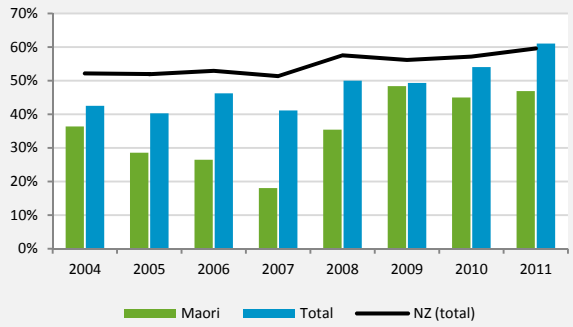
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

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, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition - helping to keep people well.*
- *Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy measure of equity of access and the effectiveness of services in targeting those at risk.*

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).	Actual 2011	Target 2013	Target 2014	Target 2015
	61%	61%	65%	≥65%

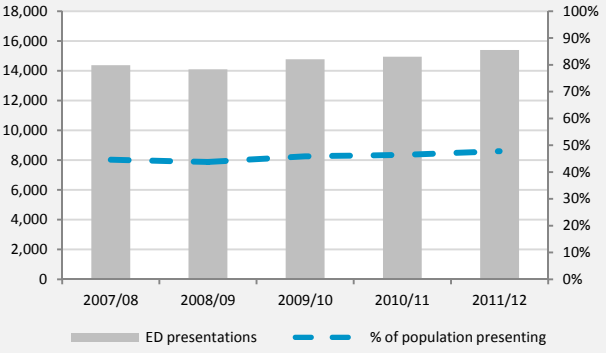


People access care urgent care when they need it.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, 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 proportion of the population presenting to the Emergency Department (ED) can be seen as a proxy measure of the availability and uptake of alternative community options to more appropriately manage and support people.*

Data sourced from individual DHBs.[10]

The percentage of the population presenting at ED.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	48%	45%	45%	45%

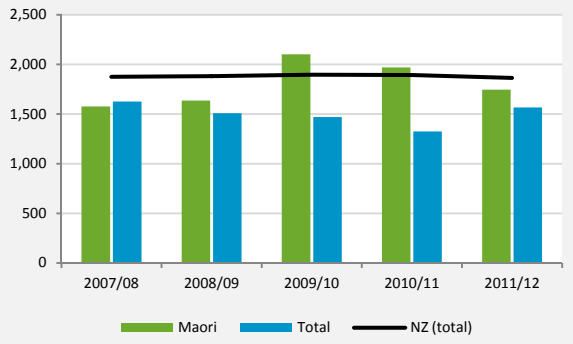


Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *A number of admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.*
- *These admissions provide an indication of the quality of early detection, intervention and disease management services. A reduction would indicate improvements in care and would also free up hospital resources for more complex and urgent cases.*
- *The key factors in reducing avoidable admissions include improving integration between primary and secondary services, access to diagnostics and the management of long-term conditions. Achievement against this measure is therefore seen as a proxy measure of a more unified health system, as well as a measure of the quality of services being provided.*

Data sourced from the Ministry of Health. [11]

The rate of avoidable hospital admissions per 100,000 population (<75).	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	1,566	<1,883	<1,883	<1,883



[10] *'Presenting' and 'Admitted' are defined by the Ministry of Health national ED health target.*

[11] *This measure is based on the national DHB performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 for the West Coast, and the target is set to maintain performance at below 95% of the national rate.*

STRATEGIC OUTCOME GOAL 3

2.7 People with complex illness have improved health outcomes

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?

For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or slowing the progression of illness, improving health outcomes by restoring functionality and improving the 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. At the same time Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. It is commonly assumed that long waiting times indicate insufficient resource or excessive demand. However, this is not always the case. If there are long waits but the number of people waiting is stable, it may reflect that a more innovation approach is needed to re-engineer processes and rethink they way we are delivering the service.

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. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that negative impact of the health of our population.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

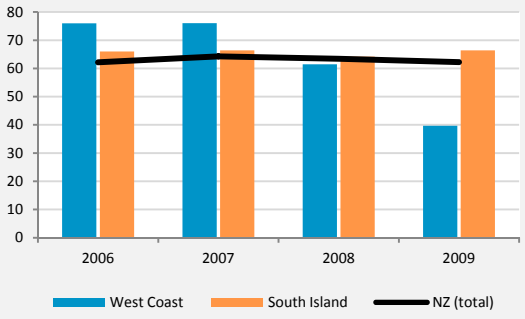
We will know we are succeeding when there is:

A reduction in premature cancer mortality rates.

- *Cancer is the second leading cause of death on the West Coast.*
- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer. Early detection increases the options for treatment, and early treatment increases the chances of survival.*
- *The rate of premature death due to cancer can be used as a proxy measure of improved specialist care and access to treatment for people with complex illness.*

Data sourced from MoH mortality collection.

Outcome Measure: The rate of deaths due to cancer in people aged under 65 (per 100,000)



A reduction in acute readmissions to hospital.

- *An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.*
- *Acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration - ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.*
- *Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.*
- *They also serve as a counter-measure to balance improvements in productivity and reductions in the length of stay and provide an indication of the integration between services to appropriately support people on discharge.*

Data sourced from Ministry of Health.

Outcome Measure: The rate of acute readmissions to hospital within 28 days of discharge.

Note: A new national definition is currently under development and we intend to use to measure and monitor performance once the data and definitions have been confirmed.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

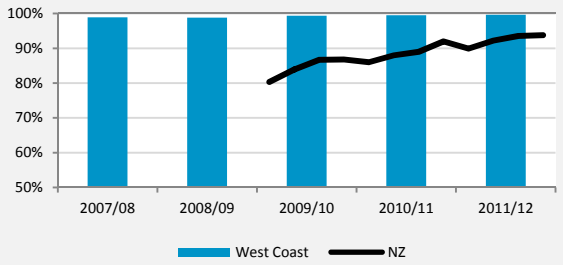
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

People have shorter waits for treatment.

- *Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.*
- *Long waits in ED are linked to overcrowding, negative outcomes, longer hospital stays and compromised standards of privacy and dignity for patients. Enhanced performance will not only improve outcomes by providing early intervention and treatment but will improve public 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 hospital but the whole health system. In this sense, this indicator is indicative of how responsive the system is to the urgent care needs of the population.*

Data sourced from individual DHBs.[12]

The percentage of patients presenting in ED who are admitted, discharged or transferred within six hours.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	99.7%	≥95%	≥95%	≥95%

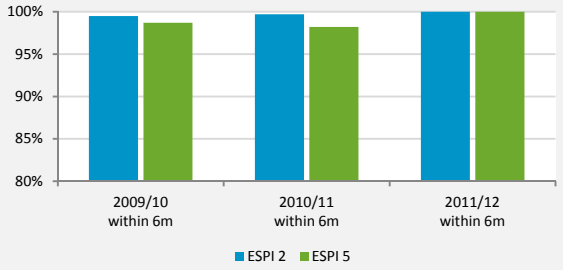


People have increased access to elective services.

- *Elective (non-urgent) services are an important part of the healthcare system: these services improve the patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *Timely access to services and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.*
- *Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is indicative of how responsive the system is to the needs of the population.*

Data sourced from Ministry of Health.[13]

The time people wait from referral to First Specialist Assessment (ESPI 2).	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	100% < 6m	100% < 5m	100% < 4m	100% < 4m
The time people wait from commitment to treat until treatment (ESPI 5).	100% < 6m	100% < 5m	100% < 4m	100% < 4m

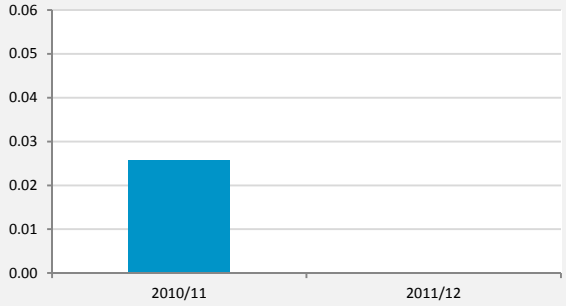


People stay safe in hospital.

- *Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.*
- *The rate of falls is particularly important, as these patients are more likely to have a prolonged hospital stay, 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.[14]

The rate of SAC level 1 and 2 falls in West Coast Hospitals.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	0.0	<0.05	<0.05	<0.05



[12] *This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10.*

[13] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available. Historical data is against a six month target, while the target reduces to 5 months for 2013/14 and 4 months from January 2015.*

STRATEGIC OUTCOME GOAL 4

2.8 People experience optimal functional independence and quality of life

Expectation

As well as providing early intervention and treatment, health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on patient care such as pain management or palliative services to improve the quality of life.

Why is this outcome a priority?

With an ageing population, the South Island will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease.

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. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

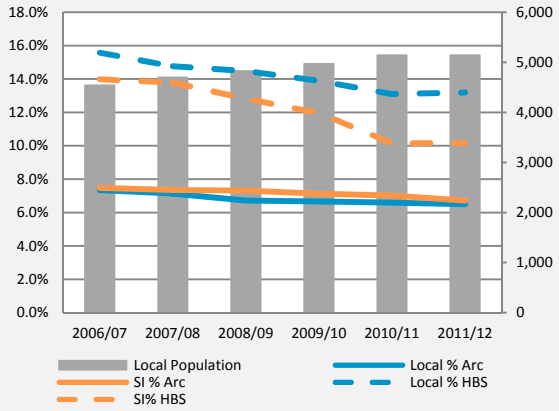
We will know we are succeeding when there is:

An increase in the proportion of the population (65+) supported to stay well in their own home.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, evaluation of older people's services have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.*
- *Living in ARC facilities is also a more expensive option, and resources could be better spent providing appropriate levels of Home-Based Support Service (HBSS) to people to stay well in their own homes.*
- *An increase in the proportion of people supported in their own home can be used as a proxy measure of how well the systems is managing age-related long-term conditions and responding to the needs of our older population.*

Data sourced from Client Claims Payments provided by SIAPO.

Outcome Measure: The percentage of the older population (65+) living in ARC compared against those receiving HBSS.



A reduction in the rate of acute readmissions to hospital (people aged 75+).

- *When older people are discharged from hospital, it is important that appropriate supports are in place to help them recover their health, functioning and independence.*
- *Readmission is often for a different condition from that which caused the original admission. This has been classed as 'post discharge syndrome', where non-specific effects associated with being in hospital for a prolonged period or a lack support in the community combine to cause other problems.*
- *Supported discharge and restorative health services enable older people to return to better health or slow the progression of disease, reducing the risk of readmission.*
- *Readmission rates for people aged 75+ can therefore act as a proxy measure of improved restorative care and community-based support for older people.*

Data sourced from Ministry of Health.

Outcome Measure: The rate of acute readmissions to hospital for people aged 75+ (within 28 days of discharge).

Note: A new national definition is currently under development and we intend to use to measure and monitor performance once the data and definitions have been confirmed.

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

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

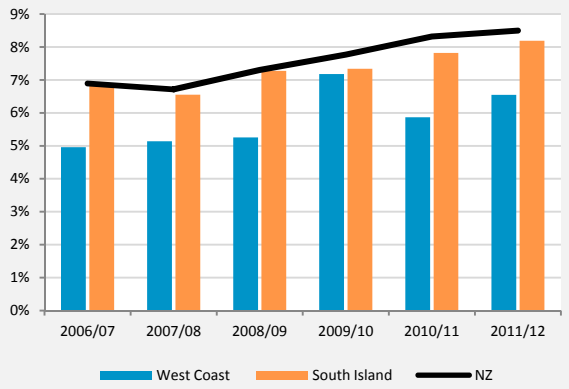
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

Fewer older people are admitted to hospital as a result of a fall.

- *Around 22,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to 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.*
- *The solutions to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*
- *A reduction in falls can therefore be seen as a proxy measure for improved health service provision for older people.*

Data sourced from National Minimum Data Set.

The percentage of the population (75+) admitted to hospital as a result of a fall.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	6.5%	6%	5.5%	5%



Service performance priorities 2013-2014

INTEGRATING THE WEST COAST HEALTH SYSTEM

3.1 Connecting the system

Aim

We aim to work within the West Coast Health Alliance to integrate and connect our health system so that it provides a seamless flow of care and people receive the right services, in the right place and at the right time.

Why is this important?

The current models of care provided in the Buller and Grey districts are not clinically or financially sustainable. There is a shortage of health professionals in these districts and despite some areas of collaboration, silos still exist between different parts of the West Coast health system. To deliver truly seamless care for our population, the whole West Coast health system must be engaged in the vision, connected through system-wide pathways and shared information systems, and supported by infrastructure that complements and enables the development of responsive service delivery models.

How will we improve outcomes for our population?

Understanding our clinical and financial reality, we are making significant changes to the way we fund and deliver health services to our population. We are committed to working collaboratively through the West Coast Health Alliance to develop and implement integrated models of care that improve the interface between primary, community and secondary care so that the right services are provided in the right place at the right time.

Our alliance approach involves bringing together health professionals from across the health system to identify and address challenges and design models of care that improve outcomes for our population and make the best use of our health system's resources. The West Coast Health Alliance supports joint planning and investment in new models of care to support people to stay well, minimise waits for treatment and reduce unnecessary hospital visits.

Already, important steps have been taken towards achieving a more sustainable future, including: improving clinical information systems; the implementation of cooperative arrangements between specialist services in Greymouth and Christchurch; the establishment of the Complex Clinical Care Network to better integrate primary, secondary and aged residential care; and the implementation of a multidisciplinary approach to patient care between general practice nurses, doctors, community nurses and district nurses.

Our vision for the future is articulated through our new model of care, which sets out an approach for how services can be delivered on the West Coast in a financially viable and clinically sustainable way. Services will cover the range of preventative, planned and emergency care, delivered across community and hospital settings.

We recognise general practice as most people's point of continuity in the health system, and we will be working with the West Coast PHO and general practices to redesign clinical process to support 'lean thinking' and provide formalised and standardised systems that are based on best practice. We will work to connect the West Coast health system through the implementation of system-wide patient pathways to improve the interface between primary and secondary care. With the engagement of clinical teams in developing and using HealthPathways, more patients will be referred to the most appropriate setting and waiting times will be improved.

A key priority will be supporting people to stay well, manage their long-term conditions, and avoid unnecessary hospital attendance and admission. We will continue to strengthen our long-term conditions management programme, which provides self-management support for people with chronic conditions. We will provide a single point of referral for complex conditions through the Complex Clinical Care Network and develop a community-based acute care response using predictive risk profiling and stratification analysis.

The development of a business case for Grey Base Hospital and Integrated Family Health Services (IFHS) and consideration of facility options for Buller sit alongside the design of new and integrated models of care for our district.

The West Coast Health Alliance will continue to develop a model for Integrated Family Health Services in the Grey/Westland and Buller communities, with a priority focus on: developing team-based approaches to providing care; the inclusion of pharmacist services in the multidisciplinary team; nurse-led services and the integration of community nursing with primary health care; developing stepped care pathways and packages of mental health care; establishing a single allied health service; and continuing to facilitate direct referral from general practice to a range of specialist nursing services, diagnostics and elective surgical booking lists.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Support the closer alignment of clinical information systems and technology. *To link clinicians across the health system and provide shared access to information that enables timely clinical decision-making at the point of care and supports the integration of services.*	Continue to implement HealthPathways (an electronic suite of patient management pathways) in the West Coast setting. Support initiatives that improve patient-centred communication and information flows between primary and secondary care.	400 localised West Coast HealthPathways in place Q4.
	Implement the regional Electronic Request Management System (ERMS) to support direct electronic referrals from primary care. Implement Mental Health Solution for Health Connect South. Implement the Electronic Shared Care Record View (eSCRV) system for the West Coast. Support the utilisation of telehealth for clinical consultations. Support migration of all DHB PCs to G2012 – COE.	ERMS implemented Q1. Mental Health Solution implemented Q1. eSCRV implemented Q2. 75% of PCs migrated to G2012 Q3.
Develop Integrated Family Health Services in the Grey/Westland and Buller communities. *An integrated, financially sustainable and clinically viable health system.*	Engage the Grey/Westland Alliance Workstream to: ▪ Undertake predictive risk profiling and stratification to identify at-risk populations in the Grey/Westland and Buller communities. ▪ Based on the risk profiling and stratification analysis, develop packages of care that support self-management and proactive community-based care. ▪ Examine actual or perceived access issues to general practice and develop options for a community-based acute care response. Maintain direct GP access to X-rays and ultrasounds. Maintain direct GP access to surgical booking lists for elective colonoscopy and cataract procedures.	Risk profiling and stratification for Grey population completed Q2. Options for a community-based acute care response determined Q4.
	Develop and implement clinical process redesign with general practice teams that supports the 'healthcare home' approach and 'lean thinking' processes.	General practice clinical process redesign completed Q4.
	Integrate Kaupapa Māori Nurse and Kaiarataki positions into the Buller and Grey/Westland IFHS model. Support the integration of community nursing (including mental health), district nursing and long-term conditions nursing with primary health care. Seek to employ an appropriate mix of generalist and specialist nurse skills to cover the full range of patient need, supported by an integrated nursing leadership structure inclusive of primary and secondary nursing.	Kaupapa and Kaiarataki positions integrated Q3. Community nursing integrated with primary care Q4. Integrated nursing leadership structure in place Q4.
	Integrate allied health to a single service within the DHB that is networked to allied health professionals in the community and primary care. Establish a single operational and leadership framework for allied health that can support the models of care in localities across the West Coast.	Single allied health service established Q4.
	Review the continuum of care for mental health and addictions services and determine where gaps and opportunities exist to improve the coordination and provision of services. Support the closer integration of mental health services across primary, community and secondary settings. Develop a 'stepped care' model and pathway for mental health patients, including integrated care arrangements.	Service review complete Q2. 'Stepped care' model for mental health established Q4.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Develop an integrated model for pharmacy on the West Coast. *To improve the patient experience, support people to better manage long-term conditions and keep people well by improving access to pharmacy services and urgent care.*	Support community pharmacists to operate from general practice on a regular basis to improve team-based approaches to the planned and structured management of patients and improve the quality of medicines-related information. Link the pharmacy model into the interdisciplinary team approach of the Complex Clinical Care Network.	Pharmacists operating from three general practice locations on a regular basis Q2.
	Implement standardisation in base pharmacy activities, such as medicines reconciliation, across community and hospital pharmacy services.	Standardised protocols introduced Q2.
	Implement quality improvement processes across pharmacy services.	Plan agreed with each pharmacy Q2.
	Introduce e-Pharmacy and medicines-related e-Medications Reconciliation (e-MR) components following Canterbury DHB implementation. Refocus the Medicines Utilisation Review Service as part of a structured approach to managing high-needs individuals or whānau.	e-Pharmacy available Q4. 40 people have had an MUR completed, with 50% of those people aged over 65, Q4.
	Agree district-wide approach to the role of pharmacists in managing common conditions. Introduce pharmacist services to selected Outreach Clinics. Investigate options to enable greater supply of medicines in urgent patient situations.	Policy for managing common conditions agreed Q2. Pharmacist outreach services commence Q2.

3.2 Managing acute demand

Aim

We aim to enhance and integrate early intervention and acute demand strategies that support the management and care of acutely unwell people in the community, help to prevent crises and the deterioration of people's conditions and help to reduce the likelihood of another event. We will also continue to ensure that more than 95% of people who do present to our Emergency Department (ED) are admitted, discharged or transferred in under six hours.

Why is this important?

Improving timely access to emergency care relies on the availability of alternative pathways and care options in the community as well as in hospital emergency departments. It is also reliant on having capacity in the community to support discharged patients and reduce the likelihood of readmission or another acute event. In this sense, good acute demand management is about improving and integrating care right across the health system and presents significant opportunities to improve the standard of care, health outcomes and the quality of people's lives. If people are able to access the services they need in a timely manner, public confidence in the West Coast health system will also be improved.

How will we improve outcomes for our population?

- Through the West Coast Health Alliance, implement acute care strategies designed to help better maintain patients in the community, avoid the need for presentations at ED and reduce the number of presentations that might be more appropriately addressed in primary care or by community nursing services.
- Maintain performance against the national health target and embed the systems and approach that have led to our success in ensuring 95% of patients attending our ED services are admitted, discharged or transferred within six hours.
- Explore opportunities to further streamline the flow of patients through ED and improve patient flow through to inpatient specialties at Grey Base Hospital in order to progressively reduce ED waiting times to less than five hours.
- Consider the flow of patients and use of observation/transition beds attached to ED in planning for the rebuild of Grey Base Hospital and the implementation of Integrated Family Health Services to ensure a whole-of-system response and reduce unnecessary hospital admissions.
- Promote the use of rural hospital medicine doctors as hospital generalist doctors in the ED and within Grey Hospital through the West Coast Rural Hospital Medicine Training Programme.
- Invest in services to support patients on discharge from hospital to improve their recovery and reduce readmissions.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Support primary acute care strategies to better manage acutely unwell people in the community. *To reduce waiting times for treatment, unnecessary presentations at ED and reduce demand on hospital services.*	Maintain zero fees for under-six-year-olds for afterhours visits to general practice. Maintain the free Afterhours Telephone Triage service to help support access to the most appropriate urgent care options. Continue to provide primary, community and ARC providers with direct access to specialist advice and support to manage patients with complex conditions through the CCCN. [15] Support weekly meetings between ED charge and GP practice managers to discuss arising issues and strategies to support at-risk patients who frequently attend the ED. Engage the Grey/Westland Alliance Workstream to: ▪ Undertake predictive risk profiling and stratification to identify at-risk populations. ▪ Based on the risk profiling and stratification analysis, develop packages of care that support self-management and a proactive community-based acute care response to reduce the need for acute interventions. ▪ Complete the free community transport pilot between Greymouth and Westport to improve access to health care.	Risk profiling and stratification for Grey population completed Q2. Options for a community-based acute care response determined Q4. 100% of children under six have access to free afterhours GP care Q4. 400 localised West Coast HealthPathways in place Q4. Triage Level 5 presentations drop by at least 5%.[16] Rate of acute medical admissions maintained at <5,000 per 100,000.

[15] *Refer to Section 3.3 for detail on targeted long-term conditions care and Section 3.8 for complex support services in the community.*
[16] *This is a three-year target seeking a drop from 2010/11 levels (4,110 for Grey and 745 for Reefton and Buller).*

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Deliver shorter stays in emergency departments. *To treat patients in a timely manner that respects patients' needs and values their time.*	Continue to achieve the national health target and embed successful processes into our system as part of normal practice. Explore options to provide additional flex to nursing hours and rosters to better match patient demand, and review options to increase the seniority level of doctors providing care in ED 24/7. Improve discharge planning in order to free up acute inpatient beds and help pull patients through into the wards from ED in a timelier fashion. As part of the rebuild of Grey Base Hospital, explore options for a new model of care and service delivery for ED and nursing resources to improve acute workload flows, including nurse treatment of triage level four and five patients. As part of the rebuild of Grey Base Hospital, explore options for the introduction of an observation/transition beds unit. Continue to support the Rural Hospital Medicine Training Programme, promoting the use of rural hospital medical doctors to work in the ED, and as generalists within Grey Hospital, with a view to expanding registrar numbers.	95% of people continue to be admitted, transferred or discharged within 6 hours of ED presentation. An increase in the number of enrolments in the Rural Hospital Training Programme - base 2 trainees.
Support patients on discharge from hospital. *To reduce readmission rates and improve outcomes for patients.*	Consolidate implementation of the West Coast's Complex Clinical Care Network (refer to section 3.8 for detail). Establish a rapid response and supported discharge service (based on CDHB CREST) through the Health of Older Persons Workstream. Implement a clinically led falls prevention strategy that includes aligned, complementary activity across the whole system: primary, community, secondary and aged residential care. Promote 'Zero Harm from Falls' in ARC settings and provide an ARC-based Vitamin D Supplementation Programme.	Rapid response and supported discharge service in place Q3. Integrated falls prevention programmes in place Q3. Falls reduction and access to falls prevention programme targets set Q4. Readmission rate for people (75+) at or below national average.

3.3 Managing long-term conditions

Aim

We aim to deliver responsive cardiovascular disease (CVD) and diabetes care as part of a seamless, integrated long-term conditions management programme supported by clinical governance and evidence-based best practice. By adopting a collaborative and consistent approach to prevention, early intervention and management, we will reduce the onset and impact of long-term chronic disease.

Why is this important?

The World Health Organisation estimates that more than 70% of healthcare 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.

How will we improve outcomes for our population?

- Continue to invest in the West Coast DHB Long-Term Conditions Management (LTCM) Programme as the overarching strategy for all long-term conditions across primary and secondary services - recognising the commonality and inter-related issues that cut across chronic conditions and that a holistic and comprehensive approach is more likely to produce better outcomes than looking at the individual conditions in isolation.
- Support continued stratification of patients with long-term conditions in the LTCM Programme, a minimum annual clinical review and appropriate allocation of tiered services and packages of care designed to help patients self-manage their conditions, live independently at home, and spend less time in hospital by facilitating discharge home.
- Support improved performance against the national 'More Heart and Diabetes Checks' health target, with progress towards 90% of the eligible population having had a CVD Risk Assessment at least once in the last five years and delivery of the Diabetes Care Improvement Package to better support people with diabetes manage their condition.
- Continue to support the West Coast 'Share-for-Care' and Health Connect South systems for sharing electronic summaries of health records between the health professionals involved in patients care. This will help reduce unnecessary duplication and provide up-to-date clinical information to inform decisions about a patient's care.
- Support the continuous quality improvement and review of established clinical pathways, including those for respiratory disease, cardiovascular disease and diabetes, to ensure consistency of access to services.
- Support joint planning and review of processes and potential improvements across the long term conditions continuum with our Local Diabetes Team, Local Cancer Team and Heart and Respiratory Team and ongoing clinical governance for the LTCM Programme through the West Coast PHO, West Coast Health Alliance and the Complex Clinical Care Network.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Improve the early identification of people 'at risk' of CVD and diabetes *To improve access to appropriate care, prevent hospital admission and ensure people are managed under a structured programme or plan.*	Continue to invest in delivery of the West Coast's Long-Term Conditions Management (LTCM) Programme including the provision of (a minimum) annual clinical reviews for LTMC patients. [17] Support general practice to maintain proactive campaign of automatic recall and direct contact with people due for review. Continue to incentivise general practice to identify those at risk of CVD or diabetes through delivery of more heart and diabetes checks. [18] Support the Grey/Westland Alliance Workstream to introduce predictive risk profiling and stratification to better identify at-risk populations.	Risk profiling and stratification for Grey population completed Q2. 78% of the eligible population having had their CVD risk assessed in the last five years Q2. 90% of the eligible population having had their CVD risk assessed in

[17] *The LTCM Programme supports those people identified with a long-term condition and patients are provided with a tailored package of care based on their level of need. Level 1 is for people who are managing well and provides an annual clinical review (which includes CVD risk assessment and diabetes reviews) and a 'Share-for-Care' health record. Level 2 is for people needing additional help and support to manage their condition, and provides quarterly clinical reviews and referral to self-management support programmes. Level 3 is for very high-needs patients with major clinical and/or social issues and includes clinical assessment and follow-up through AT&R or NASC and close clinical monitoring by both nurse specialists and general practice.*

[18] *$20,000 of the annual LTCM Programme budget is specifically targeted for incentivising general practices to deliver CVD Risk Assessments, $20,000 for CVD Screening and Treatment for at risk populations and $32,000 previously used for the Get Checked Programme has been redirected into implementing the Diabetes Improvement Package.*

	Monitor key indicators for people with diabetes who receive an LTCM programme assessment: % with acceptable cholesterol; % not smoking; % with a retinal screening within the last two years; % on kidney protective medications and % with good diabetes control. Regularly utilise practice management systems to ensure data accuracy with regard to patient CVD and diabetes risk profiles and history as part of the structured screening programme.	the last five years Q4. 70% of the population with diagnosed diabetes have annual reviews Q4.
Ensure people receive the right care in the right setting. *To empower people to modify lifestyles, self-manage their condition and stay well and to more closely align and integrate primary and secondary services involved in the early detection, follow-up and management of diabetes, CVD and other long-term conditions.*	Continue to invest in diabetes improvement packages as part of the LTCM programme with indentified minimum standard of care (aligned to the Primary Care Handbook). Continue to provide eligible populations (both new and existing) with appropriate case management through the LTCM programme. Encourage use of Share-for-Care and Health Connect South to support patient care and reduce duplicate testing. Review PHO clinical education plan and tools for self management of long-term conditions including those for diabetes and CVD. Implement ERMS to support direct electronic referrals. Support continuous quality improvement through review of clinical pathways: Diabetes, CVD and Respiratory. Link into the Complex Clinical Care Network to provide community support services to assist people living with long-term conditions in the community, help reduce acute admission and support discharge from hospital (see Section 3.8). Support general practice in the provision of care and rehabilitation of LTCM patients with direct access to diabetes and respiratory nurse educators and cardiac clinical rehabilitation nurse specialists. Through the Grey/Westland and Buller Alliance Workstreams develop an implementation plan to further enhance integration of community-based clinical nurse specialists with the provision of support and advice within the general practice environment. Provide general practice with ongoing training/education from clinical nurse specialists to improve skills and knowledge regarding diabetes, respiratory disease and CVD in primary care. Support Kaupapa Māori Nurses to work more collaboratively with general practice and secondary care services to improve outcomes for Māori with diabetes, CVD and COPD. Undertake quarterly monitoring of results against service delivery targets for CVD and diabetes and review performance with the PHO to inform targeting of activities to best effect. Provide quarterly performance updates to the WC Health Alliance. Undertake comprehensive analysis of LTCM programme data results annually to review patient outcomes and inform future direction at both individual general practice level and whole-of-system level. Use feedback from the Local Diabetes Team and Heart and Respiratory Team to help inform service planning and direction.	ERMS implemented Q1. Review of diabetes, CVD and respiratory pathways completed Q3. Kaupapa and Kaiarataki positions integrated Q3. PHO education and self management tools updated Q4. Community nursing integrated with primary care Q4. 80% of the population with diabetes will have satisfactory or better diabetes management (HbA1c level $\leq$ 64mmol/mol) Q4. 90% of the population who have had their annual diabetes review will have had a retinal screen or an ophthalmologist examination within the last two years Q4. Increased proportion of the population with diabetes and microalbuminuria are prescribed an ACE1 or an ARB Q4.[19] Rate of acute medical admissions maintained at <5,000 per 100,000. Triage Level 5 presentations drop by at least 5%.[20]
Support Rehabilitation Programmes. *To reduce the likelihood of a subsequent event and support people to optimise recovery.*	Continue to provide an organised acute stroke service locally at Grey Base Hospital through the AT&R service. Continue to participate in the regional Stroke Workstream to implement the NZ Clinical Guidelines for Stroke Management. Encourage referral of people to local cardiac and stroke follow-up and rehabilitation programmes after acute events. Support closer collaboration with Canterbury rehabilitation services to enhance support and access to a range of specialised services for people who need more advanced care.	80% of stroke patients admitted to an organised stroke service Q4. 80% of people are referred to community-based cardiac rehabilitation nurse specialist after an acute event Q4.

[19] *The Ministry is currently working on a means of data capture for this measure nationally.*
[20] *This is a three-year target seeking a drop from 2010/11 levels (4,110 for Grey and 745 Reefton & Buller).*

3.4 Elective services

Aim

Elective services are non-urgent procedures and operations that improve people's quality of life. We aim to make the best use of the resources we have available to ensure equity of access and certainty of care for our population and keep waiting times for First Specialist Assessments (FSAs) and elective surgery under five months and under four by the end of 2014.

Why is this important?

The West Coast DHB is currently reviewing intervention rates and adjusting purchasing decisions to ensure that we are providing equitable access to our population. We will direct a greater proportion of future funding into services that get ahead of the demand curve and keep people well – thereby ensuring earlier intervention, reducing the demand for hospital-level services and improving outcomes for our population.

How will we improve outcomes for our population?

- Allocate electives funding to support appropriate levels of surgery and specialist assessment, increase access to diagnostics and support alternative models of care and treatment.
- Progress implementation of the transalpine approach to improve the management and delivery of elective services, support both clinical and financial sustainability for services on the West Coast and ensure a minimum of 1,592 elective surgical discharges are delivered.
- Maintain compliance with Elective Service Patient flow Indicators (ESPIs), ensuring no patient waits more than five months for FSA or treatment, and work towards reducing waiting times to less than four months by December 2014.
- Identify productivity and efficiency gains to improve patient flow through continuous quality improvement, electronic referral management, service redesign and patient pathway mapping with Health Connect South.
- Prioritise patients using nationally recognised tools and ensure they are treated in accordance with assigned priority.
- Reduce waiting times for diagnostic services, including Computerised Tomography (CT) scanning and colonoscopy.21
- Expand the use of telemedicine technology to support the delivery of treatment and specialist assessments locally and reduce the need for West Coast patients to travel for treatment.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Continually improve access to diagnostic services. *To improve service quality, make the most effective use of available resources and reduce waiting times.*	Maintain direct GP access to diagnostics to improve referral quality and help reduce waiting times for treatment. Ensure internal data collection systems are in place to facilitate accurate local reporting of diagnostic waiting times. Monitor diagnostic waiting times for CT scanning and diagnostic colonoscopy to identify issues and barriers to access. Engage with the regional provider on any issues around waiting times for Magnetic Resonance Imaging (MRI) and coronary angiography for West Coast residents. Participate in national/regional clinical networks focused on the development of diagnostic service improvement programmes.	85% of people receive their CT scans within six weeks Q4. 75% of accepted referrals for MRI scans receive their scan within six weeks Q4. 50% of people receive urgent colonoscopy within two weeks Q4. 50% of people receive non-urgent colonoscopy within six weeks Q4. 50% of people receive surveillance colonoscopy no later than 12 weeks Q4.

[21] *Note: West Coast DHB does not deliver MRI or coronary angiography locally; waiting times for these will be monitored regionally.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Increase production capability for the delivery of elective surgery. *To meet national expectations and ensure continued, timely and appropriate access to elective services for our population.*	Engage services in theatre management, booking and production planning to improve theatre utilisation. Proactively monitor electives delivery, outpatient and inpatient waiting lists and service capacity to identify issues. Monitor ESPIs and intervention rates for key marker procedures to ensure compliance with national targets. Utilise other DHB/private resources to deliver care to our population where this is the most appropriate option.	100% of patients wait no more than 5 months for FSA or treatment Q1. 400 localised West Coast HealthPathways in place Q4. 1,592 elective surgical discharges delivered Q4. Intervention rates maintained (per 10,000 population): ▪ Major joints: 21 ▪ Cataracts: 27
	Continue to implement the transalpine approach and expand the model to an increased range of clinical specialties. Support clinical leadership, governance and oversight in reviews of service provision to identify best care for patients locally. Partner with local GPs and tertiary specialists in CDHB, to help reduce the need for patient transfers between hospital facilities. Expand the use of HealthPathways and localise pathways for the West Coast with support from Canterbury DHB. Support joint clinical appointments with CDHB.	
Continually improve service capacity and patient flow. *To improve service quality, make the most effective use of available resources and reduce waiting times.*	Increase uptake of the Electronic Request Management System (ERMS) to streamline referral management. Increase access to non-contact (virtual) FSAs in collaboration with Canterbury DHB and local GPs to streamline assessment and referral of patients to treatment lists. Ensure patients are prioritised and treated in order of assigned priority, with increased uptake of national CPAC tools. Ensure, wherever clinically appropriate, day surgery and day of surgery admissions are normal practice. 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.	ERMS implemented Q1. Average elective surgical inpatient length of stay maintained at $\leq$3.16.
	Identify opportunities to use telemedicine technology to increase access to specialist assessments, advice and support and reduce the number of follow-up appointments requiring travel to Greymouth or Christchurch. Work with Canterbury clinicians to concentrate scheduling of appointments in Christchurch to increase patient travel options and to reduce the need for overnight accommodation.	Increase in the percentage of follow-up appointments for people who live outside of the Grey district provided by telemedicine - base 1.16%.
	Participate in the Regional Electives Workstream and support delivery of the Regional Elective Services Work Plan.	Regional elective options for services with access issues developed Q4.

3.5 Cardiac services

Aim

We aim to make the best use of the resources we have available to ensure equity of access and certainty of care for our population and reduce waiting times for cardiac surgery to a maximum of four months by the end of 2014.

Why is this important?

Cardiovascular Disease (CVD) is the leading cause of death on the West Coast. Improving access to cardiac services (screening, early intervention, surgery and rehabilitation) will help our population to live longer, healthier and more independent lives. The provision of hospital-based cardiac services is closely intertwined with the delivery of the Long-Term Conditions Management Programme on the West Coast, and is part of our transalpine approach with Canterbury DHB.

How will we improve outcomes for our population?

- Progress implementation of the transalpine approach to improve cardiac service delivery, support both clinical and financial sustainability and ensure a minimum of 28 cardiac surgical discharges are provided for our population.
- Identify productivity and efficiency gains to improve patient flow through continuous quality improvement, electronic referral management, service redesign and patient pathway mapping.
- Improve access to cardiac diagnostics to facilitate appropriate treatment and referral.
- Monitor compliance with Elective Service Patient flow Indicators, ensuring no patient waits more that five months for FSA or treatment and progress is made towards reducing waiting time to less than four months by December 2014.
- Support the development of regional pathways to improve equity of access to cardiac services.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Increase production capability for the delivery of cardiac surgery. *To meet national expectations and ensure timely and appropriate access to cardiac surgical services for our population.*	Agree cardiac surgery intervention rates for West Coast residents in conjunction with the National Cardiac Surgery Clinical Network. Encourage active use of electronic HealthPathways, including clear guidelines for when to refer people for diagnostic testing. Improve access to cardiac diagnostics to facilitate appropriate referrals for treatment in accordance with the March 2013 review of the cardiac clinical pathway. Identify opportunities to provide direct GP access to CVD diagnostics (i.e. echocardiograms and exercise tolerance tests). Engage with the regional provider on any issues around waiting times for cardiac services so that no West Coast patient waits longer than five months for FSA or treatment and a maximum of four months by the end of December 2014. Monitor service provision to ensure access to cardiac interventions is not significantly below the agreed rates.	100% of patients wait no more than 5 months for FSA or treatment by Q1. ≥28 cardiac surgical discharges delivered Q4. Intervention rates maintained (per 10,000 population): ▪ Cardiac Surgery: 6.5 ▪ Percutaneous revascularisation: 11.9 ▪ Coronary angiography: 33.9 [22]
Align strategic activity across the South Island. *To ensure equity of access.*	Support the South Island Cardiac Workstream to develop and implement a regional Cardiac Services Plan. Implement regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification and appropriate transfer of patients. Work with the Canterbury DHB to meet waiting times for ACS patients accepted for coronary angiography and ensure patients are recorded on the ANZACS Q1, by ensuring timely referral and transfer of patients. Participate in the regional rollout of the national cardiac register (ANZACS QI) to enable monitoring of intervention rates.	Regional ACS pathway in place Q2. ANZACS QI in place Q4.[23] 70% of high-risk ACS patients accepted for coronary angiography have it <3 days of admission Q4. 95% of patients presenting with ACS who undergo coronary angiography recorded on ANZACS QI Q4.

[22] *The West Coast DHB does not deliver coronary angiography locally – intervention rates will be monitored regionally.*

[23] *Implementation of the ANZACS QI Register is dependent on national contracts being agreed – timeframes are anticipated. Data will be provided via the South Island Alliance (against the ACS measures) until the ANZACS Register is up and running.*

3.6 Cancer services

Aim

We aim to reduce risk behaviours and ensure consistent and timely access to quality cancer services across the whole continuum of care (screening, detection, diagnosis, treatment, management and palliative care) to reduce the impact of cancer and improve outcomes for our population.

Why is this important?

Cancer is the second leading cause of death on the West Coast and a major driver 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.

How will we improve outcomes for our population?

- Work collaboratively with local general practices, the West Coast PHO and its Navigator services, Rata Te Awhina Trust and key non-government agencies, including the Canterbury-West Coast division of the Cancer Society and the Buller-West Coast Home Hospice Trust, to deliver a seamless approach to cancer across the continuum of care, raise awareness of risk factors and encourage uptake of screening programmes.
- Support the two national cancer screening programmes operating on the Coast, the National Cervical Screening Programme (NCSP) and Breast Screen Aotearoa (BSA), and the local initiative (in response to a high incidence of bowel cancer on the West Coast) of early surveillance screening for bowel cancer among high-risk groups via surgical endoscopy at Grey Base Hospital.
- Work collaboratively with Canterbury DHB oncology services to improve access to cancer services for the West Coast population and ensure everyone ready for radiation or chemotherapy treatment receives it within four weeks.
- Identify and implement actions to provide faster cancer treatment through data quality improvement, electronic referral management, service redesign, diagnostics access and patient pathway mapping with Health Connect South.
- Expand the use of video-conferencing technology and the coverage of multidisciplinary meetings to enhance access to specialist advice for clinical review of patients and increase support and education opportunities for oncology teams managing ongoing cancer treatments locally – reducing the need for West Coast patients to travel.
- Continue to implement the Liverpool Care Pathway to improve the quality of end-of-life care for people with terminal cancer and their families/whānau and support the delivery of palliative care services through Palliative Care Nurse Specialist Services, ARC and general practice.
- Support the Southern Cancer Network (SCN) to implement the Regional and National Cancer Programme Work Plans through the development and implementation of regional pathways and data repositories.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Support cancer prevention and screening programmes. *To reduce the incidence and impact of cancer.*	Provide support to the Canterbury-West Coast division of the Cancer Society and Southern Cancer Network in health promotion and cancer awareness activities as these arise. Support the national HPV Vaccination Programme and national Breast and Cervical Cancer Screening Programmes. Support the continued implementation of the Healthy West Coast Annual Plan (refer Section 3.7).	80% of women aged 25-69 have had a cervical cancer screen in the last 3 years Q4. 70% of women aged 45-69 have had a breast cancer screen in the last 2 years Q4.
Improve access to diagnostic services. *To reduce the impact of cancer and increase treatment options.*	Continue to support the local surveillance initiative for bowel cancer for high-risk groups and families via surgical endoscopy. Work to reduce diagnostic colonoscopy waiting times to within national waiting time targets. Establish a clinical endoscopy service users working group to support the use of the national referral criteria for direct access outpatient colonoscopy. Actively promote prompt referral, triage and assessment of patients with cancer and high suspicion of cancer.	50% of patients receive urgent colonoscopy within two weeks Q4. 50% of patients receive non-urgent colonoscopy within six weeks Q4. 50% of patients receive surveillance colonoscopy no later than 12 weeks Q4.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
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.*	Support general practice to provide direct care and management of patients with cancer through access to support and advice from the DHB Oncology Nurse and Palliative Care Nurse Specialists. Support training and education of general practice staff (via DHB Oncology Nurse) to increase skills and knowledge amongst the cancer workforce in primary care. Improve appropriate patient links to providers and NGO support services from first contact with oncology services. Maintain links with Canterbury's oncology services to ensure standardisation of care and patient treatment pathways. Engage with the Canterbury on any issues around waiting times for cancer services so that no West Coast patient ready for treatment waits longer than four weeks for radiation or chemotherapy treatment. Improve the collection of faster cancer treatment data to help establish baselines for the new national indicators as part of the Faster Cancer Treatment Project. Continue use of inpatient medical ward nursing staff in the delivery of chemotherapy regimes to provide additional clinical support, improved case management 'back up' and succession planning options for the small oncology nurse team. Support the provision of education packages for clinical staff involved in cancer and palliative care and support cancer nurse coordinators to attend national/regional training and mentoring forums. Maintain high-definition video-conferencing between West Coast and Canterbury oncology services to improve coverage and functionality of multidisciplinary meetings (MDMs). Support implementation of the South Island Clinical Cancer System (SICCIS) to enable closer monitoring of service provision.	100% of patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy. Faster Cancer Treatment baselines established Q3: ▪ Patients referred urgently with high suspicion of cancer have first specialist assessment within 14 days; ▪ Patients with a confirmed diagnosis of cancer receive first cancer treatment (or other management) within 31 days; and ▪ Patients referred urgently with high suspicion of cancer receive first cancer treatment (or other management) within 62 days. Canterbury DHB's oncology and palliative care services' guidelines and medication treatment protocols in place across West Coast secondary care Q4.
Support palliative care services. *To improve quality of life for cancer patients needing palliative care and their families/whānau.*	Collaborate with Nurse Maude in the continued provision of the Liverpool Care Pathway (LCP) service on the West Coast. Undertake regular education and Programme of Experience in Palliative Approach (PEPA) 'staff exchanges' between Nurse Maude and West Coast nursing staff involved in palliative care. Support general practice and ARC with access to support, advice and training from DHB palliative care nurse specialists, to help them support palliative care patients outside the LCP. Maintain high-definition video-conferencing links between West Coast, Canterbury and Nurse Maude services to support development of the specialist community palliative physician support network, improve clinical assessment options and increase education and development opportunities.	Increased number of ARC facilities trained to provide the LCP service to residents – base 2 facilities. Increased number of people in ARC services being supported by LCP - base 18 people.
Align strategic activity across the South Island region. *To make the most effective use of resources and ensure equity of access.*	Work with the SCN (in conjunction with our local Cancer Team) to implement agreed regional initiatives in the National Cancer Programme Work Plan including: ▪ Improving functionality and coverage of MDMs; ▪ Implementing the priorities identified in National Medical Oncology Models of Care Implementation Plan and the Endoscopy Quality Improvement Programme; ▪ Implementing the national tumour standards; ▪ Implementing the priorities identified in the Prostate Cancer Quality Improvement Plan; and ▪ Participating in the development of the South Island clinical cancer information repository (MOSAIQ).	Regional audit against tumour standards complete Q3.

SUPPORTING OUR VULNERABLE POPULATIONS

3.7 Disease prevention

Aim

We aim to promote healthy lifestyles and support people to reduce the risk factors associated with long-term conditions in order to mitigate the predicted increase in these conditions, improve the health status of our population, reduce inequalities in health outcomes and improve people's quality of life.

Why is this important?

The World Health Organisation estimates that more than 70% of healthcare funds are spent on long-term conditions. Many long-term conditions share common risk factors and are preventable; smoking, inactivity, poor nutrition and rising obesity rates are major contributors to an increase in long-term conditions. The increasing rates of obesity in the West Coast population have significant implications for rates of CVD, respiratory disease, diabetes and some cancers (four of the top five causes of death on the West Coast), as well as poor psychosocial outcomes and reduced life expectancy.

How will we improve outcomes for our population?

- Support the reorientation of health services to emphasise disease prevention and health promotion and increase the provision of public health and healthy lifestyle services.
- Participate in joint planning with the Healthy West Coast Governance Group to coordinate public health services, create health-promoting environments and improve outcomes for our population.
- Participate in joint planning with the West Coast Tobacco Free Coalition to coordinate strategies to reduce smoking rates amongst the West Coast population and to improve the provision of ABC and cessation support.
- Participate in the Active West Coast Network to coordinate strategies to support and empower West Coast residents and communities to adopt healthier lifestyles.
- Identify actions to integrate systems and strategies across primary and secondary settings to support ABC smoking cessation practice as a routine component of clinical care and deliver the health target: 95% of current smokers admitted to hospital and 90% of those seen in primary care are offered brief intervention advice and support to quit. [24]
- Support actions to achieve the national health target: 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy are offered advice and support to quit.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Empower people and communities to take positive action to improve health and wellbeing. *To reduce the risk factors of long-term conditions.*	Collaborate on joint planning through the Healthy West Coast Governance Group to coordinate public health services on the West Coast and reduce duplication and gaps in delivery. Increase accessibility and availability of public health interventions that promote good nutrition, regular physical activity and breastfeeding as identified in the West Coast Bi-annual Physical Activity & Nutrition Plan 2012-2014.[25]	≥5 community nutrition courses delivered Q4. ≥360 referrals made for Green Prescription referrals Q4. ≥17 Mum-4-Mum Breastfeeding Peer support counsellors trained Q4.
Reduce the harm caused by alcohol. *To reduce a major risk factor of harm and long-term conditions.*	Support the West Coast Clinical Board and Alliance Leadership Board to monitor and champion alcohol reduction strategies across the health system. Deliver host responsibility training to improve the skills of Duty Managers in reducing alcohol-related harm. Monitor Licensed premises assessed to be at high risk of creating alcohol-related harm. Assist Police with alcohol controlled purchase operations (CPOs) to reduce the supply of liquor to minors.	≥3 monitoring visits per year to high-risk premises Q4. 95% of duty managers complete the host responsibility course Q4.

[24] *The ABC Smoking Strategy involves Asking if a patient smokes, offering Brief advice to quit and referring them to Cessation support.*
[25] *Refer to the Child, Youth and Maternal Health Section for Breastfeeding Activity for 2013/14 – Section 3.9.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Increase the number of successful quit attempts and reduce smoking prevalence amongst the West Coast population. *To reduce the major risk factor of long-term conditions and inequalities in health outcomes, particularly for Māori and Pacific people, who have disproportionately higher smoking rates.*	Contribute to the work of West Coast Tobacco Free Coalition on an integrated approach to a Smokefree Aotearoa by 2025 by: Maintaining and promoting smokefree environments and policy to support cessation and reduce second-hand smoke exposure. Undertaking at least 3 controlled purchase operations (CPOs) to ensure tobacco retailers comply with smokefree legislation. Supporting social service organisations, schools and workplaces to establish policies and interventions to reduce smoking. [26]	Increase in the percentage of year 10 students who have 'never smoked' – base 75%.
	Raise the profile of clinical smokefree leaders and disseminate key messages on the importance of ABC and smoking cessation. Continue to support clinical smokefree leaders across primary, secondary and maternity settings, including Director of Nursing, Clinical Midwifery Manager and the West Coast Clinical Board to engage colleagues in achieving ABC targets.	ABC messages and success promoted in DHB publications Q1-Q4. 90% of enrolled smokers seen in general practice are provided with advice and help to quit Q4. 95% of hospitalised smokers are provided with advice and support to quit Q4. Progress is made towards providing advice and support to quit to 90% of women who identify as smokers at the time of confirmation of pregnancy Q4.
	Enhance and integrate ABC documentation, data collection and supporting resources (including IT support tools) in primary, secondary and maternity settings to promote ABC as part of routine clinical practice. Work with Lead Maternity Carers (LMCs) and smoking cessation services to support provision of interventions to pregnant women who smoke. Build on gains made in delivery of ABC in primary care with: circulation of monthly performance bulletins at practice level; and targeting of practices where performance is low with positive inquiry follow-up to improve practice and systems. Consolidate gains made in delivery of ABC in hospital settings with: close performance monitoring by clinical nurse managers; coding department feedback to wards; monthly audits and analysis of care pathways with no intervention recorded with positive inquiry follow-up to improve practice and systems.	
	Provide ongoing ABC staff training (community, primary and secondary) including 'train the trainer', ABC documentation and process guideline training and promotion of e-learning to support a culture where ABC is part of routine clinical practice. Develop a more flexible training package that can be provided on site and for individuals to increase ABC training options. Identify and implement opportunities to provide training and resources for LMCs to increase delivery of sustained and effective ABC to pregnant women.	Flexible ABC training package implemented Q1. 4 ABC training sessions delivered for primary and community providers Q4.
	Ensure cessation support is provided in primary, secondary and maternity settings for current smokers motivated to quit by: Strengthen referral pathways between primary, secondary and maternity services and community cessation programmes. Providing targeted community-based cessation support to Māori and whānau through the Aukati Kaipaipa programme. Working with PHOs to ensure that cessation programmes and support are delivered using current best practice. Continuing to support pharmacists to provided Coast Quit. Working with Rata Te Awhina Trust to support direct referral to Coast Quit and the Aukati Kaipaipa cessation services. Working with the Tobacco Free Coalition, local cessation services and cessation specialists to improve the uptake of smoking cessation services for pregnant women who smoke.	Opportunities to improve smoking cessation services for pregnant women identified Q2 and implemented by Q4. ≥250 people enrol in the Coast Quit smoking cessation programme Q4. ≥100 people enrol in the Aukati Kaipaipa programme Q4.

[26] *Please refer to the DHB's Public Health Action Plan for further detail www.westcoastdhb.org.nz.*

3.8 Older people's health services

Aim

We aim to invest in wrap-around services for older people that are integrated across the health system to support older people to stay healthy and well, and in their own homes, for as long as possible.

Why is this important?

Older people experience more illness and disability than other population groups. As our population ages, there is an increasing demand for health services. We estimate that half our health resources support and provide health services for people aged over 65. In particular, the demand placed on Aged Residential Care (ARC) services is a significant challenge. West Coast has one of the highest utilisation rates of ARC services per capita, due in part to the under-development of community support services and the struggle to maintain an adequately skilled workforce.

An important opportunity exists to improve the health and wellbeing of our older population and improve the sustainability of the West Coast health system. By investing in prevention, rehabilitation and community support services, we can improve older people's quality of life while also reducing the demand for hospital and ARC services.

How will we improve outcomes for our population?

- Support joint planning and service delivery with primary care and community support service providers through the Complex Clinical Care Network and LTCM Programme to provide improved care and management for older people.
- Provide primary care, community, ARC and hospital staff with direct access to advice and support from specialist geriatric staff to improve the pathways of care for older people.
- Through the Complex Clinical Care Network (CCCN), provide a clear point for general practice to receive support for the assessment and case management of people with complex needs, and develop a proactive system of care to wrap services around people identified with complex needs and at risk of a hospital admission or early entry into ARC.
- Consolidate the implementation of a casemix (needs-based) service model for community support services and introduce a range of service improvements, including multidisciplinary assessments, a greater range of options to support older people in the community and goal-based care planning to maximise independence.
- Continue to participate in regional and national initiatives to improve outcomes for older people, including reviewing dementia services, the establishment of a fracture and stroke service, implementation of sector standards, and benchmarking against quality measures to identify opportunities for improvement.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Ensure older people receive timely and comprehensive clinical assessment of need. *To support the development of effective packages of care and seamless transition between providers.*	Continue to support Home and Community Support Services (HCSS) Providers and the Older Person's Health Specialist Services (OPHSS) to assess clients using InterRAI. Support ARC providers to implement clinical assessments using the InterRAI Long Term Care Facility (LTCF) module. Provide OPHSS Gerontology Nurse Specialists with the tools to help support ARC providers using InterRAI. Engage with nationally to bring forward funding to support implementation of the InterRAI LTCF module to 2013/14.	An InterRAI training plan for the LTCF module in place Q1. Training commenced Q2. 100% of ARC facilities using or training nurses to use the InterRAI LTCF tool Q4.
Invest in wrap-around services for older people. *To provide a more responsive service that better meets the needs of older people and supports them to stay well by reducing harm and hospitalisation or early entry into ARC.*	Under the CCCN develop a proactive system of care to wrap services around people with complex conditions including: A specialist interdisciplinary geriatric team to provide support to primary and community providers managing complex patients.[27] A single point of referral for assessment and enhanced service user review and reassessment, including an interdisciplinary team review with general practice and ARC. A revised service model for Home and Community Support Services based on a casemix (needs-based) approach. Goal-based restorative care planning and targeted case	Specialist Team in place Q1. Single point of referral for assessment established Q2. Service activity baseline by casemix group and targets established Q2. Rapid response and support discharge service in place Q3. 95% of people (65+) receiving long-term HCSS have had an

[27] *This interdisciplinary team includes a specialist geriatrician and two gerontology nurse specialists (2.6 specialist HOP FTE).*

	management to improve quality of life and independence. Enhanced support worker oversight from Home and Community Support Services to improve the quality of service provision. Integration of community nursing and short-term support. Introduction of a rapid response and supported discharge service (based on the Canterbury DHB's CREST model).	InterRAI assessment and have a care plan in place Q4. 95% of people entering ARC have had an InterRAI assessment Q4.
	Support the Clinical Board and West Coast Alliance to champion and monitor falls prevention activity, rates and outcomes. Implement a clinically led falls prevention strategy that aligns activity across the system: primary, community, secondary, ARC. Promote 'Zero Harm from Falls' in ARC settings and continue to provide an ARC-based Vitamin D Supplementation Programme.	Falls prevention programmes in place Q3. Falls targets set Q4. Increase in ARC residents receiving Vitamin D supplements – base 60%.
Invest in the development and expansion of targeted specialised services. *To support people to maintain independence and to remain in their own homes.*	Engage primary, community and secondary care clinical leads in the development and implementation of a Cognitive Impairment Pathway to support best practice in dementia care. Review the Pathway for consistency with the national framework. Expand 'Walking in Another's Shoes' (WIAS) dementia training for Carers beyond ARC into CSS and hospital services.	Cognitive Impairment Pathway in place Q1. Cognitive Impairment Pathway reviewed Q4. Numbers completing WIAS programme Q4.
	Develop an integrated Fracture Liaison Service.[28] Engage clinical leads and multidisciplinary stakeholders in aligning preventative care to prevent future fractures. Establish a Pathway: identification, investigation intervention.	Stakeholder engagement Q2. Pathway agreed Q3. Fracture Liaison Service in place Q4.
Engage providers in quality improvement work and capacity management. *To ensure older people receive consistent and high quality health services.*	Support the Alliance to oversee the delivery of HCSS, support sustainability of services and reduce variability in service quality. Establish a Quality Improvement Sub-Group to identify and review service risks and develop mitigation plans. Ensure HCSS providers meet Sector Standards, as part of the revised community support model. Use national core quality measures for HCSS (to be produced by the MoH) to review and improve service performance. Participate in a HCSS costing exercise conducted through the national Health of Older People (HOP) Steering Group.	All contracted HCSS providers hold a certificate of conformance with Sector Standard NZS 8158:2012 Q1. Baselines established for the core quality measures Q2. [29] Elder Abuse Guidelines implemented Q3. Review of readmission rates for people (65+ and 75+) completed quarterly Q1-Q4.
	Establish a baseline for 'inappropriate' hospital admissions and identify opportunities to reduce these. Benchmark readmission rates for the population 65+ and 75+ against other DHBs to evaluate performance.	
	Review and build on existing Elder Abuse Policies to ensure they meet the national Elder Abuse Guidelines. Provide advice and training to OPHS specialists, ARC providers and HCCS providers incorporate the Guidelines into practice.	
	Under the CCCN introduce a quality improvement programme for ARC including: clinical education, monitoring of ARC utilisation and engagement of ARC providers in capacity management.	
Align strategic activity across the South Island and Nationally. *To make the most effective use of resources.*	Continue to provide an organised acute stroke service locally at Grey Base Hospital through the AT&R service. Continue to participate in the regional Stroke Workstream to implement the NZ Clinical Guidelines for Stroke Management. Continue to participate in national/regional clinical stroke networks to identify opportunities to improve outcomes. Continue to participate in the National Health of Older People Steering Group to develop and roll-out the home and community support services standards and specifications.	Regional thrombolysis referral pathway in place Q2. 6% of potentially eligible stroke patients are thrombolysed Q4. [30] 80% of stroke patients admitted to an organised stroke service Q4.

[28] *Supported by the Minimum Data Set for hip fracture developed by the Australia NZ Hip Fracture Registry Working Group.*
[29] *These timeline is dependent on the MoH and HIQ establishing these measures.*
[30] *Collection of this data is dependent on training and data systems currently being implemented and agreed regionally.*

3.9 Child, youth and maternal health services

Aim

We aim to promote, protect and improve the health and wellbeing of children and young people on the West Coast through the delivery of integrated and effective child, youth and maternity services that support healthier choices, enable a good start in life and help young people grow into healthier adults.

Why is this important?

Sub-optimal health in childhood can lead to poorer health outcomes later in life, and behavioural patterns established in adolescence have a significant impact on an individual's health in the long term. Improving the utilisation of health services by children and young people (particularly high-needs and at-risk children) presents a significant opportunity to improve our population's health and wellbeing. Health outcomes for newborns and mothers are a vital part of this picture; achieving good rates of sustained breastfeeding, for example, is an important indicator of child health.

Supporting vulnerable children also contributes to the Government's overall priorities by improving services and reducing avoidable expenditure in the justice, health and welfare systems – "*helping to deliver better public services within financial constraints and building a more competitive and productive economy*".

How will we improve outcomes for our population?

- Support joint planning and service delivery through the West Coast Child and Youth Health Workstream to provide for whole-of-system coordination and oversight of child, youth and maternity services.
- Improve cross-agency linkages and service integration for vulnerable children and their families (particularly in education settings) to ensure vulnerable children and their families are identified and offered the services they need, and prepare to implement the national Child Health Action Plan on the West Coast.
- Enhance and expand access to developmental checks, screening and preventative services that reduce risk behaviours, support early intervention and improve health during infancy, childhood and adolescence.
- Develop an integrated service approach for young people with mild to moderate mental health and alcohol and other drug (AOD) issues in order to improve responsiveness to their needs, reduce crises and avoidable long-term consequences, and support young people to build resilience and stay well.
- Support joint immunisation planning and service delivery through the West Coast Immunisation Advisory Group with primary care, public health providers, WellChild/Tamariki Ora (WCTO) providers and Lead Maternity Carers (LMCs) to implement strategies to achieve higher immunisation coverage and to decrease the decline rates for immunisations.31
- Work collaboratively with the Canterbury DHB's Community Dental Services to support dental therapists on the Coast and improve coordination across oral health services to improve access to preventative care.
- Work collaboratively with primary, secondary and regional maternal service providers, general practice and LMCs to review and develop a more integrated approach to the delivery of maternity services on the West Coast and an improved response for vulnerable and at-risk mothers and their babies.
- Through the newly formed Maternity Quality and Safety Group, consolidate the Maternity Quality and Safety Programme across West Coast Maternity Services.
- Work collaboratively through the West Coast Breastfeeding Interest Group to create supportive breastfeeding environments on the West Coast and improve breastfeeding rates.

[31] *The West Coast DHB has higher than average 'opt-off' and 'decline' rates for immunisation. Around half of those opting off have strongly held religious views on this issue and are unlikely to change their view. Nonetheless, we will use our best endeavours to reach the national target of 90% of all eight-month-olds fully immunised by June 2014.*

Delivering the Prime Minister's Youth Mental Health Project

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Support an integrated and responsive service approach for young people with mild to moderate mental health issues. *To improve service responsiveness and better support young people and their families to maintain more stable lives.*	Expand the delivery of School-Based Health Services (SBHS) into decile 3 schools and alternative education facilities. Promote and provide HEEADSSS Assessments for adolescents enrolled in alternative education and decile 3 schools. Expand HEEADSSS assessment training to include the primary care to increase capability and promote sessions to general practice. Work with primary care providers to improve coordination of referrals resulting from provision of health clinics and HEEADSSS Assessments.	100% of D 1-3 schools and education facilities with SBHS in place Q1. HEEADSSS assessment training session provided Q2. Increase in Year 9 students receiving HEEADSSS Assessments – base 50%.
	Expand current primary mental health service coverage to include all young people aged 12-19. Undertake a gaps analysis of DHB funded or provided primary and community mental health services for young people (12-19 years) and identify opportunities to enhance/expand current service delivery.[32] Review Child, Adolescent Mental Health Services (CAMHS) services provision framework (SPF) and referral and service pathways to enhance integration between primary and specialist services. Review the continuum of care for youth with mental health/AOD issues (as part of the review of all mental health service provision on the West Coast) and determine where opportunities exist to improve the coordination and provision of services. Develop and agree an action plan to support an improved Stepped Care Model for young people.	Services expanded to young people aged 12-19 years Q1. Gap analysis of primary and community services completed Q1. Actions to be taken to enhance services agreed Q2. Review of CAMHS pathways completed Q2. Stepped Care Model for mental health established Q4.
	Under the leadership of the Child and Youth Health Workstream undertake a full stock-take and gaps analysis of all DHB funded or provided primary and community services for young people (12-19).[33] Identify and implement initiatives to address issues/gaps including the development of primary and community services, Youth One-Stop Shops or drop-in centres where relevant.	Results of stock-take and actions to be taken documented Q2.
	Review and progress on achieving phased waiting time targets for CAMHS and Youth AOD services by 2015. Identify and implement actions to achieve targets, including recommendations from the 2013 MoH-initiated review. As part of the review of the continuum of care – enhance integration between CAMHS, Youth AOD, paediatric services and primary mental health services to support implementation of the stepped care model.	80% of youth (0-19) access non-urgent services within 3 weeks Q4. 95% of youth (0-19) access non-urgent services within 8 weeks Q4.
	Review follow-up care for young people discharged from CAMHS and Youth AOD services to align care with the stepped care model. Work with primary mental health services to develop consistent protocols for follow-up after discharge and refine the collection of data to enable the tracking of outcomes.	CAMHS and Youth AOD discharge review Q3. Baseline for number of youth with discharge care plans in place established Q4.

[32] *This gap analysis will be led by the West Coast PHO, with support from the DHB, and will focus on primary mental health services to identify where new investment can enhance current services and/or resolve any identify service gaps. This stocktake will contribute to the wider review of mental health services on the Coast and to the wider stocktake of all primary and community services for young people.*

[33] *This stocktake and gap analysis will be led by the Child and Youth Health Workstream, in collaboration with other youth health service providers and will incorporate the results of the primary mental health services gap analysis being undertaken by the West Coast PHO.*

Delivering Better Public Services: Immunisation

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Increase immunisation rates and coverage. *To reduce vaccine-preventable diseases and improve health and wellbeing.*	Through the West Coast Immunisation Advisory Group: Review systems for seamless handover between maternity, general practice and WellChild services and to support timely and multiple enrolments of newborns on the National Immunisation Register (NIR) and with a general practice and WCTO provider. Explore linkages with Child Youth and Family, Ministry of Social Development and other relevant social service agencies and work more closely with the Canterbury Immunisation Service Level Alliance.	Registration system review completed Q1. 95% of newborns enrolled on the NIR at birth Q4. 100% of newborns enrolled with a GP provider by 6 weeks of age Q4.
	Refine reporting to enable NIR to provide direct support to general practice and better locate unvaccinated children. Expand reporting to include DHB, PHO and general practice level coverage reports to identify and address gaps in service delivery. Quarterly performance reports circulated to PHOs to review progress against targets.	85% of six-week-olds are fully immunised Q4. 90% of all eight-month-olds are fully immunised Q4. 95% of all two-year-olds are fully immunised Q4.
	Develop a West Coast missed events plan and implement a decline process across general practice. Focus Outreach Immunisation Services on locating and vaccinating hard-to-reach children and reducing inequalities for tamariki Māori. Identify the immunisation status of children in hospital and refer them for immunisation.	
	Develop a DHB-wide immunisation promotional programme linking with the CDHB 'Immunise for Life' programme. Promote immunisation during Immunisation Week. Ensure immunisation information is widely available for parents through antenatal education.	Narrative report on interagency activities to promote Immunisation Week Q4.
	Promote HPV vaccinations for eligible young women in the general practice setting.	60% of girls born in 2000 receive HPV dose 3 Q2.
	Provide free flu vaccination to older people aged 65+, those with chronic conditions and pregnant women. Provide free pertussis (whooping cough) vaccinations for pregnant women and their whānau.	75% of older people (65+) have their seasonal flu vaccination Q4.

Delivering Better Public Services: The Child Action Plan

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Prepare to implement the national Child Health Action Plan. *To improve the DHB's response to the needs of vulnerable and at-risk children.*	Establish leadership and management arrangements and engagement processes within the DHB and with primary and community partners regarding implementation of the Children's Action Plan. Complete a stock-take and gap analysis of all DHB-funded services for vulnerable pregnant women, children and parents. Use findings of the stock-take to inform future service planning.	Governance lead confirmed Q1. Results of services stock-take presented Q2. Actions confirmed Q4.
	Strengthen identification, risk assessment and intervention responses for suspected child abuse/neglect through continued incorporation of the Family Violence Intervention Guidelines into DHB programmes. Provide training for health professionals on the impacts of family violence and identification of child abuse, neglect, harm. Routinely screen hospitalised women aged 15+ for family violence. Identify opportunities through the MoU with CYF, Police and the DHB to improve the coordination of response to child abuse and neglect. Complete the rollout of the Shaken Baby Prevention Policy.	Shaken Baby Prevention Policy in place Q1. Child Protection Alert System in place Q4. Maintain a combined audit score of ≥170/200 for the child and partner abuse components of the VIP.
	Work with primary and community services to raise awareness of the importance of quality Early Childhood Education (ECE) in improving health and wellbeing outcomes. Strengthen connections between health and education service providers working with high-needs families with young children. Contribute to MoE initiatives that help to locate, engage and retain vulnerable children in quality early childhood education - including the development of shared information and pathways.	Share progress and realised opportunities via the Child & Youth Health Workstream Q1, Q4.

Maternal and Child Health

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Implement a collaborative and integrated approach to the delivery of maternity services.	The Child and Youth Health Workstream and Maternity Quality and Safety Group and West Coast PHO will work to: ▪ Identify processes and strategies to increase the number of women registered with an LMC by week 12 of their pregnancy; ▪ Identify processes and strategies to support pregnant woman to enrolled with a general practice; ▪ Improve the capture and collection of maternity data that will support planning and improve outcomes; ▪ Support the provision of brief advice and cessation support to pregnant women who smoke; and ▪ Review pregnancy and parenting programmes for first-time mothers to enhance programmes to better meet the needs of vulnerable groups. [34]	Maternity Quality and Safety Programme underway Q1. Increased number of pregnant women registered with an LMC by 12 weeks – base 47.6%. ≥30% of new mothers access DHB-funded parenting and pregnancy courses Q4. Progress towards target of 90% of women who identify as smokers at confirmation of pregnancy offered ABC.
	Support the Breastfeeding Interest Group to strengthen stakeholder alliances, identify opportunities to better engage women in breastfeeding and improve integration between providers. Provide access to free lactation consultants and specialist advice for mothers, with a particular focus on high-needs and high-risk women. Continue to 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.	≥100 referrals to community-based lactation support Q4. ≥17 Mum-4-Mum Breastfeeding Peer support counsellors trained Q4. ≥85% of mothers breastfeed on hospital discharge Q4. 74% of infants are fully or exclusively breastfed at 6 weeks Q4.

[34] *The Ministry of Health is currently reviewing content and service specifications for pregnancy and parenting education nationally; once national recommendation from this review have been released the DHB will review its own service delivery against these.*

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Implement a collaborative and integrated approach to the delivery of child and youth services.	Provide free access to afterhours primary care for children under six. Support the Gateway Coordinator to coordinate and implement Gateway Assessments for all children entering CYF care. Improve coverage of the B4 School Check (B4SC) programme to eligible children throughout the West Coast. Work collaboratively with WCTO providers and the Child and Youth Health Advisory Committee to ensure children have universal access to core WCTO services, including additional WCTO contacts. Support the Child and Youth Health Advisory Committee to develop an integrated/collaborative network of services to ensure there is continuity of care for mothers and babies. Monitor timeliness of access to referred services following WCTO/ B4SC assessment and implement actions to expedite service delivery.	Baseline data for Gateway Assessments established Q1. 100% of children <6 have access to free afterhours care Q4. ≥90% of all eligible children receive a B4SC Q4. 100% of children referred following a B4SC seen before their fifth birthday Q4. Avoidable hospitalisation rate for children aged 0-4 maintained <95% of national rates (<5,359 per 100,000).
	Continue to work with WellChild providers, general practice teams and schools and education services to identify children most at risk of tooth decay and support their families to maintain good oral health and access preventative care. Develop a whole-of-DHB Oral Health Promotion Plan. Identify further barriers to timely recall by DHB Community Dental Services and implement strategies to support caries-free teeth. Continue to investigate and implement alternative oral health service models for adolescents to engage more young people, particularly those in low decile schools or areas without community dentists. Implement the Level One Mobile Service in Greymouth and other priority schools on the Coast to support the preventative care model. Review the inclusion of dental services as part of the development of Integrated Family Health Services in Westport and Greymouth.	≥77% of children aged 0-4 are enrolled with DHB-funded oral health services. ≥90% of children are examined according to planned recall. ≥75% of adolescents (<18) access DHB-funded oral health services.
Support quality improvement across all services.	Consolidate the Maternity Quality and Safety programme (MQSP) and identify actions to be undertaken in 2013/14 to embed MQSP as business as usual by June 2015. Support a Canterbury/West Coast approach to ensuring alignment and improving quality outcomes with MQSP.	Second annual Maternity Quality and Safety Programme report delivered Q4.
	Support quality improvement of the B4 School Check programme, including high quality data collection and reporting. Incorporate the Quality Improvement Framework (in development 2012/13) across all WCTO services, including B4SC.	Findings of B4SC quality improvement letters incorporated Q4.
Align strategic activity across the South Island. *To make the most effective use of resources.*	Review access to regional maternal/perinatal mental health services for pregnant and postpartum West Coast women and engage with the regional provider to address any issues. Support increased liaison between mothers and babies services to strengthen relationships and provide opportunities for workforce development. Support the development of a Regional Rheumatic Fever Prevention Plan and align DHB activity with the agreed regional approach to maintain low South Island rheumatic fever rates (≤0.5 per 100,000).	Reduced waiting time between referral and treatment Q4. Regional Maternal Depression Pathway established Q4. Regional Rheumatic Fever Plan agreed Q1.

3.10 Mental health services

Aim

We aim to 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 and supports people to stay well and improve their quality of life.

Why is this important?

It is estimated that at any one time, 20% of the New Zealand population have a mental illness or addiction and 3% are severely affected by mental illness. Depression is predicted to be the second leading cause of disability in New Zealand by 2020. Our ageing population will also place an increasing demand on mental health services, as the likelihood of mental illness (predominantly dementia, depression and anxiety disorders) increases with age. Older people also have different patterns of mental illness, often accompanied by loneliness, physical frailty and co-morbid physical illness. Improving the responsiveness of our mental health services by strengthening the continuity of care, simplifying access pathways and reducing waiting times will support people to stay well and improve outcomes for our population.

How will we improve outcomes for our population?

- Undertake a gap analysis between articulated priorities in the national Mental Health and Addiction Service Development Plan and current service delivery, and prepare to implement the plan over the next five years.
- In line with the development of the Integrated Family Health Services (IFHS) model of care for Grey/Westland and Buller, strengthen the integration of mental health services across the whole of the West Coast health system, with a reorientation around the healthcare home and IFHS, to ensure we make the best use of resources and provide continuity of care for people no matter what setting they present in.
- Improve the responsiveness of child and youth specialist mental health and alcohol and other drug (AOD) services and reduce waiting times for access to services.
- Improve cross-agency linkages and service planning to implement national policies aimed at ensuring vulnerable and at-risk young people and their families are identified and supported with the service they need to stay well.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Use DHB resources effectively across the whole mental health continuum.	Undertake a gap analysis between the national Mental Health and Addiction Service Delivery Plan and current services. Identify how resources will be reprioritised (where necessary) to deliver the actions expected.	Gap analysis completed and considered Q1. Action plan operational Q2.
Implement the Prime Minister's Youth Mental Health Project and the Integrated Family Health Services (IFHS) model of care for Grey/Westland and Buller. *To support the integration of primary, community and secondary mental health services and improve the continuity of care.*	Review the continuum of care for youth with mental health/AOD issues and determine where gaps and opportunities exist to improve the coordination and provision of services. Review the Child, Adolescent Mental Health Services (CAMHS) services provision framework and referral and service pathways to enhance integration between primary and specialist services. Develop and agree an action plan to support a stepped care model to improve responsiveness of services for young people. Expand service coverage to include all young people aged 12-19.	Gap analysis completed Q1. Review of CAMHS pathways completed Q2. Stepped Care Model for mental health established Q4.
	Establish a cross-system mental health leadership group to support joint planning and integration of services. Review the continuum of care for mental health/AOD issues and determine where gaps and opportunities exist to improve the coordination and provision of services. Review and refine the Buller Shared Care Model in accordance with the learning from the pilot and continuum of care review. Recruit and employ an additional mental health liaison position to support the refined Shared Care Model. Develop a 'stepped care' model and pathway for mental health patients, including integrated care arrangements.	Service review completed Q2. Stepped Care Model for mental health established Q4. 80% of people (20-64) referred for non-urgent services are seen in three weeks Q4. 95% of people (20-64) referred for non-urgent services are seen in eight weeks Q4.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Improve the responsiveness of specialist mental health and AOD services. *To deliver increased access to services and better support people to maintain more stable lives.*	Review progress on achieving phased waiting time targets for CAMHS and Youth AOD services by 2015. Identify and implement actions to achieve targets, including recommendations from the 2013 MoH-initiated review.[35] As part of the review of the continuum of care – enhance integration between CAMHS, Youth AOD, paediatric services and primary mental health services to support implementation of the stepped care model.	80% of youth (0-19) access non-urgent (AOD) services within 3 weeks Q4. 95% of youth (0-19) access non-urgent (AOD) services within 8 weeks Q4.
	Review follow-up care for young people discharged from CAMHS and Youth AOD services to align care with the stepped care model. Work with primary care mental health services to develop consistent protocols for follow-up after discharge from CAMHS and Youth AOD and refine the collection of data to enable the tracking of outcomes.	CAMHS and Youth AOD discharge review Q3. Baseline for number of youth with discharge care plans in place established Q4.
	Continue implementation of the Coexisting Problems (CEP) Action Plan to improve the service response for clients. Review service provision framework to define CEP pathways. Provide training and support for CEP screening and assessment across the mental health division.	Clinical pathways defined Q3. 100% on intake assessments including CEP Q4.
Implement National Policy and Action Plans. *To improve the coordination between public health services and the continuum of care for vulnerable population groups.*	Review local suicide prevention approaches against the goals in the national Suicide Prevention Action Plan (yet to be released). Identify best practice and appropriate models in association with the South Island Mental Health Alliance.	Review existing model by Q2. Alignment of goals evident Q4.
	Prepare to implement actions from the national Child Health Action Plan and keep informed of demonstration site progress. Support the coordination and delivery of Gateway Assessments for all children entering Child Youth and Family (CYF) care. Undertake a stock-take and gap analysis of all DHB funded or provided primary and community mental health services for young people (12-19 years).[36]	Baseline data for Gateway Assessments established Q1. 100% of children referred by CYF receiving Gateway Assessments Q4. Results of stock-take and actions confirmed Q2.
	Support the national Drivers of Crime initiative by: Supporting schools and SBHS to deliver HEEADSSS Assessments. Extending the collaborative AOD school education programme provided by the DHB and Police into additional schools.	Increase in Year 9 students receiving HEEADSSS assessments – base 50%.
	Support the national Welfare Reforms by: Increasing referral of mental health and AOD clients to Activity, Living Skills and Education and Employment Support Services. Increasing the percentage of clients supported into employment or further education programmes. Continuing to support the Fresh Start Programme.[37]	Increased number of clients referred – base 84.[38] Increased percentage of clients supported into employment or education – base 67%.
Align activity across the South Island. *To make the most effective use of joint resources.*	Participate in the South Island Regional Mental Health Alliance and support the 2013/14 work plan. Review pathways for LMC and DHB referrals to maternal / perinatal mental health services, to reduce waiting times. Support staff to participate in Liaison Days to strengthen workforce development in Mothers and Babies Services. Participate in the regional Youth Forensic Framework.	Baseline wait time between LMC/DHB referral and treatment established Q1.

[35] *This refers to a CAMHS service review undertaken by Te Po.*
[36] *This stocktake and gap analysis will be led by the West Coast PHO in conjunction with other youth health and social services and with support from the DHB and will contribute to the wider review of the continuum of care.*
[37] *Programme led by the Ministry of Social Development that includes the ability for courts to refer youth to community-based AOD services.*
[38] *This measure refers to the Te Ara Mahi programme.*

3.11 Māori health services

Aim

We will work closely with Iwi Hapū me Whānau o Te Tai o Poutini, stakeholders and providers to ensure that Māori receive and have access to services that will improve Whānau ora.

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 area. West Coast Māori have a similar deprivation profile to non-Māori on the West Coast; however, they have poorer overall 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 generally have poorer access to health services, but they often have poorer outcomes following intervention.

How are we improving outcomes for our population?

We will focus on improving the capacity and capability of our health system to provide appropriate, accessible and integrated health services for Māori. This includes improving the responsiveness and effectiveness of mainstream service providers, reorienting and integrating Māori-specific services and delivering the national Whānau Ora initiative.

In the past several years, real gains have been made in improving Māori health:

- More Māori are enrolled with primary care. 85% of Māori are now enrolled with the West Coast Primary Health Organisation – up from 79% in 2009/10.
- More Māori with diabetes are accessing free annual checks. 94% of Māori with diabetes accessed free annual checks in 2011/12 – a significant improvement from 53% in 2009/10.
- More Māori with diabetes are better managing their condition. 71% of Māori who accessed free diabetes annual checks had satisfactory or better diabetes management in 2011/12 – up from 67% in 2009/10.
- More Māori have had their cardiovascular (CVD) risk assessed. 54% of eligible Māori adults had had a CVD risk assessment in the last five years in 2011/12 – up from just 19% in 2009/10.
- More Māori are being supported to quit smoking. 86% of hospitalised Māori smokers were offered advice and help to quit in 2011/12 – a considerable increase from 46% in 2009/10.
- Fewer Māori are going to hospital for preventable illnesses. Avoidable hospitalisation rates for Māori (aged 0-74) dropped to 1,746 per 100,000 in 2011/12 – down from 2,102 in 2009/10.

Following the review of mainstream service effectiveness for Māori and positive improvements in a number of areas, our service priorities for the coming year include maternal health, long-term conditions, child health and oral health. We anticipate that Māori will benefit from the establishment of clear patient pathways and initiatives that are targeted specifically at increasing Māori engagement in immunisation programmes, breastfeeding support and school-based health services – further reducing inequalities and disparities in health outcomes.

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 also continue to be a priority. We will work alongside providers to support the organisational transformation required for the delivery of a Whānau Ora model that is clinically sound, culturally robust and empowers patients and their whānau to better manage their health and wellbeing.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Build capacity and capability.	Enhance the capacity and capability of the Whānau Ora collective through support of the DHB-funded Māori Development Organisation - He Oranga Pounamu.	Renewal of He Oranga Pounamu service agreement Q4.
Support the sector to be outcomes-focused.	Provide advice around outcomes-based monitoring and evaluation frameworks that have proved successful. Work with the Ministry to support GP providers who are part of Whānau Ora collectives to use their practice management systems to report on whānau outcomes. Consider opportunities for the introduction of integrated contracts across government agencies to support the implementation of the Whānau Ora model.	At least one meeting held with other government funders Q1. Upon contact by the Ministry of Health (re supporting GP providers as part of Whānau Ora collectives), written feedback provided in a timely manner.
Support the Implementation of the Whānau Ora programme of action.	Support the Whānau Ora collective to move into Phase 2 of the national programme and develop a Whānau Ora model including advice and expertise in the following areas: ▪ Service planning and the provision of information and trend data for analysis; ▪ Analysis of Census 2013 returns, identifying significant population changes that might influence demand; ▪ Development of organisational infrastructure; and ▪ Support for research and professional development within the Whānau Ora collective.	Complete and distribute Māori Health Profiles Q1 Analysis of 2013 Census Māori data and distribution to Whānau Ora collective Q2. Continuation of Māori Health Scholarships funding through He Oranga Pounamu.
Support strategic change.	Participate in the Whānau Ora Regional Leadership Group. Work with other government agencies at a local and regional level to actively support the implementation of Whānau Ora and improve cross-sector collaboration. Seek opportunities for the DHB to become more informed of the national MoH contribution to Whānau Ora and help to share that information across the sector: ▪ Formalise relationships between the Whānau Ora collective, DHB and Māori service providers. ▪ Engage with the Whānau Ora collective should there be any high level Māori planning that will result in change. ▪ Share regular updates on progress received as part of the Whānau Ora Regional Leadership Group. ▪ Support continued engagement with Māori health service providers to enhance relationships with providers outside of the Whānau Ora Collective.	Formalisation of relationship between West Coast DHB and the Whānau Ora collective (including ensuring consistency of regional distribution of information through Te Herenga Hauora and SI General Managers Network) Q2.

BETTER PUBLIC HEALTH SERVICES

3.12 Living within our means

Aim

With current and projected constraints on government funds, we must focus on maximising value from our limited resources, prioritising capital more closely and funding new programmes from internal sources.

Why is this important?

Over the past year, the West Coast DHB has incurred considerable unplanned expense, a signification component of which has been associated with a high reliance on locums and the seismic state of our buildings. Short-term actions are underway to ensure we remain within budget, but future funding increases will be modest and it is critical that we stay focused on making the best use of limited health dollars for our community.

If an increasing proportion of our funding has to be directed into meeting cost growth, it will severely restrict our ability to invest in technology and services to better meet the needs of our population. It will also put continued healthcare service delivery for the West Coast at risk. We must therefore focus heavily on reducing and removing waste and duplication from our health system, doing the basics well and delivering services more efficiently to pull back our deficit.

We aim to reduce our deficit position from $3.6 to $1.1 million in 2013/14 and to break even by the end of 2014/15. This will be a challenge, but in achieving this, we will demonstrate to our community and the government that we can operate sustainably.

We will meet this challenge by focusing on: stronger procurement and recruitment controls to constrain cost growth; integrated service models, joined-up patient pathways, transalpine service development and clinically led decision-making to rebalance the system and reduce fragmentation; and; the appointment of permanent and joint staffing positions to build a more sustainable and workforce and improve the continuity of care.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Maintain a focus on efficient and effective use of resources to achieve financial sustainability.	Engage services production planning and theatre booking processes to improve the utilisation of surgery resources. Implement medications and infection control initiatives to support safer and shorter patient stays and reduce harm. Apply scrutiny to contractual arrangements and move to funder management of outsourcing to create cost efficiencies. Seek opportunities to generate increased revenue and ensure that payment is sought for IDF, insurance and ACC costs. Review the West Coast's transitional funding arrangements. Consolidate services, corporate and executive functions across the Canterbury and West Coast DHBs. Introduce tight controls and decision-making processes around repairs and maintenance to ensure investment is not wasted and that repairs are aligned to the future facilities plan.	Elective theatre utilisation maintained at ≥85%. Average elective surgical inpatient length of stay maintained at ≤3.16. Regional Patient Transfer Service agreement signed Q1. SI Procurement and Supply Chain activity achieves savings of $7.5m Q4.[39]
	Actively participate in the Regional Alliance Workstreams to achieve regional savings and reduce duplication and lead the Procurement and Supply Chain Workstream. Identify and pursue opportunities to engage with commercial service providers to maximise benefits for the sector. Identify further opportunities from national Health Benefits Limited initiatives and ensure these are applied locally to achieve mutual benefits and cost savings across the sector.	

[39] *Using agreed national methodology.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTIVITY**	**IMPACT**
Rebalance the system to support people to stay well and reduce unplanned or acute demand for health services.	Continue to implement clinically designed patient pathways across the system to support the delivery of the right care, in the right place, at the right time to support people to stay well. Invest in packages of care that support self-management and improve the management of people's long-term conditions. Establish a rapid response and supported discharge service to support people to access appropriate urgent care services in the community rather than in hospital. Develop 'stepped care' pathways and packages of care to support mental health patients to stay well, including shared care arrangements and relapse prevention planning. Continue to expand transalpine services to provide sustainable access to an increased range of clinical specialties. Support more flexible models of care and service delivery that allow early intervention and support more people to stay well including: mobile services, outreach clinics and telemedicine.	400 localised West Coast HeathPathways in place Q4. Risk profiling and stratification for Grey population complemented Q2. Rapid response and supported discharge service in place Q3. Stepped care model for mental health established Q4. Triage Level 5 presentations drop by at least 5%.[40] Acute medical admissions rate maintained at <5,000 per 100,000.
Integrate fragmented health services to reduce duplication, and waste.	Develop and implement clinical process redesign with general practice teams that supports the 'healthcare home' approach and 'lean thinking' processes. Maintain GP access to diagnostics and specialist support to reduce unnecessary hospital and specialist referrals. Implement the Electronic Request Management System (ERMS) to streamline referrals from primary to secondary care. Implement eSCRV to make a core set of patient information available at the point of care anyway in the system - to support more informed treatment and reduce duplication and waste. Integrate Kaupapa Māori Nurse and Kaiarataki positions into the Buller and Grey/Westland IFHS model. Support the integration of community nursing (including mental health), district nursing and long-term conditions nursing with primary health care. Integrate allied health to a single service within the DHB that is networked to allied health professionals in the community. Identify opportunities to use telemedicine technology to increase access to specialist assessments, advice and support and reduce the number of follow-up appointments requiring travel to Greymouth or Christchurch. Work with Canterbury clinicians to concentrate scheduling of appointments in Christchurch to increase patient travel options and to reduce the need for overnight accommodation.	General practice clinical process redesign completed Q4. ERMS implemented Q1. eSCRV implemented Q2. Kaupapa and Kaiarataki positions integrated Q3. Community nursing integrated with primary care Q4. Single allied health service established Q4. Increase in the percentage of follow-up appointments for people who live outside of the Grey district provided by telemedicine - base 1.16%.
Build a sustainable and stable workforce.	Support tighter recruitment controls with a focus on permanent and generalist appointments and vacancies in occupational groups with the biggest risk clinically. Seek to employ an appropriate mix of generalist and specialist nurse skills to cover the full range of patient need, supported by an integrated nursing leadership structure inclusive of primary and secondary nursing. Support joint clinical appointments between the Canterbury and West Coast to reduce the reliance on locums. Support models of care and training programmes that allow staff to work to the greatest extent of their scope and continue to support the Rural Hospital Medicine Training Programme, with a view to expanding registrar numbers. Support Māori and Pacific workforce training and scholarships to encourage more Māori and Pacific people to enter health fields.	Integrated nursing leadership structure in place Q4. An increase in the number of enrolments in the Rural Hospital Training Programme - base 2 trainees. 20 Māori and Pacific Health Scholarships awarded.

[40] *This is a three-year target seeking a drop from 2010/11 levels (4,110 for Grey and 745 for Reefton and Buller).*

Supporting our transformation

4.1 West Coast culture

Planning, funding and delivering health services is a highly complex business and on the West Coast is further complicated by the challenges of delivering quality health services to a relatively small population over a large geographic area. To meet the needs of our population and fully achieve our vision, we need an engaged and motivated workforce - committed to doing the best for their patients and for the health system. Our health system's culture is an important element in transforming and integrating our health system to ensure the right services are provided in the right place at the right time.

We also recognise that our vision is wider than just the DHB, and we need to engage not only our own workforce, but all the people who work in the West Coast health system. Our weekly CE updates, 'Ask.Now' publications and quarterly 'Report to the Community' keep staff across the system informed of developments in the West Coast health sector and provide opportunities for feedback and engagement. Clinically led community engagement road shows are also held annually throughout the West Coast to provide the health system workforce and our communities with updates on progress in transforming the West Coast health system and workforce developments, as well as to invite feedback.

We are working towards embedding a view of the West Coast health system as one system with one budget. Our decision-making and prioritisation framework recognises that our relationships with the organisations we fund are more than contractual. While some decisions remain the role of the DHB, others are devolved to the clinicians, alliance workstreams and providers delivering the services - ensuring rapid decision-making and clinical leadership.

In summary, our priorities are to:

- Deliver comprehensive, stable and safe services to the community;
- Support primary care development;
- Implement a single point of entry for complex care/older persons' health;
- Reconfigure secondary and transalpine services;
- Deliver transport and telemedicine solutions;
- Provide modern, fit-for-purpose facilities;
- Build capacity to transform the system; and
- Deliver on health targets and service priorities.

To deliver on these priorities and create the changes required, we must have an aligned approach to organisational culture, leadership, people, processes, technology, physical infrastructure and relationships.

A partnership approach to integration

Over recent years, we have been transforming the way we work to ensure we can meet the future needs of our population. 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 healthcare services throughout the West Coast is strengthening working partnerships between community, primary and secondary health services. Accelerating the integration of services and the development of services that provide care closer to people's homes will be a key focus for 2013/14 through the West Coast Health Alliance as we operationalise our shared vision of an integrated health system that is clinically sustainable and financially viable and wraps care around the patient to help them stay well. 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.

Over the last two years the West Coast DHB, with support from Canterbury DHB, has invested in leadership and engagement programmes that promote 'lean thinking' approaches to service and system design, including 'Xcelr8', 'Collabor8', and 'Making Time for Caring'. These programmes empower health professionals to improve the effectiveness and efficiency of our health system and are supporting the development of a culture that embraces system transformation that is 'best for patient, best for system'.

Recognising that clinical leadership as crucial to the successful integration of services, we engage health professionals from across the West Coast in all stages of service design and in the development of integrated patient pathways across the health system. Empowered health professionals are taking a lead in setting strategic direction, developing alternative models of care, reducing duplication and waste and improving patient care on the West Coast.

It is expected that this approach, of engaging our workforce and clinical leaders in determining the future direction of our health system, will foster strong cross-system partnerships and alliances that will lead to increased capacity, improved continuity of care for patients and decreased duplication and delays.

By investing in a patient-centred culture of participation, innovation, clinical leadership and continuous quality improvement, we are building momentum and support for transformation. By engaging our workforce in this culture, we seek to inspire them to make the changes that will be necessary to transform our health system.

4.2 Good governance

To support good governance across our system, we have a clear accountability framework that empowers our governors and leaders to provide direction and monitor performance. We are fortunate to have Board members who contribute a wide range of expertise to their governance role. Governance capability is supported by a mix of experts, professionals and consumers on the Board's advisory committees. Several of the West Coast's Board and advisory members are also members for the Canterbury DHB, supporting an understanding of transalpine priorities and a more regionalised approach.

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

Clinical leadership

Shared clinical/management decision-making is crucial to ensure the best health outcomes for our population. The DHB's Chief Medical Officer, Director of Nursing and Midwifery and Executive Director of Allied Health provide clinical leadership and input into DHB decision-making at the executive level.

In addition, the West Coast has recently established a Clinical Board: a multidisciplinary clinical forum that oversees the DHB's clinical activity. The Board advises the Chief Executive on clinical issues and takes an active role in setting clinical standards and encouraging best practice and innovation. Members support and influence the DHB's vision and play an important clinical leadership role, leading by example to raise the standard of patient care.

The West Coast Health Alliance Leadership Team is also clinically led governance group, and the associated alliance workstreams are made up of clinicians from across the health system working alongside management, with a clinical lead.

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 works in partnership with Poutini Ngāi Tahu, in particular Te Rūnanga o Ngāti Waewae and Te Rūnanga o Makaawhio, as well as Māori communities throughout the West Coast region, in a spirit of cooperation that encompasses the principles of the Treaty of Waitangi:

- *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; and
- *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.

The Board's Tatau Pounamu advisory committee enables local Māori participation and involvement in the strategic planning processes and the development of Māori capacity in the health and disability sector. The DHB's General Manager Māori Health provides further cultural leadership and input into decision-making at the executive level of the DHB.

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.

In 2012/13 the DHB also established a Consumer Council on the West Coast – a significant change that embraces the inclusion of those who use services in their design, delivery and review. The Council focuses on projects that enhance the collection and use of feedback, improve information sharing, contribute to design or redesign of services or facilities, reduce barriers to access, and improve the quality of the patient journey. Over the coming year, the Council aims to become accepted as an established body, utilising its reporting lines to effect real change.

Decision-making principles

The input and insight of these groups supports good decision-making, but the environment in which we operate still requires the DHB to make some hard decisions about which competing services or interventions to fund with the limited resources available. There is a need to protect vital services that are meeting an immediate health need or contributing to population health gain and to maintain key relationships and provider capacity. At the same time, we must be aware that any poor short-term prioritisation decisions may shift demand for health services towards the more acute end of the continuum or place unsustainable demand on other providers, including other DHBs.

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 the final decisions on whether to develop or implement new services. They are also applied when we review existing investments and support reallocation of funding, on the basis of evidence, to services that are more effective in improving health outcomes and reducing inequalities.

- *Effectiveness:* Services should be effective, producing more of the outcomes desired, such as a reduction in pain, greater independence and improved quality of life.
- *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 from public spending.
- *Whānau ora:* Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau.
- *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:* Implementation of the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

4.3 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.

Local collaboration

Follow the lead of the Canterbury DHB, the 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 with one health budget. We have established the West Coast Health Alliance, a partnership of health professionals and providers, to enable collaborative planning and determine appropriate models of care across the whole health system.

The West Coast Health Alliance enables and supports clinical leadership in the transformation and integration of our health system. This includes the establishment of Integrated Family Health Services (IFHS) in the Grey/Westland and Buller communities and the provision of increasingly coordinated and easily accessible services that are provided closer to home.

Six workstreams have been established to support the development of clinically designed and integrated models of care that will ensure people get the right care and support, at the right time and in the right place. These workstreams are: Pharmacy, Grey/Westland IFHS, Buller IFHS, Child and Youth Health, Public Health and Health of Older People. The workstreams are supported by an Alliance Leadership Team and Programme Office (including an Alliance Support Group).

Regional collaboration

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

The DHB Chief Executives form the Alliance Leadership Team and take responsibility for coordination of regional health service planning under the Alliance Governance Board (the DHB Chairs).

South Island regional planning is implemented through service level alliances and workstreams. 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 Regional Health Services Plan can be found at www.sialliance.health.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 that will improve health outcomes, including B4 School Checks, immunisation programmes, expanded School-Based Health Services and the rollout of the Prime Minister's Youth Mental Health Project and the Child Health Action Plan.

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

4.4 Our people

Our ability to meet future demand for health services relies on having the right people, with the right skills, working in the right place in our health system.

Demand for services is increasing and, like the community we support, our workforce is ageing. All DHBs face growing global shortages in some professional areas, widening gaps in capability as a result of technology changes and generational differences, and increasing diversity in the workforce. On top of this, the West Coast has the added challenges of attracting staff to a remote location, which has suffered over the last couple of years from major job losses as a result of industry closures and community disasters.

WEST COAST DHB WORKFORCE 2012		
Female Headcount	*Male Headcount*	*DHB Total Headcount*
912	151	1063
85.8% part time		1.5% of NZ total
Average Age	*Largest Ethnic Group*	*Avg. Length of Service*
50.3 years	NZ European 72.9%	8.39 years
Largest Workforce	*Youngest Workforce*	*Oldest Workforce*
Nursing	Management/Clerical	Allied
46% of DHB workforce	Avg. 47.6 Age years	Avg. 50.2 Age years

With increasing workforce and financial constraints and growing service demand, we need to make the best use of the health workforce we have available and cultivate a workplace environment that attracts and retains that workforce. This requires the development of integrated service delivery models and new roles that will ultimately have an impact on all health professional groups.

Similar challenges exist at a regional, national and global level. Any workforce transformation will need to be backed by policy change that supports skill shifts across professional groups and the expansion of current scopes of practice in order to enable the New Zealand health system to meet future demand.

Embedding our culture and supporting our workforce

The West Coast DHB is committed to being a good employer, and we are aware of our legal and ethical obligations in this regard. We continue to promote equity, fairness, a safe and healthy workplace, and a clear set of organisational values, including an integrated code of conduct and a commitment to continuous quality improvement and patient safety. The West Coast DHB is also committed to national change management framework.

However, in West Coast's context, it is not sufficient just to be a good employer. We are aware that a patient-centred culture of innovation, integration and clinical leadership is critical to attracting and retaining appropriately skilled health professionals to work on the West Coast. We are in the midst of transforming the way we work and engaging our workforce in determining the direction of health services throughout the West Coast.

In 2012, the DHB undertook an employee engagement survey of all our staff which demonstrated positive levels of engagement. International research suggests highly engaged people put forth considerably more effort and are much less likely to leave. 2012 results showed 67.5% of our workforce was 'engaged', with only 3% disengaged.

In the coming year, we will continue to foster positive behaviours that support our transformation and improve employee engagement. We will continue to invest in 'Xcelr8', 'Collabor8', the leadership and management development calendar, employee wellbeing and workplace support programmes.

Expanding our workforce capacity

From a recruitment perspective, there are some areas where workforce shortages affect our health system's capacity. These include Rural GPs, Nurse Practitioners and some Senior Medical Officer (SMO) specialities, such as general surgeons and obstetric and gynaecological specialists. In response, we have strengthened our focus on interactive and targeted recruitment strategies, including branding, profiling, Facebook, the introduction of joint sourcing with Canterbury DHB and Employee Referral Programmes to keep people connected to the West Coast. We also work closely with Canterbury DHB to supplement West Coast-based clinical support and services in areas such as orthopaedics.

We will continue to tap into available talent through national and regional initiatives, links with the education sector, and internships and increased clinical placements in our hospitals and primary care. The West Coast employs eleven new graduate nurses each year through the Nursing Entry to Practice Programme (NETP) and an additional placement through the Nurse Entry to Specialty Practice (NESP) programme, which have a distinct rural/remote focus on the West Coast. In addition to aligning practice development with Health Workforce New Zealand (HWNZ) funding, we have developed a set of standing orders and associated training practices that enables our health system's nursing workforce to work to the greatest extent of their scope and supports the development of a 'generalist specialist' nursing workforce. In 2013/14, we will support the new Allied Health Educator role to better utilise and engage social work and occupational therapy students.

The DHB is supporting the development of an appropriately skilled Māori health workforce through participation in the South Island Kia Ora Hauora programme, which is part of a national initiative aimed at increasing the number of Māori working in health fields. Furthermore, we will have 25% of our Māori nursing workforce participating in the Ngā Manukura ō Āpōpō Leadership Programme. Locally, we support scholarships to encourage Māori and Pacific students into health careers, and a further 4 studentships and 20 scholarships will be awarded in 2013/14.

We continue to expand capacity by better connecting our health system through investment in telemedicine, outreach clinics, electronic patient information sharing and electronic referral systems. Videoconferencing and telemedicine smooth the transfer of patients between services and support the provision of specialist services, advice and supervision without a significant increase in workforce numbers. Alongside transalpine specialist appointments, this technology is helping to increase workforce capacity on the West Coast. For example, through Rural Focused Urban Specialist (RuFUS) roles, designated clinicians in urban areas provide clinical leadership to rural centres. This supports direct patient care, sharing of available resources and skills, professional development and coordination of service provision for rural patients. Supported by the use of technology, Canterbury Clinical Nurse Specialists in paediatrics and gynae-oncology are supporting generalist nurses on the West Coast to care for patients, while Respiratory Clinical Nurse Specialists on the West Coast provide case management with support from Christchurch medical specialists.

Over the next year in conjunction with our primary care partners, we will build an integrated approach to workforce planning that will be informed by the transformation occurring across our health system. This will include improved reporting, analysis and predictive modelling to help understand our current and future needs.

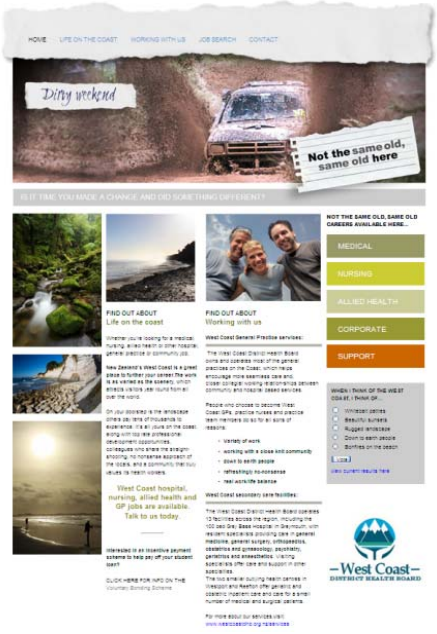
Enhancing our workforce capability

Developing our existing staff is a key strategy for enhancing the capability of the West Coast health system. We have recently strengthened our core development training calendar, which can be accessed by health professionals working anywhere in the West Coast health system. We have embedded formal performance appraisals into operational management, along with support for career plans. In 2013/14, succession planning initiatives such as talent identification will be introduced to increase talent mobility and reduce talent gaps across the organisation. Moodle technology learning/management systems and training portals will be established, and 70% of DHB employees will be using the online performance system by the end of the year.

Training and education programmes continue to support health professionals to work to the greatest extent of their scope. The Professional Development Recognition Programme (PDRP) provides and rewards nursing expertise and recognises the contribution of nurses to quality patient health outcomes. The Regional Allied Health Assistant Training Programme will expand the scope of existing roles and establish new ones. Clinical pharmacists now join wards rounds, community pharmacists are working more collaboratively with general practice teams, and physiotherapists are completing specialised assessments. New advanced gerontology nurse specialist and haematology roles also reflect a more connected and capable workforce.

We are also supporting the development of our rural medical workforce on the West Coast, with recent investment in a Rural Learning Centre in Greymouth. The aim is to encourage people to work in rural locations by reducing isolation factors through collaboration, peer support and mentoring. The Rural Learning Centre will provide opportunities for enhancing workforce capability throughout the West Coast health system. In 2013/14 the focus is on:

- Continuing to implement the 'new way of working' model of care that supports the employment and training of rural hospital generalists and rural general practitioners, alongside generalist nurses and allied health staff who work to the greatest extent of their scope and provide an interdisciplinary team approach to patient care;
- Coordinating the introduction of the new allied health assistants training programme as a pilot for the South Island and supporting existing allied health assistants to work to the greatest extent of their scope;
- Supporting the Learning and Development team to introduce online learning and the Totara learning management system across the West Coast and Canterbury DHBs; and
- Advocating for the inclusion of a teaching component in all clinical position descriptions and actively supporting staff to provide this mentoring and teaching.



The investment in videoconferencing and telehealth units in all our rural clinics and general practices throughout the West Coast enables GPs, practice nurses and pharmacists to attend peer-led, evidence-based education sessions. Aligned to the transformational change underway across the West Coast health system, these sessions promote the use of clinical best practice and integrated pathways and increase the capability of our whole system.

The South Island Tertiary Alliance has also developed its first leadership and management development curriculum for all health employees in the South Island.[41] Actively supported by HWNZ, this will support career enhancement and maximise people's potential.

We have also stepped up our participation in the HWNZ-sponsored Regional Training Hubs to support critical role identification and expand workforce capability through sharing of training resources and areas of good practice. The South Island Regional Training Hub takes the lead for the region in directing postgraduate clinical training, placements and education; career planning for HWNZ-funded trainees; new role development; and administration of activities such as bonding schemes. We will support the 2013/14 work plan for the Regional Training Hub, which can be found in the South Island Health Services Plan at www.sialliance.health.nz.

4.5 Quality and patient safety

We have made considerable changes during 2012/13 to sharpen the focus on improving the quality and safety of services provided at the West Coast DHB. An external review of quality services has prompted newly focused and additional quality roles, as well as the formation of a quality team across the organisation – sharing expertise, concentrating effort, and reducing duplication. The establishment of our Clinical Board has introduced a new level of leadership with a system-wide approach to quality improvement, and opportunities to work across organisations for patient safety improvements are beginning to be realised.

The coming year will consolidate these changes and see an increase in activity in line with the areas of interest of the Health Quality and Safety Commission (HQSC) and the HQSC's new National Patient Safety Campaign. Stronger collaboration with our Canterbury neighbours, and regionally with the wider South Island, will continue to build clinical capacity and quality improvement expertise.

Consumer engagement

The West Coast DHB is exploring new relationships with those who use our services to find ways of hearing patient stories, understanding what matters to them, and incorporating their experience and priorities into the design and evaluation of services. As part of HQSC's Experience Based Design Workstream, projects have commenced in surgical outpatients and maternity to gather patient stories and use them to make improvements to aspects of service delivery.

The West Coast DHB also produced a Quality Account for 2012/13 as a means of answering the questions that consumers identify as important in knowing whether the DHB is providing a safe and high quality service. The 2013/14 year will see an expanded Quality Account, with wider consumer consultation to identify key areas of importance.

Medication safety

The West Coast DHB is committed to reducing the incidence of medication errors and the risk of resultant patient harm. In the coming year, our Medication Safety Committee will lead the development of a culture of safety and 'zero harm' in medication-related practice. Patient stories and increased visibility of data and activities at ward level will boost clinician participation in medication-related quality improvement.

The National Medication Chart has been adopted by all acute clinical areas in the West Coast DHB. A pharmacy-led audit of charts will provide feedback around prescribing and administration practice, and identify areas for further improvement.

We are also participating in an HQSC-led medicine reconciliation programme. Our target for 2013/14 is to have 80% of all patients admitted to Grey Base Hospital (Monday to Friday, 8am to 4.30pm) to have medication reconciliation complete within 24 hours.

Preventing healthcare-associated infection

Admission to hospital exposes patients to potential harm through healthcare-associated infection, and the West Coast DHB is committed to minimising this risk through three specific projects, in line with the HQSC.

Safe hand hygiene practices significantly reduce the risk of infection. Our recent increase in approved Gold Auditors (now three) will allow for more frequent hand hygiene observation and audit, with a view to normalising this activity. We will implement our new hand hygiene quality plan, which will see clinical nurse managers championing hand hygiene for all practice in their area. Audits of hand hygiene by profession have identified three particular areas of concern, with senior medical officer, student medical staff, and student nurse results delivering less than 50% compliance. Our targets for hand hygiene in 2013/14 are to raise this to 55% for these profession groups and to 70% across all profession groups. Strengthening the ability for patients to provide feedback about this aspect of care will be an important concurrent activity.

[41] *The South Island Tertiary Alliance partners are CDHB, Canterbury and Otago Universities, the TANZ Polytechnic Network via CPIT. The other SI DHBs have the option to join this Alliance which is supported by HWNZ*

Patients are also at risk through the use of a central line, which introduces a potential track for infection: central-line-associated bacteraemia (CLAB). Processes are in place to minimise this risk both at insertion and during ongoing use, and these processes are audited continuously. While reaching the 0% CLAB target, completion of maintenance bundle documentation is more troublesome, and we aim to reach 100% completion.[42]

Patients also have a risk of infection following a surgical procedure. To address this, we continuously undertake surgical site surveillance with all patients who have had 'clean surgery' by way of a patient survey. We will continue to align this practice to the National Surgical Site Surveillance Programme as it develops.

Reducing falls in healthcare settings

Falls resulting in harm are known to significantly reduce the ongoing quality of life and function for patients, particularly those over 75 years old, and add considerable healthcare and lifestyle costs for both patients and health providers. The HQSC's National Patient Safety Campaign commences with falls prevention, and the West Coast DHB has established this as a priority area for improvement.

We will re-establish a Falls Prevention Team, bolstered with increased membership and strategies to fortify a culture of 'zero harm' from falls across the organisation. Again, ensuring that the patient voice is heard is imperative, and the team will consider options for incorporating patient and family experience in system design. Reviewing falls risk assessment and management tools, and the practice associated with their use, will be a key focus, and we will implement strategies to visually identify those at risk of falling.

We are planning increased the utilisation and visibility of falls incident data to effect change in 2013/14. In line with the national project, we will explore IT solutions for reporting of quality markers, along with documentation audits to ensure falls assessments and care planning are occurring for those over 75.

Surgical safety

The West Coast DHB has adopted the surgical safety checklist, which is used in all surgical procedures to minimise the risk of harm. Regular documentation audits are in place to ensure that usage meets the 100% target. We will also consider observational audit to identify how the checklist is used, with outcomes communicated to all staff associated with the operating theatres.

4.6 Investment in information systems

Providing a smooth patient journey through the West Coast health system requires integrated information systems and the sharing of patient information between health providers. Integrated systems will give health professionals across geographic boundaries timely access to the information they need to perform their roles and make informed clinical decisions – reducing wasted time spent 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.

Whole-of-system integration within the West Coast and across the entire South Island region is critical to achieving sustainable, efficient and patient-centred care. The West Coast DHB has recently adopted a number of key regional information systems, such as Health Connect South (HCS), Delphi Multilab and IntelePACS. These systems will continue to be enhanced and expanded to further improve and integrate the delivery of care on the Coast.

In 2013/14, the West Coast DHB will continue to deliver to the National Health IT Plan. In addition, specific local areas of focus for 2013/14 include the following.

Electronic signing of test results will improve patient safety and benefit clinicians by streamlining the sign-off process. With the implementation of HCS and the Delphi Multilab system in 2012, the West Coast can now start to roll out electronic signing of results, possibly combined with electronic ordering of results. Implementation is likely to occur in Quarter 2.

The Electronic Request Management System (ERMS) will enable general practices to send referrals electronically from their practice management systems. ERMS is being rolled out regionally by the South Island IT Alliance (led by the Canterbury DHB), and the West Coast will be the first DHB other than Canterbury to introduce this system into our district. The project has two phases, both to be delivered within the 2013 calendar year. Phase 1 will enable electronic sending of information from primary care to a centralised server, to then be faxed to the DHB. Phase 2 will replace faxing with electronic transmission into Health Connect South. Phase 2 will be implemented in Quarter 1.

The Electronic Shared Care Record View (eSCRV) is a secure system for sharing core health information (such as allergies, dispensed medications, clinical correspondence and test results) between all health professionals involved in a person's care. eSCRV will allow much closer integration of primary and secondary care systems – leading to faster, more informed treatment regardless of where a person is receiving care. We will begin rolling eSCRV out to the West Coast as soon as it is available, likely to be Quarter 2.

[42] *As with many West Coast targets, low numbers of patients using central lines means that any departure from the target process can represent a significant percentage difference.*

e-Pharmacy is a foundation component of e-Medications, which promotes patient safety by improving medications management. The e-Pharmacy system will be rolled out regionally, replacing Windose within the West Coast DHB. The rollout is likely to be implemented during Quarters 3 and 4. The West Coast will then look to implement e-Medicines Reconciliation following the Canterbury rollout.

A mental health solution for Health Connect South could allow the secure sharing of mental health records across the South Island with appropriate security and auditing. The West Coast is leading the development of this potentially regional system. It will be delivered locally in Quarter 1, with wider regional rollout to be scoped.

Provation is an endoscopy reporting tool that will provide consistent documentation of endoscopy procedures and improve standardisation across the South Island. It is being rolled out by the South Island IT Alliance, and the West Coast will be one of the first DHBs other than Canterbury to implement the system. We will have the system fully implemented by Quarter 1.

A new patient administration system (PAS) for the entire South Island will provide further integration between systems and could potentially include primary care – enabling whole-of-system integration throughout the South Island. The South Island IT Alliance has chosen Orion Health as the provider of the new system, and the West Coast will be implementing the PAS alongside Canterbury. A regional business case will be submitted in Quarter 2.

Telehealth remains an important method of enabling sustainable health care by removing the need for clinicians or patients to travel and providing patients with more timely access to care. The coming year will see the ongoing expansion of telehealth clinics and improvements in the network infrastructure of outlying clinics.

With the closer collaboration with Canterbury, it is also increasingly important to allow seamless integration between the two DHBs. We are currently investigating solutions for key enablers – such as single logins, file sharing, intranet access and integrated mail systems – which will be implemented in Quarters 1 and 2.

4.7 Repair and redesign of facilities

For almost a decade, the West Coast DHB has grappled with long-standing challenges to be clinically and financially viable. In order to improve the sustainability and quality of service provision, the West Coast health system is undergoing radical transformation. At its heart is a fundamental reorientation of health service provision on the Coast, and it is imperative that the transformation of the model of care is underpinned by modern, fit-for-purpose infrastructure that supports responsive and integrated service provision.

Our facilities are an impediment to the continued transformation of our health system. They are expensive to maintain, and their geographical and physical configuration is outdated and inefficient - hampering the introduction of modern, integrated service delivery models that would improve the quality of care. Under-investment in facilities maintenance to minimise operating deficits has resulted in significant infrastructure degradation and associated risk.

Following seismic assessments of buildings located on the Grey Base Hospital site, a number of buildings were identified as earthquake-prone and non-compliant with modern seismic standards, requiring immediate remediation to bring them above 33% of the current building code. Two buildings were closed because the facilities were deemed unsafe to occupy. This has required services to be moved into temporary or crowded spaces to complete the necessary repairs, which is putting considerable pressure on our capacity and on our workforce. In addition, Council consents for the urgent work that was required to relocate these services were provided on a temporary basis only. The DHB must urgently provide the Council with clarity about its intentions to either remediate buildings to New Building Standards or demolish them.

At the end of 2012, the Government established a Grey Base Hospital Redevelopment Partnership Board to finalise and fast-track plans to develop Grey Base Hospital in Greymouth and address the need for viable health services in Buller.

The Partnership Board, appointed by the Minister of Health, is charged with delivering a detailed business case for facilities redevelopment at Grey Base Hospital and reviewing facility options in Buller. The Business Case is due for completion by the end of May 2013, for consideration by the national Capital Investment Committee and joint Ministers in July. With approval, an implementation business case will be completed by August, with the aim to begin construction at Grey Base Hospital in July 2014 and complete the development by mid-2016.

Some of our primary and community facilities are also not appropriately located or configured and could better contribute to an integrated service model. The redevelopment of Grey and Buller provides an opportunity to build on the whole-of-health-system transformation already underway with the right infrastructure to bring integrated service provision to life. With a clear decision on the way forward for both of these sites, the whole of the West Coast health system will be able to make a significant step forward to cement a more certain and sustainable future.

4.8 Subsidiary companies

The West Coast DHB is a joint shareholder in the South Island Shared Services Agency Limited, which is wholly owned by the five South Island DHBs. The company remains in existence; however, following the move to a regional alliance framework, the staff now operate as a service to the South Island DHBs from under the employment and ownership of 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. SIAPO is funded jointly by the South Island DHBs to provide services such as audit, regional service development and project management with an annual budget of just over $4m.

4.9 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 will also meet its 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).

The West Coast DHB may also wish to enter into cooperative agreements and arrangements to: assist the DHB to meet its objectives; enhance health or disability outcomes for our population; or enhance efficiencies in the health sector. In doing so (in accordance with Section 24(1) of the NZPHD Act 2000), the DHB will ensure that the arrangements we enter into do not jeopardise our ability to deliver the services required under our statutory obligations in respect of accountability and funding agreements.

4.10 Service configuration

Service coverage

The service coverage schedule between the DHB and the Ministry is the translation of government policy into the required minimum level and standard of service that is made available to the public. The West Coast DHB will work to identify service coverage gaps through analysis of explanatory indicators, media reporting, risk reporting, formal audits and complaints mechanisms - managing and resolving any service coverage issues in a timely and transparent manner.

The West Coast DHB does not seek exemptions to the Service Coverage Schedule in 2013/14, and services not provided locally for our resident population will be provided by other DHBs, particularly the Canterbury DHB.

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 with one health budget. In practice, this means working in partnership with health professionals 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 organisational level so that there can be more effective shared decision-making within a clear set of principles and priorities. This approach has enabled significant progress in the delivery of the 'Better, Sooner, More Convenient' healthcare strategy.

Over the next twelve months, systematic changes will be made to the model of care across West Coast services as we move towards ensuring more clinically and financially sustainable healthcare delivery.

During 2013/14, a key focus will be the development of a new model of care for the Grey/Westland and Buller communities and decisions on the redevelopment of Grey Base Hospital and future options for Buller Health. The facilities redevelopments are currently being progressed through a Partnership Group appointed by the Ministry of Health, working closely with the DHB, the National Health Board and Treasury. A decision is expected in July 2013.

It is anticipated that in line with the development of the new model of care there will be a redesign of service delivery models including those for maternity services, child and youth, older person's health and mental health services – consistent with the national direction toward stepped care models. There will also be primary and secondary care service alignment and redesign in line with the new model of care and the development of transalpine service models.

To support the changes in the model of care and sustainable healthcare delivery, we will also work with the National Health Board to identify different ways to fund and contract for a range of primary and community healthcare services. This will include implementing changes in line with the national Pharmacy and PHO agreements.

Service changes

During 2013/14, there will be a continuous process of service transformation as we seek to eliminate duplication and waste and 'live within our means'. Rather than doing this through services reduction or cuts, we seek to deliver services in more productive and efficient ways – minimising unnecessary administration (especially for clinical staff) and making better use of clinical resourcing through effective production planning and closer collaboration with Canterbury.

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 Integrated Family Health Services and a comprehensive redesign of the hospital in Greymouth and services in Buller, 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 to ensure people receive the right care, in the right place, at the right time. In particular:

- Redesign of service delivery models across secondary services through the development of transalpine services in partnership with Canterbury DHB. In the coming year, this will involve orthopaedic services, health of older people services and some aspects of mental health service delivery.
- Redesign and reconfiguration of our health system to be better integrated and more responsive through the West Coast Health Alliance and through the Partnership Group with the National Health Board, Ministry and Treasury.
- Reconfiguration and shifting of service delivery throughout the region in order to achieve consistency and equity on a South Island-wide basis (as outlined in the South Island Regional Health Services Plan).

Forecast of service performance

HOW WILL WE MEASURE OUR PERFORMANCE?

As the major funder and provider of health and disability services on the West Coast, we aim to make positive changes in the health status of our population. The decisions we make about which services will be funded and delivered will have a significant impact on the health of our population and will improve the effectiveness of the 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 what 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.

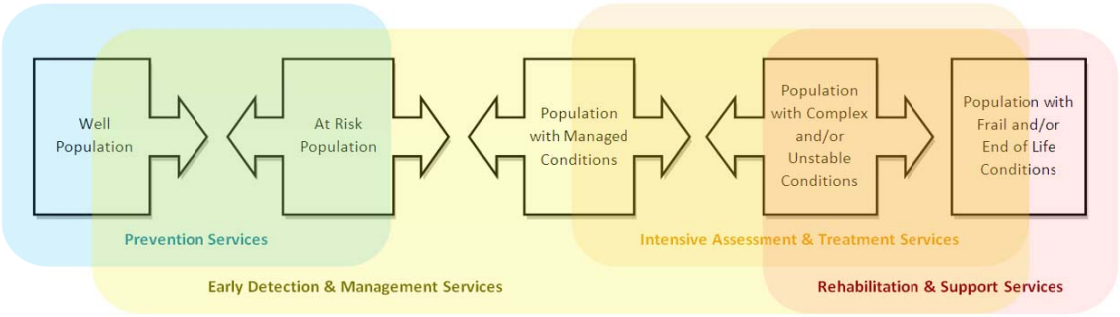
One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make. Over the longer term, we do this by measuring our performance against a set of desired outcomes (outlined in the strategic direction section of this document on page 12). In the more 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 actual performance against this forecast in our end-of-year Annual Report.[43]

Choosing measures of performance

In order to present a representative picture of performance, our 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:

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

Figure 2: Scope of DHB operations - Our outputs cover the full continuum of care for our population.



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 output measures. These measure Timeliness (T), Coverage (C), Volume (V) and Quality (Q) - all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected.

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. They 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, where research shows definite gains and positive outcomes - such as the Green Prescription and ABC Smoking Cessation programmes. This provides the DHB with greater assurance that these are quality services, allowing us to focus on monitoring implementation and whether people have timely and appropriate access.

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.

[43] *Annual Reports can be found at www.westcoastdhb.org.nz*

Setting standards

Wherever possible, we have included the past year's baseline data to support evaluation of our performance at the end of the year, and the most recently published national result to give context in terms of what we are trying to achieve. However, measures that relate to new services have no baseline data, and a number of the output measures relate to West Coast-specific services for which there is no national comparison available.

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, while 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-needs groups.

However, a significant proportion of the services funded/provided by the DHB are driven by demand – such as laboratories tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided to give the reader context in terms of the use of resource and capacity across the West Coast health system. However, these estimated volumes are not seen as targets to be achieved; they are provided for information to give context to the picture of performance.

Some data is provided for calendar rather than financial years; other data is provided to the DHB by external parties and can be affected by a lag in invoicing. Rather than footnote every instance, symbols are used to indicate where this is the case: † indicates data provided by calendar year (i.e. the 'DHB actual' is the 2011 result), while Δ indicates data that could be affected by a lag in invoicing and is subject to change (data for such measures in this document was run on or before 22 April 2013).

Where does the money go?

The table below presents a summary of the 2013/14 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.

REVENUE	TOTAL $'000
Prevention	3,482
Early detection and management	34,005
Intensive assessment & treatment	79,183
Support & rehabilitation	20,273
Grand Total	**136,944**

EXPENDITURE	TOTAL $'000
Prevention	2,424
Early detection and management	34,888
Intensive assessment & treatment	79,876
Support & rehabilitation	20,855
Grand Total	**138,044**
Surplus/(Deficit)	**(1,100)**

OUTPUT CLASS

6.1 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 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 DHB's public health unit); primary care; 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 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-needs 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-needs 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 (2013/14)

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 and legislation that support people to maintain wellness and make healthier choices.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Volunteer mothers trained to provide Mum-4-Mum breastfeeding peer support	V [44]	18	≥17	-
Lactation support and specialist advice consults provided in community settings	V	103	≥100	-
% of mothers having established breastfeeding on hospital discharge	Q [45]	91%	≥85%	-
% of smokers identified in primary care receiving advice and help to quit	C	39%	90%	34%
% of smokers identified in hospital receiving advice and help to quit	C	84%	95%	-
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	126	≥100	-
Nutrition courses provided in the community	V	11	≥5	-
People accessing Green Prescriptions for additional physical activity support	V [46]	389	≥360	-
% of priority schools supported by the Health Promoting Schools framework	C [47]	66%	66%	-

[44] *Mum-4-Mum 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.*
[45] *The percentage of women 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.*
[46] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.*
[47] *The Health Promoting Schools Framework is used to address health issues with an approach based on activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated and/or have a high proportion of Māori and/or Pacific children.*

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	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of four-year-olds provided with a B4 School Check (B4SC)	C [48]	80%	≥90%	79%
% of referred children receiving a Gateway Assessment	C	new	100%	-
% of Year 9 students in deciles 1-3 schools, alternative education facilities and teen parent units provided with a HEEADSSS assessment	C [49] †	50%	≥50%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [50]	75%	80%	77%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [50]	79%	≥70%	71%

Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of children fully immunised at eight months of age	C	new	90%	-
% of eight-month-olds 'reached' by immunisation services	Q [51]	new	90%	-
% of Year 8 girls completing HPV vaccinations (i.e. receiving Dose 3)	C [52] †	30%	60%	47%
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	54%	75%	65%
% of the older population (65+), deemed high-needs, receiving a flu vaccination	Q † [53]	56%	75%	64%

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

[49] *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. The assessment allows health concerns to be identified and addressed early.*

[50] *These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. Standards are based on national targets.*

[51] *'Reached' is defined as those children fully immunised, as well as those who have declined immunisations or have opted off the NIR. This reflects the quality of immunisation services in 'reaching' the parents of eligible children and providing advice and support to enable parents to make informed choices for their children.*

[52] *The baseline is the percentage of girls born in 1998 receiving Dose 3 by the end of 2011, and the target is for 2013 for girls born in 2000.*

[53] *The 'high-needs' population is defined as PHO enrolees who are Māori, Pacific and/or NZDep decile 9 or 10.*

OUTPUT CLASS

6.2 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, 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 (urgent) care.

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. Our current move to better integrate 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 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 (2013/14)

Primary Health Care (GP) Services *These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare 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	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of the DHB population enrolled with a Primary Health Organisation	C	95%	≥95%	96%
HealthPathways in place across the health system for West Coast residents	V [54]	new	400	-
People provided Brief Intervention Counselling (BIC) in primary care settings	V [55] Δ	325	≥300	-
Avoidable hospitalisation for children aged 0-4 rate per 100,000	Q [56]	4,062	<5,359	4,628

[54] *The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care. As of February 2013, all of Canterbury's 644 pathways are available to the West Coast; however, this measure will count only those clinical, resource and referral pathways that have been localised for the West Coast (104 as of February 2013).*

[55] *The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams, with the possibility of onward referral to a related community agency if appropriate. The aim is to provide early intervention and help people to reduce the likelihood of developing enduring conditions.*

[56] *Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The measure is based on the national DHB performance indicator SI1, defined as the standardised rate per 100,000 and the target is set to maintain performance at <95% of the national average.*

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	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of children aged under 5 enrolled in DHB-funded oral health services	C †	68%	≥77%	63%
% of enrolled children (0-12) examined according to planned recall	T †	93%	≥90%	-
% of adolescents (13-17) accessing DHB-funded oral health services	C †	81%	≥75%	72%

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	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of the eligible population having had a CVD Risk Assessment in the last 5 years	C [57]	57%	90%	49%
% of people with diagnosed diabetes who have had an annual check	C	77%	≥70%	-
% of people who have satisfactory or better diabetes management (HbA1c ≤64 mmol/mol) at their free annual diabetes check	Q	76%	80%	-

Pharmacy Services *These services include dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, demand for pharmaceuticals will likely increase.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Pharmaceutical items dispensed in the community	V Δ	588K	est. <600K	-

Referred 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 aid decision-making and improve clinical referral processes.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Laboratory tests completed for the West Coast population	V Δ	149K	est. <150K	-
Number of community referred radiological tests to Grey Hospital	V	5,807	est. >5,000	-
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T	new	85%	-

[57] *This refers to CVD risk assessments undertaken in primary care in line with the expectations of the PHO Performance Programme and the 'More heart and diabetes checks' health target.*

OUTPUT CLASS

6.3 Intensive assessment and treatment services

Output class description

Intensive assessment and treatment services are usually complex services provided by specialists and other healthcare 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 a 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 of these services, the DHB is also committed to providing high quality services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and improve health outcomes. 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 times within our hospital services.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

Specialist Mental Health Services *These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of young people (0-19) accessing specialist mental health services	C [58] Δ	5.5%	≥3.8%	2.9%
% of adults (20-64) accessing to specialist mental health services	C [58] Δ	4.7%	≥3.8%	3.4%
% of people referred for non-urgent MH and AOD services seen within 3 weeks	T [59]	63%	80%	65%
% of people referred for non-urgent MH and AOD services seen within 8 weeks	T [59]	78%	95%	77%
% of long-term clients aged 0-19 with current relapse prevention plans	Q [60]	100%	≥95%	87%
% of long-term clients aged 20-64 with current relapse prevention plans	Q [60]	36%	95%	94%

[58] *The national expectation is that around 3% of the total population will need to access specialist mental health services. This measure is based on the national DHB reporting measure PP6.*

[59] *This measure is national DHB reporting measure PP8, subject to MoH availability. Results are for the year to September 2011.*

[60] *Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what actions to take. This measure is based on the national DHB reporting measure PP7.*

Acute/Urgent Services *These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly. (They may or may not lead to hospital admission.) Hospital-based services include emergency services, short-stay acute assessment, acute medical and surgical services and intensive care services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of children under six with access to free primary care after hours	C	new	100%	-
% of general practices using telephone triage outside business hours	C	100%	100%	-
Attendances at West Coast emergency departments (EDs)	V [61]	15,394	≤14,875	-
Proportion of people (Triage 1-3) in ED seen within clinical guidelines	Q [62]	88%	≥85%	-
% of people ready for treatment waiting less than 4 weeks for radiotherapy or chemotherapy	T	100%	100%	-
Standardised acute inpatient average length of hospital stay	Q [63]	new	≤4.02	-

Elective/Arranged Services *These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Medical and Surgical First Specialist Assessments (FSAs) provided (incl. virtual)	V	7,302	est. >6,500	-
% of Medical and Surgical FSAs that are non-contact (virtual)	Q [64]	3.9%	≥3.9%	-
Elective surgical discharges (surgeries provided)	V [65]	1,751	1,592	-
% of elective/arranged surgeries provided as day cases.	Q [66]	54%	≥54%	55%
% of people who receive their surgery on the day of admission	Q [66]	77%	≥77%	79%
Standardised elective surgical inpatient average length of hospital stay	Q [63]	new	≤3.16	-
Medical and Surgical outpatient 'Did not Attend' rates	Q	8.7%	≤6%	-

Maternity Services *These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided in home, community and hospital settings by a range of health professionals, including lead maternity carers, GPs and obstetricians. Services include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Maternity deliveries in DHB facilities	V	293	est. 300	-
Baby friendly hospital accreditation of DHB facilities	Q [67]	YES	YES	-
% of total deliveries made in Primary Birthing Units	V [68]	5.5%	7%	-

[61] *This measure is based on the national ED Health Target definition. As such, it counts Grey Hospital ED and Reefton and Buller A&Es.*
[62] *This measures the 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 10 minutes; Triage 3: seen within 30 minutes of presentation).*
[63] *This measure is based on the OS3 national DHB performance measure. Average length of stay is balanced against readmissions rates to ensure service quality is appropriate.*
[64] *Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity across the system, reducing wait times for patients and taking duplication and waste out of the system.*
[65] *This number counts elective surgery volumes based on the national health target definition (excludes cardiology and dental volumes).*
[66] *When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own homes, and frees up hospital beds. Day case and day of surgery admission rates are balanced against readmissions rates to ensure service quality is appropriate. These measures were previously national measures (OS6 & OS7) but are now calculated and monitored locally.*
[67] *The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to deliver a high standard of care and implement best practice in relation to infant feeding for pregnant women and mothers and babies. An assessment and accreditation process recognises those that have achieved the required standard.*
[68] *The DHB aims to increase people acceptance and confidence in using primary birthing units rather than having women birth in secondary or tertiary facilities when it is not needed, in order to make better use of resources and to ensure limited secondary services are more appropriately available for those women who need more complex or specialist intervention.*

Assessment, Treatment and Rehabilitation Services (AT&R) *These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Admissions into inpatient AT&R services	V	151	est. >150	-
Number of outpatient and domiciliary AT&R attendances	V	1,712	est. >1,700	-
% of AT&R inpatients discharged to their own home rather than ARC	Q [69] Δ	55%	≥55%	-

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in West Coast DHB hospitals.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Rate of all patient falls resulting in harm – per 1,000 inpatient bed days	Q [70]	0.93	≤1.0	-
Rate of correctly performed hand hygiene 'moments'	Q [71]	47%	70%	-

[69] *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, 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. Therefore, a discharge from AT&R to home (rather than ARC) reflects the quality of AT&R and community support services in terms of assisting that person to regain their functional independence so that, with appropriate community supports, the person is able to safely 'age in place'. This measure excludes those who were ARC residents prior to AT&R admission.*

[70] *'All patient falls resulting in harm' includes falls resulting in very minor harm, e.g. bruising.*

[71] *This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. The 'actual' result is for the audit period 1/4/12 – 7/7/12.*

OUTPUT CLASS

6.4 Rehabilitation and support services

Output class description

Rehabilitation and support services provide people with the 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 after a clinical 'needs assessment' process and include: domestic support, personal care, community nursing, services provided in people's own homes and places of residence, day care, respite care and residential care. Services are mostly for older people, mental health clients and personal health clients with complex 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 admission 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 the national rate. Living in ARC has 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 we monitor the effectiveness of these services, and that we use the InterRAI (International Residential Assessment Instrument) tool to ensure people receive equitable access to clinically appropriate support services that best meet their needs.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

Needs Assessment and Services Coordination Services *These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Older people (65+) provided with a clinical assessment of need using InterRAI	V Δ	473	est. >470	-
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	Q [72] Δ	78.9%	95%	-
% of people entering ARC having had a clinical assessment of need using InterRAI	Q [73] Δ	90.7%	95%	-

[72] *Comprehensive clinical assessment ensures that service decisions are based on a robust, internationally verified assessment tool so that the level of support provided matches a person's level of need and people receive equitable access to support. This measure is based on the PP18 national DHB performance measure.*

[73] *InterRAI is an evidence-based geriatric assessment tool. Using InterRAI ensures assessments are high quality and consistent so that people receive equitable access to support and care. InterRAI also supports improved integration by providing health professionals with a common language of assessment and an electronic means of transferring information. This measure includes all people entering ARC.*

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.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
ARC facilities trained to provide the Liverpool Care Pathway option to residents	V [74]	2	4	-
People in ARC services being supported by the Liverpool Care Pathway	V	18	30	-

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	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of people referred to an organised stroke service after an acute event	C	71%	80%	-
% of people referred to cardiac rehabilitation services after an acute event	C [75]	100%	≥80%	-
People provided with Mental Health Activity and Living skills and Education and Employment Support services	V [76]	84	≥84	-
% of clients accessing Education and Employment support services supported into full or part time employment, or further education programmes	Q	67%	≥65%	-

Home-Based Support Services *These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
People supported by long-term home and community support services	V Δ	741	est. >740	-
Number of community-based district nursing visits provided – long-term only	V Δ	5,189	est. >5000	-
Number of Meals on Wheels provided	V	37,148	est. >37,000	-

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	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
People accessing mental health planned and crisis respite	C Δ	613	est. >600	-
Occupancy rate of mental health planned and crisis respite beds	C [77] Δ	83%	85%	-
People supported by aged care respite services	V	72	est. >70	-

[74] *The Liverpool Care Pathway is an international programme adopted nationally and reflects best-practice care. It begins with training of staff with the eventual aim of increasing the number of people supported by the pathway.*
[75] *This measure counts those who are referred to a community-based cardiac rehabilitation nurse specialist on discharge.*
[76] *These measures refer to people engaged by the Te Ara Mahi Vocational Service.*
[77] *Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directed to other areas.*

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 for lower-level care 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	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Subsidised ARC rest home beds provided (days)	V Δ	49,412	est. <50,000	-
Subsidised ARC hospital beds provided (days)	V Δ	36,542	est. <40,000	-
Subsidised ARC dementia beds provided (days)	V Δ	2,414	est. >2,000	-
Subsidised ARC psycho-geriatric beds provided (days)	V Δ	4,041	est. >4,000	-
% of ARC residents receiving vitamin D supplements	C	60%	75%	-

Financial performance 2013-2016

FISCAL 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 2013/14, 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.

7.1 Meeting our financial challenges

Like all DHBs, the West Coast DHB faces significant fiscal pressures, including: the costs of meeting major seismic challenges in relation to facilities across a number of locations on the West Coast; 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. The 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; to ensure our health system is clinically and financially sustainable, we must make decisions that are 'best for patient and best for system'. This means providing the right care and support, at the right time and 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 longterm financial wellbeing.

There are six factors that are critical to the West Coast DHB's success 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, our 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.
2. *Renegotiating 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. This remains crucial to the ongoing viability of sustained services on the West Coast.
3. *Rebalancing the system:* It is crucial that the West Coast DHB continues to reorient and rebalance our 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 our ability to introduce more effective service delivery models.
4. *Integrating fragmented health services:* Health and disability services on the West Coast need to be integrated across primary, hospital and community services with strong support from clinical leaders in developing health pathways and investment in IT and technology to support integration.
5. *Developing the transalpine approach:* Our well established partnership with Canterbury DHB needs to support the continued development of transalpine services over the next few years. This transalpine approach addresses clinical models of care across hospital-based specialities between the two DHBs, and will result in a model that will be clinically safe and deliverable within the funding available.
6. *Building a stable, sustainable workforce:* 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, to reduce the reliance on locums.

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 interactive staff engagement programmes such as Xcelr8 and other programmes that promote 'lean thinking' and empower 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 also help to ensure that the West Coast DHB is fairly remunerated for services provided and ensure revenue matches cost appropriately.

- *Return on investment over time (value for money):* Investment and divestment 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 to provide people on the Coast with a strong continuum of care irrespective of the provider of services.
- *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 services and realigning service expenditure:* The West Coast DHB is committed to delivering on Government policy by shifting appropriate services from hospital-based to community-based settings. This will enable the West Coast DHB to better manage the pressure of demand growth and achieve further productivity gains from integrating services. This move is being actively pursued through the anticipated utilisation of an Integrated Family Health Services Business Plan. This is dependent on timing and decisions in relation to the shape and form of facilities, as recommended by the Partnership Group currently charged with preparing the detailed business case in relation to West Coast facilities.

7.2 Financial outlook

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

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:

- *Seismic remediation costs:* The level of facilities repair required in order to attain moderate compliance with current building codes will exert significant financial pressure on the DHB.
- *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. Most of the West Coast DHB's workforce is on Multi-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 (e.g. implants, instruments and food products) and referred services (e.g. pharmaceutical, 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 health services. The West Coast DHB must support robust and transparent prioritisation for healthcare 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. Due to the volatility experienced by the West Coast DHB, there is a desire to negotiate a capacity agreement with Canterbury for these services, in order to remove the variability aspect on this expenditure.

Living within our means

The West Coast DHB is submitting a deficit forecast of $1.1M for the 2013/14 year. This is a reduction of $2.5M from the 2012/13 approved deficit of $3.6M. The West Coast DHB is well advanced in developing models of care that aim to achieve both financial and clinical sustainability by 2014/15. As indicated, the West Coast DHB is working closely with Canterbury DHB on a transalpine approach to further enhance collaboration and, where appropriate, is integrating services and service delivery models. This is crucial if we are to attain the fiscal results we are striving for.

We are also committed to supporting national entities' initiatives locally to achieve mutual benefits and cost savings across the sector; Table 1 indicates the level of inclusion in the 2013/14 financial projections.

Table 1: West Coast commitment to national entities' initiatives

	Capital	Operating Costs		Operating	Net
	Costs	One-Off	Ongoing	Benefits	Operating
Microsoft G2012			(50,684)		(50,684)
NZ ePrescription Service (NZePS) / CPSA	(12,728)	(19,092)	0	0	(19,092)
Hospital ePharmacy	(100,000)	0	0	0	0
Legacy Patient Administration System (PAS)	(575,000)	0	0	0	0
Finance, Procurement and Supply Chain	(165,000)	(90,000)	0	(53,000)	(143,000)
Information Services - National Infrastructure Platform	0	(21,000)	0	0	(21,000)
Information Services - Procurement	0	0	0	14,000	14,000
Human Resources	0	(16,000)	0	0	(16,000)
Procurement	0	0	0	72,000	72,000
Banking and Insurance	0	0	(18,000)	0	(18,000)
DHB Initiatives / All of Government	0	0	0	84,000	84,000
Total Impact for West Coast DHB	(852,728)	(146,092)	(68,684)	117,000	(97,776)
DHB contribution to HBL Core Funding			(63,000)		(63,000)

7.3 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 DHBs 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 2013/14 will be the same as indicated in the funding envelope received in December 2012, and the 2013/14 Transitional Pool funding will remain at 2012/13 levels, as previously agreed with the Ministry of Health.
- 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.
- 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.
- 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 the 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 / impaired as at 30 June 2012. The forecast for 2013/14 and the budget for 2013/14 and outlying years have been based on this revaluation. It has been assumed that there will be minimal change from this valuation for the 2013/14 year; however, there may be further impairments necessary dependent on the outcome of engineering assessments.
- Work will continue on the Facilities Redevelopment Plan for the Greymouth Regional Health Centre and Buller Integrated Family Health Services under the recently formed Partnership Group, and it is expected that approval from the National Capital Investment Committee will be obtained in 2013/14. However, 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 still specific Crown approval.

7.4 Asset planning and sustainable investment

Business cases

Greymouth and Buller Redevelopment: The detailed business case for the redevelopment of Greymouth Hospital and Buller health services is currently under development via the nationally appointed Partnership Group and is expected to be completed for submission to the National Capital Investment Committee (CIC) in July 2013. The business case is based on an integrated approach to service delivery across primary, community and hospital services, and CIC approval would allow construction to begin at Grey Hospital in 2014.

In the interim, an approval was obtained from the CIC to rectify some urgent issues in relation to severe seismic and electrical problems facing the Greymouth campus. However, further significant issues regarding unsafe buildings and known risks, including but not limited to the boiler house and chimney, which are both in need of replacement, have been deliberately deferred, as they will be included in the wider Greymouth business case.

The project's funding will be a mix of debt and equity, which will not be known until the business case has been completed.

Capital expenditure

The capital expenditure budget for the 2013/14 year is $3.3M (excluding capital expenditure committed in previous years), subject to approval. The capital budget will cover the replacement of clinical and other operational capital requirements and will focus 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.

7.5 Debt and equity

Ministry of Health

The West Coast DHB currently has debt facilities with the Ministry of Health (formerly the Crown Health Financing Agency), totalling $13.695M. The West Coast DHB's total term debt is currently $12.445M and is expected to remain at this amount as at June 2014, subject to borrowings required with the approval of the Greymouth Regional Health Centre Business Case.

The current debt with the Ministry of Health consists of several loans, and current interest rates range from 2.30% to 6.58%. The debt profile is:

PRINCIPAL	INTEREST RATE	MATURITY DATE
$250,000	2.37%	28-Jun-13
$250,000	2.31%	28-Jun-14
$3,500,000	6.58%	15-Apr-15
$250,000	2.30%	28-Jun-15
$3,000,000	4.75%	15-Apr-16
$250,000	2.50%	28-Jun-16
$250,000	2.69%	28-Jun-17
$4,695,000	5.22%	15-Dec-19

The West Coast DHB term liabilities are secured by a negative pledge. Without the Ministry of Health's prior written consent, the DHB cannot:

- 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.

Westpac Banking Corporation

In November 2012, the West Coast DHB changed its main bankers to Westpac Banking Corporation as part of the national health sector banking facility arranged through Health Benefits Ltd.

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 DHB is also repaying $68K equity annually as part of an agreed FRS-3 funding repayment programme with the Ministry of Health.

FORECAST OF FINANCIAL PERFORMANCE

7.6 Group statement of comprehensive income

For the years ending 2011/12 to 2015/16

in thousands of New Zealand dollars

	2011/12 Actual	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast	2015/16 Forecast
Operating Revenue					
Crown and Government sourced	127,209	128,418	131,156	133,122	135,118
Inter-DHB Revenue	106	76	36	37	38
Inter-District Flows Revenue	1,884	1,657	1,622	1,646	1,671
Patient-Related Revenue	3,096	3,212	3,371	3,422	3,473
Other Revenue	1,765	846	759	771	784
Total Operating Revenue	134,060	134,209	136,944	138,998	141,084
Operating Expenditure					
Employee benefit costs	54,036	56,253	53,310	54,227	55,039
Outsourced Clinical Services	12,243	8,423	2,532	2,575	2,613
Treatment-Related Costs	7,552	7,831	9,114	9,272	9,412
External Providers	29,503	30,046	35,866	35,167	35,684
Inter-District Flows Expense	17,504	14,528	18,308	18,582	18,862
Outsourced Services - non-clinical	854	1,598	1,460	1,482	1,504
Infrastructure Costs and Non-Clinical Supplies	11,290	13,131	10,915	10,921	10,824
Total Operating Expenditure	132,982	131,810	131,505	132,226	133,938
Result before Interest, Depn & Cap Charge	1,078	2,399	5,439	6,772	7,146
Interest, Depreciation & Capital Charge					
Interest Expense	732	689	642	653	663
Depreciation	4,757	4,535	5,085	5,293	5,645
Capital Charge Expenditure	613	775	812	826	838
Total Interest, Depreciation & Capital Charge	6,102	5,999	6,539	6,772	7,146
Net Surplus/(deficit)	(5,024)	(3,600)	(1,100)	0	0
Other comprehensive income					
Gain/(losses) on revaluation of property	(1,741)	0	0	0	0
Total comprehensive income	(6,765)	(3,600)	(1,100)	0	0

7.7 Group statement of financial position

As at 30 June for year endings 2011/12 to 2015/16

in thousands of New Zealand dollars

	30/06/2012 Actual	30/06/2013 Forecast	30/06/2014 Forecast	30/06/2015 Forecast	30/06/2016 Forecast
Assets					
Non-current assets					
Property, plant and equipment	29,040	31,109	29,804	28,407	26,618
Intangible assets	943	1,482	1,002	510	12
Other investments	2	2	2	2	2
Total non-current assets	29,985	32,593	30,808	28,919	26,632
Current assets					
Cash and cash equivalents	7,398	6,044	7,809	9,671	11,932
Other investments	58	58	58	58	58
Inventories	1,040	1,040	1,040	1,040	1,040
Debtors and other receivables	4,493	4,614	4,614	4,614	4,614
Patient and restricted funds					
Assets classified as held for sale	136	136	136	136	136
Total current assets	13,125	11,892	13,657	15,519	17,780
Total assets	43,110	44,485	44,465	44,438	44,412
Liabilities					
Non-current liabilities					
Interest-bearing loans and borrowings	12,195	12,195	8,695	9,195	12,195
Employee entitlements and benefits	3,062	3,357	3,404	3,445	3,487
Total non-current liabilities	15,257	15,552	12,099	12,640	15,682
Current liabilities					
Interest-bearing loans and borrowings	250	250	3,750	3,250	250
Creditors and other payables	9,241	8,071	8,072	8,072	8,072
Employee entitlements and benefits	8,109	8,427	8,427	8,427	8,427
Patient and restricted trust funds	57	57	57	57	57
Total current liabilities	17,657	16,805	20,306	19,806	16,806
Total liabilities	32,914	32,357	32,405	32,446	32,488
Equity					
Crown equity	66,197	71,729	72,761	72,693	72,625
Other reserves	19,569	19,569	19,569	19,569	19,569
Retained earnings/(losses)	(75,609)	(79,209)	(80,309)	(80,309)	(80,309)
Trust funds	39	39	39	39	39
Total equity	10,196	12,128	12,060	11,992	11,924
Total equity and liabilities	43,110	44,485	44,465	44,438	44,412

7.8 Group statement of movements in equity

For the years ending 2011/12 to 2015/16

in thousands of New Zealand dollars

	30/06/2012 Actual	30/06/2013 Forecast	30/06/2014 Forecast	30/06/2015 Forecast	30/06/2016 Forecast
Balance at 1 July	12,517	10,196	12,128	12,060	11,992
Contributions from the Crown	4,512	5,600	1,100	0	0
Contributions repaid to the Crown	(68)	(68)	(68)	(68)	(68)
Total comprehensive income	(6,765)	(3,600)	(1,100)	0	0
Balance at 30 June	10,196	12,128	12,060	11,992	11,924

7.9 Group statement of cashflow

For the years ending 2011/12 to 2015/16

in thousands of New Zealand dollars

	2011/12 Actual	2012/13 Forecast	2013/14 Budget	2014/15 Budget	2015/16 Budget
Cash flows from operating activities					
Cash receipts from Ministry of Health, patients and other revenue	133,962	134,149	136,704	138,754	140,836
Cash paid to employees	(53,657)	(60,921)	(55,948)	(56,917)	(57,769)
Cash paid to suppliers	(32,469)	(27,753)	(21,335)	(21,519)	(21,581)
Cash paid to external providers	(29,548)	(30,046)	(35,866)	(35,167)	(35,684)
Cash paid to other District Health Boards	(17,481)	(14,528)	(18,308)	(18,582)	(18,862)
Cash generated from operations	807	901	5,247	6,569	6,940
Interest paid	(735)	(689)	(642)	(653)	(663)
Goods and services tax (net)	31	79	0	0	0
Capital charge paid	(712)	(368)	(812)	(826)	(838)
Net cash flows from operating activities	(609)	(77)	3,793	5,090	5,439
Cash flows from investing activities					
Interest received	319	334	240	244	248
Proceeds from sale of investments	3,502	0	0	0	0
Acquisition of property, plant and equipment	(2,665)	(7,143)	(3,300)	(3,404)	(3,358)
Acquisition of intangible assets	(265)	0	0	0	0
Net cash flows from investing activities	891	(6,809)	(3,060)	(3,160)	(3,110)
Cash flows from financing activities					
Proceeds from equity injections	4,512	5,600	1,100	0	0
Repayment of equity	(68)	(68)	(68)	(68)	(68)
Cash generated from equity transactions	4,444	5,532	1,032	(68)	(68)
Borrowings raised					
Repayment of borrowings	(250)	0	0	0	0
Net cash flows from financing activities	4,194	5,532	1,032	(68)	(68)
Net increase in cash and cash equivalents	4,476	(1,354)	1,765	1,862	2,261
Cash and cash equivalents at beginning of year	2,922	7,398	6,044	7,809	9,671
Cash and cash equivalents at end of year	7,398	6,044	7,809	9,671	11,932

7.10 Summary of revenue and expenses by arm

Governance Arm: Forecast Operating Statement for the years ending 2011/12 to 2015/16

in thousands of New Zealand dollars

	2011/12 Actual	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast	2015/16 Forecast
Income					
Internal Revenue	1,176	828	826	838	851
Other income	110	87	0	0	0
Internal allocation from Provider Arm	1,320	1,321	1,053	1,072	1,087
Total income	2,606	2,236	1,879	1,910	1,938
Expenditure					
Personnel	1,102	574	602	612	621
Outsourced services	333	391	460	468	475
Other operating expenses	461	641	464	471	478
Democracy	291	255	353	359	364
Total expenses	2,187	1,861	1,879	1,910	1,938
Net Surplus / (Deficit)	419	375	0	0	0

Funder Arm: Forecast Operating Statement for the years ending 2011/12 to 2015/16

in thousands of New Zealand dollars

	2011/12 Actual	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast	2015/16 Forecast
Income					
PBF Vote Health-funding package (excluding Mental Health)	102,999	101,048	103,082	104,628	106,198
PBF Vote Health-Mental Health Ring fence	13,884	13,884	14,080	14,291	14,505
MOH-funding side contracts	2,018	5,299	6,103	6,195	6,288
Inter District Flow's	1,884	1,657	1,622	1,646	1,671
Other income	232	254	0	0	0
Total income	121,017	122,142	124,887	126,760	128,662
Expenditure					
Personal Health	77,472	74,624	90,554	91,517	92,881
Mental Health	13,790	13,954	14,079	14,291	14,506
Disability Support	17,342	17,721	18,564	18,762	19,044
Public Health	748	763	598	604	613
Māori Health	527	522	810	819	831
Governance	1,176	828	826	838	851
Total expenses	111,055	108,412	125,431	126,831	128,726
Net Surplus / (Deficit)	9,962	13,730	(544)	(71)	(64)

Provider Arm: Forecast Operating Statement for the years ending 2011/12 to 2015/16

in thousands of New Zealand dollars

	2011/12 Actual	2012/13 Forecast	2013/14 Forecast	2014/15 Forecast	2015/16 Forecast
Income					
Internal revenue-Funder to Provider	62,872	63,010	70,431	72,246	73,331
Ministry of Health side contracts and Other Government		8,413	8,263	7,927	8,045
Patient and consumer sourced	3,096	3,212	3,371	3,422	3,473
Other income	1,424	505	759	771	784
Total income	75,805	74,990	82,488	84,484	85,753
Expenditure					
Employee benefit costs	52,934	55,679	52,708	53,615	54,418
Outsourced Clinical Services	12,243	8,423	2,532	2,575	2,613
Treatment Related Costs	7,552	7,831	9,114	9,272	9,412
Outsourced Services - non clinical	521	1,207	1,000	1,016	1,031
Infrastructure Costs and Non Clinical Supplies	10,538	12,235	10,100	10,093	9,984
Internal allocation	1,320	1,321	1,053	1,072	1,087
Total Operating Expenditure	85,108	86,696	76,507	77,643	78,545
Result before Interest, Depn & Cap Charge	(9,303)	(11,706)	5,981	6,841	7,208
Interest, Depreciation & Capital Charge					
Interest Expense	732	689	642	653	663
Depreciation	4,757	4,535	5,083	5,291	5,643
Capital Charge Expenditure	613	775	812	826	838
Total Interest, Depreciation & Capital Charge	6,102	5,999	6,537	6,770	7,144
Net Surplus/(deficit)	(15,405)	(17,705)	(556)	71	64
Other comprehensive income					
Gain/(losses) on revaluation of property	(1,741)	0	0	0	0
Total comprehensive income	(17,146)	(17,705)	(556)	71	64

Summary of Forecasted Revenue and Expenditure for the year ending 30 June 2014

in thousands of New Zealand dollars

	Governance	Funder	Provider	Eliminations	Result
Revenue	1,879	124,887	82,488	71,257	137,997
Expenditure	1,879	125,431	83,044	71,257	139,097
Net Surplus (Deficit)	0	(544)	(556)	0	(1,100)

Appendices

Further information for the reader:

Appendix 1	Glossary of terms
Appendix 2	Approval of the Minister of Health
Appendix 3	Objectives of a DHB – New Zealand Public Health and Disability Act (2000)
Appendix 4	West Coast DHB organisational structure
Appendix 5	Minister of Health's letter of expectations for 2013/14
Appendix 6	West Coast's commitment to the national health targets
Appendix 7	DHB performance monitoring framework
Appendix 8	Statement of accounting policies

References

Unless specifically stated, all West Coast DHB documents referenced in this document are available on the West Coast DHB website (www.wcdhb.govt.nz).

All Ministry of Health or National Health Board documents referenced in this document are available either on the Ministry's website (www.health.govt.nz) or the National Health Board's website (www.nationalhealthboard.govt.nz).

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

8.1 Glossary of terms

ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	Management of conditions with sudden onset and rapid progression.
ALT	Alliance Leadership Team	The team leading the West Coast Health Alliance.
ARC	Aged Residential Care	Residential care for older people, including rest home, hospital, dementia and psycho-geriatric level care.
B4SC	B4 School Check	The final core WCTO check, which children receive at age four. The free check allows health concerns to be identified and addressed early in a child's development for the best possible start for school and later life.
	Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver outputs.
CPH	Community and Public Health	The division of the DHB that provides public health services.
CVD	Cardiovascular Disease	Diseases affecting the heart and circulatory system, including: ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
	Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entity	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the annual financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
	Effectiveness	The extent to which objectives are being achieved. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
ERMS	Electronic Request Management System	A system available from the GP desktop enabling referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide.
ESPIs	Elective Services Patient flow Indicators	A set of indicators developed by the Ministry to monitor how patients are managed while waiting for elective (non-urgent) services.
FSA	First Specialist Assessment	(Outpatients only) The first time a patient is seen by a doctor for a consultation in that speciality. This does not include procedures, nurse or diagnostic appointments or pre-admission visits.
HbA1c	Haemoglobin A1c	Also known as glycated haemoglobin, HbA1c reflects average blood glucose level over the past 3 months.
HCS	Health Connect South	A shared regional clinical information system that will provide a single repository for clinical records across the South Island. Already implemented in West Coast, Canterbury and South Canterbury.
HEEADSSS		An assessment provided to students attending teen parent units, alternative education facilities and deciles 1 to 3 high schools that covers Home environment; Education/employment; Eating/exercise; Activities and peer relationships; Drugs/cigarettes/alcohol; Sexuality; Suicide/depression/mood; Safety; and Spirituality.
	Impact	The contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. Normally describes results that are directly attributable to the activity of an agency. Impact measures should be attributed to DHB outputs in a credible way and represent near-term results expected from the outputs delivered.
	Input	The resources (e.g. labour, materials, money, people, technology) an organisation uses to produce outputs.
IDFs	Inter District Flows	Services (outputs) provided by a DHB to a patient whose place of residence is in another DHB's region. Under PBF, each DHB is funded on the basis of its resident population; therefore, the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	A comprehensive geriatric assessment tool.

	Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
	Intervention logic model	A framework for describing the relationships between resources, activities and results, which provides a common approach for planning, implementation and evaluation. Intervention logic focuses on being accountable for what matters: impacts and outcomes.
LMC	Lead Maternity Carer	The health professional a woman chooses to provide and coordinate the majority of her maternity care. Most LMCs are midwives, though GPs and obstetricians may also be LMCs.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ. A person's NHI number is stored on the NHI along with their demographic details. The NHI is used to help with the planning, coordination and provision of health and disability services across NZ.
NGO	Non-Government Organisations	In the context of the relationship between Health and Disability NGOs and the West Coast DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market.
OPF	Operational Policy Framework	An annual document endorsed by the Minister of Health that sets out the operational-level accountabilities all DHBs must comply with, given effect through the CFA between the Minister and the DHB.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
	Output Class	An aggregation of outputs of a similar nature.
	Outputs	Final goods and services delivered to a third party outside of the DHB. Not to be confused with goods and services produced entirely for consumption within the DHB (internal outputs or inputs).
PBF	Population-Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Professional health care received in the community, usually from a general practice, covering a broad range of health and preventative services. The first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care practitioners and are funded by DHBs to provide of a set of essential primary healthcare services to the people enrolled with that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Purchase agreement	A documented arrangement between a Minister and a department/organisation for the supply of outputs.
	Regional collaboration	Refers to DHBs across geographical 'regions' planning and delivering services (clinical and non-clinical) together. Four regions exist: Northern, Midland, Central and Southern. The Southern region includes all five South Island DHBs (Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs). Regional collaboration sometimes involves multiple regions, or may be 'sub-regional collaboration' (DHBs working together in a smaller grouping of two or three DHBs, e.g. Canterbury and West Coast).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIA(PO)	South Island Alliance (Programme Office)	A partnership between the five South Island DHBs working to support a clinically and financially sustainable South Island health system where services are as close as possible to people's homes.
SSP	Statement of Service Performance	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
WCTO	WellChild/Tamariki Ora	A free service offering screening, education and support to all New Zealand children from birth to age five.

8.2 Approval of the Minister of Health

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

26 JUL 2013

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

Dear Dr McCormack

West Coast District Health Board 2013/14 Annual Plan

This letter is to advise you I have approved and signed West Coast District Health Board's (DHB) 2013/14 Annual Plan for one year.

I appreciate the significant work that goes into preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2013, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Better Public Services (BPS): Results for New Zealanders
The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result areas of reducing the number of assaults on children, increasing participation in early childhood education and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has included step targets in your Annual Plan to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important that your board works closely with other social sector organisations and initiatives, including Whānau Ora.

National Health Targets
Your plan includes a good range of actions that will lead to improved or continued performance against the health targets. The target set has remained stable for 2013/14 allowing you to build on the results from the 2012/13 year.

West Coast DHB is performing well in most health target areas. However, in the year ahead I expect West Coast DHB to particularly focus attention on maintaining recent improvements in the primary care component of the Better Help for Smokers to Quit target, and improving performance for the More Heart and Diabetes Checks target.

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

Quality Framework

I recently wrote to DHBs emphasising the need to maintain a focus on the quality and safety of services, both within hospitals and in wider services such as aged residential care and mental health. Ensuring quality will be an on-going focus for us all in the health sector. I expect that DHBs will use the framework that was provided to help shape DHB quality discussions. Also, that DHBs will produce a 'dashboard' of key quality and safety measures to regularly monitor performance and produce Quality Accounts in 2013.

Care Closer to Home

I expect DHBs to increase their focus on integration, particularly with respect to primary care, ensuring the scope of activity is broadened and rate of improvement is increased. I look forward to seeing an integrated approach driving service development, delivery and improved overall system performance; and in preparing to implement integration changes currently under development with the sector.

I am pleased to see an enhanced commitment to tangible actions in your Annual Plan to show how you will achieve real increases in access to diagnostic and treatment services for primary care and service shifts 'closer to home'. I expect DHBs to work in partnership with primary care, using their Alliances to drive service reconfiguration and improved system performance.

I am pleased to see your DHB has developed your Annual Plan jointly with your PHOs, using existing alliances. I look forward to seeing the results of your work to improve the breadth of services with direct access from primary care. In particular, through the implementation of a 'primary options to acute care' programme and the shift of your Better, Sooner, More Convenient Business Case to a 'business as usual' focus. It is pleasing that primary care will continue to receive direct access to a full range of X-rays and ultrasounds, direct access to the colonoscopy and cataract elective surgical booking lists and management of your National Immunisation Register Services.

Health of older people

The Government expects DHBs to continue to work with primary and community care to deliver integrated services and improve overall quality of care for older people. I am pleased to see that you have developed an Annual Plan which undertakes to meet the Government's expectations for the coming year. Notably, the implementation of a local dementia pathway that follows the national framework, the management of the risk of variable service quality of home and community support services, and proactive use of your HOP specialists to advise and train health professionals in primary and aged residential care. You have also committed to roll out the Comprehensive Clinical Assessments in aged residential care facilities, and to establish a fracture liaison service. It appears that you have not implemented your wraparound services and are therefore not in a position to review them. Instead you undertake to implement the CREST model this year and subsequently monitor admissions and readmissions.

Regional and National Collaboration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities. It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions.

Guidance on national entity priorities was provided to all DHBs in April, for inclusion in final 2013/14 Annual Plans, following the successful completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. I expect that your DHB will deliver on these commitments, as included in your plan financials. Attached is a summary of National Entity Priority Initiatives that shows your DHB's commitments for 2013/14. I look forward to observing progress on the delivery of these priorities.

Living within our means

DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives are expected to continue to be a key focus for all DHBs.

I note that you are planning for a deficit of $1.1 million for 2013/14 and a breakeven result for 2014/15 and 2015/16. I will be watching with keen interest your management of financial performance during 2013/14, including the delivery of the improvement initiatives supporting your planned net result.

Budget 2013

The expectation is that you will deliver on Budget 2013 initiatives. The Ministry of Health will discuss these more fully with you and develop monitoring arrangements during 2013/14.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

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

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2013/14 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

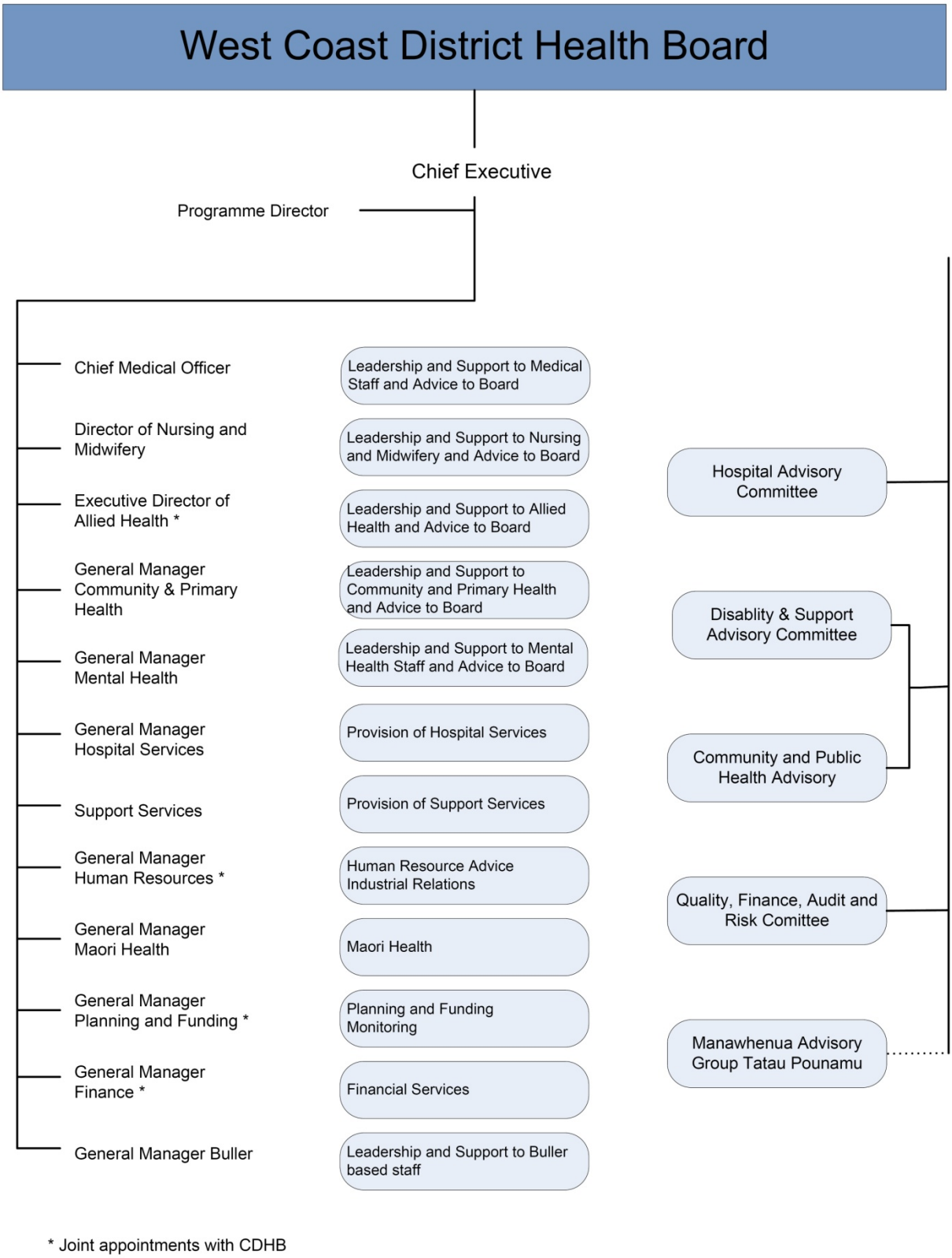
8.3 Objectives of a DHB – New Zealand Public Health and Disability Act (2000)

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.

8.4 West Coast DHB organisational structure



* Joint appointments with CDHB

8.5 Minister of Health's letter of expectations for 2013/14

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

Dr Paul McCormack
Chair
West Coast DHB
PO Box 387
GREYMOUTH 7840

Dear Paul

Letter of expectations for DHBs and subsidiary entities for 2013/14 year

Thank you for the contribution you and your staff are making to a better public health service. Public and patient confidence in health services continues to improve.

The government will be investing more money in Health this budget. This contrasts with the ongoing cuts in health spending in many parts of the world.

In this context the government continues to expect **better, sooner, more convenient** healthcare for patients and communities within constrained funding increases.

Better Public Services: Results for New Zealanders

The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result of reducing the number of assaults on children and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has been given step targets to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important Boards work closely with other social sector organisations and initiatives, including Whanau Ora.

National Health Targets

Good progress is being made on the three patient access targets. More effort is needed on the three preventive targets. DHBs are expected to include clear and specific plans for achieving all the national health targets in their Annual Plans, including the use of general practice-specific incentives where appropriate. You must demonstrate appropriate performance management arrangements for PHOs. You should show your local primary care networks are involved in, and explicitly endorse, your targets plan and your preventive targets plan in particular.

Patients' time is a valuable non-renewable resource. Timely access improves outcomes, is preferred by patients and saves cost. The government has made clear its ambitious objectives to further shorten waiting times for surgery, diagnostics, cardiac and cancer care. Your DHB is expected to meet these objectives.

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

Care Closer to Home

Integrating primary care with other parts of the health service is vital for better management of long term conditions, mental health, an aging 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. The outcome is patients treated closer to home with fewer acute and unplanned hospital admissions.

DHBs are expected to focus much more strongly on service integration across the health system particularly showing how this will be done with primary care. This includes integrated family health centres, primary care direct referral to diagnostics, clinical pathway development, and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to work with primary and community care to provide integrated services for older people that support their continued safe, independent living at home particularly to avoid a hospital admission and after a hospital discharge. DHBs should continue working with the Ministry on implementing government commitments to improving home care, stroke and dementia care.

Regional and National Collaboration

There are significant financial and clinical gains to be derived from regional DHBs working together. I expect DHBs to progress much faster implementing Regional Service Plans. This includes delivering on regional workforce, IT and capital objectives that are set and monitored in the NHB dashboard.

Further improvements in quality, efficiency and cost control will come from accelerating DHBs national work with Health Benefits Limited, Health Workforce NZ and the Health Quality and Safety Commission. More information on this will be forthcoming.

Strong clinical leadership and engagement has been pivotal to the gains made so far and remains essential.

Living within our means

The government is determined to return to surplus in 2014/15. Like the public health service as a whole, your DHB must contribute by lifting productivity and keeping to budget. DHBs are obliged to operate within their agreed financial plans. Your DHB must have detailed and defensible plans to improve financial performance year on year. The supply of equity and debt is constrained so Boards should prioritise capital investment more rigorously and fund from internal sources.

As agents of the Crown, you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership needed to deliver on the government's objectives. The performance of chief executives must be monitored against these expectations.

I appreciate the effort you and your teams are making. Thank you. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Hon Tony Ryall
Minister of Health

8.6 West Coast's commitment to the national health targets

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 – see page 25

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.[78]

West Coast contribution – see page 29

1,592 elective surgical discharges will be delivered in 2013/14.

Shorter Waits for Cancer Treatment

Government expectation

All people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.[79]

West Coast contribution – see page 32

100% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.

Increased Immunisation

Government expectation

95% of all eight-month-olds are fully vaccinated against vaccine preventable diseases.

West Coast contribution – see page 38

90% of all eight-month-olds will be fully vaccinated by 1 July 2014.

Better Help for Smokers to Quit

Government expectation

90% of smokers seen in primary care, 95% of hospitalised smokers and 90% of women at confirmation of pregnancy are offered brief advice and support to quit smoking.

West Coast contribution – see page 34

90% of primary care smokers and **95%** hospitalised smokers 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.

West Coast contribution – see page 27

Progress towards **90%** of the eligible population having had CVD risk assessed by 1 July 2014.

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

8.7 DHB performance monitoring framework

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		WEST COAST TARGET		NATIONAL TARGET	REPORTING FREQUENCY
PP1 Workforce – improving clinical leadership	Report progress of DHB to work to improve clinical leadership and engagement across all levels of the DHB and the Regional Training Hubs.					Annual
PP6 Improving the health status of people with severe mental illness through improved access	% of the population accessing specialist mental health services	Age 0-19	≥3.8%		NA	Six-monthly
		Age 20-64	≥3.8%			
		Age 65+	3.4%			
PP7 Improving mental health services using relapse prevention planning	% of long-term clients with up-to-date relapse prevention plans	Adult (20+)	95%		95%	Six-monthly
		Child & Youth	95%		95%	
PP8 Shorter waits for non-urgent mental health and addiction services	% of people referred for non-urgent **mental health** services seen within 3 and within 8 weeks		3wks	8wks	80% within 3 weeks 95% within 8 weeks	Quarterly
		Age 0-19	80%	95%		
		Age 20-64	80%	95%		
		Age 65+	80%	95%		
		Total	80%	95%		
	% of people referred for non-urgent **addictions** services seen within 3 and within 8 weeks		3wks	8wks	80% within 3 weeks 95% within 8 weeks	Quarterly
		Age 0-19	80%	95%		
		Age 20-64	80%	95%		
		Age 65+	70%	95%		
		Total	80%	95%		
PP10 Oral Health DMFT Score at Year 8	DMFT score at Year 8	2013	1.35		NA	Annual
		2014	1.35			
PP11 Children caries-free at 5 years of age	% caries-free at age 5	2013	61%		NA	Annual
		2014	65%			
PP12 Utilisation of DHB-funded dental services by adolescents	School Year 9 up to and including age 17 years	2013	75%		85%	Annual
		2014	85%			
PP13 Improving the number of children enrolled in DHB-funded dental services	% of children (age 0-4) enrolled	2013	77%		NA	Annual
		2014	85%			
	% of children (0-12) not examined according to planned recall	2013	≤10%			
		2014	≤10%			
PP18 Improving community support to maintain the independence of older people	% of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan		95%		≥95%	Quarterly

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		WEST COAST TARGET	NATIONAL TARGET	REPORTING FREQUENCY
PP20 Improved management for long-term conditions (CVD, diabetes and Stroke) Focus area 1: Cardiovascular disease	% of high-risk Acute Coronary Syndrome (ACS) patients receiving an angiogram within 3 days of admission		70%	70%	Quarterly
	% of patients presenting with ACS who undergo coronary angiography whose have completion of on the ANZACS QI ACS and Cath/PCI Register.[80]		95%	95%	
Focus area 2: Stroke services	% of potentially eligible stroke patients thrombolysed		6%	6%	
	% of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway		80%	80%	
Focus area 3: Diabetes – Management	% of enrolled people aged 45-74 with diabetes and microalbuminaria who are prescribed an ACE1 or an ARB [81]		Baseline to be established	NA	
	% of enrolled people aged 15-74 with acceptable glycaemic control (HbA1c ≤64mmol/mol)		80%	NA	
PP21 Immunisation coverage	% of two-year-olds fully immunised		95%	95%	Quarterly
PP22 Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP23 Improving wrap-around services – health of older people	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP24 Improving waiting times – cancer multidisciplinary meetings	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP25 Prime Minister's youth mental health project	Provide a written stocktake, gaps analysis and actions being considered.				Quarters 1 & 2
PP26 The Mental Health & Addiction Service Development Plan	Provide gaps analysis and report against SDP milestones.				Quarters 1, 2 & 4
PP27: Delivery of Children's Action Plan	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP28: Reducing rheumatic fever	Acute rheumatic fever rate of hospitalisation per 100,000	South Island rate	0.5 per 100,000	10% reduction	Six-monthly
SI1 Ambulatory sensitive (avoidable) hospital admissions	DHB rate vs. national rate (per 100,000)	Age 0-4	<95% (<5,359)	NA	Six-monthly
		Age 45-64	<95% (<1,578)		
		Age 0-74	<95% (<1,883)		
SI2 Regional service planning	A single progress report on behalf of the region, agreed by all regional DHBs.				Quarterly
SI3 Ensuring delivery of Service coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long-term exceptions, and any other gaps in service coverage.				Six-monthly
SI4 Elective services standardised intervention rates	Major joint replacement procedures		21 per 10,000	21.0 per 10,000	Annual
	Cataract Procedures		27 per 10,000	27.0 per 10,000	
	Cardiac surgery		6.5 per 10,000	6.5 per 10,000	Quarterly
	Percutaneous revascularisation		≥11.9 per 10,000	≥11.9 per 10,000	
	Coronary angiography services		≥33.9 per 10,000	≥33.9 per 10,000	

[80] *Implementation of the ANZACS QI Register is dependent on national contracts being agreed – timeframes are anticipated. Data will be provided via the South Island Alliance (against the ACS measure) until the ANZACS Register is up and running.*

[81] *The Ministry is currently working on a means of data capture for this measure nationally.*

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION	WEST COAST TARGET	NATIONAL TARGET	REPORTING FREQUENCY
SI5 Delivery of Whānau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers.			Annual
OS3 Inpatient length of stay	Elective LOS	≤3.16	NA	Quarterly
	Acute LOS	≤4.02		
OS8 Acute readmissions to hospital	% total population	At or below national average	NA	Quarterly
	% population aged 75+		NA	
OS10 Improving the quality of data provided to national collection systems	NHI duplications	3-6%	3-6%	Quarterly
	Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI	0.5-2%	0.5-2%	
	Standard vs. edited descriptors	75-90%	75-90%	
	Timeliness of NMDS data	2-5%	2-5% late	
	NNPAC ED admitted events have a matched NMDS event	97-99.5%	97-99.5%	
	PRIMHD File Success Rate	98-99.5%	98-99.5%	
OP1 Mental health output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	Within 5% of plan	Within 5%	Quarterly

8.8 Statement of accounting policies

The prospective financial statements in this Statement of Intent for the year ended 30 June 2014 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year. The following information is provided in respect of this Statement of Intent:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Statement of Intent.

REPORTING ENTITY AND STATUTORY BASE

West Coast DHB is a Health Board established by the New Zealand Public Health and Disability Act 2000. West Coast DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. West Coast DHB is a Reporting Entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, Public Finance Act 1989, and the Crown Entities Act 2004.

West Coast DHB has designated itself as a public benefit entity, as defined under New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

West Coast DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the West Coast community.

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

BASIS OF PREPARATION

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Section 154 of the Crown Entity Act 2004, which includes the requirement to comply with New Zealand Generally Accepted Accounting Practice (NZ GAAP). In accordance with NZ GAAP, the consolidated financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement basis

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

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

Functional and presentation currency

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

Changes in accounting policies

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

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 West Coast DHB include:

- NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. 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 has been completed and has been published in the new financial instrument standard NZ IFRS 9. 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 IFRS 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 effective for reporting period beginning on or after 1 January 2013. West Coast DHB has not yet assessed the impact of the new standard and expects it will not be early adopted.

The External Reporting Board is working through a new accounting standards framework for public benefit entities. It is expected that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefits entities. This means that the financial reporting requirements for public entities are expected to be effectively frozen in the short term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

SIGNIFICANT ACCOUNTING POLICIES

Foreign currency

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

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

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

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

Owned assets

Except for land and buildings, items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Land, buildings and building fit out are revalued to fair value as determined by an independent registered valuer, with sufficient

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

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

Additions

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

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

Donated assets are recorded at the best estimate of fair value and recognised as income. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

Depreciation

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

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

Class of Asset	Years	Depreciation Rate
Freehold Buildings & Fit Out	2– 50	2 - 50%
Leasehold Building Fit out	3 - 10	10-33%
Plant, Equipment & Vehicles	2 – 30	3.3 - 50%

The residual value of assets is reassessed annually.

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

Intangible assets

Acquisition

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

Amortisation

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

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

Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in other comprehensive income.

Other financial assets held are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the surplus or deficit. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the surplus or deficit.

Financial assets classified as held for trading or available-for-sale are recognised/derecognised on the date West Coast DHB commits to purchase/sell the investments.

Trade and other receivables

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

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

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

Cash and cash equivalents

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

West Coast DHB is party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of one month's Provider Arm funding, less net Inter-District In-Flows, plus GST.

Impairment

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

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

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

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

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

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

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

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

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

Restricted assets and liabilities

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

Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Provisions

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

Trade and other payables

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

Income tax

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

Goods and services tax

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

Revenue

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

Revenue relating to service contracts

West Coast DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or West Coast DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Services rendered

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to West Coast DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by West Coast DHB.

Interest income

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

Critical judgements in applying West Coast DHB's accounting policies

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

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

Property, plant and equipment useful lives and residual value

At each balance date West Coast DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires West Coast DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by West Coast DHB, and expected disposal proceeds from the future sale of the assets.

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

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

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

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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