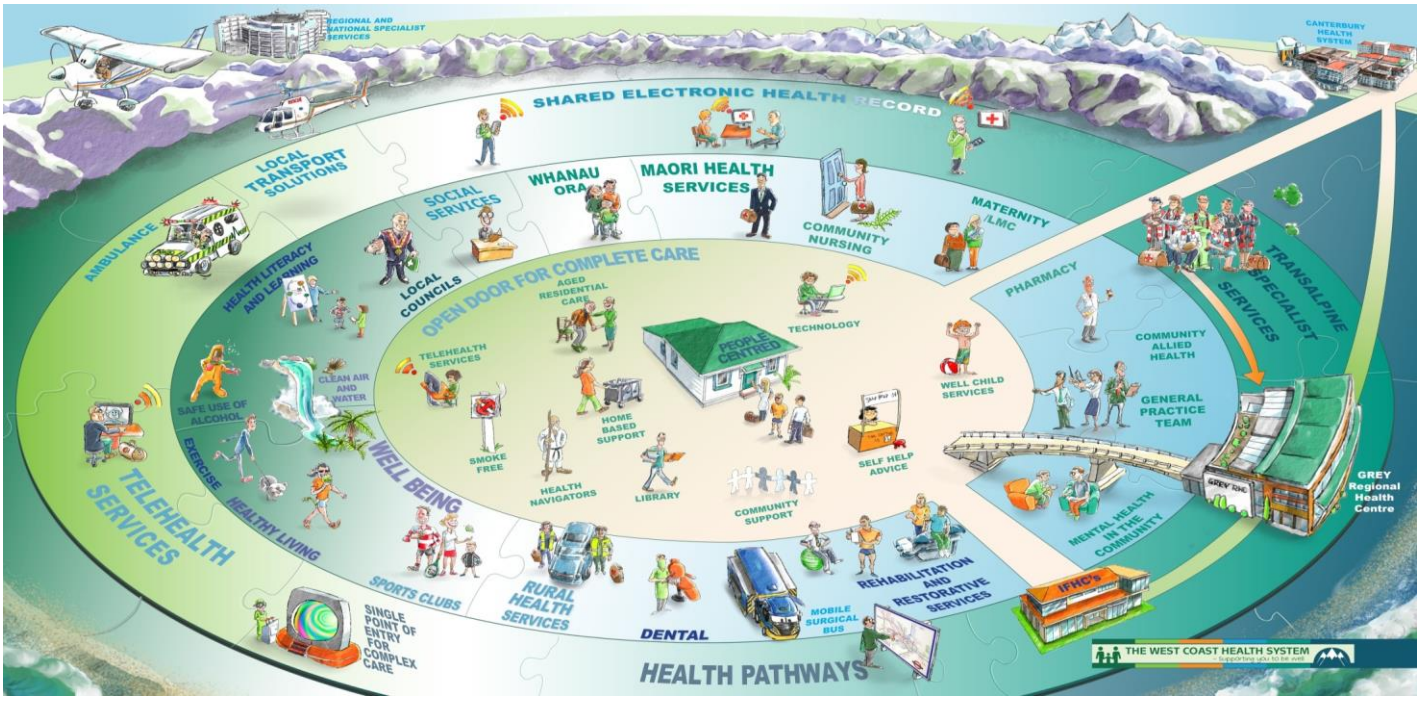
Annual Plan 2014-2015

Incorporating the Statement of Intent 2014/15-2017/18



THE WEST COAST HEALTH SYSTEM

– supporting you to be well

ANNUAL PLAN & STATEMENT OF INTENT

Produced March 2015
Pursuant to Section 149 of the Crown Entities Act 2004

West Coast District Health Board
P O Box 387, Greymouth
www.westcoastdhb.health.nz

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Statement of Responsibility

The West Coast District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2011. Each DHB is designated 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 terms of improving the health of its population, ensuring the sustainability of the health system and delivering on the expectations of Government.

Following amendments to the Crown Entities Act, sections of this Annual Plan are now extracted to form two stand-alone documents; the Statement of Intent and the Annual Statement of Performance Expectations, both of which are presented to Parliament.

The Statement of Intent describes the DHB's long-term strategic direction (focused on the next four years 2014/15 to 2017/18). The Statement of Performance Expectations describes intended service delivery for 2014/15. The Statement of Performance Expectations is used at the end of the year to compare the DHB's planned and actual performance and the audited results are then presented in the DHB's Annual Report.

The Plan also contains service and financial forecast information for the current and three subsequent years: 2014/15 to 2017/18.

The West Coast DHB has made a strong commitment to an integrated health system with joint planning and service delivery. Clinically led local and regional alliances are redesigning the way we provide health services, implementing system change and improving health outcomes. These collaborative partnerships include the West Coast Alliance, the South Island Regional Alliance and transalpine arrangements with the Canterbury DHB.

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

The actions the DHB will deliver as part of its commitment to the South Island 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 website: www.sialliance.health.nz.

The West Coast DHB also has Māori Health and Public Health Action Plans for 2014/15, 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, the undersigned, are satisfied that it represents the intentions and commitments of the West Coast DHB and West Coast Alliance for the period 1 July 2014 to 30 June 2015.

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

Peter Ballantyne
Chair West Coast DHB

Elinor Stratford
Board Member, West Coast DHB

Honourable Dr Jonathan Coleman
Minister of Health

Honourable Bill English
Minister of Finance

Date: March 2015

Approval of the Minister of Health

Office of Hon Dr Jonathan Coleman

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

Mr Peter Ballantyne
Chair
West Coast District Health Board
PO Box 387
Greymouth 7840

Dear Mr Ballantyne

West Coast District Health Board 2014/15 Annual Plan

This letter is to advise you together with the Minister of Finance, I have approved and signed West Coast District Health Board's (DHB's) 2014/15 Annual Plan for one year.

I wish to emphasise how important annual plans are for ensuring appropriate accountability arrangements are in place. I appreciate the significant work that goes into preparing your Annual Plan and thank you for your effort.

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 2014, Vote Health again received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

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 DHBs' operation and service delivery. Improvements through national, regional and sub-regional initiatives should continue to be a key focus for all DHBs.

I note the DHB is planning a deficit for 2014/15 and has a plan to return to breakeven in 2017/18. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2014/15.

The West Coast Health Facilities Redevelopment business case, which Ministers approved in 2014, included certain savings commitments that are not included in the Annual Plan. I wish to emphasise the importance of incorporating these savings into future Annual Plans. Savings commitments are integral to the decisions made by Ministers in relation to business cases, including any future business cases put forward by the DHB.

Better Public Services (BPS): Results for New Zealanders
Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whanau Ora, Children's Action Plan and Youth Mental Health.

National Health Targets
Your plan generally includes a good range of actions that will lead to improved or continued performance against the health targets. As you are aware, there is one new addition to the target set for 2014/15. From

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quarter two, the 62 day Faster Cancer treatment indicator has become the cancer health target with a target achievement level of 85 percent by July 2016.

Although West Coast DHB is performing well in most health target areas, in the year ahead, I would like you to particularly focus on improving recent results in both components of the Better help for smokers to quit target, and the More heart and diabetes checks target. I am also asking all DHBs to ensure appropriate actions are implemented to support immunisation service delivery.

Care Closer to Home
I am pleased to see tangible actions in your Annual Plan that demonstrate how you will broaden the scope of diagnostic and treatment services directly accessible to primary care.

It is important that the development of rural service level alliance teams progresses during the year. It is expected that a rural service level alliance team develops and agrees a plan for the distribution of rural funding, in accordance with the PHO Services Agreement Version 2 (July 2014).

Health of Older People
I am pleased to note your commitment to continuing price or volume increases in home and community support services, implementing your fracture liaison service, and using interRAI-based quality indicators.

Regional and National Collaboration
Greater integration between DHBs supports more effective use of clinical, financial and other resources (such as technology). In particular, clinically-led collaboration across DHBs is essential, as sharing of expertise will contribute to the realisation of regional and sub-regional benefits. I expect DHBs to make significant contributions to delivering on regional planning objectives, and to priorities specific to their regions, that will help lead to financial and clinical sustainability.

DHBs have also committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to factor in benefit impacts for the Finance Procurement Supply Chain Initiative where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

Budget 2014
I also expect that you will deliver on Budget 2014 initiatives. This includes extending free doctors' visits and prescriptions for children aged under six to all children aged under 13 from July 2015.

Annual Plan Approval
My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework. The National Health Board will contact you where change proposals need further engagement. You are reminded that you need to advise the National Health Board of any proposals that may require Ministerial approval as you review services during the year.

I would like to thank you, your staff, and your Board 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 2014/15 Annual Plan. I look forward to seeing your achievements.

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 Dr Jonathan Coleman
Minister of Health

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Part I – Overview

Message from the Chairman and Chief Executive

A Journey Well Underway

The West Coast is one of the most externally reviewed health systems in the country. In the period since 1993, no fewer than 13 reviews of West Coast health services have been undertaken. They have focused on models of care, service options, the economics of healthcare provision, workforce and facilities.

These various reviews all pointed to the same systemic challenges: a small population spread over a large geographic area; longstanding workforce shortages and a prevalence of locums leading to a loss of continuity of care; over-reliance on hospital-level services as a result of fragmented and unsustainable primary services; outdated and inefficient hospital facilities; underdeveloped transport infrastructure; poorly integrated information technology systems; and increasing service provision costs.

Importantly, the reviews all pointed to a common set of whole-of-system priorities for resolving these issues, with the patient and their journey at the centre. They included the re-energising of general practice; the systemic integration of primary care with hospital-level services; more comprehensive long-term conditions management; a strong core workforce with specialist and generalist skills; closer collaboration with the Canterbury health system; joined up transport and information systems; and fit for purpose facilities.

Extensive engagement with our community and clinicians two years ago saw us develop a comprehensive plan for systematically confronting and delivering the transformational change that was needed. During the 2013/2014 year, we have further developed and brought to life the change that this plan sets out.

Specifically, we have redesigned 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. We have agree a programme of change for a number of our services - including maternity and mental health - and we have further improved the way we deliver others, including orthopaedics and older person's health.

We have reinvigorated our recruitment strategy, the results of which are already delivering new clinical capability to the West Coast. We have further connected our information systems, including the implementation of the mental health solution shared between the West Coast, Canterbury, and South Canterbury on the *Health Connect South* platform.

We have also secured the commitment of the Government to new purpose-built healthcare facilities in both Greymouth and Westport.

In summary, we are addressing the underlying causes of unsustainable health service provision on the West Coast. We remain confident that the tangible solutions we are implementing will meet the needs of our community and enable us to provide safe and more sustainable health services for West Coasters now and into the future.

Integrating Care: A health care home and a single point of referral for complex care

The West Coast Health Alliance is now well established, and the Alliance's Grey and Buller Integrated Family Health Centre (IFHC) workstreams are leading the integration of primary care services on the West Coast. In the year ahead, the integration agenda will continue to be pursued alongside planning for the Grey and Westport IFHC facilities. The integration of primary care services is central to realising more effective, efficient and accessible care, together with the ongoing work to improve the performance of DHB-owned general practices, the further development of *HealthPathways,* and the improvements in linkages across the system.

The Complex Clinical Care Network (CCCN) has also now been established. Working alongside general practice and with the West Coast Health Alliance's Health of Older Persons Workstream, the CCCN is better supporting people with complex conditions to remain safe and well in the community and closer to their own homes, rather than in hospital settings. Ongoing commitment to the development of the CCCN and the Coast's Long-Term Conditions Management Programme are essential foundations for preventing deterioration, improving the quality of people's lives and reducing unnecessary demand on the health system.

Sustaining Care: Transalpine services and supporting health professionals

Collaboration with Canterbury continues to be a cornerstone strategy for securing reliable access to a full range of specialist services, for the most part delivered locally on the Coast and with some services delivered in Christchurch.

In 2014/2015, we will deliver on our commitment to regional collaboration and further build on the longstanding partnership between the West Coast and Canterbury health systems to ensure the future sustainability of locally delivered services. Focus services include obstetrics and gynaecology, general medicine, general surgery and anaesthesia. We will also continue to enhance the more than 20 transalpine services that are successfully delivered between the West Coast and Canterbury.

Workforce stability and capability remains another essential enabler for improving the continuity of care we provide and for reducing our historical over-reliance on locums. While we yet have some distance to travel, we have invested in new approaches to medical recruitment including the recruitment of Rural Hospital Medicine doctors, the results of which are already delivering new capability to the West Coast. Joint appointments between the West Coast and Canterbury health systems continue to ensure access to specialist care on the Coast, including in paediatrics, anaesthesia, and gerontology. Our collaboration with Canterbury on a highly successful Nursing Entry to Practice programme is ongoing, and our Rural Learning Centre will continue to work to reduce workforce isolation factors through collaboration, peer support and mentoring.

Connecting Care: Integrated information systems

Integrated information systems are critical to the delivery of joined-up care. Over the past year, we have implemented a regional e-referrals solution that better enables clinicians to provide access to the right service. Our innovative approach to the Health Connect South platform is being considered for wider regional roll-out.

In the year ahead, we will continue to support the implementation of new clinical information systems, including the Electronic Shared Care Record View (eSCRV). This will revolutionise the delivery of clinical care by ensuring that clinicians across the whole of the health system have access to the patient information they need to make the best possible decisions.

Additionally, our ongoing investment in telehealth is improving access to specialist care and reducing associated delays and costs for patients.

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

The announcement by government of new purpose-built healthcare facilities in both Greymouth and Westport confirms the future of healthcare services for people on the West Coast.

In the last twelve months, significant effort was invested by clinical teams who shaped the development of facility solutions for Greymouth and Westport. In the year ahead, clinicians will be at the forefront of developing the detailed design and plans for the new Grey Base Hospital and IFHC in Greymouth and the IFHC in Westport.

The go-ahead for these new facilities will enable us to plan and take the next steps in the journey that we are on with confidence.

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.

Nine months into 2013/14:

- We are on track to achieve our electives target.
- 100% of people needing radiation or chemotherapy treatment received treatment within 4 weeks.
- 92.5% of hospitalised smokers and 55.4% of smokers in primary care were provided with advice and support to quit (up from 89% and 44% respectively last year).
- 89% of all eight-month-olds on the West Coast were fully immunised, (up 5%).
- 69.6% of eligible people on the Coast had received a cardiovascular risk assessment in the past five years (up from 58% last year).

Clinically and financially sustainable care: A clear plan and commitment

Our vision is for an integrated health system that is clinically sustainable, financially viable and wraps care around a person to help them stay well as close to home as possible. At the heart of this vision is a fundamental re-orientation of our current service model to an integrated home and community-centric system that has the patient firmly at the centre.

As we reflect on the last twelve months, we would like to acknowledge all those across the West Coast health system who continue to travel with us on this journey of transformation. There are many people working hard to deliver a future of sustainable healthcare services for the West Coast.

In year ahead, we remain determined to continue delivering on our commitments, meet national targets, and live within our means. What this means is that we will continue our journey of transformation that is delivering - 21 years on from the first review of Coast health services in 1993 - the kind of health system which Coasters deserve and in which they can be proud.

Peter Ballantyne
Chairman West Coast DHB

David Meates
Chief Executive West Coast DHB

Date: March 2015

Introducing the West Coast DHB

The West Coast DHB has the smallest population of all of New Zealand's 20 District Health Boards, serving at total resident population of 32,145 people.

The West Coast 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 also a major employer in the West Coast district, employing over 1,000 people.

1.1 Our role and function

The West Coast DHB receives funding from Government with which to fund and provide health and disability services for the West Coast population. In accordance with legislation and the objectives of the DHB, we use this funding to:

Plan the strategic direction of health and disability services on the West Coast and determine the services required to meet the needs of the population, in partnership with primary care, clinical leaders and key stakeholders and in consultation with our community.

Fund the majority of health and disability services provided on the Coast and, through our collaborative relationships with service providers, ensure services are responsive, coordinated, and focused on what is best for the patient and the health system.

Provide health and disability services for the population of the West Coast, through our hospital and specialist services and our DHB-owned general practices.

Promote and protect population health and wellbeing through health promotion, health education and the provision of evidence-based public health initiatives.

1.2 Our operating structure

Governing the DHB

Our Board is responsible to the Minister of Health for the overall performance of the DHB and delivers against this responsibility by setting 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 requirements and maintains relationships with the Minister of Health and the West Coast community.

Five advisory committees assist the Board to meet its responsibilities. These committees are comprised of a mix of Board members and community representatives.

As part of our commitment to shared decision-making, external providers and clinical leaders also regularly present to the Board and its sub-committees.

While responsibility for the DHB's overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive. The Chief Executive is supported by an Executive Management Team, which provides clinical, strategic, financial and cultural input into decision-making and has oversight of patient safety and quality.

Since July 2010, executive services for the West Coast DHB have been shared with the Canterbury DHB, with one Chief Executive, a growing number of joint appointments and shared corporate divisions including: finance, human resources, information technology, public health and planning and funding services. These joint arrangements promote a better understanding of individual DHB issues on both sides and a closer working relationship between the two DHBs. [1]

Planning and funding health services

The DHB's role includes determining how best to use the funding we receive from Government to improve the health, wellbeing and independence of our population. We work with other providers, agencies, consumers and our community to understand our population's health need.

Through this collaboration, we ensure that services are people-centred, integrated and viable. Our collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the West Coast health system to achieve the best possible 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 primary care agreements with the West Coast Primary Health Organisation (PHO), residential mental health service agreements, Māori health service agreements and transalpine service agreements with Canterbury.

[1] *Refer to Appendix 2 for the legislative objectives of a DHB and Appendix 4 for the DHB's organisation structure.*

Providing health and disability services

The West Coast DHB owns Grey Base Hospital, Reefton Hospital and Buller Health and provides a range of hospital-based services on these sites. We also provide specialist outpatient and allied health services on an outreach/extension basis via the Reefton Health, Hokitika Health and Buller Health Centres. The DHB owns Ziman House and Kynnersley Home, which provide rest home level residential care. The DHB also owns five of the eight primary health centres on the West Coast and a number of associated health clinics in remote rural areas including Ngakawau, Karamea and Moana.

This is no small responsibility – in an average week on the West Coast: 230 people go through our Grey Base Emergency Department; 118 people are admitted to our hospitals; 34 people have elective surgery; 297 people have a specialist outpatient appointment and 2,530 general practice appointments are provided.

Promoting community health and wellbeing

The Community and Public Health Division of the Canterbury DHB provides population health and promotion services on behalf of the West Coast DHB. Working with the West Coast PHO, the DHB supports collaborative initiatives that focus on the reduction of negative behaviours and risk factors. This includes improving nutrition and physical activity and reducing tobacco smoking and alcohol consumption under the collective banner of 'Healthy West Coast'.

Community and Public Health also provides health protection services and assists in safeguarding water quality, bio-security (protecting people from disease carrying insects and other pests), the control of communicable diseases and emergency planning to prepare for a natural or biological emergency.

However, good health is determined by many factors and social determinants that sit outside the direct control of the health system. Our partnerships with other agencies (including local and regional councils, Housing NZ, Accident Compensation Corporation and the Ministries of Justice, Education and Social Development) are also vital in influencing and supporting the creation of social and physical environments that reduce the risk of ill health.

1.3 Our transalpine service model

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

While the West Coast has had informal arrangements with the Canterbury DHB, these are now being formalised through the establishment of clinically led transalpine service pathways.

This approach is not about reducing services. Formal arrangements enable both DHBs to proactively develop the most appropriate workforce and service infrastructure, to ensure future services meet the needs of both populations and are both clinically and financially sustainable.

These arrangements include joint clinical appointments and shared services that have enabled specialists to visit the West Coast and provide outpatient clinics to save patients from having to travel. Deliberate investment in telemedicine technology such as videoconferencing is also allowing clinical teams to provide better support to their patients and reducing long waits and travel for treatment.

Since 2010, more than 800 telehealth consultations have taken place in a variety of specialties, including oncology, paediatrics, general medicine, plastics, orthopaedics and general surgery – providing access to specialist advice while saving many families the inconvenience of travelling long distances for treatment.

1.4 Our 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 with the Minister and seek prior approval before making any significant service change, capital investment or disposal of Crown land. We will also comply with specific consultation expectations that the Minister communicates to us.

The Crown Entities Act requires DHBs to report annually to Parliament on their performance, as judged against our Statement of Performance Expectations. We publish this account as our Annual Report, available on our website.

In addition, DHBs have a number of other reporting obligations under the Crown Entities Act and Operational Policy Framework. These include financial and non-financial service performance reporting provided to the National Health Board including:

- 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 Elective Services Performance Indicator (ESPI) compliance reporting.

We will also meet our requirements with respect to national data collection, including: national health index, national minimum dataset, national booking reporting system, national immunisation register, national non-admitted patient collection and ethnicity reporting.

Identifying Our Challenges

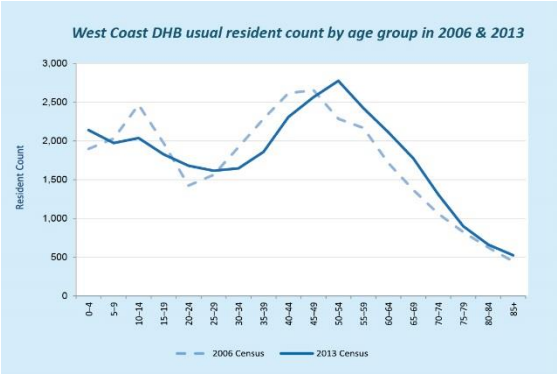
Analysing the demographics and health profile of our population helps us to predict the demand for services and influences the choices we make when prioritising and allocating resources. This information also helps us to understand the factors affecting our performance and identify areas for focus and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

2.1 Population profile

West Coast was home to a resident population of 32,145 people at the 2013 Census, an increase of 2.6% on 2006. This is a slower rate of growth than between the 2001 and 2006 censuses. Grey district has the largest population, with a resident population of 13,371 people.[2]

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 (16.1%) compared with the national rate (14.3%).

While our younger populations decreased slightly between 2006 and 2013, there was significant growth in our older population groups. 5,181 people on the Coast are aged 65 or older and 2,088 (6.5% of our total population) are aged 75 or older.



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. The ageing of our population will put significant pressure on our workforce, infrastructure and finances.

Our Māori population has a different age structure and growth pattern, with 42.4% of the West Coast Māori population under 20 years of age compared to 24.8% of the total population. However, ethnicity is a strong indicator of need for health services and must be considered when planning services for the future. One in ten West Coasters identifies as Māori (10.5% up from 9.7% in 2006). Westland district has the largest Māori population in the region, at 13.4%.

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

2.2 Health profile

West Coasters have 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 region. 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.

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 also have higher smoking rates compared with other areas in New Zealand. The 2013 Census showed that 19.6% of West Coast residents were regular smokers, compared to 14.4% of New Zealand as a whole. Amongst West Coast Māori, 32.4% of the population were regular smokers. The negative health outcomes associated with risk factors such as tobacco smoking place considerable pressure on our health system. Smoking is also a substantial contributor to socio-economically based health inequalities.

2.3 Operating environment

Geographical pressures

Meeting our population's health need is a highly complex business that is further complicated by the challenges of delivering health services to a relatively small population over a large geographic area.

Bordered by the Southern Alps on the east and the Tasman Sea on the west, the West Coast is the most rural

[2] *Unless otherwise referenced, data is based on Statistics NZ 2013 Census and Ministry of Health mortality data. See Appendix 3 for a summary of the 2013 Census.*

and isolated DHB in New Zealand. It is also the most sparsely populated, with a population density of 1.4 people per square kilometre.

While our population is just 0.76% of New Zealand's estimated resident population, the total land area covered by the West Coast DHB is 23,283 square kilometres, with great distances between towns. The distance between Karamea in the north and Haast in the south is 516 kilometres, almost the same as from Auckland to Palmerston North. This creates significant challenges, often requiring patients or health professionals to travel long distances to receive or deliver health services. 30.7% of households on the West Coast have only one resident.

This is further complicated by the fact that fewer West Coasters have access to a motor vehicle or telephone than other New Zealanders. 3.4% of West Coast households have no telecommunication systems; this is the highest proportion of any region in New Zealand.

Workforce pressures

Our ability to 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 over 1,000 people in our services and almost the same number in the community through service contracts for health and disability services with public, private and charitable organisations.

Like many DHBs, as a greater proportion of our population reaches traditional retirement age, there are concerns over the availability of a sufficient workforce to meet increasing demand for health services. However, as a result of our geographical isolation, it can be especially difficult to recruit and retain health staff to work on the West Coast. Our past reliance on temporary and locum staff has made it difficult to maintain consistency of care and is financially unsustainable.

Our ability to safely provide complex and specialised services is also challenged by the relatively small number of Senior Medical Officers and specialist clinicians in our services. While we are addressing this as part of our transalpine collaboration with the Canterbury DHB, we also need to focus on the recruitment of permanent staff with more generalist skills and the creation of new roles with wider scopes to give stability to our services.

Facility pressures

In their current configuration, our facilities limit the development of new models of service delivery, are outdated and inefficient, and are expensive to maintain. In addition, some of our primary and community facilities are not appropriately located or configured to support an integrated service model or clinical team.

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 move into temporary or crowded spaces – putting further pressure on our capacity and on our workforce.

In May 2014 approval was given for the redevelopment of the Grey Hospital and Integrated Family Health Centre. A joint Partnership Group, appointed by the Ministry of Health, is charged with delivering the facilities redevelopment. The DHB is also moving forward in addressing the need for viable health services in Buller. It is imperative that the new facilities are fit-for-purpose and designed to support rather than hinder our more responsive and integrated health system model.

While the redevelopment process is underway, it is important that we make carefully considered decisions on the repair of current facilities to ensure safety and service continuity – without over-investing in facilities that do not have a future role.

Fiscal pressures

Government has given clear signals that DHBs need to live within their means and rethink how we deliver improved health outcomes in more cost-effective ways.

Numerous factors contribute to fiscal pressures: the costs of meeting wage and salary increases; increasing demand for services including diagnostics and residential care; and rising treatment related and infrastructure costs.

Our ability to contain cost growth within affordable levels is made more difficult by rising public and cross-government expectations, an ageing population and the increasing costs of new technology.

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

The DHB will need to successfully implement a number of strategies to minimise cost growth and achieve long-term financial sustainability including: the development of integrated models of care in Grey/Westland and Buller, improved management of DHB-owned general practice, increased transalpine collaboration with the Canterbury DHB, clinically led service transformation of local services and the improved use of technology and workforce.

2.4 Critical success factors

The following areas are where the greatest gains can be made in improving health outcomes for our population and the viability of our health system. They also represent the major factors critical to our success, where failure would significantly threaten the achievement of the strategies and goals outlined in this plan.

CRITICAL SUCCESS FACTORS	KEY STRATEGIES
Integrating fragmented health services A legacy of unsustainable DHB-owned general practices with financial, access and continuity of care issues has led to fragmentation amongst general practices and secondary services and a number of inefficient, isolated services struggling to deliver in appropriate settings.	Complete the remediation of DHB-owned general practice underway with Better Health, with a focus on clinical recruitment and improved service delivery. Expand the focus of the West Coast Alliance and deliver against key projects. Support more flexible service delivery models including: mobile, in-reach and afterhours services and direct access to diagnostics and specialist advice for GPs. Continue to invest in the development of HealthPathways. Support the major design and development phases of the hospital and Integrated Family Health Centre developments on the Grey and Buller Hospital sites. Invest in the Health Care Home Strategy to increase the use of multidisciplinary teams and improve linkages across the system, particularly as the IFHCs develop.
Connecting the system Unreliable paper-based information systems and poorly performing information technology platforms have led to ineffective and inefficient service delivery, wasting time and reducing the continuity and safety of care.	Support implementation of new clinical information systems, Health Connect South and the Electronic Shared Care Record View (eSCRV). Implement eReferrals and eSign-Off systems to reduce duplication and delays. Expand the use of telemedicine technology to improve the continuity of care and reduce the associated delays and costs of patient and clinician travel. Implement national information collection systems.
Reducing reliance on secondary care High surgical intervention rates and overinvestment in secondary services (at the expense of community alternatives) has led to a reliance and demand for hospital services that far outweighs capacity and is financially unsustainable.	Implement a community-based rapid response and supported discharge service and introduce a stepped care model for Mental Health Services to support people in the community and closer to their own homes, rather than in hospital settings. Enhance the single point of referral through the Complex Clinical Care Network and introduce a casemix model to provide a more timely and flexible response. Expand the transalpine model to provide more certainty of care for West Coast residents where highly specialised services are not sustainable.
Assuring patient safety With a series of recent sentinel events, assurances are needed about the quality of services being delivered and the safety of patients in our care.	Support the rollout the national patient safety project 'Open for Better Care'. Complete implementation of the Maternity Review recommendations. Implement the recommendations of the Mental Health Service Review. Continue to review all serious events to identify issues that need resolution.
Building a sustainable workforce Longstanding clinical recruitment and retention issues have led to high use of locums and temporary staff. This not only reduces continuity of care and operational leadership capability, but is also financially unsustainable.	Seek clinicians with a wider range of generalist skills and introduce models of care that enable staff to work to the greatest extent of their scope. Implement a new general practice recruitment strategy through Better Health. Invest in the development of our rural clinical workforce through the Rural Learning Centre in Greymouth, including mentoring, training and supervision. Develop a transalpine recruitment strategy and support joint senior appointments between the West Coast and the Canterbury DHB. Invest in telemedicine systems and outreach clinics that will allow specialists to provide advice and supervision to colleagues in more remote areas.
Meeting community expectations Longstanding community frustration, has eroded confidence and trust in the West Coast health system.	Establish a Consumer Council to formalise consumer engagement. Invest in a grassroots community engagement strategy to increase transparency around imperatives for change. Engage in a proactive media campaign to better inform the community of what is happening across the health system.
Meeting Government expectations It is important that the West Coast DHB delivers against national expectations in order to maintain the confidence of Government – particularly in light of the investment being made in our health system over the next five years.	Deliver against the six national health targets. Work regionally and nationally to support tighter, collaborative purchasing and procurement processes that reduce avoidable cost growth. Through the West Coast Alliance and Hospital Redevelopment Partnership Group, accelerate implementation of the Integrated Family Health Service model. Reduce the West Coast DHB deficit and manage within future forecast budgets.

Part II – Long-Term Outlook

Our Strategic Direction

What are we trying to achieve?

3.1 Our strategic context

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. However, with increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and the whole of the New Zealand health system faces an unsustainable future.

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHB service planning.[3]

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:

1. Early intervention, targeted prevention and self-management and a shift to more home-based care.
2. A more connected system and integrated services, with more services provided in community settings.
3. Regional collaboration clusters and clinical networks, with more regional service provision.
4. 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.

To ensure the sustainability of the health system, DHBs need to shift their population's health needs away from the complex end of the continuum of care and support more people to manage their own health and stay well.

These shifts can only be achieved with the support of connected and integrated clinical networks and multidisciplinary teams and are consistent with the changes being driven across the West Coast health system to meet the needs of our population.

3.2 The West Coast vision

"An integrated West Coast health system that is clinically sustainable, financially viable and wraps care around the patient to help them stay well".

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 – consulting with partner organisations, clinical staff and the West Coast community about a range of initiatives and changes that 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, financially viable and wraps care around the patient to help them stay well.

At the heart of this vision is a fundamental reorientation of our current service model to an integrated, home and community-centric model, with the retention of a full range of hospital-level services, but delivered in more efficient and effective ways.

New services will be offered close to home that focus on prevention, early intervention and increased responsiveness. From a service delivery perspective, healthcare providers are being brought together to work as teams. There is a plan underway to implement common assessment tools and pathways that will ensure the right person or team is able to provide the right care and support at the right time and in the right place.

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.

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

Implementation of our new model of care is underway on all fronts. 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.

Important steps have already been taken towards achieving a more integrated health system, including improving clinical information systems, commencing the development of Integrated Family Health Services within the Grey/Westland and Buller communities, and setting in place a new transalpine health service for specialist services between the West Coast and Canterbury DHBs.

Recognising that clinical leadership is 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.

While many of the challenges we face are the same as other DHBs, the difference for 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' – we must develop tailored solutions that enable us to do more (for more people) with the resources we have available.

Partnerships and alliances are also critical – not only in improving outcomes for our population, but in ensuring our health system is clinically and financially sustainable. The West Coast 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.

The redevelopment of health facilities is also a critical factor in the future sustainability of health services on the West Coast. Approval for the redevelopment of the Grey Hospital and Integrated Family Health Centre was granted in May 2014 and consultation on the redesign of services in Buller is underway.

The DHB will continue to work closely with the Ministerial appointed Hospital Redevelopment Partnership Group to ensure that the new facilities development will enable our redesigned model of care to be delivered, the health needs of our community to be met and our vision for the West Coast health system to be realised.

Achieving our vision requires the transformation of our entire health system. 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.

Our West Coast Alliance and the continued engagement of stakeholders and our community in the future of our health systems is critical to our success. The development of our new model of care includes nine key components, and this is where our focus will be over the next three years:

A healthcare home, with emphasis on primary care as the point of continuity, multi-disciplinary teams working in the community to wrap care around the patient and a more integrated response to acute demand.

A single point of referral for complex care, with the introduction of a rapid response and supported discharge service to better support people at home and in community settings.

Locally delivered hospital-level services using both specialists and rural hospital medicine doctors, in closer transalpine collaboration with Canterbury.

Healthy environments and lifestyles, with emphasis on early intervention and reducing risk factors and a commitment to Smokefree Aotearoa 2025.

Strengthened mainstream service responsiveness to Māori needs, alongside supporting Kaupapa Māori service developments and Whānau Ora.

Integrated information systems, with a focus on clinical information systems that support decision-making at the point of care and extended use of telemedicine.

Maintenance and deliberate development of a local workforce of resident specialists and generalists supported by clinicians from Canterbury.

Improved transport solutions and patient transport infrastructure.

The development of modern, fit-for-purpose facilities and integrated family health services closer to people's homes that support closer alignment and integration of health teams.

3.3 National direction

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.

The ultimate health sector outcomes are that all New Zealanders lead longer, healthier and more independent lives; and the health system is cost-effective and supports a productive economy.

DHBs are expected to contribute to meeting the national health sector outcomes and Government commitments to provide *'better, sooner, more convenient health services'* by: increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money.

Alongside these longer-term national strategies and commitments, the Minister of Health's annual 'Letter of Expectations' also signals priorities for the health sector – most specifically with regards to the delivery of better public services and the six national health targets.[4]

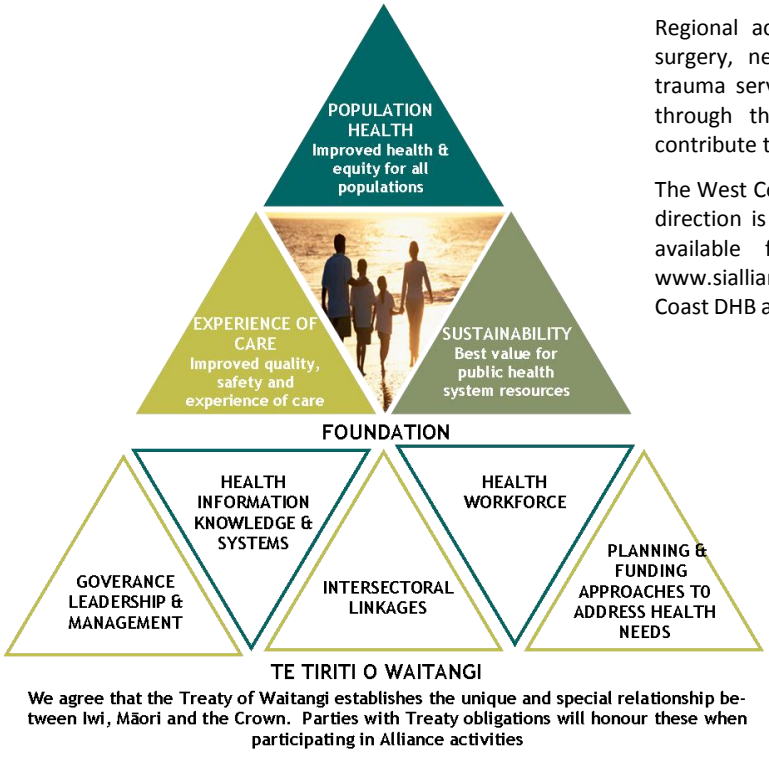
The West Coast DHB is committed to making continued progress against national priorities and health targets. Activity planned over the coming year to deliver on national expectations is part of the focus of the West Coast Alliance and prioritised by the Alliance Workstreams and the DHB's Service Divisions. Key actions for the coming years are outlined in Section 6 of this document.

3.4 Regional direction

In delivering its commitment to '*better, sooner, more convenient health services*', the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The South Island Alliance was established in 2011 to formalise the partnership between the five South Island DHBs. In 2013, the region's DHBs agreed to further develop this approach with a framework that aligns all regional activity to agreed goals. The '*best for patients, best for system*' framework has become '*Best for People, Best for System',* supporting a focus on the whole population. The shared vision has also been revised to include disability to ensure key population groups are identified within the framework:

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



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. The South Island DHBs are committed, through the Alliance, to making the best use of all available resources, strengthening clinical and financial sustainability and increasing access to services for the South Island population.

The Canterbury, Nelson Marlborough, West Coast, South Canterbury and Southern DHBs form the South Island Alliance – together providing services for 1,004,380 people (23.7% of the total NZ population).

The success of the Alliance 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

Closely aligned to the national direction, the shared outcomes goals of the South Island Alliance are:

- Improved health and equity for all populations.
- Improved quality, safety and experience of care.
- Best value for public health system resources.

To help ensure success, regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multidisciplinary representation from community and primary care, hospital and specialist services and consumers.

There are seven priority areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity will also focus on: cardiology, elective surgery, neurosurgery, public health, stroke and major trauma services. Regional asset and workforce planning, through the South Island Regional Training Hub, will contribute to improved delivery in all service areas.

The West Coast DHB's commitment in terms of the regional direction is outlined in the Regional Health Services Plan, available from the South Island Alliance website: www.sialliance.health.nz. Key deliverables for the West Coast DHB are also highlighted in Section 6 of this document.

[4] *Refer to Appendix 6 for the Minister's Letter for 2014/15 and Appendix 7 for the DHB's commitment to the Health Targets.*

Measuring Our Progress

How will we know we are making a difference?

DHBs are expected to deliver against the national health sector outcomes: '*All New Zealanders lead longer, healthier and more independent lives'* and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in meeting those commitments and in improving the health and wellbeing of their populations. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service access indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing a strategic framework, the South Island DHBs identified three high-level strategic regional goals. To achieve these goals, we have agreed a number of key strategies which will be achieved through the delivery of regional initiatives and the collective activity of all five South Island DHBs. A comprehensive indicator set is currently under development, to sit alongside the regional strategic framework and enable evaluation of regional activity.

While the regional framework is developed, the South Island DHBs have identified four collective DHB outcome goals where individual DHB performance will contribute to regional success – along with a core set of associated outcomes indicators, which will demonstrate whether we are making a positive change in the health of our populations. These are long-term outcome indicators (up to 10 years in the life of the health system) and as such, the aim is for a measurable change in health status 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 acute medical admission rates.

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

  A reduction in avoidable mortality rates.

  A reduction in acute readmission rates.

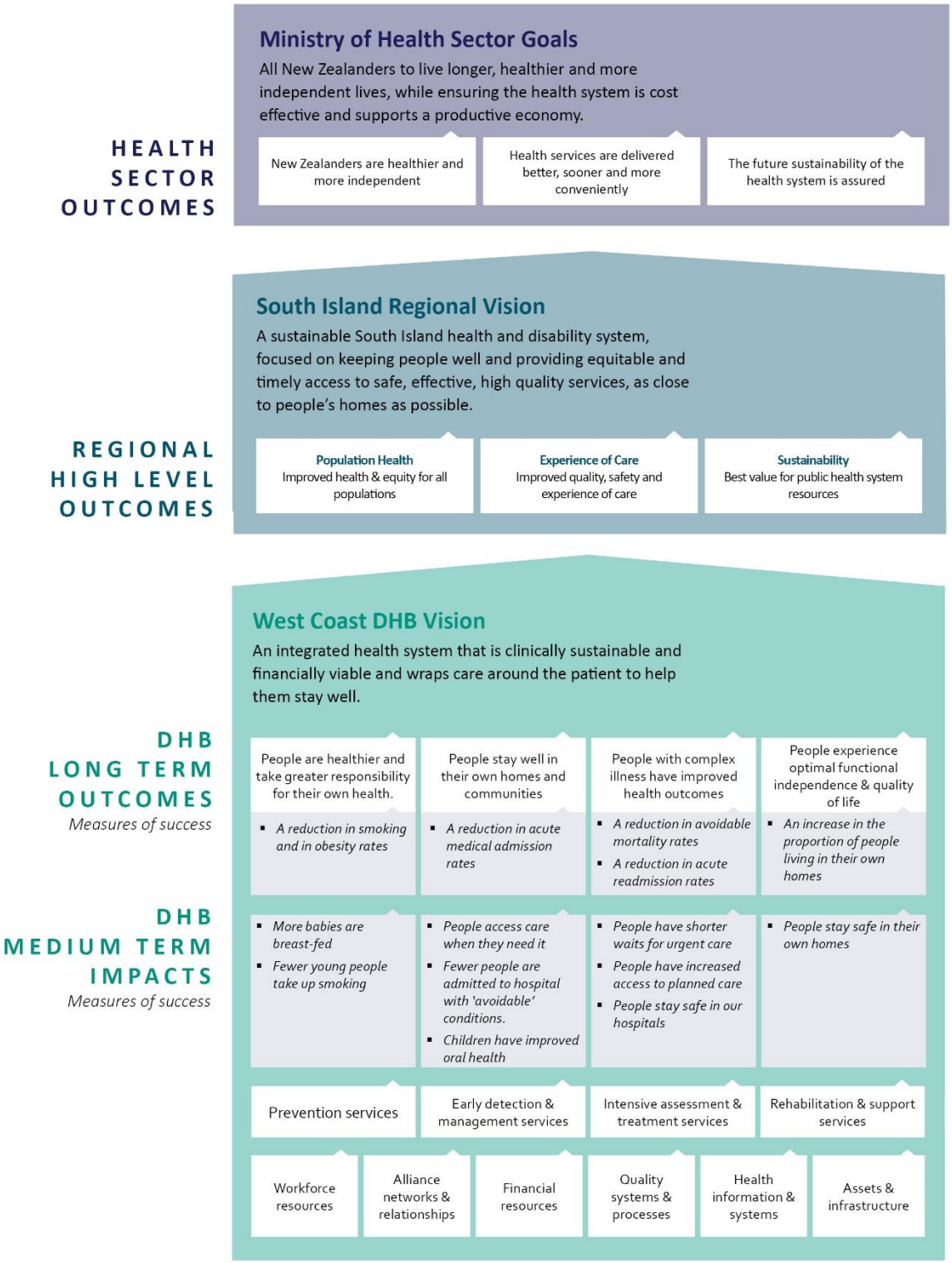
- *Outcome 4: People experience optimal functional independence and quality of life.*

  An increase in the proportion of the population living in their own homes.

Each of the South Island DHBs has also identified a set of associated medium-term indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance, and each DHB has set local targets in their Annual Plans to evaluate their performance over the next four years. These indicators will sit alongside the DHB's Statement of Performance Expectations and be reported against in the DHB's Annual Report at the end of every year.

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

Overarching intervention logic



STRATEGIC OUTCOME GOAL 1

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

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 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. Long-term conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

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

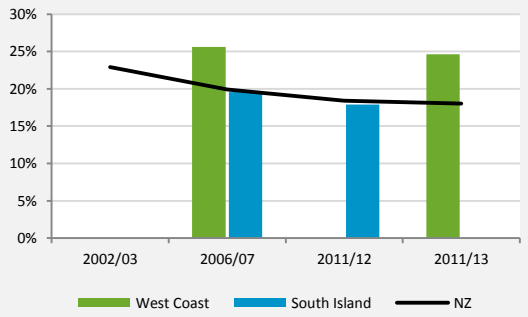
We will know we are succeeding when there is:

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.[5][6]

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

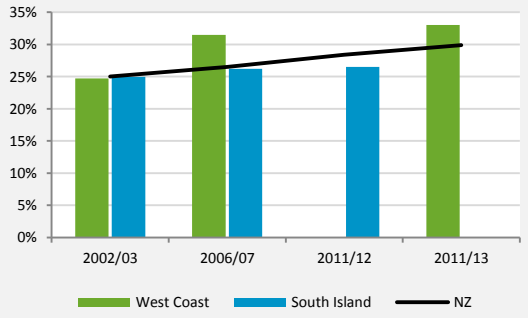


A reduction in obesity rates.

- *There has been a rise in obesity rates in New Zealand in recent decades. The 2011/13 NZ Health Survey found that 30% of adults and 10% of children are now 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 of 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.



[5] *The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. Results by region and DHB are subject to availability and results for 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs hence the different time periods presented. Ethnicity breakdowns are not provided.*

[6] The 2013 Census results for smoking (while not directly *comparable*) demonstrated greater improvements, with 20.5% of those aged 15+ smoking regularly, down from 25.7% in 2006. Rates for Māori, while improving, are still high, with 34.3% of West Coast Māori (15+) being regular smokers, down from 41.4% in 2006.

[7] *'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

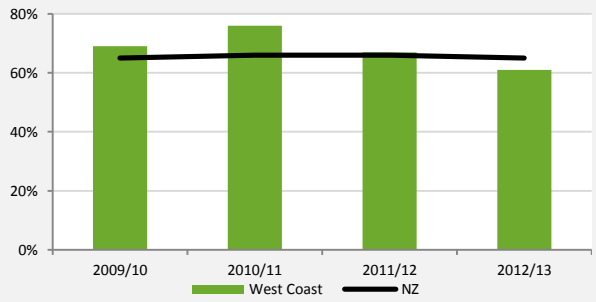
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the prevention services the DHB funds and provides:

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.*
- *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 exclusively or fully breastfed at 6 weeks.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	61%	74%	>74%	>74%	>74%

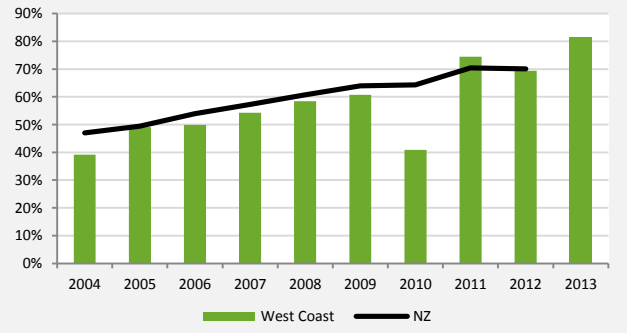


Fewer young people take up tobacco smoking.

- *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 2013	Target 2014	Target 2015	Target 2016	Target 2017
	82%	75%	>75%	>75%	>75%



[8] *This data is provided nationally by the Ministry of Health for Plunket only. It does not include local WellChild/Tamariki Ora breastfeeding results. The target is based on national Well Child standards for breastfeeding at 6 weeks.*

[9] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz. A national result for 2013 was not available at the time of publication.*

STRATEGIC OUTCOME GOAL 2

4.2 People stay well in their own homes and communities

Why is this outcome a priority?

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.

General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection, diagnosis 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 terms of improving the management of care for people with long-term conditions and reducing the exacerbations of those conditions and the complications of injury and illness.

For most people, their general practice team is their first point of contact with health services; however, supporting general practice are a range of other health professionals including midwives, community nurses, social workers, personal health providers and pharmacists. These providers also have prevention and early intervention perspectives that link people with other health and social services and support them to stay well and out of hospital.

OUTCOME MEASURES LONG TERM

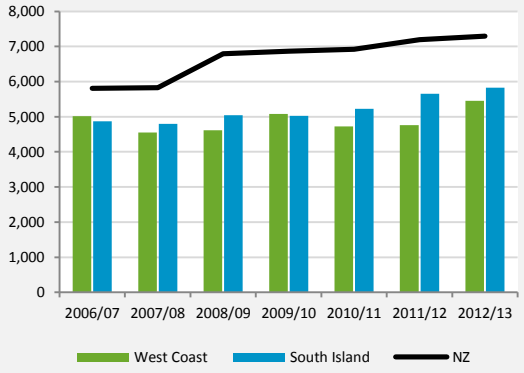
We will know we are succeeding when there is:

A reduction in acute medical admission rates.

- *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.*
- *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.*
- *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.*

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

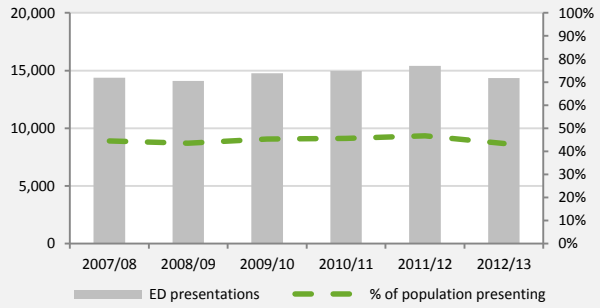
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the early detection and management services the DHB funds and provides:

People access 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.

The percentage of the population presenting at ED.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	43%	<45%	<45%	<45%	<45%

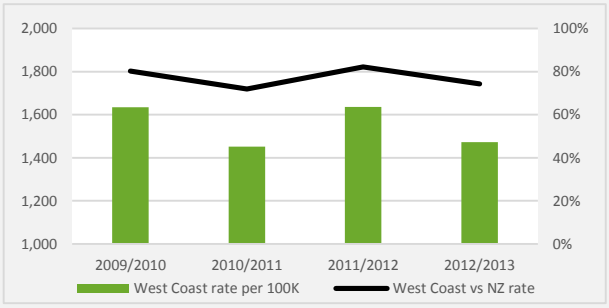


Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *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. A reduction indicates improvements in care and frees up hospital resources for more complex and urgent cases.*
- *The key factors in reducing avoidable admissions are access to diagnostics and treatment, integration between services and the systems approach to 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. [10]

The ratio of actual to expected avoidable hospital population for our population (<75).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	74%	≤95%	≤95%	≤95%	≤95%

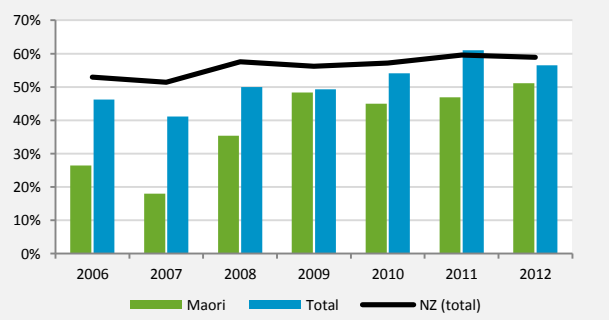


Children have improved oral health.

- *Oral health is an integral component of lifelong health and affects a person's comfort in eating, 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.*
- *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.*
- *The target for this measure have been set to hold the total population rate steady while placing particular emphasis on bring the rates for Māori and Pacific children up.*

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).	Actual 2012	Target 2014	Target 2015	Target 2016	Target 2017
	56%	≥54%	≥56%	>56%	>56%



[10] *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 population, and the target is set to maintain performance at below 95% of the national rate. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity, while this has little impact on total population results it is having a significant impact on Māori results against this measure. The DHB is working with the Ministry to resolve this issue.*

STRATEGIC OUTCOME GOAL 3

4.3 People with complex illness have improved health outcomes

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 in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures. At the same time, the Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reduces demand by moving the point of intervention earlier in the path of illness.

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 have a negative impact on the health of our population.

OUTCOME MEASURES LONG TERM

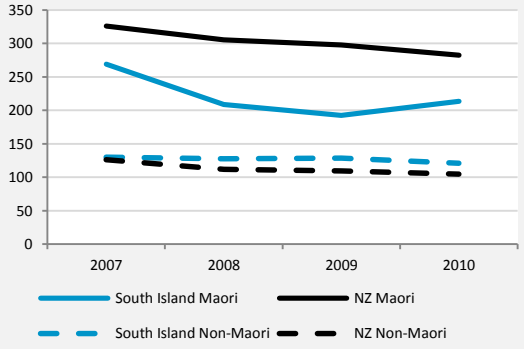
We will know we are succeeding when there is:

A reduction in avoidable mortality rates.

- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases the options for treatment and the chances of survival.*
- *Premature mortality (death before age 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the more harmful impacts and complications of a number of complex illnesses can be reduced.*
- *A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.*

Data sourced from MoH mortality collection 2010 update.

Outcome Measure: The rate of all-cause mortality for people aged under 65 (age-standardised per 100,000).

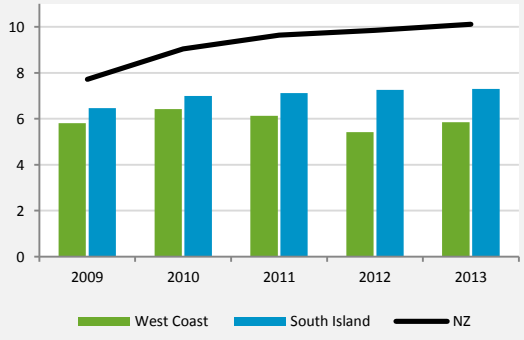


A reduction in acute readmission rates.

- *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.*
- *Some 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.*
- *Acute readmissions 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 of services and appropriate supports for people on discharge.*

Data sourced from Ministry of Health (raw rates, unstandardised).

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



IMPACT MEASURES MEDIUM TERM

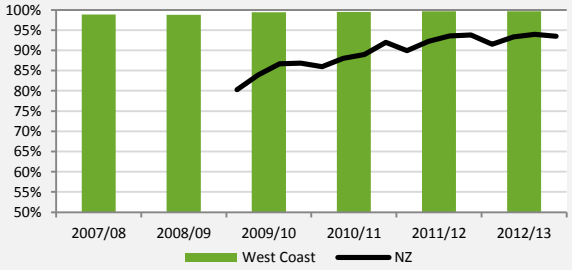
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the intensive assessment and treatment services the DHB funds and provides:

People have shorter waits for acute (urgent) care.

- *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, longer hospital stays and negative outcomes for patients. Timely ED performance signals not only good outcomes through early intervention and treatment but also fosters public confidence and trust in health services.*
- *Strategies to maintain short waits span not only the hospital but the whole health system. In this sense, this indicator reflects how responsive the whole system is to the urgent care needs of the population.*

Data sourced from individual DHBs.[11]

The percentage of people presenting at ED - admitted, discharged or transferred within six hours.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	99.7%	>95%	>95%	>95%	>95%

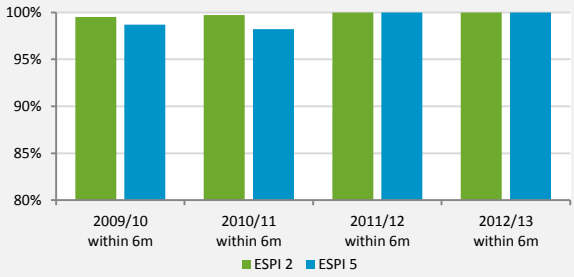


People have increased access to planned care.

- *Elective (planned) 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 that 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.[12]

Wait time (months) from referral to First Specialist Assessment (ESPI 2).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/16
	<6	<4	<4	<4	<4
Wait time (months) commitment to treatment (ESPI 5).	<6	<4	<4	<4	<4

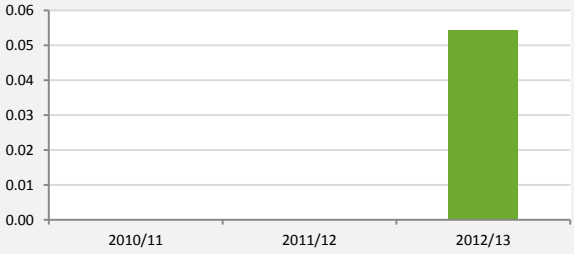


People stay safe in our hospitals.

- *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 patients are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence and an increased risk of institutional care.*
- *Achievement against this measure is also seen as a proxy indicator of the engagement of staff and clinical leaders in improving processes and championing quality.*

Data sourced from individual DHBs.[13]

The rate of SAC level 1 and 2 falls in West Coast Hospitals.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	0.05	<0.05	<0.05	<0.05	<0.05



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

[12] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance, and DHBs receive individual performance reports from the Ministry of Health on a monthly basis. National performance data is not made available. The wait time target for 2014/15 is mixed - being a maximum of 5 months for Q1 and Q2 and a maximum of 4 months from January 2015.*

[13] *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. This measure differs to that used in previous report as it refers to the total population rather than just events for those aged 65+.*

STRATEGIC OUTCOME GOAL 4

4.4 People experience optimal functional independence and quality of life

Why is this outcome a priority?

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 improving quality of life, such as pain management or palliative services.

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 reduces the rate of acute hospital admissions and frees up health resources across the system.

OUTCOME MEASURES LONG TERM

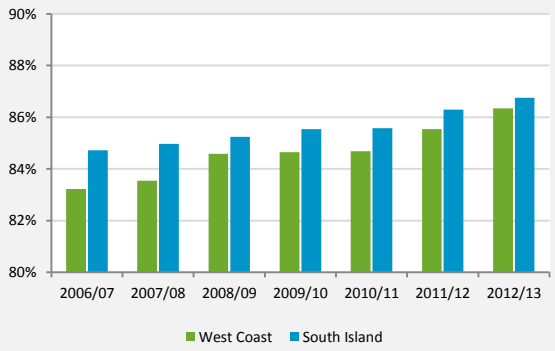
We will know we are succeeding when there is:

An increase in the proportion of the population living 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 to help people stay well in their own homes.*
- *An increase in the proportion of people supported in their own homes can be used as a proxy measure of how well the health system 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 population (75+) living in their own homes.



IMPACT MEASURES MEDIUM TERM

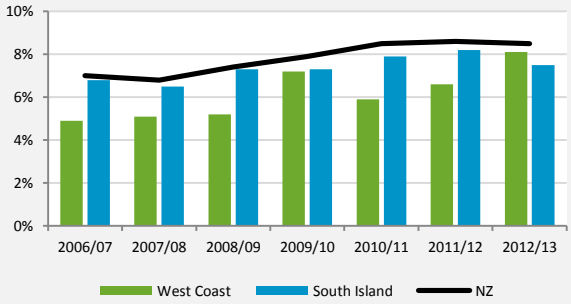
Over the next three years, we seek to make a positive impact on the health and wellbeing of the West Coast population and contribute to achieving the longer-term outcomes we seek. The following headline indicators will be used annually to evaluate the effectiveness and quality of the rehabilitation and support services the DHB funds and provides:

People stay safe in their own homes.

- *Around 22,000 New Zealanders aged 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 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 thus 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 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	8.2%	7.8%	7.4%	7%	6.6%



Our Organisational Capacity and Capability

What do we need to deliver our vision?

Having already identified the challenges we face and set a collective vision for the West Coast health system, this section highlights the strengths that we have, or will have to develop, over the next several years to support our transformation and deliver on our goals.

5.1 A patient-focused culture

Our culture is an important element in transforming and integrating our health system. 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 the patient and for the health system. We also need buy-in and support from our community.

Part of our focus is on increased transparency and engagement with our workforce and our community. Longstanding frustrations have eroded confidence and trust in the West Coast health system.

Our weekly Chief Executive updates and quarterly 'Report to the Community' newsletters keep people informed of developments across the West Coast health system and provide opportunities for feedback and engagement. Clinically led community road shows are also held annually to provide updates on progress in transforming the West Coast health system and opportunities for us to hear the views and concerns of our community.

Over the last two years, the West Coast DHB has invested in leadership and engagement programmes that encourage our workforce to ask '*What is best for the patient?*' and empower them to make change to improve the effectiveness and efficiency of our health system. The '*Xcelr8*', '*Collabor8*', and '*Making Time for Caring*' programmes promote lean thinking approaches to service and system design and support the development of a culture that prioritises patients' needs.

This approach, of engaging our workforce in determining the future direction of our health system, is fostering stronger cross-system partnerships and alliances that are improving the continuity of care for patients.

We also expect that a patient-focused and empowering culture will help attract and retain staff by promoting workforce satisfaction and engagement.

5.2 Effective governance & leadership

To support good governance across our health system, we need a clear accountability and decision-making framework that enables our leaders and community to provide direction and monitor performance.

We are fortunate to have Board members who contribute a wide range of expertise to their governance role. Their governance capability is supported by a mix of experts, professionals and consumers on the Board's advisory committees, and clinical and cultural leads attend Board and committee meetings to provide advice and consultation as required.

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

Clinical participation in decision-making

Recognising that clinical leadership is 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.

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 a Clinical Board: a multidisciplinary clinical forum that oversees the DHB's clinical activity. The Clinical 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 transformation of our health system and play an important role in raising the standard of patient care.

The West Coast Alliance Leadership Team is also a clinically led governance group, and the associated alliance workstreams include clinicians and health professionals from across the health system.

Consumer participation in decision-making

There are a number of consumer and community reference groups, advisory groups and working parties in place across the West Coast health system. Their advice and input assists in the development of new models of care and individual service improvements.

The DHB has recently established a 10-member Consumer Council to formally embrace the inclusion of those who use health and disability services in their design and development. The Council focuses on projects that: enhance the collection and use of consumer feedback; reduce barriers to access and waiting times; and improve the quality of the patient journey and the engagement of consumers and their families.

Māori participation in decision-making

Through its partnership with Tatau Pounamu, the Board is able to actively engage Poutini Ngāi Tahu, in particular Te Rūnanga o Ngāti Waewae and Te Rūnanga o Makaawhio, in the planning and design of health services and strategies to improve Māori health outcomes.

The DHB works closely with Poutini Waiora (previously Rata Te Awhina Trust), the West Coast's Māori health services provider, to improve the delivery of services to Māori, and also supports Kia Ora Hauora (the national Māori Health workforce development programme) to build Māori capacity across our health system.

The DHB's General Manager of Māori Health provides further cultural leadership and input into decision-making at the executive level of the DHB.

As part of our commitment to the principle that Māori enjoy at least the same level of health as non-Māori (and the safeguarding of cultural concepts, values and practices), the DHB produces an annual Māori Health Action Plan that sits alongside this Annual Plan but specifically identifies where and how improvements will be made for Māori in the coming year.

Decision-making principles

The advice and input of these groups supports good decision-making, but the environment in which we operate still requires the DHB to make hard decisions about which competing services or interventions to fund with the limited resources available.

The DHB has a prioritisation framework and set of principles based on best practice and consistent with our strategic direction. These principles assist us in making final decisions on whether to develop or implement new services. They are also applied when we review existing services or investments and support reallocation of funding to services that are more effective in improving health outcomes and reducing inequalities.

Effectiveness: Services should produce more of the outcomes desired, such as a reduction in pain, greater independence and improved quality of life.

Equity: Services should reduce 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 health system, workforce considerations and any risk and change management requirements.

5.3 Alliances & partnerships

Our vision is wider than just the DHB. We need to adopt a partnership approach that recognises our relationships with the organisations we fund are more than contractual.

Following the lead of Canterbury, we have established the West Coast Alliance, a partnership of health professionals and providers, to enable collaborative service planning and design, and to determine the appropriate models of care for our health system. [14]

Through the West Coast Alliance, we are working to embed a view of our health system as one system with one budget and to support the transformation and integration of our health system.

The Alliance has recently been cemented with the signing of a nationally developed District Alliance Agreement between the DHB and the West Coast PHO.

Six alliance workstreams are in place where members work collaboratively to develop more integrated models of service delivery to ensure people get the right care and support at the right time, in the right place. The alliance workstreams also support the delivery of national expectations and health targets. The activity prioritised under the Alliance workstreams informs the direction of the DHB's annual work plans every year and is reflected throughout the DHB's Annual Plan.

The current workstreams are: Grey/Westland IFHS; Buller IFHS; Pharmacy; Healthy West Coast; Child & Youth Health; and Health of Older People. In 2014/15 a seventh will be established – focused on Mental Health.

Partnerships with other agencies

At a local level, we also work with the education, social development and justice ministries, local trusts, charities and social service agencies to improve outcomes for our population – integrating services to meet shared goals through health promotion, screening, nutrition, physical activity and mental health and addictions initiatives.

Commitment to national programmes

At a national level, we work with the education, social development and justice sectors to improve outcomes for our population and achieve shared goals. From this perspective we are committed to implementing national cross-agency programmes including: the Prime Minister's Youth Mental Health Project, the Children's Action Plan and the Whānau Ora programme.

The West Coast will continue to actively participate in the development and delivery of national programmes led by the National Health IT Board, Health Quality & Safety Commission, Health Workforce NZ, the National Health Committee, Health Promotion Agency, PHARMAC and Health Benefits Limited - for the benefit of our population and the wider health system.

[14] *Refer to Appendix 5 for structural diagram of the Alliance.*

5.4 Subsidiaries

The South Island Shared Services Agency Limited is wholly owned by the five South Island DHBs and the West Coast DHB is a joint shareholder. While the company remains in existence, 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 referred to as the *South Island Alliance Programme Office*.[15]

The Programme Office 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.

5.5 Investment in information systems

Information systems are a national priority, and DHBs are taking a collective approach to implementing the Government's *National Health Information Technology Plan*. The South Island DHBs have collectively determined the strategic actions to deliver on the national plan and we are committed to this approach.

Our major priority is to enable seamless and transparent access to clinical patient information across geographic boundaries. This will benefit patients by enabling more effective clinical decision-making, improving the standards of care and reducing risks associated with missing important information.

The West Coast DHB has already adopted several key regional information systems, such as Health Connect South and the Electronic Referral Management System and will, in the next few years, replace its old hospital based patient administration system with a new supported system in line with the rest of the country.

We will continue to work closely with clinicians and stakeholders across the West Coast, to ensure that the right clinical information is available to the right people, at the right time and in the right place. Full details of the regional investment in information systems can be found in the South Island Regional Health Services Plan including the following major initiatives:

Telehealth enables sustainable health care by removing the need for clinicians or patients to travel and providing patients with timely access to care. We are continuing to expand telehealth clinics and improve the network infrastructure of outlying clinics across the Coast.

HealthPathways provides assessment, management and referral information to support health professionals to better manage the care of their patients. Over 600 clinically-designed pathways and GP resource pages are already available and we will continue to localise and refining pathways to complement our model of care.

Health Connect South (HCS) is a clinical workstation and data repository (portal) that brings a patients clinical information into one view, providing timely information at the point of care and supporting clinical decision making. A single HCS record now exists between Canterbury, West Coast and South Canterbury and will be fully implemented regionally in 2015.

The Electronic Referral Management System (ERMS) enables general practices to send referrals electronically from their desktops. ERMS is being rolled out regionally by the South Island IT Alliance (led by Canterbury), and the West Coast was the first DHB other than Canterbury to introduce this system into their district.

The Electronic Shared Care Record View (eSCRV) is a secure system that enables the sharing of core health information (i.e. allergies, medications and test results) between the health professionals involved in a person's care no matter where they are based. West Coast will implement the regional system in 2014/15.

The South Island Patient Information Care System (PICS) will be the new regional patient administration system, which will further integrate systems throughout the South Island. The West Coast will begin to upgrade its old legacy system alongside Canterbury DHB in 2014/15.

E-medications is a foundation system which promotes patient safety by improving medications management. The system has three components and is being rolled out regionally. West Coast will implement ePharmacy in 2014/15 and eMedications Reconciliation in 2015/16.

The National Patient Flow Project will create a new national view of wait times, health events and outcomes across the patient journey. The Coast will implement Phase I (collection of referrals to specialists) in 2014/15 and Phase II (non-admitted and associated referral information including diagnostic tests) from 2015/16.

The Self-Care Patient Portal – enables patients to be involved in their care and is an essential part of the national vision. West Coast DHB is working with the PHO to develop and implement a Patient Portal available to West Coast patients in the coming year

WEST COAST DHB WORKFORCE		
DHB Total Headcount	*Turnover*	*Sick Leave*
1,078	0.9%	2.95%
86% female	8.4% nationally	3.6% nationally
Average Age	*Largest Ethnic Group*	*Diversity*
52 years	NZ European	37 nationalities
Oldest Workforce	*Largest Workforce*	*FTE Terms*
SMOs	Nursing	66% part time
Avg. Age 55	49% of DHB workforce	66% permanent

[15] *Legal transfer of the employees and assets has taken place. The company will be retained as a shell, pending dissolution.*

Transalpine collaboration with Canterbury makes it increasingly important to allow seamless integration between the two DHBs. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs and will also develop a unified virtual IT team spread between the two DHBs to make better use of resources in both organisations.

5.6 Investment in people

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

Like all DHBs, our workforce is ageing and we face shortages and difficulties in recruiting to some professional areas. However, the West Coast has the added challenge of attracting staff to a remote location that has suffered from major job losses due to industry closures and community disasters in recent years.

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 and a safe and healthy workplace, underpinned by a clear set of organisational values, including a code of conduct and commitment to continuous quality improvement and patient safety.

In conjunction with the Canterbury DHB, the DHB will also review current policy and agree a phased implementation plan to meet the new Vulnerable Children's Legislation requirements for worker safety checks as this comes into effect.

However, in the West Coast's context, with financial constraints and growing demand for services, it is not sufficient to just be a good employer.

In 2011, we undertook an employee engagement survey of our staff which demonstrated positive levels of engagement. Results showed 72% of our workforce was 'engaged' with only 3% disengaged.

We need to ensure the sustainability of our services and improve the continuity of care for our population. To do this, we must reduce our use of locums, recruit to key positions, make the best possible use of our available workforce and cultivate an environment that enables people to work to the greatest extent of their scope.

Expanding our workforce capacity

From a recruitment perspective, there are a number of areas where workforce shortages affect our system's capacity. These include rural general practitioners, nurse practitioners, general surgeons and a number of specialist and allied health positions. The DHB is also looking to increase its Māori health workforce.

In response, we are strengthening our recruitment strategies and working closely with Canterbury DHB to supplement West Coast-based clinical support and services in some key areas with joint appointments.

We are supporting local scholarships to encourage Māori students into health careers and will continue to tap into available talent through links with the education sector and regional training hub and increased internships and clinical placements in our hospitals and primary care.

We will also continue to expand capacity through investment in telemedicine and electronic systems which support the provision of specialist services without a significant increase in workforce numbers.

Supported by the use of technology, Canterbury Clinical Nurse Specialists in paediatrics and 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 Canterbury medical specialists.

Enhancing our workforce capability

Developing our existing staff is a key strategy in enhancing the capability of our 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 also stepped up our participation in the Health Workforce NZ sponsored Regional Training Hubs to support critical role identification and expand workforce capability through sharing of training resources. The focus over the coming years will be on Diabetes Nurse Prescribers, Sonographers, GPEP2 training for general practice registrars and implementation of the new 70/20/10 training in medical disciplines. E-learning packages will be progressively rolled-out regionally and a full suite of packages will be available on-line 2015/16.

In addition to aligning workforce development with Health Workforce NZ funding, we have developed a set of standing orders and associated training practices that support the development of a 'generalist/specialist' nursing workforce on the West Coast. Our participation in the regional Allied Health Assistant Training Programme is also helping to expand the scope of existing allied health roles and establish new ones.

Locally we are supporting the development of our rural medical workforce with 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.

We are also supporting development of our local Māori health workforce through the national Kia Ora Hauora training programme and the Ngā Manukura ō Āpōpō Leadership Programme.

5.7 Investment in quality and safety

Over the last two years we have made considerable changes to sharpen our focus on improving the quality and safety of the services provided at the West Coast DHB. The formation of an organisational quality team is helping us to share expertise, concentrate effort and reduce duplication and the establishment of a Clinical Board has introduced a new level of leadership with a system-wide approach to quality improvement. Opportunities to work across organisations for patient safety improvements are also beginning to be realised.

Much of our current quality activity focuses on strengthening our reporting systems. With a culture of reporting well established safety issues are transparent and staff are confident the organisation will respond to needed improvement. The implementation of the South Island Incident and Risk Management system (ICNet) in 2015 will assist in identifying trends and real time tracking of events.

The priorities of the Health Quality & Safety Commission (HQSC) and the National Patient Safety Campaign have been incorporated into our quality programme. Stronger collaboration with our Canterbury neighbours and with the wider South Island will also help us to continue to build clinical capacity and quality improvement expertise.

Over the next few years key focus areas for our Clinical Board and quality team will be aligned to the following national priorities.

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 into the redesign and evaluation of services. A Consumer Council has been established and priority will be given to supporting the development of a work plan and participation in improvement teams.

The West Coast DHB also produced its first set of Quality Accounts in 2013 as a means of answering the questions that consumers consider important and identifying whether the DHB is providing a safe and high quality service. Future accounts will see wider consumer consultation to identify key areas of importance.

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 Gold Auditors undertake frequent hand hygiene observation and audit, and we are implementing our hand hygiene quality plan, with charge nurse managers championing hand hygiene. Strengthening the ability for patients to provide feedback about this aspect of care is an important concurrent activity.

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, with processes audited continuously. As at 14 April 2014 we have been CLAB free for 629 days.

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 and increase the scope of ICNet in surveillance activities.

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 the age of 75, and add considerable healthcare and lifestyle costs for both patients and health providers.

In line with the HQSC's National Patient Safety Campaign, the West Coast DHB has re-established a Falls Prevention Team - bolstered with increased membership to fortify a culture of 'zero harm' from falls across the organisation. Again, it is imperative that patient and family experience is heard and incorporated into system design. Reviewing risk assessment and management tools is also a key focus, and we are implementing strategies to visually identify those at risk of falling.

Medication and surgical safety

The West Coast DHB is committed to reducing the incidence of medication errors and the risk of resultant patient harm. Our Medication Safety Committee is leading the development of a culture of safety and 'zero harm' in medication-related practice. The National Medication Chart has been adopted by all acute clinical areas in the West Coast DHB and we are participating in an HQSC-led medicine reconciliation programme.

The West Coast DHB has also adopted the surgical safety checklist, which is used in all surgical procedures to minimise the risk of harm. 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.

5.8 Investment in facilities

The West Coast is in the midst of significantly transforming the way we deliver health services in order to improve the quality and sustainability of our system. It is imperative that this transformation is underpinned by modern, fit-for-purpose infrastructure that supports more responsive and integrated service provision.

Our current facilities are expensive to maintain, their geographical and physical configuration is outdated and inefficient, and they are hampering the introduction of more integrated service models that would improve the quality of care we deliver. Under-investment in facilities maintenance over the past decade, to minimise operating deficits, has resulted in significant infrastructure degradation and associated risk.

Seismic assessments of buildings located on the Grey Base Hospital site identified a number of buildings as earthquake-prone and non-compliant with modern seismic standards. A number of buildings were closed, deemed unsafe to occupy and some services are now crowded into temporary spaces.

Some of our primary and community facilities are also not appropriately located or configured to best contribute to our future integrated service model.

Considerable clinical engagement went into the preparation of a business care to upgrade our facilities, with over 50 hours of workshops with design teams in 2014 alone. Over 70 clinicians and staff from the West Coast DHB and PHO, general practice teams, community pharmacy, Poutini Waiora and specialist service contractors came together to ensure we could provide the best care possible for people living on the Coast.

At the end of 2012, the Government established a West Coast Hospital Redevelopment Partnership Group to confirm and fast-track plans to redevelop the Grey Base Hospital and associated Integrated Family Health Centre and address the need for viable health services and complementary infrastructure in Buller.

The Partnership Group submitted a detailed business case to the National Capital Investment Committee (CIC) in April 2014 and in May the business case was given sign-off by Cabinet allowing the project to move into the final design phase.

The approved Grey Base Hospital redevelopment is virtually a greenfield development plan. An Integrated Family Health Centre will be developed on the Grey Base Hospital site. Almost all of the Hospital will be rebuilt. A committed budget of $68 million will mean new wards, a bigger maternity unit, four older person's health cottages, an emergency department, intensive care unit and three modern state-of-the-art operating theatres.

Development of a mental health inpatient facility and energy centre will also be included.

The redevelopment of the Greymouth site provides a once-in-a-lifetime opportunity to capture the transformation already underway and bring integrated service provision to life. With a clear decision on the way forward the West Coast health system will be able to cement a more certain and sustainable future.

Site work will begin at Grey Base in 2014 and detailed planning will be a major focus for the next year. A strong clinical voice will continue to be essential in ensuring the final result is reflective of the needs of our population.

Focus will also be on Buller and the facilities required to support more integrated health services here as well. The DHB will engage with the Buller community in 2014/15 to talk about a new Integrated Family Health Centre and how this will function. The DHB will also be looking at how aged care services, maternity services and transport will be organised in the future.

Part III - Annual Outlook

Delivering Our Service Priorities

Patient-Focused Health Services

6.1 Improved access to diagnostic services

Why is this important?

Diagnostic services, such as laboratory and radiology tests, are a key enabler of a more integrated health system. Timely access to diagnostics and specialist advice can better inform a treatment plan – not only saving people's time, but also minimising the harm and complications that can arise from a delay in intervention.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY[16]**
Continue to improve patient pathway mapping and access to diagnostics to facilitate timely and appropriate referral and treatment.	Continue to maintain direct GP access to diagnostics to improve referral quality and reduce waiting times for treatment. Ensure internal data collection systems facilitate accurate local reporting of diagnostic demand and waiting times. Engage services in quarterly monitoring of diagnostic waiting times for CT scanning, MRIs and Elective Coronary Angiograms to identify any issues and barriers to access. Continue to engage with the regional provider on any issues around waiting times for Magnetic Resonance Imaging (MRI) and Elective Coronary Angiography for West Coast residents. [17] Continue to participate in regional diagnostic service improvement programmes focused on the development of diagnostics and implement agreed system changes.	Regular monitoring of diagnostic waiting times Q1. Implementation of Phase II of the National Patient Flow Project completed Q4. 90% of accepted referrals for CT scans receive their scan within six weeks. 80% of accepted referrals for MRI scans receive their scan within six weeks.
	Continue to invest in the local bowel cancer surveillance initiative for high-risk groups via surgical endoscopy services. Continue to support the clinical endoscopy service users group to support the use of the national referral criteria for direct access outpatient colonoscopy. Progressively implement actions identified through the national Endoscopy Quality Improvement (EQI) programme to support improvements in colonoscopy services. Engage services in quarterly monitoring of progress against diagnostic colonoscopy waiting times to identify any issues and barriers to access.	Regular monitoring of diagnostic waiting times Q1. 75% of people accepted for an urgent diagnostic colonoscopy wait no longer than two weeks. 60% of people accepted for non-urgent diagnostic colonoscopy wait no longer than six weeks. 60% of people scheduled for a surveillance/follow-up colonoscopy wait no longer than 12 weeks beyond plan.

[16] The Q references throughout this section refer to quarters of the financial year Q1: July-September, Q2: October-December, Q3: January-March and Q4: April-June. These are used to set and track progress.

[17] Note: West Coast DHB does not deliver MRI or Elective Coronary Angiograms locally - we will monitor waiting times and regional delivery for our population and engage with the regional providers where targets are not being met.

6.2 Improved access to elective services

Why is this important?

Elective services are non-urgent procedures and operations that improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing. Timely access to elective services is often considered by the public to be a measure of the overall effectiveness of the health system. Maintaining elective surgery levels and reducing the waiting times for assessment and treatment will therefore not only improve health outcomes, but also increase our community's confidence in the West Coast health system and its ability to meet their needs.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Allocate electives funding to support delivery of appropriate levels of surgery for West Coast residents.	Continuously monitor electives delivery against agreed volumes and ensure access is not significantly below national rates. Trial the introduction of ENT Surgery at Grey Base Hospital. Continue to use national Clinical Priority Access Criteria tools and support treatment of patients in order of priority. Continue to implement the transalpine model and utilise other DHB/private resources to deliver care where appropriate.	ENT Surgery underway Q1. 1,592 elective surgical discharges delivered Q4. Standardised Intervention rates maintained: ▪ Major joints: 21 ▪ Cataracts: 27
Identify productivity and efficiency gains to improve patient flow and reduce waiting times for elective services.	Continue to support the use of HealthPathways and electronic referrals to streamline referral for assessment and treatment. Increase access to non-contact (virtual) First Specialist Assessments (FSAs) to streamline referral of patients to treatment lists. Continue to monitor Elective Services Patient Flow Indicators and engage with Canterbury DHB as the regional provider to resolve any issues around waiting times for elective services. Continue weekly meetings of theatre management, booking and production planning personnel to improve theatre utilisation. Promote 'lean thinking' principles and, where appropriate, day surgery and day of surgery admissions to improve productivity. Engage with primary care and allied health to implement a rapid response and supported discharge service to improve patient flow through the Complex Clinical Care Network.[18] Complete implementation of Phase I of the new National Patient Flow System, including adapting local data collection to allow reporting to the national system and begin Phase II.	100% of patients wait no more than 5 months for First Specialist Assessment (FSA) or treatment Q1-Q2. 100% of patients wait no more than 4 months for FSA or treatment Q3-Q4. >600 localised West Coast HealthPathways in place Q4. >5% FSA are non-contact Q4. Implementation of Phase II of the National Patient Flow Project completed Q4. Average elective surgical inpatient length of stay maintained <3.18 days.
Support alternative models of care to reduce the need for West Coast patients to travel for treatment.	Support clinical leadership, governance and oversight in reviews of service provision to identify best care for patients locally. Work with Canterbury clinicians to concentrate scheduling of appointments in Christchurch, to increase patient travel options and to reduce the need for overnight accommodation. Further expand the use of telemedicine for specialist review and assessment to reduce the number of follow-up appointments requiring travel to Greymouth or Christchurch.	Increased proportion of follow-ups for people who live outside of the Grey district are provided by telemedicine - base 1.57%.
Work with the Regional Elective Services Alliance Workstream to support elective services delivery across the South Island.	Support the development and implementation of regional clinical pathways for elective surgery. Support establishment of a regional Major Trauma Workstream and development of a three year action plan including implementation of a Major Trauma Register. Identify a clinical resource from within the West Coast DHB to represent the Coast on the regional Major Trauma Workstream.	Regional Bariatric Surgery Pathway implemented Q1. Regional Major Trauma Workstream in place Q1. Designated Major Trauma clinical lead identified Q2. Trauma Registry in place Q4.

[18] *Refer to Section 6.10 for detail on the development of the Rapid Response and Supported Discharge Services (Casemix 8).*

6.3 Improved access to cardiac services

Why is this important?

Cardiovascular Disease is the leading cause of death in New Zealand. Improving access to cardiac services across the continuum of care (screening, early intervention, surgery and rehabilitation) will help our population to live longer, healthier and more independent lives. The provision of timely cardiac services is closely intertwined with the delivery of transalpine services through the Canterbury DHB and the activity of the Regional Cardiac Services Alliance.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Improve patient pathway mapping to facilitate timely and appropriate referral and treatment.	Continue to support the use of Cardiac HealthPathways. Maintain access to cardiac diagnostics to facilitate appropriate treatment referrals (echocardiograms/exercise tolerance tests).	100% of patients wait no more than 5 months for First Specialist Assessment (FSA) or treatment Q1-Q2.
Support the transalpine approach to improve cardiac service delivery and reduce waiting times for our population	Deliver the minimum target intervention rate for cardiac surgery for West Coast residents. Monitor cardiac service provision and engage with Canterbury DHB as the regional provider to ensure access to cardiac intervention rates are not significantly below national rates. Continue to monitor Elective Services Patient Flow Indicators and engage with Canterbury DHB as the regional provider to resolve any issues around waiting times for cardiac services. Continue to implement regional guidelines for the arrangement of transport for cardiac patients.	100% of patients wait no more than 4 months for FSA or treatment Q3-Q4. 27 cardiac surgical discharges delivered Q4. Standardised intervention rates maintained: [19] Cardiac Surgery: 6.5 Percutaneous Revascularisation: 12.5 Coronary Angiography: 34.7
Work with Canterbury DHB and the Regional Cardiac Alliance Workstream to support specialist service delivery.	Continue to implement regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification, stabilisation and appropriate transfer of ACS patients. Continue to work closely with the Canterbury DHB as the primary regional provider to ensure waiting times targets are met for ACS patients accepted for elective coronary angiography. Continue to participate in the provision and collection of data for the national Cardiac (ANZACS QI) and Cath/PCI Registers to enable monitoring of intervention rates and quality of service delivery.	Reporting to ANZACS QI Register Q1. 70% of high-risk patients will receive an angiogram within 3 days of admission (where day of admission is day 0). 95% of patients presenting with ACS who undergo angiography have completion of registry data collection within 30 days.
	Support development of a regional approach to cardiology nurse training through the Regional Training Hub. Support development of a regional Percutaneous Coronary Intervention Pathway. With regional support, implement the Accelerated Chest Pain Pathway in ED to reduce unnecessary hospital admissions. Support a regional approach to the storage and sharing of ECGs.	Participation in regional nurse educator subgroup Q1. PCI patient flow agreed Q2. Common Accelerated Chest Pain Pathway in place Q4. ECG records stored in Concerto Q4.

[19] *The West Coast DHB does not deliver Elective Coronary Angiography or Percutaneous Revascularisation locally – we will monitor waiting times and regional delivery for our population and engage with the regional providers where targets are not being met.*

6.4 Shorter stays in emergency departments

Why is this important?

Improving timely access to emergency care relies on the availability of appropriate alternative pathways and care options in the community to ensure that only those who really need specialist and emergency care present in our hospitals. It is also reliant on having capacity in the community to support patients when they are discharged to reduce the likelihood of readmission or another acute event.

In this sense the national, shorter stays in emergency departments, health target about improving and integrating care right across the health system and presents a significant opportunity to improve health outcomes and the quality of people's lives.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Implement early intervention strategies to better support people in the community and reduce presentations to Emergency.	Maintain an afterhours telephone triage service and zero primary care fees for children afterhours to support access to appropriate urgent care options. Support the development of joint acute care strategies to support at-risk patients frequently presenting in ED. Continue to localised HealthPathways to improve the referral and management of patients. Support the development of individual care plans through the PHO Long-term Conditions Management Programme (LTCM) to reduce the need for acute interventions.[20] Continue to provide primary care and Aged Residential Care (ARC) providers with direct access to specialist advice and support to manage patients with complex conditions through the Complex Clinical Care Network. Analyse national Ambulatory Sensitive Hospitalisation data and share results through the West Coast Alliance to develop population strategies to respond to conditions driving demand. Continue to support free community transport service between Greymouth and Westport to improve access to health care.	100% of children under six have access to free afterhours GP care Q1. Acute Care Service in place Q2. >600 localised West Coast HealthPathways in place Q4. Six monthly reporting on avoidable hospital admission rates Q2, Q4. Rate of acute medical admissions maintained at <5,600 per 100,000. Proportion of the population presenting to ED at <45%.
Maintain performance against the national health target – shorter stays in emergency departments.	Maintain the current approach to the delivery of ED services to continue to meet the national health target. Continue to closely monitor ED waiting times and undertake urgent work to identify any factors impacting on length of stay. Continue to explore and determine new models of care and service delivery for ED as part of the rebuild of Grey Hospital and the Grey/Westland and Buller IFHCs. Progressively implement the national ED Quality Framework and associated Quality Measures in line with national expectations.	Actions to implement national ED Quality Framework agreed Q1. Monitoring of ED Quality Measures introduced. 95% of people are admitted, discharged, or transferred from ED within 6 hours.
Invest in services to support patients on discharge from hospital to improve their recovery and reduce readmissions.	Continue active discharge planning to free up inpatient beds and help pull patients from ED in a timely fashion. Engage with primary care and allied health to implement a rapid response and supported discharge service through the Complex Clinical Care Network.[21] Review and enhance clinically led falls prevention strategies involving primary care, allied health and ARC providers in preventing ED presentations as a result of falls.	>50 patients support by the Rapid Response/Supported Discharge service Q4. Falls Prevention Service in Q3. Acute readmission rate maintained at or below 6.4%. Acute readmission rate (for people aged 75+) maintained at or below 9.6%.

[20] *Refer to Section 6.8 for detail on the PHO's Long-term Conditions Management Programme.*
[21] *Refer to Section 6.10 for detail on the development of the Rapid Response and Supported Discharge Services.*

6.5 Shorter waits for cancer treatment

Why is this important?

Cancer is the second leading cause of death on the West Coast and a major driver of hospitalisation. While cancers attributable to tobacco smoking are expected to decline (with declining tobacco consumption), cancers related to poor diet, lack of physical activity and obesity 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.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Support the delivery of cancer prevention and screening programmes to reduce the incidence and impact of cancer.	Support the Canterbury-West Coast Cancer Society and Poutini Waiora to increase cancer awareness with a focus on Skin Cancer. Support improved engagement of West Coast women in national Breast and Cervical Cancer Screening Programmes and identify initiatives that can be adopted from other DHBs to improve the rates of Māori women accessing cervical screening.	> 70% of women aged 45-69 have had a breast cancer screen in the last 2 years Q4. 80% of women aged 25-69 have had a cervical cancer screen in the last 3 years Q4.
Identify and implement actions to provide Faster Cancer Treatment to reduce the impact of cancer and improve patient outcomes.[22]	Engage with Canterbury DHB as regional provider on issues around wait times for radiation and chemotherapy treatment. Continue to support inpatient medical ward nursing staff to deliver chemotherapy regimens to improve case management, and provide 'back-up' for the small oncology nurse team. Work with Canterbury DHB to implement the agreed model for identifying people with a high suspicion of cancer and reducing waiting times from referral to treatment across all specialities. Implement quality controls to ensure Faster Cancer Treatment (FCT) reporting meets data quality expectations and seek to migrate to an electronic platform to streamline data collection. Continue to actively promote use of ERMS to prioritise referral, triage and assessment of patients with high suspicion of cancer. Support the West Coast Cancer Nurse Coordinator to work closer with Canterbury services to align information from their booking lists to improve completeness of FCT data. Engage in quarterly monitoring of progress to highlight and improve performance against FCT indicators. Continue to support general practice in the management of patients with cancer through access to support and advice from the Cancer Nurse Coordinator and Oncology Nurse Specialists. Expand the use of telemedicine technology to support oncology teams to manage cancer treatments regimes locally and reduce the need for West Coast patients to travel. Improve coverage and functionality of Multidisciplinary Meetings for specialist advice, patient referral and review. Continue to support patient navigators to inform and support patients and their families/whānau through the Cancer journey. Support the Cancer Nurse Coordinator and specialist nurses to attend national/regional training and mentoring forums.	Quarterly monitoring of wait times for cancer services Q1. 100% of patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy Q1-Q4. FCT data provided quarterly to national collection systems Q1. Progress towards meeting FCT indicators Q4: ▪ Patients with a confirmed diagnosis of cancer receive first cancer treatment within 31 days; and ▪ 85% Patients referred urgently with high suspicion of cancer receive first cancer treatment within 62 days by July 2016.
Participate in the Southern Cancer Network to support specialist service delivery.	Maintain current Oncology and Palliative Care HealthPathways to promote consistent medication treatment protocols. Support the regional review of three more tumour stream standards including provision of relevant data. Support implementation of regionally identified initiatives to reduce inequalities of access to Cancer treatment. Support the ongoing implementation of the South Island clinical cancer information system (MOSAIQ).	Regional audit against tumour standards complete Q3.

[22] *Refer to Section 6.1 for action to deliver shorter waiting times for cancer diagnostics.*

Integrated Health Services

6.6 Primary care

Why is this important?

The current model of care provided in the Buller and Grey districts is 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 health system and between DHB and privately owned general practices. To deliver truly seamless care for our population, the whole of the West Coast health system must be engaged in the vision of one integrated health system, connected through system-wide pathways backed by a shared team approach and supported by infrastructure that complements and enables the development of responsive service models.

This reorientation will be primarily driven under the West Coast Alliance through its Grey/Westland, Buller, Older Person's Health and Pharmacy Workstreams focused on the delivery of the Health Care Home approach with primary care as the point of continuity. The development of the Integrated Family Health Centres will be central to enabling the model of care to be fully realised, but without a foundation of response service models, aligned pathways and a more integrated health teams we will not achieve the population outcomes we are seeking.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Continue to ensure system-wide clinical and community engagement in determining the future direction for the West Coast health system.	Support joint planning and service development through the West Coast Alliance workstreams and service level alliances to enable the transformation of our health system.[23] Establish a process under the West Coast Alliance for approval and distribution of the Rural Primary Care Funding. Develop a communications and monitoring plan to increase the focus on performance of the system and the change being achieved through the Alliance Workstreams. Support implementation of the national primary care Integrated Performance and Incentive Framework (*yet to be released*).[24]	Rural Funding review process agreed Q1. Rural Funding allocations reviewed and distribution plan agreed Q4 and distribution plan implemented Q1 2015/16. Six monthly reporting on avoidable hospital admissions rates Q2, Q4.
Support the development and implementation of community-based responses for patients at risk of deteriorating health.	Engage with primary care and allied health through the Complex Clinical Care Network (CCCN) to develop and implement an Acute Demand Service that supports people at risk of acute admission. Develop and implement a district nursing led Rapid Response Service with the CCCN as part of the acute demand model. Complete implementation of the CCCN led Supported Discharge Service as part of the acute demand model. Pilot a triage system and single point of entry across Buller services to improve care coordination and access. Undertake predictive risk profiling and stratification of at-risk patients and match this to existing programme profiles to assist with the planning of future services. Using the risk profiling - work with general practice to identify strategies to better address the needs of patients identified at risk of deteriorating health and potential hospital admission.	Acute Demand in place Q2. >50 patients supported by the Rapid Response/Supported Discharge Service Q4. SPOE Pilot underway Q2. Profile match completed Q2 and strategies identified Q4. Rate of acute medical admissions maintained at <5,600 per 100,000. Acute Readmissions maintained at or below 6.4%.
Improve the patient and whanau experience of health care and support services across the West Coast.	Support an integrated care coordination and management approach with designated lead carer and shared care planning. Support improved care coordination through the use of multidisciplinary teams across child and youth health, mental health, cancer and older people's health services. Engage Poutini Waiora in the care coordination model and support Kaupapa Maori nurses to act as lead coordinators. Engage Māori Kaimahi in multi-disciplinary team meetings.	Increased proportion of complex LTCM patients with a named Case Manager and single care plan Q4. An increase in the proportion of Māori enrolled in the LTCM programme Q4.

[23] The West Coast Alliance currently has the following workstreams: Healthy West Coast (public health and long-term conditions); Older Persons Health; Pharmacy; Child & Youth and the Buller and Grey/Westland workstreams. Refer to Appendix 5 for a structural overview.
[24] This national Framework is under development and is yet to be released – actions are therefore yet to be determined.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Support the integration of nursing and allied health services to support the care coordination model.	Promote the role of clinical nurse specialists to general practice team and pharmacy. Investigate the integration of district nursing with community support services (CSS) to enable a more comprehensive rapid response and supported discharge service. Continue to integrate Poutini Waiora Kaupapa Māori nurse and Kaiarataki positions within primary care to provide cultural support and advice and education to general practice teams.	Opportunities for increased integration of district nursing and CSS identified Q3. Increased PHO enrolment and disease prevention screening rates for Maori Q4.
	Establish a single operational and leadership framework for allied health to support a localities based model of care.	Single allied health framework model in place Q1.
Continue to redesign models of care within DHB owned general practices to support the Health Care Home approach.	Continue to engage Better Health Limited to provide practice management support services to DHB owned general practices. Develop and implement process redesign within general practice teams that supports the Health Care Home and lean thinking approach. Explore options for extending opening hours for general practice to increase access to primary care services. Implement Standing Operating Procedures and Standing Order Delegations within general practice to support the Health Care Homes approach and lean thinking models. Develop an implementation plan for transitioning the three Greymouth general practices to the IFHC by the end of 2016.	Learning set on Health Care Home Approach in other centres distributed Q1. Standing orders in place Q1. Implementation plan for transition to IFHC agreed Q3. A reduction in waiting times for GP appointments Q3. Annual Patient Satisfaction Survey shows increased satisfaction levels Q4.
Support the localisation of HealthPathways and direct GP access to services to support the Health Care Homes approach	Continue to support the clinically-led development and localisation of HealthPathways for the West Coast setting. Support increase utilisation of the HealthPathways with training and information sessions. Benchmark acceptance rates of referrals to support the ongoing refinement of pathways and information flows. Maintain GP direct access to x-ray and ultrasounds to support shorter waits for diagnosis and treatment. Maintain the GP direct access pathway for cataracts, investigate the feasibility of access to additional elective booking lists and establish at least two new direct access pathways.	>600 localised West Coast HealthPathways in place Q4. Progressive increase in 'hits' on HealthPathways Q2, Q4. GP referred x-rays and ultrasounds maintained >5,000. 2 new GP direct access booking pathways identified Q2. Booking pathways in place Q4. Proportion of the population presenting to ED at <45%.
Continue the integration of pharmacy on the West Coast to support the Health Care Home Strategy.	Continue to support community pharmacists to operate from general practice on a regular basis to improve team based approaches to the management of patients. Refocus medicines utilisation reviews to support patients under the Complex Clinical Care Network (CCCN) and patients registered with pharmacies in the Long Term Conditions Management (LTCM) programme. Continue to develop the role of pharmacists in the management of common conditions (including new regulatory prescriber arrangements) and extend the concept of a shared pharmacist resource across hospital and community pharmacy services.	Agreed action plan for shared pharmacist resource Q1. Pharmacists operating from general practice locations in Buller, Grey and Westland districts Q2. Pharmacists accredited to deliver Medication Use Review (MUR) in all districts Q4. 70% of MUR provided are to CCCN and LTCM patients Q4.
Support the development of Integrated Family Health Centres (IFHCs) in Greymouth and Buller.	Further develop and agree the business, governance and leadership arrangements for establishing IFHCs. Continue to engage stakeholders, clinicians and the community in the development of the IFHC model and the new facilities. Work alongside private partners to define the business model for the Buller IFHC. Investigate options for co-locating pharmacy services. Define how Reefton health services will be aligned to the Integrated Family Health Services model.	Business, governance and leadership arrangements established Q4. Implementation Plan for Greymouth agreed Q3. Pharmacist role in IFHC agreed Q4.

6.7 Disease prevention

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, such as smoking, inactivity, poor nutrition and obesity. By promoting healthy lifestyles and supporting people to identify and reduce their risk factors, many long-term conditions are preventable.

With an active Healthy West Coast Alliance Workstream we are well placed to support people to reduce risk behaviours and adopt healthy lifestyles which over time will have a significant flow-on effect on rates of cardiovascular and respiratory disease, diabetes and cancer (four of the top five causes of death on the West Coast). As well as reducing poor psychosocial outcomes, mitigating the predicted increase in these conditions will help to reduce inequalities in health outcomes and improve the overall wellbeing of our population.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Increase the accessibility and availability of public health interventions that focus on healthy eating and regular physical activity.	Collaborate on joint planning through the Healthy West Coast Workstream to coordinate public health services on the West Coast and reduce duplication and gaps in delivery. Continue to hold the annual Healthy West Coast staff hui for all involved in public health interventions.	Annual Healthy West Coast hui. 500 GRx referrals Q4. 5 'Active You' programmes delivered Q4. 5 community nutrition courses delivered Q4. 50% of GRx participants are more active 6-8 months after receiving their GRx.
	In line with the 2013 Budget Diabetes Funding Package, identify opportunities to increase the proportion of Green Prescription (GRx) referrals for people with pre-diabetes and diabetes. Support delivery of group-based GRx 'Active You' Programmes to introduce activity opportunities in the community.	
	Continue to deliver community nutrition courses including Appetite for Life, Senior Chef and Cooking Skills for Life Skills. Establish links between the delivery of Appetite for Life and Te Whare Oranga Pai Programme to increase Māori engagement.	
Increase support for mothers to breastfeed and to breastfeed for longer periods.	Deliver an annual provider workshop to increase knowledge and skills on breastfeeding issues and the services available. Continue to support a breastfeeding session as a component of each DHB-run pregnancy and parenting course. Review 'Babes-in-Arms' breastfeeding support groups to ensure they meet the needs for target groups (young mums/Māori). Support 'Mum-4-Mum' training for peer support counsellors and work with the Poutini Waiora Mother & Pepe Service to increase the number of Māori Mum-4-Mum counsellors. Improve referral pathways between maternity and community lactation consultancy services. Trial the introduction of referral for breastfeeding support to the Newborn Multiple Enrolment Form.	Annual workshop held Q2. Babes in Arms review Q1. 100 lactation support and specialist advice consults provided. 74% of infants exclusive or fully breastfed at 6 weeks. 54% of infants exclusive or fully breastfed at 3 months. 59% of infants exclusive, fully or partially breastfed at 6 months.
Reduce the harm caused by alcohol.	Introduce regular reporting of alcohol related admissions to ED to Healthy West Coast Workstream. Support a pilot project focused on alcohol harm reduction in line with the DHB's Position Statement on Alcohol. Continue to support and assist Territorial Authorities to develop local alcohol policies. Continue to assist police with alcohol controlled purchase and monitoring operations to reduce the supply of liquor to minors. Participate in national Health Promotion Agency activity aimed at preventing Fetal Alcohol Spectrum Disorder.	Quarterly reporting on alcohol related admissions Q1. Pilot project identified Q1. >3 alcohol monitoring visits undertaken per year to high-risk premises.

Reduce smoking prevalence amongst the West Coast population.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Through the West Coast Tobacco Free Coalition, ensure a whole-of-system, integrated approach to Tobacco Control on the West Coast. [25]	Update the current West Coast Tobacco Control Plan. Continue to undertake controlled purchase operations (CPOs) to ensure tobacco retailers comply with smokefree legislation. Support social service organisations, schools and workplaces to establish policies and interventions to reduce smoking. Work with district councils to maximise the effectiveness and awareness of smokefree environments and policy.	Updated Tobacco Plan Q2. 3 CPOs carried-out Q4. An increase in the proportion of year 10 students who have 'never smoked' - base 69%. By 2025 <5% of the population will be a 'current smoker'.
Support increased primary care delivery of the 'better help for smokers to quit' health target.	Identify a senior primary care clinical ABC target champion. Support the development of practice specific smokefree policies to ensure the health target is owned within the practice. Maintain six-monthly face-to-face meetings with Coast Quit providers from primary practices and pharmacy. Continue circulation of monthly performance bulletins at practice level, including relevant and current research to ensure the target remains clinically relevant for primary care staff. Further enhance IT support tools to prompt clinicians to capture ABC delivery including full rollout of text-to-remind and trial of appointment scanner and dashboard reminder systems.	Target champion identified Q1. Monthly circulation of Primary Bulletin Q1. Trial of IT systems underway in two GP practices Q1. Smokefree Policies in place in all GP practices Q4. Quarterly progress towards 90% of enrolled smokers seen in general practice provided with advice and help to quit.
Align practice to ensure the 'better help for smokers to quit' health target is embedded in hospitals' systems.	Maintain monthly performance monitoring and follow-up by Charge Nurse Managers to improve practice and systems. Raise the profile of ward smokefree champions and disseminate key messages on the importance of ABC and smoking cessation. Evaluate the content of current mandatory smokefree training and work with senior management to identify strategies to encourage more staff to attend training. Review existing systems and process and identify opportunities to strengthen practises to sustain target performance. Continue bi-monthly meetings with senior staff for leadership and support until health target performance is sustained.	Monthly ward reports circulated and visible Q1. Quarterly ABC profiles in the Chief Executives Update. Training content evaluated Q2. ABC systems reviewed Q3. ≥80 staff attend training Q4. 95% of hospitalised smokers are provided with advice and support to quit. [26]
Improve the uptake and effectiveness of the ABC intervention for pregnant women who smoke.	Support the Canterbury-West Coast Maternity Quality & Safety programme workgroup to provide oversight of work in this area. Review referral processes to ensure information provided to pregnant women and whānau who smoke is standardised. Develop a localised HealthPathway for women who smoke and who confirm their pregnancy in primary care. Explore options to capture ABC delivered to pregnant women receiving primary maternity care from DHB employed midwives. Identify and implement opportunities to provide training to support LMCs to deliver ABC to pregnant women. Continue to support the LMC Smokefree Champion to maintain strong linkages between midwives, general practice and local cessation services with regular quarterly meetings.	Standardised 'Quit Pack' for pregnant women available Q2. Localised HealthPathway developed Q2. ABC data options identified Q3. Two smokechange education sessions provided for LMCs Q3. 90% of women who identify as smokers at the time of confirmation of pregnancy are provided with advice and support to quit.
Improve access into community cessation services, particularly for Māori who smoke.	Continue to provide clear pathways, smoking cessation services and support for Māori who smoke. Continue to support GPs and pharmacists to provide the Coast Quit Cessation Programme alongside the LTCM Programme. Deliver two Quit Card provider workshops to increase smoking cessation capacity targeting community health/social sectors. Identify learnings from the Mana Tamariki Mokopuna Programme to engage more Māori in cessation programmes.	> 100 enrolments in the Aukati Kai Paipa programme Q4. 500 enrolments in the Coast Quit Programme Q4. Increased proportion of total smoking cessation enrolments are Māori - base 12%.

[25] *Please refer to the DHB's Public Health Action Plan for further detail. It can be found at www.westcoastdhb.org.nz.*
[26] *The ABC Smoking Strategy involves Asking if a patient smokes, offering Brief advice to quit and referring them to Cessation support.*

6.8 Long-term conditions management

Why is this important?

The West Coast is fortunate to have a comprehensive Long-Term Conditions Management (LTCM) Programme in place as a key part of the overarching strategy for the management and support of patients with long-term conditions. By recognising the common and inter-related issues that cut across multiple conditions, the holistic and all-inclusive approach delivered by the LTCM programme can produce better outcomes than looking at individual conditions in isolation.

Through continued commitment to the programme, and the effective management of patients with long-term conditions, we can make a real difference in preventing deterioration of these conditions and the impact they have on the quality of people's lives - while at the same time reducing unnecessary demand on the health system.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Improve the early identification of people 'at risk' to ensure people are managed under a structured programme or plan.	Support general practice to utilise practice management systems to ensure data accuracy with regard to patient's risk profile and maintain a proactive practice-based campaign of automatic recall and direct contact with people due for LTCM review. Undertake comprehensive analysis of LTCM Programme data annually to review patient outcomes and inform future direction at both a general practice and whole-of-system level.	>2,000 people enrolled in the LTCM Programme Q4. Six monthly reporting on avoidable hospital admission rates Q2, Q4. Annual review of LTCM Programme data Q4.
Ensure clinical leadership supports long-term conditions management.	Continue to engage Quality Improvement Champions to support delivery of the LTCM Programme in general practice. Include meaningful, practice specific, performance data in Primary Bulletins, supported by advocacy messages targeting clinicians. Ensure continuous quality improvement through localisation of clinical HealthPathways for Diabetes, Cardiovascular Disease (CVD) and respiratory disease.	Monthly circulation of Primary Bulletin Q1. HealthPathways for Diabetes and CVD updated Q2, Q4.
Empower people to modify lifestyles, self-manage their condition through provision of the LTCM programme.	Continue to invest in the delivery of the LTCM Programme including (at a minimum) the provision of annual clinical reviews for all patients enrolled in the programme. Continue to invest in diabetes improvement packages as part of the LTCM Programme - with identified minimum standard of care (aligned to the Primary Care Handbook). Monitor and report on key indicators for people 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. Champion a patient-centred/shared care approach that supports the development of patient care plans in conjunction with the patient. Continue to encourage the use of self-management tools to support people to better manage their own health. Optimise retinal screening clinics by capturing the opportunity to provide additional intervention including disease management and lifestyle advice from nurse specialists, podiatrist and nutritionists while people wait for their treatment. Provide links into the rapid response and supported discharge service to provide community support services to people living with long-term conditions in the community.	Increased number of Maori enrolled in the LTCM Programme Q4. Increased proportion of complex LTCM patients with a named Case Manager and single care plan Q4. Quarterly reporting on LTCM indicators. Enhanced 'meet-&-greet' retinal screening clinic pilot undertaken Q1. 70% of the population with diagnosed diabetes have annual reviews. 80% of the population with diabetes have satisfactory or better diabetes management (HbA1c≤ 64mmol/mol). 90% of the population who have had an annual review have had a retinal screen or ophthalmologist exam within the last two years. Rate of acute medical admissions maintained at <5,600 per 100,000. Rate of avoidable hospital admissions maintained at <95% of national average.
Increase the capability and capacity of Health Professionals in the delivery of LTMC.	Support general practice in the provision of care of LTCM patients with direct access to advice and support from diabetes and respiratory nurse educators and cardiac clinical rehabilitation nurse specialists. Support Kaupapa Māori Nurses to work with general practice and secondary care to improve outcomes for Māori. Support integration of service processes for CCCN with those for LTCM to support the integration of community nursing with primary care nursing and the development of the Case Manager Concept.	

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Support the use of specific strategies to increase the delivery of CVD Risk Assessments in general practice.	Identify Quality Improvement Champions in general practice to support the 'More Heart & Diabetes Checks' health target. Include practice specific target performance data in the Primary Bulletin supported by advocacy messages targeting clinicians.	CVD Quality Improvement Champions in place Q2. Monthly circulation of Primary Bulletin Q1.
	Further implementation of IT support tools to support clinicians to identify the eligible population and to prompt and capture CVD Risk Assessments (CVDRAs) including full rollout of text-to-remind and trial of appointment scanner and dashboard reminder systems. Complete the roll-out of the electronic Clinical Audit Tool.	Trial IT systems in two general practices Q1. Clinical audit tools in place across general practices Q4.
	Continue to engage the Heart Foundation in providing training and education in primary care practices focused on delivery of the primary care health target. Continue to support the provision of practice visits by PHO, GP and nurse facilitators to support practices with using and reviewing performance data and developing quality improvement plans.	Heart Foundation training delivered across all practices Q4.
	Continue to implement the Primary Care Health Targets Action Plan to improve performance against the national health target. Support practices to run CVDRA After-hours Clinics in parallel to their nurse led 'planned' clinics to engage a wider group of people. Continue to provide administration support for retrospective coding of people with >20% cardiovascular risk across all practices and link this with retrospective coding of smoking cessation medication. Support the recall of patients whose CVDRA has expired by engaging additional admin or enrolled nurse support and free up registered nursing resource allocated to this activity to deliver more CVDRAs. Engage Kaupapa Māori Nurses from Poutini Waiora to assist with targeted recall and outreach services for Māori to increase CVDRA delivery to Māori patients.	Increased number of after-hours CVDRA clinics Q1. Coding match Q2. Quarterly progress towards 90% of the eligible adult population having had their cardiovascular disease risk assessed in the last five years. Quarterly increase in CVDRA delivery for Māori.
	Continue quarterly meetings between the PHO and DHB to review progress against the health target and identify opportunities. Support the West Coast Health Alliance to monitor progress against the CVDRA and Smoking Health Targets.	Quarterly monitoring against the health target.

[27] The LTCM programme provides people identified with a long-term condition 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. This programme is augmented with risk stratification using a Predictive Risk Management algorithm.

6.9 Child and maternal health

Why is this important?

Undiagnosed health issues and behavioural patterns established in childhood and adolescence have a significant impact on an individual's health in the long term. By integrating delivery models, we can streamline the coordination of similar services, reduce duplication and delays and improve the continuity of care – and also identify and better target vulnerable children. Improving health outcomes for newborns and mothers is another vital part of this picture.

With an active West Coast Child & Youth Health Alliance we are well placed to improve the quality and coordination of health services for children and young people (particularly at risk children and those with disabilities or high needs) and to support joint planning and service delivery to improve our population's health and wellbeing.

Implement a collaborative and integrated approach to the delivery of maternity services.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Implement processes and strategies to increase the number of pregnant women registered with an LMC.	Identify barriers to women booking within the first trimester and explore social media and other communication strategies as a communication tool with pregnant women Work with consumer groups to assist in educating women on the importance of early registration in pregnancy. Feed information into the Mana Tamariki Mokopuna programme and take on board opportunities identified through the programme.[28]	Link on the DHB website to 'Find Your Midwife'Q3. Increased number of women registered with an LMC by 12 weeks - base 62%.
Enhance pregnancy and parenting programmes to better meet the needs of Māori and younger women.	Review DHB-funded pregnancy and parenting programmes following the release of the Ministry of Health review on the service specifications.[29] Develop strategies to improve attendance of, Māori, Pacific Island and younger women and collect data to monitor attendance data by ethnicity to demonstrate increased engagement. Support the Mana Tamariki – Mana Mokopuna, Mana Whānau project to address the needs of young Māori mothers and their whānau who are about to have tamariki and mokopuna.	Pregnancy/parenting review complete Q2. >30% of all new mothers' access DHB-funded parenting & pregnancy courses – base established Q3.
Work collaboratively to improve the consistency and quality of services for mothers and their babies.	Continue to implement the Maternity Quality and Safety Programme and support the joint Canterbury/Coast maternity Governance Group to monitor performance against NZ Maternity Clinical Indicators. Complete implementation of the recommendations from the clinically led West Coast Maternity Review. Implement the national guidelines for the screening, diagnosis and management of gestational diabetes.	Maternity Quality and Safety Action Plan updated Q2. Maternity Review actioned Q1-Q4. National gestational diabetes guidelines in place.[30]
Improve timely newborn multi-enrolment with health services.	Support the use of the newly introduced Newborn Multiple Enrolment form across West Coast Maternity Services. Review the newborn enrolment process after three months of implementation to identify where further improvements can be made. Improve links with oral health services to expand enrolment and ensure newborns are enrolled with community dental services.	95% of newborns enrolled on the NIR at birth. 100% of newborns enrolled with a GP by 6 weeks of age.
Improve cross-agency linkages and service integration to meet the needs of vulnerable mothers and children.	Establish a Maternal Care and Unborn Wellbeing Multidisciplinary Team to support pregnant women with complex needs. Support distribution of the findings from Mana Tamariki Mokopuna to inform forums that wish to support vulnerable Māori women, tamariki and their whānau.	Maternal Care and Unborn Wellbeing MDT in place Q1. Mana Tamariki key findings report available Q2.

[28] *The Mana tamariki-Mokopuna, Mana Whanau Project (2013-17) is an innovation project developed by Poutini Waiora who in conjunction with the West Coast DHB will scope, develop and implement a pilot that addresses the needs and aspirations of young Maori whanau on the West Coast who have or are about to have tamariki and mokopuna.*

[29] *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.*

[30] *Timeframes for implementation of the programme are dependent on the national release of guidelines, expected in 2014.*

Implement a collaborative and integrated approach to the delivery of child and youth services.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Prepare a collaborative and integrated approach to the delivery of the national Child Action Plan.	Support the Cross-Sector Child & Youth Health Alliance to take the lead in establishing Children's Teams on the Coast. Hold a cross-sector Workshop to determine the local strategy in establishing multidisciplinary Children's Teams. Develop mechanisms to support effective referral pathways to/from Children's Teams and primary and secondary health services.	Cross-sector workshop Q3. Children's Team leadership group in place by Q4. Multi-disciplinary Children's Teams in place by June 2016.
	Support continued delivery and evaluation of the West Coast Violence Intervention Programme by the VIP Steering Group. Review the West Coast's current Child Protection Policy and Procedures in line with the new Vulnerable Children's Legislation. Make the revised Policy and Procedures available online to all staff. Complete implementation of eProsafe and the National Child Protection Alert System (NCPAS). Routinely screen hospitalised women aged 15+ for family violence. Continue to provide MoH-accredited training health professionals to recognise signs of abuse and maltreatment in designated services.	Child Protection Policy and Procedures updated Q1. Report on implementation of the Policy Q4. NCPAS fully operational Q4. Increased number of people trained - base 171. Combined audit score of ≥170/200 maintained for the child and partner abuse components of the VIP.
Implement the WellChild/Tamariki Ora (WCTO) Quality Improvement Framework and improve B4 School Check (B4SC) coverage for the high deprivation population.	Work collaboratively with the WCTO Quality Improvement Group to develop and implement a WCTO Quality Improvement Plan focused on achievement of the following three targets: 86% of infants receive all WCTO core contacts in their first year of life. 86% of mothers are smokefree at 2 weeks postnatal. 86% of children with a Lift the Lip score of 2-6 referred to specialist services as part of the B4SC.	Quarterly improvement demonstrated against all three WCTO targets. Six monthly reporting on avoidable hospital admission rates for children (aged 0-4) Q2, Q4.
	Continue to monitor access and referral patterns for B4 School Checks to identify opportunities to improve delivery and coverage. Explore opportunities to promote B4 School Checks to parents. Monitor timeliness of access to referred services following WCTO/ B4SC assessment and implement actions to expedite service delivery. Work with public health nurses and early childhood education providers to identify and engage children who have not had a B4 School Check – particularly Māori, Pacific and Quintile 5 children.	90% of four-year-olds receive a B4 School Check. 90% of Māori and Pacific children and children living in high deprivation areas receive a B4 School Check.
Improve the coordination across oral health services and the quality of service provision across the West Coast.	Support the Oral Health Steering Group to provide oversight in delivery of the recommendations of the Oral Health Services Review. Identify and implement effective strategies to ensure newborns are enrolled with Community Oral Health Services. Implement the Hub & Spoke Assessment Service to reduce delays in dental assessments. Work alongside WCTO providers and general practice teams to identify children most at risk of tooth decay and support families to maintain good oral health and access preventative care. Identify opportunities to engage with more young people, particularly those from low decile schools and Māori and Pacific adolescents. Ensure West Coast representation at regional forums.	Oral Health Review actions implemented Q4. 90% of children (0-4) are enrolled with DHB-funded oral health services. 90% of children are examined according to planned recall. 86% of children with a Lift the Lip score of 2-6 referred to specialist services. 85% of adolescents (13-17) access DHB-funded oral health services.
Work with the Regional Child & Youth Alliance to support specialist service delivery.	Monitor access to regional maternal/perinatal mental health services for pregnant and postpartum women and address any issues. Support the implementation of the Regional Rheumatic Fever Prevention Plan and align activity with the agreed regional approach. Undertake a root-cause analysis on any new rheumatic fever cases on the West Coast and report on lessons learned and actions taken. Support the regional review and proposal for the delivery of Fertility Services to align service delivery across the South Island.	Maintain low South Island rheumatic fever rates (< 0.3 per 100,000). Request for Proposal completed for Fertility Services Q2.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Increase immunisation coverage to reduce vaccine-preventable diseases and improve health and wellbeing. [31]	Maintain the West Coast Immunisation Advisory Group with clinical leadership across the system to provide oversight of immunisation service delivery and performance.	West Coast is represented at national and regional forums.
	Maintain and enable systems for enrolment and seamless handover between maternity, general practice and WCTO services to support timely and multiple enrolments of newborns with health services: ▪ LMCs for early hand over to GP and WCTO providers; ▪ Enrolment with General practice teams, and use of B codes; ▪ Timely NIR reporting to follow up un-enrolled children. Continue to work alongside Child Youth and Family, Ministry of Social Development and other relevant social service agencies and with the Canterbury Immunisation Service Level Alliance.	95% of newborns enrolled on the NIR at birth. 100% of newborns enrolled with a GP by 6 weeks of age.
	Continue to monitor and evaluate immunisation coverage at DHB, PHO and general practice level and circulate performance reports to maintain coverage and identify unvaccinated children. Continue to manage identified service delivery gaps by supporting the Outreach Immunisation Services to locate missing children and provide advice and immunisation. Continue to maintain internal processes whereby the immunisation status of children presenting at hospital is identified and 'missed' children referred to general practice or outreach services. Continue to support other organisations working with high needs and at risk children to identify the immunisation status of children presenting to them and link families with Outreach Services.	85% of 6 week vaccinations are completed. 90% of all eight-month-olds are fully vaccinated Q1. 95% of all eight-month-olds are fully vaccinated Q3. 95% of all two-year-olds are fully immunised.
	Implement the DHB-wide Immunisation Promotional Plan and use the 'Immunise for Life' programme to support Immunisation Week and profile the importance of immunisation and interagency activity. Ensure immunisation information is widely available.	Action Plan developed for Immunisation Week Q3. Narrative report on interagency activities Q4.
	Maintain an HPV Programme in a school setting and promote HPV vaccinations for eligible young women.	60% of girls have received HPV dose 3.
	Promote and provide free seasonal flu vaccinations for people aged over 65, pregnant women and people with chronic health conditions. Promote and provide (and monitor) free pertussis (whopping cough) vaccinations for pregnant women and their whānau.	75% of people (65+) have a flu vaccination. Quarterly monitoring of Pertussis vaccinations.

[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.*

Implement a collaborative and integrated approach to deliver the Prime Minister's Youth Mental Health Project.

OUR PERFORMANCE STORY 2014/13		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Improve joint cross-sector planning.	Formalise the membership of the Youth Health Action Group under the Child & Youth Health Alliance Workstream.	Youth Health Action group in place Q1.
Maintain HEEADSSS Wellness Checks in schools and improve coordination across primary settings.	Expand HEEADSSS assessment training opportunities to increase the number of competent providers to increase assessment capacity. [32] Engage with primary care to improve coordination of referrals resulting from HEEADSSS assessments.	Increased number of HEADSSS providers - base 4. Increase in Year 9 students receiving HEEADSSS Assessments – base 50%.[33]
Ensure West Coast health services are youth-friendly and accessible to better engage young people with health services and promote wellbeing.	Identify and implement a consumer model for youth voice representation within the WCDHB Consumer Council. Embed mechanisms for engagement with youth communities through links with high schools and community groups with youth forums.	Youth consumer model implemented (including Rangatahi Māori) Q1. Youth Specific Service options shared with the Youth Action Group Q3. Youth engagement sessions delivered Q2-Q3. Two new localised youth HealthPathways in place Q3. Increased number of schools engaged in the Wellbeing Game Q4.
	Investigate West Coast alternatives for youth-specific services similar to 'youth one-stop-shops' including mobile and youth clinics.	
	Deliver education sessions to health professionals and administration staff to improve 'youth competencies' with the specific inclusion of Māori (cultural) training to support working effectively with rangatahi.	
	Work alongside community groups with youth consultation, to ensure information on national and West Coast youth health services is easily available in online formats.	
	Review/develop localised HealthPathways to ensure 'right point of entry' for young people into the health system.	
	Encourage and support West Coast schools and the community to engage in wellbeing programmes, such as the Wellbeing Game and the enhancing positive interaction and communication in the community EPIC Programme using interagency links.	
Develop an integrated and responsive stepped care model for youth mental health services.	Work with primary care providers to strengthen their responsiveness to youth and establish a provider network for sharing experience. Identify opportunities to improve engagement rates for rangatahi Māori earlier in the continuum. Continue to maintain access to primary mental health services coverage for all young people 12-19 years including access to Brief Intervention Counselling (BIC) in primary care settings.	West Coast youth provider network established Q1. Review of utilisation rates for Māori completed Q3. Increased number of young people access BIC in primary care – base 59.
	Implement the recommendations from the Mental Health Review. Refine the service model for Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and other Drugs (AOD) Services (as part of the integrated locality based IFHC model being developed). Complete the implementation of the Health Connect South IT Solution and monitor service utilisation trends to better meet demand.	Quarterly review of progress in achieving wait time targets for CAMHS/Youth AOD. 80% of young people access non-urgent services within 3 weeks and 95% within 8wks.
	Support enhanced integration between CAMHS, Youth AOD, paediatric and primary mental health services to support the stepped care model. Refine care planning process for young people discharged from CAMHS and Youth AOD services.	Discharge Process Review Q2. Protocols agreed Q3. 95% of long-term youth SMHS clients have current relapse prevention plans Q4.

[32] *HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and depression, Safety).*
[33] *This measures counts Year 9 students in Decile 1-3 secondary schools only.*

6.10 Older people's health

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. The demand placed on Aged Residential Care (ARC) services is also a significant challenge, and the West Coast has one of the highest rates of ARC utilisation per capita.

The establishment of the West Coast's Complex Clinical Care Network (CCCN) provides a single point of referral for patients from general practice, ambulance and inpatient services. Under the CCCN delivery model, clients are assessed by the CCCN team using comprehensive assessment tools, and an individual goal-based care plan is developed with them. This restorative model allows for care to be flexed up and down according to individual need and includes peer review of cases by providers and general practice. In the coming year, the model will be expanded to offer a rapid response and supported discharge service to help prevent unnecessary hospital admissions and readmissions. Budget 2013 funding has also allowed for investment in more intensive packages of care for complex patients. By investing in a more restorative and responsive service model, we can improve the quality of life for older people on the West Coast and support them to remain safe and well (out of hospital) and in their own homes for longer.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Further enhance the CCCN as the single point of referral and consolidate and continue to refine wrap-around services for older people.	Build and expand on the skills mix available within the CCCN to further enhance the single point of referral. Allocate additional budget funding to increase input for up to 30 clients who have a higher level of complexity. [34] Support strong links between the CCCN and general practice to ensure the GP team is the point of continuity for the patient. Continue to provide specialist support to general practice and ARC providers through the CCCN Interdisciplinary Team.[35] Enhance the relationship between the CCCN, primary care and allied health including peer review and joint assessment of clients. Ensure strong client-centred goals-based planning and case management to optimise/maintain independence in the home. Investigate a nurse practitioner role to support the CCCN model and improve continuity of care through use of goals-based plans. Use the national core quality measures for Community Support Services (CSS) (*once released*) to review and improve service performance.	Increased support available to complex clients Q1. Quarterly review of case mix levels and service utilisation. 100% of staff trained in comprehensive assessment tools Q1. Quarterly KPI dashboard monitoring in place Q2. Shared Care Plans stored electronically Q4. Rate of acute medical admissions maintained at <5,600 per 100,000.
Establish a (goals-based) rapid response and supported discharge service.	Continue to engage with primary care and allied health to develop and implement a rapid response and supported discharge service and support an Inter-Disciplinary Team (IDT) response. Provide restorative and supported discharge training to enable community support workers to better respond to client need. Develop an equipment pathway to improve equipment availability to better support people at home. Review the locality of IDT meeting to improve accessibility for general practice to support the management of complex patients. Investigate the integration of district nursing and CSS to enable a more comprehensive acute demand, rapid response and supported discharge service.	Support worker training plan developed Q1. Equipment Pathway live Q2. Opportunities for integration of district nursing and CSS identified Q3. >50 patients supported by the Rapid Response/Supported Discharge Service Q4. Elective inpatient average length of hospital stay reduced to ≤3.18 days. Acute readmission rates (for people 75+) maintained at or below 9.6%.

[34] The number of high complexity clients accessing increased support will be measured through case-mix criteria changes.

[35] The CCCN IDT includes a specialist geriatrician, two gerontology nurse specialists and two clinical assessors (4.6 FTE). This team works alongside general practice to support people to stay safe and well in their own homes – with shared care planning and assessment and the provision of advice to general practice and ARC.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Ensure older people receive timely and comprehensive clinical assessment of need.	Continue to support CSS providers and the CCCN team to assess clients using InterRAI tools. Maintain InterRAI read-only access for general practice and ARC providers to improve care planning. Support ARC providers to undertake clinical assessments using the InterRAI Long Term Care Facility (LTCF) module - with advice and education from the DHB's InterRAI trainer and CCCN Gerontology Nurse Specialists. Promote the need to ensure assessments include ethnicity data.	Quarterly monitoring of InterRAI use. >95% of long-term CSS clients have had an InterRAI assessment. >95% of people entering ARC have an InterRAI assessment. 100% of ARC facilities using the InterRAI tool.
Invest in the development of targeted, specialised services and pathways to support people with more complex needs.	Continue to Promote Zero Harm from Falls In ARC settings and enhance the Vitamin D Supplementation Programme. Review and enhance clinically led falls prevention strategies involving primary care, allied health and ARC providers in preventing ED presentations as a result of falls.	75% of ARC residents receive Vitamin D. Falls Prevention Service in place Q3.
	Support clinical leads to engage regionally in aligning preventative care to prevent future fractures and implement a Fracture Liaison Service on the West Coast that aligns to the regional direction. Develop a Fracture Liaison Pathway for the West Coast. Utilise key metrics to identify those at risk of fragility fracture, and monitor ED attendances and hospital admissions.	Attendance at South Island Fracture Workshops Q1. Fracture Pathway live Q3. Quarterly key metrics dashboard live Q4.
	Continue to expand access to "Walking in Another's Shoes' (WAIS) dementia training both in ARC and community services. Engage primary, community and secondary care clinical leads in a review of the Cognitive Impairment Pathway for consistency with the regional framework and implement the revised Pathway. Develop a system pathway to identify isolated older adults with depression earlier and provide appropriate support.	Cognitive Impairment Pathway reviewed Q2. Depression Pathway live Q3. Increased number of carers completing the WIAS programme - base 42.[36]
	Engage clinical leads in the integration of stroke services and referral pathways to enable the sustained provision of an organised stroke service and demonstrated stroke pathway that meet NZ Stroke Guidelines. Review stroke thrombolysis quality procedures including processes for staff training, indicator reporting and audit. Support a standardised referral process with IDT oversight for people requiring support and rehabilitation after a stroke. Continue to participate both nationally and regionally in clinical stroke networks to align pathways and improve outcomes. Support staff training in line with NZ Stroke Guidelines. Undertake quarterly monitoring against national stroke indicators.	Clinical leads for stroke identified Q1. Current pathways reviewed against integrated model Q2. Thrombolysis quality procedures reviewed Q3. 6% of eligible stroke patients are thrombolysed Q4. 80% of eligible stroke patients admitted to an organised stroke service Q4.
Work with CDHB and the Regional Health of Older Persons Alliance to support specialist service delivery.	Attend regional Dementia Workshops to align the local review of Cognitive Impairment Pathway (CIP) with regional work. Attend regional Fracture Service Workshops to align direction. Participate in regional activity to improve health outcomes for older Māori including service data collection and review. Participate in the Regional Thrombolysis Audit.	Regionally consistent Cognitive Impairment Pathway in place Q4. Review of InterRAI and stroke data by ethnicity Q2. Thrombolysis Audit Q3.

[36] *This is a calendar year result with the base being the number of carers and health professionals undertaking WIAS training in 2013.*

6.11 Mental health

Why is this important?

In line with the development of Integrated Family Health Services (IFHS), we have a unique opportunity to introduce an integrated and responsive stepped care approach to the delivery of mental health services across the West Coast. The development of this new service model will be influenced by the recommendations of the West Coast Mental Health Services Review completed in 2014 and the service development priorities and guiding principles outlined in the national Mental Health and Addiction Service Development Plan 'Rising to the Challenge' 2012-2017.

The new model will mean services will be: located in and/or working in communities to strengthen integration across service providers; consumer-centred, collaborative and well-being focused to cement and build on gains in resilience; and focused on maximising individual and collective strengths and resources to simplify access pathways, reduce waiting times and improve the continuity of care.

Clinical governance and leadership is seen as particularly important to ensure that health providers work together better for the interests of the consumer. A Mental Health Leadership Group will be established under the umbrella of the West Coast District Alliance and will be representative of the whole system; with funders, providers and consumers collaboratively engaged in driving the change needed.

The DHB funds its mental health services in accordance with the national ring-fence funding expectations and will continue to apply the ring-fence criteria and guidelines to ensure it meets mental health expenditure commitments.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Implement prioritised actions from the West Coast Mental Health Services Review.	Establish a whole-of-system Mental Health Leadership Group to oversee the implementation of the Mental Health Review actions. Agree and adopt a systems philosophy and strengths-based recovery approach for mental health services on the West Coast.	Mental Health Alliance Workstream in place Q1.
	Begin to establish locality based services that support improved integration between primary, community and secondary services. Develop the stepped care continuum model to better focus resources and improve the way we work. Review the role of NSAC services and seek to establish agreement on eligibility criteria for a range of services to improve access including respite and residential services. Clarify locality team structures and their fit with IFHC planning. Review the current range of supports available across the community to identify opportunities to improve coordination, access and consumer responsiveness.	Mental Health representation on Grey/Westland and Buller IFHC workstreams Q1. Stepped Care model in place Q2. System-wide eligibility criteria agreed Q4. 80% of people referred for non-urgent services are seen within 3 weeks and 95% within 8 weeks. Access rates for mental health services maintained >3.8%.
	Strengthen responsiveness to Māori through collaboration with Kaupapa Māori Services, primary care and specialist services. Identify key areas of opportunity to extend the scope of the Maori mental health service team.	Māori representation on the Mental Health Alliance Q1. Review Māori mental health service utilisation rates Q3.
	Investigate opportunities to increase the level of occupational therapy (OT) and physical activity input into mental health services. Identify the optimal pathway for dementia to support earlier intervention and quality of life for consumers and their families. Continue to expand peer support and increase access to brief intervention counselling (BIC) across the age continuum. Enhance social inclusion opportunities to increase resilience through increased social networking and peer support options.	OT opportunities identified Q2. Cognitive Impairment Pathway reviewed Q2. Peer Support available in Buller Q2 and Westland Q4. Increased number of people accessing BIC in primary care – base 357.
	Formalise leadership roles within specialist mental health services to support the implementation of the stepped care model. Streamline information collection and improve the quality of data extracts to better inform future planning. Establish headline indicators and KPIs for monitoring progress.	Leadership roles formalised Q2. KPI Dashboard in place Q3.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Improve cross-agency linkages to implement national policies for ensuring vulnerable and at-risk people and their families are better supported.	Support the newly established (cross-agency) clinical governance and action groups to develop a whole-of-system Suicide Prevention and Postvention Plan. Identify best practice and appropriate training models in association with the Regional Alliance and Canterbury DHB to support staff to better identify and support people at risk. Continue to provide leadership in identifying high-risk situations or cluster(s) and preparing cross-agency evidence based responses.	Whole of System Suicide Prevention Postvention Plan in place Q2. Training in place Q3.
	Maintain collaborative relationships with Police and Education and continue to support school-based Alcohol and Other Drug (AOD) education. Increase alcohol brief intervention capacity across the system with investment in additional AOD resources into Non-Government Organisation's (NGO) services. Continue to support the delivery of HEEADSSS Assessments in West Coast schools. [37]	AOD NGO resource available Q1. Increased number of people accessing AOD BIC – base new. Increased number of Year 9 students receive HEEADSSS Assessments – base 50%.
	Continue to invest in and refer clients to services that support people into employment or further education and routinely involve Vocational Services in care planning. [38] Support vocation services to participate in care plan development. Continue to support the Fresh Start Programme.[39]	Increased number of clients supported into employment or education – base 67%. Te Ara Mahi attending discharge planning reviews Q1.
Work with the Canterbury DHB and the Regional Mental Health Alliance to support the delivery of specialist services.	Reinstate the Transalpine Mental Health Leadership Forum to lead further development of the transalpine approach to the delivery of specialist mental health services. Make increased use of available technologies to support increased family and whānau involvement in inpatient care including Skype, videoconferencing and telemedicine. Participate in the regional review of Perinatal and Maternal Mental Health Services consult liaison mechanisms and implement the regionally agreed pathway.	Transalpine Mental Health Forum in place Q1. Telemedicine service available to Eating Disorders and Mothers and Babies Services Q2. COPMIA Pathway in place Q4.

[37] This measures counts HEEADSSS Assessment delivered to Year 9 students in Decile 1-3 secondary schools only.
[38] This measure refers to the Te Ara Mahi vocational programme.
[39] Fresh Start is a Programme led by the Ministry of Social Development that includes the ability for courts to refer youth to AOD services.

6.12 Whānau Ora

Why is this important?

Although we are making progress, on average, Māori still have the poorest health status of any population group in New Zealand and are less likely to access mainstream health and disability services. 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 premature mortality rates. Service utilisation data indicates that West Coast Māori are less likely to access health services early, and as a result often have poorer outcomes following intervention.

The DHB has a specific Māori Health Action Plan for 2014/15 which is written as a companion document to the Annual Plan and outlines key actions and activity to improve outcomes for West Coast Māori. This can be found on the DHB's website.

With the introduction of the national Whānau Ora programme and the IFHC services model, opportunities also exist to work more collaboratively with agencies outside of health to reduce risk and environmental factors that negatively impact on health, to better engage Māori in health services and to reduce inequalities in health outcomes.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTION**	**EVIDENCE**
Work together to support the implementation of the national Te Puni Kokiri-led Whānau Ora initiative to ensure health and social services empower whānau and provide wrap-around services tailored to their needs.	Support the agreed Māori appointment process across the system (led by Tatau Pounamu) to enhance the capability of advisory boards and working groups.	Appointment process being used by Advisory Boards Q2.
	Work with Tatau Pounamu to assist Whānau Ora collectives with: ▪ 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; ▪ Support for research and professional development within Whānau Ora collectives; ▪ Advice around outcomes based monitoring and evaluation frameworks that have proved successful in Alliance Workstreams; ▪ Provision of information on Māori service planning and reviews that may affect providers within Whānau Ora collectives; and ▪ Identifying opportunities for the introduction of integrated contracts across government agencies to support the implementation of whānau ora models.	2013 Māori and Pacific Census Data distributed to Whānau Ora collectives by Q1. Assessment of HealthPathways stocktake completed by Q2. Relationship between Whānau Ora Commissioning Agency and WCDHB agreed Q3. EDAT Audit implemented Q4. Tai Poutini Māori health Profile update complete Q4. HealthPathways stock take completed by Q4. Increased number of West Coast participants on Kia Ora Hauora programme Q4. Increased PHO enrolment and disease prevention screening rates for Māori Q4. Increased number of Māori enrolled in the LTCM Programmes Q4. Increased proportion of total smoking cessation enrolments are Māori – base 12%.
	Work with Māori Health Providers and general practice to review patient management systems, to better support alignment to Whānau Ora. Work with HealthPathways to increase the number of Māori health service options listed. Work with the newly established South Island Whānau Ora Commissioning Agency to identify where the West Coast DHB can support implementation of the new Whānau Ora Model. Investigate the viability of the development of a Whānau Ora Government Agency network. Support the implementation of the Ethnicity Data Audit Toolkit (EDAT) with the West Coast PHO. Update Tai Poutini Māori Health Profile. Continue to support improving Māori workforce capacity and capability by working with Kia Ora Hauora locally and regionally to improve the number of Māori on health career pathways.	
	Work through the West Coast Alliance to implement the actions agreed in the 2014/15 West Coast Māori Health Action Plan.	

Clinically and Financially Viable Health Services

6.13 Connecting our information systems

Why is this important?

Over the last two years, the West Coast DHB has massively changed its information technology (IT) systems to enable a more integrated health information system – reducing duplication, saving clinical staff time and improving patient safety. Major milestones over the last two years have included going live with Health Connect South (HCS – the regional clinical workstation and data repository) and the regional Electronic Referral Management System (ERMS). The West Coast was also the first DHB to go live with the regional mental health solution for Health Connect South. These developments have enabled fast, accurate referrals and safe, efficient sharing of clinical information between South Island health professionals.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Value the patient.	Refresh the West Coast DHB website so that it is easier to navigate. Implement a Patient Portal to enable patient access to their core health information and electronic interaction with general practice.	Website refreshed Q2. Patient Portal designed Q2. Patient Portal in place Q3
Support patient safety.	Implement e-Pharmacy system for pharmacy management. Implement the National Maternity System to provide a complete and consistent set of maternity information. Implement e-Medicines reconciliation to reduce transcription errors and improve care communication. Implement RL6 software for reporting/managing incidents.	e-Pharmacy in place Q1. Maternity System in place Q2. e-Medications in place Q4. RL6 software in place Q4.
Enable integrated care.	Launch Titanium across the Community Dental Services fixed and mobile clinics to allow the team to share live clinical data. Deploy the e-Shared Care Record View (eSCRV) to integrate core clinical information and make it available at the point of care. Implement the next phase of ERMS to enable electronic triage.	Titanium launched Q1. eSCRV deployed Q1. ERMS e-Referrals triage phase live Q1.
Enhance systems for health professionals.	Enable West Coast DHB and Canterbury DHB staff to share common intranet and learning tools to better disseminate information between DHBs. Enable electronic ordering of laboratory and radiology tests for more efficient and timely delivery of these diagnostics.	Regional Learning Q4. Common Intranet Q4. e-Orders enabled Q4.
Support the Transalpine Health Service and wider regional collaboration.	Expand the use of telehealth to provide patients with more timely access to care and reduce the need for travel. Facilitate staff communication and collaboration with shared email and Lync systems between West Coast DHB and Canterbury DHB. Prepare to implement the South Island Patient Information Care System (PICS) to further integrate systems.	Merged email system WCDHB and CDHB Q2. Implementation of the South Island PICS 2016/17.
Develop IT infrastructure alongside facilities.	Implement wireless systems to support the IFHCs model with telehealth, mobile devices and electronic medicines reconciliation. Align systems with CDHB so both organisations are on the same platform, enabling more efficient asset management.	Wireless systems expansion 2015. Combined maintenance systems 2016.
Strengthen information systems and the information services team.	Enhance Medtech to improve its performance and enable other systems (e.g. Clinical Audit Tool) to operate correctly. Develop one virtual IT team spread between the WCDHB and CDHB to make better use of resources in both organisations. Adopt Virtual Desktop Infrastructure being piloted in Canterbury DHB.	Medtech improvements Q1. Combined IT helpdesk Q2. Combined IT policies and capital planning Q2.
Centralise systems for reporting.	Implement Phase 1 of National Patient Flow (NFP) collection to capture information at key points in the patient journey. Merge WCDHB/CDHB reporting systems and extract systems to allow for pooled virtual team members to act on one set of systems.	NFP Phase 1 in place Q1. Transalpine reporting Q2. Transalpine extracts 2015.

6.14 Improving quality and patient safety

Why is this important?

We have made considerable changes to sharpen our focus on improving the quality and safety of the services provided at the West Coast DHB. The formation of an organisational quality team and Clinical Board has introduced a new level of leadership with a system-wide approach to quality improvement. While much of our current quality activity focuses on strengthening safety reporting systems and engaging with consumers; the priorities of the Health Quality and Safety Commission (HQSC) have been incorporated into our quality programme.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Increase the focus on continuous improvement processes across the system.	Support the use of service level data in the implementation of the Plan-Do-Study-Act (PDSA) cycle for service improvement. Complete a Clinical Governance stocktake and implement any recommendations from the Clinical Board. Refine the DHB's Quality Accounts based on the HQSC evaluation.	Quality Database in place Q2. Governance Stocktake complete Q3. Annual publication of DHB Quality Accounts.
Improve the patient experience.	Implement the '4 Questions' (what is happening today - when am I going home?) at the bedside in medical services to increase patient involvement in decision making about their care. Integrate the patient experience survey results collected as part of the national collection system into service datasets. Support Consumer Council involvement in patient care improvement teams and the design of new facilities. Continue to use patient stories to inform the design of service improvement process and to celebrate.	Quarterly reporting on patient experience survey data. 90% completion of answers to 4 Questions in medical wards. Two consumer representatives on each improvement team.
Support projects that make a difference to improving the quality of care and reducing patient harm and contribute to the national patient safety campaign 'Open for Better Care'.	Implement the electronic incident management and feedback system (RL6) to enable shared clinical outcome reviews. Develop an electronic audit process. Integrate the national Quality Safety Markers into appropriate improvement programmes.	RL6 software in place Q4. Updated audit reporting system in place Q4.
	Promote prevention of healthcare associated infection through Open Campaign activities. Support the collection of key process information required for hip and knee data using the new electronic scope form. Support Clinical Nurse Mangers to regularly audit skin preparation to ensure appropriate action is taken in all cases. Implement national Central-Line-Associated Bacteraemia (CLAB) processes in the Neonatal Unit.	CLAB processes implemented in Neonatal Unit Q3. 95% of hip & knee replacement patients receive cefazolin ≥ 2g as surgical prophylaxis. 100% of hip and knee replacement patients have appropriate skin preparation.
	Prevent harm from falls by rolling out the electronic nursing patient observation system to record and make visible patient's falls risk. Support the development of a community-based Falls Prevention Programme to reduce re-admissions for people at risk of falls.	Mobility Plans in use at the bedside Q4. 90% of older patients (65+) have a falls risk assessments completed.
	Continue to support adherence to the '5 Moments in Hand Hygiene' with promotion of expectations of staff. Reinforce and monitor Brief and Debrief and completion of the Surgical Safety Checklist to support adherence to policy. Roll-out e-prescribing and administration across the organisation to improve medication safety.	80% compliance with good hand hygiene practice. All three parts of the surgical safety checklist used 90% of the time. e-Pharmacy rolled-out Q1. e-Medications rolled out Q4.

6.15 Supporting our health workforce

Why is this important?

Having the right workforce in the right place is a critical success factor for the West Coast DHB. Alongside concern over the continued availability of a sufficient workforce as our population ages, changing workforce patterns, the expectations of younger workers, new technology and our geographic isolation make it harder to recruit the people we need.

To meet the future needs of our population we need to use our limited workforce resource in different ways. Engaging staff in the transformation will ensure a more sustainable future. Our clinical workforce is already taking a lead in the development of alternative models of care to ensure we can continue to provide quality services. We are also expanding our capacity by supporting innovative roles that enable health professionals to work to the upper end of their scope and spend more quality time with patients.

A large focus for the coming year will be redefining the 'West Coast brand' in order to attract people to the region. We will focus on expanding and integrating training and professional development programmes and developing core leadership curricula. We will also build on the collaborative model with Canterbury, using technology such as telemedicine, to enable clinical staff in Canterbury to support the delivery of care on the West Coast. The South Island Regional Training Hub provides further opportunities for greater collaboration across workforce groups and clinical networks are well established. The development of new roles and support for training and the roll-out of national programmes will help to ensure our future workforce has the skills and capability to better meet the needs of our population.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Implement change leadership and development programmes.	Establish champions across the West Coast health system to promote best practice and support transformation based on a 'best for patient, best for system' approach. Continue to drive change and improved outcomes through the development of clinically led patient pathways. Introduce talent identification programmes and a core curriculum that supports leadership development.	Increased number of Champions roles in place. >600 HealthPathways Q4. CDHB/WCDHB core curriculum in place by Q4. Critical roles identified Q4.
Promote the desired culture of the West Coast DHB and improve employee engagement.	Invest in programmes that reiterate the desired behaviours and cultures and engage our workforce in transformation Introduce a diagnostic tool to assess current and ideal culture values and identify opportunities for change. Align systems for goal setting, performance reporting, and communications to reinforce culture messages. Use the data from the new attachment and exit technology to identify areas of concern and opportunities for improvement. Re-run a Staff Engagement Survey to determine priorities.	Cultural diagnostic tool introduced Q4. Increased participation in XcelR8 and Collabor8 Q4. 80% of staff would recommend WCDHB as an employer. Overall improvement in employee engagement results.
Expand workforce capacity through improved workforce planning, recruitment and retention.	Support regional planning programmes to identify future workforce requirements and agree a common set of planning tools to identify workforce gaps and opportunities. Digitise all HR administration systems to streamline processes and further integrate Canterbury and West Coast HR systems. Continue to support and recruit fully into Nursing Entry to Practice (NETP), Specialty Practice (NESP) and Midwifery First Year of Practice (MFYP) programmes, maximising clinical placements for undergraduate nursing and midwifery trainees. Expand rural hospital medicine and general practice training on the West Coast to support new clinical placements. Participate in the Kia Ora Hauora Māori Workforce Development Service to encourage more Māori into health. Work closely with the Canterbury DHB to supplement West-Coast based services with joint appointments and the expanded use of Telemedicine Technology.	All WCDHB recruitment undertaken by CDHB Q1. Social media recruitment campaign embedded Q1. >15 NETP, NESP and MFYP positions maintained Q4. New Dedicated Education Units embedded Q4. 12% reduction in time taken to fill vacancies. Increased proportion of FTE in permanent positions >65%.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Expand workforce capability through improved training, education, learning and career development	Support ongoing skills development, building on internal learning and development plans and the regional curriculum. Provide training in performance management tools (Sonar 6) and introduce online technology to allow more time for quality conversations on performance expectations.	>100 people complete Sonar 6 training. >50% of staff use the online system Q4.
	Promote and facilitate inter-professional and multi-disciplinary learning and activities through the Rural Learning Centre. Support the Rural Learning Centre to meet with health educators to coordinate inter-professional learning and support training needs for the new models of care.	Two Rural Hospital Medicine registrar and two GPEP 1 registrar posts in place Q1. Effective Rural Learning Programme delivered Q4.
	Invest in extending primary care education programme coverage and expand the variety of education channels. Continue to support and develop advanced clinical skill for nursing and explore and implement expanded scope roles within the West Coast Health System. Support allied health role development for: allied health assistants; pharmacy technicians; and advanced roles.	Regional Nursing Framework in place Q4. RN Diabetes Nurse prescribing supported Q4. Pharmacists accredited to provide MUR in all districts Q4.
Participate in the South Island Regional Training Hub to expand workforce capacity and capability through improved workforce planning, sourcing and training.	Support the development of regional education sessions, forums, peer support and mentoring using innovative approaches including e-learning and video conferencing. Review and standardise the career pathways and training opportunities for all Health Workforce New Zealand (HWNZ) funded trainees.	E-learning platforms established Q4. 100% of HWNZ funded staff have career plans in place Q4.
	Support the identification of vulnerable workforces and the development of plans established to mitigate these. Support a regional approach to workforce training for vulnerable workforce areas and the coordination of clinical placements to specialist training programmes. Support the development of workforce capability to match future workforce models and the shift to community care. Support the roll out of GPEP 2 in South Island. Continue to support targeted workforce initiatives across regional workstreams including training and role development.	PGY2 & PGY3 pilot Q4. GPEP2 rollout Q4. Allied Health Assistant training and development framework in place Q4. Regional training of sonography coordinated across the South Island Q4. Compliance with 70/20/10 funding criteria Q4.
	Support the development of a regional HR Platform and an integrated workforce plan for the South Island. Support the development of a common set of workforce planning tools, core HR policies, HR metrics and learning & development tools. Adopt consistent application of common terms and conditions of employment for regional health services.	Common and consistent HR policies in place Q2. Regional health workforce plan developed by Q4. Regional Recruitment and Retention Strategy agreed Q4.

6.16 Living within our means

Why is this important?

With current and projected constraints on government funds, we must focus on maximising value from our limited resources and reducing unnecessary cost and waste. 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. Rather than achieving savings through service reductions or cuts, we seek firstly to deliver services in more effective and efficient ways. This will be a challenge, but in achieving this, we will demonstrate to our community and the government that we can operate sustainably.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Integrate fragmented health services to reduce duplication and waste.	Continue to engage Better Health to improve the financial sustainability of DHB-owned general practices. Maintain GP access to diagnostics and specialist support to reduce unnecessary hospital and specialist referrals. Support the use of Health Connect South, eSCRV and the implementation of PICs to reduce duplication and waste.	ERMS e-referrals live Q1. eSCRV rolled-out Q1. Increased proportion of follow-ups for people who live outside of the Grey district provided by telemedicine - base 1.57%.
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 streamline referrals and improved care. 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 in the community rather than in hospital. Continue to expand transalpine services to provide sustainable access to an increased range of clinical specialties.	>600 localised West Coast HeathPathways in place Q4. Percentage of the population presenting to ED <45%. Rate of acute medical admissions maintained at <5,600 per 100,000.
Maintain a focus on efficient and effective use of resources and improved quality to achieve financial sustainability.	Engage services in 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 outsourcing to create cost efficiencies and ensure that payment is sought. Retain transitional funding arrangements at current levels. Implement tight controls around repairs and maintenance to ensure investment is not wasted on short-term repairs.	Elective theatre utilisation maintained at ≥85%. Average elective surgical inpatient length of stay maintained at ≤3.18 days.
Participate in regional and national initiatives focused on the efficient and effective use of resources to achieve financial sustainability.	Actively participate in the Regional Support Services Alliance to achieve regional Procurement and Supply Chain savings. Maintain clinical and Health Benefits Limited (HBL) representation on the Support Services Alliance to ensure endorsement and alignment. Identify opportunities for cost savings from HBL initiatives and apply these locally. Actively participate in the development of national business cases for Food, Linen & Laundry, Infrastructure, HR Information System, Banking & Insurance and Finance, Procurement & Supply Chain business cases – as approved by the DHB Board. Provide expert advice and support to the National Health Committee (NHC) in review of the burden of disease and the assessment and prioritisation of technologies which are driving fast growing spending. Provide clinical support to the Health Innovation Partnership. Support national PHARMAC initiatives focused on the procurement of medical devices, and the management of hospital pharmaceuticals.	South Island Capital Expenditure Plan in place Q1. Regional Procurement and Supply Chain activity achieves savings as agreed Q4. Opportunities for joint ventures explored Q4. Annual review of regional patient transport agreements undertaken Q3. Burden of disease documents reviewed as received. Regional Strategic Planning & Integration Team take on roles as Regional Prioritisation Network and liaise with NHC as required.

Service Configuration

Service coverage

The service coverage schedule between the DHB and the Ministry of Health 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 works constantly to identify service coverage gaps through analysis of performance indicators, risk reporting, formal audits and formal complaints mechanisms. We will continue to manage and resolve any service coverage issues in a timely manner.

We are not seeking any exemptions to the Service Coverage Schedule in 2014/15, and anticipate that any services not provided locally for our resident population will be contracted through other DHBs - primarily the Canterbury DHB.

Service redesign and reconfiguration

There will be a continuous process of service transformation over the coming twelve months as we seek to 'live within our means' and deliver a more clinically and financially sustainable health system.

In line with the service priorities articulated in this Annual Plan, major areas of change will be:

IFHC Development: In line with the development of IFHC services in Grey/Westland and Buller, there will be a redesign and reconfiguration of the service models for primary and secondary care. This work is closely linked with the West Coast facilities redevelopment, and timeframes are yet to be confirmed. Alliance workstreams are in place to support the development of these new models.

Maternity Services: There will be a service model redesign and reconfiguration in line with the clinically led service review of Maternity Services undertaken in 2013/14.

Older People's Health Services: We will continue to implement the new service model for older people's health (driven through the Complex Clinical Care Network). In the coming year, there will be closer integration of nursing and home-based support services to support development of a rapid response and supported discharge service.

Mental Health Services: There will be a service model redesign and reconfiguration in line with the clinically led service review of our Mental Health Services undertaken in 2013/14. The recommendations of this review are currently being considered, and it is too early to quantify the specific changes at this stage.

Regional and Transalpine Services: We will adopt consistent, regionally developed pathways for access to specialist services – particularly across cancer, cardiac and orthopaedic services and including a regional review and proposal for the delivery of Fertility Services in line with the South Island Regional Health Services Plan.

National Direction: We will work with the Ministry of Health to identify different ways to fund and contract primary and community healthcare services. This will include implementing changes in line with the national pharmacy and PHO agreements, including the introduction of the Primary Care Integrated Performance and Incentives Framework.

Service funding will also be realigned in relation to the smoking health target; resources currently based in our hospital services will be realigned to support delivery of the primary care health target.

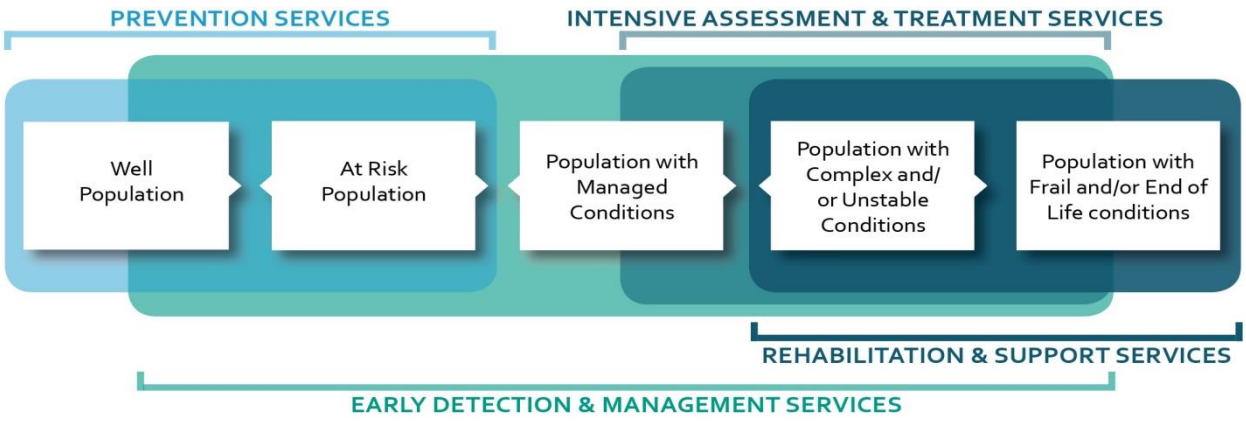
In all of these areas, the DHB will ensure service redesign is consistent with the national direction towards stepped care models, integrated service delivery and improved service quality. All of the service redesign or reconfiguration planned for the coming year is either clinically led or nationally driven, and progress will be tracked through the Health West Coast Alliance.

The DHB recognises its obligations (under the Operational Policy Framework) to notify the Minister of Health with respect to any significant service change and will continue to do so.

At times, we may wish to enter into cooperative agreements and arrangements to assist in meeting our objectives to enhance health outcomes for our population and efficiencies in the health sector. In doing so (in accordance with Section 24(1) of the NZPHD Act 2000), we will ensure that any arrangements do not jeopardise our ability to deliver the services required under our statutory obligations in respect of our accountability and funding agreements with the Crown.

Statement of Performance Expectations

What services will we deliver in the coming year?



Evaluating our performance

As the major funder and provider of health and disability services on the West Coast, we are strongly motivated to ensure our population gets the most efficient and effective services possible.

Understanding the dynamics of our population and the drivers of demand are fundamental when determining which services to fund and at what level. Just as fundamental is our ability to evaluate 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 population outcomes (Section 4).

In the more immediate term, we evaluate our performance by providing a forecast of what services we will fund and provide in the coming year and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report.[40]

Achieving equity of outcomes is an overarching priority for the West Coast health system and reflects our commitment to ensuring that our population should enjoy the best possible health status.

With a growing Māori population and persistent inequalities amongst our population, this goal pervades everything we do. All of the West Coast targets and standards are therefore set the same for all population groups, with the aim of improving performance up for all.

Specific actions with respect to improving Māori health are outlined in our Māori Health Action Plan, along with performance against key indicators by ethnicity.

Choosing performance measures

In order to present a fair picture of performance, the services we deliver 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.
- Rehabilitation and Support Services.

Identifying a set of appropriate measures for each output class is difficult. We cannot simply measure 'volumes'. 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'.

We have therefore chosen to present a mix of measures demonstrating: Timeliness (T), Coverage (C), Volume (V) and Quality (Q) - all of which help us to evaluate different aspects of our performance. Against each we have set targets to demonstrate the standard expected.

The measures chosen cover those activities we believe have the potential to make the greatest contribution to the wellbeing of our population. Others are more relevant in that they represent areas where we are developing new services or expect to see a change in activity levels or settings in the coming year.

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

Setting standards

Wherever possible, we have included a past year's baseline and national results to give context in terms of what we are trying to achieve and to support evaluation of our performance. However, measures that relate to new services have no baselines, and some 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 and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining service access while reducing waiting times and delays in treatment to demonstrate increased productivity and capacity.

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. This provides greater assurance that these are quality services, allowing the DHB to focus on monitoring implementation and timely and appropriate access.

It is important to note that a significant proportion of the services funded by the DHB are demand driven – such as laboratory tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided, not as targets to be achieved, but to give the reader context in terms of the use of resource across the West Coast health system.

Notation

Some data is provided to the DHB by external parties and can be affected by a delay in invoicing. Rather than footnote every instance, symbols are used to indicate where this is the case: Δ indicates data that could be affected by invoicing delay and is subject to change (data for these measures was pulled or before 22 May 2014).

A † symbol also indicates where data relates to the calendar year rather than financial year.

There are also a number of national health targets where performance is tracked and reported nationally on a quarterly basis rather than annually. A ◇ symbol indicates that the baseline, national average and target refer to the fourth quarter result of that year.

Where does the money go?

The table below presents a summary of the 2014/15 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	3,261
Early detection and management	36,504
Intensive assessment & treatment	78,080
Support & rehabilitation	22,332
Grand Total	**139,177**

EXPENDITURE	TOTAL $'000
Prevention	2,998
Early detection and management	36,496
Intensive assessment & treatment	78,306
Support & rehabilitation	22,377
Grand Total	140,177
Surplus/(Deficit)	**(1,000)**

OUTPUT CLASS

8.1 Prevention services

Preventative health services promote and protect the health of the population and address individual behaviours by targeting changes to physical and social environments that engage, influence and support people to make healthier choices. These services include: promotion and education programmes 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.

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 our foremost opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of babies exclusively breastfeeding on hospital discharge	Q [41]	92%	>75%	-
Lactation support and specialist advice consults provided in community settings	V	149	>100	-
Nutrition and Activity courses provided in the community	V	6	≥10	-
People referred to Green Prescriptions for additional physical activity support	V [42]	374	500	-
% of Green Prescription participants more active 6-8 months after referral	Q [43]	43%	50%	63%
% of smokers identified in primary care receiving advice and help to quit (ABC)	C	55%	90%	57%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C◇	95%	95%	96%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	124	>100	-
% of priority schools supported by the Health Promoting Schools framework	C [44]	100%	>70%	-

Population-Based Screening Services *These services help to identify people at risk of illness and pick up conditions earlier. Many are funded and provided through the National Screening Unit. The DHB's role is to encourage uptake, as indicated by high coverage rates.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of four-year-olds receive a B4 School Check (B4SC)	C [45]	81%	90%	80%
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C† [46]	55%	100%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [47]	78%	80%	77%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [47]	81%	>70%	72%

[41] The percentage of babies' breastfeeding demonstrates the effectiveness of consistent health promotion messages delivered during the antenatal, birthing and early postnatal period. Standards are based on national targets.

[42] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.

[43] Results taken from national patient survey competed by Research NZ on behalf of the Ministry of Health.

[44] The Health Promoting Schools Framework addresses health issues through 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.

[45] 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.

[46] A HEEADSSS assessment is provided to Year 9 students in low decile schools. It is free and covers: Home; Education; Employment; Eating; Exercise; Activities; Drugs; Sexuality; Suicide; Safety; and Spirituality and allows health concerns to be identified and addressed early.

[47] These are national screening programmes, and standards are based on national targets.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of newborns enrolled on the National Immunisation Register at birth	C	100%	95%	-
% of children fully immunised at eight months of age	C◇	93%	95%	90%
% of eight-month-olds 'reached' by immunisation services	Q [48]	98%	95%	95%
% of Year 8 girls completing their HPV vaccinations (i.e. receiving Dose 3)	C† [49]	44%	60%	52%
% of older people (65+) receiving a free influenza ('flu') vaccination	C†	55%	75%	65%

[48] 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children but have chosen to decline immunisations or opt off the NIR.
[49] The baseline is the percentage of girls born in 1999 receiving Dose 3 by the end of 2012, and the target is for 2014 for girls born in 2001.

OUTPUT CLASS

8.2 Early detection and management services

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.

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. 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. 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 hospital admissions, particularly acute and avoidable 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

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 or uptake of services are indicative of engagement, accessibility and responsiveness of primary care services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of the total DHB population enrolled with a Primary Health Organisation	C	94%	95%	96%
Avoidable hospital admission rate for children aged 0-4	Q [50]	102%	<101%	100%
Young people (0-19) accessing Brief Intervention Counselling	VΔ [51]	59	80	-
Adults (20+) accessing Brief Intervention Counselling	VΔ	301	>300	-
Number of HealthPathways in place across the West Coast health system	V [52]	308	>600	-

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	2012 DHB Result	2014 Target	2012 National Average
% of pre-schools children (0-4) enrolled in DHB-funded oral health services	C†	85%	90%	70%
% of enrolled children (0-12) examined according to planned recall	T†	72%	90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C† [53]	77%	85%	73%

[50] 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 and is defined as the standardised rate per 100,000 population.

[51] The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. The adult results differ slightly to that previously published (298) due to the addition of late claims.

[52] The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.

[53] The 2012/13 result differs slightly from that previously published (77%) due to population adjustments.

Long-term Conditions Management (LTCM) Programmes *These services are targeted at people with high health need due to having a long-term condition (such as CVD or Diabetes) and aim to reduce deterioration, crises and complications through good management and control of that condition. Success is demonstrated through early intervention, monitoring and management strategies which reduce the negative impact and the need for hospital admission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
People identified with a long-term condition enrolled in the PHO LTCM programme	V	2,552	>2,000	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C [54]	58%	90%	67%
% of people with diagnosed diabetes having an annual LTCM review	C	70%	>70%	-
% of people with satisfactory diabetes management	Q	78%	80%	-

Pharmacy and Referred Services *These are services which a health professional may prescribe or refer a person to help diagnose a health condition, or as part of treatment. They are provided by allied health personnel such as laboratory technicians, medical radiation technologists and pharmacists. While pharmaceuticals are largely demand driven to improve performance, we will target primary care access to diagnostics and shorter wait times to aid decision-making and improve referral processes.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Subsidised pharmaceutical items dispensed in the community	VΔ [55]	479,972	est. <600K	-
Laboratory tests completed for the West Coast population	VΔ[56]	na	est. <150K	-
Number of community requested radiological tests delivered by Grey Hospital	V	5,721	est. >5,000	-
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T [57]	53%	75%	56%
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T	100%	≥90%	79%
% of people receiving their Magnetic Resonance Imagining (MRI) within 6 weeks	T	91%	≥80%	52%

[54] This measure refers to CVDRAs undertaken in primary care in line with the national 'More heart and diabetes checks' health target.
[55] This measure covers all items dispensed in the community rather than hospital; however, it may still include some non-West Coast residents who had prescriptions filled while on the Coast.
[56] This result was not available at the time of printing due to a change in processing process.
[57] All diagnostic result baselines are the June 2013 month final result published by the Ministry of Health, and targets are set to match national standards set for all DHBs.

OUTPUT CLASS

8.3 Intensive assessment and treatment services

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. A proportion of these services are driven by demand that the DHB must meet, such as acute and maternity services, while others are planned, with provision and access 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 through appropriate corrective action. 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. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Quality improvement in service delivery, systems and processes will increase patient safety, reduce the number of events causing injury or harm and improve health outcomes. 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.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in West Coast DHB hospitals and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Rate of compliance with good hand hygiene practice	Q [58]	73%	80%	71%
% of hip and knee replacement patients receiving cefazolin ≥2g	Q [59]	new	95%	-
% of hip and knee replacement patients who have appropriate skin preparation	Q	new	100%	-
% of time all three parts of the surgical safety checklist are used	Q [60]	84%	90%	71%
% of inpatients (aged 75+) who received a falls assessment	Q [61]	53%	90%	77%
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. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C	62.5%	80%	63%
% of new mothers attending DHB-funded parenting and pregnancy courses	C	new	>30%	-
Maternity deliveries in West Coast DHB facilities	V	325	est. 300	-
Baby friendly hospital accreditation of DHB facilities	Q [62]	Yes	Yes	-

[58] This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. The baseline result is taken from national Health Quality & Safety Commission (HQSC) reporting for Quarter 4 2012/13.
[59] Cefazolin ≥2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.
[60] The surgical safety checklist, developed by the World Health Organisation, is a common sense approach to ensuring the correct surgical procedures are carried out on the correct patient. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.
[61] While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and acting accordingly. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.
[62] The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises achievement of the standard.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of children under six with access to free primary care outside business hours	C	100%	100%	-
% of general practices providing telephone triage outside business hours	C	100%	100%	-
Attendances at West Coast emergency departments (EDs)	V [63]	14,359	≤15,000	-
% of people (Triage 1-3) presenting in ED seen within clinical guidelines	Q [64]	87%	>85%	-
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T◇ [65]	100%	100%	100%
Acute inpatient average length of hospital stay (standardised)	Q [66]	3.27	≤3.27	3.99

Elective/Arranged Services *These are 'booked' or 'arranged' services for people who do not need immediate hospital treatment. 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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
First Specialist Assessments provided (medical and surgical)	V [67]	6,724	est. >6,500	-
% of First Specialist Assessments that were non-contact	Q [68]	5%	>5%	-
Elective surgical discharges delivered (surgeries provided)	V [69]	1,686	1,592	-
Elective inpatient average length of hospital stay (standardised)	Q [66]	3.30	≤3.18	3.36
Outpatient attendances	V	15,428	est. >14,500	-
Outpatient 'Did not Attend' rates (total population)	Q	8.2%	<6%	-
Outpatient 'Did not Attend' rates (Māori)	Q	14%	<6%	-
% of outpatient appointments/consultations provided by telemedicine	Q	1.57%	>1.57%	-

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of young people (0-19) accessing specialist mental health services	CΔ [70]	6.1%	>3.8%	2.8%
% of adults (20-64) accessing to specialist mental health services	CΔ	4.9%	>3.8%	3.4%
% of people referred for non-urgent MH/AOD services seen within 3 weeks	T [71]	72%	80%	76%
% of people referred for non-urgent MH/AOD services seen within 8 weeks	T	91%	95%	91%

[63] This measure is based on the national ED health target. It counts Grey Hospital ED and Buller Emergency Departments.
[64] Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.
[65] This measure is a national performance measure (PP30) and refers to all people 'ready for treatment'. It excludes Category D patients, whose treatment is scheduled with other treatments or as part of a trial.
[66] This measure is a national performance measure (OS3). When seeking to reduce average length of hospital stay, performance should be balanced against readmissions rates to ensure earlier discharge is appropriate and service quality remains high.
[67] This measure counts both medical and surgical assessments but counts only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred.
[68] Non-contact FSAs are those where specialist advice and assessment are provided without the need for a hospital appointment.
[69] This measure is a national performance measures (the electives health target) and excludes 'arranged' cardiology and dental volumes.
[70] This measure is based on the previous national performance measure (PP6) dropped in 2014/15 and expectations that 3% of the population will need access to specialist level mental health services.
[71] This measure is a national performance measure (PP8) and results are provided three months in arrears to March 2013.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Admissions into inpatient AT&R services	V	125	est. >150	-
Consultations provided by outpatient and domiciliary AT&R services	V	1,601	est. >1,700	-
% of AT&R inpatients discharged to their own home rather than into ARC	QΔ [72]	90%	≥90%	-

[72] *While living in ARC is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. Discharge from AT&R to home (rather than ARC) reflects the quality of services in terms of assisting that person to regain their functional independence. The measure excludes those who were ARC residents prior to AT&R admission.*

OUTPUT CLASS

8.4 Rehabilitation and support services

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.

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 by reducing acute demand, unnecessary ED presentation and the need for more complex intervention. These services also support the flow of patients and improve 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.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	39%	80%	-
People supported by the rapid response/supported discharge service	V	new	50	-
People (65+) access community-based falls prevention services	V [73]	new	yes	-
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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	QΔ [74]	83%	>95%	-
People supported by long-term home and community support services	VΔ	734	est. >740	-
Community-based district nursing visits provided (long-term clients only)	VΔ	4,913	est. >5000	-
Meals on Wheels provided	V	35,234	est. >37,000	-

[73] *The aim for the coming year is to establish a Falls Prevention Service on the West Coast as a means of providing better care for people 'at-risk' or following a fall - supporting people to stay safe and well in their own homes and communities.*

[74] *InterRAI is an evidence-based geriatric assessment tool, the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care.*

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Mental health planned and crisis respite service bed days used	CΔ	483	est. >500	-
Occupancy rate of mental health planned and crisis respite beds	CΔ [75]	71%	85%	-
People supported by aged care respite services	V	58	est. 70	-
Palliative Care Services *These are services that improve the quality of life of patients and their families facing terminal illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
ARC facilities trained to provide the Liverpool Care Pathway option to residents	V [76]	3	4	-
People in ARC services supported by the Liverpool Care Pathway	V	31	>30	-
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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people entering ARC having had a clinical assessment of need using InterRAI	QΔ [74]	99%	95%	-
% of ARC residents receiving vitamin D supplements	C	57%	75%	-
Subsidised ARC rest home beds provided (days)	VΔ	43,573	est. <50,000	-
Subsidised ARC hospital beds provided (days)	VΔ	40,821	est. <40,000	-
Subsidised ARC dementia beds provided (days)	VΔ	2,805	est. >3,000	-
Subsidised ARC psycho-geriatric beds provided (days)	VΔ	3,729	est. >4,000	-

[75] 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.
[76] The Liverpool Care Pathway is an international palliative care programme adopted nationally and reflects best-practice care.

Meeting Our Financial Challenges

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. The Minister of Health has made it clear that DHBs are expected to operate within existing resources and approved financial budgets and to ensure services and service delivery models are financially sustainable.

9.1 West Coast's financial outlook

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

Like the rest of the health sector the West Coast DHB faces significant financial pressures from increasing service demand, rising treatment costs, wage expectations and increased public expectations – all of which must be managed within allocated funding. While these are the most significant pressures, there are a number of locally specific pressures that also need to be managed by the West Coast DHB:

Seismic remediation costs: The level of facilities repair required to attain moderate compliance with current building codes will exert significant financial pressure on the DHB. While some of the more immediate repairs have been completed, the remainder form part of the Detailed Business Case for future facilities.

Over-reliance on locum and temporary staff: While the use of locums and temporary staff allows for services to be maintained, the DHB is currently filling a significant number of full-time positions with locums. This not only reduces continuity of care but is an expensive and unsustainable option.

Increasing expectations from the public, clinical staff and government: Changes in clinical practice and the availability of more advanced treatments and technology drive increased cost within the system. With a smaller population base, these new technologies are not always affordable and must therefore be prioritised.

Inter-District Flows (IDFs): The West Coast DHB relies heavily on larger DHBs to provide complex specialist procedures for its population. A new capacity agreement with Canterbury DHB has removed some of the variability and risk associated with spend on ID. However, it is difficult to predict the volume of services required and, while the service prices are set nationally, costs have historically exceeded funding increases.

9.2 Achieving financial sustainability

The West Coast DHB is committed to reducing its current deficit and had expected to achieve a breakeven position for 2014/15 despite these pressures. This has been affected by late advice received from the Ministry of Health in March 2015 that funding for the 2014/15 year is $1.0m lower than previously advised – resulting in a $1.0m deficit forecast.

It is clear that achieving our commitment to 'live within our means' will require a number of carefully considered actions and will not be a 'quick fix'.

To ensure our health system is clinically and financially sustainable, we must continue our drive to provide the right care, at the right time and in the right place. Savings will be made not in dollars terms, but in terms of costs avoided through more effective utilisation of the resources available and reduced demand for services.

The following factors are critical to the West Coast DHB's success in achieving financial sustainability:

Constraining cost growth: It is critical that costs are constrained. If an increasing share of funding continues to be directed into meeting cost growth our ability to maintain current service delivery levels will be at risk. The DHB will also be further restricted in terms of our ability to invest in new equipment, technology and initiatives.

Transitional funding: The West Coast DHB currently receives $17.794m additional transitional funding which continues to be vital to the fiscal sustainability of our health system.

Rebalancing the system: It is crucial that we continue to develop more integrated models of care to make the most effective use of available resources. This will support earlier intervention strategies that help people stay well and reduce the demand for hospital services.

Rebuilding general practice: The West Coast has a legacy of unsustainable DHB-owned general practice with financial, access and workforce issues. It is crucial that we complete the remediation of its general practices to ensure the financial sustainability of general practice on the Coast.

Developing the transalpine approach: Our well established partnership with the Canterbury DHB needs to continue to address the delivery of some clinical services to ensure a model that is not only financially sustainable but also clinically safe.

Investing in clinical leadership: Enabling clinical input into operational and strategic decision-making is critical in achieving not only clinically acceptable and sustainable change but in supporting the development of a stable and motivated workforce.

Reducing duplication and waste: Removing unnecessary duplication and delay will improve patient flow and free up resources across our system. Investing in initiatives and information technology that achieve these goals is therefore critical in constraining cost growth and improving productivity.

The West Coast DHB is also committed to actively supporting national entities' initiatives to achieve mutual benefits and cost savings across the sector. The table (page 68) indicates the level of inclusion in 2014/15 financial projections.

9.3 Assumptions

The financial forecasts in this plan are based on a number of key assumptions. The following are those that have a degree of risk associated with them:

- Current Government policy settings and known health service initiatives will continue. It is assumed that we will receive fair prices for services provided on behalf of other DHBs and the Crown.
- Normal operations, volumes and service delivery will continue in 2014/15, with no disruptions associated with pandemic or natural disaster.
- Population-based funding levels will remain the same, as indicated in the funding envelope received in December 2013.
- Following the late advice received in March 2015 the DHB has adjusted the 2014/15 forecast. However, the out years have not been adjusted and reflect the assumption that transitional funding (post 2014/15) will be maintained at 2013/14 levels as modelled in the financial affordability analysis performed for the hospital redevelopment business case (i.e. a reversion to the prior year funding level after the $1.0m reduction in 2014/15).
- The West Coast DHB will continue to receive Crown Funding on an early payment basis.
- Any additional compliance costs, legislative changes, sector reorganisation or service devolvement will be cost-neutral or fully funded.
- Conditions of collective employment agreements that have already been settled will be implemented as agreed, with no unplanned impacts from second tier bargaining or debate over interpretation and translation issues. 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.
- External provider increases will be made within available funding levels, after allowance for committed and demand-driven funding.
- 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 in line with the Board's strategy.
- The approved forecasted deficit will be funded via deficit support (equity injections) by the Crown.
- In line with Generally Accepted Accounting Policies, land and buildings will be re-valued every three years or sooner if required. The land and buildings were re-valued/impaired 30 June 2012. The forecast for 2014/15 and the budgets for this and outlying years have been based on this revaluation. It has been assumed that there will be minimal change from this valuation for the 2014/15 year; however, there may be further impairments necessary dependent on the outcome of engineering assessments.
- Work will continue on the facilities redevelopment plans for Greymouth and Buller under the nationally directed Partnership Group. As the Grey redevelopment has been approved, the costs and capital expenditure associated have been included in the capital budget with the operating net result reflecting the modelling per the detailed business case approved by cabinet in April 2014. As agreed in the business case the funding will be a mix of debt and equity.

  However, although the Buller facility development has also been approved (April 2014), the DHB has not had the opportunity to fully explore procurement options and their financial impacts. Development costs and any capital or lease expenditure associated with Buller have therefore not been included.

9.4 Asset planning & investment

Greymouth and Buller Redevelopment

The detailed business case for the redevelopment of Greymouth Hospital and Integrated Family Health Centre (including the energy centre) was approved by Cabinet and the national Capital Investment Committee in April 2014. Construction will begin at Grey Hospital in 2015.

A secondary tranche of redevelopment has been identified for a later stage – this includes demolition and Furniture, Fittings, and Equipment.

Approval was also obtained to rectify some urgent issues in relation to severe seismic and electrical problems facing the Greymouth campus, and these were completed in the 2013/14 year.

Capital expenditure

The business as usual capital expenditure budget for the 2014/15 year is $3.4M (excluding capital expenditure committed in previous years) and subject to approval. This 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.

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. Those 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.

9.5 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 $14.445M. The West Coast DHB's total term debt is currently $14.445M and is expected to remain at this amount as at June 2014.

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

The West Coast DHB's current debt profile is:

PRINCIPAL	INTEREST RATE	MATURITY DATE
$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
$2,000,000	4.92%	15-Apr-23
$250,000	4.30%	15-Apr-23

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 Limited.

Equity

The West Coast DHB will require deficit funding (equity) in order to offset the deficits signalled in 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.

West Coast commitment to National Initiatives

2014/15	CAPITAL COSTS	OPERATING COSTS		OPERATING BENEFITS	NET OPERATING
		ONE-OFF	ONGOING		
	$'000s	$'000s	$'000s	$'000s	$'000s
Health Benefits Limited					
Finance, Procurement and Supply Chain	(402)	(70)		(42)	(112)
Human Resource Management Information Systems		(14)			(14)
National Health IT Board					
eMedicines / eDischarge	(27)				0
National Patient Flow		(104)			(104)
Self-Care Portal		(45)			(45)
Health Quality & Safety Commission					
Patient experience indicators			(15)		(15)
Total impact for WCDHB	(429)	(233)	(15)	(42)	(290)

Statement of Financial Expectations

Where will our funding go?

10.1 Statement of comprehensive income

For the years ending 2012/13 to 2017/18

In thousands of New Zealand dollars

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Income						
Ministry of Health revenue	124,182	125,232	127,558	131,040	133,763	136,494
Patient related revenue	9,563	10,211	10,296	10,760	10,984	11,208
Other operating income	797	735	735	763	791	819
Interest income	291	588	588	588	588	588
Total Income	134,833	136,766	139,177	143,151	146,126	149,109
Operating Expenses						
Employee benefit costs	55,689	55,081	55,613	56,790	57,967	58,651
Outsourced services (clinical and non clinical)	10,563	6,042	6,068	4,300	4,330	3,960
Treatment related costs	7,368	7,261	7,342	7,498	7,654	7,810
External service providers (include Inter-disctrict outflow)	46,518	53,659	55,222	56,393	57,566	58,740
Depreciation & amortisation	4,156	3,937	3,937	4,700	5,464	5,548
Interest expenses on loans	650	684	1,364	2,388	2,550	2,565
Other expenses	12,788	10,390	9,491	9,722	9,645	9,168
Total Operating Expenses	137,732	137,054	139,037	141,791	145,176	146,442
Operating surplus before capital charge	(2,899)	(288)	140	1,360	950	2,667
Capital charge expense	677	812	1,140	2,460	2,650	2,667
Surplus / (Deficit)	(3,576)	(1,100)	(1,000)	(1,100)	(1,700)	-
Other comprehensive income	-	-	-	-	-	-
Total Comprehensive Income	**(3,576)**	**(1,100)**	**(1,000)**	**(1,100)**	**(1,700)**	**-**

10.2 Statement of financial position

As at 30 June for years ending 2012/13 to 2017/18

In thousands of New Zealand dollars

	30/06/13 Actual $'000	30/06/14 Forecast $'000	30/06/15 Plan $'000	30/06/16 Plan $'000	30/06/17 Plan $'000	30/06/18 Plan $'000
CROWN EQUITY						
General funds	69,768	70,800	89,732	99,964	101,596	101,528
Revaluation reserve	19,569	19,569	19,569	19,569	19,569	19,569
Retained earnings / (losses)	(79,185)	(80,285)	(81,285)	(82,385)	(84,085)	(84,085)
TOTAL EQUITY	**10,152**	**10,084**	**28,016**	**37,148**	**37,080**	**37,012**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	6,172	9,341	10,068	10,678	12,699	14,787
Trade & other receivables	3,968	4,218	4,218	4,218	4,218	4,218
Inventories	1,124	1,100	1,100	1,100	1,100	1,100
Assets classified as held for sale	136	136	136	136	136	136
Investments	-	-	-	-	-	-
TOTAL CURRENT ASSETS	11,400	14,795	15,522	16,132	18,153	20,241
CURRENT LIABILITIES						
Trade & other payables	7,239	7,248	7,248	7,248	7,248	7,248
Capital charge payable	-	-	-	-	-	-
Employee benefits	9,275	9,081	9,081	9,081	9,081	9,081
Borrowings	250	3,750	3,250	250	-	4,695
TOTAL CURRENT LIABILITIES	16,764	20,079	19,579	16,579	16,329	21,024
NET WORKING CAPITAL	(5,364)	(5,284)	(4,057)	(447)	1,824	(783)
NON CURRENT ASSETS						
Investments	-	165	567	567	567	567
Property, plant, & equipment	28,826	27,102	72,325	94,067	92,398	90,564
Intangible assets	1,812	1,631	1,211	791	371	49
Restricted assets	60	60	60	60	60	60
TOTAL NON CURRENT ASSETS	30,698	28,958	74,163	95,485	93,396	91,240
NON CURRENT LIABILITIES						
Employee benefits	2,927	2,835	2,835	2,835	2,835	2,835
Restricted funds	60	60	60	60	60	60
Borrowings	12,195	10,695	39,195	54,995	55,245	50,550
TOTAL NON CURRENT LIABILITIES	15,182	13,590	42,090	57,890	58,140	53,445
NET ASSETS	**10,152**	**10,084**	**28,016**	**37,148**	**37,080**	**37,012**

10.3 Statement of movements in equity

For the years ending 2012/13 to 2017/18

In thousands of New Zealand dollars

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Total Equity at Beginning of the Period	10,196	10,152	10,084	28,016	37,148	37,080
Total Comprehensive Income	(3,576)	(1,100)	(1,000)	(1,100)	(1,700)	-
Other Movements						
Contribution back to Crown - FRS3	(68)	(68)	(68)	(68)	(68)	(68)
Contribution from Crown - Capital	-	-	18,000	9,200	-	-
Contribution from Crown - Operating Deficit Support	3,600	1,100	1,000	1,100	1,700	-
Total Equity at End of the Period	**10,152**	**10,084**	**28,016**	**37,148**	**37,080**	**37,012**

10.4 Statement of cashflow

For the years ending 2012/13 to 2017/18

In thousands of New Zealand dollars

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	122,726	124,413	126,277	129,449	132,139	134,837
Other receipts	12,726	11,761	12,312	13,114	13,399	13,684
Interest received	229	588	588	588	588	588
	135,681	136,762	139,177	143,151	146,126	149,109
Cash was applied to:						
Payments to employees	55,710	60,142	60,505	59,888	61,069	61,357
Payments to suppliers	78,312	74,627	73,231	74,815	76,093	76,972
Interest paid	648	684	1,364	2,388	2,550	2,565
Capital charge	677	812	1,140	2,460	2,650	2,667
GST - net	(50)	(120)	-	-	-	-
	135,297	136,145	136,240	139,551	142,362	143,561
Net Cashflow from Operating Activities	**384**	**617**	**2,937**	**3,600**	**3,764**	**5,548**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	-	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	-	-	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	165	402	-	-	-
Purchase of property, plant, & equipment	5,142	315	48,740	26,022	3,375	3,392
	5,142	480	49,142	26,022	3,375	3,392
Net Cashflow from Investing Activities	**(5,142)**	**(480)**	**(49,142)**	**(26,022)**	**(3,375)**	**(3,392)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection	3,600	1,100	19,000	10,300	1,700	-
Loans Raised	-	2,000	28,000	12,800	-	-
	3,600	3,100	47,000	23,100	1,700	-
Cash applied to:						
Loan Repayment	-	-	-	-	-	-
Equity Repayment	68	68	68	68	68	68
	68	68	68	68	68	68
Net Cashflow from Financing Activities	**3,532**	**3,032**	**46,932**	**23,032**	**1,632**	**(68)**
Overall Increase/(Decrease) in Cash Held	(1,226)	3,169	727	610	2,021	2,088
Add Opening Cash Balance	7,398	6,172	9,341	10,068	10,678	12,699
Closing Cash Balance	**6,172**	**9,341**	**10,068**	**10,678**	**12,699**	**14,787**

10.5 Summary of revenue and expenses by arm

Funder and Governance and Funder Admin Arm: Forecast Operating Statement for the years ending 2012/13 to 2017/18

In thousands of New Zealand dollars

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Funding Arm						
Revenue						
MoH Revenue	122,823	124,340	126,561	130,267	132,974	135,689
Total Revenue	123,101	124,340	126,561	130,267	132,974	135,689
Expenditure						
Personal Health	76,174	87,264	92,429	94,389	96,351	98,315
Mental Health	13,888	14,358	14,606	14,915	15,224	15,533
Disability Support	17,864	17,703	17,566	17,938	18,311	18,685
Public Health	739	684	704	719	734	749
Maori Health	609	851	818	835	852	869
Governance & Admin	828	826	827	827	827	827
Total Expenditure	110,102	121,686	126,950	129,623	132,299	134,978
Net Surplus/(Deficit)	**12,999**	**2,654**	**(389)**	**644**	**675**	**711**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**12,999**	**2,654**	**(389)**	**644**	**675**	**711**
Governance & Funder Admin						
Revenue						
Other	894	826	827	827	827	827
Total Revenue	894	826	827	827	827	827
Expenditure						
Personnel	531	578	1,123	1,139	1,146	1,157
Outsourced services	369	462	300	306	312	318
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(715)	(214)	(596)	(618)	(631)	(648)
Total Expenditure	185	826	827	827	827	827
Net Surplus/(Deficit)	**709**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**709**	**-**	**-**	**-**	**-**	**-**

Provider Arm: Forecast Operating Statement for the years ending 2012/13 to 2017/18

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Provider Arm						
Revenue						
MoH Revenue	64,115	68,093	71,898	73,176	74,695	76,216
Patient Related Revenue	9,563	10,211	10,296	10,760	10,984	11,208
Other	744	1,323	1,323	1,351	1,379	1,407
Total Revenue	74,422	79,627	83,517	85,287	87,058	88,831
Expenditure						
Personnel	55,158	59,261	59,382	58,749	59,923	60,200
Outsourced services	10,194					
Depreciation	4,156	3,937	3,937	4,700	5,464	5,548
Interest & Capital Charge	1,327	1,496	2,504	4,848	5,200	5,232
Other	20,871	18,687	18,305	18,734	18,846	18,562
Total Expenditure	91,706	83,381	84,128	87,031	89,433	89,542
Net Surplus/(Deficit)	**(17,284)**	**(3,754)**	**(611)**	**(1,744)**	**(2,375)**	**(711)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(17,284)**	**(3,754)**	**(611)**	**(1,744)**	**(2,375)**	**(711)**

In house eliminations and Consolidated DHB: Forecast Operating Statement for the years ending 2012/13 to 2017/18

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
In House Elimination						
Revenue						
MoH Revenue	(63,584)	(68,027)	(71,728)	(73,230)	(74,733)	(76,238)
Total Revenue	(63,584)	(68,027)	(71,728)	(73,230)	(74,733)	(76,238)
Expenditure						
Other	(63,584)	(68,027)	(71,728)	(73,230)	(74,733)	(76,238)
Total Expenditure	(63,584)	(68,027)	(71,728)	(73,230)	(74,733)	(76,238)
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-
CONSOLIDATED						
Revenue						
MoH Revenue	123,354	124,406	126,731	130,213	132,936	135,667
Patient Related Revenue	9,563	10,211	10,296	10,760	10,984	11,208
Other	1,916	2,149	2,150	2,178	2,206	2,234
Total Revenue	134,833	136,766	139,177	143,151	146,126	149,109
Expenditure						
Personnel	55,689	59,839	60,505	59,888	61,069	61,357
Outsourced services	10,563	462	300	306	312	318
Depreciation	4,156	3,937	3,937	4,700	5,464	5,548
Interest & Capital Charge	1,327	1,496	2,504	4,848	5,200	5,232
Other	66,674	72,132	72,931	74,509	75,781	76,654
Total Expenditure	138,409	137,866	140,177	144,251	147,826	149,109
Net Surplus/(Deficit)	**(3,576)**	**(1,100)**	**(1,000)**	**(1,100)**	**(1,700)**	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(3,576)**	**(1,100)**	**(1,000)**	**(1,100)**	**(1,700)**	-

Part IV - Appendices

Appendices

Further information for the reader:

Appendix 1	Glossary of terms
Appendix 2	Objectives of a DHB – New Zealand Public Health and Disability Act (2000)
Appendix 3	2013 Census summary for the West Coast
Appendix 4	West Coast DHB organisational structure
Appendix 5	West Coast Alliance Structure
Appendix 6	Minister of Health's letter of expectations for 2013/14
Appendix 7	West Coast's commitment to the national health targets
Appendix 8	DHB performance monitoring framework
Appendix 9	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).

11.1 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 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.
CCCN	Complex Clinical Care Network	A single point of referral for patients from general practice, ambulance and inpatient services. Under the restorative CCCN delivery model, clients are assessed using comprehensive assessment tools and an individual goal-based care plan is developed with them.
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 Referral 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 of Health 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.

11.2 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.

11.3 2013 Census summary for the West Coast

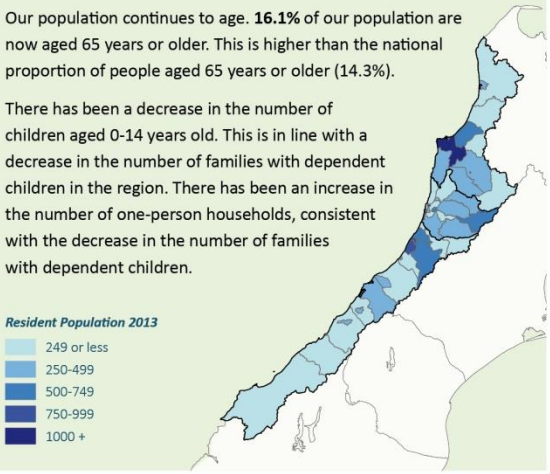
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Our resident population has increased by **2.6%** since 2006, to 32,150. This is a slower rate of growth than at the last census. However, the rate of population growth has also slowed nationally.

The Grey District has the largest population in the region, with a resident population of **13,370**. The Buller District has a population of 10,470 residents. The Westland District has a population of 8,300 residents.

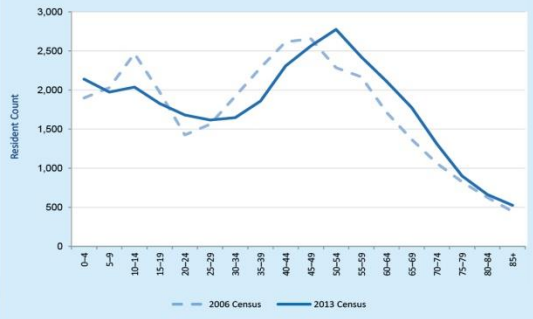
Our population continues to age. **16.1%** of our population are now aged 65 years or older. This is higher than the national proportion of people aged 65 years or older (14.3%).

There has been a decrease in the number of children aged 0-14 years old. This is in line with a decrease in the number of families with dependent children in the region. There has been an increase in the number of one-person households, consistent with the decrease in the number of families with dependent children.



Our population is also becoming more ethnically diverse. We now have greater proportions of Māori, Pacific and Asian ethnicities than in 2006. The percentage of Māori has increased from 9.7% to **10.5%**. Our Māori population are younger, with **42.4%** aged 0-19 years-old (compared to 24.8% of the total West Coast population).

West Coast DHB usual resident count by age group in 2006 & 2013



What We Don't Know

Updated population projections and estimates

The current Statistics New Zealand population projections are still based on the 2006 Census results. Projections based on the 2013 Census results will not be available until December 2014. Updated population estimates will be made available in August 2014.

WHAT THE 2013 CENSUS TELLS US

16.1% 65+

16.1% of our population are aged 65 or older, up from 13.8% in 2006.

2.6% **increase** in the number of residents on the West Coast since 2006.

32,150 People

10.5% of our population are **Māori**

30.7% of households only have one resident.

20.5% of those aged 15 years or older **smoke regularly,** down from 25.7% in 2006.

20.5%

0.8% of the total New Zealand resident population live in the West Coast. However, the West Coast is one of the **largest DHBs** by geographic region.

4.7% decrease in the number of **families** with dependent children.

15% decrease in the number of **single parent** families with dependent children.

3.4% of households have no access to telecommunication systems. This is the **highest** proportion of any region **in New Zealand**.

What Does This Mean?

Our aging population

The West Coast DHB has an increasing elderly population. While progress has been made to address the needs of older people, new service models will need to continue to be developed.

Our population distribution

We have a population that is spread over a vast geographic distance. We also have households that are hard to contact, with 3.4% without access to any telecommunications. This presents a challenge in the delivery of health services within the West Coast and demonstrates the importance of mobile delivery of services to the community.

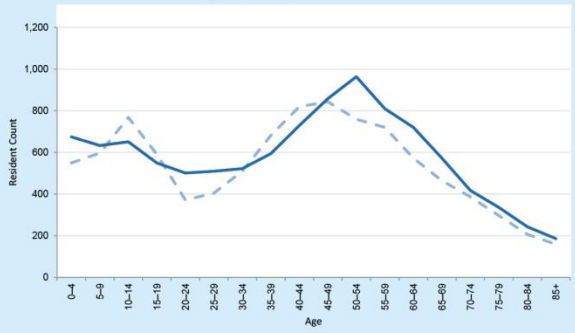
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

CENSUS Demographic Changes by DISTRICT

Please note: Due to the difference in resident populations the scale of each graph varies. — — 2006 Census ——— 2013 Census

Buller District

usual resident count by age group in 2006 and 2013



770 more residents living in Buller than in 2006.

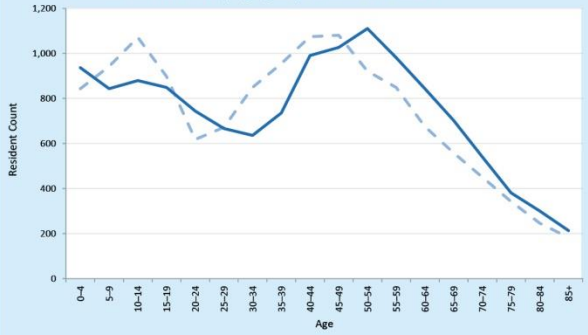
No change in the number of **families** with dependent children. The other districts have both had a decrease.

16.7%

16.7% of Buller residents are aged 65 years or older, up from 15.7% in 2006. This is the highest proportion on the Coast.

Grey District

usual resident count by age group in 2006 and 2013



150 more residents living in Grey than in 2006.

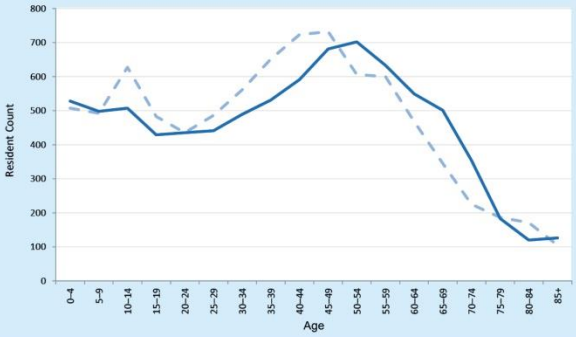
19.9% of Grey residents are aged under 15. This is the highest proportion on the Coast.

16%

16% of Grey residents are aged 65 years or older, up from 13.5% in 2006.

Westland District

usual resident count by age group in 2006 and 2013



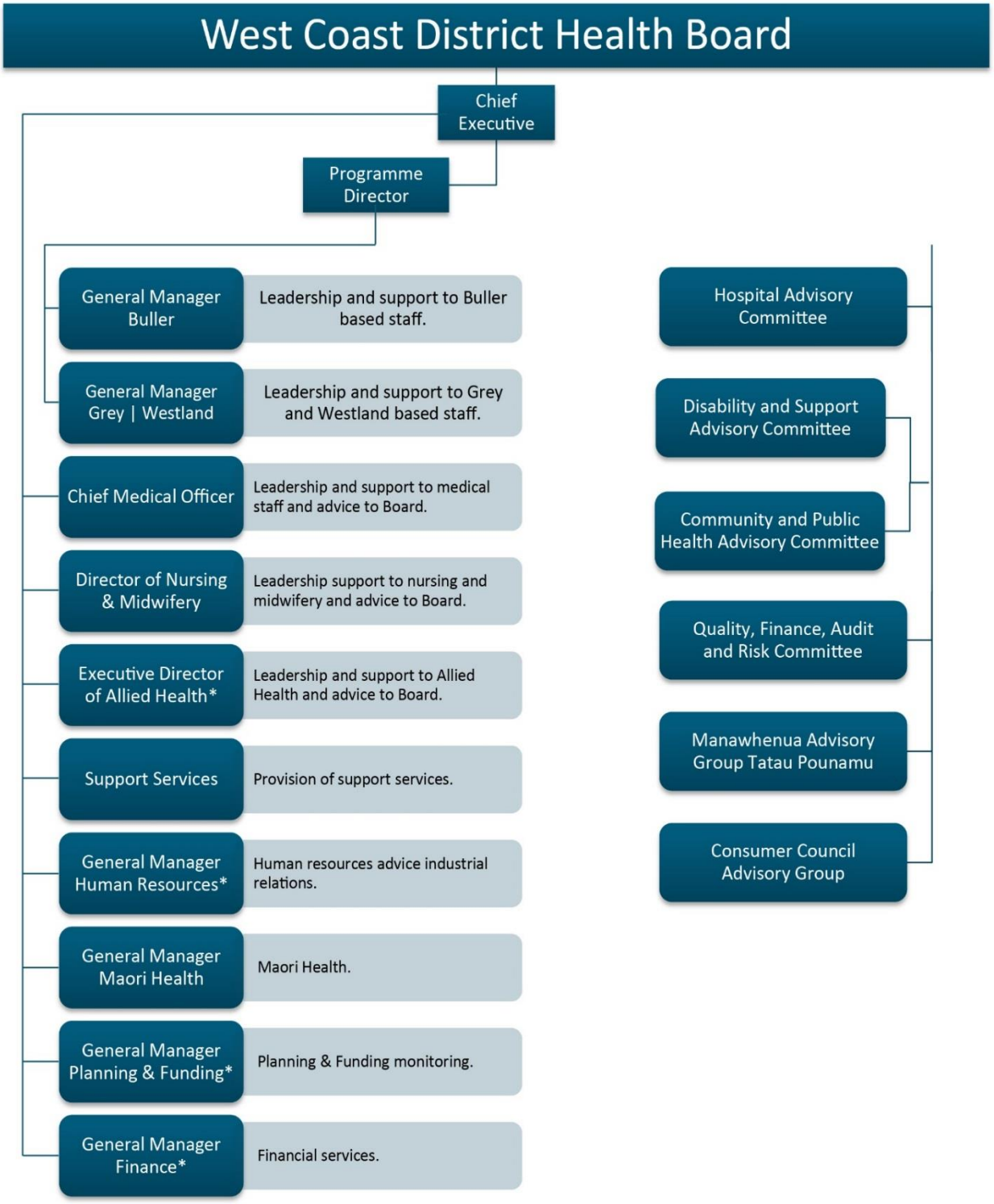
4.1% of Westland households have **no access** to telecommunication systems.

100 **fewer** residents living in Westland than in 2006.

13.4% of the population are **Māori**

This is the **highest proportion** on the Coast.

11.4 West Coast DHB organisational structure



*Joint appointments with CDHB

11.5 West Coast Alliance Structure

11.6 Minister of Health's letter of expectations for 2014/15

4/2/14

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

30 JAN 2014

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

Dear Dr McCormack

Letter of Expectations for DHBs and subsidiary entities 2014/15

Public and patient confidence in the health service continues to grow strongly. Thank you to your team. This achievement is built on the four objectives of the Government's health plan*: helping families stay healthy, better performance, best use of every dollar, and a strong and trusted workforce*. In the next year we expect continued strong focus on successful implementation.

New Zealand has come through the global financial crisis in much better shape than most other countries. That's because of this government's careful and prudent financial management. Our approach has been to protect the most vulnerable in our society, and rebuild the economy's capacity to create jobs, higher incomes and security.

Despite the toughest of times, we are providing better public services within careful funding increases. This government now invests an extra $2.5 billion a year more into the public health service. And this year's budget will again see more investment in Health.

Better Public Services: Results for New Zealanders

Of the Prime Minister's ten whole-of-government key result areas, DHBs are expected to actively engage and invest in increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children.

It is important Boards work closely with other social sector organisations and initiatives including Whanau Ora, Children's Action Plan and Youth Mental Health. The government values the contribution of NGOs and DHBs must work with them.

National Health Targets

The national health targets have proven very successful at driving major improvements for patients: more elective surgery, faster access to emergency and cancer care, and better prevention. DHBs will provide clear and specific plans for achieving all national health targets in their Annual Plans.

In particular further work is required to achieve the three preventive targets. You must demonstrate appropriate performance management arrangements for PHOs. Poor performance must be rectified and not ignored. You should again show your local primary care networks are involved in and explicitly endorse your target achievement plans.

Your DHB is expected to help patients by meeting our objectives of shorter waiting times for surgery, diagnostics, cardiac and cancer care.

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

Care Closer to Home

New Zealanders are living longer, more sedentary lives. This means more of us have chronic conditions like diabetes, asthma, dementia, cancer and mental health disorders. The sooner doctors and nurses can detect, treat or prevent these conditions, the better they can reduce the significant burden these conditions put on both patients and the health system.

A major strategy to do this is *clinical integration* – providing joined-up care across primary and secondary services. With resources and interventions flowing to where they are most effective. So patients get their care sooner and closer to home.

DHBs must focus strongly on service integration across the health system, including integrated family health centres, primary care direct referral for diagnostics, clinical pathways and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home; particularly important are avoiding a hospital admission and care after a hospital discharge. You should continue working with the Ministry to implement our commitments to improving home care, stroke services and dementia care pathways.

Regional and National Collaboration

DHBs are expected to make further progress on implementing Regional Service Plans including workforce, IT and capital objectives. DHBs are expected to strongly support the implementation of the key Health Benefits Ltd savings programmes. Further gains in quality, efficiency and cost control will also come from your work with Pharmac, Health Workforce NZ and the Health Quality and Safety Commission. The new patient satisfaction survey is one example.

Strong clinical leadership and engagement is important and remains essential.

Living Within Our Means

To support New Zealand's recovery your DHB must keep to budget. Your DHB must have detailed and effective plans to improve financial performance year on year. Equity and capital remain constrained. As agents of the Crown you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership to deliver on the government's objectives. You and your Board must monitor and hold your CEO accountable against these expectations.

Appreciation

Again, thank you for the considerable effort you and your team are making. This makes a real difference to the quality of life of many thousands of New Zealanders. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

Attached: PM's Key Result Areas and National Health Targets

Appendix 1: Prime Minister's Key Result Areas and DHB Health Targets for 2014/15

Prime Minister's Key Result Areas – Supporting Vulnerable Children

Increase immunisation rates

Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017.

Rheumatic Fever

Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017.

Assist to reduce the number of assaults on children

By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5%.

National Health Targets for 2014/15

Shorter stays in Emergency Departments

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

Improved access to elective surgery

The volume of elective surgery will be increased by at least 4,000 discharges per year.

Shorter waits for cancer treatment / transitioning to Faster Cancer Treatment

All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.

Faster cancer treatment.

The 62-day faster cancer treatment indicator that is currently a developmental measure, will transition into a full policy priority accountability measure, and will become the next cancer health target during 2014/15. Further details including the health target definition, DHB performance expectations for 2014/15, and the process for transition will be provided at the end of February 2014.

Increased immunisation

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

Better help for smokers to quit

95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Within the target a specialised identified group will include:

- progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

11.7 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 32

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.[77]

West Coast contribution – see page 30

1,592 elective surgical discharges will be delivered in 2014/15.

Shorter Waits for Cancer Treatment

Government expectation [78]

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

West Coast contribution – see page 33

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 40

95% of all eight-month-olds will be fully vaccinated.

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 36

95% hospitalised smokers, **90%** of primary care smokers and **90%** of pregnant smokers will receive 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 38

90% of the eligible population will have had CVD risk assessment once in the past five years.

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[77] *The national health target definition of elective surgery excludes dental and cardiology services.*
[78] *This national health target will change in Quarter 2 2014/15 to the Faster Cancer Treatment Health Target.*
[79] *The national health target definition excludes Category D patients, whose treatment is scheduled with other treatments or part of a trial.*

11.8 DHB performance monitoring framework

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		WEST COAST TARGET	NATIONAL TARGET	REPORTING FREQUENCY
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%	N/A	Quarterly
		Age 20-64	>3.8%		
		Age 65+	>3%		
PP7 Improving mental health services using transition (discharge) planning and employment.	% of clients discharged with a transition (discharge) plan.	Child & Youth	95%	95%	Quarterly
	Employment status of clients.	Long term Client 20+	Report as specified		
PP8 Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.	% of young people (0-19) referred for non-urgent **mental health** services seen within 3 weeks and within 8 weeks.	3wks	80%	80%	Quarterly
		8wks	95%	95%	
	% of young people (0-19) referred for non-urgent **addictions** services seen within 3 weeks and within 8 weeks.	3wks	80%	80%	
		8wks	95%	95%	
PP10 Oral Health DMFT Score at Year 8.	DMFT score at Year 8.	2014	1.32	NA	Annual
		2015	1.30		
PP11 Children caries-free at age 5 years.	% caries-free at age 5.	2014	54%	NA	Annual
		2015	56%		
PP12 Utilisation of DHB-funded dental services by adolescents.	School Year 9 up to and including age 17 years.	2014	85%	NA	Annual
		2015	85%		
PP13 Improving the number of children enrolled in DHB-funded dental services.	% of children (age 0-4) enrolled.	2014	90%	NA	Annual
		2015	90%		
	% of children (0-12) not examined according to planned recall.	2014	≤10%		
		2015	≤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
PP20 Improved management of LTC					Quarterly
Focus area 1: Long term conditions.	Report on delivery of the actions and milestone in the Annual Plan, six monthly teleconference and quarter four report against HQS Atlas diabetes measures.				
Focus area 2: Diabetes – Management.	% of enrolled people aged 15-74 with acceptable glycaemic control (HbA1c ≤64mmol/mol).		Improve or, where high, maintain performance.		
Focus area 3: Acute Coronary Syndrome.	% of high-risk patients receiving an angiogram within 3 days of admission (where the day of admission is day 0).		70%	70%	
	% of patients presenting with ACS who undergo angiography and have completion of registry data collection within 30 days		≥95%	≥95%	
Focus area 4: 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%	
PP21 Immunisation coverage.	% of two-year-olds fully immunised.		95%	95%	Quarterly

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		WEST COAST TARGET	NATIONAL TARGET	REPORTING FREQUENCY
PP22 Improving system integration.	Report on delivery of the actions and milestones identified in the Annual Plan. Quarter four report to include PHO financials statements and forecasts.				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.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP26 The Mental Health & Addiction Service Development Plan.	Report on status for a minimum of 8 actions to be completed in 2014/15 and for any actions which are in progress/going into 2014/15.				Quarterly
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.	Provide a progress report against the region's rheumatic fever prevention plan.				Quarterly
	Undertake a root cause analysis on any new rheumatic fever cases and provide a report to the Ministry on lessons learned and actions taken.				
	Acute rheumatic fever rate of hospitalisation per 100,000.	South Island rate	< 0.3 per 100,000		
PP29: Improved waiting times for diagnostic services.	% of accepted referrals for CT and MRI scans will receive scans within 6 weeks (42 days).	CT Scan	90%	90%	Monthly
		MRI Scan	80%	80%	
	% of people accepted for an urgent diagnostic colonoscopy receive their procedure within 2 weeks (14 days).		75%	75%	Monthly
	% of people accepted for a diagnostic colonoscopy receive their procedure within 6 weeks (42 days).		60%	60%	Monthly
	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date.		60%	60%	Monthly
PP30: Faster cancer treatment	% of patients referred urgently with high suspicion of cancer receiving their first cancer treatment within 62 days.		85% by July 2016	85% by July 2016	Quarterly
	< 10% of records submitted by the DHB are declined.		<10%	<10%	Quarterly
	% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy		100%	100%	Quarterly
SI1 Ambulatory sensitive (avoidable) hospital admissions.	DHB rate vs. national rate (per 100,000).	Age 0-4	<101%	NA	Six-monthly
		Age 45-64	≤95%		
		Age 0-74	≤95%		
SI2 Delivery of regional service plan.	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 (per 10,000).		21	21	Annual
	Cataract Procedures (per 10,000).		27	27	
	Cardiac surgery (per 10,000).		6.5	6.5	Quarterly
	Percutaneous revascularisation (per 10,000).		12.5	12.5	
	Coronary angiography services (per 10,000).		34.7	34.7	

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.	≤3.18	≤3.18	Quarterly
	Acute LOS.	≤3.27	≤3.27	
OS8 Acute readmissions to hospital.	% total population.	≤6.4%	NA	Quarterly
	% population aged 75+.	≤9.6%	NA	
OS10 Improving the quality of identity data within the national health index and data submitted to national collections. Focus area 1: Improving quality of identify data.	New NHI registrations in error (Group C).	1.5-6%	1.5-6%	Quarterly
	Recording on non-specific ethnicity (set to 'Not stated' or 'Response Unidentifiable').	0.5-2%	0.5-2%	
	Updating of specific ethnicity value in existing NHI record with a non-specific value.	0.5-2%	0.5-2%	
	Validated address unknown.	76-85%	76-85%	
	Invalid NHI data updates causing identity confusion.	TBC	TBC	
Focus are 2: Improving the quality of data submitted to National Collections.	NBRS links to NNPAC and NMDS.	97-99.5%	97-99.5%	Quarterly
	National collections file load success.	98-99.5%	98-99.5%	
	Standard vs. edited descriptors.	75-90%	75-90%	
	NNPAC timeliness.	95-98%	95-98%	
Focus area 3: Improving the quality of the programme for integration of mental health data (PRIMHD).	PRIMHD File Success Rate.	>95%	>95%	Quarterly
	PRIMHD data quality.	Routine audits undertaken with appropriate action where required.		
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% of plan	Quarterly
DV4: Improving patient experience	Provide patient experience data and establish baselines for future targets.			Quarterly

11.9 Statement of accounting policies

The prospective financial statements in this Statement of Intent for the year ended 30 June 2015 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 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

The West Coast District Health Board ("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 and its subsidiaries, as public benefit entities, 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 consolidated financial statements of West Coast DHB consist of West Coast DHB and 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 consolidated 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: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, and land and buildings.

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

Functional and presentation currency

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand dollars. The functional currency of West Coast DHB is 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 financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

- The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, West Coast DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means West Coast DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, West Coast DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

- Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

Subsidiaries

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. 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 GAAP, using accounting policies that are consistent with those adopted by West Coast DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive 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	10 – 50	2 - 10%
Leasehold Building	3 – 20	5 - 33%
Plant, Equipment & Vehicles	3 – 12	8.3 - 33%

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and West Coast DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the surplus or deficit when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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

Amortisation

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

Type of asset	Estimated life	Amortisation rate
Software	2 years	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.

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, sabbatical leave, retirement gratuities and sick leave

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

Annual leave, conference leave and medical education leave

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

Provisions

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

ACC Partnership Programme

West Coast DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme the DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

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.

Derivative financial instruments

West Coast DHB uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational and financing activities. West Coast DHB does not hold these financial instruments for trading purposes and has not adopted hedge accounting.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are remeasured to fair value at each balance date. The gain or loss on remeasured to fair value is recognised immediately in the surplus or deficit.

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, advance in medical technology, and expected disposal proceeds from the future sale of the assets.

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

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

In light of the Canterbury earthquakes, West Coast DHB has reviewed the carrying value of land and buildings, resulting in an impairment of land and 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 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

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