West Coast DHB

ANNUAL PLAN 2015/2016

Incorporating the Statement of Intent 2015-2018
& Statement of Performance Expectations 2015/2016

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. Established as vehicles for the public funding and provision of health and disability services, each DHB is categorised as a Crown Agent under the Crown Entities Act and is accountable to the Minister of Health.

This Annual Plan has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, relevant sections of the Public Finance Act and in line with the expectations of the Minister of Health.

The Plan sets out the goals and objectives of the West Coast DHB and describes what the DHB intends to achieve in terms of improving the health of its population and ensuring the sustainability of the health system. The Plan also contains service and financial forecast information for the current year 2015/16 and three subsequent out-years: 2016/17 to 2018/19.

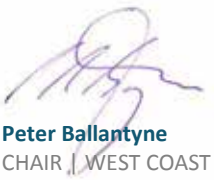
Sections of the Annual Plan are extracted to form the Statement of Intent and Statement of Performance Expectations, which are presented to Parliament. These are used at the end of the year to compare the DHB's planned and actual performance. Audited results are presented in the DHB's Annual Report.

The Minister of Health has been very clear in setting his annual expectations for 2015/16 that DHBs must focus on integration and strong clinical leadership. The West Coast DHB has made a clear commitment to a 'whole of system' approach to planning and service delivery. Clinically led local and regional alliances are vehicles for implementing system change and improving health outcomes. This includes the Healthy West Coast District Alliance and the South Island Regional Alliance.

In line with this approach, the actions outlined in this Annual Plan present a picture of the joint commitment and activity that will be delivered by the West Coast DHB and its Alliance partners to improve the health of the West Coast community and deliver against the expectations of Government.[1]

The West Coast DHB also has Māori Health Action Plan and Public Health Action Plan for 2015/16, both of which are companion documents to this Annual Plan. These Plans set out further actions and activity to improve population health and reduce inequalities in health status and outcomes. Both of these documents are available on the DHB website: www.westcoastdhb.health.nz.

In signing this Annual Plan, we are satisfied that it accurately represents the intentions and commitments of the West Coast DHB and the wider Coast health system. Together, we will continue to strive to make real gains and improvements in the health of our population.



Peter Ballantyne
CHAIR | WEST COAST DHB

Helen Gillespie

CHAIR | QUALITY, FINANCE, AUDIT & RISK COMMITTEE, WEST COAST DHB

Honourable Jonathan Coleman
MINISTER OF HEALTH

Honourable Bill English
MINISTER OF FINANCE

October 2015

[1] *The South Island Regional Health Services Plan can be found on the South Island Alliance website:www.sialliance.health.nz.*

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

23 OCT 2015

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

Dear Mr Ballantyne

West Coast District Health Board 2015/16 Annual Plan

This letter is to advise you that together with the Minister of Finance, I have approved and signed West Coast District Health Board's (DHB's) 2015/16 Annual Plan for one year.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015, Vote Health received an additional $1.7 billion in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

Living Within our Means
The Government is determined to reach surplus in 2015/16. To assist with this, 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. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I note that your DHB is planning a deficit for 2015/16 and for the following three years. I expect that you will work to improve this position in out years and will work closely with the National Health Board to achieve this. For 2015/16, I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result.

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

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With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

National Health Targets
Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. However, your recent results show continued attention to the Increased Immunisation and Faster Cancer Treatment health targets is needed. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I am concerned that the pace of progress needs to improve if the 85 percent target is to be achieved by July 2016. Please ensure delivery of this target remains a key priority for your teams.

System Integration
As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

As a small DHB, I understand that West Coast DHB intends to maintain its current levels of services shifted into the community and primary care access to radiology. It is encouraging to see the work you will undertake on integration enablers such as workforce and a single patient care plan for complex patients. I look forward to being advised of your progress with this throughout the year.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

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 Whānau Ora, Children's Action Plan and Youth Mental Health.

Tackling Obesity
I am pleased to note that your Annual Plan includes a focus on obesity, and identified a range of activities and initiatives to help tackle obesity. I have asked Ministry officials to look at what actions can be undertaken to help address childhood obesity, including, advice on a possible obesity target that will be meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

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. I am aware you have a number of service reviews under way. I have asked the National Health Board to ensure regular updates are provided as these reviews progress. Please ensure that you advise the National Health Board as early as possible of any proposals for service change that may require

Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

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 2015/16 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

Foreword from the Chairman and Chief Executive

FOCUSING ON PEOPLE FIRST

The West Coast District Health Board has an important opportunity over the coming year to consolidate the transformation that has been taking place and make a real difference in outcomes for communities on the West Coast.

At the centre of our vision are West Coast people receiving the right care at the right time, closer to home. Our vision is about an integrated system where our communities see only one health system that doesn't require navigation or create unnecessary delays. It is about our staff who are supported with the same up-to-date information no matter where they work. It is about a strong, sustainable primary care system that is proactive in the care it provides. It is about community care that is enabled to care for more people in their own homes. It is about a seamless service between Canterbury and the West Coast that means our communities receive quality care at all levels.

We know that at some point in people's lives they may receive care from a self-employed midwife, have a Before School Check, get immunised, receive messages about giving up smoking, see nurses, doctors, need care in their home or even need hospital-level care. Whether we call these services primary or secondary care is neither here nor there for the people of the West Coast. What we are trying to deliver to them is the health advice, support and services that they will need to enable them to live healthy West Coast lives.

We continue to live with the system challenges that dictate a different way of doing things including: a small population spread over a large geographic area; a prevalence of locums which can contribute to a loss of continuity of care; outdated and inefficient hospital facilities; underdeveloped transport infrastructure; and increasing service provision costs.

Working collaboratively the West Coast health system has become far more joined up as together we put in the effort required to tackle the big health issues on the Coast. It is exciting to begin to see the fruits of all the hard work.

INTEGRATING CARE: HEALTH CARE HOME AND A SINGLE POINT OF REFERRAL FOR COMPLEX CARE

The work already undertaken in primary care by the West Coast Alliance and clinicians within general practice has delivered some significant improvements. Access to primary care for planned appointments has improved with shorter waiting times and services are working closer to provide joined up services to patients.

In looking ahead there continues to be significant work that needs to be done. The West Coast Health Alliance's Integrated Family Health Centre (IFHC) Workstreams are leading the integration of primary care services on the West Coast - preparing for the new facilities in Grey and Buller. In the year ahead, the integration agenda will look at further implementing new ways of working in preparation for the move into the new facilities. This will include improving linkages across the system with HealthPathways, providing increased services in a primary and community setting, implement new ways of providing for unplanned care and further improving the performance of the DHB owned general practices.

The Complex Clinical Care Network (CCCN) is an important component in looking after the health of patients with complex needs up and down the Coast. Working alongside general practice and with the West Coast Health Alliance's Health of Older Persons Workstream, the CCCN is supporting older people with complex conditions to remain safe and well in the community and closer to their own homes. Further investment in the CCCN over the coming year will see the establishment of the Flexible Integrated Rehabilitation Service Team (FIRST) and the establishment of a Falls Champion and Fracture Liaison service.

SUSTAINING CARE: TRANSALPINE SERVICES AND SUPPORTING HEALTH PROFESSIONALS

Our transalpine collaboration with Canterbury continues to provide the West Coast with reliable access to a full range of specialist services, for the most part delivered locally, with some services delivered in Christchurch.

In late 2014 we brought together senior clinicians from Canterbury and the West Coast to review the transalpine approach. This planted the seed for a number of services progressing this approach to support high quality, sustainable services on the Coast. In the coming year we will see more departments bringing this to life with general medicine, anaesthesia and mental health among the services that will build on this collaborative approach.

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 still have some distance to travel, we continue to invest 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 in paediatrics, anaesthesia, and gerontology. There is also significant work underway around developing a flexible workforce that can move around the health system to where the demand is. This will further reduce our reliance on locums and support an integrated way of working.

CONNECTING CARE: INTEGRATED INFORMATION SYSTEMS

Integrated information systems remain critical to the delivery of joined-up care. We have introduced an electronic signoff system for receiving laboratory results, enabling clinicians to view the results from anywhere and brings the West Coast DHB into line with the electronic processes used by Canterbury colleagues.

HealthOne has improved 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. This includes general practitioners, pharmacists, radiographers, specialists and surgeons – every part of the clinical care team who are dealing with individual patients.

More resources are being put into the transalpine telehealth system, to improve access to specialist care and reduce associated delays and costs for patients. This is a great relief physically and financially for patients who live in outlying areas when they have no need to be physically present in a room with their specialist – but can be supported by local clinicians in their local areas.

JOINED-UP CARE: SETTINGS AND FIT-FOR-PURPOSE FACILITIES

Planning is well underway for our new purpose-built healthcare facilities in both Greymouth and Buller – the physical surroundings to enable us to deliver our seamless model of care services when people cannot receive services in their homes.

Clinical teams have continued to lead the discussions about the services contained in the new facilities, sitting alongside architects and other key design planners. In Greymouth we have been able to show people early designs as we get one step closer to putting that first spade in the ground. In Buller a design team has been appointed and will soon re-engage with clinicians to work on the master plan and concept design.

HEALTH TARGETS: COMMITMENTS TO THE CROWN

Every quarter the Crown asks us to report back against a series of health targets. Together, the West Coast health system has been working hard to improve our performance against these important measures.

We are now meeting targets around: provision of smoking cessation messages in primary and secondary care; delivering shorter stays for patients in our emergency department; ensuring the people who need them have heart and diabetes checks; and meeting our targets for elective surgery.

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.

Over the last twelve months we have seen significant progress in bringing this vision to life. We would like to acknowledge all those across the West Coast health system who continue to travel with us on this journey of transformation with many people working hard to deliver a future of sustainable healthcare services for the West Coast population.

As we look to the year ahead, we remain determined to continue delivering on our commitments, meet national targets, and live within our means. We will continue our journey of transformation and deliver 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

October 2015

Introducing the West Coast DHB

1.1 Who are we

The West Coast DHB has the smallest population of all of New Zealand's 20 District Health Boards, serving a total resident population of 33,685 people (0.73% of the New Zealand population).

On behalf of our population, we manage a budget of almost $141M—which includes $101M (0.89%) of the population based funding provided to DHBs.

While the West Coast has the smallest population we also have the third largest geographical area, making the West Coast DHB the most sparsely populated DHB in New Zealand. Our district extends from Karamea in the north to Jackson Bay in the south and Otira in the east, and comprises three Territorial Local Authorities: the Buller, Grey and Westland districts.

The West Coast DHB is a major employer in the West Coast district, employing over 1,000 people. The DHB also owns and manages three major facilities in Greymouth, Westport and Reefton, five general practices across the West Coast and both Kynnersley Home in Westport and Ziman in Reefton, which provide rest home level care.

1.2 What do we do

The West Coast DHB is charged by Government with improving, promoting and protecting the health and independence of the West Coast population. Like all DHBs, we receive funding from Government with which to purchase and provide services to meet the needs of our population and are expected to operate within allocated funding. In accordance with legislation we:

Plan the strategic direction of the West Coast health system and determine the services required to meet the needs of our population in partnership with clinical leaders and alliance partners and in consultation with other DHBs, service providers and our community.

Fund the majority of the health services provided on the West Coast, and through our collaborative partnerships with other service providers, ensure services are responsive, coordinated and effective. The DHB holds and monitors more than 40 service contracts and agreements with the organisations and individuals that provide health services to our population, including: the West Coast Primary Health Organisation (PHO), residential mental health services and aged care service providers.

Provide the majority of specialist health and disability services for our population, through our hospital and specialist services and our DHB owned general practices. This is no small responsibility – in an average week: 191 people go through our Grey Base Emergency Department; 132 people are admitted to our hospitals; 35 people have elective surgery; 345 people have a specialist outpatient appointment and 2,601 general practice appointments are provided.

Promote and protect our population's health and wellbeing through investment in health promotion, education and evidence-based public health initiatives. 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 Alliance and the West Coast PHO the focus of these initiatives is on the reduction of negative behaviours and risk factors. This includes improving nutrition and physical activity and reducing tobacco smoking and alcohol consumption.

1.3 Our operating structure

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, meets the needs of our population and ensures sustainable service provision. As an owner of Crown assets, the DHB is also accountable to Government for the financial and operational management of those assets.

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 jointly provided by the Canterbury DHB. The two DHBs now share senior clinical and management expertise including: a joint Chief Executive, Executive Directors, Clinical Directors and Senior Medical Officers, as well as joint planning and funding, finance, public health,

human resources, information support and corporate services teams.

The West Coast also has in place a formal Health Alliance, a partnership of health professionals and providers, who work together to enable collaborative service planning and design and to determine the appropriate models of care for our health system. Through the Alliance, we embedding a view of our health system as one system with one budget and supporting the transformation and integration of our health system. The annual work programme of the West Coast Alliance forms the basis of the DHB's Annual Plan.

1.4 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 always had informal arrangements with the Canterbury DHB, these are progressively being formalised through the establishment of clinically led transalpine service pathways. This approach is not about reducing services. Instead, formal arrangements enable both DHBs to proactively develop the workforce and service infrastructure needed to ensure future services meet the needs of both populations in a clinically and financially sustainable way.

These arrangements include joint clinical appointments and shared service models that enable specialists to provide regular outpatient clinics and surgical lists on the West Coast and save patients from having to travel. Deliberate investment in telemedicine technology such as videoconferencing is providing further access to specialist advice while also saving families the inconvenience of travelling long distances for treatment.

Since 2010 more than 1,200 video and telemedicine consultations have taken place across oncology, paediatrics, general medicine, plastics, orthopaedics and general surgery. In the coming year more departments will bring the transalpine model to life with general medicine, anaesthesia and mental health among the services that will build on this collaborative approach.

1.5 Our accountability to the Minister

As a Crown entity and responsible for Crown assets, the DHB observes Government legislation and policy as directed by the Minister of Health. As required by legislation, we engage with the Minister and seek prior approval before making any significant service change or capital investment or disposing of any Crown land.

The West Coast DHB also strives to maintain open communication with the Minister and the Ministry of Health. This includes regular financial and performance reporting and a policy where early communication is provided with regard to any material or significant service change or issue of public interest.

The DHB's reporting obligations include:

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

The Crown Entities Act also requires DHBs to report annually to Parliament on their performance, as judged against our Statement of Intent. We publish this account as our Annual Report and also publish annual Quality Accounts, highlighting innovations and improvements in service delivery. Both are available on our website.

In an average week on the West Coast

5 babies are born

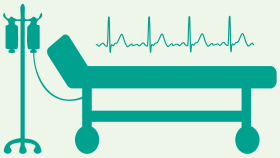
275 people attend ED

268 people attend specialist outpatient appointments

8 children receive a Before School Check (B4SC)

137 people are discharged from hospital

36 West Coasters have elective surgery, 23 of these at Grey Base Hospital



114 radiology tests are completed

2,696 people visit their general practice team

717 Meals on Wheels are delivered

6 8-month-olds are fully vaccinated

23 people receive support and advice to quit smoking

9 people are given a green prescription referral for increased physical activity

123 women have a cervical smear

75 children have a free dental check+

10 people receive brief intervention counselling in primary care*

68 people have a cardiovascular disease risk assessment

232 people are supported in aged resident care

1,773 hours of home-based support are provided to long-term clients

+ represents the 2014 calendar year. All other figures are for the 2014/15 financial year and are based on the DHB's Annual Report.
** includes telephone consultations.*

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

Based on the Census 2013 results and projections, West Coast is home to a usually resident population of 32,145 people, an increase of 2.6% on 2006. Grey district has the largest population, with an estimated resident population of 13,371 people.

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%).

Projections for 2015/16 indicate that 5,181 people on the Coast are aged 65 or over and 2,088 are 75 or over (6.5% of our total population). By 2026 more than one in every five people on the West Coast will be over 65 years of age (23.1%). This presents one of the biggest challenges to our health system.

As we age, we develop more complicated health needs and are more likely to need specialised services and more health resources. Long-term conditions become more common with age, including heart disease, stroke, cancer, respiratory disease and dementia. While more people living longer is a successful outcome in itself – the ageing of our population will put significant pressure on our workforce, infrastructure and finances. To ensure the long-term sustainability of our health system, we need to support our older population to remain healthy and well for as long as possible.

We must also consider the unique needs of other population groups in our planning for the future. Like age, ethnicity is a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others. In 2013, 10.5% of our population identified as Māori. By 2026 this percentage will have reached 12.5%.

Deprivation is another indicator of the need for health services. The West Coast has a lower mean personal income in New Zealand ($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 also 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 all largely preventable.

The most recent results from the combined 2011-2013 New Zealand Health Survey found that:

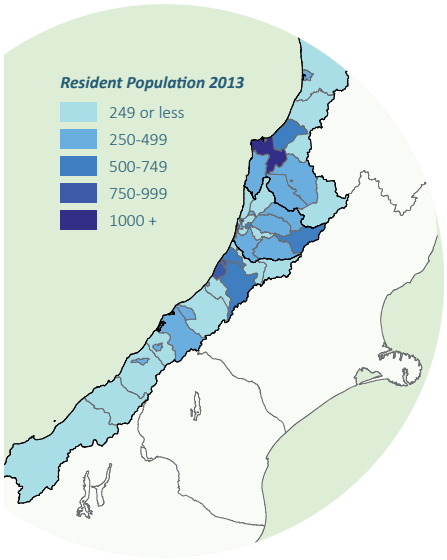
- 24.6% of our population are current smokers compared to the national average of 18% and smoking rates amongst our Māori and Pacific populations are significantly higher.
- 33% of our adult population are classified as obese 3% higher the national average.
- 14.9% of our population is likely to drink in a hazardous manner. While this rate is on a par with the national average (15%), it still amounts to more than one in every 10 adults surveyed.

As our population ages and becomes more ethnically diverse, the number of people living with long-term and complex conditions will increase. This means more demand on primary care, hospital care and residential care unless we step up our efforts to keep people healthy.

Many of the leading causes of death are conditions for which a reduction of risk factors, earlier identification and improved management and treatment can significantly improve outcomes.

Providing people with the knowledge, motivation and skills to avoid or improve their condition provides huge opportunity to improve the overall wellbeing of our population and ease the demand on our health system.

2.3 Operating environment



GEOGRAPHICAL PRESSURES

Meeting our population's health need is a 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 one of the most rural and isolated DHB in New Zealand. It is also the most sparsely populated, with a population density of just 1.4 people per km^2.

While our population is just 1.2% of New Zealand's estimated resident population, the total land area covered by the West Coast DHB is 23,283 square kilometres. Geographically we are one of the largest DHBs in New Zealand.

What this means is great distances between towns. The distance between Karamea and Haast 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.

This is further complicated by the fact that over 30% of households on the Coast have only one resident, and fewer 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. Like many DHBs, there are growing concerns over the availability of a sufficient workforce to meet increasing demand for health services as a greater proportion of our population reaches traditional retirement age.

As a result of our geographical isolation, it can be especially difficult to recruit and retain a health workforce 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 and while this will be required to some extent in the future we need to reduce our reliance on a temporary workforce.

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 these gaps as part of our transalpine collaboration with the Canterbury DHB, we will also focus on the recruitment of permanent staff with more generalist skills and the creation of new roles with wider professional 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, inefficient, and expensive to maintain. Some of our primary and community facilities are not appropriately located or configured to support an integrated service model or clinical team.

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 and considerable staff and public engagement is helping to determine our future facilities requirements.

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 deemed unsafe to occupy. It is important that the redevelopment progresses on schedule to ensure safety and service continuity and to avoid the DHB having to over-invest in facilities that do not have a future.

FISCAL PRESSURES

Government has given clear signals that DHBs need to operate within allocated funding and rethink how they deliver improved health outcomes in more cost-effective ways.

Numerous factors contribute to fiscal pressures: the increasing demand for services including diagnostics and aged residential care; rising treatment related and infrastructure costs and the rising costs of wages and salaries. Our ability to contain cost growth within affordable levels is made more difficult by increasing public and government expectations and the costs of new technology.

Fiscal pressures will be an increasing challenge, however with the transformation of our service models 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.

To achieve this, the DHB needs to successfully implement strategies alongside the development of integrated models of care in Grey and Buller, including:

- improved management of DHB-owned general practice;
- increased transalpine collaboration with the Canterbury DHB;
- increased integration and alignment of services;
- clinically led service transformation of local service models;
- the improved use of technology; and,
- better use of the health workforce across the West Coast health system.

2.4 Critical success factors

While significant progress is being made across a number of areas, the following still represent those areas where the greatest gains can be made in terms of improving health outcomes for our population. They also represent factors critical to our success, where failure would threaten the achievement of the strategic objectives outlined in this plan and the future viability of our health system.

Integrating fragmented health services: A legacy of unsustainable DHB-owned services with financial, access and continuity of care issues has led to fragmentation across the system and left a number of inefficient, isolated services struggling to deliver in appropriate settings.

Connecting the system electronically: Unreliable paper-based information systems and poorly performing information technology platforms have led to inefficient service delivery, wasting of clinical and patient time and reducing the continuity and safety of care.

Reducing over-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.

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.

Building a sustainable workforce: Longstanding clinical recruitment and retention issues have led to high use of locums and temporary staff reducing both continuity of care and clinical and operational leadership capability.

Restoring community confidence: Longstanding community frustration has eroded public confidence and trust. It is critical that promises made to our community about the transformation of our system are kept.

Meeting Government expectations: It is important that the West Coast health system 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.

Part II – Long-Term Outlook

Setting Our Strategic Direction

What are we trying to achieve?

Although they differ in size, structure and approach, DHBs have a common goal: to improve the health and wellbeing of their populations by delivering high quality and accessible health care. A growing prevalence of long-term conditions, increasing demand for services, workforce shortages, rising treatment costs and tighter financial constraints make this increasingly challenging.

3.1 Strategic context

In 2010, the National Health Board released Trends in Service Design & New Models of Care. [2] This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHBs in their service planning.

International direction emphasises that a 'whole of system' approach is required to improve health outcomes and ensure the sustainability of high quality health services. This approach entails four major service shifts:

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

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely access to care being paramount. However, the prevalence of long-term conditions and the ageing of our population means we need to move away from the traditional health model in order to support our population to maintain good health for longer.

Rather than wait for people to become acutely unwell or require institutionalised care, the whole of the health system needs to work in partnership to deliver accessible and effective services that support people to stay well and in their own homes for as long as possible.

3.2 The West Coast vision

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 service changes that will improve access to services and health outcomes for our population.

From this consultation, we have developed a vision for the future of the West Coast health system—at the heart of which is a fundamental reorientation of our current service model that puts the patient and their needs at the centre and reduces unnecessary delays in their care and treatment.

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

In line with our vision – the future model for 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.

[2] *Ministry of Health. 2010. Trends in Service Design and New Models of Care. Wellington: Ministry of Health*

Implementation of our new model of care is underway on all fronts. Access to specialist health care has improved, and the time people spend travelling to access care has been reduced. New telemedicine services and outreach clinics regularly save patients having to travel for specialist treatment and follow-up. The introduction of our Complex Clinical Care Network (CCCN) is supporting older people to stay well and in their own homes for longer and aged residential care bed utilisation is dropping.

From a service delivery perspective, healthcare providers are being brought together to work as multi-disciplinary teams. Working with the West Coast PHO we are building a strong and sustainable primary care model.

Important steps have been taken towards achieving a more integrated health system, including improving clinical information systems, commencing the development of Integrated Family Health Services across the West Coast, and establishing transalpine service arrangements with the Canterbury DHB.

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 easy answer – we must develop tailored solutions that enable us to do more (for more people) with the resources we have available.

Recognising that clinical leadership is crucial to the successful integration of services, health professionals from across the West Coast are engaged through the West Coast Alliance in all stages of service design and in the development of patient pathways across our health system. Empowered health professionals are taking a lead in setting strategic direction, and accelerating the implementation of the new model of care.

Achieving our vision requires the transformation of our entire health system. The redevelopment of our health facilities is also a critical factor in the future sustainability of West Coast health services.

Timeframes for the redevelopment of the Grey Hospital and Integrated Family Health Centre (IFHC) and the Buller IFHC will see the new facilities completed by the end of 2017.

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

The development of our new model of care includes nine key strategic components, and this is where our focus will continue to 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 (FIRST) 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, reducing risk factors and a commitment to Smokefree Aotearoa 2025.

Strengthened mainstream service responsiveness to Māori needs with a focus on 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 the closer alignment and integration of health teams.

3.3 National alignment

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

The ultimate high-level health system 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 these system outcomes and the commitments of

Government to provide 'better public services' and 'better, sooner, more convenient health services' by: increasing access to services; improving quality and patient safety; supporting the health of children, older people and those with mental illness; making the best use of information technology; and strengthening our health workforce. [3]

Alongside these longer-term goals and commitments, the Minister of Health's 'Letter of Expectations' signals annual priorities for the health sector. The 2015/16 focus is on: clinical leadership; integration; tackling the key drivers of morbidity; delivery of national health targets; fiscal discipline and performance management.

The West Coast DHB is committed to playing its part in the delivery of longer-term health system outcomes and progress against national goals. Activity planned and prioritised in the coming year is in line with our strategic direction and goals and the priorities expressed by the Minister of Health and is highlighted in Part III of our Annual Plan - Delivering our Service Priorities.

3.5 Regional commitment

In setting its expectations for better public services and better, sooner, more convenient health services the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance—together providing services for 1,081,953 people or 23.5% of the total NZ population. [4]

While each DHB is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges. Together we are committed to delivering a sustainable South Island health system, focused on keeping people well, and providing equitable and timely access to safe, effective, high-quality services—as close to people's homes as possible.

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

Closely aligned to the national direction, and operating under a 'Best for People, Best for System' framework, 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 from public health system resources

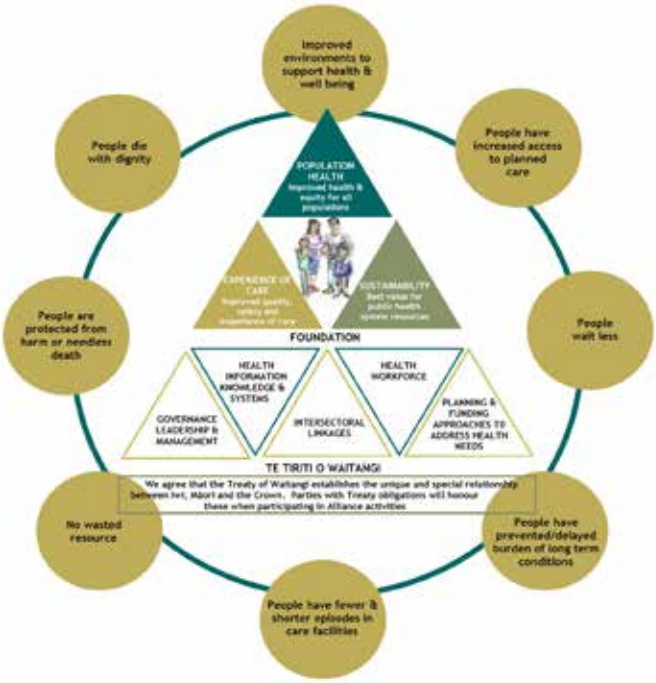
A set of high level outcomes sit alongside the 'Best for People, Best for System' framework and enable evaluation of regional activity at a population level. These are highlighted in the outer circles in Figure 1.

The South Island Health Services Plan highlights the agreed regional activity to be implemented through our service level alliances and work streams in seven priority service areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity in the coming year will also focus on: cardiac services, elective surgery, palliative care, public health, stroke and major trauma services. Workforce planning, through the South Island Regional Training Hub and regional asset planning, will contribute to improved delivery in all service areas.

West Coast's commitment in terms of the regional direction is outlined in the South Island Health Services Plan, and key deliverables are also highlighted in Part III of our Annual Plan. [5]

Figure 1. South Island Best for People, Best for System Framework.



[3] *Ministry of Health's Statement of Intent 2014-2018 available on their website – www.health.govt.nz.*
[4] *2015/16 Population Based Funding Projection provided to the Ministry of Health by Stats NZ, based off the 2013 Census.*
[5] *For further detail refer to the Regional Health Services Plan available on the South Island Alliance website: www.sialliance.health.nz.*

Measuring Our Progress

How will we know we are making a difference?

DHBs are expected to deliver against the national health system 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 their objectives under the New Zealand Public Health and Disability Act to 'improve, promote and protect the health of people and communities'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in achieving these goals and improving the health and wellbeing of their populations. There is no single indicator that can demonstrate the impact of the work DHBs do. Instead, the South Island DHBs have collectively chosen a mix of population health and service performance indicators that we believe are important to our stakeholders and that together, provide an insight into how well the health system and DHBs are performing.

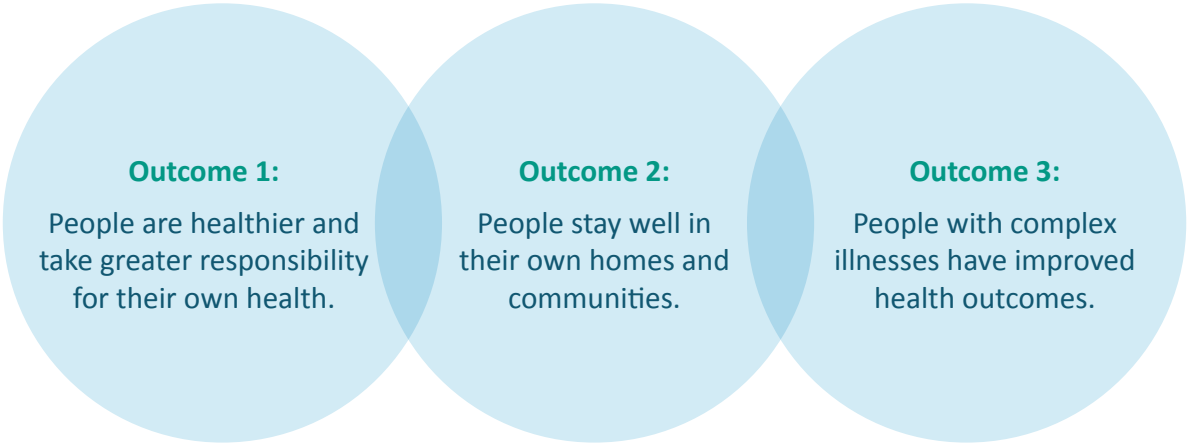
In developing our strategic framework, the South Island DHBs identified three shared high-level strategic objectives where collectively we can influence change and deliver on the expectations of Government, our communities and our patients by making a positive change in the health of our populations.

Alongside these strategic objectives (or goals) are a number of associated outcomes indicators, which will demonstrate success over time. These are long-term indicators and, as such, the aim is for a measurable change in health status over time, rather than a fixed target.

The South Island DHBs have also identified a core set of associated medium-term indicators. Because change will be evident over a shorter period of time, these indicators have been identified as the headline or main measures of performance. Each DHB has set local targets in order to evaluate their performance over the next four years and determine whether they are moving in the right direction. These impact indicators will sit alongside each DHB's Statement of Service 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.

The outcome and impact indicators were specifically chosen from existing data sources and reporting frameworks. This approach enables regular monitoring and comparison, without placing additional reporting burden on the DHBs or other providers. As part of their obligations DHBs must also work towards achieving equity and to promote this, the targets for each of the impact indicators are the same across all ethnic groups.



- ✓ A reduction in smoking rates.
- ✓ A reduction in obesity rates.

- ✓ A reduction in acute admissions to hospital
- ✓ An increase in the proportion of people living in their own homes

- ✓ A reduction in acute readmissions to hospital
- ✓ A reduction in the rate of avoidable mortality

Overarching Intervention Logic

MINISTRY OF HEALTH HIGH LEVEL OUTCOMES

Health System Vision

All New Zealanders to live longer, healthier & more independent lives, & the health system is cost effective & supports a productive economy.

New Zealanders are healthier & more independent	High-quality health & disability services are delivered in a timely & accessible manner	The future sustainability of the health system is assured

REGIONAL HIGH LEVEL OUTCOMES

South Island Regional Vision

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

Population Health Improved health & equity for all populations	**Experience of Care** Improved quality, safety & experience of care	**Sustainability** Best value from public health system resources

West Coast DHB Vision

An integrated health system that is clinically sustainable & financially viable & wraps care around the patient to help them stay well.

DHB STRATEGIC OBJECTIVES

What does success look like?

People are healthier & take greater responsibility for their own health.	People stay well, in their own homes & communities	People with complex illness have improved health outcomes
▪ *A reduction in smoking rates* ▪ *A reduction in obesity rates*	▪ *A reduction in the rate of acute admissions to hospital* ▪ *An increase in the proportion of people living in their own home*	▪ *A reduction in the rate of acute readmissions to hospital* ▪ *A reduction in the rate of avoidable mortality*

IMPACT MEASURES

How will we know we are moving in the right direction?

▪ *More babies are breastfed* ▪ *Children have improved oral health* ▪ *Fewer young people take up smoking*	▪ *People's conditions are diagnosed earlier* ▪ *Fewer people are admitted to hospital with avoidable or preventable conditions.* ▪ *Fewer people are admitted to hospital as a result of a fall*	▪ *People have shorter waits for urgent care* ▪ *People have increased access to planned specialist care* ▪ *Fewer people experience adverse events in our hospitals*

OUTPUTS

The services we deliver

Prevention & public health services	Early detection & management services	Intensive assessment & treatment services	Rehabilitation & support services

INPUTS

The resources we need

A skilled & engaged workforce	Strong alliances, networks & relationships	Sustainable financial resources	Appropriate quality systems & processes	Responsive IT & information systems	Fit for purpose assets & infrastructure

Strategic Outcome Goal 1

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

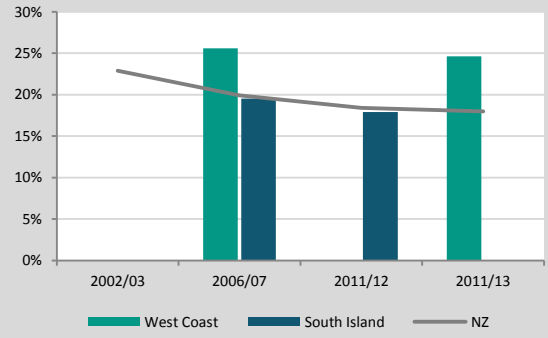
WHY IS THIS OUTCOME A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major drivers of poor health and account for a significant number of presentations across primary care and hospital and specialist services. The likelihood of developing long-term conditions increases with age, and with an ageing population, the burden of long-term conditions will grow. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on managing long-term conditions. These 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 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. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our population.

OVERARCHING OUTCOMES INDICATORS

MEASURE: THE PERCENTAGE OF THE POPULATION (15+) WHO SMOKE



Outcome: A reduction in smoking rates

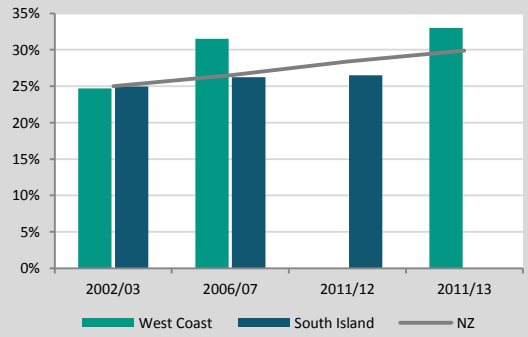
Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.

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 source: National NZ Health Survey[6]

MEASURE: THE PERCENTAGE OF THE POPULATION (15+) WHO ARE OBESE



Outcome: A reduction in obesity rates

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

This has significant implications for rates of cardiovascular and respiratory disease, diabetes and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

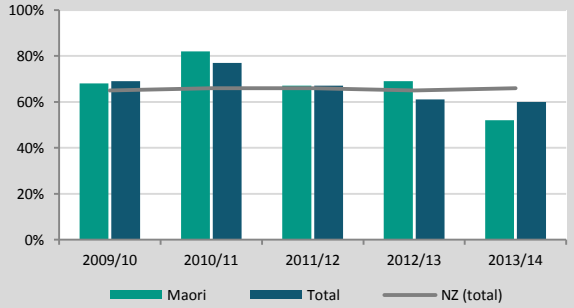
Supporting our population to achieve healthier body weights through improved nutrition and physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.

Data source: National NZ Health Survey[7]

[6] *The NZ Health Survey is completed by the Ministry of Health and results are subject to availability. From 2011, survey results were combined year-on-year in order to provide more robust results for smaller DHBs—hence the different time periods presented. Results are currently unavailable by ethnicity or region. The 2013 Census results for smoking (while not directly comparable) demonstrates that 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] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.*

MEASURE: % OF BABIES EXCLUSIVELY OR FULLY BREASTFED AT SIX WEEKS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 60%	Target: 74%	>74%	>74%	>74%

Impact: More babies are breastfed

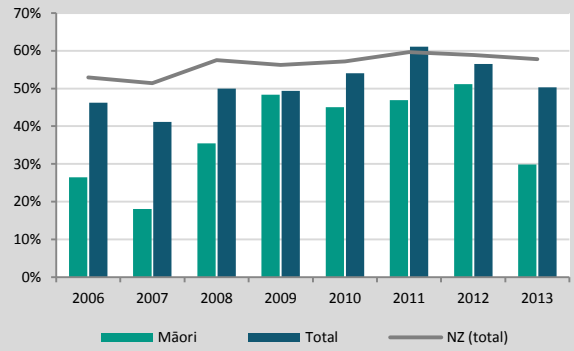
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

Breastfeeding also contributes to the wider wellbeing of mothers as well as bonding between mother and baby.

An increase in breastfeeding rates is seen as a proxy indicator of the success of health promotion and engagement activity, appropriate access to support services and a change in both social and environmental factors influencing behaviour and support healthier lifestyle choices.

Data source: Plunket via the Ministry of Health[8]

MEASURE: % OF FIVE-YEAR-OLDS CARIES FREE (NO HOLES OR FILLINGS)



2013	2015	2016	2017	2018
Actual: 50%	Target: 56%	>56%	>56%	>56%

Impact: More children have improved oral health

Oral health is an integral component of lifelong health and impacts a person's self-esteem and quality of life.

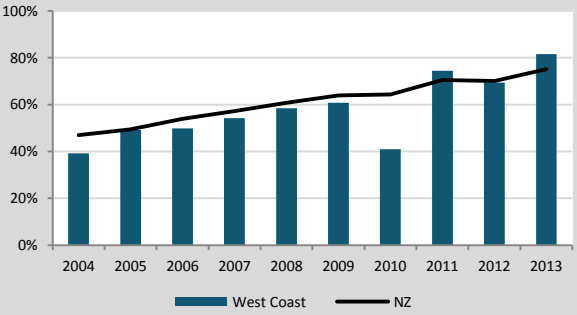
Good oral health not only reduces unnecessary hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and health outcomes.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy indicator of equity of access and the effectiveness of services in targeting those most at risk.

The target for this measure has been set to maintain the total population rate while placing particular emphasis on improving the rates for Māori and Pacific children.

Data Source: Plunket via the Ministry of Health

MEASURE: % OF 'NEVER SMOKERS' AMONG YEAR 10 STUDENTS



Actual 12/13	Target 14/15	15/16	16/17	17/18
82%	>75%	>75%	>75%	>75%

Impact: Fewer young people take up tobacco smoking.

The highest prevalence of smoking amongst younger people and reducing smoking prevalence across the total population is largely dependent on preventing young people from taking up smoking.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of health promotion and engagement activity and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.

Because Māori and Pacific have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides significant opportunities to improve long-term health outcomes for these populations.

Data source: National Year 10 ASH Survey[9]

[8] *Provider data for breastfeeding is currently unable to be combined so performance data from Plunket (as the largest provider) is presented. While this covers the majority of babies, because the smaller local WellChild/Tamariki Ora providers target Māori and Pacific mothers—results for Māori are likely to be understated. The target is based on national Well Child standards for breastfeeding at 6 weeks.*

[9] *The ASH survey is a national survey used to monitor student smoking since 1999. Run by Action on Smoking and Health, it provides an annual point prevalence snapshot of students aged 14 or 15 years. The average number of West Coast students participating in the annual survey is around 200-220 and these small numbers can lead to fluctuations between years —for more detail see www.ash.org.nz.*

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, but it reduces the pressure on our hospitals 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 at a lower cost than countries with systems that focus on specialist level care.

General practice can deliver services sooner and closer to home and through early detection, diagnosis and treatment, deliver improved health outcomes. The general practice team is also vital as a point of continuity, particularly in terms of improving the management of care for people with long-term conditions and reducing the likelihood of acute exacerbations of those conditions resulting in complications of injury and illness.

Health services also play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, allied and personal health providers and pharmacists. These providers also have prevention, early intervention and restorative perspectives and link people with other social services that can further support them to stay well and out of hospital.

Even where returning to full health is not possible, access to responsive, needs-based pain management and palliative services (closer to home and families) can help to improve the quality of people's lives.

OVERARCHING OUTCOMES INDICATORS

MEASURE: THE RATE OF ACUTE MEDICAL ADMISSIONS TO HOSPITAL *(AGE-STANDARDISED, PER 100,000)*

Outcome: A reduction in acute medical admission rates.

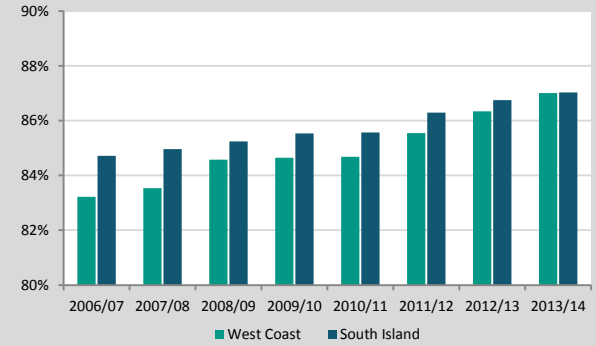
Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and premature death.

Lower acute admission rates can be used as a proxy indicator of improved management and to indicate the accessibility of timely and effective care and treatment in the community.

Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources otherwise taken up by the demand for urgent care.

Data source: National Minimum Data Set

MEASURE: THE % OF THE POPULATION (75+) LIVING IN THEIR OWN HOMES



Outcome: More people living in their own homes

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes.

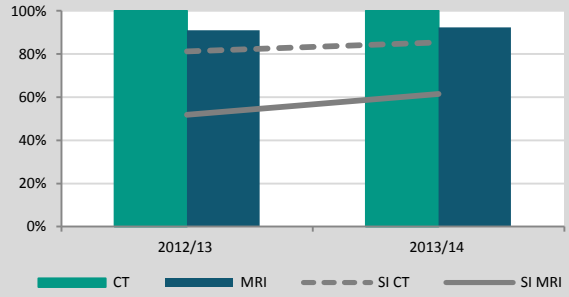
Living in ARC is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.

An increase in the proportion of older people supported in their own homes is a proxy indicator of how well the health system is responding to the needs of our older population.

Data Source: SIAPO Client Claims Payment System[10]

[10] *Updated Census population estimates used for 2013/14 have had a noticeable impact on the results for this measure with the total 75+ populations previously over counted.*

MEASURE: % OF PEOPLE WAITING LESS THAN SIX WEEKS FOR CT/MRI SCANS



2013/14	2015/16	2016/17	2017/18	2018/19
CT Actual 100%	Target: 95%	95%	95%	95%
MRI Actual 92%	Target: 85%	85%	85%	85%

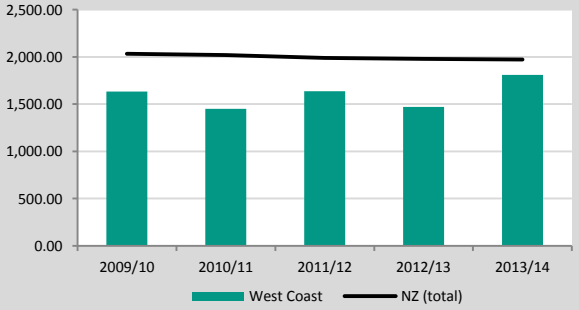
Impact: People's conditions are diagnosed earlier

Diagnostics are an important part of the healthcare system and timely access to diagnostics, by improving clinical decision-making, enables early and appropriate intervention and helps to improve the quality of care and outcomes for our population.

Timely access to diagnostics can be seen as a proxy indicator of system effectiveness where effective use of resources is needed to minimise wait times while meeting increasing demand.

Data source: Individual DHB Patient Management Systems

MEASURE: RATIO OF ACTUAL VS. EXPECTED AVOIDABLE HOSPITAL ADMISSIONS FOR THOSE AGED UNDER 75



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 82%	Target: TBC	TBC	TBC	TBC

Impact: Fewer avoidable hospital admissions

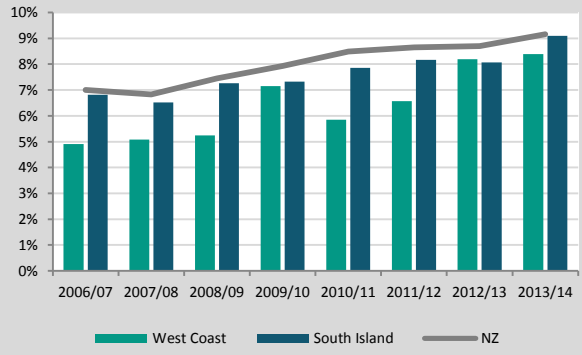
Given the increasing prevalence of chronic conditions effective primary care provision is central to ensuring the long-term sustainability of our health system.

Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions—not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

Lower avoidable admission rates are therefore seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

Data Source: Ministry of Health Performance Reporting SI1[11]

MEASURE: % OF THE POPULATION (75+) ADMITTED TO HOSPITAL AS A RESULT OF A FALL



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 8.4%	Target: 7.8%	7.4%	7%	<7%

Impact: Fewer people admitted to hospital after falls

Compared to people who do not fall, these people 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.

Solutions to reducing falls span both the health and social service sectors and include appropriate medications use, improved physical activity and nutrition, appropriate support and a reduction in personal and environmental hazards.

Lower falls rates can be seen as a proxy indicator of the responsiveness of the whole of the health system to the needs of our older population as well as a measure of the quality of the individual services being provided.

Data Source: National Minimum Data Set[12]

[11] *This measure is a 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 a rate per 100,000 people and the target is set to maintain performance below the national rate—which reflects less people presenting to hospital. The Ministry is working to resolve a definition issue with this measure and target setting for 2015/16 has been postponed while the definitions are reset.*

[12] *Updated Census population estimates used for 2013/14 have had a noticeable impact on the results for this measure with the total 75+ populations previously over counted – the actual number of people admitted as a result of a fall has dropped from 184 (2012/13) to 179.*

Strategic Outcome Goal 3

4.3 People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

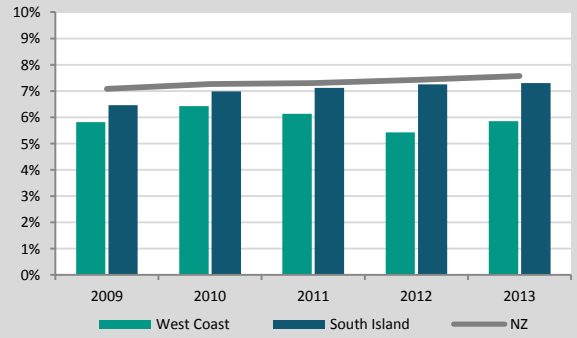
For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

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.

OVERARCHING OUTCOMES INDICATORS

MEASURE: RATE OF ACUTE READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE



Outcome: A Reduction in acute readmissions

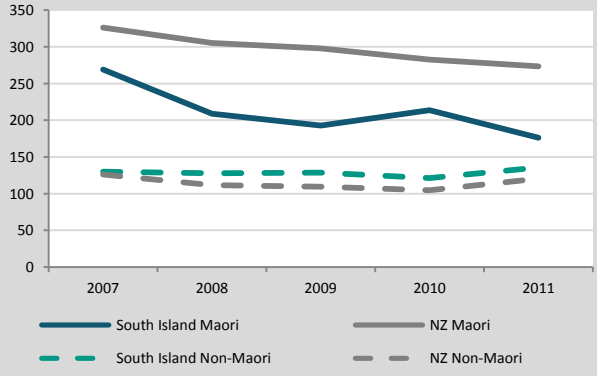
Unplanned hospital readmissions are largely (though not always) related to the care provided to the patient.

As well as reducing public confidence and driving unnecessary costs, patients are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

Because the key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge – they are a useful maker of the quality of care being provided and the level of integration between services.

Data Source: Ministry of Health Performance Data OS8[13]

MEASURE: RATE OF ALL-CAUSE MORTALITY FOR PEOPLE AGED UNDER 65 *(AGE STANDARDISED, PER 100,000 PEOPLE)*



Outcome: A reduction in avoidable mortality

Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

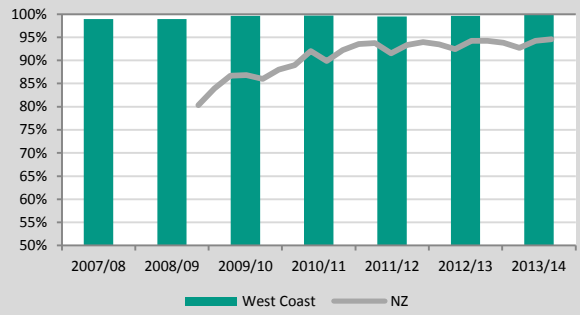
A reduction in avoidable mortality rates can be used as a proxy indicator of responsive specialist care & improved access to treatment for people with complex illness.

Data Source: National Mortality Collection[14]

[13] *This measure is a national performance indicator (OS8). The Ministry of Health is reviewing the definition for this measure and target setting has been delayed for 2015/16 while the definition is reset. The DHB has elected to present the unstandardised or 'raw' rates as these are easier to replicate and match against admissions internally and therefore enable closer analysis of performance.*

[14] *Mortality data is sourced from the national mortality collection which is three years in arrears, the data presented was released in 2014.*

MEASURE: % OF PEOPLE PRESENTING IN ED WHO ARE ADMITTED, DISCHARGED OR TRANSFERRED WITHIN SIX HOURS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 100%	Target: 95%	95%	95%	95%

Impact: People have shorter waits for urgent care

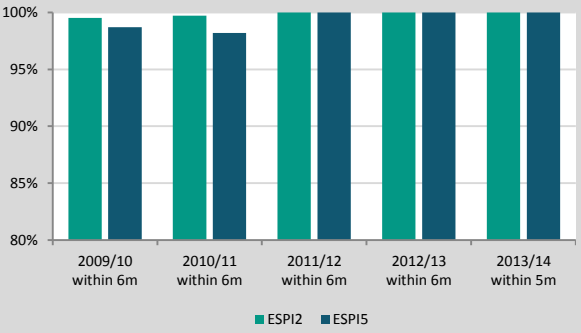
Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes for patients. Enhanced performance will not only improve patient outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.

Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Data Source: Individual DHB Patient Management Systems[15]

MEASURE: % OF PEOPLE RECEIVING THEIR SPECIALIST ASSESSMENT (ESPI 2) OR TREATMENT (ESPI 5) IN <4 MONTHS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 100%	Target: 100%	100%	100%	100%

Impact: People have increased access to planned care

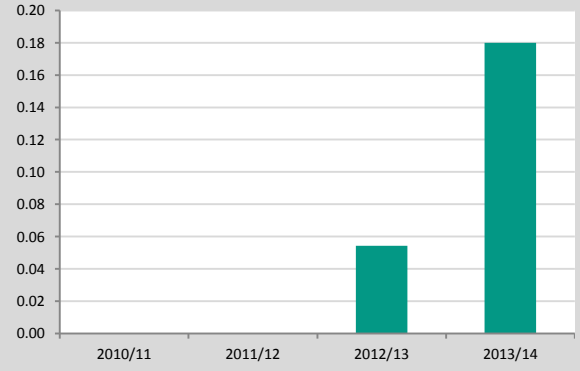
Planned services (including specialist assessment and elective surgery) are an important part of the healthcare system and improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing.

Timely access to assessment and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is a marker of how responsive the system is to the needs of the population.

Data Source: Ministry of Health Quickplace Data Warehouse[16]

MEASURE: RATE OF SAC LEVEL 1 & 2 FALLS IN WEST COAST HOSPITALS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 0.18	Target: 0.05	0.05	0.05	0.05

Impact: People experience fewer adverse events

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.

An initial jump in results is expected as people are encouraged to report falls.

Data Source: Individual DHB Quality Systems[17]

[15] *This measure is the national DHB Health Target 'Shorter Stays in ED'. In alignment with the health target reporting, the year-end result is from the final quarter of the year (April-June) and relates to presentations to the Greymouth Hospital Emergency Department.*

[16] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance. In line with the ESPI target reporting the annual results presented are those from the final quarter of the year.*

[17] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood. Data reported is per 1,000 inpatient bed days. Small numbers have a significant impact on these results — the 2013/14 result relates to 6 incidents.*

Managing Our Business

The manner in which we work, the way we interact with each other and the values of our organisation are key factors in our success. Having already identified the challenges we face and set a collective vision for the West Coast health system, this section highlights our organisational strengths and the way in which we will manage our business 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 where longstanding frustrations have eroded confidence and trust. Our 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 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 DHB has invested in leadership and workforce engagement programmes that encourage people to ask 'What is best for the patient?' and 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'.

This approach, is fostering stronger cross-system partnerships and alliances that are improving the continuity of care for patients. Our patient-focused culture is also help attract and retain staff by promoting workforce satisfaction and engagement.

5.2 Effective governance and leadership

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 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.

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 service improvements.

The DHB has formally established a 10-member Consumer Council to 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.

CLINICAL PARTICIPATION IN DECISION-MAKING

Recognising that clinical leadership is crucial to the successful integration of services, we engage health professionals from across the health system in service design and in the development of integrated patient pathways.

The West Coast has a Clinical Board that oversees the DHB's clinical activity, 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 our health systems transformation 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 its associated workstreams and service level alliances include both clinicians and health professionals from across the West Coast health system.

Clinical leadership is further facilitated by the DHB's Chief Medical Officer and Executive Directors of Midwifery and Allied Health, who provide clinical leadership and input into DHB decision making at the executive level.

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, 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.

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 a Māori Health Action Plan that sits alongside the Annual Plan and identifies where and how improvements will be made for Māori in the coming year.

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

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.

5.2 Successful alliances & partnerships

Our vision is wider than just the DHB and as such we are adopting partnership and alliance based approaches that recognise our relationships with the organisations we fund are more than just contractual.

WEST COAST ALLIANCE

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. Through the 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.

Seven clinically-led Alliance Workstreams are in place and 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 support the delivery of the West Coast health system vision as well as the delivery of national expectations and achievement of the national health targets. The work programme of the West Coast Alliance forms the basis of the DHB's Annual Plan.

PARTNERSHIPS WITH OTHER AGENCIES

Because good health is also determined by factors and social determinants outside the direct control of the health system, maintaining active partnerships with other agencies is vital. We work closely with other agencies (including local and regional councils, Housing NZ, ACC and the Ministries of Justice, Education and Social Development) to influence and support the creation of social and physical environments that reduce the risk of ill health.

Regionally we support development of our Māori health workforce through the Kia Ora Hauora training programme and the Ngā Manukura ō Āpōpō Leadership Programme.

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 also continues 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 Shared Services (Health Benefits Limited)—for the benefit of our population and wider health system.

5.3 Subsidiary companies

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 — the South Island Alliance Programme Office.

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 $6m. The West Coast DHB's contribution to the Regional Office for 2015/16 will be $120,512.

5.4 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.

The West Coast DHB has faced a number of long-term challenges to achieving clinical and financial viability. 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.

In response to these longstanding challenges, we have worked with our communities and clinical teams to develop a clear vision for a single, integrated health system that keeps people as well as possible for as long as possible, in or close to their own homes. Bringing this to life requires systematic efforts to address underlying workforce challenges.

Of significance for the coming year is the ongoing implementation of Transalpine clinical services in collaboration with the Canterbury health system and the ongoing efforts to develop and stabilise the local resident workforce. This work will build on the Transalpine Review and Planning Workshop held in October 2014 which involved 70 clinical leaders from across the Coast and Canterbury health systems. Together they agreed plans for the ongoing evolution of transalpine collaboration over the coming two years to ensure the sustainability of our services and improve the continuity of care for our population.

In conjunction with the Canterbury DHB, the West Coast DHB has reviewed its current Child Protection Policy against recent changes to Vulnerable Children's legislation and agree a phased implementation plan to meet the new requirements for worker safety checks as this comes into effect. Alongside the other 20 DHBs, West Coast will implement safety checking requirements for recruiting workers in the children's workforce and ensure this information is available to the Director General of Health to meet the requirements in the Vulnerable Children's legislation. The DHB is also reviewing relevant contracts to ensure a clause relating to the need for contracted service providers to have a Child Protection Policy is included.

At a broader level, 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.

EXPANDING OUR WORKFORCE CAPACITY

From a recruitment perspective, there are a number of areas where workforce shortages affect our system's capacity. Rural general practitioners, nurse practitioners, general surgeons and a number of specialist and allied health positions remain vulnerable to supply shortages.

In response, we are strengthening recruitment strategies, targeting programme to attract rural hospital medical specialists, working closely with Canterbury DHB and continuing to supplement West Coast-based clinical support and services with joint appointments.

Growing our rural hospital medical specialist workforce will be key to our ongoing transformation. The DHB is also looking to increase Māori participation in the health workforce through the national Kia Ora Hauora training programme and the Ngā Manukura ō Āpōpō Leadership Programme.

We are supporting local scholarships to encourage 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 integrated electronic systems, which support the provision of specialist services without a significant increase in workforce numbers.

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 pre-vocational curriculum which requires PGY2s to have a three month community placement. E-learning packages will be progressively rolled-out regionally and a full suite of packages will be available online 2015/16.

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

Online Learning modules are available to staff via the health Learner Management System (LMS), providing the right training and development for staff regardless of their location on the Coast. Modules continue to be developed for the LMS and a significant amount of development and assessment can be completed from the Coast, without the need to travel to Canterbury, or attend a face-to-face training session.

The West Coast is an active participant in the South Island Regional Training Hub Nurse Practitioner working group. This group is developing pathways within South Island health services to increase the number of nurse practitioner roles to better meet the health needs of the South Island Community.

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. Further development now includes a regional project to develop a West Coast and Canterbury standing orders process which will be integrated into HealthPathways and align within the Transalpine model. 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.

5.5 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. 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 have been 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 (Safety 1st) 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. We continue to develop and further strengthen our partnership ties with our Canterbury neighbours and with the wider South Island that will help us to continue to build sustainable 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. We will also work with

neighbouring DHBs and the HQSC to implement new Quality and Safety Markers over the coming year.

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 our 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 DHB also produced its second set of Quality Accounts in 2014 as a means of answering the questions that consumers consider important and identifying whether the DHB is providing a safe and high quality services. Future accounts will see wider consumer consultation to identify key areas of importance.

Preventing healthcare-associated infection (HAIs): Admission to hospital exposes patients to potential harm through healthcare-associated infection, and the 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 will maintain the appropriate number of trained hand hygiene auditors and implement our hand hygiene quality plan, with charge nurse managers also 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). Systems and audits are in place to minimise this risk and we have recently achieved 1000 CLAB free 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 the infection prevention and control platform (ICNet) in surveillance activities.

Reducing falls in healthcare settings: Falls resulting in harm are known to significantly reduce the 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. The introduction of Safety1st has enabled us to analyse incidents and contributing factors more easily, with all senior staff being able to access their own results in real time. We are now integrating the use of this information into related project areas.

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.

In collaboration with Canterbury we are committed to implementing an online patient vital signs observation system to enhance early detection of the deteriorating patient. The first ward will be online by mid-2016.

Medication and surgical safety: We are committed to reducing 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 quality improvement project results of our efforts to reduce adverse effects of opiates will be consolidated this year.

The National Medication Chart has been adopted in all acute clinical areas and we are participating in an HQSC-led medicine reconciliation programme with all patients' medicine reviewed at admission, discharges and transfer.

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 consider observational audit to identify how the checklist is used, with outcomes communicated to all staff associated with the operating theatres and will look to reinforce the importance of the checklist as a teamwork and communication tool. We will participate with our South Island colleagues in the introduction of the brief debrief approach and utilise the appropriate measures for improvement.

We also have active mortality and morbidity review meetings across all services with each case reviewed and link into regional forums and encourage dissemination of learnings.

5.6 Investment in information systems

Information systems are a national priority, and DHBs are taking a collective approach to implementing the National Health Information Technology Plan. The South Island DHBs have collectively determined 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 information.

The West Coast DHB has already adopted several key regional information systems, such as Health Connect South, Health One (formally eSCRV) 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:

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, referrals and management 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 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 DHBs.

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 and the West Coast was the first DHB other than Canterbury to introduce this system.

Electronic Sign Off enables clinicians to sign off their results electronically. We implemented electronic sign off of laboratory results in 2014.

HealthOne 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.

The South Island Patient Information Care System will be the new regional patient administration system, which will further integrate systems throughout the South Island. The West Coast will be moving to the new system in 2016/17.

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 2015/16 and eMedications Reconciliation in 2016/17.

National Infrastructure Platform (NIP) is a platform for improving the security, reliability and service levels of the Information Technology infrastructure that supports health services.

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

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.

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 develop a unified virtual IT team spread between the two DHBs to make better use of resources in both organisations.

5.7 Investment in facilities

In the same way that quality systems, workforce and information technology underpin our transformation, health facilities can both support and hamper the quality of the care we provide.

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, to minimise operating deficits, has resulted in significant infrastructure degradation and associated risk.

At the end of 2012, the Government established a 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.

An Integrated Family Health Centre is being developed on the Grey Hospital site. 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. Redevelopment of our 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 service transformation underway and bring integrated service provision to life. With a clear decision on the way forward our health system will be able to cement a more certain and sustainable future.

Focus in the coming year will also be on Buller and the development of facilities required to support more integrated health service here as well. The DHB undertook significant engagement with the Buller community in 2014/15 to talk about a new Integrated Family Health Centre and how this will function. We are now looking at how aged care services, mental health services, after hour services and transport will be organised in the future and will be making some significant steps forward in these areas.

In order to avoid costly and wasteful investment, close alignment and careful timing of the redevelopment is essential. The DHB is working with the Ministry of Health, through the nationally appointed Hospital Redevelopment Partnership Group, to ensure that delays are minimised.

5.8 Service reconfiguration

The service coverage schedule between the DHB and the Ministry is the translation of government policy into the minimum level and standard of service to be made available to the public.

The West Coast DHB seeks to identify service coverage gaps and risk through the monitoring of performance indicators, risk reporting, formal audits and complaints mechanism and ongoing review of patient pathways. We are committed to continuing to manage and resolve any issues we encounter and at this stage are not seeking any formal exemptions to the Service Coverage Schedule for 2015/16.

In the first instance we would anticipate that any services not able to be provided locally will be contracted through the Canterbury DHB.

SERVICE REDESIGN AND RECONFIGURATION

In line with our vision we are engaged in a continual transformation of the way we deliver health services in order to better meet the needs of our population, improve the quality of services delivery and ensure the sustainability of our health system. We anticipate that new models of care and service delivery will continue to emerge as we respond to the changing needs of our population and in line with the development of the new model of care and our IFHC and facilities redevelopment in Grey and Buller.

We recognise our obligations (under the Operational Policy Framework) to notify the Minister of Health with respect to plans for any significant service change and will continue to do so. In line with our shared decision-making principles, decisions regarding how a service is best delivered are made collectively and wherever possible under the leadership of clinical leaders and health professionals delivering the service.

The West Coast DHB also has a policy of ongoing community engagement, and will keep a steady stream of information flowing across the sector on the planned transformation of any services. Any service changes will be carefully considered so as not to destabilise or negatively affect other providers or our neighbouring DHBs.

Activity for the period of this plan includes:

Service Integration: In line with the redevelopment of facilities in Grey and Buller and the corresponding redesign of service models for primary and secondary care supporting this. Alliance workstreams are in place to support the development of these new models including the redesign of pathways for planned, unplanned and acute care under the IFHC model and the introduction of more flexible workforce models.

Older People's Health Services: We will continue to implement the new service model for older people's health (driven through the CCCN) and to strengthen and enhance home based support for older people. In the coming year, there will be closer integration of nursing and home-based support services, and the development of the 'FIRST' rapid response and supported discharge service and the Falls and Fracture Liaison Service. We will also implement the direction of travel with regards to the aged care on the Coast including a shift away from the provision of aged residential care by the DHB.

Mental Health Services: We will continue to implement service model redesign and reconfiguration of resources in line with the clinically-led service review of our Mental Health Services undertaken in 2013/14. These changes will be led by the Mental Health Workstream under the West Coast Alliance and will involve the

introduction of locality based care and an expanded role for primary and community service providers.

Regional and Transalpine Services: We will continue to adopt consistent, regionally developed pathways for access to specialist services – particularly across cancer, cardiac and orthopaedic services, delivery of fertility and ENT services and service development identified in the Regional Health Services Plan.

National Direction: We will continue to work with the Ministry of Health to align policy and service coverage arrangements nationally. This will include implementing changes in line with the national pharmacy and PHO agreements and the Vulnerable Children's Legislation.

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.

Part III – Annual Operating Intentions

Delivering Our Service Priorities

A fully integrated health system is one that provides a seamless flow of care rather than a series of isolated events. As our population ages our focus is supporting people to stay well, reducing demand and integrating our services. The answer to improving the health of our population, meeting the future demands on our system and living within our means is not more of the same services, but more of the right services delivered in the right place, at the right time by the right person.

INTEGRATED HEALTH SERVICES

6.1 System integration

One of the key elements in ensuring the sustainable transformation of the West Coast health system is to bring consumers, health professionals and services managers from across the health system together under the banner of the West Coast Health Alliance. By working alongside one another to design new models of care and patient pathways we can streamline the interface between services, make the best use of our system resources and, most importantly, improve outcomes for our population.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue to improve the integration of services on the West Coast to ensure patients receive effective and coordinated care closer to home.	▪ Continue to ensure system-wide participation, joint planning and clinically-led service development through the West Coast Health Alliance work streams and Alliance Leadership Team (ALT). ▪ Enhance alliance communication with a focus on profiling patient and provider experience to engage stakeholders and enhance the involvement of social sector partners in alliance activity.	✓ Quarterly activity and outcomes reporting to Alliance Leadership Team. ✓ Endorsement of DHB Annual Plan by the ALT.
	▪ Continue to support the utilisation of HealthPathways and the Electronic Request Management System (ERMS) to support care closer to home and streamline referrals for treatment. ▪ Survey general practice clinicians to determine utilisation and barriers to using HealthPathways or ERMS. ▪ Enable the ability to send photographs to specialists via ERMS. ▪ Ensure alignment with national access criteria for radiology through the use of HealthPathways.	✓ >650 localised Healthpathways in place Q4. ✓ Healthpathways survey completed Q4. ✓ Enable ability to send photographs to specialists via ERMS enabled Q4.
Implement service changes that support 'Seamless Access' across the patient continuum to ensures the patient receives that right care at the right time.	▪ Agree the direction of travel for older person's health on the West Coast and begin implementation of the new model. ▪ Roll out the Flexible Integrated Rehabilitation Support Team (FIRST) model, to support people to remain in their own homes. ▪ Develop a Frail Older Person's patient pathway to better support the patient journey from referral point to discharge home. ▪ Link FIRST in with the Falls and Fracture Liaison Service.	✓ Buller Aged Care Model agreed Q1. ✓ Allied FIRST role in place Q1. ✓ Frail Older Person's Patient pathway implemented Q3. ✓ >25 FIRST clients seen in the community Q4.
	▪ Implement the mental health workstream plan to support the development of locality based mental health services, closely integrated with general practice.	✓ Specialist mental health services integrated into IFHC model in Buller Q4.
Support implementation of the Integrated Performance and Incentive Framework (IPIF) and achievement against key system level measures in line with the national direction.	▪ Continue to work closely with the PHO and primary practices on improving system transformation and achieving national expectations around the delivery of high quality primary care: ▪ Provide active clinical leadership via the PHO Clinical Manager. ▪ Enable system oversight through the Healthy West Coast Alliance. ▪ Continue to support the use of tools that support and remind staff to capture and record activity and risk information. ▪ Provide regular reporting to practices and ALT around IPIF targets.	✓ Quarterly monitoring and reporting on performance against the national IPIF targets. ✓ Continued improvement and achievement against the national IPIF targets.

6.2 Primary care

The current model of care is neither clinically or financially sustainable. There is a shortage of health professionals across the West Coast, 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 enables the development of responsive service models.

The reorientation of our health system will be primarily driven under the West Coast Alliance through its Grey/Westland, Buller, Older Person's Health, Mental 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 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 more integrated health teams, we will not achieve the population outcomes we are seeking.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Improve the continuity of care provided to patients across the Coast	▪ Develop a team based approach to patient care in general practices providing improved access and continuity of care. ▪ Support CCCN and general practice to develop a single patient care plan for complex patients. ▪ Support Kaupapa Māori Nurses to work alongside general practice and secondary care to improve outcomes for Māori.	✓ Team based approach trialled in one DHB owned general practice Q4. ✓ Single patient care plan for complex patients in place Q4.
Prepare Greymouth practices to work in a single location at the new Grey IFHC.	▪ Form a team that includes the three Greymouth practices, ED and specialist outpatients to develop and implement consistent practices around recalls. ▪ Develop a consistent process across the three Greymouth practices for handling unplanned and acute care during working hours.	✓ Systems and processes for unplanned care across all Greymouth practices are the same Q3.
Prepare Buller Health to work as a single team at the new Buller IFHC.	▪ Ongoing development of models of care in preparation for the move to the new Buller IFHC. ▪ Develop a consistent process for handling patient's presentations for planned, unplanned and acute care.	✓ Updated systems and processes agreed Q2.
Provide greater access to care for patients, closer to their home.	▪ Support implementation of zero general practice and pharmacy fees for children under 13 to ensure appropriate access to care. ▪ Provide a two monthly report on average travel times for patients and reasons for travel to identify key causes of travel and implement a monthly review and action plan to address causes. ▪ Develop and implement a communications plan to encourage specialists and other health professionals to use telehealth over asking patients to travel. ▪ Support the Rural Service Level Alliance to continue to monitor the sustainability of rural practices on the West Coast and review the rural funding to ensure key issues are addressed. ▪ Develop a model of working in primary care that allows greater patient access through extended primary care hours (>9-5pm). ▪ Increase use of telehealth for specialist appointments for all Buller patients to reduce travel requirements and provide services closer to home. ▪ Provide planned nurse led care clinics, for LTC patients	✓ 100% of children <13 have access to free afterhours GP care. ✓ Plan for extended primary care hours implemented Q2. ✓ Rural SLA to meet to review rural funding Q3. ✓ Rural funding allocated agreed and distributed Q1 2016. ✓ Increased use of telehealth - base 2,717 sessions. ✓ Rate of acute medical admissions <5,800 per 100,000. ✓ Rate of avoidable hospital admissions maintained at or below current rates.

6.3 Disease prevention

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 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Improve the capability of the West Coast Health System to address the broader health determinants	▪ Develop a training programme for health care workers across the system to improve knowledge of inequities in health and promote ideas to reduce these at services level. ▪ Continue to hold the annual Healthy West Coast staff hui for all involved in the public health interventions. ▪ Engage local council, community groups and non-government agencies in discussions to address improvements to housing stock, warm home and social isolation issues for older people.	✓ Training developed Q1. ✓ Annual Healthy West Coast staff hui held for all staff working in public health interventions Q4.
Increase the support available for mothers to breastfeed and to breastfeed for longer periods.	▪ Work with the Pregnancy and Parenting Education (PPE) provider to ensure breastfeeding education is included in all courses. ▪ Take on board learnings from the Mana Tamariki Mana Mokopuna project to inform a change in approach regarding breastfeeding advice for Māori pregnant women and Whānau. ▪ Implement the West Coast Breastfeeding Priority Plan, including strengthening referral pathways between maternity and community breastfeeding services.	✓ 100 lactation support and specialist advice consults provided in the community Q4. ✓ 75% of babies are exclusively / fully breastfed at LMC discharge Q4. ✓ 60% of babies are exclusively / fully breastfed at 3 months Q4. ✓ 65% of babies are receiving breast milk at 6 months Q4.
Increase accessibility and awareness of public health interventions that focus on healthy eating and physical activity.	▪ Collaborate through the Health West Coast Alliance to develop a whole of system plan identifying actions to focus on nutrition and physical activity. This will include the development of West Coast Health System wide Nutrition Policy. ▪ Identify actions to target healthy nutrition and increased physical activity for our child and youth populations. ▪ Continue to deliver community nutrition courses including Appetite for Life, Senior Chef and Cooking Skills for Life Skills. ▪ Develop the capacity within the West Coast system to provide individual nutritional advice to patients at risk of developing CVD and/or diabetes. ▪ Work with the Community Dental Service to develop an Oral Health Promotion Plan to support healthy nutrition in early childhood and adolescence.	✓ West Coast Health System Nutrition Policy developed and implemented Q2. ✓ >5 community nutrition courses delivered - 2 alongside Te Whare Oranga Pai Q4. ✓ >500 GRx referrals made Q4. ✓ >90% of GRx participants self-report 'Feel more confident when making food choices' at completion of a nutrition course Q4.
Reduce the harm caused by alcohol.	▪ Progress the development of a West Coast DHB Alcohol Harm Reduction Strategy. ▪ Continue to engage with local councils to encourage development of Local Alcohol Policies. ▪ Continue to link with the South Island Alliance regarding the development of the project to improve data quality relating to Alcohol involvement in ED admissions. ▪ Continue to conduct alcohol controlled purchase operations (CPOs) to reduce the supply of liquor to minors.	✓ Quarterly reporting on alcohol related admissions. ✓ Quarterly reporting on alcohol consumption as recorded through primary care. ✓ >3 monitoring visits per year to high-risk premises Q4 ✓ WCDHB Alcohol Reduction Strategy developed Q4.

OUR PERFORMANCE STORY 2015/16		
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	▪ Update the current 2014-2017 West Coast Tobacco Control Plan. ▪ Continue to implement key priorities and initiatives from the West Coast Tobacco Control Plan to support less than 5% of the West Coast DHB's population being a current smoker by 2025. ▪ Through the West Coast Tobacco Free Coalition continue to work with district councils to maximise the effectiveness and awareness of smokefree environments and policy.	✓ West Coast Tobacco Control Plan updated Q1 ✓ Mechanism for review of local council smokefree policies confirmed Q1. ✓ 3 CPOs carried out Q4. ✓ Increase in the number of year 10 students who have 'never smoked' – base 73%.
Support delivery and sustainability of the 'better help for smokers to quit' health targets.	▪ Regular audit of LMC booking forms for progress against the maternity target. ▪ Continue to circulate monthly practice performance reports to the practice teams to support continue progress towards the target. ▪ Quarterly communication regarding smokefree in the CE Update (and profiling champions) to raise awareness and encourage performance. ▪ Continue to circulate monthly ward performance reports to support Smokefree Health target activities and identify patients who have not been coded.	✓ 90% of pregnant women (who identify as smokers at confirmation of pregnancy with a LMC) are offered advice or support to quit smoking. ✓ 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. ✓ 95% of hospitalised smokers are offered brief advice and support to quit smoking.
Improve access into community cessation services for Māori who smoke.	▪ Take on board learnings from the Mana Tamariki Mana Mokopuna programme to inform a change in approach regarding smoking cessation for Māori pregnant women and Whānau. ▪ Implement the Māori Smoking Cessation Plan to increase the number of Māori smokers accessing cessation services. ▪ Continue with the Aukati Kai Paipa smoking cessation programme.	✓ 100% of Māori Provider staff are trained to deliver an effective ABC intervention Q4. ✓ Increased proportion of total smoking cessation enrolments that are Māori – base 16%. ✓ ≥ 100 people enrolled in Aukati Kai Paipa smoking programme.

6. 4 Long-term conditions management

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 improving the quality of people's lives while at the same time reducing unnecessary demand on the health system.

OUR PERFORMANCE STORY 2015/16		
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 contact with people due for LTCM review. ▪ Install LTCM as part of Patient Dashboard IT tool to identify eligible patients for LTCM enrolment and support utilisation of the tool to manage patients with LTC. ▪ Identify and include people with long term mental health issues as part of the structured LTCM programme.	✓ LTCM included in Patient Dashboard Q1. ✓ Six monthly reporting on avoidable hospital admission rates Q2, Q4. ✓ >2,000 people enrolled in the LTCM Programme Q4.
Ensure clinical and consumer leadership supports long-term conditions management.	▪ Maintain the Local Diabetes Team (including consumer input) to provide cross-system oversight of diabetes service delivery. ▪ Continue to engage General Practice Quality Improvement Teams to support delivery of the LTCM Programme. ▪ Include meaningful, practice specific, performance data in practice Quality Initiative reporting, supported by advocacy messages targeting clinicians ▪ Review current service delivery against the 20 Quality Standards for Diabetes Care and implement recommendations for change.	✓ Quarterly circulation of LTC Quality Initiative reports. ✓ Stocktake against 20 Quality Standards complete Q1. ✓ >650 localised West Coast HealthPathways in place Q4.
Empower people to modify lifestyles, self-manage their condition through provision of the LTCM programme.	▪ Continue the delivery of the LTCM Programme including provision of annual clinical reviews for 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 a LTCM programme assessment including: cholesterol; smoking; retinal screening; kidney medications and good diabetes control. ▪ Enhance reporting mechanisms to report reduction in proportion of patients with HbA1c above 80 and 100 in addition to over 64. ▪ Provide quarterly optimised retinal screening clinics—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. ▪ Continue to encourage the use of self-management tools to support people to better manage their own health. ▪ Support Clinical Nurse Specialist direct involvement with practice teams to manage LTCM patients and support self-management. ▪ Provide links into the FIRST rapid response and supported discharge service to provide community support services to people living with long-term conditions in the community.	✓ Quarterly reporting on LTCM indicators for review by the Local Diabetes Team. ✓ Increased number of Māori enrolled in the LTCM Programme - base 174. ✓ 90% 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 2 years. ✓ Rate of acute medical admissions <5,800 per 100,000. ✓ Rate of avoidable hospital admissions maintained at or below current rates.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Increase the capability and capacity of Health Professionals in the delivery of Long Term Conditions Management.	▪ Support general practice in the provision of care for 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 increased case liaison between general practice clinicians and the CCCN to promote the integration of community nursing with primary care nursing and the development of the Health Care Home model for complex LTCM patients.	✓ >2,000 people enrolled in the LTCM Programme Q4. ✓ Increased number of Māori enrolled in the LTCM Programme - base 174.
Continued support for the use of specific strategies to increase the delivery of CVD Risk Assessments in general practice.	▪ Continue to support and provide training for Quality Improvement Champions in general practice to support the 'More Heart & Diabetes Checks' health target. ▪ Complete implementation of Patient Dashboards, Appointment Scanners and Query Builders to support identification of eligible population and to prompt CVD Risk Assessments (CVDRAs). ▪ Continue to provide practice specific target performance data in the Primary Bulletin supported by advocacy messages targeting clinicians to support delivery of CVDRAs. ▪ Continue to support practice visits by the PHO, GP and nurse facilitators to support practices with using and reviewing performance data and developing quality improvement plans. ▪ Continue to engage the Heart Foundation in providing training and education in primary care practices focused on delivery of the primary care health target and promotion of healthy lifestyle choices. ▪ Undertake quarterly meetings between the PHO and DHB to review progress against the health target and identify opportunities to build on the investment being made in LTCM. ▪ Provide quarterly updates to the West Coast Health Alliance to monitor progress against the CVDRA and Smoking Health Targets and identify gaps or barriers to success.	✓ Quarterly circulation of Primary Bulletin and progress against health target. ✓ Education/training planned Q1. ✓ Heart Foundation training delivered across all practices Q4. ✓ Quarterly progress towards 90% of the eligible adult population having had their cardiovascular disease risk assessed in the last 5 years. ✓ Increased percentage of eligible Māori population have had their cardiovascular disease risk assessed in the last 5 years.

6.5 Child and maternal health

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.

With an active West Coast Child and 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. Improving health outcomes for newborns and mothers is another vital part of this picture.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue to improve the consistency and quality of services for mothers and their babies.	▪ Support the development of a Transalpine Leadership and Governance framework for maternity services on the West Coast. ▪ Continue to deliver the Maternity Quality and Safety Programme and support the joint Canterbury/West Coast Maternity Governance Group to monitor performance against NZ Maternity Clinical Indicators. ▪ Complete implementation of the national guideline for the screening, diagnosis and management of gestational diabetes ▪ Implement the national maternity Clinical Information system (Badgernet) to improve information and data collection. ▪ Develop and implement consistent processes for the safe transfer of pregnant women in need of urgent maternity care between Westport and Greymouth. ▪ Monitor the new primary care maternity model to ensure viability and sustainability across the West Coast.	✓ National gestational diabetes guidelines in place Q1. ✓ Leadership and governance Framework defined Q2. ✓ National Maternity Clinical Badgernet in place and linked to National Immunisation Register Q3. ✓ Guidelines for safe transfer are developed and endorsed by the Canterbury/West Coast Maternity Governance Group. ✓ Audit of transfer process Q4. ✓ 95% of pregnant women receive continuity of primary maternity care Q4.
Continue to implement strategies to Increase the proportion of women registering with LMCs in the first trimester.	▪ Develop and implement a communications plan to inform the community about the change to midwifery model of care to increase choice and continuity of care. ▪ Continue to encourage women to register with an LMC of their choice through the 'Find your midwife' website and to register with a midwife as soon as they are pregnant. ▪ Feed information, including ethnicity data for late registration, into Mana Tamariki Mana Mokopuna project to identify opportunities to inform a change in approach	✓ Communications Plan developed Q1. ✓ Implementation begun Q2. ✓ 80% of women register with an LMC by week 12 of their pregnancy.
Enhance pregnancy and parenting programmes to better meet the needs of Māori and younger women.	▪ Using the results of the 2015 Review, identify the appropriate model for delivery of Pregnancy and Parenting Education on the West Coast which ensures the needs of Māori, Pacific and younger women are met as well as those living in our most remote areas. ▪ Support Mana Tamariki – Mana Mokopuna project to research the needs of young Māori mothers and their Whānau then provide recommendations on service change.	✓ Pregnancy and parenting model agreed Q2. ✓ Mana Tamariki action plan developed by Q4. ✓ 30% of Māori, Pacific and teen pregnant women complete DHB funded pregnancy and parenting education.
Improve timely newborn multi-enrolment with health services.	▪ Continue to monitor and review the use of the Newborn Multiple Enrolment form to encourage use and implement necessary improvements. ▪ Share enrolment rates with the Child & Youth Health Workstream to highlight gaps and identify opportunities to increase rates.	✓ 95% of newborns enrolled on the NIR at birth. ✓ 98% of newborns enrolled with PHO, WCTO, and Community Oral Health Services by 3 months of age.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Improve West Coast performance against the Well Child Tamariki Ora Quality Improvement Framework and improve B4 School Check (B4SC) coverage.	▪ Work with Well Child Tamariki Ora (WCTO) providers to develop an integrated service model, which meets the needs of all families/Whānau across the Coast. ▪ Work with WCTO providers to implement actions that support improved performance against the WCTO Quality Improvement Framework where West Coast performance is below average. ▪ Link in regionally to access support from the Regional WCTO Quality Improvement Coordinator. ▪ Continue to monitor access and referral patterns for B4 Schools Checks to identify opportunities to improve delivery and coverage.	✓ Action plan developed for each WCTO indicator Q1. ✓ Detailed WCTO Service model agreed Q2. ✓ Implementation underway Q3. ✓ 90% of four year olds receive a B4 School Check Q4. ✓ 90% of children living in high deprivation areas receive B4 School Checks Q4.
Improve and the clinical sustainability of oral health service provision across the West Coast	▪ Support the implementation of the Transalpine service model for West Coast Community Dental Service with oversight from the Oral Health Steering Group. ▪ Working through the Health West Coast Alliance, encourage a collaborative approach to oral health promotion.	✓ Framework for Transalpine operational and clinical leadership developed Q1. ✓ Leadership framework in place Q2.
Work with the regional Child and Youth Health Alliance to develop a regional approach to the management of childhood obesity.	▪ Support the development of consistent protocols and intervention guidelines for managing the treatment of child obesity. ▪ Supported enhanced collaboration with child dental services to support the regional obesity approach. ▪ Share learning from the Health Families initiative in Canterbury and Invercargill and identify opportunities for the Coast.	✓ Activity participation in the regional Public Health Workstream Q1. ✓ Common protocols and guidelines agreed Q3.

6.6 Older people's health

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. While living in aged residential care is appropriate for a small proportion of our population, evidence shows a higher level of satisfaction and better long-term outcomes where people remain in the r own homes and positively connected to their communities.

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 and supports the delivery of the right services, in the right place at the right time. Under the CCCN delivery model, client's needs are comprehensively assessed and an individual goal-based restorative 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 the patients general practice team.

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. 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 aged care) and in their own homes for longer.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Ensure older people receive a comprehensive clinical assessment of their need.	▪ Continue to support and monitor the use of the InterRAI Geriatric Assessment tool across community, specialist and ARC services to inform the development of an integrated care plan for clients. ▪ Instigate monitoring of timeframes from referral to completion of assessment for clients receiving home and community support services (HCSS). ▪ Continue to ensure ARC providers are trained or engaged in the use of InterRAI and support them to undertake 2nd assessments using the InterRAI Long term Care Facility (LTCF) module within 230 days of admission. ▪ Monitor the utilisation of long-term Home and Community Support Services (HCSS) and ARC and compare trends regionally.	✓ Quarterly monitoring of HCSS and in ARC utilisation and comparison of performance with other DHBs. ✓ Baseline established for time from referral to assessment Q4. ✓ >95% of long-term HCSS clients have an InterRAI assessment and a care plan in place. ✓ >95% of people entering ARC have an InterRAI assessment.
Continue to invest in the Complex Clinical Care Network (CCCN) as the single point of referral and to consolidate and refine wrap around services for older people.	▪ Work alongside home based providers to transfer and implement the national in-between travel settlement. ▪ Work alongside home based providers to establish teams of support workers that have regularised and guaranteed hours. ▪ Support increased collaboration between all participants in the delivery of wrap-around services for older people—including specialist and allied health services, primary care and community services providers. ▪ Continue to invest in the CCCN Team to support the delivery of quality services for older people and the provision of specialist support, advice and training to health professionals in residential, primary and community settings. ▪ Continue to manage complex clients in a proactive manner and prevent gaps in the community service response. ▪ Review the Frail Older Person's pathway from referral point to discharge home to identify opportunities for improvement. ▪ Continue to monitor key programme utilisation and outcome metrics as a means of improving the targeting of services across the system and ensuing high quality service provision.	✓ Travel Settlement Working Group established Q1. ✓ Allocation of travel funding rolled out in conjunction with MOH expectations. ✓ Bi-monthly clinical review meetings with HCSS, general practice and CCCN. ✓ CCCN educational sessions provided to primary, secondary and aged residential care Q2. ✓ Frail Older Person' Pathway implemented Q3. ✓ Rate of acute medical admissions <5,800 per 100,000.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue to develop and improve the dementia care pathway on the West Coast	▪ Continue to revise the Cognitive Impairment Pathway and implement the regional earlier diagnosis framework to identify older isolated adults. ▪ Establish a baseline for the number of people referred to Alzheimers Canterbury for support and education ▪ Support the introduction of regional training for primary care health professionals on "how to break bad news". ▪ Continue to support access to Walking in Another's Shoes (WIAS) dementia training. ▪ Maintain existing relationships with the South Island Alliance and identify opportunities to improve dementia.	✓ Cognitive Impairment Pathway in place Q1. ✓ Baseline data for Alzheimers referrals established Q2. ✓ Regional training material developed Q3. ✓ Increased number of carers completing the WIAS training – base 35. [18]
Continue the development and expansion of targeted specialised services to support older people in their own homes.	▪ Establish Falls Champion and Fracture Liaison Nurse role. ▪ Complete full implementation of the Fracture Liaison and Falls Champion Service for the West Coast. ▪ Establish key metrics to evaluate the number of people who are seen by the Fracture and Falls Service, the treatment they receive and the outcomes including ED and hospital admissions. ▪ Continue to promote zero harm from falls in ARC settings and support the Vitamin D Programme.	✓ Fracture and Falls Pathways operational Q2. ✓ Quarterly reporting on service utilisation and treatment Q3. ✓ >25 people seen by falls champion service Q4. ✓ 75% of ARC residents receive Vitamin D supplements Q4.
	▪ Engage Allied Health providers in the delivery of the Flexible Integrated Rehabilitation Support Team (FIRST) service. ▪ Action recommended improvements to the services model (following review of pathway in 2014/15) and complete full service implementation. ▪ Establish three geographical locality teams to support the delivery of FIRST care plans and the restorative model.	✓ Allied FIRST role in place Q1. ✓ Quarterly report on service utilisation and outcomes Q1. ✓ >25 people referred to FIRST Q4. ✓ Acute readmission rate for people 75+ maintained at or below current rates. [19]
Continues to provide an organised stroke service for people admitted to hospital following a stroke.	▪ Continue to engage clinical staff in the delivery of an organised stroke service as recommended in the NZ Clinical Guidelines for Stroke Management. ▪ Work alongside the regional stroke network to facilitate learnings and implement actions to support the West Coast stroke service.	✓ Quarterly regional network meetings monitor progress in meeting guidelines. ✓ 6% of potentially eligible stroke patients thrombolysed. ✓ 80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.
	▪ Continue to support the lead clinicians (designated to stroke) to champion best practice, change and education. ▪ Expand the lead stroke nurse role to 0.5 FTE to increase the focus on the development of stroke pathways and the support provided to community and primary care providers.	
	▪ Support the development of stroke thrombolysis quality assurance procedures, including processes for staff training and audit to ensure all eligible patients have access to thrombolysis.	
	▪ Enable the collection of baseline data along the stroke pathway to establish baselines for transfer of patients to inpatient and community based rehabilitation and subsequent assessments.	

[18] *There has been a drop in the number of people completing WIAS training in 2014/15 due to a delay in recruiting a replacement trainer. The baseline presented is essentially for 6 months of the 2014/15 year.*

[19] *This measure is a national performance indicator (OS8). The Ministry of Health is reviewing the definition for this measure and target setting has been delayed for 2015/16 while the definition is reset. The DHB has elected to present the unstandardised or 'raw' rates as these are easier to replicate and match against admissions internally and therefore enable closer analysis of performance.*

6.7 Mental health

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 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 has been established under the umbrella of the West Coast District Alliance and representatives from across primary care, non-government organisations and specialist services are engaged in the Group along with consumers—collaboratively engaged in driving the change needed across the system.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue to Implement prioritised actions from the West Coast Mental Health Services Review.	▪ Progress establishment of locality based services that support improved integration between primary, non-government community and secondary services. ▪ Progress the stepped care continuum model to better focus resources and improve the way we work. ▪ Continue to increase access to Brief Intervention Counselling (BIC) across the age continuum. ▪ Increase the options for people with AOD problems within primary care and community environments.	✓ Eligibility criteria agreed by Q2. ✓ Respite/residential arrangements agreed Q2. ✓ Opioid Substitution Treatment working group established Q2. ✓ Revised model for CAMHS implemented Q4. ✓ >400 BIC provided in primary care. ✓ 80% of people referred for non-urgent services are seen within 3 weeks. ✓ 95% of people referred for non-urgent services are seen within 8 weeks. ✓ Specialist Mental Health Service access rates maintained above 3.8%.
	▪ 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. ▪ Reconfigure the current range of respite and residential supports available across the community to maximise opportunities to improve coordination, access and consumer responsiveness. ▪ Working group established to progress shared care planning for people engaged in Opioid Substitution Treatment.	
	▪ Review the operation of CAMHS within locality based services in the context of the IFHS model.	
	▪ Support collaboration with Kaupapa Māori Services, primary care and specialist services to strengthen responsiveness to Māori. ▪ Identify key areas of opportunity to extend the scope of support for Māori consumers, including in primary care settings.	✓ Working group established to progress support for Māori consumers Q2. ✓ Sensory modulation programme in place Q1. ✓ Increased KPP consumer enrolment in primary care Q4. ✓ 90% of seclusion event reviews include client feedback Q4.
	▪ Maintain a focus on the sensory modulation programme. ▪ Improve the physical health of people with mental health and addictions by working within or alongside primary care. ▪ Enhance social inclusion opportunities to increase resilience by increasing social networking and peer support options.	
	▪ Review the functionality of the Mental Health Solution in the context of integration with primary care to streamline information collection and improve the quality of data extracts to better inform future planning. ▪ Establish headline indicators and KPIs for monitoring progress.	✓ Key steps agreed for improving functionality of the Mental Health Solutions Q1. ✓ Headline indicators and KPIs routinely reported Q2.

OUR PERFORMANCE STORY 2015/16		
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.	▪ With oversight of the cross-sector Suicide Prevention Clinical Governance and Action Group implement the whole of system suicide prevention and postvention plan. [20] ▪ Continue to provide leadership in identifying high-risk situations or cluster(s) and preparing cross-agency evidence based responses. ▪ In collaboration with Canterbury DHB develop a series of evidence based initiatives and responses in alignment with the National Suicide Prevention Strategy. ▪ Continue to implement prevention screening tools and training for staff to better identify and support people at risk. ▪ 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. [21] ▪ Continue to support the Fresh Start Programme. [22]	✓ Whole of System Suicide Prevention Postvention Plan in place Q1. ✓ Vocational services routinely attend discharge planning reviews Q2. ✓ Increased number of clients supported into employment or education – base 67%.
Work with the Canterbury DHB and the Regional Mental Health Alliance to support the delivery of specialist services.	▪ Formalise the Transalpine Mental Health Leadership 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 use of transalpine expertise. ▪ Work with the Ministry of Health to implement the Children of Parents with Mental Illness of Addictions (COPMIA) Guidelines as they are released.	✓ Transalpine Mental Health Leadership established Q1. ✓ Buller IFHS making use of transalpine expertise via technology by Q2. ✓ National COPMIA Guidelines anticipated release June 2015.

[20] *West Coast's Suicide Prevention and Postvention Plan will be agreed and submitted to the Ministry of Health by July 1015.*
[21] *This measure refers to the Te Ara Mahi vocational programme.*
[22] *Fresh Start is a Programme led by the Ministry of Social Development that includes the ability for courts to refer youth to AOD services.*

PATIENT-FOCUSED HEALTH SERVICES

6.8 Improved access to diagnostic services

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 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
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 develop and maintain HealthPathways to support appropriate referrals. ▪ 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. [23] ▪ Continue to participate in the national radiology service improvement initiative and regional diagnostic service improvement programmes, focused on the development of diagnostics and implement agreed system changes.	✓ Regular monitoring of diagnostic waiting times Q1. ✓ >650 Healthpathways Q4. ✓ Phase II of the National Patient Flow Project completed Q4. ✓ 95% of accepted referrals for CT scans receive their scan within six weeks Q4. ✓ 85% of accepted referrals for MRI scans receive their scan within six weeks Q4.
	▪ 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 Programme (NEQIP) 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 2 weeks Q4. ✓ 65% of people accepted for non-urgent diagnostic colonoscopy wait no longer than six weeks Q4. ✓ 65% of people scheduled for a surveillance/follow-up colonoscopy wait no longer than 12 weeks beyond plan Q4.

[23] *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. 9 Shorter stays in emergency departments

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. In this sense, the national shorter stays in emergency departments health target is 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 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue to Implement early intervention strategies to support people in the community and reduce ED presentations	▪ Continue and support the use of HealthPathways to improve the referral and management of patients. ▪ Maintain the HML telephone triage service to support access to primary care for unplanned presentations. ▪ Support implementation of zero general practice and pharmacy fees for children under 13 to ensure appropriate access to care. ▪ Continue to support the development of individualised care plan across general practice and mental health services to reduce the need for acute interventions. ▪ Continue to support the Red Cross van service between Greymouth and Westport to improve access to health care.	✓ 100% of children under 13 have access to free afterhours GP care Q1. ✓ >650 localised West Coast HealthPathways in place by Q4. ✓ Six monthly reporting on avoidable hospital admission rates Q2, Q4. ✓ Rate of acute medical admissions <5,800 per 100,000.
Maintain performance against the national health target – shorter stays in the emergency department	▪ Continue to closely monitor ED waiting times and respond to any identified factors impacting on length of stay. ▪ Maintain current performance against the ED health target. ▪ Maintain triage 4 and 5 processes where patients brought in by Ambulance go to the main reception rather than directly into ED. ▪ Continue to explore and determine new models of care and service delivery for urgent care as part of the rebuild of Grey Hospital and the Grey/Westland and Buller IFHCs. ▪ Complete implementation of the national ED Quality Framework and continue to monitor performance against the associated Quality Measures and the two locally identified measures. ▪ Identify opportunities to share performance against ED Measures with Alliance Leadership Team and Quality Team	✓ Monthly review of ED Quality Measures. ✓ Quarterly reporting against national health target results. ✓ ED metrics incorporated into ALT reporting Q3. ✓ 95% of people are admitted, discharged, or transferred from ED within 6 hours.
Increase the use of telemedicine between Buller and Grey Base Hospitals.	▪ Continue to use telemedicine in the emergency department and increase the use of video conferencing between the Buller and Grey Based teams. ▪ Implement a coordinated approach to answering video linked calls with the Canterbury DHB to improve the response to calls.	✓ 10% increase in the use of video conferencing - Base 2,717 sessions.
Continue to invest in support services to support patients on discharge from hospital.	▪ Continue to work with primary care and allied health to complete implementation of the Integrated Rehabilitation Service Team 'FIRST' rapid response and supported discharge service.	✓ >25 admissions into FIRST Q4. ✓ Acute readmission rate maintained at or below current rates.[24]

[24] *This measure is a national performance indicator (OS8). The Ministry of Health is reviewing the definition for this measure and target setting has been delayed for 2015/16 while the definition is reset. The DHB has elected to present the unstandardised or 'raw' rates, as these are easier to replicate and match against admissions internally and therefore enable closer analysis of performance.*

6.10 Improved access to elective services

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 2015/16		
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 standard intervention rates are not significantly below national rates. ▪ 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. ▪ Trial the introduction of ENT Surgery at Grey Base Hospital.	✓ 1,889 elective surgical discharges delivered Q4. ✓ ENT Surgery underway Q1. ✓ 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 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. ▪ Work with primary care and allied health to complete implementation of the 'FIRST' rapid response and supported discharge service to improve patient flow. ▪ Complete implementation of Phase II of the new National Patient Flow System, including adapting local data collection to allow reporting to the national system and begin Phase III.	✓ 100% of patients wait no more than 4 months for First Specialist Assessment (FSA) or treatment. ✓ >650 West Coast HealthPathways in place Q4. ✓ >5% FSA are non-contact Q4. ✓ Phase II of the National Patient Flow Project completed Q4. ✓ Average elective surgical inpatient length of stay maintained at or below 1.59 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.	▪ Continue commitment to the regional Major Trauma Workstream and support of the action plan including implementation of a Major Trauma Register and submission of appropriate data. ▪ Work in partnership with Canterbury (as our regional provider) to implement the NZ Spinal Cord Impairment Action Plan 2014-2019 and agreed referral processes for acute spinal cord injuries. ▪ Continue to collaborate with St John and Canterbury/West Coast Emergency Care Coordination Team (ECCT) to implement the Roadside to Bedside destination plan and to incorporate agreed spinal cord impairment destination and referrals pathways.	✓ Regional trauma transport and transfers policies agreed Q2. ✓ Trauma Registry in place Q4. ✓ Spinal Cord Impairment Guidelines disseminated Q4.

6.11 Improved access to cardiac services

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.

As the DHB does not provide highly specialised cardiac services West Coast, 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. The DHB continues to actively engage in the South Island regional cardiac work and specialist cardiology services are provided on a visiting basis from Canterbury DHB. These are supported by the Clinical Nurse Specialist based on the West Coast and bi-monthly telehealth clinics.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Improve patient pathway mapping and service coordination to facilitate timely and appropriate referral and treatment for cardiac patients.	▪ Continue to support the use of HealthPathways to improve access to diagnostics and facilitate appropriate treatment referrals, including: angiography, echocardiograms, and exercise tolerance tests. ▪ Work with Canterbury DHB and the Regional Cardiac Alliance Workstream to continue to support specialist service delivery for West Coast Patients and ensure equity of access. ▪ Monitor cardiac service provision and engage with Canterbury DHB, as the regional provider, to ensure cardiac intervention rates for West Coast patients are not significantly below national rates. ▪ Monitor wait times for cardiac services, so that patients wait no longer than 4 months for first specialist assessment or treatment. ▪ Engage with Canterbury DHB as the regional provider to resolve any issues around intervention rates or waiting times.	✓ 29 cardiac surgical discharges delivered Q4. ✓ 100% of patients wait no longer than four months for first specialist assessment or treatment. ✓ Standardised cardiac intervention rates maintained: [25] ▪ Cardiac surgery: 6.5 ▪ Percutaneous revascularisation: 12.5 ▪ Coronary angiography: 34.7
Improve patient pathway mapping and service coordination to facilitate timely and appropriate referral and treatment for patients with Acute Coronary Syndrome (ACS).	▪ Maintain the ACS pathway and implement regionally agreed processes and protocols to support local risk stratification and the appropriate transfer of ACS patients. ▪ Monitor waiting times for elective coronary angiography and engage with Canterbury DHB (as the regional provider) to resolve any issues around patient transfers and waiting times. ▪ Continue to contribute data to the national Cardiac ANZACS-QI and Surgical Register to enable reporting measures of ACS risk stratification and time to appropriate intervention.	✓ 70% of patients receive an angiogram within 3 days of admission. ✓ 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days. ✓ 95% of patients undergoing cardiac surgery have completion of Cardiac Surgery registry data collection within 30 days of discharge.
Participate in the South Island Alliance Cardiac Workstream to align cardiac service activity across the South Island.	▪ Participate in a review of the regional guidelines for the arranged transportation of cardiac patients agreed in 2013. ▪ Participate in the regional approach to standardising education for registered nurses working with patients with a cardiac condition. ▪ Continue to support the regional implementation of the Accelerated Chest Pain Pathway in Emergency Departments. ▪ Work regionally to agree and implement initiatives to improve the management of patients with Heart Failure.	✓ Regional stocktake on cardiac training complete Q4. ✓ Transport guidelines reviewed and updated Q4. ✓ Common Accelerated Chest Pain Pathway embedded Q4. ✓ Localised HealthPathway on Heart Failure published once regionally agreed.

[25] *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.*

6.12 Faster cancer treatment

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 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Implement actions to provide Faster Cancer Treatment to reduce the impact and improve patient outcomes.	▪ Provide regular data to clinicians to assist them to identify and prioritise patients with a high suspicion of, or a confirmed cancer. ▪ Actively review waiting lists to ensure patients with a high suspicion of cancer and a need to be seen within two weeks are treated within 62 days of referral. ▪ Apply the principles of 'Equity of Health Care for Māori' to best deliver high-quality, equitable health care that meets the health care needs and aspirations of Māori. ▪ Continue to improve the quality of data and data collection of patients with a high suspicion of cancer or a confirmed cancer to support improved care of these patients. ▪ Continue to work with Canterbury DHB (as regional provider to maintain referral pathways and ensure continuity of care for cancer patients. ▪ Continue to work with Canterbury to improve the accuracy of data collection to support continued monitoring and achievement of waiting times for radiation and chemotherapy treatments. ▪ Continue to support ongoing nurse education and training, including nursing certification for chemotherapy regime delivery in the acute ward; PICC line competencies in community nursing; and education of staff on the Faster Cancer Track. ▪ Improve the functionality and coverage of multidisciplinary meetings (MDMs) by implementing the regionally agreed MDM priorities. ▪ Identify and progress priorities that will support the implementation of the national Cancer Health Information Strategy (anticipated release June 2015). ▪ Provide guidance to clinicians such as urologists and radiation oncologists on the use of active surveillance treatment for prostate cancer (anticipated release July 2015).	✓ Quarterly reporting on wait times for cancer treatment. ✓ Quarterly provision of FCT data to national collections and steady improvements in data quality. ✓ 100% of patients ready for treatment continue to wait less than 4 weeks for radiotherapy or chemotherapy Q1. ✓ 85% of patients referred with a high suspicion of cancer and a need to be seen within two weeks wait 62 days or less to receive their first treatment (or other management) Q4. ✓ Care pathways and MDM proformas include the guidance on the use of active surveillance treatment for prostate cancer Q4.
Participate in the Southern Cancer Network to support specialist service delivery	▪ Implement regional tumour standard review recommendation findings from 2013/14 and 2014/15. ▪ Support the regional approach to reviewing services against at least two national tumour standards including provision of data for evaluation. ▪ Support the development of the regional plan to deliver Supportive Care Services for cancer patients and identify priorities that will support implementation on the West Coast.	✓ Regional tumour recommendations implemented as released. ✓ Regional Support Care Services Plan endorsed Q1.

BETTER PUBLIC HEALTH SERVICES

6.13 Increasing immunisation rates

Improved immunisation coverage leads to reduce rates of vaccine preventable disease and better health and independence for children, who will be enrolled with primary care and visiting their primary care provider on the regular basis. West Coast has a clinically-led cross sector Immunisation Advisory Group whose members provide collective oversight of service deliver and identity opportunities to improve immunisation rates.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Increase immunisation rates to reduce vaccine preventable disease and improve health and wellbeing.[26]	▪ Maintain the West Coast Immunisation Advisory Group with clinical leadership across the system to provide oversight of immunisation service delivery and performance. ▪ Work alongside Child Youth and Family, Ministry of Social Development and other relevant social service agencies and with the Canterbury Immunisation Service Level Alliance.	✓ West Coast is represented at national and regional forums. ✓ Immunisation information is widely available across the DHB.
	▪ Continue to support the New-Born-Enrolment process which promotes seamless handover between maternity, general practice and WCTO services and supports timely and multiple enrolments of new-borns with health services. ▪ Continue to support the National Immunisation Register (NIR) team to delivery timely reporting to follow up children with no nominated provider (unenrolled children).	✓ Quarterly immunisation performance reporting. ✓ 95% of all new-borns enrolled on the NIR at birth. ✓ 98% of all new-borns enrolled with a GP by 3months 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. ▪ Work with Outreach Immunisation Services to locate missing children and provide advice and immunisation. ▪ Maintain internal processes whereby the immunisation status of children presenting at hospital is identified and 'missed' children referred to general practice or outreach services.	✓ 85% of six weeks olds are fully immunised. ✓ 95% of eight month olds are fully immunised. ✓ 95% of two year olds are fully immunised. ✓ 90% of four year olds are fully immunised Q4.
	▪ Continue to 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.	✓ Narrative report on interagency activities for Immunisation Week.
	▪ Maintain a Human Papillomavirus (HPV) Programme in a school setting and promote HPV vaccinations for eligible young women. ▪ Work to implement and promote new national online learning tools to support the HPV programme as they are developed.	✓ 65% 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, provide and monitor free pertussis (whooping cough) vaccinations for pregnant women.	✓ 75% of people aged 65+ have a seasonal flu vaccination. ✓ Quarterly monitoring of Pertussis vaccinations.

[26] *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, which are unlikely to change. Nonetheless, we will use our best endeavours to reach the national target and continue to focus on immunising 100% of all those children whose parents consent to immunisation.*

6. 14 Reducing the incidence of Rheumatic Fever

Rheumatic fever is a serious but preventable illness that mainly affects Māori and Pacific children, and young people. While the symptoms of rheumatic fever may disappear on their own, the inflammation can cause rheumatic heart disease, where there is scarring of the heart valves, it can also be life threatening. The South Island has adopted a regional approach to reducing rheumatic fever and meeting national expectations.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Contribute to reducing the incidence of rheumatic fever by two thirds by June 2017.	▪ Support implementation of the Regional Rheumatic Fever Prevention Plan and align activity with the regional approach. ▪ Undertake a root-cause analysis on any new rheumatic fever cases on the West Coast and report on lessons learnt and action taken.	✓ Maintain low South Island rheumatic fever rates (<0.2 per 100,000 – 2 cases).

6.15 The Children's Action Plan

Far too many children suffer from assaults which can seriously diminish their life chances and, in the worst cases, result in death. Maltreatment in childhood can also have significant enduring effects on a child's development, and health and wellbeing in later life. By working together with community providers, primary care partners and other government agencies the implementation of the Children's Action Plan creates a real opportunity to make a difference to a vulnerable child's life.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Prepare a collaborative approach across services to meet the needs of vulnerable children and young people in line with the establishment of Children's Teams nationally.	▪ Support the Cross-Sector Child & Youth Alliance Workstream to oversee the establishment of a Children's Team response. ▪ Continue to review local pathways relating to children potentially at risk in line with the direction of the Children's Action Plan and development of West Coast Children's Teams. ▪ Support distribution of the key findings from Mana Tamariki Mana Mokopuna to inform pathways that support vulnerable Māori women, tamariki and their Whānau. ▪ Maintain the delivery of Gateway Assessments and monitor access and referral patterns to further develop the service.	✓ Pathways for vulnerable children and their families/Whānau are reviewed with community partners and are nationally consistent. ✓ Mana Tamariki-Mokopuna Report distributed Q3. ✓ 100% of children referred by CYF receive Gateway Assessments Q4.
Strengthen identification, risk assessment and intervention responses to reduce the number of Assaults on Children	▪ Support continual delivery and evaluation of the West Coast VIP programme by the VIP Steering Group. ▪ Continue to utilise eProsafe and the National Child Protection Alert System to support identification of children at risk. ▪ Continue to provide Ministry-accredited training for health professionals to recognise signs of abuse and maltreatment. ▪ Continue to implement the Child Injury Assessment Flow Chart in Primary Care and undertake quarterly audits to ensure compliance with agreed assessment and referral processes.	✓ eProsafe and Child Protection Alert System operational Q1. ✓ Monthly training provided and calendar confirmed Q1. ✓ Child Injury Assessment Forms implemented in all DHB owned practices Q2. ✓ Combined VIP 80/100 audit scores for the child & partner abuse components Q4.
Comply with statutory regulations in line with the Vulnerable Children's Act	▪ Support the development and implementation of plans and procedures to ensure the safety vetting of new core workers. ▪ Review the Recruitment Policy and HR Handbook for managers and update supporting documentation. ▪ Provide appropriate training to staff and line managers. ▪ Review contracts to ensure contracted service providers also have a Child Protection Policy in place.	✓ Review of documentation completed and policy on DHB website by Q1. ✓ Training completed Q1. ✓ All new core workers vetted in accordance with regulations Q1.

6. 16 The Prime Minister's Youth Mental Health Project

The expansion of access to primary mental health services alleviates the distress and suffering of young people and reduces the risk of long-term adult mental health and addiction problems. In line with the expectations of DHBs under the Prime Minister's Youth Mental Health Project; we will prioritise children and young people with the highest need and focus on strengthening relationships across the sector and between agencies to make a positive impact on the mental health and wellbeing of young people.

This work will be driven under the clinically-led, cross-sector Child and Youth Health and Mental Health Work Streams under our West Coast Alliance.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Maintain the provision of school based health services to support earlier identification of health issues.	▪ Maintain SBHS in all decile one to three secondary schools on the Coast and monitor the delivery of HEEADSSS assessments. ▪ Locally implement the "Youth Health Care in Secondary Schools: A framework for continuous quality improvement" and work with schools and public health nurses to develop a quality improvement plan at each school receiving this service.	✓ All SBHS schools have a quality improvement plan in place Q1. ✓ Increased delivery of HEEADSSS to Year 9 students – base 56%.
Raising awareness of wellbeing and encouraging young people to be well	▪ Support the Youth Health Action Group to consult with youth consumers regarding options for youth-specific services (similar to 'youth one-stop-shops'). ▪ Work with community groups to develop actions based on the recommendations of the West REAP commissioned "Girls of Concern" report. ▪ Identify and engage local youth groups in the design and layout for Coast youth health pages.	✓ Girls of Concern report actions implemented Q3. ✓ Webpages launched Q4. ✓ Preferred West Coast option for YOSS piloted Q4.
Develop an integrated and responsive stepped care model for youth mental health services aligned with the principles in 'Rising to the Challenge' and the recommendations of the West Coast Mental Health Review.	▪ Work with primary care providers to strengthen their responsiveness to youth through extending the provision of brief intervention counselling for young people 12 and over. ▪ Identify actions to improve engagement rates for Māori young (12-19) with mild to moderate mental health issues, earlier in the continuum.	✓ Actions identified to improve access rates by rangatahi Q2. ✓ An increased number of young people access Brief Intervention Counselling in primary care – base 65.
	▪ Support enhanced integration between Child and Maternal Health Service (CAMHS), Youth Alcohol and Other Drug (AOD), paediatric and primary mental health services to support the stepped care model. ▪ Support the Youth Health Action Group to formulate recommendations to better support the transition of youth to adult services based on established protocols from iCAMHS and Youth AOD services.	✓ Quarterly review of waiting time targets for CAMHS and Youth AOD services. ✓ Refined service model implemented Q4. ✓ 80% of young people access non-urgent services within 3 weeks.
	▪ Continue to refine the service model for CAMHS and Youth AOD Services (as part of the integrated locality based model being developed across the Coast) in order to increase capacity and reduce waiting times across the service. [27] ▪ Implement the National Transition Guidelines and monitor delivery to ensure planning and follow-up for young people discharged from CAMHS and Youth AOD services.	✓ 95% of young people access non-urgent services within 8 weeks. ✓ 95% of all long-term young (0-19) clients have current relapse prevention plans. ✓ 95% of CAMHS and Youth AOD clients have follow-up advice set out in discharged letters Q4.

[27] *These actions are linked to the development of the IFHC model in Grey/Westland and Buller.*

6. 17 Whānau Ora

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; 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.

With the introduction of the national Whānau Ora programme and the IFHC services model on the West Coast, opportunities exist to work more collaboratively with other agencies to reduce risk and environmental factors that have a negative impact, better engage Māori in health services and reduce inequalities in health outcomes. The DHB also has a specific Māori Health Action Plan for 2015/16 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.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
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.	▪ Initiate regular engagement with Te Pūtahitanga (the South island Whānau Ora commissioning agency) through South Island Māori GM network, Te Herenga Hauora. ▪ Work towards formalising collaboration between South Island DHBs and Te Pūtahitanga. ▪ Continue to participate in national processes and work with the Ministry of Health to obtain a broader sector view on Whānau Ora implementation and support information systems development.	✓ Regular engagement with Te Pūtahitanga Q1. ✓ Strategic Alliance Agreement in place with Te Pūtahitanga Q4.
	▪ Support the Te Waipounamu Whānau Ora collective by meeting regularly with the CEO and staff of He Oranga Pounamu (as lead agency) and Poutini Waiora (the local Whānau Ora provider) to discuss and plan how to strengthen Whānau ora initiatives on the West Coast. ▪ Engage the collective and Poutini Waiora in service planning and provide information and trend data for analysis for future planning including Census population projections. ▪ Support research and outcomes development by providing advice around outcomes based monitoring and evaluation frameworks that have proved successful in Alliance Workstreams. ▪ Communicate regularly with He Oranga Pounamu and Poutini Waiora including provision of information on service planning and reviews that may affect the provision of Whānau Ora services. ▪ Work with the collective to understand and articulate the desired outcomes for Whānau and better align provider contracts and service specifications to achieve those outcomes. ▪ Support the Māori appointment process (via He Oranga Pounamu) to enhance the capability of advisory boards and working groups to support Whānau Ora at a strategic and system level.	✓ Māori Health Plan in place Q1. ✓ Quality reporting against Māori Health Outcomes Q1. ✓ Updated Māori and Pacific Census Data distributed Q1. ✓ Regular engagement with Putahitanga, He Oranga Pounamu and Poutini Waiora. ✓ Service specification changes made to contracts in line with the development of Whānau Ora models Q4.
Support IFHC development work already occurring in the Grey and Buller regions to identify Whānau ora needs and aspirations and to assist in these coming to fruition.	▪ Work with Poutini Waiora, the West Coast PHO and general practice to review patient outcomes in line with the Whānau Ora Framework. ▪ 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.	✓ Increased number of West Coast participants on Kia Ora Hauora programme Q4. ✓ Increased PHO enrolment and disease prevention screening rates for Māori Q4.
	▪ Work through the West Coast Alliance to implement the actions agreed in the 2014/15 West Coast Māori Health Action Plan. ▪ Work with the West Coast PHO and Kaupapa Māori Health Teams to increase the number of Māori engaged in the Long Term Conditions Management Programme.	✓ Increased number of West Coast participants on Kia Ora Hauora programme Q4. ✓ Increased PHO enrolment and disease prevention screening rates for Māori Q4.

CLINICALLY AND FINANCIALLY VIABLE HEALTH SERVICES

6.18 Improving quality and patient safety

We have made considerable changes in the last few years 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 also been incorporated into our quality programme.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Increase the focus on continuous improvement processes.	▪ Support the use of service level data in the implementation of the Plan-Do-Study-Act (PDSA) cycle for service improvement. ▪ Refine the DHB's Quality Accounts based on the HQSC evaluation, expanding across the system and engaging consumer feedback. ▪ Continue active mortality and morbidity review meetings across all services and link into regional forums to disseminate learnings.	✓ Exceler8 education programme run each quarter. ✓ Annual publication of DHB Quality Accounts. ✓ Reviews meetings held.
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. ▪ Identify opportunities to increase the response rate to patient surveys via discharge activity and promotion of the surveys. ▪ Integrate the patient experience survey results collected as part of the national collection system into service datasets. ▪ Continue to support Consumer Council involvement in patient care improvement teams and the design of new facilities. ▪ Use patient stories to inform service improvement processes.	✓ 90% completion of answers to 4 Questions in medical wards. ✓ Quarterly reporting on patient experience survey data. ✓ Patient Experience response levels increased to over 33%. ✓ Two consumer representatives on each improvement team.
Support projects that make a difference to the quality of care, reduce patient harm and contribute to the national patient safety campaign 'Open for Better Care'.	▪ Implement the electronic incident management and feedback system (Safety 1st) to enable timely reviews. ▪ Integrate the national Quality Safety Markers into appropriate improvement programmes. ▪ Implement the nursing online observation system. ▪ 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. ▪ Continue to monitor Central-Line-Associated Bacteraemia (CLAB) free days and engage staff in delivery against the target. ▪ Continue to prevent harm from falls in our hospitals by rolling out the visual cues signage at the bed side. ▪ Support the development of a community-based Falls Prevention Programme to reduce admissions for people at risk of falls. ▪ Integrate reporting of falls trends and strategic improvement activity into the Falls Coalition agenda. ▪ Continue to support adherence to the '5 Moments in Hand Hygiene' with promotion of frontline leadership to improve practice. ▪ Reinforce and monitor Brief and Debrief and completion of the Surgical Safety Checklist to support adherence to policy. ▪ Consolidate actions in the medicines opiate improvement project.	✓ Safety 1st RL6 software online in the first Ward Q4. ✓ 95% of hip & knee replacement patients receive cefazolin ≥ 2g as surgical prophylaxis. ✓ 100% of hip and knee replacement patients have appropriate skin preparation. ✓ 100% of patients receive antibiotic 0-60 minutes before 'knife to skin". ✓ 90% of older patients (75+ or 55+ for Māori/Pacific) are given a falls risk assessment. ✓ 98% of older patient assessed as at risk of falling receive an individual care plan addressing these risks. ✓ e-Pharmacy in place Q2. ✓ e-Medications in place Q4. ✓ 80% compliance with good hand hygiene practice. ✓ All 3 parts of the surgical safety checklist used 90% of the time.

6.19 Connecting our information systems

Over the last three years, the West Coast DHB has massively changed its approach to information technology and upgraded its systems to enable a more integrated health information system – reducing duplication, saving clinical staff time and improving patient safety.

Major milestones over the last three years have included going live with Health Connect South (HCS – the regional clinical workstation and data repository), implementing HealthOne to better link primary and Secondary care, electronic sign off of laboratory results and implementation of the regional Electronic Referral Management System (ERMS). These developments have enabled fast, accurate referrals and safe, efficient sharing of clinical information between South Island health professionals.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Value the patient.	▪ Refresh the DHB website so that it is easier to navigate. ▪ Implement a Patient Portal to enable patient access to their core health information and e-interaction with general practice.	✓ Website refreshed Q3. ✓ 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 Q2. ✓ 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. ▪ Implement the next phase of ERMS to enable electronic triage.	✓ Titanium launched Q1. ✓ ERMS e-Referrals triage phase live Q2.
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 and Canterbury DHB. ▪ Prepare to implement the South Island Patient Information Care System (PICS) to further integrate systems.	✓ Develop updated Telehealth Strategy Q2 ✓ 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. ▪ Move to the National Infrastructure Platform (NIP) to enable an improved, more robust and better supported platform.	✓ Wireless expansion 2015. ✓ Combined maintenance systems 2016. ✓ Transition WCDHB computing Infrastructure to the NIP platform Q2
Strengthen information systems and the information services team.	▪ 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.	✓ Combined IT helpdesk Q3. ✓ Implement VDI in pilot Q4
Centralise systems for reporting.	▪ Implement Phase II of National Patient Flow (NFP) collection to include non-admitted and associated referral information including diagnostic tests ▪ Merge WCDHB/CDHB reporting and extract systems to allow for pooled virtual team members to act on one set of systems.	✓ Some transalpine reporting Q2. ✓ Full transalpine reporting 2016/17. ✓ Transalpine extracts 2016/17.

6. 20 Supporting our health workforce

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 leading the development of alternative models of care to ensure we can continue to provide quality services. We continue to expand 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.

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 the development of new roles, support for training and the roll-out of national programmes will help to ensure our workforce has the skills and capability to meet our population's needs.

OUR PERFORMANCE STORY 2015/16		
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. ▪ Develop a workforce plan that supports the delivery of outcomes from the Buller Older Person's Health and Reefton community engagements in health services planning. ▪ Embed a core curriculum that supports leadership development.	✓ Increased number of Champions roles in place. ✓ >650 HealthPathways Q4. ✓ CDHB/WCDHB core curriculum in place by Q4. ✓ Reefton and Buller Older Person's health workforce plans developed 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.	✓ Workplace Bullying programme in place Q1. ✓ Increased participation in XcelR8 and Collabor8 Q4. ✓ 80% of staff would recommend WCDHB as an employer.
	▪ Use the data from attachment and exit technology to identify areas of concern and opportunities for improvement. ▪ Re-run a Staff Engagement Survey to determine priorities.	✓ Overall improvement in employee engagement results.
Enhance the integration of West Coast Health Services	▪ Explore opportunities for team integration within district nursing, home based support and primary health services. ▪ Work collaboratively with St John to identify opportunities for integrated or shared roles.	✓ Community and primary services workforce plan completed Q4.
Expand workforce capacity through improved workforce design, planning, recruitment and retention.	▪ Create an implementation plan for each key service to deliver on the transalpine service agreements reached in 2014. ▪ Develop a rural hospital medical specialist workforce to enable the transalpine service agreements to be implemented. ▪ Implement recommendations from the Rural Nurse Specialist Review in consultation with staff. ▪ Continue to enhance role flexibility and reduce dependence on locums and casuals. ▪ Implement strategies to enhance workforce effectiveness in the context of system transformation, ICT and co-location of services.	✓ Service Plans for key services in place and agreed by Q2. ✓ At least 4 Rural hospital medical specialist FTE employed Q2. ✓ Review completed Q1. ✓ Recommendations implemented Q4.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Expand workforce capacity through improved workforce design, planning, recruitment and retention - continued…	▪ 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.	✓ 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%.
	▪ Continue to support and recruit fully into Nursing Entry to Practice (NETP), Nursing Entry to 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. ▪ Continue to support studentships and Scholarships for potential future employees to attract and retain new staff to the Coast	
	▪ Work closely with the Canterbury DHB to supplement services with joint appointments and expanded use of Telemedicine.	
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. ▪ 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 i.e. learning and video conferencing. ▪ Review and standardise the career pathways and training opportunities for Health Workforce New Zealand funded trainees.	✓ E-learning platforms established Q4. ✓ 100% of HWNZ funded staff have career plans in place Q4.
	▪ Continue to support targeted workforce initiatives across regional workstreams including training and role development. ▪ Implement the new prevocational curriculum for PGY1s and 2s in terms of needing a three month community placement. ▪ Participate in the rollout of the Calderdale framework for skill delegation for Allied Health Assistants (AHAs) and skill sharing across the health professional groups.	✓ 2 community placements created to meet the new curriculum requirements Q4. ✓ 2 areas for skill delegation for AHAs identified 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 planning tools, core HR policies, HR metrics and learning and 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 Recruitment and Retention Strategy agreed Q4.

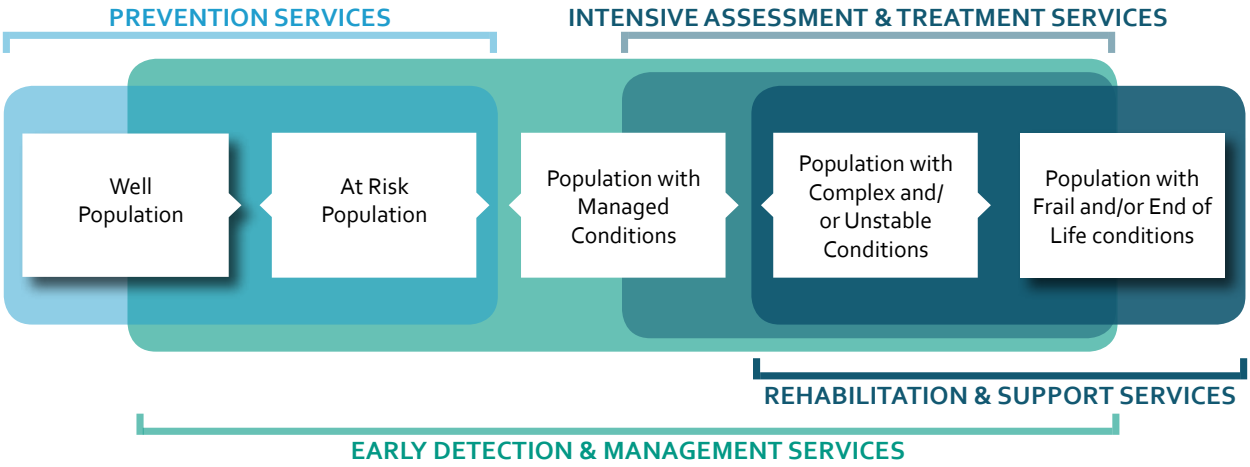
6.21 Living within our means

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.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Better connect and align the system to support technical and clinical efficiencies to reduce waste and duplication.	▪ Continue to implement clinically designed patient pathways across the system to streamline referrals and improve care. ▪ Support the use of Health Connect South, HealthONE and the implementation of PICs to reduce duplication and waste. ▪ Continue to support Better Health to improve the financial sustainability of DHB-owned general practices. ▪ Continue to expand transalpine services to provide sustainable access to an increased range of clinical specialties.	✓ >650 HeathPathways available across the system Q4. ✓ ERMS e-Referrals triage phase live Q2. ✓ Increased proportion of follow-ups for people who live outside of the Grey district provided by telemedicine - base 1.5%.
Support people to stay well and reduce unplanned or acute demand for health services.	▪ Maintain GP access to diagnostics and specialist support to reduce unnecessary hospital and specialist referrals. ▪ Invest in packages of care that support self-management and improve the management of people's long-term conditions. ▪ Complete the implementation of the FIRST (rapid response and supported discharge service) to support people in the community rather than in hospital.	✓ Rate of acute medical admissions <5,800 per 100,000. ✓ Rate of acute readmissions within 28 days maintained at or below current rates.13
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. ▪ Retain transitional funding arrangements at current levels. ▪ Apply scrutiny to contractual arrangements and outsourcing to create cost efficiencies and ensure that payment is sought. ▪ Implement tight controls around repairs and maintenance to ensure investment is not wasted on short-term fixes.	✓ Elective theatre utilisation maintained at >85%. ✓ Average elective surgical inpatient length of stay maintained at <1.59 days. ✓ Average acute inpatient length of stay maintained at <2.45 days.
Participate in regional and national initiatives focused on the efficient and effective use of resources to achieve financial sustainability.	▪ Continue to support the Regional Support Services Alliance to achieve regional Procurement and Supply Chain savings. ▪ Participate in the implementation of Shared Services initiatives aligned to the Health Benefits work programme and commit resources where required to progress the Finance, Procurement & Supply Chain, Food Services, Linen & Laundry Services and National Infrastructure Platform Detailed Business Cases. ▪ Work collaboratively with the National Health Committee (NHC) to solve sector issues including engaging with and providing advice to the NHC on: prioritisation and assessment and approaches to new and emerging technologies and technologies driving expenditure. ▪ Support the implementation of national PHARMAC initiatives including national contracting for the procurement of hospital medical devices, the management of hospital pharmaceuticals and product standardisation.	✓ Regional Capital Expenditure Plan in place Q1. ✓ Regional Procurement and Supply Chain activity achieves savings as agreed Q4. ✓ Implementation of national Health Shared Services business cases as agreed. ✓ Regional Strategic Planning & Integration Team engage with the NHC to support consistent approaches to sector issues. ✓ Implementation of national PHARMAC initiatives.

Statement of Service Performance Expectations

How will we demonstrate success?



EVALUATING OUR PERFORMANCE

We aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services on the West Coast, the decisions we make about which services will be delivered will have a significant impact on people's health and wellbeing.

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.

Over the longer term we evaluate the effectiveness of the decisions we make by tracking performance against a set of desired population outcomes which are outlined in the strategic direction section of this document and highlighted in the overarching intervention logic diagram on page 14.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver 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. [28]

When evaluating our performance, we have chosen a mixture of indicators that we believe are most important to our patients, community and stakeholders. We have also chosen a mix of indicators that together provide a measure of how well the DHB is meeting the challenges confronting the West Coast Health System.

The DHB has a separate Māori Health Action Plan and where the performance indicators align they have been included in the forecast to highlight the areas of particular priority in terms of improving health outcomes for Māori on the West Coast. [29]

Because our aim is to give a fair and accurate insight into how our health system is performing, we cannot simply measure what we delivered in terms of '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 indicators that address four key aspects of performance: Volume (V); Timeliness (T); Coverage (C); and Quality (Q).

Wherever possible, past year's baselines and national results have been included to give context in terms of what we are trying to achieve and to support evaluation of our performance. Service indicators have also been grouped into four 'output classes' that are a logical fit with the continuum care and are applicable to all DHBs. Those are: prevention services; early detection and management services; intensive assessment and treatment services; and rehabilitation and support services.

[28] *The Annual Report is tabled in Parliament and is available on the DHB's website: www.westcoastdhb.health.nz.*

[29] *Specific actions to improve Māori health are outlined in our Māori Health Action Plan, available on our website.*

SETTING STANDARDS

In setting performance standards, we have considered the changing demographics of our population, increasing areas of demand and the assumption that resources and funding growth will be limited. Targets tend to reflect the objective of increasing the coverage of prevention programmes, reducing acute or avoidable demand and maintaining service access while reducing waiting times and delays in treatment.

While a healthier population and earlier intervention can reduce avoidable demand over time – there will always be a certain level of need for some services. These services include: diagnostic tests and assessments, emergency care, maternity services, rehabilitation and respite services, aged residential care and palliative care. Estimated service volumes have been provided against these services, not as targets to be achieved, but to give context in terms of the use of resources across our health system.

With a growing Māori population and persistent inequalities amongst our population achieving equity of outcomes is an overarching priority for our health system. All of our targets are universal with the aim of bringing performance for all population groups to the same level, rather than accepting different standards for different populations.

A number of the standards set against the indicators presented are based on national expectations and may be particularly difficult for the West Coast DHB to meet as our small population number mean a small number of people can have a big impact on results. However it is important that we strive to ensure our population has equity access to services and that we monitor these indicators in order to make appropriate funding decisions as we move forward.

WHERE DOES THE MONEY GO?

The following table presents a summary of the budgeted financial expectations for 2015/16, by output class. Over time, we anticipate it will be possible to use this framework to demonstrate changes in the allocation of resources and funding from one end of the continuum of care to the other.

2015/16

REVENUE	TOTAL $'000
Prevention	2,588
Early detection and management	26,554
Intensive assessment & treatment	92,164
Support & rehabilitation	20,169
Grand Total	141,925

EXPENDITURE	TOTAL $'000
Prevention	2,392
Early detection and management	26,290
Intensive assessment & treatment	93,381
Support & rehabilitation	20,740
Grand Total	142,803

Surplus/(Deficit) - $'000	(878)

NOTE:

Rather than repeating footnotes, the following symbols have been used in the performance tables:

E Some service are demand driven and it is not appropriate to set targets, instead estimated volumes are provided to give context as to the use of resource across our system.

Δ Performance data provided by external parties can be affected by a delay in invoicing and results are subject to change.

† Performance data for some programmes relates to the calendar rather than financial year.

◇ National Health Targets are set for DHBs to achieve by the final quarter of the year. Performance data therefore refers to the fourth quarter result for any given year.

◆ This measure also appears in West Coast's Māori Health Action Plan for 2015-16.

Output Class

7.1 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: education programmes that 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 that support early intervention that support people to modify lifestyles and maintain good health.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

By supporting people to make healthier choices we can reduce the risk factors that contribute to long-term conditions and prevent or minimise the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. At-risk and high-need population groups are also more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high-needs populations and to reduce inequalities in health status and health outcomes.

SERVICE PERFORMANCE INDICATORS (2015/16)

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of babies exclusive/fully breastfed at LMC discharge	Q [30]	80%	>75%	75%
% of Māori babies exclusive/fully breastfed at LMC discharge	Q ◆	42%	75%	71%
Lactation support and specialist advice consults provided in community settings	V	117	>100	-
% of priority schools supported by the Health Promoting Schools framework	C [31]	100%	>70%	-
Nutrition and Activity courses provided in the community	V	7	>5	-
People referred to Green Prescriptions for additional physical activity support	V [32]	474	500	-
% of Green Prescription participants more active 6-8 months after referral	Q [33]	80%	>50%	62%
% of smokers enrolled with a PHO receiving advice and help to quit (ABC)	C [34]	62%	90%	86%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	95%	95%	95%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	129	>100	-
% of women smokefree at two weeks postnatal	Q [35]	88%	95%	87%
% of Māori women smokefree at two weeks postnatal	Q ◆	90%	95%	65%

[30] *Standards are based on national WellChild Quality Framework targets and baseline is to December 2013.*
[31] *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.*
[32] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.*
[33] *Results taken from national patient survey competed by Research NZ on behalf of the Ministry of Health. Target is set nationally.*
[34] *This is the national health target measure – for 2015/16 the time period of the measure has changed from offered ABC within 12 months to within 15 months. Past results are against the previous target.*
[35] *Standards are based on national WellChild Quality Framework targets and baseline is to December 2013.*

Population-Based Screening Services These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of four-year-olds receiving a B4 School Check (B4SC)	C [36]	90%	90%	91%
% of Year 9 students in decile 1-3 schools receiving a HEEADSSS assessment	C † [37]	55%	95%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [38]	79%	80%	77%
% of Māori women aged 25-69 having a cervical cancer screen in the last 3 years	C ◆	73%	80%	63%
% of women aged 50-69 having a breast cancer screen in the last 2 years	C [39]	76%	>70%	73%
% of Māori women aged 50-69 having a breast cancer screen in the last 2 years	C ◆	77%	>70%	65%

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	2013/14 Result	2015/16 Target	2013/14 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 ◇	81%	95%	92%
% of Māori children fully immunised at eight months of age	C ◆	94%	95%	88%
% of eight-month-olds 'reached' by immunisation services	Q [40]	96%	95%	-
% of Year 8 girls completing their HPV vaccinations (i.e. receiving Dose 3)	C † [41]	54%	65%	53%
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	63%	75%	69%
% of older Māori (65+) receiving a free influenza ('flu') vaccination	C † ◆	72%	75%	-

[36] 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.
[37] A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.
[38] This is a national screening programme with standards based on the national targets.
[39] This is a national screening programme with standards based on the national targets. The baseline results differ to previous years due to a change in age bands (from women aged 45-69 to women aged 50-69). The 2013/14 baseline is for the two years to March 2014.
[40] '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.
[41] The baseline is the percentage of girls born in 2000 receiving Dose 3 by the end of 2013, and the target for 2015 for girls born in 2002.

Output Class

7.2 Early detection and management services

Early detection and management services are services which help to maintain, improve and restore people's health by ensuring that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. These services are particularly important where people have multiple conditions requiring ongoing interventions or coordinated 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 can support people to maintain good health and, through earlier diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes.

Our vision of a connected system presents a unique opportunity. Providing flexible and responsive services in the community, without the need for a hospital appointment, better supports people to stay well and stabilise or manage their condition—reducing complications, acute illness or crises and therefore acute and avoidable hospital admissions. Reducing avoidable demand will have a major impact in freeing up hospital and specialist services to allow for more complex and planned interventions.

SERVICE PERFORMANCE INDICATORS (2015/16)

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of the total DHB population enrolled with a Primary Health Organisation	C	92%	95%	-
% of the Māori DHB population enrolled with a Primary Health Organisation	C ◆	92%	95%	-
Avoidable hospital admission rate for children aged 0-4	Q [42]	96%	TBC	100%
Avoidable hospital admission rate for Māori children aged 0-4	Q ◆	183%	TBC	100%
Young people (0-19) accessing Brief Intervention Counselling	V Δ [43]	65	80	-
Adults (20+) accessing Brief Intervention Counselling	V Δ	374	>300	-
Number of HealthPathways in place across the West Coast health system	V [44]	434	650	-

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	2013 Result	2015 Target	2013 National Average
% of pre-schools children (0-4) enrolled in DHB-funded oral health services	C †	75%	90%	73%
% of pre-schools Māori children (0-4) enrolled in DHB-funded oral health services	C † ◆	66%	90%	59%
% of enrolled children (0-12) examined according to planned recall	T †	78%	90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C †	72%	85%	70%

[42] 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. The definition for this measure is being revised nationally and was not available at the time of printing – targets will be confirmed once the definition is set.
[43] 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.
[44] The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.

Long-Term Conditions Management (LTCM) Programmes These services are targeted at people with high health needs due to a long-term condition 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	2013/14 DHB Result	2015/16 Target	2013/14 National Average
People identified with a long-term condition enrolled in the LTCM programme	V	2,767	>2,000	-
% of people with diagnosed diabetes having an annual LTMC review	C	99%	>90%	-
% of people with diabetes with satisfactory or better diabetes management (Hba1c ≤ 64mmol/mol) at their annual review	Q	78%	80%	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇ [45]	77%	90%	84%
% of the eligible Māori population having a CVD Risk Assessment in the last 5 years	C ◇ ◆	77%	90%	80%

Pharmacy and Referred Services These are services which a health professional may use 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 services are largely demand driven; faster and more direct access aids clinical decision-making, improves referral processes and reduces the wait for treatment.	Notes	2013/14 DHB Result	2015/16 Target	2013/14 National Average
Subsidised pharmaceutical items dispensed in the community	V Δ [46]	445k	E.<600K	-
Number of community requested radiological tests delivered by Grey Hospital	V	5,590	E.>5,000	-
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T ◇ [47]	33%	75%	55%
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T ◇	100%	>95%	80%
% of people receiving their Magnetic Resonance Imagining (MRI) within 6 weeks	T ◇	92%	85%	60%

[45] *This measure is the national 'More heart and diabetes checks' health target and refers to Cardiovascular Risk Assessments undertaken in primary care in line with the definitions.*
[46] *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.*
[47] *The diagnostic measures are national performance measures (PP29) and baselines are as at the final quarter (to June) in line with national results published by the Ministry of Health. Targets are set to match national standards set for all DHBs.*

Output Class

7.3 Intensive assessment and treatment services

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together and are usually provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. A proportion of these services are in response to an acute event and others are planned where access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and are crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives, and results in improved public confidence in the health system.

As an owner of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Improved systems and processes will support patient safety, reduce the number of events causing injury or harm and improve health outcomes.

SERVICE PERFORMANCE INDICATORS (2015/16)

Quality & Patient Safety Measures These quality and patient safety measures apply across all hospital services and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
Rate of compliance with good hand hygiene practice	Q ◇ [48]	77%	80%	75%
% of hip and knee replacement patients receiving cefazolin >2g	Q ◇ [49]	89%	95%	85%
% of hip and knee replacement patients who have appropriate skin preparation	Q ◇	100%	100%	97%
% of time all three parts of the surgical safety checklist are used	Q ◇ [50]	96%	≥90%	94%
% of inpatients (aged 75+) who received a falls assessment	Q ◇ [51]	89%	90%	89%

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	2013/14 DHB Result	2015/16 Target	2013/14 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C	62%	80%	59%
% of new mothers attending DHB-funded parenting and pregnancy courses	C	N/A	>30%	-
Maternity deliveries in West Coast DHB facilities	V	279	Est. 300	-
Baby friendly hospital accreditation of DHB facilities	Q [52]	Yes	Yes	-

[48] *This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards.*
[49] *Cefazolin >2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.*
[50] *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.*
[51] *While there is no single solution to reducing falls, an essential first step is to assess an individual's risk of falling, and acting accordingly.*
[52] *The Baby Friendly Initiative is a worldwide programme lead by 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 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). Services include accident & emergency responses, short-stay acute assessment and observation, acute care packages, acute medical and surgical services and intensive care services.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of children <13 with access to free primary care outside business hours	C [53]	New	100%	-
% of general practices providing telephone triage outside business hours	C	100%	100%	-
Attendances at the Grey Base Hospital Emergency Department	V [54]	11,043	Est.<13,000	-
% of people (Triage 1-3) presenting in ED seen within clinical guidelines	Q [55]	87%	>85%	-
% of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receive their first treatment within 62 days of referral.	T ◇ [56]	New	85%	New
% of people waiting less than 4 weeks to start radiotherapy or chemotherapy	T ◇ [57]	100%	100%	100%
Acute inpatient average length of hospital stay (standardised)	Q [58]	2.45	≤2.45	2.64

Elective/Arranged Services These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
First Specialist Assessments provided (medical and surgical)	V [59]	6,864	E.>6,000	-
% of First Specialist Assessments that were non-contact (virtual)	Q [60]	4.2%	>5%	-
Elective surgical discharges delivered (surgeries provided)	V [61]	1,695	1,889	-
Elective inpatient average length of hospital stay (standardised)	Q [58]	1.59	≤1.59	1.67
Outpatient attendances	V [62]	15,565	Est. >13k	-
% of outpatient appointments/consultations provided by telemedicine	Q	2.1%	>1.5%	-
Outpatient 'Did not Attend' rates (total population)	Q [63]	8.5%	6%	-
Outpatient 'Did not Attend' rates (Māori)	Q	18.0%	6%	-

[53] This measure was previously '100% children under six with access to free primary care after hours'.
[54] This measure is based off the national ED Health Target, but the result are for a full year.
[55] Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.
[56] This measure is the national Faster Cancer Track Health Target which was introduced in Q2 of 2014/15.
[57] 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.
[58] 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. The baseline differs to that previously published due to a change in the national definition for this measure – day stays are now included in the count.
[59] This measure counts both medical and surgical assessments but only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred. The measure is aligned to the national elective services reporting definitions which are DHB of domicile - covering all FSAs provided for West Coast residents no matter where they are delivered.
[60] Non-contact FSAs are those where specialist advice and assessment are provided without the need for a hospital appointment.
[61] This measure is the national Elective Surgery Health Target. The measure was redefined in 2015/16 and now includes inpatient surgical discharges, regardless of whether the discharge is from a surgical or non-surgical speciality and both 'elective' and 'arranged' admissions.
[62] The DNA presentations relate to medical and surgical specialist outpatient appointments only and do not cover either mental health or AT&R services. Baselines differ slightly to previous years due to an alignment of definitions, data sources and inclusion of late coding.
[63] The DNA results differ slightly to those previously published due to clarification and alignment of data definitions and timeframes and the inclusion of late coding for previous years. These DNA presentations relate to medical and surgical specialist outpatient appointments and do not include DNAs for mental health or AT&R services.

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of young people (0-19) accessing specialist mental health services	C Δ [64]	6.1%	>3.8%	3.4%
% of adults (20-64) accessing to specialist mental health services	C Δ	5.4%	>3.8%	3.8%
% of people referred for non-urgent MH/AOD services seen within 3 weeks	T [65]	76%	80%	79%
% of people referred for non-urgent MH/AOD services seen within 8 weeks	T	93%	95%	93%

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	2013/14 Result	2015/16 Target	2013/14 National Average
Admissions into inpatient AT&R services	V	131	E.>150	-
Consultations provided by outpatient and domiciliary AT&R services	V	2,060	E.>1,700	-
% of AT&R inpatients discharged to their own home rather than into ARC	Q Δ [66]	89%	90%	-

[64] 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.

[65] This measure is a national performance measures (PP6) and targets are based on the assumption that 3% of the population will need access to specialist mental health services. Results are three months in arrears and reflect specialist services (DHB and NGO) reporting through to the national PRIMHD database so may undercount service provision if providers are not reporting to the national system.

[66] 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

7.4 Rehabilitation and support services

Rehabilitation and support services provide people with the assistance they need to maintain or regain maximum functional independence often after illness or disability. These services are delivered after a clinical 'needs' assessment and include: domestic support, personal care, community nursing, respite and residential care. Services are mostly for older people, mental health clients and people with complex conditions.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

Services that support people to live 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 support enables people to maximise their function and independence. In preventing deterioration and crisis, these services have a major impact on the sustainability of the health system by reducing acute demand, avoidable hospital admissions and the need for more complex intervention. These services also support the flow of patients by enabling them to go home earlier and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

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.

SERVICE PERFORMANCE INDICATORS 2015/16

Rehabilitation Services These services restore or maximise people's health or functional ability following a health-related event and success is often measured through increased referral to appropriate services following an acute event such as a heart attack or stroke.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	55%	80%	-
People supported by the FIRST service	V	New	25	-
People (65+) access the community-based falls/fracture liaison service	V [67]	New	25	-

Home and Community-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 the capacity in the system, and success is measured against delayed entry into residential or hospital services with more people supported to live longer in their own homes.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of older people (65+) receiving long-term home and community support services who have had a clinical assessment using InterRAI	Q Δ [68]	94%	95%	-
People supported by long-term home and community support services	V Δ	751	Est. >740	-
Community-based district nursing visits provided (long-term clients only)	V Δ	4,364	Est. >4,000	-
Meals on Wheels provided	V Δ	33,082	Est. >35k	-

[67] *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.*
[68] *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. Access to services are expected to increase over time, as more people are supported to remain in their own homes.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
Mental health planned and crisis respite service bed days used	C Δ	379	Est. 500	-
People supported by aged care respite services	V	64	Est. 70	-

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 and community-based support.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of people entering ARC having had a clinical assessment using InterRAI	Q Δ [68]	97%	>95%	-
% of ARC residents receiving vitamin D supplements	C	59%	75%	-
Subsidised ARC rest home beds provided (days)	V Δ [69]	44,438	Est. <50k	-
Subsidised ARC hospital beds provided (days)	V Δ	41,352	Est. <40k	-
Subsidised ARC dementia beds provided (days)	V Δ	4,551	Est. >4,000	-
Subsidised ARC psycho-geriatric beds provided (days)	V Δ	2,394	Est. >2,000	-

[69] *All of the ARC bed baselines differ from those published in the 2014 Annual Report due to the addition of late claims.*

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 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.

8.1 West Coast's financial outlook

Funding from the Government, via the Ministry of Health, is the main source of DHB funding; supplemented by revenue agreements from 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 planned 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 still filling a significant number of full-time positions with locums. This not only reduces continuity of care but is an expensive and unsustainable option, which needs to be addressed.

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.

8.2 Achieving financial sustainability

The West Coast DHB is committed to reducing its current deficit and achieving a breakeven position. We know that affordability of the Greymouth hospital and IFHC was predicated on this basis and it is clear that the achievement of living within our means requires a number of significant actions and service redesign — it will not be a 'quick fix'.

To ensure our health system is clinically and financially sustainable, we must provide the right care and support, 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. We need to ensure that cost growth is minimised, through the development of our news models of care and other efficiencies, so that more of our total funding can be directed into improving services and service delivery.

Transitional funding: The West Coast DHB receives around $18m of additional transitional funding which is vital to the fiscal sustainability of our health system. Although this was reduced in the 2014/15 year, current advice sees this funding rising back to previous levels for 2015/16.

It is imperative that future treatment of this funding is resolved to be no longer at risk. The continuation of this funding would be consistent with the assumptions used in the financial modelling performed to evaluate the Grey redevelopment which was approved by Cabinet. If for some reasons this treatment is not achieved the impact on the ongoing affordability of the West Coast Hospital Development is significant, and impacts on the ability of the DHB to operate sustainably.

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 higher-end and more resource intensive 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 our general practices to ensure the financial sustainability of general practice on the West 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 DHB is also committed to actively supporting national initiatives to achieve mutual benefits and cost savings across the sector. Our level of inclusion in 2015/16 financial projections is provided in the table at the end of this financial section.

8.3 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 and 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 2015/16, with no disruptions associated with pandemic or natural disaster.
- Population-based funding levels for 2015/16 will remain at the level indicated by the Ministry in the funding envelope received December 2014.
- 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 and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- National and regional initiative savings and benefits will be achieved as per planning assumptions provided to the DHB, with no requirement to impair associated investments.
- 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, with forecasts for 2014/15 and budgets for 2015-2016 and beyond based on this revaluation. However, further impairments may be necessary dependent on the outcome of engineering assessments.
- Work will continue on the facilities redevelopment plans for Grey and Buller under the nationally directed Partnership Group.

The associated costs and capital expenditure for the Grey redevelopment 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 (adjusted for the 2014/15 transitional funding repayment advice). As agreed in the business case the funding will be a mix of debt and equity.

The DHB has not had the opportunity to fully explore the financial impacts of the procurement options responded to by the market for the Buller redevelopment (approved April 2014). Associated development costs and any capital or lease expenditure have therefore not been included in this Plan.

8.4 Asset planning and investment

GREY RE-DEVELOPMENT

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 late 2015.

Current fiscal modelling in relation to this facility has made some assumptions in regard to building importance level and similar aspects which, if proved to be incorrect, will create significant cost pressure, and may impede the ability to complete the facility project within its approved budget. In this instance the affordability of the project, both in terms of completion, or if additional funding is permitted the ongoing affordability for the West Coast DHB will be compromised.

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

In Buller, a design team has been appointed and will soon re-engage with clinicians to work on the master plan and concept design for the redevelopment. The outcome of this process will help guide the impending business case.

CAPITAL EXPENDITURE

The business as usual capital expenditure budget for the 2015/16 year is $3.8M; 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 DHB will continue to be disciplined and focus on the key priorities in determining capital expenditure.

Over the next six years, the key strategic capital intentions above business as usual capital expenditure include:

- Buller IFHC (notionally $8.1M)
- Mental health facility refurbishment (notionally $5M)
- Phased upgrade of rural health clinics outside of Greymouth and Westport (notionally $0.5M per clinic)
- Secondary tranche Grey Hospital redevelopment (notionally $5M)
- Move to the South Island Patient Information Care System (notionally $2.5M)
- Investment in other strategic IT / integration systems (notionally $1.8M-$2.2M p.a.)

We anticipate that the above capital intentions will be funded by internal cash except for the Buller IFHC, mental health facility refurbishment and secondary tranche Grey Hospital redevelopment projects, whereby 40-45% Crown capital support would likely be required.

We will continue to manage our cash flow effectively and any significant change to Crown support will be signaled to the respective agencies as required.

Exploratory work with regards to the Buller IFHC has started, while planning for the mental health facility project is expected to start in 2016 with the business case submission anticipated in 2017.

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 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 DHBs 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.

8.5 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 total term debt is currently $14.445M and is expected to remain at this amount as at June 2016.

THE WEST COAST DHB'S CURRENT DEBT PROFILE

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

Grey Hospital redeveloped facility is expected to be completed in the first quarter of 2017 at which time the asset will be transferred from the Ministry of Health to the DHB. Following the asset transfer, term debt will increase by $40.8M to $55.245M, based on a 60% debt and 40% equity funding ratio for this new asset, as per the detailed business case model.

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

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 Shared Services (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.

COMMITMENT TO NATIONAL INITIATIVES

2014/15 (in $'000S)	CAPITAL COSTS	OPERATING COSTS		OPERATING BENEFITS	NET OPERATING
		ONE-OFF	ONGOING		
NHITB - eMedicines Reconciliation (eMR) with eDischarge Summary	-	-	(6)	-	(6)
NHITB - Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)	-	-	-	-	-
NHITB - Replacement of legacy Patient Administration Systems	-	-	-	-	-
NHITB - National Patient Flow	-	(104)	-	-	
NHITB - MoH contribution to National Patient Flow	-	(104)	-	-	(104)
NHITB - Provider & Patient Portal	(50)	-	-	-	-
Data warehouse	-	-	(3)	-	(3)
HQSC - SSIP DHB Infections Management systems (ICNet NG system)	(55)	-	(50)	-	(50)
HQSC - Patient experience indicators	-	-	-	-	-
HBL (Health Benefits ltd)					
Core Funding	-	-	(55)	-	(55)
FPSC Integrator	-	-	(3)	-	(3)
NIP Integrator	-	-	(9)	-	(9)
FPSC (existing oracle licenses)	-	-	(18)	-	(18)
FPSC (gap funding)	-	-	(22)	-	(22)
FPSC (technology)	-	-	-	-	-
FPSC (investment)	-	-	(47)	-	(47)
FPSC (hA costs)	-	-	(90)	-	(90)
FPSC (benefits)	-	-	-	253	253
Food	-	-	(63)	-	(63)
Linen & Laundry	-	-	(7)	-	(7)
National Infrastructure Platform	-	-	-	-	-
IT Procurement	-	-	-	-	-
Human Resource Management Information System	-	-	-	-	-
Banking and insurance	-	-	(16)	-	(16)
TOTAL	(105)	(208)	(388)	253	(343)

Statement of Financial Expectations

Where will our funding go?

9.1 Statement of comprehensive income

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
INCOME						
Ministry of Health revenue	126,385	129,885	130,009	131,373	132,873	134,492
Patient related revenue	9,409	10,274	10,668	10,856	11,172	11,494
Other operating income	629	635	720	732	745	758
Interest income	608	530	528	528	528	528
Total Income	137,031	141,324	141,925	143,489	145,318	147,272
OPERATING EXPENSES						
Personnel	55,477	56,680	57,212	58,269	59,207	61,181
Outsourced services (clinical and non-clinical)	7,981	7,264	5,112	4,792	4,172	4,152
Treatment related costs	7,727	7,510	7,404	7,478	7,553	7,630
External service providers (include Inter-district outflow)	48,869	52,822	55,558	56,034	53,702	55,411
Depreciation & amortisation	4,373	4,686	4,740	5,327	5,907	5,907
Interest expenses	713	750	720	1,740	2,760	2,760
Other expenses	12,225	11,822	11,265	11,143	10,825	10,834
Total Operating Expenses	137,365	141,534	142,011	144,783	144,126	147,875
Operating surplus before capital charge	(334)	(210)	(86)	(1,294)	1,192	(603)
Capital charge expense	753	790	792	792	2,968	2,968
Surplus/(deficit)	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)
Other comprehensive income	-	-	-	-	-	-
Total comprehensive income	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)

9.2 Statement of financial position

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
CROWN EQUITY						
General funds	(89,744)	(91,812)	(92,636)	(68,798)	(70,332)	(75,766)
Revaluation reserve	19,569	19,569	19,569	19,569	19,569	19,569
Retained earnings	80,272	81,272	82,150	84,236	86,012	89,583
Total Equity	10,097	9,029	9,083	35,007	35,249	33,386
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	7,483	9,265	10,201	11,752	15,401	16,945
Trade & other receivables	8,786	4,218	4,218	4,218	4,218	4,218
Inventories	1,010	1,100	1,100	1,100	1,100	1,100
Assets classified as held for sale	136	136	136	136	136	136
Investments (3 to 12 months)	80	-	-	-	-	-
Restricted assets	61	60	60	60	60	60
Total Current Assets	17,556	14,779	15,715	17,266	20,915	22,459
CURRENT LIABILITIES						
Trade & other payables	8,751	5,448	5,448	5,448	5,448	5,448
Capital charge payable	1,836	1,800	1,800	1,800	1,800	1,800
Employee benefits	8,468	9,081	9,081	9,081	9,081	9,081
Restricted funds	61	60	60	60	60	60
Borrowings	3,750	3,250	3,250	3,250	3,250	3,250
Total Current Liabilities	22,866	19,639	19,639	19,639	19,639	19,639
Net Working Capital	(5,310)	(4,860)	(3,924)	(2,373)	1,276	2,820
NON-CURRENT ASSETS						
Investments (greater than 12 months)	-	-	-	-	-	-
Property, plant, & equipment	27,069	26,697	25,831	91,020	87,629	84,238
Intangible assets	1,681	1,222	1,206	1,190	1,174	1,158
Total Non-Current Assets	28,750	27,919	27,037	92,210	88,803	85,396
NON-CURRENT LIABILITIES						
Employee benefits	2,648	2,835	2,835	2,835	2,835	2,835
Borrowings	10,695	11,195	11,195	51,995	51,995	51,995
Total Non-Current Liabilities	13,343	14,030	14,030	54,830	54,830	54,830
Net Assets	10,097	9,029	9,083	35,007	35,249	33,386

9.3 Statement of movements in equity

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
Total Equity at Beginning of the Period	10,152	10,097	9,029	9,083	35,007	35,249
Total Comprehensive Income	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)
OTHER MOVEMENTS:						
Contribution back to Crown - FRS3	(68)	(68)	(68)	(68)	(68)	(68)
Contribution from Crown - Capital	-	-	-	27,200	-	-
Contribution from Crown - Operating Deficit Support	1,100	-	1,000	878	2,086	1,776
Total Equity at End of the Period	10,097	9,029	9,083	35,007	35,249	33,386

9.4 Statement of cashflow

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
CASH FLOW FROM **OPERATING** ACTIVITIES						
CASH WAS PROVIDED FROM:						
Receipts from Ministry of Health	123,439	128,334	128,509	129,843	131,313	132,900
Other receipts	9,648	15,890	12,888	13,118	13,477	13,844
Interest received	608	530	528	528	528	528
	133,695	144,754	141,925	143,489	145,318	147,272
CASH WAS APPLIED TO:						
Payments to employees	61,534	62,917	61,352	62,209	62,647	64,621
Payments to suppliers	68,937	77,606	75,199	75,507	72,812	74,587
Interest paid	781	713	720	1,740	2,760	2,760
Capital charge	897	826	792	792	2,968	2,968
GST - net	238	(394)	-	-	-	-
	132,387	141,668	138,063	140,248	141,187	144,936
Net Cashflow from Operating Activities	1,308	3,086	3,862	3,241	4,131	2,336
CASH FLOW FROM **INVESTING** ACTIVITIES						
CASH PROVIDED FROM:						
Sale of property, plant, & equipment	53	-	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	53	-	-	-	-	-
CASH WAS APPLIED TO:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	1,982	2,336	3,858	70,500	2,500	2,500
	1,982	2,336	3,858	70,500	2,500	2,500
Net Cashflow from Investing Activities	(1,929)	(2,336)	(3,858)	(70,500)	(2,500)	(2,500)
CASH FLOW FROM **FINANCING** ACTIVITIES						
CASH PROVIDED FROM:						
Equity Injection - Capital	-	-	-	27,200	-	-
Equity Injection - Deficit Support	-	1,100	1,000	878	2,086	1,776
Loans Raised	2,000	-	-	40,800	-	-
	2,000	1,100	1,000	68,878	2,086	1,776
CASH APPLIED TO:						
Loan Repayment	-	-	-	-	-	-
Equity Repayment	68	68	68	68	68	68
	68	68	68	68	68	68
Net Cashflow from Financing Activities	1,932	1,032	932	68,810	2,018	1,708
Overall Increase/(Decrease) in Cash Held	1,311	1,782	936	1,551	3,649	1,544
Add Opening Cash Balance	6,172	7,483	9,265	10,201	11,752	15,401
Closing Cash Balance	7,483	9,265	10,201	11,752	15,401	16,945

9.5 Summary of revenue and expenses by arm

FUNDER, GOVERNANCE & FUNDER ADMIN: FORECAST OPERATING STATEMENT YEARS ENDING 2013/14 TO 2018/19

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 Actual	30/06/15 Forecast	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
FUNDING ARM						
REVENUE						
MoH Revenue	125,344	128,694	128,797	130,137	131,613	133,208
Total Revenue	125,412	128,694	128,797	130,137	131,613	133,208
EXPENDITURE						
Personal Health	84,749	89,579	92,079	93,461	92,059	94,362
Mental Health	14,018	14,056	14,080	14,293	14,508	14,870
Disability Support	18,317	18,566	18,950	19,233	19,520	20,007
Public Health	673	704	683	692	701	719
Māori Health	817	818	809	821	833	853
Governance & Admin	705	827	827	827	827	827
Total Expenditure	119,279	124,550	127,428	129,327	128,448	131,638
Net Surplus/(Deficit)	6,133	4,144	1,369	810	3,165	1,570
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	6,133	4,144	1,369	810	3,165	1,570
GOVERNANCE & FUNDER ADMIN						
REVENUE						
Other	705	827	827	827	827	827
Total Revenue	705	827	827	827	827	827
EXPENDITURE						
Personnel	598	1,123	1,292	1,308	1,324	1,340
Outsourced services	594	450	396	376	356	336
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(487)	(746)	(861)	(857)	(853)	(849)
Total Expenditure	705	827	827	827	827	827
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-

PROVIDER ARM: FORECAST OPERATING STATEMENT YEARS ENDING 2013/14 TO 2018/19

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 Actual	30/06/15 Forecast	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
PROVIDER ARM						
REVENUE						
MoH Revenue	70,746	72,092	72,255	73,702	75,179	76,684
Patient Related Revenue	9,409	10,274	10,668	10,856	11,172	11,494
Other	1,169	1,165	1,248	1,260	1,273	1,286
Total Revenue	81,324	83,531	84,171	85,818	87,624	89,464
EXPENDITURE						
Personnel	54,879	55,557	55,920	56,961	57,883	59,841
Outsourced services	7,387	6,814	4,716	4,416	3,816	3,816
Depreciation	4,373	4,686	4,740	5,327	5,907	5,907
Interest & Capital Charge	1,466	1,540	1,512	2,532	5,728	5,728
Other	20,439	20,078	19,530	19,478	19,231	19,313
Total Expenditure	88,544	88,675	86,418	88,714	92,565	94,605
Net Surplus/(Deficit)	(7,220)	(5,144)	(2,247)	(2,896)	(4,941)	(5,141)
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	(7,220)	(5,144)	(2,247)	(2,896)	(4,941)	(5,141)
IN HOUSE ELIMINATION						
REVENUE						
MoH Revenue	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
Total Revenue	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
EXPENDITURE						
Other	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
Total Expenditure	(70,410)	(71,728)	(71,870)	(73,293)	(74,746)	(76,227)
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income						
CONSOLIDATED						
REVENUE						
MoH Revenue	125,680	129,058	129,182	130,546	132,046	133,665
Patient Related Revenue	9,409	10,274	10,668	10,856	11,172	11,494
Other	1,942	1,992	2,075	2,087	2,100	2,113
Total Revenue	137,031	141,324	141,925	143,489	145,318	147,272
EXPENDITURE						
Personnel	55,477	56,680	57,212	58,269	59,207	61,181
Outsourced services	7,981	7,264	5,112	4,792	4,172	4,152
Depreciation	4,373	4,686	4,740	5,327	5,907	5,907
Interest & Capital Charge	1,466	1,540	1,512	2,532	5,728	5,728
Other	68,821	72,154	74,227	74,655	72,080	73,875
Total Expenditure	138,118	142,324	142,803	145,575	147,094	150,843
Net Surplus/(Deficit)	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	(1,087)	(1,000)	(878)	(2,086)	(1,776)	(3,571)

Part IV – Further Information for the Reader

Appendices

Appendix 10.1	Glossary of terms
Appendix 10.2	Objectives of a DHB
Appendix 10.3	Organisational chart
Appendix 10.4	West Coast Alliance Structure
Appendix 10.5	Minister's Letter of Expectations
Appendix 10.6	West Coast's commitment to National Health Targets
Appendix 10.7	DHB Performance Monitoring Framework
Appendix 10.8	Statement of Accounting Policies

References

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

Appendix 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 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 it is free and allows health concerns to be identified and addressed early 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.
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		A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early and the assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.
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.
IPIF	Integrated Performance and Incentive Framework	IPIF has been established to support the health system to address equity, safety, quality, access and cost of services. It is a quality and performance improvement programme that will reward good performance and will be developed and implemented over several years.
	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.
SPE	Statement of Performance Expectations	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of performance expectations 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.
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.

Appendix 2

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

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

PART 3: SECTION 22:

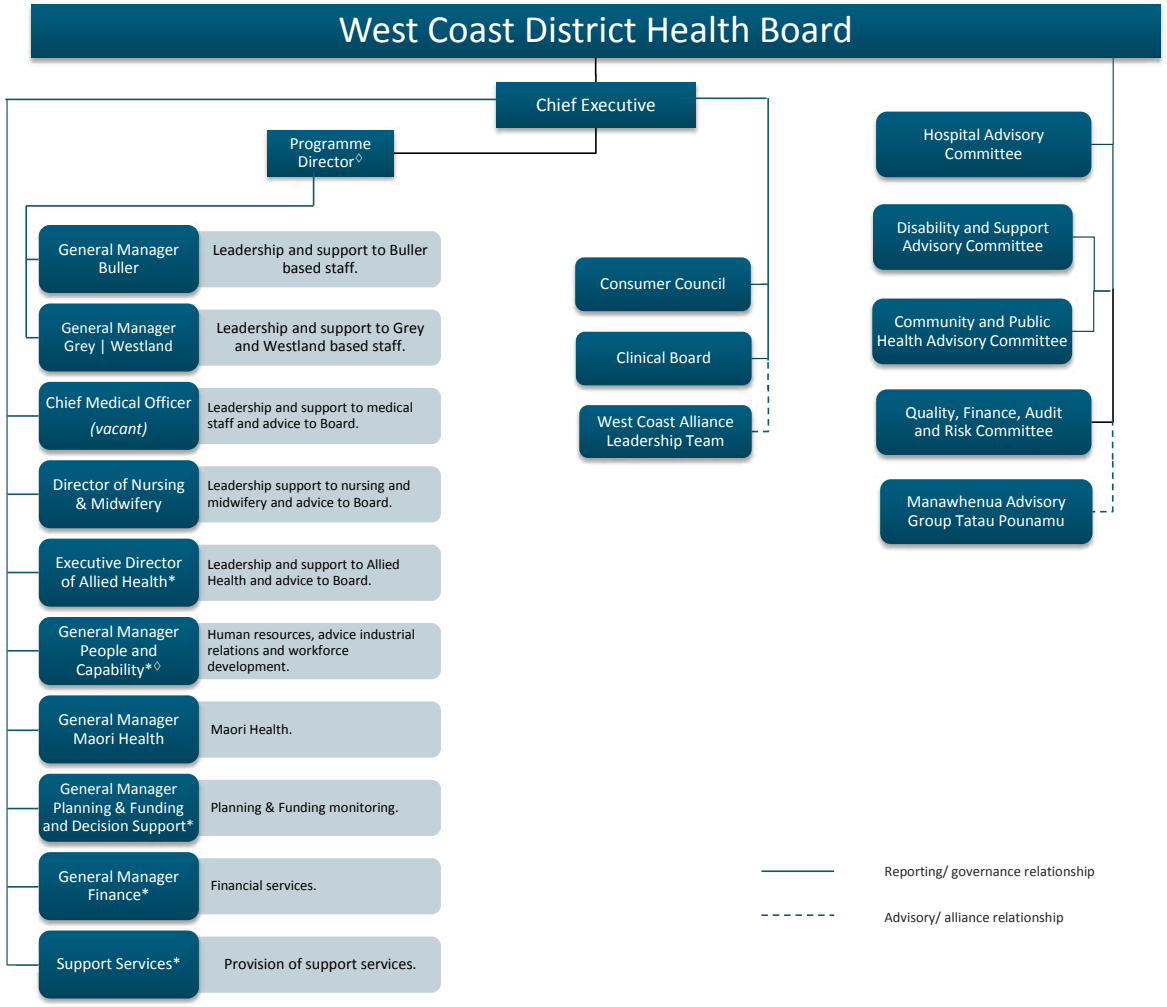
The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

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.

Appendix 3

West Coast DHB organisational structure



*Joint appointments with CDHB
◊Position filled by one individual

Appendix 4

West Coast Alliance Structure

Appendix 5

Minister of Health's letter of expectations for 2015/16

Office of Hon Dr Jonathan Coleman

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

17 DEC 2014

Mr Peter Ballantyne
Chair
West Coast DHB
37 Waiwetu Street
CHRISTCHURCH 8052

Dear Chair Peter

Letter of expectations for DHBs and subsidiary entities 2015/16

Thank you for the continued contribution you and your staff are making to a better public health service. It is important that we drive a team approach across the system.

While recognising these are tight economic times, the Government is committed to improving the health of New Zealanders and will continue to invest in key health services. Investment in our public health services has risen from a budget of $11.8 billion in 2008/09 to $15.6 billion in 2014/15. Health is the only portfolio with this sort of increase, which demonstrates the Government's on-going commitment to protecting and growing our public health services.

Fiscal Discipline/Management of the Health Portfolio

As I have discussed with you previously, DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. I recognise that DHBs want to have a greater role in the process of making back office savings to reinvest into frontline services, and want greater control of the implementation phase of the four health shared service business cases. It is essential that these business cases are implemented swiftly and savings achieved. The current transition process in place to shift responsibility for implementation of the business cases takes these considerations on board.

Leadership

Strong clinical leadership and engagement should be embedded in DHBs and utilised in all aspects of DHBs' core business eg budgeting and service design. Clinically driven service changes are encouraged where these make sense for patients and encourage positive

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system changes. DHBs are expected to include clear detail in their annual plans for 2015/16 that shows how they will foster clinical leadership.

DHB governance, senior management and clinical leaders need to work together in order to ensure we are heading in the same direction. 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. I expect you to spend time talking with clinical leaders and fostering, encouraging and supporting clinically-led decision making.

Integration between Primary and Secondary Care

Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, an aging population and patients in general. The pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings. I expect DHBs to move services closer to home in 2015/16, and DHBs need to have clear evidence of how they plan to do this. The key to better health, as well as financial sustainability, is earlier intervention and population-based initiatives delivered in the community.

National Health Targets

The national health targets are very important for driving overall hospital performance, and have resulted in major improvements in the health outcomes of New Zealanders. Health target performance continues to improve, but DHBs must remain focussed on achieving and improving performance against the targets, particularly the primary care targets, which are still some way from being achieved. I expect DHBs to work directly with primary health organisations and individual practices to drive performance against the primary care targets, and to provide clear and specific plans for achieving all national health targets in their annual plans.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator has become the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. The addition of this indicator ensures continued focus on improving cancer services.

Targets will continue to evolve over time, reflecting a range of dynamic factors. Any changes to current targets for 2015/16 are expected to be known early next year, and may entail adjustments to the electives, more heart and diabetes checks and better help for smokers to quit targets.

I also expect to see elective surgery access further boosted by [$50 million of] new funding to target more orthopaedic and general surgery, and the development of community-based intervention teams to treat musculoskeletal pain non-surgically.

Clinicians should focus on implementation of the agreed clinical prioritisation tools to support appropriate access for patients.

Tackling Key Drivers of Morbidity

As Minister of Sport and Recreation as well as Minister of Health, I am looking to strengthen the link between physical activity and keeping New Zealanders healthy. Obesity is a major risk factor for diabetes and other chronic conditions, which are key drivers of morbidity. We are currently doing a stocktake of 'what works' to reduce obesity, but in the meantime I expect all DHBs to be considering what they can do to help reduce the incidence of obesity in New Zealand.

A key Government priority is reducing the number of children living in material hardship. DHBs are already working closely with other social sector organisations to achieve sector goals in relation to the Government's Better Public Services initiatives and other cross-agency initiatives, such as Whānau Ora, Social Sector Trials, Children's Action Plan and Youth Mental Health. I expect district health boards to support cross-agency work that delivers outcomes for children across a range of dimensions – health, education, social and justice.

Refreshed New Zealand Health Strategy

At my request, the Ministry of Health is planning to update and refresh the New Zealand Health Strategy. Once this process is completed, the Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for delivery of health services to New Zealanders into the future. I expect DHBs to take an active part in the consultation for the refresh of the Strategy.

Additionally, a renewed focus on strategic direction should be evident in DHB annual plans for 2015/16. Therefore, all DHBs must refresh their statements of intent in 2015/16 and build these in to their annual plans. I also encourage you to take a strong interest in the Ministry of Health's four-year plan when it is available, as it will provide further clarity on how the sector is expected to manage its resources and prioritise activities over the next four years.

Finally, please keep in mind that the Budget 2015 process will clarify these and other Government priorities, and more information will be provided when available. Please share this letter with your clinical leaders and local primary care networks.

I thank you for the considerable effort you and your team are making, and I look forward to working with you in the future.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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Appendix 6

West Coast's commitment to the national health targets

SHORTER STAYS IN EMERGENCY DEPARTMENTS

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

Target: 95% of people presenting at ED will be admitted, discharged or transferred within six hours.

West Coast contribution – see section 6.9

IMPROVED ACCESS TO ELECTIVE SURGERY

Expectation: More New Zealanders have access to elective surgical services. Nationally, DHBs will deliver an increase in the volume of elective surgery by an average of 4000 per year.

Target: 1,889 elective surgical discharges will be delivered in 2015/16.

West Coast contribution – see section 6.10

FASTER CANCER TREATMENT

Expectation: 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016

Target: 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

West Coast contribution – see section 6.12

INCREASED IMMUNISATION

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

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

West Coast contribution – see section 6.13

BETTER HELP FOR SMOKERS TO QUIT

Expectation: 90% of smokers seen in primary care, 95% of hospitalised smokers and 90% of women at confirmation of pregnancy with general practice or a Lead Maternity Carer (LMC) are offered brief advice and support to quit smoking.

Target: 90% of smokers seen in primary care and 95% hospitalised smokers will receive advice and help to quit, 90% of pregnant smokers being offered advice and help to quit smoking.

West Coast contribution – see section 6.3

MORE HEART AND DIABETES CHECKS

Expectation: 90% of the eligible population have their cardiovascular risk assessed once every five years.

Target: 90% of the eligible population will have had CVD risk assessment within the past five years.

West Coast contribution – see section 6.4

Appendix 7

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%	3%	Quarterly
		Age 20-64	>3.8%		
		Age 65+	>3.0%		
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%	Quarterly
		8wks	95%	95%	
PP10 Oral Health DMFT Score at Year 8.	DMFT score at Year 8.	2015	1.30	NA	Annual
		2016	1.28		
PP11 Children caries-free at age 5 years.	% caries-free at age 5.	2015	56%	NA	Annual
		2016	56%		
PP12 Utilisation of DHB-funded dental services by adolescents.	School Year 9 up to and including age 17 years.	2015	85%	NA	Annual
		2016	85%		
PP13 Improving the number of children enrolled in DHB-funded dental services.	% of children (age 0-4) enrolled.	2015	90%	95%	Annual
		2016	95%		
	% of children (0-12) not examined according to planned recall.	2015	<10%	<10%	
		2016	<10%		
PP20 Improved management of LTC					
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.				Quarterly
Focus area 2: Diabetes Care Improvement Packages and Diabetes Management (HbA1c).	% of enrolled people aged 15-74 with acceptable glycaemic control (HbA1c ≤64mmol/mol).		Improve or, where high, maintain percentages.		
	Narrative quarterly report on DHB progress towards meeting its deliverables for Diabetes Care Improvement Packages (DCIP) identified in the 2015/16 annual plans				
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%	
	% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.		>95%	>95%	
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI.				

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		WEST COAST TARGET	NATIONAL TARGET	REPORTING FREQUENCY
Focus area 4: Stroke services.	% of potentially eligible stroke patients thrombolysed.		6%	6%	Quarterly
	% of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway.		80%	80%	
	Report on delivery of the actions and milestones identified in the Annual Plan.				
PP21 Immunisation coverage.	% of two-year-olds fully immunised.		95%		Quarterly
	% of five-year-olds fully immunised.		90% by end 2015/16 95% by end 2016/17		
	% of eligible girls fully immunised with dose three of HPV vaccine		65% for dose 3		
PP22 Improving system integration.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP23 Improving wrap-around services – health of older people.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
	% of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan		Provision of data that demonstrates an improvement on current performance		
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 2015/16 and for any actions which are in progress/going into 2016/17.				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	< 0.2 per 100,000		
PP29: Improved waiting times for diagnostic services.	% of accepted referrals for elective coronary angiography will receive procedure within 3 months (90 days).		95%	95%	Monthly
	% of accepted referrals for CT and MRI scans will receive scans within 6 weeks (42 days).	CT Scan	95%	95%	
		MRI Scan	85%	85%	
	% of people accepted for an urgent diagnostic colonoscopy receive their procedure within 2 weeks (14 days).		75%	75%	
	% of people accepted for a diagnostic colonoscopy receive their procedure within 6 weeks (42 days).		65%	65%	
	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date.		65%	65%	
PP30: Faster cancer treatment	(<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%	
SI1 Ambulatory sensitive (avoidable) hospital admissions.	DHB rate vs. national rate	Age 0-4	TBC	NA	Six-monthly
		Age 45-64	TBC		
		Age 0-74	TBC		

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION	WEST COAST TARGET	NATIONAL TARGET	REPORTING FREQUENCY
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	
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 (LOS).	Average Elective LOS.	≤1.59	1.59	Quarterly
	Average Acute LOS.	≤2.45	≤2014 baseline	
OS8 Acute readmissions to hospital.	% total population.	Improvement on baseline performance		Quarterly
	% population aged 75+.			
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 A).	>1.5% to ≤ 6%	>1.5% to ≤ 6%	Quarterly
	Recording on non-specific ethnicity (set to 'Not stated' or 'Response Unidentifiable').	>0.5% to ≤2%	>0.5% to ≤2%	
	Updating of specific ethnicity value in existing NHI record with a non-specific value.	>0.5% to ≤2%	>0.5% to ≤2%	
	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% to <99.5%	≥97% to <99.5%	Quarterly
	National collections file load success.	≥98% to <99.5%	≥98% to <99.5%	
	Standard vs. edited descriptors.	≥75% to <90%	≥75% to <90%	
	NNPAC timeliness.	≥95% to <98%	≥95% to <98%	
Focus area 3: Improving the quality of the programme for integration of mental health data (PRIMHD).	PRIMHD data quality.	Routine audits undertaken with appropriate action where required.		Quarterly
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

Appendix 8

Statement of accounting policies

The prospective financial statements in this Annual Plan for the year ended 30 June 2016 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 Annual Plan:

(i) Cautionary Note

The Annual Plan'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 West Coast DHB expects to take place.

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Annual Plan.

REPORTING ENTITY AND STATUTORY BASE

West Coast DHB ("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 has designated itself as a public benefit entity (PBEs) for financial reporting purposes.

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. West Coast DHB does not operate to make a financial return.

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

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

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 the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards. These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new PBE accounting standards.

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 Canterbury DHB is NZD.

Changes in accounting policies

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

Standards, issued but not yet effective and not early adopted.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. West Coast DHB will apply these updated standards in preparing its 30 June 2016 financial statements and expects there will be minimal or no change in applying these updated accounting standards.

SIGNIFICANT ACCOUNTING POLICIES

Foreign currency

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

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

Budget figures

The budget figures are those approved by West Coast DHB in its Annual Plan (incorporating the Statement of Intent) which is 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
- leased assets
- 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.

Revaluations

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 revenue and expense. 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 revenue. Additions to land and buildings between valuations are recorded at cost.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

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 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.

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

Where a physical asset is gifted to or acquired for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue.

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*
Freehold Buildings	3 - 50
Fit Out Plant & Equipment	3 - 50
Plant and Equipment	2 - 20
Vehicles	3 - 5

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. Staff training and other costs associated with maintaining computer software are recognised as an expense 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:

Type of asset	*Estimated life*	*Amortisation rate*
Software	2-10 years	10 - 50%

INVESTMENTS

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

Equity 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 Canterbury 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.

A receivable is considered impaired when there is evidence that West Coast DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

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. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

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

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

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 OF PROPERTY, PLANT, AND EQUIPMENT AND INTANGIBLE ASSETS

West Coast DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

RESTRICTED ASSETS AND LIABILITIES

Donations and bequests received with restrictive conditions are treated as a liability 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 using the effective interest method.

EMPLOYEE ENTITLEMENTS

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 - 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 West Coast 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, West Coast 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 a re-measurement to fair value is recognised immediately in the surplus or deficit.

The full fair value of a forward foreign exchange derivative is classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, foreign exchange derivatives are classified as non-current.

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 revenue

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

OPERATING LEASE PAYMENTS

Payments 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 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 ACCOUNTING ESTIMATES AND ASSUMPTIONS

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 programs;
- Review of second hand market prices for similar assets; and,
- Analysis of prior asset sales.

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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

ANNUAL PLAN AND STATEMENT OF INTENT

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