West Coast DHB Annual Report 2019/20

Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004

TABLE OF CONTENTS

Directory

Board Members

Hon Rick Barker, Chair	*(Term commenced 9 December 2019)*
Tony Kokshoorn, Deputy Chair	*(Term commenced 9 December 2019)*
Jenny Black, Chair	*(Term ended 8 December 2019)*
Chris Mackenzie, Deputy Chair	*(Term ended 8 December 2019)*
Chris Auchinvole	
Susan Barnett	*(Term commenced 9 December 2019)*
Sarah Birchfield	*(Term commenced 9 December 2019)*
Kevin Brown	*(Term ended 8 December 2019)*
Helen Gillespie	
Anita Halsall-Quinlan	*(Term commenced 9 December 2019)*
Michelle Lomax	*(Term ended 8 December 2019)*
Edie Moke	
Peter Neame	
Nigel Ogilvie	
Elinor Stratford	*(Term ended 8 December 2019)*
Francois Tumahai	

Acting Chief Executive

Dr Andrew Brant

Registered Office

West Coast District Health Board
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Greymouth

New Zealand Business Number

9429000098038

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Bank of New Zealand

Part I
Overview

Statutory Information

This Annual Report presents West Coast DHB's financial and non-financial performance for the year ended 30 June 2020. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

The West Coast DHB focuses on the provision of services for our resident population that improve health outcomes, reduce inequalities in health status, and improve the delivery and effectiveness of the services provided.

We take a consistent approach to improving the health and wellbeing of our community and:

- Promote messages related to improving lifestyle choices, physical activity and nutrition, and reducing risk behaviours such as smoking, to improve and protect the health of individuals and communities
- Work collaboratively with the primary and community health sectors to provide an integrated and patient-centred approach to service delivery
- Develop continuums of care and patient pathways that help to better manage long-term conditions and reduce acute demand on hospital services
- Work with our hospital and specialist services to provide timely and appropriate quality services to our population and improve productivity, efficiency and effectiveness
- Take a restorative approach through better access to home and community-based support, rehabilitation services and respite care to support people in need of personal health or disability services, to better manage their conditions, improve their wellbeing and quality of life, and increase their independence
- Collaborate across the whole health system to reduce disparities and improve health outcomes for Māori and other high-need populations and to increase their participation in the health and disability sector
- Actively engage health professionals, providers and consumers of health services in the design of health pathways and service models that benefit the population, and support a partnership model that provides a strong and viable voice for the community and consumers in health service planning and delivery
- Uphold the ethical and quality standard expected of public sector organisations and of providers of health services
- Have processes in place to maintain and improve quality, including certification and a range of initiatives and performance targets aligned to national health priority areas and the Health Quality and Safety Commission's work programme.

Statement of Responsibility

We are responsible for the preparation of West Coast District Health Board's financial statements and performance information, including the performance information for an appropriation required under section 19A of the Public Finance Act 1989, and for the judgements made in them.

We have the responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, except for the substantial uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003 and the uncertain impact on the financial statements as described in note 13 on page 60, these financial statements and the performance information fairly reflect the financial position and operations of West Coast District Health Board for the year ended 30 June 2020.
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Signed on behalf of the Board:

Hon Rick Barker
Chair

18 December 2020

Helen Gillespie
Chair | Quality, Finance, Audit & Risk Committee

Foreword from the Chair and Chief Executive

We are pleased to welcome you to our Annual Report for the 2019/20 financial year. This year has had its challenges and as always, in true West Coast style, we have risen to them.

The COVID-19 pandemic and its ongoing effects on the health and wellbeing of our communities have dominated the year. Our West Coast health system has been instrumental in the success of our regional response to date – highlighting the benefits of our integrated health model and the value of a whole of system response.

We'd like to acknowledge both our own West Coast DHB teams and our health system colleagues who often went above and beyond the call of duty to ensure that the healthcare needs of our communities were met. They have rightfully earned our heartfelt thanks and respect.

From General Practice, to pharmacy, to community-based care, to Aged Residential Care, to Community & Public Health and Canterbury Health Laboratories (that also provides services to the Coast) and, of course, to our multi-disciplinary hospital-based services – everyone demonstrated incredible professionalism and dedication in the provision of care and services as part of our regional COVID-19 response.

On behalf of all Coasters, thank you all for helping to keep us all safe through your exceptional efforts.

We know there will be further extraordinary demands on our health system over the coming year which will require our combined efforts. Thank you in advance for your mahi, for always putting the people we serve at the centre of everything we do, and for the pride and dedication with which you provide the best possible care.

Migration into our newest facility, Te Nikau Hospital & Health Centre, marked an important milestone for the Coast. It's an impressive building which provides a good benchmark for the other facility builds and upgrades underway and planned, which we look forward to migrating into in the future.

Facilities update

Te Nikau Hospital & Health Centre will officially open in September 2020. The opening will provide an opportunity to formally celebrate the completion of and migration into West Coast DHB's newest facility. This facility will be a testament to the enormous efforts of many of our staff who were involved in the various aspects of the planning, design and construction phases – a critical part of ensuring that our new facility meets the needs of the community.

Great progress is being made on the new Buller Health Centre, with the planned demolition that's needed to make way for construction well underway. Construction of the new $21 million Buller Health Centre is expected to start early in 2021.

Construction of Cowper Hub – the new West Coast DHB administration building on Cowper Street – was completed in November 2019. The building provides a facility for all DHB personnel not based within Te Nikau Hospital & Health Centre or in the existing Corporate Services building.

The work required to complete the fit out of the new Haast Health Centre is expected to be completed shortly, with the anticipated move into the new facility earmarked for early 2021. The new clinic, which is co-located with St John in the existing St John premises in Haast Township, includes an accessible toilet, waiting room, consult room, treatment room and multi-use storage/utility room with staff amenities being shared with St John staff. There will be direct access from the clinic into St John to facilitate patient transfer.

Implementing a rural generalist model

Over the past year, the DHB has taken several steps towards implementing a rural generalist model, a proven strategy for creating a more integrated and sustainable workforce in more remote rural health systems.

It involves all professions – medical, nursing, midwifery and allied health – working to the full extent of their scope of practice as members of a multi-disciplinary team. A rural generalist doctor, for example, may be qualified to work in both general practice and hospital settings with a speciality in obstetrics for example. They would also be supported by local and Christchurch based specialists, enhancing the capacity, capability and resilience of our health system.

Developing a core workforce of rural generalists will improve the sustainability of services, support a more integrated model of care and provide continuity of care for our population. By

improving service access, it will also help us to support people to stay well, reduce health inequalities and improve health outcomes – all key goals for our health system.

As part of the expansion of their scope of key clinical roles, professionals can access education and leadership training.

The DHB will always need to refer people to larger centres for highly specialised care, such as: neurosurgery, forensic services, some cardiac care and cancer treatments, specialised burns treatments and neo-natal intensive care; however, the implementation of a rural generalist model supports our primary focus of ensuring that Coasters receive the right level of care in the right place, from the right people, at the right time.

Hauora Māori

Addressing inequalities in health outcomes for our Māori community remains a key focus of the DHB. Our Hauora Māori team regularly engages with staff from across the health system in the use and application of the Health Equity Assessment Tool (HEAT). HEAT is a planning tool used to identify areas of change and help improve programmes and services to promote health equity when making health decisions. Its use plays an important role in ensuring that we continue to improve the health outcomes of Coast Māori.

One example of our success is the achievement of 97% of Māori children receiving a B4 School Check at age four where the national average is 67%.

People at the heart of all we do

Consistent with our vision for the West Coast health system and our organisational values, West Coast DHB is committed to being a good employer and a great place to work and develop.

We continue to ensure our People and Capability policies and processes across the West Coast DHB reflect best practice including our Code of Conduct, Health and Safety Policy, and Diversity, Inclusion and Belonging Policy.

We are also committed to ensuring that we have ongoing engagement with our people in the development, review and renewal of programmes and policies. We do this by engaging regularly with our people via multiple channels and initiatives, including our "Care Starts Here" programme of work.

Workplace safety, health and wellbeing

We are committed to providing a safe and healthy workplace, supported by a professional Wellbeing, Health and Safety team, which includes experts on workplace safety, occupational health, rehabilitation and employee wellbeing.

A key area of focus for the foreseeable future is minimising the impact of the COVID-19 pandemic on our staff by providing ongoing wellbeing support for those who need it.

Our people, and their whānau, are also encouraged to use the range of available support if they are faced with work or personal issues. These supports extend to tailored care packages for individuals and teams and a toolkit of self-care options.

Recruitment, selection and equal opportunities

West Coast DHB is fortunate to have a diverse, flexible and highly skilled workforce that contributes significantly to the provision of quality, culturally and individually appropriate services.

We are committed to encouraging and supporting our current workforce and to attracting new people to the West Coast health system to ensure that we continue to be well placed to meet the healthcare needs of our communities today and into the future.

Thank you

Once again, our staff, our alliance partners and the many community providers who are part of the wider West Coast health system have risen to this year's significant challenges. Your dedication to continually providing world-leading care and support to our population is hugely appreciated by those we support and provide services for across the Coast.

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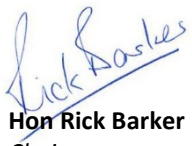


Hon Rick Barker
Chair

Dr Andrew Brant
Acting Chief Executive

18 December 2020

Part II
Improving Outcomes

Monitoring Our Performance

As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

DHBs have a number of different roles and associated responsibilities. In our governance role, we are concerned with health equity and outcomes for our population and the sustainability of our health system. As a funder, we are concerned with the effectiveness of our health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the services we deliver and the efficiency with which they are delivered.

There is no single performance measure or indicator that can easily reflect the impact of the work we do. In line with our vision for the future of our health system, we have developed an overarching intervention logic and system outcomes framework to monitor and evaluate our performance over time.

The framework helps to illustrate our population health-based approach to performance improvement, by highlighting the difference we want to make in terms of the health and wellbeing of our population. It also encompasses national direction and expectations, through the inclusion of national targets and system level performance measures.

At the highest level, the framework reflects our three strategic objectives and aligns to three wellbeing goals, that we share with our regional DHB partners, where we believe our success will have a positive impact on the health of our population.

Aligned to each wellbeing goal, we have identified several long-term population health indicators which will provide insight into how well our system is performing over time. The nature of population health is such that it may take several years to see marked improvements. Our focus is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

MAIN MEASURES OF PERFORMANCE

To evaluate our performance over the shorter term, we have identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change will be evident over a shorter period, these contributory measures have been selected as our main measures of performance.

We have set performance standards for these measures to evaluate our performance and determine if we are moving in the right direction. Tracking our performance in this way helps us to evaluate our success in areas that are important to our community and stakeholders and is an essential part of the way in which we hold ourselves to account.

These contributory measures sit alongside our annual Statement of Performance Expectations (the following section of this report), outlining the service we plan to deliver and the standards we expect to meet in the coming year. They are also reflected in our System Level Measures Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

The intervention logic diagram on the following page demonstrates the anticipated value chain, by illustrating how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to the goals of the wider South Island region and delivers on the expectations of Government.

As part of our obligations under legislation, DHBs must work towards achieving equity for all population groups. To promote this goal, the performance standards set are the same for all populations. As a means of evaluating whether we have made a difference in reducing inequities, performance is reported by ethnicity wherever breakdowns are available.

Overarching Intervention Logic Framework

Te Tiriti O Waitangi

We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Māori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

Wellbeing Outcomes

People are healthier and enabled to take greater responsibility for their own health

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions. Cancers, heart disease, musculoskeletal conditions, respiratory disease, diabetes and mental illness are major drivers of poor health and premature mortality and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates that long-term conditions make up 87.3% of all health loss in New Zealand up from 82.5% in 1990.[1]

WHERE ARE WE FOCUSED?

Tobacco smoking, inactivity, poor nutrition and hazardous drinking and substance abuse are major risk factors for several of the most common long-term conditions. These are modifiable risk factors and can be reduced through supportive environments and improved awareness, which enable people to take personal responsibility for health and wellbeing. Public health promotion and education services, by supporting people to make healthier lifestyle choices, will improve health outcomes for our population. Because these major risk factors also have strong socio-economic gradients, a change in behaviours will contribute to reducing inequities in health outcomes between population groups.

OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

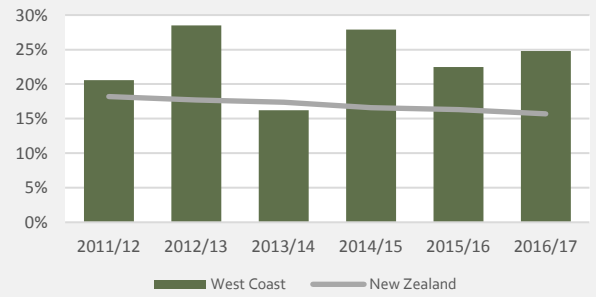
The latest NZ Health Survey results indicate that 25% of our population smoke. The West Coast's smoking rates are well above the national average (16%), and further work is needed to help our community understand the health risks associated with smoking and change their behaviour. Combined results from 2014/2017 show that smoking rates are highest among our Māori population.

Providing smokers with brief advice to quit smoking at every opportunity, increases their chances of making a quit attempt. The likelihood of that quit attempt being successful is increased if cessation support is also provided.

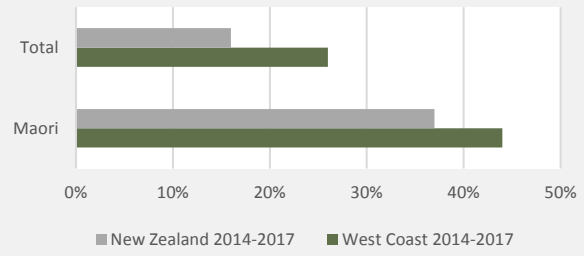
We continue to deliver brief smoking advice and cessation support at all contact points across our health system, with a focus on pregnant women. In 2019/20, 100% of pregnant smokers (identified as smokers when registering with a lead maternity carer) were offered brief advice and support to quit smoking.

In the past 15 months, 93% of current smokers identified in primary care were offered brief advice to quit. More than 90% of hospitalised smokers were also offered brief advice and cessation support during their hospital stay.

Proportion of the population (15+) who currently smoke



Proportion of the population (15+) who currently smoke



Data source: National NZ Health Survey [2]

[1] Ministry of Health, Health and Independence Report 2017.

[2] The NZ Health Survey is an annual survey commissioned by the Ministry of Health which collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2016/17 Survey is the most recently released time series available and while total population results are presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers. For further information refer to the Ministry website for the NZ Health Survey results.

OUTCOME MEASURE – A REDUCTION IN OBESITY RATES

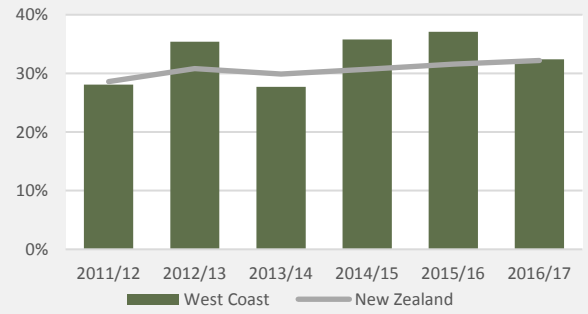
The last reported Health Survey showed the West Coast obesity rate falling slightly to align with the national average in 2016/17.

Obesity impacts on people's quality of life and is a significant risk factor for many long-term conditions. While many of the drivers of obesity sit outside of the direct control of the health system, we have a role in supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to make healthier choices.

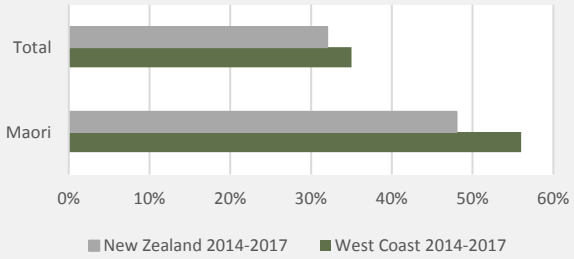
Children who may need weight management and healthy lifestyle support are identified at their B4 School (health) Check prior to starting school. In 2019/20, 94% of West Coast four-year-olds received their B4 School Check and 100% of those children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice.

We also continue to invest in lifestyle programmes that support people to increase physical activity or make healthy food choices, including the Green Prescription programme. In 2019/20, 450 people were referred into the Green Prescription programme by their health professional.

Proportion of the population (15+) who identify as obese



Proportion of the population (15+) who identify as obese



Data source: National NZ Health Survey [3]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

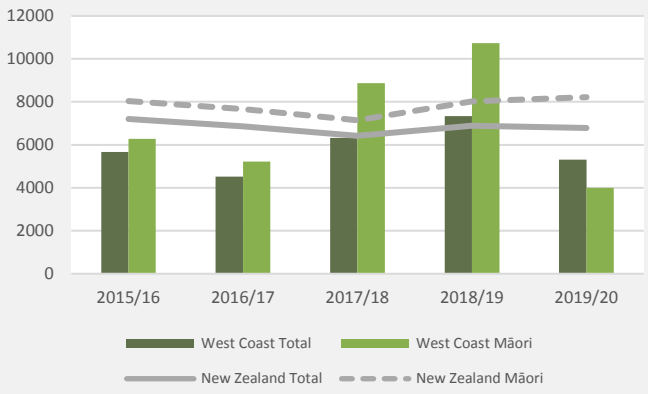
Fewer avoidable hospital admissions

In 2019/20, West Coast's ambulatory sensitive hospital (ASH) admission rate for children under five was 5,304 per 100,000, which was well below both the target and the national rate of 6,778.

While the ASH rate is disproportionately impacted by our small population numbers, it is positive to note that following two years of increasing rates performance has dropped back to a lower level of admissions. With a small population, small changes in clinical practice or support for individual families can contribute to changes in ASH rates. The difference in the total rate between March 2019 and March 2020 represents 36 fewer hospital admissions across the year. The Māori rate reflects 16 fewer events over the same period.

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system that engages earlier with parents and children. In the past year, 90% of newborns were enrolled with a primary care team before three months of age.

Measure: Rate of Ambulatory sensitive hospitalisations for children (0-4)	2017/18	2018/19	Target	Result
	6,324	7,333	<6,871	5,304



Data Source: Ministry of Health Performance Reporting [4]

[3] The NZ Health Survey is an annual survey commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2016/17 Survey is the most recently released time series available and while total population results are presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers.

[4] This is a national DHB performance indicator and captures hospital admissions for conditions considered preventable, including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The ASH results are published three months in arrears and the results reflect the 12 months to March 2020.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Children have improved oral health

West Coast DHB provides free oral health care for children from birth to 17 years, with a key focus on ensuring that all eligible children are enrolled and are examined on time.

The percentage of five-year-old children whose teeth are caries-free (have no holes or fillings) decreased slightly compared with last year for the total population and for Māori.

Performance data shows that while 98% of 0-12-year-old children enrolled with oral health services were examined according to planned recall, only 88% of children aged 0-4 were enrolled in 2019/20.

A transalpine Oral Health Alliance is working to improve oral health outcomes and address equity gaps – sharing data across child health services to better identify children and help establish contact with families.

Measure: Children caries-free at age 5	2017	2018	Target	Result
	57%	59%	>60%	55%

Data Source: DHB School & Community Oral Health Services [5]

Fewer young people take up smoking

The Action on Smoking and Health (ASH) Survey is one of the largest youth smoking surveys in the world. It is a census style questionnaire that surveys around 30,000 students on their smoking behaviour and attitudes.

The 2019 survey results show a slight drop-off from 2018 rates for the West Coast with 71% of West Coast Year 10 students reporting having never smoked compared to 80% across New Zealand. The small West Coast population contributes to fluctuations between years, however further focus is needed to ensure more of our young people are not taking up smoking.

Measure: 'Never Smokers' amongst Year 10 students	2017	2018	Target	Result
	78%	76%	>79%	71%

Data Source: National ASH Year 10 Survey [6]

[5] This measure is a national DHB performance indicator and is reported annually for the school year.

[6] The ASH Survey is a national survey used to monitor student smoking rates since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students who are aged 14 or 15 years at the time of the survey. Ethnicity breakdowns are not provided due to small survey numbers. For further information see www.ash.org.nz.

People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

When people are supported to stay well and can access the care they need closer to home in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital admission, residential care or premature mortality (death). This is not only better in terms of people's health outcomes and quality of life, 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 premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital level response.

WHERE ARE WE FOCUSED?

The general practice team is a vital point of ongoing continuity, particularly in terms of improving care for people with long-term conditions and supporting people to avoid a deterioration of their condition that might lead to a hospital admission. As such, we are investing in general practice, community based allied health, pharmacy and diagnostic services with the aim of improving access to services closer to people's homes and enabling earlier detection and diagnosis and treatment.

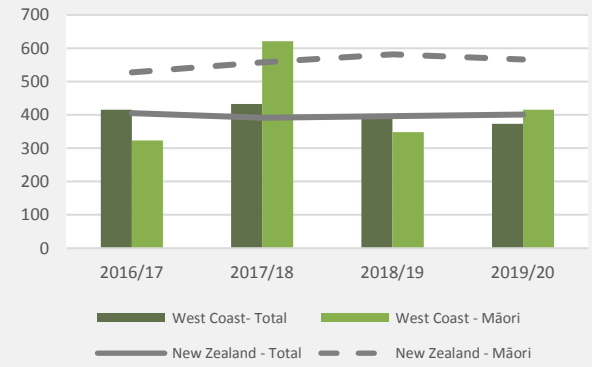
OUTCOME MEASURE – A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand. In 2019/20, 51% of admissions to Grey Hospital were acute.

Acute hospital bed-days are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatments that reduces the crisis and deterioration that leads to an acute hospital admission. The measure also reflects the quality and effectiveness of discharge planning in supporting people to go home earlier.

Our acute hospital bed day rate is positive in comparison to national rates, particularly for Māori. Our primary care-led Long-term Conditions Management Programme is a key factor in reducing acute admissions. The Programme supports people to better manage their health and long-term conditions and helps to prevent people from becoming acutely unwell. Over 3,900 people were enrolled in the Programme in 2019/20.

Rate of acute hospital bed-days



Data Source: National Minimum Data Set[7]

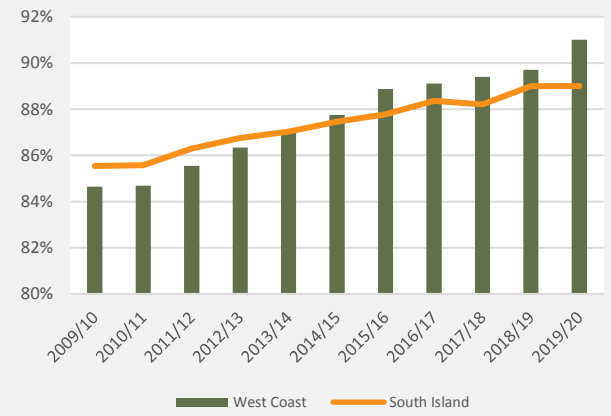
OUTCOME MEASURE – MORE PEOPLE LIVING IN THEIR OWN HOME

The proportion of the West Coast population (aged 75+) living in their own homes continues to increase, lifting a further 1% compared to last year to 91%. Consistent with our strategy, this positive trend suggests our older population is able, or being supported, to live more independently and is a positive trend as our population continues to age.

Several local programmes support our older population to maintain their health and wellbeing and to age-in-place for longer, including: age-related harm prevention and long-term condition strategies, falls prevention programmes, restorative rehabilitation, home-based support and respite services.

Falls in older people are a common and frequently lead to injury and hospitalisation, a loss of confidence, and an increased risk of admittance to institutional care. In 2019/20, 84 people over the age of 65 were supported by our In-Home Falls Prevention Service and many more accessed community-based Strengths and Balance classes to reduce their falls risk.

Proportion of the population (75+) living in their own home



[7] This is a national System Level Measure, data is provided by the Ministry of Health via the national minimum data set. There is a difference in presentation to the 2019-23 Statement of Intent as the Ministry baselines were originally presented against calendar year. These have been reset during the 2019/20 year to financial years. The baseline results have been reset to reflect the current series. This measure is age standardised and presented as a rate per 100,000 people.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People's conditions are diagnosed earlier

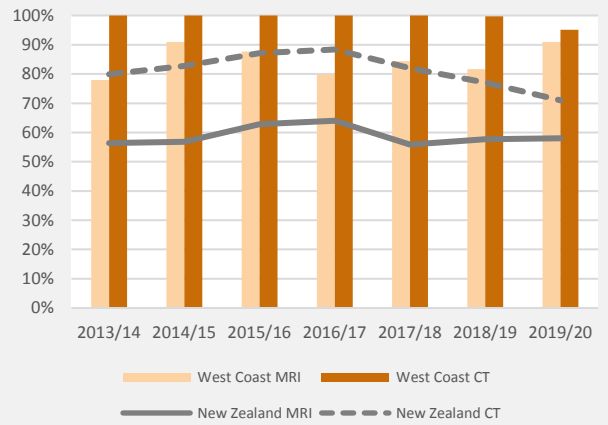
Diagnostics are an important part of the healthcare journey. Timely access to diagnostics improves clinical decision making and enables early and appropriate intervention, improving the quality of care and outcomes for our population.

Demand for CT and MRI scanning has been exceeding capacity across both the public and private sectors and wait times are increasing across the country.

The Canterbury DHB delivers MRIs for our population and capacity constraints in Canterbury impact on West Coast wait times. Additional clinics and work to improve patient flow in Canterbury has reduced waits in 2019/20.

During the relocation of services to the new Te Nikau facility the CT machine was unable to be used for two weeks, which has impacted on CT performance in 2019/20. We expect this to lift back to previous levels in the coming year now the move has been completed.

Measure: People receiving their non-urgent MRI or CT scan within six weeks		2017/18	2018/19	Target	Result
	MRI	84%	82%	90%	91%
	CT	100%	100%	95%	95%



Fewer avoidable hospital admissions

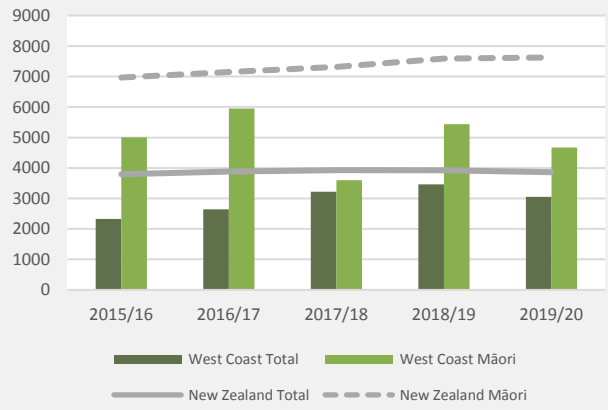
In 2019/20, West Coast's avoidable hospital admission rate for 45-64-year-olds was 3,056 per 100,000 people. This result is better than both the target and the national rate of 3,858.

Our Māori rate decreased to 4,670. While our rate is disproportionately impacted by small population numbers (the difference represents just 2 fewer admissions over the past year) it is significantly lower than the national Māori rate at 7,626 admissions per 100,000.

This measure is seen as a marker of good quality primary care and a well integrated and connected health system, particularly in relation to long-term conditions which, if not well managed, often lead to hospital admissions.

High enrolment rates are an indication of good engagement with our health system. In 2019/20, 96% of the total population and 90% of Māori were enrolled with a West Coast general practice. This was a 4% increase on enrolments over the previous year for Māori. Enrolments in the primary care-led Long-term Conditions Management Programme remain high with over 3,900 people enrolled during in 2019/20.

Measure: Ambulatory sensitive hospitalisation for adults (45-64)	2017/18	2018/19	Target	Result
	3,224	3,458	<3,496	3,056



Data source: Ministry of Health Performance Reporting[8]

[8] This measure is a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results reflect updated national data provided by the Ministry of Health in June 2020 being results for the 12 months to March 2020.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

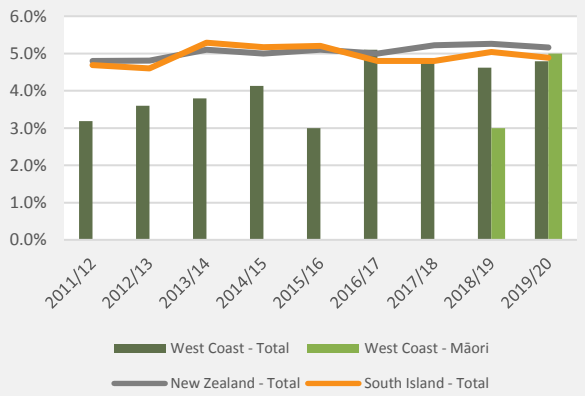
Fewer falls related hospitalisations

At 4.8%, the proportion of our population (aged 75+) admitted to hospital following a fall increased slightly compared with the previous year but remains 0.4% lower than the national average. The increase was due to nine additional admissions during the year compared with 2018/19. The Maori rate increased compared with the previous year however the numbers are small with five admissions compared with three the previous year.

This continued lower rate is a positive trend. With an ageing population, our focus on falls prevention is crucial in supporting our strategic direction, helping people to stay well and independent, and reducing avoidable demand on services.

In the last year, 84 people accessed the community-based falls prevention service on the Coast, this was lower than previous years due to COVID restrictions in place during quarter three and four. The service has resumed and along with our community-based Strengths and Balance classes will support people at risk of falls.

Measure: Population (75+) admitted to hospital because of a fall	2017/18	2018/19	Target	Result
	4.8%	4.6%	<5.0%	4.8%



Data Source: National Minimum Data Set

People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are indicative of a well functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it.

As the primary provider of hospital and specialist services on the West Coast, this goal also considers the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population, people's experience of care and their confidence in the health system. Ineffective or poor quality treatment and long waits for treatment also waste resources and add unnecessary cost.

WHERE ARE WE FOCUSED?

We are in the middle of a significant facilities redevelopment and repair programme and are transforming the way we deliver services to increase capacity with the resources we have available. We are focusing on improving the flow of patients across our system and reducing duplication of effort to maintain service access while reducing waiting times for treatment. We also aim to increase the value from our investment in technology to support clinical decision making and improve the quality of the care we provide.

OUTCOME MEASURE – A REDUCTION IN AMENABLE MORTALITY

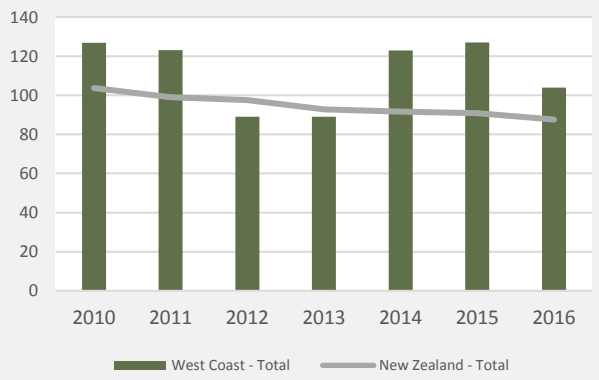
The last available mortality rates are positive with amenable mortality rates falling for the total West Coast population.

Prevention, screening and long-term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment. The West Coast Long-term Conditions Management Programme continues to have high uptake with over 3,900 people enrolled in 2019/20.

Cancer is one of the leading causes of mortality in New Zealand and contributes to a high proportion of premature deaths. Faster Cancer Treatment performance has improved compared with the previous year with 83% of West Coast patients receiving treatment within 62 days of referral and 93% receiving treatment within 31 days of a decision to treat being made.

Mental illness also contributes greatly to premature mortality and mental health remains a major focus for the DHB. In the past year over 500 people accessed Brief Intervention Support in primary care and 6% of our adult population accessed specialist mental health support.

Measure: rate of amenable mortality for people aged under 75 (age standardised, per 100,000 people)



Data Source: National Mortality Collection[9]

[9] Performance data for this measure is sourced from the national mortality collection which is three years in arrears. 2017 results were not available nationally at the time of printing.

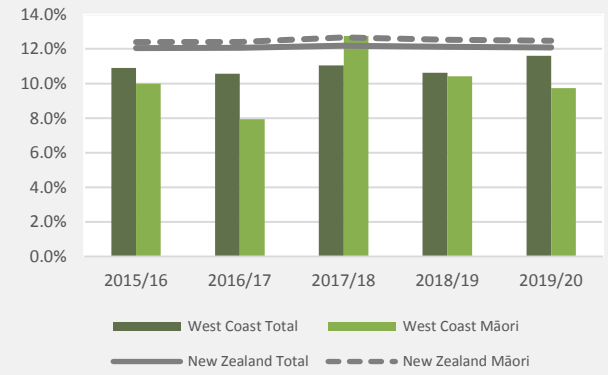
OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

Patients who are readmitted to hospital are more likely to experience negative long-term outcomes. Readmissions to hospital also reduce public confidence in our health system and increase operational costs.

West Coast's readmission trend remains relatively flat for the total population despite a slight increase in 2019/20. At 11.6% our readmission rate is below the national average of 12.1%. The West Coast Māori rate continues a positive downward trend falling from 10.4% to 9.7% in the last year.

Service quality, patient safety and good discharge planning are key factors in reducing acute readmissions. The DHB has made a strong commitment to the implementation of the Health Quality and Safety Commission's Open for Better Care Campaign. FIRST, our Flexible Integrated Rehabilitation Support Team, is also now operational with eight people supported back into the community following discharge from our hospitals in the past year.

Proportion of people acutely readmitted to hospital within 28 days of discharge



Data Source: National Minimum Data Set

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

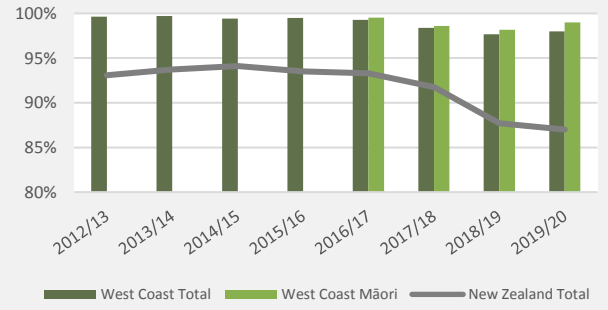
People have shorter waits for urgent care

West Coast DHB continues to be a leading performer against the national Shorter Stays in ED health target, with 98% of people presenting in our Emergency Department being admitted, transferred or discharged within six hours.

There were 11,043 presentations to the West Coast Emergency Department this year, compared to 11,829 in 2018/19, with COVID-19 lockdown likely impacting on numbers.

Several community-based urgent care options support people to access urgent care in the community, rather than in our ED including: extended access to general practice after hours, with free after-hours general practice consultations for children under 14 years and telephone triage services.

Measure: People are admitted, discharged or transferred from ED within 6 hours	2017/18	2018/19	Target	Result
	98%	98%	95%	98%



Data Source: National Minimum Data Set

People have shorter waits for planned care

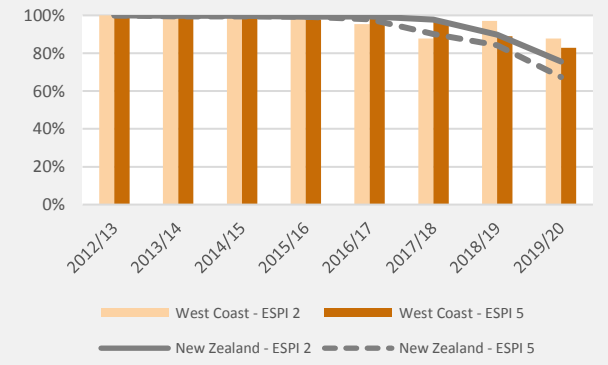
As is evident across the country, increasing service demands and the impact of COVID-19 restrictions have reduced performance against waiting time expectations.

While the West Coast DHB has missed the waiting time targets for both measures in 2019/20, performance is well above the New Zealand average.

In the past year 3,220 planned care interventions were delivered for the West Coast population, including 1,791 inpatient surgical events, 1,196 minor procedures, and 233 non-surgical interventions.

The DHB continues to explore opportunities to improve wait times, particularly in orthopaedics and plastics which are service areas with the longest waiting time delays. We are working closely with the Canterbury DHB in the development of Transalpine services to support access for our population.

Measure: People receiving specialist assessment and treatment within set timeframes.		2017/18	2018/19	Target	Result
	ESPI 2	88%	97%	100%	88%
	ESPI 5	97%	89%	100%	83%



Data Source: Ministry of Health Quickplace Warehouse [10]

[10] These indicators are two of the national Elective Services Patient Flow Indicators (ESPIs), established to track system performance. In line with national ESPI reporting, the annual results refer to the final month of each year (June). ESPI 2 represents those people receiving their First Specialist Assessment within four months and ESPI 5 represents those given a commitment receiving that treatment within four months.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

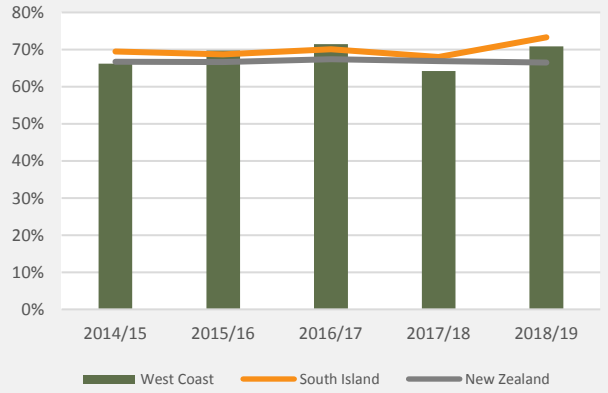
People Are Supported on Discharge

Research indicates that people having a psychiatric admission have increased vulnerability immediately following discharge, including higher risk of suicide, while those leaving hospital with a formal discharge plan and links to community-based services and supports, are less likely to experience early readmission.

This indicator is a marker of good discharge planning, service integration and the continuity of care between hospital and community services. West Coast performance improved between 2017/18 and 2018/19 and is now above the national average for this important measure.

The DHB works closely with the local community provider of Alcohol and Other Drug services to ensure good links and integration between services.

Measure: Inpatients accessing community-based MH and AOD services within seven days of discharge	2017/18	2018/19	Target	Result
	64%	71%	80%	n.a.

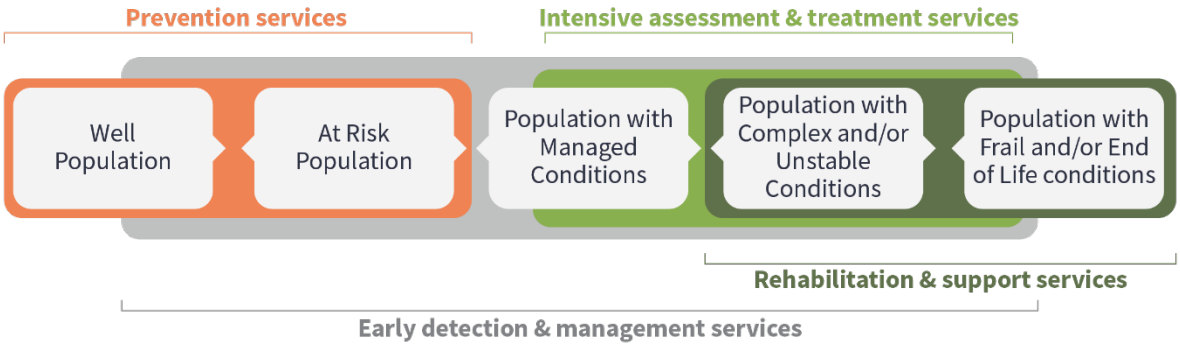


Data Source: National Mental Health KPI Framework.[11]

[11] Data for this measure is provided via the national KPI programme and the results for 2019/20 have not yet been released to DHBs.

Part III
Delivering on our Plans

Statement of Service Performance



Evaluating Our Performance

As both the major funder and provider of health services on the West Coast, the decisions we make and the way in which we deliver services have a significant impact on people's health and wellbeing.

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes, encompassed in our Outcomes Framework. These longer-term health indicators are highlighted on the previous pages.

We also evaluate our performance on an annual basis by providing a forecast of the services we plan to deliver and the standards we expect to meet. The Statement of Service Performance set out in this section presents the DHB's performance against the 2019/20 forecast, presented in our 2019-2023 Statement of Intent and available on our website.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service delivered, services have been grouped into four service classes. These are common to all DHBs and reflect the type of services provided across the full health and wellbeing continuum (illustrated above):

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

Under each service class we have identified a mix of service measures that we believe are important to our community and stakeholders and provide a fair indication of how well the DHB is performing.

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time.

To ensure a balanced, well rounded picture the mix of measures identified address four key aspects of service performance that matter most to our population:

Access (A)
Are services accessible, is access equitable, are we engaging with all of our population?

Timeliness (T)
How long are people waiting to be seen or treated, are we meeting expectations?

Quality (Q)
How effective is the service, are we delivering the desired health outcomes?

Experience (E)
How satisfied are people with the service they receive, do they have confidence in us?

As part of our obligations under legislation DHBs must also work towards achieving equity. To promote this goal, and as a means of evaluating whether we have made a difference for our Māori population, we have identified a core set of performance measures that are important in terms of Māori health. These measures are presented by ethnicity on page 30.

SETTING STANDARDS

In setting performance standards for each year, we consider the changing demographic of our population, areas of increasing demand, and the assumption that resources and funding growth would be limited.

While targeted interventions can reduce demand in some areas, there will always be some service areas where the DHB cannot influence demand, such as maternity, dementia or palliative care services.

It is not appropriate to set targets for these services however they are an important part of the picture of health need and service delivery in our region. We have set service level estimates for these services and report on service access to give context in terms of the use of resources across our health system.

In areas where we do have more influence, targets set for 2019/20 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

Many of the performance targets are national targets set for all DHBs. The West Coast's small population size means one or two people can have a disproportionate impact on our results and performance can easily fluctuate year-on-year. We knew that a number of the standards would be difficult to meet.

What we could not predict at the time was the unprecedented events of 2020, with the COVID-19 pandemic affecting all parts of our health system. The lockdown and level three and four restrictions severely limited access to services and service delivery models had to be redesigned to support social distancing and ensure the safety of both patients and staff.

Services most impacted were those face-2-face and group session services and services where older people would be at risk. Some providers changed their service models from visits to phone calls and while this meant services were still being provided, not everyone had systems in place to record these sessions. Other services were unable to function in level three and four and could only resume in level two.

The diversion of general practice and hospital services onto the COVID-19 response, along with people staying away from general practice and pharmacy during lockdown, has meant routine wellness checks have not been completed such as brief advice on smoking, intervention counselling, diabetes screens and breast screening.

Non-urgent specialist assessments and outpatient appointments had to be reduced or cancelled in response to COVID restrictions and waiting time targets have been particularly difficult to meet following the cancellation of sessions, assessments or treatments during lockdown.

Considering these factors, it is pleasing to see that many of the service targets have been met due to the efforts of providers to reschedule assessments and treatments following the lockdown. Footnotes have been added where it has been clear that performance has been impacted by COVID-19.

NOTES FOR THE READER

We note that several national performance measures were dropped from the DHB performance framework during the 2019/20 year. This included acute and elective lengths of stay which the DHB was tracking as part of its Statement of Performance Expectations set. With the national data no longer available the DHB has not been able to report results for these two measures for 2019/20. We have also footnoted where other national data has been delayed and was not available at the time of printing.

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

Δ Performance data is provided by external parties and can be affected by a delay in invoicing or reporting. Results for previous years are subject to change as a result of incorporating late data.

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

◇ The measure is reported nationally as a key DHB performance target and in line with national performance reporting, fourth quarter (April-June) are reported as the annual result.

◆ The measure is a core Māori health measure. Refer to page 30 for a breakdown of results by ethnicity.

Performance Key		
	Rating	Criteria
✓	Achieved	Standard reached
↺	Partially Achieved	Standard not reached but performance maintained or improved or the equity gap between population groups has reduced
✗	Not Achieved	Standard not reached and performance dropped

E Some services are demand driven. It is not appropriate to set targets for these services, but service volume estimates are provided to give context in terms of the use of resources across our health system and the direction of travel.

Performance Key for Estimated Volumes		
	Rating	Criteria
✓	Achieved	Performance is moving in the indicated (desired) direction of travel or is within 10% of estimated volumes.
✗	Not Achieved	Performance is moving against the desired direction of travel or variance is greater than 10% of estimated volumes.

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services are those that promote and protect the health of the whole population, or targeted sub-groups, and influence individual behaviours by targeting changes to physical and social environments to engage, influence and support people to make healthier choices.

By supporting people to make healthier choices, the DHB can reduce the major risk factors that contribute to poor health such as smoking, poor diet, obesity, lack of physical exercise and hazardous drinking. High-need population groups are more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are also designed to spread consistent messages to a large number of people and can therefore also be a very cost-effective health intervention.

SERVICE PERFORMANCE 2019-2020

Population Protection Services – Healthy Environments							
These services address aspects of the physical, social and built environment to protect health and improve health outcomes.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q	14	14	E. 15	15	-	✓
Licensed alcohol premises identified as compliant with legislation	Q[12]	95%	96%	90%	100%	-	✓
Networked drinking water supplies compliant with Health Act	Q[13]	56%	81%	97%	n.a	-	-

Health Promotion and Education Services							
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement and healthier choices.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Mothers receiving breastfeeding support and lactation advice in community settings	A	191	193	>100	228	-	✓
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q[14]◆	72%	76%	75%	n.a	n.a	-
Babies exclusively/fully breastfed at three months	Q◆	61%	64%	70%	n.a	n.a	-
People provided with Green Prescriptions for additional physical activity support	A[15]	458	458	>400	450	-	✓
Green Prescription participants more active six to eight months after referral	Q	65%	n.a	>50%	n.a	-	-
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC) in the last 15 months	Q◆	88%	96%	90%	93%	80%	✓
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q◆	91%	91%	95%	91%	-	↺
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[16]◆	98%	100%	90%	100%	-	✓

[12] The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. Compliance is a proxy measure of the success of education and training for licensed premises and reflects a culture that encourages a responsible approach to alcohol. Due to COVID-19 restrictions, no Controlled Purchase Operations were conducted in the period 1 January 2020 to 30 June 2020. Controlled Purchase Operations compliance in this instance refers to the period 1 July 2019 to 31 December 2019 only.

[13] This measure relates to the percent of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. Errors were identified in the Ministry of Health's 2017/18 Annual Report on drinking water quality, the result has been updated to 56%, different to the previously reported 63% result. Water quality reports are published one year in arrears with 2018/19 being the latest available at the time of printing.

[14] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. These breastfeeding measures are part of the national Well Child/Tamariki Ora Quality Framework. Result for 2018/19 were released this year, results for 2019/20 were not available at the time of printing.

[15] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. During COVID, green prescriptions continued to be provided virtually and so were not impacted by the lockdown restrictions. The DHB has been advised that the bi-annual survey, which tracked patient activity following referral, is no longer being undertaken by the Ministry of Health.

[16] This data is sourced from the national Maternity Dataset and is provided by the Ministry of Health. The 2019/20 result reflects the performance of the West Coast system in quarters one, two, and four. Data for quarter three has not been provided by the Ministry of Health.

Population-Based Screening Services							
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Four-year-olds provided with a B4 School Check (B4SC)	A◆	98%	93%	90%	94%	73%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q◆	96%	94%	95%	100%	96%	✓
Women aged 25-69 having a cervical cancer screen in the last 3 years	A◆	74%	72%	80%	72%	70%	↺
Women aged 50-69 having a breast cancer screen in the last 2 years	A◆	72%	77%	70%	72%	71%	✓

Immunisation Services							
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2017/18 Results	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Children fully immunised at eight months of age	A[17]◆	83%	79%	95%	78%	91%	×
Proportion of eight-month-olds 'reached' by immunisation services	Q	96%	96%	95%	95%	95%	✓
Young people (Year 8) completing the HPV vaccination programme	A[18]†◆	39%	n/a	75%	53%	61%	↺
Older people (65+) receiving a free influenza ('flu') vaccination	A[19]†◆	56%	55%	75%	58%	57%	↺

[17] The West Coast has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. In 2019/20, 75 West Coast children were not fully immunised at eight months of age.

[18] The Human Papillomavirus (HPV) vaccination aims to protect young people from the risk of developing HPV-related cancers later in life. The programme consists of two vaccinations and is free to young people under 26 years of age. An error was identified in the Ministry of Health's calculation for HPV in 2018/19 and this result is not available, results for the current year more accurately reflect performance. In total 183 young people received their final HPV dose in 2019/20.

[19] Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including people aged over 65 and people with long-term or chronic conditions. West Coast delivered 359 more vaccinations in 2019/20 than the previous year and preliminary results for 2020/21 indicate coverage has again increased significantly in response to COVID-19 messaging.

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

The New Zealand health system 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 increases with age.

Our vision of an integrated system presents a unique opportunity. For most people their general practice team is their first point of contact with health services and is vital as a point of continuity and in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services, we are better able to support people to stay well, identify issues earlier, and reduce complications, acute illness and unnecessary hospital admissions. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support.

SERVICE PERFORMANCE 2019/20

Primary Care (General Practice) Services							
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Notes	2017/18 Results	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A◆	94%	94%	95%	96%	95%	✓
Newborns enrolled with a PHO by three months of age	A◆	83%	95%	85%	90%	86%	✓
Young people (12-19) accessing brief intervention/counselling in primary care	A[20]Δ	215	159	>150	90	-	×
Adults (20+) accessing brief intervention/counselling in primary care	AΔ	527	498	>450	427	-	×
Number of integrated HealthPathways in place across the health system	Q	632	683	E. >600	677	-	✓
Proportion of general practices offering the primary care patient experience survey	E	86%	100%	100%	100%	-	✓

Long-Term Condition Services							
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	2017/18 Results	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management programme	A◆	4,099	4,045	E>3,500	3,959	-	✓
Population identified with diabetes having an annual LTCM review	A[21]◆	79%	85%	>90%	61%	-	×
Population with diabetes, having an HbA1c test at their LTCM review, showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q◆	54%	53%	>60%	56%	-	↺

[20] The Brief Intervention Counselling service aims to support people with mild to moderate mental health concerns to improve their health outcomes and quality of life. The service includes the provision of free counselling sessions and extended GP consultations. Changes have been made to how BICs are reported in 2019/20. Previously all BIC counselling sessions were reported, now only the first session is reported which provides a more accurate count of service utilisation. COVID-19 restrictions have also impacted on the number of people being seen in comparison to previous years.

[21] The West Coast primary care-led Long-term Conditions Management Programme is successfully embedded and identifying more people with diabetes on the West Coast which enables people to access improved support for managing their condition. The number of people recorded with diabetes involved in the Programme increased by 63 people (5%) in the past 12 months. Annual reviews were impacted in 2019/20 by COVID-19 restrictions in place during quarter three and four.

Oral Health Services							
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Children (0-4) enrolled in DHB funded oral health services	A[22]†◆	108%	101%	95%	88%	-	×
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T†◆	95%	96%	90%	98%	-	✓
Adolescents (13-17) accessing DHB funded oral health services	A[23]†	77%	76%	85%	73%	-	×

Pharmacy and Referred Services							
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2017/18 Results	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of subsidised pharmaceutical items dispensed in the community	A[Δ]	460k	471k	E.<500K	498k	-	✓
People being dispensed 11 or more long-term medications (rate per 1,000)	Q†[24]	4.5	n.a	E. <4.4	n.a	-	-
Number of community referred radiological tests delivered at Te Nikau	A	6,199	6,035	E.>5,000	5,570	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T	90%	88%	90%	95%	90%	✓
People receiving their Magnetic Resonance Imagining (MRI) scans within six weeks	T	84%	82%	90%	91%	58%	✓
People receiving their Computed Tomography (CT) scan within six weeks	T	100%	99.7%	95%	95%	71%	✓

[22] Oral health is an integral component of lifelong health and wellbeing. Early and continued contact with oral health services helps to set life-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights. The West Coast will adopt the LinKIDS service model from the Canterbury DHB in 2020/21, to support improved enrolment rates.

[23] Work to identify barriers to adolescent oral health access is ongoing and led by the transalpine Oral Health Service Development Group established to improve oral health performance. COVID lockdown and level 3 and 4 restrictions have impacted on access to private dental services in the past year.

[24] Data is sourced from the national Health Quality and Safety Commission's Atlas of Healthcare Variation. Results have not been made available since 2017.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are those more complex services provided by health professionals and specialists working closely together to respond to the needs of people with more severe, complex or life-threatening health conditions. They are usually (but not always) provided in hospital settings, which enables the co-location of specialist expertise and equipment. Some services are delivered in response to acute events, others are planned, and access is determined by clinical referral and triage, treatment thresholds and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is 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 result in improved 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. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

SERVICE PERFORMANCE 2019-2020

Quality and Patient Safety							
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2017/18 Results	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Staff compliant with good hand hygiene practice	Q[25]◇	82%	84%	80%	81%	85%	✓
Inpatients (aged 75+) receiving a falls risk assessment	Q◇	92%	68%	90%	71%	88%	↺
Response rate to the national inpatient patient experience survey	E◇	58%	28%	>30%	35%	24%	✓
Proportion of inpatients who responded in the survey that 'hospital staff included their family/whānau or someone close to them in discussions about their care'	E◇	53%	55%	65%	64%	59%	↺

Specialist Mental Health and Alcohol and Other Drug (AOD) Services							
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Proportion of the population (0-19) accessing specialist mental health services	A△	5.4%	5.3%	>3.8%	5.5%	4.0%	✓
Proportion of the population (20-64) accessing specialist mental health services	A△	5.9%	5.6%	>3.8%	6.0%	4.1%	✓
People referred for mental health and AOD services seen within 3 weeks	T[26]	81%	81%	80%	n.a	77%	-
People referred for mental health and AOD services seen within 8 weeks	T[26]	95%	92%	95%	n.a	91%	-

[25] In order to support the response to the COVID-19 pandemic, the Health Quality & Safety Commission temporarily suspended the requirement for DHBs to report on manually collected quality and safety markers from March until June 2020. Results for 2019/20 for the first three measures refer to the last completed quarter October to December 2019. Further detail and results for previous years can be found at www.hqsc.govt.nz.

[26] As part of the annual audit process, coding inconsistencies were identified with regards to the mental health wait time data for 2019/20, for both the three and eight week wait time measures. The DHB was unable to undertake a reconciliation process in time to confirm the results for the year prior to the publishing of this report. However, work is being undertaken to review the data collection and coding processes to confirm the 19/20 year's results and ensure the accuracy of results going forward.

Maternity Services							
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2017/18 Results	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[27]†◆	80%	n.a	80%	n.a	-	-
Number of maternity deliveries in West Coast DHB facilities	A	264	241	E. 250	246	-	✓
Baby friendly hospital accreditation achieved in DHB facilities	Q	Yes	Yes	Yes	Yes	-	✓

Acute and Urgent Services							
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of presentations at the Te Nikau Emergency Department (ED)	A	11,616	11,829	E.<13,000	11,043	-	✓
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T	82%	77%	85%	83%	-	↺
Proportion of the population presenting at ED (per 1,000 people)	Q[28]	356	365	<356	366	-	×
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T[29]	80%	72%	90%	83%	86%	↺
Average acute inpatient length of stay (bed days per 1,000 people)	Q[30]	2.34	2.13	2.30	n.a	-	-

Elective and Arranged Services							
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of First Specialist Assessments provided	A[31]	7,022	6,240	E.>6,000	5,258	-	×
Number of planned care intervention delivered	A[32]	new	new	3,211	3,220	-	✓
Average elective inpatient length of stay (bed days per 1,000 people)	Q[33]	1.20	1.19	1.45	n.a	-	-
Number of outpatient consultations provided	A[34]	14,328	13,663	E.>13,000	12,075	-	×
Proportion of outpatient appointments provided by telemedicine	Q	4.2%	5.1%	>5%	5.2%	-	✓
Outpatient appointments where the patient was booked but did not attend (DNA)	Q[Δ◆]	6.13%	7.7%	<6%	7.2%	-	↺

[27] Data is sourced from the national Maternity Clinical Indicators report and the results for 2018/19 and 2019/20 are yet to be released nationally.

[28] More than half of the presentations to the West Coast Emergency Department in 2019/20 were for triage 4 and 5 patients which places unnecessary pressure on emergency and hospital services. The DHB is looking to extended general practice hours and telephone triage to provide greater availability for people to attend their general practice after work. This will help to reduce unnecessary presentations to the emergency department.

[29] Small population numbers impact performance against this measure, with just six patients seen outside of timeframes across the whole year. A breach analysis is completed for every patient who is seen outside of timeframes to identify lessons and improve processes.

[30] This measure is no longer being reported by the Ministry of Health and comparable results are not available for the 2019/20 year.

[31] A first specialist assessment is the assessment undertaken by a specialist following referral by a patient's primary care practitioner to determine the treatment to be delivered. West Coast DHB experienced a drop in FSAs delivered in March, April, and May which coincides with COVID restrictions.

[32] The planned care intervention measure recognises the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing, including those delivered in community settings. The West Coast's planned care interventions target is made up of three components: elective surgical discharges (1,791), minor procedures (1,196) and non-surgical interventions (233).

[33] This measure is no longer being reported by the Ministry of Health and comparable results are not available for the 2019/20 year.

[34] Non-urgent outpatient appointments were cancelled from late March due to COVID restrictions and a recovery programme is underway.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide the assistance people need to live safely and independently in their own homes, or regain functional ability, after a health related event. These services help provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evidenced by less dependence on hospital and residential care services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness, or crisis these services have a major impact on the sustainability of our health system. Rehabilitation and support services also support patient flow by enabling people to go home from hospital earlier.

SERVICE PERFORMANCE 2019-2020

Assessment, Treatment and Rehabilitation (AT&R) Services							
These services restore or maximise people's health or functional ability following a health related event such as a fall, heart attack or stroke. Service utilisation is monitored to ensure people are appropriately supported after an event.	Notes	2017/18 Results	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A[35]	2	9	10	8	-	×
People (65+) supported by the community-based In-Home Falls Prevention Service	A[36]	148	143	>120	84	-	×
Proportion of inpatients referred to an organised stroke service after an acute event	Q	96%	94%	80%	95%	-	✓
Proportion of AT&R inpatients discharged home rather than into residential care	Q[Δ]	90%	85%	80%	93%	-	✓

Home-Based Support Services							
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Number of Meals on Wheels provided	A[37Δ]	34,977	36,511	E. 35,000	41,966	-	×
People supported by district nursing services	A[Δ]	1,645	1,797	E. >1,000	1,803	-	✓
People supported by long-term home-based support services	A[Δ]	1,211	1,100	E. >1,000	1,041	-	✓
Proportion of people supported by long-term home-based support services who have had a clinical assessment of need (using InterRAI) in the last 12 months	Q[38Δ]	91%	75%	95%	77%	-	↺

[35] The Flexible Integrated Rehabilitation Support Team (FIRST) provides a range of home-based rehabilitation services to facilitate people's early discharge from hospital. The service is part of the broader continuum of care for older people, ensuring a seamless transfer of care between hospital and community settings. The COVID restrictions in quarters three and four have impacted results. This service has resumed.

[36] Falls are one of the leading causes of hospital admission for people aged over 65. The community-based Falls Prevention Service provides care for people 'at-risk' of a fall or following a fall and supports people to stay safe and well in their own homes. Due to COVID restrictions the falls prevention service was unable to operate as fully in quarters three and four which impacted results. Falls champions focused on the most frail and vulnerable people.

[37] This is a demand driven service provided following an assessment of need, higher volumes for this past year may reflect additional stressors and the impact of lockdown restrictions on people's normal lives, along with the natural ageing of our population. The DHB will monitor service utilisation over the coming year to identify any changing patterns or drivers of demand.

[38] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning by using evidence-based practice guidelines to ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live. Process difficulties with identifying those people who are eligible for an InterRAI assessment continue to impact results we continue to work to resolve this.

Aged Residential Care Services							
The DHB subsidises ARC for people who meet the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2017/18 Result	2018/19 Results	2019/20 Target	2019/20 Results	2019/20 NZ Average	
Proportion of the population (75+) accessing rest home level services in ARC	A[39Δ]	4.4%	3.8%	E.<6.0%	3.4%	-	✓
Proportion of the population (75+) accessing hospital level services in ARC	A[Δ]	6.6%	6.4%	E.<6.5%	5.1%	-	✓
Proportion of the population (75+) accessing dementia services in ARC	A[40Δ]	1.2%	1.1%	E. 1.0%	0.7%	-	×
Proportion of the population (75+) accessing psychogeriatric services in ARC	A[Δ]	0.6%	0.3%	E. 0.4%	0.3%	-	×
People entering ARC having had a clinical assessment of need using InterRAI	Q[41Δ]	100%	88%	95%	91%	88%	↺

[39] The proportions of people living in West Coast ARC facilities are impacted by the small 75+ small population. Between 2018/19 and 2019/20 the number of people accessing hospital level care fell by 13 people and the number of people accessing dementia level care fell by 8 people. The total population increased by 285 over this same period.

[40] While the proportion of the population accessing dementia and psychogeriatric residential care services has fallen below 10% of estimated volumes, appropriateness for these services is assessed using the InterRAI assessment tool. The difference in dementia volumes (for example) relates to 8 fewer people being assessed as needing dementia care on the West Coast compared to the previous year and neither result is seen by the DHB as an indication of poor performance.

[41] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services. The DHB continues to work with service providers to encourage the use of the tool.

Māori Health Performance 2019/20

Like all DHBs, faced with growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority for the West Coast DHB. All of our performance targets are universal and have been set with the aim of bringing performance for all population groups to the same level.

Working with local stakeholders, the DHB has identified a number of key areas of focus and a set of core performance indicators. These are indicators seen as particularly important to our community in terms of improving and monitoring Māori health outcomes. These indicators were identified in our forecast Statement of Performance Expectations for 2019/20 using the symbol (◆). The results for Māori are presented below to highlight progress in reducing equity gaps. The NZ average results are the national results for Māori.

SERVICE PERFORMANCE 2019-2020

MĀORI HEALTH INDICATORS							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Note	2017/18	2018/19	2019/20 Target	2019/20	2019/20 NZ average	
Māori babies exclusive/fully breastfed at LMC discharge	Q[42]	66%	76%	75%	n.a	n.a	-
Māori babies exclusive/fully breastfed at three months	Q	53%	64%	70%	n.a	n.a	-
Māori smokers, enrolled with a PHO, receiving advice and help to quit	Q	87%	96%	90%	92%	78%	✓
Māori smokers, identified in hospital, receiving advice and help to quit	Q[43]	88%	92%	95%	89%	-	×
Pregnant Māori women, identified as smokers at confirmation of pregnancy with an LMC receiving advice and help to quit smoking	Q	100%	100%	90%	100%	-	✓
Māori children receiving a B4 School Check at age four	A	106%	98%	90%	97%	67%	✓
Māori four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q	83%	83%	95%	100%	97%	✓
Māori women (25-69) having a cervical smear in the last three years	A	65%	68%	80%	68%	62%	↺
Māori women (50-69) having a breast screen in the last two years	A[44]	61%	70%	70%	67%	67%	×
Māori babies fully immunised at eight months of age	A[45]	91%	83%	95%	81%	84%	×
Eligible Māori completing the HPV vaccination programme	A[46]†	30%	n/a	75%	47%	61%	↺
Older Māori (65+) having had a seasonal influenza vaccination	A[47]†	50%	50%	75%	44%	45%	×
Māori population enrolled with a PHO	A	85%	86%	95%	90%	87%	↺
Māori newborns enrolled with a PHO by three months of age	A[48]	n/a	88%	85%	74%	75%	×
Enrolled Māori, identified with a long-term condition, engaged in the primary care LTCM programme	A	261	266	>233	266	-	✓

[42] Data is provided by the Ministry of Health. Results for 2017/18 were provided this year; results for 2019/20 have not yet been released.

[43] This measure is impacted by small population numbers, between 2018/19 and 2019/20, 18 more people were offered brief advice to quit in hospital but 26 more smokers were hospitalised in the period.

[44] The breast screening measures refer to participation in national screening programmes and standards are set nationally. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment. Improving rates for cervical screening remains a priority and the DHB is working closely with community providers to try and lift these rates. The breast screening target was missed by just 11 people over the period.

[45] The West Coast has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. In 2019/20, 13 West Coast Maori children were not fully immunised at eight months of age.

[46] The Human Papillomavirus (HPV) vaccination aims to protect young people from the risk of developing HPV-related cancers later in life. The programme consists of two vaccinations and is free to young people under 26 years of age. An error was identified in the Ministry of Health's calculation for HPV in 2018/19 and this result is not available, results for the current year more accurately reflect performance. In total 183 young Maori received their final HPV dose in 2019/20.

[47] Small population numbers and an ageing population have a significant impact on these results. The actual number of older Māori having a flu vaccination in 2019 was about the same as the year before with 148 people vaccinated. The 65+ population grew by 13% in this time and the system needs to adjust it capacity to response to the ageing population.

[48] Small population numbers impact performance against this measure, with just 18 children not enrolled at three months over the course of the year.

Māori identified with diabetes halving a HbA1c test in the last year	A	87%	81%	90%	84%	-	↺
Māori, having an HbA1c test, with acceptable glycaemic control	Q	41%	42%	>60%	50%	-	↺
Māori children (0-4) enrolled in DHB oral health services	A[49]	96%	90%	95%	77%	-	×
Māori children (0-12) examined according to planned recall	T†	n/a	93%	90%	97%	-	✓
Māori women registered with an LMC by 12 weeks of pregnancy	A[50]	79%	n/a	80%	n/a	-	-
Māori outpatient 'Did not Attend' rates	Q[51]	15%	15%	<6%	16%	-	×

[49] Oral health is an integral component of lifelong health and wellbeing. Early and continued contact with oral health services helps to set life-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights. The West Coast will adopt the LinKIDS service model from the Canterbury DHB in 2020/21, to support improved enrolment rates. The number of Māori enrolled fell by just 52 between 2018/19 and 2019/20.

[50] Data is sourced from the national Maternity Clinical Indicators report and the results for 2018/19 and 2019/20 are yet to be released.

Part IV
Managing our Business

Board's Report and Statutory Disclosure

To the stakeholders on the affairs of the Board for the year ended 30 June 2020

PRINCIPAL ACTIVITIES

West Coast DHB is a New Zealand based district health board (DHB), which provides health and disability support services principally to the people of the West Coast.

RESULTS

During the year, West Coast DHB recorded a net deficit of $18.969m against the budgeted deficit of $6.613m (2018/19 result was a net deficit of $11.555m).

Board and committee member attendance	Board		QFARC[52]		ADVISORY[53]	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Board Members						
Chris Auchinvole	8	8			5	5
Hon Rick Barker#	5	5	2	2	2	2
Jenny Black*	3	3	3	3	3	3
Susan Barnett#	5	5			2	2
Sarah Birchfield#	5	5	2	2	5	5
Kevin Brown*	2	3			2	3
Helen Gillespie (LA)	5	8	4	4	5	5
Anita Halsall-Quinlan#	5	5			2	2
Tony Kokshoorn#	5	5	2	2	2	2
Michelle Lomax*	2	3			2	3
Chris Mackenzie*	3	3	3	3	3	3
Edie Moke	8	8	5	5	4	5
Peter Neame	8	8			5	5
Nigel Ogilvie	8	8	2	2	5	5
Elinor Stratford*	3	3			3	3
Francois Tumahai	7	8			2	5
Committee Members						
Lynnette Beirne					4	5
Dr Cheryl Brunton					5	5
Jenny McGill					3	5
Joe Mason					4	5
Paula Cutbush					5	5
Chris Lim					5	5

LA - Leave of absence 1 July 2019 – 31 July 2019
**Term ended 8 December 2019*
#Term commenced 9 December 2019

[52] QFARC – Quality, Finance, Audit & Risk Committee.

[53] Advisory – Advisory Committee *CPHAC & DSAC & HAC formed into one Committee from March 2018

Directors' and Board members' loans

There were no loans made by the Board to Board Members or Directors.

Directors' and Board members' insurance

The Board has arranged policies of Board Members' or Directors' Liability Insurance which, together with a Deed of Indemnity, ensures that generally Board Members or Directors will incur no monetary loss as a result of actions taken by them as Board Members or Directors. Certain actions are specifically excluded, for example the incurring of penalties and fines which may be imposed in respect of breaches of the law.

Use of Board information

During the year, the Board did not receive any notices from Board Members or Directors requesting the use of Board information, received in their capacity as Board Members or Directors, which would not otherwise have been available to them.

Information on Ministerial directions

WHOLE OF GOVERNMENT APPROACH

The direction to support a whole of government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property.

West Coast DHB applies the Government Rules of Sourcing for procurement.

West Coast DHB works closely with the Government Chief Information Officer to ensure compliance with directions in relationship to ICT.

West Coast DHB is exempt from the direction regarding Property functional leadership.

AUTHENTICATION SERVICES

The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizeable ICT business transactions and investment specifically listed within the 2014 direction.

West Coast DHB works closely with the Government Chief Information Officer to ensure that our technology environment is compliant with the expected standards and applicable directions as provided, this includes authentication services.

ELIGIBILITY DIRECTION

The 2011 Eligibility Direction issued under s.32 of the NZ Public Health and Disability Act 2000.

West Coast DHB strictly and consistently assesses patient eligibility against the Public Health and Disability Act 2000 to ensure that all eligible consumers are recognised as such.

COVID-19 RESPONSE DIRECTION

The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID-19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand.

Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction.

People at the Heart of All We Do

Consistent with our vision for the West Coast health system and our organisational values, the West Coast DHB is committed to being a good employer and a great place to work and develop.

We are committed to an ethos of co-design, which includes engaging our people in the development, ongoing review, and renewal of programmes and policies. To that end, we continue to engage our people via multiple channels and initiatives including our programme of work, "Care Starts Here". One of the most significant outputs of this programme includes the development and the refreshing of People and Capability policies and processes across both West Coast DHB and Canterbury DHB, including our Code of Conduct, Health and Safety Policy and Diversity, Inclusion and Belonging Policy.

Staff Ethnicity	Number
African	5
Asian not further defined	3
Chinese	3
Cook Island Māori	1
European not further defined	35
Indian	50
Latin American / Hispanic	3
Middle Eastern	2
NZ European	513
NZ Māori	50
Other Asian	6
Other ethnicity	80
Other European	98
Other Pacific Island	1
Pacific Island not further defined	1
Refused to answer	68
Samoan	2
Southeast Asian	39
Tongan	2
Unknown	215
Total	**1,177**

Staff Mix by Average Age	Average age
Medical	49.58
Nursing	49.67
Allied Health	51.23
Support	50.58
Management & Administration	49.17

Staff Mix by Gender	Number	Percentage
Female	984	84%
Male	193	16%
Total	1,177	100%

Staff Identifying a Disability[54]	Number
Yes	41

Source: Payroll and max. as at July 2020

Leadership, Accountability and Culture

Healthcare is fundamentally about people caring for people. To deliver high quality care to the community, the West Coast health system puts people - and their care - at the heart of all decisions. To achieve this requires a culture where we care for our people, as much as we care for our patients. This means we need leadership that is responsive and accountable to our people, and provides clarity of purpose based on bringing the right people together, at the right time, to provide the right service. To create a broad network of widely distributed clinical and operational leadership, the 20 DHBs have committed to implementing a shared approach to talent management and leadership development, underpinned by the State Services Commission [SSC] framework used by the core public sector. This approach allows the West Coast DHB to support leaders to realise their potential and create a safe environment in which everyone understands their contribution and has a sense of belonging.

Our expectations are that our leaders will tell a clear, consistent, and compelling story about our direction of travel; will be accountable and responsive to their team's needs; will motivate and energise their teams to meet agreed organisational goals; and will be responsible and accountable for outcomes.

Recruitment, Selection and Induction

West Coast DHB is committed to the shared approach to talent management including attracting, selecting and engaging people across the West Coast health system, regionally and nationally for the needs of today and into the future. To achieve this, we are taking a talent lifecycle management approach from succession planning and strategic sourcing to selection,

[54] This data is voluntarily given and unlikely to reflect the true number of staff that identify as having a disability

candidate care and induction. The purpose of this approach is to support an integrated West Coast health system by maximising opportunities that result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey and patient outcomes throughout the West Coast health system.

As part of these approaches we are fully committed to enhancing our practices with respect to equity and diversity. We are also active participants in the development of consistent regional approaches to talent management and sourcing and associated support systems; as well as influencing the shape of national direction in this critical area.

Workplace Wellbeing, Health and Safety

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by a professional Wellbeing, Health and Safety team through our partnership with Canterbury DHB, which includes experts in workplace safety, occupational health, rehabilitation, and employee wellbeing. In addition to working alongside our people and health and safety representatives, this dedicated team also provides advice and support to all levels of management.

Our people, and their whānau, are provided with a range of support options if they are faced with work or personal issues that are negatively impacting on them. We enable access to meaningful support at the time it is needed, including post-incident support, wellbeing check-ins, tailored packages of care for individuals and teams, as well as providing a toolkit of self-care options.

Our Wellbeing, Health and Safety programmes, designed with our people, promote the proactive safety and wellbeing through activities such as:

- Health monitoring programme which includes screening and immunisation;
- Free influenza vaccinations annually;
- Wellbeing programmes and activities to encourage and support our people in terms of healthier lifestyles;
- Promotion of a safe work environment and safe work practices;
- Workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training.

We enable our people to be and stay well at work through our injury prevention programmes as well as supporting our people to return to work following an injury, illness or other life event.

We do not tolerate any form of harassment, workplace bullying or discrimination. We are continually improving our policies, procedures and responses when issues of bullying, harassment or discrimination do arise. This includes a programme of work to improve our policies, code of conduct, manager capability to address issues and integrate restorative workplace practises. We continue to improve our people's access to advice and resolution services when they are not having a positive experience at work.

Equal Opportunities and Positive Behaviours

Consistent with our vision and organisational values, West Coast DHB is committed to maintaining and enhancing practices which minimise all forms of discrimination, bullying and harassment in the workplace and barriers to the recruitment, retention, development and promotion of our employees.

We have a diverse, flexible and highly skilled workforce that contributes significantly to the provision of quality, culturally and individually appropriate services. We are actively auditing and improving our talent management practises to ensure people, regardless of their diversity, have the opportunity to be a part of West Coast DHB.

We are committed to identifying and dealing with all examples of unacceptable behaviour. All individuals, on joining West Coast DHB, are made familiar with our organisational values and our policies that guide how we do things. We actively have conversations about behaviour with our people to identify and change any behaviour that does not live up to our Care Starts Here behaviours of Valuing Everyone, Doing the Right Thing and Being and Staying Well.

Remuneration and Recognition

The West Coast DHB is committed to applying fair and equitable remuneration and reward practises, taking into account our internal environment, external market relativities as well as the financial environment we operate within. Our remuneration policy is geared towards creating a rewarding workplace for our people by valuing everyone's contribution and encouraging personal development and fostering equality of opportunity. Under this framework, our structure provides clear progression paths that are aligned to the principles of individual performance development, employee competency and organisational affordability.

We regularly test our remuneration against external market and internal comparisons to ensure relativity and parity across all sectors within the West Coast DHB.

Employee Engagement

An engagement survey was conducted in October 2018 with the following results.

The survey had a 34% return rate with an overall score for organisational effectiveness of 55%. While this score was below the survey industry benchmark average of 61% across all organisations, it was acknowledged that there are specific challenges the DHB sector faces affecting the score. In January 2019 the following messages from the survey were published to all staff:

- 43% of people feel we have technology to support our processes;
- 87% believe that their immediate leader handles stressful situations well;
- 73% feel safe to tell the truth even when it is unpopular;
- 75% believe honesty and directness are valued at West Coast DHB.

These results were broadly in line with surveys conducted prior to 2018 with over 80% of respondents reporting high levels of engagement, being particularly confident in similarly themed areas such as empowerment, purpose and work satisfaction.

Employee Development and Promotion

We are focused on supporting and developing the health workforce at a local, regional and national level aligned to our shared approach to leadership development and talent management. Our structures and approach enable us to place the right people into the right roles at the right time.

Our people will have access to a broad range of clinical and non-clinical individual, leadership and managerial capability building. These development opportunities are structured to support effective transition between different roles and leadership contexts.

We use a blended learning approach that focuses on creating a great user experience whether online or face-to-face, supported by healthLearn - our South Island learning management platform. We recognise that learning needs to be accessible, relevant and timely, and reinventing the way people learn is one of our main missions.

We are also able to leverage relationships with the Canterbury DHB, University of Otago, the University of Canterbury, and ARA (formerly CPIT), as well as the TANZ network (7 South Island and lower North Island polytechnic institutes), which makes available a common curriculum of development aligned to the vision for our health system.

Part V
Financial Performance

Statement of Comprehensive Revenue and Expense[55]

For the year ended 30 June 2020

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2019/20 Actual	2019/20 Budget	2018/19 Actual
Revenue				
Patient care revenue	2(i)	161,577	158,840	153,670
Other operating revenue	2(ii)	644	610	599
Interest revenue		81	204	331
Total revenue		**162,302**	**159,654**	**154,600**
Expenses				
Personnel costs	3	78,835	66,649	67,602
Depreciation and amortisation expense	9,10	2,733	3,226	3,391
Outsourced services		10,893	9,113	8,708
Clinical supplies		9,503	8,265	8,018
Infrastructure and non-clinical expenses		10,211	10,293	10,907
Payments to other health service providers		66,954	66,388	64,508
Other operating expenses	4	1,449	1,355	1,614
Finance costs		3	-	-
Capital charge	5	690	978	1,407
Total expenses		**181,271**	**166,267**	**166,155**
Net surplus/(deficit)		**(18,969)**	**(6,613)**	**(11,555)**
Total comprehensive revenue and expenses		**(18,969)**	**(6,613)**	**(11,555)**

[55] This statement is to be read in conjunction with the Notes to the Financial Statements. Explanations of major variances against budget are provided in Note 22

Statement of Changes in Equity[56]

For the year ended 30 June 2020

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2019/20 Actual	2019/20 Budget	2018/19 Actual
Balance at 1 July		**14,087**	**14,087**	25,710
Total comprehensive revenue and expenses		(18,969)	(6,613)	(11,555)
Owner transactions				
Capital contributions from the Crown		8,000	106,076	-
Repayment of capital to the Crown		(68)	(68)	(68)
Balance at 30 June	14	**3,050**	**113,482**	**14,087**

[56] This statement is to be read in conjunction with the Notes to the Financial Statements. Explanations of major variances against budget are provided in Note 22

Statement of Financial Position[57]

As at 30 June 2020

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2019/20 Actual	2019/20 Budget	2018/19 Actual
Assets				
Current assets				
Cash and cash equivalents	6	6,153	4,460	6,360
Receivables	7	4,459	4,428	3,915
Inventories	8	1,044	1,098	1,077
Patient deposits	15	72	56	72
Total current assets		**11,728**	**10,042**	**11,424**
Non-current assets				
Property, plant and equipment	9	35,326	132,098	31,062
Intangible assets	10	817	499	696
Total non-current assets		**36,143**	**132,597**	**31,758**
Total assets		**47,871**	**142,639**	**43,182**
Liabilities				
Current liabilities				
Payables and deferred revenue	11	13,262	12,779	10,336
Employee entitlements and benefits	13	29,223	13,893	16,278
Patient deposits and restricted funds	15,16	83	62	82
Total current liabilities		**42,568**	**26,734**	**26,696**
Non-current liabilities				
Employee entitlements and benefits	13	2,253	2,423	2,399
Total non-current liabilities		**2,253**	**2,423**	**2,399**
Total liabilities		**44,821**	**29,157**	**29,095**
Net assets/equity				
Contributed capital	14	93,858	191,932	85,926
Revaluations	14	25,100	25,098	25,100
Accumulated surpluses/(deficits)	14	(115,908)	(103,548)	(96,939)
Total equity		**3,050**	**113,482**	**14,087**
Total equity and liabilities		**47,871**	**142,639**	**43,182**

[57] This statement is to be read in conjunction with the Notes to the Financial Statements. Explanations of major variances against budget are provided in Note 22

Statement of Cash Flows[58]

For the year ended 30 June 2020

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2019/20 Actual	2019/20 Budget	2018/19 Actual
Cash flows from operating activities				
Receipts from Ministry of Health, patients and other revenue		162,055	158,893	155,187
Payments to suppliers		(87,651)	(87,828)	(86,729)
Payments to employees		(75,347)	(74,586)	(68,123)
Interest received		81	204	330
Interest paid		(3)	-	-
Goods and services tax (net)		532	451	157
Capital charge paid		(690)	(978)	(1,407)
Net cash flow from operating activities	17	**(1,023)**	**(3,844)**	**(585)**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		-	-	(24)
Purchase of property, plant and equipment		(6,744)	(12,740)	(4,574)
Purchase of intangible assets		(372)	(324)	(113)
Net cash flow from investing activities		**(7,116)**	**(13,064)**	**(4,711)**
Cash flows from financing activities				
Capital contributions from the Crown		8,000	15,074	-
Repayment of capital to the Crown		(68)	(68)	(68)
Net cash flow from financing activities		**7,932**	**15,006**	**(68)**
Net increase /(decrease) in cash and cash equivalents		(207)	(1,902)	(5,364)
Cash and cash equivalents at the start of the year		6,360	6,362	11,724
Cash and cash equivalents at the end of year	6	**6,153**	**4,460**	**6,360**

[58] This statement is to be read in conjunction with the Notes to the Financial Statements. Explanations of major variances against budget are provided in Note 22. The GST component of cash flows from operating activities reflects the movement in opening and closing net GST paid to the Inland Revenue Department. The GST (net) component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statement purposes.

Notes to the Financial Statements

For the year 30 June 2020

1. Statement of Accounting Policies

Reporting entity

West Coast District Health Board (West Coast DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989. The DHB's ultimate parent is the New Zealand Crown.

West Coast DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. The DHB does not operate to make a financial return.

West Coast DHB is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

The financial statements are for the year ended 30 June 2020, and were approved for issue by the Board on 18 December 2020.

Basis of Preparation

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

West Coast DHB's Chair received a letter of comfort from the Ministers of Health and Finance to enable the Board of West Coast DHB to satisfy itself, for the purposes of the 2019/20 financial statements, that it is appropriate to prepare those financial statements on a going concern basis. The letter states that the Government is committed to working with West Coast DHB over the medium term to maintain its financial viability, and also acknowledges that equity support may be required and the Crown will provide such support where necessary to maintain viability.

West Coast DHB requires this letter of comfort in the event that actual future cashflows are significantly unfavourable to one or more of the assumptions in our cashflow projections, such as the reliance on receiving full deficit funding for the 2019/20 financial year. The letter of comfort therefore provides the required basis for the Board of West Coast DHB to prepare the 2019/20 financial statements on a going concern basis. It also gives the Board comfort that financial support will be provided to maintain viability in the medium term if required

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000, the Crown Entity Act 2004 and the Public Finance Act 1989, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

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

PRESENTATION CURRENCY AND ROUNDING

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand dollars ($000), other than remuneration paid to board and committee members disclosed in Note 3 and related party disclosures in Note 19.

CHANGES IN ACCOUNTING POLICIES

There have been no changes in the DHB's accounting policies since the date of the last audited financial statements.

STANDARDS ISSUED BUT NOT YET EFFECTIVE AND NOT EARLY ADOPTED

Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to West Coast DHB are:

FINANCIAL INSTRUMENTS

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

West Coast DHB plans to apply this standard in preparing its 30 June 2022 financial statements. West Coast DHB has not yet assessed the effects of the new standard.

Summary of Significant accounting policies

Significant accounting policies are included in the note to which they relate. Significant accounting policies that do not relate to a specific note are outlined below.

GOODS AND SERVICES TAX (GST)

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an

input tax, it is recognised as part of the related asset or expense.

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

Commitments and contingencies are disclosed exclusive of GST.

INCOME TAX

The West Coast DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

BUDGET FIGURES

The budget figures are derived from the 2019/20 Annual Plan and Statement of Intent. The budget was prepared in accordance with the accounting policies adopted by the Board for the preparation of the financial statements. The policies comply with the Tier 1 PBE standards.

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

The Board has exercised the following critical judgements in applying the West Coast DHB's accounting policies:

- Classification of leases – refer to Note 4
- Useful life and fair value assessment of property, plant and equipment – refer to Note 9
- Provision of debtors – refer to Note 7
- Provision of employee entitlements, including gratuity and long service leave – refer to Note 13

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

In preparing these financial statements, the West Coast DHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed in the notes.

2. Revenue

ACCOUNTING POLICY

The specific accounting policies for significant revenue items are explained below.

Ministry of Health population-based funding

West Coast DHB receives annual funding from the Ministry of Health, which is based on population levels within the West Coast DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

Ministry of Health contract revenue

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as West Coast DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the Ministry of Health to receive or retain funding.

Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the Ministry of Health. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Inter-district flows

Inter-district patient inflow revenue occurs when a patient treated within West Coast DHB's district is domiciled outside of the district. Inter-district patient inflow revenue is recognised when eligible services are provided.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Interest revenue

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

Provision of other services

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion at the balance date, based on the actual service provided as a percentage of the total services to be provided.

Other grants

Non-government grants are recognised as revenue when they become receivable unless there is an obligation to return the funds if conditions of the grant are not met. If there is such an obligation the grants are initially recorded as grants received in advance, and recognised as revenue when conditions of the grant are satisfied.

Sale of goods or services

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

Donations, trust and bequest funds

Donations and bequests to West Coast DHB are recognised as revenue when control over assets is obtained. A liability, rather than revenue, is recognised where fulfilment of any restrictions is not probable. Those donations and bequests with restrictive conditions are appropriated from retained earnings to the trust funds component of equity.

When expenditure is subsequently incurred in respect of these funds it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust funds component of equity to retained earnings.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at fair value when the West Coast DHB obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Donated services

Volunteer services received are not recognised as revenue or expenses by the West Coast DHB.

2(i) Breakdown of patient care revenue

	Note	2019/20 Actual	2018/19 Actual
Ministry of Health population-based funding		148,419	141,818
Inter-district flows		2,052	1,824
Ministry of Health other contracts & other government contracts		1,435	996
ACC contract revenue		1,662	1,781
Other patient care related revenue		8,009	7,251
Total patient care revenue		**161,577**	**153,670**

2(ii) Breakdown of other operating revenue

	Note	2019/20 Actual	2018/19 Actual
Cash donations and bequests received		9	42
Rental revenue		135	142
Training and development		88	96
Gain on sale of fixed assets		14	23
Other		398	296
Total other operating revenue		**644**	**599**

3. Employee Benefit Costs

ACCOUNTING POLICY

Salaries and wages

Salaries and wages are recognised as an expense as employees provide services.

Superannuation schemes

Defined contribution schemes

Employer contributions to KiwiSaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are expensed in the surplus or deficit as incurred.

Defined benefit schemes

West Coast DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme 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/deficit in the plan will affect future contributions be individual employers, because there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Breakdown of personnel costs and further information			
	Note	2019/20 Actual	2018/19 Actual
Wages, salaries and other personnel costs		57,027	58,689
Contributions to defined contribution schemes		1,983	1,887
(Decrease)/increase in liability for employee entitlements		8,941	1,802
Increase/(decrease) in Holidays Act compliance provision		11,300	5,190
Restructuring expenses		34	34
Total Personnel Costs		**78,835**	**67,602**

Employer contributions to defined contribution schemes include contributions to KiwiSaver, the Government Superannuation Fund and the DBP Contributors Scheme.

Remuneration of employees

The number of employees or former employees who received remuneration and other benefits of $100,000 or more within specified $10,000 bands are shown in the table below.

A total of 142 employees (2019: 132) received total remuneration of greater than $100,000. The figure stated includes payment for additional duties, lump sum payments, including payment of back pay and employer contributions to superannuation and KiwiSaver schemes.

The Chief Executive's remuneration is excluded as this service is delivered by Canterbury DHB as an outsourced service. West Coast DHB is charged a fee for the Chief Executive services under a management services agreement between Canterbury DHB and West Coast DHB. This amount is disclosed in the related party transactions (note 19).

Of the 142 employees, 127 are clinical employees (2019: 119) and 15 are non-clinical employees (2019: 13).

Remuneration of Employees earning more than $100,000 per annum		
Specified band	2019/20 Actual	2018/19 Actual
$100,000 - $109,999	42	38
$110,000 - $119,999	17	13
$120,000 - $129,999	21	27
$130,000 - $139,999	15	11
$140,000 - $149,999	11	3
$150,000 - $159,999	2	8
$160,000 - $169,999	5	3
$170,000 - $179,999	-	1
$180,000 - $189,999	1	1
$190,000 - $199,999	2	-
$200,000 - $209,999	1	1
$210,000 - $219,999	3	1
$220,000 - $229,999	2	2
$230,000 - $239,999	-	-
$240,000 - $249,999	2	1
$250,000 - $259,999	-	-
$260,000 - $269,999	1	1
$270,000 - $279,999	1	3
$280,000 - $289,999	1	1
$290,000 - $299,999	-	2
$300,000 - $309,999	2	-
$310,000 - $319,999	2	-
$320,000 - $329,999	2	2
$330,000 - $339,999	1	-
$340,000 - $349,999	1	2
$350,000 - $359,999	2	2
$360,000 - $369,000	-	1
$370,000 - $379,999	1	2
$380,000 - $389,000	1	1
$390,000 - $399,000	-	-
$400,000 - $409,999	3	-
$410,000 - $419,999	-	1
$420,000 - $429,999	-	1
$430,000 - $439,999	-	3
Total employees	**142**	**132**

Compensation and other benefits in relation to cessation of employment

During the year, the Board made payments to former employees in respect of the termination of their employment. These payments include amounts required to be paid pursuant to employment contracts in place, for example amounts for redundancy (based on length of service), and payment in lieu of notice.

During the year ended 30 June 2020, Nil (2019: 2) employees received payments relating to the termination of their employment. (2019: $33,763).

Board & Committee fees

Total value of remuneration paid to each Board member during the year was (in whole dollars):				
Year ended 30 June 2020	Board	QFARC	Advisory Committee	Total
Board members				
Chris Auchinvole	16,711	-	1,250	17,961
Rick Barker	19,633	500	500	20,633
Jenny Black	14,000	500	750	15,250
Susan Barnett	9,911	-	500	10,411
Sarah Birchfield	9,911	500	1,250	11,661
Kevin Brown	6,800	-	500	7,300
Helen Gillespie	16,711	938	1,250	18,899
Anita Halsall-Quinlan	9,911	-	500	10,411
Tony Kokshoorn	12,388	500	500	13,388
Michelle Lomax	6,800	-	500	7,300
Chris Mackenzie	8,500	250	750	9,500
Edie Moke	16,420	1,625	1,000	19,045
Peter Neame	16,711	-	1,375	18,086
Nigel Ogilvie	16,711	500	1,250	18,461
Elinor Stratford	6,800	-	938	7,738
Francois Tumahai	16,711	-	500	17,211
Total	**204,629**	**5,313**	**13,313**	**223,254**

The DHB has provided a deed of indemnity to Board Members for certain activities undertaken in the performance of the DHB's functions.

The DHB has effected Directors' and Officers' Liability and Professional Indemnity insurance cover during the financial year in respect of the liability or costs of Board members and employees.

No Board members received compensation or other benefits in relation to cessation (2019: Nil).

The total value of remuneration paid or payable to committee members appointed by the Board who are not board members during the financial year was:

Total value of remuneration paid to each Committee member during the year was (in whole dollars):	
Year ended 30 June 2020	Total
Advisory committee members	
Lynnette Beirne (CPHAC&DSAC)	1,000
Paula Cutbush (HAC)	1,250
Chris Lim (HAC)	1,250
Joseph Mason (CPHAC&DSAC)	1,000
Jenny McGill (CPHAC&DSAC)	750
Total	**5,250**

4. Other Operating Expenses

ACCOUNTING POLICY

Other operating expenses are expensed in the financial year in which they are incurred.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of lease expense over the lease term.

Breakdown of other operating expenses	Note	2019/20 Actual	2018/19 Actual
Impairment of debtors	7	103	(4)
Loss on disposal of property, plant and equipment	9	7	158
Audit fees (for the audit of the financial statements-excl disbursements)		121	118
Audit related fees for assurance and related services (Internal and Quality Audits)		77	(7)
Board and advisory members fees	3	228	228
Operating lease expenses		565	560
Other		347	561
Total operating expenses		**1,449**	**1,614**

Operating leases as leasee

West Coast DHB leases a number of buildings under operating leases.

The future aggregate minimum lease payments to be paid under non-cancellable operating lease are as follows:	Note	2019/20 Actual	2018/19 Actual
Not more than one year		111	125
later than one year and not later than five years		24	15
Total non-cancellable operating lease		**135**	**140**

5. Capital Charge

ACCOUNTING POLICY

Capital charge is expensed in the financial year to which the charge relates.

Further information

The West Coast DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the year ended 30 June 2020 was 6% (2019: 6%).

6. Cash and Cash Equivalents

ACCOUNTING POLICY

Cash and cash equivalents includes cash on hand, deposits held at call with banks, and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are presented within borrowings in current liabilities in the statement of financial position.

Breakdown of cash and cash equivalents and further information			
	Note	2019/20 Actual	2018/19 Actual
Bank balances and call deposits	21	6,153	6,360

Bank Facility

West Coast DHB is a party to a DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2020, this limit was $7.545m (2019: $7.444m).

Financial assets recognised subject to restrictions

The West Coast DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts (not included in the above) and interest earned is allocated to the individual patients (see note 15).

Bank balance includes unspent donations received of $11k (2019: $10k) that are subject to restrictions. The restrictions generally specify how the donation is required to be spent (see note 16).

7. Receivables

ACCOUNTING POLICY

Short-term debtor and other receivables are recorded at the amount due, less any provision for un-collectability.

A receivable is considered uncollectable when there is evidence that the amount will not be fully collected. The amount that is uncollectable is the difference between the amount due and the present value of the amount expected to be collected.

Bad debts are written off during the period in which they are approved.

Breakdown of Debtors and other receivables			
	Note	2019/20 Actual	2018/19 Actual
Trade receivables		433	290
Ministry of Health receivables		2,992	2,396
Other Crown receivables		420	557
Accrued revenue		329	487
Prepayments		312	204
Less: Provision for un-collectability		(27)	(19)
Total receivables	21	**4,459**	**3,915**

The ageing profile of receivables at year end are as follows:	2019/20			2018/19		
	Gross Receivable	Provision for uncollectability	Net	Gross Receivable	Provision for uncollectability	Net
Not past due	3,965	-	3,965	3,577	-	3,577
Due 1-30 days	77	-	77	271	-	271
Past due 31-60 days	17	-	17	7	-	7
Past due 61-90 days	352	-	352	1	-	1
Past due more 90 days	75	(27)	48	78	(19)	59
Total Gross Receivables	**4,486**	**(27)**	**4,459**	**3,934**	**(19)**	**3,915**

All receivables greater than 30 days in age are considered to be past due.

The carrying amount of debtors and other receivables approximates their fair value.

Trade receivables, prepayments and other receivables are from exchange revenue transactions. Receivables from the Ministry of Health can be a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in Receivables from the Ministry of Health is Nil (2019: Nil)

Due to the large number of receivables, the assessment of uncollectability is generally performed on a collective basis, based on the analysis of past collection history and write-offs.

Movements in the provision for uncollectability of receivables	Note	2019/20 Actual	2018/19 Actual
Balance 1 July		19	65
Receivables written off during the year	4	(149)	(42)
Additional provision made during the year	4	103	(4)
Closing balance 30 June		**27**	**19**

8. Inventories

ACCOUNTING POLICY

Inventories are held primarily for consumption in the provision of services and are stated at the lower of cost and current replacement cost.

Cost is principally determined on a weighted average cost basis.

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

Breakdown of Inventories	Note	2019/20 Actual	2018/19 Actual
Pharmaceuticals		181	176
Surgical and medical supplies		846	887
Other supplies		17	14
Total Inventories		**1,044**	**1,077**

There were no write-downs of inventories or reversal of prior year write-downs during the year (2019: Nil).

No inventories are pledged as a security for liabilities but some inventories are subject to retention of title clauses.

9. Property, Plant and Equipment

ACCOUNTING POLICY

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Coast Health Care Limited (a Hospital and Health Service) were vested in the West Coast DHB on 1 January 2001. Accordingly, assets were transferred to the West Coast DHB at their net book values as recorded in the books of the Hospital and Health Service.

In effecting this transfer, the Board has recognised the cost (or, in the case of land and buildings, the valuation) and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Property, plant and equipment acquired since the establishment of the district health board

Property, plant and equipment consists of the following asset classes: land, buildings, clinical equipment, fixtures and fittings, other equipment and motor vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value at least every three years. Fair value is determined from market-based evidence by an independent registered valuer.

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

Additions between revaluations are recorded at cost. The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the surplus or deficit.

Assets subject to a revaluation cycle are reviewed with sufficient regularity to ensure that the carrying amount does not differ significantly from fair value at balance date.

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 the West Coast DHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction (for example a donated asset), it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the West Coast DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are expensed in the surplus or deficit as they are incurred.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in the revaluation reserves in respect of those assets are transferred to the accumulated surplus or deficit with in equity.

Depreciation

Depreciation is provided on a straight-line basis on all assets with a cost or valuation above $2,000, at rates which will write off the cost (or revaluation) of the assets to their estimated residual values over their useful lives.

Assets below $2,000 are expensed in the surplus or deficit in the month of purchase, except where they form part of a larger asset group purchase. The estimated useful lives of major classes of assets are as follows:

	Years	Depreciation rate
Freehold Buildings	3 – 60	1.7% to 33%
Fit Out Plant and Equipment	3 – 50	2% to 33%
Plant and Equipment	2 – 20	5% to 50%
Motor Vehicles	3 – 10	10% to 33%

The residual value and useful life of an asset is reviewed and adjusted if applicable each year. Work in progress is not depreciated.

Impairment of property, plant and equipment

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 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. If any such indication exists, the asset's recoverable amounts are estimated.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

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

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent register valuer, Preston Rowe Paterson, PRP West Coast Ltd. The valuation was completed on March 2018, was reviewed and is effective as at 30 June 2018. There has been no material movement in the fair value since the last revaluation.

Land

Land is valued at fair value using the market-based evidence based on its highest and best use with reference to comparable land values. Vacant land is valued at Net Current Value.

Buildings

Specialised hospital buildings are valued using depreciated replacement cost because no reliable market data is available for such buildings. The following buildings were valued on the basis of Depreciated Replacement Cost:

- Buller Hospital
- Reefton Hospital
- Grey Hospital
- Hokitika Health Clinic
- Ngakawau Clinic
- Lake Brunner Clinic
- Fox Glacier Clinic
- Franz Josef (55% owned WCDHB)

Non-specialised operational buildings (for example residential buildings) are valued using market-based evidence.

The resulting movement in property and plant has been recognised as equity in the Property Revaluation Reserve (refer to note 14).

Breakdown of property, plant and equipment					
	Land	Buildings & fit-out	Plant, equipment & vehicles	Work in progress	**Total**
Cost or Valuation					
Balance at 30 June 2019	6,855	12,559	22,623	8,366	**50,403**
Additions	-	2,797	405	4,390	**7,592**
Disposals/transfers	-	-	(131)	(824)	**(955)**
Balance at 30 June 2020	**6,855**	**15,356**	**22,897**	**11,932**	**57,040**
Accumulated depreciation and impairment losses					
Balance at 1 July 2019	-	(2,041)	(17,300)	-	**(19,341)**
Depreciation charge for the year	-	(1,417)	(1,066)	-	**(2,483)**
Elimination on disposal/transfer	-	110	-	-	**110**
Balance at 30 June 2020	**-**	**(3,348)**	**(18,366)**	**-**	**(21,714)**
Carrying amount 30 June 2020	**6,855**	**12,008**	**4,531**	**11,932**	**35,326**
Cost or Valuation					
Balance at 30 June 2018	6,855	12,861	22,653	4,796	**47,165**
Additions	-	17	707	4,615	**5,339**
Disposals/transfers	-	(319)	(737)	(1,045)	**(2,101)**
Balance at 30 June 2019	**6,855**	**12,559**	**22,623**	**8,366**	**50,403**
Accumulated depreciation and impairment losses					
Balance at 30 June 2018	-	(81)	(16,946)	-	**(17,027)**
Depreciation charge for the year	-	(2,099)	(1,101)	-	**(3,200)**
Elimination on disposal/transfer	-	139	747	-	**886**
Balance at 30 June 2019	**-**	**(2,041)**	**(17,300)**	**-**	**(19,341)**
Carrying amount 30 June 2019	**6,855**	**10,518**	**5,323**	**8,366**	**31,062**

Impairment

Engineering reviews of Grey Base buildings during the 2013 financial year identified structures which are earthquake prone. For these structures, the West Coast DHB considered whether their carrying value exceeded their recoverable amount. As a result, the West Coast DHB recognised $2.6m asset impairment at 30 June 2013. As at 30 June 2020, no further impairment was considered necessary.

Restrictions on title

Some of the West Coast DHB's land is subject to the Ngai Tahu Claims Settlement Act 1998. This requires the land to be offered to Ngai Tahu at market value as part of any disposal process.

Work in progress

Buildings in the course of construction total $7.403m (2019: $5.195m).

Finance Leases

West Coast DHB had no assets held under finance leases (2019: Nil).

Capital Commitments

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred. Capital commitments pertaining to the new Te Nikau hospital facility are held by the Ministry of Health until such time as these assets are handed over to the West Coast DHB.

Capital commitments		
	2019/20	2018/19
Buildings	479	2,638
Plant, equipment and vehicles	1,498	691
Intangibles	271	174
Total capital commitments at balance date	**2,248**	**3,503**

10. Intangible Assets

ACCOUNTING POLICY

Acquisition and development

Intangible assets that are acquired by the West Coast DHB are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each period is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

	Years
Acquired computer software	2-10

Impairment

Refer to the policy for impairment of property, plant and equipment in Note 9. The same approach applies to the impairment of intangible assets.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Estimating useful lives of software assets

Software has an infinite life, which requires West Coast DHB to estimate the useful life of the software assets.

In accessing the useful lives of software assets, a number of factors are considered, including:

- Period of time the software is expected to be in use;
- Effects of technological change on systems and platforms; and
- Expected timeframe for the development and replacement of systems and platforms

An incorrect estimate of the useful lives of software will affect the amortisation expense recognised in the surplus or deficit, and the carrying amount of the software assets in the statement of financial position.

Breakdown of intangible assets

Movements for each class of intangible assets are as follows:

Breakdown of Intangibles	Acquired software	NZ Health Partnerships Ltd	**Total**
Cost or Valuation			
Balance at 30 June 2019	4,647	652	**5,299**
Additions	408	-	**408**
Disposals/transfers	(38)	-	**(38)**
Balance at 30 June 2020	**5,017**	**652**	**5,669**
Accumulated amortisation and impairment losses			
Balance at 1 July 2019	(4,271)	(332)	**(4,603)**
Amortisation charge for the year	(251)	-	**(251)**
Elimination on disposal/transfer	2	-	**2**
Balance at 30 June 2020	**(4,520)**	**(332)**	**(4,852)**
Carrying Value at 30 June 2020	**497**	**320**	**817**
Cost or Valuation			
Balance at 30 June 2018	4,526	567	**5,093**
Additions	121	85	**206**
Balance at 30 June 2019	**4,647**	**652**	**5,299**
Accumulated amortisation and impairment losses			
Balance at 30 June 2018	(4,080)	(48)	**(4,128)**
Amortisation charge for the year	(191)	-	**(191)**
Impairment Losses		(284)	**(284)**
Balance at 30 June 2019	**(4,271)**	**(332)**	**(4,603)**
Carrying value 30 June 2019	**376**	**320**	**696**

Restrictions

There are no restrictions over the title of intangible assets and no intangible assets are pledged as security for liabilities.

Capital commitments

West Coast DHB has contracted capital commitments of $271k (2019: $174k) in relation to intangible assets.

Impairment of New Zealand Health Partnerships Limited (NZHPL)

No further impairment of the NZHPL Change Management and Supply Chain was recognised in June 2020 (2019: $284k). The prior year impairment was to recognise the variation between the underlying value of the Finance Procurement Information Management (FPIM) programme asset held by NZHPL, and the underlying investment carried by DHBs.

NZHPL has issued B Class Shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain Shared Service. The following rights are attached to these shares.

- Class B Shares confer no voting rights.
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services.
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by NZHPL from the Finance, Procurement and Supply Chain Shared Service.
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company.

- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

The rights attached to "B" Class shares include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and, therefore, the benefits conferred through this access. The service level agreement will contain five provisions specific to the recognition of the investment within the financial statements of DHBs. The five provisions are:

- The service level agreement is renewable indefinitely at the option of the DHBs; and
- The DHBs intend to renew the agreement indefinitely; and
- There is satisfactory evidence that any necessary conditions for renewal will be satisfied; and
- The cost of renewal is not significant compared to the economic benefits of renewal; and
- The fund established through the on-charging of depreciation by NZHPL will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

The application of these five provisions mean the investment, upon capitalisation on the implementation of the FPSC Programme, will result in the asset being recognised as an indefinite life intangible asset.

11. Payables and deferred revenue

ACCOUNTING POLICY
Short-term payables are recorded at the amount payable

Breakdown of Payables and Deferred Revenue			
	Note	2019/20 Actual	2018/19 Actual
Payables and deferred revenue under exchange transactions			
Creditors		1,636	1,733
Accrued expenses		8,771	6,687
Deferred revenue		592	316
Total payables and deferred revenue under exchange transactions		**10,999**	**8,736**
Payables and deferred revenue under non-exchange transactions			
Taxes payable		2,263	1,600
Total Payables and deferred revenue under non-exchange transactions		2,263	1,600
Total Payables and deferred revenue		**13,262**	**10,336**

Creditors are non-interest bearing and are normally settled on 30 days terms. Therefore, the carrying value of the creditors and other payables approximates their fair value.

12. Borrowings

ACCOUNTING POLICY

Borrowings are recognised initially at fair values plus transaction costs. Subsequent to initial recognition, borrowings are stated at amortised cost using the effective interest rate method.

Borrowings are classified as current liabilities until West Coast DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Overdraft facility

Amount drawn under the NZHPL banking facility is recorded at the amount payable plus accrued interest.

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the net present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease periods as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the group will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICES

Lease classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the 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 option in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum payments. Classification as a finance lease means the asset is recognised in the statement of finance position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Management has exercised its judgement on the appropriate classification of leases, and has determined that no lease arrangements are finance leases.

West Coast DHB has a maximum overdraft limit of $7.545m (2019: $7.444m) with NZHPL as at 30 June 2020. Refer to note 6 for further information. As at 30 June 2020, the West Coast DHB had Nil borrowings (2019: Nil).

13. Employee Entitlements

ACCOUNTING POLICY

Short-term employee entitlements

Employee entitlements that the West Coast DHB expects to settle within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, retiring and long service leave entitlements expected to be settled within 12 months, medical education leave, and sick leave.

Sick leave

The sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent the West Coast DHB anticipates it will be used by staff to cover those future absences.

Long-term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the year in which the employee renders the related service, such as sabbatical leave, long service leave, and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to employees based on years of service, years to entitlement,
- The likelihood that staff will reach the point of entitlement
- Contractual entitlement information; and
- The present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, continuing medical education leave and expenses, annual leave, long service leave that is available for use, and sabbatical leave that is available for use are classified as a current liability. Long service leave, sabbatical leave and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Sabbatical leave, long service leave and retirement gratuities

The present value of sabbatical leave, long service leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Key assumptions used in calculating these liabilities include the discount rate, the salary escalation rate and resignation rates. Any changes in these assumptions will affect the carrying amount of the liability.

The discount rates used have been obtained from the NZ Treasury published risk-free discount rates as at 4 July 2020. The salary inflation factor has been determined after considering historical salary inflation patterns.

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying value amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $170,000 (2019: $200,000) higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $165,000 (2019: $200,000) higher/lower.

Breakdown of Employee entitlements and benefits

	2019/20 Actual	2018/19 Actual
Current portion		
Accrued salary and wages	2,468	2,227
Annual leave	5,786	4,938
Holidays Act compliance provision	16,490	5,190
Continuing medical education leave and expenses	1,047	796
Long-service leave	552	677
Other leave	1,915	1,611
Retirement gratuities	757	618
Sabbatical leave	101	108
Sick leave	107	113
Total current portion	**29,223**	**16,278**
Non-current portion		
Long-service leave	304	269
Retirement gratuities	1,811	1,992
Sabbatical leave	138	138
Total non-current portion	**2,253**	**2,399**
Total employee entitlements	**31,476**	**18,677**

Holidays Act compliance

A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 ("the Act").

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation programme associated with the MOU is a significant undertaking and work to assess, rectify and remediate all areas of non-compliance will continue through the 2020/21 financial year. At West Coast DHB, the formal Review Phase, as set out in the MOU, was completed in March 2020 with all non-compliance issues identified. Efforts are now focused on rectifying payroll systems and processes to ensure ongoing compliance, as well as analysis, testing and remediating the results of retrospective areas of non-compliance for relevant individual employees.

West Coast DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

14. Equity

ACCOUNTING POLICY

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Crown equity;
- Accumulated surpluses/(deficits)
- Property revaluation reserves

Property revaluation reserves

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Breakdown of Equity				
Reconciliation of movement in equity and reserves	Crown equity	Property revaluation reserve	Accumulated surpluses/ (deficits)	Total equity
2019/20				
Balance at 1 July 2019	85,926	25,100	(96,939)	14,087
Surplus/(deficit) for the year	-	-	(18,969)	(18,969)
Capital contributions from the Crown	6,000	-	-	6,000
Repayment of capital to the Crown	(68)	-	-	(68)
Other movement/adjustment	2,000	-	-	2,000
Balance at 30 June 2020	**93,858**	**25,100**	**(115,908)**	**3,050**
2018/19				
Balance at 1 July 2018	85,994	25,681	(85,965)	25,710
Surplus/(deficit) for the year	-	-	(11,555)	(11,555)
Repayment of capital to the Crown	(68)	-	-	(68)
Movement in revaluation of buildings, fixtures and fittings	-	(581)	581	-
Balance at 30 June 2019	**85,926**	**25,100**	**(96,939)**	**14,087**

Capital Management

West Coast DHB's capital is its equity, which comprises Crown equity, accumulated surpluses/(deficits), and property revaluation reserves. Equity is represented by net assets.

West Coast DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the issue of derivatives.

The Board manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities and general financial dealings to ensure that it effectively achieves its objectives and purposes, whilst remaining a going concern.

15. Patient Deposits

West Coast DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts and any interest earned is allocated to the individual patient balances. These deposits are classified as a current asset/liability because the Board expects that most of these deposits held on behalf of patients will be distributed in the next 12 months.

Movement of patient deposits			
	Note	2019/20 Actual	2018/19 Actual
Opening balance patients deposits		72	71
Interest earned		-	1
Closing balance		**72**	**72**

16. Restricted Funds

West Coast DHB has funds donated for specific purposes which have not yet been met. This is recorded as a liability in our statement of financial position and included in our cash balance (see note 6). The table below shows the movement of these restricted funds. The carrying value of the restricted funds is equal to the fair value of the restricted funds.

Movement of restricted funds			
	Note	2019/20 Actual	2018/19 Actual
Opening balance restricted funds		10	12
Monies received		30	40
Payments made		(29)	(42)
Closing balance		**11**	**10**

17. Reconciliation of Net Surplus/(Deficit) for the Period with Net Cash Flows from Operating Activities

	Note	2019/20 Actual	2018/19 Actual
Net surplus/(deficit)		**(18,969)**	**(11,555)**
Add/(less) non-cash items:			
Depreciation and amortisation expense		2,733	3,391
Revaluation reserve movement		-	581
Net movement in non-cash items		**2,733**	**3,972**
Movements in working capital:			
(Increase)/decrease in receivables		(544)	(208)
(Increase)/decrease in inventories		33	(19)
Increase/(decrease) in payables and deferred revenue		2,925	1,154
Increase/(decrease) in employee benefits		12,799	6,071
Net movement in working capital		**15,213**	**6,998**
Net cash flow from operating activities		**(1,023)**	**(585)**

18. Contingencies

Contingent liabilities

SUPERANNUATION SCHEMES

West Coast DHB is a participating employer in the DBP Contributors Scheme ("the Scheme"), which is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, West Coast DHB could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, West Coast DHB could be responsible for an increased share of the deficit.

Outstanding legal proceedings

West Coast DHB has no material outstanding legal proceedings as at 30 June 2020 (2019: Nil).

Contingent assets

The West Coast DHB has no contingent assets (2019: Nil).

19. Related Party Transactions

ACCOUNTING POLICY

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

West Coast DHB is controlled by the Crown.

Related party disclosures have not been made for transactions with related parties that are:

- Within a normal supplier or client/recipient relationship; and
- On terms and conditions no more or less favourable than those that it is reasonable to expect that the group would have adopted in dealing with the party at arm's length in the same circumstances.

Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies.

Significant transactions with government related entities

West Coast DHB and West Coast DHB collectively continue to maintain a transalpine approach to the delivery of health services. This includes both clinical, as well as non-clinical, shared staff. All other related party transactions with West Coast DHB and its subsidiary West Coast Linen Services have been entered into on an arm's length basis.

West Coast DHB has received funding from the Crown, ACC and other government entities of $151.52m to provide health services in the West Coast area for the year ended 30 June 2020 (2019: $144.59m). Refer to note 7 for amounts receivable.

Revenue earned from other DHBs for the care of patients domiciled outside West Coast DHB's district as well as services provided to other DHBs amounted to $2.05m for the year ended 30 June 2020 (2019: $1.82m).

Expenditure to other DHBs for the care of patients from West Coast DHB's district and services provided from other DHBs amounted to $23.07m for the year ended 30 June 2020 (2019: $23.40m).

Other significant transactions with government-related entities

In conducting its activities, West Coast DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. West Coast DHB is exempt from paying income tax. See note 11 for amounts payable.

West Coast DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2020 totalled $1.77m (2019: $2.166m). These purchases included capital charge from Ministry of Health, blood products from the New Zealand Blood Service, electricity from Genesis Energy and services from educational institutions.

Compensation of key management personnel

West Coast DHB Board members have been paid under the fees framework for members appointed to bodies in which the Crown has an interest. The fees are set by Cabinet. The full time equivalent for Board members has been determined based on the frequency and length of meetings and the estimated time for Board members to prepare for meetings. Analysis of Board member fees is provided in Note 3.

At June 2020, the executive management team consisted of 4 members (2019: 4) employed by West Coast DHB and a further 7 members, including the Chief Executive, who were employed by West Coast DHB (2019: 7). The key management personnel services provided by the Office of the Chief Executive are provided to West Coast DHB under contract by West Coast DHB and are invoiced accordingly - 2020: $312k (2019: $309k).

No executive management personnel were Board members (2019: Nil).

Remuneration includes all salary, leave payments and lump sum payments. Post-employment benefits are West Coast DHB contributions to superannuation and Kiwi Saver schemes.

Compensation of key management personnel		
	2019/20 Actual	2018/19 Actual
Board Members		
Remuneration	223,254	219,505
Full-time equivalent members	2.15	2.15
Executive management		
Remuneration	978,167	985,017
Post -employment benefits	24,977	27,403
Full-time equivalent members	3.80	4.00
Total key management personnel remuneration	**1,226,398**	**1,231,925**
Total full-time equivalent members	**5.95**	**6.15**

20. Events after Balance Date

The Crown transferred the Te Nikau facility totalling $121m to West Coast DHB by Order in Council on 1 August 2020.

Other than this, there were no events after 30 June 2020, which could have a material impact on the information in West Coast DHB's financial statements. (2019: Nil)

21. Financial Instruments

Financial instrument categories

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

	2019/20 Actual	2018/19 Actual
Loans and receivables		
Cash and cash equivalents	6,153	6,360
Receivables	4,459	3,915
Total loans and receivables	**10,612**	**10,275**
Financial liabilities measured at amortised cost		
Payables (excluding deferred revenue and taxes)	10,407	8,420

West Coast DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances (note 6), trade receivables (note 7), payables (note 11) and loans. Refer to specific notes to the financial statements for applicable detailed explanations for the instruments.

The Board has policies providing risk management for interest rates and the concentration of credit. The Board is risk averse and seeks to minimise exposure from its treasury activities. The Board's Quality, Finance, Audit and Risk Committee provides oversight for risk management.

Financial instrument risks

The West Coast DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk and liquidity risk. The DHB has a series of policies to manage the risk associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

MARKET RISK

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. West Coast DHB has very low price risk as it does not hold any debt or investments.

Fair value interest rate risk

Fair value interest rate risk is the risk that the value of a financial instrument will fluctuate due to changes in market interest rates. West Coast DHB has funds held by NZHPL and there is interest rate risk to those funds.

Cash flow interest rate risk

Cash flow interest rate is the risk that the cash flows from a financial instrument will fluctuate because of changes in market interest rates. The West Coast DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not significant due to minimal amounts invested in these types of deposits.

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. West Coast DHB has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2020 (2019: Nil)

Credit risk

Credit risk is the risk that a third party will default on its obligation causing West Coast DHB to incur a loss. Due to the timing of cash inflows and outflows, surplus cash is invested with registered banks or NZHPL.

In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL and receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statements of financial positions.

The Board places its cash and term investments with quality financial institutions via a national DHB shared banking arrangement, facilitated by NZHPL.

Concentrations of credit risk of accounts receivable are high due to the reliance on the Ministry of Health, which comprises 67% (2019: 52%) of the debtors of West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHBs) total reliance on government debtors is 76% (2019: 66%). The Board considers the risk arising from this concentration of credit to be very low.

Credit quality of financial assets

The credit quality of financial assets that are neither past due nor impaired are identified in the table below:

Credit quality of financial assets		
	2019/20 Actual	2018/19 Actual
Counterparties with credit ratings		
Bank of New Zealand Limited AA-	141	142
Westpac AA-	-	53
Total cash and cash equivalents	**141**	**195**
Counterparties without credit ratings		
NZ Health Partnerships Limited	6,065	6,221
Cash on Hand	6	6
Gross receivables (not past due)	3,965	3,934
Total Counterparties without credit ratings	**10,036**	**10,161**

LIQUIDITY RISK

Management of liquidity risk

Liquidity risk is the risk that the group will encounter difficulty raising funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements.

Contracted maturity analysis of financial liabilities

The table below analyses financial liabilities (excluding derivatives) into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows. There were no interest cash outflows over the last financial years.

Maturity groupings of financial liabilities					
	Carrying amount	Contracted cash flows	Less than 1 year	1-2 years	More than 2 years
2019/20					
Payables	13,262	13,262	13,262	-	-
Total	**13,262**	**13,262**	**13,262**	**-**	**-**
2018/19					
Payables	10,336	10,336	10,336	-	-
Total	**10,336**	**10,336**	**10,336**	**-**	**-**

22. Explanation of Major Variances against Budget

Explanations for major variances from the DHB's budgeted figures in the 2019/20 Annual Plan are as follows:

Statement of Comprehensive Revenue and Expense

REVENUE

Revenue had a 1.1% favourable variance between our planned revenues of $160.492m compared to actual revenue of $162.302m. The main factors influencing this favourable variance were:

- COVID-19 related revenue $986k
- Additional In between travel funding from the Ministry of Health $311k
- Pay equity Funding, GP practice funding and other MoH contracts were $673k higher than budget.

EXPENSES

Expenses had an 8.5% unfavourable variance between our planned expenditure of $167.105m compared to actual expenditure of $181.271m. The main factors influencing this overspend were:

- Holiday Act compliance provisioning of $11.300m.
- Outsourced personnel $0.940m over budget principally related to locum costs to cover vacancies and unplanned leave.
- COVID-19 costs included in Payments to other health service providers totalled $0.498m.
- Depreciation costs were favourable to budget due to the delay in opening Te Nikau.
- Expenditure on clinical supplies was $1.250m higher than budgeted primarily due to increased pharmaceutical and blood products.

Balance Sheet

The Property Plant and Equipment budget includes the Te Nikau facility that was planned to be transferred prior in 2019/20. The building was transferred from the Ministry of Health to the West Coast DHB in August 2020. The handover value is $121m.

Employee entitlements includes $11.300m of Holidays Act Compliance provision that was not in the budget.

The contributed capital variance to budget also relates to the delayed handover of the Te Nikau facility.

Cash Flow

In the Annual Plan, purchase of Property Plant and Equipment included $9m for the Buller facility. The Buller facility is now expected to be completed in 2022. This is offset by an equity injection from the Crown.

23. Revenue Appropriation

Under the Public Finance Act, West Coast DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by West Coast DHB for the financial year 2019/20 is $142.29m (2018/19: $135.31m) which equals the Government's actual expenses incurred in relation to the appropriation.

24. Summary of Cost of Services

The table below summarises the revenue and expenditure for the four output classes for the year ended 30 June 2020.

	2019/20 Actual	2019/20 Budget	2018/19 Actual
Revenue			
Prevention	3,357	3,528	3,423
Early Detection and Management	38,926	30,573	29,603
Intensive Assessment and Treatment	91,354	103,800	100,494
Rehabilitation and Support	28,662	21,751	21,089
Total Revenue	**162,299**	**159,652**	**154,609**
Expenditure			
Prevention	4,751	3,990	4,159
Early Detection and Management	48,600	32,524	32,456
Intensive Assessment and Treatment	96,734	107,662	107,816
Rehabilitation and Support	31,183	22,089	21,733
Total Expenditure	**181,268**	**166,265**	**166,164**
Surplus/(Deficit)	**(18,969)**	**(6,613)**	**(11,555)**

25. The Effects of COVID-19 on West Coast DHB

On 11 March 2020, the World Health Organisation declared the outbreak of the COVID-19 pandemic. Two weeks later the New Zealand Government declared a State of National Emergency. The country was in lockdown at Alert Level 4 from 26 March to 27 April, and then remained in lockdown at Alert Level 3 until 13 May.

The effect of COVID-19 on our 2019/20 operations is reflected in these financial statements, based on the information available as at 30 June 2020. The forecasted impact of COVID-19 on West Coast DHB's outyears performance is dependent on several uncertain parameters and the long-term impact will take some time to determine; and will include factors impacting our variable revenue streams such as electives, IDF and ACC, and the costs associated with these such as additional costs required to catch up on lost throughput to meet performance targets.

The main impacts on the 2019/20 financial statements due to COVID-19 are explained below.

Government funding

The Ministry of Health provided additional funding in 2019/20 for the West Coast DHB COVID-19 response.

Operating expenses

As a result of COVID-19, the West Coast DHB has incurred additional expenditure of in areas including:

- Payroll - The pandemic presented unique challenges for staffing and roster modelling to ensure both staff and patient safety, which has led to higher payroll costs. Other contributing additional costs include substantially lower level of leave taken since the pandemic declaration.
- Treatment related costs - These additional costs are comprised of consumables to ensure that all DHB staff and patients had appropriate access to PPE, as well as costs incurred managing testing sites.
- Other expenses - Other expenses include communication costs to keep the community, staff and patients informed.
- External provider costs – some testing performed in primary care.

The operating costs above are partially offset by additional Government funding and other revenue as outlined above.

Balance sheet impacts

- Employee benefits balances are higher due to both lower annual leave taken and CME entitlements being extended by 12 months increasing the liability.

An impairment assessment has been completed for tangible and intangible assets. No impairments have been recognised as a result of the assessments due to COVID-19.

Part VI
Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of West Coast District Health Board's financial statements and performance information for the year ended 30 June 2020

The Auditor-General is the auditor of West Coast District Health Board (the Health Board). The Auditor-General has appointed me, Julian Tan, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and the performance information, including the performance information for an appropriation, of the Health Board on his behalf.

We have audited:

- the financial statements of the Health Board on pages 39 to 70, that comprise the statement of financial position as at 30 June 2020, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 10 to 31 and note 24 on page 69.

Qualified opinion on the financial statements

In our opinion, except for the possible effects of the matter described in the *Basis for our qualified opinion* section of our report, the financial statements of the Health Board on pages 39 to 70:

- present fairly, in all material respects:
    - its financial position as at 30 June 2020; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information – Our work was limited because the Health Board was unable to report reliably on waiting times for its mental health and alcohol and other drug services

In our opinion, except for the possible effects of the matter described in the *Basis for our qualified* opinion section of our report, the performance information of the Health Board on pages 10 to 31 and note 24 on page 69:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2020, including:

- for each class of reportable outputs:
  - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
  - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 18 December 2020. This is the date at which our opinion is expressed.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

Financial statements

As outlined in Note 13 on page 62, the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues.

During the audit for the year ended 30 June 2019, we were unable to obtain sufficient appropriate audit evidence to determine whether the amount of the Health Board's provision of $5 million as at 30 June 2019 was reasonable because of the work that was yet to be completed to remediate these issues. We accordingly expressed a qualified opinion on the financial statements for the year ended 30 June 2019.

The Health Board has made progress during the current year in estimating the amount of the provision and we have been able to obtain sufficient appropriate audit evidence that the provision of $16 million as at 30 June 2020 is reasonable. However, until the process is completed, there are uncertainties surrounding the amount of the provision.

Our opinion on the current year's financial statements is qualified because of the possible effects of this matter on the comparability of the current year's provision and the 2019 provision.

Performance information

An important part of the Health Board's performance information is reporting on waiting times for mental health and alcohol and other drug services. As explained in footnote 26 on page 26 of the annual report, coding inconsistencies were identified with regard to the waiting time data for the year ended 30 June 2020 for both the three and eight week wait time performance measures. The Health Board was unable to undertake a reconciliation process to correct these inconsistencies before finalising the annual report. As a result, our work was limited and there were no practicable audit procedures we could apply to obtain assurance that the reported information fairly reflected the performance against these measures for the year ended 30 June 2020.

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our unmodified opinion on the financial statements and the basis for our qualified opinion on the performance information.

Emphasis of matters

Without further modifying our opinion, we draw attention to the following disclosures.

The Health Board is reliant on financial support from the Crown

Note 1 on page 44 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including the Health Board's responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Health Board will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Health Board over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

Note 25 on pages 69 to 70 of the financial statements outlines the impact of Covid-19 on the Health Board.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Health Board for the preparing the financial statements and the performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare the financial statements and the performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000, and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers, taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material

misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board to express an opinion on the consolidated audited information. We are responsible for the direction, supervision and performance of the of the Health Board audit. We remain solely responsible for our audit opinion.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 9 and 33 to 37, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

Other than in our capacity as auditor, we have no relationship with, or interests in, the Health Board.

Julian Tan
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand