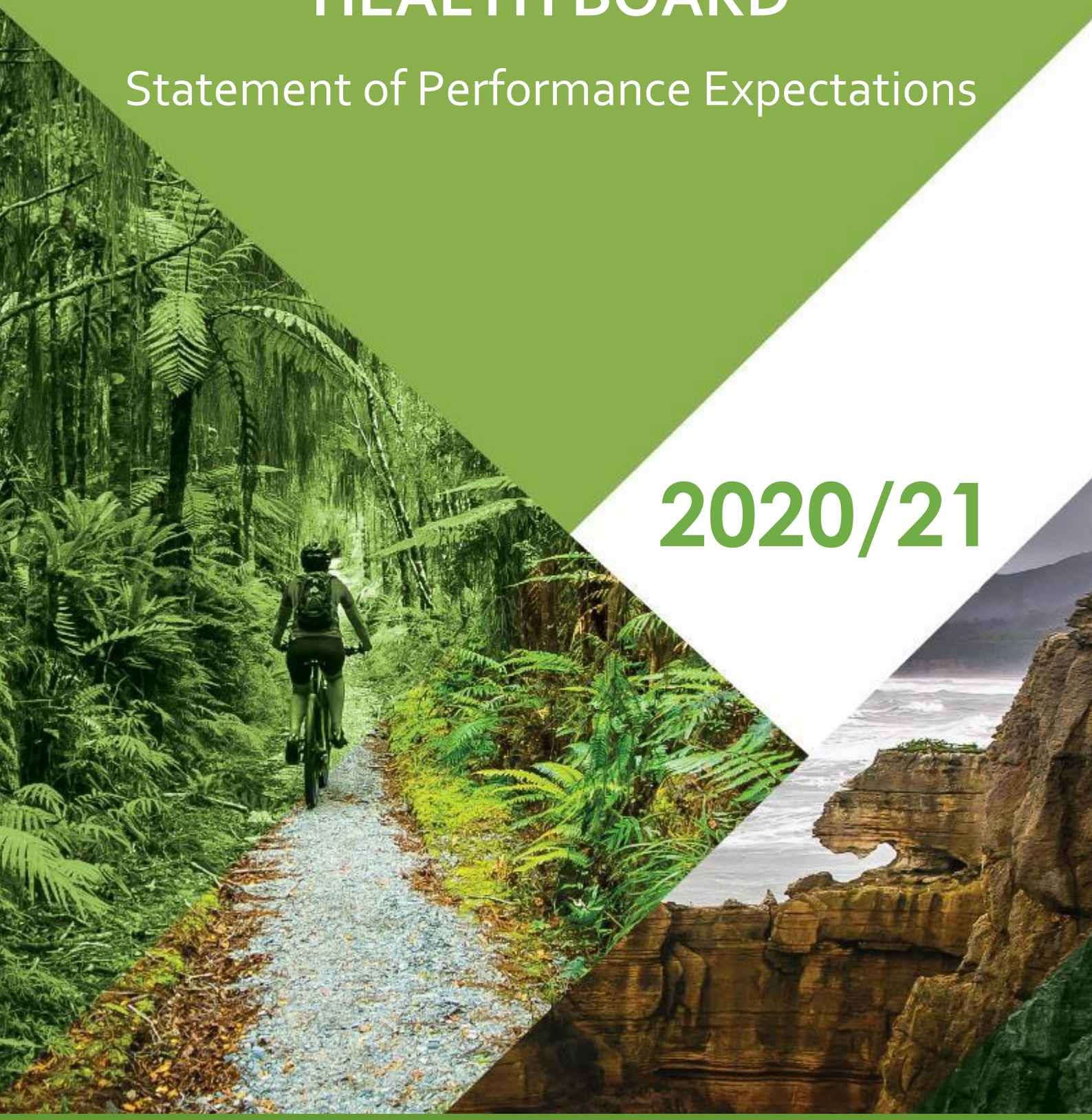
E.96

WEST COAST DISTRICT HEALTH BOARD

Statement of Performance Expectations



2020/21

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entitles Act 2004.

Statement of Joint Responsibility

The West Coast District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2001. Each DHB is categorised as a Crown Agent under the Crown Entities Act and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

This document is the DHB's Statement of Performance Expectations which has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and the expectations of the Minister of Health.

Linking with our Statement of Intent, the Annual Plan describes our strategic goals and objectives in terms of improving the health of our population and ensuring the sustainability of our health system. It also contains our Statement of Performance Expectations for 2020/21 and the actions we will take to deliver on national priorities and expectations in the coming year.

The Statement of Performance Expectations is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in our Annual Report.

The West Coast DHB has made a strong commitment to 'whole of system' service planning. We work collaboratively and in partnership with other service providers, agencies and community organisations to meet the needs of our population and support several clinically-led Alliances as key vehicles for implementing system improvement and change.

We share a joint vision for the future of our health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our local Alliance with the West Coast PHO, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the Canterbury DHB.

We recognise our role in actively addressing disparities in health outcomes for Māori and we are committed to making a difference. We work closely with Tatau Pounamu and our Kaupapa Māori provider (Poutini Waiora) in a spirit of communication and co-design that encompasses the principles of Te Tiriti o Waitangi and seeks to address equity for Māori.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity and is in line with Government expectations for 2020/21.

Honourable Rick Barker
CHAIR

Tony Kokshoorn
DEPUTY CHAIR

David Meates
CHIEF EXECUTIVE

12 August 2020

Table of Contents

OVERVIEW

Who are we and what do we do?

Introducing the West Coast DHB

1.1 Who are we?

The West Coast District Health Board (DHB) is one of twenty DHBs in New Zealand, charged by the Crown with improving, promoting and protecting the health and independence of our resident population.

Like all DHBs, we receive funding from Government to provide or purchase the services required to meet the needs of our population, and we are expected to operate within that allocated funding.

In 2020/21, we will receive approximately $175 million dollars to meet the needs of our population. In accordance with legislation, and consistent with Government objectives, we will use that funding to:

Plan the future direction of our health system and, in collaboration with clinical leads and alliance partners, develop demand strategies and determine the services required to meet the needs of our population.

Fund the health services required to meet the needs of our population and, through collaborative partnerships and ongoing performance monitoring, ensure these services are safe, equitable and effective.

Provide health services to our population, through our hospital and specialist services, general practices, and community and home-based support services.

Promote and Protect our population's health and wellbeing through investment in health protection, promotion and education services and the delivery of evidence-based public health initiatives.

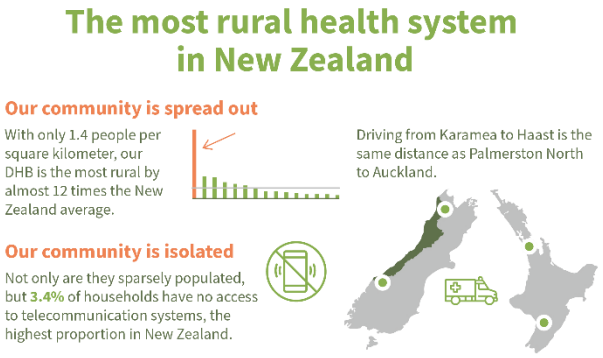
1.2 What makes us different?

The West Coast DHB has the smallest population of any DHB in New Zealand. We are responsible for 32,550 people, or 0.7% of the total New Zealand population.

While we are the smallest DHB by population, we are the third largest DHB by geographical area, making the West Coast DHB the most sparsely populated DHB in the country with only 1.4 people per square kilometre.

We own and operate four major health facilities in Westport, Reefton, Greymouth and Hokitika and eight smaller clinics in our more remote areas. Unlike most other DHBs, we own and operate four of the seven general practices on the Coast; we also operate a district nursing and home-based support service. This makes us a major local employer, with more than 1,000 people directly employed by the West Coast DHB.

In addition, we hold and monitor more than 80 service contracts with other organisations and individuals who also provide health and disability services to our population, including pharmacies, midwives, aged residential care providers, public health and Māori health providers and the West Coast PHO.



As New Zealand's smallest and most rural DHB, our population levels and the resources we have available to us mean we cannot provide a full range of specialist services on the West Coast.

The West Coast 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, a formal transalpine service partnership, established with the Canterbury DHB in 2010, means Canterbury specialists are providing regular outpatient clinics and surgical lists on the West Coast. This partnership, and a deliberate investment in telehealth technology, is providing our population with improved access to specialised services without having to travel long distances for assessment and treatment.

This direction is being further supported by the introduction of a rural-generalist workforce model, a proven strategy for remote rural health systems.

This model will provide continuity of care for our population by addressing workforce shortages and service fragmentation. By improving service access, it will also help us to support people to stay well, reduce health inequalities and improve health outcomes – key goals for our health system.

The rural generalist model will be applied across all professions (medical, nursing and allied health), with a core workforce of rural generalists working to the full extent of their scope of practice. For example, a rural generalist doctor could be qualified to work in both general practice and hospital settings with a specialty in obstetrics, general medicine or anaesthetics. Our rural generalists will be members of multi-disciplinary teams working alongside both local and Christchurch-based specialists, enhancing the capacity, capability and resilience of our health system.

Our future is dependent on the development of this more integrated and sustainable workforce model and key actions and activity to progress this work have been highlighted through our Annual Plan.

1.4 Our population profile

The West Coast population of 32,550 people has been almost unchanged for the last ten years and is predicted to decrease slightly over the next ten years.

Our population's age structure is older than the rest of New Zealand, with 21.8% of our population aged over 65, compared with the national average of 16.2%.[1]

By 2025 one in every four people on the West Coast will be over 65 years of age.

Many long-term conditions become more common with age, including heart disease, stroke, cancer and dementia. As the average age of our population increases more people will need care and support, putting increasing pressure on our system.

Deprivation is a strong predicator of the need for health services and a key driver of health inequities. The 2018 Census recorded one in every ten residents on the West Coast were living in areas classified as socio-economically deprived. Higher proportions of our population were receiving unemployment or invalid benefits, had no educational qualifications and did not have access to a motor vehicle or telephone.

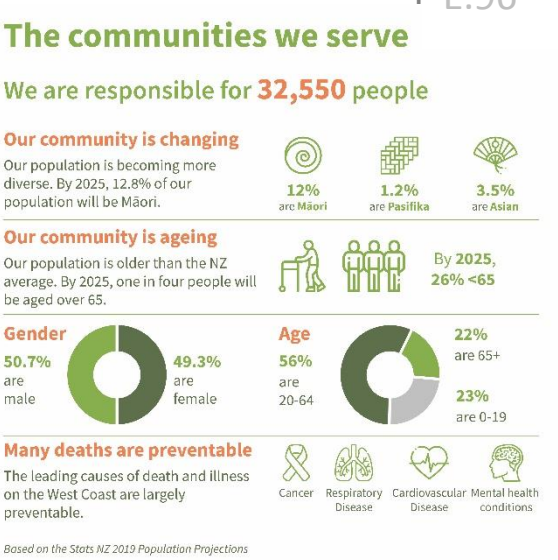
We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others. Ethnicity, like age and deprivation, is a strong predicator of need for health services. There are currently 3,890 Māori living on the West Coast (12% of our population) and by 2025 that proportion is predicted to increase to 12.8%.

Our Māori population has a considerably younger age structure, with 10.3% of our Māori population aged under five, compared to 5.6% of the total population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on the health needs of our younger Māori population.

1.5 Our population's health

West Coasters have higher morbidity and mortality rates resulting in a slightly a lower life expectancy (80.4 years) compared with the national average (81.4 years).

While West Coast Māori continue to have poorer overall health status and life expectancy (78.3 years), the inequity is reducing and at 2.1 years the differential between Māori and non- Māori is considerably better than the national gap, where Māori life expectancy (75.1 years) is almost 6.3 years lower than the total population.



Like the rest of New Zealand, an increasing number of people on the West Coast are living with long-term conditions such as heart disease, respiratory disease, cancer, diabetes and depression.

The increasing prevalence of long-term physical and mental health conditions is one of the main drivers of demand for health services and the primary cause of health loss and death amongst adults. In 2018/19, over 4,000 people (13% of our population) were identified as having one or more long-term conditions.[2]

A reduction in known risk factors, such as smoking, poor diet, lack of physical activity and hazardous drinking, could dramatically reduce pressure on our health system and improve health outcomes for our population. All four have strong socio-economic links, so reducing these risk factors will also contribute to reducing health inequities between population groups.

The most recent combined results from the New Zealand Health Survey (2014-2017) found that:

- 26% of our population are current smokers, much higher than the national average of 16.2%. Smoking rates amongst Māori are higher at 44%.
- More than a third (35%) of our total adult population are classified as obese. Rates for our Māori population are higher at 56%.
- Our population's fruit and vegetable intake is similar to the national average (41.1% vs 39.8%) however Māori rates were lower at 30.8%.
- 10% of our total adult population were identified as inactive (little or no physical activity). Rates for Māori were slightly higher at 13%.
- 16% of our adult population are likely to drink in a hazardous manner. While this rate is lower than the national average, it reflects hazardous drinking habits for one in every eight adults on the Coast. [3]

[1] Unless otherwise referenced figures comes from Stats NZ population projections provided by Ministry of Health February 2020.

[2] People enrolled with the West Coast PHO Long-Term Conditions Management Programme June 2019.

[3] Combined results from the 2014-2017 New Zealand Health Surveys have been used as small population numbers can have a distorting impact on annual results. Results incorporating the 2017/18 and 2018/19 Surveys are yet to be released. Refer to www.health.govt.nz.

1.6 Our Operating Challenges

Like the rest of the health sector, the West Coast DHB is experiencing growing demand pressures as our population ages and increasing fiscal pressures as treatment and wage costs raise. We also face several unique challenges due to our size and geographic isolation which add to our operating challenges.

Rurality: Geographically we are the third largest DHB in the country, covering a total land area of 23,283 square kilometres, but we are the smallest by population. This means patients and health professionals often have to travel long distances to access or deliver services. Our rurality is one of our biggest challenges and magnifies all the operating pressures we face.

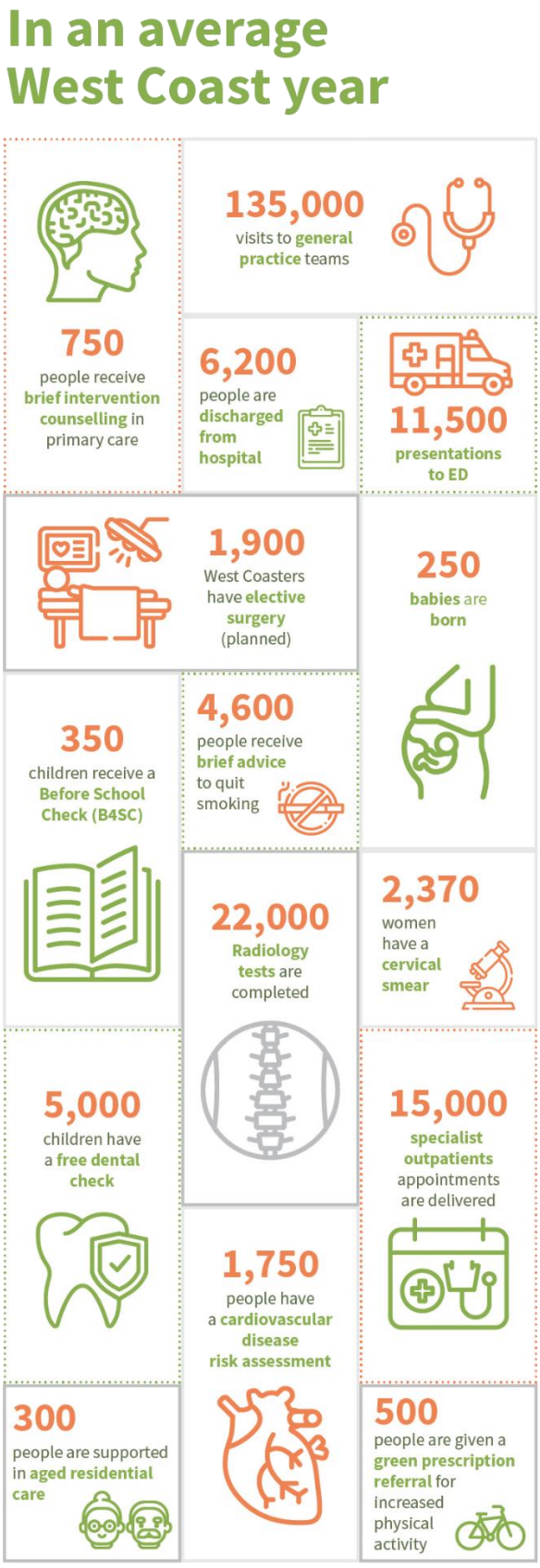
Workforce shortages: In our isolated environment, recruiting and retaining specialised staff is difficult and further complicated by the ageing of our workforce and national workforce shortages. This has led to an over-reliance on locums and short-term contractors, which reduces the continuity of care for our population and is unsustainable financially. The development of a highly skilled rural-generalist workforce is a critical factor in the future sustainability of our health system.

Service fragmentation: Because of our small population size, long travel distances and workforce challenges, services are often fragmented and person dependent. A history of over-reliance on hospital services also means services are not always delivered by the most appropriate person or in the most appropriate setting. Our locality-based service delivery model will support the development of multi-disciplinary teams and bring more services closer to people's homes.

Facilities pressures: Several of our health facilities are outdated, expensive to maintain, poorly located or seismically compromised. They create inefficiencies, add to financial pressures and do not support the more flexible models of care needed to respond to our population's needs. Completion of Te Nikau (the Grey Hospital and Integrated Health Centre) and the Buller Health Centre are critical to our future success.

Financial viability: Our population is static, and we receive limited annual increases in funding. Meeting increasing service demand, treatment and infrastructure costs, and national expectations around wages and salaries is a significant challenge. We need to carefully consider where we commit resources and reallocate funding into activity and services that will provide the greatest return in terms of health gain.

Variation: Our small size means any variation, in service demand, the capacity of the individuals and teams, or the way services are provided can have a significant impact on service provision, patient experience and the financial viability of our system. We need to take a new approach, recognising our strengths, but working collectively to build a more integrated and resilient system, better able to provide consistent and effective care to our population.



THE YEAR AHEAD

What can you expect from us?

Monitoring Our Performance

2.1 Improving health outcomes

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 strive to improve the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver, the efficiency with which it is delivered and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of the work we do and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an overarching intervention logic and an outcomes framework.

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 identifies three wellbeing goals, 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 population health indicators which will provide insight into how well our system is performing over time. These population health indicators are set out in our Statement of Intent and reported against annually in our Annual Report.

Refer to Appendix 3 for the Intervention Logic Diagram which illustrates 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.

2.2 Accountability to our community

Over the shorter-term, we evaluate our service performance by monitoring ourselves against a forecast of the service we plan to deliver and the standards we expect to meet. This forecast is set out in our Statement of Performance Expectation.

The results are reported publicly in our Annual Report, alongside our year-end financial performance.

Refer to Appendix 5 for the DHB's Statement of Performance Expectations for 2020/21 and Appendix 6 for the DHB's Statement of Financial Expectations.

2.3 Accountability to the Minister

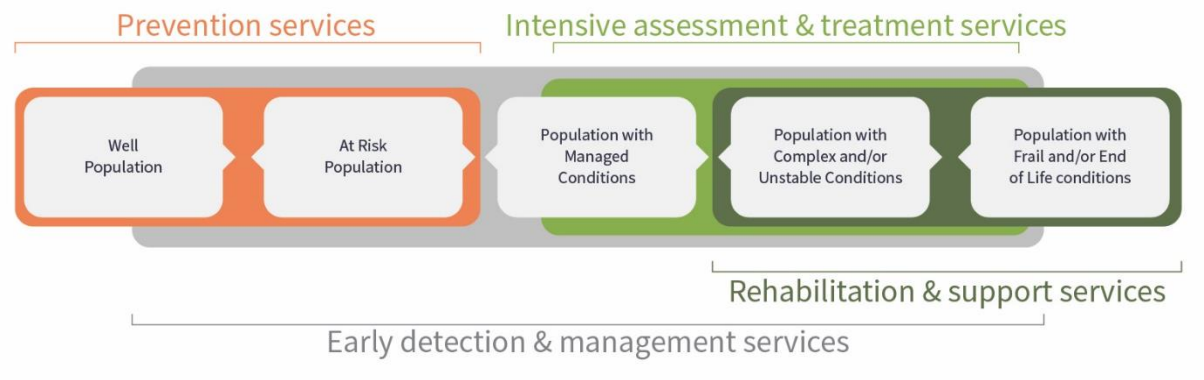
As a Crown entity, responsible for Crown assets, the DHB also provides a wide range of financial and non-financial performance reporting to the Ministry of Health on a monthly, quarterly and annual basis.

The DHB's obligations include quarterly performance reporting in line with the Ministry's non-financial performance monitoring framework. This framework aims to provide a rounded view of DHB performance in key priority areas and uses a mix of performance markers across five dimensions. These dimensions reflect the key areas of national priority:

- Improved Child Wellbeing (CW)
- Improved Mental Health Wellbeing (MH)
- Improved Wellbeing through Prevention (PV)
- Better population health outcomes supported by a Strong and equitable public health System (SS)
- Better population health outcomes supported by Primary Health Care (PH).

The national framework and expectations for 2020/21 is set out on the following pages.

Statement of Performance Expectations



3.1 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.

Having a limited pool of resources and faced with growing demand for health services and increasing fiscal pressures, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

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. These longer-term outcomes are highlighted in the DHB's Statement of Intent.

On an annual basis, we track our performance against an annual statement of performance expectations, our forecast of the services we plan to deliver and the standards we expect to meet. The results are presented in our Annual Report at the end of the year.

The following section presents the West Coast DHB's Statement of Performance Expectations for 2020/21.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service we deliver, services have been grouped into four service classes. These are common to all DHBs and reflect the types 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.

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.

It is important to include a mix of service measures under each service class to ensure a balanced, well-rounded picture and provide a fair indication of how well the DHB is performing.

The mix of measures identified in our Statement of Performance Expectations address the four key aspects of service performance we believe are most important to our community and stakeholders:

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?

SETTING STANDARDS

In setting performance standards, we consider the changing demography of our population, areas of increasing service demand and the assumption that resources and funding growth will be limited.

Targets reflect the strategic objectives of the DHB: increasing the reach of prevention programmes, reducing acute or avoidable hospital admissions and maintaining access to services while reducing waiting times and delays in treatment. We also seek to improve the experience of people in our care and increase public confidence in our health system.

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

It's 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. Service level estimates have been provided to give context in terms of the use of resources across our health system.

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB.

All of our performance targets are universal, set with the aim of reducing disparities between population groups. A number of key focus areas have been identified to improve Māori health. These are signalled with the following symbol (◆). These service measures will be reported by ethnicity in our year-end Annual Report to highlight progress in achieving this goal.

Wherever possible, past years' results have been included in our forecast to give context in terms of our current performance and what we are trying to achieve.

PERFORMANCE EXPECTATIONS

Many of the performance targets presented in our forecast are national expectations set for all DHBs. Our small population size can mean that a small number of people can have a disproportionate impact on our results and performance can vary year on year. While the West Coast DHB is committed to maintaining high standards of service delivery, we note that some of the national expectations are particularly challenging to meet in this regard.

The pressures on our system will be compounded by the unknown impact of the COVID 19 pandemic. Our future environment may be quite different, depending on how the pandemic plays out in New Zealand and around the world. While many of the longer-term population goals and service level expectations (outlined in our Statement of Intent and Statement of Performance Expectations) are unlikely to change, our ability to deliver against them will be compromised.

Population health outcomes are heavily influenced by changes in people's environments and economic situations, and negative impacts are anticipated.

NOTES FOR THE READER

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

Δ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.

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

E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources.

◆ These measures have been identified as key focus areas for Māori. Progress by ethnicity will be reported in the DHB's Annual Report.

3.2 Where does the money go?

In 2020/21 the DHB will receive approximately $175 million dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2020/21, by service class.

	2020/21
Revenue	
Prevention	$3,878
Early detection & management	$33,646
Intensive assessment & treatment	$114,216
Rehabilitation & support	$23,984
Total Revenue - $'000	$175,724
Expenditure	
Prevention	$4,607
Early detection & management	$34,735
Intensive assessment & treatment	$115,793
Rehabilitation & support	$22,895
Total Expenditure - $'000	$178,030
Surplus/(Deficit) - $'000	($2,306)

3.3 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. These services include: the use of legislation and policy to protect the population from environmental risks and communicable disease; education programmes and services to raise awareness of risk behaviours and healthy choices; and health protection services such as immunisation and screening programmes that support people to modify lifestyles and maintain good health.

By supporting people to make healthier choices, we 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 large numbers of people and can therefore also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Health Services – Healthy Environments				
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2017/18 Results	2018/19 Results	2020/21 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q[4]	14	14	E.15
Licensed alcohol premises identified as compliant with legislation	Q[5]	95%	96%	90%
Networked drinking water supplies compliant with Health Act	Q[6]	81%	81%	97%

Health Promotion and Education Services				
These services inform people about risk factors and support them to make healthy choices. Success is evident through high levels of engagement with services.	Notes	2017/18 Results	2018/19 Results	2020/21 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A	191	193	E>150
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q[7]◆	77%	76%	75%
Babies exclusively/fully breastfed at three months	Q◆	61%	61%	70%
People provided with Green Prescriptions for additional physical activity support	A[8]	458	458	E>400
Green Prescription participants more active six to eight months after referral	Q	65%	n.a	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC) in the last 15 months	Q[9]◆	88%	96%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q◆	91%	91%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[10]◆	98%	100%	90%

[4] Submissions influence policy in the interests of improving and protecting the health of the population and providing a healthy and safe environment for our population. The number of submissions varies in a given year and may be higher (for example) when Territorial Authorities are consulting on long-term plans.

[5] New Zealand law prevents retailers from selling alcohol to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. Compliance is seen as a proxy measure of the success of education and training and reflects a culture that encourages a responsible approach to alcohol.

[6] This measure relates to the percentage of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies: large, medium, minor, small and rural agricultural. Water quality annual reports are published one year in arrears, the latest report for 2017/18 can be found on the Ministry of Health website. Results for 2018/19 are expected in June 2020.

[7] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. These measures are part of the national Well Child/Tamariki Ora Quality Framework and data from providers is not able to be combined so performance from the largest provider (Plunket) is presented.

[8] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a biannual patient survey completed by Research New Zealand on behalf of the Ministry. 2018/19 results are not yet available.

[9] The ABC programme has a cessation focus and refers to health professionals asking about smoking status, providing Brief advice and providing cessation support. The provision of professional advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts.

[10] This data is sourced from the national Maternity Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance. Standards have been set nationally in line with other ABC programme smoking targets.

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 Results	2018/19 Results	2020/21 Target
Four-year-olds provided with a B4 School Check (B4SC)	A[11]◆	98%	93%	90%
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%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A[12]◆	74%	72%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A[12]◆	72%	77%	70%

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	2020/21 Target
Children fully immunised at eight months of age	A[13]◆	83%	79%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q	96%	96%	95%
Young people (Year 8) completing the HPV vaccination programme	A[14]❖◆	39%	30%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A[15]❖◆	56%	55%	75%

[11] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing health concerns to be identified and addressed early. Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational attainment and quality of life. A referral for children identified with weight concerns allows families to access support to maintain healthier lifestyles.

[12] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment. The measures refer to national screening programme results and standards.

[13] 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. The DHB's focus is to immunise all those who opt-in to the immunisation programme. 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided with advice to enable them to make informed choices for their children - but may have chosen to decline immunisations or opt off the NIR.

[14] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme consists of two vaccinations and is free to young people under 26 years of age. Baseline results refer to young women only, the programme was widened to include boys in 2020/21. The 2018/19 HPV result is subject to data quality issues and we believe is under-reflecting performance.

[15] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for more vulnerable people at risk of serious complications, including people aged over 65, people with long-term or chronic conditions or pregnant women.

3.4 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

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. Cancer, cardiovascular disease, diabetes, and respiratory disease are the four leading long-term conditions for our population.

Early detection and management services are those that help to maintain, improve and enable people's good health and wellbeing. These services include detection of people at risk, identification of disease and the effective management and coordination of services for people with long-term conditions. These services are by nature more generalist and accessible from multiple providers at different locations. Providers include general practice, allied health, personal and mental health service providers and pharmacy, radiology and laboratory service providers.

The DHB is introducing new technologies and developing a workforce with the skills to provide a wider range of preventative treatment and services, closer to people's homes. Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with local primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and helps to improve their quality of life by reducing complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

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	2020/21 Target
Newborns enrolled with a PHO by three months of age	A◆	83%	95%	85%
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A◆	94%	94%	95%
Young people (12-19) accessing brief intervention/counselling in primary care	A[16Δ]	215	159	E>150
Adults (20+) accessing brief intervention/counselling in primary care	AΔ	527	498	E>450
Number of integrated HealthPathways in place across the health system	Q[17]	632	683	E>600
Proportion of general practices offering the primary care patient experience survey	E[18]	86%	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	2020/21 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A[19]◆	4,099	4,045	E>3,500
Enrolled population (15-74), identified with diabetes, having an annual diabetes review	A◆	79%	85%	>85%
Population with diabetes, having an annual review and HbA1c test, demonstrating acceptable glycaemic control (HbA1c <64 mmol/mol)	Q[20]◆	54%	53%	60%

[16] 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.

[17] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The pathways support consistent access to treatment and care no matter where in the health system people present.

[18] The Patient Experience Survey is a national online survey used to determine patients' experience in primary care and how well they perceive their care is managed. The information will be used to improve the quality of service delivery and patient safety.

[19] This measure refers to the primary care programme where enrolled patients are provided with an annual review, targeted care plan and self-management advice to help change their lifestyle, improve their health and reduce the negative impacts of their long-term condition.

[20] Diabetes is a leading long-term condition and a contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.

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 Results	2018/19 Results	2020/21 Target
Children (0-4) enrolled in school and community oral health services	A[21]❖◆	108%	101%	95%
Enrolled children (0-12) receiving their oral health exam according to planned recall	T❖◆	95%	96%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A❖	77%	76%	85%

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	2020/21 Target
Number of subsidised pharmaceutical items dispensed in the community	AΔ	460k	471k	E<500K
People being dispensed 11 or more long-term medications (rate per 1,000)	Q[22]❖	4.5	n.a	<4.1
Number of community-referred radiological tests delivered	A	6,199	6,035	E>5,500
People receiving their urgent diagnostic colonoscopy within two weeks	T[23]	90%	88%	90%
People receiving their Magnetic Resonance Imagining (MRI) scans within six weeks	T	84%	82%	90%
People receiving their Computed Tomography (CT) scan within six weeks	T	100%	99.7%	95%

[21] 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.

[22]The use of multiple medications is most common in the elderly and can lead to reduced drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and high costs for the system with little health benefit. Multiple medication use requires monitoring and review to validate whether all of the medications are complementary and necessary. Data is sourced from the HQSC Atlas of Healthcare Variation and the 2018/19 result is not yet available.

[23] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and, by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). The radiology measures refer to non-urgent scans.

3.5 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.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

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	2020/21 Target
Staff compliance with good hand hygiene practice	Q[24]	82%	84%	80%
Inpatients (aged 75+) receiving a risk assessment to reduce serious harm from falls	Q	92%	68%	90%
Patients responding to the national inpatient patient experience survey	E[25]	58%	28%	>30%
Proportion of patients 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%

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 Results	2018/19 Results	2020/21 Target
Proportion of the population (0-19) accessing specialist mental health services	A[26Δ]	5.4%	5.3%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	A[Δ]	5.9%	5.6%	>3.8%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T	81%	81%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	95%	92%	95%

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	2020/21 Target
Number of maternity deliveries in West Coast DHB facilities	A	264	241	E.250
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[27❖◆†]	80%	n.a	80%
Baby Friendly Hospital accreditation achieved in DHB facilities	Q	Yes	Yes	Yes

[24] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. In line with national reporting results refer to the final quarter of each year (April-June). Further detail and quarterly results for the past several years can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[25] There is growing evidence that patient experience is a good indicator of the quality of health services and stronger partnerships and family-centred care have been linked to improved health outcomes. The national DHB inpatient experience survey covers four patient experience domains: communication, partnership, co-ordination and physical and emotional needs. Response rates vary around the country with an average of 24% across all DHBs in Q2 2019. DHBs are required to have at least 30 responses for results to be meaningful and West Coast aims to be consistently at this level.

[26] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. West Coast rates are high and it is expected they will come down as the DHB implements in its strategy to better support people earlier and closer to home. Data is sourced from the national Mental Health dataset (PRIMHD) and results are three months in arrears.

[27] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report – data is a year in arrears and the 2018/19 data is yet to be released.

Acute and Unplanned 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 Results	2018/19 Results	2020/21 Target
Number of unplanned presentations at the Emergency Department (ED)	A	11,616	11,829	E<13,000
People admitted, discharged or transferred from ED within 6 hours of presentation	T	98%	98%	95%
Proportion of people presenting in ED (in triage 1-3), seen within clinical guidelines	T[28]	82%	77%	85%
Proportion of people presenting at ED triaged in category 4 or 5	A	56%	54%	<60%
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral.	T	80%	72%	90%

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 Results	2018/19 Results	2020/21 Target
Number of First Specialist Assessments provided	A	7,022	6,240	E>6,000
Proportion of people that wait <4 months for their First Specialist Assessment	T	87.7%	97.0%	100%
Number of planned care intervention delivered	A[29]	new	new	TBC
Proportion of people that wait <4 months from a commitment to treat to treatment	T	96.8%	89.0%	100%
Number of outpatient consultations provided	A	14,328	13,663	E>13,000
Proportion of outpatient appointments provided by telemedicine	Q[30]	4.2%	5.1%	>5%
Outpatient appointments where the patient was booked but did not attend	Q[31Δ◆]	6.1%	7.7%	<6%

[28]This measure demonstrates whether people presenting in ED are seen in order of clinical need and reflects national triage standards: Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation.

[29] The new planned care intervention measure reflects a change in national expectations, recognising 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 target is made up of three components: elective surgical discharges, Minor Procedures and Non-Surgical Interventions. At the time of printing the target was yet to be confirmed by the Ministry of Health.

[30] Increasing value from technology is a key strategic focus for the DHB and the use of telehealth or videoconferencing technology helps to reduce unnecessary travel for patients, their families and clinical staff – particularly when specialists are based in other DHBs.

[31] When appointments are missed, it can negatively affect people's recovery and long-term outcomes. It is also a costly waste of resources for the DHB.

3.6 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services are those that provide people with the support they need to continue to live safely and independently in their own homes, or regain functional ability, after a health-related event. Services are mostly provided to older people, or people with mental health or complex personal health conditions, following a clinical assessment of the person's needs.

These services are considered to provide people with a much higher quality of life as a result of being able to stay active and positively connected to their communities. Even when returning to full health is not possible, access to responsive support services enables people to maximise their independence. In preventing acute illness, crisis or deterioration of function, these services have a major impact on the sustainability of our health system, by reducing acute service demand and the need for more complex interventions or residential care. These services also support patient flow by enabling people to go home from hospital earlier.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services restore or maximise people's health following a health-related event and service utilisation is monitored to ensure people are appropriately supported.	Notes	2017/18 Results	2018/19 Results	2020/21 Target
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A[32]	2	9	15
People (65+) supported by the community-based In-Home Falls Prevention Service	A[33]	148	143	>120
Proportion of stroke patients admitted to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q	96%	94%	80%
Proportion of AT&R inpatients discharged home rather than into residential care	Q[34Δ]	90%	85%	80%

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 Results	2018/19 Results	2020/21 Target
Number of Meals on Wheels provided	A[Δ]	34,977	36,511	E>35,000
People supported by district nursing services	A[Δ]	1,645	1,797	E>1,600
People supported by long-term home-based support services	A[Δ]	1,211	1,100	E>1,000
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[35]	91%	75%	95%

Aged Residential Care Services				
While demand will increase as our population ages, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2017/18 Results	2018/19 Results	2020/21 Target
Proportion of the population (75+) accessing rest home level services in ARC	A[36Δ]	4.4%	3.8%	E<5.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A[Δ]	6.6%	6.4%	E.<6.5%
Proportion of the population (75+) accessing dementia services in ARC	A[Δ]	1.2%	1.1%	E.1.0%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A[Δ]	0.6%	0.3%	E.0.4%
People entering ARC having had a clinical assessment of need using InterRAI	Q	100%	88%	95%

[32] 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.

[33] 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.

[34] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge home reflects the effectiveness of services in terms of assisting people to regain functional independence.

[35] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used to support clinical decision making and care planning, ensure assessments are of high quality and that people receive appropriate and equitable access to services irrespective of where they live.

[36] By helping older people maintain functional independence they are able to safely remain in their own homes for longer, reducing the demand for rest-home-level care. Access rates for more complex care such as dementia and psychogeriatric care are less amenable and growth is more attributable to the ageing of our population. Measures refer to people accessing DHB funded ARC services and exclude people paying privately.

Statement of Financial Expectations

4.1 West Coast's financial outlook

Funding from the Government, via the Ministry of Health, is the main source of DHB funding. This is supplemented by revenue agreements with ACC, research grants, donations, training subsidies and patient co-payments.

While health continues to receive a large share of government funding, if we are to be sustainable, we must rethink how we will meet increasing demand for health care within a more moderate growth platform.

Like the rest of the health sector, the West Coast DHB is experiencing growing financial pressure driven by increasing demand, rising treatment costs and wage expectations and heightened public expectations. We also face several unique challenges due to our size and geographic isolation which add to our fiscal pressures:

Rurality: Geographically we are the third largest DHB in the country, but we are the smallest by population. This means people must travel long distances to access or deliver services and the operational costs of service delivery are magnified.

Workforce shortages: Difficulties in recruiting staff to the West Coast means the DHB relies heavily on locums and contractors to fill gaps. While the use of locums allows services to be maintained in the short term, this reduces continuity of care and is an expensive and unsustainable solution.

Facilities pressures: Several of our health facilities are outdated, expensive to maintain, poorly located or seismically compromised. The level of remediation required to attain moderate compliance with current building codes is significant. We have also experienced long delays in completion of the Te Nikau facility, which has led to increased construction costs and delayed anticipated operational savings.

Financial Viability: Each DHB is funded to cover the cost of services provided to their resident population. Because of our small size, we rely on larger DHBs to provide more complex specialist services for our population and must pay for those services. While the service prices are set nationally, cost increases have historically exceeded annual funding increases. Multi-Employer Collective Agreements (MECA) settled in the past have also significantly exceeded the affordability parameters of the DHB. The flow-on effects of these settlements, to other staff groups and external providers organisations will put immense pressure on the financial sustainability of our health system.

Variation: Our small size means any variation, in service demand, capacity, treatment regime, staffing or infrastructure requirements can have a significant financial impact on our bottom line.

4.2 Forecast financial results

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $175m to meet the needs of our population in 2020/21.

This represents an 8.4% increase on the previous year and whilst this equates to a $13.5m increase in funding, it includes revenue for pay equity settlements and capital change on new facilities, which come with associated expenditure. The DHB's forecasts are based on receiving the minimum percentage funding increase available to DHBs in 2021/22.

The West Coast DHB is predicting a $2.3m deficit result for the 2020/21 year.

As part of its package the West Coast DHB also receives transitional funding which is vital to the fiscal sustainability of our health system.

4.3 Closing the gap

Alongside the transformation of our workforce and service delivery models we are focused on driving and capturing efficiency improvements that will ensure the future viability of our health system.

If we are to be sustainable, we must rethink how we will meet our population's growing health need within a more moderate growth platform. There is no easy solution. Savings will be made, not in dollar terms, but in costs avoided through more effective use of available resources and improvements in the health of our population. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system.

The DHB's focus for the coming year will include:

- Integrating finance and operational systems and improving workforce and production planning to ensure we are using our resources in the most effective way.
- Progressing the implementation of our Rural Generalist workforce model to reduce our reliance on locums and contractors.
- Optimising investment in shared electronic systems and telehealth technology to reduce delays in care, DNAs and travel costs.
- Integrating, realigning and prioritising services that deliver maximum health benefit and are sustainable long-term.
- Capturing opportunities to increase revenue with successful bids for national funding

- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Considering the future use of all DHB assets to optimise investment.
- Tightening cost growth including moderating treatment, back office, support and FTE costs.
- Streamlining and standardising processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.

Savings identified for the coming year and two out-years have been highlighted in the Delivering Against National Priorities and Targets section of this Plan. Service changes proposed for the coming year are outlined in the Service Configuration section.

4.4 Major assumptions

Revenue and expenditure estimates in this document have been based on current government policy settings, service delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results.

In preparing our financial forecasts, we have made the following assumptions:

- Population-based funding levels for 2020/21 are based on the funding advice received by the Ministry in June 2020 and West Coast DHB is assuming an 8.4% increase in 2020/21.
- The West Coast DHB will receive additional funding to cover increase in capital charges once Te Nikau facility is completed.
- Out-years funding is assumed at an average increase of 2.41% per annum.
- The West Coast DHB will continue to receive Crown funding on an early payment basis.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Funding for all aspects of pay equity settlements has been folded into the DHB's population-based funding. Additional funding will be received from the Crown for the expired settlements that are currently being negotiated. The quantum of this revenue has been assumed as cost neutral over the anticipated 2% previously advised and included.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluations. External provider increases will also be settled within available funding levels.
- The approved forecasted deficit will be funded via Crown deficit support (equity injections).
- Work will continue on the facilities redevelopment for Grey Base under the nationally appointed Hospital Redevelopment Partnership Group.
- Work will continue on the facilities redevelopment for Buller Integrated Family Health Centre project, managed by West Coast DHB and governed by West Coast Partnership Group
- The associated costs and capital expenditure for the Grey Base redevelopment have been included in the capital budget with completion and migration date of August 2020.

  The net operating result, for 2020/21 and out-years, largely reflects the modelling as per the detailed business case approved by Cabinet in 2014 (adjusted for the 2014/15 transitional funding repayment as well as known changes such as capital charge changes).
- Revaluations of land and building will continue and will impact on asset values. In addition to periodic revaluations, further impairment in relation to redevelopment and remediation of our facilities may be necessary.
- Treatment related costs will increase in line with known inflation factors, reasonable price impacts on providers and foreseen adjustments for the impact of growth within services.
- National and regional initiative savings and benefits will be achieved as planned.
- Transformation will not be delayed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- There will be no further disruptions associated with pandemics or natural disasters.

4.5 Capital investment

GREYMOUTH REDEVELOPMENT

In December 2012, the Minister of Health appointed the Hospital Redevelopment Partnership Group (HRPG) to govern the West Coast DHB's facility redevelopment. The West Coast HRPG provides project governance, which includes oversight of the project programme and budget.

In 2014, approval was given for a new Grey Base Hospital and IFHC redevelopment. Construction commenced on the combined project in May 2016 with completion originally scheduled for June 2018.

Completion is now scheduled for the first half of 2020/21 financial year. The revised budget for this development is currently $122.5m. The total costs are yet to be finalised.

The Grey Base redevelopment includes a second tranche upgrade/replacement of other aspects of the Grey Base site. The Board has approved the preliminary site

masterplan for the Grey Base campus and the business case for the new Mental Health Facility is progressing, with $15m having been made available from Government for replacement of the Mental Health Inpatient Unit.

BULLER REDEVELOPMENT

In Buller, the DHB and clinical teams have worked together with an appointed design team to develop a full concept design for the IFHC development.

An Implementation Business Case has been progressed and options submitted to the HRPG, as we move closer to bringing this facility to life.

In December 2018 the $20m Buller IFHC project was approved, with the ongoing project management moving to West Coast DHB.

The Buller facilities design has been approved and services have been decanted to allow for the staged demolition to make way for the new facility. The IFHC is expected to be completed in February 2022.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $3.3m for the 2020/21 year. In addition to the normal capital requirements, the Grey Base redevelopment requires greater investment in capital equipment than would normally be afforded, for example additional Information and Technology infrastructure.

Strategic capital for 2020/21-2021/22 comprises of:

- Mental Health & Grey Base redevelopment including demolition and enabling.
- Reefton IFHC redevelopment (notionally $4m).
- Phased upgrade of clinics outside Westport and Greymouth (notionally $0.450m per clinic).
- Move to the South Island Patient Information Care System (notionally $1.8m).
- Investment in other strategic IT/integration systems, including regional IT systems, (notionally $0.5m - $1m per annum).

We anticipate the above capital intentions will be funded by internal cash except for the Buller IFHC, Mental Health, Reefton IFHC facility redevelopment and secondary tranche Grey Base redevelopment projects, where Crown capital support would likely be required.

4.6 Debt and equity

Te Nikau is now expected to be completed in the first quarter of 2020/21 at which time the asset will be transferred from the Ministry of Health to the DHB. Following the asset transfer, the Ministry will simultaneously increase the equity of the DHB for the value of the build.

The $20m Buller IFHC project is being funded with equity drawdowns as the project progresses.

The West Coast DHB will require deficit funding (equity) in order to offset the deficits signalled in outlying years. The DHB is also repaying $68K equity annually as part of an agreed FRS-3 funding repayment programme with the Ministry of Health.

4.7 Additional considerations

SUBSIDIARY COMPANY AND PARTNERSHIPS

With an annual budget of just over $5m, the South Island Alliance Programme Office is jointly funded by the five South Island DHBs to provide audit, project management and regional service development services. West Coast's contribution for 2020/21 will be approximately $0.180m.

With an annual budget of over $14m, the New Zealand Health Partnership Limited is jointly funded by all 20 DHBs to enable DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB's contribution to the running of the Health Partnership for 2020/21 will be approximately $0.25m.

DISPOSAL OF LAND

The West Coast DHB has land and building assets located right across the West Coast, some of which are subject to leasehold interests and arrangements. The DHB is engaged in a process of considering the future of these assets based on our new locality model and future facilities requirements. It is anticipated that recommendations on the future of some DHB assets will be made in 2020/21.

Necessary approvals will be sought to dispose of any DHB land identified as surplus to requirements. This includes first undertaking the required consultation and obtaining the consent of the responsible Minister. Land would also be valued and offered to parties with the statutory right to receive an offer under the Public Works Act and Ngāi Tahu Claims Settlement Act (and any other relevant legislation), before being made available for public sale.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

No compensation is sought by the Crown in line with the Public Finance Act Section 41(D).

ACQUISITION OF SHARES

Before the West Coast DHB subscribes, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister(s) and obtain their approval.

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. These are presented in the DHB's Statement of Intent, available on our website www.wcdhb.health.nz.

4.8 Statement of Comprehensive Income – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Income						
Ministry of Health revenue	**142,732**	**149,100**	159,189	161,524	163,937	166,393
Patient related revenue	7,249	7,123	8,499	7,512	7,620	7,776
Other operating income	4,302	5,119	7,988	11,652	11,736	11,811
Interest income	330	82	48	84	96	96
Total Income	**154,613**	**161,424**	175,724	180,772	183,389	186,076
Operating Expenses						
Personnel	67,605	66,964	70,515	71,520	73,296	76,208
Outsourced services (clinical and non clinical)	8,708	10,757	8,857	9,036	8,700	8,834
Treatment related costs	8,018	8,906	9,255	9,204	9,408	9,540
External service providers (include Inter-district outflow)	64,518	66,875	70,087	70,892	69,935	69,355
Depreciation & amortisation	3,390	2,766	4,082	4,540	4,296	4,356
Interest expenses	-	-	-	-	-	-
Other expenses	12,518	11,520	10,495	10,692	11,484	11,648
Total Operating Expenses	**164,757**	**167,788**	**173,290**	**175,884**	**177,119**	**179,941**
Operating surplus before capital charge	**(10,144)**	**(6,364)**	**2,434**	**4,888**	**6,270**	**6,135**
Capital charge expense	1,407	700	4,740	8,690	8,712	8,844
Surplus / (Deficit)	**(11,551)**	**(7,064)**	**(2,306)**	**(3,802)**	**(2,442)**	**(2,709)**
Other comprehensive income						
Revaluation of land and Buildings	**-**	**-**	-	-	-	-
Total Comprehensive Income	**(11,551)**	**(7,064)**	**(2,306)**	**(3,802)**	**(2,442)**	**(2,709)**

4.9 Statement of Financial Position – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
CROWN EQUITY						
General funds	85,926	93,858	231,354	239,786	239,718	239,650
Revaluation reserve	25,098	25,098	25,098	25,098	25,098	25,098
Retained earnings	(96,935)	(103,998)	(106,304)	(110,106)	(112,548)	(115,257)
TOTAL EQUITY	**14,089**	**14,958**	**150,148**	**154,778**	**152,268**	**149,490**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	6,362	1,218	6,383	1,634	520	7
Trade & other receivables	3,931	4,491	4,491	4,491	4,491	4,491
Inventories	1,077	1,160	1,160	1,160	1,160	1,160
Assets classified as held for sale						
Investments (3 to 12 months)						
Restricted assets	56	56	56	56	56	56
TOTAL CURRENT ASSETS	**11,426**	**6,925**	**12,090**	**7,341**	**6,227**	**5,714**
CURRENT LIABILITIES						
Trade & other payables	12,582	15,092	14,749	12,440	12,640	13,416
Capital charge payable	-	-	-	-	-	-
Employee benefits	14,052	14,052	14,052	14,052	14,052	14,052
Restricted funds	62	62	62	62	62	62
Borrowings	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES	**26,696**	**29,206**	**28,863**	**26,554**	**26,755**	**27,530**
NET WORKING CAPITAL	**(15,270)**	**(22,281)**	**(16,773)**	**(19,213)**	**(20,528)**	**(21,816)**
NON CURRENT ASSETS						
Investments (greater than 12 months)	320	320	320	320	320	320
Property, plant, & equipment	31,062	38,819	167,457	174,116	172,650	170,877
Intangible assets	376	499	1,543	1,954	2,224	2,509
TOTAL NON CURRENT ASSETS	**31,758**	**39,638**	**169,320**	**176,390**	**175,194**	**173,706**
NON CURRENT LIABILITIES						
Employee benefits	2,399	2,399	2,399	2,399	2,398	2,400
Borrowings	-	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	**2,399**	**2,399**	**2,399**	**2,399**	**2,398**	**2,400**
NET ASSETS	**14,089**	**14,958**	**150,148**	**154,778**	**152,268**	**149,490**

4.10 Statement of Movement in Equity – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Total Equity at Beginning of the Period	25,708	14,089	14,958	150,148	154,777	152,267
Total Comprehensive Income	(11,551)	(7,064)	(2,306)	(3,802)	(2,442)	(2,709)
Other Movements						
Contribution back to Crown - FRS3	-	-	-	-	-	-
Contribution from Crown - Capital	-	2,001	130,500	8,500	-	-
Contribution from Crown - Operating Deficit Support	-	6,000	7,064	-	-	-
Other Movements	(68)	(68)	(68)	(68)	(68)	(68)
Total Equity at End of the Period	**14,089**	**14,958**	**150,148**	**154,777**	**152,267**	**149,490**

4.11 Statement of Cashflow – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	142,861	148,630	159,189	161,524	165,528	166,393
Other receipts	12,327	12,533	16,440	19,164	12,408	20,363
Interest received	330	204	96	84	96	96
	155,519	**161,367**	**175,725**	**180,772**	**178,032**	**186,852**
Cash was applied to:						
Payments to employees	68,123	76,963	77,918	79,044	80,460	83,485
Payments to suppliers	86,864	86,904	91,634	94,609	90,480	92,099
Interest paid	-	-	-	-	-	-
Capital charge	1,407	630	4,740	8,690	8,712	8,844
GST - net	(157)	406	12	-	(3,586)	492
	156,237	**164,903**	**174,304**	**182,343**	**176,066**	**184,921**
Net Cashflow from Operating Activities	**(718)**	**(3,536)**	**1,421**	**(1,571)**	**1,966**	**1,931**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	(24)	24	12	(2)	-	12
Receipt from sale of investments	-	-	-	-	-	-
	(24)	24	12	(2)	-	12
Cash was applied to:						
Purchase of investments & restricted assets	(135)	-	-	-	-	-
Purchase of property, plant, & equipment	4,687	9,564	11,264	11,608	3,012	2,388
	4,552	**9,564**	**11,264**	**11,608**	**3,012**	**2,388**
Net Cashflow from Investing Activities	**(4,576)**	**(9,540)**	**(11,252)**	**(11,610)**	**(3,012)**	**(2,376)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	-	2,000	8,000	8,500	-	-
Equity Injection - Deficit Support	-	6,000	7,064	-	-	-
Loans Raised	-	-	-	-	-	
	-	**8,000**	**15,064**	**8,500**	**-**	**-**
Cash applied to:						
Equity Repayment	68	68	68	68	68	68
Other	-	-	-	-	-	
	68	**68**	**68**	**68**	**68**	**68**
Net Cashflow from Financing Activities	**(68)**	**7,932**	**14,996**	**8,432**	**(68)**	**(68)**
Overall Increase/(Decrease) in Cash Held	(5,362)	(5,144)	5,165	(4,749)	(1,114)	(513)
Add Opening Cash Balance	11,724	6,362	1,218	6,383	1,634	520
Closing Cash Balance	**6,362**	**1,218**	**6,383**	**1,634**	**520**	**7**

4.12 Summary of Revenue and Expenses by Arm – year ending 30 June

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Funding Arm	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	141,835	147,794	158,090	160,456	162,857	165,301
Patient Related Revenue	1,827	2,057	1,845	2,088	2,124	2,166
Other	338	344	3,572	7,308	7,320	7,327
Total Revenue	144,000	150,195	163,506	169,852	172,301	174,795
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	102,373	105,637	109,907	111,500	111,755	111,598
Mental Health	15,125	15,803	17,065	16,308	16,548	16,713
Disability Support	22,415	22,017	26,296	23,508	23,688	23,925
Public Health	631	1,142	595	636	648	654
Maori Health	824	805	899	852	852	861
Governance & Admin	828	840	893	876	900	912
Total Expenditure	142,197	146,244	155,654	153,680	154,391	154,663
Net Surplus/(Deficit)	**1,803**	**3,951**	**7,852**	**16,172**	**17,910**	**20,132**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**1,803**	**3,951**	**7,852**	**16,172**	**17,910**	**20,132**

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Governance Arm	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	864	840	940	924	948	961
Total Revenue	864	840	940	924	948	961
Expenditure						
Personnel	1,130	1,210	1,207	1,236	1,260	1,291
Outsourced services	974	918	945	936	936	950
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	415	550	534	468	480	487
Total Expenditure	2,519	2,678	2,686	2,640	2,676	2,728
Net Surplus/(Deficit)	**(1,655)**	**(1,838)**	**(1,746)**	**(1,716)**	**(1,728)**	**(1,767)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(1,655)**	**(1,838)**	**(1,746)**	**(1,716)**	**(1,728)**	**(1,767)**

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Provider Arm	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	897	1,306	1,099	1,068	1,080	1,092
Patient Related Revenue	8,877	9,297	10,009	9,312	9,444	9,624
Other	77,656	79,156	85,738	82,404	84,072	84,912
Total Revenue	87,430	89,759	96,846	92,784	94,596	95,628
Expenditure						
Personnel	66,475	65,754	69,307	70,284	72,036	74,917
Outsourced services	7,735	9,839	7,911	8,100	7,764	7,884
Depreciation	3,390	2,766	4,082	4,540	4,296	4,356
Interest & Capital Charge	1,407	700	4,740	8,690	8,712	8,844
Other	20,120	19,876	19,217	19,428	20,412	20,700
Total Expenditure	99,127	98,935	105,258	111,042	113,220	116,701
Net Surplus/(Deficit)	**(11,697)**	**(9,176)**	**(8,412)**	**(18,258)**	**(18,624)**	**(21,073)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(11,697)**	**(9,176)**	**(8,412)**	**(18,258)**	**(18,624)**	**(21,073)**

4.12 Summary of Revenue and Expenses by Arm – year ending 30 June (continued)

As at 30 June for the years ending 2018/19 to 2023/24

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
In House Elimination	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(77,680)	(79,370)	(85,567)	(82,788)	(84,456)	(85,308)
Total Revenue	(77,680)	(79,370)	(85,567)	(82,788)	(84,456)	(85,308)
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(77,679)	(79,369)	(85,567)	(82,788)	(84,456)	(85,308)
Total Expenditure	(77,679)	(79,369)	(85,567)	(82,788)	(84,456)	(85,308)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
CONSOLIDATED	Audited Actual $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	142,732	149,100	159,191	161,524	163,937	166,396
Patient Related Revenue	10,704	11,354	11,854	11,400	11,568	11,790
Other	1,178	970	4,682	7,848	7,884	7,892
Total Revenue	154,614	161,424	175,727	180,772	183,389	186,079
Expenditure						
Personnel	67,605	66,964	70,517	71,522	73,297	76,211
Outsourced services	8,709	10,757	8,857	9,036	8,700	8,834
Depreciation	3,390	2,766	4,082	4,540	4,296	4,356
Interest & Capital Charge	1,407	700	4,740	8,690	8,712	8,844
Other	85,054	87,301	89,838	90,788	90,827	90,542
Total Expenditure	166,165	168,488	178,033	184,576	185,832	188,788
Net Surplus/(Deficit)	**(11,550)**	**(7,064)**	**(2,306)**	**(3,804)**	**(2,443)**	**(2,709)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(11,550)**	**(7,064)**	**(2,306)**	**(3,804)**	**(2,443)**	**(2,709)**

APPENDICES

Further Information

Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Overarching Intervention Logic Diagram
Appendix 3	Statement of Accounting Policies

Documents of interest

The following documents can be found on the West Coast DHB's website (www.westcoastdhb.health.nz). Read in conjunction with this document, they provide additional context to the picture on health service delivery and transformation across our health system.

- West Coast DHB Statement of Intent
- West Coast System Level Measures Improvement Plan
- West Coast DHB Disability Action Plan
- South Island Regional Health Services Plan

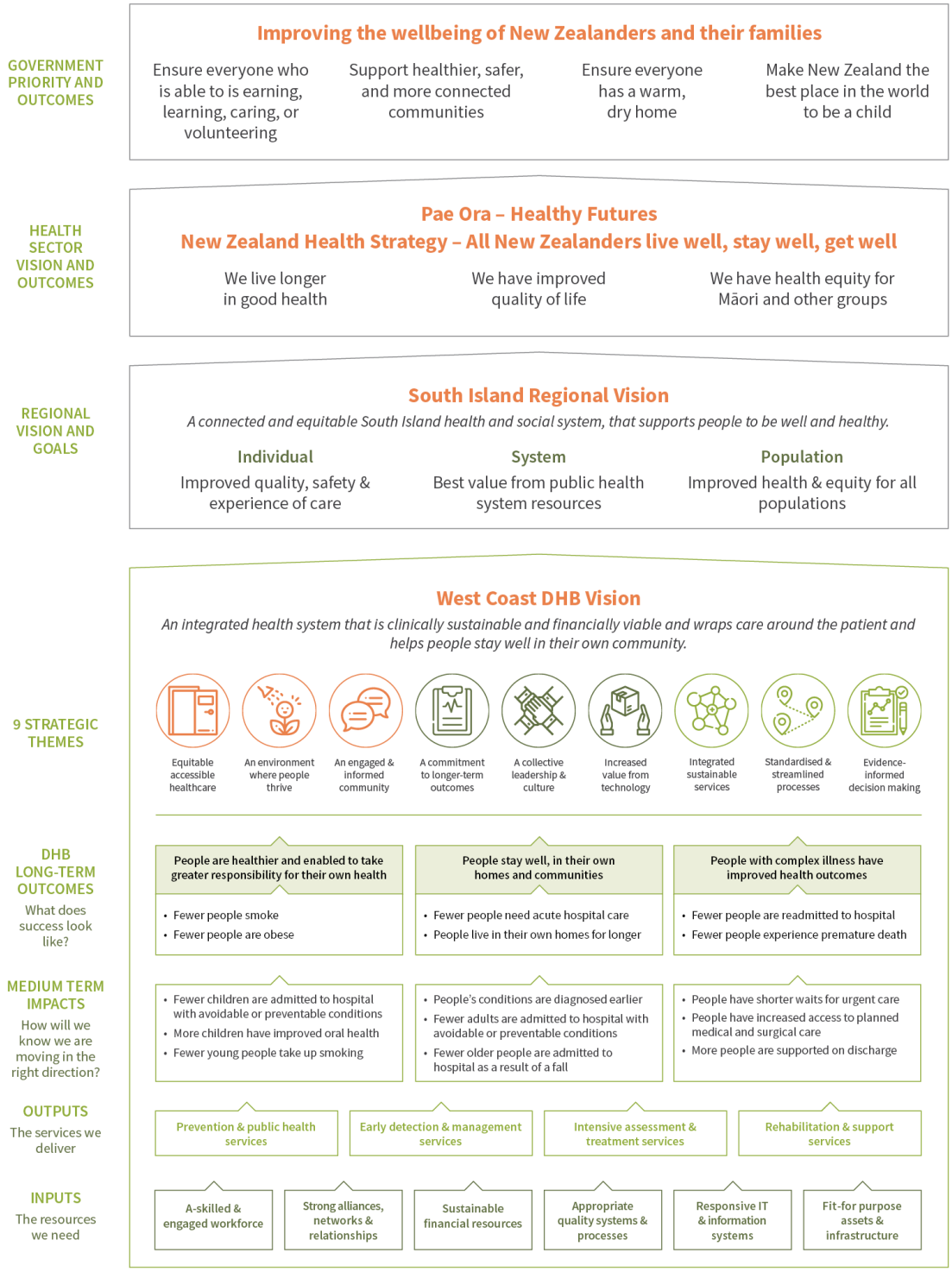
References

Unless specifically stated, all West Coast DHB documents referenced in this document are available on the West Coast DHB website, www.westcoastdhb.health.nz. Referenced regional documents are available from the South Island Alliance Programme Office website: www.siapo.health.nz. Referenced Ministry of Health documents are available on the Ministry's website: www.health.govt.nz. The Crown Entities Act 2004 and the Public Finance Act 1989, referenced in this document, are available on the Treasury website: www.treasury.govt.nz.

Appendix 1 Glossary of Terms

Alliance	The West Coast Alliance	The Alliance is a collective alliance of healthcare leaders, professionals and providers from across the West Coast providing leadership to enable the transformation of our health system in collaboration with system partners and on behalf of the population.
	Baby Friendly Hospital Initiative	A worldwide programme led by the World Health Organization and UNICEF to encourage a high standard of care. An assessment/accreditation process recognises the standard.
CCCN	Complex Clinical Care Network	The Complex Clinical Care Network is a multidisciplinary team providing a single point of referral for patients from general practice, ambulance and inpatient services. Under the restorative delivery model, clients are assessed using comprehensive assessment tools and an individual goal-based care plan is developed with them.
ERMS	Electronic Referral Management System	ERMS is a system available from the GP desktop which enables referrals to public hospitals and private providers to be sent and received electronically, streamlining the referral process and ensuring referrals are directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	A set of six wait time focused indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in West Coast, Canterbury and South Canterbury and rolling out across the remainder of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making by providing evidence-based practice guidelines, ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in New Zealand.
	Poutini Waiora	A Māori Health and Social Service provider that delivers holistic care to whānau across the West Coast. The service is primarily mobile with kaimahi visiting whānau in their homes or in community settings. Poutini Waiora has a number of service contracts with the DHB.
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs in New Zealand with a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them. PHOs provide these services either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
PRIMHD	Programme for the Integration of Mental Health Data	The Ministry of Health's national mental health and addiction information collection holding both activity and outcomes data collected from district health boards and non-governmental organisations. PRIMHD is part of the Ministry's national data warehouse.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tatau Pounamu	Tatau Pounamu is the Manawhenua Advisory Group made up of the manawhenua health advisors mandated by the Papatipu Rūnanga as the Te Tiriti o Waitangi partners to West Coast DHB. Tatau Pounamu works with West Coast DHB to develop and implement strategies for Māori health gain, support the delivery of health and disability support services consistent with Māori cultural concepts, values, and practices, and support Māori aspirations for health, reducing inequalities between Māori and other New Zealanders.
	Tertiary Care	Highly specialised care often only provided in a smaller number of locations.

Appendix 2 Overarching Intervention Logic Diagram



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.

Appendix 3 Statement of Accounting Policies

The prospective financial statements in this Statement of Intent and in the DHB's Annual Plan for the year ended 30 June 2021 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ GAAP, as appropriate for public benefit entities. PBE FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 4 of this document.

REPORTING ENTITY AND STATUTORY BASE

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.

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

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 2018/19 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 2018/19 financial year. The letter of comfort therefore provides the required basis for the Board of West Coast DHB to prepare the 2018/19 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.

IMPAIRMENT OF REVALUED ASSETS

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant and equipment into the impairment accounting standards PBE IPSAS 17, PBE IPSAS 21 and PBE IPSAS 26. Previously, only property, plant and equipment that were measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire

class-of-asset to which it belongs. This amendment is effective for the 30 June 2020 financial statements, with early adoption permitted. The timing of the DHB adopting this amendment will be guided by the Treasury's decision on when the Financial Statements of the Government will adopt the amendment.

SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the note to which they relate. Significant accounting policies 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 2018/19 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 **Error! Reference source not found.**
- Useful life and fair value assessment of property, plant and equipment – refer to **Error! Reference source not found.**
- Provision of debtors – refer to **Error! Reference source not found.**
- Provision of employee entitlements, including gratuity and long service leave – refer to **Error! Reference source not found.**

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.

Revenue

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 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 West Coast DHB.

Employee Benefit Costs

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.

Other Operating Expenses

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.

Capital Charge

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

Cash and Cash Equivalents

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.

Receivables

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

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.

Inventories

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.

Property, Plant and Equipment

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Coast Health Care Limited (a Hospital and Health Service) were vested in West Coast DHB on 1 January 2001. Accordingly, assets were transferred to 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 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 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 – 50	2% 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.

Intangible Assets

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. The same approach applies to the impairment of intangible assets.

Payables and deferred revenue

Short-term payables are recorded at the amount payable

Borrowings

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 are 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 if 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 deprecated 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.

Employee Entitlements

Short-term employee entitlements

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

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

Sick leave

The 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 with in 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

Equity

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.

Related Party Transactions

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 Statement of Performance Expectations

Published August 2020
Pursuant to Section 149 of the Crown Entities Act 2004

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

ISSN: 2703-6170 (Online)