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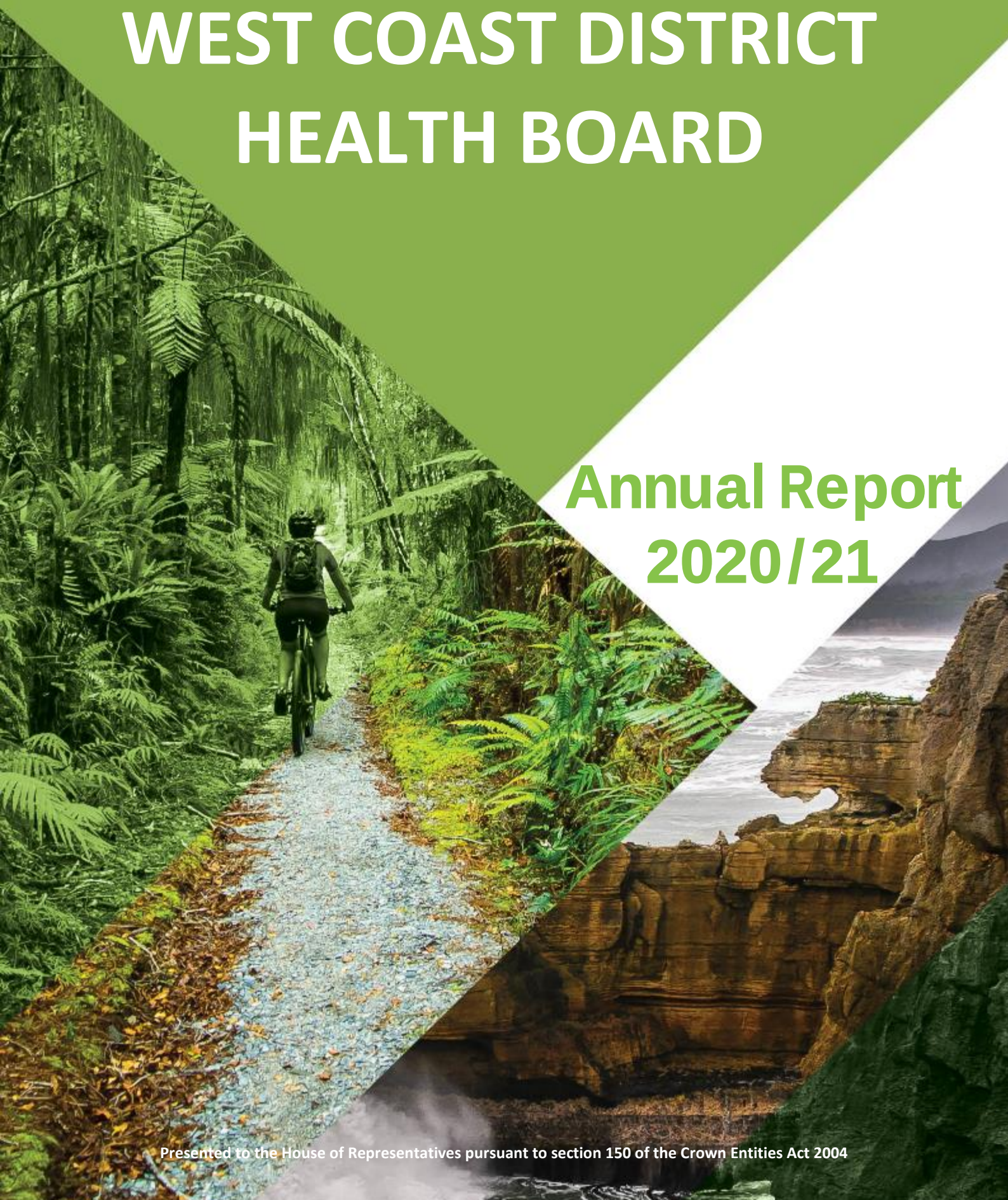
# WEST COAST DISTRICT HEALTH BOARD



## Annual Report 2020/21

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

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## Board Members

Hon Rick Barker, Chair
Tony Kokshoorn, Deputy Chair
Chris Auchinvole
Susan Barnett
Sarah Birchfield
Helen Gillespie
Anita Halsall-Quinlan
Edie Moke
Peter Neame
Nigel Ogilvie
Francois Tumahai

## Chief Executive

Dr Peter Bramley

## Registered Office

West Coast District Health Board
PO Box 387
71-111 Waterwalk Road
Greymouth

## New Zealand Business Number

9429000098038

## Auditor

Audit New Zealand on behalf of the Auditor-General

## Banker

Bank of New Zealand

# Part I
# Overview

# Statutory Information

This Annual Report presents West Coast DHB's financial and non-financial performance for the year ended 30 June 2021. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

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

# Statement of Responsibility

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

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

For the current financial year, the requirement of the Crown Entities Act 2004, section 156(3)(a) was not complied with on account of the late completion of the audit engagement due to auditor shortage in New Zealand and the consequential effects of COVID-19, including lockdowns

In our opinion, except for the substantial uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003 and the uncertain impact on the financial statements as described in note 13 on page 65, these financial statements and the performance information fairly reflect the financial position and operations of West Coast District Health Board for the year ended 30 June 2021.
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Signed on behalf of the Board:

**Hon Rick Barker**
*Chair*

30 March 2022

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

30 March 2022

# Foreword from the Chair and Chief Executive

We are pleased to share our Annual Report for the 2020/21 financial year. Despite operating in an ever-changing pandemic environment, it was a year of delivering quality care.

To do our mahi effectively, we need to ensure West Coast District Health Board staff are well supported to do their jobs well and provide excellent service to the community. Fortunately, we have an exceptional team working across the West Coast Health System who are dedicated to ensuring that the health and wellbeing needs of our communities are met.

Thank you to each one of you for the mahi that you continue to do in these challenging times. Our achievements wouldn't have been possible without your dedication and expertise.

The Government announced earlier this year, that all DHBs will be replaced by new health entities: Health New Zealand, a new Māori Health Authority and a new Public Health Agency. It's been signalled that there will be a 'locality model' developed which will see a series of nationally-coordinated and locally-driven agencies as part of the new health system. Finer details on how the new system will look are still to be determined.

This time of transition is unsettling for many of our people, but our mandate has not changed – which is to strive to meet the health needs of our community, and we will continue to provide services that improve the health and wellbeing of West Coasters.

We continue to see positive health outcomes such as:

- 97 percent of four-year olds provided with a B4 School Check (B4SC)
- 80 percent of children fully immunised at eight months
- 86 percent of new-borns enrolled with a PHO at three months
- 13,023 outpatient consultations provided – 4.4 percent of these consultations were provided by telemedicine
- 94 percent of people receiving their urgent diagnostic colonoscopy within two weeks
- 3,612 planned care interventions delivered
- 97 percent of stroke patients admitted to an organised stroke service (with a demonstrated stroke pathway) after an acute event.

### The COVID-19 pandemic continues to provide challenges

We have all played our part in preventing COVID-19 from getting a permanent foothold in Aotearoa New Zealand to date, and it has stretched our healthcare system and our people. We are grateful to everyone who has stepped up to the challenge to support our COVID-19 response.

Our COVID-19 vaccination programme kicked off in April 2021 and we have been scaling up at pace as part of our fight against the virus. At the time of publishing this report (early December) we had just reached 90 percent of Coasters having had at least one vaccination against COVID-19, with more than 80 percent being fully vaccinated.

We have only been able to achieve our impressive vaccination rates through working in close partnership with mana whenua, general practices, West Coast Primary Health Organisation (PHO), Community & Public Health and Canterbury Health Laboratories (that also provides services to the Coast), aged residential care providers, our multi-disciplinary health services and other disability and health service providers as well as community leaders – with a strong health equity focus. Everyone demonstrated incredible professionalism and dedication in the provision of care and services as part of our regional COVID-19 response.

### National Bowel Screening Programme

The National Bowel Screening Programme (NBSP) was officially rolled out in the West Coast District Health Board region on Monday, 31 May 2021.

Free bowel screening kits aimed at saving lives will arrive in the mailboxes of West Coast people aged 60 to 74 provided they are registered with a General Practice. On the Coast, around 6,505 people will be eligible to take part during the first two years of the programme.

We anticipate that investigations prompted by returned tests will enable us to treat about 10 cancers in the first year. We also expect to pick up some pre-cancerous and non-cancerous polyps and, in these instances, the participants will become part of our surveillance programme. Finding and removing them early dramatically increases people's chance of a successful outcome.

### Hauora Māori

Addressing inequalities in health outcomes for our Māori community is a key focus of the DHB. Our Hauora Māori team played a pivotal role in the delivery of health care by ensuring that our people had access to the right tools to enable them to improve programmes and services to promote health equity across the health system for Coast Māori.

One example of our success is having provided advice and offered help-to-quit to 100 percent of Māori women who were smokers at the time their pregnancy was confirmed.

### Rural generalist model implementation

The on-going implementation of a rural generalist model, a proven strategy for creating a more integrated and sustainable workforce in more remote rural health systems, continued to make progress throughout the year.

The model involves all professions – medical, nursing, midwifery and allied health – working to the full extent of their scope of practice as members of a multi-disciplinary team. It also supports our primary focus of ensuring that Coasters receive the right level of care in the right place, from the right people, at the right time.

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

### Investing in Facilities

The new $21m Buller Health facility is progressing well, with construction now well underway. The project is currently on schedule and is expected to be completed in the second quarter of 2023.

Our new Haast Health Centre, co-located with St John's base in the Haast township, opened in mid-December 2020. The new clinic includes an accessible toilet, waiting room, consult room, treatment room and multi-use storage/utility room with staff amenities being shared with St John staff. There is also direct access from the clinic into the St John part of the facility, to facilitate patient transfer.

### Engaging with our people – Tāngata Ora | Our People survey

We are always interested to hear what our staff have to say so we can do our best to address their needs. We ran the Tāngata Ora | Our People Survey in May 2021 and received more than 5,000 responses from across both West Coast and Canterbury DHBs. The survey gave our executive team and leaders a clearer understanding of how we can better support our people to do their best work.

Some of the key themes that shone through as already working well included: staff feeling positive about their working relationship with their team and leaders, people finding their work meaningful, and being confident about their understanding of the health and safety processes in their work area.

We acknowledge that there is always room for improvement and have started working with leaders to address feedback on some of those themes: on the better use of data and insight to plan and resource

workloads based on current and future demand for example, managing reports of bullying and harassment better, and addressing poor performance more effectively.

We thank everyone who took the time to provide their valuable input, enabling us to work towards supporting wellness at work, with the benefits of that work contributing to improving our care of both staff and the public.

He aha te mea nui o te ao? He tangata, he tangata, he tangata.

What is the most important thing in the world? It is the people, it is the people, it is the people.

**Hon Rick Barker**
*Chair*
30 March 2022

**Dr Peter Bramley**
*Chief Executive*
30 March 2022

# Part II Improving Outcomes

# Are We Making A Difference?

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 several different roles and associated responsibilities. In our governance role we are concerned with health 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.

Because of the wide scope of our responsibilities, there is no single performance measure or indicator that can easily reflect the impact of the work we do. Instead, in line with our vision for the future of our health system, we have developed an overarching intervention logic and an outcomes framework to help us monitor and evaluate our performance over time.

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 a small number of long-term population health indicators which will provide insight into how well our system is performing over time. The framework encompasses national direction and expectations through the inclusion of national targets and system level measures.


Because the nature of population health means it may take several years to see marked improvements against these outcome indicators, our focus in this space is to develop and maintain positive trends over time, rather than to achieve annual fixed targets.

To evaluate our performance over the shorter term, we have also identified a secondary set of contributory measures, where our service performance will impact on the outcomes we are seeking.

Because change will be evident over a shorter period, these contributory (or impact) measures have been selected as our main measures of performance.

We have set performance standards for these impact measures to determine whether we are moving in the right direction. Tracking our performance against these indicators helps us to evaluate our success in areas that are important to our community, our Board and Government.

These medium-term impact measures sit alongside our annual Statement of Performance Expectations (the following section of this report), which outlines the services we planned to deliver and the standards we expected to meet in 2020/21. Collectively these measures form an essential part of the way in which we are held to account.

Many of the long and medium-term measures selected were deliberately chosen from national DHB reporting frameworks, to enable comparison with other DHBs and give context to our performance.

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

The intervention logic framework on the following page illustrates how we anticipate the services that we fund or deliver (annual outputs) will have an impact on the health of our population, contribute to the longer-term population health outcomes desired, and deliver on the expectations and priorities of Government.

# West Coast DHB - Overarching Intervention Logic Framework


## Te Tiriti O Waitangi

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

# Wellbeing Outcomes

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

### WHY IS THIS A PRIORITY?

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

### WHERE ARE WE FOCUSED?

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

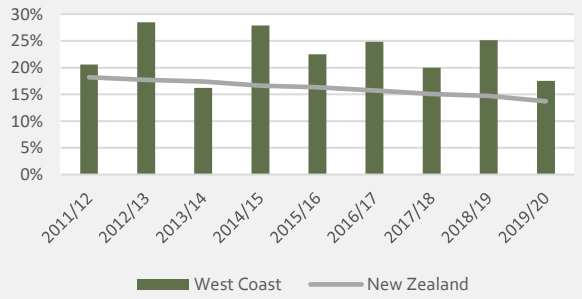
### OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

The West Coast's smoking rates have dropped against previous years but remain just above national average. The latest NZ Health Survey results indicate that 18% of our population smoke. Combined results from 2017/2020 show that smoking rates are highest among our Māori population (31%) compared with 21% for the total population.

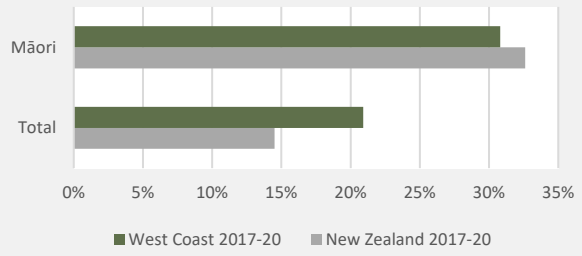
Providing smokers with brief advice to quit smoking at every opportunity, increases their chances of making a quit attempt. The likelihood of that quit attempt being successful is increased if cessation support is also provided. We continue to invest in work to help our community understand the health risks associated with smoking with brief advice to quit being offered through primary care and in our hospitals.

We are focusing on the delivery of key messages and cessation support to pregnant women. In 2020/21, 93% of pregnant women, identified as smokers when registering with a lead maternity carer, were offered brief advice and support to quit smoking.

Proportion of the population (15+) who currently smoke




Proportion of the population (15+) who currently smoke




Data source: National NZ Health Survey [2]

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

[2] The NZ Health Survey is an annual survey commissioned by the Ministry of Health which collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2019/20 Survey is the most recently released time series available and while total population results are presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers. For further information refer to the Ministry website for the NZ Health Survey results.

## OUTCOME MEASURE – A REDUCTION IN OBESITY RATES

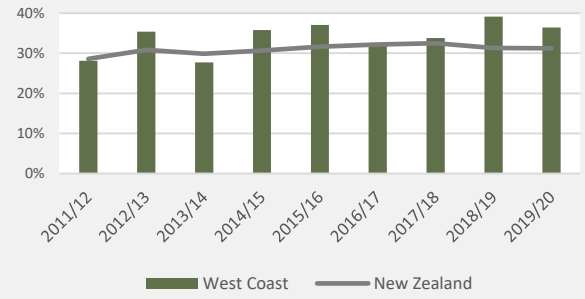
Like smoking, obesity impacts on the quality of people's lives and is a significant risk factor for several long-term conditions. We have a role in supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to make healthier choices.

The latest NZ Health Survey results shows the West Coast obesity rate is slightly higher than the national rate at 36% vs 31%. Combined results from 2017/2020 show a similar pattern but, like smoking, West Coast Māori have a lower obesity rate compared to the national average at 45% compared with 48%.

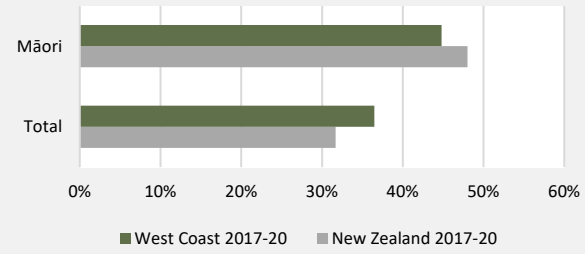
Our public health nurses identify children who may need nutrition support as part of their B4 School Check, prior to starting school. In 2020/21, 97% of West Coast four-year-olds received their B4 School Check and all but three of the families of children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice (88%).

We also continue to invest in lifestyle programmes that support people to increase physical activity or make healthy food choices, including the Green Prescription programme. In 2020/21, 452 people were referred into the Green Prescription programme by their health professional and over 1,300 people have accessed the services in the past three years.

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




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




Data source: National NZ Health Survey [3]

## IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

### Fewer avoidable hospital admissions

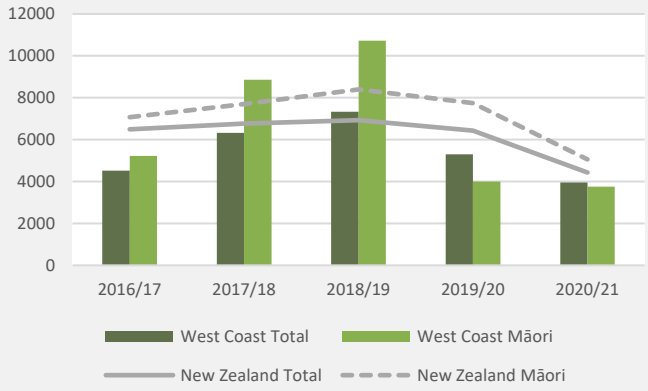
In 2020/21, West Coast's ambulatory sensitive hospital (ASH) admission rate for children under five was 3,956 per 100,000, which was well below both the target and the national rate of 4,432.

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system that engages earlier with children and their parents/caregivers.

With a population of our size, small changes in clinical practice or support for individual families can contribute to changes in ASH rates. The difference in the total rate between March 2020 and March 2021 represents 24 fewer hospital admissions across the year and one less Māori admission.

Engagement with primary care is a key driver in reducing avoidable hospital admissions and in the past year 86% of all new-borns on the West Coast were enrolled with a primary care team before three months of age.

| Measure: Rate of Ambulatory sensitive hospitalisations for children (0-4) | 2018/19 | 2019/20 | Target | Result |
|---|---|---|---|---|
| | 7,333 | 5,304 | <6,871 | 3,956 |




Data Source: Ministry of Health Performance Reporting [4]

[3] The NZ Health Survey is an annual survey commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2019/20 Survey is the most recently released time series available and while total population results are presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers.

[4] This is a national DHB performance indicator and captures hospital admissions for conditions considered preventable, including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The ASH results are published three months in arrears and the results reflect the 12 months to March 2021.

## IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

### Children have improved oral health

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

The percentage of five-year-olds whose teeth are caries-free (no holes or fillings) increased compared with the previous year, with a 3% improvement for the total population and 4% for Māori.

Service performance data for 2020/21 shows 88% of all children aged 0-4 were enrolled with a community dental service and 82% of all children aged 0-12 had their teeth examined according to planned recall.

The transalpine Oral Health Service Development Group is working to improve oral health outcomes and address equity gaps. In the coming year the focus includes sharing data across child health services to identify children and help establish contact with families and bringing in dedicated clinical oversight to support services improvements.

| Measure: Children caries-free at age 5 | 2018 | 2019 | Target | Result |
|---|---|---|---|---|
| | 59% | 55% | >59% | 58% |


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

### Fewer young people take up smoking

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

The 2019 survey results show a slight drop-off from 2018 rates for the West Coast with 71% of West Coast Year 10 students reporting having never smoked compared to 80% across New Zealand.

The small West Coast population contributes to fluctuations between years, however further focus is needed to ensure more of our young people are not taking up smoking. Our public health team continues to undertake controlled purchase operations to ensure that licenced premises are not selling tobacco to young people under the legal age of 18.

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


Data Source: National ASH Year 10 Survey [6]

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

[6] The ASH Survey is a national survey used to monitor student smoking rates since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students who are aged 14 or 15 years at the time of the survey. Ethnicity breakdowns are not provided due to small survey numbers. The ASH survey was not completed in 2020 due to COVID. Results for 2021 are expected early in 2022. For further information see www.ash.org.nz.

# People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

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

WHERE ARE WE FOCUSED?

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

## OUTCOME MEASURE – A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

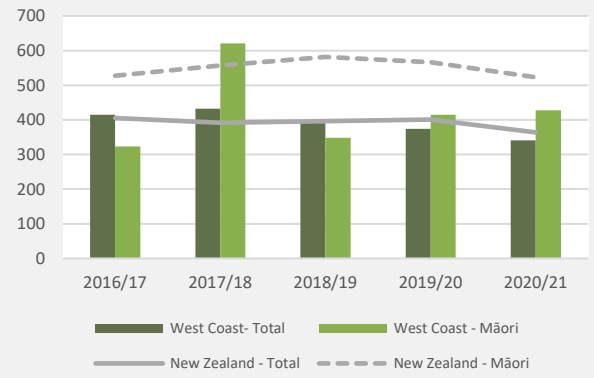
Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand. In 2020/21, 51% of admissions to Grey Hospital were acute.

Acute hospital bed-days are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatments that reduce the crisis and deterioration that leads to an acute hospital admission.

West Coast's acute hospital bed day rates are positive compared with national rates, particularly for Māori.

Our primary care-led Long-Term Conditions Management Programme is a key factor in reducing acute admissions. The Programme supports people to better manage their health and long-term conditions and helps to prevent people from becoming acutely unwell. Over 2,700 people were enrolled in the Programme in 2020/21, just over 7% who were Māori.

Rate of acute hospital bed-days




Data Source: National Minimum Data Set[7]

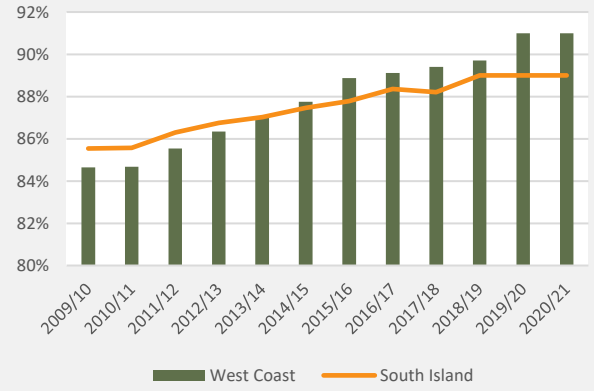
## OUTCOME MEASURE – MORE PEOPLE LIVING IN THEIR OWN HOME

The proportion of the West Coast population (aged 75+) living in their own homes remained stable at 91% in 2020/21. Consistent with our strategy, this suggests our older population is being supported to live more independently and is a positive trend as our population continues to age.

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

Falls are a common occurrence for older people and frequently lead to injury, hospitalisation and an increased risk of admittance to institutional care. In 2020/21, 136 people over the age of 65 were supported by our Falls Prevention Service, 52 more people than in the previous year.

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




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

## IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

### People's conditions are diagnosed earlier

Timely access to diagnostics improves clinical decision making and enables early and appropriate intervention, improving the quality of care and outcomes for our population.

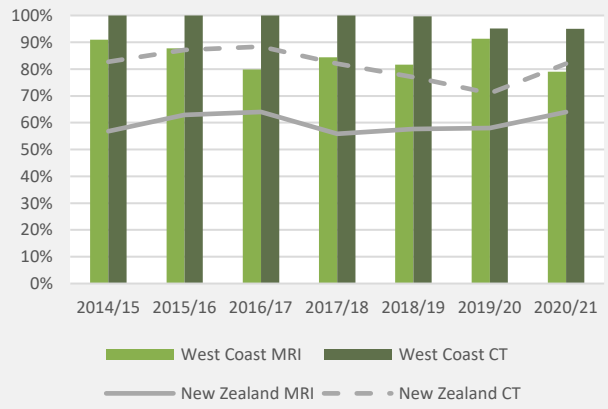
West Coast CT wait times continue to meet the national target of 95% and are well above the national average of 82%.

MRI wait times are not as positive, however despite not meeting the national target West Coast wait times for MRI scans remain well above the national average of 64%.

The number of MRI referrals increased by 324 (39%) over the past year and several factors are driving this increased demand including new drug and treatment programmes, increased surgical volumes, and population growth and ageing.

A private provider based in Christchurch delivers MRIs for the West Coast population and logistics and patient choice also play a part in the delays. We are looking closely at the patient-related delays to understand what might be done to reduce these.

| Measure: People receiving their non-urgent MRI or CT scan within six weeks | 2018/19 | 2019/20 | Target | Result |
|---|---|---|---|---|
| MRI | 82% | 91% | 90% | 79% |
| CT | 100% | 95% | 95% | 95% |




### Fewer avoidable hospital admissions

In 2020/21, West Coast's avoidable hospital admission rate for 45-64-year-olds was 3,198 per 100,000 people. This result is better than both the target and the national rate of 3,572.

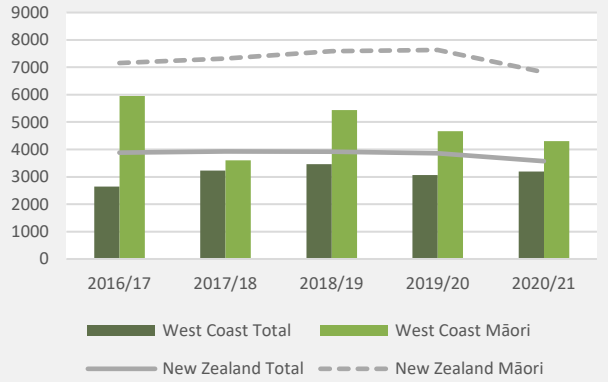
Our Māori rate has continued to trend downwards to 4,302, however rates are disproportionately impacted by small population numbers with results reflecting just two less admissions for Māori compared to last year. More relevant is that West Coast Māori rates remain significantly lower than the national Māori rate of 6,818 admissions per 100,000.

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

High general practice enrolment rates are an indication of good engagement with our health system. In 2020/21, 98% of the total population and 88% of Māori were enrolled with a West Coast general practice.

Increasing engagement with our Māori and more vulnerable populations will continue to be a focus for our health system in the coming year. Equity actions have been highlighted throughout the DHB's 2021/22 Annual Plan with an emphasis on the development of kaupapa Māori services and pathways to support earlier intervention and reduce hospital admissions.

| Measure: Ambulatory sensitive hospitalisation for adults (45-64) | 2018/19 | 2019/20 | Target | Result |
|---|---|---|---|---|
| | 3,458 | 3,064 | <3,501 | 3,198 |




Data source: Ministry of Health Performance Reporting[8]

[8] This measure is a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results reflect updated national data provided by the Ministry of Health in June 2021 being results for the 12 months to March 2021.

## IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

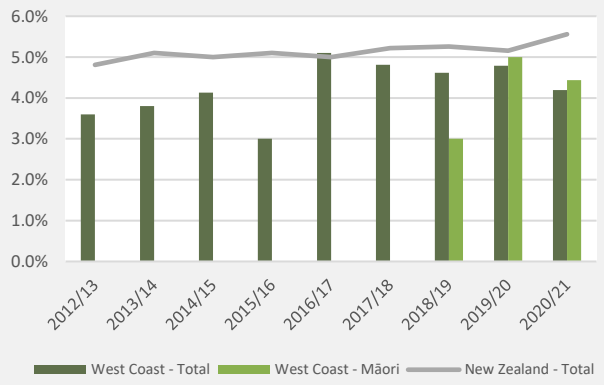
### Fewer falls related hospitalisations

With an aging population, reducing the rate of falls leading to hospital admissions, reflects a significant investment for the West Coast health system. Our focus on falls prevention is crucial in supporting people to stay well and independent and reducing demand on services across our health system.

Positively, at 4.2%, the proportion of our population aged 75 and over admitted to hospital following a fall fell slightly compared with the previous year and remains 1.4% lower than the national average. West Coast's Māori rate also fell compared with the previous year however the numbers are small with four admissions compared with five the previous year.

In the last year 52 more people, 136 in total, accessed the community-based falls prevention service on the Coast and the number of inpatients provided with a falls assessment in our hospitals lifted 6% to 77%.

| Measure: Population (75+) admitted to hospital because of a fall | 2018/19 | 2019/20 | Target | Result |
|---|---|---|---|---|
| | 4.6% | 4.8% | <5.0% | 4.2% |




Data Source: National Minimum Data Set

# People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

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

WHERE ARE WE FOCUSED?

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

## OUTCOME MEASURE – A REDUCTION IN AMENABLE MORTALITY

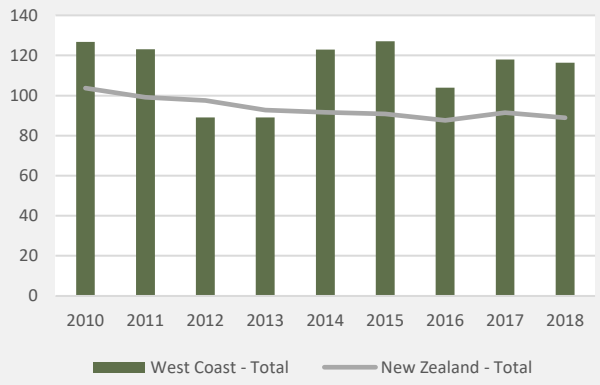
The last available mortality rates are positive with West Coast amenable mortality rates falling slightly.

Prevention, screening and long-term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment.

Cancer is one of the leading causes of mortality in New Zealand and contributes to a high proportion of premature deaths. Faster Cancer Treatment performance data shows 81% of West Coast patients received urgent cancer treatment within 62 days of referral in 2020/21 – reflecting just seven patients seen outside of national timeframes across the full year.

We continue to support access to brief intervention counselling (BIC) in general practice with 683 people accessing BIC support in 2020/21. We continue to work closely with our primary and community-based service providers to ensure a strong continuum of care for people with mental illness and addictions. In the coming year we will partner with iwi, providers and consumers to undertake a collective redesign process to better tailor our mental health and addictions services to support and achieve equity of outcomes for our population.

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




Data Source: National Mortality Collection[9]

[9] Performance data for this measure is sourced from the national mortality collection which is three years in arrears. 2019 results were not available nationally at the time of printing.

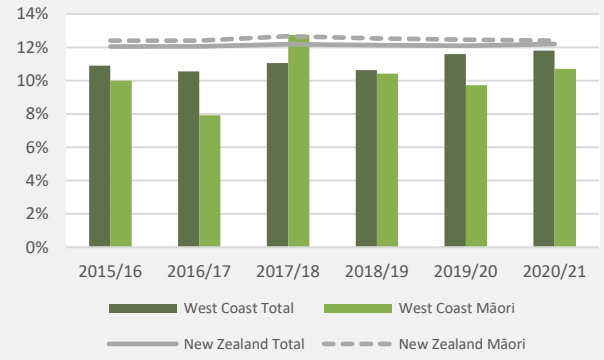
## OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

Lower readmission rates are important, as patients who are readmitted to hospital within 28 days of discharge are more likely to experience negative long-term outcomes. Readmissions also reduce public confidence and increase costs for the system.

West Coast's readmission trend remains relatively flat for the total population at 11.8% and below the national average of 12.2%. Our Māori readmission rate increased from 9.7% to 10.7% in the last year, reflecting a drop in the number of actual admissions rather than a real increase in readmissions.

Community-based support services provide care and assistance to people following discharge from hospital as part of a restorative approach aimed at enabling people to stay in their own homes for longer. In the past year over 2,400 people were supported by district nursing and 1,122 people by home-based support services.

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




Data Source: National Minimum Data Set

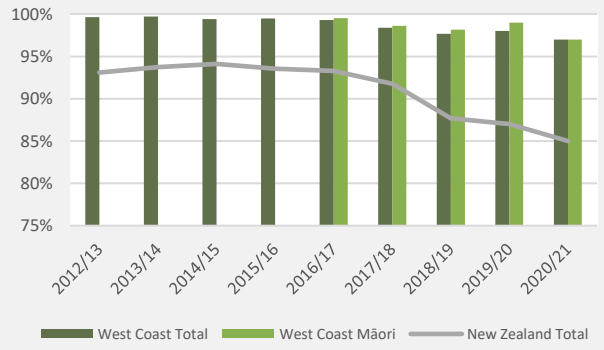
## IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

### People have shorter waits for urgent care

The increasing number of people presenting to emergency departments for treatment is putting urgent care services under pressure across the country. While West Coast's performance has dropped a little compared to the previous year we continue to deliver against the national Shorter Stays in ED target, with 97% of people presenting in our Emergency Department being admitted, transferred or discharged within six hours – compared to 85% nationally.

The migration into Te Nikau is complete with new unplanned care areas and ways of working operational. This includes extended hours of operation for primary care within the Te Nikau facility. This has helped to keep ED presentations down; there were 10,666 presentations to our ED this year, compared to 11,889 in 2019/20. Two West Coast general practices are now also offering telehealth options enabling easier access to urgent care in the community.

| Measure: People are admitted, discharged or transferred from ED within 6 hours | 2018/19 | 2019/20 | Target | Result |
|---|---|---|---|---|
| | 98% | 98% | 95% | 97% |




Data Source: National Minimum Data Set

### People have shorter waits for planned care

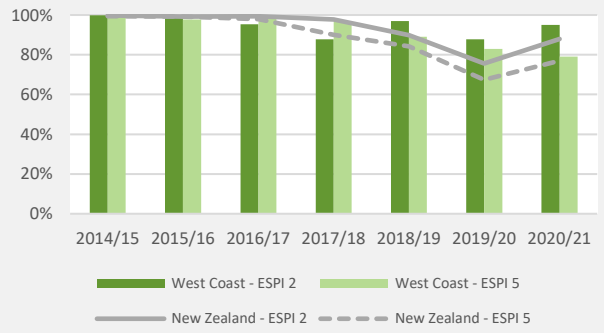
As is evident across the country, increasing service demands and COVID restrictions have impacted on DHBs' capacity to meet waiting time expectations for planned care.

While the West Coast DHB has missed the targets for both measures in 2020/21, performance improved against the ESPI 2 target (specialist assessment in under four months) and both ESPI 2 and 5 performance remains above the national average.

In the past year 3,612 planned care interventions were delivered for the West Coast population, including 1,938 inpatient surgical events, 1,562 minor procedures, and 112 non-surgical interventions.

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

| Measure: People receiving specialist assessment and treatment within set timeframes. | | 2018/19 | 2019/20 | Target | Result |
|---|---|---|---|---|---|
| | ESPI 2 | 97% | 88% | 100% | 95% |
| | ESPI 5 | 89% | 83% | 100% | 79% |




Data Source: Ministry of Health Quickplace Warehouse [10]

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

## IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

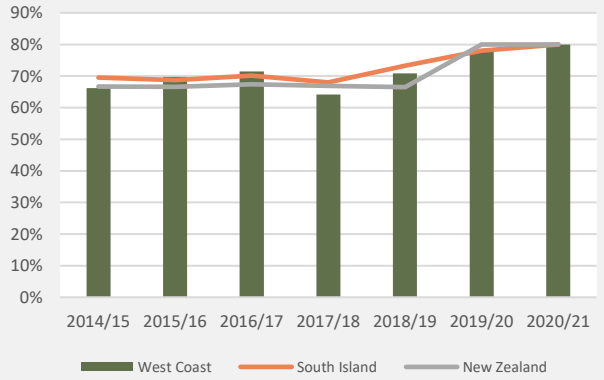
### People Are Supported on Discharge

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

This indicator is a marker of good discharge planning, service integration and the continuity of care between hospital and community services. West Coast performance improved by 2% in 2020/21, meeting the national target of 80% for this important measure.

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

| Measure: Inpatients accessing community-based MH and AOD services within seven days of discharge | 2018/19 | 2019/20 | Target | Result |
|---|---|---|---|---|
| | 71% | 78% | 80% | 80% |

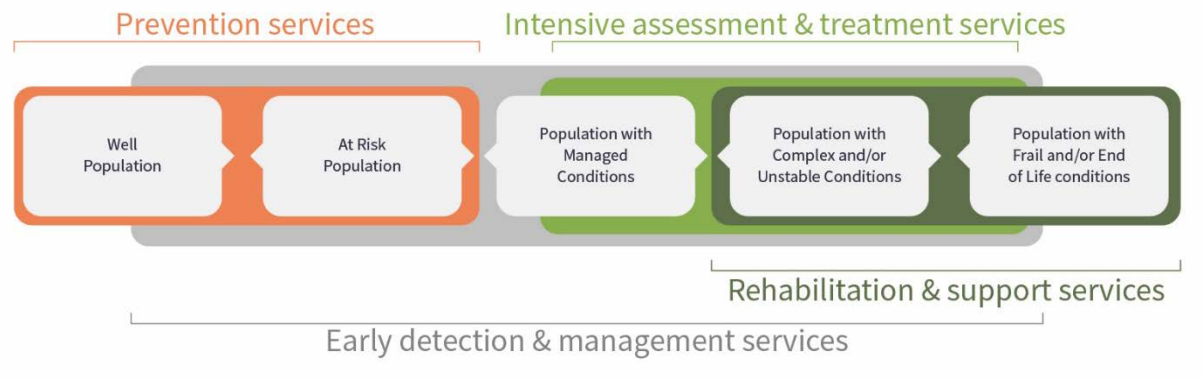



Data Source: National Mental Health KPI Framework.[11]

[11] Data for this measure is provided via the national KPI programme.

# Part III
# Delivering on our Plans

# Statement of Service Performance




## Evaluating Our Performance

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

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

On an annual basis, we track our performance against our forecast of the services we plan to deliver and the standards we expect to meet. The DHB's service performance for the year is set out in this section measuring delivery against the forecast presented in our 2020/21 Statement of Performance Expectations, available on our website.

### 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.

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

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

To ensure a balanced, well rounded picture, the mix of measures identified address four key aspects of service performance:

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

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

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

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

As part of our obligations under legislation DHBs must also work towards achieving equity. To promote this goal and as a means of evaluating whether we have made a difference for our Māori population, we have identified a core set of performance measures that are important in terms of Māori health. These measures are presented by ethnicity on page 32.

### 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.

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.

In areas where we do have more influence, targets set for 2020/21 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

## 2020/21 PERFORMANCE

Going into the 2020/21-year, the West Coast DHB was still contending with an operational backlog related to the COVID-19 lockdown in 2020 which necessitated the postponement of deferrable services and the temporary closure of many community-based services.

It was difficult to predict the impact of COVID on our health system, but we knew that many of the national standards could be difficult to meet as we addressed the backlog from the previous year. We also anticipated there would be ongoing constrains with our limited workforce being stretched across business-as-usual service delivery and our COVID response.

The work required to reschedule appointments and catch-up on service delivery was not insignificant and we are grateful to all the people working in our system who made it possible for us to reengage with people and worked hard to get services back up and running.

Several pressure areas related to COVID are evident in the results for the 2020/21 year.

National workforce shortages are reducing capacity in some specialist services, with fewer people migrating from overseas and long recruitment delays related to limited space in managed isolation.

General practice and public health are stretched with additional requirements around streaming, testing and supporting COVID vaccinations reducing overall capacity. We are working closely with the West Coast PHO to address this challenge and ensure people have continued access to care.

Public confidence levels and behaviours also appear to have changed, along with resilience levels across our community. Increasingly acute and complex presentations to emergency and mental health services are reflective of national patterns, with drivers being complex in nature.

We have included three additional measures in our Statement of Service Performance to help highlight to the reader the use of health system resources in responding to COVID regarding COVID testing and the delivery of COVID vaccinations. Footnotes have also been added where it has been clear that performance has been impacted by COVID.

We note also that many of the performance targets are national targets set for all DHBs. Our small population size means that two or three people can have a significant impact on our results and performance can fluctuate year on year. This is evidence in our results for 2020/21 and volumes have been reflected in footnotes to add context to our performance.

Our response to these pressures is highlighted through our Annual Plan for the coming year with a focus on equity, building capacity across our community services and ensuring both the clinical and financial sustainably of our system.

## 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 can be affected by a delay in invoicing or reporting. Results for previous years are also subject to change from incorporating late data.

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

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

◆ The measure is a core Māori health measure. Refer to page 32 for a breakdown of results by ethnicity.

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

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

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

## Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services are those that promote and protect the health of the whole population, or targeted sub-groups, and influence individual behaviours by targeting changes to physical and social environments to engage, influence and support people to make healthier choices. 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 behaviour 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 to protect health and improve health outcomes. | Notes | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally | Q[12] | 14 | 15 | E.15 | 13 | - | ✖ |
| Licensed alcohol premises identified as compliant with legislation | Q[13] | 96% | 100% | 90% | 0% | - | ✖ |
| Networked drinking water supplies compliant with Health Act | Q[14] | 81% | 78% | 97% | n.a | - | - |

[12] Due to ongoing involvement of public health staff in COVID response work our Community & Public Health (CPH) team have had to prioritise completion of submissions based on the public health issues addressed and the availability and capacity of CPH staff.

[13] This measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. No CPOs were conducted in the West Coast DHB in the period 1 July 2020 to 30 June 2021 due to CPH staff being redeployed to support the COVID response.

[14] Water quality annual reports are published one year in arrears, the latest report for 2019/20 can be found on the Ministry of Health website.

| Health Promotion and Education Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| These services inform people about risk factors and support them to make healthy choices. | Notes | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Mothers receiving breastfeeding support and lactation advice in community settings | A | 193 | 228 | E>150 | 165 | - | ✓ |
| Babies exclusively/fully breastfed at LMC discharge (six weeks) | Q[15]◆ | 76% | 72% | 75% | n.a | - | - |
| Babies exclusively/fully breastfed at three months | Q[15]◆ | 61% | 64% | 70% | 62% | 59% | ✗ |
| People provided with Green Prescriptions (GRx) for additional physical activity support | A | 458 | 450 | E>400 | 452 | - | ✓ |
| GRx participants more active six to eight months after referral | Q[16] | n.a | n.a | 50% | n.a | - | - |
| Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC) in the last 15 months | Q[17]◆ | 96% | 93% | 90% | 88% | 76% | ✗ |
| Smokers identified in hospital, receiving advice and support to quit smoking (ABC) | Q[17]◆ | 91% | 91% | 95% | 89% | - | ✗ |
| Women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC) | Q[17]◆ | 100% | 100% | 90% | 93% | - | ✓ |

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Four-year-olds provided with a B4 School Check (B4SC) | A◆ | 93% | 94% | 90% | 97% | 88% | ✓ |
| Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention | Q[18]◆ | 94% | 100% | 95% | 88% | 93% | ✗ |
| Women aged 25-69 having a cervical cancer screen in the last 3 years | A[19]◆ | 72% | 72% | 80% | 75% | 70% | ↺ |
| Women aged 50-69 having a breast cancer screen in the last 2 years | A◆ | 77% | 72% | 70% | 74% | 66% | ✓ |

[15] Breastfeeding data is provided by the Ministry of Health and is not able to be combined with local provider data, so performance from the largest provider (Plunket) is presented. Results on LMC discharge for 2020/21 results are not yet available. Breastfeeding at three-months fell slightly against the previous year, reflecting 15 fewer children (including 7 fewer Māori) being breastfed. We continue to invest in parenting and pregnancy courses and lactation support to encourage mothers to breastfeed. An error was identified in the 2018/19 three-month breastfeeding result reported in the 2019/20 annual report. The reported result of 64% was incorrect and has been updated in this year's annual report to 61%.

[16] The DHB has been advised that the biannual survey, which tracked patient activity following referral, is no longer being undertaken by the Ministry of Health.

[17] The ABC programme refers to health professionals asking about smoking status, providing Brief advice and providing cessation support. The fall in performance reflects several things: the impact of COVID lockdowns, the redeployment of staff onto COVID programmes and the resignation of our Smokefree Coordinator during the last half of the year. A new Coordinator is in place and we expect rates to pick up again as the new person gets established in the role. The lower result for pregnant women in 2020/21 reflects just two women who were identified as smokers but did not receive smoking cessation advice.

[18] 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. This result is disproportionately impacted by small population numbers, reflecting just three children who were missed over the course of the 2020/21 year.

[19] Cervical cancer risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment. West Coast's result has improved since last year and, while still below the national target, performance is above the national average and heading in the right direction. The number of screens completed for the total population increased by 271. The number of screens provided to Māori increased by 34 compared with 2019/20's result while the eligible Māori population increased by 49 over the same period.

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Children fully immunised at eight months of age | A[20]◆ | 79% | 78% | 95% | 80% | 88% | ↺ |
| Proportion of eight-month-olds 'reached' by immunisation services | Q | 96% | 95% | 95% | 97% | 94% | ✓ |
| Young people (Year 8) completing the HPV vaccination programme | A[21]❖◆ | 30% | 53% | 75% | 52% | 63% | ✗ |
| Older people (65+) receiving a free influenza ('flu') vaccination | A[22]❖◆ | 55% | 58% | 75% | 75% | 67% | ✓ |
| Number of COVID-19 vaccinations delivered on the West Coast | A[23] | - | - | 11,640 | 10,782 | - | ✗ |
| Proportion of the eligible West Coast population fully vaccinated (i.e. receiving two doses) | C[24] | - | - | - | 15.8% | 11.5% | - |

[20] 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 which is reflected in our efforts to 'reach' parents and provide them with advice to make informed choices for their children. In 2020/21 62 children did not receive all their vaccinations by eight months of age.

[21] Human Papillomavirus (HPV) vaccination coverage is strongly impacted by the views of our Gloriavale Community who do not vaccinate. There were 15 more young people immunised compared with the previous year, however the eligible population grew by 35 over the same time and the redeployment of our public health nurses to support the COVID-19 vaccine programme impacted further on our results. We are anticipating this will pick up in the coming year with more dedicated vaccinators engaged in the COVID programme.

[22] 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. The increased focus on respiratory illness in 2020/21 helped the West Coast administer 1,037 more vaccinations including 55 more vaccinations to Māori than the previous year.

[23] These measures have been added to the Statement of Performance as a measure of significant interest to our population. The vaccination numbers for the first measure reflect total COVID vaccinations delivered on the West Coast and may include some vaccinations delivered to people who were working or visiting the West Coast region but who are not domiciled or enrolled here. The target reflects the number agreed with the Ministry of Health as part of vaccination rollout plan and vaccination data has been provided by the Ministry of Health. The total number of vaccinations delivered includes: 6,543 first dose vaccinations and 4,239 second dose vaccinations. Total vaccinations delivered by sequencing group includes: 59 delivered to Group 1, 4,649 delivered to Group 2, 5,389 delivered to Group 3 and 685 delivered to Group 4.

[24] Fully vaccinated is defined as two doses having been administered to an individual, and people eligible for the COVID vaccination programme refers to those aged over 16, which was the age band at the time. The proportion fully vaccinated includes West Coast residents receiving two doses of the COVID vaccine irrespective of where they received those doses – i.e. overseas or in another DHB region. The proportion of the population vaccinated includes: 9.3% of our Māori population; 17.5% of our Pacific population and 24.1% of our Asian population. There was no population coverage target set for the programme in 2021/21. In line with national reporting by the Ministry of Health, the proportion of the population fully vaccinated at 30 June 2021 has been calculated using the Health Service User (HSU) population. There is an acknowledged difference between the Statistics New Zealand projected population and the HSU population used nationally for tracking the COVID vaccinations programme delivery, however the HSU population enables closer matching for demographics such as location and ethnicity. Further information relating to the national definitions and calculation of these measures can be found along with a comprehensive breakdown of COVID reporting in the Ministry of Health 2020/21 Annual Report.

## 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Newborns enrolled with a PHO by three months of age | A◆ | 95% | 90% | 85% | 86% | 89% | ✓ |
| Proportion of the total population enrolled with a PHO | A◆ | 94% | 96% | 95% | 98% | 94% | ✓ |
| Young people (12-19) accessing brief intervention counselling in primary care | A[25]Δ | 159 | 90 | E>150 | 147 | - | ✓ |
| Adults (20+) accessing brief intervention counselling in primary care | AΔ | 498 | 427 | E>450 | 536 | - | ✓ |
| Number of integrated HealthPathways in place across the system | Q[26] | 683 | 667 | E>600 | 813 | - | ✓ |
| Proportion of general practices offering the primary care patient experience survey | E | 100% | 100% | 100% | 100% | - | ✓ |

| Long-Term Condition Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions. | Notes | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management programme | A[27]◆ | 4,045 | 3,959 | E>3,500 | 2,777 | - | ✗ |
| Enrolled population (15-74), identified with diabetes, having an annual diabetes review | A[28]◆ | 85% | 61% | >85% | 58% | - | ✗ |
| Population with diabetes, having an annual review and HbA1c test, demonstrating acceptable glycaemic control (HbA1c <64 mmol/mol) | Q◆ | 53% | 56% | 60% | 56% | - | ↺ |

[25] 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.

[26] The increase in HealthPathways reflects the number of additional pages created in response to COVID and a change in the way some pages are counted, with pages having been split out into individual pathways to provide additional clarity for services.

[27] This measure refers to the primary care long-term conditions 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. People are confirmed as engaged in the programme through contact with their general practice and the drop-off in comparison to the previous years is related to people's reluctance to attend general practice during lockdowns and higher alert levels, capacity issues for general practice who have prioritised the COVID response above recalling patients and refinement of the data over the past year to ensure the count is reflecting unique individuals even if they have more than one long-term condition. The West Coast PHO is closely tracking these numbers to ensure that people are getting the support they need to manage their condition.

[28] 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. The proportion of people having an annual review fell slightly in 2020/21 with 15 fewer reviews undertaken than 2019/20. This is not surprising considering the competing priorities in 2020/21.

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Children (0-4) enrolled in school and community oral health services | A[29]❖◆ | 101% | 88% | 95% | 88% | - | ↺ |
| Enrolled children (0-12) receiving their oral health exam according to planned recall | T[29]❖◆ | 96% | 98% | 90% | 82% | - | ✖ |
| Adolescents (13-17) accessing DHB-funded oral health services | A❖ | 76% | 73% | 85% | 78% | 59% | ↺ |

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Number of subsidised pharmaceutical items dispensed in the community | A[30Δ] | 471k | 498k | E<500K | 555k | - | ✖ |
| People being dispensed 11 or more long-term medications | Q[31]❖ | 4.1 | 4.0 | <4.1 | n.a | - | - |
| Number of community-referred radiological tests delivered | A[32] | 6,035 | 5,570 | E>5,500 | 7,160 | - | ✓ |
| People receiving their urgent diagnostic colonoscopy within two weeks | T | 88% | 95% | 90% | 94% | 91% | ✓ |
| People receiving their Magnetic Resonance Imagining (MRI) scans within six weeks | T[33] | 82% | 91% | 90% | 79% | 64% | ✖ |
| People receiving their Computed Tomography (CT) scan within six weeks | T | 99.7% | 95% | 95% | 95% | 82% | ✓ |
| Number of COVID-19 Laboratory tests processed | A[34] | - | - | - | 1,538 | - | - |

[29] The COVID lockdown in 2020 significantly impacted the delivery of community dental services on the West Coast. Due to the small team and the spread of our rural population it was difficult to catch up with examinations after the programme had to be suspended. Additional capacity and clinical oversight is being sought to help improve performance in the coming year.

[30] Changes to national pharmacy expectations, in response to international supply restrictions, led to increased dispensing over the past year with prescriptions for three-month supplies being reduced to one month at a time for some medications.

[31] This measure is a rate per 1,000 people and data is sourced from the HQSC Atlas of Healthcare Variation – results for 2020 are yet to be released nationally.

[32] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. As our population ages the demand for radiology tests is likely to increase. Additional demand over the past year has been driven by increasing referrals from General Practice as well as some referrals which have historically come from unplanned care and ED shifting into the community.

[33] Increasing demand for diagnostics services has impacted a little on the wait times for MRI scans in 2020/21 with the number of MRI referrals increasing by 324 (39%). However, because the West Coast does not have an MRI machine and MIRs are contracted to a private provider in Canterbury, logistics and patient choice also play a strong part in the delays. We are looking closely at the patient-related delays to understand what might be done to reduce these. In total there were 155 more MRI scans delivered in 2020/21 compared to the previous year.

[34] This number reflects the COVID tests delivered by the West Coast DHB during the 2020/21 financial year - irrespective of where the person being tested lived. This measure has been added to the Statement of Performance as a measure of significant interest to our population, there was no estimate set in 2021/21.

## 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Staff compliance with good hand hygiene practice | Q[35] | 84% | 81% | 80% | 82% | 86% | ✓ |
| Inpatients (aged 75+) receiving a risk assessment to reduce serious harm from falls | Q | 68% | 71% | 90% | 77% | 87% | ↺ |
| Patients responding to the national inpatient patient experience survey | E[36] | 28% | 35% | >30% | n.a | - | - |
| 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[36] | 55% | 64% | 65% | n.a | - | - |

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Proportion of the population (0-19) accessing specialist mental health services | A[Δ] | 5.3% | 5.5% | >3.8% | 5.7% | 4.0% | ✓ |
| Proportion of the population (20-64) accessing specialist mental health services | A[37Δ] | 5.6% | 6.0% | >3.8% | 5.9% | 3.9% | ✓ |
| People referred for non-urgent mental health and AOD services seen within 3 weeks | T[38] | 81% | n.a | 80% | 82% | 76% | - |
| People referred for non-urgent mental health and AOD services seen within 8 weeks | T[38] | 92% | n.a | 95% | 96% | 92% | - |

[35] 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.

[36] The national vendor responsible for the inpatient survey changed during the 2020/21 year and national results are not available for this period.

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

[38] As part of the 2019/20 annual audit process, coding inconsistencies were identified with regards to the mental health wait time data, for both the three and eight-week wait time measures. Over the past 12 months work has been undertaken to identify and resolve process issues. We believe we have now aligned our processes and completed training with staff, but without a full reconciliation of every record it is possible that there may still be some inconsistencies in the 2020/21 data. We have decided not to identify these results as achieved for that reason.

| Maternity Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need. | Notes | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Number of maternity deliveries in West Coast DHB facilities | A | 241 | 246 | E.250 | 230 | - | ✓ |
| Women registered with a Lead Maternity Carer by 12 weeks of pregnancy | A[39]✧◆† | 81% | n.a | 80% | n.a | - | - |
| Baby Friendly Hospital accreditation achieved in DHB facilities | Q | Yes | Yes | Yes | Yes | - | ✓ |

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Number of unplanned presentations at the Emergency Department | A | 11,829 | 11,043 | E<13,000 | 10,666 | - | ✓ |
| People admitted, discharged or transferred from Emergency Department (ED) within 6 hours of presentation | T | 98% | 98% | 95% | 97% | 85% | ✓ |
| Proportion of people presenting in ED (in triage 1-3), seen within clinical guidelines | T[40] | 77% | 83% | 85% | 78% | - | ✖ |
| Proportion of people presenting at ED triaged in category 4 or 5 | A | 54% | 52% | <60% | 43% | - | ✓ |
| Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral. | T[41] | 72% | 83% | 90% | 81% | 87% | ✖ |

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Number of First Specialist Assessments provided | A | 6,240 | 5,258 | E>6,000 | 6,023 | - | ✓ |
| Proportion of people that wait <4 months for their First Specialist Assessment | T | 97% | 88% | 100% | 95% | 88% | ↺ |
| Number of planned care intervention delivered | A | new | 3,220 | 3,140 | 3,612 | - | ✓ |
| Proportion of people that wait <4 months from a commitment to treat to treatment | T[42] | 89% | 83% | 100% | 79% | 77% | ✖ |
| Number of outpatient consultations provided | A | 13,663 | 12,075 | E>13,000 | 13,023 | - | ✓ |
| Proportion of outpatient appointments provided by telemedicine | Q[43] | 5.1% | 5.2% | >5% | 4.4% | - | ✖ |
| Outpatient appointments where the patient was booked but did not attend | Q[44]Δ◆ | 7.7% | 7.2% | <6% | 5.3% | - | ✓ |

[39] Data is sourced from the Ministry's national Maternity Clinical Indicators report and is a year in arrears. The 2019 data is yet to be released.

[40] This measure demonstrates whether people presenting in ED are seen in order of clinical need and reflects national triage standards: Triage 1: immediately on presentation; Triage 2: within 10 minutes; Triage 3: within 30 minutes of presentation. There has been an increase in the complexity of people presenting to ED, and while we are still meeting national timeframes for seeing people within 6 hours this is challenging our ability to reach people within the shorter clinical recommended timeframes. There were 779 more people presenting in triage 1-3 compared to the previous year. Further implementation of our rural generalist model will increase our capacity and ensure we can better respond to the increasing demand evident across our population.

[41] Small population numbers disproportionately impact performance against the target for this measure, with just seven patients seen outside of timeframes across the whole year. A breach analysis is completed for every patient who is seen outside of timeframes to identify lessons and improve processes. Those patients who were outside of timeframes over the last year have been complex cases.

[42] In line with national reporting, the annual wait time results refer to the final month of each year (June). Performance fell slightly in 2020/21 with wait time targets missed for 74 patients compared with 44 patients in 2019/20. The DHB has a Planned Care Improvement Plan agreed with the Ministry of Health and we continue to work towards delivery of this Plan and a reduction in waiting times.

[43] 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. There were 57 fewer telehealth appointments compared with the previous year.

[44] There has been a strong focus from the West Coast on improving DNA rates, particularly for Māori. Performance reflects the considerable efforts of our Hauora Māori team working with services and the clinical booking unit to identify and reduce barriers to people attending appointments.

## 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| People supported by Early Supported Discharge (Formerly FIRST) | A[45] | 9 | 8 | 15 | 9 | - | ↺ |
| People (65+) supported by the community-based In-Home Falls Prevention Service | A | 143 | 84 | >120 | 136 | - | ✓ |
| Proportion of stroke patients admitted to an organised stroke service (with a demonstrated stroke pathway) after an acute event | Q | 94% | 95% | 80% | 97% | - | ✓ |
| Proportion of AT&R inpatients discharged home rather than into residential care | Q[46Δ] | 85% | 93% | 80% | 96% | - | ✓ |

| 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 | 2018/19 Result | 2019/20 Results | 2020/21 Target | 2020/21 Results | 2020/21 NZ Av | |
| Number of Meals on Wheels provided | AΔ | 36,511 | 41,966 | E>35,000 | 47,711 | - | ✓ |
| People supported by district nursing services | AΔ | 1,797 | 1,803 | E>1,600 | 2,438 | - | ✓ |
| People supported by long-term home-based support services | AΔ | 1,100 | 1,041 | E>1,000 | 1,122 | - | ✓ |
| 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[47] | 75% | 77% | 95% | 78% | - | ↺ |

[45] The Early Supported Discharge service 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. Performance is in line with prior years and is related to vacancies, highlighting the DHB's difficulty in recruiting to some specialist roles.

[46] 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 is positive and reflects the effectiveness of our services in terms of assisting people to regain functional independence after an acute event.

[47] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used to support clinical decision making and care planning. Consistent use of the national tool ensures assessments are of high quality and that people receive appropriate and equitable access to services irrespective of where they live. Performance has lifted compared to the previous year and we continue to work with assessors to improve the use of the tool across our service areas.

| 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 | 2018/19 Result | 2019/20 Result | 2020/21 Target | 2020/21 Result | 2020/21 NZ Av | |
| Proportion of the population (75+) accessing rest home level services in ARC | A$^{\Delta}$ | 3.8% | 3.4% | E<5.0% | 3.7% | - | ✓ |
| Proportion of the population (75+) accessing hospital-level services in ARC | A$^{\Delta}$ | 6.4% | 5.1% | E.<6.5% | 5.2% | - | ✓ |
| Proportion of the population (75+) accessing dementia services in ARC | A$^{48\Delta}$ | 1.1% | 0.7% | E.1.0% | 0.6% | - | ✖ |
| Proportion of the population (75+) accessing psychogeriatric services in ARC | A$^{\Delta}$ | 0.3% | 0.3% | E.0.4% | 0.4% | - | ✓ |
| People entering ARC having had a clinical assessment of need using InterRAI | Q | 88% | 91% | 95% | 94% | 96% | ↺ |

[48] While the proportion of the population accessing dementia care on the West Coast is below our estimates, the appropriate level of service need is assessed using the InterRAI assessment tool. The difference in dementia volumes relates to three fewer people accessing dementia care than in the previous year.

# Māori Health Performance 2020/21

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

Working with local stakeholders, the DHB has identified a number of key areas of focus and a set of core performance indicators. These are indicators seen as particularly important to our community in terms of improving and monitoring Māori health outcomes. These indicators were identified in our forecast Statement of Performance Expectations for 2020/21 using the symbol (◆). The results for Māori are presented below to highlight progress in reducing equity gaps. The NZ average results are the national results for Māori.

SERVICE PERFORMANCE 2020/21

| MĀORI HEALTH INDICATORS | | | | | | | |
|---|---|---|---|---|---|---|---|
| Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori. | Note | 2018/19 Result | 2019/20 Result | 2020/21 Target | 2020/21 Result | 2020/21 NZ Av | |
| Māori babies exclusive/fully breastfed at LMC discharge | Q[49] | 76% | 64% | 75% | n.a | - | - |
| Māori babies exclusive/fully breastfed at three months | Q[49] | 48% | 55% | 70% | 48% | 47% | ✗ |
| Māori smokers, enrolled with a PHO, receiving advice and help to quit | Q[50] | 96% | 92% | 90% | 87% | 73% | ✗ |
| Māori smokers, identified in hospital, receiving advice and help to quit | Q | 92% | 89% | 95% | 93% | - | ↺ |
| Pregnant Māori women identified as smokers at confirmation of pregnancy with an LMC receiving advice and help to quit smoking | Q | 100% | 100% | 90% | 100% | - | ✓ |
| Māori children receiving a B4 School Check at age four | A[51] | 98% | 97% | 90% | 84% | 81% | ✗ |
| Māori four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention | Q[52] | 83% | 100% | 95% | 60% | 91% | ✗ |
| Māori women (25-69) having a cervical smear in the last three years | A[53] | 68% | 68% | 80% | 68% | 59% | ↺ |
| Māori women (50-69) having a breast screen in the last two years | A | 70% | 67% | 70% | 74% | 62% | ✓ |
| Māori babies fully immunised at eight months of age | A[54] | 83% | 81% | 95% | 84% | 77% | ↺ |
| Eligible Māori completing the HPV vaccination programme | A[55]† | n/a | 47% | 75% | 49% | 59% | ↺ |

[49] Breastfeeding data at LMC discharge for 2020/21 has not yet been released nationally. Performance against the three-month target is disproportionately impacted by small population numbers reflecting seven fewer children being breastfed than in the previous year. The DHB continues to invest in pregnancy and parenting courses and lactation support for mothers to encourage breastfeeding. An error was identified in the 2018/19 three-month breastfeeding result for Māori reported in the 2019/20 annual report. The reported result of 64% was incorrect and has been updated in this year's annual report to 48%.

[50] The ABC programme refers to health professionals Asking about smoking status, providing Brief advice and providing Cessation support. The fall in performance reflects several things: the impact of COVID lockdowns, the redeployment of staff onto COVID programmes and the resignation of our Smokefree Coordinator during the last half of the year. A new Coordinator is in place and we expect rates to pick up again as the new person gets established in the role.

[51] 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. Three more Māori children received their B4 school check than the previous year, the target was missed by just 9 children over the course of the year.

[52] Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. A referral for children identified with weight concerns allows families to access support to maintain healthier lifestyles. Performance against the target is disproportionately impacted by small population numbers with just two Māori children missed in 2020/21.

[53] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. There were 34 more screens completed in 2020/21 compared with 2019/20 which reflects an increase in the number of women engaged in the programme but also the increasing population, with 49 more women eligible for screen in comparison to the previous year.

[54] The West Coast has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. In 2020/21, there were 10 Māori children who were not fully immunised at eight months of age.

[55] Human Papillomavirus (HPV) vaccination coverage is strongly impacted by the views of our Gloriavale community who do not vaccinate. The redeployment of our public health nurses to support the COVID-19 vaccine programme also further impacted further on our results. We are anticipating this will pick up in the coming year with more dedicated vaccinators engaged in the COVID programme. The target was missed by 88 children over the course of the year.

| MĀORI HEALTH INDICATORS CONTINUED… | | | | | | | |
|---|---|---|---|---|---|---|---|
| Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori. | Note | 2018/19 Result | 2019/20 Result | 2020/21 Target | 2020/21 Result | 2020/21 NZ Av | |
| Older Māori (65+) having had a seasonal influenza vaccination | A[56]† | 50% | 44% | 75% | 58% | - | ↺ |
| Māori new-borns enrolled with a PHO by three months of age | A[57] | 88% | 74% | 85% | 72% | 72% | ✖ |
| Māori population enrolled with a PHO | A[58] | 86% | 90% | 95% | 88% | 84% | ✖ |
| Enrolled Māori, identified with a long-term condition, engaged in the primary care LTCM programme | A[59] | 266 | 266 | >233 | 203 | - | ✖ |
| Enrolled Māori population (15-74), identified with diabetes having an annual diabetes review | A[60] | 81% | 84% | >85% | 71% | - | ✖ |
| Māori with diabetes, having an annual review and HbA1c test, with acceptable glycaemic control | Q[60] | 42% | 50% | 60% | 48% | - | ✖ |
| Māori children (0-4) enrolled in DHB oral health services | A[61] | 90% | 77% | 95% | 74% | - | ✖ |
| Māori children (0-12) examined according to planned recall | T[61]† | 93% | 97% | 90% | 84% | - | ✖ |
| Māori women registered with an LMC by 12 weeks of pregnancy | A[62] | 77% | n.a | 80% | n.a | - | - |
| Outpatient appointments where a Māori patient was booked but did not attend the appointment | Q[63] | 15% | 16% | <6% | 9% | - | ↺ |

[56] 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. The increased focus on respiratory illness in 2020/21 helped the West Coast administer 1,037 more vaccinations including 55 more vaccinations to Māori than the previous year.

[57] Small population numbers disproportionately impact performance against this target. The number of babies born increased slightly compared with 2019/20, the target was missed by just 10 children over the course of the year. The Newborn Multi-Enrolment Form process has been reviewed to ensure notification is completed soon after birth even if the baby is not returning to the West Coast immediately.

[58] The number of Māori enrolled with a PHO increased to 3,562 in 2020/21 compared with 3,482 in 2019/20, however the population increased by 150 in this time which is reflected in the lower overall enrolment rates. The PHO is working closely with Poutini Waiora (our Māori health provider) to engage Māori who are new to the region with a general practice.

[59] This measure refers to the primary care long-term conditions 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. People are confirmed as engaged in the programme through contact with their general practice and the drop-off in comparison to the previous years is related to people's reluctance to attend general practice during lockdowns and higher alert levels, capacity issues for general practice who have prioritised the COVID response above recalling patients and refinement of the data over the past year to ensure the count is reflecting unique individuals even if they have more than one long-term condition. The West Coast PHO is closely tracking these numbers to ensure that people are getting the support they need to manage their condition.

[60] The number of diabetes annual reviews declined from 104 to 92, and the number of Māori with unacceptable glycaemic control increased from 41 to 47 in the 12 months covered by this report. This is unsurprising with primary stretched across several competing priorities and staff redeployed to support the COVID vaccination programme. The Whakakotahi Whanau Ora model is being used in general practices across the West Coast to better engage with high need, low access, Māori patients and provide wrap-around support to them and their whānau. We expect this work will support improved outcomes in 2021/22.

[61] The COVID lockdown in 2020 significantly impacted the delivery of community dental services on the West Coast. Due to the small team and the spread of our rural population it was difficult to catch up with examinations after the programme had to be suspended. Additional capacity and clinical oversight is being sought to help improve performance in the coming year.

[62] Data is sourced from the Ministry's national Maternity Clinical Indicators report and is a year in arrears. The 2019 data is yet to be released.

[63] This performance reflects the considerable efforts of our Hauora Māori team working with services and the clinical booking unit over the past year to identify and reduce barriers to people attending appointments. This work will continue in the coming year with more service reviewing their booking processes and working with the team to identify ways in which access to services can be improved.

# Part IV
# Managing our Business

# Board's Report and Statutory Disclosure

To the stakeholders on the affairs of the Board for the year ended 30 June 2021

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, West Coast DHB recorded a net deficit of $8.034m against the budgeted deficit of $2.306m (2020 result was a net deficit of $18.969m).

| Board and committee member attendance | Board | | QFARC[64] | | ADVISORY[65] | |
|---|---|---|---|---|---|---|
| | Attended | Maximum Meetings | Attended | Maximum Meetings | Attended | Maximum Meetings |
| **Board Members** | | | | | | |
| Chris Auchinvole | 8 | 8 | | | 4 | 4 |
| Hon Rick Barker | 8 | 8 | 4 | 4 | 4 | 4 |
| Susan Barnett | 8 | 8 | | | 3 | 4 |
| Sarah Birchfield | 8 | 8 | 4 | 4 | 4 | 4 |
| Helen Gillespie | 8 | 8 | 4 | 4 | 2 | 4 |
| Anita Halsall-Quinlan | 8 | 8 | | | 4 | 4 |
| Tony Kokshoorn | 7 | 8 | 4 | 4 | 3 | 4 |
| Edie Moke | 8 | 8 | 4 | 4 | 4 | 4 |
| Peter Neame | 7 | 8 | | | 4 | 4 |
| Nigel Ogilvie | 7 | 8 | 4 | 4 | 3 | 4 |
| Francois Tumahai | 7 | 8 | | | 2 | 4 |
| **Committee Members** | | | | | | |
| Lynnette Beirne | | | | | 4 | 4 |
| Dr Cheryl Brunton | | | | | 4 | 4 |
| Joseph Mason | | | | | 4 | 4 |
| Paula Cutbush | | | | | 4 | 4 |
| Chris Lim | | | | | 4 | 4 |

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

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

## Directors' and Board members' loans

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

## Directors' and Board members' insurance

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

## Use of Board information

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

## Information on Ministerial directions

### WHOLE OF GOVERNMENT APPROACH

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

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

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

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

### AUTHENTICATION SERVICES

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

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

### ELIGIBILITY DIRECTION

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

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

### COVID-19 RESPONSE DIRECTION

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

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

# People at the Heart of All We Do

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

We are committed to an ethos of co-design, which includes engaging our people in the development, ongoing review, and renewal of programmes and policies. To that end, we continue to engage our people via multiple channels, initiatives, and programmes.

Amongst this work is the development or updating of People and Capability policies and processes across both West Coast DHB and Canterbury DHB, including our Code of Conduct, Health and Safety Policy and Diversity, Inclusion and Belonging Policy.

| Staff Ethnicity[66] | Number |
|---|---|
| New Zealand European | 412 |
| Māori | 46 |
| British and Irish | 40 |
| Indian | 38 |
| Other European | 38 |
| Other Ethnicity | 24 |
| Filipino | 22 |
| European | 11 |
| Other Asian | 15 |
| Australian | 7 |
| African | 5 |
| Chinese | 5 |
| Dutch | 4 |
| Other Southeast Asian | 4 |
| Middle Eastern | 3 |
| Other Pacific Peoples | 5 |
| Unknown | 437 |
| Grand Total | 1,116 |

| Staff Mix by Average Age[66] | Average age |
|---|---|
| Medical | 42.28 |
| Nursing | 50.14 |
| Allied Health | 52.34 |
| Support | 54.77 |
| Management & Administration | 50.14 |

| Staff Mix by Gender[66] | Number | Percentage |
|---|---|---|
| Female | 933 | 83.6% |
| Male | 183 | 16.4% |
| Total | 1,116 | 100% |

| Staff Identifying a Disability[66] [67] | Number |
|---|---|
| Yes | 37 |

### Leadership, Accountability and Culture

Healthcare is fundamentally about people caring for people. To deliver high quality care to the community, the West Coast health system puts people - and their care - at the heart of all decisions. To achieve this requires a culture where we care for our people, as much as we care for our patients. This means we need leadership that is responsive and accountable to our people and provides clarity of purpose based on bringing the right people together, at the right time, to provide the right service.

To create a broad network of widely distributed clinical and operational leadership, the 20 DHBs have committed to implementing a shared approach to talent management and leadership development, underpinned by the Public Services Commission [PSC], formally known as State Services Commission [SSC], framework used by the core public sector. This approach allows the West Coast DHB to create transferable leaderships skills across DHBs and the public sector.

To develop leadership capability across the West Coast DHB a leadership development initiative, called the Hub for the Essentials of Leadership and Management (HELM), was developed in partnership with Canterbury DHB.

HELM is a learning initiative designed to support everyone to lead through blended learning solutions accessible to all staff. In addition, it offers targeted development programmes to address key areas of leadership development need.

[66] Source: Payroll and max. as at August 2021

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

### Recruitment, Selection and Induction

West Coast DHB is committed to a shared approach to talent acquisition and management including attracting, selecting and engaging people across the West Coast health system, regionally and nationally for the needs of today and into the future. To achieve this, we are taking a talent lifecycle approach from succession planning and strategic sourcing, to selection, candidate care and induction. As part of this approach we are reviewing workforce strategies and planning for the coming years, to support a rural health generalist West Coast health system by maximising opportunities that result in faster recruitment turnaround and more engaged employees; thereby ultimately improving the patient journey and patient outcomes throughout the West Coast health system.

As part of these approaches we are fully committed to enhancing our practices with respect to equity and diversity. There will be a significant focus on ensuring our recruitment, selection and induction processes are equitable and embrace the development of a diverse workforce. We are also active participants in the development of consistent regional approaches to talent management and sourcing and associated support systems; as well as influencing the shape of national direction in this critical area.

### Workplace Wellbeing, Health and Safety

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by professional leads in Wellbeing, Health and Safety. Our teams include experts in workplace safety, occupational health, rehabilitation, and employee mental health and wellbeing. In addition to working alongside our people and health and safety representatives, advice and support are provided to all levels of management.

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

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

- Health monitoring programme which includes screening and immunisation
- Free annual influenza vaccinations
- Development and promotion of resources to foster the wellbeing of our people
- Promotion of a safe work environment and safe work practices
- Workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training
- Facilitating connecting to care for our people if they need mental health support

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

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

### Equal Opportunities and Positive Behaviours

We are an organisation that is committed to practices which minimise all forms of discrimination, bullying and harassment in the workplace as well as barriers to the recruitment, retention, development and promotion of our employees. This year, a new Equity and Diversity team was created within our People and Capability function that will lead work to better hire, support and grow our diverse workforce with a particular focus on our Māori workforce as well as Pacifica peoples, tāngata with disabilities, our LGBTQIA+ workforce and other minority groups thereby enabling us as an organisation to better reflect the community we serve.

We continue to review our processes and practices, deliver organisational initiatives and learning, and ensure we continue to review our talent acquisition and development practices to enable all people to be successful.

As part of our commitment to diversity and inclusion, we are working to grow our organisational ability to actively provide more opportunities for people with disabilities who face barriers to employment.

We remain committed to identifying and dealing with all examples of unacceptable behaviour. This year saw a refreshed version of our Code of Conduct developed and communicated to all new and existing staff which clearly outlines a strengths-based approach to how our people are expected to behave at work. We continue to have conversations with staff and managers about what is and is not acceptable behaviour and often take a restorative approach to ensuring people's behaviours are in line with our organisational values.

### Remuneration and Recognition

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

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

### Employee Engagement

In May 2021 the first employee engagement since 2016 was run to better understand how our tāngata (people) were feeling and to use that information to drive quick wins as well as short-, and long-term goals. The survey, Tāngata Ora, was composed of around 60 questions and available for 15 days receiving 5144 responses (42% of staff) from both the Canterbury and West Coast District Health Boards.

Several common themes appeared which assisted both DHBs in developing appropriate and effective actions. In this respect, our divisional leaders utilised the results to develop and implement action plans for their respective teams.

The mahi of Tāngata Ora will continue with a follow-up survey in 2022 establishing an annual measure of employee engagement and satisfaction with the organisation.

### Employee Development and Promotion

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

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

West Coast DHB focuses on creating a great learning experience that is accessible for all employees. This includes partnering with other DHBs to develop a fit for purpose learning management platform to meet our organisational needs

West Coast DHB has a system to record performance and development conversations and processes between managers and their staff called My Success and Development. This service now. based system was a change from the largely paper based approach that the organisation previously used. The online system has been rolled out with feedback reviewed and incorporated into future system updates. The system is also supported by delivery of online learning and workshops to introduce the organisation to having great success and development conversations whilst setting realistic and measurable goals

# Part V
# Financial Performance

# Statement of Comprehensive Revenue and Expense [68]

For the year ended 30 June 2021

IN THOUSANDS OF NEW ZEALAND DOLLARS

| | Note | 2020/21 Actual | 2020/21 Budget | 2019/20 Actual |
|---|---|---|---|---|
| **Revenue** | | | | |
| Patient care revenue | 2(i) | 178,080 | 171,296 | 161,577 |
| Other operating revenue | 2(ii) | 818 | 4,381 | 644 |
| Interest revenue | | 52 | 48 | 81 |
| **Total revenue** | | **178,950** | **175,725** | **162,302** |
| | | | | |
| **Expenses** | | | | |
| Personnel costs | 3 | 74,015 | 70,515 | 78,835 |
| Depreciation and amortisation expense | 9,10 | 5,382 | 4,082 | 2,733 |
| Outsourced services | | 10,398 | 8,857 | 10,893 |
| Clinical supplies | | 9,795 | 9,255 | 9,503 |
| Infrastructure and non-clinical expenses | | 9,209 | 9,005 | 10,211 |
| Payments to other health service providers | | 73,787 | 70,087 | 66,954 |
| Other operating expenses | 4 | 1,294 | 1,490 | 1,449 |
| Finance costs | | 2 | - | 3 |
| Capital charge | 5 | 3,102 | 4,740 | 690 |
| **Total expenses** | | **186,984** | **178,031** | **181,271** |
| | | | | |
| **Net surplus/(deficit)** | | **(8,034)** | **(2,306)** | **(18,969)** |
| | | | | |
| **Other comprehensive revenue & expenses** | | | | |
| Gain/(losses) on revaluation of land and buildings | 14 | 5,518 | - | - |
| **Total other comprehensive revenue & expenses** | | 5,518 | - | - |
| | | | | |
| **Total comprehensive revenue & expenses** | | **(2,516)** | **(2,306)** | **(18,969)** |

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

# Statement of Changes in Equity [69]

For the year ended 30 June 2021

IN THOUSANDS OF NEW ZEALAND DOLLARS

| | Note | 2020/21 Actual | 2020/21 Budget | 2019/20 Actual |
|---|---|---|---|---|
| Balance at 1 July | | **3,050** | **14,958** | 14,087 |
| Total comprehensive revenue & expenses | | (2,516) | (2,306) | (18,969) |
| **Owner transactions** | | | | |
| Capital contributions from the Crown | | 122,887 | 137,564 | 8,000 |
| Repayment of capital to the Crown | | (68) | (68) | (68) |
| **Balance at 30 June** | 14 | **123,353** | **150,148** | **3,050** |

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

# Statement of Financial Position [70]

As at 30 June 2021

IN THOUSANDS OF NEW ZEALAND DOLLARS

| | Note | 2020/21 Actual | 2020/21 Budget | 2019/20 Actual |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current assets** | | | | |
| Cash and cash equivalents | 6 | 3,415 | 6,383 | 6,153 |
| Receivables | 7 | 5,649 | 4,491 | 4,459 |
| Inventories | 8 | 1,311 | 1,160 | 1,044 |
| Patient deposits | 15 | 72 | 56 | 72 |
| **Total current assets** | | **10,447** | **12,090** | **11,728** |
| | | | | |
| **Non-current assets** | | | | |
| Property, plant and equipment | 9 | 162,107 | 167,457 | 35,326 |
| Intangible assets | 10 | 971 | 1,863 | 817 |
| **Total non-current assets** | | **163,078** | **169,320** | **36,143** |
| **Total assets** | | **173,525** | **181,410** | **47,871** |
| | | | | |
| **Liabilities** | | | | |
| **Current liabilities** | | | | |
| Payables and deferred revenue | 11 | 15,183 | 14,749 | 13,262 |
| Employee entitlements and benefits | 13 | 33,049 | 14,052 | 29,223 |
| Patient deposits and restricted funds | 15,16 | 83 | 62 | 83 |
| **Total current liabilities** | | **48,315** | **28,863** | **42,568** |
| | | | | |
| **Non-current liabilities** | | | | |
| Employee entitlements and benefits | 13 | 1,857 | 2,399 | 2,253 |
| **Total non-current liabilities** | | **1,857** | **2,399** | **2,253** |
| **Total liabilities** | | **50,172** | **31,262** | **44,821** |
| | | | | |
| **Net assets/equity** | | | | |
| Contributed capital | 14 | 216,677 | 231,354 | 93,858 |
| Revaluations | 14 | 28,957 | 25,098 | 25,100 |
| Accumulated surpluses/(deficits) | 14 | (122,281) | (106,304) | (115,908) |
| **Total equity** | | **123,353** | **150,148** | **3,050** |
| **Total equity and liabilities** | | **173,525** | **181,410** | **47,871** |

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

# Statement of Cash Flows [71]

For the year ended 30 June 2021

IN THOUSANDS OF NEW ZEALAND DOLLARS

| | Note | 2020/21 Actual | 2020/21 Budget | 2019/20 Actual |
|---|---|---|---|---|
| **Cash flows from operating activities** | | | | |
| Receipts from Ministry of Health, patients and other revenue | | 179,442 | 175,629 | 162,055 |
| Payments to suppliers | | (95,601) | (91,634) | (87,651) |
| Payments to employees | | (79,317) | (77,918) | (75,347) |
| Interest received | | 52 | 96 | 81 |
| Interest paid | | - | - | (3) |
| Goods and services tax (net) | | (158) | (12) | 532 |
| Capital charge paid | | (3,102) | (4,740) | (690) |
| **Net cash flow from operating activities** | 17 | **1,316** | **1,421** | **(1,023)** |
| | | | | |
| **Cash flows from investing activities** | | | | |
| Receipts from sale of property, plant and equipment | | - | 12 | - |
| Purchase of property, plant and equipment | | (5,743) | (10,016) | (6,744) |
| Purchase of intangible assets | | (183) | (1,248) | (372) |
| **Net cash flow from investing activities** | | **(5,926)** | **(11,252)** | **(7,116)** |
| | | | | |
| **Cash flows from financing activities** | | | | |
| Capital contributions from the Crown | | 1,940 | 15,064 | 8,000 |
| Repayment of capital to the Crown | | (68) | (68) | (68) |
| **Net cash flow from financing activities** | | **1,872** | **14,996** | **7,932** |
| | | | | |
| Net increase /(decrease) in cash and cash equivalents | | (2,738) | 5,165 | (207) |
| Cash and cash equivalents at the start of the year | | 6,153 | 1,218 | 6,360 |
| **Cash and cash equivalents at the end of year** | 6 | **3,415** | **6,383** | **6,153** |

Buildings totalling $120.9m (2020: nil) were acquired by means of equity injection during the year.

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

# Notes to the Financial Statements

For the year 30 June 2021

## 1. Statement of Accounting Policies

### Reporting entity

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

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

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

The financial statements are for the year ended 30 June 2021, and were approved for issue by the Board on 30 March 2022.

### Basis of preparation

#### HEALTH SECTOR REFORMS

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

#### OPERATING AND CASH FLOW FORECASTS

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 13 prior to 1 July 2022, additional financial support would be needed from the Crown.

#### LETTER OF COMFORT

The Board has received a letter of comfort dated 13 October 2021 from the Ministers of Health and Finance. The letter of comfort states that the Government is committed to working with West Coast DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

#### AUDIT COMPLETED LATE

The Audit was completed on 30 March 2022. This was completed later than required by the Crown Entities Act 2004, section 156(3)(a). This was due to an auditor shortage in New Zealand and the consequential effects of COVID-19, including lockdowns.

### Statement of compliance

The financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP). An exception was observed regarding the compliance of the Crown Entity Act 2004, where the audit was completed at a date later than required by Crown Entities Act 2004, due to the reasons in the paragraph above

The financial statements have been prepared in accordance with 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:

*Amendment to PBE IPSAS 2 Cash Flow Statement*

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ending 30 June 2022, with early application permitted. This amendment will result in additional disclosures. West Coast DHB does not intend to early adopt the amendment.

*PBE FRS 48 Service Performance Reporting*

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. West Coast DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. It does not plan to early adopt the standard

*Financial instruments*

PBE IPSAS 41 Financial Instruments replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2022, with earlier adoption permitted.

West Coast DHB have not adopted PBE IFRS 9 and the standard is no longer available for adoption. West Coast DHB plans to apply PBE IPSAS 41 in preparing its 30 June 2022 financial statements. West Coast DHB has not yet assessed the effects of the new standard.

## Summary of significant accounting policies

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

### GOODS AND SERVICES TAX (GST)

All items in the financial statements are exclusive of goods and services tax (GST), apart from 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 2020/21 statement of performance expectations. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

### CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

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

- Classification of leases – refer to note 4.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

In preparing these financial statements, the Board 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 in respect of:

- Estimating the fair value of land and buildings – refer to Note 9.
- Measuring the liabilities for Holidays Act 2003 remediation, long service leave, retirement gratuities, sabbatical leave, and continuing medical education leave – refer to Note 13.

## 2. Revenue

ACCOUNTING POLICY

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

### Ministry of Health population-based funding

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

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

### Ministry of Health contract revenue

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

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

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

### Inter-district flows

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

### ACC contract revenue

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

### Interest revenue

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

### Provision of other services

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

### Other grants

Non-government grants are recognised as revenue when they become receivable unless there is an obligation to return the funds if conditions of the grant are not met. If there is such an obligation the grants

are initially recorded as grants received in advance, and recognised as revenue when conditions of the grant are satisfied.

### Sale of goods or services

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

### Donations, trust and bequest funds

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

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

### Vested or donated physical assets

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

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

### Donated services

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

## 2(i) Breakdown of patient care revenue

| | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| MoH population-based funding | | 164,581 | 148,419 |
| Inter-district flows | | 2,231 | 2,052 |
| Ministry of Health other contracts & other government contracts | | 1,765 | 1,435 |
| ACC contract revenue | | 1,707 | 1,662 |
| Other patient care related revenue | | 7,796 | 8,009 |
| **Total patient care revenue** | | **178,080** | **161,577** |

## 2(ii) Breakdown of other operating revenue

| | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| Cash donations and bequests received | | 191 | 9 |
| Rental revenue | | 156 | 135 |
| Training and Development | | 104 | 88 |
| Gain on sale of Fixed Assets | | 16 | 14 |
| Other | | 351 | 398 |
| **Total other operating revenue** | | **818** | **644** |

### Revenue Appropriation

Under the Public Finance Act, West Coast DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by

West Coast DHB for the financial year 2021 is $158.59m (2020: $142.29m) which equals the Government's actual expenses incurred in relation to the appropriation.

| Revenue Appropriation | | | |
|---|---|---|---|
| | Note | Actual $'000's | MOH Budget $'000's |
| Original Appropriation | | 150,957 | 151,334 |
| Supplementary Estimates | | 3,722 | 3,722 |
| **Total appropriation revenue** | | **154,679** | **155,056** |

## 3. Employee Benefit Costs

ACCOUNTING POLICY

Salaries and wages

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

Superannuation schemes

*Defined contribution schemes*

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

*Defined benefit schemes*

West Coast DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

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

The funding arrangements for the scheme are governed by section 44 of the National Provident Fund Restructuring Act 1990 and by a Trust Deed. This Act requires that any increase or decrease to the employer contribution rate should result in contributions being at a level which, on reasonable assumptions, is likely to achieve neither a surplus nor deficit in the trust fund of the scheme at the time that the last contributor to that scheme ceases to so contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and the interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

In practice, at present, a single contribution rate is determined for all employers, which is expressed as a multiple of the contributions of members of the scheme who are employees of that employer. The current employer contribution rate is three times contributor contributions, inclusive of Employer Contribution Withholding Tax. The Actuary has recommended a stepped approach to changing the employer contribution rate, as follows:

- 1 April 2021 – 31 March 2022: Four times contributor contributions
- From 1 April 2022: Five times contributor contributions

There is no minimum funding requirement.

As at 31 March 2021, the scheme had a past service surplus of $1.3m or 2.2% of the liabilities (2020: $2.8m deficit or 4.1% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. This surplus was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 39 Employee Benefits.

| Breakdown of personnel costs and further information | | | |
|---|---|---|---|
| | Note | 2020/21 Actual | 2019/20 Actual |
| Wages, salaries and other personnel costs | | 65,340 | 64,019 |
| Contributions to defined contribution schemes | | 2,081 | 1,983 |
| Increase/(Decrease) in liability for employee entitlements | | 3,826 | 1,499 |
| Increase/(Decrease) in Holidays Act compliance provision | | 2,749 | 11,300 |
| Restructuring expenses | | 19 | 34 |
| | | **74,015** | **78,835** |

[72]

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

### Remuneration of employees

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

A total of 158 employees (2020: 142) received total remuneration of greater than $100,000. The figure stated includes payment for additional duties, lump sum payments, including payment of back pay and employer contributions to superannuation and KiwiSaver schemes.

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

Of the 158 employees, 142 are clinical employees (2020: 127) and 16 are non-clinical employees (2020: 15).

[72] The 2019/20 comparative figures have been restated to correct a classification error. There is no change to the total employee cost.

| Remuneration of Employees earning more than $100,000 per annum | | |
|---|---|---|
| Specified band | 2020/21 Actual | 2019/20 Actual |
| $100,000 - $109,999 | 51 | 42 |
| $110,000 - $119,999 | 18 | 17 |
| $120,000 - $129,999 | 18 | 21 |
| $130,000 - $139,999 | 16 | 15 |
| $140,000 - $149,999 | 14 | 11 |
| $150,000 - $159,999 | 1 | 2 |
| $160,000 - $169,999 | 9 | 5 |
| $170,000 - $179,999 | 3 | - |
| $180,000 - $189,999 | 1 | 1 |
| $190,000 - $199,999 | 2 | 2 |
| $200,000 - $209,999 | 1 | 1 |
| $210,000 - $219,999 | - | 3 |
| $220,000 - $229,999 | 3 | 2 |
| $230,000 - $239,999 | 1 | - |
| $240,000 - $249,999 | 1 | 2 |
| $250,000 - $259,999 | - | - |
| $260,000 - $269,999 | 1 | 1 |
| $270,000 - $279,999 | 1 | 1 |
| $280,000 - $289,999 | 2 | 1 |
| $290,000 - $299,999 | 1 | - |
| $300,000 - $309,999 | 3 | 2 |
| $310,000 - $319,999 | 1 | 2 |
| $320,000 - $329,999 | 2 | 2 |
| $330,000 - $339,999 | 1 | 1 |
| $340,000 - $349,999 | 3 | 1 |
| $350,000 - $359,999 | - | 2 |
| $360,000 - $369,000 | 1 | - |
| $370,000 - $379,999 | - | 1 |
| $380,000 - $389,000 | 2 | 1 |
| $390,000 - $399,000 | - | - |
| $400,000 - $409,999 | 1 | 3 |
| $410,000 - $419,999 | - | - |
| $420,000 - $429,999 | - | - |
| $430,000 - $439,999 | - | - |
| **Total employees** | **158** | **142** |

### Compensation and other benefits in relation to cessation of employment

During the year, the Board made payments to 1 former employee (2020: nil) in respect of the termination of their employment totalling $8k (2020: nil). These payments include amounts required to be paid pursuant to employment contracts in place, for example amounts for redundancy (based on length of service), and payment in lieu of notice.

### Board & Committee fees

| Total value of remuneration paid to each Board member during the year was (in whole dollars): | | | | |
|---|---|---|---|---|
| Year ended 30 June 2021 | Board | QFARC | Advisory Committee | 20/21 Total |
| **Board members** | | | | |
| Chris Auchinvole | 17,122 | - | 1,000 | 18,122 |
| Rick Barker | 34,658 | 1,000 | 1,000 | 36,658 |
| Susan Barnett | 17,923 | - | 1,129 | 19,052 |
| Sarah Birchfield | 17,065 | 1,000 | 1,000 | 19,065 |
| Helen Gillespie | 17,310 | 1,004 | 316 | 18,630 |
| Anita Halsall-Quinlan | 17,915 | - | 1,474 | 19,389 |
| Tony Kokshoorn | 21,133 | 1,000 | 750 | 22,883 |
| Edie Moke | 17,371 | 1,000 | 1,000 | 19,371 |
| Peter Neame | 17,121 | - | 1,250 | 18,371 |
| Nigel Ogilvie | 17,093 | 1,133 | 816 | 19,042 |
| Francois Tumahai | 17,095 | - | 500 | 17,595 |
| **Total** | **211,806** | **6,137** | **10,235** | **228,178** |

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

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

No Board members received compensation or other benefits in relation to cessation (2020: Nil).

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

| Total value of remuneration paid to each Committee member during the year was (in whole dollars): | |
|---|---|
| Year ended 30 June 2021 | 20/21 Total |
| **Advisory committee members** | |
| Lynnette Beirne (CPHAC&DSAC) | 1,130 |
| Paula Cutbush (HAC) | 1,506 |
| Chris Lim (HAC) | 1,000 |
| Joseph Mason (CPHAC&DSAC) | 1,177 |
| **Total** | **4,813** |

Total fees paid, or payable to Board & Committee members for the year was $232,991(2020: $228,504)

## 4. Other Operating Expenses

ACCOUNTING POLICY

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

### Operating leases

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

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

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

| Breakdown of other operating expenses | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| Impairment of debtors | 7 | 65 | 103 |
| Loss on disposal of property, plant and equipment | 9 | 8 | 7 |
| Audit fees (for the audit of the financial statements-excl disbursement) | | 123 | 121 |
| Audit related fees for assurance and related services (Internal and Quality Audits) | | 79 | 77 |
| Board and advisory members fees | 3 | 233 | 228 |
| Operating lease expenses | | 455 | 565 |
| Other | | 331 | 347 |
| **Total operating expenses** | | **1,294** | **1,449** |

### Operating leases as leasee

West Coast DHB leases several buildings under operating leases.

| The future aggregate minimum lease payments to be paid under non-cancellable operating lease are as follows: | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| Not more than one year | | 65 | 111 |
| later than one year and not later than five years | | 71 | 24 |
| Later than five years | | 27 | - |
| **Total non-cancellable operating lease** | | **163** | **135** |

## 5. Capital Charge

ACCOUNTING POLICY

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

### Further information

The West Coast DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June and 31 December. The capital charge rate for the year ended 30 June 2021 was 5% (2020: 6%).

## 6. Cash and Cash Equivalents

ACCOUNTING POLICY

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

| Breakdown of cash and cash equivalents and further information | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| Bank balances and call deposits | | 3,415 | 6,153 |
| **Cash and cash equivalents in the statement of cash flows** | 21 | **3,415** | **6,153** |

### Bank Facility

West Coast DHB is a party to a DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit

balance with NZHPL, which will incur interest at credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2021, this limit was $8.115m (2020: $7.545m).

### Financial assets recognised subject to restrictions

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

The bank balance includes unspent donations received of $11k (2020: $11k) that are subject to restrictions. The restrictions generally specify how the donation is required to be spent (see note 16).

## 7. Receivables

ACCOUNTING POLICY

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

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

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

Breakdown of Debtors and other receivables

| | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| Trade receivables | | 83 | 433 |
| Ministry of Health receivables | | 4,775 | 2,992 |
| Other Crown receivables | | 212 | 420 |
| Accrued revenue | | 309 | 329 |
| Prepayments | | 339 | 312 |
| Less: Provision for un-collectability | | (69) | (27) |
| **Total receivables** | 21 | **5,649** | **4,459** |

The ageing profile of receivables at year end are as follows:

| | 2020/21 | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| | Gross Receivable | Provision for uncollectability | Net | Gross Receivable | Provision for uncollectability | Net |
| Not past due | 4,846 | - | 4,846 | 3,965 | - | 3,965 |
| Due 1-30 days | 146 | - | 146 | 77 | - | 77 |
| Past due 31-60 days | 30 | - | 30 | 17 | - | 17 |
| Past due 61-90 days | 587 | - | 587 | 352 | - | 352 |
| Past due more 90 days | 111 | (69) | 42 | 75 | (27) | 48 |
| **Total Gross Receivables** | **5,718** | **(69)** | **5,649** | **4,486** | **(27)** | **4,459** |

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

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

Trade receivables, prepayments and other receivables are from exchange revenue transactions. Receivables from the Ministry of Health can be a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in Receivables from the Ministry of Health is nil (2020: Nil).

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

| Movements in the provision for uncollectability of receivables | | | |
|---|---|---|---|
| | Note | 2020/21 Actual | 2019/20 Actual |
| Balance 1 July | | 27 | 19 |
| Receivables written off during the year | 4 | (23) | (149) |
| Additional provision made during the year | | 65 | 103 |
| **Closing balance 30 June** | | **69** | **27** |

## 8. Inventories

ACCOUNTING POLICY

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

Cost is principally determined on a weighted average cost basis.

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

| Breakdown of Inventories | | | |
|---|---|---|---|
| | Note | 2020/21 Actual | 2019/20 Actual |
| Pharmaceuticals | | 233 | 181 |
| Surgical and medical supplies | | 1,065 | 846 |
| Other supplies | | 13 | 17 |
| **Total Inventories** | | **1,311** | **1,044** |

There were no write-downs of inventories or reversal of prior year write-downs during the year (2020: Nil).

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

## 9. Property, Plant and Equipment

ACCOUNTING POLICY

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

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

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

### Revaluations

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

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

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

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

### Additions

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

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

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

### Subsequent costs

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

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

### Disposals

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

### 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 – 70 | 1.4% to 33% |
| Fit Out Plant and Equipment | 3 – 50 | 2% to 33% |
| Plant and Equipment | 2 – 20 | 5% to 50% |
| Motor Vehicles | 3 – 15 | 6.6% 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.

Property, plant, and equipment are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to its recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expense and decreases the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in surplus or deficit. For assets not carried at a revalued amount, the total impairment loss is recognised in surplus or deficit. The reversal of an impairment loss on a revalued asset is recognised in other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in surplus or deficit, a reversal of an impairment loss is also recognised in surplus or deficit.

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

### Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered valuer, Coast Valuations Limited. The valuation was completed in March 2021, and was reviewed and is effective as at 30 June 2021.

### Land

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

Restrictions on the DHB's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefit of outright ownership.

### Buildings

Specialised hospital buildings are valued using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions used in the 30 June 2021 valuation include:

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity. There have been optimisation adjustments made to Buller Health (based on proposed redevelopment plans) and the old Grey Base Hospital (in the process of being demolished) for the most recent valuation.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information. Construction costs range from $2,200 to $13,000 per square metre, depending on the nature of the specific asset valued.
- There are no significant asbestos issues associated with the buildings.
- There are no earthquake-prone issues associated with the buildings.
- The remaining useful life of assets is estimated after considering factors such as the condition of the asset, the DHB's future maintenance and replacement plans, and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.
- The valuers report included a statement of 'significant valuation uncertainty' due to COVID-19

Te Nikau Hospital and Health Centre construction project suffered delays and a dispute with one of the contractors, therefore it is unclear whether the actual costs incurred reflect current replacement costs. Construction costs of hospitals in other regions are less comparable due to different resource availability, building sizes and requirements and weather-related delays. There is a lack of major construction projects in the West Coast region to provide alternative replacement cost information relating to Te Nikau Hospital and Health Centre.

The following buildings were valued based on Depreciated Replacement Cost:

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

Non-specialised operational buildings (for example residential buildings) are valued using market-based evidence. The following market rents and capitalisation rates were used in the 30 June 2021 valuation:

- Market rents range from $250 to $300 per square metre.
- Capitalisation rates are market-based rates of return and range from 6.75% to 7.5%.

A comparison of the carrying value of buildings valued using depreciated replacement cost and buildings valued using market-based evidence is as follows:

| | **2020/21 $'000s** | **2019/20 $'000s** |
|---|---|---|
| Depreciated replacement cost | 136,600 | 10,957 |
| Market-based evidence | 10,090 | 7,743 |
| Total carrying value of buildings | 146,690 | 18,700 |

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

| Breakdown of property, plant and equipment | | | | | |
|---|---|---|---|---|---|
| | Land | Buildings & fit-out | Plant, equipment & vehicles | Work in progress | **Total** |
| **Cost or Valuation** | | | | | |
| Balance at 30 June 2020 | 6,855 | 15,356 | 22,897 | 11,932 | **57,040** |
| Additions | - | 126,224 | 5,217 | 123,933 | **255,374** |
| Disposals/transfers | - | (1,263) | 7 | (128,975) | **(130,231)** |
| Revaluation increase(decrease) | 1,855 | (2,391) | - | - | **(536)** |
| **Balance at 30 June 2021** | **8,710** | **137,926** | **28,121** | **6,890** | **181,647** |
| **Accumulated depreciation and impairment losses** | | | | | |
| Balance at 1 July 2020 | - | (3,348) | (18,366) | - | **(21,714)** |
| Depreciation charge for the year | - | (3,794) | (1,334) | - | **(5,128)** |
| Disposal/transfer | - | 1,153 | 95 | - | **1,248** |
| Elimination on revaluation | - | 6,054 | - | - | **6,054** |
| **Balance at 30 June 2021** | **-** | **65** | **(19,605)** | - | **(19,540)** |
| **Carrying amount 30 June 2021** | **8,710** | **137,991** | **8,516** | **6,890** | **162,107** |
| **Cost or Valuation** | | | | | |
| Balance at 30 June 2019 | 6,855 | 12,559 | 22,623 | 8,366 | **50,403** |
| Additions | - | 2,797 | 405 | 4,390 | **7,592** |
| Disposals/transfers | - | | (131) | (824) | **(955)** |
| **Balance at 30 June 2020** | **6,855** | **15,356** | **22,897** | **11,932** | **57,040** |
| **Accumulated depreciation and impairment losses** | | | | | |
| Balance at 30 June 2019 | - | (2,041) | (17,300) | - | **(19,341)** |
| Depreciation charge for the year | - | (1,417) | (1,066) | - | **(2,483)** |
| Disposal/transfer | - | 110 | - | - | **110** |
| **Balance at 30 June 2020** | **-** | **(3,348)** | **(18,366)** | **-** | **(21,714)** |
| **Carrying amount 30 June 2020** | **6,855** | **12,008** | **4,531** | **11,932** | **35,326** |

### Restrictions on title

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

### Work in progress

Buildings in the course of construction total $4.473m (2020: $7.403m).

### Finance Leases

West Coast DHB had no assets held under finance leases (2020: Nil).

### Capital Commitments

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

| Capital commitments | 2020/21 | 2019/20 |
|---|---|---|
| Buildings | 100 | 479 |
| Plant, equipment and vehicles | 563 | 1,498 |
| Intangibles | 25 | 271 |
| **Total capital commitments at balance date** | **688** | **2,248** |

## 10. Intangible Assets

ACCOUNTING POLICY

### Acquisition and development

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

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

### Amortisation

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

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

| | Years |
|---|---|
| Acquired computer software | 2-10 |

### Impairment

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

### Estimating useful lives of software assets

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

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

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

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

### Breakdown of intangible assets

Movements for each class of intangible assets are as follows:

| Breakdown of Intangibles | Acquired software | NZ Health Partnerships Ltd | **Total** |
|---|---|---|---|
| **Cost or Valuation** | | | |
| Balance at 30 June 2020 | 5,017 | 652 | **5,669** |
| Additions | 497 | - | **497** |
| Disposals/transfers | - | - | **-** |
| **Balance at 30 June 2021** | **5,514** | **652** | **6,166** |
| | | | |
| **Accumulated amortisation and impairment losses** | | | |
| Balance at 1 July 2020 | (4,520) | (332) | **(4,852)** |
| Amortisation charge for the year | (254) | - | **(254)** |
| Impairment Losses | - | (89) | **(89)** |
| **Balance at 30 June 2021** | **(4,774)** | **(421)** | **(5,195)** |
| **Carrying Value at 30 June 2021** | **740** | **231** | **971** |
| | | | |
| **Cost or Valuation** | | | |
| Balance at 30 June 2019 | 4,647 | 652 | **5,299** |
| Additions | 408 | - | **408** |
| Disposals/transfers | (38) | - | **(38)** |
| **Balance at 30 June 2020** | **5,017** | **652** | **5,669** |
| | | | |
| **Accumulated amortisation and impairment losses** | | | |
| Balance at 1 July 2019 | (4,271) | (332) | **(4,603)** |
| Amortisation charge for the year | (251) | - | **(251)** |
| Elimination on disposal/transfer | 2 | - | **2** |
| **Balance at 30 June 2020** | **(4,520)** | **(332)** | **(4,852)** |
| **Carrying Value at 30 June 2020** | **497** | **320** | **817** |

### Restrictions

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

### Capital commitments

West Coast DHB has contracted capital commitments of $25k (2020: $271k) in relation to intangible assets.

### Impairment of New Zealand Health Partnerships Limited (NZHPL)

An impairment of the NZHPL Change Management and Supply Chain as recommended by NZHPL, ($89k) was recognised in June 2021 (2020: $Nil). The impairment is to recognise the variation between the underlying value of the Finance Procurement Information Management (FPIM) programme asset held by NZHPL, and the underlying investment carried by DHBs.

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

- Class B Shares confer no voting rights.
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services.
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by NZHPL from the Finance, Procurement and Supply Chain Shared Service.
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company.
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.
- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

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

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

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

## 11. Payables and Deferred Revenue

ACCOUNTING POLICY

Short-term payables are recorded at the amount payable

| Breakdown of Payables and Deferred Revenue | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| **Payables and deferred revenue under exchange transactions** | | | |
| Creditors | | 2,078 | 1,636 |
| Accrued expenses | | 8,806 | 8,771 |
| Deferred revenue | | 1,946 | 592 |
| **Total payables and deferred revenue under exchange transactions** | | **12,830** | **10,999** |
| | | | |
| **Payables and deferred revenue under non-exchange transactions** | | | |
| Taxes payable | | 2,353 | 2,263 |
| Total Payables and deferred revenue under non-exchange transactions | | 2,353 | 2,263 |
| **Total Payables and deferred revenue** | | **15,183** | **13,262** |

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

## 12. Borrowings

ACCOUNTING POLICY

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

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

### Overdraft facility

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

### Finance leases

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

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

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

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

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICES

### Lease classification

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

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

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

West Coast DHB has a maximum overdraft limit of $8.115m (2020: $7.545m) with NZHPL as at 30 June 2021. Refer to note 6 for further information. As at 30 June 2021, the West Coast DHB had nil borrowings (2020: Nil).

## 13. Employee Entitlements

ACCOUNTING POLICY

### Short-term employee entitlements

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

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

### Sick leave

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

### Long-term employee entitlements

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

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

### Presentation of employee entitlements

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

### Sabbatical leave, long service leave and retirement gratuities

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

The discount rates used have been obtained from the NZ Treasury published risk-free discount rates as at 4 July 2021. The salary inflation factor has been determined after considering historical salary inflation patterns.

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying value amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $129,000 (2020: $170,000) higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $115,000 (2020: $165,000) higher/lower.

| Breakdown of Employee entitlements and benefits | | |
|---|---|---|
| | 2020/21 Actual | 2019/20 Actual |
| **Current portion** | | |
| Accrued salary and wages | 2,627 | 2,468 |
| Annual leave | 6,412 | 5,786 |
| Holidays Act Compliance provision | 19,234 | 16,490 |
| Continuing medical education leave and expenses | 1,239 | 1,047 |
| Long-service leave | 344 | 552 |
| Other leave | 2,086 | 1,915 |
| Retirement gratuities | 632 | 757 |
| Sabbatical leave | 101 | 101 |
| Sick leave | 374 | 107 |
| **Total current portion** | **33,049** | **29,223** |
| | | |
| **Non-current portion** | | |
| Long-service leave | 200 | 304 |
| Retirement gratuities | 1,597 | 1,811 |
| Sabbatical leave | 60 | 138 |
| **Total non-current portion** | **1,857** | **2,253** |
| **Total employee entitlements** | **34,906** | **31,476** |

### Holidays Act compliance

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

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

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

The remediation programme associated with the MOU is a significant undertaking and work to assess, rectify and remediate all areas of non-compliance will continue through the 2021/22 financial year. At West Coast DHB, the formal Review Phase, as set out in the MOU, was completed in March 2020 with all non-compliance issues identified. Efforts are now focused on rectifying payroll systems and processes to ensure ongoing compliance, as well as analysis, testing and remediating the results of retrospective areas of non-compliance for relevant individual employees.

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

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

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

## 14. Equity

ACCOUNTING POLICY

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

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

### Property revaluation reserves

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

| Breakdown of Equity | | | | |
|---|---|---|---|---|
| Reconciliation of movement in equity and reserves | Crown equity | Property revaluation reserve | Accumulated surpluses/ (deficits) | Total equity |
| **2020/21** | | | | |
| Balance at 1 July 2020 | 93,858 | 25,100 | (115,908) | 3,050 |
| Surplus/(deficit) for the year | - | - | (8,034) | (8,034) |
| Capital contributions from the Crown | 122,887 | - | - | 122,887 |
| Repayment of capital to the Crown | (68) | - | - | (68) |
| Movement in revaluation of land | - | 2,055 | - | 2,055 |
| Movement in revaluation of buildings, fixtures and fittings | - | 1,802 | 1,661 | 3,463 |
| **Balance at 30 June 2021** | **216,677** | **28,957** | **(122,281)** | **123,353** |
| **2019/20** | | | | |
| Balance at 1 July 2019 | 85,926 | 25,100 | (96,939) | 14,087 |
| Surplus/(deficit) for the year | - | - | (18,969) | (18,969) |
| Capital contributions from the Crown | 6,000 | - | - | 6,000 |
| Repayment of capital to the Crown | (68) | - | - | (68) |
| Other movement/adjustment | 2,000 | - | - | 2,000 |
| **Balance at 30 June 2020** | **93,858** | **25,100** | **(115,908)** | **3,050** |

### Capital management

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

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

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

## 15. Patient Deposits

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

| Movement of patient deposits | | | |
|---|---|---|---|
| | Note | 2020/21 Actual | 2019/20 Actual |
| Opening balance patients deposits | | 72 | 72 |
| **Closing balance** | | **72** | **72** |

## 16. Restricted Funds

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

| Movement of restricted funds | | | |
|---|---|---|---|
| | Note | 2020/21 Actual | 2019/20 Actual |
| Opening balance restricted funds | | 11 | 10 |
| Monies received | | - | 30 |
| Interest earned | | - | - |
| Payments made | | - | (29) |
| **Closing balance** | | **11** | **11** |

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

| | Note | 2020/21 Actual | 2019/20 Actual |
|---|---|---|---|
| **Net surplus/(deficit)** | | **(8,034)** | **(18,969)** |
| **Add/ (less) non-cash items:** | | | |
| Depreciation and amortisation expense | | 5,382 | 2,733 |
| ***Total non-cash items*** | | **5,382** | **2,733** |
| | | | |
| **Add/(less) items classified as investing or financing activities** | | | |
| Net (gain)/loss on disposal of property, plant and equipment | | (16) | - |
| Impairment on investments | | 89 | - |
| ***Total items classified as investing or financing activities*** | | **73** | - |
| | | | |
| **Movements in working capital:** | | | |
| (Increase)/decrease in receivables | | (1,190) | (544) |
| (Increase)/decrease in inventories | | (267) | 33 |
| Increase/(decrease) in payables and deferred revenue | | 1,922 | 2,925 |
| Increase/(decrease) in employee benefits | | 3,430 | 12,799 |
| ***Net movement in working capital*** | | **3,895** | **15,213** |
| | | | |
| **Net cash flow from operating activities** | | **1,316** | **(1,023)** |

## 18. Contingencies

### Contingent liabilities

SUPERANNUATION SCHEMES

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

### Outstanding legal proceedings

West Coast DHB has no material outstanding legal proceedings as at 30 June 2021 (2020: Nil).

### Contingent assets

The West Coast DHB has no contingent assets (2020: Nil).

## 19. Related Party Transactions

ACCOUNTING POLICY

Transactions eliminated on consolidation

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

West Coast DHB is controlled by the Crown.

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

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

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

### Significant transactions with government related entities

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

West Coast DHB has received funding from the Crown, ACC and other government entities of $168.02m to provide health services in the West Coast area for the year ended 30 June 2021 (2020: $151.52m). Refer to note 7 for amounts receivable.

Revenue earned from other DHBs for the care of patients domiciled outside West Coast DHB's district as well as services provided to other DHBs amounted to $2.23m for the year ended 30 June 2021 (2020: $2.05m).

Expenditure to other DHBs for the care of patients from West Coast DHB's district and services provided from other DHBs amounted to $29.14m for the year ended 30 June 2021 (2020: $23.07m).

### Other significant transactions with government-related entities

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

West Coast DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2021 totalled $4.42m (2020: $1.77m). These purchases included capital charge from Ministry of Health, blood products from the New Zealand Blood Service, electricity from Genesis Energy and services from educational institutions.

### Compensation of key management personnel

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

At June 2021, the executive management team consisted of 4 members (2020: 4) employed by West Coast DHB and a further 8 members, including the Chief Executive, who were employed by Canterbury DHB (2020: 7). The key management personnel services provided by the Office of the Chief Executive are provided to West Coast DHB under contract by Canterbury DHB and are invoiced accordingly - 2021: $318k (2020: $312k).

No executive management personnel were Board members (2020: Nil).

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

| Compensation of key management personnel | 2020/21 Actual | 2019/20 Actual |
|---|---|---|
| **Board Members** | | |
| Remuneration | 228,178 | 223,254 |
| Full-time equivalent members | 2.15 | 2.15 |
| | | |
| **Executive management** | | |
| Remuneration | 987,313 | 978,167 |
| Post -employment benefits | 24,445 | 24,977 |
| Full-time equivalent members | 3.70 | 3.8 |
| **Total key management personnel remuneration** | **1,239,936** | **1,226,398** |
| **Total full-time equivalent members** | **5.85** | **5.95** |

## 20. Events after Balance Date

- COVID-19 continues to have an operational impact on the West Coast DHB. On 17 August 2021, all New Zealand moved to Alert Level 4. During September and October 2021 all New Zealand except Auckland and Northland moved to Alert Level 3 and 2. On 2 December 2021, New Zealand moved to the COVID-19 Protection Framework, also known as the traffic light system. The Ministry of Health has continued to fund applicable COVID-19 response related activities since balance date.
- On the weekend of 17 July 2021, Westport was impacted by a significant weather event; as a result of flooding the West Coast DHB wrote off 19 vehicles. The YTD costs of this event (as at 30 December 2021) are $495k.
- On 21 December 2021 the Minister of Finance and the Minister of Health jointly approved the Grey Base Acute Mental Health Facility project with a Crown equity contribution of $20m.
- During the month of December 2021, the West Coast DHB processed payments for the MECA settlement totalling $3.363m. The West Coast DHB received funding of $2.698m in December 2021 from the Ministry of Health to fund these payments.
- West Coast DHB received $6m of deficit support on 17 January 2022 from the Ministry of Health.

## 21. Financial Instruments

### Financial instrument categories

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

| | 2020/21 Actual | 2019/20 Actual |
|---|---|---|
| **Loans and receivables** | | |
| Cash and cash equivalents | 3,415 | 6,153 |
| Receivables | 5,649 | 4,459 |
| **Total loans and receivables** | **9,064** | **10,612** |
| | | |
| **Financial liabilities measured at amortised cost** | | |
| Payables (excluding deferred revenue and taxes) | 10,884 | 10,407 |

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

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

## Financial instrument risks

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

### MARKET RISK

#### *Price risk*

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

#### *Fair value interest rate risk*

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

#### *Cash flow interest rate risk*

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

#### *Currency risk*

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. West Coast DHB has low currency risk given that most financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2021 (2020: Nil)

#### *Credit risk*

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

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

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

Concentrations of credit risk of accounts receivable are high due to the reliance on the Ministry of Health, which comprises 85% (2020: 67%) of the debtors of West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHBs) total reliance on government debtors is 88% (2020: 76%). The Board considers the risk arising from this concentration of credit to be very low.

*Credit quality of financial assets*

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

| Credit quality of financial assets | 2020/21 Actual | 2019/20 Actual |
|---|---|---|
| **Counterparties with credit ratings** | | |
| Bank of New Zealand Limited AA- | 105 | 141 |
| **Total cash and cash equivalents** | **105** | **141** |
| | | |
| **Counterparties without credit ratings** | | |
| NZ Health Partnerships Limited - no defaults in the past | 3,368 | 6,065 |
| Cash on Hand | 6 | 6 |
| Gross receivables (not past due) | 4,844 | 3,965 |
| **Total Counterparties without credit ratings** | **8,218** | **10,036** |

LIQUIDITY RISK

*Management of liquidity risk*

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

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

*Contracted maturity analysis of financial liabilities*

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

| Maturity groupings of financial liabilities | Carrying amount | Contracted cash flows | Less than 1 year | 1-2 years | More than 2 years |
|---|---|---|---|---|---|
| **2020/21** | | | | | |
| Payables | 15,183 | 15,183 | 15,183 | - | - |
| **Total** | **15,183** | **15,183** | **15,183** | - | - |
| **2019/20** | | | | | |
| Payables | 13,262 | 13,262 | 13,262 | - | - |
| **Total** | **13,262** | **13,262** | **13,262** | - | - |

## 22. Explanation of Major Variances against Budget

Explanations for major variances from the DHB's budgeted figures in the 2020/21 Annual Plan are as follows:

### Statement of Comprehensive Revenue and Expense

REVENUE

Revenue had a 1.8% favourable variance between our actual revenue of $178.950m compared to planned revenue of $175.725m. The main factors influencing this favourable variance were:

- Favourable variance in debt/equity and Capital Charge funding of $0.900m
- Additional planned care revenue of $0.400m
- Additional population-based funding revenue of $0.800m
- Inter-District Flows revenue is favourable to budget $0.400m
- COVID-19 related revenue $1.067m

EXPENSES

Expenses had a 5.0% unfavourable variance between our planned expenditure of $178.031m compared to actual expenditure of $186.984m. The main factors influencing this overspend were:

- Personnel costs were unfavourable to budget due to personnel related to the COVID-19 vaccination programme of $0.674m, MECA accrual for impending settlement $1.138m, Holidays Act provision $2.7m, as well as circa 17 FTE for cleaning personnel brought inhouse.
- Outsourced personnel $1.541m over budget relates to locum costs to cover vacancies and unplanned leave.
- Depreciation costs were unfavourable to budget $1.300m due to higher depreciation on the new Te Nikau Facility with additional charge of $1.600m for the year.
- Expenditure on clinical supplies was $0.620m higher than budgeted primarily due to increased costs of pharmaceutical and blood products.
- COVID-19 related clinical & non-clinical expenses of $0.272m.
- Infrastructure and non-clinical expenses were unfavourable to budget mainly driven by transport and travel $0.210m unfavourable to budget.
- Capital charge expense is favourable due to change in the calculation rate from 6% to 5%.

### Statement of Financial Position

The favourable variance in Property Plant and Equipment against budget reflects the delay in actual spend against the Buller Integrated Family Health Centre redevelopment project. This delay also drives the variance in the contributed capital. We had budgeted quarterly drawdowns which were not drawn down due to the timing of the actual spend against the project.

Employee entitlements variance mainly relates to the Holidays Act 2003 remediation liability and higher leave entitlements then budgeted at year end.

### Statement of Changes in Equity

Opening balance was $11.908m less than budget due to last year's deficit being lower than planned, relating to the Holidays Act Provision.

### Statement of Cash Flow

In the Annual Plan, purchase of Property Plant and Equipment included $8m for the Buller facility. The Buller facility is now expected to be completed in 2023. This is offset by an equity injection from the Crown.

## 23. Summary of Cost of Services

ACCOUNTING POLICY

*Cost allocation*

The cost of outputs has been determined using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output. Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged based on asset utilisation. Personnel costs are charged based on actual time incurred. Property and other premises costs, such as maintenance, are charged based on floor area occupied to produce each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

The table below summarises the revenue and expenditure for the four output classes for the year ended 30 June 2021.

| | 2020/21 Actual | 2020/21 Budget | 2019/20 Actual |
|---|---|---|---|
| **Revenue** | | | |
| Prevention | 3,705 | 3,878 | 3,357 |
| Early Detection and Management | 34,681 | 33,646 | 38,926 |
| Intensive Assessment and Treatment | 114,010 | 114,216 | 91,354 |
| Rehabilitation and Support | 26,554 | 23,984 | 28,662 |
| **Total Revenue** | **178,950** | **175,724** | **162,299** |
| | | | |
| **Expenditure** | | | |
| Prevention | 4,931 | 4,607 | 4,751 |
| Early Detection and Management | 36,351 | 34,735 | 48,600 |
| Intensive Assessment and Treatment | 119,437 | 115,793 | 96,734 |
| Rehabilitation and Support | 26,265 | 22,895 | 31,183 |
| **Total Expenditure** | **186,984** | **178,030** | **181,268** |
| | | | |
| **Surplus/(Deficit)** | **(8,034)** | **(2,306)** | **(18,969)** |

## 24. The Effects of COVID-19 on West Coast DHB

The effect of COVID-19 on our 2020/21 operations is reflected in these financial statements, based on the information available as at 30 June 2021. The forecasted impact of COVID-19 on West Coast DHB's outyears performance is dependent on several uncertain parameters and the long-term impact will take some time to determine; and will include factors impacting our variable revenue streams such as electives, IDF and ACC, and the costs associated with these such as additional costs required to catch up on lost throughput to meet performance targets.

The main impacts on the 2020/21 financial statements due to COVID-19 are explained below.

### Government funding

The Ministry of Health provided additional $1.067m funding in 2020/21 to the West Coast DHB for COVID-19 response and vaccination programme. This funding was distributed through the DHB to the West Coast PHO, general practitioners and aged care providers.

### Operating expenses

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

- An increase in payroll costs of $0.674m - The pandemic presented unique challenges for staffing and roster modelling to ensure both staff and patient safety, which has led to higher payroll costs. Other contributing additional costs include substantially lower level of leave taken since the pandemic declaration.
- Treatment related costs of $0.044m - These additional costs are comprised of consumables to ensure that all DHB staff and patients had appropriate access to PPE, as well as costs incurred managing testing sites.
- Other expenses of $0.091m - other expenses include advertising costs to keep the community, staff and patients informed, additional security, costs to establish vaccination centres & IT equipment.

### Balance sheet impacts

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

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

# Part VI
# Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

# Independent Auditor's Report

## To the readers of West Coast District Health Board's financial statements and performance information for the year ended 30 June 2021

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

We have audited:

- the financial statements of the Health Board on pages 41 to 76, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board on pages 21 to 33.

## Opinion

### Unmodified opinion on the financial statements

In our opinion:

- the financial statements of the Health Board on pages 41 to 76, which have been prepared on the disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and

### Qualified opinion on the performance information

In our opinion, except for the possible effects of the matter described in the *Basis for our opinion* section of our report, the performance information of the Health Board on pages 9 to 33:

- presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2021, including:
    - for each class of reportable outputs:
        - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and
        - its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and
- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 30 March 2022. This is the date at which our opinion is expressed.

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

## Basis for our opinion

**Our work was limited in the prior year because the Health Board was unable to report reliably on waiting times for mental health and alcohol, and other drug services**

An important part of the Health Board's performance information is reporting on waiting times for mental health and alcohol, and other drug services. As explained in footnote 38 on page 28 of the performance information, coding inconsistencies were identified in the prior year with regards to the mental health wait time data, for both the three and eight-week time measures.

Because insufficient reliable evidence was available in the prior year, our work was limited and there were no practicable audit procedures we could apply to obtain assurance that the reported information fairly reflected the performance against these measures for 30 June 2020. Our audit opinion on the performance information for the year ended 30 June 2020 was modified accordingly.

This issue has been resolved for the 30 June 2021 year. As the issue cannot be resolved for the 30 June 2020 year, the Health Board's performance information reported for these performance measures for the 30 June 2021 year may not be directly comparable to the 30 June 2020 performance information.

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

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

## Emphasis of matters

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

***The financial statements have been prepared on a disestablishment basis***

The Basis of preparation note on page 46 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all district health boards and establish a new Crown entity, Health New Zealand, is expected to come into effect on 1 July 2022. The Health Board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity at their carrying value.

The Health Board also describes that if it was required to settle the Holidays Act compliance provision disclosed in note 13 prior to 1 July 2022, additional financial support would be needed from the Crown. The Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board with equity support up until Health New Zealand is established.

***Uncertainties in estimating the holiday pay provision under the Holidays Act 2003***

Note 13 on page 66 outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board has estimated a provision of $19 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

***Uncertainty over the fair value of Te Nikau Hospital and Health Centre***

Note 9 on page 59 outlines that there is less certainty in estimating the fair value of the new hospital, Te Nikau Hospital and Health Centre, than there would have been under normal circumstances for the reasons provided by the Health Board. A 'significant valuation uncertainty' statement was also included in the valuer's report due to Covid-19.

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

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand. The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

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

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

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

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

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

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

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

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

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

involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.
- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.
- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.
- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board.
- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.
- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision, and performance of the of the Health Board audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

## Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 7 and 35 to 39, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on

our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

## Independence

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

Other than the audit, we have no relationship with, or interests in, the Health Board.

John Mackey
Audit New Zealand
On behalf of the Auditor-General
Christchurch, New Zealand