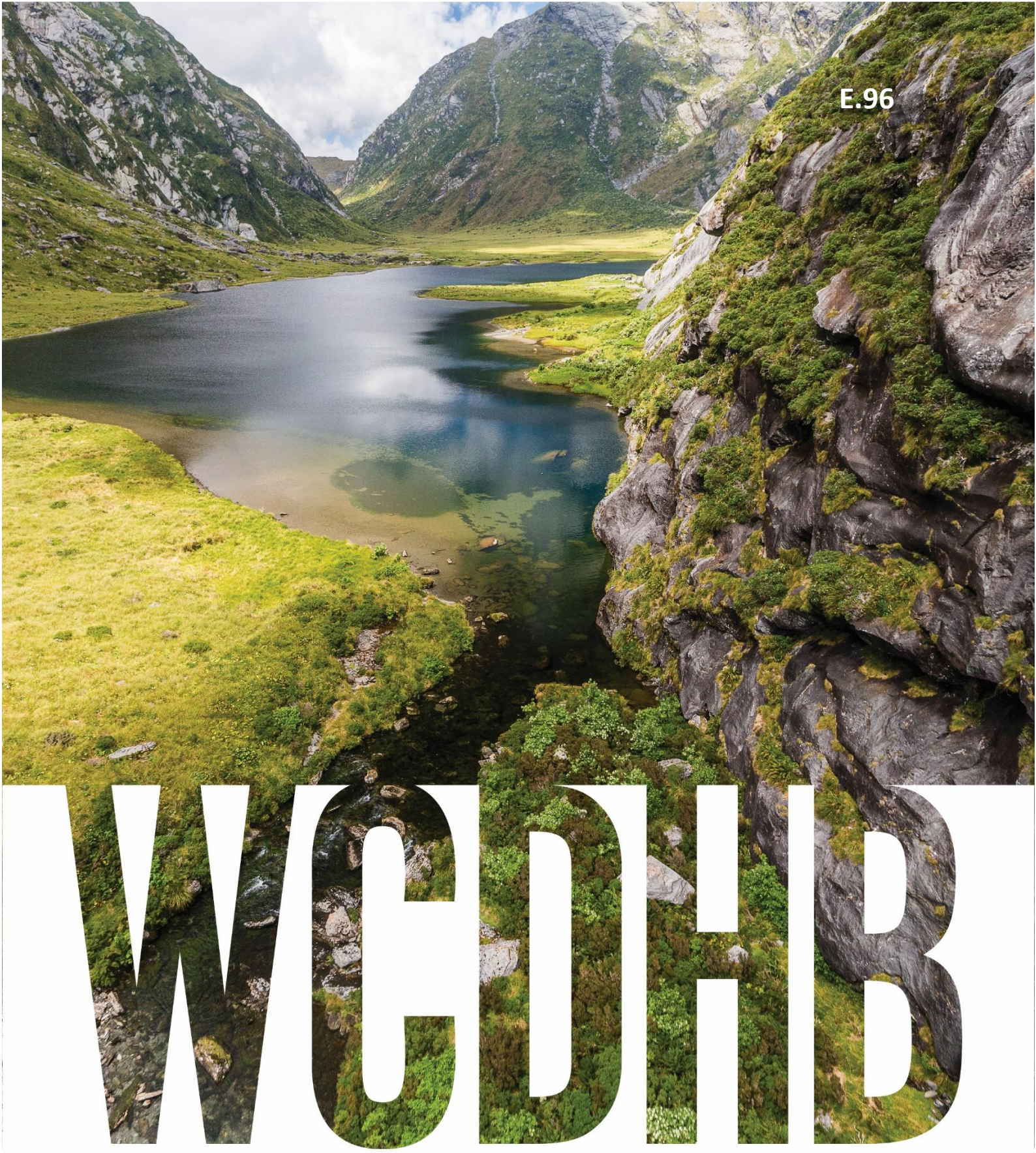

WEST COAST DISTRICT HEALTH BOARD
STATEMENT OF PERFORMANCE EXPECTATIONS 2021/22

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

Cover picture provided by Development West Coast – taken in Haast on the West Coast.

Statement of Joint Responsibility

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

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

Linking with our Statement of Intent, and System Level Measures Improvement Plan, this document describes our strategic and operational goals in terms of improving the health of our population and ensuring the sustainability of our health system. It also highlights service performance expectations for the coming year and presents our financial forecasts for 2021/22 and the subsequent outyears.

The Statement of Performance Expectations is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in the DHB's Annual Reports, published annually on our website.

The West Coast DHB works collaboratively and in partnership with other service providers, agencies and organisations to improve health outcomes for the West Coast population. This includes our participation in several clinically-led Alliances, the West Coast Alliance with the West Coast PHO, the South Island Regional Alliance with our four partner South Island DHBs, and our transalpine partnership with the Canterbury DHB.

We also recognise our role and responsibility in actively addressing inequities in health outcomes for Māori and are committed to making a difference. We work closely with Tatau Pounamu (our Manawhenua advisory group) and Poutini Waiora (our kaupapa Māori provider) in a spirit of partnership and co-design that encompasses the principles of Te Tiriti o Waitangi and seeks to achieve health equity for Māori on the West Coast.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity for the coming year and is in line with Government expectations for 2021/22.

Honourable Rick Barker
CHAIR | WEST COAST DHB

Tony Kokshoorn
DEPUTY CHAIR | WEST COAST DHB

Dr Peter Bramley
CHIEF EXECUTIVE | WEST COAST DHB

August 2021

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OVERVIEW

Who are we and what do we do?

Introducing the West Coast DHB

1.1 Who are we?

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

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

In 2021/22, we will receive approximately $188m to meet the needs of our population. In accordance with legislation, and consistent with Government objectives, we will use that funding to:

Plan and, in collaboration with clinical leads, alliance partners, and iwi, develop demand strategies and determine the services we need in place to improve the health and wellbeing our population.

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

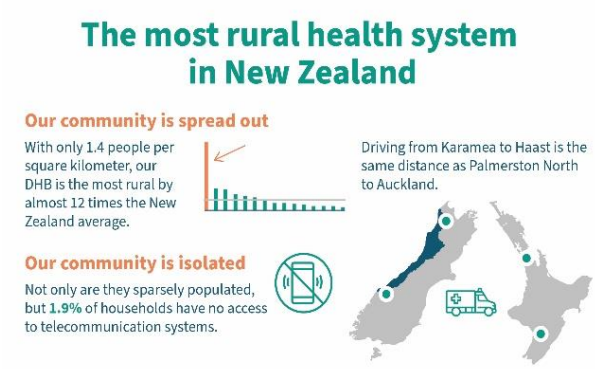
Provide health services to our population, through our hospital and specialist services, general practices, and community and home-based support services.

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

1.2 What makes us different?

The West Coast DHB has the smallest population of any DHB in the country. We are responsible for 32,395 people, 0.6% of the total New Zealand population.

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



Unlike most other DHBs, we own and operate four of the seven general practices on the Coast; we also operate a district nursing and home-based support service. This makes us a major local employer and more than 1,000 people are employed by the DHB.

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

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

A transalpine service partnership, established with the Canterbury DHB in 2010, means Canterbury specialists are providing regular outpatient clinics and surgical lists on the West Coast. This partnership, and a deliberate investment in telehealth technology, is providing our population with improved access to specialised services and reducing the need to travel long distances for assessment and treatment.

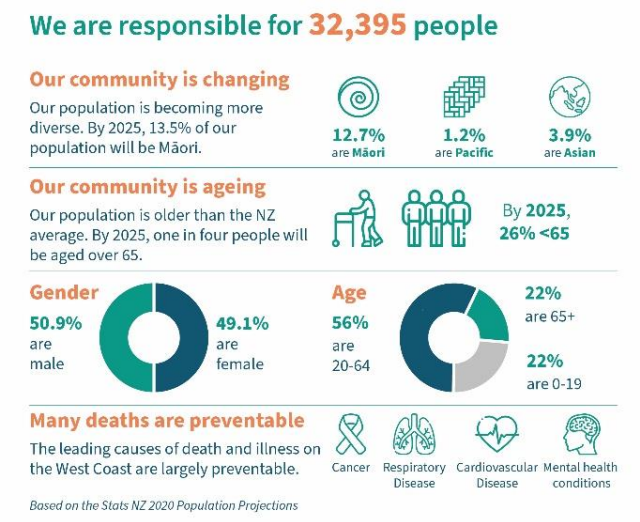
1.3 Our population profile

While the population of New Zealand continues to grow the West Coast population of 32,395 has been relatively static and is predicted to slowly decrease over the next ten years. As a result, our population's age structure is significantly older than the rest of New Zealand, with 22% of our population aged over 65, compared with the national average of 16%.

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

Our population is increasingly diverse and there are currently 4,120 Māori living on the West Coast (12.7% of our population). By 2025 that proportion is predicted to increase to 13.3%. This is contrary to the trend for overall population on the West Coast and is driven by migration and a younger age structure amongst our Māori population.

Latest population statistics show 9.7% of our Māori population is aged under five, compared to 4.7% of our non-Māori population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on the health needs of our younger Māori population.



We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others and along with age and ethnicity, deprivation and disability are strong predictors of the need for health services.

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

The 2013 national Disability Survey suggests 24% of the total population and 26% of Māori identify as disabled. The Survey estimated around 41,000 people were living with a disability in the Nelson, Tasman, Marlborough and West Coast region. Using the national rate, that would translate to almost 7,800 people in our population. For adults the main impairments are physical (47%) and hearing (20%) disabilities and for children they are learning, speaking, and developmental delays (54%).

1.4 Our population's health

West Coast Māori continue to have poorer overall health status and a lower life expectancy (78.3 years) than the national rate (80.4 years), but the inequity is slowly reducing. At 2.1 years, the differential between Māori and non-Māori on the West Coast is considerably better than the national gap, where Māori life expectancy (75.1 years) is almost 6.3 years lower than non-Māori.

Many long-term conditions become more common with age, including heart disease, stroke, and dementia. As people age they develop more complex health needs and are more likely to need specialist services. The increasing prevalence of long-term physical and mental health conditions is one of the main drivers of demand for health services on the Coast.

In 2019/20, almost 4,000 people (12% of our population) were identified as having one or more long-term conditions, such as heart disease, respiratory disease, cancer, diabetes and depression, and were enrolled with our primary care long-term conditions programme.

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

- 26% of our total population and 44% of our Māori population are current smokers, much higher than the national average of 16.2%.
- More than a third (35%) of our total adult population and more than half (56%) of our Māori population are classified as obese.
- 10% of our total adult population were identified as inactive (little or no physical activity). Rates for Māori were similar at 13%.
- 16% of our adult population are likely to drink in a hazardous manner. While lower than the national average, it reflects hazardous drinking habits for one in eight adults on the Coast.

A reduction in these known risk factors could dramatically improve health outcomes for our population and reduce pressure on our health system. All four risk factors have strong socio-economic links, so changing these behaviours would also contribute to reducing health inequities between population groups.

1.5 Our operating challenges

Like the rest of the health sector, the West Coast DHB is experiencing growing demand pressure as our population ages; and increasing fiscal pressure as treatment and wage costs raise.

Persistent inequities in health outcomes tell us that we need to do things differently and we cannot address the wider determinants of health inequity on our own. We need to part with iwi, other government agencies and service providers to increasingly address socioeconomic factors that impact significantly on health status, access and outcomes.

We also face several unique challenges due to our size and geographic isolation which add to our operating challenges.

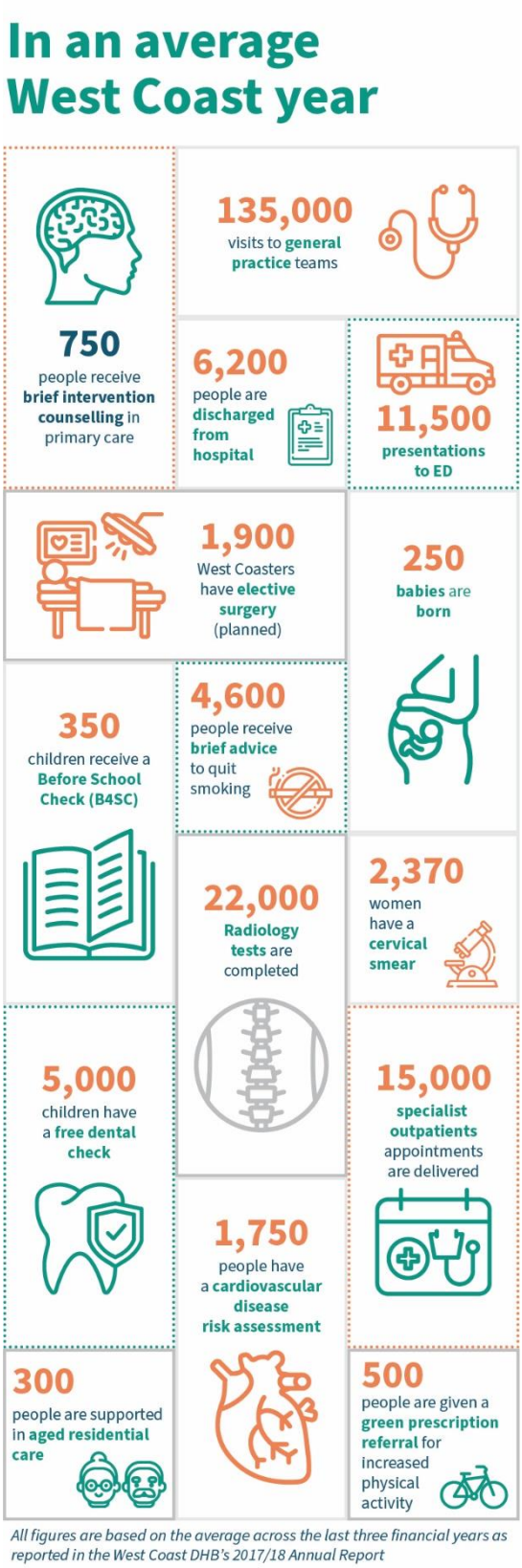
Rurality: Covering the largest geographical area with the smallest population and health workforce means patients and health professionals often have to travel long distances to access or deliver services. Our rurality is one of our biggest challenges and magnifies all the operating pressures we face.

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

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

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

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



All figures are based on the average across the last three financial years as reported in the West Coast DHB's 2017/18 Annual Report

THE YEAR AHEAD

What can you expect from us in 2021/22?

Monitoring Our Performance

2.1 Improving health outcomes

As part of our accountability to our community and Government, we must be able 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 equity for our population and the sustainability of our health system. In our funder role, 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, the experience of the people we serve, and the safety and wellbeing of the people who work for us.

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

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

At the highest level, the framework reflects our three strategic objectives and identifies three wellbeing goals, where we believe our success will have a positive impact on the health of our population.

Aligned to each goal, we have identified several population health indicators which will provide insight into how well our system is performing over time. These indicators are also reflected in the DHB's System Level Measures Improvement Plan developed in partnership with the West Coast PHO and available on our website.

2.2 Improving service performance

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

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

Over the shorter-term, we evaluate our service performance by monitoring ourselves against a forecast of the service we plan to deliver and the standards we expect to meet. The DHB reports annually against our Service Performance alongside our Financial Performance in our Annual Reports which can be found on our website.

The Intervention Logic Diagram (Appendix 2), illustrates how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to our longer-term goals, the goals of the wider South Island region and the expectations of Government.

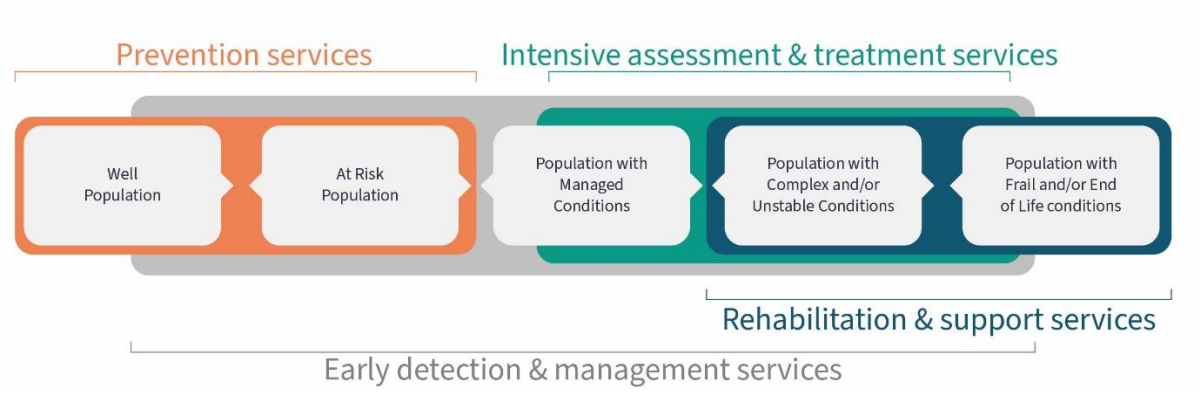
The following section presents the West Coast DHB's Statement of Performance Expectations for 2021/22.

2.3 Accountability to the Ministry

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

The DHB's obligations include quarterly performance reporting in line with the Ministry's non-financial performance monitoring framework. This framework aims to provide a rounded view of DHB performance in key priority areas and uses a mix of performance markers across five dimensions. The framework and expectations for 2020/21 are presented in the DHB's Annual Plan.

Statement of Performance Expectations



3.1 Evaluating our performance

IDENTIFYING PERFORMANCE MEASURES

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

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

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

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

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

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

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

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

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

SETTING STANDARDS

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

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

In considering our drive towards equity, performance targets are universal, set with the aim of reducing disparities between population groups. Key focus areas have been identified to improve Māori health and breakdowns by ethnicity are aligned to each measure.

While targeted interventions can reduce service demand in many 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.

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

PERFORMANCE EXPECTATIONS

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

the national expectations are particularly challenging to meet in this regard.

The pressures on our system in 2021/22 will be compounded by the unknown impact of the COVID-19 pandemic. Our future environment may be quite different, depending on how the pandemic plays out in New Zealand and around the world. While many of the longer-term population goals and service level expectations (outlined in our Statement of Intent) are unlikely to change, our ability to deliver against them may be compromised by changes in people's environments and economic situations.

NOTES FOR THE READER

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

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

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

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

3.2 Where does the money go?

In 2021/22 the DHB will receive approximately $188m million dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2021/22, by service class.

	2021/22
Revenue	
Prevention	3,698
Early detection & management	33,778
Intensive assessment & treatment	122,329
Rehabilitation & support	28,231
Total Revenue - $'000	188,036
Expenditure	
Prevention	3,888
Early detection & management	35,629
Intensive assessment & treatment	130,270
Rehabilitation & support	29,932
Total Expenditure - $'000	199,719
Surplus/(Deficit) - $'000	(11,683)

3.3 Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services are those that promote and protect the health of the whole population, or targeted sub-groups, and influence individual behaviours by targeting changes to physical and social environments to engage, influence and support people to make healthier choices. These services include: the use of legislation and policy to protect the population from environmental risks and communicable disease; education programmes and services to raise awareness of risk behaviours and healthy choices; and health protection services such as immunisation and screening programmes that support people to modify lifestyles and maintain good health.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Health Services – Healthy Environments					
These services address aspects of the physical, social and built environment to protect health and improve health outcomes.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q[1]	Total	14	15	E.15
Licensed alcohol premises identified as compliant with legislation	Q[2]	Total	96%	100%	>90%
Tobacco retailers identified as compliant with legislation	Q[2]	Total	100%	100%	>90%

Health Promotion and Education Services					
These services inform people about risk factors and support them to make healthy choices. Success is evident through high levels of engagement.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Mothers receiving breastfeeding and lactation support in community settings	A	Total	193	228	E>150
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q[3]	Māori	67%	n.a	75%
		Total	76%	n.a	
Babies exclusively/fully breastfed at three months	Q	Māori	64%	55%	70%
		Total	61%	64%	
People provided with Green Prescriptions for physical activity support	A	Total	458	450	E>400
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q[4]	Māori	96%	92%	90%
		Total	96%	93%	
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q	Māori	92%	89%	95%
		Total	91%	91%	
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[5]	Māori	100%	100%	90%
		Total	100%	100%	

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

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

[3] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. These measures are part of the national Well Child/Tamariki Ora Quality Framework and data from providers is not able to be combined so performance from the largest provider (Plunket) is presented. The 2018/19 baseline differs to the previous year's reported result due to a transcribing error it was reported as 76% and should have been 67%.

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

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

Population-Based Screening Services					
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Four-year-olds provided with a B4 School Check (B4SC)	A[6]	Māori	98%	97%	90%
		Total	93%	94%	
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q	Māori	83%	100%	95%
		Total	94%	100%	
Women aged 25-69 having a cervical cancer screen in the last 3 years	A[7]	Māori	68%	68%	80%
		Total	72%	72%	
Women aged 45-69 having a breast cancer screen in the last 2 years	A[7]	Māori	68%	66%	70%
		Total	76%	69%	
People aged 60-74 participating in the national bowel screening programme	A	Māori	new	new	60%
		Total	new	new	

Immunisation Services					
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates indicate a well-coordinated, successful service.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Children fully immunised at eight months of age	A[8]	Māori	83%	81%	95%
		Total	79%	78%	
Proportion of eight-month-olds 'reached' by immunisation services	Q	Total	96%	95%	95%
Children fully immunised at two years	A	Māori	94%	90%	95%
		Total	83%	82%	
Young people (Year 8) completing the HPV vaccination programme	A[9]❖	Māori	30%	47%	75%
		Total	30%	53%	
Older people (65+) receiving a free influenza ('flu') vaccination	A[10]❖	Māori	50%	44%	75%
		Total	55%	58%	

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

[7] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment. The measures refer to national screening programme results and standards. From July 2021 the national expectation for Breast Screening was extended to include women 45 to 69 years. Reported baseline results have been updated from previous years. Results are no longer comparable with previously published results.

[8] The West Coast has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. The DHB's focus is to immunise all those who opt-in to the immunisation programme. 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided with advice to enable them to make informed choices for their children - but may have chosen to decline immunisations or opt off the NIR.

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

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

3.4 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

The New Zealand health system is experiencing an increasing prevalence of long-term conditions, so-called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age. Cancer, cardiovascular disease, diabetes, and respiratory disease are the four leading long-term conditions for our population.

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

General Practice Services					
These services support people to maintain their health and wellbeing. High levels of engagement are indicative of an accessible, responsive service.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Newborns enrolled with a PHO by three months of age	A	Māori	88%	74%	85%
		Total	95%	90%	
Proportion of the population enrolled with a Primary Health Organisation	A	Māori	86%	90%	95%
		Total	94%	96%	
Youth (12-19) accessing brief intervention/counselling in primary care	A[11Δ]	Total	159	90	E>150
Adults (20+) accessing brief intervention/counselling in primary care	A[Δ]	Total	498	427	E>450
Number of integrated HealthPathways in place across the health system	Q[12]	Total	683	677	E 600

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	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A[13]	Māori	266	266	E. >200
		Total	4,045	3,959	E>3,500
Enrolled population (15-74), identified with diabetes, having an annual diabetes review	A	Māori	81%	84%	>85%
		Total	85%	61%	
Population with diabetes, having an annual review and HbA1c test, demonstrating acceptable glycaemic control (HbA1c <64 mmol/mol)	Q[14]	Māori	42%	50%	60%
		Total	53%	56%	

[11] 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.

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

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

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

Oral Health Services					
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Children (0-4) enrolled in school and community oral health services	A[15]❖	Māori	90%	77%	95%
		Total	101%	88%	
Enrolled children (0-12) receiving their oral health exam according to planned recall	T❖	Māori	93%	97%	90%
		Total	96%	98%	
Adolescents (13-17) accessing DHB-funded oral health services	A[16]❖	Total	76%	73%	85%

Pharmacy and Referred Services					
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of subsidised pharmaceutical items dispensed in the community	AΔ	Total	471k	498k	E<500K
People receiving their urgent diagnostic colonoscopy within two weeks	T[17]	Total	88%	95%	90%
Number of community-referred radiological tests delivered	A	Total	6,035	5,570	E>5,500
People receiving Magnetic Resonance Imagining (MRI) scans within six weeks	T	Total	82%	91%	90%
People receiving Computed Tomography (CT) scans within six weeks	T	Total	99.7%	95%	95%

[15] Oral health is an integral component of lifelong health and wellbeing. Early and continued contact with oral health services helps to set life-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[16] Adolescent oral health data is provided by the Ministry of Health. No data is available for Māori utilisation.

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

3.5 Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety					
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Staff compliance with good hand hygiene practice	Q[18]	Total	84%	81%	80%
Inpatients (aged 75+) receiving a risk assessment to reduce serious harm from falls	Q	Total	68%	71%	90%
Patients responding to the national inpatient patient experience survey	P[19]	Total	28%	35%	>30%
Proportion of patients who responded in the survey that 'hospital staff included their family/whānau or someone close to them in discussions about their care'	P	Total	55%	64%	65%

Specialist Mental Health and Alcohol and Other Drug (AOD) Services					
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Proportion of the population (0-19) accessing specialist mental health services	A[20Δ]	Māori	6.2%	5.6%	>3.8%
		Total	5.3%	5.5%	
Proportion of the population (20-64) accessing specialist mental health services	A[Δ]	Māori	9.7%	9.6%	>3.8%
		Total	5.6%	6.0%	
People referred for non-urgent mental health and AOD services seen within 3 weeks	T[21]	Total	81%	n.a	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	Total	92%	n.a	95%

[18] 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

[19] There is growing evidence that patient experience is a good indicator of the quality of health services and stronger partnerships and family-centred care have been linked to improved health outcomes. The national DHB inpatient experience survey covers four patient experience domains: communication, partnership, co-ordination and physical and emotional needs.

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

[21] Coding inconsistencies were identified with regards to the mental health wait time data for 2019/20, for both the three and eight-week wait time measures. The DHB was unable to undertake a reconciliation process in time to confirm the results for the year prior to the publishing of this report. Work is ongoing to review the data collection and coding processes to ensure the accuracy of results going forward.

Maternity Services					
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of maternity deliveries in West Coast DHB facilities	A	Total	241	246	E.250
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[22]❖†	Māori	81%	n.a	80%
		Total	81%	n.a	
Baby Friendly Hospital accreditation achieved in DHB facilities	Q	Total	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	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of unplanned presentations at the Emergency Department (ED)	A	Total	11,829	11,043	E<13,000
People admitted, discharged or transferred from ED within 6 hours of presentation	T	Māori	98%	99%	95%
		Total	98%	98%	
Proportion of people presenting in ED (in triage 1-3), seen within clinical guidelines	T[23]	Total	77%	83%	85%
Proportion of people presenting at ED triaged in category 4 or 5	A	Total	54%	54%	<60%
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral.	T	Total	72%	83%	90%

Elective and Arranged Services					
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of First Specialist Assessments provided	A	Total	6,240	5,258	E>6,000
Proportion of patients waiting less than four months for their first specialist assessment	T	Total	97.0%	88%	100%
Number of planned care interventions delivered	A[24]	Total	new	3,220	3,140
Proportion of patients given a commitment to treat and treated within four months	T	Total	89.0%	83%	100%
Number of outpatient consultations provided	A	Total	13,663	12,075	E>13,000
Proportion of outpatient appointments provided by telemedicine	Q[25]	Total	5.1%	5.2%	>5%
Outpatient appointments where the patient was booked but did not attend	Q[26Δ]	Māori	15%	16%	<6%
		Total	7.7%	7.2%	

[22] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report – data is a year in arrears and the 2019 data is yet to be released.

[23] This measure demonstrates whether people presenting in ED are seen in order of clinical need and reflects national triage standards: Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation; Triage 4: seen within 60 minutes; Triage 5: seen within 120 minutes.

[24] The new planned care intervention measure reflects a change in national expectations, recognising the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing including those delivered in community settings. The West Coast's planned care target is made up of three components: elective surgical discharges, Minor Procedures and Non-Surgical Interventions. At the time of printing the target was yet to be confirmed by the Ministry of Health.

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

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

3.6 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

These services are considered to provide people with a much higher quality of life as a result of staying 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. Service utilisation is monitored to ensure people are appropriately supported.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
People (65+) supported by the community In-Home Falls Prevention Service	A[27]	Total	143	84	>120
Proportion of stroke patients admitted to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q	Total	94%	95%	80%
Proportion of AT&R inpatients discharged home rather than into ARC	Q[28Δ]	Total	85%	93%	80%

Home-Based Support Services					
These services support people to maintain functional independence. Clinical assessment ensures access is appropriate and equitable.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of Meals on Wheels provided	A[Δ]	Total	36,511	41,966	E>35,000
People supported by district nursing services	A[Δ]	Total	1,797	1,803	E>1,600
People supported by long-term home-based support services	A[Δ]	Total	1,100	1,041	E>1,000
Proportion of people supported by long-term home-based support services who have had a clinical assessment of need (using InterRAI) in the last year	Q[29]	Total	75%	77%	95%

Aged Residential Care Services					
While demand will increase as our population ages, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Proportion of the population (75+) accessing rest home level services in ARC	A[30Δ]	Total	3.8%	3.4%	E<4.5%
Proportion of the population (75+) accessing hospital- level services in ARC	A[Δ]	Total	6.4%	5.1%	E.<6.0%
Proportion of the population (75+) accessing dementia services in ARC	A[Δ]	Total	1.1%	0.7%	E.1.0%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A[Δ]	Total	0.3%	0.3%	E.<0.4%
People entering ARC having had a clinical assessment of need using InterRAI	Q	Total	88%	91%	95%

[27] Falls are one of the leading causes of hospital admission for people aged over 65. The community-based Falls Prevention Service provides care for people 'at-risk' of a fall or following a fall and supports people to stay safe and well in their own homes.

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

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

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

Statement of Financial Expectations

4.1 West Coast's financial outlook

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

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

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

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

Facilities pressures: Several of our smaller facilities are outdated, expensive to maintain, poorly located or seismically compromised. The level of remediation required to attain moderate compliance with current building codes is significant. However, the completion of the Te Nīkau facility and the progress on the Buller Health rebuild will significantly improve the quality of our facilities and the efficiencies that can be obtained from these modern facilities.

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

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

4.2 Forecast financial results

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $188m to meet the needs of our population in 2021/22.

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

This represents a $9m increase in funding, however it also includes revenue for pay equity settlements and capital charge relief funding on new facilities, which come with associated expenditure.

The West Coast DHB is predicting a $11.7m deficit result for the 2021/22 year.

4.3 Closing the gap

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

There is no easy solution. Savings will be made, not in dollar terms, but in costs avoided through more effective use of available resources and improvements in the health of our population. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system.

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

- Integrating finance and operational systems and improving workforce and production planning to ensure we are using our resources in the most effective way.
- Continuing the implementation of our Rural Generalist workforce model to reduce our reliance on locums and contractors.
- Optimising investment in shared electronic systems and telehealth technology to reduce delays in care, DNAs and travel costs.
- Integrating, realigning and prioritising services that deliver maximum health benefit and are sustainable long-term.
- Capturing opportunities to increase revenue with successful bids for national funding.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Considering the future use of all DHB assets to optimise investment.
- Tightening cost growth including moderating treatment, back office, support and FTE costs.

- Streamlining and standardising processes to remove variation, duplication and waste.
- Empowering clinical decision making to reduce delays and improve the quality of care.

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

4.4 Major assumptions

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

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

- Population-based funding levels for 2021/22 are based on the funding advice received from the Ministry.
- Out-years population funding is assumed at an average increase of circa 3.3% per annum.
- The West Coast DHB will continue to receive Crown funding on an early payment basis.
- Costs of compliance with any new national expectations or policy will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Funding for all aspects of pay equity settlement is included in the DHB's population-based funding.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluations. External provider increases will also be settled within available funding levels.
- The approved forecasted deficit will be funded via Crown deficit support (equity injections).
- Work will continue on the facilities redevelopment for Buller Integrated Family Health Centre project, managed by West Coast DHB and governed by West Coast Partnership Group
- Revaluations of land and buildings will continue and will impact on asset values. In addition to periodic revaluations, further impairment in relation to redevelopment and remediation of our facilities may be necessary.
- Treatment related costs will increase in line with known inflation factors, reasonable price impacts on providers and foreseen adjustments for the impact of growth within services.
- National and regional initiative savings and benefits will be achieved as planned.
- Transformation will not be delayed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- There will be no further disruptions associated with pandemics or natural disasters.

4.5 Capital investment

GREYMOUTH REDEVELOPMENT

Completion of the new Te Nīkau facility occurred early in 2020/21.

The Grey Base redevelopment includes a second tranche upgrade/replacement of other aspects of the Grey Base site. The Board has approved the preliminary site masterplan for the Grey Base campus and the DHB is working with the Ministry on finalising the business case for replacement of the Mental Health Inpatient Unit.

BULLER REDEVELOPMENT

In December 2018 the Buller IFHC project was approved, with the ongoing project management moving to West Coast DHB. The planned cost of this redevelopment excluding asbestos remediation is $21m.

The Buller facilities design has been approved and services have been decanted to allow for construction of the new facility. The IFHC is expected to be completed in May 2023.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $17.5m for the 2021/22 year, of which approximately $11.5m relates to Crown funded Buller IFHC.

Strategic capital for 2021/22-2022/23 comprises of:

- Mental Health & further Grey Base redevelopment.
- Reefton IFHC redevelopment.
- Phased upgrade of clinics outside Westport and Greymouth.
- Move to the South Island Patient Information Care System (SIPICS).
- Investment in other strategic IT/integration systems, including regional IT systems.
- Investments in clinical equipment, including a CT scanner, motor vehicles and general equipment.

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

4.6 Debt and equity

The $21m Buller IFHC project is being funded with equity drawdowns as the project progresses.

The DHB will require deficit funding (equity) to offset the 2020/21 deficit, as well as 2021/22 and outlying years.

The DHB is also repaying $68K equity annually as part of an agreed FRS-3 funding repayment programme with the Ministry of Health.

4.7 Additional considerations

SUBSIDIARY COMPANY AND PARTNERSHIPS

The South Island Alliance Programme Office is jointly funded by the five South Island DHBs to provide audit, project management and regional service development services.

New Zealand Health Partnerships Limited is jointly funded by all 20 DHBs to enable DHBs to collectively maximise and benefit from shared service opportunities.

DISPOSAL OF LAND

The West Coast DHB has land and building assets located right across the West Coast, some of which are subject to leasehold interests and arrangements. The DHB is engaged in a process of considering the future of these assets based on our new locality model and future facilities requirements. It is anticipated that recommendations for the disposal of some of the DHB assets will be made in 2021/22.

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

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

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

ACCOUNTING POLICIES

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

4.8 Statement of Comprehensive Income – years ending 30 June

2019/20 to 2024/25

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Income						
Ministry of Health revenue	149,769	166,369	175,784	181,224	187,188	193,215
Patient related revenue	8,009	7,796	7,860	7,872	8,112	8,352
Other operating income	4,525	4,894	4,392	4,529	4,602	4,712
Total Income	**162,303**	**179,059**	**188,036**	**193,625**	**199,902**	**206,279**
Operating Expenses						
Personnel (excl Holidays Act Remediation)	67,535	71,265	74,667	75,358	76,460	78,099
Outsourced services (clinical and non clinical)	10,893	10,398	9,866	9,881	10,063	10,258
Treatment related costs	9,503	9,804	10,229	10,536	10,884	11,232
External service providers (include Inter-district outflow)	66,954	73,708	78,808	80,312	82,129	83,988
Depreciation & amortisation	2,733	5,382	6,354	6,552	6,744	6,948
Interest expenses	-	-	-	-	-	-
Other expenses	11,663	10,469	11,008	11,286	11,717	11,986
Total Operating Expenses	**169,281**	**181,026**	**190,932**	**193,925**	**197,997**	**202,511**
Operating result before capital charge	**(6,978)**	**(1,967)**	**(2,896)**	**(300)**	**1,905**	**3,768**
Capital charge expense	690	3,102	6,204	6,504	6,504	6,504
Surplus / (Deficit) before Holidays Act Remediation	**(7,668)**	**(5,069)**	**(9,100)**	**(6,804)**	**(4,599)**	**(2,736)**
Holidays Act Remediation expense	11,300	2,747	2,583	2,635	2,687	2,741
Surplus / (Deficit)	**(18,968)**	**(7,816)**	**(11,683)**	**(9,439)**	**(7,286)**	**(5,477)**
Other comprehensive income						
Revaluation of land and Buildings	-	(5,518)	-	-	-	-
Total Comprehensive Income	**(18,968)**	**(2,298)**	**(11,683)**	**(9,439)**	**(7,286)**	**(5,477)**

4.9 Statement of Financial Position – years ending 30 June

2019/20 to 2024/25

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
CROWN EQUITY						
General funds	93,858	216,678	230,910	247,542	256,915	264,136
Revaluation reserve	25,100	28,956	28,956	28,956	28,956	28,956
Retained earnings	(115,908)	(122,061)	(133,744)	(143,183)	(150,470)	(155,946)
TOTAL EQUITY	**3,050**	**123,573**	**126,122**	**133,315**	**135,401**	**137,146**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	6,153	3,415	(5,259)	(3,483)	2,195	7,158
Trade & other receivables	4,484	5,865	5,865	5,865	5,865	5,865
Inventories	1,044	1,097	1,097	1,097	1,097	1,097
Assets classified as held for sale						
Investments (3 to 12 months)						
Restricted assets	47	-	-	-	-	-
TOTAL CURRENT ASSETS	**11,728**	**10,377**	**1,703**	**3,479**	**9,157**	**14,120**
CURRENT LIABILITIES						
Trade & other payables	15,730	17,549	17,549	17,549	17,548	17,550
Capital charge payable	-	-	-	-	-	-
Employee benefits	26,755	30,422	30,422	30,422	30,422	30,422
Restricted funds	83	63	63	63	62	62
Borrowings	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES	**42,568**	**48,034**	**48,034**	**48,034**	**48,032**	**48,034**
NET WORKING CAPITAL	**(30,840)**	**(37,657)**	**(46,331)**	**(44,555)**	**(38,875)**	**(33,914)**
NON CURRENT ASSETS						
Investments (greater than 12 months)	320	231	320	320	320	320
Property, plant, & equipment	35,326	162,115	171,827	176,668	173,052	169,284
Intangible assets	497	741	2,163	2,739	3,303	3,855
TOTAL NON CURRENT ASSETS	**36,143**	**163,087**	**174,310**	**179,727**	**176,675**	**173,459**
NON CURRENT LIABILITIES						
Employee benefits	2,253	1,857	1,857	1,857	2,399	2,399
Borrowings	-	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	**2,253**	**1,857**	**1,857**	**1,857**	**2,399**	**2,399**
NET ASSETS	**3,050**	**123,573**	**126,122**	**133,315**	**135,401**	**137,146**

Note: The cash position assumes WCDHB receives full equity deficit support indicative funding

4.10 Statement of Movement in Equity – years ending 30 June

2019/20 to 2024/25

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Total Equity at Beginning of the Period	14,086	3,050	123,573	126,122	133,315	135,401
Total Comprehensive Income	(18,968)	(2,298)	(11,683)	(9,439)	(7,286)	(5,477)
Other Movements						
Contribution back to Crown - FRS3	(68)	(68)	(68)	(68)	(68)	(68)
Contribution from Crown - Capital	2,000	122,889	12,000	5,000	-	-
Contribution from Crown - Operating Deficit Support	6,000	-	2,300	11,700	9,440	7,290
Other Movements	-	-	-	-	-	-
Total Equity at End of the Period	**3,050**	**123,573**	**126,122**	**133,315**	**135,401**	**137,146**

4.11 Statement of Cashflow – years ending 30 June

2019/20 to 2024/25

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	149,689	179,705	175,784	181,224	187,188	193,215
Other receipts	12,366	523	12,240	12,401	12,714	13,064
Interest received	81	52	-	-	-	-
	162,136	**180,280**	188,023	193,625	199,902	206,280
Cash was applied to:						
Payments to employees	75,347	79,396	77,250	77,993	79,147	80,840
Payments to suppliers	87,649	97,324	109,989	112,015	114,212	117,463
Interest paid	3	-	-	-	-	-
Capital charge	690	3,170	6,204	6,504	6,504	6,504
GST - net	(532)	99	-	-	-	-
	163,157	**179,988**	193,443	196,512	199,863	204,807
Net Cashflow from Operating Activities	**(1,021)**	**292**	**(5,420)**	**(2,887)**	**39**	**1,472**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	-	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	-	-	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	7,116	5,038	17,487	11,969	3,732	3,732
	7,116	**5,038**	**17,487**	**11,969**	**3,732**	**3,732**
Net Cashflow from Investing Activities	**(7,116)**	**(5,038)**	**(17,487)**	**(11,969)**	**(3,732)**	**(3,732)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital & Other	2,000	2,076	12,000	5,000	-	-
Equity Injection - Deficit Support	6,000	-	2,300	11,700	9,440	7,290
Loans Raised	-	-	-	-	-	-
	8,000	**2,076**	**14,300**	**16,700**	**9,440**	**7,290**
Cash applied to:						
Equity Repayment	68	68	**68**	**68**	**68**	**68**
Other	-	-	-	-	-	
	68	**68**	**68**	**68**	**68**	**68**
Net Cashflow from Financing Activities	**7,932**	**2,008**	**14,232**	**16,632**	**9,372**	**7,222**
Overall Increase/(Decrease) in Cash Held	(205)	(2,738)	(8,675)	1,776	5,679	4,962
Add Opening Cash Balance	6,358	6,153	3,415	(5,259)	(3,483)	2,195
Closing Cash Balance	**6,153**	**3,415**	**(5,259)**	**(3,483)**	**2,195**	**7,158**

Note: The planned cash closing balances assumes WCDHB receives full equity deficit support indicative funding

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

2019/20 to 2024/25

Funding Arm	2019/20 Audited Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Revenue						
Ministry of Health revenue	148,419	164,690	174,259	180,012	185,952	192,096
Patient related revenue	-	-	-	-	-	-
Other operating income	2,380	2,297	1,956	2,002	2,050	2,099
Total Revenue	**150,799**	**166,987**	**176,215**	**182,014**	**188,002**	**194,195**
Expenditure						
Personal Health	105,807	115,544	123,758	126,005	128,708	131,447
Mental Health	15,807	16,807	18,182	18,541	18,924	19,320
Disability Support	22,206	25,427	26,252	26,846	27,376	27,922
Public Health	1,097	787	576	576	576	576
Maori Health	808	867	927	1,021	1,045	1,072
Governance & Admin	840	893	953	972	996	1,020
Total Expenditure	**146,565**	**160,325**	**170,647**	**173,960**	**177,625**	**181,356**
Surplus / (Deficit)	**4,234**	**6,662**	**5,568**	**8,054**	**10,377**	**12,839**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**4,234**	**6,662**	**5,568**	**8,054**	**10,377**	**12,839**

Governance Arm	2019/20 Audited Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Revenue						
Ministry of Health revenue	-	-	-	-	-	-
Patient related revenue	-	-	-	-	-	-
Other operating income	846	918	1,003	1,020	1,045	1,075
Total Revenue	**846**	**918**	**1,003**	**1,020**	**1,045**	**1,075**
Expenditure						
Personnel (excl Holidays Act Remediation)	1,204	1,244	1,368	1,344	1,384	1,266
Outsourced services	907	935	960	936	950	977
Treatment related costs	1	5	3	-	-	-
Depreciation	-	0	1	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other expenses	565	443	442	276	277	290
Total Expenditure	**2,677**	**2,627**	**2,774**	**2,556**	**2,611**	**2,533**
Surplus/(Deficit)	**(1,831)**	**(1,709)**	**(1,771)**	**(1,536)**	**(1,566)**	**(1,458)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**(1,831)**	**(1,709)**	**(1,771)**	**(1,536)**	**(1,566)**	**(1,458)**

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

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Provider Arm	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
Ministry of Health revenue	1,350	1,680	1,525	1,212	1,236	1,119
Patient related revenue	8,009	7,796	7,860	7,872	8,112	8,352
Other operating income	80,910	88,295	93,272	95,155	97,003	98,906
Total Revenue	**90,269**	**97,771**	**102,657**	**104,239**	**106,351**	**108,377**
Expenditure						
Personnel (excl Holidays Act Remediation)	66,331	70,021	73,299	74,014	75,075	76,833
Outsourced services	9,986	9,463	8,906	8,945	9,113	9,281
Treatment related costs	9,502	9,799	10,226	10,536	10,884	11,232
Depreciation	2,733	5,381	6,354	6,552	6,744	6,948
Interest & Capital Charge	690	3,102	6,204	6,504	6,504	6,504
Other expenses	11,098	10,027	10,565	11,010	11,440	11,696
Total Expenditure	**100,340**	**107,793**	**115,554**	**117,561**	**119,760**	**122,494**
Surplus / (Deficit)	**(10,071)**	**(10,022)**	**(12,897)**	**(13,322)**	**(13,409)**	**(14,117)**
Holidays Act Remediation expense	11,300	2,747	2,583	2,635	2,687	2,741
Surplus / (Deficit)	**(21,371)**	**(12,769)**	**(15,480)**	**(15,957)**	**(16,097)**	**(16,858)**
Other Comprehensive Income	-	(5,518)	-	-	-	-
Total Comprehensive Income	**(10,071)**	**(4,504)**	**(12,897)**	**(13,322)**	**(13,409)**	**(14,117)**

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
In House Elimination	Audited Actual $'000	Audited Actual $'000	Audited Actual $'000	Audited Actual $'000	Audited Actual $'000	Audited Actual $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(79,611)	(86,617)	(91,839)	(93,648)	(95,496)	(97,368)
Total Revenue	**(79,611)**	**(86,617)**	**(91,839)**	**(93,648)**	**(95,496)**	**(97,368)**
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other expenses	(79,611)	(86,617)	(91,839)	(93,648)	(95,496)	(97,368)
Total Expenditure	**(79,611)**	**(86,617)**	**(91,839)**	**(93,648)**	**(95,496)**	**(97,368)**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**

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

CONSOLIDATED	2019/20 Audited Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Revenue						
Ministry of Health revenue	149,769	166,370	175,784	181,224	187,188	193,215
Patient related revenue	8,009	7,796	7,860	7,872	8,112	8,352
Other operating income	4,525	4,893	4,392	4,529	4,602	4,712
Total Revenue	**162,303**	**179,059**	**188,036**	**193,625**	**199,902**	**206,279**
Expenditure						
Personnel (excl Holidays Act Remediation)	67,535	71,265	74,667	75,358	76,460	78,099
Outsourced services	10,893	10,398	9,866	9,881	10,063	10,258
Treatment related costs	9,503	9,804	10,229	10,536	10,884	11,232
External service providers (incl Inter-district outflow)	66,954	73,708	78,808	80,312	82,129	83,988
Depreciation	2,733	5,382	6,354	6,552	6,744	6,948
Interest & Capital Charge	690	3,102	6,204	6,504	6,504	6,504
Other expenses	11,663	10,469	11,008	11,286	11,717	11,987
Total Expenditure	**169,971**	**184,128**	**197,136**	**200,429**	**204,501**	**209,015**
Surplus / (Deficit) before Holidays Act Remediation	**(7,668)**	**(5,069)**	**(9,100)**	**(6,804)**	**(4,599)**	**(2,736)**
Holidays Act Remediation expense	11,300	2,747	**2,583**	**2,635**	**2,687**	**2,741**
Surplus / (Deficit)	**(18,968)**	**(7,816)**	**(11,683)**	**(9,439)**	**(7,286)**	**(5,477)**
Other Comprehensive Income	-	(5,518)	-	-	-	-
Total Comprehensive Income	**(18,968)**	**(2,298)**	**(11,683)**	**(9,439)**	**(7,286)**	**(5,477)**

APPENDICES

Further Information for the reader

Appendices and Attachments

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

Documents of interest

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

- West Coast DHB Annual Plan
- West Coast DHB System Level Measures Improvement Plan
- West Coast DHB Disability Action Plan

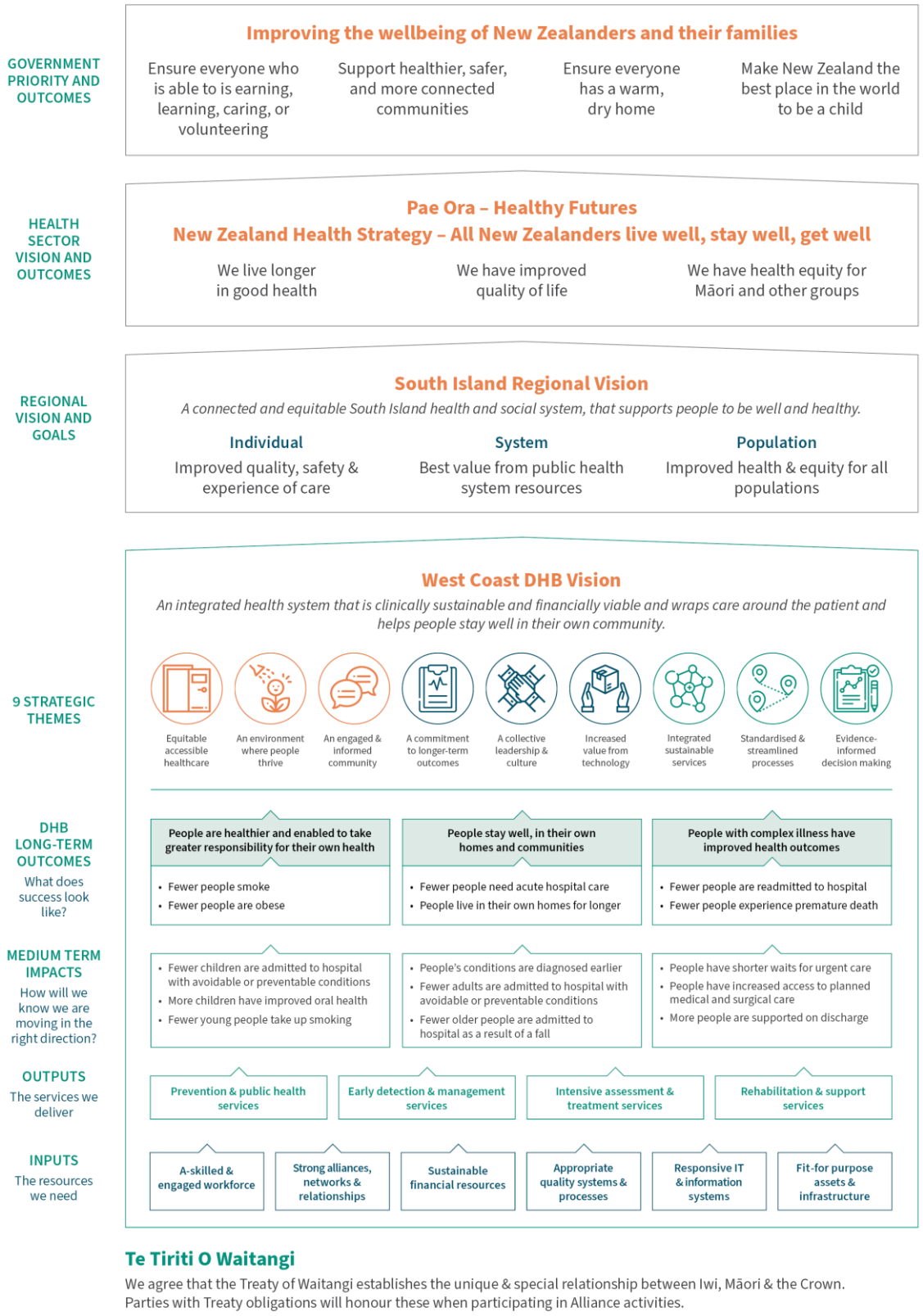
References

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

Appendix 1 Glossary of Terms

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

Appendix 2 Overarching Intervention Logic Diagram



Te Tiriti O Waitangi

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

Appendix 3 Statement of Accounting Policies

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

The following information is provided in respect of this Plan:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Appendix 5 of the Annual Plan.

REPORTING ENTITY AND STATUTORY BASE

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

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

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

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

Basis of Preparation

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

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

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

Statement of compliance

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

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

PRESENTATION CURRENCY AND ROUNDING

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

CHANGES IN ACCOUNTING POLICIES

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

STANDARDS ISSUED BUT NOT YET EFFECTIVE AND NOT EARLY ADOPTED

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

FINANCIAL INSTRUMENTS

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

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

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

IMPAIRMENT OF REVALUED ASSETS

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

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

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

SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the note to which they relate. Significant accounting policies are outlined below.

GOODS AND SERVICES TAX (GST)

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

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

Commitments and contingencies are disclosed exclusive of GST.

INCOME TAX

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

BUDGET FIGURES

The budget figures are derived from the 2021/22 Annual Plan and Statement of Intent. The budget was prepared in accordance with the accounting policies adopted by the Board for the preparation of the financial statements. The policies comply with the Tier 1 PBE standards.

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

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

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

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

Revenue

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

Ministry of Health population-based funding

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

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

Provision of other services

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

Other grants

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

Sale of goods or services

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

Donations, trust and bequest funds

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

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

Vested or donated physical assets

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

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

Donated services

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

Employee Benefit Costs

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

Other Operating Expenses

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

Operating leases

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

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

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

Capital Charge

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

Cash and Cash Equivalents

Cash and cash equivalents 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.

Receivables

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

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

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

Inventories

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

Cost is principally determined on a weighted average cost basis.

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

Property, Plant and Equipment

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

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

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

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

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

Revaluations

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

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

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

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

Additions

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

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

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

Subsequent costs

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

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

Disposals

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

Depreciation

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

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

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

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

Impairment of property, plant and equipment

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

Non-cash generating assets

Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If any such indication exists, the asset's recoverable amounts are estimated.

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

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

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

Intangible Assets

Acquisition and development

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

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

Amortisation

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

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

	Years
Acquired computer software	2-10

Impairment

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

Payables and deferred revenue

Short-term payables are recorded at the amount payable

Borrowings

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

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

Overdraft facility

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

Finance leases

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

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

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

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

Employee Entitlements

Short-term employee entitlements

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

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

Sick leave

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

Long-term employee entitlements

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

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

Presentation of employee entitlements

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

Equity

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

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

Property revaluation reserves

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

Related Party Transactions

Transactions eliminated on consolidation

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

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