West Coast DHB

ANNUAL REPORT 2017/18

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Part I
Overview

Foreword from the Chair and Chief Executive

32,600 reasons to make a difference

Walking alongside our communities

Our DHB team of just over 1,000 people, and all the others working together in the West Coast Health Alliance put their hearts and souls into making a difference for the people on the West Coast.

We recognise the importance of good access to general practice services, to hospitals and specialists, to oral health care and to mental health services; for ourselves, our family, our friends and neighbours, our colleagues and people we see in the streets.

We are constantly challenged to think about how we can improve the way we provide services to the 32,600 people living between Haast and Karamea.

Providing people on the West Coast with better access to health services and care, closer to home

We continue to work with our TransAlpine colleagues in Canterbury, and many services and departments span both Coasts. This means we can draw on the best specialists available, either through appointments on the Coast, or helping people get appointments in Canterbury. We are focused on providing as many services as possible on the Coast wherever possible in line with our goal to provide more care closer to home. This saves people's time and does wonders for their well-being. We are continuing to increase the use of telehealth, both transalpine with our Canterbury colleagues and up and down the Coast itself – where it saves people's time and means less travel and improved access to specialist advice.

Our health system continues to focus on the person at the centre of care, in the middle of our health system. This means we need to continue to be creative to find new ways of working that are flexible and sustainable and ensure that people receive the right care at the right time provided by the right person. Whether it's a visit to the general practice team or a call to the after-hours triage nurse for free health advice, there is no wrong door to enter our health system and we constantly strive to improve waiting times and ensure our care pathways put people at the centre of everything we do.

The rise of rural generalism

The term 'rural generalism' can mean different things to different people. On the West Coast we have embraced this workforce model and are at the early stages of introducing changes to the way we work, which will benefit both staff and people at the receiving end of care. The rural generalism model sees each profession working to the full extent of its scope of practice, as part of an inter-professional and multi-disciplinary team to provide services within a 'system of care' to our community.

This way of working applies to all clinical staff groups, and provides staff opportunities to upskill and learn new skills, and for Coasters rural generalist is the key to being able to provide and retain health services on the West Coast by enhancing the skills, knowledge and scope of practice of the health professionals who work on the Coast.

Rural generalism is an integrated style of working across services and is designed to provide a broad scope of health care in a rural context. More tangible progress is planned for the 2018/19 year which will see the model rolled out across medical, nursing and allied health services.

We continue to promote West Coast DHB as a Rural Health Centre of Excellence that offers training and academic opportunities for all professions. The initial focus has been in obstetrics, with paediatrics and medicine ripe for expanded roles under the rural generalism approach to providing sustainable care.

There's no health without mental health

Reorienting our mental health services has been a journey which has, importantly, involved staff, NGO providers, service users and other stakeholders. Good progress has been made this year with our plans to provide a wider range of services closer to where people live. We want to ensure that wherever you are on the Coast and however you enter our services, people receive timely, consistent quality care and support.

We are transforming the way we work to ensure we're always focused on the needs of the person we're supporting. We will build strong teams based in local communities at our Health Centres in Buller, Greymouth and Reefton. Easy access to primary and community mental health care closer to home, will help free up specialist support for those who need it, whenever they need it.

For those working in mental health and addiction on the Coast there are exciting opportunities to increase their skills, and provide care and support to people throughout their lives – from children to older people. We are looking to develop and invest in training to ensure a well-equipped workforce that is sustainable. In mental health we're also working to have local teams of rural generalists with easy access to specialist support for clinical advice, and streamlined systems for referring people in crisis and those with more complex needs who need specialised care and support.

We are mindful of the suicide statistics. We also know many people never engage with our services so with an increased focus on suicide prevention, and post-vention, along with improved access to services, we hope to improve outcomes for Coasters.

Using data is helping us develop new evidence-informed models which balancing the demands for patient care and wellbeing with the need for sustainable clinical services and business practices.

A dedicated project team is overseeing the numerous areas of service redesign and innovation, and they are committed to a co-design approach involving stakeholders as part of the process.

Key appointments made during the year

In August 2017 Philip Wheble, former team leader of Planning and Funding was appointed General Manager of West Coast Health Services. In 2018 we appointed Rhoda MacDonald as Manager Integrated Health Services, Northern Region.

Service changes

In August 2017 the Coast's Community Dementia Services came under the management of the Complex Clinical Care Network (CCCN) to better meet the needs of the West Coast community.

The service had previously operated by Mental Health Services. This change has improved accessibility to a broader range of services to ensure people are well supported. Having their care coordinated from a single team has improved services to people living with dementia and their families.

In Buller we closed the old Dunsford Aged Residential Care Ward and residents moved to modern facilities at the O'Conor Home.

Facilities

New facilities are progressing at Greymouth – with the new Grey Hospital and Health Centre taking shape. There have been some delays with the building programme and it's now expected to be complete during 2019. In the meantime work has progressed on the new models of care, in readiness for moving into modern new purpose-designed facilities.

Post the September 2017 election, community re-engagement commenced in the Buller community, with a new government taking a fresh approach to the new Buller Health building which will now be located on the site of the current Buller Health facility. Following further staff and community engagement, high level concept plans and requirements of the new facility have been agreed and approvals and more detailed designs are being progressed.

Māori Health

We have identified key areas of focus and set some core performance indicators to help us identify whether we are improving Māori Health outcomes. Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori. We can report success is some key areas around quit smoking advice and B4 School checks and enrolling in oral health services we still have work to do to make a meaningful difference across the board.

Our performance – are we making a difference?

We measure our performance across the strategic objectives of our health system: increasing engagement with prevention programmes; reducing acute or avoidable demand for hospital services and maintaining or increasing access to services while reducing waiting times and delays in treatment.

While we have made very good progress in many areas, there remain some challenges due to the realities of being a remote rural environment with a dispersed population.

In all but the final quarter of this year more than 90% of smokers identified in general practice were provided with advice about quitting

smoking and offered cessation support. We have also invested an incentivised smokefree pregnancy programme.

The number of people in our population identifying as obese has dropped over the past year to the national average of 32%. In the final quarter of this year 100% of four year olds identified as obese were offered a referral to a health professional for assessment and family-based nutrition, activity and lifestyle advice. More than 450 Coasters were referred to the Green Prescription programme with the latest survey showing that 65% of participants remained more active 6-8 months post referral.

Fewer young people are taking up smoking with 78% of 14-15 year olds identifying as never have smoked.

It's pleasing to note that 9 out of 10 people on the West Coast are enrolled with a general practice. This is key to having well organised health care.

More older Coasters (aged 75+) are living in their own homes. This is consistent with our strategy of supporting our older population to live more independently. A number of local programmes support ageing-in-place, including falls prevention programmes. On the Coast the proportion of the population admitted to hospital as a result of a fall is lower than the previous year and lower than the national average.

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

Of course, none of this would be possible without our staff and everyone else who works across the Coast in health and social support roles. Thank you for everything you do. Your positive contribution helps keep Coasters well, and ensures they have access to health services when they need them.

The transformation of our health system continues and we look forward to working together to make it better.

Jenny Black
Chair

David Meates
Chief Executive

25 October 2018

Part II
Improving Outcomes

Are We Making a Difference?

"As part of our accountability to our community and Government, we need to demonstrate whether we are achieving our goals and objectives, delivering on our commitments, and improving the health and wellbeing of our population".

DHBs have a number of different roles and associated responsibilities. There is no single performance measure or indicator that can easily reflect the impact of the work we do.

In our governance role, we are striving to improve health outcomes for our population. As a funder, we are concerned with the effectiveness of the health system and return on investment. As an owner and provider of services, we are concerned with the quality of the services we deliver and the efficiency with which we deliver them. Our overarching goal is better health for our people.

In line with the vision for the future of our health system, we have developed an outcomes framework and established three high-level strategic goals. These three goals are focused on areas where we believe we can influence change and where our success will have a positive impact on the health of our population.

Alongside each goal we have identified a number of long-term population health measures that are important to our stakeholders. Tracking our performance against these measures will help us to evaluate our success and will provide an insight into how well our health system is performing.

The nature of health is such that it may take a number of years to see marked improvements against some of these outcome measures. Our focus for the long-term outcomes is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

Working with the rest of the South Island DHBs, we have also collectively identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change in this space will be evident over a shorter period of time, these indicators have been selected as our main measures of performance.

We have set local standards against these contributory measures in order to determine whether we are moving in the right direction.

These measures sit alongside our statement of performance expectations, outlining the services we plan to deliver and the standards we expect to meet in the coming year and form an essential part of the way in which we are held to account.

Our statement of service performance for 2017/18, in the annual performance section of this report, provides a snapshot of the services provided for our population in the past year. Many of the measures selected were deliberately chosen from national reporting frameworks, to enable comparison with other DHBs and give context to our performance.

The performance expectations set across all these measures reflect the strategic objectives of our health system: increasing engagement with prevention programmes; reducing acute or avoidable demand for hospital services; and maintaining or increasing access to services while reducing waiting times and delays in treatment.

As part of our obligations under legislation, DHBs must work towards achieving equity across our population. To promote this goal, the standards set for each measure are the same for all population groups. As a means of evaluating whether we have made a difference for our Māori population, performance against a core set of our performance measures has been reported by ethnicity.

The DHB has also evaluated its performance against the national health targets, as these were very much in effect when the DHB set performance expectations for the year.

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

West Coast DHB - Outcomes Intervention Logic Framework

MINISTRY OF HEALTH SECTOR OUTCOMES

Health System Vision

All New Zealanders live well, stay well, get well.

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

REGIONAL STRATEGIC GOALS

South Island Regional Vision

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

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

West Coast DHB Vision

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

9 STRATEGIC THEMES

DHB LONG TERM OUTCOMES

What does success look like?

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

MEDIUM TERM IMPACTS

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

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

OUTPUTS

The services we deliver

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

INPUTS

The resources we need

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

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.

Monitoring Our Progress

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

WHY IS THIS OUTCOME A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions such as cancer, heart disease, respiratory disease, diabetes and depression. These conditions are major drivers of poor health and premature mortality (death) and place significant pressure on the health system in terms of demand for health services. The likelihood of developing long-term conditions increases with age and long-term conditions are more prevalent amongst Māori and Pacific Island populations. With Statistics New Zealand predicting that by 2026 one in every four people on the West Coast will be aged over 65 and 14.4% of our population will be Māori, meeting the health service demand associated with long-term conditions will be a major challenge for our health system.

WHERE ARE WE FOCUSED?

Tobacco smoking, inactivity, poor nutrition, alcohol consumption and obesity are significant risk factors for a number of the most prevalent long-term conditions. While tobacco consumption has decreased in New Zealand in recent years, the proportion of adults who lead sedentary lifestyles is increasing and obesity rates are amongst the highest in the world. These avoidable risk factors can be reduced through supportive environments and strategies that improve awareness and encourage personal responsibility for health and wellbeing. Supporting people to make healthier choices will improve the quality of their lives and, by reducing the prevalence and impact of long-term conditions, will reduce the pressure on our health system. Our focus is on smoking and obesity. Because these risk factors have strong socio-economic gradients, this focus will contribute to reducing health inequalities between population groups.

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in smoking rates

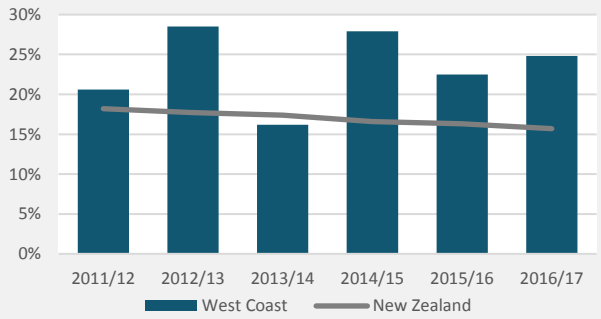
The latest NZ Health Survey results reported that 25% of our population smoke. The West Coast's smoking rates are still well above the national average (16%), are further work is needed to help our community understand the health risks associated with smoking.

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

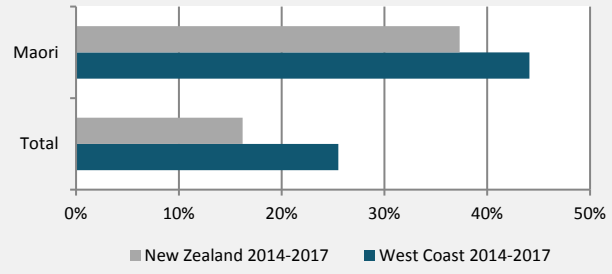
In 2017/18 we continued to focus on delivering brief smoking advice and cessation support, at all contact points across our health system. In all but the final quarter of the past year more than 90% of smokers identified in general practice were provided with brief advice and offered cessation support.

We have also increased our focus on supporting pregnant women to quit smoking and have invested in an incentivised smoke free pregnancy programme. In the past year, 29 pregnant women and 6 of their partners received support to quit smoking through the programme.

Proportion of the population (15+) who currently smoke



Proportion of the population (15+) who currently smoke



Data source: National NZ Health Survey [1]

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

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in obesity rates

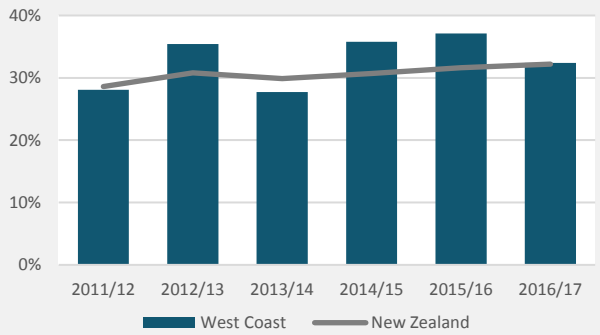
The NZ Health Survey results reported that the proportion of our population identifying as obese has dropped over the past year to the national average of 32%.

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

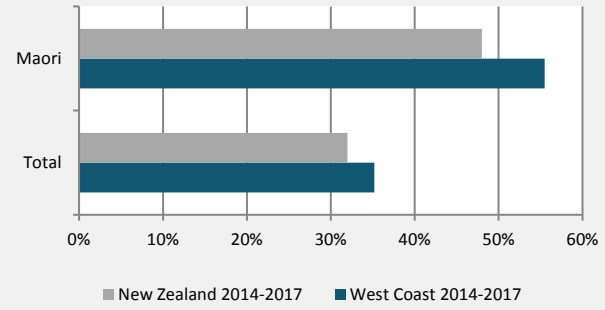
We identify children and families who may need support at the B4 School (health) Check prior to children starting school. In the final quarter of this year, 100% of four year old children identified as obese were offered a referral to a health professional for assessment and family-based nutrition, activity and lifestyle advice.

We also continue to invest in lifestyle programmes that support adults to increase physical activity or make healthy food choices, including the Green Prescription programmes. Over 450 people were referred by their health professional to the Green Prescription programme in 2017/18. The latest bi-annual survey results showed 65% of participants remained more active 6-8 months after referral.

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

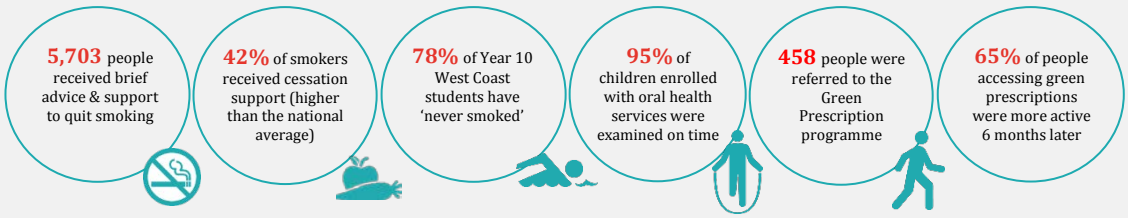


Proportion of the population (15+) who identify as obese



Data source: National NZ Health Survey [2]

Fast Facts



[2] *The NZ Health Survey is an annual survey commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2016/17 Survey is the most recently released time series available and while total population results are now presented annually, ethnicity breakdowns are only presented over combined time periods (due to small survey/sample numbers). For further information refer to the Ministry of Health website for the NZ Health Survey results. The Survey defines 'Obese' as having a Body Mass Index (BMI) of >30, or >32 for people of Māori and Pacific ethnicity.*

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

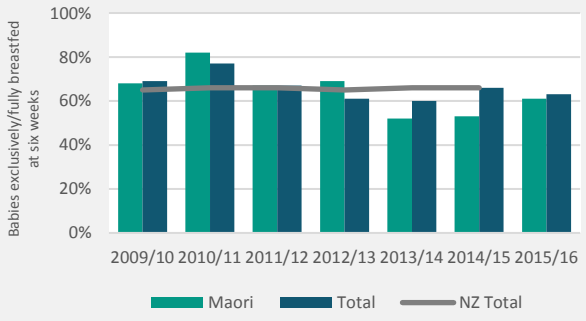
More babies are breastfed

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

The DHB has been unable to access breastfeeding results (at six weeks of age) from the national Well Child Quality Framework reports since 2015/16. The national reports do report breastfeeding results at three months. This shows West Coast at 61%, just above the national target (60%) and 3% higher than the national average. Māori breastfeeding rates at three months remained static at 55%, but are 8% higher than the national average for Māori.

The DHB funds a range of services to encourage and support women to breastfeed, including peer support programmes and community-based specialist lactation support. In 2017/18 191 women accessed specialist breastfeeding advice.

	2015/16	2016/17	Target	Result
	63%	n.a	75%	n.a



Data source: Plunket via the Ministry of Health [3]

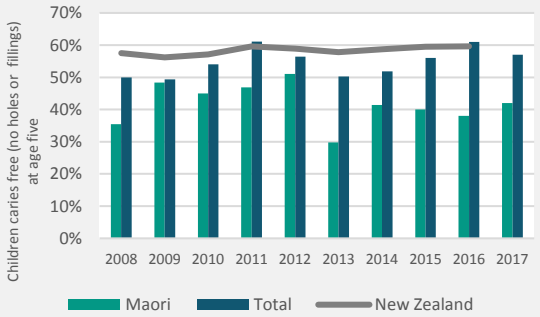
Children have improved oral health

The DHB provides free oral health care for children from birth to 17 years, with a key focus of our school and community oral health service to ensure that all eligible children are enrolled and are examined on time.

The percentage of five-year-old children whose teeth are caries-free (have no holes or fillings) has dropped back to just above 2015 levels (57%). However improved rates are evident for our Māori children with a 4% increase in children carries free compared to the previous year. This is a positive result for this high need population group.

The oral health service has been working to address equity gaps and improve oral health outcomes. A new multiple enrolment process and development of a Transalpine Oral Health Alliance will help the service to better identify children and establish and maintain contact with families.

	2015	2016	Target	Result
	56%	61%	63%	57%



Data Source: DHB School & Community Oral Health Services [4]

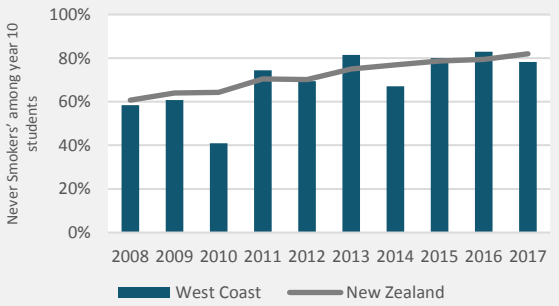
Fewer young people take up smoking

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

The 2017 survey results show a drop off in results for the 2017 year, with 78% of Year 10 students (age 14/15) identifying as never having smoked.

The overall trend is positive for this measure, reflecting the impact of supportive legislation and social environments, combined with local health-led initiatives such as our Health Promoting Schools programme.

	2015	2016	Target	Result
	80%	83%	>75%	78%



Data Source: National Year 10 ASH Snapshot Survey [5]

[3] *The data for this measure is no longer available to the DHB. The streamlined national Well-Child Tamariki Ora (WCTO) Quality Framework includes two breastfeeding measures: babies fully/exclusively breastfed on LMC discharge and babies being breastfed at three months. The DHB tracks the LMC and three month measures under its Statement of Performance Expectations.*

[4] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year. National results had not been made available for the 2017 year at the time of printing. The DHB considers this target to be partially achieved due to the improved results for Maori children, as a high need population group. Reducing equity gaps is a priority for the DHB.*

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

People stay well in their own homes and communities

WHY IS THIS OUTCOME A PRIORITY?

When people are supported to stay well, and can access the care they need closer to home and in the community, they are less likely to need hospital-level interventions or residential care. This is not only better in terms of health outcomes, but it reduces pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke, and achieve those health outcomes at a lower cost than health systems that focus more heavily on a specialist or hospital-level response.

This is particularly important for the West Coast DHB. Our hospital capacity is under significant pressure and it will be several years before the redevelopment, repair and remediation of our facilities are complete. Even then, if we do not change demand we will not have the resources to meet demand. We own four of the seven general practices on the West Coast and are uniquely positioned to change the focus.

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in acute medical admissions

With the right intervention and support, people can avoid the deterioration of their condition or reduce the likelihood of an event that leads to hospital admission, complications, long-term illness or even premature death. We seek to reduce medical admissions that are potentially avoidable through prevention, earlier intervention or closer management in primary care.

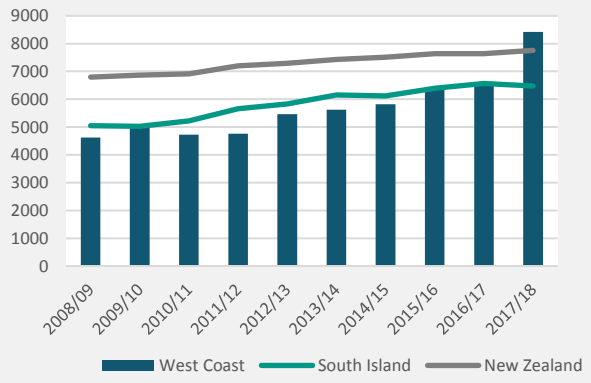
Like the rest of New Zealand, the West Coast's acute medical admission rates have been steadily increasing as our population ages and more people are living with long-term conditions. With our small population numbers the Coast's rates are particularly impacted by this combination of factors. However, at 8,417 per 100,000 people in 2017/18, our rate has lifted well above the previous year and national results.

The increase is 796 admissions, an average of just over two per day. Increases in average lengths of stay have been moderate, and do not suggest an increase in complexity of presentations. We believe this is an anomaly associated with changes in admission processes rather than increased demand and further review is being undertaken on the drivers behind this increase. We anticipate this will drop back in the coming year.

The provision of organised general practice is core to keeping people well. High enrolment rates are an indication of good engagement with our health system and enrolment with general practice remains high, at 94%.

Our primary care-led Long-term Conditions Management Programme is also a key factor in reducing acute medical admissions. The programme supports people to better manage their health and helps to prevent them from becoming acutely unwell. Over 4,000 people were enrolled in the Long-term Conditions Management Programme in 2017/18.

Acute medical admissions per 100,000 people



Data Source: National Minimum Data Set [6]

[6] *This measure is age standardised and presented as a rate per 100,000 people.*

OUTCOME MEASURE - DEMONSTRATING PROGRESS

More people living in their own homes

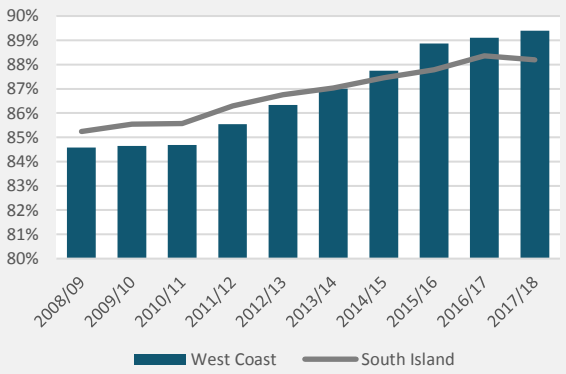
The proportion of the West Coast population (aged 75+) living in their own homes continues to increase lifting to 89.4% compared to 89.1% last year. Consistent with our strategy, this positive trend suggests our older population is healthier and is able, or being supported, to live more independently.

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

Falls in older people are very common. They frequently lead to injury and hospitalisation, a loss of confidence, and an increased risk of admittance to institutional care.

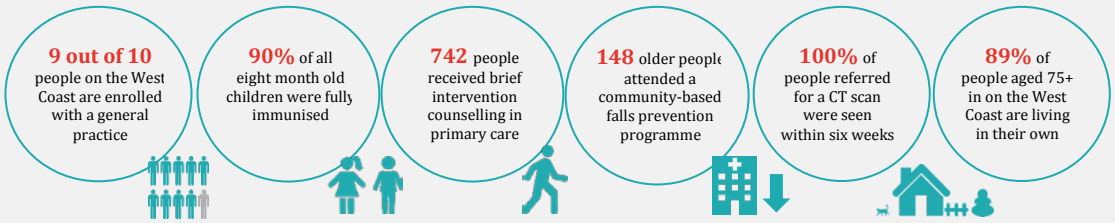
At 4.8%, the proportion of our population (75+) admitted to hospital as a result of a fall is lower than the previous year and 0.4% lower than the national average.

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



Data Source: SIAPO Client Claims Payment System

Fast Facts



IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People's conditions are diagnosed earlier

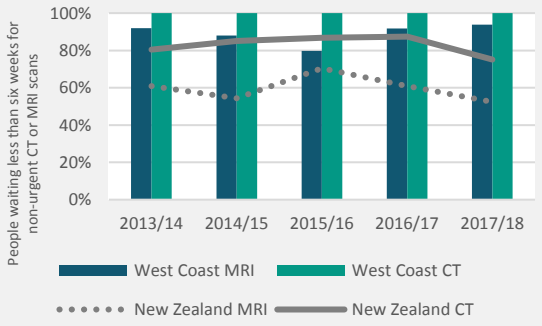
Diagnostics are an important part of the healthcare journey and timely access to diagnostics improves clinical decision making and enables early and appropriate intervention. This improves the quality of care and outcomes for our population.

Demand for CT and MRI scanning has been exceeding capacity across both the public and private sectors and wait times are increasing across the country. The Canterbury DHB delivers MRIs for our population and while Canterbury has been experiencing capacity issues over the past year, this target has still been met for our population.

The West Coast DHB has also continued to achieve the wait time target for CT scans, with 100% of people referred seen within six weeks.

In the past year 1,907 West Coast referrals were made for CT or MRI scans.

	2015/16	2016/17	Target	Result
MRI	80%	92%	90%	94%
CT	100%	100%	95%	100%



Data Source: DHB Patient Management System

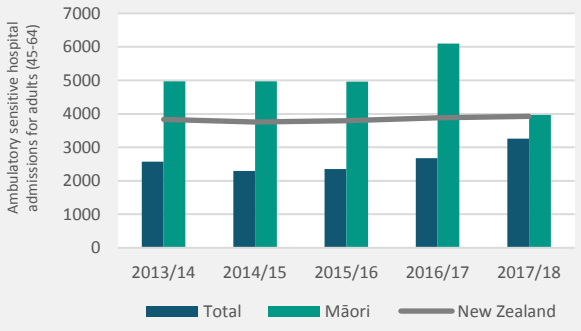
Fewer avoidable hospital admissions

In 2017/18, West Coast's avoidable hospital admission rate for 45-64 year-olds was 3,262 per 100,000 people. While above the local target, it is well below the national rate (3,925). Our Māori rate has improved over the past year, closing the equity gap. The national Māori rate was 7,824 admissions per 100,000, significantly higher than the West Coast result at 3,970.

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

High enrolment rates are an indication of good engagement with our health system and Māori enrolment with general practice has lifted 2% to 85% in 2017/18.

	2015/16	2016/17	Target	Result
	2,353	2,675	<2,652	3,262



Data Source: Ministry of Health Performance Reporting [7]

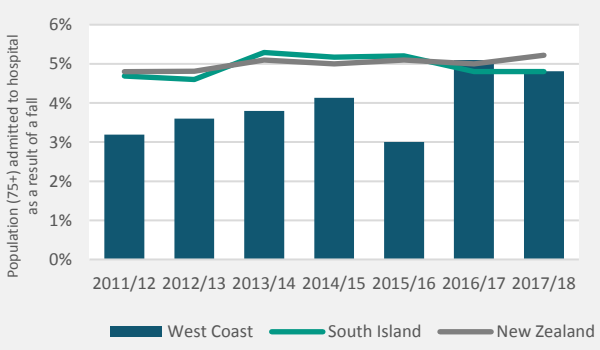
Fewer falls-related hospitalisations

At 4.8%, the proportion of our population (75+) admitted to hospital as a result of a fall is lower than the previous year and 0.4% lower than the national average.

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

In the last year, 148 people accessed a community-based falls prevention programme, a 26% increase on the previous year, and 95% of older inpatients received a falls assessment to help them stay safe while in our hospitals.

	2015/16	2016/17	Target	Result
	3.0%	5.1%	<4.9%	4.8%



Data Source: National Minimum Data Set [8]

[7] *This measure is a national DHB performance indicator (SI1) and captures hospital admissions for conditions considered preventable, including: diabetes, asthma, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim is to maintain current performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The results differ to those previously presented, being based off the national March 2018 series provided by the Ministry of Health in August 2018 – baselines have been reset to reflect the current series.*

[8] *This measure was reset in 2013/14 to reflect the updated 75+ population in line with the 2013 Census. The target has been set with the aim of reducing fall rates to below the previous year.*

People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

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

As the primary provider of hospital and specialist services on the West Coast, this goal also reflects the quality and effectiveness of the treatment we provide. Unnecessary waits, ineffective treatment or adverse events can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population. They can also impact on people's experience of care and their confidence in the health system and ineffective treatment or adverse events also add avoidable costs and waste valuable resources.

WHERE ARE WE FOCUSED?

In order to meet the increasing demand from our ageing population, within our current resources, we are focusing on improving the coordination of care and reducing duplication of effort in order to maintain service access and reduce waiting times for treatment. This include a focus on ensuring safe care in our hospitals and supporting people on discharge from our hospitals, to ensure they regain their independence and avoid another event that might negatively impact on their health.

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in acute readmissions to hospital

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

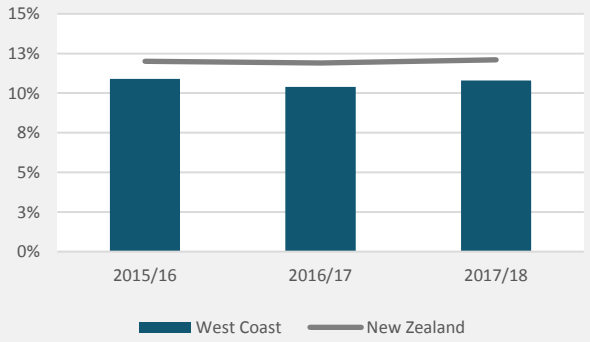
West Coast's readmission trend has been relatively flat over the last couple of years and at 10.8% our readmission rate is below the national average, which is a positive result. We will be monitoring this trend over the next few years.

Service quality, patient safety and good discharge planning are key factors in reducing acute readmissions. The DHB has made a strong commitment to the implementation of the Health Quality and Safety Commission's Open for Better Care Campaign.

We have a particular focus on the supported discharge and rehabilitation of older people where readmission rates are higher, with investment in our Complex Clinical Care Network and falls prevention and rehabilitation programmes.

In the past year, 98% of people were referred to a stroke unit or organised stroke service after an acute stroke event and FIRST, our Flexible Integrated Rehabilitation Support Team, is now up and running with two people supported back into the community following discharge from our hospitals.

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



Data Source: National Minimum Data Set [9]

[9] *This measure is a national DHB performance indicator (OS8). The results differ to those previously published following a national reset of the definition by the Ministry of Health in 2017/18. Two previous year's results have been provided by the Ministry as baselines as part of the definition change. The DHB is not able to access data prior to this definition change, hence the shorter time series presented.*

OUTCOME MEASURE - DEMONSTRATING PROGRESS

A reduction in avoidable mortality

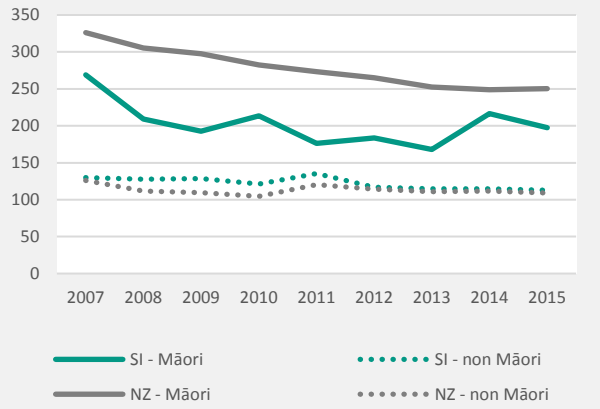
The latest release of national mortality data (2015) shows South Island mortality trends continues to be positive, with Māori rates dropping back down after a previous increase in 2014, and remaining well below national rates.

Prevention, screening and long-term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment. Rapid access to complex treatment such as radiation therapy or surgery is also an important factor in determining a positive outcome for many conditions, such as cancer, cardiovascular disease or stroke.

Cancer is one of the leading causes of mortality on the West Coast and contributes to a high proportion of premature deaths. The DHB missed the national Faster Cancer Treatment health target by only a small number of people in each quarter in 2017/18 with 80% of people identified with a high suspicion of cancer being seen and treated within 62 days in the final quarter of the year. This result reflected three patients who were seen outside of the national wait time target.

Mental illness contributes greatly to premature mortality. Mental health remains a major focus for the coming year and the DHB is working closely with community service providers to increase capacity and support for people with mental health and alcohol and drug issues.

All-cause mortality rate for people under 65 years of age



Data Source: National Mortality Collection [10]

Fast Facts

7,022 people had a first specialist assessment, **88%** within 4 months of referral

1,962 elective surgeries were delivered, **97%** within 4 months of decision to treat

94% of patients received their surgery on the day of admission

80% of patients with high suspicion of cancer received their first treatment within 62 days

95% of people referred to non-urgent mental health services were seen within 8 weeks

98% of patients where admitted to an organised stroke service after an acute event

[10] *The data presented is the most current available and is sourced from the national mortality collection which is released three years in arrears. The measures are age standardised and presented as a rate per 100,000 people.*

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

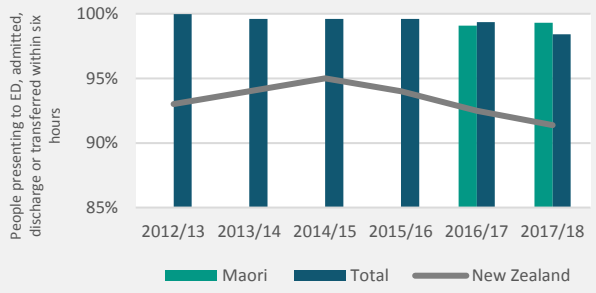
People have shorter waits for urgent care

There were 11,616 ED presentations in Greymouth Hospital this year, compared to 11,382 in 2016/17. In spite of this increase in demand, the DHB continues to be a leading performer against the Shorter Stays in ED health target, with 98% of people presenting in our ED being admitted, transferred or discharged within six hours.

A number of community-based urgent care options support our hospital ED including: free after-hours for children under 13 years, telephone triage and extended access to general practices after hours.

This strong performance result also reflects the commitment of our ED team and services across our hospitals to respond to an increasing number of people within the target timeframes.

	2015/16	2016/17	Target	Result
	99%	99%	95%	98%



Data Source: DHB Patient Management Systems [11]

People have shorter waits for planned care

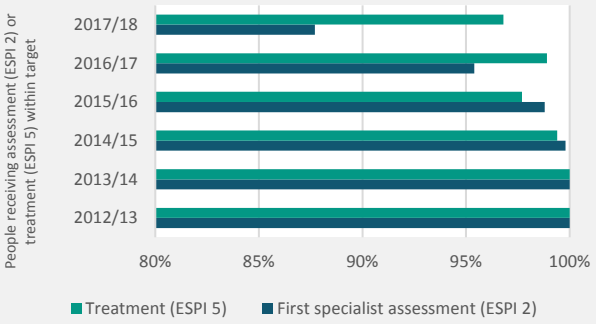
More than 7,000 patients attended a first specialist assessment, with 87.7% of all those patients seen within four months (ESPI2).

Of those patients given a commitment for treatment, 96.8% were seen within four months (ESPI5). West Coast also met the elective surgery health target, delivering 1,962 elective surgeries in 2017/18.

These figures reflect ongoing pressure in some service areas, particularly in orthopaedics, making it challenging to achieve the four-month wait time targets. The DHB is working closely with Canterbury DHB to engage additional orthopaedic resource to reduce wait times.

In the past year 15% of first specialist assessment were delivered virtually, without the need (or wait) for a hospital appointment – meaning less disruption for patients and a better use of our limited specialist resource.

	2015/16	2016/17	Target	Result
ESPI2	98.8%	95.4%	100%	87.7%
ESPI5	97.7%	98.9%	100%	96.8%



Data Source: Ministry of Health Quickplace Warehouse [12]

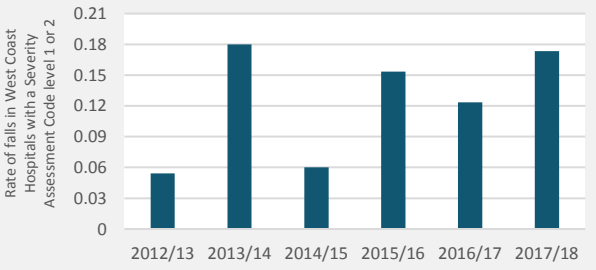
People experience fewer adverse events in hospital

The rate of serious falls in our hospitals has increased this year after a drop in 2016/17.

Key quality projects are focused on adoption of the national falls assessment process, standardising fall prevention visual cues and improving post-fall care. Our new electronic incident management system is also helping to raise awareness around falls and may be improving our reporting of events.

Our hospital teams provided 95% of all inpatients aged 75+ with a falls assessment in the third quarter of this year, allowing mitigation strategies and care plans to be put in place for patients at risk of a fall.[13]

	2015/16	2016/17	Target	Result
	0.15	0.12	0.05	0.17



Data Source: Individual DHB Quality Systems [14]

[11] *This indicator is a national DHB health target (Shorter Stays in ED) and excludes those who did not wait in ED or had pre-arranged appointments. In line with national health target reporting, the annual results refer to the final quarter of each year (01 April - 30 June).*

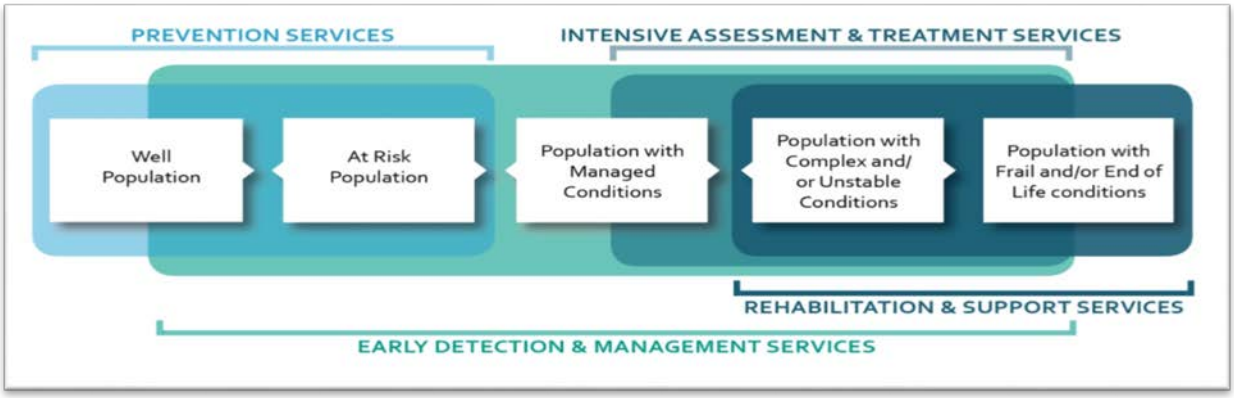
[12] *These indicators are two of the national Elective Services Patient Flow Indicators (ESPIs), established to track system performance. In line with national ESPI reporting, the annual results refer to the final month of each year (June).*

[13] *The reference refers to the January to March 2017 period, being the most recently published.*

[14] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest consequence and likelihood. The measure is a rate per 1,000 inpatient bed days and the difference between 2016/17 and 2017/18 is 18 events.*

Part III
Delivering on our Plans

Statement of Service Performance



Evaluating Our Performance

Having constrained facilities, a limited pool of resources and a growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

Over the longer term, we evaluate the effectiveness of our decisions, and the quality of our services, by tracking performance against the desired population health outcomes presented on the previous pages.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The statement of service performance set out in this section presents the DHB's actual performance against the 2017/18 forecast, presented in our 2017/18 Statement of Intent.

IDENTIFYING PERFORMANCE MEASURES

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

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

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

In presenting our performance picture, we have not simply presented the volume of services provided. The number of people who receive a service is often less important, for example, than whether the service was delivered at the right time.

To present a well-rounded performance picture, the mix of measures we have identified address four key aspects of service performance:

Access (A)
Timeliness (T)
Coverage (C)
Quality (Q).

The DHB is responsible for improving the health and wellbeing of our population across the full continuum of care. While targeted interventions can reduce demand in some areas, there will always be some service areas where the DHB cannot influence demand, such as maternity, dementia or palliative care services.

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

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

Nationally, DHB performance has also been evaluated by tracking performance against six national health targets. The West Coast DHB's performance against the health targets identified for 2017/18 is presented on page 22.

Setting Standards

Targets set in 2017/18 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

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

On the West Coast our population size also means that a small number of people can have a disproportionate impact on our results. For this reason some of the standards set can be difficult for the West Coast to meet, particularly those relating to small sub-groups within our population where the difference between meeting the target or not can be half a dozen people.

However, the DHB remains committed to maintaining high standards of service delivery and it is pleasing to see that performance has largely been positive.

NOTES ON THE DATA

The following symbols have also been used to provide context in the performance tables:

E Services are demand driven. It is not appropriate to set targets but service volumes are provided to give context in terms of the use of resources across our health system.

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

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

◇ The measure is a national target set for DHBs to achieve by the final quarter, or final month, of the year. In line with national performance reporting, fourth quarter (April-June) or June results are reported as the annual result.

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

Performance Key		
	Rating	Criteria
✓	**A**chieved	Standard reached
↺	**P**artially Achieved	Standard not reached but performance maintained or improved or the equity gap between population groups has reduced
✘	**N**ot Achieved	Standard not reached and performance dropped

National Health Target Performance

This was a positive year for the West Coast DHB in terms of delivery against national health targets. Results below show the quarterly results across the 2017/18 year. The national average (NZ) reflects the final quarter.

Increased Immunisation

The target is: 95% of eight-month old children are fully immunised (i.e. having had their primary course of immunisation art six weeks, three months and five months).

Target 95%		
Q1	82%	✖
Q2	83%	✖
Q3	81%	✖
Q4	**85%**	✖
NZ 91%		

Raising Healthy Kids

The target is: 95% of children, identified as obese at their B4 School Check, are offered a referral to a health professional for clinical assessment and healthy lifestyle interventions.

Target 95%		
Q1	90%	✖
Q2	95%	✓
Q3	100%	✓
Q4	**100%**	✓
NZ 98%		

Better Help For Smokers to Quit

The target is: 90% of PHO enrolled patients, who smoke, are offered advice and help to quit smoking from a health professional at least once every 15 months.

Target 90%		
Q1	94%	✓
Q2	91%	✓
Q3	90%	✓
Q4	**88%**	✖
NZ 90%		

Shorter Stays in ED

The target is: 95% of patients presenting in an Emergency Department (ED) are admitted, discharged, or transferred within six hours. Result reflect presentations to the Grey Base Hospital Emergency Departments.

Target 95%		
Q1	99%	✓
Q2	99%	✓
Q3	98%	✓
Q4	**98%**	✓
NZ 91%		

Improved Access to Elective Surgery

The target is: an increase in the volume of elective surgeries by at least 4,000 discharges per year (nationally). West Coast's target for 2017/18 was 1,905.

Target 1,905		
Q1	458	
Q2	995	
Q3	1,452	
Q4	**1,962**	✓

Faster Cancer Treatment

The target is 90% of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receive their first cancer treatment within 62 days of referral.

Target 90%		
Q1	69%	✖
Q2	80%	✖
Q3	81%	✖
Q4	**80%**	✖
NZ 91%		

2017/18 Service Performance

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Prevention services are publically funded services that promote and protect the health of the whole population or targeted sub-groups. The DHB invests in these services as a means of addressing individual behaviours and targeting physical and social environments that can influence and support people to make healthier choices.

The four leading long-term conditions—cancer, cardiovascular disease, diabetes, and respiratory disease—make up 80% of the disease burden for our population. By supporting people to make healthier choices, we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequalities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore also be a very cost-effective health intervention.

SERVICE PERFORMANCE 2017-2018

HEALTH PROMOTION AND EDUCATION SERVICES							
These services inform people about risks and support them to make healthy choices. Success is evident through increased engagement which leads, over time, to positive behaviour choices and a healthier population.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Mothers receiving breastfeeding and lactation advice in the community	A[15]	200	208	>100	191	-	✓
Babies exclusive/fully breastfed at LMC discharge (4-6 weeks)	Q[16]◆	83%	82%	75%	n.a	n.a	-
Babies exclusive/fully breastfed at three months	Q[16]◆	58%	61%	60%	61%	58%	✓
People provided with Green Prescriptions for additional physical activity	A[17]	543	558	>500	458	-	✗
Green Prescription participants more active 6-8 months after referral	Q[17]	58%	-	50%	65%	-	✓
Smokers, enrolled with a PHO, receiving advice and support to quit	C[18]◇	79%	91%	90%	88%	90%	✗
Smokers, identified in hospital, receiving advice and support to quit	C◆	97%	87%	95%	92%	94%	↺
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit	C◆	100%	89%	90%	100%	89%	✓
Women smokefree at two weeks postnatal	Q[19]◆	76%	82%	95%	n.a	n.a	-

[15] This programme aims to improve breastfeeding rates and to create a supportive breastfeeding environment. Evidence shows that infants who are not breastfed have a higher risk of developing chronic illnesses during their lifetimes. The percentage of babies being breastfed can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period. Standards are set nationally.

[16] These measures are part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The Framework covers health promotion, education, screening and support services and checks are provided free to all New Zealand children from birth to five years. Results are published by the Ministry and the latest LMC breastfeeding results had not been published at the time of printing, the three month breastfeeding measures reflects the six months to December 2017.

[17] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data (for the quality measure) is sourced from a national patient survey competed every two years by Research NZ on behalf of the Ministry of Health. This is a demand driven service and the PHO continues to encourage general practice to refer patients who would benefit from additional support. Newspaper, radio and social media advertising also encourage people to seek out support from their general practice.

[18] This is a national target (Better Help for Smokers to Quit). Evidence shows that the majority of smokers want to quit and need help to do so. The provision of profession advice and cessation support is shown to both increase the likelihood of smokers making quit attempts and the success rate. The DHB is disappointed to have not met the target with three of the seven West Coast practices have achieved the target and a fourth achieving 89%, missing the target by just two patients. The DHB is heartened by the positive trend in the proportion of smokers who are recorded has having accessed cessation support. At 42% in the final quarter of the year, the DHB results is above the national average and trending upwards.

[19] This measure is part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The 2016/17 results reflect the 6 months to December 2016, the full year and the 2017/18 result was not available at the time of printing.

POPULATION-BASED SCREENING SERVICES							
These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake and success is indicated by high coverage rates.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Four-year-olds provided with a B4 School Check (B4SC)	C[20]◆	74%	90%	90%	98%	93%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q[21]◆	new	81%	95%	100%	98%	✓
Young people (Year 9) in decile 1-3 schools receiving a HEEADSSS assessment	C[22]	68%	82%	95%	75%	-	✗
Women aged 25-69 having a cervical smear in the last three years	C[23]◆	75%	75%	80%	74%	73%	✗
Women aged 50-69 having a mammography in the last two years	C[23]◆	76%	77%	70%	72%	72%	✓

IMMUNISATION SERVICES							
These services help to reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Children fully immunised at eight months of age	C[24]◇◆	78%	80%	95%	85%	91%	↺
Eight-month-olds 'reached' by immunisation services	Q[25]◇	100%	95%	95%	98%	95%	✓
Young women (Year 8) completing HPV vaccination programme	C[26]†◆	43%	39%	75%	39%	67%	↺
Older people (65+) receiving a free influenza ('flu') vaccination	C[27]†◆	61%	55%	75%	56%	54%	↺

[20] *The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.*

[21] *This measure is a national health target (Raising Healthy Kids) introduced at the start of 2016/17. 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 and quality of life. A referral allows families to access support to maintain healthier lifestyles.*

[22] *A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety. The service had a vacancy during this past year which impacted on the delivery of assessments. This role has now been filled.*

[23] *The cervical and breast cancer screening measures refer to participation in national screening programmes and age bands and standards are set nationally. 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. Rates for cervical and breast screening remain a priority with results dropping back on last year's performance. The DHB is working closely with community providers to try and lift these rates.*

[24] *The West Coast has a large community within its population who decline immunisations or opt off the National Immunisation Register (NIR) and this makes delivering all of the national immunisation targets extremely challenging. The DHB strives to offer and encourage immunisation to all the eligible population and to immunise all those who opt-in to the programme.*

[25] *'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children but have chosen to decline immunisations or opt off the National Immunisation Register.*

[26] *Around 150 women are diagnosed with cervical cancer and 50 women die from it each year in New Zealand. The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme is free to young people under 26 years of age. The DHB continues to struggle with delivery against this target. The number of young people identified as eligible is captured via Census numbers but many board out of region during the school year and strong views on immunisation from one large local community group make this a challenging target to meet. The DHB is working with schools to encourage young people to engage in the HPV programme. In the 2017/18 year 42% of girls received dose one of the programme so we anticipate a higher results in 2018/19.*

[27] *The denominator for this measure changed from the number of people enrolled with a PHO to the Census population in 2017. Previous year's results are not directly comparable. This measure is also impacted by the increasing proportion of population aged over 65. The actual number of older people having a flu vaccination in 2018 has increased by 170 people, compared to 2017.*

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

SERVICE PERFORMANCE 2017-2018

PRIMARY CARE (GENERAL PRACTICE) SERVICES							
These services support people to maintain their health and wellbeing and avoid unnecessary hospital admission. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive system.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Population enrolled with a Primary Health Organisation (PHO)	C◆	89%	90%	95%	94%	93%	↺
Number of integrated HealthPathways in place across the system	Q[28]	654	655	650	632	-	✖
Young people (0-19) accessing Brief Intervention Counselling	A[29]	219	200	>80	215	-	✓
Adults (20+) accessing Brief Intervention Counselling	A	558	548	>300	527	-	✓
General practices offering the primary care patient experience survey	Q[30]	new	new	85%	86%	-	✓
Avoidable hospital admission rate for children (0-4)	Q[31]◆	5,415	4,361	<4,757	6,031	6,748	✖

[28] The clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals across the West Coast or to Canterbury. The pathways support consistent access to treatment and care no matter where people present. The slight drop in the number of pathways reflects the ongoing review and consolidation of pathways to keep them current.

[29] The Brief Intervention Counselling Service aims to support people with mild to moderate mental health concerns to improve their health outcomes and quality of life. The service provides free counselling sessions (or extended consultations) for issues including depression and anxiety. A joint triage process between primary care and specialist child and adolescent services has been introduced and may be contributing to increased referrals.

[30] The Patient Experience Survey a national online survey to determine patient's experience in primary care and their perception of how well their overall care is managed. The survey was initially piloted in a small number of DHB regions and is now being progressively rolled-out across the country with an increasing number of general practices on the West Coast now offering their patients the opportunity to provide feedback. The information collected will be used to help improve the quality of service delivery.

[31] Some admissions to hospital are seen as avoidable through early intervention and treatment and the rate of these admissions provides an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. The DHB's aim is to maintain current performance below the national rate (which reflects less people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented – baselines have been reset to reflect the current 2018 series provided by the Ministry of Health, and are to March of each year. Small population numbers have a disproportionate impact on West Coast results with the difference between 2016/17 and 2017/18 being just 30 admissions. ASH rates for children is a key improvement measures in the DHBs System Level Improvement Plan for 2018/19 with a focus on improving breastfeeding rates and oral health, with dental conditions and respiratory infections being the leading conditions driving our avoidable admissions.

LONG-TERM CONDITIONS SERVICES

These services are targeted at people with high health needs related to long-term or chronic conditions. High enrolment and engagement levels are indicative or a successful service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Enrolled population, identified with a long-term condition, engaged in the primary care Long-Term Conditions Management Programme	A[32]	3,793	3,860	>2,000	4,099	-	✓
People identified with diabetes having an HbA1c test in the last year	C[33]†	91%	74%	90%	79%	-	↺
People identified with diabetes with acceptable glycaemic control (evidenced via their HbA1c test)	Q[33]†	63%	54%	80%	54%	-	↺
Eligible population having a cardiovascular disease (CVD) risk assessment in the last 5 years	C[34]◇◆	91%	91%	90%	90%	88%	✓

ORAL HEALTH SERVICES

These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High enrolment and timely access to treatment are indicative of an accessible and efficient service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Children (0-4) enrolled in DHB-funded oral health services	C[35]†◆	87%	97%	95%	108%	-	✓
Children (0-12) enrolled in DHB oral health services examined according to planned recall	T[35]†	78%	93%	90%	95%	-	✓
Adolescents (13-17) accessing DHB-funded oral health services	C[35]†	75%	75%	85%	77%	-	↺

PHARMACY AND REFERRED SERVICES

These are services health professionals use to help diagnose or monitor health conditions. Timely access to services improves clinical decision-making and reduces delays in treatment.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Subsidised pharmaceutical items dispensed in the community	A	455k	466k	E.<600K	460k	-	✓
Community Referred Radiology tests completed	A	5,504	5,817	E.>5,000	6,199	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T	100%	100%	90%	93%	90%	✓
People receiving their MRI scans within six weeks	T[36]	80%	92%	90%	94%	52%	✓
People receiving their CT scans within six weeks	T[36]	100%	100%	95%	100%	75%	✓

[32] This measure refers to the primary care run LTCM programme where patients who are enrolled with the PHO are provided with an annual review, targeted care plan and packages of care, appropriate referrals and self-management advice to help change their lifestyle, improve their health and reduce the negative impacts of their condition. Cardiovascular disease and diabetes are two of the four leading long-term conditions on the Coast and are targeted by the programme, along with chronic obstructive pulmonary disease.

[33] Diabetes is a leading long-term condition and contributor to many other conditions. An annual HbA1c test (of a patient's blood glucose levels) is a means of assessing the management of people's condition and a level of less than 64mmol/mol reflects an acceptable blood glucose level. The proportion of people with good management of their condition has remained static while the number of people receiving an annual HbA1c teat has increased. This demonstrates the DHB and PHO commitment to identifying people with diabetes and enrolling them in the Long-Term Conditions Management (LTCM) Programme. This will link people with services that (over time) will support them to better manage their diabetes.

[34] Cardiovascular disease is one of the leading causes of death on the West Coast. By identifying those at risk of cardiovascular disease early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious event.

[35] The DHB reviewed its oral health service enrolment processes in 2016/17, linking the School and Community Dental Service with the Immunisation and Well Child teams to encourage families to connect with services and lift enrolment rates. A new approach was also adopted to better cover staff vacancies. Both these factors have contributed to improved performance this year. The number of children physically enrolled with the service was higher than the anticipated population (based off Census and Stats NZ population projections) with 2,096 children enrolled in 2018/19.

[36] These diagnostic measures are national DHB performance measures (PP29). The wait times refer to non-urgent MRI and CT scans.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events, others are planned and access is determined by clinical triage, treatment thresholds, capacity, 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 results in improved confidence in the health system.

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

SERVICE PERFORMANCE 2017-2018

QUALITY AND PATIENT SAFETY							
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Rate of staff compliance with good hand hygiene practice	Q[37]◇	81%	80%	80%	78%	85%	✗
Hip and knee replacement patients receiving routine antibiotics before surgery	Q◇	95%	96%	95%	100%	97%	✓
Hip and knee replacement patients receiving antiseptic skin preparation in surgery	Q◇	100%	100%	100%	100%	98%	✓
Response rate to the national inpatient experience survey	Q	35%	28%	>30%	58%	26%	✓
Response to the communications domain in the inpatient patient experience survey 'rate your experience of communications out of 10'.	Q	9.3	8.9	>8.0	8.8	8.5	✓

MATERNITY SERVICES							
These are services provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Women registered with an LMC by 12 weeks of pregnancy	C[38]†◆	54%	79%	80%	n.a	n.a	-
New mothers attending DHB-funded parenting/pregnancy courses	C[39]	100%	91%	>30%	62%	-	✓
Maternity deliveries in West Coast facilities	A	246	250	E. 300	264	-	↺
Baby friendly hospital accreditation achieved in DHB facilities	Q[40]	Yes	Yes	Yes	Yes	-	✓

[37] *These quality measures are national safety markers with definitions and standards set nationally. The 2017/18 results are the most recent available being: January-March 2018 for hand hygiene, October to December 2017 for the Hip and Knee measures and June 2018 for patient experience. Three more hand hygiene auditors commenced auditing in 2018. This meant that areas that had not previously been audited were able to be included and while this impact on performance initially, having more auditors is helping to reinforce the importance of hand hygiene. The DHB is anticipating a lift in results in the coming year.*

[38] *Early registration with a LMC is encouraged to promote the good health and wellbeing of mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report and the 2016/17 result is the most recent available being to December 2016, reported in February 2018.*

[39] *The result for 2016/17 differs from that previously published (100%) due to a clarification of the definition regarding first time mothers. The number of women attending courses is small and hence the results fluctuate between years. The difference in the number of first time mothers attending courses in 2017/18 compared to 2016/17 is ten mothers.*

[40] *The Baby Friendly Initiative is a worldwide programme led by the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises the standard.*

ACUTE/URGENT SERVICES

These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Early intervention can reduce the impact of the event and as such, multiple options and shorter waiting times are indicative of a responsive system.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
General practices providing telephone triage outside business hours	A	88%	88%	100%	100%	-	✓
Presentations at the Grey Base Hospital Emergency Department (ED)	A[41]	11,742	11,382	E.<13k	11,616	-	✓
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T [42]	80%	79%	85%	82%	-	↺
Population presenting at Grey Base Hospital ED (per 1,000 people)	Q[43]	349	342	<342	356	-	✗
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral	T[44]◇	80%	56%	90%	80%	91%	↺
Acute inpatient average length of hospital stay (standardised)	Q[45]	2.40	2.36	2.30	2.34	-	↺

ELECTIVE/ARRANGED SERVICES

These are medical and surgical services provided for people who do not need immediate hospital treatment, where assessment or treatment is 'booked' or 'arranged.' Maintaining access while reducing waiting times is indicative of an efficient and responsive service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
First Specialist Assessments provided	A[46]	6,591	7,232	E.>6,000	7,022	-	✓
First Specialist Assessments that were non-contact (virtual)	Q[47]	12.5%	16%	>10%	15%	-	✓
Elective/arranged surgical discharges (surgeries provided)	A[48]◇	1,942	1,979	1,905	1,962	-	✓
Elective inpatient average length of hospital stay (standardised)	Q[45]	1.55	1.34	1.40	1.20	-	✓
Outpatient consultations provided	A	15,257	15,479	E. >13k	14,328	-	✓
Proportion of outpatient appointments provided by telemedicine	Q[49]	2.3%	3.3%	>5%	4.2%	-	↺
Outpatient appointments where the patient was booked but did not attend (DNA)	Q[50]◆	5.9%	5.6%	<6%	6.13	-	✗

[41] This measure is aligned to the national target (Shorter Stays in ED) and counts presentations to the Grey Base Hospital Emergency Department. The measure excludes those who do not wait to be seen and those with pre-arranged appointments.

[42] 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.

[43] There has been a slight increase in the rate at which our population is presenting to ED, this is reflected in the increase in the total number of people presenting to ED and reflective of a national trend. The DHB is working on changing models of care to support more people to access care earlier, in the community, to avoid unnecessary ED presentations.

[44] This is a national target (Faster Cancer Treatment) and presents a rolling six month result. There has been a definition change for this measure for the 2017/18 year allowing patients to delay their own treatment or for treatment to be delayed due to clinical considerations (and for this not to affect the result). Previous years counted these actions as delays and results from previous years are therefore not directly comparable. Small population numbers have a disproportionate impact on results for the West Coast. The performance result for 2017/18, reflects the DHB missing timeframes for six patients.

[45] This is a national performance measure (OS3). By shortening hospital length of stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective surgery. Importantly, addressing the factors that influence a patient's length of stay includes reducing the rate of patient complications and infection, and integration activity to support patients to return home sooner. Performance is balanced against readmission rates to ensure earlier discharge is appropriate and service quality remains high.

[46] This measure counts medical and surgical assessments but only the first assessments (where the specialist determines treatment) and not follow-ups or consultations after treatment has occurred. The measure is aligned to the national elective services reporting definitions which are DHB of domicile, meaning this result relates to all First Specialist Assessments provided for West Coast residents, no matter where they are delivered.

[47] Non-contact FSAs are those where specialist advice and assessment is provided without the need (or the wait) for a hospital appointment.

[48] This is a national health target (Improved Access to Elective Services) and does not include all surgery or procedures delivered by the DHB.

[49] This measure has been updated to reflect the proportion of total outpatient appointments delivered using telehealth or videoconferencing technology—reducing unnecessary travel for patients and their families.

[50] The DNA rate is calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not. When patients fail to turn up to appointments, it is costly for the DHB and can negatively affect their recovery and long-term outcomes. The DHB has a DNA project underway to understand the drivers behind these results and change processes to support more people to make appointments.

SPECIALIST MENTAL HEALTH SERVICES							
These are services for those most severely affected by mental illness and/or addictions that require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of an efficient and responsive service.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Young people (0-19) accessing specialist mental health services	C[51]	5.5%	5.3%	>3.8%	5.4	3.9%	✓
Adults (20-64) accessing specialist mental health services	C[51]	5.2%	5.7%	>3.8%	5.9	3.9%	✓
People referred for non-urgent mental health and alcohol and other drug (AOD) services seen within three weeks	T	81%	76%	80%	81%	79%	✓
People referred for non-urgent mental health and AOD services seen within eight weeks	T	94%	89%	95%	95%	93%	✓

SPECIALIST ASSESSMENT, TREATMENT AND REHABILITATION (AT&R) SERVICES							
These are services provided to restore functional ability and enable people to live as independently as possible. An increase in the proportion of older people discharged home, rather than into aged residential care (ARC) reflects a successful outcome.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Admissions into inpatient AT&R services	A	91	71	E.<150	87	-	✓
Inpatients (aged 75+) who received a falls risk assessment	Q[52]	88%	91%	90%	95%	92%	✓
Proportion of AT&R inpatients discharged to their own home rather than into aged residential care	Q[53Δ]	82%	79%	80%	90%	-	✓

[51] This measure is a national DHB performance measure (PP6) and standards are set nationally based on the expectation that 3% of the population will need access to specialist mental health support.

[52] This measure is a national safety marker with definitions and standards set nationally by the NZ Quality and Safety Commission. The 2017/18 results are the most recent available being January-March 2018.

[53] A discharge from AT&R services to home, rather than into residential care, is seen as reflective of the quality and effectiveness of services in assisting that person to regain their functional independence. With appropriate community supports, people who are able to remain safely in their own homes and communities and to 'age in place' report higher levels of satisfaction and quality of life. Small population numbers have a significant impact on this measure – the difference in the number of people discharged home between 2016/17 and 2017/18 was twenty seven people.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

SERVICE PERFORMANCE 2017-2018

REHABILITATION SERVICES							
These services restore or maximise people's health or function following a health-related event such as a fall, heart attack or stroke. Largely demand driven, success is measured through appropriate services referral following an acute event.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A[54]	new	yes	yes	2	-	✓
People (65+) accessing the community-based falls prevention service	A[55]	16	117	>25	148	-	✓
People referred to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q	31%	91%	80%	98%	-	✓

HOME AND COMMUNITY-BASED SUPPORT SERVICES							
These services aim to restore or maximise people's health or functional ability, following a health related event. Largely demand driven, success is measured through appropriate service referral.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Meals on Wheels provided	A [56Δ]	33,561	33,772	E.35,000	34,977	-	↺
Number district nursing visits provided	A [57Δ]	4,246	4,782	E.>4,000	3,556	-	✗
Number of people supported by long-term home and community support services	A [58Δ]	786	1,079	E.>740	1,211	-	✓
Proportion of people receiving long-term home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q[59Δ]	93%	93%	95%	91%	-	✗

[54] *Flexible Integrated Rehabilitation Support Team (FIRST) is a new service established to work with clients in their own homes to enable them to remain as independent as possible and to support a seamless transfer for patients following an inpatient stay in hospital.*

[55] *Falls are one of the leading causes of hospital admission for people aged over 65. The aim of the Falls Prevention Programme is to provide better care for people 'at-risk' of a fall, or who have experience a fall, and to support people to stay safe and well in their own homes. Building capacity and increasing referrals into this service has been a priority for the DHB and referrals into the service are steadily increasing.*

[56] *Meals on Wheels is a subsidised service available for people who can't prepare a hot meal without help because of a medical condition or a disability, who have no family or whānau help readily available, and need the meal to maintain good nutrition and independence. This may be a short intervention or a longer-term solution to support people to stay well in their own homes.*

[57] *District nursing visits are demand driven and can fluctuate between years. The 2016/17 result differs from that previously printed (3,830) due to late invoicing and clarification of the definition. The DHB will report on people supported in future years to better reflect the capacity of the service.*

[58] *The 2016/17 result differs from that previously printed (1,079) due to late invoicing. This is demand driven service and the increase in people supported is aligned to the DHB's strategy of supporting more people in their own homes and the ageing of our population.*

[59] *The International Residential Assessment Instrument (interRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning by using evidence based practice guidelines to ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live. The DHB continues to work with clinical assessors, nurse managers and providers to raise awareness of the benefits of the assessments and increase rates of completion.*

RESPITE AND DAY SERVICES							
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or so that a specific health need can be addressed. Largely demand driven, access to services is expected to increase over time as more people are supported to remain in their own homes.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
People supported by aged care respite services	A[60Δ]	61	45	E. 70	51	-	↺
Number of mental health planned and crisis respite service bed-days accessed	A[60Δ]	365	482	E. 500	422	-	✗

AGED RESIDENTIAL CARE SERVICES							
With an ageing population, demand for aged residential care (ARC) is expected to increase. However a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ average	
Number of ARC rest home (level) bed-days provided	A[61]	35,363	31,410	E.<50k	25,831	-	✓
Number of ARC hospital (level) bed-days provided	A	37,843	39,796	E.<40k	38,784	-	✓
Number of ARC dementia bed-days provided	A	5,439	5,424	E >4,000	7,888	-	✓
Number of ARC psycho-geriatric bed-days provided	A	3,314	3,408	E.>2,000	2,889	-	✓
People entering ARC having had a clinical assessment using InterRAI	Q	90%	100%	95%	100%	-	✓

[60] *The West Coast had been operating with reduced ARC capacity in 2016/17 and respite capacity had been limited as a result. This capacity is being built back up and more beds are becoming available and being accessed for respite use.*

[61] *The drop in the number of rest home bed days is in line with the DHB's strategy - supporting people to stay in their own homes for longer. The increase in dementia bed days over the last year, corresponds to an increase in the number of dementia level beds available in aged residential care facilities on the West Coast. There were 11 additional clients with dementia supported on the West Coast in 2017/18 compared with 2016/17.*

Māori Health Performance

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

Working with local stakeholders, the DHB has identified a number of key areas of focus and a set of core performance indicators. These are indicators seen as particularly important to our community in terms of improving and monitoring Māori health outcomes. These indicators were identified in our forecast Statement of Performance Expectations for 2017/18 using the symbol (◆). The results for Māori are presented below to highlight progress in reducing equity gaps. The NZ average results are the national results for Māori.

SERVICE PERFORMANCE 2017-2018

MĀORI HEALTH INDICATORS							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Note	2015/16	2016/17	2017/18 Target	2017/18 Result	2017/18 NZ Ave	
Māori babies exclusive/fully breastfed at LMC discharge	Q[62]	70%	77%	75%	n.a	n.a	-
Māori babies exclusive/fully breastfed at three months	Q[62]	58%	57%	60%	54%	48%	✖
Māori smokers, enrolled with a PHO, receiving advice and help to quit	C[63]◇	77%	91%	90%	87%	87%	✖
Māori smokers, identified in hospital, receiving advice and help to quit	C	100%	82%	95%	96%	94%	✓
Pregnant Māori women, identified as smokers at confirmation of pregnancy with an LMC receiving advice and support to quit smoking	C	100%	100%	90%	100%	88%	✓
Māori women smokefree at two weeks postnatal	Q[62]	63%	68%	95%	n.a	n.a	-
Māori children receiving a B4 School Check at age four	C[64]	80%	92%	90%	106%	93%	✓
Māori four year-olds (identified as obese at their B4SC) offered a referral for clinical assessment, and family-based nutrition, activity or lifestyle intervention	Q◇	new	100%	95%	100%	98%	✓
Māori women (25-69) having a cervical smear in the last three years	C	68%	63%	80%	65%	67%	↺
Māori women (50-69) having a mammography in the last two years	C[65]	70%	67%	70%	61%	65%	✖
Māori babies fully immunised at eight months of age	C[66]◇	82%	95%	95%	88%	86%	✖
Eligible Māori girls completing the HPV vaccination programme	C†	47%	27%	75%	30%	66%	↺
Older Māori (65+) having had a seasonal influenza vaccination	C†	64%	51%	75%	50%	46%	✖
Māori population enrolled with a PHO	C	89%	83%	95%	85%	91%	↺
Rates of avoidable hospital admissions for Māori children (0-4 years)	Q[67]	6,429	5,476	<4,757	9,070	7,741	✖
Enrolled Māori, identified with a long-term condition, engaged in the primary care LTCM programme	A	233	235	>233	261	-	✓
Eligible Māori having their CVD risk assessed in the past five years	C	88%	88%	90%	88%	86%	↺
Māori children (0-4) enrolled in DHB oral health services	C†	75%	81%	95%	96%	-	✓
Māori women registered with a LMC by 12 weeks of pregnancy	C[62]	54%	80%	80%	n.a	n.a	-
Māori outpatient 'Did not Attend' rates	Q	13%	15%	<6%	15%	-	✖

[62] *The latest LMC results had not been published nationally at the time of printing this includes smoking at two weeks post-natal. The result for three month breastfeeding reflects the six months to December 2017. The DHB continues to support local peer support groups to lift these rates.*

[63] *The DHB continues to work with all general practices to ensure all smokers after offer advice and support to quit smoking.*

[64] *This measure is based on Census population projections, there were four children more than projected in the 2017/18 year.*

[65] *Rates for breast and cervical screening remain a priority, the DHB is working closely with community providers to try and lift screening rates.*

[66] *This result reflects just three Maori children who were not immunised on time, or declined immunisations, in the final quarter of the year.*

[67] *The results presented differ to those previously presented, being based on the national March 2018 series provided by the Ministry of Health. Small numbers have a disproportionate impact on results for the West Coast. The difference between 2016/17 and 2017/18 results was just 16 events.*

Part IV
Managing our Business

Board's Report and Statutory Disclosure

To the stakeholders on the affairs of the Board for the year ended 30 June 2018

PRINCIPAL ACTIVITIES

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

RESULTS

During the year, West Coast DHB recorded a net deficit of $2.949m against the budgeted deficit of $2.041m (2016/17 result was a net deficit of $0.800m).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	Board		QFARC		HAC		CPHAC&DSAC		ADVISORY*	
	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended
Chris Auchinvole	8	7			5	5			3	3
Jenny Black	8	7	6	6	5	5	5	5	3	2
Kevin Brown	8	8			5	5			3	3
Helen Gillespie	8	7	6	5					3	2
Michelle Lomax	8	7			5	5			3	3
Chris Mackenzie	8	7	6	5					3	3
Edie Moke	8	6	6	5					3	2
Peter Neame	8	8					5	4	3	3
Nigel Ogilvie	8	8			5	4			3	3
Elinor Stratford	8	8					5	5	3	3
Francois Tumahai	8	6					5	2	3	2
Lynnette Beirne							5	4	3	3
Sarah Birchfield							5	5	3	3
Dr Cheryl Brunton							5	4	3	2
Jenny McGill							5	4	3	2
Mary Molloy							5	4	3	3
Joe Mason							5	2	3	3
Paula Cutbush					5	5			3	2
Gail Howard					5	3				
Chris Lim					5	5			3	2

QFARC – Quality, Finance, Audit & Risk Committee
HAC – Hospital Advisory Committee
CPHAC&DSAC – Community & Public Health & Disability Support Advisory Committee
*Advisory – Advisory Committee *CPHAC & DSAC & HAC formed into one Committee from March 2018*

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD INFORMATION

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

INFORMATION ON MINISTERIAL DIRECTIONS

WHOLE OF GOVERNMENT APPROACH

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

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

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

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

REQUIREMENT TO IMPLEMENT NEW ZEALAND BUSINESS NUMBER

The Direction requires West Coast DHB to implement the New Zealand Business Number (NZBN) in key systems by Dec 2018. This Direction was issued in May 2016 under s.107 of the Crown Entities Act.

West Coast DHB has recently replaced its key finance and supply chain business system the replacement system has taken the NZBN requirements, as provided to date, into account.

Work is also ongoing to identify other impacts and to establish the changes that need to be implemented as a result of this Direction.

AUTHENTICATION SERVICES

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

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

ELIGIBILITY DIRECTION

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

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

Statutory Information

This Annual Report presents West Coast DHB's financial and non-financial performance for the year ended 30 June 2018. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

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

People at the Heart of All We Do

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

We are committed to engaging our people in the development, and ongoing review and renewal, of programmes and policies. To that end, in late 2017 we established a programme of work, entitled "Care Starts Here" within which one of the most significant outputs includes the development and the refreshing of People and Capability policies and processes across both West Coast DHB and Canterbury DHB, including our Code of Conduct, Health and Safety Policy and Equality, Diversity and Inclusion Policy.

Staff Ethnicity	Number
Americas	7
Australian	8
British	31
Chinese	2
Filipino	15
Indian	27
Irish	3
Māori	29
Middle Eastern	1
New Zealand European	344
New Zealander	3
Not Stated / Don't Know	473
Other	2
Other African	2
Other Asian	3
Other European	14
Pacific Peoples	4
South African	5
Total	973

Staff Mix by Average Age	Average age
Medical	49.13
Nursing	50.44
Allied Health	51.90
Support	54.87
Management & Administration	49.51

Staff Mix by Gender	Number	Percentage
Female	825	85%
Male	148	15%
Total	973	100%

Staff Identifying a Disability[68]	Number
Yes	0

LEADERSHIP, ACCOUNTABILITY AND CULTURE

It is often said that an organisation's strength is derived from its leaders and leadership behaviour, systems and processes, and storytelling – in other words its culture. This, coupled with aligned strategies, structures, staffing, and skills as well as integrated physical infrastructure, relationships and networks, provides the best chance of achieving our vision, as well as having the ability to meet the challenges of delivering quality health services to a physically remote and widely distributed population. To meet this considerable challenge we need an engaged, motivated, and highly skilled workforce that is committed to doing its best for our patients and for the wider health system.

Our leadership practices are concerned with ensuring that those who know best are the ones who are involved in developing and determining outcomes. This approach, together with effective governance arrangements within West Coast DHB and across our health system, works in a way to deliver positive patient outcomes.

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

RECRUITMENT, SELECTION AND INDUCTION

We utilise an integrated approach to attracting, selecting and engaging people across the West Coast health system for today, tomorrow and the future. This approach has a range of elements including recruitment, selection, induction, candidate care, talent management, succession

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

planning, and strategic sourcing. The purpose of this approach is to support an integrated West Coast health system by providing proactive, targeted and agile initiatives at every level; maximising opportunities that result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey throughout the West Coast health system.

As part of these approaches we fully embrace best practices of equity and diversity. We are also active participants in the development of consistent regional approaches to recruitment and associated support systems in this critical area.

WORKPLACE WELLBEING, HEALTH AND SAFETY

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

There is a health monitoring programme which includes screening and immunisation. The entire workforce, and their families, are provided with free access to an Employee Assistance Programme if they are faced with work or personal issues that are negatively impacting on them. There is also access to onsite work place confidential support services through an external provider.

Wellbeing programmes and activities to encourage and support our people in terms of healthier lifestyles are available throughout the organisation. There are many opportunities for workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training. As part of this approach, our people are supported and encouraged to be responsible for building and maintaining a healthy and safe environment at work.

West Coast DHB continues to participate in the ACC Workplace Safety Management Practices Programme to promote a safe work environment. Injury prevention programmes are developed to reduce the risk of injury and there is a focus on supporting staff to return to work following an injury or illness. We do not tolerate any form of harassment or workplace bullying and ensure all staff are aware of harassment policies and procedures to deal with such a situation. This includes discussions with individuals new to the organisation at orientation, and through information and training for managers to facilitate early intervention.

EQUAL OPPORTUNITIES AND POSITIVE BEHAVIOURS

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

We have a diverse, flexible and highly skilled workforce. This reflects the demographics of our community and contributes significantly to the provision of culturally and individually appropriate services.

We are committed to identifying and dealing with all examples of unacceptable behaviour. All individuals on joining West Coast DHB are made familiar with our Code of Conduct, Bullying and Harassment Policy, Good Employer Policy and Equal Opportunities Policy.

REMUNERATION AND RECOGNITION

Our policy is to ensure a fair, equitable, and transparent approach to remuneration management as well as a consistent approach to conditions of employment for both our IEA and MECA contracted workforces. Our IEA remuneration strategy remunerates at an agreed market line which includes consideration of appropriate market data and provides a progression path aligned to the principles of performance, employee competency development and organisational affordability.

We also monitor feedback from employee engagement, exit, and attachment surveys to ensure our practices remain relevant.

EMPLOYEE ENGAGEMENT

In June 2011, West Coast DHB undertook a staff survey to measure the engagement of our people.

The survey was well represented by all demographics and professional groups. The results demonstrated that 80% of West Coast DHB's overall workforce is either engaged or highly engaged, with only 2% reported as disengaged. The areas that people reported to be most happy with were:

- **Empowerment** – they value the work they do and have a high level of confidence;
- **Commitment** – they are committed to their colleagues and prepared to go the extra mile;
- **Nature of the job** – the work people do is mentally stimulating and challenging;
- **Patient Safety** – they would be comfortable being a patient here and feel confident raising any concerns.

We are planning a new engagement survey in 2018/2019.

EMPLOYEE DEVELOPMENT AND PROMOTION

We are focused on supporting and developing our employees. Our structures, processes and policies enable us to place the right people into the right roles at the right time.

Our people are supported by a robust process of individual and managerial capability building. Our managers and leaders have access to an array of development programmes as they move into different leadership contexts.

Information, resources and tools are provided online, supported by content on HealthLearn – our South Island e-learning platform. In addition, we provide face-to-face development opportunities for individuals and teams.

We are also part of a tertiary alliance with the University of Otago, the University of Canterbury, and ARA (formerly CPIT), a member of the TANZ network (10 South Island and lower North Island polytechnic institutes), which makes available a common curriculum of development to all employees.

Statement of Responsibility

We are responsible for the preparation of West Coast DHB financial statements and the statement of service performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by West Coast DHB under section 19A of the Public Finance Act 1989.

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

In our opinion, these financial statements and the statement of service performance fairly reflect the financial position and operations of West Coast DHB for the year ended 30 June 2018.

Signed on behalf of the Board:

Jenny Black
Chair

25 October 2018

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

25 October 2018

Part V
Financial Performance

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2018

In thousands of New Zealand dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Revenue				
Patient care revenue	2(i)	147,812	147,417	141,960
Other operating revenue	2(ii)	977	416	403
Interest revenue		380	420	408
Total revenue		149,169	148,253	142,771
Expenses				
Personnel costs	3	60,139	59,796	57,483
Depreciation and amortisation expense	9,10	2,959	3,400	3,373
Outsourced services		8,664	7,487	8,692
Clinical supplies		8,906	8,288	8,402
Infrastructure and non-clinical expenses		10,432	10,002	9,966
Payments to other health service providers		58,143	58,419	53,094
Other operating expenses	4	1,468	1,414	1,479
Finance costs		-	-	343
Capital charge	5	1,387	1,488	739
Total expenses		152,098	150,294	143,571
Net surplus/(deficit)		**(2,929)**	**(2,041)**	**(800)**
Other comprehensive revenue & expenses				
Gain/(losses) on revaluation of land and buildings		3,599	-	-
Total other comprehensive revenue & expenses		3,599	-	-
Total comprehensive revenue & expenses		**670**	**(2,041)**	**(800)**

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

Statement of Changes in Equity

For the year ended 30 June 2018

In thousands of New Zealand dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Balance at 1 July		25,108	25,108	12,409
Total comprehensive revenue & expenses		670	(2,041)	(800)
Owner transactions				
Capital contributions from the Crown	12	-	81,273	13,567
Repayment of capital to the Crown		(68)	(68)	(68)
Balance at 30 June	14	**25,710**	**104,272**	**25,108**

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

Statement of Financial Position

As at 30 June 2018

In thousands of New Zealand dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Assets				
Current assets				
Cash and cash equivalents	6	11,724	12,687	10,811
Receivables	7	3,707	5,123	4,992
Inventories	8	1,058	1,007	1,059
Patient deposits	15	71	74	69
Total current assets		16,560	18,891	16,931
Non-current assets				
Property, plant and equipment	9	30,138	103,730	26,250
Intangible assets	10	965	873	1,203
Total non-current assets		31,103	104,603	27,453
Total assets		47,663	123,495	44,384
Liabilities				
Current liabilities				
Payables and deferred revenue	11	9,176	9,249	7,502
Borrowings	12	-	-	-
Employee entitlements and benefits	13	10,251	7,201	8,987
Patient deposits and restricted funds	15,16	83	69	89
Total current liabilities		19,510	16,519	16,578
Non-current liabilities				
Borrowings	12	-	-	-
Employee entitlements and benefits	13	2,443	2,703	2,698
Total non-current liabilities		2,443	2,703	2,698
Total liabilities		21,953	19,222	19,276
Net assets/equity				
Contributed capital	14	85,994	167,267	86,062
Revaluations	14	25,681	22,082	22,082
Accumulated surpluses/(deficits)	14	(85,965)	(85,077)	(83,036)
Total equity		25,710	104,272	25,108
Total equity and liabilities		**47,663**	**123,494**	**44,384**

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

Statement of Cash Flows

For the year ended 30 June 2018

In thousands of New Zealand dollars

	Note	2018 Actual	2018 Budget	2017 Actual
Cash flows from operating activities				
Receipts from Ministry of Health, patients and other revenue		149,497	147,798	145,240
Payments to suppliers		(77,056)	(77,848)	(76,218)
Payments to employees		(67,444)	(67,906)	(65,900)
Interest received		420	416	408
Interest paid		-	-	(343)
Goods and services tax (net)		(362)	-	(706)
Capital charge paid		(1,296)	(1,488)	(739)
Net cash flow from operating activities	17	3,759	972	1,742
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		7	-	-
Purchase of property, plant and equipment		(2,690)	(2,501)	(2,330)
Purchase of intangible assets		(95)	-	(383)
Net cash flow from investing activities		(2,778)	(2,501)	(2,713)
Cash flows from financing activities				
Capital contributions from the Crown		-	3,473	-
Repayment of capital to the Crown		(68)	(68)	(68)
Net cash flow from financing activities		(68)	3,405	(68)
Net increase /(decrease) in cash and cash equivalents		913	1,876	(1,039)
Cash and cash equivalents at the start of the year		10,811	10,811	11,850
Cash and cash equivalents at the end of year	6	**11,724**	**12,687**	**10,811**

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

The GST component of cash flows from operating activities reflects the movement in opening and closing net GST paid to the Inland Revenue Department. The GST (net) component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statement purposes.

Notes to the Financial Statements

For the year 30 June 2018

1. Statement of Accounting Policies

REPORTING ENTITY

West Coast District Health Board (the 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 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate parent is the New Zealand Crown.

The 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.

The DHB is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice. The financial statements are for the year ended 30 June 2018, and were approved for issue by the Board on 25 October 2018.

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.

STATEMENT OF COMPLIANCE

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

The financial statements have been prepared in accordance 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. Previously, only property, plant and equipment 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.

INTERESTS IN OTHER ENTITIES

In January 2017, The XRB issued new standards for interests in other entities (PBE IPSAS 34-38). These new standards replace the existing standard for interests in other entities (PBE IPSAS 6-8). The new standards are effective for periods beginning on or after the 1 January 2019, with early adoption permitted.

The DHB plans to apply the new standards in preparing the 30 June 2020 financial statements. The DHB has not yet assessed the effects of these new standards.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

GOODS AND SERVICES TAX (GST)

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

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

Commitments and contingencies are disclosed exclusive of GST.

INCOME TAX

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

BUDGET FIGURES

The budget figures are derived from the 2017/18 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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

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

2. Revenue

ACCOUNTING POLICY

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

Ministry of Health population-based funding

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

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

Ministry of Health contract revenue

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of

quantifiable units of service are treated as exchange contracts and revenue is recognised as West Coast DHB provides the services.

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

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

Provision of other services

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

Other grants

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

Sale of goods or services

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

Donations, trust and bequest funds

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

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

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at fair value when 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.

2(i) BREAKDOWN OF PATIENT CARE REVENUE

	2018 Actual $000	2017 Actual $000
Ministry of Health population-based funding	132,214	124,768
Inter-district flows	1,710	1,661
Ministry of Health other contracts & other government contracts	4,709	6,790
ACC contract revenue	1,994	1,778
Other patient care related revenue	7,185	6,963
	147,812	**141,960**

2(ii) BREAKDOWN OF OTHER OPERATING REVENUE

	2018 Actual $000	2017 Actual $000
Cash donations and bequests received	83	10
Donated assets	432	-
Rental revenue	183	164
Training and development	120	48
Gain on sale of fixed assets	7	12
Other	152	169
	977	**403**

3. Employee Benefit Costs

ACCOUNTING POLICY

Salaries and wages

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

BREAKDOWN OF PERSONNEL COSTS AND FURTHER INFORMATION

	2018 Actual $000	2017 Actual $000
Wages, salaries and other personnel costs	56,754	55,062
Contributions to defined contribution schemes	1,717	1,596
(Decrease)/increase in liability for employee entitlements	1,036	597
Restructuring expenses	632	228
	60,139	**57,483**

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

REMUNERATION OF EMPLOYEES

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

A total of 99 employees (2017: 94) received total remuneration of greater than $100,000. The figure stated includes payment for additional duties, lump sum payments, including payment of back pay and employer contributions to superannuation and KiwiSaver schemes.

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

Of the 99 employees, 91 are clinical employees (2017: 88) and 8 are non-clinical employees (2017: 6).

REMUNERATION OF EMPLOYEES EARNING MORE THAN $100,000 PER ANNUM.

Specified band	2018 Actual	2017 Actual	Specified band	2018 Actual	2017 Actual
$100,000 - $109,999	25	23	$260,000 - $269,999	2	-
$110,000 - $119,999	17	18	$270,000 - $279,999	-	3
$120,000 - $129,999	11	12	$280,000 - $289,999	2	2
$130,000 - $139,999	7	3	$290,000 - $299,999	1	1
$140,000 - $149,999	4	5	$300,000 - $309,999	1	-
$150,000 - $159,999	3	3	$310,000 - $319,999	3	2
$160,000 - $169,999	2	2	$320,000 - $329,999	1	1
$170,000 - $179,999	2	2	$330,000 - $339,999	2	3
$180,000 - $189,999	1	-	$340,000 - $349,999	2	1
$190,000 - $199,999	1	2	$350,000 - $359,999	-	-
$200,000 - $209,999	2	-	$360,000 - $369,000	1	3
$210,000 - $219,999	-	2	$370,000 - $379,999	-	1
$220,000 - $229,999	-	2	$380,000 - $389,000	3	1
$230,000 - $239,999	1	1	$390,000 - $399,000	-	-
$240,000 - $249,999	1	-	$400,000 - $409,999	1	-
$250,000 - $259,999	3	1			
Total employees				**99**	**94**

COMPENSATION AND OTHER BENEFITS IN RELATION TO CESSATION OF EMPLOYMENT

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

During the year ended 30 June 2018, 30 (2017: 7) employees received payments relating to the termination of their employment totalling $632,201 (2017: $227,522). The majority of the payments relate to the closure of the age-related hospital level care facility, Dunsford Ward in Westport.

BOARD & COMMITTEE FEES

The total value of remuneration paid to each Board member during the year was:

Year ended 30 June 2018	Board	Advisory Committee	Total
Board members			
Chris Auchinvole	16,320	1,500	17,820
Jenny Black (Chairperson)	33,600	1,750	35,350
Kevin Brown	16,320	1,813	18,133
Helen Gillespie	16,320	1,500	17,820
Michelle Lomax	16,320	1,938	18,258
Chris Mackenzie (Deputy Chairperson)	20,400	2,000	22,400
Edie Moke	16,570	1,250	17,820
Peter Neame	16,320	1,500	17,820
Nigel Ogilvie	16,320	1,500	17,820
Elinor Stratford	16,320	2,063	18,383
Francois Tumahai	16,320	1,000	17,320
	201,130	**17,814**	**218,944**

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

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

No Board members received compensation or other benefits in relation to cessation (2017: nil).

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

Year ended 30 June 2018	Total Advisory Committee Fees
Advisory committee members	
Lynnette Beirne (CPHAC&DSAC)	1,750
Sarah Birchfield (CPHAC&DSAC)	2,000
Paula Cutbush (HAC)	1,500
Gail Howard (HAC)	750
Chris Lim (HAC)	1,750
Joseph Mason (CPHAC&DSAC)	750
Jenny McGIll (CPHAC&DSAC)	1,500
Mary Molloy (CPHAC&DSAC)	1,750
	11,750

4. Other Operating Expenses

ACCOUNTING POLICY

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

Operating leases

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

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

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

BREAKDOWN OF OTHER OPERATING EXPENSES

	Note	2018 Actual $000	2017 Actual $000
Impairment of debtors	7	51	39
Loss on disposal of property, plant and equipment	10	62	-
Audit fees paid to Audit NZ (for the audit of the financial statements- excluding disbursements)		113	110
Audit related fees for assurance and related services paid to other providers (Internal and Quality Audits)		48	113
Board and advisory members fees	3	231	230
Operating lease expenses		541	574
Other		422	413
		1,468	**1,479**

OPERATING LEASES AS LEASEE

The future aggregate minimum lease payments to be paid under non-cancellable operating lease are as follows:

	Note	2018 Actual $000	2017 Actual $000
Not more than one year		70	108
Later than one year and not later than five		30	2
Later than five years		-	-
Total non-cancellable operating lease		**100**	**110**

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

5. Capital Charge

ACCOUNTING POLICY

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

FURTHER INFORMATION

The West Coast DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the period ended 30 June 2018 was 6% (2017: 7% for six months to December 2016; 6% for six months to June 2017).

6. Cash and Cash Equivalents

ACCOUNTING POLICY

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

BREAKDOWN OF CASH AND CASH EQUIVALENTS AND FURTHER INFORMATION

	Note	2018 Actual $000	2017 Actual $000
Bank balances and call deposits		11,724	10,811
Term deposits less than 3 months		-	-
Cash and cash equivalents in the statement of cash flows	21	**11,724**	**10,811**

BANK FACILITY

West Coast DHB is a party to a DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2018, this limit was $7.253m (2017: $6.085m).

FINANCIAL ASSETS RECOGNISED SUBJECT TO RESTRICTIONS

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

Bank balance includes unspent donations received of $12k (2017: $20k) that are subject to restrictions. The restrictions generally specify how the donation is required to be spent (see note 16).

7. Receivables

ACCOUNTING POLICY

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

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

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

BREAKDOWN OF RECEIVABLES AND FURTHER INFORMATION

	Note	2018 Actual $000	2017 Actual $000
Trade receivables		310	358
Ministry of Health receivables		2,669	2,290
Other Crown receivables		431	1,413
Accrued revenue		31	395
Prepayments		330	601
Less: Provision for uncollectability		(64)	(65)
Total receivables		**3,707**	**4,992**

The ageing profile of receivables at year end is detailed below:

	2018			2017		
	Gross Receivable $000	Provision for uncollectability $000	Net $000	Gross Receivable $000	Provision for uncollectability $000	Net $000
Not past due	3,549	-	3,549	4,741	-	4,741
Due 1-30 days	44	-	44	-	-	-
Past due 31-60 days	22	-	22	8	-	8
Past due 61-90 days	31	-	31	-	-	-
Past due more 90 days	125	(64)	61	308	(65)	243
Total gross receivables	**3,771**	**(64)**	**3,707**	**5,057**	**(65)**	**4,992**

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

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

Trade receivables, prepayments and other receivables are from exchange revenue transactions. Receivables from the Ministry of Health can be a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in Receivables from the Ministry of Health is $nil (2017: $nil)

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

Movements in the provision for uncollectability of receivables are as follows:

	Note	2018 Actual $000	2017 Actual $000
Balance 1 July		65	52
Receivables written off during the year		(52)	(26)
Impairment reversed		-	-
Additional provision made during the year	4	51	39
Closing balance 30 June		**64**	**65**

8. Inventories

ACCOUNTING POLICY

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

Cost is principally determined on a weighted average cost basis.

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

BREAKDOWN OF INVENTORIES

	2018 Actual $000	2017 Actual $000
Pharmaceuticals	146	189
Surgical and medical supplies	898	852
Other supplies	14	18
	1,058	**1,059**

There were no write-downs of inventories or reversal of prior year write-downs during the year (2017: nil).

The amount of inventories recognised as an expense during the year ended 30 June 2018 was $2.053m (2017: $2.118m), which is included in the clinical supplies item of the statement of comprehensive revenue and expense.

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

9. Property, Plant and Equipment

ACCOUNTING POLICY

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

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

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

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

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

Revaluations

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

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

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

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

Additions

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

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

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

Subsequent costs

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

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

Disposals

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

Depreciation

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

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

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

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

Impairment of property, plant and equipment

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

Non-cash generating assets

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

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment

loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Estimating useful lives and residual values of property, plant and equipment

West Coast DHB reviews the useful lives and residual values of all of its property, plant and equipment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by West Coast DHB, and expected disposal proceeds from the sale of the future asset.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the statement of financial position. West Coast DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets;
- Asset replacement programs;
- Review of second hand market prices for similar assets; and
- Analysis of prior asset sales.

Changes to useful lives and residual values of land and buildings

West Coast DHB has made changes to past assumptions concerning useful lives and residual values.

The rebuild programme which commenced in 2015, we expect the new Grey facilities to be commissioned in the 2018/2019 year. The unused buildings on the Grey campus as a result from the new rebuild are expected to be physically demolished in the 2019/2020 year. In the prior year, we expected the existing Grey Base Hospital buildings would be demolished in the 2018/19 year.

West Coast DHB also reviewed the useful lives of other facilities (mainly Buller campus), the net impact on depreciation expense in 2017/2018 was $72,000.

During the 2016/17 year, West Coast DHB reviewed the residual values on the motor vehicle fleet, and the useful lives of the vehicle fleet. The result of this review meant the depreciation expense for motor vehicles has decreased in 2017/2018 by $180,000.

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent register valuer, Preston Rowe Paterson, PRP West Coast Ltd. The valuation was completed on March 2018, was reviewed and is effective as at 30 June 2018.

Land

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

Buildings

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

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

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

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

BREAKDOWN OF PROPERTY, PLANT AND EQUIPMENT AND FURTHER INFORMATION

FINANCIAL YEAR ENDED 30 JUNE 2018

	Land	Buildings & fit-out	Plant, equipment & vehicles	Leased assets	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Cost or Valuation						
Balance at 30 June 2017	6,735	14,317	24,453	-	3,195	48,700
Additions	-	576	851	-	2,970	4,397
Disposals/transfers	-	(12)	(2,651)	-	(1,369)	(4,032)
Revaluation increase(decrease)	120	(2,020)	-	-	-	(1,900)
Cost or valuation balance at 30 June 2018	**6,855**	**12,861**	**22,653**	**-**	**4,796**	**47,165**
Accumulated depreciation and impairment losses						
Balance at 1 July 2017	-	(4,064)	(18,386)	-	-	(22,450)
Depreciation charge for the year	-	(1,515)	(1,164)	-	-	(2,679)
Elimination on disposal/transfer	-	-	2,604	-	-	2,604
Elimination on revaluation	-	5,498	-	-	-	5,498
Accumulated depreciation and impairment losses at 30 June 2018	**-**	**(81)**	**(16,946)**	**-**	**-**	**(17,027)**

FINANCIAL YEAR ENDED 30 JUNE 2017

	Land	Buildings & fit-out	Plant, equipment & vehicles	Leased assets	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Cost or Valuation						
Balance at 30 June 2016	6,735	14,112	25,114	43	1,981	47,985
Additions	-	162	973	-	1,722	2,857
Disposals/transfers	-	43	(1,634)	(43)	(508)	(2,142)
Transfer from non-current assets held for sale	-	-	-	-	-	
Cost or valuation balance at 30 June 2017	**6,735**	**14,317**	**24,453**	**-**	**3,195**	**48,700**
Accumulated depreciation and impairment losses						
Balance at 30 June 2016	-	(2,408)	(18,711)	(7)	-	(21,126)
Depreciation charge for the year	-	(1,649)	(1,299)	-	-	(2,948)
Elimination on disposal/transfer	-	(7)	1,624	7	-	1,624
Elimination on revaluation	-	-	-	-	-	-
Accumulated depreciation and impairment losses at 30 June 2017	**-**	**(4,064)**	**(18,386)**	**-**	**-**	**(22,450)**

CARRYING AMOUNTS

	Land	Buildings & fit-out	Plant, equipment & vehicles	Leased assets	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000	$'000
At 30 June 2016	6,735	11,704	6,403	36	1,981	26,859
At 30 June 2017	6,735	10,253	6,067	-	3,195	26,250
At 30 June 2018	**6,855**	**12,780**	**5,707**	**-**	**4,796**	**30,138**

IMPAIRMENT

Engineering reviews of Grey Base buildings during the 2013 financial year identified structures which are earthquake prone. For these structures, West Coast DHB considered whether their carrying value exceeded their recoverable amount. As a result, West Coast DHB recognised a $2.6m asset impairment at 30 June 2013. As at 30 June 2018, no further impairment was considered necessary.

RESTRICTIONS ON TITLE

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

WORK IN PROGRESS

Buildings in the course of construction total $3.462m (2017: $2.460m)

FINANCE LEASES

West Coast DHB had no assets held under finance leases (2017: nil)

CAPITAL COMMITMENTS

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

	2018 Actual $000	2017 Actual $000
Buildings	179	108
Plant, equipment and vehicles	466	184
Intangibles	105	33
Total capital commitments at balance date	**750**	**325**

10. Intangible Assets

ACCOUNTING POLICY

Acquisition and development

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

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

Amortisation

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

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

	Years
Acquired computer software	2-10

Impairment

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Estimating useful lives of software assets

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

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

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

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

BREAKDOWN OF INTANGIBLE ASSETS

Movements for each class of intangible assets are as follows:

FINANCIAL YEAR ENDED 30 JUNE 2018

	Acquired software	Internally developed software $'000	NZ Health Partnerships Ltd $'000	Total $'000
Cost				
Balance at 30 June 2017	4,451	-	567	5,018
Additions	92	-	-	92
Disposals/transfers	(17)	-	-	(17)
Cost at 30 June 2018	**4,526**	**-**	**567**	**5,093**
Accumulated amortisation and impairment losses				
Balance at 1 July 2017	(3,815)	-	-	(3,815)
Amortisation charge for the year	(280)	-	-	(280)
Elimination on disposal/transfer	15	-	-	15
Impairment Losses	-	-	(48)	(48)
Accumulated depreciation and impairment losses at 30 June 2018	**(4,080)**	**-**	**(48)**	**(4,128)**

FINANCIAL YEAR ENDED 30 JUNE 2017

	Total software	Internally developed software $'000	NZ Health Partnerships Ltd $'000	Total $'000
Cost				
Balance at 30 June 2016	4,304	-	567	4,871
Additions	381	-	-	381
Disposals/transfers	(234)	-	-	(234)
Cost at 30 June 2017	**4,451**	**-**	**567**	**5,018**
Accumulated amortisation and impairment losses				
Balance at 30 June 2016	(3,623)	-	-	(3,623)
Amortisation charge for the year	(426)	-	-	(426)
Elimination on disposal/transfer	234	-	-	234
Impairment losses	-	-	-	-
Accumulated depreciation and impairment losses at 30 June 2017	**(3,815)**	**-**	**-**	**(3,815)**

CARRYING AMOUNTS

	Total software	Internally developed software $'000	NZ Health Partnerships Ltd $'000	Total $'000
At 30 June 2016	681	-	567	1,248
At 30 June 2017	636	-	567	1,203
At 30 June 2018	**446**	**-**	**519**	**965**

RESTRICTIONS

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

CAPITAL COMMITMENTS

West Coast DHB has contracted capital commitments of $105,000 (2017: $33,000) in relation to intangible assets.

IMPAIRMENT OF NEW ZEALAND HEALTH PARTNERSHIPS LIMITED (NZHPL)

An impairment of the NZHPL Change Management and Supply Chain as recommended by NZHPL ($48K) was recognised in June 2018.

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

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

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

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

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

11. Payables and deferred revenue

ACCOUNTING POLICY

Short-term payables are recorded at the amount payable

BREAKDOWN OF PAYABLES AND DEFERRED REVENUE

	Note	2018 Actual $000	2017 Actual $000
Payables and deferred revenue under exchange transactions			
Creditors		2,988	2,514
Accrued expenses		4,668	2,959
Deferred revenue		72	670
Total payables and deferred revenue under exchange transactions		**7,728**	**6,143**
Payables and deferred revenue under non-exchange transactions			
Taxes payable		1,448	1,359
Capital charge payable		-	-
Total Payables and deferred revenue under non-exchange transactions		**1,448**	**1,359**
Total Payables and deferred revenue		**9,176**	**7,502**

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

12. Borrowings

ACCOUNTING POLICY

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

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

Overdraft facility

Amount drawn under the NZHPL banking facility 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.

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICES

Lease classification

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

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

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

BREAKDOWN OF BORROWINGS

	Note	2018 Actual $000	2017 Actual $000
Current	-	-	-
Non-current	21	-	-
Total Borrowings	**-**	**-**	**-**

West Coast DHB has a maximum borrowing limit of $7.253m (2017: $6.085m) with NZHPL as at 30 June 2018. Refer to note 6 for further information.

CONVERSION OF CROWN LOANS TO EQUITY

In September 2016, Cabinet agreed that the DHB sector should no longer access Crown debt and for existing DHB Crown debt to be converted to Crown equity. On 15 February 2017, West Coast DHB Crown loans of $14.445m were converted into Crown equity. From that day onward, all Crown capital contributions to DHBs would be made via Crown equity injections. The termination of the Crown loan agreement and conversion of Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

13. Employee Entitlements

ACCOUNTING POLICY

Short-term employee entitlements

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

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

Sick leave

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

Long-term employee entitlements

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

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

Presentation of employee entitlements

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Sabbatical leave, long service leave and retirement gratuities

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

The discount rates used have been obtained from the NZ treasury published risk-free discount rates as at 4 July 2017. The salary inflation factor has been determined after considering historical salary inflation patterns.

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

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

Continuing medical education leave and expenses

The continuing medical education leave and expense liability assumes that the utilisations of the annual entitlement, which can be accumulated up to three years, will on average be 83% (2017: 85%) of the full entitlement. This utilisation assumption is based on recent experience.

BREAKDOWN OF EMPLOYEE ENTITLEMENTS AND BENEFITS

	2018 Actual $000	2017 Actual $000
Current portion		
Accrued salary and wages	2,727	1,664
Annual leave	4,320	4,179
Continuing medical education leave and expenses	767	690
Long-service leave	305	302
Other leave	1,567	1,569
Retirement gratuities	466	484
Sabbatical leave	19	-
Sick leave	80	99
Total current portion	**10,251**	**8,987**
Non-current portion		
Long-service leave	618	613
Retirement gratuities	1,746	2,010
Sabbatical leave	79	75
Total non-current portion	2,443	2,698
Total employee entitlements	**12,694**	**11,685**

14. Equity

ACCOUNTING POLICY

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

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

Property revaluation reserves

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

BREAKDOWN OF EQUITY

Reconciliation of movement in equity and reserves	Crown equity	Property revaluation reserve	Accumulated surpluses/ (deficits)	Total equity
Balance at 1 July 2017	86,062	22,082	(83,036)	25,108
Surplus/(deficit) for the year	-	-	(2,929)	(2,929)
Capital contributions from the Crown – debt/equity conversion	-	-	-	-
Repayment of capital to the Crown	(68)	-	-	(68)
Movement in revaluation of land	-	120	-	120
Movement in revaluation of buildings, fixtures and fittings	-	3,479	-	3,479
Movement in revaluation of building, fixtures and fittings due to impairment	-	-	-	-
Other movement/adjustment	-	-	-	-
Balance at 30 June 2018	**85,994**	**25,681**	**(85,965)**	**25,710**
Balance at 1 July 2016	72,563	22,082	(82,236)	12,409
Surplus/(deficit) for the year	-	-	(800)	(800)
Capital contributions from the Crown – debt/equity conversion	14,445	-	-	14,445
Repayment of capital to the Crown	(68)	-	-	(68)
Movement in revaluation of land	-	-	-	-
Movement in revaluation of buildings, fixtures and fittings	-	-	-	-
Movement in revaluation of building, fixtures and fittings due to impairment	-	-	-	-
Other movement/adjustment	(878)	-	-	(878)
Balance at 30 June 2017	**86,062**	**22,082**	**(83,036)**	**25,108**

CAPITAL MANAGEMENT

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

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

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

15. Patient Deposits

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

MOVEMENT OF PATIENT DEPOSITS

	Note	2018 Actual $000	2017 Actual $000
Opening balance patients deposits		69	67
Monies received		-	-
Interest earned		2	3
Payments made		-	(1)
Closing balance		**71**	**69**

16. Restricted Funds

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

MOVEMENT OF RESTRICTED FUNDS

	Note	2018 Actual $000	2017 Actual $000
Opening balance restricted funds		20	7
Monies received		56	30
Interest earned		-	-
Payments made		(64)	(17)
Closing balance		12	20

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

	Note	2018 Actual $000	2017 Actual $000
Net surplus/(deficit)		**(2,929)**	**(800)**
Add/ (less) non-cash items:			
Donated assets		(432)	-
Depreciation and amortisation expense		2,959	3,373
Equity receivable		-	(878)
		2,527	2,495
Movements in working capital:			
(Increase)/decrease in receivables		1,267	949
(Increase)/decrease in inventories		1	(74)
Increase/(decrease) in payables and deferred revenue		1,884	(1,425)
Increase/(decrease) in employee benefits		1,009	597
Net movement in working capital		4,161	47
Net cash flow from operating activities		**3,759**	**1,742**

18. Contingencies

CONTINGENT LIABILITIES

SUPERANNUATION SCHEMES

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

As at 31 March 2018, the scheme had a past service surplus of $6.606m (exclusive of Employer Superannuation Contribution Tax) (2017: $7.953m). This surplus was calculated using the discount rate equal to expected return on net assets, but otherwise the assumptions and methodology were consistent with the requirement of PBE IPAS 25.

In March 2015 the actuary of the scheme has recommended that the employer contributions remain suspended. Employer contributions were stopped from 1 April 2017.

OUTSTANDING LEGAL PROCEEDINGS

West Coast DHB has no material outstanding legal proceedings as at 30 June 2018 (2017: nil).

COMPLIANCE WITH HOLIDAYS ACT 2003

Many public and private sector entities, including the DHB, are continuing to investigate historic underpayment of holiday entitlements.

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

DHBs have decided to take a national approach and have been working with key stakeholders to define a baseline interpretation document for the health sector. This is substantially agreed, but there are some remaining issues which are in the process of being resolved. The intention is that,

once the baseline document is agreed, this would be used by each DHB to systematically assess their liability.

West Coast DHB has not made an estimate and instead disclosed a contingent liability in its financial statements.

Until the baseline document is agreed and approved by DHBs nationally, MBIE and the NZCTU, there is uncertainty over any actual costs that will be required to be paid to DHB staff, so any future liability cannot be reasonably estimated.

CONTINGENT ASSETS

The West Coast DHB has no contingent assets (2017: nil).

19. Related Party Transactions

ACCOUNTING POLICY

Transactions eliminated on consolidation

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

West Coast DHB is controlled by the Crown.

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

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

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

SIGNIFICANT TRANSACTIONS WITH GOVERNMENT RELATED ENTITIES

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

West Coast DHB has received funding from the Crown, ACC and other government entities of $139m to provide health services in the West Coast area for the year ended 30 June 2018 (2017: $133m). Refer to note 7 for amounts receivable.

Revenue earned from other DHBs for the care of patients domiciled outside West Coast DHB's district as well as services provided to other DHBs amounted to $1.71m for the year ended 30 June 2018 (2017: $1.66m).

Expenditure to other DHBs for the care of patients from West Coast DHB's district and services provided from other DHBs amounted to $20.33m for the year ended 30 June 2018 (2017: $19.62m).

OTHER SIGNIFICANT TRANSACTIONS WITH GOVERNMENT-RELATED ENTITIES

In conducting its activities, West Coast DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to

all tax and levy payers. West Coast DHB is exempt from paying income tax. See note 11 for amounts payable.

West Coast DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2018 totalled $351k (2017: $770k). These purchases included the purchase of blood products from the New Zealand Blood Service, electricity from Genesis Energy and services from educational institutions.

COMPENSATION OF KEY MANAGEMENT PERSONNEL

	2018 Actual $	2017 Actual $
Board members		
Remuneration	218,943	218,693
Full-time equivalent members	2.15	2.15
Executive management		
Remuneration	1,106,933	1,081,000
Post -employment benefits	30,000	20,000
Full-time equivalent members	4.00	5.00
Total key management personnel remuneration	1,355,876	1,319,693
Total full-time equivalent members	6.15	7.15

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

At June 2018, the executive management team consisted of 4 members (2017: 5) employed by West Coast DHB and a further 7 members, including the Chief Executive, who were employed by Canterbury DHB (2017: 6). The key management personnel services provided by the Office of the Chief Executive are provided to West Coast DHB under contract by Canterbury DHB and are invoiced accordingly- 2018: $316k (2017: $300k).

No executive management personnel were Board members (2017: nil).

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

20. Events after Balance Date

There were no significant events after balance date (2017: Nil)

21. Financial Instruments

FINANCIAL INSTRUMENT CATEGORIES

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

West Coast DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances (note 6), trade receivables (note 7), payables (note 11) and loans

(in February 2017 all loans were swapped to equity). Refer to specific notes to the financial statements for applicable detailed explanations for the instruments.

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

	2018 Actual $000	2017 Actual $000
Loans and receivables		
Cash and cash equivalents	11,724	10,811
Receivables	3,707	4,992
Investments	-	-
Total loans and receivables	**15,431**	**15,803**
Financial Liabilities measured at amortised cost		
Payables (excluding deferred revenue and taxes)	**7,656**	**5,473**

FINANCIAL INSTRUMENT RISKS

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

MARKET RISK

Price risk

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

Fair value interest rate risk

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

Cash flow interest rate risk

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

Sensitivity analysis

As at June 2018, if the floating rates had been 100 basis points higher/lower, with all other variance held constant, the deficit for the year would have been $5K lower/higher (2017: +/-$5K)

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. West Coast DHB has low currency risk given that the majority of financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2018 (2017: nil)

Credit risk

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

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

The Board places its cash and term investments with quality financial institutions via a national DHB shared banking arrangement, facilitated by NZHPL. West Coast DHB has experienced no defaults of interest or principal payments for term deposits.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry, which comprises 72% (2017: 46%) of the debtors of West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHB) total reliance on Government debtors is 84% (2017: 74%). The Ministry of Health, as the government funder of health and disability support services for the West Coast region and other Crown entities are high credit quality entities and the Board considers the risk arising from this concentration of credit to be very low.

Credit quality of financial assets

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

	2018 Actual $000	2017 Actual $000
Counterparties with credit ratings		
Cash and cash equivalents		
Westpac New Zealand Ltd- rating AA-	35	64
Total cash and cash equivalents	**35**	**64**
Counterparties without credit ratings		
NZ Health Partnerships Ltd - no defaults in the past	11,683	10,743
Receivables:		
Existing counterparty with no defaults in the past	3,593	4,141
Existing counterparty with defaults in the past	-	-
Total counterparties without credit ratings	**15,276**	**14,884**

LIQUIDITY RISK

Management of liquidity risk

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

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

Contracted maturity analysis of financial liabilities

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

	Carrying amount $'000	Contracted cash flows $'000	Less than 1 year $'000	1-2 years $'000	More than 2 years $'000
2018					
Payables	9,176	9,176	9,176	-	-
Total	**9,176**	**9,176**	**9,176**	**-**	**-**
2017					
Payables	7,502	7,502	7,502	-	-
Total	**7,502**	**7,502**	**7,502**	**-**	**-**

22. Explanation of Major Variances against Budget

Explanations for major variances from the DHB's budgeted figures in the 2017/2018 Annual plan are as follows:

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

REVENUE

Revenue had a 1% favourable variance between our planned revenues of $148m compared to actual revenue of $149m. The main factors influencing this favourable variance were:

Patient care revenue was $398K higher than budgeted, mainly due to:

- Higher than planned revenue of $212K from Health Workforce NZ, mainly for medical workforce training
- Favourable variance of $170K in non- government revenue streams such as non-eligible, patient co-payments and WCPHO revenue.

Other operating revenue was $561K higher than planned mainly due to due to donations totalling $515K.

EXPENSES

Expenses had a 1% unfavourable variance between our planned expenditure of $150m compared to actual expenditure of $152m. The main factors influencing this overspend were:

- Depreciation which was $0.438m lower than budget which was due to a review of the useful lives of our buildings in Grey and Buller districts.

- Overall personnel costs were unfavourable to budget by $0.343m. Allied and Medical employees spend was favourable to budget by $1.4m due to inability to recruit to vacant positons (this saving was offset in outsourced below). Offsetting this favourable result was Nursing employees spend – showing an unfavourable result to budget of $1.7m largely due to MECA settlement and restructure costs.

- Outsourced personnel which was $1.177m above budget, principally related to locum costs which continue to be incurred for a number of reasons, with the major driver continuing to be the difficulties in recruitment and retention of all medical staff from RMOs to GPs. While every effort is made to mitigate locum costs, the issues with the level of Locum payments are part of the challenges of the operating environment for the West Coast DHB.

- Expenditure on clinical supplies were $0.630m higher than budgeted due to high costs pharmaceuticals and increased costs in air transfers.

OTHER COMPREHENSIVE INCOME

Gain on revaluation of land and buildings of $3.6m was not budgeted.

STATEMENT OF FINANCIAL POSITION

Cash and cash equivalents were less than expected mainly due to not receiving the deficit support funding from Ministry of Health. The Other main variant in our budgeted cash position is due to the delay in the commissioning of the Grey campus which has delayed capital expenditure on FFE.

Receivables were $1.4m better than expected due to better debt collection management.

Property, plant and equipment variance of $74m relates to delay in commissioning of the Grey campus development.

Employee entitlements – current portion increase relates to accrual of unpaid salary and wages at year end – mainly driven from unpaid MECA settlements.

STATEMENT OF CHANGES IN EQUITY

The total comprehensive revenue and expenses was $2.711m better than budgeted due to the statement of comprehensive revenue and expenses explanation provided above. The major difference being the gain on revaluation of land and buildings of $3.6million was not budgeted.

Capital contributions from the Crown, unfavourable variance is related to the delay in commissioning of the Grey campus redevelopment $77.8m and $3.4m deficit support not received from the Ministry of Health.

STATEMENT OF CASH FLOWS

The balance of the cash and cash equivalents at the end of the year was $0.963m less than budgeted as discussed above this mainly relates to capital expenditure for Grey Facility development timeframes and deficit support funding not received.

23. Revenue Appropriation

Under the Public Finance Act, West Coast DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by West Coast DHB for the financial year 2017/18 is $132.050m (2017: $126.540m) which equals the Government's actual expenses incurred in relation to the appropriation.

24. Statement of Intent

West Coast DHB is required to complete its Statement of Performance Expectations by the start of the financial year under section 149C of the Crown Entities Act 2004. This requirement has not been met for the 2018/19 year. The 2018/19 Statement of Performance Expectations is yet to be approved by the Board at the time of issuing the 30 June 2018 financial statements.

25. Summary of Cost of Services

The table below summarises the revenue and expenditure for the four output classes for the year ended 30 June 2018.

	2018 Actual $000	2018 Budget $000	2017 Actual $000
Revenue			
Prevention	3,372	2,082	2,977
Early Detection and Management	28,560	23,678	27,129
Intensive Assessment and Treatment	97,035	100,047	93,234
Rehabilitation and Support	20,203	22,445	19,432
Total Revenue	**149,170**	**148,252**	**142,772**
Expenditure			
Prevention	3,665	2,409	3,086
Early Detection and Management	29,165	42,639	26,781
Intensive Assessment and Treatment	99,170	72,851	94,708
Rehabilitation and Support	20,099	32,394	18,997
Total Expenditure	152,099	150,293	143,572
Surplus/(Deficit)	**(2,929)**	**(2,041)**	**(800)**

Part VI
Independent Auditor's Report

Independent Auditor's Report

To the readers of West Coast District Health Board's financial statements and performance information for the year ended 30 June 2018

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

Opinion

We have audited:

- the financial statements of the Health Board on pages 42 to 78, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include the statement of accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 8 to 32 and 79

In our opinion:

- the financial statements of the Health Board on pages 42 to 78:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2018; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with the applicable financial reporting framework; and
- the performance information of the Health Board on pages 8 to 32 and 79
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2018, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriations; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 25 October 2018. This is the date at which our opinion is expressed.

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

Compliance with the Holidays Act 2003

District Health Boards (DHBs) have been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003. A national approach is being taken to remediate these issues. Due to the nature of DHB employment arrangements, this is a complex and time consuming process. This matter may result in significant liabilities for some DHBs. The Health Board has provided further disclosure about this matter in note 18 on page 72. Our opinion is not modified in respect of this matter.

Failure to complete the statement of performance expectations for the reporting period beginning 1 July 2018

We draw your attention to the disclosures made in note 24 on page 78 about the failure to comply with section 149C of the Crown Entities Act 2004, which requires the DHB to complete its statement of performance expectations before the start of the financial year. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

Basis for our opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our responsibilities arise from the Public Audit Act 2001.

Other information

The Board is responsible for the other information. The other information comprises the information included on pages 4 to 6 and 34 to 40, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

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

Independence

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

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

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