Annual Report 2018/19

Photo courtesy of Wendy Elwood

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

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

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Board Members
Jenny Black, Chair
Chris Mackenzie, Deputy Chair
Chris Auchinvole
Kevin Brown
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Michelle Lomax
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Peter Neame
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Part I
Overview

Statutory Information

This Annual Report presents West Coast DHB's financial and non-financial performance for the year ended 30 June 2019. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

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

Statement of Responsibility

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

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

In our opinion, except for the substantial uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003 and the uncertain impact on the financial statements as described in note 13 on page 63, these financial statements and the performance information fairly reflect the financial position and operations of West Coast District Health Board for the year ended 30 June 2019.
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Signed on behalf of the Board:

Jenny Black
Chair

29 October 2019

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

29 October 2019

Foreword from the Chair and Chief Executive

32,600 reasons to make a difference

Our communities are at the heart of our healthcare services

Our DHB team of just over 1,000 people, and all the others working together in the West Coast Alliance are dedicated to ensuring that Coasters are always at the heart of our healthcare services.

We have some unique challenges compared to the rest of New Zealand, in terms of our population's health status, socio-demographics, our small population size, and the large geographical area we cover from Karamea to Haast.

To address these challenges, we need to work together so that our patients, clients, neighbours, friends and whānau have access to the right level of care in a timely way.

Improving accessibility to health services and care closer to home for West Coasters

We are continually looking at ways to improve how we provide integrated well-connected services across our health system that wraps care around the patient and helps people to stay healthy and well in their own community while being both clinically and financially viable. To achieve this, we need to ensure our services are more accessible and available closer to people's homes.

Over the past year, we have focused on how to embed our new integrated primary/community service model into the West Coast health system so that we can better support the health needs of our population. Our move to Te Nīkau Grey Hospital and Health Centre will underpin this transformation by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service delivery.

We continue to work with our Canterbury DHB colleagues to deliver clinically-led transalpine service pathways across the Coast. Our formal transalpine arrangement allows the West Coast DHB to develop its workforce and infrastructure to ensure we meet the health needs of our population. Canterbury-based specialists provide regular outpatient clinics and surgical lists on the Coast. These services are supported by the use of telehealth technology, with both our Canterbury colleagues as well as up and down the Coast itself, thereby saving patients and their whānau the inconvenience of travelling long distances for assessment and treatment.

Leadership in a rural generalist workforce

We are leading the way in the development of a rural workforce, and are successfully overseeing the transformation of our rural generalist model. By applying this model to all our professions - medical, nursing and allied health – we are developing a more sustainable workforce that is able to provide greater continuity of care and access to care to our Coast communities.

Rural generalism can mean different things to different people. In reality it is a health system where there is a partnership with the community, improved access to primary care, improved continuity and consistency of care, improved coordination between general practice, hospitals and community providers, community-based care via integrated family health centres and greater clinical leadership while living within our means.

By working under a rural generalist model, our staff are provided with opportunities to upskill and to learn new skills enabling them to work to the full extent of their scope of practice. This way of working lends itself well to the provision of services within a 'system of care' to our community by a highly skilled inter-professional and multi-disciplinary team.

Māori Health

It is especially important that we are clearly focused as an organisation and a health system on reducing inequalities in health outcomes for our Māori community. The introduction by our Māori Health team of Takarangi Cultural Competency framework to the DHB's workforce is a step in the right direction. Takarangi framework objectives focus on improving the responsiveness to the needs of Māori, improving practice, increasing participants' ability to work with clients and whānau, learning about how to use Māori cultural procedures and processes, and improving confidence in delivering integrated practice.

Transforming our mental health services

We have made good progress over the past year in our review of, and planning for, the future transformation of our mental health services. We have consulted with our service users, staff, NGO providers and other stakeholders about how to effectively reorient our services and have made some important decisions. We want to improve equity and access to our crisis response services, provide stronger more visible community and district-wide services and ensure that we have

greater capability and capacity to provide 24/7 mental health services.

Our focus is now on putting strong operational structures in place to deliver robust community-based rural mental health services across the Coast including crisis response. In everything we do, our people receiving treatment and care and wellbeing support remain the focus of our care model. This means that people presenting in crisis will be more likely to be seen closer to home and receive better continuity of care.

We are confident that future changes will provide those working in mental health and addiction with exciting opportunities to increase their skills thus allowing them to provide a wider range of care and support to people across the Coast.

Our people are diverse, flexible and highly skilled

We are fortunate to have a diverse, flexible and highly skilled workforce that is focused on meeting the needs of our population and doing their best for the patient and the system. In our rurally isolated environment, we face significant difficulties in recruiting and retaining the right people with the right skills to support our system. Attracting and retaining capable people, with a real passion for rural health, is one of our critical success factors.

We are committed to being a good employer. We promote equity, provide a safe and healthy workplace and have a clear set of organisational values and core operational policies. We are passionate about fostering a culture where everyone understands their contribution, is empowered to make good decisions and where they are well supported to thrive.

Key appointments made during the year

In June 2019 Brittany Jenkins, former Nurse Manager – Workforce Development was appointed Director of Nursing and Rosalie Waghorn was appointed Quality and Patient Safety Manager.

Earlier in the year, we appointed Deborah Wright as Manager Integrated Health Services, Northern Region.

Facilities update

Te Nīkau Grey Hospital and Health Centre is progressing and although the handover date is currently unknown staff are looking forward to their new facilities. Following handover of the building from the contractor to the Ministry of Health, the DHB will prepare the facility for operational use over a period of approximately 10 weeks. The facility will be clinically cleaned and stocked and staff orientation and training will occur during this time. The migration of the existing hospital to the new facility will follow over a period of 10 days.

Construction of the new West Coast DHB administration building on Cowper Street commenced in early June after the old Cowper Street building and the two adjoining DHB owned houses were demolished in late May. The building will provide a facility for most other DHB personnel who will not be based within Te Nīkau Grey Hospital and Health Centre, or in the existing corporate services building. Construction of this is expected to be completed late 2019.

Work has progressed on the planned new Buller Health facility since the project was transferred back to the West Coast DHB from the Ministry of Health in December 2018. In May, following a re-engagement process, West Coast DHB's Board endorsed the final Buller Health facility concept design. It is anticipated that the design will be completed by late 2019.

Tracking our performance

Our performance is measured against the strategic objectives of our health system: people are healthier and enabled to take greater responsibility for their own health; people stay well in their own homes and communities and people with complex illnesses have improved health outcomes.

While we have made very good progress in many areas, we are always looking for ways we can improve delivery of health services across a remote rural environment to a diverse population.

We have extended our Smokefree Pregnancies Incentive programme to provide mothers with incentives into the first four months post-partum as part of the Sudden Unexplained Death in Infancy (SUDI) prevention programme.

A focus by DHB owned practices on the consenting process for BreastScreen Aotearoa and support from Poutini Waiora has seen our breast screening rates for Māori women increase from 61% to 69% and for Pasifika women from 32% to 44%.

As a result of the strong partnership between Poutini Waiora, the West Coast Primary Health Organisation and DHB Clinical Nurse Specialists, we can report success in improved care for Māori with diabetes. This work will continue next year with the intention to expand the model in to Reefton.

It is pleasing to see that initial data extraction from Medtech systems at our general practices show a promising number of adults have had their alcohol consumption documented. This will provide a good basis from which to develop some ongoing monitoring.

A quality improvement project that has seen collaboration between our DHB B4 School Check (B4SC) service, and our integrated nutrition services has decreased the proportion of families declining a referral as a result of a high Body Mass Index (BMI) at the check. 73% of children identified as obese at their B4SC are now accepting support and ongoing monitoring of their growth, up from 40% on 2017/18.

In late 2018/19, a Food Security Steering Group consisting of representatives from a number of agencies including Community and Public Health, the Ministry of Social Development, the Department of Internal Affairs and community members was established. The group's primary focus is looking at how our regional food system can support access to nourishing food for all Coasters.

With an ageing population and the increased prevalence of long-term conditions placing significant pressure on our ability to meet the needs of our population we have been working to increase our capacity to provide the necessary services. Education and support about end of life care in both Aged Residential Care as well as community providers has been provided to staff with additional support received through our transalpine agreement from Canterbury DHB's Palliative Care service.

All community pharmacies have new service agreements with the DHB which are 'evergreen' and support the provision of integrated pharmacy services to our communities as well as enabling regular service updates through a national annual review. We now have two integrated pharmacy positions working across both hospital and the community who are focused on improving access to pharmacy services for our more complex patients.

We would like to thank all of our staff along with our alliance partners and the many community providers who are part of the wider West Coast health system. You can all be proud of your contributions as your efforts have made such a difference to those we support and provide services to across the Coast.

We look forward to an exciting year ahead with the planned migration to Te Nīkau Grey Hospital and Health Centre and the transformation of our health system towards more integrated and sustainable service delivery.

Jenny Black
Chair

David Meates
Chief Executive

29 October 2019

Part II
Improving Outcomes

Are We Making a Difference?

DHBs have a number of different roles and associated responsibilities. 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 the return on investment in terms of health outcomes. As a provider, we are concerned with the quality of the services we deliver and the efficiency with which we deliver them.

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

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

At the highest level the framework reflects three outcome goals, where we believe success will have a positive impact on the health of our population. The framework also encompasses national direction and expectations, through the inclusion of national targets and system level measures.

Under each outcome goal we have identified a number of long-term population health indicators which will provide insight into how well our health system is performing over time.

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

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

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

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

These measures sit alongside our Statement of Performance Expectations (in the following section of this report), which outlines the services we planned to deliver and the standards we expected to meet in the past year, and they form an essential part of the way in which we are held to account.

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

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

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 the expectations and priorities of Government.

West Coast DHB – Overarching 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

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. Cancers, heart disease, musculoskeletal conditions, respiratory disease, diabetes and mental illness are major drivers of poor health and premature mortality and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates that long-term conditions make up 87.3% of all health loss in New Zealand up from 82.5% in 1990. By 2026 almost a quarter of the West Coast population will be aged over 65, and 13% 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, hazardous drinking and substance abuse are major risk factors for a number of the most common long-term conditions. These are modifiable risk factors and can be reduced through supportive environments and improved awareness, which enable people to take personal responsibility for health and wellbeing. Public health, promotion and education services, by supporting people to make healthier lifestyle choices, will improve health outcomes for our population. Because these major risk factors also have strong socio-economic gradients, a change in behaviours will contribute to reducing inequities in health outcomes between population groups.

Tobacco smoking, inactivity, poor nutrition, alcohol consumption and obesity are significant risk factors for a number of the most prevalent long-term conditions. These are modifiable risk factors which can be reduced through supportive environments and strategies that enable people to change their behaviours 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 reducing smoking and obesity rates. Because these risk factors have strong socio-economic gradients, this focus will contribute to reducing health inequities for our Māori and Pacific populations.

OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

A reduction in smoking rates

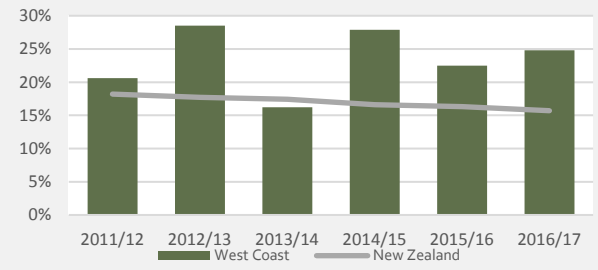
The latest NZ Health Survey results indicate that 25% of our population smoke. The West Coast's smoking rates are still well above the national average (16%), are further work is needed to help our community understand the health risks associated with smoking, and change their behaviour. Combined results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

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

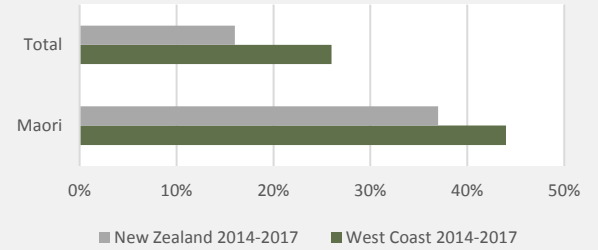
We continue to deliver brief smoking advice and cessation support at all contact points across our health system, with a particular focus on pregnant women. In 2018/19, 100% of pregnant smokers (identified as smokers when registering with a lead maternity carer) were offered brief advice and support to quit smoking.

In the past 15 months, more than 96% of current smokers in primary care were offered brief advice to quit and more than 40% were offered cessation support. More than 90% of hospitalised smokers were also offered brief advice and cessation support in 2018/19.

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 presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers. For further information refer to the Ministry website for the NZ Health Survey results.

OUTCOME MEASURE – A REDUCTION IN OBESITY RATES

A reduction in obesity rates

The West Coast obesity rate fell slightly to the level of the national average between 2015/16 and 2016/17.

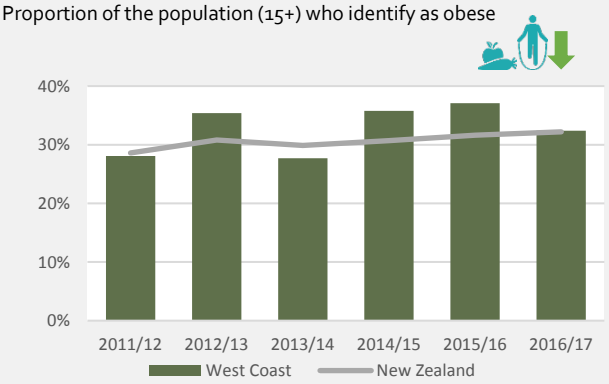
Obesity impacts on people's quality of life and is a significant risk factor for many long-term conditions. While many of the drivers sit outside of the direct control of the health system, we have a role in supporting the creation of health promoting environments and the delivery of programmes that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

Children and families who may need weight management and healthy lifestyle support are identified at their B4 School (health) Check prior to starting school. In 2018/19, 93% of four-year-olds received their B4 School Check and 94% of those children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice.

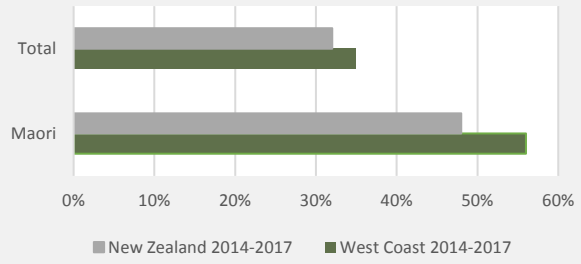
We also continue to invest in lifestyle programmes that support people to increase physical activity or make healthy food choices, including the Green Prescription programme. In 2018/19, 458 people were referred by their health professional to the Green Prescription programme.

Signs are positive with the latest bi-annual survey results showing 65% of participants remained more active 6-8 months after taking up a green prescription 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]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer avoidable hospital admissions

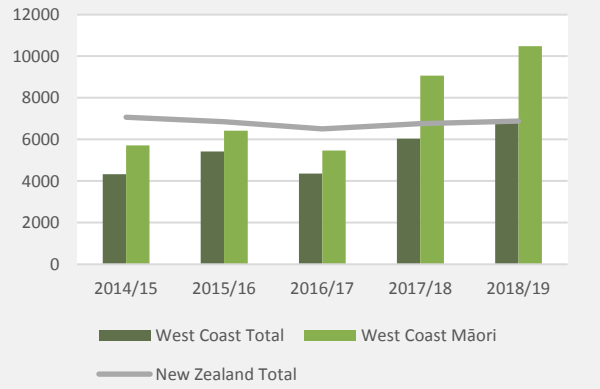
In 2018/19, West Coast's ambulatory sensitive hospital (ASH) admission rate for children under five was 6,968 per 100,000, which was above the target and national rate of 6,881.

The West Coast ASH rate for children is adversely impacted by our small population. The difference in the total population rate between March 2018 and March 2019 represents only 14 hospital admissions across the whole year. The increase in the Māori rate reflects just four more events over the same time period.

Work is ongoing to identify the reasons behind the increases over the past two years, however with such small population numbers changes in clinical practice may be a contributing factor. Upper respiratory and ear, nose and throat infections are the largest contributor to this year's ASH rate followed closely by dental conditions.

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system that engages earlier with parents and children. In the past year, 95% of new-borns were enrolled with a primary care team before three months of age.

Measure: Rate of ASH admissions for children (0-4)	2016/17	2017/18	Target	Result
	4,361	6,031	<6,416	6,968



Data Source: Ministry of Health Performance Reporting [3]

[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 presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers. For further information refer to the Ministry website for the NZ Health Survey results. The Survey defines 'Obese' as having a Body Mass Index (BMI) of >30, or >32 for people of Māori and Pacific ethnicity.

[3] This measure is a national DHB performance indicator and captures hospital admissions for conditions considered preventable, including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the DHB's aim is to maintain performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The results presented differ to those previously published, being based off the national March 2019 series provided by the Ministry of Health in August 2019.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

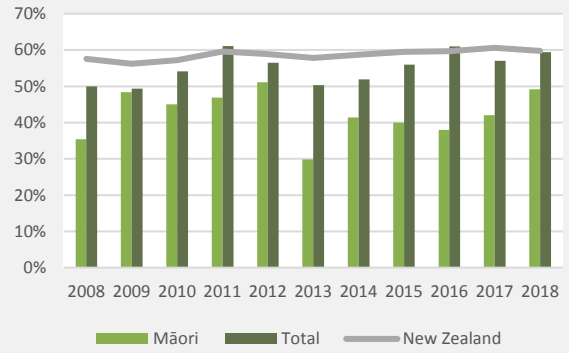
Children have improved oral health

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

The percentage of five-year-old children whose teeth are caries-free (have no holes or fillings) has improved slightly compared with last year for the total population (59%) sitting just below the New Zealand average rate (60%). Māori rates (49%) improved for the second year in a row continuing the positive trend which has seen an increase of 11% over the past two years. Positive strides are being made in this space.

A transalpine Oral Health Alliance is working to address equity gaps and improve data use and sharing across child services to better identify children and help establish contact with families. Enrolment data for 2018/19 shows than 100% of children aged 0-4 are enrolled with the DHB's school and community oral health services.

Measure: Children caries-free at age 5	2016	2017	Target	Result
	61%	57%	58%	59%



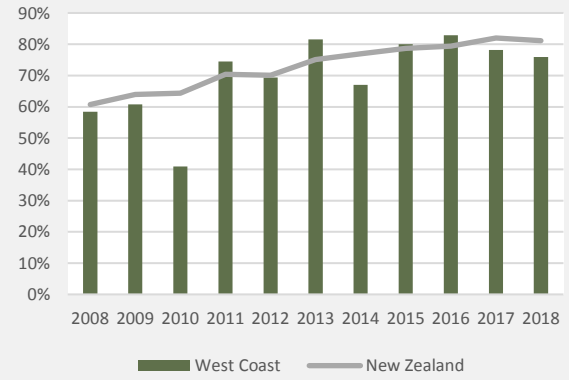
Data Source: DHB School & Community Oral Health Services [4]

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 West Coast 2018 survey results show a slight drop-off from 2017 which is in line with national results. Overall 76% of West Coast year 10 students reported having never smoked compared to 81% across New Zealand. The small West Coast population contributes to fluctuations between years, however the long term trend is a clear reduction in smoking rates amongst young people.

Measure: 'Never Smokers' amongst Year 10 students	2016	2017	Target	Result
	83%	78%	>79%	76%



Data Source: National ASH Year 10 Survey [5]

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

[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. The 2018 results are preliminary and are subject to change. 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, in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital admission, residential care or premature mortality (death). This is not only better in terms of people's health outcomes and quality of life, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital-level response.

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN ACUTE MEDICAL ADMISSIONS

A reduction in the rate of acute hospital admissions

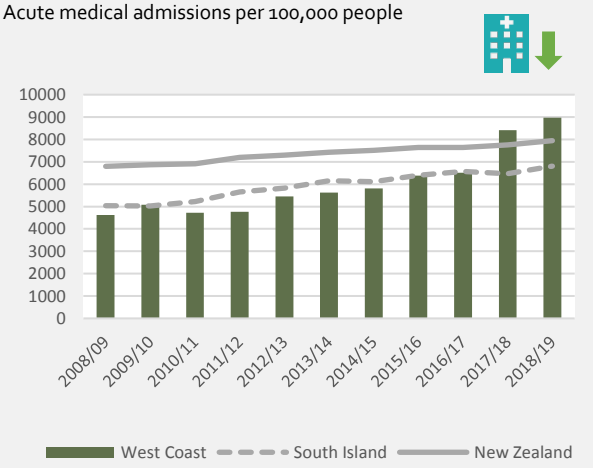
With the right intervention and support, people can avoid the deterioration of their condition or reduce the likelihood of an event that leads to hospital admission, complications, long-term illness or even premature death. We seek to reduce medical admissions that are potentially avoidable through prevention, 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 8,967 per 100,000 people in 2018/19, our rate has lifted well above both the South Island and national average.

The increase between 2017/18 and 2018/19 is 120 admissions, an average of two per week. West Coast has experienced a significant decrease in the average length of stay for acute services from 2.34 in 2017/18 to 2.13 this year as well as a significant reduction in bed days, suggesting a change in clinical admitting practice may be contributing to the increase over the past two years. We are working with staff to identify the drivers behind this.

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 2018/19

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 – MORE PEOPLE LIVING IN THEIR OWN HOMES

More people living in their own homes

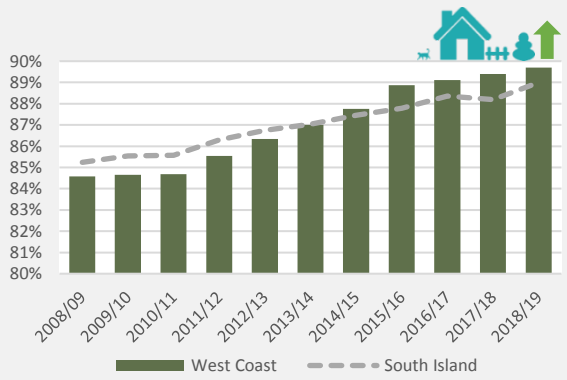
The proportion of the West Coast population (aged 75+) living in their own homes continues to increase, lifting to 89.7% compared to 89.4% last year. Consistent with our strategy, this positive trend suggests our older population is healthier and is able, or being supported, to live more independently.

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 4.6%, the proportion of our population (75+) admitted to hospital as a result of a fall is lower than the previous year and 0.6% lower than the national average.

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



Data Source: SIAPO Client Claims Payment System

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People's conditions are diagnosed earlier

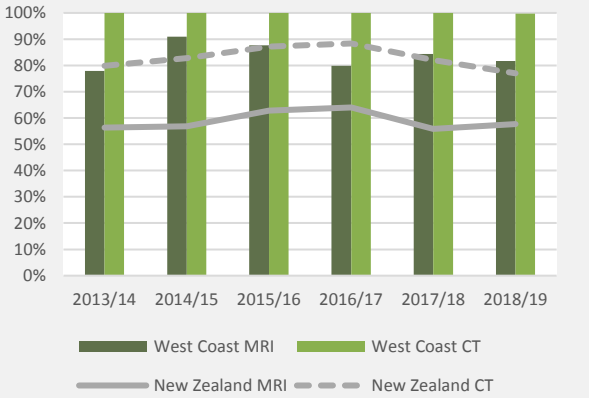
Diagnostics are an important part of the healthcare journey and timely access to diagnostics improves clinical decision making and enables early and appropriate intervention. This improves the quality of care and outcomes for our population.

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 Canterbury has been experiencing capacity issues over the past year, which is reflected in the wait times for our population.

The West Coast DHB has continued to achieve the wait time target for CT scans, with 99.7% of people referred seen within six weeks.

In the past year 1,822 West Coast referrals were accepted for CT or MRI scans.[7]

Measure: People receiving scans within 6 weeks		2016/17	2017/18	Target	Result
	MRI	80%	84%	90%	82%
	CT	100%	100%	95%	99.7%



Data Source: DHB Patient Management System

[7] The radiology measures are national DHB performance indicators, baselines presented differ from those previously reported, having been reset from year-end results (June of each year) to full year (12 month) results.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

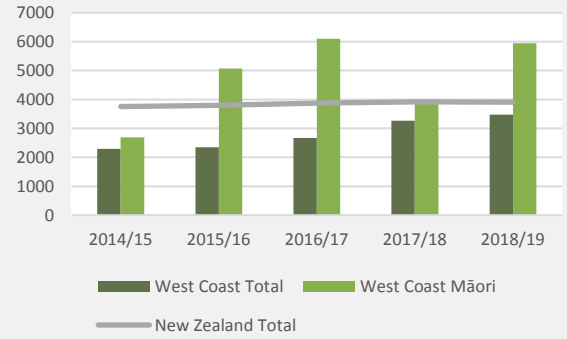
Fewer avoidable hospital admissions

In 2018/19, West Coast's avoidable hospital admission rate for 45-64 year-olds was 3,480 per 100,000 people. This result is better than the target of 3,892 and below the national rate (3,905). Our Māori rate has increased to 5,942 following a low in 2017/18 of 3,970, however this represents just 16 additional admissions over the year. The national Māori rate remained significantly higher than the West Coast result at 8,092 admissions per 100,000.

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

High enrolment rates are an indication of good engagement with our health system and Māori enrolment with general practice increased to 86% in 2018/19.

Measure: Rate of ASH admissions for adults (45-64).	2016/17	2017/18	Target	Result
	2,666	3,262	<3,892	3,480



Data Source: Ministry of Health Performance Reporting [8]

Fewer falls-related hospitalisations

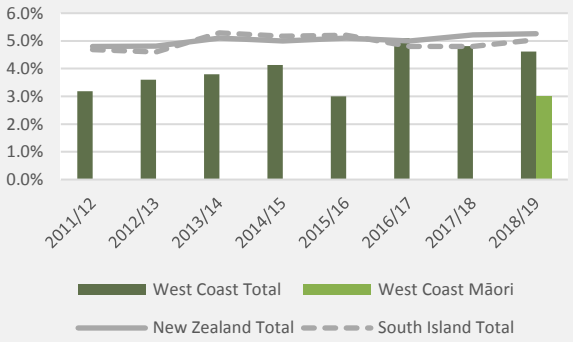
At 4.6%, the proportion of our population (aged 75+) admitted to hospital as a result of a fall is lower than the previous year and 0.7% lower than the national average.

This is a positive trend which is in contrast to the increasing South Island rate. 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, 143 people accessed the community-based falls prevention service on the Coast.

We have begun to track Māori fall rates and will look to investigate these in 2019/20, as they occur at a younger age.

Measure: Population (75+) admitted to hospital as a result of a fall	2016/17	2017/18	Target	Result
	5.1%	4.8%	<5.0%	4.6%



Data Source: National Minimum Data Set

[8] This measure is a national DHB performance indicator 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 performance below the national rate (which reflects fewer people presenting to hospital), and to reduce the equity gap between population groups. The results presented differ to those previously published, being based off the national March 2019 series provided by the Ministry of Health in August 2019.

People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

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

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

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

Fewer people readmitted to hospital

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

West Coast's readmission trend has been relatively flat over the last couple of years and at 10.6% our readmission rate is below the national average of 12%.

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.

FIRST, our Flexible Integrated Rehabilitation Support Team, is now up and running, with 14 people supported back into the community following discharge from our hospitals. In the past 12 months, 143 people accessing the community-based falls prevention service and 98% of people were referred to a stroke unit or organised stroke service after an acute stroke event.

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. The results differ to those previously published following a national reset of the definition by the Ministry of Health in 2017/18. Two previous years' results were provided by the Ministry as baselines as part of a definition change.

OUTCOME MEASURE – A REDUCTION IN AVOIDABLE MORTALITY

A reduction in mortality rates

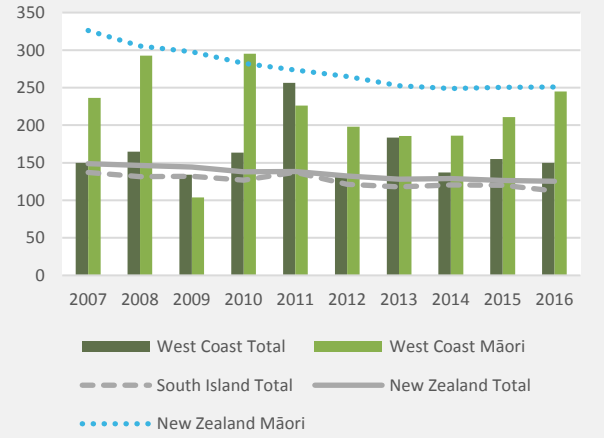
The latest release of national mortality data (2016) shows the West Coast mortality rate fell in 2016 in line with both the South Island and New Zealand rates. Māori rates increased in 2016 (245 per 100,000) compared with the previous year (211 per 100,000) although the West Coast Māori rate remains below the national rate.

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 Coast and contributes to a high proportion of premature deaths. The DHB missed the national Faster Cancer Treatment target by no more than 3 people in each quarter of 2018/19 with just 11 people not being seen and treated within 62 days across the whole year.

Mental illness and addiction also contribute greatly to premature mortality and in 2018/19, 93% of people with non-urgent mental health conditions were seen within 8 weeks.

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



Data Source: National Mortality Collection [10]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

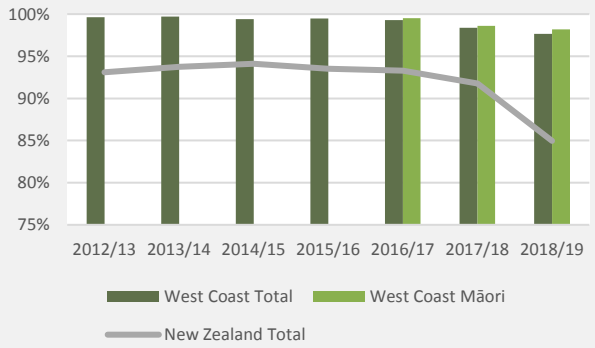
People have shorter waits for urgent care

There were 11,829 presentations to the Greymouth Hospital Emergency Department this year, compared to 11,616 in 2017/18. 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 people to access urgent care including: the extension of free after-hours general practice consultations for children under 14 years, telephone triage services and extended access to general practice after hours.

Work has been undertaken this year to develop new processes and procedures in anticipation of moving into the new Grey Base facility 'Te Nikau' including criteria for a short stay unit which will also contribute to sustained performance in this area.

People are admitted, discharged or transferred from ED within 6 hours	2016/17	2017/18	Target	Result
	99%	98%	95%	98%



Data Source: DHB Patient Management Systems [11]

[10] The data presented is the most current available 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.

[11] This indicator is a national DHB performance measure and excludes those who did not wait in ED or had pre-arranged appointments. This measure was previously a national health target and baselines presented differ from those previously reported, having been reset from final quarter results (April-June) to full year (12 month) results.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for planned care

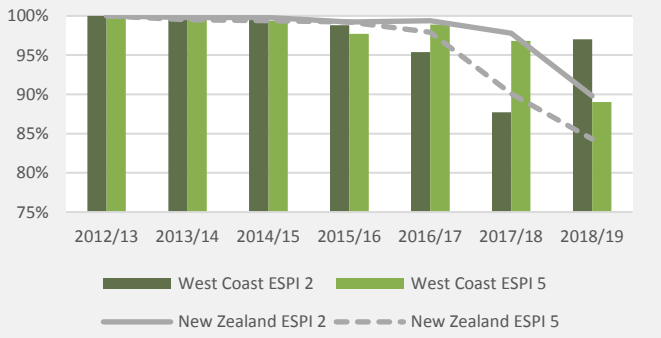
As is evident across the country, increasing service demands are putting pressure on DHBs to meet waiting time expectations. While the West Coast DHB has missed the waiting time targets for both of these measures, performance is well above the New Zealand average.

More than 6,000 patients attended a first specialist assessment in 2018/19, 97% of all those patients were seen within four months (ESPI2).

Of those patients given a commitment for treatment, 89% were seen within four months (ESPI5) and 1,940 elective surgeries were delivered in 2018/19.

The DHB is working closely with Canterbury DHB to identify where improvements can be made and reduce wait times, particularly in orthopaedics and plastics which are service areas with the longest waiting time delays.

Measure: People receiving specialist assessment and treatment with set timeframes.		2016/17	2017/18	Target	Result
	ESPI 2	95.4%	87.7%	100%	97.0%
	ESPI 5	98.9%	96.8%	100%	89.0%



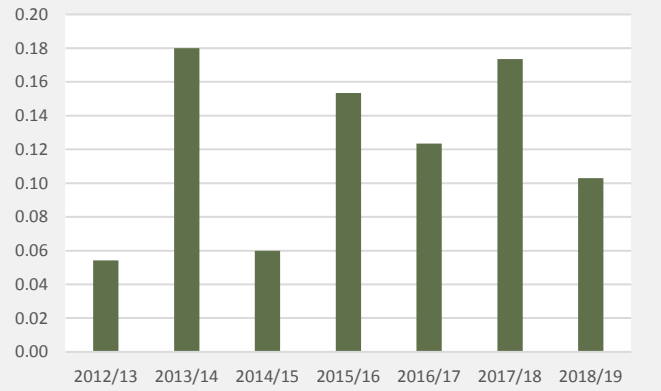
Data Source: Ministry of Health Quickplace Warehouse [12]

People experience fewer adverse events in hospital

The rate of serious falls per 1,000 bed days in our hospitals fell significantly this year although this result is influenced by very small numbers.

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 improving our reporting of events.

Measure: Rate of falls with a severity assessment code (SAC) of level 1&2	2016/17	2017/18	Target	Result
	0.12	0.17	<0.09	0.10



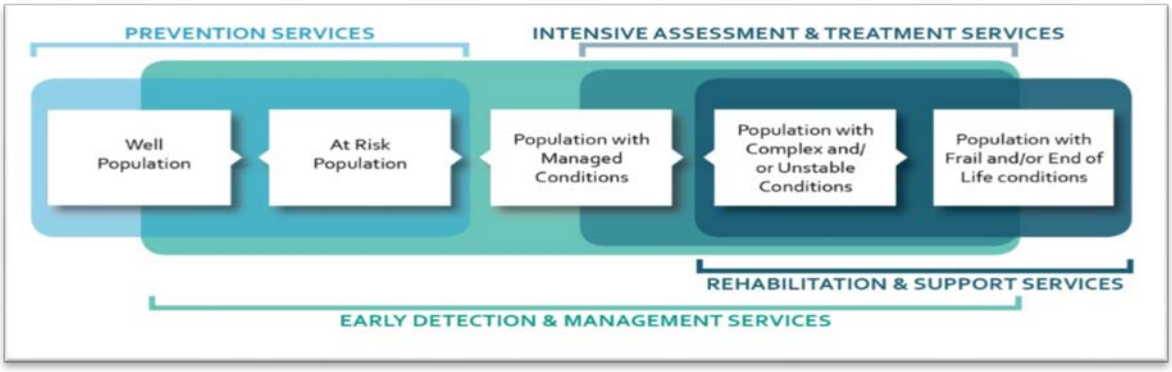
Data Source: Individual DHB Quality Systems [13]

[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). ESPI 2 represented those people receiving their first specialist assessment within four months and ESPI 5 represents those given a commitment to treatment receiving that treatment within four months. These results reflect 24 and 25 people respectively that did not meet ESPI timeframes in June 2019.

[13] 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 reflects just three incidents in 2018/19.

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 2018/19 forecast, presented in our 2018/19 Statement of Intent.

IDENTIFYING PERFORMANCE MEASURES

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

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

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

In health, the number of people who receive a service can be less important than whether the service was delivered at the right time. In presenting a well-rounded performance picture, we have not simply presented the volume of services provided but have addressed four key aspects of service performance:

- Access (A)
- Timeliness (T)
- Quality (Q)
- Experience (E).

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

Setting Standards

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

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

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

In areas where we do have more influence, targets set for 2018/19 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

Many of the performance targets are national targets set for all DHBs. The West Coast's small population size means one or two people have a disproportionate impact on our results and performance can vary year-on-year. We knew that a number of the standards would be difficult to meet, considering this factor. It is pleasing to see that performance has been positive across many areas.

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 reported nationally as a key DHB performance target and in line with national performance reporting, fourth quarter (April-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

2018/19 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 also be a very cost-effective health intervention.

SERVICE PERFORMANCE 2018/19

Population Health Services – Healthy Environments							
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [14]	15	14	E. 15	14	-	↺
Licensed alcohol premises identified as compliant with legislation	Q [15]	85%	95%	90%	96%	-	✓
Networked drinking water supplies compliant with Health Act	Q	95%	63%	97%	81%	-	↺

Population-Based Screening Services							
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Four-year-olds provided with a B4 School Check (B4SC)	A [16]◆	90%	98%	90%	93%	91%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q [17]◆	81%	96%	95%	94%	97%	×
Women aged 25-69 having a cervical cancer screen in the last 3 years	A [18]◆	75%	74%	80%	72%	71%	×
Women aged 50-69 having a breast cancer screen in the last 2 years	A [18]◆	77%	72%	70%	77%	72%	✓

[14] The expected number of submissions varies in a given year - it may be higher, for example, when Territorial Authorities are consulting on their draft long-term plans.

[15] New Zealand law prevents retailers from selling alcohol to young people aged under 18 years, with the aim of reducing alcohol-related harm for this age group. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. Compliance can be seen as a proxy measure of the success of education and training and reflects a culture that encourages a responsible approach to alcohol.

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

[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 attainment and quality of life. The referral allows families to access support to maintain healthier lifestyles. This is a national performance measure, but no longer a national health target. Baselines differ from those previously reported having been reset to reflect a full year (12 month) result rather than the final quarter result (Jan-June) for each year. Small numbers impact on this result and 94% reflects just two children who were not offered a referral during the year.

[18] The cervical and breast screening measures refer to participation in national screening programmes 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. Improving rates for cervical screening remains a priority and the DHB is working closely with community providers to try and lift these rates.

Health Promotion and Education Services							
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Notes	2016/17 Result	2017/18 Result	2018/19 Target	2018/19 Result	2018/19 NZ average	
Mothers receiving breastfeeding/lactation support in community settings	A [19]	208	191	>100	193	-	✓
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q [20]◆	77%	72%	75%	n/a	n/a	-
Babies exclusively/fully breastfed at three months	Q [20]◆	56%	61%	70%	n/a	n/a	-
People provided with Green Prescriptions for additional physical activity	A [21]	558	458	>500	458	-	↺
Green Prescription participants more active 6-8 months after referral	Q [21]	-	65%	50%	-	-	-
Smokers enrolled with a PHO, receiving advice and support to quit smoking in the last 15 months (ABC)	Q [22]◆	91%	88%	90%	96%	86%	✓
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q [22]◆	93%	91%	95%	91%	92%	↺
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q [23]◆	95%	98%	90%	100%	91%	✓

Immunisation Services							
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Children fully immunised at eight months of age	A [24]◆	82%	83%	95%	79%	90%	✗
Proportion of eight-month-olds 'reached' by immunisation services	Q [25]	97%	96%	95%	96%	96%	✓
Young women (Year 8) completing the HPV vaccination programme	A[26]†◆	39%	39%	75%	n/a	n/a	-
Older people (65+) receiving a free influenza ('flu') vaccination	A[27]†◆	55%	56%	75%	55%	56%	✗

[19] 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.

[20] These measures are part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. Results are published by the Ministry and breastfeeding results for 2018/19 had not been published at the time of printing. Baselines have been updated to reflect full year results.

[21] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a national patient survey completed by Research NZ on behalf of the Ministry of Health. In 2016/17, a decision was made nationally to shift to bi-annual surveys. The next survey will be in 2019/20.

[22] ABC programme has a cessation focus and refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support. The provision of professional advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts. The baseline results for the Hospital Smoking indicator differ from those previously published having been recalculated from final quarter to full year results. The target was missed by just 50 people over the course of the year.

[23] This measure is part of the national measures set (Better Help for Smokers) and data is sourced from the Ministry of Health's national Maternity Dataset which covers approximately 80% of pregnancies nationally. As such, the measure is seen as developmental and results are used to indicate trends rather than absolute performance. The baseline results differ from those previously published having been recalculated from final quarter to full year results.

[24] This is a national DHB performance measure, but no longer a national health target. Baselines differ from those previously reported having been reset to reflect a full year (12 month) result rather than the final quarter of the year (April-June). The DHB did not achieve the 95% target in any of the four quarters in 2018/19 (achieving 77%, 80%, 83% and 75% respectively). The West Coast has a large community within its population who decline immunisations or opt off the national immunisation register and this makes delivering this national target very challenging. The full year result reflects 72 children not immunised over the course of the year.

[25] 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided with advice to enable them to make informed choices for their children - but have chosen to decline immunisations or opt off the NIR. This measure has been updated to reflect full year, rather than final quarter results, to align with the 8-month immunisation measure.

[26] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV related cancer later in life. The vaccination programme consists of two vaccinations and is free to young people under 26 years of age. The DHB is working with the Ministry of Health to ratify results for 2018/19 with confusion arising from the change in programme from three-dose to two-dose and national systems not recognising which programme people are on and when they have completed their 'final' dose. The DHB was not able to confirm a result for this measure at the time of printing.

[27] The increasing proportion of our population aged over 65 distorts performance slightly against this measure. The number of older people having a flu vaccination in 2018 has increased by 76 people, compared to 2017. While a focus on Measles vaccinations has likely impacted on these results in 2018/19, more work is need to lift rates.

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 2018/19

Primary Care (General Practice) Services							
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible, responsive service.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Population enrolled with a Primary Health Organisation (PHO)	A ◆	90%	94%	95%	94%	94%	↺
Newborns enrolled with a PHO by three months of age	A [28]◆	77%	83%	85%	95%	90%	✓
Young people (0-19) accessing brief intervention counselling in primary care	A [29]Δ	200	215	>150	159	-	✓
Adults (20+) accessing brief intervention counselling in primary care	A [29]Δ	548	527	>450	498	-	✓
Number of integrated HealthPathways across the health system	Q [30]	655	632	E. 600	683	-	✓
Proportion of general practices offering the primary care patient experience survey	E [31]	new	86%	85%	100%	-	✓

Long-Term Conditions Management (LTCM) Services							
These services are targeted at people with high health needs with the aim of reducing complications and crisis through earlier intervention and treatment and by supporting people to better manage and control their conditions.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Enrolled population, identified with a long-term condition, engaged in the primary care LTCM programme	A [32]◆	3,860	4,099	>3,000	4,045	-	✓
Population identified with diabetes having an annual LTCM review	A ◆	74%	79%	90%	85%	-	↺
Population with diabetes having an HbA1c test at their LTCM review showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q [33]◆	54%	54%	80%	53%	-	×
Eligible population having a cardiovascular disease risk assessment in the last 5 years	A [34]◆	91%	90%	90%	87%	84%	×

[28] This measure is part of the national Well Child/Tamariki Ora (WCTO) Quality Framework and standards are set nationally. A change in how this measure is calculated in 2018/19 more accurately captures enrolment figures. Due to this change the 2016/17 results are not comparable with previous years.

[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 includes the provision of free counselling sessions and extended GP consultations.

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

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

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

[33] Diabetes is a leading long-term condition and a contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition and a level of less than 64mmol/mol reflects an acceptable blood glucose level. The DHB has been engaged in a local initiative aimed at high risk patients who have been hard to engage with in regards to their diabetes care in an effort to support them (over time) to better manage their condition. The lift in those identified with diabetes shows the impact the project is having. Not unexpected as the DHB picks up these harder to reach patients the proportion with well managed diabetes has dropped. The West Coast DHB has supported the extension of the Initiative in 2019/20 and we expect that the HBA1c results will improve overtime.

[34] Cardiovascular disease is a leading cause 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. West Coast DHB is focused on working with general practice teams and Poutini Waiora in the coming year to identify opportunities to provide CVD risk assessments and target support through the use of practice specific performance data.

Oral Health Services							
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Children (0-4) enrolled in DHB funded oral health services	A [35]†◆	97%	108%	95%	101%	-	✓
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T †◆	93%	95%	90%	96%	-	✓
Adolescents (13-17) accessing DHB-funded oral health services	A †	75%	77%	85%	76%	-	×

Pharmacy and Referred Services							
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Number of subsidised pharmaceutical items dispensed in the community	A Δ	466k	460k	E.<500K	471k	-	✓
People (65+) being dispensed 11 or more long-term medications (rate per 1,000)	Q†[36]	4.2	4.5	E. 4.4	n/a	n/a	-
Number of community-referred radiological tests delivered at Grey Base Hospital	A	5,817	6,199	E.>5,000	6,035	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T [37]	90%	90%	90%	88%	87%	×
People receiving their MRI scans within six weeks	T [38]	80%	84%	90%	82%	58%	×
People receiving their CT scan within six weeks	T [38]	100%	100%	95%	99.7%	77%	✓

[35] Oral health is an integral component of lifelong health and wellbeing. Early and continued contact with oral health services helps to set life-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights. A transalpine Oral Health Service Development Group has been established to improve performance in this area with a particular focus on equity and lifting engagement with adolescents and Maori and Pacific children. We anticipate this work will continue to improve performance over the next few years.

[36] The use of multiple medications is most common in the elderly and can lead to reduced drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and high costs for the system with little health benefit. Multiple medication use requires monitoring and review to validate whether all of the medications are complementary and necessary. This data is provided by the New Zealand Health Quality and Safety Commission. Results for 2018/19 were not available at the time of printing.

[37] A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon) to identify issues and support appropriate treatment. Baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results. Small numbers impact on these results with only five people being seen outside of the timeframes in 2018/19.

[38] These MRI and CT diagnostic measures are national DHB performance measures and refer to non-urgent scans, baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results. A number of factors are driving pressure in this area including: new drug and treatment programmes and increased surgical volumes along with population growth and ageing. Canterbury provides MRI scans for West Coast patients and additional mitigation strategies embedded in 2018/19 are beginning to reduce wait times. While the target was missing in the first eleven months, performance by the final month of the year (June 2019) has lifted to 94.4% of people receiving their MRI within 6 weeks. West Coast achieved the CT wait time targets in eleven months of this year, seeing 100% of patients within timeframes except in June where 4 patients were seen outside of timeframes.

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 improves 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 2018-2019

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.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Staff compliant with good hand hygiene practice	Q [39]◇	80%	82%	80%	84%	86%	✓
Hip & knee replacement patients receiving routine antibiotics before surgery	Q ◇	96%	97%	95%	100%	98%	✓
Inpatients (aged 75+) receiving a falls risk assessment	Q [40]◇	91%	92%	90%	68%	89%	×
Response rate to the national inpatient patient experience survey	E [41]◇	28%	58%	>30%	28%	24%	×
Proportion of patients who felt 'hospital staff included their family /whānau or someone close to them in discussions about their care'	E◇	76%	53%	65%	55%	59%	↺

Maternity Services							
These services are 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.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A [42]†◆	79%	80%	80%	n/a	n/a	-
Number of maternity deliveries in West Coast DHB facilities	A	250	264	E. 300	241	-	↺
Baby friendly hospital accreditation achieved in DHB facilities	Q [43]	Yes	Yes	Yes	Yes	-	✓

[39] These quality measures are national safety markers set to drive improvements in key patient safety areas. In line with national reporting, results refer to the final quarter of each year (April-June). The 2017/18 results for three of the indicators have been updated to reflect the final quarter's results (April-June) which were not available at the time of printing (previous results were: hand hygiene 78%, routine antibiotics 100%, falls assessment 95%). The 2018/19 results reflect Jan-March 2019 for hand hygiene and falls, Oct-Dec 2018 for the Hip and Knee measure and April-June for the patient experience survey results, being the most recent results available. Quarterly results for the last several years are available publically on the Quality and Safety Commission's website www.hqsc.govt.nz, as part of the Health Quality Intelligence programme.

[40] A change in the tool being used for inpatient falls assessments has resulted in data not being captured correctly in 2018/19. This issue has been identified and improvement is expected over the coming year.

[41] Inpatient survey results are susceptible to significant fluctuations due to the small numbers involved and the traditionally low rate of responses to surveys. The West Coast Quality Team is working with Canterbury to identify improvements and to encourage uptake of the surveys.

[42] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report. The 2016/17 and 2017/18 result cover the calendar year to December 2016 and December 2017. The 2018/19 results had not been released at the time of printing.

[43] 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 and 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. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Presentations at the Grey Base Hospital Emergency Department (ED)	A	11,382	11,616	E.<13,000	11,829	-	✓
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T [44]	79%	82%	85%	77%	-	×
Proportion of the population presenting at ED (per 1,000 people)	Q[45]	342	356	<356	365	239	×
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 [46]	68%	80%	90%	72%	88%	×
Average acute inpatient length of stay (bed days per 1,000 people)	Q [47]	2.36	2.34	2.30	2.13	2.49	✓

Elective and Arranged Services							
These are medical and surgical services provided for people who do not need immediate hospital treatment. Their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service. The West Coast DHB is also striving to reduce travel time for patients.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Number of First Specialist Assessments provided	A [48]	7,232	7,022	E.>6,000	6,240	-	✓
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [49]	16%	15%	>10%	7%	-	×
Number of elective/arranged surgical discharges (surgeries provided)	A ◇	1,979	1,962	1,916	1,940	-	✓
Average elective inpatient length of stay (bed days per 1,000 people)	Q [47]	1.34	1.20	1.45	1.19	1.53	✓
Number of outpatient consultations provided	A	15,479	14,328	E. >13k	13,663	-	✓
Proportion of outpatient appointments provided by telemedicine	Q [50]	3.3%	4.2%	>5%	5.1%	-	✓
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [51Δ◆]	5.6%	6.1%	<6%	7.7%	-	×

[44] 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.

[45] This is not an unexpected result as the West Coast population ages.

[46] This is a national performance measure, but no longer a national health target. Baselines differ to previously printed results, having been reset from final quarter (six months from Jan-June) to full year (12 month) results. There was a definition change for this measure from 2017/18, allowing patients to delay own treatment or for treatment to be delayed due to clinical considerations (without affecting the result), 2016/17 results are therefore not directly comparable. In 2018/19 the DHB reached 72% in the first quarter 70% in the second quarter, 77% in the third quarter and 74% in the fourth quarter. Small numbers impact this measure on the West Coast with just 11 patients seen outside of timeframes across the whole year. A breach analysis is completed for every patient who is seen outside of timeframes to identify lessons and improve processes.

[47] Because factors that influence a patient's length of stay include complications and infection and lack of integration activity to support patients to return home sooner, lower rates are positive. By shortening lengths of stay the DHB also frees up beds and resources and increases productivity.

[48] There appear to have been changes in booking processes that have seen a drop in the number of First Specialist Assessments being counted. The DHB is working with clinical staff and the booking unit to ensure all assessments are being captured, no matter where they are delivered.

[49] Non-contact assessments are those where advice or assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients. Changes in internal processes have meant written advice from a specialist, which was previously being coded as an FSA is now excluded from this result. The 2018/19 result is a more accurate representation of the number of non-contact FSAs being delivered.

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

[51] When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes, and it is costly in terms of wasted resources for the DHB. This measure is calculated as the proportion of all medical and surgical outpatient appointments where the patient was expected to attend on the day but did not. Long mail delays experienced in 2018/19 are thought to have impacted on DNA rates with people receiving late notice of outpatient appointment times. The DHB is partnering with Poutini Waiora in 2019/20 to investigate opportunities to reduce Maori DNA rates which is anticipated to help improve overall rates in the coming year.

Specialist Mental Health Services							
These are services for those most severely affected by mental illness and/or addictions, who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive service.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Young people (0-19) accessing specialist mental health services	A [52Δ]	5.3%	5.4%	>3.8%	5.3%	3.9%	✓
Adults (20-64) accessing specialist mental health services	A [Δ]	5.7%	5.9%	>3.8%	5.6%	4.0%	✓
People referred for non-urgent mental health and alcohol and other drug (AOD) services seen within 3 weeks	T [53]	76%	81%	80%	81%	78%	✓
People referred for non-urgent mental health and AOD services seen within 8 weeks	T[54]	89%	95%	95%	92%	92%	×
Adult inpatients accessing community services within 7 days of discharge	Q [55]	71%	64%	80%	n/a	n/a	-

[52] The access measures are national DHB performance measures (PP6). Standards are set based on expectations that at least 3% of the population will need access to specialist mental health services during their lifetime. West Coast rates are high and with part of the DHB's strategy being to better support people earlier and closer to home, it is expected that rates will come down over time. Data is sourced from the Ministry's national PRIMHD dataset and results are provided three months in arrears. Providers include non-government service providers who provide specialised mental health services and submit records to the national dataset.

[53] The wait time measures are national DHB performance measures and standards are set nationally. Data is sourced from the Ministry's national PRIMHD database and results are provided three months in arrears. Wait times are being impacted by recruitment delays in filling vacancies. Improvement to wait times is also expected following the implementation of a new triage process once recruitment has been completed.

[54] A slight increase in overall numbers of clients as well as staff shortages in the Child and Adolescents Mental Health Service have had an impact on wait times. This is expected to improve as the Mental Health Services proposal for change is fully implemented and vacancies are filled.

[55] This measure is seen as an indicator of suicide prevention activity and patient safety, reflecting continued support for people who have experienced an acute psychiatric episode requiring hospitalisation. Research indicates that people have increased vulnerability immediately following discharge, including higher risk for suicide, while those leaving hospital with a formal discharge plan and links with community services and supports are less likely to experience early readmission. Data is sourced from the NZ Mental Health and Addictions KPI Programme reports (indicator KPI 19) and standards are set nationally. Results for 2018/19 were not available at the time of printing.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

SERVICE PERFORMANCE 2018/19

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 increased proportion of people discharged home, rather than into aged residential care (ARC), reflects a successful outcome.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Proportion of AT&R inpatients discharged home rather than into ARC	Q[56Δ]	79%	90%	80%	85%	-	✓
Proportion of inpatients referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	Q[57]	89%	96%	80%	94%	-	✓
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A [58]	yes	2	3	9	-	✓
People (65+) supported by the community-based Falls Prevention Service	A [59]	117	148	>120	143	-	✓

Home-Based Support Services							
These are services designed to support people to continue living in their own homes and to maintain their functional independence. Largely-demand driven, clinical assessment ensures access to services is appropriate and equitable.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Number of Meals on Wheels provided	A [Δ]	33,772	34,977	E. 35,000	36,511	-	✓
People supported by district nursing services	A	1,628	1,645	E. >1,000	1,797	-	✓
People supported by long-term home-based support services	A [Δ]	1,079	1,211	E. >1,000	1,100	-	✓
Proportion of people supported by long-term home-based support services, who have had a clinical assessment of need using the InterRAI assessment tool	Q [60Δ]	93%	91%	95%	75%	-	×

[56] A discharge from AT&R services to home is seen as reflective of the quality and effectiveness of services in assisting that person to regain their functional independence. Due to a transcribing error the 2016/17 result differs from the result reported in the 2018/19 Statement of Intent (91%).

[57] This is national DHB performance measure. Baselines differ to previously printed results, being reset from final quarter (April-June) to full year (12 month) results, one quarter in arrears.

[58] The Flexible Integrated Rehabilitation Support Team (FIRST) provides a range of home-based rehabilitation services to facilitate people's early discharge from hospital. The service is a comprehensive part of the broader continuum of care for older people, ensuring a seamless transfer of care between hospital and community settings.

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

[60] 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. A review of home based support data identified a number of inconsistencies and the team is currently not able to separate out the people eligible for InterRai assessment from all those receiving long term home based support, which has impacted on results. The team is working on fixing the processes.

Respite and Day Services							
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need addressed, or to give carers a break. Largely demand-driven, access to services is expected to increase over time, as more people are supported to remain safe and well in their own homes.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Number of mental health planned and crisis respite service bed-days accessed	A Δ	482	422	E. 500	427	-	↺
Older people supported by aged care respite services	A [61]Δ	45	51	E. 70	31	-	×

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.	Notes	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Proportion of the population (75+) accessing rest home level services	A [62]Δ	4.6%	4.4%	E.<6.0%	3.8%	-	✓
Proportion of the population (75+) accessing hospital-level services	A Δ	6.2%	6.6%	E.<6.5%	6.4%	-	✓
Proportion of the population (75+) accessing dementia services	A Δ	0.8%	1.2%	E. 0.85%	1.1%	-	↺
Proportion of the population (75+) accessing psychogeriatric services	A [63]Δ	0.5%	0.6%	E. 0.45%	0.3%	-	✓
People entering ARC having had a clinical assessment of need using InterRAI	Q [64]Δ	100%	100%	95%	88%	88%	×

[61] Aged Care Respite is one service available for carer relief on the West Coast. Work has been undertaken to ensure these services are being used appropriately to avoid deconditioning and instead provide more wraparound services that people can access in their own homes. This aligns with the Coast model of care to keep people in their homes longer. The drop in numbers supported by respite is therefore not unexpected and is not seen as a negative result.

[62] These Aged Residential Care (ARC) measures refer to people accessing DHB funded ARC services and excludes people choosing to enter ARC and pay privately and people living independently in a retirement village. The South Island has historically had higher ARC rates than national levels and by providing high quality health services to help older people to retain their health and remain in their own homes for longer, we expect to see a reduction in demand for rest home level care. Access rates for more complex care such as dementia and psychogeriatric care are driven by the age of our population and is less amendable.

[63] The West Coast has a limited number of psychogeriatric beds available which results in some clients receiving services in Canterbury. Until more beds become available on the West Coast, results may fluctuate.

[64] Small numbers impact the achievement of this target with only nine people not receiving a clinical assessment in 2018/19. Work is ongoing to identify these people and determine the cause of them not receiving an assessment.

Māori Health Performance 2018/19

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. These are indicators seen as particularly important to our community in terms of improving and monitoring Māori health outcomes and were identified in our forecast Statement of Performance Expectations for 2018/19 using the symbol (◆).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.

Māori Health Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between Māori and non-Māori.	Note	2016/17	2017/18	2018/19 Target	2018/19 Result	2018/19 NZ average	
Māori babies exclusive/fully breastfed at LMC discharge	Q[65]	82%	66%	75%	n/a	n/a	-
Māori babies exclusive/fully breastfed at three months	Q	52%	53%	70%	n/a	n/a	-
Māori smokers, enrolled with a PHO, receiving advice and help to quit	Q	91%	87%	90%	96%	83%	✓
Māori smokers, identified in hospital, receiving advice and help to quit	Q[66]	92%	88%	95%	92%	91%	↺
Pregnant Māori women, identified as smokers at confirmation of pregnancy with an LMC receiving advice and help to quit smoking	Q[66]	100%	100%	90%	100%	92%	✓
Māori children receiving a B4 School Check at age four	A	92%	106%	90%	98%	90%	✓
Māori four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q[67]	100%	83%	95%	83%	97%	↺
Māori women (25-69) having a cervical smear in the last three years	A	63%	65%	80%	68%	67%	↺
Māori women (50-69) having a mammography in the last two years	A	67%	61%	70%	70%	66%	✓
Māori babies fully immunised at eight months of age	A[68]	91%	91%	95%	83%	84%	×
Eligible Māori girls completing the HPV vaccination programme	A[69]†	27%	30%	75%	n/a	n/a	-
Older Māori (65+) having had a seasonal influenza vaccination	A[70]†	51%	50%	75%	50%	45%	↺
Māori population enrolled with a PHO	A	83%	85%	95%	86%	90%	↺
Māori new-borns enrolled with a PHO by three months of age	A[71]	n/a	n/a	85%	88%	75%	✓
Enrolled Māori, identified with a long-term condition, engaged in the primary care LTCM programme	A	235	261	>233	266	-	✓
Māori identified with diabetes halving a HbA1c test in the last year	A	73%	87%	90%	81%	-	×
Māori, having an HbA1c test, with acceptable glycaemic control	Q[33]	46%	41%	>80%	42%	-	↺
Eligible Māori having their CVD risk assessed in the past five years	A[72]	88%	88%	90%	87%	82%	×
Māori children (0-4) enrolled in DHB oral health services	A[73]†	81%	96%	95%	90%	-	×
Māori children (0-12) examined according to planned recall	T†	n/a	n/a	90%	93%	-	✓
Māori women registered with an LMC by 12 weeks of pregnancy	A[74]†	80%	79%	80%	n/a	-	-
Māori outpatient 'Did not Attend' rates	Q	15%	15%	<6%	15%	-	↺

[65] Breastfeeding measures are part of the Well Child/Tamariki Ora Quality Framework, 2016/17 and 2017/18 results has been reset to reflect full year results.

[66] The baselines for the hospital and maternity smoking measures differ from those previously reported having been reset to reflect full year rather than final quarter results.

[67] These measures are national DHB performance measures, but no longer national health targets. Baselines differ from those previously reported having been reset to reflect full year rather than final quarter results. Small numbers impact on these results and this reflects five out of six children being offered a referral in 2018/19.

[68] This is a national DHB performance measure, baselines differ from those previously reported being reset to reflect a full year rather than a final quarter result.

[69] The DHB is working with the Ministry to ratify results for 2018/19 following a change in the HPV programme from three-dose to two-dose and national systems not recognising when people have completed their 'final' dose. The result for 2018/19 is not therefore available.

[70] Small population numbers and an ageing population have a significant impact on these results. The actual number of older Māori having a flu vaccination in 2018 has increased by 30 people, compared to 2017.

[71] A change in how this measure is calculated more accurately captures enrolment figures, however 2018/19 results are therefore not comparable with previous years.

[72] More than 900 Māori people completed their CVDRA in past 5 years with the target being missed by just 39 people.

[73] The move to a new patient management system in October 2018 changed how ethnicity rates have been calculated for the oral health measures. Work is underway to produce a combined ethnicity register using data from internal DHB systems and the new national enrolment system. Once complete this will allow consistent and standardised ethnicity calculations to be made.

[74] These results have been updated to include Jan-Dec 2017 results, which were not available at the time of printing.

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 2019

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 $11.555m against the budgeted deficit of $6.087m (2017/18 result was a net deficit of $2.929m).

Board and committee member attendance	Board		QFARC[75]		ADVISORY[76]	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Board members						
Chris Auchinvole	8	8	-	-	7	7
Jenny Black	8	8	5	5	7	7
Kevin Brown	5	8	-	-	4	7
Helen Gillespie[77]	4	5	4	4	3	4
Michelle Lomax	5	8	-	-	4	7
Chris Mackenzie	6	8	4	5	4	7
Edie Moke	7	8	5	5	4	7
Peter Neame	7	8	-	-	6	7
Nigel Ogilvie	7	8	-	-	4	7
Elinor Stratford	8	8	-	-	7	7
Francois Tumahai	6	8	-	-	5	7
Committee Members						
Lynnette Beirne					6	7
Sarah Birchfield					7	7
Dr Cheryl Brunton					6	7
Jenny McGill					4	7
Mary Molloy[78]					1	1
Joe Mason					6	7
Paula Cutbush					6	7
Chris Lim					5	7

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

[75] *QFARC – Quality, Finance, Audit & Risk Committee. Jenny Black, Helen Gillespie, Chris Mackenzie and Edie Moke are members*

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

[77] *Leave of absence 29 March 2019 to 30 June 2019*

[78] *Resigned 10 August 2018*

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.

People at the Heart of All We Do

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

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

Staff Ethnicity	Number
Americas	9
Australian	9
British	37
Chinese	3
Filipino	20
Indian	27
Irish	3
Māori	34
Middle Eastern	1
New Zealand European	381
New Zealander	10
Not Stated / Don't Know	453
Other	1
Other African	3
Other Asian	7
Other European	22
Pacific Peoples	5
South African	7
Total	**1,032**

Source: Payroll as at July 2019

Staff Mix by Average Age	Average age
Medical	48.54
Nursing	50.24
Allied Health	51.87
Support	56.74
Management & Administration	49.36

Staff Mix by Gender	Number	Percentage
Female	869	84%
Male	163	16%
Total	1032	100%

Staff Identifying a Disability[79]	Number
Yes	0

Leadership, Accountability and Culture

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

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

Recruitment, Selection and Induction

West Coast DHB is committed to the shared approach to talent management including attracting, selecting and engaging people across the West Coast health system, regionally and nationally for the needs of today and into the future. To achieve this, we are taking a talent lifecycle management approach from succession planning and strategic sourcing to selection, candidate care and induction. The purpose of this approach is to support an integrated West Coast health system by maximising opportunities that

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

result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey and patient outcomes throughout the West Coast health system.

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

Workplace Wellbeing, Health and Safety

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

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

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

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

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

We do not tolerate any form of harassment, workplace bullying or discrimination. We are continually improving our policies, procedures and responses when issues of bullying, harassment or discrimination do arise. This includes a programme of work to improve our policies, code of conduct, manager capability to address issues and clearly communicating our escalation pathways to all our people.

Equal Opportunities and Positive Behaviours

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

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

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

Remuneration and Recognition

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

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

Employee Engagement

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

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

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

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

Focus groups were planned to occur in March | April of 2019 to be run by an independent provider to explore with staff areas that were highlighted in the survey for further development. However, due to a range of other matters these groups were deferred and will occur in late 2019/20 when the new structure is embedded.

Employee Development and Promotion

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

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

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

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

Part V
Financial Performance

Statement of Comprehensive Revenue and Expense[80]

For the year ended 30 June 2019

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2018/19 Actual	2018/19 Budget	2017/18 Actual
Revenue				
Patient care revenue	2(i)	153,670	148,108	147,812
Other operating revenue	2(ii)	599	4,084	977
Interest revenue		331	360	380
Total revenue		**154,600**	**152,552**	**149,169**
Expenses				
Personnel costs	3	67,602	61,977	60,139
Depreciation and amortisation expense	9,10	3,391	4,110	2,959
Outsourced services		8,708	8,480	8,664
Clinical supplies		8,018	7,750	8,906
Infrastructure and non-clinical expenses		10,907	10,586	10,432
Payments to other health service providers		64,508	62,978	58,143
Other operating expenses	4	1,614	1,234	1,468
Finance costs		-	-	-
Capital charge	5	1,407	1,524	1,387
Total expenses		**166,155**	**158,639**	**152,098**
Net surplus/(deficit)		**(11,555)**	**(6,087)**	**(2,929)**
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		**(11,555)**	**(6,087)**	**670**

[80] 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[81]

For the year ended 30 June 2019

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2018/19 Actual	2018/19 Budget	2017/18 Actual
Balance at 1 July		**25,710**	**25,707**	**25,108**
Total comprehensive revenue & expenses		(11,555)	(6,087)	670
Owner transactions				
Capital contributions from the Crown	12	-	80,750	-
Repayment of capital to the Crown	14	(68)	(68)	(68)
Balance at 30 June	14	**14,087**	**100,302**	**25,710**

[81] 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[82]

As at 30 June 2019

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2018/19 Actual	2018/19 Budget	2017/18 Actual
Assets				
Current assets				
Cash and cash equivalents	6	6,360	10,665	11,724
Receivables	7	3,915	3,726	3,707
Inventories	8	1,077	1,058	1,058
Patient deposits	15	72	54	71
Total current assets		**11,424**	**15,503**	**16,560**
Non-current assets				
Property, plant and equipment	9	31,062	105,547	30,138
Intangible assets	10	696	1,003	965
Total non-current assets		**31,758**	**106,550**	**31,103**
Total assets		**43,182**	**122,053**	**47,663**
Liabilities				
Current liabilities				
Payables and deferred revenue	11	10,336	11,917	9,176
Borrowings	12	-	-	-
Employee entitlements and benefits	13	16,278	7,321	10,251
Patient deposits and restricted funds	15,16	82	70	83
Total current liabilities		**26,696**	**19,308**	**19,510**
Non-current liabilities				
Borrowings	12	-	-	-
Employee entitlements and benefits	13	2,399	2,443	2,443
Total non-current liabilities		**2,399**	**2,443**	**2,443**
Total liabilities		**29,095**	**21,751**	**21,953**
Net assets/equity				
Contributed capital	14	85,926	166,675	85,994
Revaluation Reserve	14	25,100	25,681	25,681
Accumulated surpluses/(deficits)	14	(96,939)	(92,054)	(85,965)
Total equity		**14,087**	**100,302**	**25,710**
Total equity and liabilities		**43,182**	**122,053**	**47,663**

[82] 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[83]

For the year ended 30 June 2019

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2018/19 Actual	2018/19 Budget	2017/18 Actual
Cash flows from operating activities				
Receipts from Ministry of Health, patients and other revenue		155,187	152,192	149,497
Payments to suppliers		(86,729)	(83,123)	(77,056)
Payments to employees		(68,123)	(69,327)	(67,444)
Interest received		330	360	420
Interest paid		-	1	-
Goods and services tax (net)		157	2,822	(362)
Capital charge paid		(1,407)	(1,524)	(1,296)
Net cash flow from operating activities	17	**(585)**	**1,401**	**3,759**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment		(24)	-	7
Purchase of property, plant and equipment		(4,574)	(5,341)	(2,690)
Purchase of intangible assets		(113)	-	(95)
Net cash flow from investing activities		**(4,711)**	**(5,341)**	**(2,778)**
Cash flows from financing activities				
Capital contributions from the Crown		-	2,949	-
Repayment of capital to the Crown		(68)	(68)	(68)
Net cash flow from financing activities		**(68)**	**2,881**	**(68)**
Net increase /(decrease) in cash and cash equivalents		(5,364)	(1,059)	913
Cash and cash equivalents at the start of the year		11,724	11,724	10,811
Cash and cash equivalents at the end of year	6	**6,360**	**10,665**	**11,724**

[83] 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 2019

1. Statement of Accounting Policies

Reporting entity

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

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

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

The financial statements are for the year ended 30 June 2019, and were approved for issue by the Board on 29 October 2019.

Basis of Preparation

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

West Coast DHB's Chair received a letter of comfort from the Ministers of Health and Finance to enable the Board of West Coast DHB to satisfy itself, for the purposes of the 2018/19 financial statements, that it is appropriate to prepare those financial statements on a going concern basis. The letter states that the Government is committed to working with West Coast DHB over the medium term to maintain its financial viability, and also acknowledges that equity support may be required and the Crown will provide such support where necessary to maintain viability.

West Coast DHB requires this letter of comfort in the event that actual future cashflows are significantly unfavourable to one or more of the assumptions in our cashflow projections, such as the reliance on receiving full deficit funding for the 2018/19 financial year. The letter of comfort therefore provides the required basis for the Board of West Coast DHB to prepare the 2018/19 financial statements on a going concern basis. It also gives the Board comfort that financial support will be provided to maintain viability in the medium term if required

Statement of compliance

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

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

PRESENTATION CURRENCY AND ROUNDING

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

CHANGES IN ACCOUNTING POLICIES

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

STANDARDS ISSUED BUT NOT YET EFFECTIVE AND NOT EARLY ADOPTED

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

FINANCIAL INSTRUMENTS

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

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

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

IMPAIRMENT OF REVALUED ASSETS

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

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

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

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 2018/19 Annual Plan and Statement of Intent. The budget was prepared in accordance with the accounting policies adopted by the Board for the preparation of the financial statements. The policies comply with the Tier 1 PBE standards.

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

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

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

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

2. Revenue

ACCOUNTING POLICY

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

Ministry of Health population-based funding

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

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

Provision of other services

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

Other grants

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

Sale of goods or services

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

Donations, trust and bequest funds

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

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

Vested or donated physical assets

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

	Note	2018/19 Actual	2017/18 Actual
MoH population-based funding		141,818	132,214
Inter-district flows		1,824	1,710
Ministry of Health other contracts & other government contracts		996	4,709
ACC contract revenue		1,781	1,994
Other patient care related revenue		7,251	7,185
Total patient care revenue		**153,670**	**147,812**

2(ii) Breakdown of other operating revenue

	Note	2018/19 Actual	2017/18 Actual
Cash donations and bequests received		42	83
Donated assets		-	432
Rental revenue		142	183
Training and Development		96	120
Gain on sale of Fixed Assets		23	7
Other		296	152
Total other operating revenue		**599**	**977**

3. Employee Benefit Costs

ACCOUNTING POLICY

Salaries and wages

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

Breakdown of personnel costs and further information			
	Note	2018/19 Actual	2017/18 Actual
Wages, salaries and other personnel costs		58,689	56,754
Contributions to defined contribution schemes		1,887	1,717
(Decrease)/increase in liability for employee entitlements		6,992	1,036
Restructuring expenses		34	632
		67,602	**60,139**

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 132 employees (2018: 99) 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 132 employees, 119 are clinical employees (2018: 91) and 13 are non-clinical employees (2018: 8).

Remuneration of Employees earning more than $100,000 per annum		
Specified band	2018/19 Actual	2017/18 Actual
$100,000 - $109,999	38	25
$110,000 - $119,999	13	17
$120,000 - $129,999	27	11
$130,000 - $139,999	11	7
$140,000 - $149,999	3	4
$150,000 - $159,999	8	3
$160,000 - $169,999	3	2
$170,000 - $179,999	1	2
$180,000 - $189,999	1	1
$190,000 - $199,999	-	1
$200,000 - $209,999	1	2
$210,000 - $219,999	1	-
$220,000 - $229,999	2	-
$230,000 - $239,999	-	1
$240,000 - $249,999	1	1
$250,000 - $259,999	-	3
$260,000 - $269,999	1	2
$270,000 - $279,999	3	-
$280,000 - $289,999	1	2
$290,000 - $299,999	2	1
$300,000 - $309,999	-	1
$310,000 - $319,999	-	3
$320,000 - $329,999	2	1
$330,000 - $339,999	-	2
$340,000 - $349,999	2	2
$350,000 - $359,999	2	-
$360,000 - $369,000	1	1
$370,000 - $379,999	2	-
$380,000 - $389,000	1	3
$390,000 - $399,000	-	-
$400,000 - $409,999	-	1
$410,000 - $419,999	1	-
$420,000 - $429,999	1	-
$430,000 - $439,999	3	-
Total employees	**132**	**99**

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 2019, 2 (2018: 30) employees received payments relating to the termination of their employment totalling $33,763 (2018: $632,201).

Board & Committee fees

Total value of remuneration paid to each Board member during the year was (in whole dollars):				
Year ended 30 June 2019	Board	QFARC	Advisory Committee	Total
Board members				
Chris Auchinvole	16,320		1,750	18,070
Jenny Black (Chairperson)	33,600	750	1,750	36,100
Kevin Brown	16,320		1,000	17,320
Helen Gillespie	16,320	1,188	750	18,258
Michelle Lomax	16,320		1,063	17,383
Chris Mackenzie (Deputy Chairperson)	20,400	750	1,500	22,650
Edie Moke	16,320	1,062	1,250	18,632
Peter Neame	16,320		1,500	17,820
Nigel Ogilvie	16,320		1,000	17,320
Elinor Stratford	16,320		2,062	18,382
Francois Tumahai	16,320		1,250	17,570
Total	**200,880**	**3,750**	**14,875**	**219,505**

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 (2018: Nil).

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

Total value of remuneration paid to each Committee member during the year was (in whole dollars):	
Year ended 30 June 2019	Total
Advisory committee members	
Lynnette Beirne (CPHAC&DSAC)	1,500
Sarah Birchfield (CPHAC&DSAC)	1,750
Paula Cutbush (HAC)	1,750
Chris Lim (HAC)	1,250
Joseph Mason (CPHAC&DSAC)	1,500
Jenny McGill (CPHAC&DSAC)	750
Mary Molloy (CPHAC&DSAC)	250
Total	**8,750**

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	2018/19 Actual	2017/18 Actual
Impairment of debtors	7	(4)	51
Loss on disposal of property, plant and equipment	9	158	62
Audit fees (for the audit of the financial statements-excl disbursement)		118	113
Audit related fees for assurance and related services (internal and quality audits)		(7)	48
Board and advisory members fees	3	228	231
Operating lease expenses		560	541
Other		561	422
Total operating expenses		**1,614**	**1,468**

Operating leases as leasee

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

The future aggregate minimum lease payments to be paid under non-cancellable operating lease are as follows:			
	Note	2018/19 Actual	2017/18 Actual
Not more than one year		125	70
later than one year and not later than five years		15	30
Later than five years		-	-
Total non-cancellable operating lease		**140**	**100**

5. Capital Charge

ACCOUNTING POLICY

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

Further information

The West Coast DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the year ended 30 June 2019 was 6% (2018: 6%).

6. Cash and Cash Equivalents

ACCOUNTING POLICY

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

Breakdown of cash and cash equivalents and further information			
	Note	2018/19 Actual	2017/18 Actual
Bank balances and call deposits		6,360	11,724
Term deposits less than 3 months		-	-
Cash and cash equivalents in the statement of cash flows	21	**6,360**	**11,724**

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 2019, this limit was $7.444m (2018: $7.253m).

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 $10k (2018: $12k) 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 Debtors and other receivables			
	Note	2018/19 Actual	2017/18 Actual
Trade receivables		290	310
Ministry of Health receivables		2,396	2,669
Other Crown receivables		557	431
Accrued revenue		487	31
Prepayments		204	330
Less: Provision for uncollectability		(19)	(64)
Total receivables		**3,915**	**3,707**

The ageing profile of receivables at year end are as follows:						
	2018/19			2017/18		
	Gross Receivable	Provision for uncollectability	Net	Gross Receivable	Provision for uncollectability	Net
Not past due	3,577		3,577	3,549		3,549
Due 1-30 days	271		271	44		44
Past due 31-60 days	7		7	22		22
Past due 61-90 days	1		1	31		31
Past due more 90 days	78	(19)	59	125	(64)	61
Total Gross Receivables	**3,934**	**(19)**	**3,915**	**3,771**	**(64)**	**3,707**

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 (2018: 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			
	Note	2018/19 Actual	2017/18 Actual
Balance 1 July		65	65
Receivables written off during the year		(42)	(52)
Impairment reversed		-	-
Additional provision made during the year	4	(4)	51
Closing balance 30 June		**19**	**64**

8. Inventories

ACCOUNTING POLICY

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

Cost is principally determined on a weighted average cost basis.

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

Breakdown of Inventories			
	Note	2018/19 Actual	2017/18 Actual
Pharmaceuticals		176	146
Surgical and medical supplies		887	898
Other supplies		14	14
Total Inventories		**1,077**	**1,058**

There were no write-downs of inventories or reversal of prior year write-downs during the year (2018: Nil).

The amount of inventories recognised as an expense during the year ended 30 June 2019 was $1.611m (2018: $2.053m), 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 2019/20 year. The unused buildings on the Grey campus as a result from the new rebuild are expected to be physically demolished in the 2019/20 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 2017/18 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 2017/18 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. There has been no material movement in the fair value at June 2019, since the last valuation.

Land

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

Buildings

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

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

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

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

Breakdown of property, plant and equipment

	Land	Buildings & fit-out	Plant, equipment & vehicles	Leased assets	Work in progress	Total
Cost or Valuation						
Balance at 30 June 2018	6,855	12,861	22,653	-	4,796	**47,165**
Additions	-	17	707	-	4,615	**5,339**
Disposals/transfers	-	(319)	(737)	-	(1,045)	**(2,101)**
Revaluation increase(decrease)	-	-	-	-	-	**-**
Balance at 30 June 2019	**6,855**	**12,559**	**22,623**	**-**	**8,366**	**50,403**
Accumulated depreciation and impairment losses						
Balance at 1 July 2018	-	(81)	(16,946)	-	-	**(17,027)**
Depreciation charge for the year	-	(2,099)	(1,101)	-	-	**(3,200)**
Elimination on disposal/transfer	-	139	747	-	-	**886**
Elimination on revaluation	-	-	-	-	-	**-**
Balance at 30 June 2019	**-**	**(2,041)**	**(17,300)**	**-**	**-**	**(19,341)**
Carrying amount 30 June 2019	**6,855**	**10,518**	**5,323**	**-**	**8,366**	**31,062**

	Land	Buildings & fit-out	Plant, equipment & vehicles	Leased assets	Work in progress	**Total**
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)**
Transfer from non-current assets held for sale	120	(2,020)	-	-	-	**(1,900)**
Balance at 30 June 2018	**6,855**	**12,861**	**22,653**	**-**	**4,796**	**47,165**
Accumulated depreciation and impairment losses						
Balance at 30 June 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**
Balance at 30 June 2018	**-**	**(81)**	**(16,946)**	**-**	**-**	**(17,027)**
Carrying amount 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 $2.6m asset impairment at 30 June 2013. As at 30 June 2019, 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 $5.195m (2018: $3.462m)

Finance Leases

West Coast DHB had no assets held under finance leases (2018: Nil)

Capital Commitments

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

Capital commitments		
	2018/19	2017/18
Buildings	2,638	179
Plant, equipment and vehicles	691	466
Intangibles	174	105
Total capital commitments at balance date	**3,503**	**750**

10. Intangible Assets

ACCOUNTING POLICY

Acquisition and development

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

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

Amortisation

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

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

	Years
Acquired computer software	2-10

Impairment

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Estimating useful lives of software assets

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

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

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

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

Breakdown of intangible assets

Movements for each class of intangible assets are as follows:

Breakdown of Intangibles	Acquired software	Internally developed software	NZ Health Partnerships Ltd	**Total**
Cost or Valuation				
Balance at 30 June 2018	4,526	-	567	**5,093**
Additions	121	-	85	**206**
Disposals/transfers	-	-	-	**-**
Balance at 30 June 2019	**4,647**	**-**	**652**	**5,299**
Accumulated amortisation and impairment losses				
Balance at 1 July 2018	(4,080)	-	(48)	**(4,128)**
Amortisation charge for the year	(191)	-	-	**(191)**
Elimination on disposal/transfer	-	-	-	**-**
Impairment Losses	-	-	(284)	**(284)**
Balance at 30 June 2019	**(4,271)**	**-**	**(332)**	**(4,603)**
Carrying Value at 30 June 2019	**376**	**-**	**320**	**696**
Cost or Valuation				
Balance at 30 June 2017	4,451	-	567	**5,018**
Additions	92	-	-	**92**
Disposals/transfers	(17)	-	-	**(17)**
Balance at 30 June 2018	**4,526**	**-**	**567**	**5,093**
Accumulated amortisation and impairment losses				
Balance at 30 June 2017	(3,815)	-	-	**(3,815)**
Amortisation charge for the year	(280)	-	-	**(280)**
Elimination on disposal/transfer	15	-	-	**15**
Impairment Losses	-	-	(48)	**(48)**
Balance at 30 June 2018	**(4,080)**	**-**	**(48)**	**(4,128)**
Carrying value 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 $174k (2018: $105k) 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 ($284k) was recognised in June 2019 (2018: $48k). The impairment was to recognise the variation between the underlying value of the Finance Procurement Information Management (FPIM) programme asset held by NZHPL, and the underlying investment carried by DHBs.

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

- Class B Shares confer no voting rights.

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

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

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

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

11. Payables and deferred revenue

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

Breakdown of Payables and Deferred Revenue			
	Note	2018/19 Actual	2017/18 Actual
Payables and deferred revenue under exchange transactions			
Creditors		1,733	2,988
Accrued expenses		6,687	4,668
Deferred revenue		316	72
Total payables and deferred revenue under exchange transactions		**8,736**	**7,728**
Payables and deferred revenue under non-exchange transactions			
Taxes payable		1,600	1,448
Capital charge payable		-	-
Total Payables and deferred revenue under non-exchange transactions		1,600	1,448
Total Payables and deferred revenue		**10,336**	**9,176**

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.

West Coast DHB has a maximum borrowing limit of $7.444m (2018: $7.253m) with NZHPL as at 30 June 2019. Refer to note 6 for further information. As at the 30 June 2019, West Coast had Nil borrowings (2018: Nil)

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 2019. 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 (2018: $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 ((2018: $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 85% (2018: 83%) of the full entitlement. This utilisation assumption is based on recent experience.

Breakdown of Employee entitlements and benefits		
	2018/19 Actual	2017/18 Actual
Current portion		
Accrued salary and wages	2,227	2,727
Annual leave	10,128	4,320
Continuing medical education leave and expenses	796	767
Long-service leave	677	305
Other leave	1,611	1,567
Retirement gratuities	618	466
Sabbatical leave	108	19
Sick leave	113	80
Total current portion	**16,278**	**10,251**
Non-current portion		
Long-service leave	269	618
Retirement gratuities	1,992	1,746
Sabbatical leave	138	79
Total non-current portion	**2,399**	**2,443**
Total employee entitlements	**18,677**	**12,694**

Holidays Act compliance

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

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2019, in preparing these financial statements, the $5.190m DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

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

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

14. Equity

ACCOUNTING POLICY

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

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

Property revaluation reserves

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

Breakdown of Equity

Reconciliation of movement in equity and reserves	Crown equity	Property revaluation reserve	Accumulated surpluses/ (deficits)	Total equity
2018/19				
Balance at 1 July 2018	85,994	25,681	(85,965)	25,710
Surplus/(deficit) for the year	-	-	(11,555)	(11,555)
Capital contributions from the Crown – debt/equity conversion	-	-	-	-
Repayment of capital to the Crown	(68)	-	-	(68)
Movement in revaluation of land	-	-	-	-
Movement in revaluation of buildings, fixtures and fittings	-	(581)	581	-
Movement in revaluation of building, fixtures and fittings due to impairment	-	-	-	-
Other movement/adjustment	-	-	-	-
Balance at 30 June 2019	**85,926**	**25,100**	**(96,939)**	**14,087**
2017/18				
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**

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	2018/19 Actual	2017/18 Actual
Opening balance patients deposits		71	69
Monies received		-	-
Interest earned		1	2
Payments made		-	-
Closing balance		**72**	**71**

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	2018/19 Actual	2017/18 Actual
Opening balance restricted funds		12	20
Monies received		40	56
Interest earned		-	-
Payments made		(42)	(64)
Closing balance		**10**	**12**

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

	Note	2018/19 Actual	2017/18 Actual
Net surplus/(deficit)		**(11,555)**	**(2,929)**
Add/ (less) non-cash items:			
Donated assets		-	(432)
Depreciation and amortisation expense		3,391	2,959
Revaluation reserve movement		581	-
Net movement in non-cash items		**3,972**	**2,527**
Movements in working capital:			
(Increase)/decrease in receivables		(208)	1,267
(Increase)/decrease in inventories		(19)	1
Increase/(decrease) in payables and deferred revenue		1,154	1,884
Increase/(decrease) in employee benefits		6,071	1,009
Net movement in working capital		**6,998**	**4,161**

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.

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 deficit will affect future contributions by employers, as there is no prescribed basis for allocation.

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 2019, the scheme had a past service deficit of $1.8m (1.9% of the liabilities) (2018: $6.606m). . This amount is exclusive of Employer Superannuation Contribution Tax). This deficit 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.

The current employer contribution rate is one times contributor contributions, inclusive of employer Contribution Withholding Tax. The actuary has recommended a stepped approach to changing the employer contribution rate, as follows:

1 April 2020-31 March 2021	Three times contributor contributions
1 April 2021 -31 March 2022	Four times contributor contributions
From 1 April 2022	Five time contributor contributions

The key assumptions in the review were:

- The difference in the future investment returns and the rates of CPI inflation assumed when calculating future factors for transfers from this Scheme to the DBP Annuitant Scheme (DPA Scheme)
- The pensioner mortality assumptions, which are based on the results of recent pensioners' mortality investigation, and include an allowance for improving mortality
- The future investment returns assumed for the Scheme over the next ten years.

The following table shows the Scheme investment return over the next ten years, and the difference between investment return and CPI inflation assumed when calculating future factors for transfers from the Scheme to the DPA Scheme.

Scheme investment return over next ten years		
	31-Mar-19 %	31-Mar-18 %
DPBC Scheme investment return, next 10 years	1.70	1.10
Transfer factors: Difference between investment return and CPI inflation		
First 10 years	0.40	(0.30)
Thereafter	1.50	1.80

OUTSTANDING LEGAL PROCEEDINGS

West Coast DHB has no material outstanding legal proceedings as at 30 June 2019 (2018: Nil).

Contingent assets

The West Coast DHB has no contingent assets (2018: 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 $144.59m to provide health services in the West Coast area for the year ended 30 June 2019 (2018: $139m). 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 $1.82m for the year ended 30 June 2019 (2018: $1.71m).

Expenditure to other DHBs for the care of patients from West Coast DHB's district and services provided from other DHBs amounted to $23.40m for the year ended 30 June 2019 (2018: $20.33m).

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 2019 totalled $2.166m (2018: $351k). These purchases included capital charge from Ministry of Health, blood products from the New Zealand Blood Service, electricity from Genesis Energy and services from educational institutions.

Compensation of key management personnel

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

At June 2019, the executive management team consisted of 4 members (2018: 4) employed by West Coast DHB and a further 7 members, including the Chief Executive, who were employed by Canterbury DHB (2018: 7). The key management personnel services provided by the Office of the Chief Executive are provided to West Coast DHB under contract by Canterbury DHB and are invoiced accordingly- 2019: $309k (2018: $316k).

No executive management personnel were Board members (2018: Nil).

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

Compensation of key management personnel		
	2018/19 Actual	2017/18 Actual
Board Members		
Remuneration	219,505	218,943
Full-time equivalent members	2.15	2.15
Executive management		
Remuneration	985,017	1,106,933
Post-employment benefits	27,403	30,000
Full-time equivalent members	4.00	4.00
Total key management personnel remuneration	**1,231,925**	**1,355,876**
Total full-time equivalent members	**6.15**	**6.15**

20. Events after Balance Date

There were no significant events after balance date (2018: 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:

	2018/19 Actual	2017/18 Actual
Loans and receivables		
Cash and cash equivalents	6,360	11,724
Receivables	3,915	3,707
Investments	-	-
Total loans and receivables	**10,275**	**15,431**
Financial liabilities measured at amortised cost		
Payables (excluding deferred revenue and taxes)	8,420	7,656

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.

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 2019, 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 (2018: +/-$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 2019 (2018: 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 of Health, which comprises 52% (2018: 72%) of the debtors of West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHB) total reliance on Government debtors is 66% (2018: 84%). 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:

Credit quality of financial assets		
	2018/19 Actual	2017/18 Actual
Counterparties with credit ratings		
Bank of New Zealand Limited AA-	142	-
Westpac AA-	53	35
Total cash and cash equivalents	**195**	**35**
Counterparties without credit ratings		
NZ Health Partnerships Limited - no defaults in the past	6,221	11,683
Cash on Hand	6	-
Gross receivables (not past due)	3,934	3,593
Total Counterparties without credit ratings	**10,161**	**15,276**

LIQUIDITY RISK

Management of liquidity risk

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

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

Contracted maturity analysis of financial liabilities

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

Maturity groupings of financial liabilities					
	Carrying amount	Contracted cash flows	Less than 1 year	1-2 years	More than 2 years
2018/19					
Payables	10,336	10,336	10,336	-	-
Total	**10,336**	**10,336**	**10,336**	**-**	**-**
2017/18					
Payables	9,176	9,176	9,176	-	-
Total	**9,176**	**9,176**	**9,176**	**-**	**-**

22. Explanation of Major Variances against Budget

Explanations for major variances from the DHB's budgeted figures in the 2018/19 Annual Plan are as follows:

Statement of Comprehensive Revenue and Expense

REVENUE

Revenue had a 1% favourable variance between our planned revenues of $152.5m compared to actual revenue of $154.5m. The main factors influencing this favourable variance were:

- Favourable IDF wash-up $90k
- IBT Wash-up in January 2019 $790k
- Increase in school services revenue for increase in service deliverables $125k
- MECA, pay-equity and safe staffing funding $530k.
- We received $580k more than expected in other revenues. These revenues include co-payments from residents $110k in our ARC facilities. Revenue from the WCPHO for the primary care initiative $294k and other income of $180k.

EXPENSES

Expenses had a 5% unfavourable variance between our planned expenditure of $158.6m compared to actual expenditure of $166.2m. The main factors influencing this overspend were:

- Holiday Act compliance provisioning of $5.2m.
- $1.5m in payments to other health service providers mainly in IDFs, Hospital ARC bed days, PHO primary care initiatives and outsourced surgical services.
- Impairment of New Zealand Health Partnerships Limited investment of $0.285m.
- Expenditure on clinical supplies was $0.285m higher than budgeted due to increased costs in air transfers.
- Outsourced personnel which was $0.228m over budget, this was principally related to locum costs to cover vacancies and unplanned leave.

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 $0.189m better than expected due to continued focus on debt collection management.

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

Current liabilities – $7.388m unfavourable variance to budget relates to the provision of the Holidays Act compliance ($5.190m) and a combination of increase leave balances (6% increase from prior year) and revaluation of leave balances due to MECA and SECA settlements.

Statement of Changes in Equity

The total comprehensive revenue and expenses was $5.4m more than budgeted due to West Coast DHB net deficit being unfavourable. The two major factors driving the unfavourable result were the Holidays Act compliance provision and the impairment New Zealand Health Partnerships Limited investment.

Capital contributions from the Crown, unfavourable variance is related to the delay in commissioning of the Grey campus redevelopment $77.8m and $2.95m 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 $4.305m 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 2018/19 is $135.319m (2018: $132.050m) which equals the Government's actual expenses incurred in relation to the appropriation.

24. Summary of Cost of Services

The table below summarises the revenue and expenditure for the four output classes for the year ended 30 June 2019.

	2018/19 Actual	2018/19 Budget	2017/18 Actual
Revenue			
Prevention	3,423	6,055	3,372
Early Detection and Management	29,603	73,508	28,560
Intensive Assessment and Treatment	100,494	66,109	97,035
Rehabilitation and Support	21,089	6,884	20,203
Total Revenue	**154,609**	**152,556**	**149,170**
Expenditure			
Prevention	4,159	6,296	3,665
Early Detection and Management	32,456	76,443	29,165
Intensive Assessment and Treatment	107,816	68,745	99,170
Rehabilitation and Support	21,733	7,159	20,099
Total Expenditure	**166,164**	**158,643**	**152,099**
Surplus/(Deficit)	**(11,555)**	**(6,087)**	**(2,929)**

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 2019

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

We have audited:

- the financial statements of the Health Board on pages 40 to 73, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date, and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 9 to 32 and 73.

Qualified opinion – Our audit was limited due to the uncertainties associated with the calculation of employee entitlements under the Holidays Act 2003

In our opinion, except for the matters described in the Basis for our qualified opinion section of our report:

- the financial statements of the Health Board on pages 40 to 73:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2019; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 9 to 32 and 73:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2019, including:
    - for each class of reportable outputs:

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

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 29 October 2019. This is the date at which our qualified opinion is expressed.

The basis for our qualified opinion is explained below, and we draw your attention to the matter of the Health Board being reliant on financial support from the Crown. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Basis for our qualified opinion

As outlined in note 13 on page 64, the Health Board has been investigating issues associated with the calculation of employee entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. Due to the nature of health sector employment arrangements, this is a complex and time consuming process and is yet to be completed. The Health Board has estimated a provision as at 30 June 2019 of $5.2 million to remediate these issues. However, until further work is undertaken by the Health Board, there are substantial uncertainties surrounding the amount of its liability. Because of the work that has yet to be completed to remediate these issues, we have been unable to obtain sufficient audit evidence to determine the appropriateness of the amount of the provision.

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 qualified opinion.

The Health Board is reliant on financial support from the Crown

Without further modifying our opinion, we draw your attention to the disclosures made in note 1 on page 45 that outline that the Board, in reaching the conclusion that the Health Board is a going concern, has taken into consideration the letter of comfort received from the Ministers of Health and Finance. The letter confirms that the Crown will provide the Health Board with financial support, where necessary, to maintain viability. We consider these disclosures to be adequate. We consider the disclosures to be appropriate and our opinion is not modified in respect of this matter.

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 them 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 3 to 7 and 34 to 38, 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.

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