West Coast DHB

ANNUAL REPORT 2016/17

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

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Directory

BOARD MEMBERS

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Chris Mackenzie, Deputy Chair *(from 5 December 2016)*
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Kevin Brown
Helen Gillespie
Michelle Lomax
Edie Moke (*from 5 December 2016)*
Peter Neame
Nigel Ogilvie (*from 5 December 2016*)
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Francois Tumahai
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Peter Ballantyne, Chair *(term ended 4 December 2016)*
Warren Gilbertson (*term ended 4 December 2016)*
Sharon Pugh *(term ended 4 December 2016)*
Joseph Thomas *(term ended 4 December 2016)*

CHIEF EXECUTIVE

David Meates

REGISTERED OFFICE

West Coast DHB
Grey Base Hospital
High Street
Greymouth

AUDITOR

Audit New Zealand on behalf of the Auditor-General

BANKER

Westpac Banking Corporation

Part I
Overview

Foreword from the Chair and Chief Executive

WALKING ALONGSIDE OUR PATIENTS

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

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

Collectively, we are involved in several projects focused on specific service improvements.

When we are thinking about better ways to keep our older folk safe and well at home, we are talking about our mums and dads and aunts and uncles and grandparents, or those of our friends and neighbours. So much of what we hear back from people is how wonderful staff have been, how caring and compassionate, how attentive and inquiring. Of course there are also times when we make mistakes, and our system encourages us to speak up so we can learn and find ways to avoid making them again.

We are constantly challenged to figure out how our services can be best delivered to the 32,600 people living between Haast and Karamea. There are many services that we just don't have enough people to make viable.

We work closely with our transalpine colleagues in Canterbury, and many departments span both Coasts. We can draw on the best specialists available, either through appointments on the Coast, or helping people to get to appointments in Canterbury. We are intently focused on increasing the number of services available on the Coast where it's feasible, so people don't have to spend time and money getting over to Christchurch. We are increasing the use of telehealth, both transalpine and up and down the Coast itself – where it is safe and useful for our patients.

Our vision is to have the patient at the centre of our system, and this means we have to be creative to find ways that our health system can be flexible, sustainable and provide the right care, in the right place at the right time. A health system that centres care around the individual, reducing the need for multiple visits, increasing access to care through the use of technology, and wrapping services around the patient through a single integrated service model.

In the 2016/17 Annual Plan we asked ourselves a number of very pertinent questions: are we increasing access to primary and community services? Reducing the number of visits needed to get the right care? Reducing wait times? Wrapping services around individuals to get the best health benefits? Reducing travel for our patients? Addressing inequities? Making things better for West Coasters? While we have made inroads into all these areas, these remain relevant questions.

BUILDING BLOCKS

We have continued the work that needs to happen as we transition to the new Grey health facilities in 2018 – what we need to take with us, what needs to be replaced, where people will work in the new or existing facilities. And there's other planning going on – notably we merged our two DHB-owned general practices in Greymouth so they can smoothly transition to operating as one from the new Integrated Family Health Centre (IFHC).

In Buller, the Government-appointed Hospital Redevelopment Partnership Group has spent some months finalising site details. At the end of this reporting period, West Coast DHB is working on a plan to re-engage with our clinicians, staff and the community on the design of the new purpose-built IFHC, due to be built around 2019/2020.

These facilities are the building blocks. The people who work in them depend very much on the work going on in community settings. We have strengthened our home-based support services teams; our allied health and district nursing professionals are travelling to deliver health care closer to home; plus, we're increasing our use of telehealth so it's not costing our patients as much in time and money to travel to appointments.

We are focused on looking at how we deliver the health of older people across the Coast, how we

support people to stay at home, and ways to empower people to keep themselves well. Our diversional therapists are actively working with people previously isolated at home, to get them active and back in touch with their communities. We continue to work with residents and their families to come up with solutions that work for them, within the options we have available.

KEEPING OUR COMMITMENTS

Our Māori Health team has initiated some ambitious endeavours this year to work on the poor health outcomes in our growing Māori populations. Work is underway on several fronts, including tackling faster cancer treatments, working with young mums and their babies, and encouraging Māori to become smokefree. We're providing opportunities for our health and social services workforce to gain a better understanding of Māori health issues through the Tipu Ora programmes and planning for the Takarangi Cultural Competency framework sessions.

MENTAL WELLBEING JUST AS IMPORTANT AS PHYSICAL WELLBEING

We have spent some time re-focusing on the 2014 review of our mental health services. During 2016/17, we started to re-engage with our own staff, the broader health system, including NGOs, and patients of the service. While we have much work to do over the next year, we are starting to formulate plans of better models of care, improved mental health services, and new ways to deliver them, so timely access is improved for people needing either community-based or inpatient services. We are very aware of the grim statistics around suicide. We also know many people never engage with our services, so we want to change both of those things for the better.

EARS TO THE GROUND

We have been particularly focused on listening to our communities better, with several grass roots community meetings over the past year, and we plan to continue this open dialogue. While our Board might set strategic direction, we need input from our communities to ensure we are travelling the right path and our people understand the choices we make.

In those places where there has been disconnect with locals, sometimes due to factors beyond our control, we have seen all sorts of issues created. We are looking at ways to correct misinformation, and re-engage with these local communities.

PROMOTING HEALTHY LIFESTYLES

Our Community & Public Health team has been working on a number of fronts to encourage better outcomes for people with mental health challenges, setting up workshops and working alongside the community's initiatives. Alongside those, the team was instrumental in organising a series of well-attended public and school-based presentations by presenter Nathan Mikaere-Wallis on the effects of alcohol on the teenage brain.

This team has also been looking at food security issues for Coasters, working with DHB nutritionists and staff from the West Coast Primary Health Organisation. What that means is thinking through ways to assist those who do not have enough access to nutritious and affordable food, and therefore have higher levels of distress.

Quality drinking water has remained an issue for several Coast communities. Constant 'boil water' notices for the likes of Punakaiki have proved challenging for the residents and visitors, along with local council officials who are looking for solutions.

We would like to thank all of our staff and the people who work right across our health system. You are making a big impact on the health of our population. We have a lot more work ahead of us, together we will make a difference.

Jenny Black
Chair

David Meates
Chief Executive

26 October 2017

Part II
Improving Outcomes

Are We Making a Difference?

DHBs have a number of different roles and associated responsibilities. In our governance role we strive to improve health outcomes for our population, as a funder we are concerned with the effectiveness of the health system and return on investment, and as an owner and provider of services we are concerned with the quality of the services we deliver and the efficiency with which we deliver them.

As part of our accountability to Government and to our community, we need to demonstrate whether we are succeeding in achieving our objectives. However, there is no single measure that reflects the impact of the work we do.

We have a clear vision for the West Coast health system and in achieving this vision have established three high-level strategic objectives or goals:

Alongside these goals we have identified a set of outcome measures with which to evaluate how well our health system is performing.

Tracking our performance against these measures helps us to evaluate our success in areas that are important to the Government, our Board and our community. They form an essential part of the way in which we are held to account.

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 for the long-term outcomes is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

Working with the rest of the South Island DHBs, we have also collectively identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been identified as our main measures of performance. We have set standards for these measures in order to determine whether we are moving in the right direction.

The statement of service performance, in the annual performance section of this report, provides a snapshot of the services provided for our population in the past year. We monitor performance against these service performance indicators annually. Many of the measures selected are deliberately chosen from national reporting frameworks, to enable comparison with other DHBs and give context to our performance.

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

As part of our obligations under legislation, DHBs must work towards achieving equity. To promote this goal, the standards set against each measure are the same for all population groups. As a means of evaluating whether we have made a difference for our Māori population over the past year, we present performance against a core set of measures in the annual performance section of this report.

West Coast DHB is also evaluated in terms of its performance against the national health targets. West Coast DHB's health target results for 2016/17 are also presented in the annual performance section of this report.

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 - Outcomes Intervention Logic Framework

MINISTRY OF HEALTH HIGH LEVEL OUTCOMES

Health System Vision

All New Zealanders to live longer, healthier & more independent lives, & the health system is cost effective & supports a productive economy.

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 HIGH LEVEL OUTCOMES

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.

DHB STRATEGIC OBJECTIVES

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*

IMPACT MEASURES

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 specialist 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

People are Healthier and take Greater Responsibility for their own Health

WHY IS THIS OUTCOME A PRIORITY?

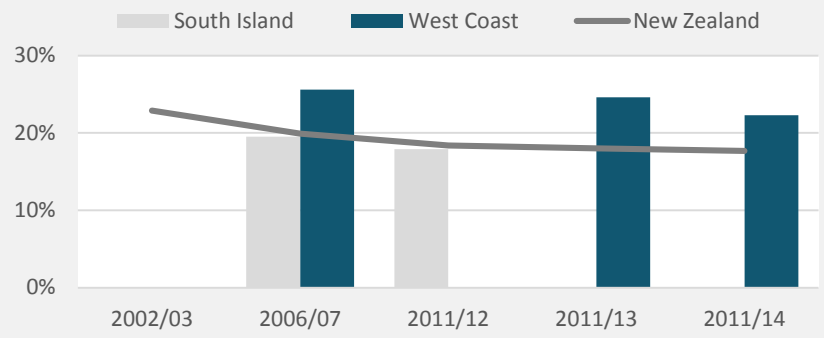
New Zealand is experiencing a growing prevalence of long-term conditions such as respiratory and cardiovascular disease, cancer and diabetes. These conditions are the leading drivers of poor health and premature mortality (death) and place significant pressure on the health system in terms of demand for health services. The likelihood of developing a long-term condition increases with age and these conditions are more prevalent amongst Māori and Pacific Island populations. With 12% of the West Coast population being Māori and Statistics New Zealand predicting that by 2026 one in every four people on the Coast will be aged over 65, meeting the health service demand associated with long-term conditions will be a major challenge for our health system.

WHERE ARE WE FOCUSED?

Tobacco consumption, inactivity, poor nutrition and obesity are major contributors to the most prevalent long-term conditions. While tobacco consumption in New Zealand has decreased in recent years, the proportion of adults who lead sedentary lifestyles is increasing and obesity rates are amongst the highest in the world. These avoidable risk factors can be reduced through supportive environments and preventative strategies that improve personal awareness and responsibility for health and wellbeing. Supporting people to make healthier choices will not only improve the quality of people's lives and the health status of our population, but will reduce avoidable pressure on our health system. Our focus is on reducing the two largest risk factors - smoking and obesity.[1]

A reduction in smoking rates

PERCENTAGE OF THE POPULATION (15+) WHO CURRENTLY SMOKE



Data source: National NZ Health Survey.[2]

The West Coast's smoking rates continue to decline. The latest NZ Health Survey reported that 22% of our population smoke, moving slightly closer to the whole of New Zealand population rate of 17.7%.

We have continued to focus on delivering brief smoking advice and cessation support at all contact points across our health system, to encourage smokers to quit. In the last quarter of this year 91% of smokers identified in general practice, and 87% of smokers identified in our hospitals, were provided with brief advice and offered cessation support.

We have also increased our focus on supporting pregnant women to quit smoking and have invested in an incentivised smoke free pregnancy programme. In the last quarter of 2016/17, 93.5% of women who identified as a smoker when registering with a Lead Maternity Carer were offered brief advice and support.

22% of adults were current smokers in 2014 *(down from 25% in 2013)*

4,743 people in primary care and 1,068 people in our hospitals received brief advice & support to quit

33% of people who smoke accepted smoking cessation support *(higher than the national result)*

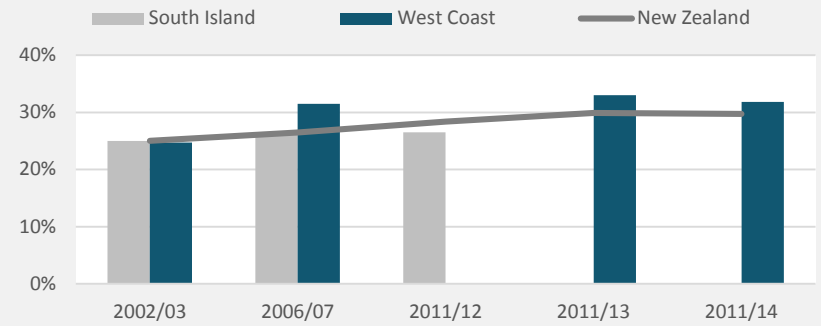
80% of West Coast year 10 students have never smoked

[1] *The performance graphs in this section present the total South Island and total national results including West Coast, rather than presenting West Coast DHB compared to the rest of the South Island DHBs or the rest of New Zealand.*

[2] *The NZ Health Survey is completed by the Ministry of Health. Since 2011, survey results were combined year-on-year, hence the different time periods presented. Results are unavailable by ethnicity or South Island and the 2014 survey presents the most recent data by DHB.*

A reduction in obesity rates

PERCENTAGE OF THE POPULATION (15+) WHO ARE OBESE



Data source: National NZ Health Survey.[3]

While West Coast obesity rates remain above the national average, the most recent NZ Health Survey suggests a slight drop to 32%, which is a positive sign.

Obesity impacts on people's quality of life and is a significant risk factor for many chronic conditions, including cardiovascular disease and respiratory disease. Many of the drivers of obesity sit outside the direct control of the health system, but not outside our influence.

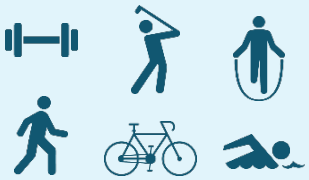
We have continued to focus on supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to adopt healthier lifestyle choices. This includes West Coast DHB's commitment to the Healthy Schools programme with 80% of priority schools adopting the framework.

The Green Prescription programme supports inactive adults to make healthy lifestyle changes and health professionals refer patients in need of support, to increase their physical activity levels and make healthy food choices. Over 558 people across the West Coast were referred to the programme in 2016/17, higher than the previous year. The latest annual results survey showed over half (58%) of Green Prescription participants were more active 6-8 months after referral.

We are also increasing support for children in line with the adoption of the national Healthy Kids health target. In the final quarter of the year, 81% of four year old children identified as obese at their B4 School Check were offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle advice.

Oral health and obesity are associated. Positive trends in oral health can be seen as a proxy indicator of improved nutrition and behaviour modification. Significant improvements have been made in engaging people with school and community dental services on the West Coast in 2016/17. West Coast DHB reached two of its three service targets, with 97% of all children under four years old enrolled with the service and 93% of all children under 12 years old examined on time. The percentage of five year old children being caries-free also improved, with 61% of children having no holes or fillings.

32% of adults were identified as obese in 2014



558 green prescription referrals were made *(2.8% higher than the previous year)*

81% of children identified as obese at their B4 School Check were referred to family-based healthy lifestyle interventions

5,073 children enrolled with school & community dental services

93% of children had their oral health check-up on time *(up from 78% the previous year)*

[3] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30, or >32 for Māori and Pacific people.*

Impact Measures – contributing towards our strategic objectives

More babies are breastfed

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

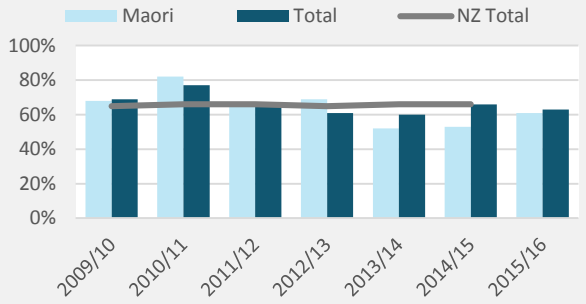
2015/16 results are the latest full year available and West Coast's breastfeeding rates appeared to have dropped slightly for the total population in that year. However, rates for Māori had continued to climb which is positive.

A range of services are available locally to encourage and support women to breastfeed, including peer support programmes and community-based lactation support.

Over 208 women were able to access specialist advice in the community to support breastfeeding in the past year, through the West Coast's lactation support programme.

Data source: Plunket via the Ministry of Health.[4]

Percentage of babies exclusively or fully breastfed at six weeks	2014/15	2015/16	2016/17 Target	2016/17 Result
	66%	63%	75%	n.a



More children have improved oral health

The percentage of five year old children whose teeth are caries-free (have no holes or fillings) has continued to improve, and West Coast DHB surpassed its target in 2016/17.

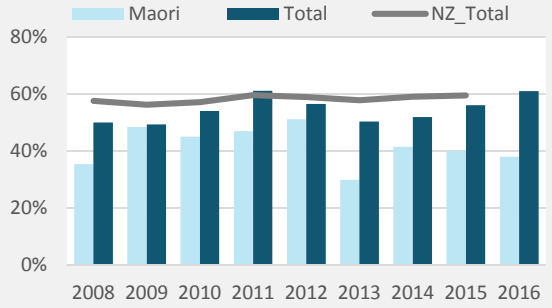
We provide free oral health care for children from birth to 17 years, with a key focus of the school and community oral health service being to ensure that all eligible children are enrolled and examined on time.

Improvements in the proportion of enrolled children being seen and examined on time will continue to have a positive effect on outcomes in future years. Of the 97% of children enrolled this year, 93% were examined according to plan, compared to 78% in 2015/16.

The service is working to address gaps for Māori, and has a multiple enrolment process in place, sharing data across WellChild, immunisation and dental services to better identify children and establish contact with families.

Data source: DHB School & Community Dental Service.[5]

Percentage of five-year-olds caries-free (no holes or fillings)	2014	2015	2016 Target	2016 Result
	52%	56%	57%	61%



Fewer young people take up tobacco smoking

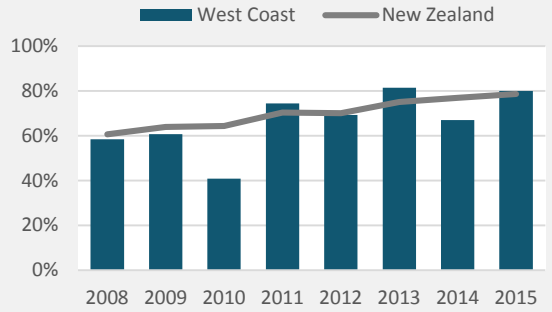
The Action on Smoking and Health (ASH) Survey is one of the largest youth smoking surveys in the world. It is a census style questionnaire asking around 30,000 students every year about their smoking behaviour and attitudes.

The 2015 ASH survey results are the most recent available and show a continuation of the positive trend for West Coast students, with 80% of Year 10 students (age 14/15) never having smoked.

This trend reflects the impact of supportive legislation and social environments combined with local health-led initiatives such as our Health Promoting Schools programme. A continued decline in adult smoking rates will also have a positive influence on these rates.

Data source: National Year 10 ASH Survey[6]

Percentage of 'never smokers' among Year 10 students	2014	2015	2016 Target	2016 Result
	67%	80%	>75%	n.a.



[4] *The standard for this measure is set nationally as part of the national Well Child Quality Framework. Provider data is not able to be combined for this measure and the performance data presented is from the largest provider (Plunket), which covers the majority of mothers on the West Coast. However, because the smaller local providers primarily target Māori and Pacific mothers, results for these ethnicities may be under-stated. 2016/17 results had not been released and were not available to West Coast DHB at the time of printing.*

[5] *This measure is a national DHB performance indicator (PP11) reported annually for the school year. National results had not been made available for the 2016 year at the time of printing.*

[6] *The ASH survey is a national survey used to monitor student smoking since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students aged 14 or 15 years at the time of the survey. The number of West Coast students participating in the survey is around 200-220 and small numbers can lead to fluctuations between years. The 2016 survey results had not been released at the time of printing. For more detail, see www.ash.org.nz.*

People stay well in their own homes and communities

WHY IS THIS OUTCOME A PRIORITY?

Studies show countries with strong primary and community care systems have lower rates of premature mortality from long-term conditions and achieve better health outcomes, at a lower cost, than countries that focus more heavily on a specialist level response. When people are supported to stay well, and can access the care they need in the community, they are less likely to experience a deterioration of their condition that could lead to acute illness, hospital admission and the kind of complications that might lead to a long-stay or residential care.

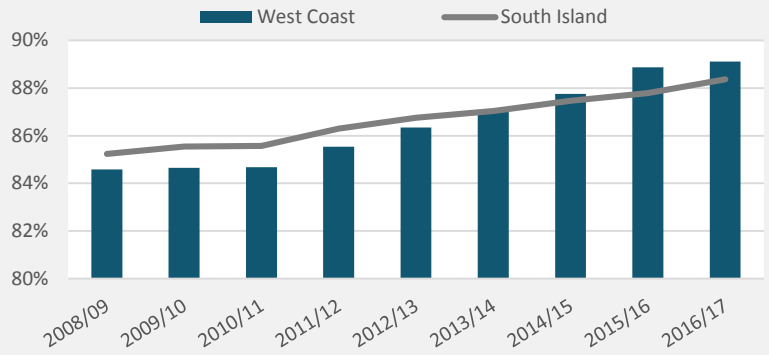
This is not only a better experience and health outcome for our population, but improving the health system's response to people's needs reduces pressure on our hospitals and frees up specialist capacity and financial resources.

WHERE ARE WE FOCUSED?

With an ageing population, and limited capacity and resources, our focus is on reducing two major areas of pressure for our system; by supporting more people to stay safe and well in their own homes for longer, and reducing acute medical admissions into our hospitals.

More people living in their own homes

PERCENTAGE OF THE POPULATION (75+) LIVING IN THEIR OWN HOME



Data source: SIAPO Client Claims Payment System.

The proportion of the West Coast population (aged 75+) living in their own homes continues to steadily increase, reaching 89% in 2016/17. Consistent with our strategy, this suggests our older population is gradually becoming healthier and living more independently.

A number of local programmes help to support our older population to age-in-place and contribute to these positive results, including: medication management; age-related harm prevention and long-term condition strategies; our new falls prevention programme; the restorative rehabilitation and home-based support services; and, respite services provided through our Complex Clinical Care Network (CCCN).

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. Our new community-based falls prevention programme supported 117 people in the last year and 91% of older inpatients received a falls assessment to help them stay safe while in our hospitals.

West Coast DHB piloted the FIRST (Flexible Integrated Rehabilitation Support Team) service with two patients this year, and will look to roll out the service in 2017/18. FIRST is a new approach to supporting people on discharge from hospital by providing services in their own homes. This improves their function and enables them to remain as independent as possible. The FIRST service delivers a coordinated interdisciplinary team response, working with the client and their natural supports to maximise their abilities. This enables more timely and coordinated discharge, reduces the need for future hospital admissions, and helps to keep people in their own homes rather than residential care.

89% of people 75+ are living in their own homes

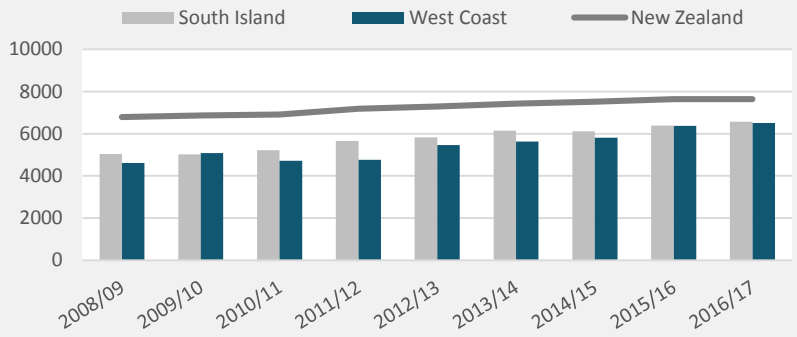
117 people accessed a community-based falls prevention programme to reduce their falls risk

91% of older patients were given a falls assessment to reduce their risk of harm while in our hospitals

79% of people admitted into our older persons' assessment, treatment and rehab service were discharged back to their own home rather than into residential care

A reduction in acute medical admission rates

RATE OF ACUTE MEDICAL ADMISSIONS TO HOSPITAL



Data source: National Minimum Data Set.[7]

Determining the reasons for acute hospital admissions is complex, as it is in part a whole-of-system measure. But with the right intervention and support, many people can avoid deterioration of their medical condition or reduce the likelihood of an event that leads to hospital admission, unnecessary complications, long-term illness or even premature death.

Like the rest of the country, the proportion of acute medical admissions (per 100,000 people) on the West Coast is slowly increasing as our population ages and as more people are living with long-term conditions. However, at 6,506 per 100,000 people, the Coast's current rate still remains well below the national rate (7,638).

This is a positive reflection of the efforts of health professionals and providers from across the health system to keep people safe and well in their own homes and communities, and reduce the need for a hospital visit.

Enrolments with general practice remain high, at 90%. The provision of organised general practice is core to improving the health of our population. High enrolment rates are an indication of good engagement with our health system.

Over 650 integrated clinical HealthPathways are now in place to support the management and referral of patients, which has reduced the time people spend waiting for treatment.

Continued investment in Brief Intervention Counselling services has meant 200 young people and 548 adults have been able to access free mental health support in primary care over the past year.

The primary care-led Long-term Conditions Management (LTCM) Programme is also a key factor in our low acute medical admission rates. The programme supports people to better manage their health and helps to prevent them from becoming acutely unwell. Over 3,800 people were enrolled in the Programme in 2016/17.

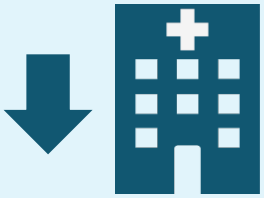
When we compare the West Coast's rate to the national rate (in terms of avoided admissions) we can see the impact of this earlier intervention. If the West Coast's acute medical admission rate was the same rate as the rest of the country, 284 more people would have needed to be admitted and treated in our hospital in the past year.

9/10 people living on the coast are enrolled with a general practice

100% of children under 13 have access to free primary care after-hours

748 people received brief intervention counselling in primary care in 2016/17

3,860 people are enrolled in the long-term conditions management programme



West Coast's acute medical admission rate is 22% lower than the national average.

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

Impact Measures – contributing towards our strategic objectives

People's conditions are diagnosed earlier

Diagnostics are an important part of the healthcare system, and timely access to diagnostics, by improving clinical decision-making, enables early and appropriate intervention. This helps to improve the quality of care and outcomes for our population.

MRIs are delivered by Canterbury DHB on behalf of West Coast DHB. Canterbury has been experiencing capacity issues over the past year, however we are pleased to see that the target for MRIs has been met.

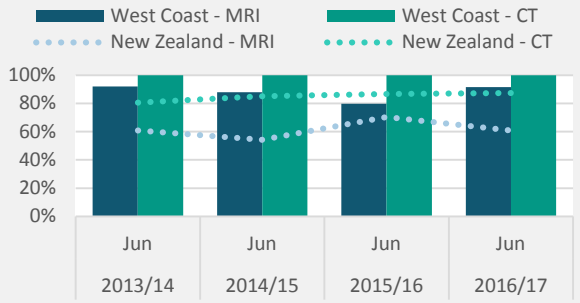
West Coast has also continued to achieve the wait time target for CT scans, with 100% of people seen within six weeks for non-urgent scans, a pleasing result.

In the past year 1,435 West Coast residents were referred for a non-urgent CT scan and 1,055 for an MRI.

Data source: DHB Patient Management System.

Percentage of people waiting less than six weeks for non-urgent CT or MRI scans

	2015/16	2016/17 Target	2016/17 Result
CT	100%	95%	100%
MRI	80%	85%	92%



Fewer avoidable hospital admissions

This measure reflects the proportion of admissions that are considered to have been potentially avoidable through earlier intervention in a primary care setting. In 2016/17 the rate of avoidable admissions on the West Coast was 2,699 admissions per 100,000 people. This remains well below the national rate (3,833) and is consistent with previous years.

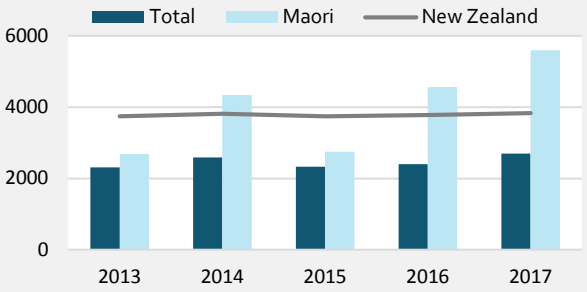
A wide range of local initiatives contribute to preventing avoidable hospital admissions. These include our primary care-led Long-Term Conditions Management (LTCM) Programme, local HealthPathways and our community-based Complex Clinical Care Network, all of which support people to better manage their health.

Rates for Māori (while impacted by small numbers) are higher and further work is needed to reduce avoidable admissions amongst our Māori population.

Data source: Ministry of Health Performance Reporting.[8]

Rate of ambulatory sensitive hospital admissions for those aged 45-64

2014/15	2015/16	2016/17 Target	2016/17 Result
2,326	2,396	<2,401	2,699



Fewer people admitted to hospital after falls

At 5.1%, the percentage of the population admitted to hospital as a result of a fall is higher than the previous years and just above the national rate and target.

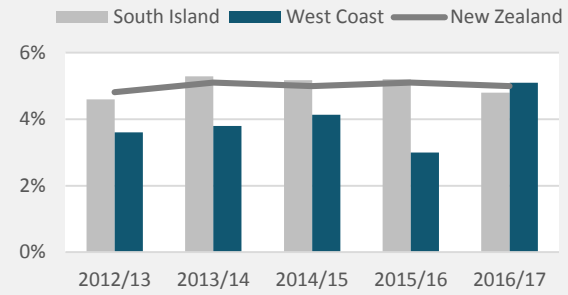
We have a Falls Prevention Strategy in place in our hospitals which promotes clinically-led falls prevention. Care plans and strategies for patients at risk of falling and a community-based falls prevention programme help people to stay well and independent. These strategies also help to reduce demand on services.

A total of 117 people accessed our community-based falls prevention programme in the last year and 91% of older inpatients received a falls assessment to help them stay safe while in our hospitals.

Data source: National Minimum Data Set.[9]

Percentage of the population (75+) admitted to hospital as a result of a fall

2014/15	2015/16	2016/17 Target	2016/17 Result
4.1%	3.0%	<4.9%	5.1%



[8] *This measure is a national DHB performance indicator (SI1) and captures ambulatory sensitive hospital admissions i.e. admissions for conditions considered preventable or avoidable through earlier intervention, including: diabetes, asthma, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and West Coast DHB's aim is to maintain current performance below the national rate (which reflects fewer people presenting to hospital) and to reduce the equity gap between population groups. The results differ to those previously presented, being based off the national March 2017 series provided by the Ministry of Health in August 2017 – baselines have been reset to reflect the current series. It is important to note the effect of small numbers on the Māori results for this measure - the 2016/17 result refers to 47 events, 10 more than in the previous year.*

[9] *From 2013/14, results reflect the updated 75+ population in line with the 2013 Census. Small numbers have a disproportionate impact on results here, with the difference between the 2015/16 and 2016/17 results being 52 people.*

People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

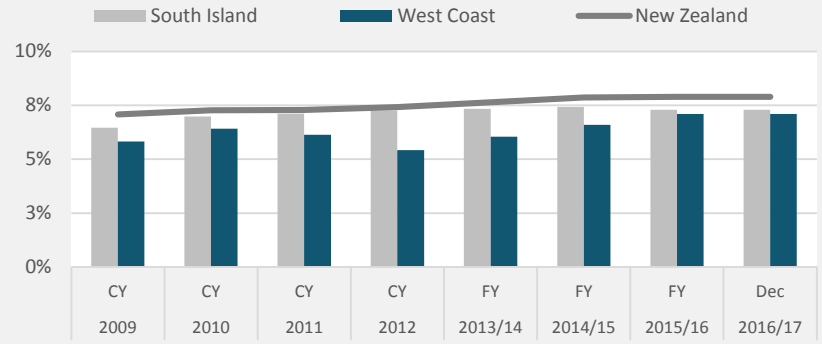
For people who need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning system, matching capacity to demand by managing the flow of patients between services and moving the point of intervention to earlier in the path of illness. This outcome also reflects the importance of the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays, readmissions 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 also waste resources and add unnecessary cost into the system.

WHERE ARE WE FOCUSED?

Having a strong primary care foundation and managing more people with less-complex conditions in the community is of benefit to our population and a priority focus for our health system, however it also means that people we see in our hospitals are likely to be frailer, have more complex conditions, and be at greater risk of readmission and complications. Our focus is to give our community assurance that they are receiving the best and safest care possible – by maintaining low premature mortality rates and reducing readmission rates.

A reduction in acute readmissions

RATE OF ACUTE READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE



Data source: National Minimum Data Set.[10]

As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative long-term outcomes. The West Coast's readmission trend has levelled off slightly, which is a positive result, although the total numbers are very small and can fluctuate between years.

Improved patient safety and quality processes are key factors in reducing acute readmissions. The West Coast DHB has made a strong commitment to Zero Harm and the implementation of the Health Quality and Safety Commission's Open for Better Care Campaign. The rate of staff compliance with good hand hygiene practices continues to meet target at 80%. The proportion of patients receiving precautionary antiseptic skin treatments prior to surgery is 100% for the fourth year in a row and 91% of older inpatients (75+) received a falls assessment to reduce their risk of harm while in our hospitals. Serious events, causing harm, in our hospitals have reduced by 20% on the previous year.

We have a particular focus on older people and instances of heart failure and falls, where readmission rates are higher. In 2016/17, 91% of people experiencing a stroke on the West Coast were referred to our stroke rehabilitation service.

The FIRST (Flexible Integrated Rehabilitation Support Team) service was piloted this year with rollout expected in 2017/18. FIRST is a new, coordinated, interdisciplinary team approach to supporting people on discharge from hospital by providing services in their own homes. This improves their function and enables them to remain as independent as possible.

Compliance with good hand hygiene practices is maintained at 80%, helping to prevent avoidable infection in our hospitals

91% of patients aged 75+ had a falls risk assessment while in our hospitals

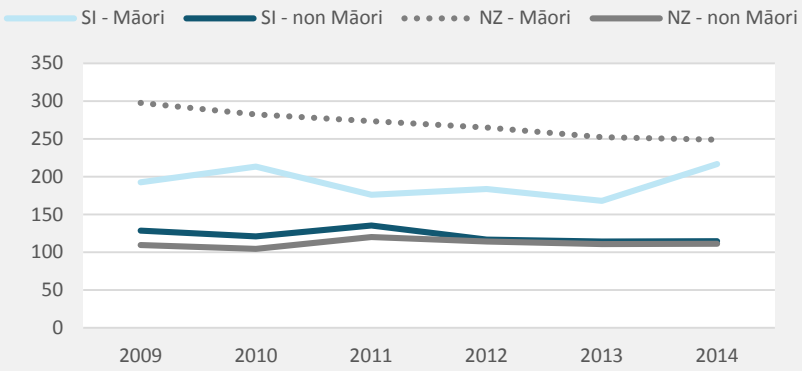
91% of our population were referred to stroke rehabilitation after an acute event

2 people were supported by the new FIRST service which will deliver integrated rehabilitation support to people in their own homes

[10] *This measure is a national DHB performance indicator (OS8). Because the national definition was still being confirmed at the time West Coast DHB's Annual Plan was produced in 2016, unstandardised rates have been used to enable the calculation of a South Island rate.*

A reduction in avoidable mortality

RATE OF ALL-CAUSE MORTALITY FOR PEOPLE AGED UNDER 65



Data source: National Mortality Collection.[11]

There has been a slight increase in mortality rates across the South Island for Māori, but the overall mortality trend continues to be positive and is consistently below national rates.

Our Complex Clinical Care Network and the primary care Long-Term Condition Management Programme help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment.

For those people who did need a higher level of intervention, West Coast DHB delivered 1,979 elective surgeries, over 7,200 first specialist assessments, and 15,400 outpatient appointments in 2016/17. Of those patients who received treatment, 99% waited less than four months to access that treatment.

Cancer is one of the leading causes of mortality on the West Coast and contributes to a high proportion of all premature deaths. Uptake of cancer screening rates were disappointing with 75% of women having a cervical cancer screen in the past year against an 80% target, and little change in uptake compared to previous years. Breast screening rates were slightly higher (77%) but there is still room for improvement. West Coast DHB also missed the national Faster Cancer Treatment health target in the final quarter of the 2016/17 year.[12]

Mental health is an area of concern and mental illness contributes to mortality. Many common mental health problems such as depression, anxiety and substance abuse also have life-long consequences for the quality of people's lives. Ensuring access to appropriate services therefore has a positive impact on both health and social outcomes for our population.

The proportion of our population accessing specialist mental health services has remained high at 5.3% for 0-19-year olds and 5.7% for adults 20-64. Our services work hard in the face of this high level of demand to meet national wait time targets; 76% of people referred for non-urgent mental health and alcohol and other drug services were seen within three weeks, and 89% of people were seen within eight weeks.

The West Coast has continued to be the leading performer against the Shorter Stays in ED health target, with more than 99% of people presenting in our ED being admitted, transferred or discharged within six hours in every quarter of the year.

More than 7,200 patients attended a first specialist assessment.

Of those patients given a commitment for treatment, 99% waited less than four months

1,979 elective surgeries were delivered to Coasters in 2016/17

99% of people presenting to ED were seen within 6 hours

Shorter stays in Emergency Departments

(West Coast is leading the country for this target)

< 3 weeks

76% of non-urgent mental health clients were seen within three weeks *(89% within eight weeks)*

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

[12] *Small population numbers have a significant impact on delivery of this target and West Coast DHB missed the final quarter target by four people.*

Thanks to theNounProject.com for some of the icons used in this document: Maciej Swierczek, Leonides Delgado, Adrien Coquet, Sandy Priyasa, Irene Hoffman, Arafat Uddin, Vicons Design, Jose Manuel de Laa, icons.design, Royyan Wijaya

Impact Measures – contributing towards our strategic objectives

People have shorter waits for urgent care

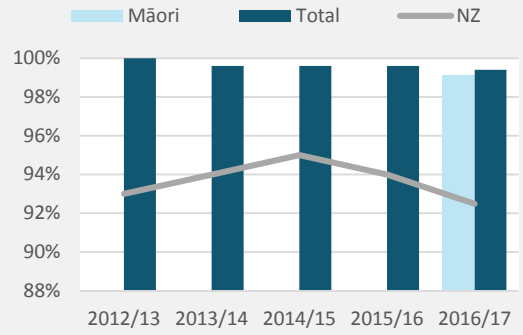
The West Coast has continued to be the leading performer against the Shorter Stays in ED health target, with 99.4% of people presenting in our ED being admitted, transferred or discharged within six hours in the last quarter of the year.

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

Strong performance results also reflect the team work within ED and across the wider hospital to support the flow of patients and enable the ED team to respond well within target timeframes.

Data source: DHB Patient Management System.[13]

Percentage of people presenting to ED admitted, discharged, or transferred within six hours	2014/15	2015/16	2016/17 Target	2016/17 Result
	99.6%	99.6%	95%	99.4%



People have shorter waits for specialist care

More than 7,200 patients attended a first specialist assessment - with 95.4% of all those patients seen within four months (ESPI2).

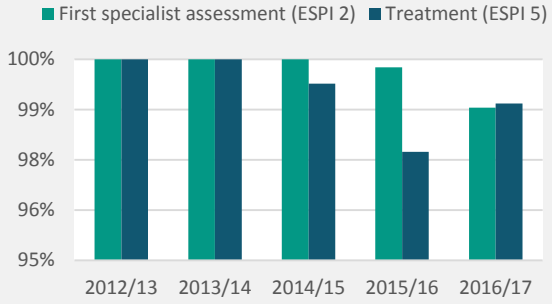
Of those patients given a commitment for treatment, 98.9% waited no longer than four months for treatment (ESPI5). West Coast DHB also met the elective surgery health target, delivering 1,979 elective surgeries in 2016/17.

These figures reflect ongoing pressure in some service areas, particularly in orthopaedics, making it challenging to achieve the four-month time frames. Work continues in these areas to support wait times being met in a more consistent and sustainable manner.

This year, 16% of the first specialist assessments were delivered virtually, without the wait for a hospital appointment - meaning less disruption for patients.

Data source: Ministry of Health Quickplace Warehouse.[14]

Percentage of people receiving specialist assessment (ESPI 2) or treatment (ESPI 5) within 4 months		2015/16	2016/17 Target	2016/17 Result
	ESPI2	98.8%	100%	95.4%
	ESPI5	97.7%	100%	98.9%



People experience fewer adverse events

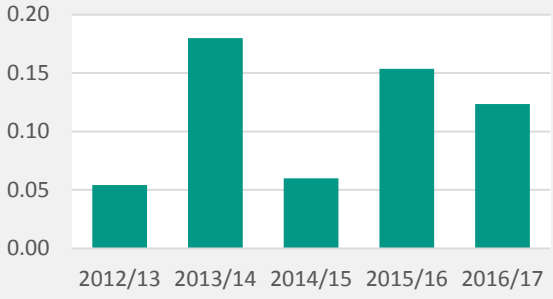
The rate of serious falls in our hospitals reflects a positive downward trend.

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

Our hospital teams provided 91% of all inpatients aged over 75 with a falls assessment in the third quarter of this year, allowing mitigation strategies and care plans to be put in place for patients at risk, and supporting the achievement of this target

Data source: DHB Quality Reporting System. [15]

Rate of SAC level 1 & 2 falls in our hospital	2014/15	2015/16	2016/17 Target	2016/17 Result
	0.06	0.15	0.05	0.12



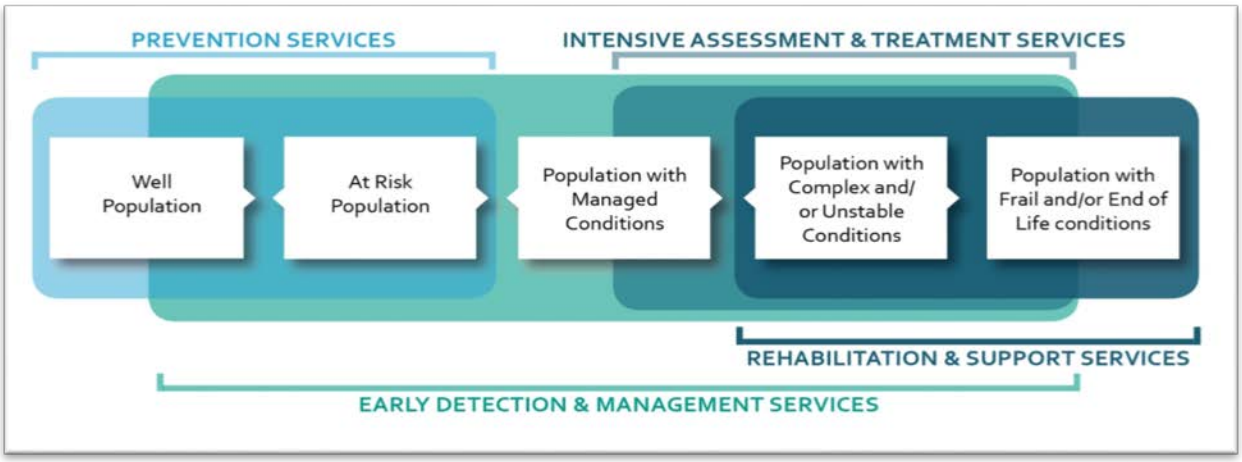
[13] *This measure is the national DHB health target (Shorter Stays in ED). In line with national health target reporting, the annual results refer to the final quarter of each year (01 April - 30 June).*

[14] *These two measures are national Elective Services Patient Flow Indicators (ESPIs) established to track system performance. Standards are set nationally and in line with national reporting. The annual results presented are from the final month (June) of each year.*

[15] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents represent those with both the highest consequence and likelihood. The rate is presented per 1,000 inpatient beds but small numbers still have a significant impact on these results — the 2016/17 result relates to four incidents.*

Part III
Delivering on our Plans

2016/17 Statement of Service Performance



Evaluating our Performance

Over the longer term we evaluate the effectiveness of our decisions and the quality of our service delivery by tracking performance against the set of desired long-term outcomes presented on the previous pages.

We also evaluate our service performance on an annual basis by providing a forecast of the services we plan to deliver and the standards we expect to meet. This statement of service performance presents our actual performance against the 2016/17 forecast.[16]

The snapshot covers the services provided for the West Coast population across the full continuum of care (pictured above) and measures have been grouped into four service (or output) classes that are a logical fit with the continuum:

- prevention services
- early detection and management services
- intensive assessment and treatment services
- rehabilitation and support services.

Each output class includes measures which help to evaluate West Coast DHB's performance over time, recognising the funding received, Government priorities, and expectations and system capacity.

Because it would be overwhelming to measure every service delivered, for each output class a mix of services are chosen which are important to our community and stakeholders, and provide a fair representation of how well West Coast DHB is performing.

In presenting our performance picture, we have not simply presented the volumes of services delivered. The number of people who receive a service is often less important than whether enough of the right people received the service, or whether the service was delivered at the right time. We have therefore presented a mix of measures that address four key aspects of performance:

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

West Coast DHB is responsible for funding health services to our population, across the full continuum of care. Some of the measures presented in the statement of service performance therefore reflect the broader scope of services provided to our population, not just those provided directly by West Coast DHB.

As part of our obligations under legislation, DHBs must work towards achieving equity. To promote this goal, West Coast DHB has presented its performance against a core set of performance measures (identified as important for Māori health) as a means of evaluating whether we have made a difference for our Māori population over the past year. This snapshot follows the statement of service performance.

Nationally, DHB performance is also evaluated by tracking performance against six national health targets. West Coast DHB's performance over the past year is set out on page 21.

[16] *The 2016/17 Annual Plan, incorporates the Forecast Statement of Service Performance, and is available on the DHB's website: www.westcoastdhb.health.nz.*

Setting standards

In setting performance standards for 2016/17, we considered the changing demographic of our population, areas of increasing demand, and the assumption that resources and funding growth would be limited. Targets reflect the objective of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing waiting times and delays in treatment.

On the West Coast our small population size means a very small number of people can have a disproportionate effect on our results. For this reason, some of the standards set may be particularly difficult for the West Coast DHB to meet. However, it is important that we strive to ensure our population has equitable access to services and we monitor these indicators in order to make appropriate funding decisions as we move forward.

NOTES ON THE DATA

Rather than repeating footnotes, the following symbols have also been used to provide context in the performance tables:

E Some service are demand-driven such as: diagnostics, emergency, maternity, and palliative care services. It is not appropriate to set targets for these services, instead estimated service volumes are provided to give context in terms of the use of resources across our health system.

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

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

◇ National health targets are set for DHBs to achieve by the final quarter, or final month, of the given year. In line with national performance reporting, fourth quarter (April-June) or June results are reported as the annual result.

◆ The measure is identified as an important Māori health measure. For a breakdown of results by ethnicity refer to the snapshot on page 31.

The reader should also note that the results for some measures, where the performance data comes from third parties or national reports, was anticipated but unfortunately not available (n.a) at the time of printing this report. These instances have been footnoted throughout the report.

Performance Key

	Rating	Criteria
✓	Achieved	Standard reached
➲	Partially Achieved	Standard not reached but performance improved or maintained
✖	Not Achieved	Standard not reached and performance dropped

National Health Targets

This was a positive year in terms of delivery against many of the national health targets. The West Coast DHB improved or maintained performance on all but two of the targets. The table below shows the quarterly results across the 2016/17 year. The national average reflects the final quarter result.

National Health Targets								
Success is measured by achievement of the target but also by improved performance and comparison to other DHBs.	Notes	2016/17 Target	Q1	Q2	Q3	Q4	National Average	Rating
Children fully immunised at eight months of age	◇	95%	76%	80%	91%	80%	92%	✖
Smokers enrolled with a PHO receiving advice and help to quit	◇	90%	84%	91%	92%	91%	89%	✓
Percentage of people presenting in ED admitted, discharged or transferred within six hours	◇	95%	99%	99%	100%	99%	95%	✓
Elective surgical discharges delivered (surgeries provided)	◇	1,906	480	991	1,441	1,979	-	✓
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	◇[17]	85%	61%	75%	75%	56%	81%	✖
Percentage of obese children identified at B4SC offered a referral for clinical assessment and healthy lifestyle interventions	◇	95%	40%	0%	17%	81%	91%	➲

Small population numbers and a large number of parents opting out of, or declining, immunisation makes the immunisation health target challenging for the West Coast. The focus for our teams continues to be on reaching all parents and offering immunisation and 94% of the children whose parents consented to immunisation were immunised in the final quarter of this year, representing a huge effort from the team.[18]

The West Coast achieved the Better Help for Smokers to Quit – Primary Care health target, with 91% of hospitalised smokers having received help and advice to quit in the final quarter. Best-practice initiatives continue to improve performance including dashboards, education, and active clinical leadership.

Delivery against the national Shorter Stays in ED and Elective Surgery targets continue to be positive areas for the West Coast, with consistent delivery against these targets. The transalpine approach with Canterbury has helped the West Coast exceed the electives health target by 73 surgeries.

Performance against the Faster Cancer Treatment target was disappointing in the final quarter of the year. Small population numbers make this target particularly difficult to meet and the performance result for quarter four reflects West Coast DHB missing the target by just four patients.

Raising Healthy Kids is a new national health target and DHBs are expected to achieve this target by December 2017. While the West Coast team has not yet reached the new target, considerable effort has been made over the past year and performance has significantly improved. West Coast DHB anticipates reaching the target by the end of the 2017 year.

[17] *West Coast DHB has corrected its published results against this health target to reflect the removal of duplicate records and correction of treatment dates for two records which would have aligned the results with different quarters: the previous results were Q1: 63%, Q2: 76% and Q3: 83%.*

[18] *West Coast DHB has a large community within its population who decline immunisations and this makes delivering the national immunisation target extremely challenging. The opt-off and decline rate for eight-month old children was 15% in the final quarter. West Coast DHB's team is focused on immunising all the children whose parents consent to immunisation and reached 94% of those children (64 of 68) in the final quarter of the year, with only four children being missed.*

Prevention Services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR WEST COAST DHB?

Preventive health services promote and protect the health of the population. They help to address individual behaviours by targeting changes to physical and social environments that 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 the total population. These diseases are largely preventable. 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 also our foremost opportunity to target improvements in the health of high-need populations and to reduce inequalities in health status and health outcomes. Prevention services are also designed to spread consistent messages to large numbers of people, and can therefore be very cost-effective.

SERVICE PERFORMANCE (2016/17)

Health Promotion and Education Services							
These services inform people about risks and support them to make healthy choices. Success begins with awareness and engagement followed by positive behaviour changes.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National Average	Rating
Babies exclusively breastfeeding on hospital discharge	Q[19]	84%	91%	≥75%	86%	-	✓
Babies exclusive/fully breastfed at LMC discharge	Q[20]◆	75%	n.a	75%	n.a	n.a	-
Lactation support and specialist advice consultations provided in community settings	A[21]	172	200	>100	208	-	✓
Priority schools supported by the Health Promoting Schools Framework	C[22]	100%	100%	>70%	80%	-	✓
Nutrition and activity courses provided in the community	A	9	4	>5	6	-	✓
People referred to Green Prescriptions for additional physical activity support	A[23]	478	543	500	558	-	✓
Green Prescriptions participants more active 6-8 months after referral	Q[23]	86%	58%	>50%	n.a	n.a	-
Women smokefree at two weeks postnatal	Q[24]◆	81%	76%	95%	n.a	n.a	-
Smokers enrolled with a PHO receiving advice/help to quit	C◇	90%	79%	90%	91%	89%	✓
Smokers identified in hospital receiving advice/help to quit	C[25]◆◇	98%	97%	95%	87%	95%	✖

[19] The percentage of babies breastfeeding can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period. Standards are set in alignment with World Health Organisation recommendations.

[20] This measure is part of the national Well Child/Tamariki Ora (WCTO) performance framework and standards are set nationally. The Framework covers health promotion, education, screening and support services and checks are provided free to all New Zealand children from birth to five years. Results are published by the Ministry and the 2016/17 results were not available at the time of printing.

[21] The 2015/16 result has been updated to reflect the full year which was not available at the time of printing the 2016/17 Annual Plan.

[22] The Health Promoting Schools Framework is a DHB sponsored programme that supports schools to address health issues through the promotion of activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated and/or have a high proportion of Māori and/or Pacific children. The definition of a 'priority school' has changed which has resulted in the change in performance. Although results appear to have dropped, the number of schools supported has increased from 12 to 13.

[23] 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 competed by Research NZ on behalf of the Ministry of Health. In 2017, a decision was made nationally to shift to biennial surveys. The next survey will be in 2017/18.

[24] This measure is part of the national Well Child performance framework and standards are set nationally. The 2015/16 results reflect the six months to December 2015: the full year and the 2016/17 results were not available at the time of printing.

[25] The West Coast results are impacted by small population numbers and this result reflects just 34 people being missed. This work continues to be a priority and results are reviewed on a monthly basis, with smokefree champions highlighting misses and pinpointing gaps in staff knowledge or awareness. Investigations are made into each missed case. A number of staff changes in the final quarter meant processes were not followed consistently and this has been reflected in the result.

Population-Based Screening Services

These services help to identify people at risk of illness and pick up conditions earlier. West Coast DHB's role is to encourage uptake and success is indicated by high coverage rates.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Four year olds receiving a B4 School Check (B4SC)	C[26]◆	92%	74%	>90%	90%	94%	✓
% of four year olds (identified as obese at B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q[27]◇	new	new	95%	81%	91%	➲
Year 9 students (in decile 1-3 schools) receiving a HEEADSSS assessment	C[28]†	46%	68%	95%	82%	-	➲
Women (25-69) having a cervical smear in the last 3 years	C[29]◆	74%	75%	80%	75%	75%	➲
Women (50-69) having a mammography in the last 2 years	C[27]◆	75%	76%	>70%	77%	72%	✓

Immunisation Services

These services help to reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Newborns enrolled on the Nat. Immunisation Register at birth	C	100%	100%	>95%	100%	-	✓
Children fully immunised at eight months of age	C[30]◆◇	85%	78%	95%	80%	92%	➲
Eight month olds 'reached' by immunisation services	Q[31]◇	98%	100%	95%	95%	97%	✓
Year 8 girls completing their HPV vaccinations (Dose 3)	C[32]†◆	53%	43%	70%	39%	66%	✖
Older people (65+) receiving a free influenza (flu) vaccination	C[33]†◆	64%	61%	75%	55%	56%	✖

[26] The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.
[27] This measure is the national Raising Healthy Kids health target, introduced at the start of 2016/17.
[28] A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.
[29] Cervical and breast cancer screening are national programmes and age bands and standards are set nationally. Rates for cervical screening are the same as the previous year and national rates but are below target. Improving cervical screening rates remains a focus for 2017/18.
[30] West Coast DHB has a large community within its population who decline immunisations and this makes delivering all of the national immunisation targets extremely challenging. The opt-off and decline rate for eight-month old children was 15% in the final quarter. West Coast DHB's team immunised 94% of all the consenting children in the final quarter of the year, with only four children missed.
[31] 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children. This measure is included to reflect how well West Coast DHB and general practice teams are doing at contacting parents and providing professional advice - irrespective of the final choices made by parents who may choose to decline immunisations or opt off the National Immunisation Register.
[32] The Human Papillomavirus (HPV) vaccination aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. The programme is free to young people under 26 years of age. Like all the immunisation targets, strong anti-immunisation views make meeting this target challenging on the West Coast. We also have a higher number of young people who are counted as eligible via Census but who are not actually in school on the Coast (i.e. boarding out of region or moving away during the year), making this a challenging target. West Coast DHB is working with schools to lift these numbers and encourage young people to engage in the HPV programme. In the 2016/17 year 135 girls were identified as being enrolled in schools on the Coast and of these, 70% consented to the programme.
[33] The denominator for this measure has changed from the number of people enrolled with a PHO to the Census population. This has had a negative impact on results for the most recent year and means results from previous years are not directly comparable. The actual number of flu vaccinations delivered was 3,143, compared to 3,125 in 2015/16.

Early Detection and Management Services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR WEST COAST DHB?

New Zealand 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. Early detection and management services help to maintain, improve and restore people's health by ensuring that those at risk of developing a long-term condition, or with early disease onset, are identified early and their condition appropriately managed. These services are particularly important where people have multiple conditions requiring ongoing interventions or coordinated support.

Because these services can better support people to stay well and avoid negative complications or acute illness, they help reduce the likelihood of a hospital admission. They therefore not only have a positive impact on people's health but reduce the pressure on the health system, freeing up limited capacity across our hospital and specialist services.

SERVICE PERFORMANCE (2016/17)

Primary Care Services							
These are services offered in community settings by general practice teams, to improve, maintain or restore people's health. High enrolment or access levels are indicative of a responsive system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
DHB population enrolled with a Primary Health Organisation	C◆	91%	89%	95%	90%	-	➲
Number of HealthPathways in place across the health system	V[34]	614	654	650	655	-	✓
Avoidable hospital admission rate for children (0-4)	Q[35]◆	4,455	5,564	<5,388	4,394	6,474	✓
Young people (0-19) referred to Brief Intervention Counselling	A[36]	126	219	>80	200	-	✓
Adults (20+) accessing Brief Intervention Counselling	A[34Δ]	413	558	>300	548	-	✓

Oral Health Services							
These services help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.	Notes	2014	2015	2016 Target	2016 Result	2016 National	Rating
Children (0-4) enrolled in DHB-funded oral health services	C[37]†◆	100%	87%	95%	97%	-	✓
Enrolled children (0-12) examined according to planned recall	T†◆	89%	78%	90%	93%	-	✓
Adolescents (13-17) accessing DHB-funded oral health services	C†	70%	75%	85%	75%	67%	➲

[34] *The HealthPathways website helps ensure a consistent approach to care and equitable access to services by providing general practice with online access to clinically designed pathways that guide patient care and provide advice on treatment.*

[35] *Some hospital admissions are seen as avoidable through early intervention and treatment, and therefore provide an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. West Coast DHB's aim is to maintain current performance below the national rate (which reflects fewer people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based off the national March 2017 series provided by the Ministry of Health in August 2017. Baselines have been reset to reflect the current series and are to March of each year.*

[36] *The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. A joint triage process between primary care and specialist child and adolescent services has been introduced and the primary-care led Long-Term Conditions Management Programme has been expanded to incorporate people with mental health issues. Both these factors have helped contributed to an increase in referrals. The 2015/16 result for adults (548) has been updated to reflect 10 additional sessions that were reported after the Annual Report was printed.*

[37] *West Coast DHB reviewed its oral health service enrolment processes and linked the School and Community Dental Service in with the Immunisation and Well Child teams to encourage families to connect with services and lift enrolment rates. A new approach has also been adopted to better cover staff vacancies and both these factors have helped contributed to improved performance.*

Long-Term Conditions Management Services (LTCM)							
These services are targeted at people with high health needs with the aim of reducing crises and complications through earlier identification and good management (and control) of that condition and any possible side-effects.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
People identified with a long-term condition enrolled in the LTCM Programme	A	3,666	3,793	>2,000	3,860	-	✓
People identified with diabetes having an annual LTMC review	C[38]	96%	91%	>90%	74%	-	✖
People with diabetes having satisfactory or better diabetes management (Hba1c ≤ 64mmol/mol	Q[39]	69%	63%	80%	54%	-	✖
Eligible population having a CVD risk assessment in the last 5 years	C[40]◆◇	91%	91%	90%	91%	90%	✓

Pharmacy and Referred Services							
These are services health professionals use to help diagnose or monitor a health condition. While largely demand-driven, faster, direct access aids clinical decision-making, improves referral processes and reduces the wait for treatment.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Subsidised pharmaceutical items dispensed in the community	A[41]	443K	455K	E.<600K	466k	-	✓
Community requested radiological tests delivered by Grey Base Hospital	A[42]	5,289	5,504	E.>5,000	5,817	-	✓
People receiving urgent diagnostic colonoscopy within 2 weeks	T[43]◇	83%	100%	85%	100%	92%	✓
People receiving CT scans within 6 weeks	T◇	100%	100%	95%	100%	87%	✓
People receiving MRI scans within 6 weeks	T◇	88%	80%	85%	92%	61%	✓

[38] There has been an increase in the number of people identified with diabetes on the national virtual diabetes register, which has impacted on the results for this measure. The actual number of checks delivered has increased with 62 more people receiving a review compared to the previous year. West Coast DHB and the PHO remain committed to identifying and enrolling people in the Long-Term Conditions Management (LTCM) Programme to better support the management of all long-term conditions including diabetes.

[39] An annual review includes an HbA1c test of patient's blood glucose levels to assessing the management of people's diabetes condition - HbA1c ≤64mmol/mol reflects an acceptable blood glucose level. The delivery of the LTCM programme aims to better support people to manage their diabetes and this remains a priority for the coming year.

[40] This measure refers to cardiovascular disease (CVD) risk assessments undertaken in primary care and was previously the national 'More Heart and Diabetes Checks' health target. By identifying those at risk of CVD early, we can help them to change their lifestyle, improve their health and reduce the rate of avoidable CVD-related hospitalisation for our population.

[41] This measure excludes items dispensed in hospitals, but may include some non-residents who had prescriptions filled while on the Coast.

[42] The baseline result for 2014/15 has been updated (from 5,935) to ensure consistency with the current definition.

[43] These diagnostic measures are national performance measures (PP29). Standards are set nationally and results are for the final month of the year (June) in alignment with national results published by the Ministry of Health.

Intensive Assessment and Treatment Services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR WEST COAST DHB?

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

As an owner of specialist services, West Coast 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 and redirect resources away from other services. Improved systems and processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes.

SERVICE PERFORMANCE (2016/17)

Quality & Patient Safety							
These quality and patient safety measures are national markers championed by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.[44]	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Rate of compliance with good hand hygiene practice	Q[45]◇	83%	81%	80%	80%	84%	✓
Hip and knee replacement patients receiving cefazolin >2g	Q[46]◇	100%	95%	95%	96%	97%	✓
Hip and knee replacement patients receiving appropriate skin preparation (antiseptic)	Q◇	100%	100%	100%	100%	98%	✓
Inpatients (aged 75+) receiving a falls assessment	Q[47]◇	88%	88%	90%	91%	92%	✓

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. Service utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Women registered with an LMC by 12 weeks of pregnancy	C[48]	56%	54%	80%	n.a	n.a	-
Proportion of new mothers attending DHB-funded parenting and pregnancy courses	C	69%	100%	30%	100%	-	✓
Maternity deliveries in West Coast DHB facilities	A	256	246	Est. 300	250	-	✓
Baby friendly hospital accreditation of DHB facilities	Q[49]	Yes	Yes	Yes	Yes	-	✓

[44] These quality measures are national safety markers with definitions and standards set nationally. The 2015/16 results are the most recent results published nationally, being Q3 (January-March 2016).

[45] This measure is based on ward audits of the Medical and Surgical Wards conducted according to Hand Hygiene NZ standards. The 2015/16 baseline has been updated to the final quarter result for the year, which was not available at the time of printing the previous report.

[46] Cefazolin >2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.

[47] While there is no single solution to reducing falls, an essential first step is to assess an individual's risk of falling, and act accordingly.

[48] The aim of this measure is to encourage providers to engage mothers early in their pregnancy to promote good health and wellbeing of both mother and baby. The data for this measure comes from the national NZ Maternity Clinical Indicators report. Baselines were updated in line with the adoption of this measure as one of the new national Better Public Services measures, including slight clarification of the definition. The national 2016/17 results were not available to West Coast DHB at the time of printing.

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

Acute/Urgent Services

These are services delivered in response to illnesses that have an abrupt onset or progress rapidly. While largely demand-driven, earlier intervention and shorter wait times are indicative of an effective and responsive system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Children (0-13) with access to free primary care after hours	C	new	100%	100%	100%	-	✓
General practices providing telephone triage after hours	C[50]	88%	88%	100%	88%	-	➲
Attendances at Grey Base Hospital Emergency Department	A[51]	11,376	11,742	E.<13,000	11,382	-	✓
People (triage level 1-3) presenting in Emergency who are seen within clinical guidelines	Q[52]	85%	80%	>85%	79%	-	✖
People waiting less than 4 weeks to start radiotherapy or chemotherapy	T[53]	100%	100%	100%	100%	-	✓
People (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[54] ◇	50%	80%	85%	56%	81%	✖
Acute inpatient average length of stay (standardised)	Q[55]	2.35	2.40	≤2.35	2.36	2.50	➲

Elective/Arranged Services

These services are for people who do not need immediate hospital treatment, where treatment is 'booked' or 'arranged.' Improved access is seen as indicative of an effective system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
First specialist assessments provided (medical and surgical)	A[56]	6,663	6,591	E.>6,000	7,232	-	✓
First specialist assessments that were non-contact (virtual)	Q[57]	5.5%	12.5%	>5%	16%	-	✓
Elective surgical discharges (surgeries provided)	A[58]	2,053	1,942	1,906	1,979	-	✓
Elective inpatient average length of stay (standardised)	Q	1.63	1.55	≤1.55	1.34	1.56	✓
Outpatient attendances	A[59]	16,903	15,257	E.>13,000	15,479	-	✓
Outpatient appointments/consultations provided by telemedicine	Q[60]	1.9%	2.3%	>5%	3.3%	-	➲
Outpatient 'Did not Attend' rates	Q[61] ◆	6.9%	5.9%	<6%	5.6%	-	✓

[50] The difference between 100% and the 88% result is one practice, which continues to redirect callers to Healthline after hours.

[51] This measure uses the definitions for the national health target (Shorter Stays in ED) and reflects attendances at Grey Base Hospital ED.

[52] Triage 1: seen immediately on presentation; Triage 2: seen within 10 minutes; Triage 3: seen within 30 minutes of presentation. There has been a slight reduction in performance over the past year as a result of increased attendances in the triage 3 category.

[53] This is a national DHB performance measure (PP30) and excludes where treatment is scheduled with other treatments or part of a trial.

[54] This measure is the national health target (Faster Cancer Treatment) which presents a rolling six-month result to June. Small population numbers have a disproportionate impact on results: the 56% performance result for quarter four reflects West Coast DHB missing four patients.

[55] This is a national performance measure (OS3). By shortening hospital length of stay, the DHB delivers on the national productivity priorities, and by addressing the factors that influence a patient's length of stay the DHB is reducing complications and infection, and support patients to return home sooner. Performance is balanced against readmission rates to ensure discharge is appropriate and service quality remains high.

[56] This measure counts both medical and surgical assessments but only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred. The measure is aligned to the national elective services reporting definitions which are DHB of domicile. This covers all FSAs provided for West Coast residents, no matter where they are delivered.

[57] Non-contact FSAs are those where specialist advice and assessment are provided without the need (or wait) for a hospital appointment. A transcription error resulted in the 2013/14 result (4.2%) being incorrectly published as the 2014/15 result. This has been corrected.

[58] This measure is the national health target (Improved Access to Elective Surgery). The measure was redefined in 2015/16 to include inpatient surgical discharges, regardless of whether the discharge is from a surgical or non-surgical speciality, and both 'elective' and 'arranged' admissions. Baselines from 2014/15 have been aligned to the new definition.

[59] This measure relates to elective related medical and surgical specialist outpatient appointments and excludes mental health or AT&R services.

[60] The baselines for this measure have been updated to reflect the improved collection of telehealth data and to better align the measure with the outpatient attendance measure definition (from 2.2% in 2014/15 and 2.6% in 2015/16). The measure reflects the proportion of outpatient appointments delivered using telehealth or videoconferencing technology—reducing unnecessary travel for patients and their families.

[61] This measure is calculated as the proportion of all appointments where the patient was expected to attend on the day but did not. When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes and is also costly in terms of wasted resources for the DHB. The 2015/16 result has been updated (from 6%) to correct a rounding error.

Specialist Mental Health Services							
These are services for those most severely affected by mental illness or addictions. Improved access and shorter wait times are indicative of the systems positive response to demand.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Young people (0-19) accessing specialist mental health services	C[62]	6.1%	5.5%	>3.8%	5.3%	3.8%	✓
Adults (20-64) accessing specialist mental health services	C	5.0%	5.2%	>3.8%	5.7%	3.9%	✓
People referred for non-urgent mental health and Alcohol and Other Drug (AOD) services seen within 3 weeks	T[63]	77%	81%	80%	76%	79%	✗
People referred for non-urgent mental health and AOD services seen within 8 weeks	T[63]	93%	94%	95%	89%	94%	✗

Assessment, Treatment and Rehabilitation Services (AT&R)							
These are services that restore functional ability and enable people to live as independently as possible. An increase in the proportion of older people discharged home, rather than into residential care or into a hospital environment reflects a successful outcome for the patient and the service.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Admissions into inpatient AT&R services	A[64]	124	91	E.>150	71	-	✗
Consultations provided by outpatient and domiciliary AT&R services	A	3,194	2,716	E.>2,500	3,117	-	✓
AT&R inpatients discharged to their own home rather than into aged residential care	Q[65]	83%	82%	90%	79%	-	✗

[62] This measure is a national DHB performance measure (PP6) and standards are set nationally based on the expectation that 3% of the population will need access to specialist mental health support. Results reflect specialist services reporting through to the national PRIMHD database and results are three months in arrears.

[63] This measure is a national performance measure (PP8) and targets are set nationally. The results are provided three months in arrears and like the PP6 measure above reflect specialist services (DHB and NGO) reporting through to the national PRIMHD database. West Coast DHB's Child and Adolescent Mental Health Service is currently undergoing a transformation working closely with primary care to ensure earlier support for young people across our system and to reduce demand for specialist services. It is anticipated that demand and waiting times will improve as West Coast DHB develops its new model of care across both mental health and community services.

[64] An increasing focus on restorative care delivered in people's own homes and through domiciliary appointments (via West Coast DHB's Complex Clinical Care Network) is resulting in fewer people needing to be admitted into our hospitals in order to access Assessment Treatment and Rehabilitation (AT&R) services. This is a positive result and West Coast DHB has reset estimates for this measure in 2017/18.

[65] While living in ARC is appropriate for a small proportion of our population, for most people, remaining safe and well in their own homes provides a higher quality of life. A discharge from AT&R to home, rather than into residential care, is seen as reflective of the quality and effectiveness of services in terms of assisting that person to regain their functional independence. However, as more rehabilitation services are made available in people's own homes and in the community, only the most complex patients will need to access AT&R in hospital and a higher proportion of these people will need ongoing support and care. West Coast DHB is reconsidering this measure in this light and also notes the impact of very small numbers on this measure – the difference in the number of people discharged home between 2015/16 and 2016/17 was three people.

Rehabilitation and Support Services

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR WEST COAST DHB?

Services that support people to live safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. Even when returning to full health is not possible, timely access to assessment, advice and support enables people to maximise their function and independence.

In preventing deterioration and crisis, these services have a major impact on the sustainability of the health system by reducing acute demand, avoidable hospital admissions, and the need for more complex intervention. These services also support the flow of patients, by enabling them to go home earlier, and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

SERVICE PERFORMANCE 2015/16

Rehabilitation Services							
These services restore or maximise people's health or functional ability following a health-related event such as a heart attack or stroke. Success is measured through increased referral to services following an acute event.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
People admitted to an organised stroke service (with demonstrated stroke pathway) after an acute event	C[66]	41%	31%	80%	91%	-	✓
People supported by the FIRST service	V[67]	new	new	yes	yes	-	✓
People (65+) accessing the community-based falls/fracture liaison service	V[68]	new	16	25	117	-	✓

Home and Community-Based Support Services							
These are services that help to restore functional independence and support people to continue living in their own homes. Largely demand-driven, the number of people being supported is indicative of the capacity in the system.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
% of people (65+) receiving long-term home and community support services who have had a clinical assessment using InterRAI	Q[69]	93%	93%	95%	93%	-	➲
People supported by long-term home and community support services	V	792	786	E. >740	1,079	-	✓
Community-based district nursing visits provided (long-term clients only)	V[70]	4,171	4,246	E. >4,000	3,830	-	✖
Meals on Wheels provided	V	37,306	33,561	E. >35k	33,772	-	✓

[66] Small patient numbers have a disproportionate effect on results – the 2016/17 result reflects 50 people and is a preliminary result, awaiting confirmation of the final quarter result at the time of printing. The performance improvement since 2015/16 reflects the West Coast's progress towards meeting the national definition of an organised stroke service. West Coast DHB has worked hard to establish a clear pathway for stroke patients and now has a dedicated stroke nurse in place. West Coast DHB will continue to work with the South Island Stroke Network to improve the journey for patients and to implement the NZ Stroke Guidelines.

[67] The FIRST service is a new approach to supporting people on discharge from hospital. The aim for the year was to recruit a service lead and establish the service. This has occurred: two people have been through the service as pilot cases.

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

[69] InterRAI is an evidence-based clinical assessment tool, the use of which ensures assessments are high quality, consistent and that people receive equitable access to support and care. The 2016/17 result represents Q1 of the year. West Coast DHB has since been working with home-based support providers and software vendors to ensure the accuracy of the InterRAI assessment data being gathered with the introduction of new systems and processes during the year. West Coast DHB anticipates being able to report this again in the 2017/18 year.

[70] There has been a drop in the number of nursing visits provided this year, however this is a demand driven service and all complex clients are assessed and supported by the multi-disciplinary team in the Complex Clinical Care Network.

Respite and Day Services							
These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Success is measured by increased access and effective use of capacity.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Mental health planned and crisis respite bed days used	C	457	365	E. 500	482	-	✓
People supported by aged care respite services	V[71]	56	61	E. 70	45	-	✗

Residential Care Services							
These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. A decrease in the number of bed days for aged residential care (ARC) is seen as indicative of more people being successfully supported to continue living in their own homes.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
% of people entering aged residential care (ARC) having had a clinical assessment using InterRAI	Q[72]	97%	90%	>95%	100%	-	✓
Subsidised ARC rest home beds provided (days)	V[73]	40,488	35,363	E. <50k	31,410	-	✓
Subsidised ARC hospital beds provided (days)	V	37,537	37,843	E. <40k	39,796	-	✓
Subsidised ARC dementia beds provided (days)	V	5,399	5,439	E. >4,000	5,424	-	✓
Subsidised ARC psycho-geriatric beds provided (days)	V	2,167	3,314	E. >2,000	3,408	-	✓

[71] The West Coast has been operating with reduced ARC capacity over the past year and respite capacity has been limited as a result. It is anticipated that capacity will be built up again over the coming year and more beds will be available and accessed for respite use.

[72] InterRAI is a comprehensive clinical assessment tool, developed to improve the quality of life of vulnerable people which helps to ensure they receive equitable access to the right support and care to meets their needs. West Coast DHB has been working with clinical assessors, nurse managers and aged care providers to raise awareness of the benefits of the assessments and increase rates of completion.

[73] The drop in the number of rest home bed days is in line with West Coast DHB's strategy - supporting people to stay in their own homes for longer. However, it is also likely to have been compounded by capacity issues across West Coast ARC facilities over the past year, with one 28 bed facility having to close due to not receiving ongoing certification from the Ministry of Health. West Coast DHB will wait until the next year to determine any trend in this area.

Māori Health Performance

In preparing its Annual Plan and Statement of Intent, West Coast DHB has identified planned activity and standards against a set of national indicators specifically established to support improvements in health outcomes for Māori. Performance against these indicators for the 2016/17 year is presented below.

Māori Health Action Plan Indicators							
Success is measured by achievement of the targets and a reduction in the equity gap between our Māori and non-Māori population groups.	Notes	2014/15	2015/16	2016/17 Target	2016/17 Result	2016/17 National	Rating
Māori population enrolled with a Primary Health Organisation	C [74]	90%	89%	95%	83%	-	✖
Māori women smokefree at two weeks postnatal	Q[75]	65%	n.a	95%	n.a	n.a	-
Māori babies exclusive/fully breastfed at LMC discharge	Q[75]	59%	n.a	75%	n.a	n.a	-
Māori four year olds receiving a B4 School Check (B4SC)	C [76]	107%	80%	>90%	92%	-	✓
Māori babies fully immunised at eight months old	C◇	80%	82%	95%	95%	88%	✓
Māori girls completing the HPV vaccination programme	C [77]†	28%	47%	70%	27%	72%	✖
Rate of avoidable hospital admissions for Māori (0-4 years)	Q[78]	5,581	6,279	<6,818	5,227	6,474	✓
Māori children (0-4) enrolled in DHB-funded oral health services	C†	88%	75%	95%	81%	-	➲
Enrolled Māori children (0-12) examined according to planned recall	T[79]†	88%	n.a	90%	n.a	n.a	-
Māori smokers identified in hospital receiving advice and help to quit	C[80]◇	94%	100%	95%	82%	95%	✖
Eligible Māori having a CVD risk assessment in the last five years	C	87%	88%	90%	88%	87%	➲
Māori women (25-69) who have had a cervical smear in the last three years	C[81]	62%	68%	80%	63%	65%	✖
Māori women (50-69) who have had a mammography in the last two years	C[80]	76%	70%	>70%	67%	64.5%	✖
Older Māori (65+) having had a seasonal influenza vaccination	C[82]†	69%	64%	75%	51%	48%	✖
Māori outpatient 'Did not Attend' rates	Q[83]	15%	13%	6%	15%	-	✖

[74] Small population numbers have a disproportionate impact on results with the difference between 2015/16 and 2016/17 being 75 people.

[75] These measures are part of the national Well Child/Tamariki Ora performance framework and standards are set and reported nationally. The Framework covers health promotion, education, screening and support services and checks are provided free to all New Zealand children from birth to five years. Results are published by the Ministry and 2014/15 results have been updated to reflect the final results published in August 2016. The 2015/16 and 2016/17 results were not yet available to the DHB at the time of printing.

[76] This measure differs to that set in the Annual Plan which was 'High-Needs' children, including Maori, Pacific and children living in high deprivation areas. This has been replaced nationally with data no longer available by this subset. Baselines have been reset to reflect Māori.

[77] The Human Papillomavirus (HPV) vaccination aims to protect young women from the risk of developing cervical cancer later in life. The programme is free to young people under 26 years of age. Like all the immunisation targets, strong anti-immunisation views make meeting this target challenging on the West Coast. We also have a higher number of young people who are counted as eligible via Census but who are not actually in school on the Coast. West Coast DHB is working with schools to lift these numbers and encourage young girls to engage in the HPV programme.

[78] Some hospital admissions are seen as avoidable through early intervention and treatment and therefore provide an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. This measure is a national DHB performance indicator (SI1), and is defined as a standardised rate per 100,000 people. West Coast DHB's aim is to maintain current performance below the national rate (which reflects fewer people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based on the national March 2017 series provided by the Ministry of Health in August 2017. Baselines have been reset to reflect the current series and are to March of each year.

[79] West Coast DHB was anticipating completing a shift to the electronic oral health system during the year, which did not occur as planned, unfortunately as manual results were not collated (in anticipation of the shift) the results for this measure are not available by ethnicity again in 2016/17.

[80] This work continues to be a priority and results are reviewed on a monthly basis, with smokefree champions investigating each missed case.

[81] Cervical and breast cancer screening are national programmes and age bands and standards are set nationally. Rates for cervical screening for Maori women are disappointing, lower than the previous year and national rates. Improving cervical screening rates remains a focus for 2017/18.

[82] This result is affected by a change in definition in 2016/17, being based on Census numbers rather than PHO enrolments, previous year's results are not directly comparable. The number of older Māori having a flu vaccination has increased by eight people, compared to the 2015/16 year.

[83] This measure is calculated as the proportion of all outpatient appointments where the patient was expected to attend on the day but did not. When patients fail to turn up to scheduled appointments it can negatively affect their recovery and long-term outcomes and it is also costly in terms of wasted resources for the DHB. The baselines for this measure have been rounded and updated to reflect improved clarity over the DNA count (previously 14.8% 2014/15 and 13.6% 2015/16).

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 2017.

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 $800k against the budgeted deficit of $554k (2015/16 result was a net deficit of $897k).

BOARD AND COMMITTEE MEMBER ATTENDANCE

	Board		QFARC		HAC		CPHAC&DSAC	
	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended
Chris Auchinvole**	5	5			3	3		
Peter Ballantyne*	3	3	4	4	4	3	4	3
Jenny Black**	5	4	3	3	3	3		
Kevin Brown	8	6			7	5		
Warren Gilbertson*	3	3	4	3				
Helen Gillespie	8	8	7	7				
Michelle Lomax	8	6	4	4	3	3		
Chris Mackenzie**	5	5	3	1				
Edie Moke**	5	4	3	3				
Peter Neame	8	7			4	4	3	3
Nigel Ogilvie	5	5			3	3		
Sharon Pugh*	3	2			4	4		
Elinor Stratford	8	8	4	4			7	7
Joseph Thomas*	3	3	4	1				
Francois Tumahai	8	6					3	2
John Vaile*	3	3					4	3
Lynnette Beirne							7	6
Sarah Birchfield							5	5
Dr Cheryl Brunton							7	7
Jenny McGill							7	4
Mary Molloy							7	4
Joe Mason							7	7
Paula Cutbush					7	7		
Gail Howard					7	5		
Richard Wallace					7	2		
Chris Lim					7	7		

QFARC – Quality, Finance, Audit & Risk Committee
HAC – Hospital Advisory Committee
CPHAC&DSAC – Community & Public Health & Disability Support Advisory Committee

**Term ended 4 December 2016*
***Term commenced 5 December 2016*

BOARD FEES

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

Year ended 30 June 2017	Board	Advisory Committee	Total
Board members			
Chris Auchinvole**	9,345	750	10,095
Peter Ballantyne*	14,361	1,000	15,361
Jenny Black**	19,239	750	19,989
Kevin Brown	16,320	1,250	17,570
Warren Gilbertson*	6,975	750	7,725
Helen Gillespie	16,320	2,188	18,508
Michelle Lomax	16,320	1,938	18,258
Chris Mackenzie**	11,681	250	11,931
Edie Moke**	9,345	750	10,095
Peter Neame	16,320	1,500	17,820
Nigel Ogilvie**	9,345	750	10,095
Sharon Pugh*	6,975	1,250	8,225
Elinor Stratford	16,320	3,188	19,508
Joseph Thomas*	8,719	250	8,969
Francois Tumahai	16,320	500	16,820
John Vaile*	6,975	750	7,725
Advisory committee members			
Lynnette Beirne (CPHAC&DSAC)	-	1,500	1,500
Sarah Birchfield (CPHAC&DSAC)	-	1,250	1,250
Paula Cutbush (HAC)	-	1,750	1,750
Gail Howard (HAC)	-	1,250	1,250
Chris Lim (HAC)	-	1,750	1,750
Jo Mason (CPHAC&DSAC)	-	1,750	1,750
Jenny McGIll (CPHAC&DSAC)	-	1,000	1,000
Mary Molloy (CPHAC&DSAC)	-	1,000	1,000
Richard Wallace (HAC)	-	500	500
	200,880	**29,563**	**230,443**

**Term ended 4 December 2016*
***Term commenced 5 December 2016*

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD INFORMATION

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

INFORMATION ON MINISTERIAL DIRECTIONS

WHOLE OF GOVERNMENT APPROACH

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

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

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

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

REQUIREMENT TO IMPLEMENT NEW ZEALAND BUSINESS NUMBER

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

West Coast DHB intends to replace its key finance and supply chain business system within the timeframe of the Direction, and the replacement system has taken the NZBN requirements, as provided to date, into account.

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

AUTHENTICATION SERVICES

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

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

ELIGIBILITY DIRECTION

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

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

Statutory Information

This Annual Report presents West Coast DHB's financial and non-financial performance for the year ended 30 June 2017. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

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

People at the Heart of All We Do

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

We are committed to engaging our people in the development, and ongoing review and renewal, of programmes and policies. This includes our good employer programmes.

Staff Ethnicity	Number
Americas	6
Australian	7
British	23
Chinese	2
Filipino	8
Indian	20
Irish	2
Māori	30
Middle Eastern	2
New Zealand European	331
New Zealander	3
Not Stated / Don't Know	544
Other	3
Other African	3
Other Asian	5
Other European	9
Pacific Peoples	5
South African	6
Total	1,009

Staff Mix by Average Age	Average age
Medical	48.79
Nursing	51.00
Allied Health	51.21
Support	55.52
Management & Administration	59.19

Staff Mix by Gender	Number	Percentage
Female	859	85%
Male	150	15%
Total	1,009	100%

Staff Identifying a Disability[84]	Number
Yes	0

LEADERSHIP, ACCOUNTABILITY AND CULTURE

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

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

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

RECRUITMENT, SELECTION AND INDUCTION

We utilise an integrated approach to attracting, selecting and engaging people across the West Coast health system for today, tomorrow and the future. This approach has a range of elements including recruitment, selection, induction, candidate care, talent management, succession planning, and strategic sourcing. The purpose of this approach is to support an integrated West Coast health system by providing proactive, targeted and agile initiatives at

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

every level; maximising opportunities that result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey throughout the West Coast health system.

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

WORKPLACE WELLBEING, HEALTH AND SAFETY

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

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

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

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

EQUAL OPPORTUNITIES AND POSITIVE BEHAVIOURS

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

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

We are committed to identifying and dealing with all examples of bullying and harassment and have a zero tolerance policy in respect of such behaviour. All individuals on joining West Coast DHB are made familiar with our Bullying and Harassment Policy, Good Employer Policy and Equal Opportunities Policy.

REMUNERATION AND RECOGNITION

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

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

EMPLOYEE ENGAGEMENT

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

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

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

We are planning a new engagement survey in the near future.

EMPLOYEE DEVELOPMENT AND PROMOTION

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

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

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

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

Statement of Responsibility

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

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

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

In our opinion, these financial statements and the statement of service performance fairly reflect the financial position and operations of West Coast DHB for the year ended 30 June 2017.

Signed on behalf of the Board:

Jenny Black
CHAIR | WEST COAST DHB

Helen Gillespie
CHAIR | QUALITY, FINANCE, AUDIT & RISK COMMITTEE

26 October 2017

Part V
Financial Performance

Statement of Comprehensive Revenue and Expense

For the year ended 30 June 2017

In thousands of New Zealand dollars

	Note	2017 Actual	2017 Budget	2016 Actual
Revenue				
Patient care revenue	2	141,960	143,819	140,316
Other operating revenue	2	403	726	646
Interest revenue	2	408	470	327
Total revenue		142,771	145,015	141,289
Expenses				
Employee benefit costs	3	57,483	58,062	57,142
Depreciation and amortisation expense	10,11	3,373	4,572	4,572
Outsourced services	4a	8,692	6,638	7,284
Clinical supplies		8,402	7,858	7,781
Infrastructure and non-clinical expenses		9,966	8,767	8,673
Payments to other health service providers	4b	53,094	56,084	52,649
Other operating expenses	4c	1,479	1,956	2,456
Finance costs	5	343	648	651
Capital charge	6	739	984	978
Total expenses		143,571	145,569	142,186
Net surplus/(deficit)		**(800)**	**(554)**	**(897)**
Other comprehensive revenue & expenses				
Gain/(losses) on revaluation of land and buildings		-	-	-
Total other comprehensive revenue & expenses		-	-	-
Total comprehensive revenue & expenses		**(800)**	**(554)**	**(897)**

This statement is to be read in conjunction with the Notes to the Financial Statements

Statement of Changes in Net Assets/Equity

For the year ended 30 June 2017

In thousands of New Zealand dollars

	Note	2017 Actual	2017 Budget	2016 Actual
Balance at 1 July		12,409	12,409	12,496
Total comprehensive revenue & expenses		(800)	(554)	(897)
Owner transactions				
Capital contributions from the Crown	12, 23	13,567	554	878
Repayment of capital to the Crown		(68)	(68)	(68)
Balance at 30 June	15	**25,108**	**12,341**	**12,409**

This statement is to be read in conjunction with the Notes to the Financial Statements

Statement of Financial Position

As at 30 June 2017

In thousands of New Zealand dollars

	Note	2017 Actual	2017 Budget	2016 Actual
Assets				
Current assets				
Cash and cash equivalents	7	10,811	14,195	11,850
Debtors and other receivables	8	4,992	5,600	5,941
Inventories	9	1,059	986	986
Patient deposits	16	69	74	74
Total current assets		16,931	20,855	18,851
Non-current assets				
Property, plant and equipment	10	26,250	24,706	26,858
Intangible assets	11	1,203	1,328	1,248
Total non-current assets		27,453	26,034	28,106
Total assets		**44,384**	**46,889**	**46,957**
Liabilities				
Current liabilities				
Borrowings	12	-	3,500	3,500
Creditors and other payables	13	7,502	8,161	8,979
Employee entitlements and benefits	14	8,987	9,313	8,407
Patient deposits and restricted funds	16,17	89	66	74
Total current liabilities		16,578	21,040	20,960
Non-current liabilities				
Borrowings	12	-	10,945	10,945
Employee entitlements and benefits	14	2,698	2,563	2,643
Total non-current liabilities		2,698	13,508	13,588
Total liabilities		**19,276**	**34,548**	**34,548**
Net assets/equity				
Contributed capital	15	86,062	82,770	72,563
Revaluations	15	22,082	22,082	22,082
Accumulated surpluses/(deficits)	15	(83,036)	(92,511)	(82,236)
Total equity		25,108	12,341	12,409
Total equity and liabilities		**44,384**	**46,889**	**46,957**

This statement is to be read in conjunction with the Notes to the Financial Statements

Statement of Cash Flows

For the year ended 30 June 2017

In thousands of New Zealand dollars

	Note	2017 Actual	2017 Budget	2016 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health, patients and other revenue		145,240	144,545	146,076
Cash paid to suppliers		(76,218)	(74,695)	(72,307)
Cash paid to employees		(65,900)	(64,670)	(65,175)
Interest received		408	470	327
Interest paid		(343)	(648)	(651)
Goods and services tax (net)		(706)	-	767
Capital charge paid		(739)	(984)	(978)
Net cash flow from operating activities	18	1,742	4,018	8,059
Cash flows from investing activities				
Purchase of property, plant and equipment		(2,330)	(2,500)	(2,693)
Purchase of intangible assets		(383)	-	(166)
Net cash flow from investing activities		(2,713)	(2,500)	(2,859)
Cash flows from financing activities				
Capital contributions from the Crown		-	878	1,000
Repayment of capital to the Crown		(68)	(68)	(68)
Net cash flow from financing activities		(68)	810	932
Net increase /(decrease) in cash and cash equivalents		(1,039)	2,328	6,132
Cash and cash equivalents at the start of the year		11,850	11,867	5,718
Cash and cash equivalents at the end of year	7	**10,811**	**14,195**	**11,850**

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.

This statement is to be read in conjunction with the Notes to the Financial Statements

Notes to the Financial Statements

For the year 30 June 2017

In thousands of New Zealand dollars

1 Statement of Accounting Policies

REPORTING ENTITY

West Coast DHB is a district health board established by the New Zealand Public Health and Disability Act 2000. West Coast DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

West Coast DHB is a public benefit entity (PBE) for financial reporting purposes.
West Coast DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the West Coast community. West Coast DHB does not operate to make a financial return.

The financial statements of West Coast DHB are for the year ended 30 June 2017 and were authorised for issue by the Board on 26 October 2017.

BASIS OF PREPARATION

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

STATEMENT OF COMPLIANCE

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

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

MEASUREMENT BASIS

The financial statements are prepared on the historical cost basis except that land and buildings are stated at their fair values.

PRESENTATION CURRENCY AND ROUNDING

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand dollars. The functional currency is NZD.

CHANGES IN ACCOUNTING POLICIES

The accounting policies set out below have been applied consistently to all periods presented in these financial statements.

SIGNIFICANT ACCOUNTING POLICIES

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.

ASSETS CLASSIFIED AS HELD FOR SALE

Non-current assets classified as held for sale are measured at the lower of cost and fair value, less cost to sell, and are not amortised or depreciated.

BUDGET FIGURES

The budget was approved by the Board and published in the 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.

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.

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.

2 Revenue

ACCOUNTING POLICY

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

Ministry of Health population-based revenue

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.

BREAKDOWN OF PATIENT CARE REVENUE

	2017 Actual $000	2016 Actual $000
Ministry of Health population based funding	124,768	122,033
Inter district flows	1,661	1,487
Other Ministry of Health & other government contracts	6,790	6,879
Accident Compensation Corporation	1,778	2,106
Other patient care revenue	2,666	3,213
West Coast Primary Health Organisation	4,297	4,598
	141,960	**140,316**

BREAKDOWN OF OTHER OPERATING REVENUE

	2017 Actual $000	2016 Actual $000
Donations received	10	9
Rental revenue	164	172
Training and Development	48	116
Insurance	-	8
Gain on sale of Fixed Assets	12	-
Other	169	341
	403	**646**

BREAKDOWN OF INTEREST REVENUE

	2017 Actual $000	2016 Actual $000
Interest revenue	408	327
	408	**327**

3 Employee Benefit Costs

ACCOUNTING POLICY

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 EMPLOYEE BENEFIT COSTS

	2017 Actual $000	2016 Actual $000
Wages, salaries and other personnel costs	55,062	55,736
Contributions to defined contribution schemes	1,596	1,573
(Decrease)/increase in liability for employee entitlements	597	(410)
Restructuring expenses	228	243
	57,483	**57,142**

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

4a Outsourced Services

ACCOUNTING POLICY

The outsourced costs are expensed in the financial year in which they are incurred.

BREAKDOWN OF OUTSOURCED SERVICES

	2017 Actual $000	2016 Actual $000
Outsourced personnel and services		
Medical and nursing services	6,953	5,787
Allied health services	11	6
Other services	1,728	1,491
	8,692	**7,284**

Outsourced personnel costs are incurred in purchasing services from contractors and locums, both as part of planned service delivery and to cover staff vacancies.

4b Payments to Other Health Service Providers

ACCOUNTING POLICY

Payments to other health service providers are expensed in the financial year in which they are incurred.

BREAKDOWN OF PAYMENTS TO OTHER HEALTH SERVICE PROVIDERS

	2017 Actual $000	2016 Actual $000
Personal health and Māori health services	23,063	22,963
Mental health services	2,564	3,199
Public health services	335	377
Disability support services	8,625	8,640
Inter district patient outflows	18,507	17,470
	53,094	**52,649**

Personal and Māori Health Services include payments for primary health care, community pharmaceuticals, laboratory tests and patient travel (national travel assistance programme). Mental Health Services include payments for day activity centres, community residential care and primary health care initiatives.

Public Health Services are payments for healthy lifestyles and screening programmes. Disability Support Services include payments for aged related care, in homes, rest homes and hospital level.

4c Other Operating Expenses

ACCOUNTING POLICY

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

BREAKDOWN OF OTHER OPERATING EXPENSES

	Note	2017 Actual $000	2016 Actual $000
Impairment of debtors	8	39	1
Loss on disposal of property, plant and equipment		-	-
Audit fees (for the audit of the financial statements)		110	107
Audit related fees for assurance and related services (Internal and Quality Audits)		113	95
Board and advisory members fees		230	192
Operating lease expenses		574	555
Other		413	1,506
		1,479	**2,456**

5 Finance Costs

ACCOUNTING POLICY

Borrowing costs are expensed in the financial year in which they are incurred.

BREAKDOWN OF FINANCE COSTS

	2017 Actual $000	2016 Actual $000
Interest expense	343	651
	343	**651**

6 Capital Charge

ACCOUNTING POLICY

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

BREAKDOWN OF CAPITAL CHARGE

	2017 Actual $000	2016 Actual $000
Capital charge	739	978
	739	**978**

The West Coast DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the period from 1 July 2016 to 31 December 2016 was 7%, which was reduced to 6% from 1 January 2017 to the period ended 30 June 2017 (2016: 8%).

7 Cash and Cash Equivalents

ACCOUNTING POLICY

Cash and cash equivalents comprise of cash balances, call deposits and deposits with a maturity of no more than three months from date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of West Coast DHB's cash management are included as a component of cash and cash equivalents for the purposes of the statement of cash flows.

CASH AND CASH EQUIVALENTS

	Credit Rating	Note	2017 Actual $000	2016 Actual $000
Bank balances and call deposits	AA-		10,811	11,850
Term deposits less than 3 months	AA-		-	-
Cash and cash equivalents in the statement of cash flows		22	**10,811**	**11,850**

The carrying amount of cash at bank and call deposits approximates their fair value.

ASSETS RECOGNISED IN A NON-EXCHANGE TRANSACTION THAT ARE 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 16).

Bank balance includes unspent donation received of $20k (2016: $7k) that is subject to restrictions. The restrictions generally specify how the donation is required to be spent (see note 16).

BANK FACILITY

West Coast DHB is a party to the "DHB Treasury Services Agreement" between New Zealand Health Partnership Limited (NZHP) and the participating DHBs. This Agreement enables NZHP to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at credit interest rate received by NZHP plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one 12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For the West Coast DHB this equates to $6.085m (2016: $5.943m).

As from 1 July 2015, the operations of Health Benefits Limited transferred under the Health Sector (Transfers) Act 1993 to a new company called NZ Health Partnerships Ltd.

CREDIT RISK

Credit risk is the risk that a third party will default on its obligation causing the Board to incur a loss. In the normal course of business, West Coast DHB is exposed to credit risk from cash and term deposits with banks and trade receivables. For each of these, the maximum credit exposure is best represented by the carrying amount in the statement of financial position.

The Board places its cash and term investments with high quality financial institutions via a national DHB shared banking arrangement, facilitated by NZ Health Partnerships Limited

INTEREST RATE RISK

Interest rate risk is the risk that the fair value of financial instruments will fluctuate or, the cash flows from a financial instrument will fluctuate, due to changes in market interest rates.

Surplus funds for daily operations are swept into a NZHP facility where NZHP invest funds until required. The rate of interest for call funds at 30 June 2017 was 2.24% (2016: 2.88%).

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. Term deposits held at fixed rates expose the West Coast DHB to fair value interest rate risk.

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 2017 (2016: $nil)

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 is exposed to debt securities price risk on its investments. This price risk arises due to market movements in listed debt securities. The price risk is managed by diversification of West Coast DHB's investment portfolio in accordance with the limits set out in West Coast DHB's investment policy.

8 Debtors and Other 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	2017 Actual $000	2016 Actual $000
Trade receivables		358	902
Ministry of Health receivables		2,290	2,754
Other Crown receivables		1,413	1,329
Accrued revenue		330	566
Prepayments		601	390
		4,992	**5,941**

Trade and other receivables are non-interest bearing and receipt is normally on 30 day terms. Therefore 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 (2016: $878k)

MOVEMENTS IN THE PROVISION FOR UNCOLLECTABILITY OF RECIEVABLES

	Note	2017 Actual $000	2016 Actual $000
Balance 1 July		52	52
Receivables written off during the year		(26)	(1)
Impairment reversed		-	-
Additional provision made during the year	4c	39	1
Closing balance 30 June		**65**	**52**

CREDIT RISK

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry, which comprises 46% (2016: 46%) of the debtors of West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHB) total reliance on Government debtors is 74% (2016: 69%). 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.

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

AGEING PROFILE OF TRADE RECEIVABLES

	Credit Rating	Gross Receivable 2017 $000	Impairment 2017 $000	Net 2017 $000	Gross Receivable 2016 $000	Impairment 2016 $000	Net 2016 $000
Due 0-30 days		4,141		4,141	5,241	-	5,241
Past due 31-60 days		8		8	20	-	20
Past due 61-90 days		-		-	34	-	34
Past due more 90 days		308	(65)	243	308	(52)	256
Total Gross Receivables	No Credit rating	**4,457**	**(65)**	**4,392**	**5,603**	**(52)**	**5,551**

Trade receivables are due from patients and external parties to whom the West Coast DHB has provided health and disability services and other clinical supplies and services. Receivables due from the Ministry of Health, ACC, Pharmac, Crown entities and other DHBs are included as trade receivables.

At the balance date there were no significant other concentrations of credit risk (2016: nil).

9 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

	2017 Actual $000	2016 Actual $000
Pharmaceuticals	189	183
Surgical and medical supplies	852	788
Other supplies	18	15
	1,059	**986**

There were no write-downs of inventories or reversal of prior year write-downs during the year (2016: $0). The amount of inventories recognised as an expense during the year ended 30 June 2017 was $2.118m (2016: $1.593m).

No inventories are pledged as a security for liabilities but some inventories are subject to retention of title clauses. The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

10 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

Assets, other than land, buildings and fixtures and fittings, acquired by the Board since its establishment, and other than those vested from the Hospital and Health Service, are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisitions and installation including materials, labour, direct overheads, financing and transport costs.

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
Freehold Buildings	3 – 50
Fit Out Plant and Equipment	3 – 50
Plant and Equipment	2 – 20
Motor Vehicles	3 – 5

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 assets' 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.

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 is effective as at June 2015.

Specialised buildings are valued using depreciated replacement cost because no reliable market data is available for such buildings. Greymouth, Westport and Reefton Hospitals, Fox Glacier Clinic and Ngakawau Clinic were valued on the basis of Depreciated Replacement Cost.

Non-specialised buildings (for example residential buildings) are valued using market-based evidence. Residential houses and leasehold sections were valued at Net Current Value.

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.

Due to the rebuild programme which commenced in 2015, we expect some of the existing Grey Base Hospital buildings will be demolished in the 2018/19 year. In the prior year, we expected the existing Grey Base Hospital buildings would be demolished in the 2017/18 year. This will reduce the 2017/18 depreciation expense by $720,000.

West Coast DHB also reviewed the useful live of other facilities (mainly Buller campus), the net impact on depreciation expense is minimal.

During the 2016/17 year , West Coast DHB reviewed the residual values on the motor vehicle fleet. The result of this review means the depreciation expense for motor vehicles will decrease in 2017/2018 by $180,000.

BREAKDOWN OF PROPERTY, PLANT AND EQUIPMENT

FINANCIAL YEAR ENDING 30 JUNE 2017

	Freehold land (at valuation) $'000	Freehold buildings + fitout (at valuation) $'000	Plant, equipment and vehicles $'000	Leased assets $'000	Work in progress $'000	Total $'000
Cost or valuation						
Balance at 30 June 2016	6,735	14,112	25,114	43	1,981	47,985
Additions	-	162	973	-	1,722	2,857
Disposals/transfers	-	43	(1,634)	(43)	(508)	(2,142)
Transfer from non-current assets held for sale	-	-	-	-	-	
Balance at 30 June 2017	**6,735**	**14,317**	**24,453**	**-**	**3,195**	**48,700**
Depreciation						
Balance at 30 June 2016	-	(2,408)	(18,711)	(7)	-	(21,126)
Depreciation charge for the year	-	(1,649)	(1,299)		-	(2,948)
Disposals	-	(7)	1,624	7	-	1,624
Balance at 30 June 2017	**-**	**(4,064)**	**(18,386)**	**-**	**-**	**(22,450)**

FINANCIAL YEAR ENDING 30 JUNE 2016

	Freehold land (at valuation) $'000	Freehold buildings + fitout (at valuation) $'000	Plant, equipment and vehicles $'000	Leased assets $'000	Work in progress $'000	Total $'000
Cost or valuation						
Balance at 1 July 2015	6,599	19,483	24,499	344	718	45,843
Additions	-	136	1,188	-	1,621	2,945
Disposals/transfers	-	(8)	(573)	-	(358)	(939)
Realisation of June 2015 Revaluation in Fixed Asset Register		(5,499)	-	(301)		(5,800)
Transfer from non-current assets held for sale	136	-	-	-	-	136
Balance at 30 June 2016	**6,735**	**14,112**	**25,114**	**43**	**1,981**	**47,985**
Depreciation						
Balance at 1 July 2015	-	-	(17,593)	-	-	(17,593)
Depreciation charge for the year	-	(2,416)	(1,665)	(7)	-	(4,088)
Disposals	-	8	547	-	-	555
Balance at 30 June 2016	**-**	**(2,408)**	**(18,711)**	**(7)**	**-**	**(21,126)**

CARRYING AMOUNT

	Freehold land (at valuation) $'000	Freehold buildings + fitout (at valuation) $'000	Plant, equipment and vehicles $'000	Leased assets $'000	Work in progress $'000	Total $'000
At 1 July 2016	**6,735**	**11,704**	**6,403**	**36**	**1,981**	**26,859**
At 30 June 2017	**6,735**	**10,253**	**6,067**	**-**	**3,195**	**26,250**

REVALUATION

Freehold property and plant was revalued 30 June 2015 by Preston Rowe Paterson (registered valuers). Grey Base, Westport and Reefton Hospitals, Fox Glacier Clinic and Ngakawau Clinic were valued on the basis of Depreciated Replacement Cost. All other operational assets were valued at fair value (market based). Residential houses and leasehold sections were valued at Net Current Value. The resulting movement in property and plant has been recognised as equity in the Property Revaluation Reserve (refer to note 15).

IMPAIRMENT

Engineering reviews of Grey Base buildings during the 2013 financial year identified structures which are earthquake prone. For these structures, West Coast DHB considered whether their carrying value exceeded their recoverable amount. As a result, West Coast DHB recognised a $2.6m asset impairment at 30 June 2013. As at 30 June 2017, no further impairment was considered necessary.

RESTRICTIONS

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.

11 Intangible Assets

ACCOUNTING POLICY

Acquisition

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 10. 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

MOVEMENT OF INTANGIBLE ASSETS ARE AS FOLLOWS:

	2017 Actual $000	2016 Actual $000
Software		
Cost		
Opening balance	4,304	4,141
Additions	381	163
Disposals	(234)	-
Closing balance	4,451	4,304
Amortisation		
Opening balance	(3,623)	(3,139)
Amortisation charge for the year	(426)	(484)
Disposals	234	-
Closing balance	(3,815)	(3,623)
NZ Health Partnerships Limited (formally Health Benefits Limited)	567	567
Carrying amounts	**1,203**	**1,248**

RESTRICTIONS

There are no restrictions over the title of intangible assets and no intangible assets are pledged as security for liabilities. There is no impairment for the financial year ended 30 June 2017. There has been no change since last year.

NZ HEALTH PARTNERSHIPS LIMITED

The West Coast DHB has contributed $567,000 (2016: $567,000) to New Zealand Health Partnerships Limited (NZHP), formally Health Benefits Limited, in relation to the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by NZHP, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

NZHP 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 NZHP 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 the "B" Class share 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 NZHP 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.

As from 1 July 2015, the operations of Health Benefits Limited transferred under the Health Sector (Transfers) Act 1993 to a new company called NZ Health Partnerships Ltd.

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.

BREAKDOWN OF BORROWINGS

	Note	2017 Actual $000	2016 Actual $000
Current – Ministry of Health		-	3,500
Non-current - Ministry of Health	21	-	10,945
Total Borrowings		**-**	**14,445**

INTEREST RATE RISK

As at 30 June 2017, West Coast DHB had no Ministry of Health loans, previously these were issued at fixed rates of interest and the carrying amounts of borrowings were approximate their fair values.

SECURED LOANS

As at 30 June 2017, West Coast DHB has no secured loans with the Ministry of Health (2016: $14.445m). The decrease in the Ministry of Health loans is a result of a conversion of Crown loans to Crown equity. Refer to Note 23 for more detailed information.

FAIR VALUE

The fair value together with the carrying amount shown secured loans are shown below:

	Note	Carrying amount 2017 Actual $000	Fair value 2017 Actual $000	Carrying amount 2016 Actual $000	Fair value 2016 Actual $000
Secured loans	21	-	-	14,445	15,169
				14,445	**15,169**
Unrecognised (losses)/gains		**-**	**-**	**-**	**724**

13 Creditors and Other Payables

ACCOUNTING POLICY

Trade and other payables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method.

BREAKDOWN OF CREDITORS AND OTHER PAYABLES

	Note	2017 Actual $000	2016 Actual $000
Trade payables		5,472	6,663
ACC levy payable		125	355
GST and PAYE tax payable		1,234	1,906
Revenue in advance		671	55
		7,502	**8,979**

Creditors and other payables 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.

All of the Creditors and Other Payables balances are derived from exchange transactions.

LIQUIDITY RISK

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

West Coast DHB manages liquidity risk by monitoring forecast and actual cash flow requirements.

The tables below analyse Canterbury DHB's financial liabilities and assets into relevant maturity groupings based on the remaining period at balance date to the contractual maturity date, based on undiscounted cash flows:

CONTRACTUAL MATURITY ANALYSIS OF FINANCIAL LIABILITIES

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000
2017						
Secured Ministry of Health loans	-	-	-	-	-	-
Creditors and other payables	7,502	7,502	7,502	-	-	-
Total	**7,502**	**7,502**	**7,502**	**-**	**-**	**-**
2016						
Secured Ministry of Health loans	14,445	14,445	3,500	-	4,695	6,250
Creditors and other payables	8,979	8,979	8,979	-	-	-
Total	**23,424**	**23,424**	**12,479**	**-**	**4,695**	**6,250**

CONTRACTUAL MATURITY ANALYSIS OF FINANCIAL ASSETS

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
	$000	$000	$000	$000	$000	$000
2017						
Cash and cash equivalents	10,811-	10,811-	10,811-	-	-	-
Debtors and other receivables	4,992	4,992	4,992	-	-	-
Patient deposits	69	69	69	-	-	-
Total	**15,872**	**15,872**	**15,872**	**-**	**-**	**-**
2016						
Cash and cash equivalents	11,850	11,850	11,850	-	-	-
Debtors and other receivables	5,941	5,941	5,941	-	-	-
Patient deposits	74	74	74	-	-	-
Total	**17,865**	**17,865**	**17,865**	-	-	-

14 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 payable beyond 12 months.

Long service leave and retirement gratuities

Entitlements that are payable beyond 12 months, have been calculated on an actuarial basis. The calculations are based on likely future entitlements accruing to staff, based on years of service, year's entitlement, the likelihood that staff will reach a point of entitlement and contractual entitlement information. The obligation is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at balance date.

Sabbatical leave

The West Coast DHB's obligation payable beyond 12 months has been calculated on entitlements accruing to staff, based on years of service, years of entitlement and the likelihood that staff will reach the point of entitlement and contractual obligations.

Critical accounting estimates and assumptions

The present value of 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 this liability include the discount rate, the salary escalation rate and resignation rates. Any changes in these assumptions will affect the carrying amount of the liability. The discount rates used have been obtained from the NZ treasury published risk-free discount rates as at 4 July 2017.

BREAKDOWN OF EMPLOYEE ENTITLEMENTS AND BENEFITS

	2017 Actual $000	2016 Actual $000
Current portion		
Liability for long-service leave	302	248
Liability for retirement gratuities	484	511
Liability for annual leave	4,179	3,937
Liability for other leave	1,569	1,505
Liability for sick leave	99	118
Liability for continuing medical education/ sabbatical leave	690	656
Salary and wages accrued	1,664	1,432
Total current portion	**8,987**	**8,407**
Non-current portion		
Liability for long-service leave	613	651
Liability for sabbatical leave	75	80
Liability for retirement gratuities	2,010	1,912
Total non-current portion	**2,698**	**2,643**
Total employee entitlements	**11,685**	**11,050**

15 Equity

ACCOUNTING POLICY

Equity

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

- Contributed capital;
- Revaluation reserve; and
- Accumulated surpluses/ (deficit).

Revaluation reserve

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	Trust/ Special funds	Accumulated surpluses/ (deficits)	Total equity
Balance at 1 July 2016	72,563	22,082	-	(82,236)	12,409
Surplus/(deficit) for the year	-	-	-	(800)	(800)
Capital contributions from the Crown – debt/equity conversion	14,445	-	-	-	14,445
Repayment of capital to the Crown	(68)	-	-	-	(68)
Movement in revaluation of land	-	-	-	-	-
Movement in revaluation of buildings, fixtures and fittings	-	-	-	-	-
Movement in revaluation of building, fixtures and fittings due to impairment	-	-	-	-	-
Other movement/adjustment	(878)	-	-	-	(878)
Balance at 30 June 2017	**86,062**	**22,082**	**-**	**(83,036)**	**25,108**
Balance at 1 July 2015	71,694	22,082	39	(81,319)	12,496
Surplus/(deficit) for the year				(897)	(897)
Capital contributions from the Crown	878	-	-	-	878
Repayment of capital to the Crown	(68)	-	-	-	(68)
Movement in revaluation of land	-	-	-	-	-
Movement in revaluation of buildings, fixtures and fittings	-	-	-	-	-
Movement in revaluation of building, fixtures and fittings due to impairment	-	-	-	-	-
Other movement/adjustment	59		(39)	(20)	-
Balance at 30 June 2016	**72,563**	**22,082**	**-**	**(82,236)**	**12,409**

West Coast DHB's capital is its equity, which comprises accumulated funds and other reserves. Equity is represented by net assets. The Board is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which imposes 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.

PROPERTY REVALUTATION RESERVE

The revaluation reserve relates to land, buildings, fixtures and fittings. West Coast DHB's land, buildings, fixtures and fittings were revalued as at 30 June 2015 by Preston Rowe Paterson (registered valuers). Grey Base, Westport and Reefton Hospitals as well as Fox Glacier Clinic and Ngakawau Clinic were valued on the basis of depreciated replacement cost. All other operational assets were valued at fair market basis. Residential houses and leasehold sections were valued at current net value.

16 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.

MOVEMENT OF PATIENT DEPOSITS

	Note	2017 Actual $000	2016 Actual $000
Opening balance patients deposits		67	63
Monies received		-	-
Interest earned		3	4
Payments made		(1)	-
Closing balance		**69**	**67**

17 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 7). 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	2017 Actual $000	2016 Actual $000
Opening balance restricted funds		7	7
Monies received		30	54
Interest earned		-	-
Payments made		(17)	(54)
Closing balance		**20**	**7**

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

	2017 Actual $000	2016 Actual $000
Deficit for the period	(800)	(897)
Add back non-cash items:		
Depreciation and amortisation expense	3,373	4,572
Remove non-cash revenue:		
Donated assets	-	-
Add back other items:		
Equity receivable	(878)	878
Movements in working capital:		
(Increase)/decrease in debtors and other receivables	949	4,280
(Increase)/decrease in inventories	(74)	(2)
Increase/(decrease) in creditors and other payables	(1,425)	(362)
Increase/(decrease) in employee benefits	597	(410)
Net movement in working capital	47	3,506
Net cash inflow/(outflow) from operating activities	**1,742**	**8,059**

CAPITAL CONTRIBUTION FROM THE CROWN

On 15 February 2017 all existing Crown loans were converted into Crown equity, this was a one-off non cash transaction and it is therefore not recorded in the statement of cash flow. Refer to note 23 for more information.

19 Commitments

West Coast DHB currently leases property and equipment in the normal course of its business. These leases are for premises, which have non-cancellable leasing period ranging from one to five years. West Coast DHB's non-cancellable operating leases have varying terms, escalation clauses and renewal rights.

BREAKDOWN OF COMMITMENTS

	2017 Actual $000	2016 Actual $000
Capital Commitments		
Buildings	108	111
Plant, equipment and vehicles	184	189
Intangibles	33	135
Total capital commitments at balance date	**325**	**435**
Non-cancellable operating lease commitments		
Not more than one year	108	110
Later than one year and not later than five	2	48
Later than five years	-	-
Total non-cancellable operating lease and supply commitments	**110**	**158**

ACCOUNTING POLICY

Finance leases

Leases which effectively transfer to West Coast DHB substantially all the risks and benefits incident to ownership of the leased items are classified as finance leases. These are capitalised at the lower of the fair value of the asset or the present value of the minimum lease payments.

The assets' corresponding lease liabilities are recognised in the statement of financial position. The leased assets are depreciated over the period the West Coast DHB is expected to benefit from their use.

The Public Finance Act 1989 requires DHBs to obtain approval from the Minister of Health prior to entering a finance lease arrangement.

Operating leases

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Operating lease expenses are recognised in the surplus or deficit on a systematic basis over the period of the lease.

Critical judgement in applying accounting policies

DETERMING LEASE SCHEMES

Determining whether a lease agreement is finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to West Coast 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 options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the

statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

West Coast DHB has exercised its judgement on the appropriate classification of its leases and has determined all lease arrangements are operating leases.

20 Contingencies

CONTINGENT LIABILITIES

SUPERANNUATION SCHEMES

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

OUTSTANDING LEGAL PROCEEDINGS

West Coast DHB has no material outstanding legal proceedings as at 30 June 2017 (2016: nil).

HOLIDAYS ACT COMPLIANCE

West Coast DHB is part of a national DHB group reviewing and setting a Holidays Act Compliance baseline. This baseline will be agreed with the Ministry of Business, Innovation & Employment (MBIE), and the NZ Council of Trade Unions (NZCTU), and the intent is to work through an audit of DHB compliance against these baselines. Until these baselines are agreed and approved by DHBs nationally, MBIE and the NZCTU, there is uncertainty over any actual costs which may arrive from this audit, so any future liability cannot be reasonably estimated.

CONTINGENT ASSETS

The West Coast DHB has no contingent assets (2016: nil).

21 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 a wholly owned entity of the Crown.

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

SIGNIFICANT TRANSACTIONS WITH GOVERNMENT RELATED ENTITIES

West Coast DHB has received funding from the Crown, ACC and other government entities of $133.38m to provide health services in the West Coast area for the year ended 30 June 2017 (2016: $131.27m). Refer to note 8 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 $1.66m for the year ended 30 June 2017 (2016: $1.56m). Expenditure to other DHBs for the care of patients from West Coast DHB's

district and services provided from other DHBs amounted to $19.62m for the year ended 30 June 2017 (2016: $18.52m).

COLLECTIVELY, BUT NOT INDIVIDUALLY, 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 13 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 2017 totalled $770m (2016: $1.912m). These purchases included the purchase of blood products from the New Zealand Blood Service, coal from Solid Energy and services from educational institutions.

COMPENSATIONS OF KEY MANAGEMENT PERSONNEL

EXECUTIVE MANAGEMENT TEAM

	2017		2016	
	FTE	Actual $000	FTE	Actual $000
Short-term employee benefits-executive management	5	1,081	5	1,031
Post-employment benefits		20		13
		1,101		**1,044**

The executive management team consisted of 5 members (2016: 5) employed by West Coast DHB and a further 6 members, including the Chief Executive, who were employed by Canterbury DHB (2016: 6). The key management personnel services provided by the Office of the Chief Executive are provided to West Coast DHB under contract by Canterbury DHB and are invoiced accordingly- 2017: $300k (2016: $300k). For the year under review, no executive management personnel were Board members (2016: nil). Short-term employee benefits include all salary, leave payments and lump sum payments. Post-employment benefits are West Coast DHB contributions to superannuation and KiwiSaver schemes.

Analysis of Board and committee members' fees member remuneration is provided on page 34.

PAYMENT IN RESPECT OF TERMINATION 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, etc.

During the year ended 30 June 2017, 7 (2016: 13) employees received payments relating to the termination of their employment totalling $227,522 (2016: $243,000), excluding retiring gratuities paid out. No Board members received compensation or other benefits in relation to cessation (2016: nil).

REMUNERATION OF EMPLOYEES

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

Specified band	2017 Actual	2016 Actual	Specified band	2017 Actual	2016 Actual
$100,000 - $109,999	23	22	$250,000 - $259,999	1	4
$110,000 - $119,999	18	16	$260,000 - $269,999	-	2
$120,000 - $129,999	12	6	$270,000 - $279,999	3	1
$130,000 - $139,999	3	6	$280,000 - $289,999	2	2
$140,000 - $149,999	5	3	$290,000 - $299,999	1	1
$150,000 - $159,999	3	1	$300,000 - $309,999	-	1
$160,000 - $169,999	2	2	$310,000 - $319,999	2	3
$170,000 - $179,999	2	2	$320,000 - $329,999	1	2
$180,000 - $189,999	-	-	$330,000 - $339,999	3	-
$190,000 - $199,999	2	-	$340,000 - $349,999	1	1
$200,000 - $209,999	-	2	$350,000 - $359,999	-	2
$210,000 - $219,999	2	1	$360,000 - $369,000	3	-
$220,000 - $229,999	2	-	$370,000 - $379,999	1	-
$230,000 - $239,999	1	1	$380,000 - $389,000	1	1
$240,000 - $249,999	-	-	$390,000 - $399,000	-	1
Total employees				94	83

94 employees (2016: 83) 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 figures stated above exclude the Chief Executive's remuneration as this service is delivered by Canterbury DHB as an outsourced service.

Of the 94 employees shown, 88 are clinical employees (2016: 77) and are 6 non clinical employees (2016: 6).

22 Financial Instruments

West Coast DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances (note 7), investments (note 11), trade receivables (note 8), payables (note 13) 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.

23 Conversion of Existing Crown Loans to Crown Equity

In September 2016 Cabinet agreed that the DHB sector should no longer access Crown debt and agreed to convert all existing DHB Crown debt into Crown equity.

On 15 February 2017 all existing Crown loans were converted into Crown equity and from that day onward all Crown capital contributions would be made via Crown equity injections.

The termination of the loan agreement and the conversion of existing Crown loans to equity was completed by a non-cash transaction, other than for interest due at the conversion date.

As a consequence of the changes there has been a decrease in 2016/17 for the interest costs avoided from the conversion date until the end of the 2016/17 year and increasing DHB appropriations for the increased capital charge cost to the DHB thereafter.

THE IMPACT ON THE STATEMENTS OF ACCOUNT FOR WEST COAST DHB IS AS FOLLOWS:

	Note	2017 Actual $000	2016 Actual $000
Opening balance –Crown loans		14,445	14,445
Increase in Crown loans		-	
Repayment of Crown loans			
Conversion of loans to equity		(14,445)	
Closing Balance –Crown loans	12	**-**	**14,445**

	Note	2017 Actual $000	2016 Actual $000
Opening balance – contributed capital		72,563	71,694
Capital contribution from/(repayment to) the Crown		(946)	869
Conversion of Crown loans to Crown equity		14,445	-
Closing balance – contributed capital	15	**86,062**	**72,563**

24 Events after Balance Date

There were no other events after 30 June 2017 which could have a material impact on the information in West Coast DHB's financial statements.

25 Explanation of Major Variances Against Budget

STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The financial result for the full financial year to June 2017 is a deficit of $0.800m, which is $0.246m over the approved deficit of $0.554m.

REVENUE

The major factors affecting the 2% unfavourable variance between our planned revenue of $145.015m and actual revenue of $142.772m were less than planned revenue in Ministry of Health side contracts, ACC, non-eligible and age related care co-payments.

EXPENSES

Our expenditure had a 1.3% favourable variance between our planned expenditure of $145.569m compared to actual expenditure of $143.573m. The main factors influencing this underspend were:

- Depreciation which was $1.199m lower than budget which was due to a review of the useful lives of our buildings in Grey and Buller districts.

- Outsourced personnel which was $2.054m above budget, principally related to locum costs which continue to be incurred for a number of reasons, with the major driver continuing to be the difficulties in recruitment and retention of all medical staff from RMOs to GPs. While every effort is made to mitigate locum costs, the issues with the level of Locum payments are part of the challenges of the operating environment for the West Coast DHB.
- Funder payments to external providers, were favourable to budget by $2.990m. Pharmaceuticals was the main driver for this favourable variance due to the continued revision of on-going Pharmacy costs and the level of PHARMAC rebates.

STATEMENT OF CHANGES IN EQUITY

The variance to budget in the statement of changes in equity for the year ended 30 June 2017 is related to the debt to equity conversion. In February 2017, our loans with the Ministry of Health were repaid with an equity injection of $14.455m.

STATEMENT OF FINANCIAL POSITION

The debt to equity conversion in February 2017 is also the main variance to budget in the statement of financial position in Liabilities and Equity. The other main variance to budget in in cash balance – this is due to capital expenditure purchasing for our Grey Facility rebuild and deficit support funding not received from Ministry of Health for financial year 2015/2016.

STATEMENT OF CASH FLOWS

The balance of the cash and cash equivalents at the end of the year was $3.4m less than budgeted as discussed above this mainly relates to capital expenditure for Grey Facility development timeframes and deficit support funding not received.

26 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 2016/17 is $126,540,213 which equals the Government's actual expenses incurred in relation to the appropriation. The performance measures are set out in the statement of service performance on pages 19 to 31.

Statement of Revenue and Expenditure by Output Class

In thousands of New Zealand dollars

This table summarises the revenue and expenditure for the four output classes for the year ending 30 June 2017. The basis of arriving at the net cost for each output class can be found under the statement of accounting policy in the notes to the financial statements.

	2017 Actual $000	2017 Budget $000
Revenue		
Prevention	2,977	2,784
Early Detection and Management	27,129	26,931
Intensive Assessment and Treatment	93,234	94,707
Rehabilitation and Support	19,432	20,593
Total Revenue	**142,772**	**145,015**
Expenditure		
Prevention	3,086	2,433
Early Detection and Management	26,781	26,354
Intensive Assessment and Treatment	94,708	95,733
Rehabilitation and Support	18,997	21,049
Total Expenditure	**143,572**	**145,569**
Surplus/(Deficit)	**(800)**	**(554)**

The budget figures are those as per the Annual Plan Output Class, which is why the total revenue and expenditure differ slightly to the budgeted statement of comprehensive revenue and expenses.

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 2017

The Auditor-General is the auditor of West Coast District Health Board (the District 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, of the District Health Board on his behalf.

We have audited:

- the financial statements of the District Health Board on pages 42 to 75, that comprise the statement of financial position as at 30 June 2017, the statement of comprehensive revenue and expense, statement of changes in net assets/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 District Health Board on pages 7 to 31 and 76.

Opinion

Unmodified opinion on the financial statements

In our opinion, the financial statements of the District Health Board on pages 42 to 75:

- present fairly, in all material respects:
    - its financial position as at 30 June 2017; 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.

Qualified opinion on the performance information because of limited controls on information from third-party health providers in the prior year

In respect of the 30 June 2016 comparative information only, some significant performance measures of the District Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), relied on information from third-party health providers, such as primary health organisations. The District Health Board's control over much of this information was limited, and there were no practicable audit procedures to determine the effect of this limited control.

For example, the primary care measure that included advising smokers to quit relied on information from general practitioners that we were unable to independently test.

The limited control over information from third-party health providers meant that our work on the affected performance information contained in the statement of performance for the comparative year was limited, and our audit opinion on the performance information for the year ended 30 June 2016 was modified accordingly.

The limited control over information from third parties has been resolved for the 30 June 2017 year, however, the limitation cannot be resolved for the 30 June 2016 year, which means that the District Health Board's performance information reported in the statement of performance for the 30 June 2017 year, may not be directly comparable to the 30 June 2016 performance information.

In our opinion, except for the matters described above, the performance information of the Health Board on pages 7 to 31 and 76.

- presents fairly, in all material respects, the District Health Board's performance for the year ended 30 June 2017, 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;
    - what has been achieved with the appropriation; and
    - the actual expenses or capital expenditure incurred as 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 26 October 2017. This is the date at which our opinion is expressed.

The basis for our opinion is explained below. 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 opinion

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

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

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

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

The Board is responsible on behalf of the District 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 determines is necessary to enable it to prepare the financial statements and the performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the District Health Board for assessing the District 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 District 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 it 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 District 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 District 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 District 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 District 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 District 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 2 to 5 and 33 to 40, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the District 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 District Health Board.

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