WEST COAST DISTRICT HEALTH BOARD

2019-2023 STATEMENT OF INTENT

Incorporating the 2019/20 Statement of Performance Expectations

Statement of Joint Responsibility

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

This document is our Statement of Intent which has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health.

The Statement of Intent sets out our strategic goals and objectives, and describes what we aim to achieve in terms of improving the health of our population and ensuring the sustainability of our health system. It also contains our Statement of Performance Expectations for the coming year.

The Statement of Performance Expectations is presented to Parliament and is used at the end of the year to compare the planned and actual performance of the DHB. Audited results are presented in our Annual Report.

The West Coast DHB has made a strong commitment to 'whole of system' service planning. We work collaboratively and in partnership with other service providers, agencies and community organisations to meet the needs of our population and support a number of clinically-led Alliances as key vehicles for implementing system improvement and change.

Our alliance framework means we share a joint vision for the future of our health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our local West Coast Alliance with the West Coast PHO, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the Canterbury DHB.

We also recognise our role in actively addressing disparities in health outcomes for Māori and we are committed to making a difference. We work closely with Tatau Pounamu and Poutini Waiora, directly and through the West Coast Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of Te Tiriti o Waitangi.

In signing this Statement of Intent, we are satisfied that it fairly represents our joint intentions and activity, and is in line with Government expectations for 2019/20.

Jenny Black
CHAIR | WEST COAST DHB

Chris Mackenzie
DEPUTY CHAIR | WEST COAST DHB

David Meates
CHIEF EXECUTIVE | WEST COAST DHB

September 2019

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Foreword from the Chair and Chief Executive

The West Coast DHB is the smallest and the most rural health system in the country. This presents a number of unique challenges, and in response we have committed a new approach which recognises our strengths and seeks to build a much more integrated and resilient system.

While our vision is simple, it is ambitious - an integrated health system that is both clinically and financially viable; a health system that wraps care around people and helps them to stay healthy and well in their own community.

Transforming the way we work

Over the past few years we have charted a course to transform our health system and better respond to your health needs. A strong platform now exists to launch the next phase of our journey, to really accelerate integration, bring health services closer to your home and provide the right mix of support in the right place, at the right time.

With the development of three locality bases, in Westport, Greymouth and Hokitika, services traditionally seen as hospital-based will begin to be available in primary and community settings.

We will do this by enhancing general practice and investing more in community-based health services to build capacity and capability and better support the integration of services such as: palliative care, mental health and addiction services, community nursing, restorative care and rehabilitation services.

Transforming our workforce models

In supporting this direction, we need to ensure that we have strong teams in place. The development of a truly rural workforce is at the heart of our transformation and is one of the most complex and challenging aspects of our vison. Establishing a rural generalist model will take strong clinical leadership and ongoing conversations within and beyond our health sector.

We envisage a future where our people will work across traditional boundaries, to support the creation of one truly rural workforce that will provide greater continuity and access to care for our population. We are committed to developing and growing our rural workforce model, with deliberate investment in training and support for people to work at the top of their scope in 2019/20.

Addressing equity

We are also strengthening our focus on actions that will improve health outcomes for Māori. These actions are outlined in our Annual Plan and System Level Measures Improvement Plan, companion documents to this Statement of Intent. To support this work, we are deliberately investing in strategies to build a workforce that better reflects the diversity of our community.

Launching new facilities

Te Nikau (the new Grey Hospital and Health Centre) will underpin our transformation in the coming year, by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service delivery.

Construction of the new administration building on Cowper Street is expected to commence shortly. Our Board also endorsed the final Buller Health facility concept in May 2019. A facilities mock-up space is expected to be established this year, allowing staff, consumers and the wider community to engage in the next phases of design and 'test' the layout to ensure that things are functional and fit for purpose. The new facility is expected to be complete by September 2021.

The DHB is also investing in the Haast community with a new rural clinic based in the Haast town centre. This modern facility will enable greater collaboration with St John and support our rural nurse specialists to provide the best care for our southern community.

Collaborating for better outcomes

In supporting our communities to thrive, we welcome the opportunity of working with a whole range of agencies, local authorities, education, social welfare and justice, and will be looking for new ways to collaborate in the coming year.

We will continue to work with our regional counterparts, particularly Canterbury DHB, as part of our shared transalpine model, to support the delivery of services for our community and to progress regional priorities outlined in the South Island Regional Health Services Plan. We will also continue our planned investment in regional information systems and solutions that will support our transformation.

In our health system, achieving the best outcomes for our community relies on everyone coming together. We cannot achieve our goals without the dedication and hard work of our staff and other health providers across the district, and we thank them for their ongoing commitment and dedication. We also thank our local community for their advice and input into service design and for keeping our focus on what matters for patients, whānau and our community.

We look forward to bringing our vision to life in 2019/20.

David Meates
Chief Executive
September 2019

Jenny Black
Chair, West Coast DHB

OVERVIEW

Who are we and what do we do?

Introducing the West Coast DHB

1.1 Who are we?

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

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

In 2019/20, we will receive approximately $159.7 million dollars to meet the needs of our population. In accordance with legislation, and consistent with Government objectives, we will use that funding to:

Plan the future direction of our health system and, in collaboration with clinical leads and alliance partners, develop demand strategies and determine the services required to meet the needs of our population.

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

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

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

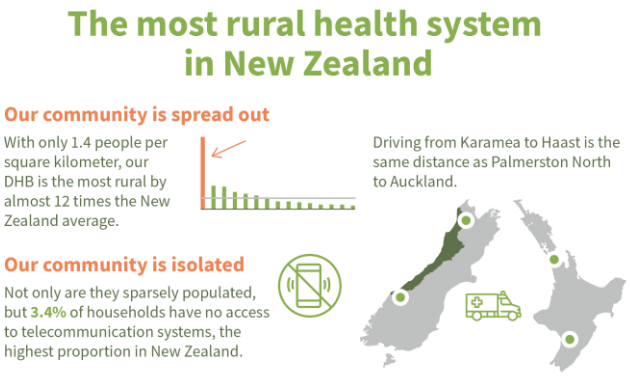
1.2 What makes us different?

The West Coast DHB has the smallest population of any DHB in New Zealand. We are responsible for 32,410 people, or 0.65% of the total New Zealand population.

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

We own and operate four major health facilities in Westport, Reefton, Greymouth and Hokitika and eight smaller clinics in our more remote areas. Unlike most other DHBs, we own and operate four of the seven general practices on the Coast and we also operate a district nursing and home-based support service. This makes us a major local employer, with more than 1,000 people directly employed by the West Coast DHB.

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



As New Zealand's smallest DHB, our population levels and the resources we have available to us mean we cannot provide a full range of specialist services on the West Coast. In some instances, we must refer patients to larger centres with more specialised capacity.

A formal transalpine service partnership established with the Canterbury DHB means Canterbury specialists provide regular outpatient clinics and surgical lists on the West Coast. This arrangement, and our deliberate investment in telemedicine technology, provides our population with improved access to highly specialised services and helps to save people and their families from having to travel long distances for assessment and treatment.

The West Coast and Canterbury DHBs have shared operational resources since 2010. This includes a joint chief executive, executive directors, clinical leads and corporate service teams.

1.4 Our population profile

The West Coast has a relatively static population, almost unchanged for the last ten years and predicted to decrease slightly over the next ten years. However, our population has an older age structure, compared to NZ as a whole, with 19.4% of our population aged over 65, compared with the national average of 15.8%.

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

Many long-term conditions become more common with age, including heart disease, stroke, cancer, and dementia. As the average age of our population increases more people will need treatment and support, putting increasing pressure on our system.

Deprivation is a strong predicator of the need for health services and a key driver of health inequities. In 2018, one in every ten residents on the West Coast (3,003 people) were living in areas classified as socio-economically deprived. Higher proportions of our population are receiving unemployment or invalid

benefits, have no educational qualifications and do not have access to a motor vehicle or telephone. [1]

We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others. Ethnicity, like age and deprivation, is a strong predicator of need for health services. There are currently 3,970 Māori living on the West Coast (12.2% of our population) and by 2025 that proportion is predicted to increase to 13.4%.

Our Māori population has a considerably younger age structure, with 10.3% of our Māori population aged under five, compared to 5.7% of the total population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on the health needs of our younger Māori population.

1.5 Our population's health

West Coasters have higher morbidity and mortality rates resulting in a slightly a lower life expectancy (80.4 years) compared with the national average (81.4 years). West Coast Māori continue to have poorer overall health status and life expectancy (78.3 years). However, the equity gap for life expectancy on the Coast is reducing and at 2.1 years is considerably better than the national gap, where Māori life expectancy (75.1 years) is almost 6.3 years lower than the total population.

Like the rest of New Zealand, an increasing number of people on the West Coast are living with long-term conditions such as heart disease, respiratory disease, cancer, diabetes and depression.

The increasing prevalence of long-term physical and mental health conditions is one of the major drivers of demand for health services and the main cause of health loss and death amongst adults. In 2017/18, over 4,100 people (13% of our population) were identified as having one or more long term conditions.[2]

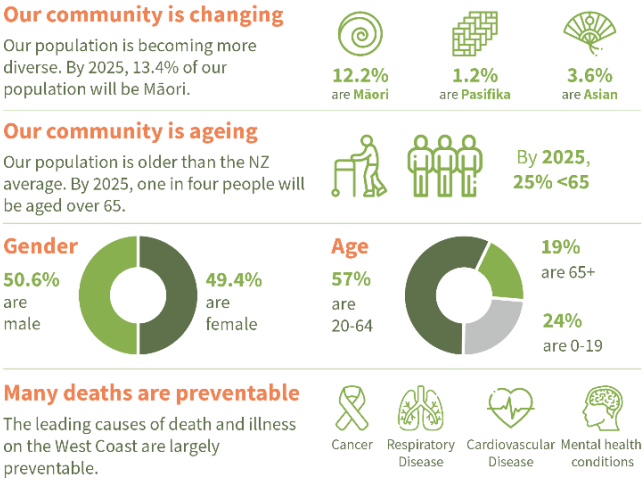
A reduction in known risk factors such as smoking, poor diet, lack of physical activity and hazardous drinking could dramatically reduce pressure on our health system and greatly improve health outcomes for our population. All four major risk factors have strong socio-economic gradients, so population health interventions that reduce these risk factors will also contribute to reducing health inequities between population groups.

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

- 26% of our population are current smokers (higher than the national average). Smoking rates amongst Māori are higher (44%).
- More than a third (35%) of our total adult population are classified as obese. Rates for our Māori population are higher (56%).
- Our population's fruit and vegetable intake is similar to the national average (41.1% vs 39.8%) however Māori rates were lower at 30.8%.
- 10% of our total adult population were identified as inactive (little or no physical activity). Rates for Māori were slightly higher (13%).
- 16% of our adult population are likely to drink in a hazardous manner. While this rate is lower than the national average, it reflects hazardous drinking habits for one in every eight adults on the Coast. [3]

The communities we serve

We are responsible for 32,465 people



Based on the Stats NZ Dec 2018 Population Projections

1.6 Our Operating Challenges

As we develop strategies and redesign service models to respond to our population's health needs and the increasing pressures on our system, we need to be mindful of our unique operational challenges.

Rurality: Geographically we are the third largest DHB in the country, covering a total land area of 23,283 square kilometres, but we are the smallest by population. This means patients and health professionals often have to travel long distances to access or deliver services. Our rurality is one of our biggest challenges and magnifies all the operating pressures we face.

[1] PHO enrolments and Stats NZ population projections provided by Ministry of Health July 2018.

[2] People enrolled with the West Coast PHO Long-Term Conditions Management Programme June 2018.

[3] Results from the NZ Health Survey should be interpreted with caution as small population numbers can have a distorting impact on results. Regional results for the 2017/18 Survey are expected to be release in 2019. Refer to www.health.govt.nz.

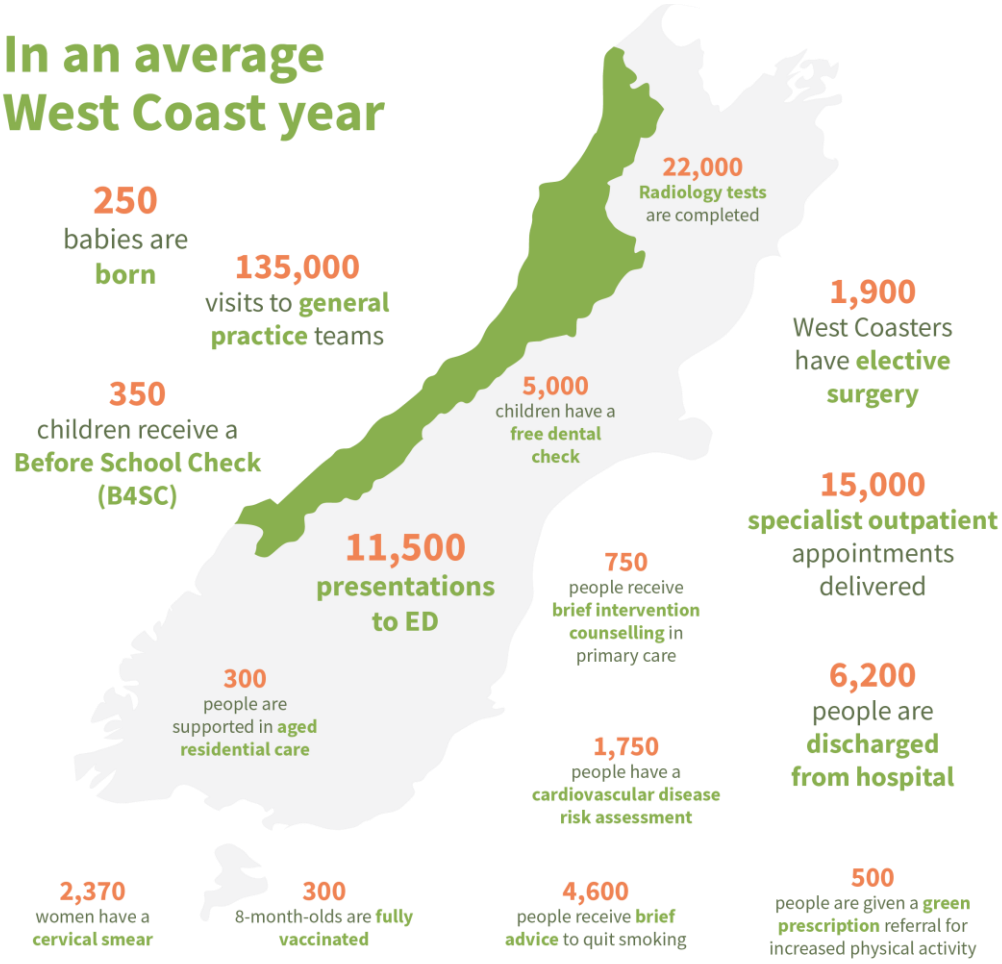
Service fragmentation: Because of our small population size and long travel distances, services are often fragmented and person dependent. A history of over-reliance on hospital services also means not all of our services are being delivered by the most appropriate person or in the most appropriate settings.

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

Facilities pressures: A number of our health facilities are outdated, expensive to maintain, poorly located or seismically compromised. They do not support the more flexible models of care needed to response to our population's need, create inefficiencies and add to financial pressure. Completion of Grey Hospital and Health Centre (Te Nikau) and Buller Health Centre are critical to our future success. Careful consideration also needs to be given to the long-term future of all the facilities we own and operate across the West Coast.

Financial viability: Meeting increasing service demand, treatment and infrastructure costs, and national expectations around wage and salary increases is a significant challenge. Our population is not growing and we receive limited annual increases in funding. Financial pressures mean the DHB needs to carefully consider where we commit resources and reallocate investment into activity and services that will provide the greatest return in terms of health gain.

Variation: Unlike larger urban DHBs, the biggest challenge for the West Coast health system is less about managing volume and more about managing variation. Not all variation is negative, some helps us deliver more patient centred care. However, variation in the demand for a service, in the capacity of the individuals and teams that provide the service, or in the way in which services are provided, all affect the flow of patients through our system. To ensure we can consistently provide the best possible care to our community, we need to understand and manage this variation and reduce the negative impacts on service provision, patient experience and health outcomes.



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

LONG-TERM OUTLOOK

What are we trying to achieve?

2

Our Strategic Direction

2.1 The West Coast Vision

Our resources are limited and the pressures facing our health system mean that services cannot continue to be provided in the same way. In order to improve the health and wellbeing of our population, we need to integrate and connect services across our health system and ensure greater collaboration between teams and with our patients, whānau and community.

Our vision is of an integrated West Coast health system that is both clinically sustainable and financially viable; a health system that wraps care around the patient and helps people to stay well in their own community.

Our vision is underpinned by three strategic objectives:

- The development of services that support people to stay well and enable them to take greater responsibility for their own health.
- The development of primary/community-based services that support people in the community and provide a point of ongoing continuity, which for most people will be general practice.
- The freeing-up of hospital-based specialist resources to be more response to episodic events, provide timely access to more complex care and specialist advice to primary care.

Delivering on our strategic objectives and achieving our vision will result in a health system that is:

People-centred: This means services will be focused on meeting people's needs and will value their time as an important resource. We will minimise waiting times and reduce the need for people to travel to multiple locations, at inconvenient times, or far from home, unless there are good clinical reasons to do so.

Integrated: This means improved continuity, coordination and consistency of care with the most appropriate health professional available and able to provide care, where and when it is needed. Services will be supported by the timely flow of information to enable informed clinical decision-making.

Based on a single system: This means services and providers will work in a mutually supportive way for the same purpose, to support people to stay well. Resources will be flexible across services and across the wider West Coast health system and tools and processes will help to manage and reduce variation.

Clinically sustainable and financially viable: This means our health system will achieve levels of efficiency that will allow an appropriate range of services to be sustainably maintained. There will be a stable workforce of health professionals in place to provide these services, with strong clinical leadership to support the provision of safe and effective care.

2.2 Nationally consistent

The West Coast vison is closely aligned to the Government's long-term vision for the health sector, as articulated through the NZ Health Strategy with its central theme 'live well, stay well, get well.'

It also reflects alignment with the Government theme 'Improving the well-being of New Zealanders and their families' and the priority outcomes: Support healthier, safer, more connected communities; Make New Zealand the best place in the world to be a child; and Ensure everyone who is able to, is earning, learning, caring or volunteering.

The Minister of Health's annual Letter of Expectations also signals priorities and expectations for DHBs. The expectations for the coming year signal a strong focus on equity in health and wellness.

The priorities emphasised for 2019/20 are:

- Improving child wellbeing;
- Improving mental wellbeing;
- Improving wellbeing through prevention;
- Better population health outcomes, supported by a strong and equitable public health and disability system;
- Better population health outcomes, supported by primary health care;
- Strong fiscal management.

The DHB's Annual Plan outlines how we will deliver on the Minister's expectations in the coming year. The Minister's Letters of Expectation for 2019/20 are attached as Appendix 2.

2.3 Regionally responsive

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Regional Alliance to address our shared challenges and develop more responsive and effective health services.

Our jointly developed South Island Health Services Plan outlines our regional direction, priorities and agreed work programme for 2019-2022.

There are six regional priority focus areas: Data and Information; First 1,000 Days; Mental Health; Acute Demand Management; Social Determinants of Health; and Advance Care Plans.

West Coast DHB has made a strong regional commitment and is engaged in a number of work streams including: cardiac, child health, major trauma, mental health, cancer, telehealth, and workforce.

The Regional Health Services Plan can be found on the Alliance website: www.sialliance.health.nz.

2.4 Committed to achieving equity

Not everyone living on the West Coast experiences the same health outcomes, and some people experience advantages and opportunities that others do not.

Social determinants, such as education, employment, housing and geographical location can impact on opportunity as can aspects of a person's identity including age, gender, ethnicity, social class, sexual orientation, ability or religion. Equity is about fairness and we are committed to reducing disparities and achieving equity in health outcomes for our population, particular for our growing Māori population.

Acknowledging and taking steps to address inequities in our system can be confronting and challenging, but is necessary if we are to progress towards equity. By making this commitment we acknowledge that we will need to evolve our workforce, build health literacy and cultural capabilities and redesign service delivery models, to better meet the diverse needs of all the people in our community.

The DHB's planning is guided by a range of national strategies, including: He Korowai Oranga (the Māori Health Strategy), Ala Mo'ui (Pathways to Pacific Health and Wellbeing), the Healthy Ageing Strategy and the NZ Disability Strategy. We are also supported by tools such as the Health Equity Assessment Tool (HEAT) to assess, identify and address disparities.

Actions to deliver health equity are identified throughout the DHB's Annual Plan for 2019/20.

Our Immediate Focus

In transforming our health system, the West Coast DHB aims to become a leader in the provision of rural health services and identify opportunities to add value and reduce variation, duplication and waste.

In 2018, our Board identified nine Strategic Themes that highlight factors seen as critical to our immediate and long-term success. These align closely with the themes of the New Zealand Health Strategy and provide overarching framework for the way services will be planned, developed and delivered.

We have already started to do things differently. We have made a commitment to clinically-led service design and reducing inequities, we are working more collaboratively with our partner organisations through the West Coast Alliance, and we have formalised transalpine partnerships with the Canterbury DHB.

In the coming year, we are working on several large changes to enable the creation of three integrated locality bases (central, northern and southern) supported by a rural inpatient service and improved coordination services. This direction will improve access to services closer to people's homes, improve clinical support and help to reduce variation, with new standardised and streamlined processes.

The development of a highly skilled, rural-generalist workforce, able to flex across traditional service areas, is critical to our future success. Our focus for the coming year includes the deliberate creation of an environment where our people can thrive including access to professional education, leadership training, clinical support and a collective leadership culture.

Taking a population health approach to prevention is a critical factor in our strategy to improve wellbeing by addressing the risk factors and behaviours associated with poor health. The Healthy West Coast Alliance and our Community and Public Health Team are taking the lead in the development of strategies and initiatives to make healthier choices easier.

Connecting information systems and sharing data is another critical success factor. Updated information systems give us access to real-time information at the point of care, improving clinical decision-making and reducing the time people waste waiting. Support for progressing this work and capturing increased value from available technology will include deliberate investment in shared electronic systems, telehealth technology and data analytics.

Improving equity is a critical factor in our longer-term success and our investment in information systems will help to support a greater focus on equity across our health system. Real time data identifying disparities in access or engagement, will enable more informed decision making on models of service delivery that better support equitable health outcomes for our population. This will also be supported by investment in our Takarangi Cultural Competency Framework.

The successful completion and migration into Te Nikau (the new Grey Hospital and Health Centre) and the development of the Buller Health Centre are also major pieces of work for the DHB in the coming year. These facilities will support the realisation of integrated service delivery models that will help to ensure the future sustainability of our health system.

The actions and activity aligned to these pieces of work are reflected in our 2019/20 Annual Plan.

MEDIUM-TERM OUTLOOK

How are we going to get there?

3

Managing Our Business

This section highlights how we will organise and manage our business to support the realisation of our vision, enable the delivery of equitable, integrated and sustainable services and improve the health and wellbeing of our population.

3.1 Partnering for better outcomes

Our vision is based on bringing to life a truly integrated system. Working collaboratively with our health and social service partners is a critical factor in achieving our goals and objectives.

The DHB's major strategic partnerships include:

The West Coast Alliance: Where the DHB and the PHO come together with other local service providers to improve the delivery of public health services and realise opportunities to improve health outcomes. This focus includes delivery against the West Coast's System Level Improvement Plan, which is incorporated into the DHB's Annual Plan.

The Consumer Council: The DHB is committed to a culture that focuses on the patient and supports consumer participation in the design of services and strategies to improve wellbeing. We seek input from consumers through our Alliance work, with consumers represented on work streams. The DHB also has a Consumer Council, to ensure a strong and viable voice in health service planning and redesign. In the coming year we will work with the Council to develop a framework to support greater local community engagement with locality teams.

The Family Violence Interagency Response Group: Regular interagency meetings assess risk in reported cases of family violence, so that collective responses can be planned and implemented. The DHB is a partner in this work alongside Police, Women's Refuge, Presbyterian Support and Oranga Tamariki.

Transalpine Partnership: Connecting up the Canterbury and West Coast health systems is enabling more coordinated care, reducing duplication and supporting more sustainable access to specialist services for our population. The two DHBs also share a Chief Executive, executive management team, clinical leads, corporate services teams and information systems.

Public Health Partnership: All DHBs have a statutory responsibility to improve, promote and protect the health and wellbeing of their populations. Community & Public Health is a division of the Canterbury DHB and takes a lead in the delivery of public health strategies and services for our population. This includes the development of the West Coast's Public Health Action Plan, which is incorporated into our Annual Plan and supported locally by the West Coast Alliance.

3.2 Commitment to Māori

The values of our organisation, the way in which we work, and the manner in which we interact with others are all key factors in our success.

As a Crown agency, we recognise our responsibilities to uphold our obligations under the Te Tiriti o Waitangi. We work to improve the quality of care and equity of health outcomes for Māori and to address any systemic inequity, consistent with the recognised Tiriti principles of partnership, participation and protection.

The relationships and partnerships we build with our Māori stakeholders are fundamental to this work. We have a memorandum of understanding with Tatau Pounamu, our Māori advisory group, where we actively engage with Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Members of Tatau Pounamu also bring a Māori perspective to the redesign of services and the building of capacity across community services through participation in the West Coast Alliance.

We also promote a culture that addresses disparities through open discussion, the use of the Health Equity Assessment Tool (HEAT), universal performance targets and professional development and mentoring. A crucial vehicle for this work is our Takarangi Competency framework, an evidence-based model that influences and shapes practice and supports improved cultural competency amongst our workforce.

3.3 Commitment to quality

Our commitment to quality improvement is in line with the NZ Triple Aim: improved quality, safety and experience of care; improved health and equity for all; and better value from public health resources.

West Coast DHB is committed to health excellence, with a strong focus on service quality and system performance. Working in partnership with patients and whānau is central to improved performance and we have made a commitment to using our inpatient experience survey results to improve the way we communicate with patients and their families.

The national Health Quality and Safety Commission (HQSC) Quality & Safety Markers supplement our local performance framework and are used to monitor patient safety and the effectiveness of improvement activity. We report results to our community in our Quality Accounts which can be found on our website.

Expectations for externally contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. We also work with the other South Island DHBs, as a partner in the regional Quality and Safety Alliance, to implement quality and safety improvements.

3.4 Performance management

To support good governance, we have an outcome-based decision-making and accountability framework that enables our stakeholders, Board and executive to monitor service performance and provide direction.

At the broadest level, we monitor our health system performance against a core set of desired population outcomes, captured in our outcomes framework. The framework defines success from a population health perspective and is used as a means of evaluating the effectiveness of our investment decisions.

The DHB's service and financial performance is monitored through monthly and quarterly reporting to our Board and to the Ministry of Health against key financial and non-financial indicators aligned to the national performance framework. Our service performance is also audited annually against our Statement of Performance Expectations set out in section 4 of this document. The results are published in our Annual Report which can be found on our website.

3.5 Asset management

Having the right assets in the right place and managing them well is critical to the ongoing provision of high-quality and cost-effective health services.

As at 30 June 2018, the West Coast DHB had $47.663M worth of assets on its books. As an owner of Crown assets, we are accountable to Government for the financial and operational management of those assets. Our capital intentions are updated annually to reflect known changes in asset states, and intentions in line with our facilities redevelopment.

The DHB is also developing a Long-term Investment Plan with a ten-year outlook. This Plan will reflect the anticipated impact of changing patterns of demand and new models of care on our future asset requirements, and will support future investment decisions.

Refer to Section 4 for a summary of the DHB's major capital investments to 2023.

3.6 Ownership interests

The West Coast DHB has an ownership interest in two partnerships to support the delivery of health services.

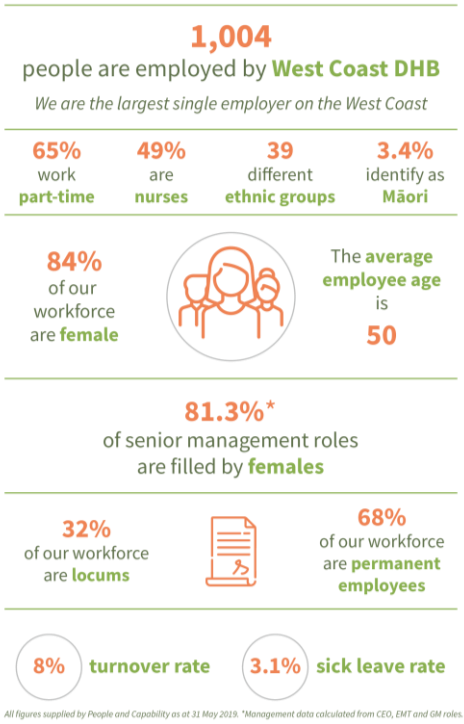
The South Island Shared Service Agency Limited: functions as the South Island Alliance Programme Office. It is jointly owned and funded by the five South Island DHBs and provides audit services and drives regional service development on our behalf.

The New Zealand Health Partnership Limited: is owned and funded by all 20 DHBs and aims to enable DHBs to collectively maximise and benefit from shared service opportunities. The West Coast DHB participates in the Finance, Procurement and Supply Chain programme.

We do not intend to acquire shares or interests in any other companies, trust or partnerships in 2019/20.

Building Our Capability

3.7 Investing in our people



The DHB is committed to being a good employer. We promote equity, fairness, a safe and healthy workplace, and have a clear set of organisational values and core operational policies. These include a Code of Conduct, Equality, Diversity and Inclusion Policy and a Wellbeing Policy. The DHB is will also implement the national Care Capacity Demand Management agreement by June 2021.

In our rurally isolated environment, we face significant difficulties in recruiting and retaining people with the right skills to support our system. Attracting and retaining capable people, with a real passion for rural health, is one of our critical success factors.

We are reviewing our people processes and systems and engaging in conversations about how we can put our people at the heart of all that we do. There is a strong commitment to making things better. The DHB has committed to a People Strategy to positively motivate and support the wellbeing of our people.

A range of initiatives will be developed and rolled out to deliver on the priorities that matter to our people, and in doing so we will create a culture where:

- Everyone understands their contribution
- Everyone can get stuff done
- Everyone is empowered to make it better
- Everyone is enabled to lead
- Everyone is supported to thrive.

Alongside our People Strategy work, we identify available talent and expand workforce capability

through participation in the regional Workforce Development Hub, links with the education sector, sharing of education resources and support for internships and clinical placements in our hospitals.

The DHB has also identified two key areas of workforce development for the period of this Plan:

Rural Generalist Workforce: The DHB is deliberately investing in the development of a rural-generalist model, a proven strategy for more remote rural health systems. We are applying this model across all our professions – medical, allied health and nursing - and as part of this strategy each profession will work to the full extent of their scope of practice and as part of a multi-disciplinary team.

A core workforce of rural generalists will support improved sustainability of services, the development of more integrated models of care and improve the continuity of care for our population. For example, a rural generalist doctor could be qualified to work in obstetrics or anaesthetics as well as in general practice and hospital medicine.

This move to a less siloed and more sustainable model will also provide opportunities for our workforce to evolve and will help us attract people who want to work in a more integrated rural-based model.

Māori Health Workforce: The DHB also seeks to encourage greater participation of Māori in the health workforce. Employee ethnicity data shows Māori make up 12% of the West Coast population but just 3.4% of the DHB workforce.[4]

In support of this direction the DHB is participating in the national Kia Ora Hauora programme, aimed at increasing the number of Māori working in health, by supporting pathways into tertiary education, local Māori health scholarships and work placements.

In collaboration with Canterbury DHB, we are supporting a review of recruitment practices, particularly those that may unintentionally limit job placements for Māori applicants.

With 49% of staff having no ethnicity recorded, we are engaging with staff to improve the collection and recording of ethnicity data to improve workforce planning and support.

The DHB is also committed to building a culturally competent workforce and will continue to advance the Takarangi Competency framework, an evidence-based model that influences and shapes practice.

3.8 Investing in information systems

Improved access to patient information enables more effective clinical decision-making, improved standards of care and reduces the time people spend waiting.

The South Island DHBs have determined collective actions to deliver on the national Digital Health Strategy. The West Coast DHB is committed to this approach and has heavily invested in the move to regional and sub-regional solutions, implementing Health Connect South, HealthOne and the shared Electronic Referral Management System. The next focus will be implementation of the (single) South Island Patient Information Care System (PICS).

Our transalpine partnership with Canterbury DHB provides critical support to the West Coast in regards to applications management and support for planned upgrades. We now share many of the same software solutions and are working to implement a combined transalpine service desk.

Supported by a new Transalpine Security Manager, the DHB is also focused on security improvements, including: improvements to the authentication of systems, joint policies and a move to joint security appliances. The West Coast DHB has contributed to a consolidated transalpine list of mission, clinical and business critical systems and will be expanding this to include the systems we maintain locally.

Telehealth, videoconferencing and mobile technology that support staff to work remotely, are an important factor in addressing our isolation challenges. We will continue to expand this capability in the coming year, with the move to a more accessible mobile-based telehealth solution, providing more remote communities on the Coast with access to telehealth options.

There are also a host of technological advancements being incorporated into Te Nikau to improve patient care. Digitisation of the facility is occurring through the use of regional solutions which promote electronic workflows: electronic orders, e-referrals and Patientrack, an e-observations platform designed to support patient safety.

Areas for investment for the period of this Plan include:

- Implementation of a combined transalpine service desk, in quarter one.
- Approval of the e-Pharmacy business case, with project start planned for quarter one.
- Approval and implementation of electronic orders for radiology, to support improved workflows in Te Nikau, in quarter two.

[4] Note: This number is likely to be understated with 49% of our workforce not declaring their ethnicity. Of those who have declared their ethnicity 6.0% have identified as Māori.

- Approval of the business case for implementation of South Island PICS, with project start planned for quarter four.
- Implementation of new mobile-based telehealth capability, providing improved mobility and greater access to the technology across the wider health system, by the end of 2019/20.

The DHB will report quarterly to the Ministry of Health on our ICT investment to support collective decision making and maximise the value of sector investment.

3.9 Investing in facilities

In the same way that quality systems, workforce and information technology underpin and enable our transformation, health facilities can both support and hamper the quality of the care we provide.

The West Coast DHB is in the midst of significantly transforming the way we deliver health services to our community. Te Nikau (the new Grey Hospital and Health Centre) will underpin this transformation by providing modern, fit-for-purpose infrastructure capable of supporting more responsive and integrated service delivery.

Delays with the building programme have meant the DHB has been unable to realise anticipated efficiency savings over the past year. Increased construction and fixtures and fitting costs are also creating significant pressure. It is critical that the redevelopment is completed without further delay.

Areas of investment for the period of this Plan include:

- Te Nikau: The Grey Base redevelopment is now expected to be completed (with migration of services and staff into the new facilities) in the third quarter of 2019/20.

- Grey Base Energy Centre: A replacement Energy Centre is part of the Grey redevelopment and completion is anticipated in 2019.
- DHB Administration Block: A concept design has been agreed for a new administration building in Greymouth. The building will provide a facility for all DHB personnel not based with Te Nikau. Construction is expected to commence in 2019, with completion early 2020.

- Buller Health Centre: In December 2018 approval was given for the $20m Buller project. Management of the project has been transferred back to the DHB and the design phase for the new facility has begun. At this stage we anticipate confirming the construction contract in 2019 with the new facility anticipated in 2021.

- Grey Base Mental Health Facility: The current mental health facility is subject to a seismically related section 124 notice that expires in June 2020. A master site plan is currently being scoped with reference to a replacement facility, more aligned to the new model of care for mental health. A business case will then be developed.
- Relocation of the Hannah's Clearing Clinic: An opportunity has been presented to relocate the Clinic based in Hannah's Clearing to the Haast Township, collocated in the same building as St John. Scoping and design work is underway to understand the implications of a move.

Monitoring Our Performance

3.11 Improving health outcomes

As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

DHBs have a number of different roles and associated responsibilities. In our governance role, we are concerned with health equity and outcomes for our population and the sustainability of our health system. As a funder, we are concerned with the effectiveness of our health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver, the efficiency with which it is delivered, and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of the work we do and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an over-arching intervention logic and system outcomes framework.

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

At the highest level, the framework reflects our three strategic objectives and aligns to three wellbeing goals, that we share with our regional DHB partners, where we believe our success will have a positive impact on the health of our population.

Aligned to each wellbeing goal, we have identified a number of population health indicators which will provide insight into how well our system is performing over time. The nature of population health is such that it may take a number of years to see marked improvements. Our focus is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

MAIN MEASURES OF PERFORMANCE

To evaluate our performance over the shorter-term, we have identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been selected as our main measures of performance.

We have set performance standards for these measures in order to evaluate our performance and determine if we are moving in the right direction. Tracking our performance in this way helps us to evaluate our success in areas that are important to our community and stakeholders and is an essential part of the way in which we hold ourselves to account.

These contributory measures sit alongside our annual Statement of Performance Expectations, outlining the service we plan to deliver and the standards we expect to meet in the coming year. They are also reflected in our System Level Measures Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

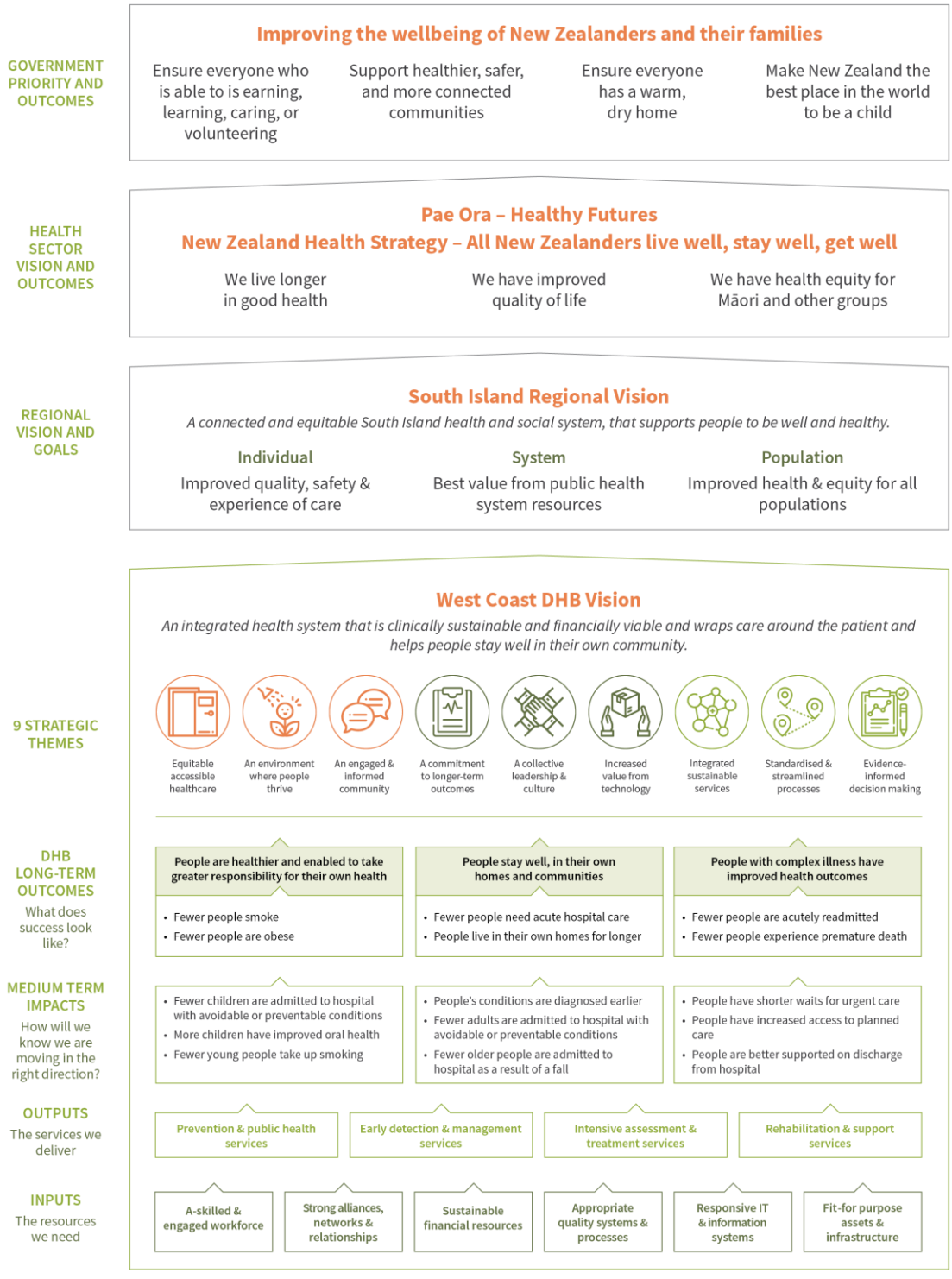
The intervention logic diagram on the following page demonstrates the anticipated value chain, by illustrating how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to the goals of the wider South Island region and delivers on the expectations of Government.

Our year-end service performance results are reported to our community in our Annual Report, alongside our year-end financial results. The DHB's Annual Reports can be found on our website www.wcdhb.health.nz

Our Statement of Performance Expectations for 2019/20 can be found in the Annual Operating Intentions section of this document (Section 4).

As a Crown entity, responsible for Crown assets, the DHB also provides regular financial and non-financial performance reporting to the Ministry of Health. The DHB's obligations under the Ministry's monitoring framework are highlighted in the DHB's Annual Plan.

Overarching Intervention Logic Diagram



Te Tiriti O Waitangi

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

Wellbeing Outcomes

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

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions. Cancers, heart disease, musculoskeletal conditions, respiratory disease, diabetes and mental illness are major drivers of poor health and premature mortality and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates that long-term conditions make up 87.3% of all health loss in New Zealand up from 82.5% in 1990.[5]

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN SMOKING RATES

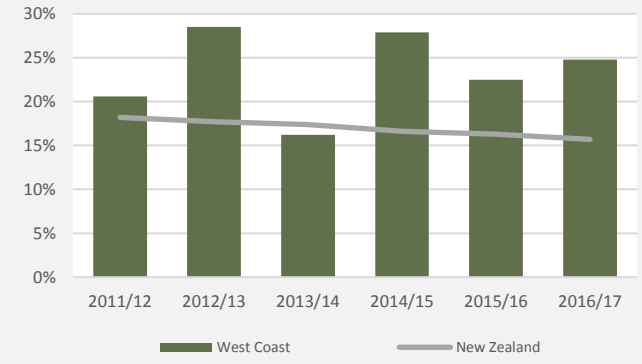
Smoking and exposure to second-hand smoke causes an estimated 4,627 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequities in health status between population groups.

Data Source: National NZ Health Survey [6]

Measure: proportion of the population (15+) who smoke



A REDUCTION IN OBESITY RATES

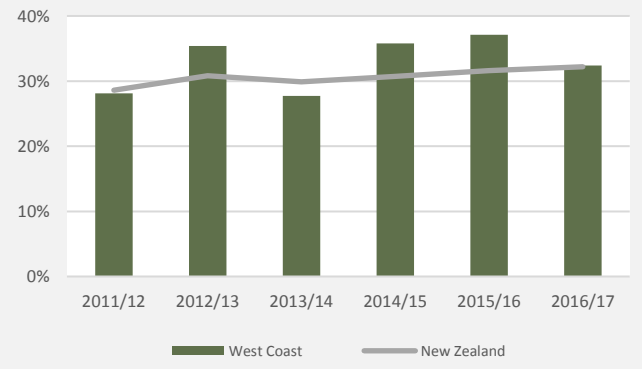
There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicities. Obesity is set to overtake tobacco as the leading risk to health and the most recent NZ Health Survey found 32% of all adults and 12% of children were obese.

Not only does obesity impact on the quality of people's lives, but it is a significant risk factor for many of the leading long-term conditions on the West Coast including heart disease, respiratory disease, diabetes and stroke.

Supporting people to achieve a healthier body weight is fundamental to improving people's wellbeing and to preventing poor health and disability at all ages.

Data Source: National NZ Health Survey [7]

Measure: proportion of the population (15+) who have obesity



[5] Ministry of Health, Health and Independence Report 2017

[6] The NZ Health Survey, commissioned by the Ministry of Health, collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. Every year about 14,000 households take part in the survey with total population results presented annually and ethnicity breakdowns presented over combined time periods (due to small population numbers). Smoking rates, by ethnicity, over the combined period 2014-2017 reflect 25.5% of the total West Coast population identified as current smokers, compared to 44.1% of our Māori population. Regional data from the 2017/18 Survey is due to be released in mid-late 2019.

[7] The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people. Rates by ethnicity over the combined period 2014-2017 reflect 35.2% of the total population identified as obese, compared to 55.5% of Māori.

FEWER AVOIDABLE HOSPITAL ADMISSIONS

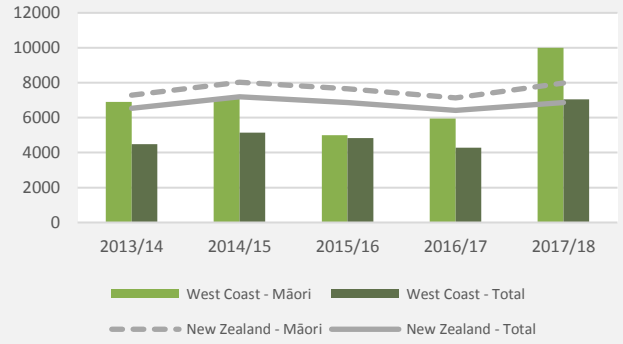
A number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, a reduction in risk factors and earlier intervention by primary and community services.

Ensuring children have the best start to life is a crucial component in the long-term health and wellbeing of our population and keeping children out of hospital is a priority. A reduction in preventable admissions will also free up hospital and specialist resources and reduce pressure on our health system.

This measure is seen as an indicator of the accessibility and effectiveness of health care and a marker of increased integration between health and social services. Disparities are evident for Māori children and closing this gap is a focus for the DHB.

Data Source: Ministry of Health DHB Performance Reporting [8]

Measure: Rate of ambulatory sensitive hospital admission for children (0-4)	Base	Target			
	17/18	19/20	20/21	21/22	22/23
	7,053	<6,871	<6,871	<6,871	<6,871



CHILDREN HAVE IMPROVED ORAL HEALTH

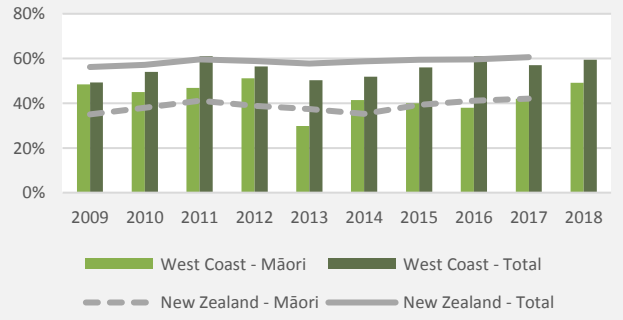
Poor oral health is a marker for a range of poor health outcomes in childhood and later in life. There is a direct link between good nutrition and good oral health, and good nutrition is also an important factor in supporting a healthy weight and reducing obesity.

Rates of early childhood caries (holes or fillings) are high on the West Coast, with significant disparities for Māori. Reducing this disparity provides a significant opportunity to improve long-term health outcomes for Māori children.

Improvements in the proportion of children caries-free at age five is seen as a proxy indicator of the effectiveness of mainstream services in reaching those most at risk. It is also an indicator of improved nutrition and wellbeing.

Data Source: School & Community Oral Health Services and Statistics NZ Population Projections

Measure: children caries-free at age five	Base	Target			
	2018	2019	2020	2021	2022
	59%	>60%	>60%	>60%	>60%



FEWER YOUNG PEOPLE TAKE UP SMOKING

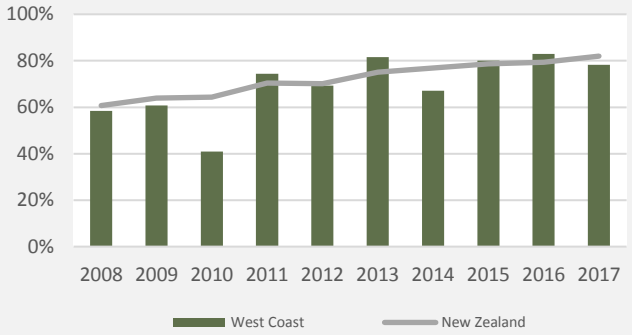
The highest prevalence of smoking is amongst younger people, and preventing young people from taking up smoking is a key contributor to reducing smoking rates across our total population.

Because Māori and Pacific people have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups and reduce inequities.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity and a change in the social and environmental factors that support healthier lifestyles.

Data Source: National ASH Year 10 Survey[9]

Measure: 'never smokers' amongst Year 10 students	Base	Target			
	2018	2019	2020	2021	2022
	78%	>79%	>79%	>79%	>79%



[8] This measure is a national System Level Measure and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and to reduce equity gaps between populations. The measure is a non-standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2018. ASH rates on the West Coast are disproportionately impacted by small population numbers and should be interpreted with caution. The number of events for Māori was 41 in 2017/18 compared with 25 events in 2016/17.

[9] The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. Run by Action on Smoking & Health the survey provides valuable insights into tobacco use trends amongst young people. The 2018 results were not available at the time of printing. For more detail see www.ash.org.nz.

3.13 People stay well, in their own homes and communities

WHY IS THIS A PRIORITY?

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

Health services also play an important role in supporting people to regain functionality after illness and supporting people to remain independent for longer. Even where returning to full health is not possible, access to responsive, needs-based rehabilitation, pain management and palliative care services can help to improve the quality of people's lives.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

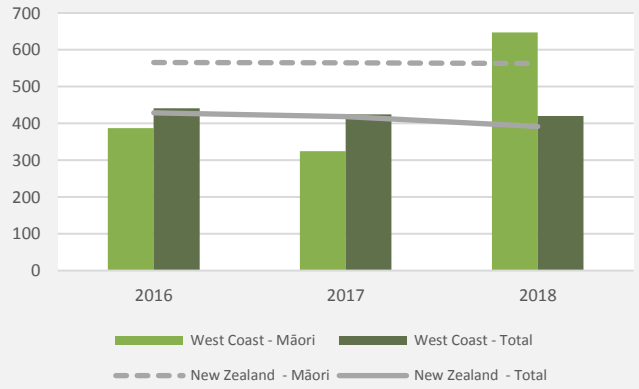
Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand.

Acute hospital bed-days are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatments that reduce crisis and deterioration. The measure also reflects the quality and effectiveness of discharge planning.

Reducing acute hospital admissions and the length of time people spend in our hospitals has a positive effect on people's health. It also enables more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care, allowing the DHB to provide more planned care.

Data Source: National Minimum Data Set[10]

Measure: rate of acute hospital bed-days (age standardised, per 1000 people)



MORE PEOPLE LIVING LONGER IN THEIR OWN HOME

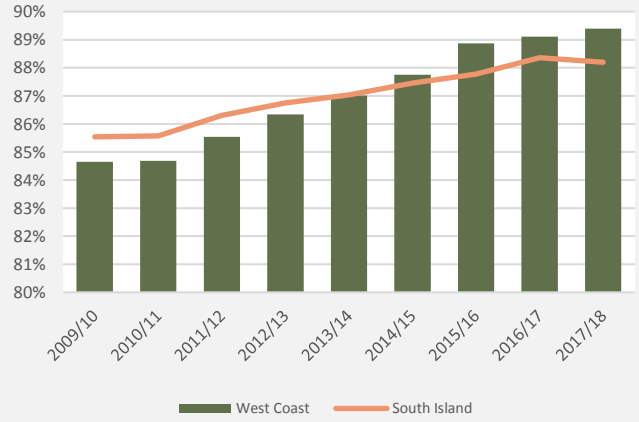
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes when people remain in their own homes and are positively connected to their local communities.

Living in residential care is also a more expensive option and resources could be better spent providing home-based support and packages of care to help people stay well in their own homes.

An increase in the proportion of older people living in their own homes is seen as a proxy indicator of how well the health system is managing age-related and long-term conditions, responding to the needs of our older population groups and enabling people's wishes to remain in their own homes,.

Data Source: SIAPO Client Claims Payment System

Measure: proportion of the population (75+) living in their own home



[10] This is a national System Level Measures and data is provided by the Ministry of Health via the national minimum data set. This is a newly introduced measure with only a three-year time period currently available for comparison, a longer-term view will build over time.

PEOPLE'S CONDITIONS ARE DIAGNOSED EARLIER

People want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

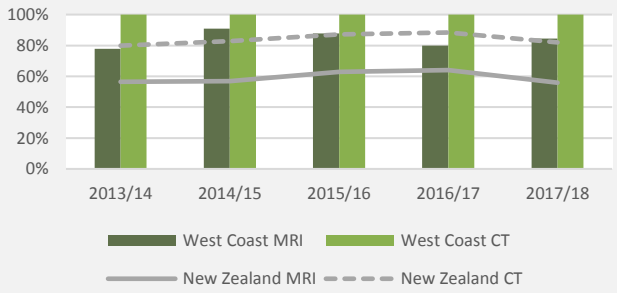
Timely access to diagnostics, by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes.

Wait times for diagnostics therefore can be seen as a proxy indicator of the responsiveness of our health system and our ability to match capacity with demand, particularly when we are seeking to minimise wait times and operating within a constrained environment.

Data Source: DHB Patient Management System[11]

Measure: people receiving non-urgent MRI or CT scan within six weeks

	Base	Target			
	17/18	19/20	20/21	21/22	22/23
MRI	84%	90%	90%	90%	90%
CT	100%	95%	95%	95%	95%



FEWER AVOIDABLE HOSPITAL ADMISSIONS

An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, risk factor reduction, earlier intervention and the effective management of long-term conditions.

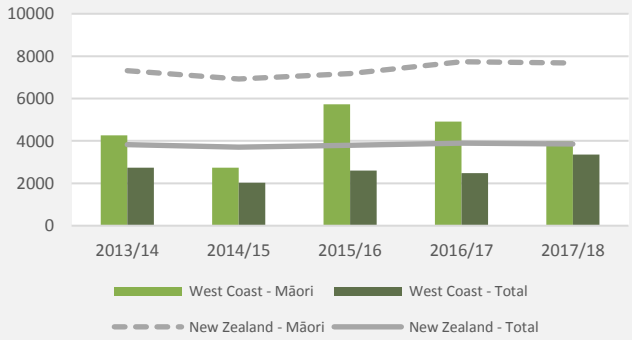
With the right approach, people can live healthier lives and minimise the deterioration of their condition that leads to acute illness or hospital admission. A reduction in avoidable admissions will also reduce pressure on hospital and specialist service resources.

A key factor in reducing avoidable hospital admissions is improved coordination between primary and secondary services. As such, this measure is seen as an indicator of the accessibility and effectiveness of primary care and a marker of a more integrated health system.

Data Source: Ministry of Health Performance Reporting [12]

Measure: Rate of ambulatory sensitive hospital admission for adults (45-64)

Base	Target			
17/18	19/20	20/21	21/22	22/23
3,350	<3,496	<3,496	<3,496	<3,496



FEWER FALLS-RELATED HOSPITAL ADMISSIONS

Compared to older people who do not fall, those who fall experience prolonged hospital stays, loss of confidence and independence and increased risk of institutional care.

With an ageing population, our focus on reducing harm from falls will help people stay well and independent and reduce the demand for hospital and residential services.

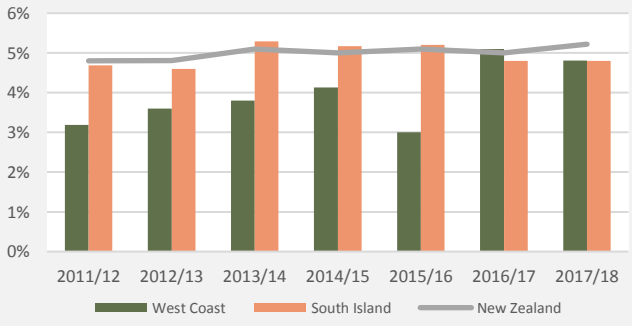
Solutions to preventing falls include appropriate medications use, improved physical activity and nutrition, access to restorative support and rehabilitation and a reduction in personal and environmental hazards.

This measure is seen as an indicator of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the services being provided.

Data Source: National Minimum Data Set[13]

Measure: population (75+) admitted to hospital as a result of a fall

Base	Target			
17/18	19/20	20/21	21/22	22/23
4.8%	<5.0%	<5.0%	<5.0%	<5.0%



[11] The radiology measures are national DHB performance indicators. Baselines differ to previously printed results, having been reset from year-end (June of each year) to full year (12 month) results.

[12] This measure is a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations. The measure is a standardised rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry to June 2018.

[13] The target has been set with the aim of maintaining rates below the national average. Small population numbers have a disproportionate impact on West Coast results, the difference between 2015/16 and 2016/17 was 52 people.

3.14 People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN AMENABLE MORTALITY

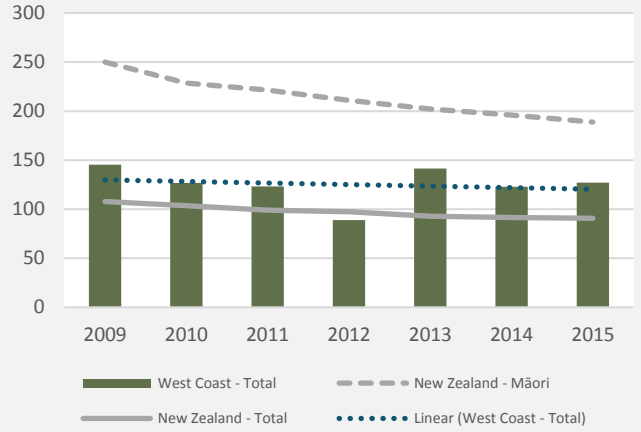
Amenable mortality is defined as premature death (before age 75) from conditions that could have been avoided through lifestyle change, earlier intervention, and the effective management of long-term conditions.

There are many economic, environmental and behavioural factors that have an influence on people's life expectancy. However, timely diagnosis, improved management of long-term conditions and access to safe and effective treatment are crucial factors in improving survival rates for most complex illnesses, such as cancer, diabetes and heart disease.

A reduction in the rate of amenable mortality can be used to reflect the responsiveness of the health system to the needs of people with complex illness, and as an indicator of access to timely and effective care.

Data Source: National Mortality Collection[14]

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



A REDUCTION IN ACUTE READMISSIONS

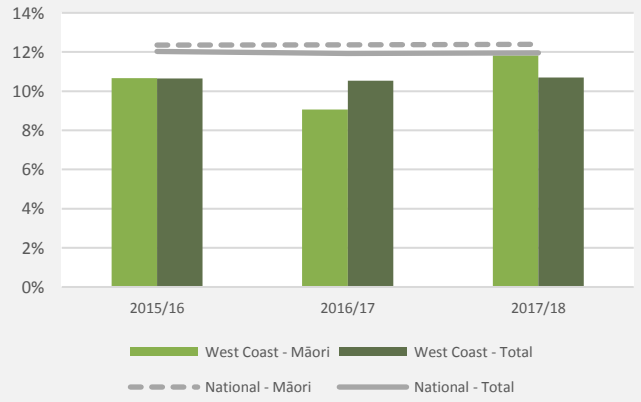
As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

Key factors in reducing acute readmissions include patient safety and quality standards, discharge planning and care coordination at the interface between services. Ensuring people receive effective treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided, and the integration between service providers. These rates are also a good balancing-measure to productivity measures such as reductions in lengths of stay.

Data Source: Ministry of Health Performance Reporting [15]

Measure: rate of acute readmissions to hospital within 28 days of discharge (standardised) per 100,000 people



[14] The performance data for this measure is sourced from the national mortality collection which is three years in arrears and excludes rates where there are fewer than 30 deaths recorded. Ethnicity breakdowns are therefore not available for the West Coast. Note: 2015 results are provisional.

[15] This data is provided by the Ministry of Health and sourced from the National Minimum Data Set. Data is provided three months in arrears, with results being the year to March 2018. This measure has a new national definition and a longer-term view will build over time.

SHORTER WAITS FOR URGENT CARE

Emergency Departments (EDs) are often seen as a barometer of the effectiveness, efficiency and responsiveness of the hospital and wider health system.

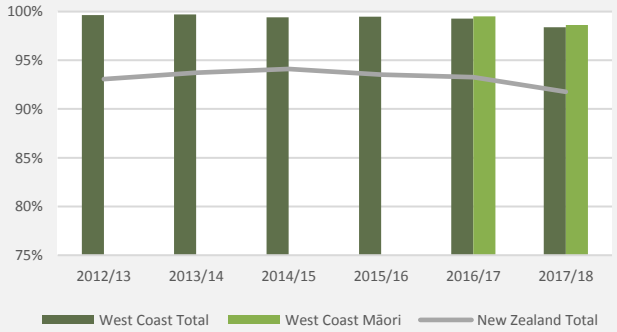
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improved patient outcomes, by enabling early intervention and treatment, but will improve public confidence and trust in our health services.

Solutions to reducing ED wait times address the underlying causes of delay and span not only hospital services but the wider health system, ensuring that only those who require emergency services present to ED. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Data Source: DHB Patient Management System [16]

Measure: people admitted, discharged or transferred from ED within 6 hours

Base	Target			
17/18	19/20	20/21	21/22	22/23
98%	95%	95%	95%	95%



SHORTER WAITS FOR PLANNED CARE

Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort, slowing the progression of disease and helping to restore independence and wellbeing.

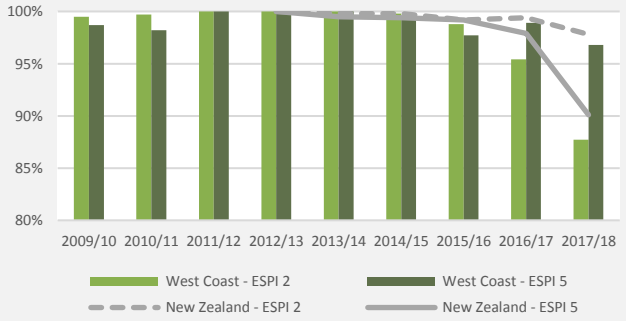
Improved performance against these measures requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our system, a proxy for how well we are managing the flow of patients across our services.

Data Source: Ministry of Health Elective Services Website [17]

Measure: people receiving specialist assessment and treatment within set time frames

Base	Target			
17/18	19/20	20/21	21/22	22/23
ESPI2 88%	100%	100%	100%	100%
ESPI5 97%	100%	100%	100%	100%



PEOPLE ARE SUPPORTED ON DISCHARGE

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

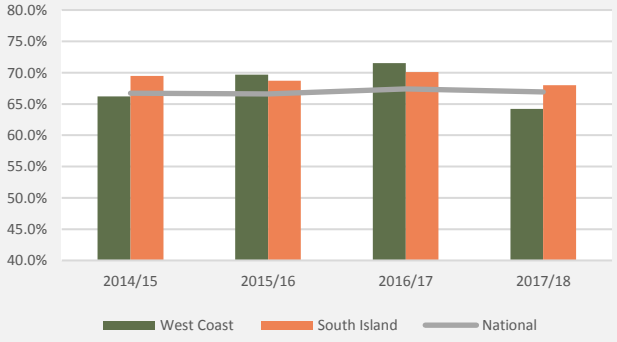
A responsive community support system and continuity of care is an essential element in helping people with complex conditions to maintain clinical and function ability and to establish a more stable lifestyle with improved quality of life.

In this sense, this indicator is a marker of good discharge planning, integration and the continuity of care between hospital and community services and an indicator of a strong and responsive mental health system.

Data Source: National Mental Health KPI Framework.

Measure: inpatients accessing community-based MH and AOD services within seven days of discharge

Base	Target			
17/18	19/20	20/21	17/18	19/20
64%	80%	80%	80%	80%



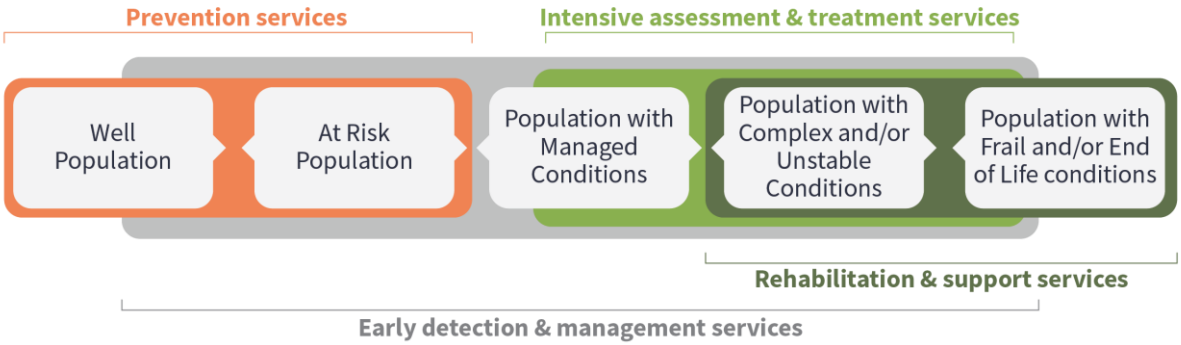
[16] This measure is a national DHB performance indicator, but no longer a national health target, baselines differ to previously printed results having been reset from the quarter four year-end results (April-June) to full year (12 month) results.

[17] These measures are part of the national Elective Services Patient Flow Indicators (ESPIs) set and are a measure of whether DHBs are meeting expectations at key point in a patient's journey. ESPI 2 refers to the wait from referral to a person's first specialist assessment. ESPI 5 refers to the wait from the point from when treatment was agreed until treatment is delivered. The results presented refer to performance in the final month of each year (June).

THE YEAR AHEAD

What can you expect from us?

Statement of Performance Expectations



4.1 Evaluating our performance

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

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

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes. These longer-term health outcomes are highlighted in the Monitoring Our Performance section above.

On an annual basis, we evaluate our performance by providing a statement of performance expectations i.e. a forecast of the services we plan to deliver and the standards we expect to meet. The results are presented in our Annual Report at the end of the year.

The following section presents the West Coast DHB's Statement of Performance Expectations for 2019/20.

IDENTIFYING PERFORMANCE MEASURES

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

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

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

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

To ensure a balanced, well-rounded picture, the mix of measures identified address four key aspects of service performance that matter most to our population:

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

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

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

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

SETTING STANDARDS

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

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

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

It's not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region. Service level estimates have been provided to give context in terms of the use of resources across our health system.

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

UNDERSTANDING PERFORMANCE EXPECTATIONS

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB.

All of our performance targets are universal, set with the aim of reducing disparities between population groups. A number of key focus areas have been identified to improve Māori health. These are signalled with the following symbol (◆). These service measures will be reported by ethnicity in our year-end Annual Report to highlight progress in achieving this goal.

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

NOTES FOR THE READER

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

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

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

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

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

◆ This measure has been identified as a key focus area for Māori. Progress by ethnicity will be reported in the DHB's Annual Report.

4.2 Where does the money go?

In 2019/20 the DHB will receive approximately $159.6 million dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2019/20, by service class.[18]

	2019/20
Revenue	
Prevention	3,528
Early detection & management	30,573
Intensive assessment & treatment	103,800
Rehabilitation & support	21,751
Total Revenue - $'000	159,652
Expenditure	
Prevention	3,990
Early detection & management	32,524
Intensive assessment & treatment	107,662
Rehabilitation & support	22,089
Total Expenditure - $'000	166,265
Surplus/(Deficit) - $'000	(6,613)

[18] The DHB's financial position for 2019/20 is yet to be approved by the Ministry of Health and may be subject to change with approval of the DHB's 2019/20 Annual Plan.

4.3 Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Health Services – Healthy Environments				
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [19]	15	14	E. 15
Licensed alcohol premises identified as compliant with legislation	Q [20]	85%	95%	90%
Networked drinking water supplies compliant with Health Act	Q [21]	95%	63%	97%

Health Promotion and Education Services				
These services inform people about risk factors and support them to make healthy choices. Success is evident through high levels of engagement with services.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Mothers receiving breastfeeding support and lactation advice in community settings	A	208	191	>100
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q [22]◆	77%	72%	75%
Babies exclusively/fully breastfed at three months	Q ◆	56%	61%	70%
People provided with Green Prescriptions for additional physical activity support	A [23]	558	458	>400
Green Prescription participants more active six to eight months after referral	Q	-	65%	>50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC) in the last 15 months	Q ◆	91%	88%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q [24]◆	93%	91%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q [25]◆	95%	98%	90%

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

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

[21] This measure relates to the percentage of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies: large, medium, minor, small and rural agricultural.

[22] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. These breastfeeding measures are part of the national Well Child/Tamariki Ora Quality Framework, data from providers is not able to be combined so performance from the largest provider (Plunket) is presented. Updated information has allowed baselines to be reset to present a full (12 month) result rather than the final quarter (six months) as previously presented.

[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 bi-annual national patient survey completed by Research NZ on behalf of the Ministry of Health.

[24] The ABC programme has a cessation focus and refers to health professionals asking about smoking status, providing Brief advice and providing Cessation support. The provision of professional advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts. The baselines for the hospital smoking measure has been reset to present full year (12 month) results, rather than the final quarter of each year (April-June).

[25] This data is sourced from the national Maternity Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance. Standards have been set nationally in line with other smoking targets, baselines differ to previous year being reset to present full year results.

Population-Based Screening Services				
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Four-year-olds provided with a B4 School Check (B4SC)	A [26]◆	90%	98%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q [27]◆	81%	96%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A [28]◆	75%	74%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A [28]◆	77%	72%	70%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Children fully immunised at eight months of age	A [29]◆	82%	83%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q	97%	96%	95%
Young people (Year 8) completing the HPV vaccination programme	A [30]†◆	39%	39%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A [31]†◆	55%	56%	75%

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

[27] Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational attainment and quality of life. The referral allows families to access support to maintain healthier lifestyles. This is a national performance measure and baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter result (Jan-June).

[28] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment. The measures refer to national screening programmes results and standards.

[29] The West Coast has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR). This makes reaching the target extremely challenging. The DHB's focus is to immunise all those who opt-in to the immunisation programme. 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided with advice to enable them to make informed choices for their children - but may have chosen to decline immunisations or opt off the NIR. Baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter of the year (April-June) as previously presented.

[30] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing cervical cancer later in life. The vaccination programme consists of two vaccinations and is free to young women and men under 26 years of age. The target groups for 2019/20 is the proportion of young people born in 2006 completing the programme during the year. Baseline results refer to young women only, the programme was widened in 2019/20.

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

4.4 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

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

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

Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and reduces the burden of long-term conditions through improved self-management and the avoidance of complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

General Practice Services				
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A ◆	90%	94%	95%
New-borns enrolled with a PHO by three months of age	A [32]◆	77%	83%	85%
Young people (12-19) accessing brief intervention/counselling in primary care	A [33]Δ	200	215	>150
Adults (20+) accessing brief intervention/counselling in primary care	A [33]Δ	548	527	>450
Number of integrated HealthPathways in place across the health system	Q [34]	655	632	E. >600
Proportion of general practices offering the primary care patient experience survey	E [35]	new	86%	100%

Long-Term Condition Services				
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A [36]◆	3,860	4,099	E>3,500
Population identified with diabetes having an annual LTCM review	A ◆	74%	79%	>90%
Population with diabetes, having an HbA1c test at their LTCM review, showing acceptable glycaemic control (HbA1c <64 mmol/mol)	Q [37]◆	54%	54%	>60%

[32] This is a national performance measure and results have been reset in June 2019 as national data sources move from the PHO register to the National Enrolment Service (NES). The Ministry of Health provided estimates for DHB's annual enrolment rates for 2018 and 2019 based off the new system.

[33] Brief intervention/counselling aims to support people with mild to moderate mental health concerns to improve their health outcomes and quality of life. The service includes the provision of free counselling sessions and extended GP consultations.

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

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

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

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

Oral Health Services				
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Children (0-4) enrolled in DHB funded oral health services	A [38]†◆	97%	108%	95%
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T †◆	93%	95%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A †	75%	77%	85%

Pharmacy and Referred Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of subsidised pharmaceutical items dispensed in the community	A Δ	466k	460k	E.<500K
People being dispensed 11 or more long-term medications (rate per 1,000)	Q [39]†	4.2	4.5	E. <4.4
Number of community-referred radiological tests delivered at Te Nikau	A	5,817	6,199	E.>5,000
People receiving their urgent diagnostic colonoscopy within two weeks	T [40]	90%	90%	90%
People receiving their Magnetic Resonance Imagining (MRI) scans within six weeks	T [40]	80%	84%	90%
People receiving their Computed Tomography (CT) scan within six weeks	T [40]	100%	100%	95%

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

[39]The use of multiple medications is most common in the elderly and can lead to reduced drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and high costs for the system with little health benefit. Multiple medication use requires monitoring and review to validate whether all of the medications are complementary and necessary. Data is sourced from the HQSC Atlas of Healthcare Variation.

[40] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and, by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). The radiology measures are national DHB performance indicators referring to wait times for non-urgent scans. Baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results.

4.5 Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually (but not always) provided in hospital settings, which enables the collocation of expertise and equipment. A proportion of these services are delivered in response to acute events, others are planned, and access is determined by clinical triage, treatment thresholds, capacity, and national service coverage agreements.

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Staff compliant with good hand hygiene practice	Q [41◇]	80%	82%	80%
Inpatients (aged 75+) receiving a falls risk assessment	Q ◇	91%	92%	90%
Response rate to the national inpatient patient experience survey	E [42◇]	28%	58%	>30%
Proportion of inpatients who responded in the survey that 'hospital staff included their family/whānau or someone close to them in discussions about their care'	E ◇	76%	53%	65%

Specialist Mental Health and Alcohol and Other Drug (AOD) Services				
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Proportion of the population (0-19) accessing specialist mental health services	A [43Δ]	5.3%	5.4%	>3.8%
Proportion of the population (20-64) accessing specialist mental health services	A Δ	5.7%	5.9%	>3.8%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T [44]	76%	81%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	89%	95%	95%

[41] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. Standards are set nationally and in line with national reporting results for the quality measures refer to the final quarter of each year (April-June). The 2017/18 results have been update to reflect the final quarter's results which were not available at the time of printing the 2017/18 annual report. Further detail and quarterly results for several years can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[42] There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers and family-centred care have been linked to improved health and clinical, financial, service and satisfaction outcomes. The DHB inpatient experience survey covers four domains of patient experience: communication, partnership, co-ordination and physical and emotional needs. Response rates to the national survey vary around the country with an average of 25% across all DHBs in June 2018, with four DHBs achieving above 30%. West Coast aims to be consistently at this level. Further detail and full results can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[43] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. West Coast rates are high and with part of the DHB's strategy being to better support people earlier and closer to home, it is expected that rates will come down over time. Data is sourced from the national PRIMHD dataset and results are three months in arrears.

[44] Timely access to appropriate intervention and treatment, by reducing long waits for diagnosis or treatment, contributes to improved quality of care and health outcomes and improves people's confidence in the health system. These measures are national DHB performance indicators and standards are set nationally. Data is sourced from the national PRIMHD database and results are three months in arrears.

Maternity Services				
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A [45]†◆	79%	80%	80%
Number of maternity deliveries in West Coast DHB facilities	A	250	264	E. 250
Baby friendly hospital accreditation achieved in DHB facilities	Q [46]	Yes	Yes	Yes

Acute and Urgent Services				
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of presentations at the Te Nikau Emergency Department (ED)	A [47]	11,382	11,616	E.<13,000
Proportion of people (Triage 1-3) presenting in ED, seen within clinical guidelines	T [48]	79%	82%	85%
Proportion of the population presenting at ED (per 1,000 people)	Q	342	356	<356
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T [49]	68%	80%	90%
Average acute inpatient length of stay (bed days per 1,000 people)	Q [50]	2.36	2.34	2.30

Elective and Arranged Services				
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of First Specialist Assessments provided	A	7,232	7,022	E.>6,000
Number of planned care intervention delivered	A [51]	new	new	3,211
Average elective inpatient length of stay (bed days per 1,000 people)	Q	1.34	1.20	1.45
Number of outpatient consultations provided	A	15,479	14,328	E.>13,000
Proportion of outpatient appointments provided by telemedicine	Q [52]	3.3%	4.2%	>5%
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [53]Δ◆	5.6%	6.13%	<6%

[45] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report the 2017/18 data is yet to be released.

[46] 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.

[47] This measure is aligned to the national shorter stays in ED indicator and excludes those who do not wait and those with pre-arranged appointments.

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

[49] This is a national DHB performance measure and baselines differ to previously printed results, having been reset from final quarter (rolling six months from Jan-June of each year) to full year (12 month) results. There was a definition change for this measure in 2017/18, allowing patients to delay their treatment or for treatment to be delayed due to clinical considerations without impacting on the result, 2016/17 results are therefore not directly comparable.

[50] By shortening the average length of a hospital stay, the DHB delivers on the national improved hospital productivity priority and frees up resources to provide more elective (planned) surgery. Addressing the factors that influence length of stay includes reducing the rate of complications and infection and activity to support patients to return home sooner. This is a national DHB performance indicator and standards are set nationally.

[51] The new planned care intervention measure reflects a change in national expectation that continues to recognise the delivery of elective surgery but also recognises the delivery of minor procedures and non-surgical interventions that are required to improve people's health and wellbeing. The new measure also recognised interventions delivered in both hospital and community settings. The West Coast's planned care interventions target is made up of three components: elective surgical discharges (1,883), Minor Procedures (1,230) and Non-Surgical Interventions (9).

[52] Increasing value from technology is a key strategic focus for the DHB and the use of telehealth or videoconferencing technology helps to reduce unnecessary travel for patients, their families and clinical staff – particularly when specialists are based in other DHBs. This measure has been updated to reflect the proportion of total outpatient appointments delivered using telehealth.

[53] When patients fail to turn up to appointments, it can negatively affect their recovery and long-term outcomes, and it is costly in terms of wasted resources for the DHB. This measure is the proportion of all medical and surgical outpatient appointments where the patient was expected to attend but did not.

4.6 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

These services are considered to provide people with a much higher quality of life as a result of being able to stay active and positively connected to their communities. Even when returning to full health is not possible, access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness, crisis or deterioration of function, these services have a major impact on the sustainability of our health system, by reducing acute service demand and the need for more complex interventions or residential care. These services also support patient flow by enabling people to go home from hospital earlier.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services restore or maximise people's health following a health-related event and service utilisation is monitored to ensure people are appropriately supported.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
People supported by the Flexible Integrated Rehabilitation Support Team (FIRST)	A [54]	yes	2	10
People (65+) supported by the community-based In-Home Falls Prevention Service	A [55]	117	148	>120
Proportion of inpatients referred to an organised stroke service after an acute event	Q [56]	89%	96%	80%
Proportion of AT&R inpatients discharged home rather than into residential care	Q[57Δ]	79%	90%	80%

Home-Based Support Services				
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Number of Meals on Wheels provided	A [Δ]	33,772	34,977	E. <35,000
People supported by district nursing services	A [Δ]	1,628	1,645	E. >1,000
People supported by long-term home-based support services	A [Δ]	1,079	1,211	E. >1,000
Proportion of people supported by long-term home-based support services who have had a clinical assessment of need (using InterRAI) in the last 12 months	Q [58Δ]	93%	91%	95%

Aged Residential Care Services				
While demand will increase as our population ages, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2016/17 Result	2017/18 Results	2019/20 Target
Proportion of the population (75+) accessing rest home level services in ARC	A [59Δ]	4.6%	4.4%	E.<6.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A [Δ]	6.2%	6.6%	E.<6.5%
Proportion of the population (75+) accessing dementia services in ARC	A [Δ]	0.8%	1.2%	E. 1.0%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A [Δ]	0.5%	0.6%	E. 0.4%
People entering ARC having had a clinical assessment of need using InterRAI	Q [Δ]	100%	100%	95%

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

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

[56] This is a national DHB performance measure. Baselines differ to previously printed results, being reset from final quarter to full year results, one quarter in arrears.

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

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

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

Statement of Financial Performance Expectations

4.7 West Coast's financial outlook

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

While health continues to receive a large share of government funding, if we are to be sustainable, we must rethink how we will meet our population's need within a more moderate growth platform.

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

Over-reliance on locum staff: Difficulties in recruiting staff to the rurality of the West Coast means the DHB has to rely heavily on locums to fill gaps. While the use of locums allows services to be maintained in the short term, this reduces continuity of care for patients and is an expensive and unsustainable solution.

The costs of inter-district flow: Each DHB is funded to cover the cost of services provided to their resident population. Because of our small size, we rely on larger DHBs to provide more complex specialist services for our population and must pay for those services. While the service prices are set nationally, cost increases have historically exceeded annual funding increases.

In addition, we are in the midst of a significant facilities redevelopment and remediation programme which adds further financial pressure including:

The costs of seismic remediation: The level of remediation required to attain moderate compliance with current building codes will put significant financial pressure on the DHB. While some of the more immediate repairs have been completed, the remainder form part of the future facilities build.

The cost of building delays: Delays in completion of our Grey Base and IFHC redevelopments increase construction costs and delay anticipated operational savings as efficiencies cannot be realised.

There is no easy solution. Improving the health of our population is the only way to reduce the demand curve. Savings will be made, not in dollar terms, but in costs avoided through more effective use of available resources. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system. The DHB is committed to continuing its deliberate strategy in this regard.

4.8 Planned results

The West Coast DHB is predicting a $6.613 million-dollar deficit result for the 2019/20 year.

It is anticipated that the West Coast DHB will receive funding, from all sources, of approximately $159.7m to meet the needs of our population in 2019/20.

This represents a 3.26% increase on the previous year and whilst this equates to a $5m increase in funding, it includes revenue for pay equity settlements which come with associated expenditure. The DHB's forecast is based on receiving the minimum percentage funding increase available to DHBs in 2019/20.

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

MAJOR ASSUMPTIONS

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

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

- Population-based funding levels for 2019/20 are based on the funding advice received by the Ministry in May 2019 and further updated with Planned Care funding advice in June 2019.
- Out-years funding is assumed at an average of 2.41% increase per annum.
- The West Coast DHB will continue to receive Crown Funding on an early payment basis.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Funding for all aspects of pay equity settlements will be cost neutral and fully funded. We have assumed that additional funding will be received from the Crown for the expired settlements that are currently being negotiated. The quantum of this revenue has been assumed as cost neutral over the anticipated 2% previously advised and included.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluations. External provider increases will also be settled within available funding levels.

- The approved forecasted deficit will be funded via Crown deficit support (equity injections).
- Work will continue on the facilities redevelopment for Grey Base under the nationally appointed Hospital Redevelopment Partnership Group.
- Work will continue on the facilities redevelopment for Buller Integrated Family Health Centre project, managed by West Coast DHB and governed by West Coast Partnership Group
- The associated costs and capital expenditure for the Grey Base redevelopment have been included in the capital budget with an estimated completion date of late 2019.

  The net operating result, for 2019/20 and out-years, reflects the modelling as per the detailed business case approved by Cabinet in 2014 (adjusted for the 2014/15 transitional funding repayment as well as known changes such as capital charge changes).

  Given the recent changes to debt and equity, the project will be 100% equity funded by the Crown. As a consequence, future operating costs associated with financing the development will increase significantly after the interim funding arrangements in relation to this change cease (anticipated after year two).
- Revaluations of land and building will continue and will impact on asset values. In addition to periodic revaluations, further impairment in relation to redevelopment and remediation of our facilities may be necessary.
- Treatment related costs will increase in line with known inflation factors, reasonable price impacts on providers and foreseen adjustments for the impact of growth within services.
- National and regional initiative savings and benefits will be achieved as planned.
- Transformation will not be delayed due to sector or legislative changes and investment to meet increased demand will be prioritised and approved in line with the Board's strategy.
- There will be no further disruptions associated with pandemics or natural disasters.

4.9 Closing the gap

Alongside the transformation of our health services we are focused on efficiency improvements that will take the wait and waste out of our system.

The DHB will carefully consider all opportunities and options to ensure the most effective use of all available resources including:

- Integrating systems and services and improving production planning to ensure we use our resources in the most effective way.
- Streamlining and standardising processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.
- Prioritising services that deliver maximum health benefit and are sustainable long-term.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Tightening cost growth including moderating treatment, back office, support and FTE costs.

Service changes proposed for the coming year are outlined in the Managing Our Business section of this document.

4.10 Capital investment

GREYMOUTH REDEVELOPMENT

In December 2012, the Minister of Health appointed the Hospital Redevelopment Partnership Group (HRPG) to govern the West Coast DHB's facility redevelopment. The West Coast HRPG provides project governance, which includes oversight of the project programme and budget.

In 2014, approval was given for a new Grey Base Hospital and IFHC redevelopment. Construction commenced on the combined project in May 2016 with completion originally scheduled for June 2018. Completion is now scheduled for the third quarter of 2019/20. The revised budget for this development is currently $77.8m and it is expected that there will be additional costs. At this stage we anticipate an additional $10-13m. These additional costs will be finalised in due course.

The redevelopment includes a second tranche which will include the upgrade/replacement of other aspects of the Grey Base site.

Planning for redevelopment of the mental health facility is also expected to start in 2019.

BULLER REDEVELOPMENT

In Buller, the DHB and clinical teams have worked together with an appointed design team to develop a full concept design for the IFHC development.

An Implementation Business Case has been progressed and options submitted to the HRPG, as we move closer to bringing this facility to life.

In December 2018 the $20m Buller IFHC project was approved, with the ongoing project management moving to West Coast DHB.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, the business as usual capital expenditure budget totals $3.987m for the 2019/20 year. In addition to the normal capital requirements, the Grey redevelopment requires greater investment in capital equipment than would normally be afforded, for example additional Information and Technology infrastructure.

Strategic capital for 2019/20-2021/23 comprises of:

- Mental health redevelopment (notionally $5m).
- Te Nikau furniture, fit out and equipment (notionally $1.7m).
- Reefton IFHC redevelopment (notionally $4m).
- Phased upgrade of clinics outside Westport and Greymouth (notionally $0.450m per clinic).
- Secondary tranche Grey Base redevelopment (notionally $5m).
- Move to the South Island Patient Information Care System (notionally $1.8m).
- Investment in other strategic IT/integration systems, including regional IT systems, (notionally $0.5m - $1m per annum).

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

4.11 Debt and equity

Te Nikau is now expected to be completed in the third quarter of 2019/20 at which time the asset will be transferred from the Ministry of Health to the DHB. Following the asset transfer, the Ministry will simultaneously increase the equity of the DHB for the value of the build.

The West Coast DHB will require deficit funding (equity) in order to offset the deficits signalled in outlying years. The DHB is also repaying $68K equity annually as part of an agreed FRS-3 funding repayment programme with the Ministry of Health.

4.12 Additional considerations

SUBSIDIARY COMPANY AND PARTNERSHIPS

With an annual budget of just over $5m, the South Island Alliance Programme Office is jointly funded by the five South Island DHBs to provide audit, project management and regional service development services. West Coast's contribution for 2019/20 will be approximately $0.170m.

With an annual budget of over $9.3m, the New Zealand Health Partnership Limited is jointly funded by all 20 DHBs to enable DHBs to collectively maximise and benefit from shared service opportunities. West Coast DHB's contribution to the running of the Health Partnership for 2019/20 will be approximately $0.2m.

DISPOSAL OF LAND

The DHB currently has a stock of assets, consisting of properties and parcels of land right across the West Coast, a number of which have existing leasehold arrangements. The DHB is engaged in an ongoing process of considering the future of these assets based on future models of care and facilities requirements.

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

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

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

ACCOUNTING POLICIES

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

4.13 Statement of comprehensive income – year ending 30 June

As at 30 June for the years ending 2017/18 to 2021/23 [60]

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited Actual	Unaudited Actual	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Income						
Ministry of Health revenue	**136,789**	**142,732**	147,127	150,937	154,855	158,876
Patient related revenue	7,187	7,249	7,746	7,401	7,512	7,623
Other operating income	4,812	4,303	4,577	4,646	4,715	4,786
Interest income	380	330	204	205	208	211
Total Income	**149,168**	**154,614**	159,654	163,189	167,290	171,496
Operating Expenses						
Personnel	60,132	67,605	66,649	69,802	71,546	73,235
Outsourced services (clinical and non clinical)	8,663	8,708	9,113	9,190	9,283	9,374
Treatment related costs	8,919	8,018	8,265	8,688	8,819	8,951
External service providers (include Inter-district outflow)	58,152	64,519	66,388	67,053	67,553	68,051
Depreciation & amortisation	2,911	3,390	3,226	4,174	4,073	4,282
Interest expenses	-	-	-	-	-	-
Other expenses	11,935	12,517	11,648	11,968	10,863	11,004
Total Operating Expenses	**150,712**	**164,757**	**165,289**	**170,875**	**172,137**	**174,897**
Operating surplus before capital charge	**(1,544)**	**(10,143)**	**(5,635)**	**(7,686)**	**(4,847)**	**(3,401)**
Capital charge expense	1,387	1,407	978	6,559	7,759	8,959
Surplus / (Deficit)	**(2,931)**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**
Other comprehensive income						
Revaluation of land and Buildings	**(3,599)**	**-**	-	-	-	-
Total Comprehensive Income	**668**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**

[60] The financial position for 2019/20 is yet to be approved by the Ministry of Health and may be subject to change with approval of the DHB's Annual Plan.

4.14 Statement of financial position – year ending 30 June

As at 30 June for the years ending 2017/18 to 2021/23 [64]

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited Actual	Unaudited Actual	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
CROWN EQUITY						
General funds	85,994	85,926	191,932	206,108	218,646	250,937
Revaluation reserve	25,681	25,098	25,098	25,098	25,098	25,098
Retained earnings	(85,968)	(96,935)	(103,548)	(117,793)	(130,399)	(142,759)
TOTAL EQUITY	**25,707**	**14,089**	**113,482**	**113,413**	**113,345**	**133,276**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	11,724	6,362	4,460	3,793	4,176	2,607
Trade & other receivables	3,725	3,931	4,428	3,931	3,931	3,931
Inventories	1,058	1,077	1,098	1,077	1,077	1,077
Assets classified as held for sale	-	-	-	-	-	-
Investments (3 to 12 months)	-	-	-	-	-	-
Restricted assets	54	56	56	56	56	56
TOTAL CURRENT ASSETS	**16,561**	**11,426**	**10,042**	**8,857**	**9,240**	**7,671**
CURRENT LIABILITIES						
Trade & other payables	11,917	12,582	12,779	11,611	11,602	11,608
Capital charge payable	-	-	-	-	-	-
Employee benefits	7,525	14,052	13,893	14,052	14,052	14,052
Restricted funds	71	62	62	62	62	62
Borrowings	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES	**19,513**	**26,696**	**26,734**	**25,725**	**25,716**	**25,722**
NET WORKING CAPITAL	**(2,952)**	**(15,270)**	**(16,692)**	**(16,868)**	**(16,477)**	**(18,051)**
NON CURRENT ASSETS	-	-	-	-	-	-
Investments (greater than 12 months)	519	320	320	320	320	320
Property, plant, & equipment	30,137	31,062	131,778	129,647	128,957	150,050
Intangible assets	446	376	499	2,713	2,943	3,357
TOTAL NON CURRENT ASSETS	**31,102**	**31,758**	**132,597**	**132,680**	**132,220**	**153,727**
NON CURRENT LIABILITIES						
Employee benefits	2,443	2,399	2,423	2,399	2,398	2,400
Borrowings	-	-	-	-	-	-
TOTAL NON CURRENT LIABILITIES	**2,443**	**2,399**	**2,423**	**2,399**	**2,398**	**2,400**
NET ASSETS	**25,707**	**14,089**	**113,482**	**113,413**	**113,345**	**133,276**

4.15 Statement of movement in equity – year ending 30 June

As at 30 June for the years ending 2017/18 to 2021/23 [64]

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Audited Actual	Unaudited Actual	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
Total Equity at Beginning of the Period	25,107	25,707	14,088	113,482	113,413	113,345
Total Comprehensive Income	668	(11,550)	(6,613)	(14,245)	(12,606)	(12,360)
Other Movements						
Contribution back to Crown - FRS3	-	-	-	-	-	-
Contribution from Crown - Capital	-	-	100,000	-	-	20,000
Contribution from Crown - Operating Deficit Support	-	-	6,074	14,245	12,606	12,360
Other Movements	(68)	(68)	(68)	(68)	(69)	(68)
Total Equity at End of the Period	**25,707**	**14,088**	**113,482**	**113,413**	**113,345**	**133,276**

4.16 Statement of cashflow – year ending 30 June

As at 30 June for the years ending 2017/18 to 2021/23 [64]

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Actual	Forecast	Plan	Plan	Plan	Plan
	$'000	$'000	$'000	$'000	$'000	$'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	136,808	142,861	147,127	150,937	154,855	158,876
Other receipts	12,689	12,327	11,766	18,803	9,773	14,838
Interest received	420	330	204	205	208	211
	149,917	**155,519**	**159,097**	**169,945**	**164,836**	**173,925**
Cash was applied to:						
Payments to employees	67,444	68,123	74,586	77,897	79,004	81,155
Payments to suppliers	77,056	86,864	87,828	89,024	89,169	95,254
Interest paid	-	-	-	-	-	-
Capital charge	1,296	1,407	978	6,559	7,759	8,959
GST - net	362	(157)	(451)	213	34	-
	146,158	**156,237**	**162,941**	**173,693**	**175,966**	**185,368**
Net Cashflow from Operating Activities	**3,759**	**(718)**	**(3,844)**	**(3,748)**	**(11,130)**	**(11,443)**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	7	(24)	-	-	-	-
Receipt from sale of investments	-	-	-	-	-	-
	7	(24)	-	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	(135)	-	-	-	-
Purchase of property, plant, & equipment	2,785	4,687	13,064	3,464	2,664	2,664
	2,785	**4,552**	**13,064**	**3,464**	**2,664**	**2,664**
Net Cashflow from Investing Activities	**(2,778)**	**(4,576)**	**(13,064)**	**(3,464)**	**(2,664)**	**(2,664)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection - Capital	-	-	9,000	-	-	-
Equity Injection - Deficit Support	-	-	6,074	6,613	14,245	12,606
Loans Raised	-	-	-	-	-	
	-	**-**	**15,074**	**6,613**	**14,245**	**12,606**
Cash applied to:						
Equity Repayment	68	68	68	68	68	68
Other	-	-	-	-	-	
	68	**68**	**68**	**68**	**68**	**68**
Net Cashflow from Financing Activities	**(68)**	**(68)**	**15,006**	**6,545**	**14,177**	**12,538**
Overall Increase/(Decrease) in Cash Held	913	(5,362)	(1,902)	(667)	383	(1,569)
Add Opening Cash Balance	10,811	11,724	6,362	4,460	3,793	4,176
Closing Cash Balance	**11,724**	**6,362**	**4,460**	**3,793**	**4,176**	**2,607**

4.17 Summary of Revenue and Expenses by Arm – year ending 30 June

As at 30 June for the years ending 2017/18 to 2021/23 [64]

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Funding Arm	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	135,636	141,835	146,111	149,902	153,794	157,789
Patient Related Revenue	-	-	-	-	-	-
Other	1,789	2,165	2,386	2,423	2,459	2,495
Total Revenue	137,426	144,000	148,497	152,325	156,253	160,284
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-	-
Personal Health	95,415	102,373	104,682	106,502	108,181	109,883
Mental Health	14,549	15,126	15,832	16,064	16,300	16,541
Disability Support	21,590	22,416	23,129	23,308	23,490	23,676
Public Health	642	631	635	641	647	652
Maori Health	814	824	842	845	848	850
Governance & Admin	826	828	840	874	887	900
Total Expenditure	133,836	142,198	145,960	148,234	150,353	152,502
Net Surplus/(Deficit)	**3,589**	**1,802**	**2,537**	**4,091**	**5,900**	**7,782**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**3,589**	**1,802**	**2,537**	**4,091**	**5,900**	**7,782**

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Governance Arm	Audited Actual $'000	Unaudited Actual $'000	Plan $'000	Plan $'000	Plan $'000	Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	2,828	865	889	922	934	950
Total Revenue	2,828	865	889	922	934	950
Expenditure						
Personnel	1,167	1,130	1,184	1,213	1,241	1,265
Outsourced services	943	974	915	919	929	938
Depreciation	1	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	717	415	450	468	472	475
Total Expenditure	2,828	2,519	2,549	2,600	2,642	2,678
Net Surplus/(Deficit)	**1**	**(1,654)**	**(1,660)**	**(1,678)**	**(1,708)**	**(1,728)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**1**	**(1,654)**	**(1,660)**	**(1,678)**	**(1,708)**	**(1,728)**

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

As at 30 June for the years ending 2017/18 to 2021/23 [64]

Provider Arm	2017/18 Audited Actual $'000	2018/19 Unaudited Actual $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Revenue						
MoH Revenue	1,153	897	1,016	1,035	1,062	1,085
Patient Related Revenue	7,187	7,249	7,746	7,401	7,512	7,623
Other	77,746	79,284	81,079	82,688	84,329	86,007
Total Revenue	86,086	87,430	89,841	91,124	92,903	94,715
Expenditure						
Personnel	58,965	66,475	65,465	68,589	70,305	71,970
Outsourced services	7,720	7,735	8,198	8,271	8,354	8,436
Depreciation	2,910	3,390	3,226	4,174	4,073	4,282
Interest & Capital Charge	1,387	1,407	978	6,559	7,759	8,959
Other	21,624	20,120	19,462	20,187	19,209	19,479
Total Expenditure	92,606	99,127	97,329	107,780	109,700	113,126
Net Surplus/(Deficit)	**(6,520)**	**(11,697)**	**(7,488)**	**(16,656)**	**(16,797)**	**(18,411)**
Other Comprehensive Income	(3,599)	-	-	-	-	-
Total Comprehensive Income	**(2,921)**	**(11,697)**	**(7,488)**	**(16,656)**	**(16,797)**	**(18,411)**

In House Elimination	2017/18 Audited Actual $'000	2018/19 Unaudited Actual $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Revenue						
MoH Revenue	-	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-	-
Other	(77,171)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Total Revenue	(77,171)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Expenditure						
Personnel	-	-	-	-	-	-
Depreciation	-	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-	-
Other	(77,170)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Total Expenditure	(77,170)	(77,680)	(79,572)	(81,181)	(82,800)	(84,451)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**

CONSOLIDATED	2017/18 Audited Actual $'000	2018/19 Unaudited Actual $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Revenue						
MoH Revenue	136,789	142,731	147,127	150,937	154,856	158,874
Patient Related Revenue	7,187	7,249	7,746	7,401	7,512	7,623
Other	5,192	4,634	4,782	4,852	4,922	5,001
Total Revenue	149,169	154,614	159,655	163,190	167,290	171,498
Expenditure						
Personnel	60,132	67,605	66,651	69,804	71,547	73,238
Outsourced services	8,663	8,709	9,113	9,190	9,283	9,374
Depreciation	2,911	3,390	3,226	4,174	4,073	4,282
Interest & Capital Charge	1,387	1,407	978	6,559	7,759	8,959
Other	79,007	85,053	86,300	87,708	87,234	88,005
Total Expenditure	152,101	166,164	166,268	177,435	179,896	183,858
Net Surplus/(Deficit)	**(2,931)**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**
Other Comprehensive Income	(3,599)	-	-	-	-	-
Total Comprehensive Income	**668**	**(11,550)**	**(6,613)**	**(14,245)**	**(12,606)**	**(12,360)**

APPENDICES

Further Information

5

Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Minister's Letters of Expectation 2019/20
Appendix 3	Statement of Accounting Policies

Documents of interest

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

- West Coast DHB Annual Plan
- West Coast System Level Measures Improvement Plan
- West Coast DHB Public Health Action Plan
- West Coast DHB Disability Action Plan
- West Coast DHB Quality Accounts
- South Island Regional Health Services Plan

References

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

Appendix 1 Glossary of Terms

Alliance	The West Coast Alliance	The Alliance is a collective alliance of healthcare leaders, professionals and providers from across the West Coast providing leadership to enable the transformation of our health system in collaboration with system partners and on behalf of the population.
CCCN	Complex Clinical Care Network	The Complex Clinical Care Network is a multidisciplinary team providing a single point of referral for patients from general practice, ambulance and inpatient services. Under the restorative delivery model, clients are assessed using comprehensive assessment tools and an individual goal-based care plan is developed with them.
	Crown Entity	Crown Entity is a generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister but are included in the financial statements of the Government.
ERMS	Electronic Referral Management System	ERMS is a system available from the GP desktop which enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including: wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in West Coast, Canterbury and South Canterbury and rolling out across the remainder of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring that needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in New Zealand.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs in New Zealand with a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them. PHOs provide these services either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Primary Care	Professional health care provided in the community, usually from a general practice, covering a broad range of health and preventative services and often a person's first level of contact with the health system.
	Secondary Care	Specialist or complex care that is typically provided in a hospital setting.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Highly specialised care often only provided in a smaller number of locations.

Appendix 2 Minister's Letters of Expectation 2019/20

Hon Dr David Clark

MP for Dunedin North

Minister of Health Associate Minister of Finance

Ms Jenny Black
West Coast District Health Board
PO Box 387
Greymouth, 7840

12 JUL 2019

Tēnā koe Jenny

UPDATE: Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out an update to the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20. This builds on my December 2018 letter, attached for your reference. I want to emphasise that my strong focus remains on the expectations set out in that letter.

I also want to acknowledge your engagement with the important conversations we have been having on improving financial sustainability and clinical performance.

While I recognise there are a number of challenges, it is my expectation that DHBs ensure their local communities can access high quality sustainable services that deliver equitable outcomes.

Wellbeing Budget

Budget 2019 is about delivering better wellbeing for all New Zealanders and driving intergenerational change. There are five key priorities – taking mental health seriously, improving child poverty, supporting Māori and Pasifika aspirations, building a productive nation, and transforming the economy.

Budget 2019 builds on last year's Vote Health investment. A record $19.871 billion is being invested for 2019/20 to support a stronger, more sustainable health and disability system.

Our Government has signalled a willingness not just to invest, but also to make the fundamental changes needed to deliver long term and sustainable change. Budget initiatives are also based around evidence on what will make the greatest contribution to the long term improvement of living standards and wellbeing.

Monitoring improved performance

High performing DHBs are needed to support the delivery of the Government's priorities. I am concerned about the sector's overall financial position, and some areas of service performance.

As you are aware I have worked with the Ministry of Health (Ministry) to ensure DHB performance is supported through a stronger performance programme. This will help DHBs to be more sustainable, and to improve financial and clinical performance to ensure better and more equitable outcomes for New Zealanders. I have made it clear that you have a responsibility to address the range of performance challenges in partnership with the Ministry.

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Your DHB's performance will be reported to me regularly, and I support the use of data and benchmarking to identify variation as well as opportunities for improvement. This will also support collaboration across DHBs regionally and nationally to make the most of our collective capability. I expect all DHBs to contribute to, and participate in, such work to help ensure the system is safe, equitable, efficient, and maximises the resource use across the whole system.

Fiscal responsibility

I have made my expectations on improving financial performance very clear, and DHBs need to have a plan to return to financial sustainability.

You have been provided with your confirmed budget allocations for 2019/20 and I expect you to be considering ways to contain expenditure, including maximising available capability and resources in the system, tightly managing recruitment and staff leave, and improving consistency of clinical pathways and decision-making.

Continuing to do things in the same way as we are now is not sustainable operationally, clinically or financially. There will be a dedicated focus in 2019/20 on strengthening sustainability planning and establishing an on-going sustainability programme.

You will be aware that Budget 2019 invests an extra $94.7 million over four years to help improve DHB financial sustainability. This new funding will enable DHBs to work more collaboratively across your regions, to share and build on best practice, to implement new service models that transform the way we use workforce and facilities, and to make the best use of the available funding and capacity in your region.

Capital investment

Budget 2019 invests $1.7 billion over two years for capital investment projects, building on last year's investment to restore our hospitals and health facilities. This funding will be prioritised for mental health projects, high growth areas with increased demand, and health facilities that are no longer fit for purpose. I urge that in all investment, environmental sustainability be a significant consideration.

Some business cases for new infrastructure projects are already well advanced and have been indicatively prioritised for consideration. I expect this process to be completed with DHBs being advised of the outcomes in July/August 2019.

The Ministry of Business, Innovation and Employment is developing a new framework which will focus on skills development and training as a requirement of construction projects. New construction procurement guidelines will also be applied across government. I expect you to apply the changes to the procurement of new construction projects.

National Asset Management Plan

In the long term, we need to better map out future infrastructure requirements. This will enable the Government to make more informed decisions, and better prioritise remediation work and plan for new facilities.

I am pleased that you are actively supporting the National Asset Management Plan programme of work. I expect that any requests for information from the project team are responded to in a timely manner.

It is also my expectation that you will update your DHB's Asset Management Plans. These are a requirement of the Ministry, and will assist in the formulation of the capital investment pipeline, and the ongoing work on the National Asset Management Plan.

The Budget also provides some funding to lift capacity and capability within the Ministry, notably to establish a new health infrastructure unit that will provide better support to DHBs.

Update on my priority areas

Improving child wellbeing

As you know, child wellbeing is a key priority for this Government. I expect your annual plans to reflect how you are actively working to improve childhood immunisation coverage and eliminate inequity, especially for Māori.

As I have said in my earlier letter of expectations, I expect you to support the reduction of family violence and sexual violence through addressing abuse as a fundamental healthcare responsibility.

Improving mental wellbeing

Mental health and addiction is a top priority in the Wellbeing Budget with $1.9 billion over four years being invested into a range of mental wellbeing initiatives and mental health and addiction facilities. These strongly align with the Government's response to He Ara Oranga, the report of the independent inquiry into mental health and addiction.

We have a unique opportunity to improve the mental health and wellbeing of all New Zealanders. We need to embed a focus on wellbeing and equity at all points of the system. We also need to focus more on mental health promotion, prevention, identification, and early intervention.

It is my expectation that you will work closely with the Ministry and key partners in your region to help drive this transformation; your leadership is essential.

Improving wellbeing through prevention

Our Government's vision is for a welfare system that ensures people have an adequate income and standard of living, are treated with respect, can live in dignity and are able to participate meaningfully in their communities. DHBs have an important and ongoing role working alongside social sector partners to improve the welfare and health system outcomes for their population.

I have introduced a new priority section in DHB annual plans, given the considerable overlaps between people engaging with the welfare system as well as the health and disability support system. Over half the proportion of working age people receiving a main benefit have a health condition or a disability, or care for someone with a health condition or disability.

Better population health outcomes supported by a strong and equitable public health and disability system

Planned Care

I am confident that the changes to how planned care is planned, funded and monitored will remove the current disincentives to developing better ways of delivering services.

The new planned care approach will enable DHBs to deliver more appropriate, timely, high quality services to support the health and wellbeing of New Zealanders. DHBs will be able to provide care in the most appropriate setting, with the right workforce.

There will also be a greater focus on equity, quality, and people's experience of our services. I expect DHBs to create robust plans for these services and to consistently meet volume, waiting time, and other quality expectations.

Cancer Action Plan

I have asked the Ministry to work with you and other stakeholders to develop a Cancer Action Plan. I expect you to support and drive the development of this important work, and to deliver on the local actions within your Plan.

Health Research Strategy Implementation

Research, evidence and innovation is critical to addressing inequities and in continuously improving the quality and outcomes of services provided.

I am aware that the Ministry is working with DHBs and other government agencies to develop a work programme to implement the Health Research Strategy. I encourage you to continue to work closely with the Ministry to progress this important work.

Workforce

DHBs have a key role in training our health and disability workforce. I expect that all DHBs continue to maintain a strong focus on this area to build capacity and capability, and to implement an equitable approach to funding professional development.

In your current annual plan I expect you to develop a sustainable approach to nursing career pathways, including actions to support equitable funding for professional development for nurse practitioners.

Care Capacity Demand Management

At the end of last year I outlined my expectation that DHBs are to implement Care Capacity Demand Management (CCDM) in line with the process and timetable set out in the 2018-2020 MECA.

I expect to see significant progress on CCDM implementation this year, as well as detailed planning to ensure full implementation by June 2021.

I expect you to confirm that you have met my expectation to include implementing CCDM in the performance expectations of your Chief Executive and that you are updating these expectations to include implementation in midwifery services.

Devolution of the pay equity appropriation

I have supported the devolution of the pay equity appropriation. I expect you to work with the Ministry to ensure a seamless transition of responsibilities.

The Ministry has an ongoing stewardship responsibility to ensure that Care and Support Workers (Pay Equity) Settlement Act obligations are met.

The Government's agenda to improve the health and wellbeing of New Zealanders is significant, as evidenced by the sizable investments being made. I am confident that DHBs will present strong plans to support delivery of our priorities and I am looking forward to seeing progress against both measures and activities during the year.

I have appreciated the willingness shown by DHB teams to focus on equity and outcomes, and have confidence that you will all embrace the direction and implement plans to deliver it.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

19 DEC 2018

Ms Jenny Black
Chair
West Coast District Health Board

Dear Jenny

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

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Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing

carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Appendix 3 Statement of Accounting Policies

The prospective financial statements in this Statement of Intent and in the DHB's Annual Plan for the year ended 30 June 2017 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ GAAP, as appropriate for public benefit entities. PBE FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Annual Plan.

REPORTING ENTITY AND STATUTORY BASE

West Coast District Health Board ("West Coast DHB") was established by the NZ Public Health and Disability Act 2000. The 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 has designated itself and its subsidiaries, as public benefit entities (PBEs) for financial reporting purposes.

The 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. The DHB does not operate to make a financial return.

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

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 consolidated 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 public sector PBE accounting standards.

Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: land and buildings.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value.

Functional and presentation currency

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

Changes in accounting policies

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

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

The purchase method is used to prepare the consolidated financial statements, which involves adding together like items of assets, liabilities, equity, income and expenses on a line-by-line basis. All significant intragroup balances, transactions, income and expenses are eliminated on consolidation.

West Coast DHB's investments in its subsidiaries are carried at cost in West Coast DHB's own "parent entity" financial statements.

Subsidiaries

Subsidiaries are entities controlled by West Coast DHB. Control exists when West Coast DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

West Coast DHB measures the cost of a business combination as the aggregate of the fair values, at the date of exchange, of assets given, liabilities incurred or assumed, in exchange for control of subsidiary plus any costs directly attributable to the business combination.

Associates

Associates are those entities in which West Coast DHB has significant influence, but not control, over the financial and operating policies.

The consolidated financial statements include West Coast DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When West Coast DHB's share of losses exceeds its interest in an associate, West Coast DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that West Coast DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

West Coast DHB's investments in associates are carried at cost in West Coast DHB's own "parent entity" financial statements.

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. Unrealised gains arising from transactions with associates are eliminated to the extent of West Coast DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus /deficit.

Budget figures

The budget figures are those approved by West Coast DHB in its Annual Plan (incorporating the Statement of Intent) which is tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by West Coast DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are:

- freehold land
- freehold buildings and building fitout
- leasehold buildings
- plant, equipment and vehicles
- work in progress

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Revaluations

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expense. Any decreases in value relating to land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in other comprehensive revenue. Additions to land and buildings between valuations are recorded at cost.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

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

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.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

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

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to West Coast DHB. All other costs are recognised in the surplus or deficit when incurred.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss is recognised in the surplus or deficit. It is calculated as the difference between the net sales price and the carrying amount of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Depreciation

Depreciation is charged to the surplus or deficit using the straight-line method so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. Land is not depreciated.

The estimated useful lives of major classes of assets and resulting rates are:

Class of Asset	**Year**	**Dep Rate**
Freehold Buildings & Fitout	10 – 80	1.25 -10%
Leasehold Buildings	3 - 20	5 - 33%
Plant, Equipment and Vehicles	3 - 12	8.3 - 33%

The residual value of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and West Coast DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Staff training and other costs associated with maintaining computer software are recognised as an expense when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Amortisation

Amortisation is charged to the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are:

Type of asset	Estimated life	Amortisation rate
Software	2-10 years	10 - 50%

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified.

A receivable is considered impaired when there is evidence that West Coast DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Other inventories are stated at cost (calculated using the weighted average method).

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

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Impairment

The carrying amounts of West Coast DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset, at which point it is recognised in the surplus or deficit.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in other comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in other comprehensive income is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in other comprehensive income.

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where West Coast DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

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 other comprehensive income, a reversal of the impairment loss is also recognised in other comprehensive income.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Impairment of property, plant, equipment and intangible assets

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 and intangible assets 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. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost using the effective interest method.

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

Employee entitlements

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit plans

West Coast DHB makes contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which 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 or deficit will affect future contributions by individual employers, as there is no prescribed basis for allocations. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave, retirement gratuities and sick leave

West Coast DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the year-end date. West Coast DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. The sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent West Coast DHB anticipates it will be used by staff to cover those future absences.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

Presentation of employee entitlements

Non vested long service leave and retirement gratuities are classified as non-current liabilities; all other employee entitlements are classified as current liabilities.

Provisions

A provision is recognised when West Coast DHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

ACC WSMP (Work Place Safety Management Programme)

West Coast DHB currently belongs to the ACC WSMP programme whereby the DHB receives a discount on levies by maintaining the appropriate audit standards on a bi-annual basis. West Coast DHB estimates the unpaid ACC levy and recognises a provision for this estimate.

Trade and other payables

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

Income tax

West Coast DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

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/deficits.

Revaluation reserve

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

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

The net GST paid to, or received from Inland Revenue, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed as exclusive of GST.

Revenue

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.

Rental revenue

Lease revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

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.

Donations and bequests

Donations and bequests received with restrictive conditions are treated as a liability until the specific terms from which the funds were derived are fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

Vested or donated physical assets

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

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

Donated services

Volunteer services received are not recognised as revenue or expenses by the group.

Operating lease payments

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of disposal group) are not depreciated or amortised while they are classified as held for sale.

Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with NZ GAAP requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. These estimates and assumptions may differ from the actual results. The estimates and underlying assumptions are reviewed on an ongoing basis.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

Property, plant and equipment useful lives and residual value

At each balance date West Coast DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires West Coast DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by West Coast DHB, advance in medical technology, and expected disposal proceeds from the future sale of the assets.

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
- Analysis of prior asset sales.

In light of the Canterbury earthquakes, West Coast DHB has reviewed the carrying value of land and buildings, resulting in an impairment.

Other than this review, West Coast DHB has not made any other significant changes to past assumptions concerning useful lives and residual values.

Retirement and long service leave

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any change in these assumptions will impact on the carrying amount of the liability.

Leases classification

Determining whether a lease agreement is a 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.

Non-government grants

West Coast DHB must exercise judgement when recognising grant income to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

Statement of Intent

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