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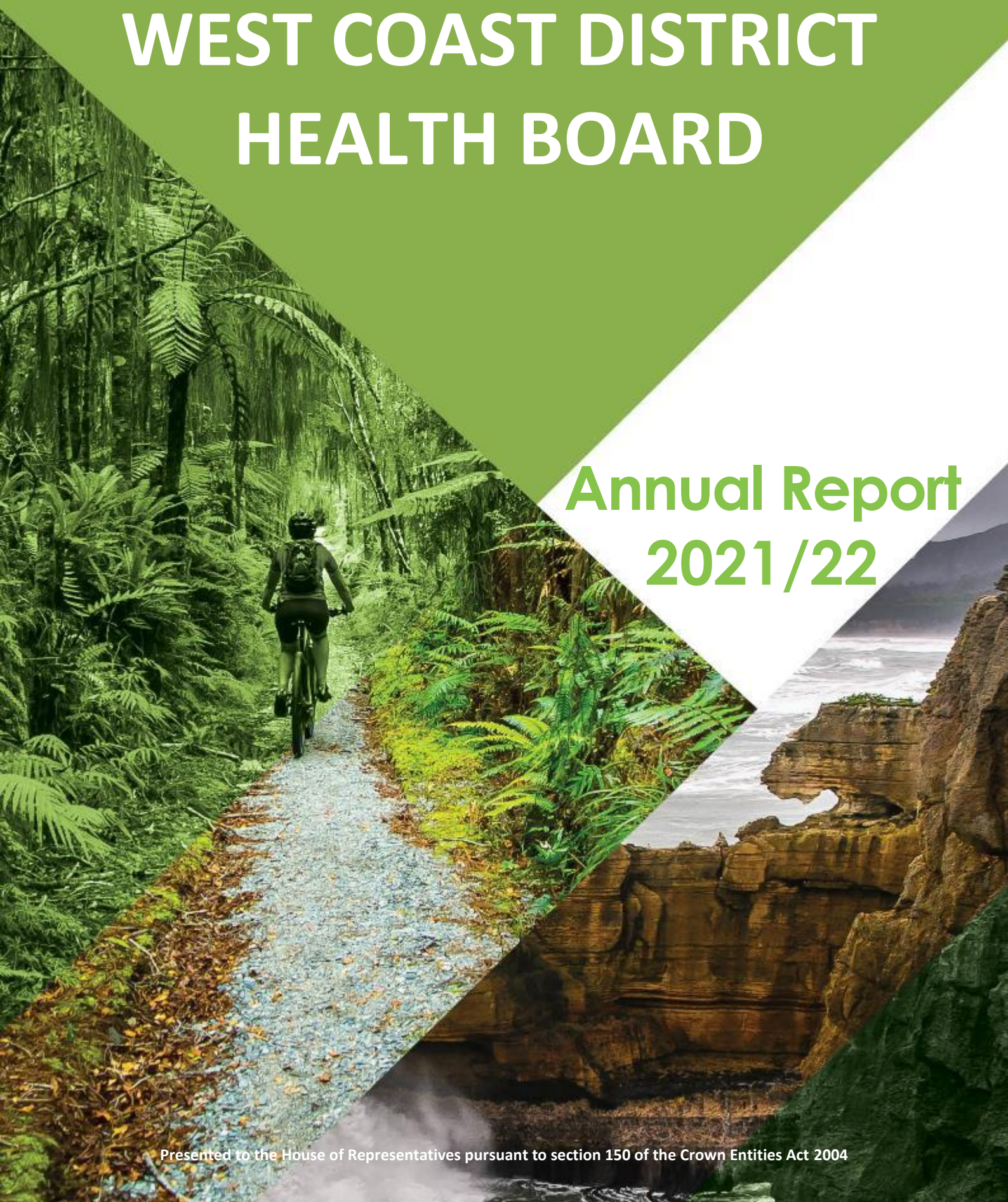
WEST COAST DISTRICT HEALTH BOARD



Annual Report 2021/22

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

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Board Members

Hon Rick Barker, Chair
Tony Kokshoorn, Deputy Chair
Chris Auchinvole
Susan Barnett
Sarah Birchfield
Helen Gillespie
Anita Halsall-Quinlan
Edie Moke
Peter Neame
Nigel Ogilvie
Francois Tumahai

Chief Executive

Dr Peter Bramley

Registered Office

West Coast District Health Board
PO Box 387
71-111 Waterwalk Road
Greymouth

New Zealand Business Number

9429000098038

Auditor

Audit New Zealand on behalf of the Auditor-General

Banker

Bank of New Zealand

Part I
Overview

Statutory Information

This Annual Report presents West Coast DHB's financial and non-financial performance for the year ended 30 June 2022. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (n) of the same Act.

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

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

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

Statement of Responsibility

For the 12 months ended 30 June 2022

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the West Coast DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

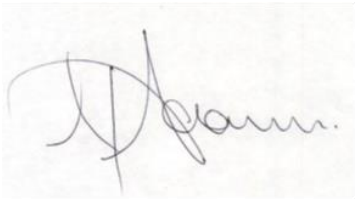
The Board and Management of Te Whatu Ora take responsibility for the preparation of the West Coast District Health Board group's financial statements and statement of performance, and for the judgements made in them.

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

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

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the West Coast District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:



Naomi Ferguson
Acting Chair
Dated: 22 March 2023

Amy Adams
Board Member
Dated: 22 March 2023

Part II
Improving Outcomes

Are We Making A Difference?

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

As a DHB we had several different roles and associated responsibilities. In our governance role we strived to improve health outcomes for our population and the sustainability of our health system. As a funder, we were concerned with the effectiveness of the health system and the return on our investment in terms of health outcomes. As an owner and provider of services, we were focused on the quality of the care delivered, the efficiency with which it was delivered and the safety and wellbeing of the people who work for us.

Because of the wide scope of our responsibilities, there is no single performance measure or indicator that could easily reflect the impact of this work. Instead, in line with our vision for the future of our health system, we developed an overarching intervention logic and an outcomes framework to help us monitor and evaluate our performance over time.

At the highest level, the framework reflected three strategic objectives and identified three wellbeing goals, where we believed our success would have a positive impact on the health of our population.

Aligned to each wellbeing goal, we identified a small number of long-term population health indicators which provided insight into how well our system performed over time. The framework encompassed national direction and expectations through the inclusion of national targets and system level measures.

Because the nature of population health means it may take several years to see marked improvements against these outcome indicators, our focus in this space was to develop and maintain positive trends over time, rather than to achieve annual fixed targets.

To evaluate our performance over the shorter term, we identified a secondary set of contributory measures, where our service performance impacted on the outcomes we were seeking. Because change will be evident over a shorter period, these contributory (or impact) measures were selected as our main measures of performance.

Tracking our performance against these indicators helped us to evaluate our success in areas that are important to our community, our Board and Government. As such, we set performance standards for these contributory measures to determine if we were moving in the right direction.

These medium-term impact measures sat alongside our annual Statement of Performance Expectations (the following section of this report), which outlined the services we planned to deliver and the standards we expected to meet in 2021/22. Collectively these measures formed an essential part of the way in which we were held to account.

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

As part of our obligations under legislation, DHBs worked towards achieving equity for all population groups. To promote this goal, the standards set were the same for all population groups. As a means of evaluating whether we made a difference in reducing inequities, performance has been reported by ethnicity wherever information is available.

The intervention logic framework on the following page illustrates how we anticipated the services that we fund or deliver (annual outputs) would impact on the health of our population, contribute to the longer-term population health outcomes desired, and deliver on the expectations and priorities of Government.

West Coast DHB - Overarching Intervention Logic Framework

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

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.[1]

WHERE ARE WE FOCUSED?

Tobacco smoking, inactivity, poor nutrition and hazardous drinking and substance abuse are major risk factors for many 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 their 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.

OUTCOME MEASURE – A REDUCTION IN SMOKING RATES

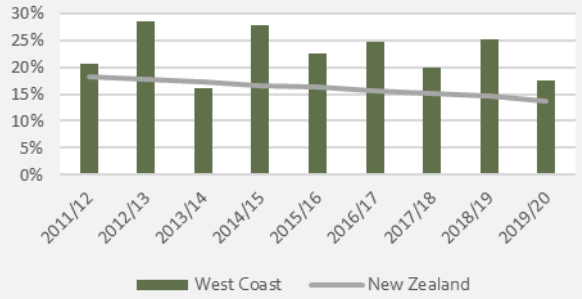
The 2019-20 NZ Health Survey (the latest available with DHB breakdowns) reports that 18% of the West Coast population were current smokers. A positive trend is clear with total population smoking rates falling from 2011/12 but rates remain slightly higher than the New Zealand population.

Combined results from 2017-2020 Surveys show that, like national trends, smoking rates continue to be highest amongst our Māori population (31%) compared with 21% for the total population. Positively, our Māori rates have dropped significantly over this time reflecting our equity focus on these populations.

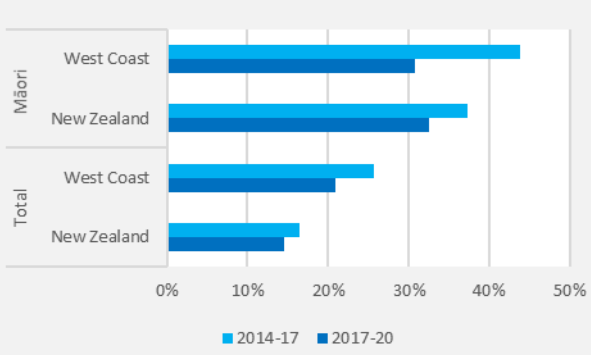
Providing smokers with brief advice to quit smoking at every opportunity increases their chances of making a quit attempt. The likelihood of that quit attempt being successful is increased if cessation support is also provided. We continued to invest in work to help our community understand the health risks associated with smoking with brief advice to quit being offered through primary care and in our hospitals.

We focused on the delivery of key messages and cessation support to pregnant women. In 2021/22, 88% of pregnant women, identified as smokers when registering with a lead maternity carer, were offered brief advice and support to quit smoking.

Proportion of the population (15+) who currently smoke



Proportion of the population (15+) who currently smoke



Data source: National NZ Health Survey [2]

[1] Ministry of Health, Health and Independence Report 2017.

[2] The NZ Health Survey is an annual survey commissioned by the Ministry of Health which collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. The 2019/20 Survey is the most recently released time series available and while total population results are presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers. For further information refer to the Ministry website for the NZ Health Survey results.

OUTCOME MEASURE – A REDUCTION IN OBESITY RATES

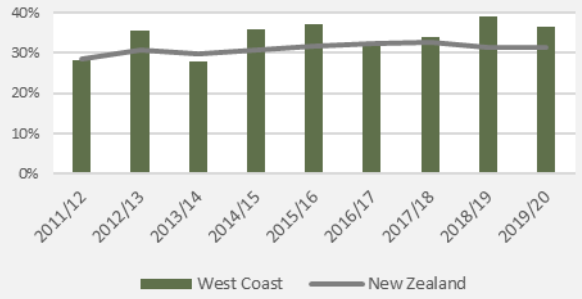
Like smoking, obesity impacts on the quality of people's lives and is a significant risk factor for many long-term conditions. The health system has a key role in supporting the creation of health promoting environments and the delivery of programmes that encourage and support people to make healthier choices.

The 2019/20 NZ Health Survey reported that West Coast's obesity rate was slightly higher than the national rate at 36% vs 31%. Combined results from 2017-2020 showed a similar pattern but, like smoking, West Coast Māori have a lower obesity rate compared to the national average at 45% compared with 48%.

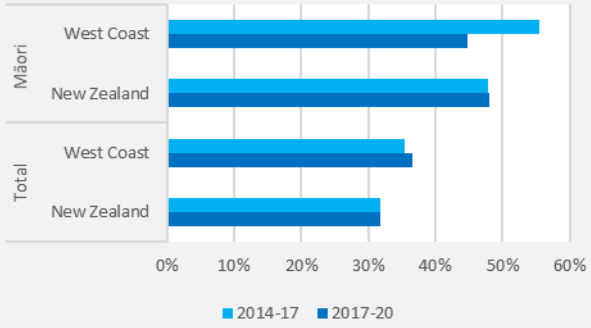
Our public health nurses identify children who may need nutrition support as part of their B4 School Check, prior to starting school. In 2021/22, 99% of four-year-olds received their B4 School Check. All but six of the families of children who were identified as obese were offered a referral to a health professional for assessment, nutrition, activity and lifestyle advice (82%).

We also continue to invest in lifestyle programmes that support people to increase physical activity or make healthy food choices, including the Green Prescription programme. There was a reduction in the number of people accessing this service in 2021/22 as COVID-19 and workforce pressure impacted on the delivery of community-based programmes, however we continue to focus on improved delivery in this area.

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



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



Data source: National NZ Health Survey [3]

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer avoidable hospital admissions

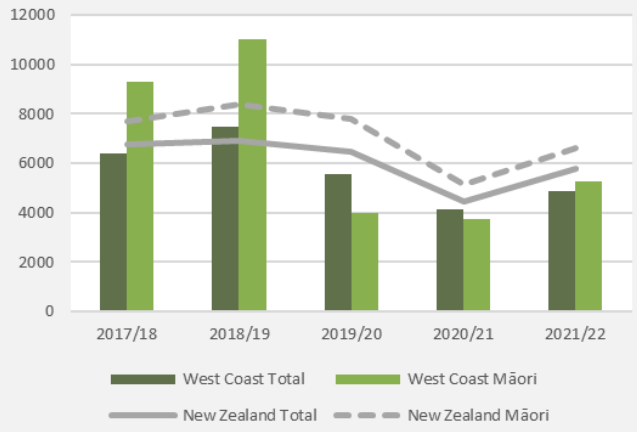
In 2021/22, West Coast's ambulatory sensitive hospital (ASH) admission rate for children under five was 4,855 per 100,000 a slight increase in comparison to the previous year; however still well below both the target and the national rate of 5,772.

This measure is seen as a marker of good quality primary care and a well-integrated and connected health system that engages earlier with children and their parents/caregivers to prevent hospital admissions.

With a population of our size, small changes in clinical practice or support for individual families can contribute to changes in ASH rates. The difference in the total rate between March 2021 and March 2022 represented just 12 additional hospital admissions across the year, six of which were Māori admissions.

Engagement with primary care is a key driver in reducing avoidable hospital admissions and in the past year 83% of all newborns on the West Coast were enrolled with a primary care team before three months of age and 80% of all eight-month and two-year-old children were fully immunised.

Measure: Rate of Ambulatory sensitive hospitalisations for children (0-4)	2019/20	2020/21	2021/22 Target	2021/22 Result
	5,533	4,150	<6,871	4,855



Data Source: Ministry of Health Performance Reporting [4]

[3] The NZ Health Survey is an annual survey commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use, and key factors that affect their health. The 2019/20 Survey is the most recently released time series available and, while total population results are presented annually, ethnicity breakdowns are only presented over combined time periods due to small survey/sample numbers.

[4] This was a national DHB performance indicator and captures hospital admissions for conditions considered preventable, including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The ASH results are published three months in arrears and the results reflect the 12 months to March 2022. Minor edits to previous results reflect coding updates.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Children have improved oral health

The percentage of five-year-olds whose teeth were caries-free (no holes or fillings) remained stable for the total population compared with 2020/21, rates for Māori fell slightly to 45% during the year.

Service performance data for 2021/22 shows 85% of all children aged 0-4 were enrolled with a community dental service and 51% of all children aged 0-12 had their teeth examined according to planned recall.

Enrolment rates for Māori children 0-4 were lower at 60% although 68% of all children aged 0-12 had their teeth examined according to planned recall.

Community dental services on the West Coast were significantly impacted by COVID-19 restrictions and closures of community clinics along with workforce shortages and staff illness. Oral health services and improving enrolment and access rates are a focus for the team in 2022/23.

Measure: Children caries-free at age 5	2019	2020	2021 Target	2021 Result
	55%	58%	>59.2%	58%

Data Source: DHB School & Community Oral Health Services [5]

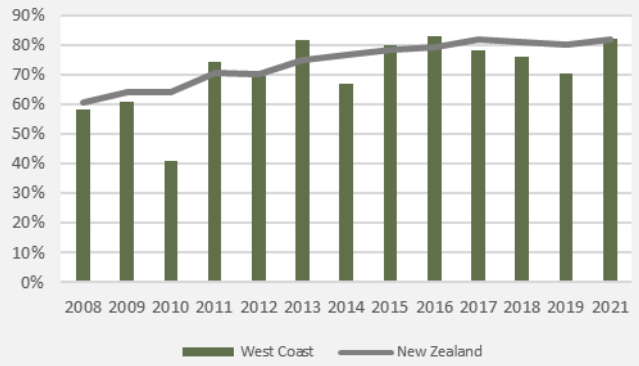
Fewer young people take up smoking

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

The 2021 survey result shows a positive improvement on rates for the previous four years, with 82% of West Coast Year 10 students reporting having never smoked compared to 82.5% across New Zealand.

Our public health team continues to focus in this area including smokefree policies, smoking cessation programmes and controlled purchase operations to ensure that licenced premises are not selling tobacco to young people under the legal age of 18.

Measure: 'Never Smokers' amongst Year 10 students	2019	2020	2021 Target	2021 Result
	71%	NA%	>79%	82%



Data Source: National ASH Year 10 Survey [6]

[5] This performance measure was a national DHB performance indicator and was reported annually for the school year. National results for 2021 were not available at the time of publishing, results for 2022 will not be available until 2023.

[6] The ASH Survey is a national survey used to monitor student smoking rates since 1999. Run by Action on Smoking and Health, it provides an annual snapshot (for the school year) of students who are aged 14 or 15 years at the time of the survey. Ethnicity breakdowns are not provided due to small survey numbers. The ASH Survey was not completed in 2020 due to the COVID-19 outbreak. Results for 2022 are expected to be released in early in 2023. For further information see www.ash.org.nz.

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 not only has a positive impact on people's health outcomes and quality of life, but also reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital level response.

WHERE ARE WE FOCUSED?

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

OUTCOME MEASURE – A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

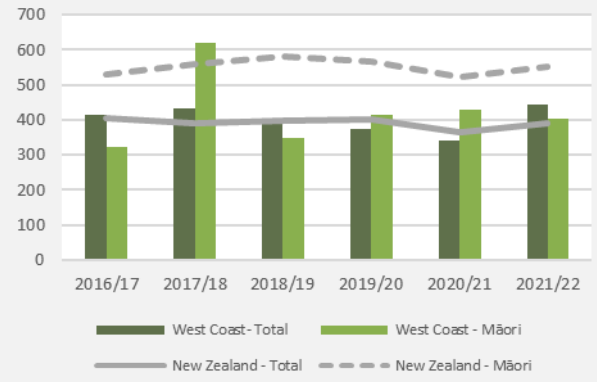
Acute (unplanned) hospital admissions account for almost two thirds of hospital admissions in New Zealand, challenging capacity for planned care.

The West Coast's total acute hospital bed day rate lifted over the past year although rates for Māori were positive compared with the total population and national rates.

Improving access to primary care is a key focus as we work to alleviate pressure on our hospital services and reduce acute presentations. This includes improving primary care enrolment and working with general practice to ensure people can book timely appointments to reduce the type of crisis and deterioration that leads to an acute hospital admission.

As at June 2022, 97% of our population was enrolled with general practice and over 1,800 people were enrolled in the primary care-led Long-Term Conditions Management Programme.

Rate of acute hospital bed-days



Data Source: National Minimum Data Set[7]

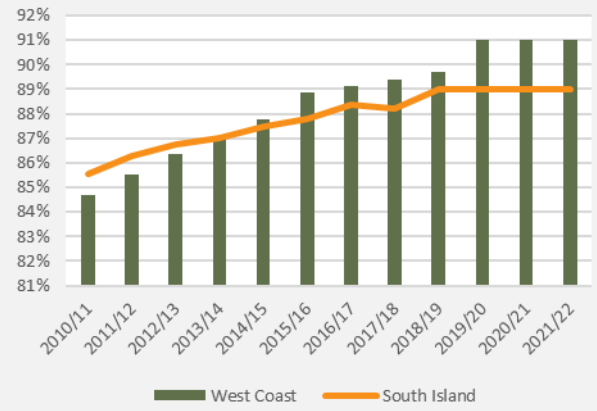
OUTCOME MEASURE – MORE PEOPLE LIVING IN THEIR OWN HOME

The proportion of the West Coast population aged over 75 living in their own homes remained stable at 91% in 2021/22. Consistent with our strategy, this suggests our older population is being supported to live more independently and is a positive trend as our population continues to age.

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

Falls are a common occurrence for older people and frequently lead to injury, hospitalisation and an increased risk of admittance to institutional care. COVID-19 impacted referrals for strength and balance classes as workforce pressures resulted in reduced volumes in 2021/22, just 52 people over the age of 65 were supported by our Falls Prevention Service however this is expected to increase in 2022/23.

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



[7] This is a national System Level Measure, data is provided by the Ministry of Health via the national minimum data set. This measure is age standardised and presented as a rate per 1,000 people. The reported results reflect the 12-month period to March as June results are not available at the time of publication.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People's conditions are diagnosed earlier

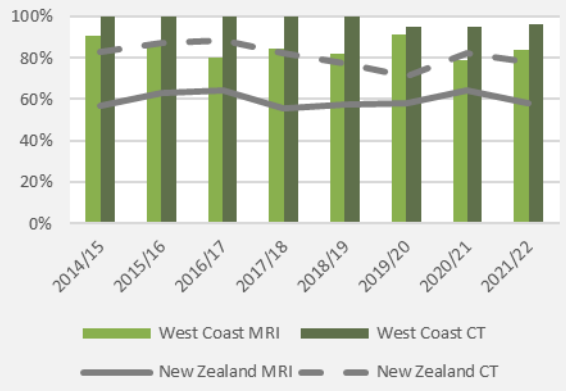
Timely access to diagnostics improves clinical decision making and enables early and appropriate intervention, improving the quality of care and outcomes for our population.

With 96% of patients scanned and reported within six weeks, West Coast CT wait times continued to meet the national target in 2021/22 and were well above the national average of 78%.

MRI wait time performance improved to 84%, and while we are not yet meeting the national target our wait times for MRIs are well above the national average of 58%.

A private provider based in Christchurch delivers MRIs for the West Coast population and logistics and patient choice can play a part in the delays. We are looking closely at wait times with our Canterbury colleagues to understand what might be done to reduce these.

Measure: People receiving their non-urgent MRI or CT scan within six weeks		2019/20	2020/21	2021/22 Target	2021/22 Result
	MRI	91%	79%	90%	84%
	CT	95%	95%	95%	96%



Fewer avoidable hospital admissions

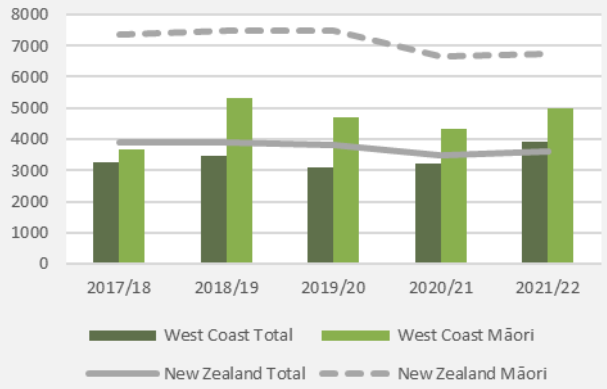
In 2021/22, West Coast's avoidable hospital admission rate for 45-64-year-olds was 3,916 per 100,000 people. This result is higher than the target and slightly higher than the national rate of 3,590.

Our Māori rate has also lifted compared to the previous year, however these rates are disproportionately impacted by small population numbers with results reflecting just four more admissions for Māori compared to last year. More relevant is that West Coast Māori rates remain significantly lower than the national Māori rate of 6,736 admissions per 100,000.

High general practice enrolment rates are an indication of good engagement with our health system. In 2021/22, 97% of the total population and 88% of Māori were enrolled with a West Coast general practice.

Increasing engagement with our Māori and more vulnerable populations continues to be a focus for our health system. Equity actions have been highlighted throughout Te Whatu Ora's Te Pae Tata Interim New Zealand Health Plan with an emphasis on the development of kaupapa Māori services and pathways to support earlier intervention and reduce hospital admissions. We are progressing this focus through our localities work in 2022/23.

Measure: Ambulatory sensitive hospitalisation for adults (45-64)	2019/20	2020/21	2021/22 Target	2021/22 Result
	3,108	3,205	<3,017	3,916



Data source: Ministry of Health Performance Reporting[8]

[8] This measure was a national DHB performance indicator and refers to hospitalisations for conditions considered preventable including: asthma, vaccine preventable diseases, dental conditions and gastroenteritis. The aim was 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 reflect national data provided by the Ministry of Health in June 2022, being results for the 12 months to March 2022. Results are updated as population changes are revised, and coding is completed. Prior year results have been updated to reflect this.

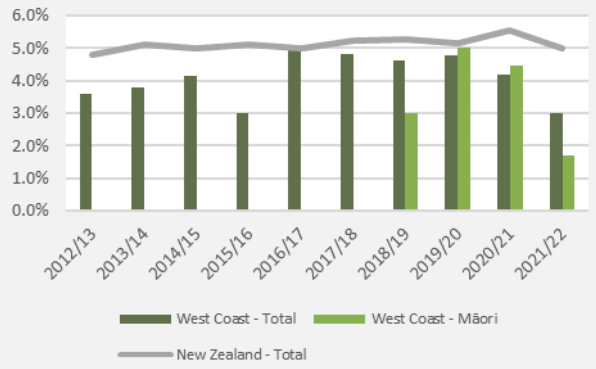
IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

Fewer falls related hospitalisations

With an ageing population, reducing the rate of falls leading to hospital admissions reflects a significant investment for the West Coast health system. Our focus on falls prevention is crucial in supporting people to stay well and independent and reducing demand on services across our health system.

The proportion of our population aged 75 and over admitted to hospital because of a fall reduced in 2021/22 to 3.0%, this was 22 fewer admissions than the prior year and was 2.0% lower than the national average. West Coast's Māori rate also fell significantly compared with the previous year however the numbers are small with two fewer admissions compared with the previous year.

Measure: Population (75+) admitted to hospital because of a fall	2019/20	2020/21	2021/22 Target	2021/22 Result
	4.8%	4.2%	<5.0%	3.0%



Data Source: National Minimum Data Set

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 indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it.

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

WHERE ARE WE FOCUSED?

We are in the middle of a significant facilities redevelopment and repair programme and 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.

OUTCOME MEASURE – A REDUCTION IN AMENABLE MORTALITY

The last available mortality rates were positive with West Coast amenable mortality rates falling slightly.

Prevention, screening and long-term condition programmes help to make a difference to people's life expectancy by ensuring effective diagnosis and earlier access to treatment.

Cancer is one of the leading causes of mortality in New Zealand and contributes to a high proportion of premature deaths. In the last year 72% of women 25-69 accessed cervical screening services and 77% of women 45-69 had a breast screen. The new bowel screening programme has also been established on the West Coast and 58% of our population aged 60-74 participated in the programme in 2021/22.

We continue to work closely with our primary and community-based service providers to ensure a strong continuum of care for people with mental illness and addictions. Over 500 people accessed brief intervention counselling (BIC) in general practice in 2021/22. Alongside this service a choice and access programme called Te Tumu Waiora is also being established to further support people manage their health and wellbeing by talking over issues, working through blocks and developing goals. This is a free service for people enrolled in participating general practices and aims to support people manage their conditions before they become acute.

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

Data Source: National Mortality Collection[9]

[9] Performance data for this measure is sourced from the national mortality collection which is three years in arrears. 2019 results were not available nationally at the time of printing.

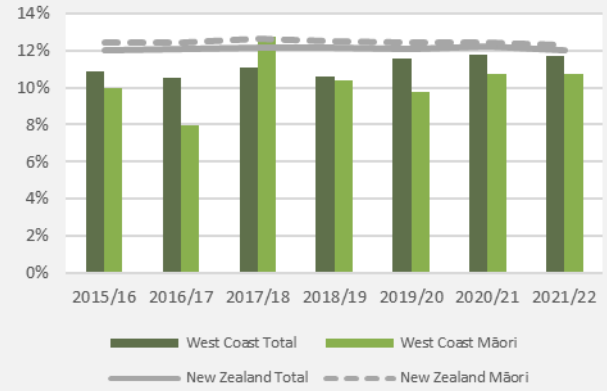
OUTCOME MEASURE – A REDUCTION IN ACUTE READMISSIONS TO HOSPITAL

Lower readmission rates are important, as patients who are readmitted to hospital within 28 days of discharge are more likely to experience negative long-term outcomes. Readmissions also reduce public confidence and increase costs for the system.

West Coast's readmission trend remains relatively flat for the total population and in line with the national average. Our Māori readmission rate increased slighted compared to the previous year, however the rate is impacted by small population numbers with just 14 more readmissions in 2021/22 compared with the previous year.

Community-based support services provide care and assistance to people following discharge from hospital as part of a restorative approach aimed at enabling people to stay in their own homes for longer. In the past year over 1,400 people were supported by district nursing and 1,078 people by home-based support services.

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



Data Source: National Minimum Data Set

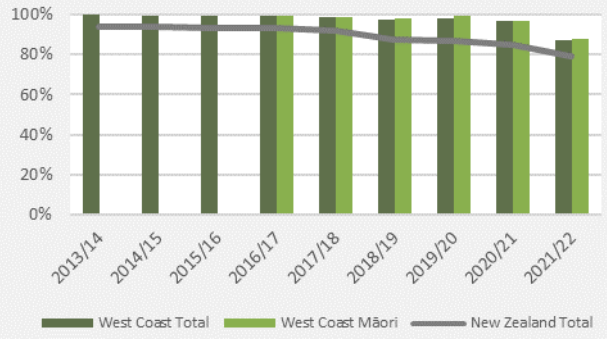
IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

People have shorter waits for urgent care

The increasing number of people presenting to emergency departments for treatment put urgent care services under pressure across the country. While West Coast's ED wait time performance remains above the national average, it has fallen to 87% in 2021/22. This result is reflective of national demand but also local vacancies and workforce pressures from COVID-19 are impacting timeliness.

The on-site general practice operating from the Te Nikau hospital site in Greymouth enables the delivery of unplanned GP visits for those people who present at the emergency department but who may not need emergency care. Overall Emergency Department presentations fell slightly in the past year to 10,549, with some of this reduction being patients choosing to visit the on-site general practice instead of waiting for emergency care.

Measure: People are admitted, discharged or transferred from ED within 6 hours	2019/20	2020/21	2021/22 Target	2021/22 Result
	98%	97%	95%	87%



Data Source: National Minimum Data Set

People have shorter waits for planned care

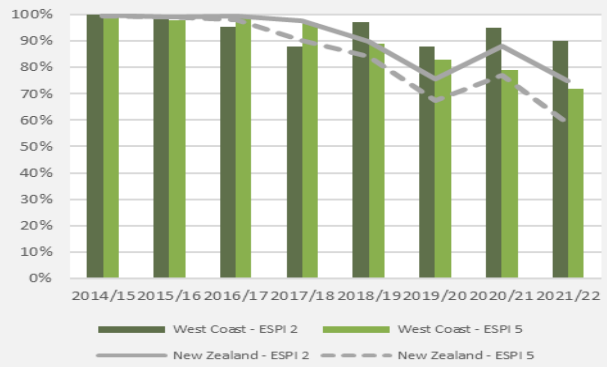
As was evident across the country, increasing acute service demands and the impact of COVID-19 on our workforce impacted on our capacity for the delivery of planned care.

In the past year 3,034 planned care interventions were delivered for the West Coast population, including 1,655 inpatient surgical events, 1,295 minor procedures, and 84 non-surgical interventions.

However, while remaining above national averages, the West Coast missed the wait time targets for both Elective Services Patient Flow Indicators (ESPI) in 2021/22.

The DHB continues to explore opportunities to improve wait times. We are working closely with the national planned care working group as well as Canterbury in the support and development of transalpine services for our population.

Measure: People receiving specialist assessment and treatment within set timeframes.		2019/20	2020/21	2021/22 Target	2021/22 Result
	ESPI 2	88%	95%	100%	90%
	ESPI 5	83%	79%	100%	72%



Data Source: Ministry of Health Quickplace Warehouse [10]

[10] These are two of the national Elective Services Patient flow Indicators (ESPIs), established to track system performance. In line with national ESPI reporting, the annual results refer to the final month of each year (June). ESPI 2 represented those people receiving their First Specialist Assessment within four months and ESPI 5 represents those given a commitment to treatment receiving that treatment within four months.

IMPACT MEASURES – CONTRIBUTING TOWARDS OUR STRATEGIC GOALS

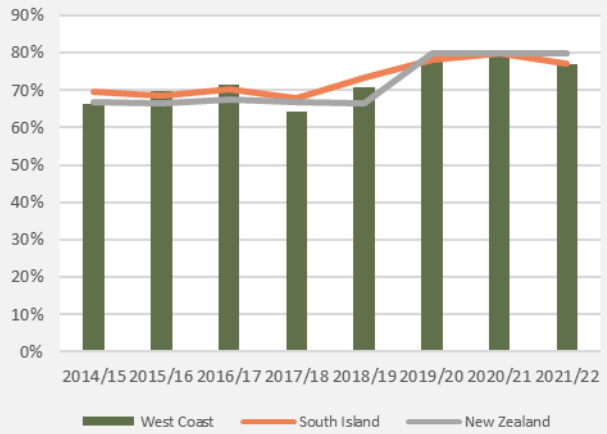
People Are Supported on Discharge

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

This indicator is a marker of good discharge planning, service integration and the continuity of care between hospital and community services. West Coast performance fell slightly in 2021/22 which was not unexpected as workforce pressures due to COVID-19 made community resourcing difficult.

The DHB works closely with the local community provider of Alcohol and Other Drug services to ensure good links and integration between hospital and community-based services.

Measure: Inpatients accessing community-based MH and AOD services within seven days of discharge	2019/20	2020/21	2021/22 Target	2021/22 Result
	78%	80%	80%	77%

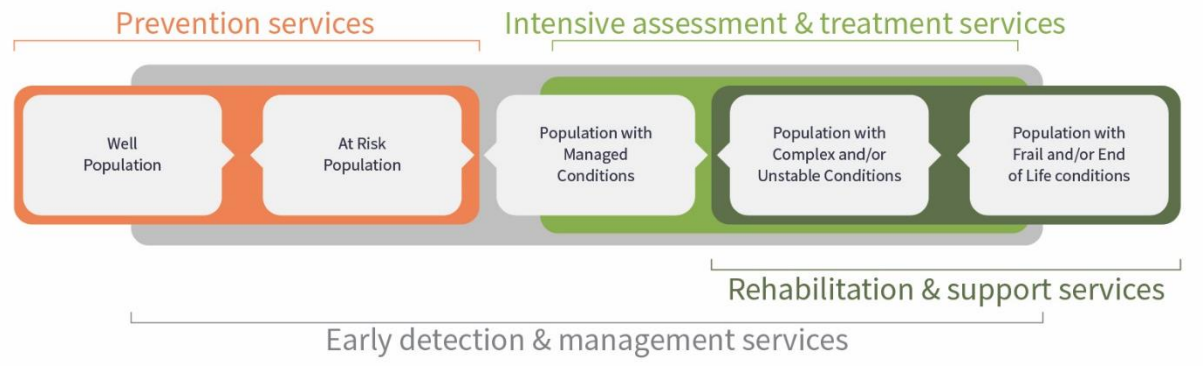


Data Source: National Mental Health KPI Framework.[11]

[11] Data for this measure is provided via the national KPI programme.

Part III
Delivering on our Plans

Statement of Service Performance



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.

Over the longer term, we evaluated the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes. These longer-term outcomes are highlighted on the previous pages.

On an annual basis, we tracked our performance against our forecast of the services we planned to deliver and the standards we expected to meet. West Coast's service performance for the year is set out in this section measuring delivery against the forecast presented in our 2021/22 Statement of Performance Expectations, available on our website.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service we deliver, services have been grouped into four service classes. These were common to all DHBs and reflected 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 identified a mix of service measures that we believed to be important to our community and stakeholders and would provide a fair indication of how well the DHB performed.

In health, the number of people who received 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 in our Statement of Service Performance addressed four key aspects of service performance:

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

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

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

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

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

SETTING STANDARDS

In setting performance standards for 2021/22, we considered the changing demography of our population, areas of increasing service demand and the assumption that resources and funding growth would be limited.

While targeted interventions can reduce demand in some areas, there will always be some service areas where we cannot influence demand , such as 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.

In areas where we had more influence, targets set for 2021/22 reflected our objectives of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining service access, while reducing wait times.

2021/22 PERFORMANCE

Going into the 2021/22 year, we were conscious of the operational backlog related to the COVID-19 lockdown in 2020 and the impact alert level restrictions, diversion of staff and COVID-19 outbreaks could have on our system and our service performance.

We knew that many of the national standards could be difficult to meet if we experienced lockdowns or outbreaks and that primary and community service delivery would be interrupted by staff sickness, restrictions around group activities and prioritisation of COVID-19 related services.

The beginning of the 2021/22 year saw the DHB diverting considerable public health, primary care and pharmacy staffing resources to rolling out the COVID-19 vaccination programme across our region - reaching 89% of our population by June 2022.

Our system was greatly impacted by the COVID-19 outbreak in 2022 with our primary, community and hospital services stretched to capacity as we responded to demand with a reduction in staffing numbers due to pandemic leave and vacancies, increasing infection control expectations, and alert level restrictions.

Delivery of some services operating in the community from people's homes, schools and marae were paused or restricted to comply with alert level and infection control restrictions and many others had to prioritise service delivery due to staff sickness levels.

The work required to reschedule appointments and catch-up on service delivery was significant and we are grateful to all the people working in our system who supported this work.

We have included three additional COVID-19 related measures in our Statement of Service Performance for 2021/22 to help highlight to the reader the diversion of health system resources in responding to COVID-19. These cover the delivery of COVID-19 vaccination and testing services. Footnotes have also been added to the document where it has been clear that performance has been impacted by COVID-19.

NOTES FOR THE READER

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

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

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

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

Performance Key		
	Rating	Criteria
✓	Achieved	Standard reached.
↺	Partially Achieved	Standard not reached but performance has been maintained or improved or the equity gap between population groups has been reduced.
✘	Not Achieved	Standard not reached and performance has dropped.

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.

Performance Key for Estimated Volumes		
	Rating	Criteria
✓	Achieved	Performance is moving in the indicated (desired) direction of travel or is within 10% of estimated volumes.
✘	Not Achieved	Performance is moving against the desired direction of travel or variance is greater than 10% of estimated volumes.

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

POPULATION HEALTH SERVICES – HEALTHY ENVIRONMENTS								
These services address aspects of the physical, social and built environment to protect health and improve health outcomes.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q[12]	Total	15	13	E.15	8	-	✖
Licensed alcohol premises identified as compliant with legislation	Q[13]	Total	100%	0%	>90%	n. a	-	-
Tobacco retailers identified as compliant with legislation	Q[14]	Total	100%	n.a	>90%	100%	-	✓

HEALTH PROMOTION AND EDUCATION SERVICES								
These services inform people about risk factors and support them to make healthy choices. Success is evident through high levels of engagement.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Mothers receiving breastfeeding and lactation support in community settings	A	Total	228	165	E>150	169	-	✓
Babies exclusively/fully breastfed at LMC discharge (six weeks)	Q[15]	Māori	64%	n.a	75%	n.a	n.a	-
		Total	72%	n.a		n.a	n.a	-
Babies exclusively/fully breastfed at three months	Q[15]	Māori	55%	48%	70%	n.a	n.a	-
		Total	64%	62%		n.a	n.a	-
People provided with Green Prescriptions for physical activity support	A[16]	Total	450	452	E>400	200	n.a	✖
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q[17]	Māori	92%	87%	90%	69%	64%	✖
		Total	93%	88%		71%	67%	✖
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	Q[17]	Māori	89%	93%	95%	75%	-	✖
		Total	91%	89%		77%	-	✖
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[17]	Māori	100%	100%	90%	-	-	-
		Total	100%	93%		88%	-	✖

[12] Due to ongoing involvement of public health staff in COVID-19 response work our Community & Public Health (CPH) team had had to prioritise completion of submissions based on the public health issues addressed and the availability and capacity of CPH staff.

[13] This measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. Due to diversion of team to COVID-19 activity, no CPOs were conducted in the West Coast DHB in the period 1 July 2021 to 30 June 2022.

[14] Measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years of age) into tobacco retailers. Compliance is seen as a proxy measure of the success of education and training for retailers and reflects a culture that encourages a responsible approach to alcohol and tobacco. No CPOs took place in 2020/21 due to COVID pressures. One operation took place in Greymouth in 2021/22 covering 11 retailers with 100% compliance.

[15] Breastfeeding data is provided by the Ministry of Health and is not able to be combined with local provider data, so performance from the largest provider (Plunket) is presented. Results for Breastfeeding at LMC discharge and 3-months are reported nationally in arrears and were not available for 2021/22 at the time of reporting.

[16] The number of green prescription referrals has fallen between 2020/21 and 2021/22, impacted by the pandemic response as practices prioritised COVID-19 support and emergency care. Clients were not engaging as much during this period which limited the opportunity to offer this service. Additional staff were recruited to the Green Prescriptions team which will support improved volumes in 2022/23.

[17] The ABC programme refers to health professionals Asking about smoking status, providing Brief advice and providing Cessation support. Performance has fallen with the impact of COVID lockdowns, the redeployment of staff onto COVID-19 programmes and the resignation of our Smokefree Coordinator during the last half of the year. A new coordinator is in place and we expect rates to pick up again as the new person gets established in the role. The lower result for pregnant women in 2021/22 reflects just five women who were identified as smokers but did not receive smoking cessation advice, there were no pregnant Māori smokers identified in the 2021/22 year, so no result has been recorded. Hospital smoking performance in 2021/22 was impacted by a combination of factors including a change in the patient management system as well as reduced capacity due to COVID-19 during the year.

POPULATION-BASED SCREENING SERVICES								
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Four-year-olds provided with a B4 School Check (B4SC)	A[18]	Māori	97%	84%	90%	101%	65%	✓
		Total	94%	97%		99%	66%	✓
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q[19]	Māori	100%	60%	95%	100%	92%	✓
		Total	100%	88%		82%	93%	✖
Women aged 25-69 having a cervical cancer screen in the last 3 years	A[20]	Māori	68%	68%	80%	66%	67%	✖
		Total	72%	75%		72%	55%	✖
Women aged 45-69 having a breast cancer screen in the last 2 years	A[21]	Māori	66%	67%	70%	68%	59%	↺
		Total	69%	75%		77%	66%	✓
People aged 60-74 participating in the national bowel screening programme	A[22]	Māori	new	new	60%	56%	49%	↺
		Total	new	new		58%	59%	↺

[18] Results of greater than 100% occur when the Statistics New Zealand estimated population is less than the actual population in a region, this impacts smaller population groups in particular.

[19] 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. This result is disproportionately impacted by small population numbers, reflecting ten children who were missed in 2021/22.

[20] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer, by allowing for earlier intervention and treatment. The measures refer to national screening programme results and standards. Cervical Screening is measured over a three-year period, with influencing rates, lockdowns, workforce pressure, and reluctance from women to attend clinics all impacted performance.

[21] From July 2021 the national expectation for Breast Screening was extended to include women 45 to 69 years, reported baseline results have been updated from previous years. Breast Screening rates have improved for this group over the past three years with 81 more women screened compared with the previous period including 6 Māori women. Reported results are not comparable with previously published results.

[22] The National Bowel Screening Programme (NBSP) is for people aged 60 to 74, eligible people are invited to complete a faecal immunochemical test (FIT) in the comfort of the own homes and return the test for analysis. The FIT can detect tiny traces of blood in bowel motions that may be an early sign of pre-cancerous polyps (growths) or bowel cancer. If a test is positive, participants are invited for additional screening, usually a colonoscopy. The National Bowel Screening programme went live on the West Coast in May 2021, as such there is no previous data to compare against. All districts have started the programme at different times and so national comparisons should be treated with caution.

IMMUNISATION SERVICES								
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates indicate a well-coordinated, successful service.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Children fully immunised at eight months of age	A[23]	Māori	81%	84%	95%	89%	72%	↺
		Total	78%	80%		80%	86%	↺
Proportion of eight-month-olds 'reached' by immunisation services	Q	Total	95%	97%	95%	97%	91%	✓
Children fully immunised at two years	A	Māori	90%	79%	95%	82%	70%	↺
		Total	82%	80%		80%	84%	↺
Young people (Year 8) completing the HPV vaccination programme	A[24]❖	Māori	47%	49%	75%	60%	49%	↺
		Total	53%	52%		60%	54%	↺
Older people (65+) receiving a free influenza ('flu') vaccination	A[25]❖	Māori	44%	58%	75%	60%	53%	↺
		Total	58%	75%		69%	63%	✖
Number of COVID-19 vaccinations delivered on the West Coast	A[26]	Māori	-	-	-	5,960	-	
		Total	-	10,782		60,143		
Proportion of the eligible West Coast population fully vaccinated (i.e. receiving two doses)	C[27]	Māori	-	-	-	84%	80%	✓
		Total	-	-		89%		

[23] The West Coast has a large community within its population who decline immunisations or choose to opt-off the National Immunisation Register (NIR), this has historically made meeting the national target difficult. Despite a growing population as well as the impact of COVID-19 over the past 12 months, the West Coast worked hard to maintain the total immunisation rates and pleasingly has increased the Māori rate by 5%. Overall, 66 children did not receive all their vaccinations by eight months of age including eight Māori.

[24] Human Papillomavirus (HPV) vaccination coverage is impacted by the views of our Gloriavale Community who do not vaccinate. There were 51 more young people immunised compared with the previous year including seven Māori, the eligible population increased by 33 in this time. While the target was not reached, vaccination numbers increased across all ethnic groups compared with the 2020/21 year which is a positive result considering the COVID-19 and capacity-related challenges faced by primary care and our vaccination teams over the past year.

[25] There was a significant reduction in vaccinations provided in 2021/22 with 365 fewer vaccinations including eight fewer Māori vaccinations compared with 2020/21. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and hospitalisations among people with diabetes and chronic lung disease. Vaccination rates were impacted by the focus on the COVID-19 vaccination programme, as well as an increase in the 65+ population. However, Māori rates rose slightly with a reduction in the total eligible population.

[26] The COVID-19 vaccination measures have been added to the Statement of Performance as a measure of significant interest to our population. The vaccination numbers for the first measure reflect total COVID-19 vaccinations delivered on the West Coast and may include some vaccinations delivered to people who were working or visiting the West Coast region but who are not domiciled or enrolled here. The total number of vaccinations delivered includes: 20,854 first dose vaccinations, 22,059 second dose vaccinations and 17,230 booster 1 and 2 vaccinations.

[27] Fully vaccinated was defined as two doses of the COVID-19 vaccination having been administered to an individual and people eligible for the COVID-19 vaccination programme as those aged 12 and over. The proportion fully vaccinated included West Coast residents who received two doses irrespective of where they received those doses – i.e. overseas or in another DHB region. In line with national reporting by the Ministry of Health, the population fully vaccinated was calculated using the Health Service User (HSU) population. Previous results have been removed due to the changes in eligible population and HSU population between years. There was an acknowledged difference between the Statistics New Zealand projected population and the HUS population used for tracking the COVID-19 vaccination programme delivery, however the HSU population enabled closer matching for demographics such as location and ethnicity.

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

ORAL HEALTH SERVICES								
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Children (0-4) enrolled in school and community oral health services	A[28]❖	Māori	77%	74%	95%	60%	-	✖
		Total	88%	88%		85%	-	✖
Enrolled children (0-12) receiving their oral health exam according to planned recall	T[33]❖	Māori	97%	84%	90%	68%	-	✖
		Total	98%	82%		51%	-	✖
Adolescents (13-17) accessing DHB-funded oral health services	A[33]❖	Total	73%	78%	85%	77%	60%	✖

GENERAL PRACTICE SERVICES								
These services support people to maintain their health and wellbeing. High levels of engagement are indicative of an accessible, responsive service.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Newborns enrolled with a PHO by three months of age	A[29]	Māori	74%	72%	85%	74%	67%	↺
		Total	90%	86%		83%	85%	✖
Proportion of the population enrolled with a Primary Health Organisation	A[30]	Māori	90%	88%	95%	88%	83%	↺
		Total	96%	98%		97%	94%	✓
Youth (12-19) accessing brief intervention/counselling in primary care	A[31Δ]	Total	90	147	E>150	103	-	✖
Adults (20+) accessing brief intervention/counselling in primary care	A[Δ]	Total	427	536	E>450	407	-	✖
Number of integrated HealthPathways in place across the health system	Q[32]	Total	677	813	E> 600	1,028	-	✓

[28] Community dental services on the West Coast continued to be impacted by COVID-19 with the Omicron outbreak in 2021/22 significantly impacting service delivery. Due to the small team and the spread of our rural population it was difficult to provide services to all children especially combined with workforce shortages and COVID-19 illness. Improving oral health is a priority focus for the West Coast in 2022/23.

[29] The number of newborns enrolled by 3-months fell below the national target for the total population in 2021/22, however this reflects very small population numbers. There were five fewer newborns enrolled with the eligible population increasing by five during the same period. The rate for Māori increased slightly with four additional Māori registered by 3-months.

[30] The number of children enrolled with a PHO fell slightly in 2021/22, the reduction in those enrolled was compounded by an increase of 330 in the population compared with the 2020/21 year. Māori enrolments increased by 110 in 2021/22 however this was offset by an increase in the eligible population.

[31] Brief intervention/counselling service aims to support people with mild to moderate mental health concerns to improve their health outcomes and quality of life. The service includes the provision of free counselling sessions and extended GP consultations. There was a reduction in the number of youth accessing these services in 2021/22 compared with the previous year. These services are demand driven and fluctuations can occur from year to year. COVID-19 is likely to have impacted BIC referrals in 2021/22, youth aged 12-25 years who were referred into the Melon online digital programme are not included in this year's figures which may have also impacted BIC volumes.

[32] The increase in HealthPathways reflects the number of additional pages created in response to COVID-19 and a change in the way some pages are counted, with pages having been split out into individual pathways to provide additional clarity for services.

LONG-TERM CONDITION SERVICES								
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Enrolled population, identified with a long-term condition, engaged in the primary care Long-term Conditions Management (LTCM) programme	A[33]	Māori	266	203	E. >200	175	-	✖
		Total	3,959	2,777	E>3,500	1,839	-	✖
Enrolled population (15-74), identified with diabetes, having ar annual diabetes review	A[34]	Māori	84%	71%	>85%	46%	-	✖
		Total	61%	58%		49%	-	✖
Population with diabetes, having an annual review and HbA1c test, demonstrating acceptable glycaemic control (HbA1c <64 mmol/mol)	Q	Māori	50%	48%	60%	57%	-	↺
		Total	56%	56%		66%	-	✓

Pharmacy and Referred Services								
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Number of subsidised pharmaceutical items dispensed in the community	A$^{\Delta}$	Total	498k	555k	E<500K	530k	-	✓
People receiving their urgent diagnostic colonoscopy within two weeks	T	Total	95%	94%	90%	95%	90%	✓
Number of community-referred radiological tests delivered	A[35]	Total	5,570	7,160	E>5,500	6,700	-	✓
People receiving Magnetic Resonance Imagining (MRI) scans within six weeks	T	Total	91%	79%	90%	84%	58%	↺
People receiving Computed Tomography (CT) scans within six weeks	T	Total	95%	95%	95%	96%	78%	✓
Number of COVID-19 Laboratory tests processed	A[36]	-	-	1,538	-	2,304	-	

[33] This measure refers to the primary care long-term conditions 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. People are confirmed as engaged in the programme through contact with their general practice. Enrolments reflect the number of unique individuals even if they have more than one long-term condition. Overall programme activity was impacted by the COVID-19 response this year.

[34] 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. The proportion of people having an annual review fell significantly for both the total and Māori populations compared with 2020/21. The diabetes programme was significantly reduced due to COVID-19 in 2021/22 however work is underway to identify those people due or overdue for an annual review as part of the LTC programme.

[35] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. While still above historic rates, the volume of tests delivered fell slightly in the year to June 2022, this is likely a reflection of people avoiding general practice as COVID-19 spread throughout the community. As our population ages the demand for radiology tests is likely to continue to increase.

[36] This number reflects the COVID-19 tests delivered by the West Coast DHB during the 2021/22 financial year - irrespective of where the person being tested lived. This measure has been added to the Statement of Performance as a measure of significant interest to our population, there was no estimate set in 2021/22.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

QUALITY AND PATIENT SAFETY								
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Staff compliance with good hand hygiene practice	Q[37]	Total	81%	82%	80%	86%	87%	✓
Inpatients (aged 75+) receiving a risk assessment to reduce serious harm from falls	Q[38]	Total	71%	77%	90%	n/a	-	-
Patients responding to the national inpatient patient experience survey	P[39]	Total	35%	n.a	>30%	20%`	-	✖
Proportion of patients who responded in the survey that 'hospital staff included their family/whānau or someone close to them in discussions about their care'	P[39]	Total	64%	n.a	65%	65%	-	✓

SPECIALIST MENTAL HEALTH AND ALCOHOL AND OTHER DRUG (AOD) SERVICES								
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Proportion of the population (0-19) accessing specialist mental health services	A[40Δ]	Māori	5.6%	6.7%	>3.8%	4.7%	4.2%	✓
		Total	5.5%	5.7%		4.8%	3.8%	✓
Proportion of the population (20-64) accessing specialist mental health services	A[Δ]	Māori	9.6%	9.3%	>3.8%	9.0%	7.1%	✓
		Total	6.0%	5.9%		6.0%	3.7%	✓
People referred for non-urgent mental health and AOD services seen within 3 weeks	T[41]	Total	n.a	82%	80%	87%	79%	✓
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	Total	n.a	96%	95%	98%	94%	✓

[37] Quality results are provided in arrears - for 2021/22 for hand hygiene refers to the last completed quarter January to March 2022. Further detail and results for previous years can be found at www.hqsc.govt.nz .

[38] Inpatients falls risk assessments are no longer being reported to the Health Quality and Safety Commission and results for the June 2022 period are not available.

[39] The national vendor responsible for the inpatient survey changed during the 2020/21 year and survey response data is not available for this period. West Coast internal survey response data show 6,710 surveys were completed of the 33,304 surveys sent to patients in the 2021/22 year. We note more surveys were historically sent by the DHB than the national inpatient survey vendor which may explain the drop in completed survey results.

[40] There is a national expectation that around 3-4% of the population will need access to specialist level mental health services during their lifetime. The reduction in 0-19 access rates reflects just 61 fewer youth accessing services in 2021/22 compared with the prior year including 30 Māori youth.

[41] This is a national measure and results reflect the quarter to 1 April to 31 March 2022, being the most recently available national data.

MATERNITY SERVICES								
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Number of maternity deliveries in West Coast DHB facilities	A	Total	246	230	E.250	242	-	✓
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[42]❖†	Māori	77%	83%	80%	n.a	n.a	-
		Total	87%	89%		n.a	n.a	-
Baby Friendly Hospital accreditation achieved in DHB facilities	Q	Total	Yes	Yes	Yes	Yes		✓

ACUTE AND UNPLANNED SERVICES								
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Number of unplanned presentations at the Emergency Department (ED)	A	Total	11,043	10,666	E<13,000	10,549	-	✓
People admitted, discharged or transferred from ED within 6 hours of presentation	T[43]	Māori	99%	97%	95%	88%	86%	✖
		Total	98%	97%		87%	79%	✖
Proportion of people presenting in ED (in triage 1-3), seen within clinical guidelines	T[44]	Total	83%	78%	85%	n.a.	-	-
Proportion of people presenting at ED triaged in category 4 or 5	A	Total	52%	43%	<60%	43%	-	✓
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral.	T[45]	Total	83%	81%	90%	60%	84%	✖

[42] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the health and wellbeing of both the mother and the developing baby. Data is sourced from the Ministry's national Maternity Clinical Indicators report – data is reported nationally in arrears and the 2021 data is yet to be released.

[43] Shorter wait times in ED is a national performance measure of timeliness and quality of care. In the 2021/22-year ED wait times were impacted by workforce pressures due to vacancies and staff illness exacerbated by the COVID-19 outbreak. As at June 2022 the Te Nikau Hospital acute zone was managing 11 FTE of nursing vacancies. Recruitment of vacant staff is a priority to reduce wait times in 2022/23.

[44] This measure demonstrates whether people presenting in ED are seen in order of clinical need and reflects national triage standards. In February 2022 West Coast changed patient management systems which impacted the collection of some ED triage data. Changes have now been made to ensure this is collected going forward however the data for the 2021/22 year is incomplete. The proportion of people seen within clinical guidelines between 1 July and 31 January was 61%.

[45] Small population numbers disproportionately impact performance against the target for this measure, with just twelve patients who did not meet the target in 2021/22. Reduced performance reflects a combination of system capacity and comorbidity of patients. Some delays to referrals and notifications have been impacted by COVID-19 with staff sickness vacancies. A breach analysis is completed for every patient who is seen outside of timeframes to identify lessons and improve processes. We continue to closely monitor and track patients to support delivery of timely services.

ELECTIVE AND ARRANGED SERVICES								
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Number of First Specialist Assessments provided	A[46]	Total	5,258	6,023	E>6,000	5,050	-	✖
Proportion of patients waiting less than four months for their first specialist assessment	T[47]	Total	88%	95%	100%	90%	74%	✖
Number of planned care interventions delivered	A[48]	Total	3,220	3,612	3,140	3,034	-	✖
Proportion of patients given a commitment to treat and treated within four months	T[49]	Total	83%	79%	100%	72%	59%	✖
Number of outpatient consultations provided	A[50]	Total	12,075	13,023	E>13,000	11,851	-	✖
Proportion of outpatient appointments provided by telemedicine	Q	Total	5.2%	4.4%	>5%	5.3%	-	✓
Outpatient appointments where the patient was booked but did not attend	Q[51Δ]	Māori	16%	9%	<6%	8.9%	-	↺
		Total	7.2%	5.3%		6.0%	-	✖

[46] A First Specialist Assessment (FSA) is the assessment undertaken by a specialist following referral by a patient's primary care practitioner to determine the treatment to be delivered. Delivery of FSAs were impacted by COVID-19 demand and COVID-19-related workforce challenges across our hospital services and in primary care. A national programme of work is underway to address Planned Care delivery impacted by COVID-19 with patients waiting more than 365 days prioritised.

[47] ESPI 2 performance fell in 2021/22 with 89 people missing the target as at June compared with 39 the previous year. See footnote above regarding pressures on service delivery.

[48] The planned care intervention measure recognises the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing, including those delivered in community settings. COVID-19 significantly impacted service delivery on the West Coast with increased infection prevention controls and workforce pressures making it difficult to meet targets. As many patients also require travel to Canterbury, there are additional challenges to ensuring patients are able to travel and be seen outside of the district. There were 1,655 inpatient discharges, 1,295 minor procedures and 84 non-surgical interventions completed in 2021/22.

[49] ESPI 5 performance fell slightly with 110 patients missing wait time targets compared with 74. See footnote above regarding pressures on service delivery.

[50] As with other primary and secondary services, outpatient appointments were impacted by the COVID-19 outbreak with workforce pressures limiting the number of appointments available. The West Coast focused efforts on seeing the longest waiting and most vulnerable members of our community.

[51] The increase in DNA rates for the total population was not unanticipated in light of the COVID-19 environment, we are pleased to see the Māori rate fall slightly in this time however. A DNA rate project ran for 12-months in 2021/22 and findings have been implemented to continue addressing high rates of Māori DNAs. Changes centred around contacting patient's prior to appointments, utilising other key stakeholders to make contact with hard to reach whānau, and ensuring contact details are updated at every possible opportunity have been made to promote continued improvement.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services								
These services restore or maximise people's health. Service utilisation is monitored to ensure people are appropriately supported.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
People (65+) supported by the community In-Home Falls Prevention Service	A[52]	Total	84	136	>120	52	-	✗
Proportion of stroke patients admitted to an organised stroke service (with a demonstrated stroke pathway) after an acute event	Q	Total	95%	97%	80%	97%	-	✓
Proportion of AT&R inpatients discharged home rather than into ARC	Q$^{\Delta}$	Total	93%	96%	80%	95%	-	✓

Home-Based Support Services								
These services support people to maintain functional independence. Clinical assessment ensures access is appropriate and equitable.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Number of Meals on Wheels provided	A$^{\Delta}$	Total	41,966	47,711	E>35,000	52,123	-	✓
People supported by district nursing services	A[53]$^{\Delta}$	Total	1,803	2,438	E>1,600	1,467	-	✗
People supported by long-term home-based support services	A$^{\Delta}$	Total	1,041	1,122	E>1,000	1,078	-	✓
Proportion of people supported by long-term home-based support services who have had a clinical assessment of need (using InterRAI) in the last year	Q[54]	Total	77%	78%	95%	76%	-	✗

[52] The number of people supported by in-home falls prevention services has been impacted by COVID-19. A reduction in referrals as well as fewer people wanting in home support have impacted overall volumes. Some data from northern and southern regions of the district are not available due to clerical workforce shortages, which will have also impacted on results for 2021/22.

[53] In February 2022 the West Coast changed patient management systems. Following this change some data including district nursing was impacted and is not currently able to be captured. It is likely the actual volume is higher than reflected in the result and we are working on improving data capture.

[54] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used to support clinical decision making and care planning. Performance fell compared with the previous year as stretched resources, national shortages of trained interRAI assessors and workforce pressures impacted delivery of services. We continue to work with assessors to support the use of the tool across the West Coast.

Aged Residential Care Services								
While demand will increase as our population ages, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	Target Group	2019/20 Results	2020/21 Results	2021/22 Target	2021/22 Results	2021/22 NZ Av	
Proportion of the population (75+) accessing rest home level services in ARC	A^{Δ}	Total	3.4%	3.7%	E<4.5%	3.0%	-	✓
Proportion of the population (75+) accessing hospital- level services in ARC	A^{Δ}	Total	5.1%	5.2%	E.<6.0%	5.5%	-	✓
Proportion of the population (75+) accessing dementia services in ARC	$A^{55\Delta}$	Total	0.7%	0.6%	E.1.0%	0.5%	-	✖
Proportion of the population (75+) accessing psychogeriatric services in ARC	A^{Δ}	Total	0.3%	0.4%	E.<0.4%	0.5%	-	✖
People entering ARC having had a clinical assessment of need using InterRAI	Q^{56}	Total	91%	94%	95%	92%	89%	✖

[55] While the proportion of the population accessing dementia care on the West Coast is below our estimates, the appropriate level of service need is assessed using the InterRAI assessment tool. The difference in dementia volumes relates to three fewer people accessing dementia care than in the previous year. Psychogeriatric services are higher than anticipated but estimate targets are impacted by very small numbers, with 14 people accessing these services compared with 13 the previous year.

[56] West Coast InterRAI rates are impacted by small numbers with just four people not receiving an assessment prior to entering ARC, workforce pressures as a result of COVID-19 limited the timely delivery of interRAI assessments.

Part IV
Managing our Business

Board's Report and Statutory Disclosure

To the stakeholders on the affairs of the Board for the year ended 30 June 2022

Principal Activities

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

Results

During the year, West Coast DHB recorded a net deficit of $16.107m against the budgeted deficit of $11.684m (2021 result was a net deficit of $8.034m).

Board & Committee fees

Total value of remuneration paid to each Board member during the year was (in whole dollars):				
Year ended 30 June 2022	Board	QFARC	Advisory Committee	21/22 Total
Board members				
Chris Auchinvole	17,490		1,000	18,490
Rick Barker	34,647	1,000	1,000	36,647
Susan Barnett	17,490		250	17,740
Sarah Birchfield	17,490	1,000	1,000	19,490
Helen Gillespie	17,490	1,250	500	19,240
Anita Halsall-Quinlan	17,490		1,000	18,490
Tony Kokshoorn	21,862	750	500	23,112
Edie Moke	17,490	1,000	1,000	19,490
Peter Neame	17,490		1,250	18,740
Nigel Ogilvie	17,490	1,000	1,000	19,490
Francois Tumahai	17,490		250	17,740
Total	**213,919**	**6,000**	**8,750**	**228,669**

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

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

No Board members received compensation or other benefits in relation to cessation (2021: Nil).

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

Total value of remuneration paid to each Committee member during the year was (in whole dollars):	
Year ended 30 June 2022	21/22 Total
Advisory committee members	
Lynnette Beirne (CPHAC&DSAC)	750
Paula Cutbush (HAC)	250
Chris Lim (HAC)	750
Joseph Mason (CPHAC&DSAC)	750
Total	**2,500**

Total fees paid, or payable to Board & Committee members for the year was $231,169 (2021: $232,991)

Board and committee member attendance	Board		QFARC[57]		ADVISORY[58]	
	Attended	Maximum Meetings	Attended	Maximum Meetings	Attended	Maximum Meetings
Board Members						
Chris Auchinvole	8	8			3	4
Hon Rick Barker	8	8	4	4	4	4
Susan Barnett	7	8			1	4
Sarah Birchfield	8	8	4	4	3	4
Helen Gillespie	6	8	4	4	3	4
Anita Halsall-Quinlan	7	8			2	4
Tony Kokshoorn	7	8	2	4	1	4
Edie Moke	8	8	4	4	3	4
Peter Neame	7	8			3	4
Nigel Ogilvie	8	8	4	4	3	4
Francois Tumahai	7	8			1	4
Committee Members						
Lynnette Beirne					2	4
Dr Cheryl Brunton					3	4
Joseph Mason					2	4
Paula Cutbush					1	4
Chris Lim					3	4

Directors' and Board members' loans

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

Directors' and Board members' insurance

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

Use of Board information

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

Information on Ministerial directions

WHOLE OF GOVERNMENT APPROACH

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

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

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

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

[57] QFARC – Quality, Finance, Audit & Risk Committee.
[58] Advisory – Advisory Committee *CPHAC & DSAC & HAC formed into one Committee from March 2018

AUTHENTICATION SERVICES

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

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

ELIGIBILITY DIRECTION

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

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

COVID-19 RESPONSE DIRECTION

The COVID-19 Public Health Response Act 2020 was passed as standalone legislation to provide a different legal framework for responding to COVID-19. The Act allows the Minister of Health (or the Director-General of Health in specified circumstances) to make orders under section 11 to give effect to the public health response to COVID-19 in New Zealand.

Several associated directives, epidemic notices and orders have since been issued by Government to manage specific matters during the COVID-19 pandemic and the DHB is working in line with this national direction.

People at the Heart of All We Do

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

We are committed to an ethos of co-design, which includes engaging our people in the development, ongoing review, and renewal of programmes and policies. To that end, we continue to engage our people via multiple channels, initiatives, and programmes.

Amongst this work is the development or updating of People and Capability policies and processes across both West Coast DHB and Canterbury DHB, including our Code of Conduct, Health and Safety Policy, and Diversity, Inclusion and Belonging Policy.

Staff Ethnicity[59]	Number
New Zealand European	352
Other European	126
Indian	51
Māori	50
Asian	47
Other Ethnicity	28
African	5
Middle Eastern	3
Fijian	2
Samoan	2
Cook Islands Māori	1
Tongan	1
Other Pacific Peoples	1
Unknown	378
Grand Total	1,047

Staff Mix by Average Age[59]	Average age
Medical	40.5
Nursing	49
Allied Health	51
Support	54
Management & Administration	48

Staff Mix by Gender[59]	Number	Percentage
Female	869	83%
Male	178	17%
Total	1,047	100%

Staff Identifying a Disability[59] [60]	Number
Yes	33

Leadership, Accountability and Culture

Healthcare is fundamentally about people caring for people. To deliver high quality care to the community, the West Coast health system puts people - and their care - at the centre of all decisions. To achieve this requires a culture where we care for our people, as much as we care for our patients. This means we need leadership that is responsive and accountable to our people and provides clarity of purpose based on bringing the right people together, at the right time, to provide the right service.

To create a broad network of widely distributed clinical and operational leadership, the 20 DHBs have committed to implementing a shared approach to talent management and leadership development, underpinned by the Public Services Commission framework used by the core public sector. This approach allows the West Coast DHB to create transferable leaderships skills across DHBs and the public sector.

To develop leadership capability across the West Coast DHB a leadership development initiative, called the Hub for the Essentials of Leadership and Management (HELM), was developed in partnership with Canterbury DHB.

HELM is a learning initiative designed to support everyone to lead through blended learning solutions accessible to all staff. In addition, it offers targeted development programmes to address key areas of leadership development and management capability.

The helmleaders.org website has undergone an update and review to meet basic Web Content Accessibility Guidelines (WCAG) as part of our organisation signing the Ministry of Social Development's accessibility charter.

[59] Source: Payroll and max. as at July 2022

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

Recruitment, Selection and Induction

West Coast DHB undertakes a shared approach to talent acquisition and management including attracting, selecting and engaging people across the West Coast health system, regionally and nationally for the needs of today and into the future. We continually review our workforce strategies and undertake planning for the coming years, to support a rural health generalist West Coast health system by maximising opportunities that result in faster recruitment turnaround and more engaged employees; thereby ultimately improving the patient journey and patient outcomes throughout the West Coast health system.

We are fully committed to enhancing our practices with respect to equity and diversity. There has been a significant focus on ensuring our recruitment, selection and induction processes are equitable and embrace the development of a diverse workforce.

Partnering with Mana Taurite we have implemented a policy that ensures all Māori and Pacifica that meet job role requirements will go straight to interview. Along with implementing new recruitment campaigns specifically targeting these areas of the community we are raising awareness of the West Coast health system becoming an employer to consider.

Workplace Wellbeing, Health and Safety

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by professional leads in Wellbeing, Health and Safety. Our teams include experts in workplace safety, occupational health, rehabilitation, and employee mental health and wellbeing. In addition to working alongside our people and health and safety representatives, advice and support are provided to all levels of management.

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

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

- Promotion of a safe work environment, safe work practices and critical risk management;
- Workforce engagement and participation in health and safety, including health and safety committees and a range of options for safety training;
- Health monitoring programme which includes screening and immunisation;
- Free annual influenza vaccinations;
- An online hub, where wellbeing resources can be easily accessed by all staff;
- Development and promotion of resources to foster the wellbeing of our people;
- Development of new wellbeing resources to support our people with emerging needs (e.g. managing fatigue post COVID-19);
- Provision of face to face wellbeing sessions for teams;
- Sharing our key resources Nationally, so that all health staff can benefit from them (e.g. understanding burnout online module on HealthLearn);
- Facilitating connecting to care for our people if they need mental health support;
- Providing mental health expertise to our HR Advisory team and Injury Management Team, to help them better support our staff.

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

We do not tolerate any form of harassment, workplace bullying or discrimination and continually review our policies, procedures and responses when issues of bullying, harassment or discrimination arise. This includes a programme of work to improve our policies, a code of conduct, and enabling manager capability to address issues and integrate restorative workplace practises. We continue to improve our people's access to advice and resolution services when they are not having a positive experience at work.

Equal Opportunities and Positive Behaviours

We are an organisation that is committed to practices which minimise all forms of discrimination, bullying and harassment in the workplace as well as barriers to the recruitment, retention, development and promotion of our employees.

A newly established Equity, and Diversity and Inclusion kapa| team was created within our People and Capability function in August 2021. Over the past year the workforce development kapa has led a number of key initiatives

work to better hire, support and grow our diverse workforce with a particular focus on our Māori workforce as well as Pacific peoples, tāngata with disabilities, our LGBTQIA+ workforce and other minority groups, thereby enabling us as an organisation to better reflect the community we serve.

As part of our commitment to equity, diversity and inclusion, some of our key initiatives have included:

- Adopting new, fresh mana enhancing recruitment campaigns to attract Māori and Pasifika into our entry level career path opportunities;
- Creating a culture of authentic belonging for all our kaimahi by celebrating and honouring key dates and events in our calendar;
- Designing and implementing a growing Māori leaders programme, Tū Tangata Tū Rangatira, an in-depth programme that spans over nine-months;
- Supporting with the implementation of the CDHB Disability Action Plan, including supporting Project Search, which provides internship opportunities for young people with intellectual disabilities.

We continue to review our processes and practices, deliver organisational initiatives and learning, and ensure we continue to review our talent acquisition and development practices to enable all people to be successful.

Remuneration and Recognition

The West Coast DHB is committed to applying fair and equitable remuneration and reward practises, taking into account our internal environment, external market relativities as well as the financial environment we operate within.

The majority of our employees are on Multi Employer Collective Agreements (MECA) that are negotiated nationally. Remuneration of employees on Individual Employment Agreements (IEA) that are not under union coverage are reviewed on an annual basis based on external market data.

Employee Engagement

In May 2021 the first employee engagement since 2016 was run to better understand how our tāngata (people) were feeling and to use that information to drive quick wins as well as short-, and long-term goals. The transalpine survey, Tāngata Ora, was composed of around 60 questions and available for 15 days receiving 5,144 responses (42% of staff) from both the Canterbury and West Coast District Health Boards.

Several common themes appeared which assisted both DHBs in developing appropriate and effective actions. In this respect, our divisional leaders utilised the results to develop and implement action plans for their respective teams.

Due to the pandemic and movement towards Te Whatu Ora, follow up surveys are currently on hold. We are continuing employee engagement and satisfaction with targeted workshop interventions when possible across the organisation.

Employee Development and Promotion

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

Our people will have access to a broad range of individual, leadership and managerial capability building. These development opportunities are structured to support effective transition between different roles and leadership contexts, which is supported through our leadership and management platform (helmleaders.org).

West Coast DHB focuses on creating a great learning experience that is accessible for all employees. This includes partnering with other DHBs to develop a fit for purpose learning management platform to meet our organisational needs.

West Coast DHB has a system to record performance and development conversations and processes between managers and their staff called My Success and Development. This service now. based system, implemented in 2017, was a change from the largely paper based approach that the organisation previously used. The system is also supported by delivery of online learning and workshops to introduce the organisation to having great success and development conversations whilst setting realistic and measurable goals

Remuneration of employees

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

A total of 214 employees (2021: 158) received total remuneration of greater than $100,000. The figure stated includes payment for additional duties, lump sum payments, including payment of back pay and employer contributions to superannuation and KiwiSaver schemes.

The Chief Executive's remuneration is excluded as this service is delivered by Canterbury DHB as an outsourced service. West Coast DHB is charged a fee for the Chief Executive services under a management services agreement between Canterbury DHB and West Coast DHB. This amount is disclosed in the related party transactions (note 20).

Of the 214 employees, 200 are clinical employees (2021: 142) and 14 are non-clinical employees (2021: 16).

Remuneration of Employees earning more than $100,000 per annum		
Specified band	2021/22 Actual	2020/21 Actual
$100,000 - $109,999	52	51
$110,000 - $119,999	41	18
$120,000 - $129,999	29	18
$130,000 - $139,999	23	16
$140,000 - $149,999	16	14
$150,000 - $159,999	9	1
$160,000 - $169,999	6	9
$170,000 - $179,999	6	3
$180,000 - $189,999	2	1
$190,000 - $199,999	2	2
$200,000 - $209,999	2	1
$210,000 - $219,999	1	-
$220,000 - $229,999	1	3
$230,000 - $239,999	1	1
$240,000 - $249,999	1	1
$250,000 - $259,999	-	-
$260,000 - $269,999	2	1
$270,000 - $279,999	4	1
$280,000 - $289,999	1	2
$290,000 - $299,999	3	1
$300,000 - $309,999	1	3
$310,000 - $319,999	-	1
$320,000 - $329,999	1	2
$330,000 - $339,999	1	1
$340,000 - $349,999	2	3
$350,000 - $359,999	2	-
$360,000 - $369,000	2	1
$370,000 - $379,999	1	-
$380,000 - $389,000	0	2
$390,000 - $399,000	1	-
$400,000 - $409,999	1	1
Total employees	**214**	**158**

Compensation and other benefits in relation to cessation of employment

During the year, the Board made no payments to former employee's (2021: 1) in respect of the termination of their employment totalling nil. (2021: $8k). These payments include amounts required to be paid pursuant to employment contracts in place, for example amounts for redundancy (based on length of service), and payment in lieu of notice.

Part V
Financial Performance

Statement of Comprehensive Revenue and Expense [61]

For the year ended 30 June 2022

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2021/22 Actual	2021/22 Budget	2020/21 Actual
Revenue				
Patient care revenue	2(i)	201,000	187,108	178,080
Other operating revenue	2(ii)	878	880	818
Interest revenue		139	48	52
Total revenue		**202,017**	**188,036**	**178,950**
Expenses				
Personnel costs	3	88,797	77,250	74,015
Depreciation and amortisation expense	10,11	6,454	6,356	5,382
Outsourced services		10,242	9,866	10,398
Clinical supplies		10,205	10,223	9,795
Infrastructure and non-clinical expenses		12,259	9,738	9,209
Payments to other health service providers		82,641	78,806	73,787
Other operating expenses	4	1,518	1,281	1,294
Finance costs		2	0	2
Capital charge	5	6,006	6,200	3,102
Total expenses		**218,124**	**199,720**	**186,984**
Net surplus/(deficit)		**(16,107)**	**(11,684)**	**(8,034)**
Other comprehensive revenue & expenses				
Gain/(losses) on revaluation of land and buildings	15	23,024	-	5,518
Total other comprehensive revenue & expenses		**23,024**	-	**5,518**
Total comprehensive revenue & expenses		**6,917**	**(11,684)**	**(2,516)**

[61] This statement is to be read in conjunction with the notes to the Financial Statements. Explanations of major variances against budget are provided in note 23

Statement of Changes in Equity [62]

For the year ended 30 June 2022

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2021/22 Actual	2021/22 Budget	2020/21 Actual
Balance at 1 July		**123,353**	**123,572**	3,050
Total comprehensive revenue & expenses		6,917	(11,683)	(2,516)
Owner transactions				
Capital contributions from the Crown		13,632	14,300	122,887
Repayment of capital to the Crown		(69)	(68)	(68)
Balance at 30 June	15	**143,833**	**126,121**	**123,353**

[62] This statement is to be read in conjunction with the notes to the Financial Statements. Explanations of major variances against budget are provided in note 23

Statement of Financial Position [63]

As at 30 June 2022

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2021/22 Actual	2021/22 Budget	2020/21 Actual
Assets				
Current assets				
Cash and cash equivalents	6	5,024	(5,259)	3,415
Receivables	7	7,932	5,864	5,649
Inventories	8	1,451	1,097	1,311
Patient deposits	16	72	0	72
Assets Held for Sale	9	3,178	0	0
Total current assets		**17,657**	**1,702**	**10,447**
Non-current assets				
Property, plant and equipment	10	186,538	171,827	162,107
Intangible assets	11	942	2,483	971
Total non-current assets		**187,480**	**174,310**	**163,078**
Total assets		**205,137**	**176,012**	**173,525**
Liabilities				
Current liabilities				
Payables and deferred revenue	12	15,759	14,922	15,183
Borrowings	13	14	0	0
Employee entitlements and benefits	14	43,396	33,049	33,049
Patient deposits and restricted funds	16,17	83	63	83
Total current liabilities		**59,252**	**48,034**	**48,315**
Borrowings	13	2	0	0
Employee entitlements and benefits	14	2,050	1,857	1,857
Total non-current liabilities		**2,052**	**1,857**	**1,857**
Total liabilities		**61,304**	**49,891**	**50,172**
Net assets/equity				
Contributed capital	15	230,240	230,908	216,677
Revaluations	15	51,981	28,957	28,957
Accumulated surpluses/(deficits)	15	(138,388)	(133,744)	(122,281)
Total equity		**143,833**	**126,121**	**123,353**
Total equity and liabilities		**205,137**	**176,012**	**173,525**

[63] This statement is to be read in conjunction with the notes to the Financial Statements. Explanations of major variances against budget are provided in note 23

Statement of Cash Flows [64]

For the year ended 30 June 2022

IN THOUSANDS OF NEW ZEALAND DOLLARS

	Note	2021/22 Actual	2021/22 Budget	2020/21 Actual
Cash flows from operating activities				
Receipts from Ministry of Health, patients and other revenue		200,275	188,023	179,442
Payments to suppliers		(116,093)	(109,988)	(95,601)
Payments to employees		(78,730)	(77,250)	(79,317)
Interest received		139	-	52
Interest paid		-	-	-
Goods and services tax (net)		(350)	-	(158)
Capital charge paid		(6,006)	(6,204)	(3,102)
Net cash flow from operating activities	18	**(765)**	**(5,419)**	**1,316**
Cash flows from investing activities				
Receipts from sale of property, plant and equipment			-	-
Purchase of property, plant and equipment		(10,799)	(15,752)	(5,743)
Purchase of intangible assets		(391)	(1,735)	(183)
Net cash flow from investing activities		**(11,190)**	**(17,487)**	**(5,926)**
Cash flows from financing activities				
Capital contributions from the Crown		13,632	14,300	1,940
Repayment of capital to the Crown		(68)	(68)	(68)
Net cash flow from financing activities		**13,564**	**14,232**	**1,872**
Net increase /(decrease) in cash and cash equivalents		1,609	(8,674)	(2,738)
Cash and cash equivalents at the start of the year		3,415	3,415	6,153
Cash and cash equivalents at the end of year	6	**5,024**	**(5,259)**	**3,415**

No buildings were acquired by means of equity injection during the year. (2021: $120.9m)

[64] This statement is to be read in conjunction with the notes to the Financial Statements. Explanations of major variances against budget are provided in note 23. The GST component of cash flows from operating activities reflects the movement in opening and closing net GST paid to the Inland Revenue Department. The GST (net) component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statement purposes.

Notes to the Financial Statements

For the year 30 June 2022

1. Statement of Accounting Policies

Reporting entity

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

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

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

The financial statements are for the year ended 30 June 2022.

Basis of preparation

HEALTH SECTOR REFORMS

On 21 April 2021 the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities – the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the West Coast District Health Boards assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements because all assets, liability functions and staff of the West Coast DHB transferred to Te Whatu Ora.

OPERATING AND CASH FLOW FORECASTS

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2022/23 financial year. However, if the DHB was required to settle the holiday pay liability disclosed in note 14 prior to 1 July 2023, additional financial support would be needed from the Crown.

BREACH OF STATUTORY REPORTING DEADLINE

The 2021/22 annual report of West Coast District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

This timeframe was not met because Audit New Zealand was unable to complete the audit within this timeframe due to an auditor shortage and the consequential effects of Covid-19, including lockdowns.

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP). An exception was observed regarding the compliance of the Crown Entity Act 2004, where the audit was completed at a date later than required by Crown Entities Act 2004.

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

PRESENTATION CURRENCY AND ROUNDING

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand dollars ($'000), other than remuneration paid to board and committee members disclosed in note 3 and related party disclosures in note 20.

CHANGES IN ACCOUNTING POLICIES

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

NEW AMENDMENT APPLIED

Amendment to PBE IPSAS 2 Cash Flow Statement

An amendment to PBE IPSAS 2 requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. The new information required by this amendment has been disclosed in note 13.

Summary of significant accounting policies

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

GOODS AND SERVICES TAX (GST)

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

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

Commitments and contingencies are disclosed exclusive of GST.

INCOME TAX

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

BUDGET FIGURES

The budget figures are derived from the 2021/22 statement of performance expectations. The budget figures have been prepared in accordance with GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICIES

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

- Classification of leases – refer to note 4.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

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

- Estimating the fair value of land and buildings – refer to note 10.
- Measuring the liabilities for Holidays Act 2003 remediation, long service leave, retirement gratuities, sabbatical leave, and continuing medical education leave – refer to note 14.

2. Revenue

ACCOUNTING POLICY

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

Ministry of Health population-based funding

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

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

Provision of other services

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

Other grants

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

Sale of goods or services

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

Donations, trust and bequest funds

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

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

Vested or donated physical assets

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

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

Donated services

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

2(i) Breakdown of patient care revenue

	Note	2021/22 Actual	2020/21 Actual
MoH population-based funding		180,249	164,581
Inter-district flows		2,164	2,231
Ministry of Health other contracts & other government contracts		8,756	1,765
ACC contract revenue		1,630	1,707
Other patient care related revenue		8,201	7,796
Total patient care revenue		**201,000**	**178,080**

2(ii) Breakdown of other operating revenue

	Note	2021/22 Actual	2020/21 Actual
Cash donations and bequests received		49	191
Rental revenue		158	156
Training and Development		106	104
Gain on sale of Fixed Assets		72	16
Other		493	351
Total other operating revenue		**878**	**818**

Revenue Appropriation

Under the Public Finance Act, West Coast DHB is required to disclose the revenue appropriation provided to it by the Government for the year, the equivalent expense against that appropriation and the service performance measures that report against the use of that funding. The appropriation revenue received by West Coast DHB for the financial year 2022 is $166.46m (2021: $158.59m) which equals the Government's actual expenses incurred in relation to the appropriation.

3. Employee Benefit Costs

ACCOUNTING POLICY

Salaries and wages

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

The funding arrangements for the scheme are governed by section 44 of the National Provident Fund Restructuring Act 1990 and by a Trust Deed. This Act requires that any increase or decrease to the employer contribution rate should result in contributions being at a level which, on reasonable assumptions, is likely to achieve neither a surplus nor deficit in the trust fund of the scheme at the time that the last contributor to that scheme ceases to so contribute. The Trust Deed specifies that immediately before the scheme is wound up, the assets and the interests of all contributors in the scheme will be transferred to the DBP Annuitants Scheme. Employers have no right to withdraw from the plan.

In practice, at present, a single contribution rate is determined for all employers, which is expressed as a multiple of the contributions of members of the scheme who are employees of that employer. The current employer contribution rate is four times contributor contributions, inclusive of Employer Contribution Withholding Tax. The Actuary has recommended the employer contribution rate of four times contributor contributions continues.

There is no minimum funding requirement.

As at 31 March 2022, the scheme had a past service deficit of $0.6M or 1.7% of the past service liabilities (2021: $1.3m deficit or 2.2% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. This deficit was calculated using a discount rate equal to the expected return on the assets but otherwise the assumptions and methodology were consistent with the requirements of PBE IPSAS 39; Employee Benefits.

Breakdown of personnel costs and further information			
	Note	2021/22 Actual	2020/21 Actual
Wages, salaries and other personnel costs		70,895	65,340
Contributions to defined contribution schemes		2,304	2,081
Increase/(Decrease) in liability for employee entitlements		10,347	3,826
Increase/(Decrease) in Holidays Act compliance provision		5,166	2,749
Restructuring expenses		85	19
		88,797	**74,015**

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

4. Other Operating Expenses

ACCOUNTING POLICY

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

Operating leases

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

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

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

Breakdown of other operating expenses			
	Note	2021/22 Actual	2020/21 Actual
Impairment of debtors	7	58	65
Loss on disposal of property, plant and equipment	10	30	8
Audit fees (for the audit of the financial statements-excl disbursement)		141	123
Audit related fees for assurance and related services (Internal and Quality Audits)		16	79
Board and advisory members fees		231	233
Operating lease expenses		589	455
Other		453	331
Total operating expenses		**1,518**	1,294

Operating leases as leasee

West Coast DHB leases several buildings under operating leases.

The future aggregate minimum lease payments to be paid under non-cancellable operating lease are as follows:			
	Note	2021/22 Actual	2020/21 Actual
Not more than one year		81	65
later than one year and not later than five years		147	71
Later than five years		31	27
Total non-cancellable operating lease		**259**	**163**

5. Capital Charge

ACCOUNTING POLICY

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

Further information

The West Coast DHB pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June and 31 December. The capital charge rate for the year ended 30 June 2022 was 5% (2021: 5%).

6. Cash and Cash Equivalents

ACCOUNTING POLICY

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

Breakdown of cash and cash equivalents and further information	Note	2021/22 Actual	2020/21 Actual
Bank balances and call deposits		5,024	3,415
Cash and cash equivalents in the statement of cash flows	22	**5,024**	**3,415**

Bank Facility

West Coast DHB is a party to a DHB Treasury Services Agreement between New Zealand Health Partnerships Limited (NZHPL) and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHPL, which will incur interest at credit interest rate received by NZHPL plus an administrative margin. The maximum borrowing facility available to any DHB is the value of one month's Provider Arm funding inclusive of GST. As at 30 June 2022, this limit was $8.710m (2021: $8.115m).

Financial assets recognised subject to restrictions

The West Coast DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts (not included in the above) and interest earned is allocated to the individual patients (see note 16).

The bank balance includes unspent donations received of $11k (2021: $11k) that are subject to restrictions. The restrictions generally specify how the donation is required to be spent (see note 17).

7. Receivables

ACCOUNTING POLICY

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

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

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

Breakdown of Debtors and other receivables	Note	2021/22 Actual	2020/21 Actual
Trade receivables		254	83
Ministry of Health receivables		5,901	4,775
Other Crown receivables		475	212
Accrued revenue		544	309
Prepayments		860	339
Less: Provision for un-collectability		(101)	(69)
Total receivables	22	**7,932**	**5,649**

The ageing profile of receivables at year end are as follows:						
	2021/22			2020/21		
	Gross Receivable	Provision for uncollectability	Net	Gross Receivable	Provision for uncollectability	Net
Not past due	7,639		7,639	4,846	-	4,844
Due 1-30 days	80		80	146		146
Past due 31-60 days	34		34	30	-	30
Past due 61-90 days	152		152	587	-	587
Past due more 90 days	128	(101)	27	111	(69)	42
Total Gross Receivables	**8,033**	**(101)**	**7,932**	**5,720**	**(69)**	**5,649**

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

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

Trade receivables, prepayments and other receivables are from exchange revenue transactions. Receivables from the Ministry of Health can be a blend of both exchange and non-exchange revenue transactions. The value of non-exchange balances in Receivables from the Ministry of Health is nil (2021: Nil).

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

Movements in the provision for uncollectability of receivables			
	Note	2021/22 Actual	2020/21 Actual
Balance 1 July		69	27
Receivables written off during the year	4	(26)	(23)
Additional provision made during the year		58	65
Closing balance 30 June		**101**	**69**

8. Inventories

ACCOUNTING POLICY

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

Cost is principally determined on a weighted average cost basis.

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

Breakdown of Inventories			
	Note	2021/22 Actual	2020/21 Actual
Pharmaceuticals		298	233
Surgical and medical supplies		1,138	1,065
Other supplies		15	13
Total Inventories		**1,451**	**1,311**

There were no write-downs of inventories or reversal of prior year write-downs during the year (2021: Nil).

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

9. Non-current assets held for sale

ACCOUNTING POLICY

A non-current asset is classified as held for sale if its carrying amount will be recovered principally through sale rather than through continuing use. Non-current assets held for sale, while classified as held for sale are recognised in surplus or deficit.

Any impairment losses for write-downs of non-current assets held for sale, while classified as held for sale, are recognised in 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 a disposal group) are not depreciated or amortised while they are classified as held for sale.

Breakdown of non-current assets held for sale			
	Note	2021/22 Actual	2020/21 Actual
Non-current assets held for sale include:			
Land		1,600	-
Buildings		1,578	-
Total non-current assets held for sale		**3,178**	-

The West Coast DHB owns land and buildings on the West Coast, which have been classified as held for sale following the Board's approval to sell the properties, as they will provide no future use to the West Coast DHB. The sale is expected to be completed by June 2023.

The accumulated property revaluation reserve recognised in equity for these properties is $4.77M.

10. Property, Plant and Equipment

ACCOUNTING POLICY

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

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

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

Revaluations

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

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

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

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

Additions

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

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

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

Subsequent costs

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

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

Disposals

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

Depreciation

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

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

	Years	Depreciation rate
Freehold Buildings	3 – 70	1.4% to 33%
Fit Out Plant and Equipment	3 – 50	2% to 33%
Plant and Equipment	2 – 20	5% to 50%
Motor Vehicles	3 – 15	6.6% to 33%

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

Impairment of property, plant and equipment

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

Property, plant, and equipment are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might 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, a 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 its recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expense and decreases the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in surplus or deficit. For assets not carried at a revalued amount, the total impairment loss is recognised in surplus or deficit. The reversal of an impairment loss on a revalued asset is recognised in other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset.

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

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

Estimating the fair value of land and buildings

The most recent valuation of land and buildings was performed by an independent registered valuer, Coast Valuations Limited. The valuation was completed in May 2022, and was reviewed and is effective as at 30 June 2022.

Land

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

Restrictions on the DHB's ability to sell land would normally not impair the value of the land because it has operational use of the land for the foreseeable future and will receive substantially the full benefit of outright ownership.

Buildings

Specialised hospital buildings are valued using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions used in the 30 June 2022 valuation include:

- The replacement asset is based on the replacement with modern equivalent assets, with adjustments where appropriate for optimisation due to over-design or surplus capacity. There have been optimisation adjustments made to Buller Health (based on proposed redevelopment plans) and the old Grey Base Hospital (in the process of being demolished) for the most recent valuation.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information. Construction costs range from $2,5 00 to $15,300 per square metre, depending on the nature of the specific asset valued.
- There are no significant asbestos issues associated with the buildings.
- There are no earthquake-prone issues associated with the buildings.
- The remaining useful life of assets is estimated after considering factors such as the condition of the asset, the DHB's future maintenance and replacement plans, and experience with similar buildings. Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Te Nikau Hospital and Health Centre construction project suffered delays and a dispute with one of the contractors, therefore it is unclear whether the actual costs incurred reflect current replacement costs. Construction costs of hospitals in other regions are less comparable due to different resource availability, building sizes and requirements and weather-related delays. There is a lack of major construction projects in the West Coast region to provide alternative replacement cost information relating to Te Nikau Hospital and Health Centre.

The following buildings were valued based on Depreciated Replacement Cost:

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

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

The following market rents and capitalisation rates, where appropriate, were used in the 30 June 2022 valuation:

- Market rents range from $250 to $300 per square metre.
- Capitalisation rates are market-based rates of return and range from 6.75% to 7.5%.

A comparison of the carrying value of land & buildings valued using depreciated replacement cost and land & buildings valued using market-based evidence is as follows:

	2021/22 $'000s	2020/21 $'000s
Depreciated replacement cost	153,685	136,600
Market-based evidence	10,880	10,090
Total carrying value of buildings	164,565	146,690

The resulting movement in property and plant has been recognised as equity in the Property Revaluation Reserve (refer to 15).

Breakdown of property, plant and equipment

	Land	Buildings & fit-out	Plant, equipment & vehicles	Work in progress	Total
Cost or Valuation					
Balance at 30 June 2021	8,710	137,926	28,121	6,890	**181,647**
Additions		470	1,832	10,908	**13,210**
Disposals/transfers		(66)	(897)	(2,373)	**(3,336)**
Revaluation increase (decrease)	90	18,746			**18,836**
Transfer to Assets Held for Sale	(1,600)	(1,578)			**(3,178)**
Balance at 30 June 2022	**7,200**	**155,498**	**29,056**	**15,425**	**207,179**
Accumulated depreciation and impairment losses					
Balance at 1 July 2021	-	65	(19,605)	-	**(19,540)**
Depreciation charge for the year	-	(4,389)	(1,777)		**(6,166)**
Disposal/transfer	-	100	777		**877**
Elimination on revaluation	-	4,188			**4,188**
Balance at 30 June 2022	-	**(36)**	**(20,605)**	-	**(20,641)**
Carrying amount 30 June 2022	**7,200**	**155,462**	**8,451**	**15,425**	**186,538**
Cost or Valuation					
Balance at 31 July 2020	6,855	15,356	22,897	11,932	**57,040**
Additions	-	126,224	5,217	123,933	**255,374**
Disposals/transfers	-	(1,263)	7	(128,975)	**(130,231)**
Revaluation increase (decrease)	1,855	(2,391)	0	0	**(536)**
Balance at 30 June 2021	**8,710**	**137,926**	**28,121**	**6,890**	**181,647**
Accumulated depreciation and impairment losses					
Balance at 31 July 2020	-	(3,348)	(18,366)	-	**(21,714)**
Depreciation charge for the year	-	(3,794)	(1,334)	-	**(5,128)**
Disposal/transfer	-	1,153	95	-	**1,248**
Elimination on revaluation		6,054			**6,054**
Balance at 30 June 2021	-	**65**	**(19,605)**	-	**(19,540)**
Carrying amount 30 June 2021	**8,710**	**137,991**	**8,516**	**6,890**	**162,107**

Restrictions on title

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

Work in progress

Buildings in the course of construction total $12.510m (2021: $4.473m).

Finance Leases

The net carrying amount of assets held under finance leases is $16k (2021: $30k) for clinical equipment. Note 13 provides further information about finance leases

Capital Commitments

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

Capital commitments		
	2021/22	**2020/21**
Buildings	8,900	100
Plant, equipment and vehicles	2,436	563
Intangibles	40	25
Total capital commitments at balance date	**11,376**	**688**

11. Intangible Assets

ACCOUNTING POLICY

Acquisition and development

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

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

Amortisation

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

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

	Years
Acquired computer software	2-10

Impairment

Refer to the policy for impairment of property, plant and equipment in note 10. The same approach applies to the impairment of intangible assets.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Estimating useful lives of software assets

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

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

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

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

Breakdown of intangible assets

Movements for each class of intangible assets are as follows:

Breakdown of Intangibles	Acquired software	NZ Health Partnerships Ltd	Total
Cost or Valuation			
Balance at 30 June 2021	5,514	652	**6,166**
Additions	286	-	**286**
Disposals/transfers	-	-	-
Balance at 30 June 2022	**5,800**	**652**	**6,452**
Accumulated amortisation and impairment losses			
Balance at 1 July 2021	(4,774)	(421)	**(5,195)**
Amortisation charge for the year	(288)	-	**(288)**
Impairment Losses	-	(27)	**(27)**
Balance at 30 June 2022	**(5,062)**	**(448)**	**(5,510)**
Carrying Value at 30 June 2022	**738**	**204**	**942**
Cost or Valuation			
Balance at 30 June 2020	5,017	652	**5,669**
Additions	497	-	**497**
Disposals/transfers	-	-	-
Balance at 30 June 2021	**5,514**	**652**	**6,166**
Accumulated amortisation and impairment losses			
Balance at 1 July 2020	(4,520)	(332)	**(4,852)**
Amortisation charge for the year	(254)	-	**(254)**
Elimination on disposal/transfer	-	(89)	**(89)**
Balance at 30 June 2021	**(4,774)**	**(421)**	**(5,195)**
Carrying Value at 30 June 2021	**740**	**231**	**971**

Restrictions

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

Capital commitments

West Coast DHB has contracted capital commitments of $40k (2021: $25k) in relation to intangible assets.

Impairment of New Zealand Health Partnerships Limited (NZHPL)

An impairment of the NZHPL Change Management and Supply Chain as recommended by NZHPL ($27k) was recognised as at June 2022 (2021: $89). The impairment is to recognise the variation between the underlying value of the Finance Procurement Information Management (FPIM) programme asset held by NZHPL, and the underlying investment carried by DHBs.

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

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

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

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

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

12. Payables and Deferred Revenue

ACCOUNTING POLICY

Short-term payables are recorded at the amount payable

Breakdown of Payables and Deferred Revenue	Note	2021/22 Actual	2020/21 Actual
Payables and deferred revenue under exchange transactions			
Creditors		1,358	2,078
Accrued expenses		10,695	8,806
Deferred revenue		2,166	1,946
Total payables and deferred revenue under exchange transactions		**14,219**	**12,830**
Payables and deferred revenue under non-exchange transactions			
Taxes payable		1,540	2,353
Total Payables and deferred revenue under non-exchange transactions		**1,540**	**2,353**
Total Payables and deferred revenue		**15,759**	**15,183**

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

13. Borrowings

ACCOUNTING POLICY

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

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

Overdraft facility

The amount drawn under the NZHPL banking facility is recorded at the amount payable plus accrued interest.

Finance leases

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

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

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

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

CRITICAL JUDGEMENTS IN APPLYING ACCOUNTING POLICES

Lease classification

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

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

Management has exercised its judgment on the appropriate classification of leases and has determined that a number of lease arrangements are finance leases.

Breakdown of borrowings and further information	Note	2021/22 Actual	2020/21 Actual
Current portion			
Finance leases		14	14
Non-Current portion			
Finance leases		2	16
Total Borrowings		**16**	**30**

West Coast DHB has a maximum overdraft limit of $8.710m (2021: $8.115m) with NZHPL as at 30 June 2022. Refer to note 6 for further information. As at 30 June 2022, the West Coast DHB had nil borrowings (2021: nil).

Fair value

The fair value of finance leases is $16k (2021: $30k). Fair value has been determined using contractual lease cash flows discounted using a rate based on market borrowing rates at balance date

Analysis of finance leases	Note	2021/22 Actual	2020/21 Actual
Minimum lease payments payable			
Not later that one year		16	16
Later than one year and not later than five years		2	18
Later than five years			
Total minimum lease payments		**18**	**34**
Future finance charges		(2)	(4)
Present value of minimum lease payments		**16**	**30**
Present value of minimum lease payments payable			
Not later that one year		14	14
Later than one year and not later than five years		2	16
Later than five years			
Totat present value of minimum lease payments		**16**	**30**

Description of finance leasing arrangements

West Coast DHB has entered into a finance lease for a clinical equipment item. The net carrying amount of the leased item within clinical equipment is included in note 10 (PPE)

There are not restrictions placed on West Coast DHB by any of the finance leasing arrangements

Finance lease liabilities are effectively secured, as the rights to the leased asset revert to the lessor in the event of default in payment.

The table below provides a reconciliation between the opening and closing balance of finance lease liabilities:

Reconcilliation of movements in liabilities arising from financing liabilities	
	Finance Leases $'000
Balance at 1 July 2021	30
Cash outflows	(14)
New Leases	-
Balance at 30 June 2022	**16**

14. Employee Entitlements

ACCOUNTING POLICY

Short-term employee entitlements

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

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

Sick leave

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

Long-term employee entitlements

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

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

Presentation of employee entitlements

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

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

Sabbatical leave, long service leave and retirement gratuities

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

The discount rates used have been obtained from the NZ Treasury published risk-free discount rates as at 5 July 2022. The salary inflation factor has been determined after considering historical salary inflation patterns.

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying value amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $122,000 (2021: $129,000) higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the sabbatical, long service leave, and retirement gratuities obligations would be an estimated $122,000 (2021: $115,000) higher/lower.

Breakdown of Employee entitlements and benefits	2021/22 Actual	2020/21 Actual
Current portion		
Accrued salary and wages	5,892	2,627
Annual leave	7,460	6,412
Holidays Act Compliance provision	24,400	19,234
Continuing medical education leave and expenses	1,741	1,239
Long-service leave	522	344
Other leave	2,244	2,086
Retirement gratuities	522	632
Sabbatical leave	94	101
Sick leave	521	374
Total current portion	**43,396**	**33,049**
Non-current portion		
Long-service leave	336	200
Retirement gratuities	1,544	1,597
Sabbatical leave	170	60
Total non-current portion	**2,050**	**1,857**
Total employee entitlements	**45,446**	**34,906**

Holidays Act compliance

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

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

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

The remediation programme associated with the MOU is a significant undertaking and work to assess, rectify and remediate all areas of non-compliance will continue through the 2022/23 financial year. At West Coast DHB, the formal Review Phase, as set out in the MOU, was completed in March 2020 with all non-compliance issues identified. Efforts are now focused on rectifying payroll systems and processes to ensure ongoing compliance, as well as analysis, testing and remediating the results of retrospective areas of non-compliance for relevant individual employees.

West Coast DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This

was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This indicative liability amount is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties as to the actual amount West Coast DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the liability provision within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

15. Equity

ACCOUNTING POLICY

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

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

Property revaluation reserves

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

Breakdown of Equity				
Reconciliation of movement in equity and reserves	Crown equity	Property revaluation reserve	Accumulated surpluses/ (deficits)	Total equity
2021/22				
Balance at 1 July 202	216,677	28,957	(122,281)	123,353
Surplus/(deficit) for the year	-	-	(16,107)	(16,107)
Capital contributions from the Crown	13,632	-	-	13,632
Repayment of capital to the Crown	(69)	-	-	(69)
Movement in revaluation of land	-	90	-	90
Movement in revaluation of buildings, fixtures and fittings	-	22,934	-	22,934
Balance at 30 June 2022	**230,240**	**51,981**	**(138,388)**	**143,833**
2020/21				
Balance at 1 July 2020	93,858	25,100	(115,908)	3,050
Surplus/(deficit) for the year	-	-	(8,034)	(8,034)
Capital contributions from the Crown	122,887	-	-	122,887
Repayment of capital to the Crown	(68)	-	-	(68)
Movement in revaluation of land	-	2,055	-	2,055
Movement in revaluation of buildings, fixtures and fittings	-	1,802	1,661	3,463
Balance at 30 June 2021	**216,677**	**28,957**	**(122,281)**	**123,353**

Capital management

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

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

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

16. Patient Deposits

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

Movement of patient deposits	Note	2021/22 Actual	2020/21 Actual
Opening balance patients deposits		72	72
Monies received		-	-
Interest earned		-	-
Payments made		-	-
Closing balance		**72**	**72**

17. Restricted Funds

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

Movement of restricted funds	Note	2021/22 Actual	2020/21 Actual
Opening balance restricted funds		11	11
Monies received		-	-
Interest earned		-	-
Payments made		-	-
Closing balance		**11**	**11**

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

	Note	2021/22 Actual	2020/21 Actual
Net surplus/(deficit)		**(16,107)**	**(8,034**
Add/ (less) non-cash items:			
Depreciation and amortisation expense		6,454	5,38
Total non-cash items		**6,454**	**5,38**
Add/(less) items classified as investing or financing activities			
Net (gain)/loss on disposal of property, plant and equipment		(42)	(16
Impairment on investments		27	8
Total items classified as investing or financing activities		**(15)**	**7**
Movements in working capital:			
(Increase)/decrease in receivables		(2,095)	(1,190
(Increase)/decrease in inventories		(140)	(267
Increase/(decrease) in payables and deferred revenue		598	1,92
Increase/(decrease) in employee benefits		10,540	3,43
Net movement in working capital		**8,903**	**3,89**
Net cash flow from operating activities		**(765)**	**1,31**

19. Contingencies

Contingent liabilities

SUPERANNUATION SCHEMES

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

Outstanding legal proceedings

West Coast DHB has no material outstanding legal proceedings as at 30 June 2022 (2021: Nil).

Contingent assets

The West Coast DHB has no contingent assets (2021: Nil).

20. Related Party Transactions

ACCOUNTING POLICY

Transactions eliminated on consolidation

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

West Coast DHB is controlled by the Crown.

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

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

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

Significant transactions with government related entities

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

West Coast DHB has received funding from the Crown, ACC and other government entities of $191m to provide health services in the West Coast area for the year ended 30 June 2022 (2021: $168.02m). Refer to note 7 for amounts receivable.

Revenue earned from other DHBs for the care of patients domiciled outside West Coast DHB's district as well as services provided to other DHBs amounted to $2.164m for the year ended 30 June 2022 (2021: $2.23m).

Expenditure to other DHBs for the care of patients from West Coast DHB's district and services provided from other DHBs amounted to $31.385m for the year ended 30 June 2022 (2021: $29.14m).

Other significant transactions with government-related entities

In conducting its activities, West Coast DHB is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. West Coast DHB is exempt from paying income tax. See note 12 for amounts payable.

West Coast DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2022 totalled $7.22m (2021: $4.42m). These purchases included capital charge from Ministry of Health, blood products from the New Zealand Blood Service, electricity from Meridian Energy and services from educational institutions.

Compensation of key management personnel

West Coast DHB Board members have been paid under the fees framework for members appointed to bodies in which the Crown has an interest. The fees are set by Cabinet. The full time equivalent for Board members has been determined based on the frequency and length of meetings and the estimated time for Board members to prepare for meetings. Analysis of Board member fees is provided on page 31.

At June 2022, the executive management team consisted of 4 members (2021: 4) employed by West Coast DHB and a further 8 members, including the Chief Executive, who were employed by Canterbury DHB (2021: 8). The key management personnel services provided by the Office of the Chief Executive are provided to West Coast DHB under contract by Canterbury DHB and are invoiced accordingly - 2022: $314k (2021: $318k).

No executive management personnel were Board members (2021: Nil).

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

Compensation of key management personnel	2021/22 Actual	2020/21 Actual
Board Members		
Remuneration	228,669	228,178
Full-time equivalent members	2.15	2.15
Executive management		
Remuneration	968,479	987,313
Post -employment benefits	15,487	24,445
Full-time equivalent members	3.70	3.70
Total key management personnel remuneration	**1,212,635**	**1,239,936**
Total full-time equivalent members	**5.85**	**5.85**

21. Events after Balance Date

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000, and establishing Health New Zealand (Te Whatu Ora) and the Māori Health Authority (Te Aka Whai Ora). District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

22. Financial Instruments

Financial instrument categories

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

	2021/22 Actual	2020/21 Actual
Loans and receivables		
Cash and cash equivalents	5,024	3,415
Receivables	7,932	5,649
Investments	-	-
Total loans and receivables	**12,956**	**9,064**
Financial liabilities measured at amortised cost		
Payables (excluding deferred revenue and taxes)	12,053	10,884

West Coast DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances (note 6), trade receivables (note 7), payables (note 12) and loans. Refer to specific notes to the financial statements for applicable detailed explanations for the instruments.

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

Financial instrument risks

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

MARKET RISK

Price risk

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

Fair value interest rate risk

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

Cash flow interest rate risk

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

Currency risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates. West Coast DHB has low currency risk given that most financial instruments it deals with are in New Zealand dollars. Foreign currency forward exchange contracts are used to manage foreign currency exposure where necessary. There were no forward exchange contracts outstanding at 30 June 2022 (2021: Nil)

Credit risk

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

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

The Board places its cash and term investments with quality financial institutions via a national DHB shared banking arrangement, facilitated by NZHPL.

Concentrations of credit risk of accounts receivable are high due to the reliance on the Ministry of Health, which comprises 74% (2021: 85%) of the debtors of West Coast DHB. Together with other Crown receivables (ACC, Pharmac, and other DHBs) total reliance on government debtors is 80% (2021: 88%). The Board considers the risk arising from this concentration of credit to be very low.

Credit quality of financial assets

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

Credit quality of financial assets	2021/22 Actual	2020/21 Actual
Counterparties with credit ratings		
Bank of New Zealand Limited AA-	275	105
Total cash and cash equivalents	**275**	**105**
Counterparties without credit ratings		
NZ Health Partnerships Limited - no defaults in the past	4,810	3,368
Cash on Hand	7	6
Gross receivables (not past due)	7,639	4,844
Total Counterparties without credit ratings	**12,456**	**8,218**

LIQUIDITY RISK

Management of liquidity risk

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

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

Contracted maturity analysis of financial liabilities

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

Maturity groupings of financial liabilities	Carrying amount	Contracted cash flows	Less than 1 year	1-2 years	More than 2 years
2021/22					
Payables	15,759	15,759	15,759	-	-
Total	**15,759**	**15,759**	**15,759**	-	-
2020/21					
Payables	15,183	15,183	15,183	-	-
Total	**15,183**	**15,183**	**15,183**	-	-

23. Explanation of Major Variances against Budget

Explanations for major variances from the DHB's budgeted figures in the 2021/22 Annual Plan are as follows:

Statement of Comprehensive Revenue and Expense

REVENUE

Patient care revenue was $13.8M favourable to budget, mainly due to:

- Additional funding received for Pay Equity; $2.6M for Nursing and Midwifery, $0.27M for Support Workers and $0.90M received for PSA Admin and Clerical pay equity settlement. This is offset by expenditure in personnel costs.
- Additional revenue for Planned Care and Improvement Action Plan of $0.52M.
- COVID-19 related revenue of $9.25M
- Additional revenue in the Primary Practices related to COVID Care in the Community of $0.21M.
- Pharmac GST rebate higher than budgeted due to COVID-19 related Pharmaceuticals, $0.132M.

EXPENSES

Expenses were $18.40M unfavourable to budget. The main factors influencing this overspend were:

Personnel costs were $11.55M unfavourable to budget, mainly due to:

- An increase in the Holidays Act Provision of $2.55M that was not budgeted.
- Unbudgeted costs for those employed in the COVID-19 Response of $3.46M.
- Pay equity settlements; Nursing & Midwifery $2.6M, Support Workers $0.27M and PSA Administration and Clerical Pay Equity settlement of $0.90M.
- Pay equity accrued at 30 June, Nursing and Midwifery $2.05M.

Outsourced Personnel costs are unfavourable due to:

- COVID personnel contracted for COVID response; Vaccination Programme, COVID Hub and Rapid Antigen Tests distribution of $0.43M.
- Outsourced services relating to the COVID response of $0.73M
- Outsourced Medical personnel is favourable and offsets the unfavourable variance in Medical Personnel Cost due to less reliance on use of locums for medical staff.

Statement of Financial Position

Cash and Cash equivalents is favourable mainly due to unspent capex of $6.3M. Of this, $3.5M relates to Te Rau Kawakawa Project and $2.8M unspent on baseline capex.

The favourable variance in Assets Held for Sale is higher than budget due to the proposal for the sale of some West Coast DHB properties which was not budgeted.

Property, Plant and Equipment balance is higher than budget due to the revaluation of Land and Buildings; completed at 30 June 2022. The revaluation was completed upon request from the Te Whatu Ora Board and was not budgeted. The net impact is $23.02M which also includes a delay in Te Rau Kawakawa construction of $6.3M and $3.18M of Land and Buildings transferred to Assets Held for Sale.

Employee Entitlements and benefits is unfavourable due to increase in the Holidays Act provision of $2.55M, MECA accruals of $2.05M and higher leave entitlements owing at year end, than expected.

Statement of Changes in Equity

Revaluation of land & buildings resulted in an increase in value of $23.02M and a revaluation of the Holidays Act provision resulted in an increase of $2.55M.

West Coast DHB received $6M of deficit support, $4.3M more than expected and $7.63M of equity drawdowns for Te Rau Kawakawa Project, which was $4.37M less than planned.

Statement of Cash Flow

Total funds received was more than forecast due to funding received in relation to our COVID-19 response ($9.25M) and funding for Pay Equity ($3.77M).

Payments to suppliers were more than forecast primarily due to COVID-19 related expenditure.

Cash outflows from investing activities was lower than expected due to delay in Te Rau Kawakawa construction ($3.5M) and baseline capex ($2.8M).

24. Summary of Cost of Services

ACCOUNTING POLICY

Cost allocation

The cost of outputs has been determined using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output. Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity or usage information. Depreciation is charged based on asset utilisation. Personnel costs are charged based on actual time incurred. Property and other premises costs, such as maintenance, are charged based on floor area occupied to produce each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

The table below summarises the revenue and expenditure for the four output classes for the year ended 30 June 2022.

	2021/22 Actual	2021/22 Budget	2020/21 Actual
Revenue			
Prevention	8,320	3,698	3,705
Early Detection and Management	38,864	33,777	34,681
Intensive Assessment and Treatment	126,103	122,331	114,010
Rehabilitation and Support	28,730	28,230	26,554
Total Revenue	**202,017**	**188,036**	**178,950**
Expenditure			
Prevention	8,581	3,888	4,931
Early Detection and Management	41,665	35,628	36,351
Intensive Assessment and Treatment	136,748	130,272	119,437
Rehabilitation and Support	31,130	29,931	26,265
Total Expenditure	**218,124**	**199,719**	**186,984**
Surplus/(Deficit)	**(16,107)**	**(11,683)**	**(8,034)**

25. The Effects of COVID-19 on West Coast DHB

In the 2021/22 year COVID-19 activity was centred around keeping COVID-19 out of the community. The effect of COVID-19 on our 2021/22 operations is reflected in these financial statements, based on the information available as at 30 June 2022. The forecasted impact of COVID-19 on West Coast DHB's outyears performance is dependent on several uncertain parameters and the long-term impact will take some time to determine; and will include factors impacting our variable revenue streams such as electives, IDF and ACC, and the costs associated with these such as additional costs required to catch up on lost throughput to meet performance targets.

The main impacts on the 2021/22 financial statements due to COVID-19 are explained below.

Government funding

The Ministry of Health provided $9.25M of funding to West Coast DHB in 21/22 for COVID-19 response. $2.19M of this revenue was distributed through the DHB to the West Coast PHO, general practitioners and aged care providers. The other $7.05M was revenue received for incremental costs relating to West Coast DHB's complete COVID-19 response:

- Community Testing relating to the distribution of Rapid Antigen testing and the setup and running costs for these distribution centres $0.314M
- Establishment of the COVID Hub and the costs associated with the day to day running of this; $2.204M
- Costs associated with isolation and COVID response; $2.16M
- Vaccination related costs – this includes the vaccination drives throughout the coast, the vaccination centres and the vaccination teams; $4.57M

Operating expenses

As a result of COVID-19, the West Coast DHB has incurred additional expenditure which was funded by revenue as above. Additional expenditure was:

- An increase in payroll costs of $3.47M
- Outsourced services of $1.05M
- Treatment related costs $0.168
- Other Expenses of $1.89M
- Costs passed through to external providers of $2.18M

Balance sheet impacts

An impairment assessment has been completed for tangible and intangible assets. No impairments have been recognised as a result of the assessments due to COVID-19.

Part VI
COVID-19 Additional Performance Information

Information provided by the Ministry of Health.

Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

HSU 2021

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

HSU 2020

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of West Coast DHB, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[65]

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

Percentage of the eligible population who have completed their primary COVID-19 vaccination course[66] (HSU 2021 vs HSU 2020)

Year[67]	HSU 2021 Percentage of the eligible population who have completed their primary course	HSU 2020 Percentage of the eligible population who have completed their primary course
2020/2021	14.18%	14.65%
2021/2022	74.50%	76.96%
Total	88.68%	91.61%

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 74% compared with 77% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals

interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in West Coast DHB during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

[65] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology
[66] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[67] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.

COVID-19 vaccine doses administered by dose type and year (HSU 2020)

Year[68]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[69]
2020/21	6,364	4,125	0	0	10,489
2021/22	20,854	22,059	17,053	177	60,143
Total	27,218	26,184	17,053	177	70,632

By 30 June 2022, a total of 70,632 COVID-19 vaccinations had been administered, of which 85% were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore, deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

COVID-19 vaccine doses administered by age group[70]

Age group	Primary course				
(years)[71]	Dose 1	Dose 2	Booster 1	Booster 2	Total[72]
0 to 11	1,259	622	0	0	1,881
12 to 15	1,507	1,448	2	0	2,957
16 to 19	1,082	1,089	256	0	2,427
20 to 24	1,076	1,078	462	0	2,616
25 to 29	1,268	1,269	633	0	3,170
30 to 34	1,439	1,436	831	1	3,707
35 to 39	1,256	1,278	857	2	3,393
40 to 44	1,301	1,354	952	0	3,607
45 to 49	1,472	1,528	1,233	2	4,235
50 to 54	1,764	1,875	1,594	5	5,238
55 to 59	1,985	2,150	1,968	8	6,111
60 to 64	1,875	2,144	2,241	17	6,277
65 to 69	1,351	1,722	1,955	30	5,058

[68] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[69] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.
[70] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[71] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[72] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

Age group (years)[71]	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total[72]
70 to 74	989	1,369	1,695	33	4,086
75 to 79	600	833	1,147	34	2,614
80 to 84	384	524	704	21	1,633
85 to 89	162	226	333	13	734
90+	84	114	190	11	399
Total	20,854	22,059	17,053	177	60,143

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

COVID-19 people vaccinated by age group during 2021/22[73]

Age group[74] (years)	Partial [75]		Primary course [76]			Booster course		
	Partially vaccinated	Partially vaccinated (% eligible)	Completed primary course	Completed primary course (% eligible)	Received first booster (18+)	First booster (% eligible) (18+)	Received second booster (50+)	Received second booster % eligible (50+)
0 to 11	1,046	24%	532	12%	0	0%	0	0%
12 to 15	1,313	81%	1,169	72%	0	0%	0	0%
16 to 19	1,202	91%	1,188	90%	146	34%	0	0%
20 to 24	1,120	84%	1,119	84%	454	39%	0	0%
25 to 29	1,159	67%	1,169	68%	591	45%	0	0%
30 to 34	1,485	75%	1,480	75%	822	50%	0	0%
35 to 39	1,292	73%	1,323	74%	846	56%	0	0%
40 to 44	1,263	71%	1,309	74%	925	62%	0	0%
45 to 49	1,371	67%	1,432	70%	1,144	69%	0	0%
50 to 54	1,750	72%	1,864	77%	1,554	71%	5	3%
55 to 59	1,917	68%	2,066	73%	1,891	77%	6	2%
60 to 64	1,956	68%	2,189	76%	2,234	83%	16	5%
65 to 69	1,455	59%	1,789	72%	1,972	87%	26	8%
70 to 74	1,067	55%	1,437	73%	1,746	92%	36	11%
75 to 79	688	52%	965	73%	1,264	95%	34	13%
80 to 84	403	50%	562	70%	755	98%	24	14%
85 to 89	200	53%	276	73%	374	97%	13	16%
90+	99	45%	139	64%	204	104%	12	20%
Total	20,786	63%	22,008	66%	16,922	72%	172	8%

[73] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[74] Age groupings in this table reflect age of the persons at end of financial year.
[75] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[76] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

COVID-19 vaccine doses[77] administered by ethnicity[78] (1 July 2021 – 30 June 2022)

Ethnicity (Note 1, 2)	Primary course				
	Dose 1	Dose 2	Booster 1	Booster 2	Total
Asian	727	738	644	1	2,110
European/other	17,432	18,709	14,968	166	51,275
Māori	2,394	2,313	1,243	10	5,960
Pacific peoples	246	244	158	-	648
Unknown	55	55	40	-	150
Total	20,854	22,059	17,053	177	60,143

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

COVID-19 people vaccinated by ethnicity during 2021/22[79]

Ethnicity (Note 1)	Partially vaccinated (12+)	Partially vaccinated(12+) (% eligible)	Completed Primary Course (12+)	Completed primary course (12+) (%)	Received First Booster (18+)	Received first booster (18+) (% eligible)	Received second booster, 50+	Received second booster (% eligible, 50+)
Asian	669	66%	712	70%	645	78%	1	3%
Māori	2,194	75%	2,219	75%	1,235	58%	9	8%
European/ other	16,595	68%	18,245	74%	14,844	74%	162	9%
Pacific peoples	227	71%	239	75%	157	69%	0	0%
Unknown	55	108%	61	120%	41	58%	0	0%
Total	19,740	68%	21,476	74%	16,922	72%	172	8%

[77] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
[78] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.
[79] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022

Ethnicity (Note 1, 2)	Partially Vaccinated 12+	Partially Vaccinated 12+ % of HSU2021	Completed Primary Course 12+	Completed Primary Course 12+ % of HSU2021	Received First Booster 18+	Received First Booster 18+ % of Eligible	Received Second Booster 50+	Received Second Booster % of Eligible (50+)
Asian	907	90%	900	89%	645	78%	1	3%
Māori	2,563	87%	2,464	84%	1,235	58%	9	8%
European /other	22,222	91%	21,850	89%	14,844	74%	162	9%
Pacific peoples	286	90%	278	87%	157	69%	0	0%
Unknown	75	147%	72	141%	41	58%	0	0%
Total	26,053	90%	25,564	89%	16,922	72%	172	8%

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)

Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)

Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)

Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

All counts exclude those who died prior to 30-Jun-2022

Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ:[80]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
    a. Official national and subnational projections
    b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

Stats NZ:

'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [81]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB

[80] https://www.stats.govt.nz/methods/population-statistics-user-guide.
[81] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

Comparison of HSU 2021 to the Stats NZ projected resident population

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 33,113 health service users in the HSU 2021. This is an increase of 758 people from the HSU 2020 (an approximate 2% increase), and 413 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[82]

Ethnicity	HSU 2021	Stats NZ PRP	Difference (Note 1)
Māori	3,830	4,130	300
Pacific peoples	408	380	-28
Asian	1,222	1,250	28
European/other	27,601	26,900	-701
Unknown	52	0	-52
Total (Note 1)	33,113	32,660	-453

Note 1: The total population estimate based on HSU 2021 (as at 31 December 2021) is 33,113. This is 453 above the Stats NZ total projected population of 32,660 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

[82] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

DHB population by ethnicity: HSU 2020 and Stats NZ PRP[83]

Ethnicity	HSU 2020	Stats NZ PRP	Difference
Māori	3,672	4,040	368
Pacific peoples	368	380	12
Asian	1,103	1,240	137
European/other	27,145	27,100	45
Unknown	67	0	67
Total (Note 1)	32,355	32,760	405

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 32,355. This is 405 less than the Stats NZ total projected population of 32,760 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2020.

COVID-19 mortality rates

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[84] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

> 'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

[83] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

[84] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in [Canterbury/West Coast DHB] by age group at the time of death (as at 30 June 2022).

Age group (years)	
<10	0
10 to 19	1
20 to 29	0
30 to 39	0
40 to 49	2
50 to 59	2
60 to 69	13
70 to 79	42
80 to 89	66
90+	57
Total	**183**

COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in [Canterbury/West Coast DHB] by the ethnicity of the individual (as at 30 June 2022).

Ethnicity	
Asian	5
European/other	163
Māori	11
Pacific peoples	4
Unknown[85]	0
Total	**183**

[85] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

Part VII Independent Auditor's Report

Independent Auditor's Report

To the readers of West Coast District Health Board's financial statements and performance information for the year ended 30 June 2021

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

Opinion

We have audited:

- the financial statements of the Health Board on pages 39 to 72 that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expense, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the performance information of the Health Board on pages 6 to 29.

In our opinion:

- the financial statements of the Health Board on pages 39 to 72, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2022; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 6 to 29:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and

- what has been achieved with the appropriation; and

- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit of the financial statements and the performance information was completed on 22 March 2023. This is the date at which our opinion is expressed.

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

Emphasis of matters

Without modifying our opinion, we draw attention to the following matters:

The financial statements have been prepared on a disestablishment basis

Note 1 on page 44 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 14 on pages 62 and 63, outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board has estimated a provision of $24.4 million, as at 30 June 2022, to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

HSU population information was used in reporting Covid-19 vaccine strategy performance results

Additional performance information on pages 74 to 84 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 81. The information outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table

that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of Covid-19

Note 25 on pages 71 and 72 to the financial statements and page 19 of the performance information outline the ongoing impact of Covid-19 on the Health Board.

Basis for our opinion

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

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

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

Responsibilities of the Board of Te Whatu Ora – Health New Zealand for the financial statements and the performance information

The preparation of the final financial statements and performance information for the Health Board is the responsibility of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

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

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

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit, carried out in accordance with the Auditor General's Auditing Standards, will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if,

individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

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

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

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

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

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

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

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

- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.

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

- We obtain sufficient appropriate audit evidence regarding the financial statements and the performance information of the entities or business activities within the Health Board to express an opinion on the consolidated financial statements and the consolidated performance information. We are responsible for the direction, supervision and performance of the group audit. We remain solely responsible for our audit opinion.

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

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 1 to 5 and 30 to 38 but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

Independence

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

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

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