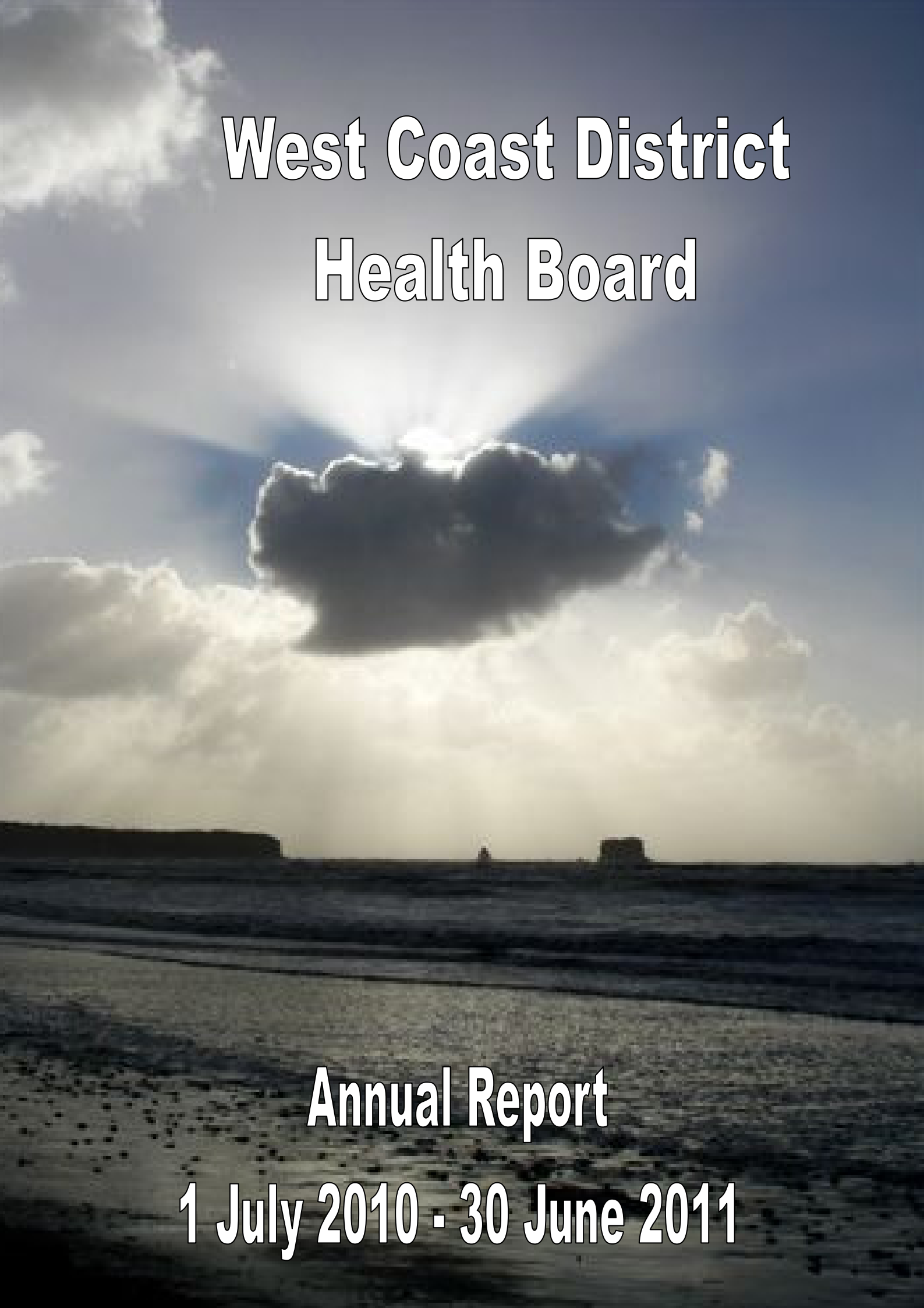

# West Coast District Health Board

# Annual Report

## 1 July 2010 - 30 June 2011

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***Cover Photo "Point Elizabeth at Sunset"***
***Courtesy of Sandra Gibbens***

***Photo "Hector Beach"***
***Courtesy of West Coast Tourism***

# 1. OUR CLINICAL LEADERS AND LEADERSHIP

## West Coast District Health Board's Executive Management Team

| | |
|---|---|
| David Meates | Chief Executive |
| Hecta Williams | General Manager - West Coast District Health Board/ Community and Mental Health Services |
| Dr Carol Atmore | Chief Medical Advisor |
| Karyn Kelly | Director of Nursing & Midwifery |
| Stella Ward | Executive Director of Allied Health (West Coast and Canterbury District Health Boards) |
| Wayne Turp | General Manager - Planning and Funding |
| Wayne Champion | General Manager - Hospital and Support Services (July 2010 to March 2011) |
| Garth Bateup | Acting General Manager - Hospital Services (on secondment from Canterbury District Health Board March 2011) |
| Colin Weeks | Chief Financial Manager |
| Mark Bowen | Risk and Quality Manager |
| Gary Coghlan | General Manager - Māori Health |
| Allan McGilvray | General Manager - Human Resources (West Coast and Canterbury District Health Boards) |
| Dr Vicki Robertson | Medical Director Hospital Services |

## West Coast District Health Board's Provider Arm Clinical Leaders

**Secondary Service Resident Specialists**

| | |
|---|---|
| Anaesthetics | Dr Anders Johnson and Dr Marion Johnson |
| Emergency Department | Dr Roger Mills, Dr Tom Barry, Dr Peter Kyriakoudis and Dr Abi Rayner |
| General Medicine | Dr Paul Holt and Dr Upanada Bopitiya |
| General Surgery | Mr Terry Mixter, Mr Jonathan Pace and Mr Phil Shouler |
| Geriatrics Services | Dr Upanada Bopitiya |
| Obstetrics/Gynaecology | Dr Vicki Robertson, Dr Denis Benichou and Dr Patrick Cerf |
| Orthopaedics Services | Mr Pradu Dayaram and Mr Amer Khan |
| Paediatrics Services | Dr John Garrett |
| Psychiatry Services | Dr Anna Boggis, Dr Karen Cairns, Dr Alfred Delario, Dr James Foulds, Dr Cameron Lacey, Dr Robert Moore, Dr Jane Nugent, Dr Malcolm Stanton, Dr David Stoner, and Dr Daniel Svoboda |
| Rural Primary Practice Student Training (Regional Coordinator) | Dr Greville Wood |

**Service Managers**

| | |
|---|---|
| Michele Coghlan | Nurse Manager, Clinical Services |
| Maureen Frankpitt | Nurse Manager, Community and Primary Care Services |
| Raewyn McKnight | Service Manager - Allied Health, Diagnostics & Support Services |
| Jenny Robertson | General Manager – Buller Health Services |
| Amber Salanoa-Haar | Allied Health Clinical Advisor |
| Lois Scott | Operations Manager – Mental Health Services |
| Barbara Smith | Manager – Reefton Health Services |

# 2. DIRECTORY

### Chief Executive
David Meates

### Registered Office
West Coast District Health Board
Grey Base Hospital
High Street
Greymouth
West Coast

### Auditor
Audit New Zealand on behalf of the Auditor-General

### Banker
Crown Health Finance Agency
Bank of New Zealand

## THE BOARD

## Board Members During 2010/2011

Dr Paul McCormack - Chair from December 2010
Peter Ballantyne - Deputy Chair from December 2010
Kevin Brown
Warren Gilbertson
Helen Gillespie
Sharon Pugh
Elinor Stratford
John Vaile
Susan Wallace

Mary Molloy (from 6 December 2010)
Doug Truman (from 6 December 2010)

Mohammed Shahadat (1 July 2010 – 5 December 2010)
Rex Williams (1 July 2010 – 5 December 2010)

## Board Committees

The Board has four standing Committees to provide for more detailed consideration of particular aspects of the Board's activities. These are:

- Hospital Advisory Committee
- Community and Public Health Committee and Disability Support Committee
- Audit, Risk and Finance Committee
- Tatau Pounamu Manawhenua Advisory Group

Each Committee is responsible for monitoring the Board's progress towards meeting specific Board objectives. The Terms of Reference for each Committee define their specific roles and responsibilities. The Board and Advisory Committees are also involved in strategic planning days.

## Advisory Committee Members

### Hospital Advisory Committee

**Warren Gilbertson**
Chair from 27 January 2011

**Sharon Pugh**
Deputy Chair from 27 January 2011

**Dr Paul McCormack**
Deputy Chair and member until 27 January 2011

**Paula Cutbush**

**Gail Howard**

**Barbara Holland**

**Helen Gillespie** to 27 January 2011

**Mary Molloy**

**Doug Truman** from 27 January 2011

**Richard Wallace**

### Community and Public Health Advisory Committee and Disability Support Advisory Committee [Combined Meetings held from 8 April 2010 ]

**Elinor Stratford**
Chair from 27 January 2011

**Kevin Brown**
Deputy Chair from 27 January 2011 (replaced Elinor Stratford as Deputy)

**Susan Wallace**
Chair and member to 27 January 2011

**Lynnette Beirne** from 24 March 2011

**Cheryl Brunton**

**Marie Mahuika-Forsyth**

**Barbara Holland**

**Mary Molloy** from 27 January 2011

**Patricia Nolan**

**Sharon Pugh**

**John Vaile** from 27 January 2011

**John Ayling** from 24 March 2011

**Robyn Moore** from 3 June 2011

### Audit, Risk and Finance Committee

**Helen Gillespie**
Chair

**Peter Ballantyne**
Deputy Chair from 27 January 2011

**Dr Paul McCormack**

**Susan Wallace** from 27 January 2011

**Rex Williams**

### Tatau Pounamu Manawhenua Advisory Group

**Richard Wallace**
Chair

**Ben Hutana**
Deputy Chair

**Rehia McDonald**

**Marie Maihuka-Forsyth**

**George Nathan** to July 2010

**Tania Pu**

**Elinor Stratford**

**Francois Tumahai**

## VISION STATEMENT

***"To be the New Zealand centre of excellence for rural health services"***

# 3. REPORT FROM THE BOARD

2010/11 has been a year of significant changes that will shape the future for the West Coast District Health Board.

David Meates commenced as West Coast District Health Board Chief Executive contracted from Canterbury District Health Board at the start of the financial year, enhancing the high level of collaboration between the West Coast District Health Board and the Canterbury District Health Board.

Following the Local Government elections and ministerial appointments, a new Board took office under chair Dr Paul McCormack. Mary Molloy and Doug Truman were elected as new members to the Board. Susan Wallace was appointed to both the West Coast District Health Board and to the Canterbury District Health Board.

Improved clinical networks between staff of both District Health Boards, the joint appointment of the Executive Director of Allied Health and changes in the Human Resources and Payroll departments are tangible examples of this increased level of cooperation. As a result, initial work was commenced on the provision of direct support from the specialist orthopaedic, paediatric, geriatric, and mental health services from Canterbury; on shared professional development for clinical staff, and the beginning of work on aligning of clinical practice and policy procedures for allied health services.

This year has seen a District Health Board focus on the Better, Sooner, More Convenient health policy and the new models of care to be delivered from new facilities called Integrated Family Health Centres, starting in Westport. This will guide the provision of healthcare in the Buller for the future and is also providing valuable learning for the future development of such a centre in Greymouth.

Finding sufficient permanent clinical staff continued to prove to be a challenge for the District Health Board. We have begun a new approach to ensure that we are successful in recruiting the skilled people whom we need. The longer-term initiatives undertaken to help address the skilled health workforce shortage on the West Coast now appear to be starting to bear fruit.

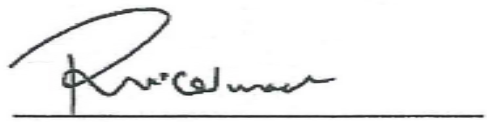
The programme to provide rural General Practice and Rural Hospital training in both hospital and general practice settings saw registrars working at the Rural Academic General Practice, and in both Grey Base Hospital and Buller Health. At the start of the 2011 academic year six new West Coast students and 16 previous recipients received West Coast District Health Board scholarships to assist their tertiary studies in health related areas.

The West Coast District Health Board continues to strive for excellence throughout all its services. Newly implemented staffing roster and incident procedures are examples of the changes that are underway to make our services safe and responsive to community expectations.

The performance of the West Coast District Health Board against the Government Health targets is very heartening. We continue to lead the country for “Shorter Stays in Emergency Departments” and our performance in “Improved access to elective surgery” resulted in a significant number of extra procedures undertaken. When combined with an increase in acute surgery this was a great result for West Coasters.

Also the West Coast District Health Board‘s operating result was a deficit of $6,843,000 which was within the deficit budget agreed with the Minister of Health of $7,200,000.

We would like to acknowledge all members of the staff of the West Coast District Health Board and all others working in the West Coast health system. Their hard work and dedication over the last twelve months have resulted in a service that the West Coast community should be proud of.



**Dr Paul McCormack**
***Chair***
***28 October 2011***

**Peter Ballantyne**
***Deputy Chair***
***28 October 2011***

# 4. THE YEAR IN REVIEW

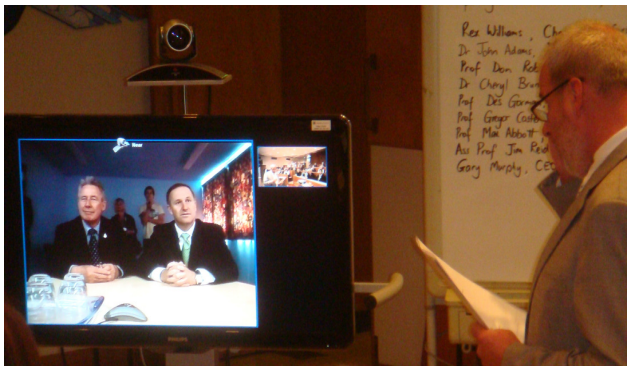
- A major explosion at the Pike River Coal mine occurs on November 19, 2010. The West Coast health system emergency response swings into action for the anticipated rescue / recovery operation. Tragically 29 men lose their lives in the disaster. Canterbury District Health Board staff helps West Coast in its emergency response.
- A major earthquake occurs in Christchurch on 4th September 2010. It causes considerable damage. A further serious quake takes place on 22nd February 2011, with the loss of 181 lives and significantly more damage to buildings and infrastructure. West Coast District Health Board staff helps Canterbury in its emergency response.

**People**

- The West Coast District Health Board contracts with Canterbury District Health Board for Chief Executive services – as such, David Meates is appointed Chief Executive of the West Coast District Health Board in addition to holding that role in the Canterbury District Health Board, further enhancing collaboration between our two District Health Boards.
- Following the District Health Board elections and ministerial appointments the new District Health Board's Board takes office. The Board is Dr Paul McCormack (chair), Peter Ballantyne (deputy chair), Kevin Brown, Warren Gilbertson, Helen Gillespie, Mary Molloy, Sharon Pugh, Elinor Stratford, Doug Truman, John Vaile and Susan Wallace.
- Carl Hutchby is selected to be the Clinical Director of the Greymouth Medical Centre and Rural Academic General Practice, the first nurse to be chosen for such a role.
- Nine new graduate nurses began their nursing careers at the West Coast District Health Board.
- Whataroa-based Dr Martin London is awarded the prestigious Peter Snow Memorial Award at the New Zealand Rural General Practice Network's annual conference.
- Six new West Coast students and 16 previous recipients receive West Coast District Health Board scholarships to assist their tertiary studies in health related areas during the 2011 academic year.
- West Coast Enrolled Nurses were supported in their transition to the new scope of practice.
- 30 Registered Nurses enrol in HWNZ funded Postgraduate education.

**Facilities**

- A significantly upgraded West Coast District Health Board dental facility is opened at Hokitika Primary School.
- The Rural Academic General Practice, a training facility that enables graduate staff to specialise in applying their skills in a rural environment is opened at Grey Base Hospital by Prime Minister John Key (via teleconference) and Grey District mayor Tony Kokshoorn.
- There is construction of a combined West Coast District Health Board and St John health centre / ambulance station in Franz Josef.

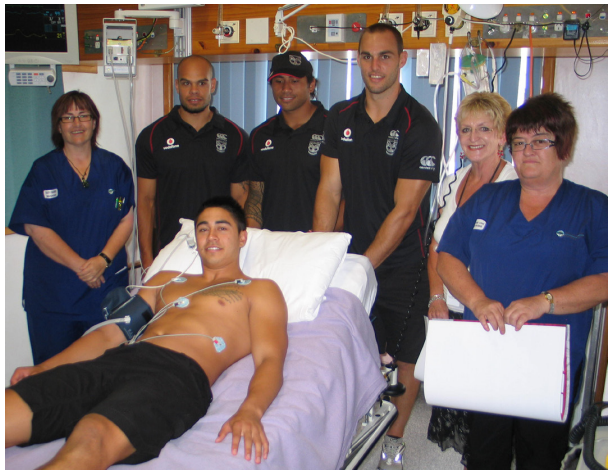


- Concept plans for the future redevelopment of the Grey Base Hospital site into the West Coast regional Health Base are developed.
- The West Coast District Health Board Health Centre at Ngakawau suffers damage as the result of an arson attack during the Christmas break.

**Services**

- February sees the West Coast District Health Board lead the country in being the first District Health Board to fully implement new standardised medication charts.
- Throughout the year the District Health Board progressively installs tele-health equipment at clinics in, Fox Glacier, Hari Hari, Whataroa, Franz Josef and Haast, in addition to the facilities already available in Greymouth, Buller, Hokitika and Reefton. Telemedicine supports the delivery of medical care and education by remote transmission of audio and video data in real or delayed time. Child health and cancer care is supported by videolink form Christchurch
- A mix of allied health, nursing, medical and support staff from across the West Coast health system have been taking part in the Xcelr[8] programme which empowers clinicians and organisational leaders to make positive, effective changes across the care spectrum for their patients and staff.
- The Fresh Future appeal presented a cheque for $57,000 to the McBrearty maternity ward and Parfitt paediatric ward. West Coast staff and public joined in with the fund-raising through a "Charity walk" around the Greymouth floodwall.
- The South Westland practice of the District Health Board is expanded from a single to a two-doctor service with the appointment of Dr Sheryl Larsen.
- The Buller Joint Action Group work with the District Health Board and the West Coast Primary Health Organisation to engage with the community, healthcare providers and staff over the model of care and facilities for the proposed Buller Integrated Family Health Centre.

**Our Community**



- The Warriors rugby league team came to Greymouth for the Miners Solidarity Day league match against the Newcastle Knights. While in town, four of the Warriors took the opportunity to visit Grey Base Hospital to promote Heart Week and visit some of our patients.
- West Coast mothers show their commitment to breastfeeding with figures showing breastfeeding rates at six months are nearly twice the national target, thanks largely to a multi-pronged approach between the District Health Board, the West Coast Primary Health Organisation and community and public health services.
- Medical and nursing students got a taste of life as a rural health professional as they ventured to the West Coast District Health Board and up Mount Cheeseman as part of 'Country Scrubs', annual wilderness medicine weekend.

**Financial**

- West Coast District Health Board achieved its financial goal for the year of operating within the $7,200,000 deficit budget agreed with the Minister of Health, with an actual deficit of $6,843,000.

# 5. WEST COAST DISTRICT HEALTH BOARD PERFORMANCE AGAINST THE NATIONAL HEALTH TARGETS

| Target | Actual Performance in 2010/2011 | Achieved |
|---|---|---|
| ***Shorter Stays in ED:*** 95% of patients are to be admitted, discharged or transferred from an ED within 6 hours. | 99.5% | ✓ |
| ***Improved Access to Elective Surgery:*** West Coast's volume of elective surgery is to be increased to 1,592 in 2010/2011. | 1710 | ✓ |
| ***Shorter Waits for Cancer Radiotherapy Treatment:*** 100% of people needing cancer radiation therapy are to have it within **six** weeks (for period up to 30 November 2010). | 89.6% | ✗ |
| 100% of people needing cancer radiation therapy are to have it within **four** weeks (from 1 December 2010). | 88.2% | ✗ |
| ***Increased Immunisation:*** 90% of two year olds are to be fully immunised. | 84% | ✗ |
| ***Better Help for Smokers to Quit:*** 90% of hospitalised smokers are to receive help and advice to quit. | 85% | ✗ |
| ***Better Diabetes and Cardiovascular Services: Average progress made towards three target indicators***[1] | 72% | ✗ |
| ***Better Diabetes and Cardiovascular Services: >***74% of the eligible adult population who have had a fasting-lipid/glucose test in the last five years. | 76.3% | ✓ |
| ***Better Diabetes and Cardiovascular Services:*** 65% of people with diabetes who have attended a free annual review. | 66% | ✓ |
| ***Better Diabetes and Cardiovascular Services:*** 80% of those receiving a diabetes annual review who have satisfactory or better diabetes management. | 71% | ✗ |

Refer to Statement of Service Performance Section commencing on page 25 for further detail.

[1] Rolling 12 month average, 3 months in arrears to 31 March 2011 (latest available data at time of publication).

# 6. MEETING THE STATUTORY OBJECTIVES AND FUNCTIONS OF A DISTRICT HEALTH BOARD UNDER THE NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

# STATUTORY DISCLOSURE

## Legislative Responsibilities

Section 42 (3) of the New Zealand Public Health and Disability Act 2000 requires District Health Boards to report:

- the extent to which the District Health Board has met its objectives under Section 22 of the New Zealand Public Health and Disability Act 2000;
- how the District Health Board has given effect and intends to give effect to functions specified in Section 23 (1) (a) to (e) of the New Zealand Public Health and Disability Act 2000; and
- on the performance of the hospital and related services it owns.

The following section reports the West Coast District Health Board's performance for the year ended 30 June 2011 for the above legislative responsibilities and requirements under Sections 22 and 23 (1) (a) to (e) of the Act. Further detail on performance is provided in the Statement of Service Performance commencing on page 25.

## Part One - Section 42(3) (b): Report on the extent that the West Coast District Health Board has met the objectives under Section 22 of the New Zealand Public Health and Disability Act 2000

### A. To improve, promote and protect the health of people and communities

**Public Health**

The Healthy West Coast Governance Group, that includes senior level representatives from the West Coast District Health Board, West Coast Primary Health Organisation and Community and Public Health has continued to provide leadership for public health and health promotion initiatives on the West Coast in 2010/2011. This year Healthy West Coast has progressed its collaborative framework through joint planning in the areas of nutrition and physical activity (including breastfeeding), tobacco control/smokefree and immunisation, the utilisation of alliance contracting principles and joint decision-making over the utilisation of public health funding.

Healthy West Coast has well established communication channels with the public health network Active West Coast. This network has taken an active role in advocating for healthy public environments through the local council submission process.

**Primary Health**

Primary health care professionals – doctors, nurses, pharmacists and other allied health professional – and the West Coast Primary Health Organisation, play a key role in improving, promoting and protecting the health of individuals and communities. The West Coast Primary Health Organisation provides clinical programmes and health promotion activities that contribute to the implementation of the Primary Health Strategy and the government's Better, Sooner, More Convenient health policy.

Considerable work was undertaken during 2010/2011 on implementation of Better, Sooner, More Convenient Primary Health services that will provide sustainable services into the future. The major focus of work has been on developing new models of care for the Buller Integrated Family Health Centre as well as progress on core general practice redesign and aligning community based district and mental health nursing and allied health services to general practices.

Progress continued to be made in a number of areas including increasing enrolments in the long term conditions management programme, healthy lifestyles and self management and green prescriptions programmes. 2010/2011 has seen an increase in overall Primary Health Organisation enrolments, including an increase in Māori enrolments, as well as increased access to free sexual health and contraceptive services for under-22s, increased referrals to smoking cessation and primary mental health services and increased immunisation coverage at age two years.

**Healthy Eating Healthy Action (HEHA)**

In 2010/2011 a priority of the HEHA programme has included the provision of breastfeeding support services (including community-based lactation consultation, antenatal classes, Mum4Mum peer support service) and education for professionals. Consultation has occurred with mothers, clinicians and breastfeeding stakeholders in the Buller and Grey Districts to inform the establishment of a breastfeeding pathway of care.

The provision of funding to Māori Community Groups for projects that support improved nutrition and increase physical activity, supporting workplace wellness and completion of the South Island Evaluation of School Based Edible Gardens has been a key focus this year.

## B. To promote the integration of health services, especially primary and secondary health services

**Primary / Secondary Integration – Better Sooner More Convenient**

After delays in the previous year, the implementation of Better Sooner More Convenient commenced in earnest during 2010/2011 following the formal establishment of the Alliance Leadership Team in June 2010 and the appointment of a programme coordinator in February 2011.

Early in the year it was realised that the original scope and ambition of the Better, Sooner, More Convenient Primary Care proposal with 13 distinct components and work streams was not going to progress fast enough within the resources available. Consequently the work plans were condensed to focus on four key imperatives for the year: core general practice re-design, remodelling of community based services, development of new models of care, and facilities for the establishment of integrated community health centres. Each work stream maintained its overall focus on a 'whole of system' approach to improving the delivery of primary and community services and included a strong element of connection and integration with secondary services.

Achievements during the year included:

- Significant progress towards the redesign of planned and acute service delivery for people living in the Buller District in anticipation of the establishment of an integrated family health centre there.
- HML Nurse Triage System (out of hours tele-health access) for all primary practices on the West Coast to provide on-call advice and support to those concerned about their health overnight and at weekends.
- An improvement in the enrolment rate of Māori into primary health services and the collection of specific health data to better identify and address the specific needs of Māori living on the West Coast.
- Closer working between primary health practitioners through the establishment of full multidisciplinary team meetings in more than 80% of primary services.
- The allocation of a Community Mental Health Nurse to primary practices with the intent of better linkage between primary practices, secondary services and emergency departments.
- The construction and opening of the Academic practice on Grey Base Hospital site.
- The introduction of Medtech (patient information systems) in nearly all primary practices and the extension of videoconferencing facilities to rural clinics
- A focus on the establishment of mechanisms to improve patient self care for those who have long term conditions.
- The alignment of 'Carelink' assessors with each primary practice to ensure better connection and support for frail elderly people who move between community and hospital care
- The introduction of 'interRAI' – an assessment and care planning mechanism that will improve quality and consistency of care planning for the elderly.

The District Health Board believes that one of the biggest wastages within our health system is the patient's time. All of the above contributed towards the delivery of health care in the home or as close to as possible to home for those requiring support and in turn, helped to improve the linkages and referral processes between community and hospital services when secondary advanced or specialist care is required.

## C. To promote effective care or support for those in need of personal health or disability support services

**Cancer**

A great portion of care for people with cancer continues to be provided in the community by general practice and other health agencies.

Secondary support is provided by visiting oncology specialists from Canterbury and with our own resident Clinical Nurse Specialists in oncology and palliative care.

During 2010/2011 the initiatives undertaken to provide effective cancer services included:

- The West Coast District Health Board's multi-disciplinary Local Cancer Team met regularly to prioritise and action the recommendations designed to bridge service gaps identified in the study on cancer and palliative care pathways "The Journey of Treatment and Care for People with Cancer on the West Coast", which forms the basis of our District Health Board's cancer control strategy and action plan. A key focus of the Team's work this year was around improving palliative care services and support.
- Implementation of the "Liverpool Pathway of Care for the Dying" was been completed for two rest homes on the West Coast.
- Formalisation of palliative care services and support through Nurse Maude. This included the establishment of Specialist Community Palliative Care support through Dr Amanda Landers who provides regular visits to the West Coast, after-hours back-up, training and education to hospital-based, community and rest home/residential care nurses, as well as direct "live link" clinical support in the management of individual palliative care cases.
- Specialist oncology outpatient services were commenced in Westport via the use of tele-health links for assessment and follow-up (in clinically appropriate cases). This proved highly successful and was well received by both patients and the oncology specialists; and allowed savings in both time and travel costs to both. (Part of our provision of our Better, Sooner, More Convenient approach to patient care). We are looking to expand this to Franz Josef, Reefton and Karamea in 2011/2012.
- Extension of chemotherapy drug regimes (oxaliplatin and pacllitaxol) being able to be provided locally on the West Coast through the oncology nurse specialists in Greymouth and Westport, to help eliminate the need for patients to have to travel to Christchurch for their care.
- The West Coast District Health Board worked with the Southern Cancer Network to promote inter-District Health Board collaboration in service planning and delivery of regional cancer services.
- Radiotherapy waiting times were monitored through regular weekly and monthly updates. During the year to 30 June 2011, 63 West Coast patients were given radiotherapy cancer treatment. Of these, 7 patients were treated outside the target waiting times for starting treatment following first specialist assessment. Three patients were delayed due to capacity constraints at the radiotherapy facilities in Christchurch, 2 were delayed due to patients own choice, 1 was delayed due to clinical considerations (patient not medically ready to commence radiation treatment), and 1 was delayed due to other reasons (not specified).

The West Coast District Health Board continued to support the national cervical screening and breast screening programmes throughout the year. The District Health Board also conducted colonoscopy screening services to provide proactive screening for people with high risk and / or family history of bowel cancer.

**Child Health Services**

The majority of child health care on the West Coast is provided by primary and community services, including by general practice, Tamariki Ora/Well Child providers, and Public Health Nursing Services. During 2010/2011 there has been a focus on improving effective care for children in specialist services

Co-ordination between West Coast District Health Board Child Health services has improved the services provided to children and young people referred to Child Development, Mental Health and Paediatric Services. A combined intake worker has been implemented resulting in a single point of entry along with a combined service multidisciplinary triage meeting to assess referrals and identify the most appropriate service mix for children with multiple or complex health needs.

Progress on improving paediatric medical services on the West Coast has also been made. The West Coast visiting consultant paediatrician is also employed by the Canterbury District Health Board, enhancing our ability to promote effective care for children on the West Coast, as the consultant is available to support care of children on the Coast from Christchurch. Planning for the implementation of 'virtual' ward rounds to be undertaken by the consultant paediatrician using telehealth to promote effective care is almost completed and this initiative will be implemented in 2011/2012.

**Diabetes**

The Local Diabetes Team (LDT) continued to meet regularly and was closely involved in monitoring progress of diabetes service delivery initiatives and closer inter-sectoral collaboration during the year.

A new record total of 831 free annual diabetes checks were undertaken this financial year, compared to 751 in 2009/2010. Overall, the percentage of people accessing these free checks met the 65% target (set against the population estimated to have diabetes in 2010/2011.) Actual results were 59% for Māori (up from 47% last year); 22% for Pacific Island (up from 11% last year) and 67% for other populations (up from 49.7% last year).

Higher numbers of patients seen in 2010/2011, resulted in the identification of higher numbers of people who had poor diabetic management (HBA1c levels above 8.0). None of the target population groups met the 80% target for good diabetes management, with Māori at 66%, Pacific Island population at 33%, other population and overall population at 71% for the 2010/2011 year. This is expected to improve over time now that the patients with poorer control are identified and able to be followed more closely through the Long Term Conditions patient recall and monitoring programme.

Mobile retinal screening services continue to be delivered at main centres throughout the West Coast in 2010/2011.

**Long Term Conditions Management – Cardiovascular Disease, Diabetes, Stroke Care Management, Cancer Control, Respiratory Disease and Palliative Care**

Roll-out of the Long Term Conditions Care Management Plan (LTC) programme continued during 2010/2011 and is now well established within all of the general practice teams on the West Coast as part of the process of planned care. The LTC programme covers all stages of the health and illness continuum for people with chronic conditions in terms of optimising a healthy environment, providing for at risk populations, managing the acute event, initial management (first six months) of a chronic condition and the longer term management (over six months) of a chronic condition.

The LTC programme stratifies individuals into one of three levels of care depending on the complexity of their health problems and ability to self-manage their condition, and provides additional support through:

- Providing an in-depth annual review for each condition, and provide a package of care based on level of need.
- Providing a jointly developed care plan called "My Shared Health Record" for each patient.
- Referral of patient to other community support programmes as required.

Progress on supporting the LTC programme in 2010/2011 included:

- Integration of the Health Navigator service into practices, with the aim of supporting patients with complex social issues affecting their ability to access health care and social support services.
- Integration of a West Coast Primary Health Organisation Kaiawhina into practices to support the LTC programme among Māori patients within the Grey district.
- An upgrade of information technology utilised to support the programme, including the implementation of HealthViews and clinical pathways support.
- Establishment of closer links with general practices and the secondary service Cardiac Nurse Specialists to further support people with cardiovascular disease.

Enrolments in the LTC programme as at 30 June 2011 stood at 2675.

**Older person's services**

During 2010/2011 Carelink worked with the West Coast Primary Health Organisation on the Better, Sooner, More Convenient project to develop an integrated approach to older peoples' care, including linkage of Needs Assessment and Service Coordination (NASC) staff with primary health teams. Moves also started towards streamlining access to short-term homecare through Carelink.

This past year saw a marked improvement in collaboration between West Coast District Health Board and Canterbury District Health Board services for older people, with a Canterbury geriatrician contracted to help develop services, particularly community Assessment, Treatment and Rehabilitation (AT&R).

Progress was made on the reconfiguration of community home support services through aligning the West Coast District Health Board's provider arm home support service more closely to community nursing and appointing a dedicated clinical nurse manager.

Community services for frail older people and their families were boosted by the setting up of accredited befriending services by Age Concern Canterbury, in Westport and Hokitika. The 2-year pilot project for HomeShare day-care servicers has proven successful and was extended and increased.

Supports for people living with dementia was significantly increased by June 2011 with contracts signed with Presbyterian Support to extend HomeShare to people with dementia, and through the establishment of monthly carer support groups in Greymouth, Westport and Hokitika provided by Alzheimers Canterbury, with backing from Presbyterian Support on the Coast.

Coordinated planning for dementia services has improved with four workstreams established. A start was also made on working with the regional dementia team to improve dementia training for paid carers in rest home and other agencies.

West Coast District Health Board nursing staff and primary health teams were seconded to help assist a local rest home/longstay hospital with its work on general improvement in quality issues. This has helped to foster better collaborative relationships between health services and the rest home sector.

Aged residential care services in the Buller region have been the subject of extensive consultation over the year as part of the model of care work in the Buller.

**Mental Health**

During 2010/2011 the West Coast District Health Board has continued to support the development of effective mental health support services. The development of a Collaborative Forum involving mental health service providers and other organisations working with mental health service users has increased collaborative working and promotion of effective services, particularly for long term mental health service users. The forum involves both primary and secondary clinical service providers along with mental health rehabilitation support services providing support for independent living, education and employment, activity and living skill and peer support services.

Considerable work has also been undertaken during 2010/2011 on realigning community based mental health services to primary practices, community allied health services and district nursing services as part of the implementation of the Better Sooner More Convenient Business Case. The major focus of the work having been in Westport where initiatives promoting effective care and support have included the implementation of joint triage meetings involving secondary mental health services, brief intervention mental health services and primary practice nursing services as well as some joint case management when clinically appropriate.

**Upskilling of our Workforce**

A number of initiatives were undertaken to upskill our staff during 2010/2011 to promote effective care and support for patients including:

- Nurse Practitioner Training: As part of the Rural Learning Centre, a Nurse Practitioner and Nurse Practitioner Trainee position were created within the Rural Academic Practice. While we were unsuccessful in recruiting a Trainee we did successfully recruit a Nurse Practitioner. This provides additional capacity within the Primary Heath Care service and provides the base for development of Nurse Practitioners throughout the organisation.
- A business case for a Nurse Practitioner in Aged care has been written in response to the increasing need in this area. This will be presented for consideration in 2011/2012.
- Standing Orders Training: 2010 saw the roll out of Standing Orders training for nurses working in the primary sector and where there is limited access to Doctors. This process enables upskilling and best utilisation of nursing and medical resources. In 2011 the use of Standing Orders continues with ongoing evaluation and refinement of process, including the amended Medicines Act which further enables the use of Standing Orders.
- The Clinical Nurse Specialist group are considering integrating the use of Standing Orders into their service, with a view to future Clinical Nurse Specialist prescribing. This group have either completed or are in the process of completing Postgraduate education to support the inclusion of Clinical Nurse Specialist prescribing in their scope of practice.
- Post Graduate Nursing Education: In 2010/2011 record numbers of Post Graduate nursing students took up the opportunity of study with a total of 28 for the year.
- Professional Development and Recognition Programme (PDRP): The Regional PDRP group developed a shared PDRP website to enable West Coast nurses access to current and up to date resources. The website supports the improved streamlined National Programme and is a base for enabling transition to new scopes such as the new EN scope of practice and the expanded scope of practice for Registered Nurses
- In 2011 the West Coast District Health Board in partnership with Canterbury District Health Board delivered the programme to support enrolled nurses in transitioning to their new scope of practice, this new expanded scope increases the flexibility of the nursing workforce and the role of the Enrolled Nurses within it. A large number of West Coast Enrolled Nurses have chosen to transition.
- Safe Staffing Healthy Workplaces: The West Coast was a demonstration site and achieved key learning's including; improved rostering and matching of resource to patient requirements, using the TrendCare patient management tool. A TrendCare coordinator has been appointed which will further enhance to effect of this acuity tool and SSHW principles.
- Care Capacity: Work commenced on collecting and analysing data to map our capacity to deliver care at Grey Base Hospital. This work is ongoing and has been based on a whole of systems approach. Reefton and Buller will be included in the future, as well as a refining of the work that has already been done.
- Professional Supervision Project: 2010 saw the implementation of the Professional Supervision Project, whereby 10 nurses across primary and secondary commenced training in order to provide professional supervision for nurses outside of Mental Health. These 10 trainees will complete their training in October 2011.
- Falls Project: An evaluation was undertaken on patient fall rates and recommendations developed for implementation in 2010/2011.

## D. To promote the inclusion and participation in society and independence of people with disabilities

The West Coast District Health Board, as a good employer, has a policy to support and promote equal employment opportunities for people with disabilities and to ensure the absence of discrimination against individuals.

The Community and Public Health Advisory Committee and Disability Support Advisory Committee advises the Board on disability issues and oversees the implementation of the Disability Action Plan and the West Coast Improving Services for Elderly Plan for improving older persons health. The West Coast District Health Board's draft Disability Plan promotes opportunity and access to facilities and services for people with disabilities.

West Coast District Health Board has worked with the newly formed Disability Resource Centre to fund disability awareness training.

Mental Health Rehabilitation Services including Education and Employment Support and Activity and Living Skills Support Services promotes and support independence, inclusion and participation in society for people with a long term mental illness.

## E. To reduce health inequalities by improving health outcomes for Māori and other population groups

The West Coast District Health Board remains committed to achieving a reduction, and elimination of disparities in health outcomes between Māori and non-Māori living within Te Tai O Poutini. The reducing inequalities framework continues to be used to improve mainstream effectiveness when reviewing staffing or financial decisions the West Coast District Health Board makes. Improving access is an essential benchmark for the improvement of Māori health status through their involvement in clinical programmes and many of our strategies focus on this target.

- The West Coast District Health Board Chair Dr Paul McCormack and board member Elinor Strafford regularly attended meetings with Tatau Pounamu - the iwi-appointed Mana Whenua planning and advisory health committee. This group comprises representatives from Poutini Ngāi Tahu, Te Rūnanga O Ngati Wae Wae and Te Rūnanga O Makaawhio, as well as Ngā Maata Waka o Mawhera and Ngā Maata Waka o Kawatiri. There was also iwi representation on all of the Board Committees of the West Coast District Health Board.
- Māori involvement in the development of the Better, Sooner More Convenient Business Case has seen the inclusion of significant Māori objectives such as the planned employment of Māori Nurses and Māori health navigators in each of the Integrated Family Healthcare Centres across Te Tai o Poutini.
- Targeted strategies have seen improvement in key areas of need for Māori health including; smoking cessation (brief advice), immunisation, breastfeeding, West Coast Primary Health Organisation enrolment rates, Long Term Conditions Programme enrolments, cervical screening and Breast screening rates.
- The Māori Health Provider, Rata Te Awhina, has restructured its governance to include a majority representation from both Rūnanga on the Board. Rata Te Awhina is now in the process of aligning its service delivery to meet the objectives within the Better, Sooner More Convenient Business case for Māori which is consistent with the planned integration of health services on the West Coast.
- A Māori Clinical Advisory Group was established and had input into the development of the Kaiawhina and Māori Nurse positions, and into the development of the 2011/2012 Māori Health Plan.
- Joint Regional strategies have been developed by Te Herenga Hauora – South Island collective of Māori General Managers/Directors and include collaborating in the following areas; access to elective surgery, Tamariki oral health, Māori Workforce development, pathway planning for Māori Mental health service delivery, Māori whanau transferred to other District Health Boards.

## F. To reduce, with a view to eliminating, health outcomes disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders

The West Coast District Health Board continued to work toward eliminating disparities in health outcomes, through the ongoing provision of services and programmes designed to address inequalities. This has included targeted smoking cessation, breastfeeding and immunisation services as well as the provision of a hospital Kaiawhina and Kaupapa Māori Health Services.

Work on addressing inequalities through the implementation of the Better, Sooner, More Convenient Primary Care proposal began during 2010/2011. This includes working with Rata Te Awhina Trust the existing provider of Māori health services on the West Coast and both Te Rūnanga o Ngati Waewae and Te Rūnanga o Makawhio in developing a model of care within Integrated Family Health Centres for primary and community health services.

## G. To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services

The Health Equity Assessment Tool (HEAT) has been used in the development of health plans, business cases, new services and service change proposals including the development of the Better, Sooner, More Convenient Business Case for primary care services. Its use has also resulted in the inclusion of plans for Māori nurses to be positioned within Integrated Family Health Services. Use of the HEAT provides an effective prioritisation framework and takes into account the need to reduce health inequalities for Māori and for other populations.

## H. To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services

The West Coast District Health Board consultation policy is based on the Ministry of Health best practice guidelines "Consultation Guidelines for District Health Boards".

The West Coast District Health Board remains committed to improving engagement with communities on the West Coast not only when plans include significant changes to service provision, but also to help determine the needs of the population in the early stages of the planning, implementation and monitoring of service delivery.

A number of health advisory and service improvement committees that focus on planning for specific populations (such as older people, children and youth, Māori ), or disease states (such as diabetes, respiratory conditions, cancer) were maintained in 2010/2011. These are committed to improving community participation in the planning and monitoring of health service delivery and developing the trust and confidence of our community through open and transparent processes.

During 2010/2010 the initiated a programme of strategic planning forums on a whole of system basis, inviting local District Mayoralty, Territorial Local Authorities and other community and public sector participation in developing a future vision for good health care throughout the West Coast.

During 2010/2011 a Joint Action Group was established in Buller to engage with the community health care providers and staff over the model of care and facilities for the proposed Buller Integrated Family Health Centre. The first of a series of community updates regarding developments in the way health care will be provided was given to the Buller community towards the end of the year and will be followed up during 2011/2012 with a range of community engagement process as the plan for a better systems of healthcare in the Buller get implemented.

The West Coast District Health Board also participated in a number of community network forums, including the Disability Information Network, Te Rito family violence networks (Buller, Grey and Westland), WISE group meetings, Active West Coast and the Intersectoral Forum through which the West Coast District Health Board sought opportunities for community participation into the planning and feedback on the provision of services.

## I. To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations

The West Coast District Health Board operated a quality audit and monitoring function, and actively encouraged an organisational culture that is supportive of continuous quality improvement and quality initiatives through a systems approach.

Quality initiatives undertaken during the year included:

- Tikanga Best practice Training: Tikanga Best Practice is implemented as a policy and procedure and generally is well supported by staff. During 2010/2011 Tikanga Best Practice training has been provided for staff working in secondary care. This training continues to be provided to clinical staff in a hospital setting and recently has been delivered on eight occasions in the Buller and at Grey Base Hospital working with the Hannan Ward clinical nurse leader and local Kaumatua regarding Tikanga Best Practice Training for staff within secondary care.
- National Medication Chart: The new National Medication Chart has been implemented through the Inpatient services of the West Coast District Health Board. The West Coast led the country, being the first District Health Board to fully implement the new standardised medication charts.
- Patient Falls : A small working party has worked on improving the West Coast District Health Board Falls Prevention processes and has established a revised assessment process and monitoring process
- Health Pathways: The Health Pathways Group continues its work adapting the Canterbury District Health Board Pathways for use on the West Coast.
- Acute Theatre Booking Process: Grey Base Hospital Theatre staff have worked on developing a process for the prioritisation of acute theatre bookings.
- Modified Early Warning System (MEWS): This project has developed and implemented a process for the recognition and management of clinically deteriorating patients.

- ISBAR Communication Tool for Nursing and Clinical Staff: The ISBAR communication tool is used by nursing and clinical staff and is a system that provides a clear process for communicating a patient's state to another health professional. This tool has been introduced throughout the Hospital Services.

The West Coast District Health Board monitored ethical and quality standards performance through its contracting process, by the inclusion of commitments for all providers to deliver services against national standards and service frameworks, and the maintenance of certification of services where required by the Health and Disability Services (Safety) Act 2001.

### J. To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations

The Board meets all requirements for the operation of its facilities including waste management and air discharge. It maintains its facilities to a good standard with automated boiler systems heating hospital facilities and rural clinical replacements built with a greywater management system that returns near clear water to the environment.

### K. To be a good employer

The West Coast District Health Board operates a comprehensive range of Human Resource policies that meet the requirements of being a good employer under the New Zealand Public Health and Disabilities Act 2000. Primary level accreditation under the Workplace Safety Management Programme administered through ACC, was maintained in 2010/2011. Of specific note in the 2010/2011 period, the collaborative relationship between the West Coast and Canterbury District Health Boards has been strengthened and advanced management programmes for leaders and potential leaders in the organisation has progressed significantly. Plans for 2011/2012 includes employee engagement work, performance management, recruitment, safety and health and frontline staff training.

## Part Two - Section 42(3)(i): Statement of how West Coast District Health Board has given effect and intends to give effect to its functions specified in Section 23 (1) (a)-(e) of the New Zealand Public Health and Disability Act 2000

### A. To ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement

Crown Funding Agreement requirements observed and deliverables met during the year.

The Board has met the requirements of all funding agreements that it has entered into.

### B. To actively investigate, facilitate, sponsor and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote and protect the health of people and to promote the inclusion and participation in society and independence of people of disabilities

The Board has continued an active commitment and regular participation in:

- District Health Board New Zealand, an association of District Health Boards that acts on matters of common interest;
- South Island Shared Services Agency Limited, jointly owned by the South Island District Health Boards to assist with health planning and to provide support services to District Health Boards (Note: this Agency has been subsequently been restructured in August 2011 to become the South Island Alliance Programme, focussing on regional planning);
- Management and staff were involved in numerous forums and workshops with the Ministry of Health, other District Health Boards and local agencies;
- Management and staff were actively involved in national policy advisory and review groups that relate to the health and disability sector.

In particular, during 2010/2011 the Board has seen:

- Primary / secondary sector integration and inter-agency collaboration continued as a key focus for the West Coast District Health Board during the year. An Alliance Leadership Team, as part of the Better, Sooner, More Convenient

programme, has overseen the planning for a Buller Integrated Family Health Centre. This project has led to very close collaboration between the West Coast District Health Board and West Coast Primary Health Organisation, together with other health service providers and the Buller community.

- Collaboration on service planning and delivery has progressed between the West Coast and Canterbury District Health Boards. There is a single Chief Executive operating across both District Health Boards, the joint apportionment of a range of senior clinical positions, amalgamation of the Human Resource and Payroll services for both Districts and the convergence of planning and funding.
- Active participation in the development of the Regional Clinical Services plan for the South Island.

## C. To issue relevant information to the resident population, persons in the health and disability sector and persons in any other sector working to improve, promote and protect the health of people for the purposes of the two functions above

This has been conducted via various print and news media, website, publications and public consultation, attendances at meetings, and this report.

## D. To establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement

The West Coast District Health Board maintained a number of processes to enable Māori to participate in and contribute to strategies for Māori Health improvement in 2010/2011. This included Tatau Pounamu Mana Whenua Advisory Group regularly meeting with West Cost District Health Board representatives, clinical staff, the West Coast District Health Board chair, and members of senior management at 6-weekly meetings to provide input into Māori health initiatives, annual and strategic planning, and service delivery. A number of hui were also held with both Rūnanga , including the Rūnanga chairs, to discuss Mori health initiatives on ways to improve Māori health. Outcomes of this included agreement to change the governance structure and service delivery model for Rata Te Awhina Māori health provider services, and to align these along side general practice as part of the future direction for Better, Sooner, More Convenient services for patients.

Iwi representation on all of the Board Committees of the West Coast District Health Board contributed to participation in the governance and key strategic decision making processes of the Board.

Three community consultation Hui have been held in each of the districts with the intention of gaining feedback on the draft Māori health plan. These were very well attended.

The West Coast Primary Health Organisation Māori Health Plan has been aligned to the West Coast District Health Board Māori Health Plan with common strategies and expected outcomes. The General Manager Māori Health and West Coast Primary Health Organisation Chief Executive Officer work together in areas of common interest. There are three elected Māori representatives on the West Coast Primary Health Organisation board that have provided input into the Primary Health Organisation's three-year strategic plan (including one from Rata Te Awhina and one from each of the Rūnanga ).

Delegated Iwi representatives participated in several health strategy groups and management committees including the chronic care strategy group, local diabetes committee, patient pathways, and discharge planning.

The Māori Health team has had significant involvement in developing Māori objectives within the Better, Sooner More Convenient Business case. Additionally, Rata Te Awhina Trust management are on the General Practice work stream and consultation has occurred with the Tatau Pounamu Mana Whenua Advisory Group.

## E. To continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori

During 2010/2011 the West Coast District Health Board has undertaken the following initiatives to foster the development of Māori capacity for participating in the health and disability sector and providing for the needs of Māori :

- Tikanga Best practice Training: Tikanga Best Practice is implemented as a policy and procedure and generally is well supported by staff. During 2010/2011 Tikanga Best Practice training was provided for staff working in secondary care. This training continues to be provided to clinical staff in a hospital setting and was delivered on eight occasions in the Buller and at Grey Base Hospital, working with the Hannan Ward clinical nurse leader and local Kaumatua regarding Tikanga Best Practice Training for staff within secondary care.

- Treaty of Waitangi and Inequalities Training: Training to enhance mainstream effectiveness for Māori patients continued in 2010/2011 - this being a key pathway as set out within He Korowai Oranga the National Māori Health plan. Strategic and outcomes focused dimensions were added to the trainings in 2010/2011.
- Kia Ora Hauora Māori Workforce Development: During 2010/2011 two Educators Breakfasts were hosted; one in the Buller and one in Greymouth. They were both exceptionally well attended with a mix of teachers, government agencies, Māori students and District Health Board clinical staff attending. Work is continuing into 2011/12, developing local strategies designed to increase the number of Māori entering the health and disability workforce, particularly on the Coast. West Coast District Health Board also commenced work with Mokowhiti Consultancy during 2010/2011 to develop and foster a work placement programme, NCEA Study preparation Wananga, and helping to find external scholarships to promote further education and development.
- West Coast District Health Board Scholarships: Our District Health Board continued to provide health scholarships to West Coast students studying for a career in medicine, nursing or allied health. Māori were well represented among scholarship recipients in 2010/2011.
- There was iwi representation on all of the Board Committees of the West Coast District Health Board to help guide the development of Māori capacity and service responsiveness to Māori across West Coast health services.

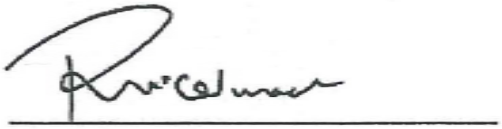
# 7. STATEMENT OF RESPONSIBILITY

Pursuant to Section 155 of the Crown Entities Act 2004, we acknowledge that:

a) The preparation of financial statements and statement of service performance of West Coast District Health Board and the judgements used therein, are our responsibility.

b) The establishment and maintenance of internal control systems, designed to give reasonable assurance as to the integrity and reliability of the financial reports for the year ended 30 June 2011, are our responsibility.

c) In our opinion, the financial statements and statement of service performance for the year under review fairly reflect the financial position and operations of West Coast District Health Board.



**Dr Paul McCormack**
***Chair***
***28 October 2011***

**Peter Ballantyne**
***Deputy Chair***
***28 October 2011***

# 8. AUDITORS REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

**Independent Auditor's Report**

**To the readers of**
**West Coast District Health Board's**
**financial statements and statement of service performance**
**for the year ended 30 June 2011**

The Auditor-General is the auditor of West Coast District Health Board (the Health Board). The Auditor-General has appointed me, Ian Lothian, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and statement of service performance of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 53 to 86, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, 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 statement of service performance of the Health Board on pages 25 to 52.

**Opinion**

In our opinion:

- the financial statements of the Health Board on pages 53 to 86:
    - comply with generally accepted accounting practice in New Zealand; and
    - fairly reflect the Health Board's:
        - financial position as at 30 June 2011; and
        - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board on pages 25 to 52:
    - complies with generally accepted accounting practice in New Zealand; and
    - fairly reflects the Health Board's service performance for the year ended 30 June 2011, including:
        - its performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and

- its revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 28 October 2011. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

**Basis of opinion**

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and statement of service performance are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that would affect a reader's overall understanding of the financial statements and statement of service performance. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health Board's preparation of the financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control 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.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

**Responsibilities of the Board**

The Board is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board's financial position, financial performance and cash flows; and
- fairly reflect its service performance achievements.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

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

**Responsibilities of the Auditor**

We are responsible for expressing an independent opinion on the financial statements and statement of service performance and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

**Independence**

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the New Zealand Institute of Chartered Accountants.

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

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

# 9. STATEMENT OF SERVICE PERFORMANCE

## FOR THE 12 MONTHS ENDED 30 JUNE 2011

This section details the Board's performance to its service objectives and performance targets, as stated in the 2010-13 Statement of Intent, the formal accountability document that sets out the District Health Board's plans and performance targets at the start of the financial year.

## NATURE AND SCOPE OF ACTIVITIES

The West Coast District Health Board was established under the New Zealand Public Health and Disability Act 2000, and is the principal funder and provider of health and disability services to the 32,205[2] people living in the West Coast district.

With its small resident population, (just over 0.7% of the New Zealand population), high proportional tourist numbers and large geographic area (8.5% of New Zealand's land area) the West Coast District Health Board faces challenges not faced by other District Health Boards. Geography and rurality create significant diseconomies of scale in the delivery of services provided and funded by the West Coast District Health Board. Notwithstanding, this, the Board both funds and provides a broad range of health services to the West Coast population.

The West Coast District Health Board periodically conducts and updates its needs analyses and surveys, and collects other data in order to ascertain the health needs and priorities of the West Coast population. Initiatives aimed at meeting these needs and priorities form the basis of the West Coast District Health Board's District Strategic Plan, and are operationalised through their inclusion in the District Health Board's District Annual Plan and Statement of Intent that outlines our service objectives and performance targets over a 3 year period.

## DISTRICT HEALTH BOARD GOVERNANCE AND MANAGEMENT

The governance and management function is charged with monitoring, identifying factors adversely affecting, and implementing strategies to improve the health status of the West Coast population.

The governance role of the West Coast District Health Board is also focused on monitoring the delivery and performance of services by, its provider arm, other District Health Boards and other parties engaged by it in strategies to improve health status.

The role also encompasses activities that facilitate co-operative and collaborative arrangements with other organisations in the health and disability sector.

2010-2011 saw greater formal involvement and collaboration between West Coast and Canterbury District Health Boards. Initial work was commenced on the provision of direct support from the specialist orthopaedic, paediatric and geriatric services from Canterbury; on shared professional development for clinical staff, and the beginning of work on aligning of clinical practice and policy procedures for allied health services. The two Boards have shared the same Chief Executive from the start of the financial year, and during the year, made a joint appointment of the Executive Director of Allied Health and changes in sharing of Human Resources and Payroll departments.

## SERVICE PERFORMANCE

Objectives and performance targets have been divided up according to the functional areas that they relate to.

[2] District Health Board Population Projection for 2010/11, provided by Statistics New Zealand, 2008

## OUTCOMES AND PRIORITIES

### Output Class 1: Public Health Services

Public health services are the domain of many organisations across the West Coast including:

- Ministry of Health: principally as a funder of public health services and also a regulator and planner Regional Public Health. The Ministry of Health is also a provider of services.
- District Health Board: in both funding and provision.
- Primary Health Organisation: mainly in the area of provision of primary health care services, but with some public health functions.
- Community and Public Health: in the provision of health promotion and health protection services.
- A significant array of private and non-government organisations, including Māori providers, Regional Sports Trusts.
- Local and regional government.

District Health Boards plan, fund and ensure the provision of health and disability services to their populations. They are required to assess the health and disability support needs of the people in their regions, and to manage their resources appropriately in addressing those needs. Funding is allocated to District Health Boards using a weighted population-based funding formula. The district public health priorities are determined by the District Health Board in response to the community need.

A proportion of the public health services provided on the West Coast are funded and provided by Community and Public Health through the Canterbury District Health Board. The West Coast District Health Board is working collaboratively with both the West Coast Primary Health Organisation and Community and Public Health under the banner of Healthy West Coast. The Healthy West Coast Governance Group consists of senior level representatives from the three organisations and is focused on joint planning and delivery for public health services. In 2010/2011 this joint planning focused on tobacco control/smokefree, increasing immunisation and nutrition and physical activity. This joint planning and implementation assists in avoiding duplication and providing value for money for West Coast residents.

The Healthy West Coast Governance Group has clear lines of communication to the operational health promotion network 'Active West Coast' which is coordinated by Community and Public Health. The network promotes healthy lifestyles by collaborating to encourage and assist our communities to adopt and maintain healthy lifestyles including a focus on physical activity, smokefree, nutrition, alcohol and other health promotion areas. During 2010/11 Active West Coast jointly developed thirteen joint written submissions relating to and including smokefree environments, gambling, town development, land transport, road safety and district annual plan submissions for the three West Coast Territorial Local Authorities and West Coast Regional Council. Membership of this network includes the West Coast District Health Board, West Coast Primary Health Organisation, Community and Public Health, Territorial Local Authorities, and a range of Non-Government Organisations including the Disability Resource Service.

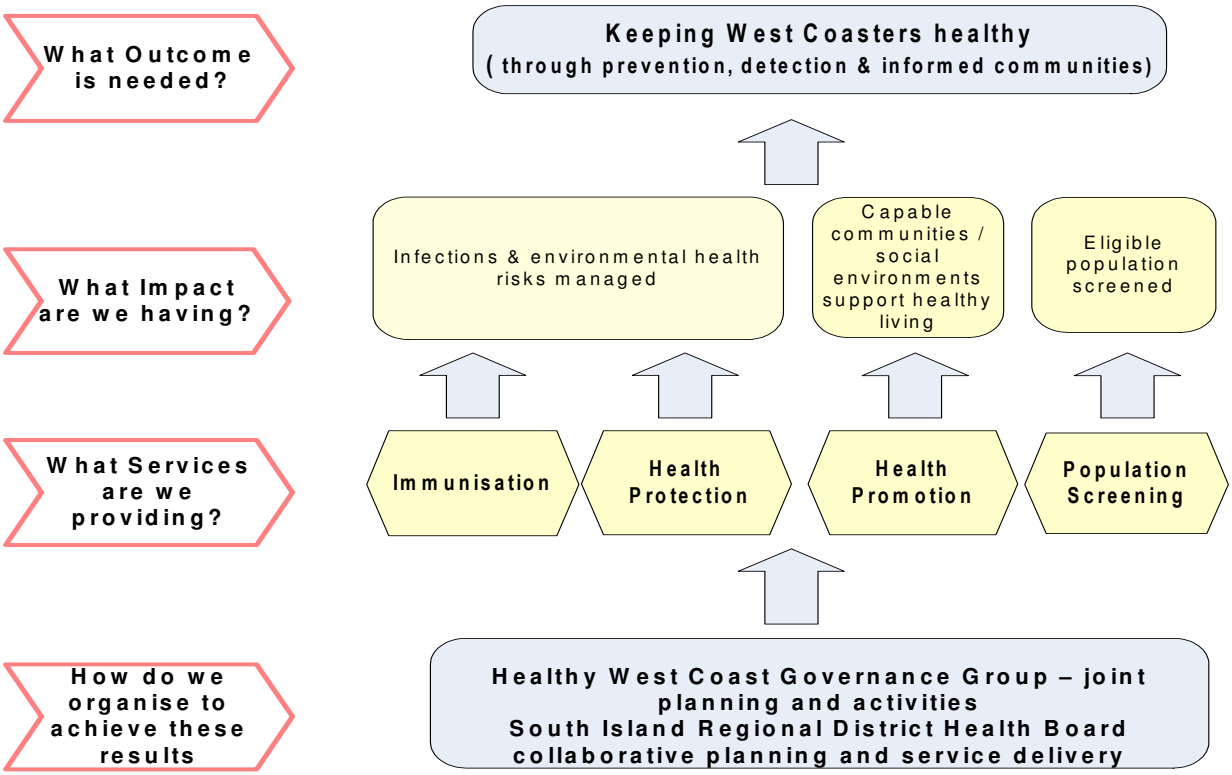
Improving Immunisation coverage continued to be a focus for the West Coast District Health Board in 2010/11. Primary practice processes relating to timely recall have improved and Outreach Immunisation Services continued to focus on coverage for tamariki Māori and children residing in New Zealand Deprivation Index 9 and 10 areas. The impact of these activities resulted in a 2% increase in the percentage of 2 year olds fully immunised and maintenance of high coverage rates for tamariki Māori (see section 10.1.1).

A key focus of the West Coast Tobacco Control Activity Plan 2010/11 was the implementation of the Ask, Brief advice & Cessation strategy across both primary and secondary care services. Within secondary care, initiatives included; mandatory smokefree / ABC training for all clinical staff, an improved and efficient recording 'sticker' system, smokefree ward champions being established and regular communication and engagement between the smokefree coordinator and staff. The impact of these activities resulted in 'better support for smokers to quit' and progress towards the health target over this period, rising from 57% at the start of the year to 83 by the last quarter of the year.

Other successes included the continuation and expansion of the HEHA Tai Poutini Breastfeeding initiative that is delivered by the West Coast Primary Health Organisation. The initiative includes; access to community based lactation-consultants, provision of Mum4Mum peer support programme, ante-natal breastfeeding support, education to primary care and maternity staff around breastfeeding and a continued focus on establishing and

maintaining environments that support breastfeeding. This initiative has continued to contribute to high full and exclusive breastfeeding rates, particularly for Māori on the West Coast (see section 10.1.3).

**Outcomes for Public Health Services**




| **Outcome** | **Keeping West Coasters Healthy; through prevention detection and informed communities.** | | | |
|---|---|---|---|---|
| **Actions/ Services** | **To achieve this Outcome the West Coast District Health Board will look to Improve Nutrition, Reduce harm caused by Tobacco, and increase Immunisation by providing Health promotion, Immunisation, Health Protection, Population Screening services.** | | | |
| **Measure** | **Results for 2010/2011** | | | |
| | **Main measures of performance** | **Target** | **Actual** | **Achieved** |
| Full and exclusive breastfeeding at six months | Māori | 27% | 28% | ✓ |
| | Total | 35% | 42% | ✓ |
| % of year 10 students living in a smokefree home | Total | 65% | 71% | ✓ |
| Children fully immunised at age two | Māori | 80% | 90% | ✓ |
| | Total | 86% | 84% | ✖ |

Factors contributing to the overall target 86% of children being fully immunised at age 2 years of age not being met included a 6.1% “opt off” rate from the programme by parents (with children being partially vaccinated rather than

fully immunised), and a 7.8% "declined to be immunised" rate, with parents not giving consent for their children to be vaccinated.

## Output Class Two: Primary and Community Services

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health and to reducing health inequalities between different groups. New Zealand is experiencing an increasing prevalence rate of long-term chronic conditions including diabetes and cardiovascular disease. Some groups of New Zealanders suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. Long-term conditions require an increased focus across the primary/secondary interface to ensure that people at risk are recognised early and conditions managed effectively.

The three key goals from the national Primary Health Care Strategy are:

- **Transparent national priorities –** District Health Boards, Primary Health Organisations and the Ministry focused on national health priorities and working collaboratively to improve sector performance.
- **Collective stewardship and governance –** Communities and Primary Health Organisations engaged to identify population needs and target responses consistent with national priorities.
- **Enhanced delivery –** A continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

Access to primary health care services is a significant issue for the West Coast population for a number of reasons, including population density, geographic spread and an ongoing shortage of General Practitioners. During 2010/2011 the General Practitioner shortage has begun to ease with the recruitment of additional General Practitioners to the region and the benefits of a number of recruitment and retention initiatives, including the establishment of a GP training programme and a Rural Academic Practice beginning to be seen. There continues to be an environment in which it can take up to 20 days for a routine appointment. However, more practices have opened their books to new enrolments.

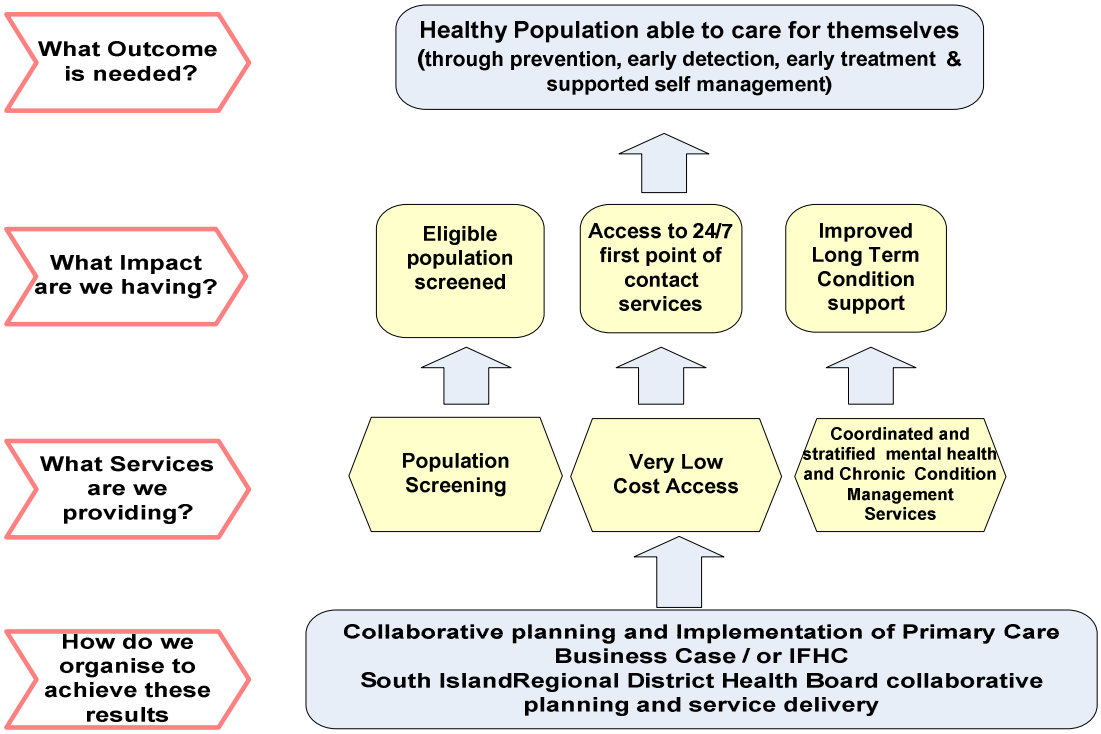
Health outcomes on the West Coast compare unfavourably across a number of health measures with those of other New Zealanders. Considerable inequalities remain in enrolment, access and participation in clinical programs, particularly for Māori. Many deaths, illnesses and hospitalisations on the West Coast are preventable; so for this reason, an increasing focus on prevention and early detection, treatment in primary care, improving integration of clinical care across primary, community and secondary services to address these inequalities has been taken in 2010/2011.

The West Coast District Health Board provides a range of primary and community services including physiotherapy, occupational therapy, speech therapy, social work, district nursing, public health nursing, well child/tamariki ora services, nurse specialists (in diabetes, respiratory and cardiovascular disease), Lead Maternity Care Services, personal care, home based support, sexual health services and so on as close to areas of population in our district as possible. It also operates General Practitioner practices in Greymouth, Reefton, Westport and South Westland.

Non-Government Organisation providers form a critical core of the primary and community services delivered on the West Coast. St John provides emergency first response and retrieval services across the region, and private pharmacies operate in Hokitika, Greymouth and Westport. Primary general practice services, chronic conditions management programmes, navigator and primary mental health services are provided across the West Coast region through the West Coast Primary Health Organisation, with disease state management and whānau ora health services targeted at Māori provided through Māori Health Provider Services. Voluntary sector organisations, such as the Cancer Society, Home Hospice Trust, Arthritis Foundation and a host of similar organisations also play a pivotal role in the delivery of health care services and support within our community.

A number of initiatives were undertaken in our primary and community health services in 2010/2011, particularly in regard to implementation of primary and secondary integration through the Better, Sooner, More Convenient programme; in cancer care; child health services; and in long term conditions management in cardiovascular disease, diabetes, respiratory disease, and palliative care. These initiatives are outlined in Section 6 of this Annual Report. Trends and outcomes in key indicators of these areas of activity are given in the table below and in the specific Output Class Two results in section 10.2 of this Annual Report.

**Outcomes for Primary and Community Services**




| **Outcome** | **Healthy population able to care for themselves through prevention, early detection early treatment and supported self management.** | | | |
|---|---|---|---|---|
| **Actions/Services** | **To achieve this Outcome the West Coast District Health Board will look to increase the use of three-tiered treatment and self-management under the West Coast Chronic Conditions Management programme. It will look at reducing financial barriers to people accessing primary general care through the provision of very low cost access fees; and early screening and ongoing support for people with raised risk profiles for developing chronic and long term conditions.** | | | |
| **Measure** | **Results for 2010/2011** | | | |
| | **Main measures of performance (includes quantity, quality, timeliness and effectiveness of outputs)** | **Target** | **Actual** | **Achieved** |
| Reduction in indirectly standardised Ambulatory Sensitive admissions to hospitals over time, by age and population cohort.<br>(Actual data for this is for the 12-month period to 31 March 2011; the latest available comparative data for these measures at time of publication). | Age 0 -74<br>Māori<br>Other | <br>95<br><95 | <br>95.5<br>90.5 | <br>✖<br>✓ |
| | Aged 0-4<br>Māori<br>Other | <br>95<br>≤ 100 | <br>86.1<br>101.6 * | <br>✓<br>✖ |
| | Age 45-64<br>Māori<br>Other* | <br>95<br><95 | <br>119.2 *<br>91.3 | <br>✖<br>✓ |

| | | | | |
|---|---|---|---|---|
| Percentage of population with access to Very Low Cost Access fees in primary care | West Coast population enrolled with the West Coast Primary Health Organisation who have access to Very Low Cost Access fees as percentage of total West Coast population. ** | >95% | 100% | ✓ |

* *While above target, the outcome results not significantly different from the national level at the 99% confidence level, due to the low number of individual patients that make up these results.*

** *All West Coast practices are in the Very Low Cost Access scheme.*

Changes in ambulatory sensitive admission rates are driven over longer periods of time. The West Coast Primary Health Organisation has been expanding its work and focus on long term conditions patient management programme throughout 2010/201, which is deigned to help manage many of the conditions that are included in this measurement. At present, there is no clear pattern emerging with regard to stabilising and improving results for Māori and Pacific Island populations. It is noted that the raw numbers of patient in these categories is small, so measurement of these population cohorts is subject to large proportional change between 6-monhtly periods when the data is updated by the Ministry of Health.

## Output Class 3: Hospital services

Our hospitals provide a range of inpatient and outpatient services to the people of our region. The West Coast District Health Board has primary level care hospital facilities at Westport and Reefton, and its base secondary care level hospital at Greymouth. All three sites have an Emergency Department as well as inpatient beds. Core services provided at Grey Base Hospital include inpatient and outpatient general medical, paediatric medical, surgical, orthopaedic, gynaecology, obstetric, mental health and geriatric Assessment Treatment and Rehabilitation services, as well as elective surgery in the fields of urology, child dental and plastic surgery and a range of visiting specialist medical and surgical sub-specialty outpatient services. These are supported by allied health and nursing services including physiotherapy, occupational therapy, speech therapy, social work, podiatry, district nursing, nurse specialists (in diabetes, respiratory, and cardiovascular disease), orthotics, Lead Maternity Care Services, personal care, home-based support, hospital pharmacy, laboratory and radiology diagnostic services. Tertiary level services are funded for our population via inter-district flows to other District Health Boards.

The key contracted service outputs delivered by the West Coast District Health Board are based on a contract made between the Planning and Funding department of the District Health Board and the hospital services (provider role of District Health Board) for the year.

**i). Acute Services**

Emergency Department services were provided at Grey Base, Buller and Reefton Hospitals. These services were successful in delivering upon the national Health Target of seeing more than 95% of patients within 6 hours; with 99.5% of presentations being seen within this timeframe during the year.

Acute inpatient services provided at Grey Base Hospital include general medical, paediatric medical, surgical, orthopaedic, gynaecology, obstetric and mental health beds. In addition, acute General Practice-level medical beds are provided at Buller and at Reefton hospitals.

Acute mental health services are provided in the community through the West Coast District Health Board's TACT team, with preventative primary mental health services also provided through the West Coast Primary Health Organisation, in order to help manage the number of patients requiring acute assessment through early intervention.

The Emergency Department After-Hours Services Plan that was put in place in 2009/10 to help reduce demands on emergency services has so far failed to achieve the desired result of reducing the large number of inappropriate triage level 4 and 5 attendances at Emergency Department to target levels. There has been a reduction in the overall number of Triage level five attendances during 2010/2011 compared to 2009/10 – but this is well below our target. This will remain a focus for our District Health Board into the 2011/2012 year ahead.

**ii). Elective Services**

The priorities for our Secondary Health Services in 2010/2011 were to maintain ongoing compliance with Elective Service Patient Flow Indicators (ESPIs); to ensure that the overall delivery of 1592 elective operations to the West Coast population; to deliver key elective procedures at a nationally appropriate Standardised Intervention Rates (SIR) and delivery level; and to identify ways of improving the patient flow for those accessing those services.

West Coast was successful in meeting these priorities. ESPI compliance was maintained for our services through out the year. West Coast also delivered a record 1710 publicly funded elective surgical operations in the key surgical specialties. This was significantly above plan and helped contribute to the overall delivery of increased surgical volumes for South Island as a region. It is not anticipated that this will set any precedent however, and it is planned to return to the 1592 level of surgical delivery in 2011/2012.

West Coast District Health Board focused its continuous quality improvement efforts in three key areas during 2010/2011:

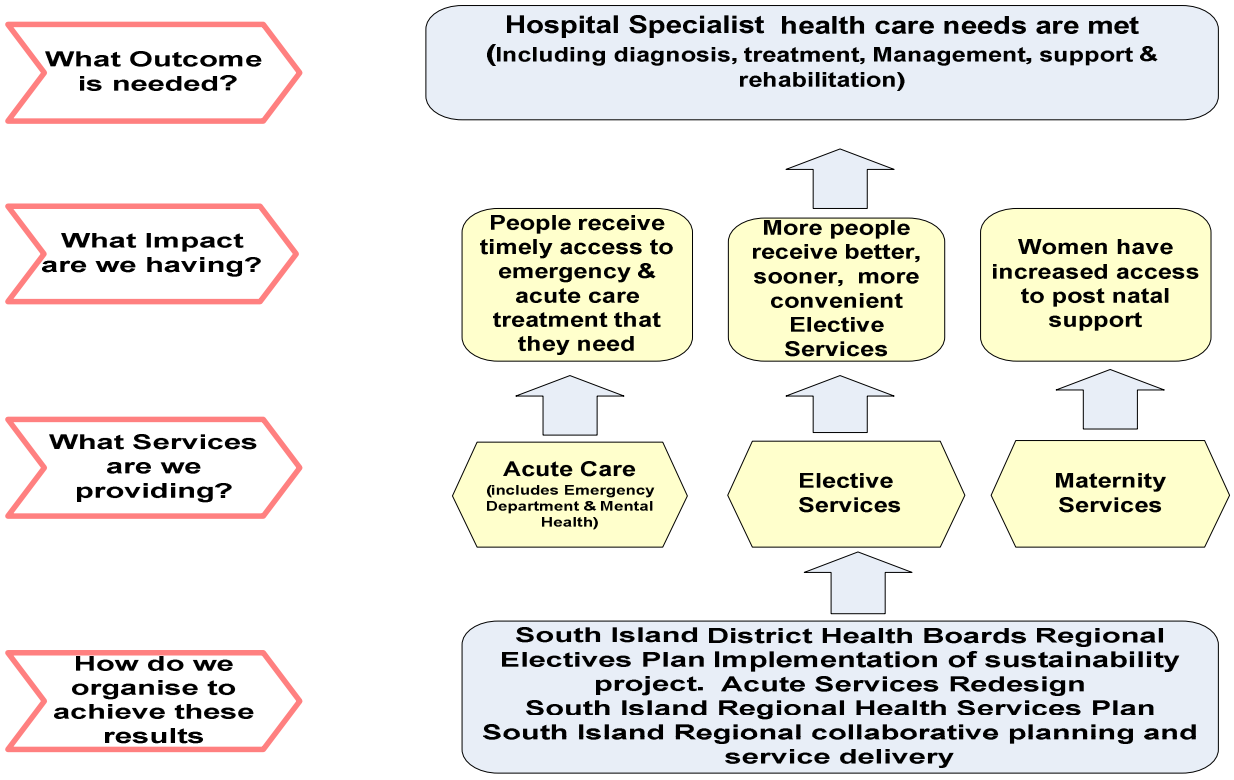
1. Improving scheduling and appointments, including:
    - Improved processes for both inpatient and outpatient services to increase referral numbers that were both seen and treated;
    - maintaining a list of patients that could come in at short notice for surgery in the event of other case cancellations;
    - development of a new roster system for senior medical staff;
    - implementation of a new capacity and production planning system;
    - close monitoring and recall of longer- wait patients and of elective patients under active review;
    - Review of booking processes, roles and responsibilities;
    - Improving email capabilities for notifying patients of outpatient and theatre appointment details and receiving information and updates back from patients in return;
    - Exploration of options around senior physiotherapist-led orthopaedic clinics commenced, to help reduce waiting times for patients accessing both outpatient and elective surgery in our operating theatres.
2. Theatre efficiency to improve utilisation, including:
    - Opening of additional theatre space on Mondays and Fridays for endoscopy procedures to free up theatre space for more major procedures;
    - Increased the volume of urology surgery undertaken during the year at Grey;
    - Back-filling of short-notice patient cancellations and “no shows” with replacement cases;
    - Initiation of an Orthopaedic supplies and loan instrument procurement projects;
    - Establishment of a nurse daily theatre list coordination role with in the theatre.
3. Improvement of patient flow within day and inpatients units at Grey Base Hospital, including:
    - Formal review of all waiting lists to identify patients that could be fast-tracked for surgery;
    - Initiation of a “Patient readiness-for-theatre” project within the wards, including additional pre-anaesthetic clinics and pre-operative checks.
    - Redirection of the discharge planning project to include greater representation and involvement of the allied health team – both to help improve throughput and to improve patient follow-up and care coordination within the wards and in the community following discharge from hospital.
    - Quality Improvement training projects undertaken on wound healing for total knee joint replacement patients to reduce length of stay, and the development of teaching materials for laparoscopic patients.

West Coast District Health Board continued to participate throughout 2010/2011 in the ongoing South Island-wide regional planning process for the delivery of additional elective services and development of a wider regional strategy for surgical service delivery and future provision.

West Coast District Health Board also embarked on more formal ties for clinical support with Canterbury District Health Board, following the joint appointment of Chief Executive from July 2010; most particularly in secondary services. As a result, initial work was commenced on the following areas:

- the provision of direct support from the specialist orthopaedic, paediatric, geriatric, and mental health services from Canterbury on shared professional development for clinical staff;
- recruitment of an orthopaedic surgeon;
- shared work-shopping and planning around the child development service;
- shared professional development
- development of new graduate mentoring and opportunities to visit Canterbury clinicians for learning and support;
- increased professional supervision and support in Allied Health services, including supervision using telehealth;
- the beginning of work on aligning of clinical practice and policy procedures for allied health services, following the joint appointment of a Director of Allied Health between the two Boards.

**Outcomes for Hospital Services**



| **Outcome** | **Hospital specialist care needs are met** | | | |
|---|---|---|---|---|
| **Actions/Services** | **To achieve this outcome the West Coast District Health Board will look to deliver services that are timely and safe.** | | | |
| **Measure** | **Results for 2010/2011** | | | |
| | **Main measures of performance (includes quantity, quality, timeliness and effectiveness of outputs).** | **Target** | **Actual** | **Achieved** |
| Acute inpatient length of stay (days)<br>[OS4] | Average length of stay for acute patients with a length of stay of one night or more. The measure is indirectly standardised for Diagnostic Related Group cluster and co-morbidities. | 3.93 days | 3.62 days | ✓ |
| Standardised acute readmissions to hospital<br>[OS8] | The rate of unplanned acute readmissions within 28 days of original discharge from hospital. The rate is indirectly standardised for a range of factors using regression methods. | <8.21% | 8.37% | ✗ |
| Elective and arranged inpatient length of stay (days)<br>[OS3] | Average length of stay for elective and arranged patients with a length of stay of more than one night. The measure is indirectly standardised for Diagnostic Related Group cluster and co-morbidities. | <3.9 days | 3.82 days | ✓ |
| 30 Day Mortality Rate<br>[OS9] | The mortality rate within 30 days of admission for patients in hospital. The rate is indirectly standardised for a range of factors using regression methods. | 1.95% | 1.79% | ✓ |
| Assessment, Treatment and Rehabilitation Services | Number of patients through Provider Arm inpatient Services. | 130 | 128* | - |
| | Number of patient falls as a percentage of bed days for Assessment, Treatment and Rehabilitation service. | <1.5% | 1.4% | ✓ |
| | Number of patient falls as a percentage of bed days for Dementia and Psychogeriatric Assessment, Treatment and Rehabilitation service. | <1.5% | 1.3% | ✓ |
| Post-natal Stay | Percentage of women with identified risk profiles offered extended lengths of post-natal stay. | 100% | 100% | ✓ |

| | | | | |
|---|---|---|---|---|
| Mental Health:<br>Provider Arm Acute Mental Health patients | Unplanned readmissions within one month of discharge. | <5 | 13.9 | ✘ |
| Provider Arm Elective Mental Health patients | Percentage of people in contact with mental health services for two or more years with Relapse prevention plans. | 98% | 98% | ✓ |

*Excludes 21 ACC-funded Assessment Treatment and Rehabilitation (AT&R) patients discharged during the year from the geriatric and psychogeriatric AT&R services. This is a volume target only not a quality measure and has not been rated.

In the first three measures above, West Coast compared favourably to other District Health Board regions. West Coast was second lowest in acute inpatient stays measure (OS4), where the national average was 4.03 days; in spite of not meeting our 8.21% target, was best in New Zealand for standardised acute readmissions measure (OS8) where the national average was 9.9%; and was sixth best in the country for our elective and arranged inpatient length of stay (OS3 measure), where the national average for the year was 4.03 days. While meeting our target for 30-day mortality rate (OS9 measure) however, West Coast was worst in the country in terms of our result of 1.79%, which was higher than the nation average of 1.48% for the year. There were 63deaths for West Coast in this category, which accounted for 0.8% of the national total 30-day mortalities during 2010/2011.

An increase in inpatient bed day utilisation (up from 1704 bed days in 2009/2010 to 2598 bed days in 2010/2011) led to a need to trial different models of care using respite care bed days. This had the effect of increasing the unplanned readmission rates. The number of funded inpatient bed days has been increased for 2011/2012, and plans have been developed to ensure more coordinated respite for managing patients of lower complex needs.

**Output Class Four: Support Services**

Support services for older people and people with mental illness are linked to a range of other outpatient and community services, including General Practice, district nursing services, physiotherapy, occupational therapy, social work, outreach services, community mental health teams, meals on wheels, home help and personal care (through the West Coast District Health Board and Access Homehealth), and carer support.

The West Coast District Health Board provider arm offers inpatient and outpatient specialist assessment, treatment and rehabilitation services for older people at Grey Base Hospital, as well as Carelink, a community-based Needs Assessment and Service Co-ordination (NASC) service working out of Greymouth and with a base in Westport. The West Coast District Health Board provider arm also supplies long-term aged residential care facilities at Grey Base Hospital, Buller Health and Reefton Health, including a specialist dementia unit at Grey Base Hospital. The West Coast District Health Board funder arm also funds a range of other providers to deliver long-term aged residential care rest home and hospital level services, as well as respite care and daycare at Westport, Reefton, Greymouth and Hokitika.

PACT is funded to provide residential care services in the community for people with mental health issues. The West Coast District Health Board provider arm provides mental health assessment, treatment and rehabilitation service, inpatient and outpatient services at Grey Hospital, and Needs Assessment and Service Co-ordination services at Greymouth and Westport.

Palliative care is principally provided in the home, in the District Health Board's hospital facilities, or through individual placements in other facilities where this is clinically appropriate. 2010/2011 saw the formalisation and expansion of the palliative care support network with the Community Palliative Care Specialist from Nurse Maude, as well as training opportunities for staff involved in the provision of palliative care.

The work of voluntary sector organisations such as the Disability Resource Centre, Alzheimers Canterbury, Presbyterian Support, Age Concern, CARE wheelchair van drivers, CCS and the like play a vital role in supporting the health needs of people in our community. This is a role that is greatly appreciated by the West Coast District Health Board.

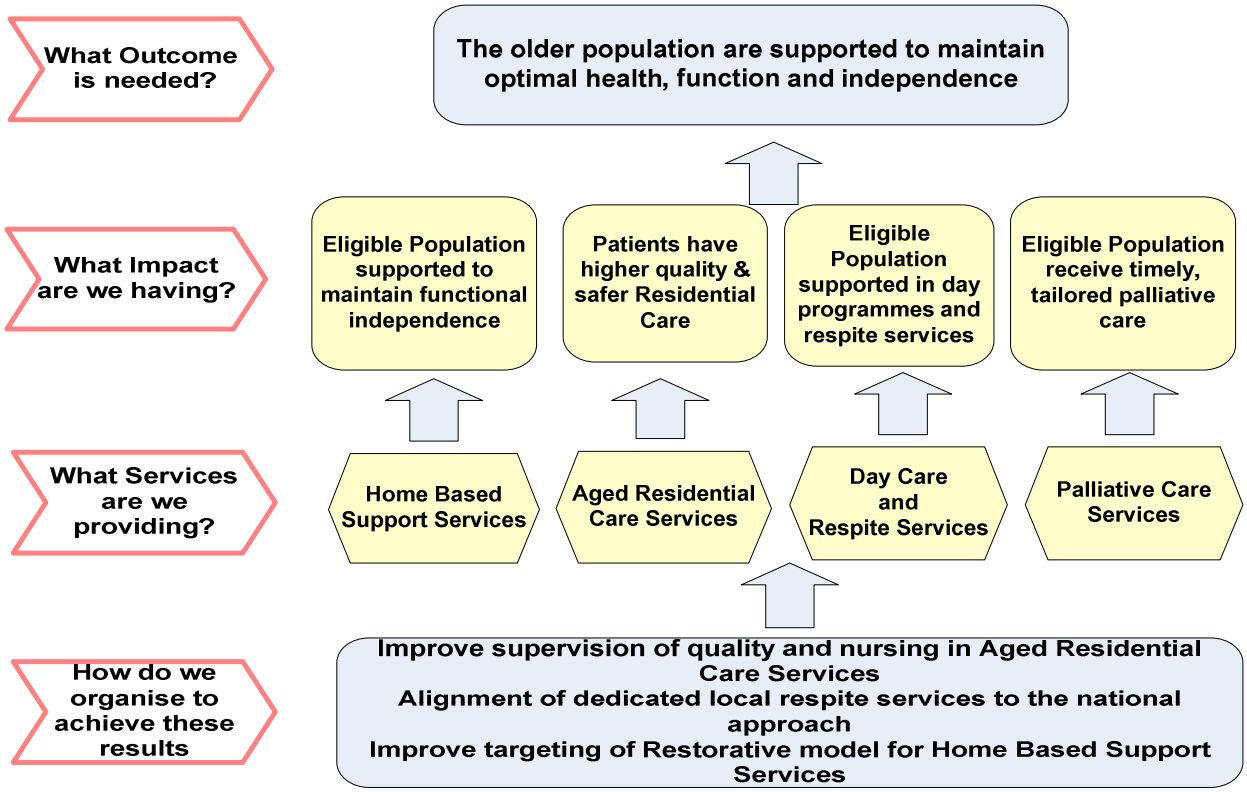
During 2010-2011 West Coast District Health Board participated in the regional workplan for older persons services to improve the equity of access to support services throughout the South Island and to disseminate innovation

among District Health Boards. West Coast District Health Board continued expanding the range of services supporting people living at home and their carers through new contracts with Presbyterian Support Services and Alzheimers Canterbury.

West Coast District Health Board worked closely with the other South Island District Health Boards to align access to support services and to adopt common quality standards, through the use of InterRAI, common access criteria and a regional service specification for home support. West Coast District Health Board also took the lead in undertaking a regional and national stocktake of respite, carer support and daycare to inform the South Island District Health Board's strategy on developing these services.

Growing collaboration with Canterbury District Health Board led to stronger links between Canterbury and West Coast specialist services for older people and as a result, West Coast District Health Board engaged a Canterbury District Health Board geriatrician for an 18-month period to develop the next stage in collaborative services for older people.

**Outcomes for Support Services**



| **Outcome** | **The older population are supported to maintain optimal health, function and independence** | | | |
|---|---|---|---|---|
| **Actions/Services** | **To achieve this outcome the West Coast District Health Board will work to maintain function and independence through the provision of an increasing range of support services including, home based support services, aged residential care, day care and respite care services.** | | | |
| **Measure** | **Results for 2010/2011** | | | |
| | **Main measures of performance (includes quantity, quality, timeliness and effectiveness of outputs)** | **Target** | **Actual** | **Achieved** |
| Non-residential Support Services | Proportion of older population in rest home care (75+ year old population in rest home level care ) | **6.0%** | **6.3%** | ✘ |
| Residential Care Support Services | Proportion of older population in specialist dementia care (75+ year old population). | **0.8%** | **0.8%** | ✓ |
| Palliative Care Services | Patients requiring specialised palliative care are provided with appropriate care to meet their individual clinical needs. | **100** | **100** | ✓ |

The proportion of people aged 75+ entering rest home level care rose from 6.0% to 6.3% during 2010-2011. This directly reflected the absence of a manager for the Needs Assessment and Service Coordination service Carelink for the first 6 months of 2011, and a delay in appointing a manager for the West Coast District Health Board provider-arm home support service until July 2011. Both factors resulted in a delay in rolling out the planned move to restorative home support and intensive homecare packages using skilled homecare workers, which are essential for any reduction in rest home entry to be achieved. Both these appointments are now in place and the project on track again.

## Statement of Performance based on Output Classes

The Statement of Revenue and Expenditure for the year ending 30 June 2011 has been prepared based on the four output classes. The basis of arriving at the net cost for each output class can be found in under note 1 in the Notes to the financial statements.

### West Coast District Health Board
### Statement of Revenue and Expenditure by Output Class

**For the year ended 30 June 2011**

*in thousands of New Zealand dollars*

| | 2011 Actual | 2011 Budget |
|---|---|---|
| **Income** | | |
| Hospital services | 65,179 | 61,004 |
| Primary & Community health sevices | 43,856 | 43,183 |
| Support services | 18,828 | 20,977 |
| Public Health services | 2,789 | 3,235 |
| **Total income** | 130,652 | 128,399 |
| | | |
| **Expenditure** | | |
| Hospital services | 69,729 | 66,055 |
| Primary & Community health sevices | 45,387 | 45,927 |
| Support services | 20,318 | 20,761 |
| Public Health services | 2,060 | 2,855 |
| **Total Expenditure** | 137,495 | 135,599 |
| | | |
| **Surplus/ (Deficit)** | | |
| Hospital services | (4,551) | (5,052) |
| Primary & Community health sevices | (1,531) | (2,744) |
| Support services | (1,490) | 216 |
| Public Health services | 729 | 380 |
| **Total Surplus / (Deficit)** | (6,843) | (7,200) |

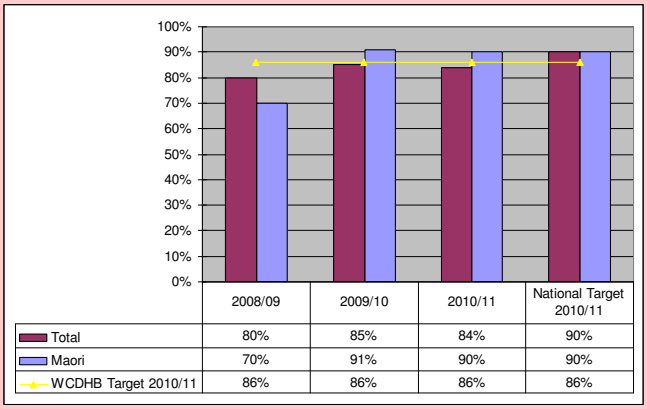
# 10 OUTPUT CLASS AREAS AND STATEMENT OF SERVICE PERFORMANCE

One of the functions of the West Coast District Health Board's Statement of Intent 2010 – 2013 was to show how the Board would evaluate and assess the services and products we deliver to others in 2010/2011 as part of our long-term objectives within the four key output classes: public health, primary and community, hospital, and support services. For each output class there are agreed national performance measures and target for the desired outcomes and objectives. These performance measures are indicated below. They are not intended to be a comprehensive list and do not cover all of the activity of the West Coast District Health Board. These measures highlight our activity toward achieving our local and national strategies, priorities and targets.

## 10.1 OUTPUT CLASS ONE – PUBLIC HEALTH

### 10.1.1 Increased Immunisation

***Long Term Objective - Work towards the national target of 90% of children fully vaccinated at age 2 years.***

| **Associated Measures of Performance** | |
|---|---|
| **An increase in the number of children fully immunised at age two, across all populations** | **Target: 86%** **Partially Achieved** |
|  <br>2008/09 \| 2009/10 \| 2010/11 \| National Target 2010/11<br>Total: 80% \| 85% \| 84% \| 90%<br>Maori: 70% \| 91% \| 90% \| 90%<br>WCDHB Target 2010/11: 86% \| 86% \| 86% \| 86% | The target of 86% set for 2010/2011 was surpassed for our Māori population (at 90% immunisation coverage at age 2 years), but fell short for the overall population at 84% for the year.<br>Results for the overall population were down due to a combination of factors of children not getting fully vaccinated, including a 6.1% "opt off" rate from the programme by parents (with children being partially vaccinated rather than fully immunised), and a 7.8% "declined to be immunised" rate, with parents not giving consent for their children to be vaccinated. Together with those fully vaccinated, this accounted for 98% of the 2-year old population of our community. |
| **Key Outputs for 2010/2011 (from the District Annual Plan)** | |
| Continue to provide Outreach Immunisation Services with a focus on reducing inequalities in coverage for tamariki Māori and children in New Zealand Deprivation Index 9 and 10 areas | **Achieved** |
| Implement the joint West Coast District Health Board/ West Coast Primary Health Organisation /Community and Public Health's Healthy West Coast Plan | **Achieved** |
| Improve practice process for immunisation, particularly relating to providing timely recall information (using the long term conditions model of engagement and collaboration) and offering flexibility around clinic times | **Partially Achieved** Practice processes have improved and there has been an increase in % of immunisations completed on time. |
| Ongoing provision of practice nurse training by the Immunisation Coordinator | **Achieved** |

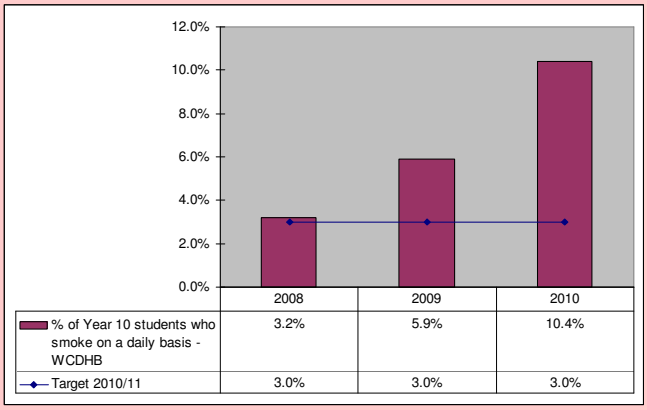
## 10.1.2 Better Help For Smokers To Quit

***Long Term Objective - To reduce the smoking rate on the West Coast by five percent over the next three years.***

**Associated Measures of Performance**

**Year 10 Student that smoke on a daily basis.**

**Progress Target: 3%** **Not Achieved**



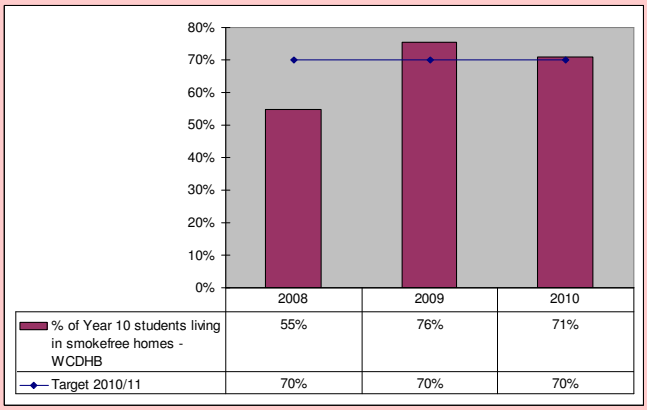

The West Coast District Health Board has not achieved the target for the percentage of Year 10 students on a daily basis. In fact the percentage of Year 10 Students that smoke on daily basis has increased to 10.4% in 2010; up 7% more than the target of only 3% set for 2010/2011.

However, there was a reduction in the number of schools participating in the survey in 2010 which has reduced the sample size and resulted in the survey not being directly comparable with the 2009 data.

Work to decrease the rate of Year 10 students who smoke on a daily basis continued to be a focus of the smoking cessation programme, including a youth initiative focused on reducing initiation of smoking and reducing smoking rates in the Buller District, which was established in 2010/2011.

**Year 10 students living in smokefree homes**

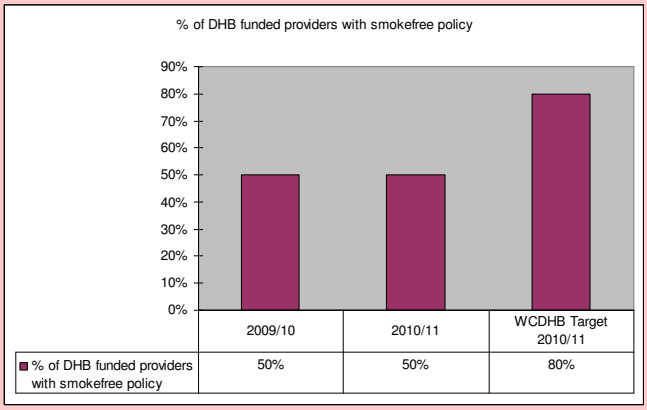
**Target: 70%** **Achieved**




The West Coast District Health Board has achieved the target of 70% of Year 10 students living in smokefree homes 2010 by 1%. A reduction of 5% from 76% in 2009 reflects that the results are likely affected by the reduction in the number of schools participating in the survey in 2010, which has reduced the sample size and resulted in the survey not being directly comparable with the 2009 data.

**District Health Board funded providers with smokefree policies in place.**

**Target: 80%** **Not Achieved**

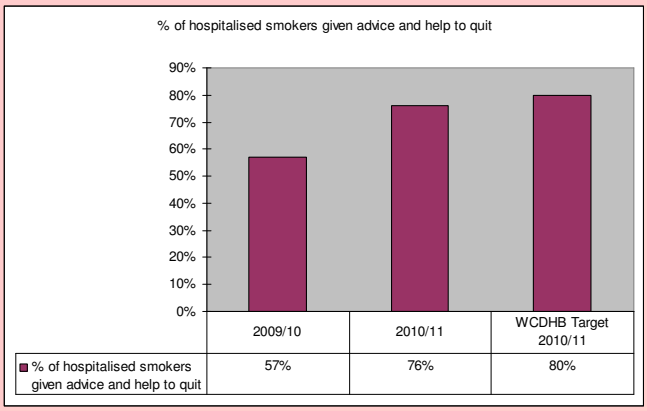



In 2010/2011 half of the West Coast District Health Board-funded providers had smokefree policies in place. This is 30% less than the 80% target set by the District Health Board for 2010/2011.

A vacancy in the Smokefree Co-ordinator position for part of 2010/2011 has impacted on progress on this work, which continues to be a focus into 2011/12

**Hospitalised smokers provided smoking cessation advice and help to quit.**

**Target: 80%** **Not Achieved**

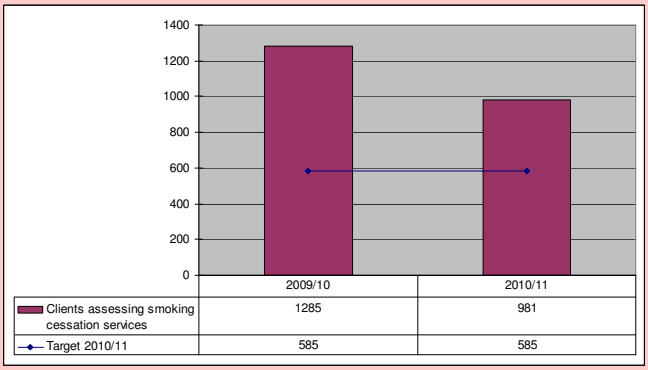



76% of hospitalised smokers were given advice and help to quit in 2010/2011; less than the target set by the District Health Board for the year. This represents a considerable increase by 19% from the 57% of hospitalised smoker offered advice and help to quit in 2009/10.

The rate achieved remains below the national target of 90%. The West Coast District Health Board will continue to focus on increasing the percentage of hospitalised smokers offered advice to quit in order to achieve the increased national target of 95% in 2011/12.

**Clients accessing smoking cessation services.**

**Target: 585** **Achieved**




The West Coast District Health Board target to support 585 smokers to quit smoking in 2010/2011 was achieved. 981 clients accessed smoking cessation services in 2010/2011; 396 more than the target for the year.

Smokers were supported to quit through a range of services including through the West Coast Primary Health Organisation's Coast Quit programme; the Aukati Kai Paipa programme aimed at support Māori to quit; and through the District Health Board's hospital and community Smoking Cessation Services.

| **Key Outputs for 2010/2011 (from the District Annual Plan)** | |
|---|---|
| Continued implementation of the Ask, Brief Advice and Cessation strategy to ensure patients across community, primary and secondary services are provided with advice and support to quit. | **Achieved** |
| Implement the joint West Coast Smokefree plan in conjunction with key stakeholders. | **Achieved** |
| Smokefree environment – increase the number of smokefree homes and workplaces on the West Coast. | **Achieved** |
| Implementation of specific programmes including pregnant women, youth and Māori . | **Achieved** |

## 10.1.3 Improve Nutrition, Increase Physical Activity and Reduce Obesity

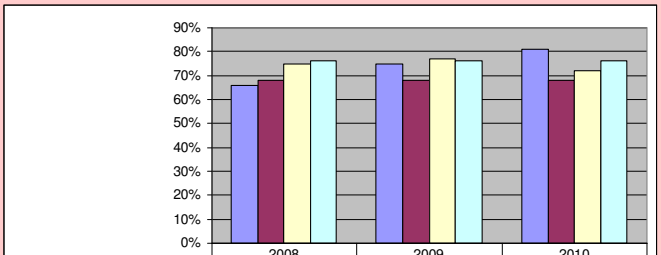
***Long Term Objective - The West Coast District Health Board will support the Healthy Eating Healthy Action Strategy and reflect the priority population health objective to improve nutrition, increase physical activity and reduce obesity.***

**Associated Measures of Performance**

**Increase breastfeeding rates at 6 weeks**

**Target – Māori : 68%** **Achieved**

**Target – Total : 76%** **Not Achieved**




| | 2008 | 2009 | 2010 |
|---|---|---|---|
| Breast feeding at 6 weeks - Maori | 66% | 75% | 81% |
| Beast feeding at 6 weeks Target 2010/11 - Maori | 68% | 68% | 68% |
| Breast feeding at 6 weeks - Total | 75% | 77% | 72% |
| Breast feeding at 6 weeksTarget 2010/11 - Total | 76% | 76% | 76% |

Note: The result used are from Plunket breastfeeding data only

During the 2010 calendar year the West Coast District Health Board breastfeeding target of 76% of all babies fully or exclusively breastfeed at 6 weeks was not achieved. This was in spite of the usual follow-up and encouragement to women to breastfeed wherever possible being undertaken. Total breastfeeding rates fell by 5% from the previous year to 72%, although the rate remains higher than the national average.

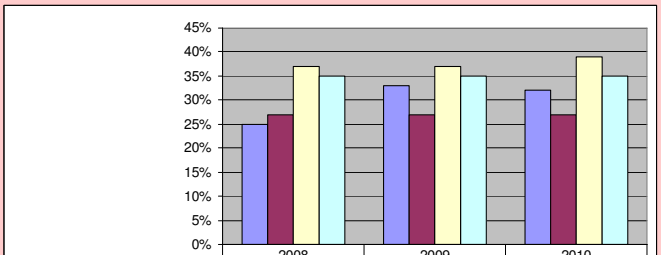
In contrast the target for Māori pepi was achieved with 81% of pepi Māori fully or exclusively breastfeed at 6 weeks in 2010. 13% above the 2010 target and a 6% increase on the rate achieved in 2009.

Initiatives to support the decision and initiation of breastfeeding included breastfeeding education for health professional and social service agency staff, breastfeeding ante-natal classes and the provision of community based lactation consultation services. 116 clients accessed the community-based lactation consultation service in 2010/2011 (including 67 living in decile 8-10 areas and 49 from rural areas).

**Increase breastfeeding rates at 6 months**

**Target – Māori : 27%** **Achieved**

**Target – Total : 35%** **Achieved**




| | 2008 | 2009 | 2010 |
|---|---|---|---|
| Breast feeding at 6 months - Maori | 25% | 33% | 32% |
| Breast feeding at 6 monthsTarget 2010/11 - Maori | 27% | 27% | 27% |
| Breast feeding at 6 months - Total | 37% | 37% | 39% |
| Breast feeding at 6 monthsTarget 2010/11 - Total | 35% | 35% | 35% |

Note: The result used are from Plunket breastfeeding data only

The 2010/2011breastfeeding targets for both the total population and for pepi Māori exclusively or fully breastfeed at 6 months were achieved in 2010. 39% of all babies were fully and exclusively breastfed at 6 months, an increase of 2% on the rate achieved in 2009.

In contrast 32% of Māori pepi were fully or exclusively breastfed at 6 months in 2010, which was 5% above the target. Initiatives to support continued breastfeeding included the Mum4Mum peer support programme (31 new Mum4Mum volunteer peer supporters graduated in 2010/2011) , Babes in Arms, Plunket breastfeeding support groups and breastfeeding friendly cafes and workplaces

**Key Outputs for 2010/2011 (from the District Annual Plan)**

| | |
|---|---|
| Implement the West Coast Breastfeeding Action Plan in conjunction with the West Coast Primary Health Organisation. | **Achieved** |
| Continue to implement the breastfeeding initiative for Tai Poutini (with a focus on increasing rates among women living in New Zealand Deprivation Index 8, 9 and 10 areas, young women and Māori women. | **Achieved** |
| Establish environments (such as workplaces, cafes and community facilities) that support breastfeeding. | **Achieved** |

# 10.2 OUTPUT CLASS TWO – PRIMARY AND COMMUNITY SERVICES

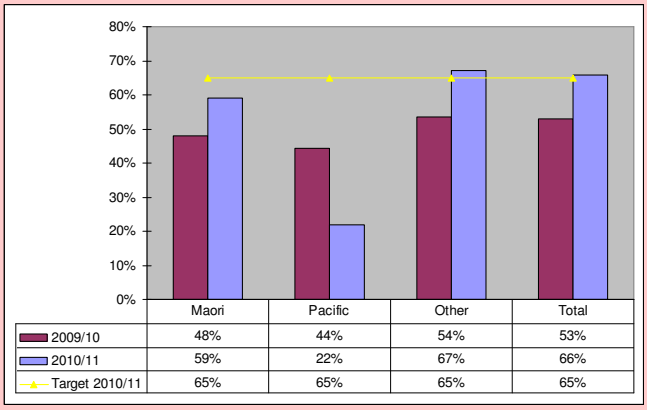
## 10.2.1 Better Diabetes And Cardiovascular Services

***Long Term Objective - Improving local responsiveness to reduce the impact and incidence of diabetes and cardiovascular disease, as shown through key indicators of performance in terms of access to free annual diabetes checks, better diabetes management, and cardiovascular risk assessment monitoring.***

**Associated Measures of Performance**

**Increase the percentage of patients with diabetes accessing free annual checks**

**Target:** **Partially Achieved (As per table below)**




| | Maori | Pacific | Other | Total |
|---|---|---|---|---|
| 2009/10 | 48% | 44% | 54% | 53% |
| 2010/11 | 59% | 22% | 67% | 66% |
| Target 2010/11 | 65% | 65% | 65% | 65% |

Percentage of the population estimated to have diabetes* accessing free annual checks. The data in the table above is for the financial years; and is different from the 2009/10 rate recorded last year (49%) based on the 2009 calendar year results.

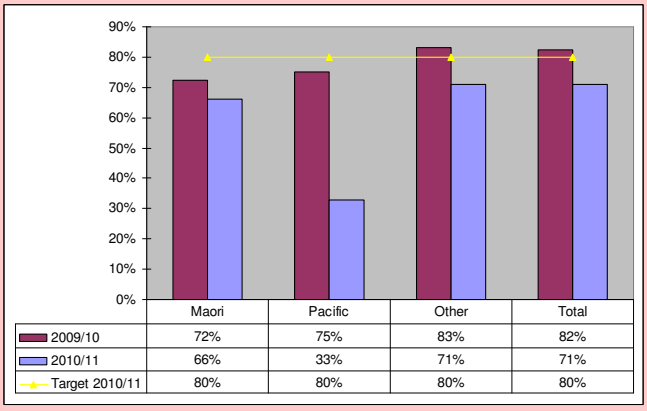
| | Target | Actual | Achieved |
|---|---|---|---|
| Māori | 65% | 59% | ✘ |
| Pacific | 65% | 22% | ✘ |
| Other | 65% | 67% | ✓ |
| Total | 65% | 66% | ✓ |

A total of 831 free annual diabetes checks were undertaken this financial year, compared to 751 in 2009/10. Representing a 13% increase overall. There was an 11% increase for Māori during this same period from 48% to 59%, which is still below the 65% target.

It is noted that the estimated population* used for calculating the rate this year for Māori was 130 and Pacific Island populations was 14. These are dropping to 93 and 8 respectively in 2011/12. On these population estimates, the 2010/2011 results for Māori would be 82% and Pacific would be 38%.

**Increase the percentage of patients with good diabetes management**

**Target:** **Not Achieved (As per table below)**




| | Maori | Pacific | Other | Total |
|---|---|---|---|---|
| 2009/10 | 72% | 75% | 83% | 82% |
| 2010/11 | 66% | 33% | 71% | 71% |
| Target 2010/11 | 80% | 80% | 80% | 80% |

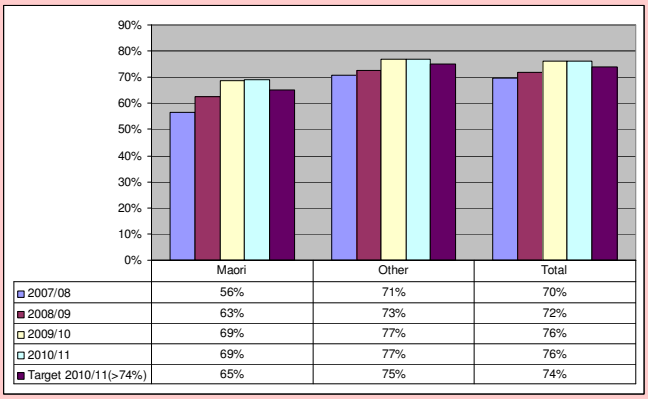
| | Target | Actual | Achieved |
|---|---|---|---|
| Māori | 80% | 66% | ✘ |
| Pacific | 80% | 33% | ✘ |
| Other | 80% | 71% | ✘ |
| Total | 80% | 71% | ✘ |

Higher numbers of patients were seen this year, resulting in the identification of higher numbers of people who had poor diabetic management (HBA1c levels above 8.0). This is expected to improve over time now that these patients have been identified and are able to be followed more closely through the Long Term Conditions patient recall and monitoring programme.

* (based on an annually re-estimated and renewed population denominator calculations issued by the Ministry of Health)

**Increase the percentage of patients with five-year Cardiovascular Disease risk assessments undertaken**

**Target:** **Achieved against local targets for 2010/2011. ***
**(As per table below)**




| | Maori | Other | Total |
|---|---|---|---|
| 2007/08 | 56% | 71% | 70% |
| 2008/09 | 63% | 73% | 72% |
| 2009/10 | 69% | 77% | 76% |
| 2010/11 | 69% | 77% | 76% |
| Target 2010/11(>74%) | 65% | 75% | 74% |

Actual data is for the rolling five-year period to 31 March 2011; being the latest available data at time of compilation.

| | Target | Actual | Achieved |
|---|---|---|---|
| **Māori** | **>65%** | **69.1%** | ✓ |
| **Pacific** | **n/a** | **n/a** | **n/a** |
| **Other** | **>75%** | **77.0%** | ✓ |
| **Total** | **>74%** | **76.3%** | ✓ |

The West Coast District Health Board has met the local targets for 2011/12, (which were originally set against the actual result outcomes for 2008/09). Progress against the national target of 80% of eligible patients with a CVD risk assessment over 5 years still has a way to go, and has been static in relation to the actual results achieved in 2009/10.

**Key Outputs for 2010/2011 (from the District Annual Plan)**

Continued promotion and implementation of the West Coast Primary Health Organisation's Long term Condition Management programme to encourage uptake of diabetes annual reviews and cardiovascular risk assessment through the West Coast Primary Health Organisation and education within the community; with support from services in secondary care.

**Achieved**

There has been a dramatic increase in the number of patients enrolled in the Long Term Conditions (LTC) programme and its associated diabetes, cardiovascular (CVD) and chronic obstructive pulmonary disease (COPD) annual reviews, as illustrated in the following table:

| | 2008/09 | 2009/10 | 2010/2011 |
|---|---|---|---|
| **Total LTC Enrolment** | **124** | **1655** | **2675** |
| **Diabetes Annual Reviews** | **672*** | **751** | **831** |
| **CVD Annual Reviews** | **528** | **837** | **939** |
| **COPD Annual Reviews** | **61** | **148** | **211** |

As a result, more patients with high clinical needs have been provided with annual reviews, and close support and management for their care needs. This has resulted in a corresponding drop in average performance in the average key outcome measures for diabetes and CVD while their needs are addressed. It is expected that these outcome results will once again rise as this closer care now being provided improves direct patient care.

* 2008 calendar year (as previously calculated)

Improved Information Technology interface and two-way data sharing between primary and secondary services - through progressive implementation of inter-active Information Technology data sharing systems between West Coast District Health Board provider arm service and primary General Practitioner practices.

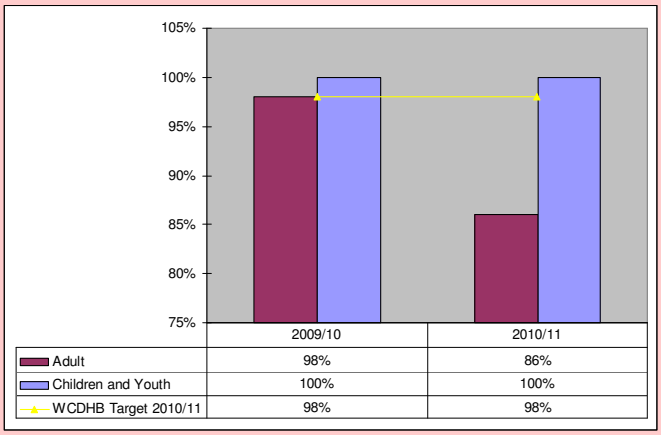
**Not Achieved**

Implementation delayed. This project is being worked upon in 2011/2012 as part of Better, Sooner, More Convenient implementation

| | |
|---|---|
| Formation of a multidisciplinary Local Cardiovascular Team to inform future direction of care and service improvement (along similar lines to the West Coast District Health Board's Local Diabetes Team and Local Cancer Team). | **Achieved**<br>A Local Heart and Respiratory Team was established and commenced work to start aligning cardiac and respiratory services with the West Coast District Health Board and West Coast Primary Health Organisation Long Term Conditions framework. |

## 10.2.2 Improving Mental Health Services

***Long Term Objective - The West Coast District Health Board will ensure that 100% of long-term clients have up to date relapse prevention plans (National Mental Health Sector Standard criteria 16.4).***

| **Associated Measures of Performance** | |
|---|---|
| **Ensure that 100% of long-term clients have up to date relapse prevention plans** | **Target: 98%** **Achieved** |
|  <br>2009/10 2010/11<br>Adult 98% 86%<br>Children and Youth 100% 100%<br>WCDHB Target 2010/11 98% 98% | During 2010/2011 mental health services have continued to focus on improving the quality of health services. The Knowing the People planning project has continued and the District Health Board has maintained a high percentage of long term clients in the service with up to date relapse prevention plans. 98% of adults and 100% of children and adolescents have up to date relapse prevention plans.<br>The integration of primary and secondary mental health services has progressed during 2010/2011 with a focus on developing models of care for the Buller Integrated Family Health Centre as well as core general practice redesign which aligns community based mental health services to primary practice. |
| **Key Outputs for 2010/2011 (from the District Annual Plan)** | |
| Continue the Knowing the People planning project. Utilise information gathered to focus services on improving the quality of life of patients. | **Achieved.** |
| Continue to implement the West Coast District Health Board Mental Health Service Quality Improvement Programme through internal review, evaluation and audit. | **Achieved** |
| Reconfigure Community Rehabilitation Service, from secondary care to non government organisation | **Not Achieved.**<br>During the year, a Request For Proposal process to establish a Non-Government Organisation-based service was abandoned in favour of including planning for mental health support work services within Integrated Family Health Services. |
| The quality improvement initiatives for 2010/2011 will focus on integrating primary and secondary services, including single entry point for patients, packages of care, shared cared arrangement and other initiatives | **Partially Achieved.** |
| Delivery of secondary mental health and addiction services within Integrated Family Health Centres. | **Not Achieved.**<br>During 2010/2011 work has focused on developing an integrated model of care for the Buller Integrated Family Health Centre. Physical co-location or provision of secondary mental health services has not yet been established. |

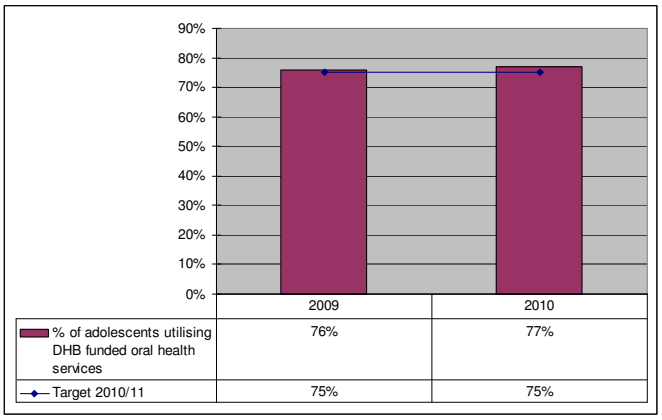
## 10.2.3 Improving Oral Health

***Long Term Objective - The West Coast District Health Board will work towards 85% adolescent oral health utilisation.***

**Associated Measures of Performance**

**Increase the utilisation of oral health services among adolescents**

**Progress Target: 75%** **Achieved**




| | 2009 | 2010 |
|---|---|---|
| % of adolescents utilising DHB funded oral health services | 76% | 77% |
| Target 2010/11 | 75% | 75% |

Increasing adolescent utilisation of oral health services continues to be a focus for the West Coast District Health Board. In the 2010 school year 77% of adolescent's utilised oral health services a slight increase of 1% from the 2009 school year.

Enrolments in community dental service increased from during this period from 29 in the 2009 school year to 49 in 2010 school year. This is an area where the District Health Board continues to focus particularly in rural areas, where access to dentists requires significant travel and adolescents who have left school or are not accessing services with contracted dentists.

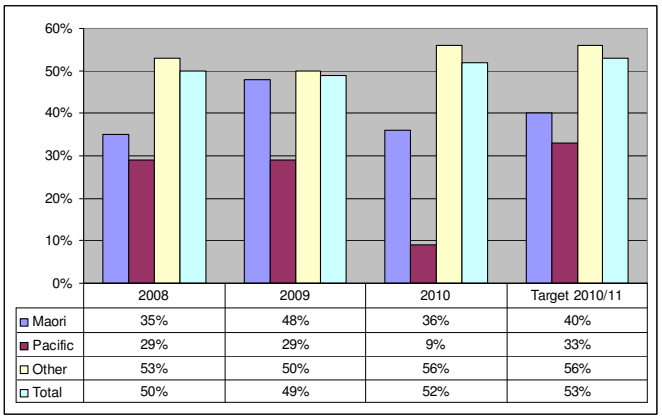
**Key Outputs for Adolescent oral health services for 2010/2011 (from the District Annual Plan)**

| | |
|---|---|
| Complete implementation of the preventative model of service delivery for oral health. | **Achieved.** |
| Continue to provide a dental service for school aged-children throughout the West Coast during the implementation of the Oral Health Business Case. | **Partially Achieved.**<br>Services were provided to 96% of pre and primary school aged children within the time frame of their scheduled examination. The target was 100%. |
| Increase adolescent enrolments in the School dental Service with a particular focus on out of school youth and adolescents not accessing services from private dental providers | **Achieved.** |
| Maintain contracts with local dentists for the provision of child and adolescent oral health services | **Achieved.** |

**Increase the number of five year olds dental caries-free**

**Target – Māori : 40%** **Not Achieved**

**Target – Other : 56%** **Achieved**




| | 2008 | 2009 | 2010 | Target 2010/11 |
|---|---|---|---|---|
| Maori | 35% | 48% | 36% | 40% |
| Pacific | 29% | 29% | 9% | 33% |
| Other | 53% | 50% | 56% | 56% |
| Total | 50% | 49% | 52% | 53% |

During 2010/2011, the West Coast District Health Board continued to work towards improving the percentage of children dental caries free at age 5.

Overall 52% of West Coast 5 year olds were dental caries free in the 2010 school year – just 1% below the target of 53%. However, the Māori target of 40% of tamariki was not achieved and there was a sharp reduction in the percentages of tamariki Māori dental caries free at age 5 between 2009 and 2010 school years.

Implementation of topical fluoride service for preschoolers has been completed and health education for parents of preschoolers has begun. The focus for this service in 2011/2012 is on increasing preschool enrolment rates to address the current inequity for tamariki Māori .

**Key Outputs for Pre-schooler oral health services for 2010/2011 (from the District Annual Plan)**

| | |
|---|---|
| Complete implementation of the West Coast District Health Board's Oral Health Business Case. | **Achieved.** |

| | |
|---|---|
| Complete implementation of the preschool topical fluoride services and health education for preschoolers most at risk of decay. | **Achieved**<br>Implementation was complete across the service and is ongoing. Education continues to expand and will continue throughout 2011/12 |
| Work collaboratively to cross reference preschool enrolments in primary care with enrolments in dental services. | **Partially Achieved**<br>Collaborative work with primary care providers has begun and this continues to be a focus in 2011/12. |

## 10.3 OUTPUT CLASS THREE – HOSPITAL SERVICES

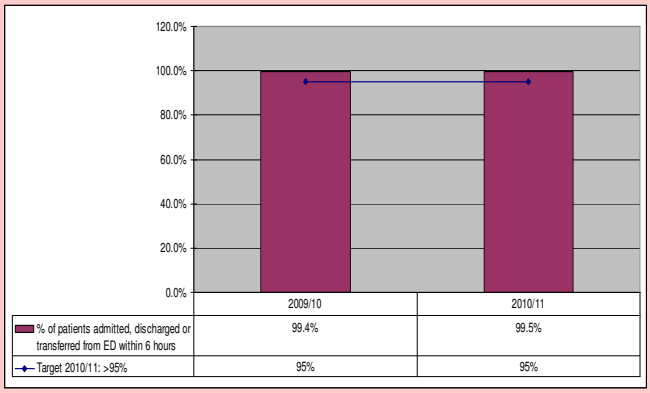
### 10.3.1 Shorter Stays in Emergency Department

***Long Term Objective - Shorter lengths of stay for patients in Emergency Department services. The West Coast District Health Board will maintain compliance with national targets for patient length of stay in our Emergency Department Services.***

**Associated Measures of Performance**

**More than 95% of patients will be admitted, discharged or transferred from an Emergency Department within 6 hours.**

**Target: >95%** **Achieved**

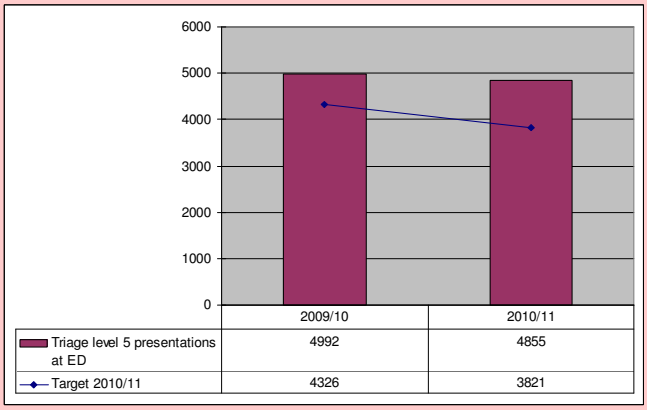



The West Coast District Health Board achieved the national target of 95% of patients admitted, discharged or transferred from the Emergency Department within 6 hours. In 2010/2011 99.5% of patients attending West Coast District Health Board Emergency services during were admitted, discharged or transferred within six hours.

**Reduction of inappropriate triage level 5 attendances**

**(Target: 35% reduction over three years)**

**Target: 3821** **Not Achieved**




There were 4855 Triage level 5 attendances during 2010/2011, compared to a target level of just 3821 attendances. This was a slight decrease of 137 attendances from 2009/10, but short of the 505 required per annum to reach the longer term target.

The 3-year target by 2012/13 is 2812 Triage level 5 attendances; being a reduction of 35% over three years from a target base of 4326 set in 2009/10.

**Key Outputs for 2010/2011 (from the District Annual Plan)**

| | |
|---|---|
| Close monitoring of Emergency Department service provision to ensure people are treated within the national waiting times guidelines. | **Achieved.** |

| | |
|---|---|
| Reduction in inappropriate triage level 5 attendance | **Not Achieved.**<br>The annual decrease of 505 less visits per year required to meet the long-term target did not materialise – with only 137 fewer visits in 2010/2011 compared to 2009/2010. |

## 10.3.2 Improved Access to Elective Services

***Long Term Objective – The West Coast District Health Board will maintain compliance in all Elective Services Patient Flow Indicators.***

**Associated Measures of Performance**

**Compliance with all Elective Services Patient Flow Indicators (ESPI) for indicators 1-8 (see definitions below)**

**Targets (all 8 ESPI measures):** **Achieved**

| | West Coast District Health Board Target | Actual | Achieved |
|---|---|---|---|
| **ESPI 1: >90%** | 92% | 100% | ✓ |
| **ESPI 2: <2%** | 1.6% | 0.3% | ✓ |
| **ESPI 3: <5%** | 4.0% | 1.2% | ✓ |
| **ESPI 4: <5%** | 0.0% | 0.0% | ✓ |
| **ESPI 5: <5%** | 4.0% | 1.9% | ✓ |
| **ESPI 6: <15%** | 12% | 0.0% | ✓ |
| **ESPI 7: <5%** | 4.0% | 2.2% | ✓ |
| **ESPI 8: >90%** | 92% | 100% | ✓ |

West Coast District Health Board met all of its targets for the eight Elective Services Patient Flow Indicators (ESPI) for in 2010/2011.

ESPI Definitions:

- ESPI 1 – District Health Board services appropriately acknowledge and process referrals within ten working days.
- ESPI 2 – Patients waiting longer than six months for their first specialist assessment (FSA).
- EPSI 3 – Patients without a commitment to treatment whose priorities are higher than the actual treatment threshold.
- ESPI 4 – Clarity of treatment status.
- EPSI 5 – Patients given a commitment to treatment but not treated within six months.
- ESPI 6 – Patients in active review who have not received a clinical assessment within the last six months.
- EPSI 7 – Patients who have not been managed according to their assigned status and who should have received treatment.
- ESPI 8 – Proportion of patients treated who were prioritized using nationally recognized processes or tools.

**Appropriate standardised intervention rates in key procedures**

**Target:** **Partially Achieved**

| | West Coast District Health Board Target | Actual | Achieved |
|---|---|---|---|
| **Elective surgical discharges**[3] | 292 | 431.4 | ✓ |
| **Major Joint Replacement**[4] | 21.0 | 36.7 | ✓ |
| **Cataracts**[5] | 27.0 | 73.7 | ✓ |
| **Cardiac Procedures**[6] | 6.23 | 5.3 | ✗ |

The West Coast District Health Board achieved the target set for the elective surgical discharges (per 10,000 population) delivering 1,710 elective operations; a rate of 431.43 per 10,000 people. Standardised intervention rates targets were also meet for major joint replacements for hip and knee surgery and cataract surgery.

In 2010/2011 the target of 6.23 procedures/10,000 for interventional cardiac procedures for people aged 15+ was not achieved, with 4 operations fewer than the anticipated intervention level of 26 cases being undertaken, and no patients on waiting lists for this surgery.

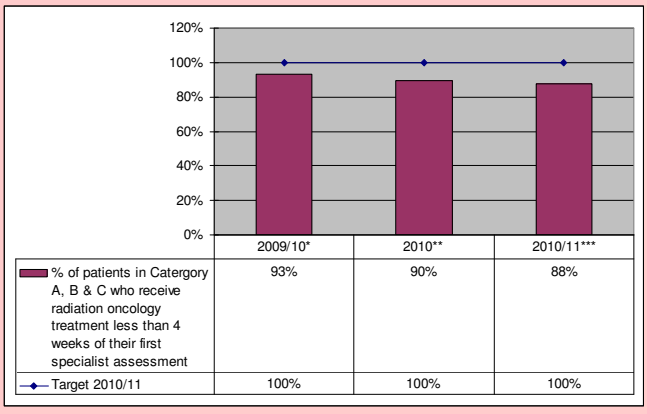
[3] Elective Surgical Discharges (per 10,000 population)
[4] including Hip and Knee replacement (per 10,000 population)
[5] Cataracts (per 10,000 population)
[6] including coronary artery bypass graft , valve replacement and repair for people aged 15+ (per 10,000 population)

| Key Outputs for 2010/2011 (from the District Annual Plan) | |
|---|---|
| Maintain compliance with Elective Service Patient Flow Indicators 1-8 | **Achieved.** |
| Ensure that the West Coast District Health Board delivers 1592 elective discharges per year as required by the Ministry of Health as our proportional share of delivering the Minister's expectations of an overall aggregate increase in elective discharges across the country, and in keeping with our longer-term goal of moving toward greater national equity of access. | **Achieved.**<br>1710 elective discharges were delivered. Indeed, these intervention rates were delivered at significantly higher levels than the expected discharge rate. Overall, West Coast District Health Board delivered 1.17% of the national total of elective surgical interventions in 2010/2011 – even though our population is just over 0.7% of the New Zealand population. |
| Use the Continuous Quality Improvement process to identify productivity and efficiency improvements in patient flow processes. | **Achieved**<br>West Coast District Health Board focused its continuous quality improvement efforts in three key areas during 2010/11; scheduling and appointments for both inpatient and outpatient services; theatre efficiency to improve utilisation; and improvement of patient flow within day and inpatients units at Grey Base Hospital. |
| Monitor Standardised Intervention Rates (SIRs) of the target elective procedures to ensure that these are being delivered at national appropriate levels. | **Partially Achieved**<br>Achieved for three of the four key targets (as per results above). Cardiac surgery intervention rates remained slightly below target, but this was due to 4 fewer cases being treated than expected (22 operations delivered against an anticipated intervention of 26 cases for the 2010/2011 year). |

## 10.3.3 Shorter Waits For Cancer Treatment

***Long Term Objective – Shorter waits for cancer treatment.***

| Associated Measures of Performance | |
|---|---|
| **All patients receive radiation oncology treatment within six weeks of their first specialist assessment (excluding Category D) by July 2010 and within four weeks by December 2010.** | **Target: 100%** **Not Achieved** |




2010 * For the period 1 July -30 November 2010.

2010/2011** For the period 1 December 2010 to 30 June 2011.

The West Coast District Health Board did not achieve the national target of 100% of patients receiving radiation oncology treatment within six weeks of their first specialist assessment for the period I July 2010 – 1 30 November 2010. The target after 1 December 2010 became four weeks and this target was also not achieved.

89.6% of patients in the period I July 2010 – 1 30 November 2010 received radiation oncology treatment within 6 weeks. For the period after 1 December 2010 the 88.3%.

| | Actual | Achieved |
|---|---|---|
| **Seen within 6 weeks*** | **89.6%** | ✘ |
| **Seen within 4 weeks*** | **88.2%** | ✘ |

| Key Outputs for 2010/2011 (from the District Annual Plan) | |
|---|---|
| Close monitoring of radiotherapy service provision to ensure people are treated according to their need within the national waiting times guidelines. | **Not achieved**<br><br>While regular weekly and monthly monitoring was undertaken, the 100% targets were not met for 7 of the 63 patients treated during the year. Three patients were delayed due to capacity constraints at the radiotherapy facilities in Christchurch, 2 were delayed due to patients own choice, 1 was delayed due to clinical considerations (patient not medically ready to commence radiation treatment), and 1 was delayed due to other reasons (not specified) . |

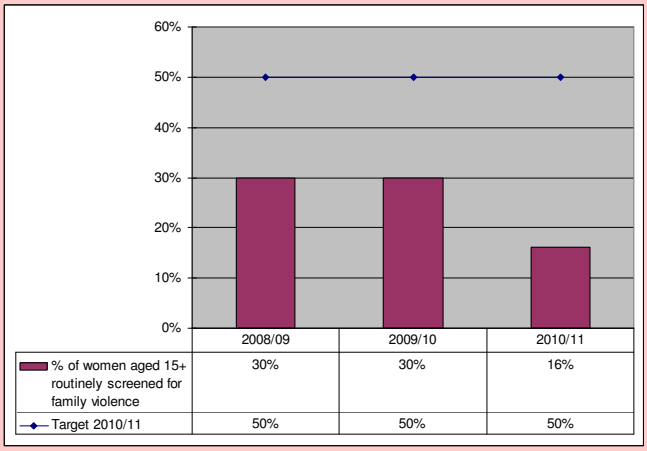
## 10.3.4 Improved Hospital Responsiveness To Family Violence, Child Abuse And Neglect

***Long Term Objective – Routine family violence screening is implemented across West Coast District Health Board hospital services.***

**Associated Measures of Performance**

**All women aged 15+ are screened for family violence**

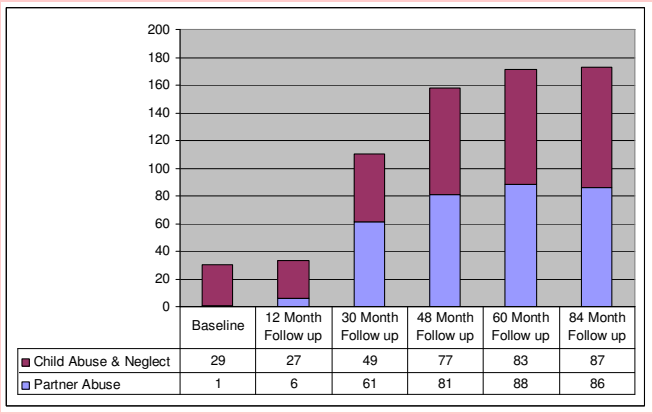
**Target: 50%** **Not Achieved**




Routine screening for family violence was implemented in the Emergency Department in 2008/2009 then extended to Mental Health, Public Health Nursing, Social Work, Maternity and Sexual Health Services in 2009/2010. In 2010/2011 implementation of screening was extended to Community Nursing and Child Health Services. The drop in performance against target while there was a vacancy in service coordinator position suggests that this programme is not yet systematically embedded with District Health Board staff and requires further work.

In 2010/2011, 16% of women aged 15+ were routinely screened for family violence – a significant reduction from the 30% achieved in 2009/10 and well below the West Coast District Health Board target of 50%. Increasing the screening rates remained a focus for improving detection and response to child abuse and neglect was continued in 2010/2011.

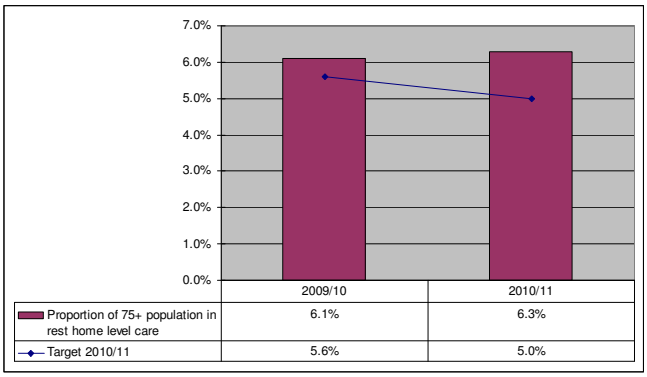
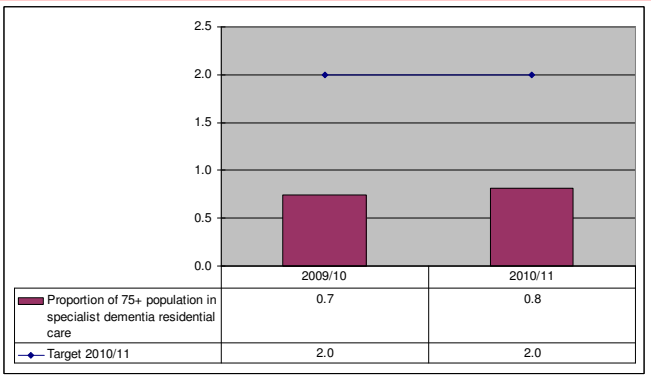
With the rate showing evidence of falling during 2010/2011, the co-location of a Child, Youth and Family Social Worker within Grey Base Hospital was undertaken to help arrest this decline and enhance this response as we move ahead.

| **Child abuse and partner abuse combined external audit score** | |
|---|---|
|  | During 2010/2011, the response of Grey Base Hospital to family violence, child abuse and neglect was audited. This was the 5th follow-up audit from baseline undertaken in 2004.The West Coast District Health Board achieved the target of a score of 170 or above with a combined external audit score of 173. |
| **Key Outputs for 2010/2011 (from the District Annual Plan)** | |
| Continue to employ a family violence response co-ordinator and a Child Protection co-ordinator | **Partially Achieved.**<br>During 2010/2011 the child protection co-ordinator resigned there was a period of vacancy as a result. |
| Co-ordinate an intersectoral steering group to plan, assist in implementation and monitor the development of the hospital response to family violence | **Not Achieved.**<br>During 2010/2011 the steering group was restructured with working groups established to oversee this work. |
| Continue to provide mandatory training on family violence, child abuse and neglect to all District Health Board staff | **Achieved.** |
| Continue to implement routine family violence screening in child health and community nursing services. | **Partially Achieved**<br>Not fully achieved in 2010/2011 due to continuing staff changes in child health. |
| Continue to support District Health Board employees by promoting the Employee Assistance Programme as a means for offering support for victims of violence and abuse and work towards implementing further support for staff. | **Achieved.** |

# 10.4 OUTPUT CLASS FOUR – SUPPORT SERVICES

## 10.4.1 Improving The Health Of Older People

***Long Term Objective – The West Coast District Health Board will progressively implement the Health of Older People Strategy to develop more integrated health and disability services that are responsive to older peoples' varied and changing needs***

| **Associated Measures of Performance** | |
|---|---|
| **Proportion of 75+ population in rest home level care** | **Target: 5.0%** **Not Achieved** |
|  | The proportion of the 75+ population in rest home level care increased slightly from 6.1% in 2009/10 to 6.3% in 2010/2011. This is 1.3% above the West Coast District Health Boards upper threshold target of 5% of the 75+ population in rest home level care.<br>The absence of a manager for the Needs Assessment and Service Coordination service Carelink for the first 6 months of 2011, and a delay in appointing a manager for the West Coast District Health Board provider-arm home support service until July 2011 were both contributory factors to a delay in rolling out the planned move to restorative home support and intensive homecare packages using skilled homecare workers, essential for any reduction in rest home entry to be achieved. With these roles filled, this goal will continue to be a priority in 2011/2012. |
| **Proportion of 75+population in specialist residential care** | **Target: 2.0%** **Not Achieved** |
|  | During 2010/2011 0.8% of the 75+ population was in specialist dementia residential care. This was a slight increase from 0.7% in 2009/2010 but remains below the West Coast District Health Board target of 2.0% set for 2010/2011 as an upper threshold limit.<br>This is unlikely to change substantially until more dementia rest home beds are established, when the number is likely to rise quickly. Two residential providers have signalled their possible interest in providing dementia rest home beds – one in Westport and one in Greymouth. |
| **Key Outputs for 2010/2011 (from the District Annual Plan)** | |
| Extending the use of InteRAI assessment tool for older people and others with chronic and disabling conditions. | **Achieved** |
| Complete the reconfiguration and up-skilling of home-based support service staff. | **Partially Achieved.**<br>Funding was provided for carer training and collaborative work with other South Island District Health Boards has resulted in the development of a regional service specification. |

| | |
|---|---|
| Continue to increase the availability of community-based support services, including day care, planned respite, falls prevention and support for carers. | **Partially Achieved.**<br><br>An accredited visiting service was implemented by Age Concern. Planning was commenced for the implementation of memory and carer support to begin in 2011/12, along with an extension of the Home Share day care services. |
| Improve quality of aged residential care through collaboration on staffing, training and quality issues, and the establishment of dementia rest home level beds. | **Partially Achieved.**<br><br>Collaborative meetings with rest home providers continued, along with planning for the establishment of rest home level dementia beds. |

# 11. FINANCIAL STATEMENT

## West Coast District Health Board
## Statement of comprehensive income

**For the year ended 30 June 2011**
*in thousands of New Zealand dollars*

| | Note | 2011 Actual | 2011 Budget | 2010 Actual |
|---|---|---|---|---|
| **Income** | | | | |
| Revenue | 2 | 129,229 | 127,352 | 125,741 |
| Other operating income | 3 | 1,151 | 949 | 1,233 |
| Interest income | 6a | 272 | 98 | 295 |
| **Total income** | | 130,652 | 128,399 | 127,269 |
| | | | | |
| **Expenditure** | | | | |
| Employee benefit costs | 5a | 51,634 | 50,654 | 50,768 |
| Other personnel costs | 5b | 1,038 | 1,539 | 1,421 |
| Depreciation and amortisation expense | 8,9 | 4,578 | 4,583 | 5,074 |
| Outsourced services | 4a | 14,546 | 11,126 | 12,247 |
| Clinical supplies | | 7,708 | 7,120 | 7,112 |
| Infrastructure and non-clinical expenses | | 9,684 | 9,680 | 9,607 |
| Payments to other health service providers | 4b | 45,980 | 47,666 | 45,389 |
| Other operating expenses | 4c | 861 | 1,002 | 1,174 |
| Finance costs | 6b | 776 | 833 | 848 |
| Capital charge | 7 | 690 | 1,396 | 1,332 |
| **Total expenditure** | | 137,495 | 135,599 | 134,972 |
| | | | | |
| **Surplus/(deficit)** | 14 | (6,843) | (7,200) | (7,703) |
| | | | | |
| **Other comprehensive income** | | | | |
| Gain/(losses) on revaluation of property | 14 | (2,578) | 0 | (6,363) |
| Other changes recognised directly in equity | 14 | 0 | 0 | 0 |
| **Total other comprehensive income** | | (2,578) | 0 | (6,363) |
| | | | | |
| | | | | |
| **Total comprehensive income** | | (9,421) | (7,200) | (14,066) |

*The accompanying notes form part of these financial statements*

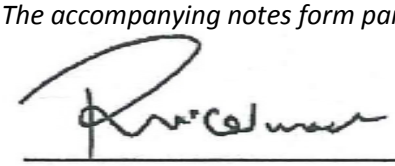
# West Coast District Health Board
# Statement of financial position

**As at 30 June 2011**

*in thousands of New Zealand dollars*

| | Note | 2011 Actual | 2011 Budget | 2010 Actual |
|---|---|---|---|---|
| **Assets** | | | | |
| **Non-current assets** | | | | |
| Property, plant and equipment | 8 | 33,002 | 40,820 | 36,379 |
| Intangible assets | 9 | 940 | 1,386 | 1,148 |
| Other investments | 11 | 2 | 0 | 2 |
| **Total non-current assets** | | 33,944 | 42,206 | 37,529 |
| **Current assets** | | | | |
| Inventories | 10 | 791 | 718 | 761 |
| Other investments | 11 | 4,500 | 0 | 1,587 |
| Debtors and other receivables | 12 | 4,182 | 2,950 | 3,478 |
| Cash and cash equivalents | 13 | 1,922 | 4,109 | 3,176 |
| Patient and restricted funds | 21 | 56 | 64 | 55 |
| Assets classified as held for sale | 19 | 136 | 246 | 246 |
| **Total current assets** | | 11,587 | 8,087 | 9,303 |
| **Total assets** | | 45,531 | 50,293 | 46,832 |
| **Liabilities** | | | | |
| **Non-current liabilities** | | | | |
| Interest-bearing loans and borrowings | 15 | 11,195 | 12,445 | 5,000 |
| Employee entitlements and benefits | 16 | 2,858 | 2,625 | 2,910 |
| **Total non-current liabilities** | | 14,053 | 15,070 | 7,910 |
| **Current liabilities** | | | | |
| Interest-bearing loans and borrowings | 15 | 1,500 | 250 | 7,945 |
| Creditors and other payables | 17 | 10,313 | 10,850 | 9,634 |
| Employee entitlements and benefits | 16 | 7,092 | 5,538 | 6,494 |
| Patient and restricted trust funds | 21 | 56 | 64 | 55 |
| **Total current liabilities** | | 18,961 | 16,702 | 24,128 |
| **Total liabilities** | | 33,014 | 31,772 | 32,038 |
| **Equity** | | | | |
| Crown equity | 14 | 61,753 | 61,668 | 54,609 |
| Other reserves | 14 | 21,310 | 28,172 | 23,888 |
| Retained earnings/(losses) | 14 | (70,585) | (71,358) | (63,742) |
| Trust funds | 14 | 39 | 39 | 39 |
| **Total equity** | | 12,517 | 18,521 | 14,794 |
| **Total equity and liabilities** | | 45,531 | 50,293 | 46,832 |

*The accompanying notes form part of these financial statements*



Dr Paul McCormack
*Chair*
*28 October 2011*

Peter Ballantyne
*Deputy Chair*
*28 October 2011*

# West Coast District Health Board
# Statement of changes in equity

**For the year ended 30 June 2011**

*in thousands of New Zealand dollars*

| | Note | 2011 Actual | 2011 Budget | 2010 Actual |
|---|---|---|---|---|
| **Balance at 1 July** | | 14,794 | 18,589 | 22,379 |
| Contributions from the Crown | | 7,212 | 7,200 | 6,549 |
| Contributions repaid to the Crown | | (68) | (68) | (68) |
| Total comprehensive income | | (9,421) | (7,200) | (14,066) |
| **Balance at 30 June 2011** | 14 | 12,517 | 18,521 | 14,794 |

*The accompanying notes form part of these financial statements*

# West Coast District Health Board
# Statement of cash flows
**For the year ended 30 June 2011**
*in thousands of New Zealand dollars*

| | Note | 2011 Actual | 2011 Budget | 2010 Actual |
|---|---|---|---|---|
| **Cash flows from operating activities** | | | | |
| Cash receipts from Ministry of Health, patients and other revenue | | 129,181 | 128,853 | 126,854 |
| Cash paid to suppliers | | (78,287) | (76,594) | (74,876) |
| Cash paid to employees | | (52,322) | (52,192) | (52,842) |
| *Cash generated from operations* | | (1,428) | 67 | (864) |
| Interest received | | 820 | 98 | 172 |
| Interest paid | | (814) | (833) | (848) |
| Goods and services tax (net) | | 58 | 0 | 152 |
| Capital charge paid | | (723) | (1,396) | (1,400) |
| **Net cash flows from operating activities** | 13 | (2,087) | (2,064) | (2,788) |
| **Cash flows from investing activities** | | | | |
| Proceeds from sale of investments | | 1,587 | 1,589 | 9 |
| Acquisition of investments | | (4,500) | 0 | 0 |
| Acquisition of property, plant and equipment | | (3,053) | (4,220) | (2,664) |
| Acquisition of intangible assets | | (95) | (600) | 0 |
| **Net cash flows from investing activities** | | (6,061) | (3,231) | (2,655) |
| **Cash flows from financing activities** | | | | |
| Proceeds from equity injections | | 7,212 | 7,200 | 6,549 |
| Repayment of equity | | (68) | (68) | (68) |
| *Cash generated from equity transactions* | | 7,144 | 7,132 | 6,481 |
| Borrowings raised | | 0 | 0 | 0 |
| Repayment of borrowings | | (250) | (250) | (250) |
| **Net cash flows from financing activities** | | 6,894 | 6,882 | 6,231 |
| Net increase in cash and cash equivalents | | (1,254) | 1,587 | 788 |
| Cash and cash equivalents at beginning of year | | 3,176 | 2,522 | 2,388 |
| **Cash and cash equivalents at end of year** | 13 | 1,922 | 4,109 | 3,176 |

*The accompanying notes form part of these financial statements*

# West Coast District Health Board
# Statement of commitments

**As at 30 June 2011**

*in thousands of New Zealand dollars*

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| **Capital commitments** | | 232 | 1,065 |

| | 2011 Actual | 2010 Actual |
|---|---|---|
| **Non-cancellable commitments - contracted services** | | |
| Not more than one year | 3,229 | 4,915 |
| One to two years | 849 | 2,500 |
| Two to three years | 70 | 465 |
| Three to four years | 3 | 77 |
| Four to five years | 0 | 77 |
| Over five years | 0 | 200 |
| | 4,151 | 8,234 |

The West Coast District Health Board holds fixed term contracts for the provision of health services and the provision of food, cleaning and orderly services.

| | 2011 Actual | 2010 Actual |
|---|---|---|
| **Non-cancellable commitments – operating lease commitments** | | |
| Not more than one year | 182 | 301 |
| One to two years | 33 | 144 |
| Two to three years | 15 | 33 |
| Three to four years | 10 | 11 |
| | 240 | 489 |

The West Coast District Health Board leases motor vehicles and has some short term accommodation leases.

# Notes to the financial statements

**For the year ended 30 June 2011**

## 1 Statement of Accounting Policies

### Reporting Entity

The West Coast District Health Board is a Health Board established by the New Zealand Public Health and Disability Act 2000. The West Coast District Health Board is a Crown Entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

The West Coast District Health Board is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993; and the Crown Entities Act 2004.

The West Coast District Health Board is a public benefit entity, as defined under NZIAS 1.

The West Coast District Health Board's activities involve the funding, planning and delivering of health and disability services and mental health services in a variety of ways to the community.

The financial statements of the West Coast District Health Board have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000, Public Finance Act 1989 and Crown Entities Act 2004.

The financial statements for the West Coast District Health Board are for the year ended 30 June 2011, and were approved by the Board on 28 October 2011.

### Statement of Compliance

The financial statements of the West Coast District Health Board have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

### Basis of Preparation

The financial statements are presented in New Zealand dollars, rounded to the nearest thousand. The financial statements have been prepared on the historical cost basis, modified by the revaluation of land, buildings, fixtures and fittings.

The financial statements have been prepared on a going concern basis that reflects the formal ongoing support of the Ministry of Health. The West Coast District Health Board is currently reviewing its service delivery model with the Ministry, with the intention of moving to an economically sustainable status. The Board considers the adoption of the going concern assumption to be appropriate on this basis.

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

### Changes In Accounting Policy

There have been no changes in accounting policy during the year, which have been applied on a basis consistent with the prior year.

### Standards, Amendments and Interpretations Issued that are Not Yet Effective and Have Not Been Early Adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the West Coast District Health Board include:

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurements. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and

measurement of financial assets have been completed and has been completed and has been published in the new financial instrument standard NZ IFRS. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39.

The approach in NZ IAS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014.

- NZ IAS 24 Related Party Disclosure. This standard has not yet been adopted by the West Coast District Health Board and will be for the June 2012 year end. The effect of adopting the revised statement NZ IAS 24 will be:
  - More information regarding the transactions between the West Coast District Health Board and other entities controlled, jointly controlled, or significantly influenced by the Crown.
  - Disclosure of any related party transactions with Ministers of the Crown.
  - Commitments with related parties will need to be disclosed.

The West Coast District Health Board has not yet assessed the impact these statements and amendments will have on its financial statements, but does not believe any adjustment will be significant.

## Significant Accounting Policies

### Revenue

Revenue is measured at the fair value of consideration received or receivable.

#### Revenue from the Crown

The West Coast District Health Board is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the West Coast District Health Board meeting its objectives as specified in the statement of intent.

Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates. Where there are explicit conditions attached to the revenue requiring surplus funds to be repaid, revenue is carried forward as a liability in the statement of financial position and allocated to the period in which the revenue is earned.

#### 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.

### Trust and Bequest Funds

Donations and bequests to the West Coast District Health Board 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 statement of financial performance and an equivalent amount is transferred from the trust funds component of equity to retained earnings.

### Goods and Services Tax (GST)

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

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

## Taxation

The West Coast District Health Board is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under the Income Tax Act 2007.

## Trade and Other Receivables

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

## Investments

At each balance sheet date the West Coast District Health Board assesses whether there is any objective evidence that an investment is impaired.

**Bank Deposits**

Investments in bank deposits are measured at fair value.

For bank deposits, impairment is established when there is objective evidence that the West Coast District Health Board will not be able to collect amounts due according to the original terms of the deposits. Significant financial difficulties of the bank, probability that the bank will enter into bankruptcy, and default in payments are considered indicators that the deposit is impaired.

**Equity Investments**

The West Coast District Health Board designates equity investments at fair value through equity, which are initially measured at cost.

After initial recognition, these investments are measured at their fair value with gains and losses recognised directly in equity, except for impairment losses which are recognised in the surplus or deficit.

On derecognition the cumulative gain or loss previously recognised in equity is recognised in the surplus or deficit. For equity investments classified as fair value through equity, a significant or prolonged decline in fair value of the investment below its cost is considered an indication of impairment. If such evidence exists for investments through equity, the cumulative loss measured as the difference between acquisition cost and the current value, less any impairment loss on that financial asset previously recognised in the surplus or deficit is removed from equity and recognised in the surplus or deficit. Impairment losses recognised in the statement of financial performance on equity on investments are not reversed through the surplus or deficit (see page 28).

## Inventories

Inventories are held primarily for consumption in the provision of services, and are stated and the lower of cost or current replacement cost. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

## Cash and Cash Equivalents

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

## Impairment

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

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

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

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

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

### Financial Instruments

Financial instruments held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the surplus or deficit. Financial instruments held as being available-for-sale are stated at fair value, with any resultant gain or loss recognised directly in equity.

Loans and receivables are stated at fair value, using the effective interest method. Any gains or losses are recognised in the surplus or deficit.

### Assets Classified as Held for Sale

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

### Property, Plant and Equipment

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Coast Health Care Limited (a Hospital and Health Service) were vested in the West Coast District Health Board on 1 January 2001. Accordingly, assets were transferred to the West Coast District Health Board at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost (or, in the case of land and buildings, the valuation) and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

### Property, Plant and Equipment Acquired Since the Establishment of the District Health Board

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

### Revaluation of Land, Buildings, fixtures and fittings

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

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

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

### Disposal of Property, Plant and Equipment

When an item of property, plant and equipment is disposed of, any gain or loss is recognised in the surplus or deficit and is calculated at the difference between the net sale price and the carrying value of the asset.

### 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 written off in the month of purchase, except where they form part of a larger asset group purchase. The estimated useful lives of major classes of assets are as follows:

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

Capital work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

## Intangible Assets

Intangible assets that are acquired by the West Coast District Health Board 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 |

## Trade and other payables

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

## Employee Entitlements

### Short-term employee entitlements

Employee entitlements that the West Coast District Health Board 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 West Coast District Health Board recognises a liability for sick leave to the extent that the compensated absences are expected to be paid out in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance sheet date to the extent the West Coast District Health Board anticipates it will be used by staff to cover those future absences.

**Bonuses**

The West Coast District Health Board recognises a liability and an expense for bonuses where it is contractually obliged to pay them, or where there is a past practice that has created a constructive obligation.

### Long -term employee entitlements

Employee entitlements that are payable beyond 12 months.

**Long Service Leave and Retirement Gratuities**

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

**Sabbatical Leave**

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

## Superannuation Schemes

**Defined Contribution Schemes**

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

**Defined Benefit Schemes**

The West Coast District Health Board belongs to the National Provident Fund, which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefits 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 a surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is accounted for as a defined contribution scheme. Further information on this scheme is disclosed in note 16.

## Leased Assets

**Finance Leases**

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

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

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

**Operating Leases**

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

## Interest-bearing Borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised costs with any difference between cost and redemption value recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

## Capital Charge

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

## Borrowing Costs

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

## Budget Figures

The budget figures are those approved by the Board and published in its District Annual Plan and Statement of Intent. The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the Board for the preparation of these financial statements. They comply with the NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by the West Coast District Health Board for the preparation of these financial statements.

## Cost Allocation

The West Coast District Health Board has arrived at the net cost of outputs for the four output classes using the cost allocation methodology outlined below.

### Cost Allocation Methodology

Direct Costs are those costs directly attributable to an output class. Indirect costs are those costs that cannot be directly attributable to an output class or identified in an economic feasible manner, with a specific output class.

Direct costs are charged directly to each output class. Indirect costs are allocated to output classes based on costs drivers and related activity. Depreciation and facility costs are allocated on the basis of floor area occupied by the production of each output.

Indirect personnel costs, including human resource and payroll costs are allocated on the basis of full time equivalent staff numbers within the output class areas and indirect information system costs on the number of work-stations within the output class areas.

## Critical Judgements in applying the West Coast District Health Board's Accounting Policies

Management has exercised the following critical judgements in applying the West Coast District Health Board's accounting policies for the period ended 30 June 2010.

### Leases Classifications

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

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

The West Coast District Health Board has exercised its judgement on the appropriate classification of leases and has determined that all its leases are operating leases.

## Critical Accounting Estimates and Assumptions

In preparing these financial statements, the West Coast District Health 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 discussed below:

### Property, plant and equipment useful lives and residual value

At each balance date the West Coast District Health Board reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires the West Coast District Health Board to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the West Coast District Health Board, and expected disposal proceeds from the future sale of the asset. An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the surplus or deficit.

The West Coast District Health Board minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programs;
- review of second hand market prices for similar assets; and
- analysis of prior asset sales.

The West Coast District Health Board has made significant changes to past assumptions concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 8.

# West Coast District Health Board
# Notes to the financial statements
*in thousands of New Zealand dollars*

## 2 Revenue

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Ministry of Health Crown Funding Agreement | | 113,400 | 110,376 |
| Ministry of Health (other) | | 4,704 | 4,838 |
| Accident Compensation Corporation Insurance | | 1,992 | 1,796 |
| Inter district patient inflows and other District Health Boards | | 1,750 | 1,723 |
| Patients and consumers | | 2,829 | 2,687 |
| Other government entities | | 384 | 327 |
| West Coast Primary Health Organisation | 23 | 4,170 | 3,994 |
| | | 129,229 | 125,741 |

Revenue for health services includes all revenue received from the Crown (via the Ministry of Health), Accident Rehabilitation and Compensation Insurance Corporation and other sources.

## 3 Other operating income

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Donations received | | 103 | 96 |
| Rental income | | 188 | 157 |
| Other | | 860 | 980 |
| | | 1,151 | 1,233 |

## 4a Outsourced services

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| **Outsourced personnel** | | | |
| Medical and nursing services | | 9,178 | 8,107 |
| Allied health services | | 117 | 166 |
| Other services | | 1,246 | 550 |
| **Outsourced services** | | | |
| Clinical services | | 4,005 | 3,424 |
| | | 14,546 | 12,247 |

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

## 4b Other Health Service Providers

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Personal health and Maori health services | | 18,122 | 18,385 |
| Mental health services | | 2,543 | 2,624 |
| Public health services | | 457 | 524 |
| Disability support services | | 7,298 | 7,176 |
| Inter district patient outflows | | 17,560 | 16,680 |
| | | 45,980 | 45,389 |

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

Public health services are payments for healthy lifestyles - nutrition and exercise. Disability support services include payments for aged related care, in homes, rest homes and hospital level.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 4c *Other operating expenses*

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Impairment of trade receivables (bad and doubtful debts) | 20 | 65 | 121 |
| Loss on disposal of property, plant and equipment | | 41 | 26 |
| Audit fees (for the audit of the financial statements) | | 93 | 91 |
| Audit related fees for assurance and related services (IFRS assurance audit) | | 0 | 0 |
| Fees paid to auditor for other services | | 0 | 0 |
| Board and advisory members fees | 24 | 222 | 225 |
| Community consultation | | 10 | 27 |
| Operating lease expenses | 18 | 397 | 667 |
| Restructuring expenses | | 33 | 17 |
| | | 861 | 1,174 |

## 5a Employee benefit costs

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Wages and salaries | 50,324 | 49,701 |
| Contributions to defined contribution plans including Kiwi Saver | 1,010 | 902 |
| Increase in employee benefit provisions | 300 | 165 |
| | 51,634 | 50,768 |

## 5b Other personnel costs

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Other personnel costs | 1,038 | 1,421 |

These are costs incurred in relation to employees but not benefits paid directly to the employee, including costs of recruiting and training staff and costs of professional registration.

## 6a Interest income

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Interest income | 272 | 295 |

## 6b Finance costs

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Interest expense | 776 | 848 |

## 7 Capital charge

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Capital charge | 690 | 1,332 |

The West Coast District Health Board pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity. The capital charge rate for the period ended 30 June 2011 was 8% (2010: 8%). The total capital charge expense for 2011 was $689,582 (2010: $1,332,267). This included a credit of $253,672 which related to the 09/10 year; without this credit actual cost would have been $943,254.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 8 Property, plant and equipment

| | Freehold land (at valuation) | Freehold buildings (at valuation) | Plant, equipment and vehicles | Leased assets | Fixtures and fittings | Work in progress | Total |
|---|---|---|---|---|---|---|---|
| **Cost** | | | | | | | |
| Balance at 1 July 2009 | 6,005 | 13,354 | 18,750 | 253 | 17,584 | 261 | 56,207 |
| Additions | 0 | 1 | 2,034 | 20 | 34 | 350 | 2,439 |
| Disposals | 0 | 0 | (1,416) | 0 | 0 | 0 | (1,416) |
| Revaluations | 0 | (3,167) | 0 | 0 | (5,994) | 0 | (9,161) |
| Assets reclassified | 0 | 0 | (44) | 0 | 44 | 0 | 0 |
| Work in progress allocated | 0 | 0 | 201 | 0 | 0 | (201) | 0 |
| Balance at 30 June 2010 | 6,005 | 10,188 | 19,525 | 273 | 11,668 | 410 | 48,069 |
| Balance at 1 July 2010 | 6,005 | 10,188 | 19,525 | 273 | 11,668 | 410 | 48,069 |
| Additions | 0 | 313 | 2,362 | 47 | 174 | 510 | 3,406 |
| Disposals | 0 | 0 | (552) | 0 | 0 | 0 | (552) |
| Revaluations | 346 | (1,535) | 0 | 0 | (3,581) | 0 | (4,770) |
| Transfer from non-current assets held for sale | 44 | 128 | 0 | 0 | 0 | 0 | 172 |
| Work in progress allocated | 0 | 307 | 1 | 20 | 2 | (330) | 0 |
| Balance at 30 June 2011 | 6,395 | 9,401 | 21,336 | 340 | 8,263 | 590 | 46,325 |
| **Depreciation and impairment losses** | | | | | | | |
| Balance at 1 July 2009 | 0 | (14) | (10,835) | (208) | (34) | 0 | (11,091) |
| Depreciation charge for the year | 0 | (1,047) | (1,932) | (46) | (1,753) | 0 | (4,778) |
| Assets reclassified | 0 | 0 | 25 | 0 | (25) | 0 | 0 |
| Disposals | 0 | 0 | 1,381 | 0 | 0 | 0 | 1,381 |
| Revaluations | 0 | 1,043 | 0 | 0 | 1,755 | 0 | 2,798 |
| Balance at 30 June 2010 | 0 | (18) | (11,361) | (254) | (57) | 0 | (11,690) |
| **Depreciation and impairment losses** | | | | | | | |
| Balance at 1 July 2010 | 0 | (18) | (11,361) | (254) | (57) | 0 | (11,690) |
| Depreciation charge for the year | 0 | (923) | (2,103) | (15) | (1,234) | 0 | (4,275) |
| Transfer to non-current assets held for sale | 0 | (62) | 0 | 0 | 0 | 0 | (62) |
| Disposals | 0 | 0 | 511 | 0 | 0 | 0 | 511 |
| Revaluations | 0 | 963 | 0 | 0 | 1,230 | 0 | 2,193 |
| Balance at 30 June 2011 | 0 | (40) | (12,953) | (269) | (61) | 0 | (13,323) |
| **Carrying amounts** | | | | | | | |
| At 1 July 2009 | 6,005 | 13,340 | 7,915 | 45 | 17,550 | 261 | 45,116 |
| At 30 June 2010 | 6,005 | 10,170 | 8,164 | 19 | 11,611 | 410 | 36,379 |
| At 1 July 2010 | 6,005 | 10,170 | 8,164 | 19 | 11,611 | 410 | 36,379 |
| **At 30 June 2011** | 6,395 | 9,361 | 8,383 | 71 | 8,202 | 590 | 33,002 |

**Freehold land, buildings, fixtures and fittings**

Freehold property and plant was revalued 30 June 2011 by Coast Valuations (registered valuers). Greymouth, Westport and Reefton Hospitals are stated at optimised depreciated replacement cost. Fox Glacier and Ngakawau Clinics are valued based on depreciated replacement cost. Remaining core assets are stated at fair value (market value based). The resulting movement in property and plant has been recognised in equity in a Property Revaluation Reserve (refer to note 14). The economic life of the majority of the Greymouth Hospital structural assets has been revised from nine years to five years. The estimated reduction in the economic life of Greymouth Hospital has been based on the proposal to redevelopement the site subject to funding and goverment approval within five years. The economic life of both Westport and Reefton Hospital structural assets has been revised from four years to three years. These values reflect the West Coast District Health Board's intention to replace these facilities in the near future.

**Restrictions**

Some of the West Coast District Health Board'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.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 9 Intangible assets

| | Software | Total |
|---|---|---|
| **Cost** | | |
| Balance at 1 July 2009 | 2,068 | 2,068 |
| Additions | 350 | 350 |
| Disposals | (38) | (38) |
| Balance at 30 June 2010 | 2,380 | 2,380 |
| | | |
| Balance at 1 July 2010 | 2,380 | 2,380 |
| Additions | 95 | 95 |
| Balance at 30 June 2011 | 2,475 | 2,475 |
| | | |
| **Amortisation and impairment losses** | | |
| Balance at 1 July 2009 | (974) | (974) |
| Amortisation charge for the year | (296) | (296) |
| Disposals | 38 | 38 |
| Balance at 30 June 2010 | (1,232) | (1,232) |
| | | |
| Balance at 1 July 2010 | (1,232) | (1,232) |
| Amortisation charge for the year | (303) | (303) |
| Balance at 30 June 2011 | (1,535) | (1,535) |
| | | |
| **Carrying amounts** | | |
| At 1 July 2009 | 1,094 | 1,094 |
| At 30 June 2010 | 1,148 | 1,148 |
| | | |
| At 1 July 2010 | 1,148 | 1,148 |
| **At 30 June 2011** | 940 | 940 |

## 10 Inventories

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Pharmaceuticals | 123 | 132 |
| Surgical and medical supplies | 569 | 542 |
| Other supplies | 99 | 87 |
| | 791 | 761 |

There were no write downs of inventories or reversal of prior years writedowns during the year (2010: $0). The amount of inventories recognised as an expense during the year ended 30 June 2011 was $1,457,568: (2010: $2,401,491).

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

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 11 Other investments

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| **Non-current** | | | |
| Equity instrument | | 2 | 2 |
| | | 2 | 2 |
| **Current** | | | |
| Term deposit (matured 1 November 2010-7.79%) | | | 1,587 |
| Term deposit (maturing 22 September 2011 - 3.75%) | 20 | 1,000 | |
| Term deposit (maturing 22 October 2011 - 3.5%) | | 1,000 | |
| Term deposit (maturing 22 November 2011 - 4.0%) | | 1,000 | |
| Term deposit (maturing 22 December 2011 - 4.5%) | | 1,500 | 0 |
| | | 4,500 | 1,587 |
| **Total investments** | | 4,502 | 1,589 |

The West Coast District Health Board has a 4% share in South Island Shared Services Agency Limited (2010: 4%). Currently, South Island Shared Services Agency Limited are restructuring and West Coast District Health Boards investment maybe affected by the outcome of this restructuring. The West Coast District Health Board has funds deposited with the BNZ bank (2010: ASB Bank Limited).

## 12 Debtors and other receivables

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Trade receivables | 20 | 538 | 337 |
| Ministry of Health receivables | | 1,993 | 1,570 |
| Other Crown receivables | | 961 | 543 |
| Accrued revenue | | 423 | 800 |
| Prepayments | | 267 | 228 |
| | 20 | 4,182 | 3,478 |

Trade receivables are shown net of provision for doubtful debts amounting to $47,514 (2010: $75,234) recognised in the current year and arising from patient debt and small balances uneconomic to pursue. Ministry of Health receivables are shown net of provision for doubtful debts amounting to $17,842 (2010: $46,052).

## 13 Cash and cash equivalents

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Bank balances | | 41 | 69 |
| Petty cash and imprest | | 8 | 9 |
| Call deposits | | 1,873 | 3,098 |
| **Cash and cash equivalents in the statement of cash flows** | 20 | 1,922 | 3,176 |

In December 2010 the West Coast District Health Board received a donation of $57,000 from the Fresh Futures T+B1rust to be spent on equipment for neo-natal and paediatric patients. The balance of this donation (including the balance of prior years donations) plus interest, remaining at 30 June 2011 was $58,623 (included in bank balances above). At balance date approval had been given to spend $20,049 of these funds. The West Coast District Health Board 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 21).

**Working capital facility**

The West Coast District Health Board has a working capital facility supplied by the Bank of New Zealand.

The facility consists of a bank overdraft with a debit limit of $6,310,000. As at 30 June 2011 $nil had been drawn (2010: $nil). The working capital facility is secured by a negative pledge. Without the bank's prior written consent the West Coast District Health Board can not perform the following actions:

- Create or permit to exist any security interest over its assets except in certain circumstances agreed with the leader
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee
- Make a substantial change in the nature or scope of its business as presently conducted
- Dispose of any of its assets except disposals at full value in the ordinary course of business
- Raise, or increase the principal amount of a loan except with the Crown Financing Agency

The West Coast District Health Board is required to meet certain bank covenants:

- the gearing ratio (debt to debt plus equity) will at all times be less than or equal to 80%, and
- the actual net operating deficit for each monthly period from 1 July shall not exceed the budgeted net operating deficit for that month by more than 25% or $2,000,000.

During the year ended 30 June 2011 the West Coast District Health Board was not in breach of these covenants.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 13 Cash and cash equivalents (continued)

**Reconciliation of deficit for the period with net cash flows from operating activities:**

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Deficit for the period | | (6,843) | (7,703) |
| **Add back non-cash items:** | | | |
| Depreciation and amortisation expense | | 4,578 | 5,074 |
| **Remove non-cash revenue:** | | | |
| Donated assets | | (14) | (25) |
| **Add back items classified as investing activity:** | | | |
| Net loss/(gain) on disposal of property, plant and equipment | | 41 | 26 |
| **Movements in working capital:** | | | |
| (Increase)/decrease in debtors and other receivables | | (704) | 24 |
| (Increase)/decrease in inventories | | (30) | (43) |
| Increase/(decrease) in creditors and other payables | | 339 | 226 |
| Increase/(decrease) in employee benefits | | 546 | (367) |
| Net movement in working capital | | 151 | (160) |
| Net cash inflow/(outflow) from operating activities | | (2,087) | (2,788) |

## 14 Equity and reserves

**Reconciliation of movement in equity and reserves**

| | Crown equity | Property revaluation reserve | Trust/ Special funds | Retained earnings | Total equity |
|---|---|---|---|---|---|
| Balance at 1 July 2009 | 48,128 | 30,251 | 39 | (56,039) | 22,379 |
| Surplus/(deficit) for the year | | | | (7,703) | (7,703) |
| Contribution from the Crown | 6,549 | | | | 6,549 |
| Equity repaid to the Crown | (68) | | | | (68) |
| Movement in revaluation of land | | 0 | | | 0 |
| Movement in revaluation of buildings, fixtures and fittings | | (6,363) | | | (6,363) |
| **Balance at 30 June 2010** | 54,609 | 23,888 | 39 | (63,742) | 14,794 |
| Balance at 1 July 2010 | 54,609 | 23,888 | 39 | (63,742) | 14,794 |
| Surplus/(deficit) for the year | | | | (6,843) | (6,843) |
| Contribution from the Crown | 7,212 | | | | 7,212 |
| Equity repaid to the Crown | (68) | | | | (68) |
| Movement in revaluation of land | | 346 | | | 346 |
| Movement in revaluation of buildings, fixtures and fittings | | (2,924) | | | (2,924) |
| **Balance at 30 June 2011** | 61,753 | 21,310 | 39 | (70,585) | 12,517 |

The West Coast District Health Board's capital is its equity, which comprises accumulated funds and other reserves. Equity is represented by net assets. The Board is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which imposes restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the issue of derivatives. The Board manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 14 Capital and reserves (continued)

**Property Revaluation Reserve**

The revaluation reserve relates to land, buildings, fixtures and fittings.

West Coast District Health Board's land, buildings, fixtures and fittings were revalued as at 30 June 2011 by Coast Valuations (registered valuers).

Greymouth, Westport and Reefton Hospitals are stated at optimised depreciated replacement cost, Fox Glacier and Ngakawau Clinics are valued based on depreciated replacement cost and remaining core assets are stated at fair value (market based).

| **Trust funds** | **2011 Actual** | **2010 Actual** |
|---|---|---|
| **Balance at beginning of year** | 39 | 39 |
| **Transfer from retained earnings in respect of:** | | |
| Interest received | 0 | 0 |
| Donations and funds received | 0 | 0 |
| **Transfer to retained earnings in respect of:** | | |
| Funds spent | 0 | 0 |
| **Balance at end of year** | 39 | 39 |

Trust funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the statement of financial performance. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds.

## 15 Interest-bearing loans and borrowings

| | **Note** | **2011 Actual** | **2010 Actual** |
|---|---|---|---|
| **Non-current** | | | |
| Crown Health Financing Agency | 20 | 11,195 | 5,000 |
| | | 11,195 | 5,000 |
| **Current** | | | |
| Crown Health Financing Agency | 20 | 1,500 | 7,945 |
| | | 1,500 | 7,945 |

**Secured bank loans**

The West Coast District Health Board has a secured bank loan with the Crown Health Financing Agency.

The details of terms and conditions are as follows:

| **Interest rate summary** | **Note** | **2011 Actual** | **2010 Actual** |
|---|---|---|---|
| | | **%** | **%** |
| Crown Health Financing Agency | 20 | 4.75-7.28 | 6.11-7.44 |

| **Repayable as follows:** | | **2011 Actual** | **2010 Actual** |
|---|---|---|---|
| *Within one year* | | 1,500 | 7,945 |
| *One to two years* | | 0 | 1,500 |
| *Two to three years* | | 0 | 0 |
| *Three to four years* | | 3,500 | 0 |
| *Four to five years* | | 3,000 | 3,500 |
| *Later than five years* | | 4,695 | 0 |
| | 20 | 12,695 | 12,945 |

| **Total loan facility limits** | **2011 Actual** | **2010 Actual** |
|---|---|---|
| Crown Health Financing Agency | 12,695 | 12,945 |
| | 12,695 | 12,945 |

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 15 Interest-bearing loans and borrowings (continued)

***Security and terms***

The Crown Health Finance Agency loans are secured by a negative pledge. This restricts the West Coast District Health Board's actions in the following areas, without the Crown Health Financing Agency's prior

*A Security Interest:*
Create any security interest over its assets except in certain defined circumstances,
*B Loans and Guarantees:*
Lend money to another person or entity (except in the normal course of business), or give a guarantee,
*C Change of Business:*
Make or threaten to make a substantial change in the nature or scope of its business as presently conducted,
*D Disposals:*
Dispose of any assets except in the normal course of business or disposals for full value,
*E Provide Services:*
Other than for proper value and on reasonable commercial terms.

## 16 Employee entitlements and benefits

| | 2011 Actual | 2010 Actual |
|---|---|---|
| **Non-current liabilities** | | |
| Liability for long-service leave | 489 | 502 |
| Liability for sabbatical leave | 108 | 106 |
| Liability for retirement gratuities | 2,261 | 2,302 |
| | 2,858 | 2,910 |

| | 2011 Actual | 2010 Actual |
|---|---|---|
| **Current liabilities** | | |
| Liability for long-service leave | 182 | 223 |
| Liability for sabbatical leave | 76 | 77 |
| Liability for retirement gratuities | 543 | 447 |
| Liability for annual leave | 3,766 | 3,453 |
| Liability for other leave | 872 | 862 |
| Liability for sick leave | 64 | 107 |
| Liability for continuing medical education leave | 190 | 249 |
| Salary and wages accrued | 1,399 | 1,076 |
| | 7,092 | 6,494 |

**Liability for defined benefit plan**

The West Coast District Health Board makes contributions to the National Provident Fund, a defined benefit scheme that provides pension benefits for employees on retirement. The scheme is managed by the Board of Trustees of the National Provident Fund. The defined benefit plan 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 a deficit or surplus will affect future contributions by individual employers, as there is no prescribed basis for allocation.

The West Coast Dsitrcit Health Board has therefore accounted for defined benefit plan contributions as if they were to a defined contribution plan. Contributions to the scheme have therefore been recognised in the surplus or deficit incurred.

# Notes to the financial statements
*in thousands of New Zealand dollars*

## 17 Creditors and other payables

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Trade payables | | 8,334 | 7,242 |
| ACC levy payable | | 362 | 400 |
| GST and PAYE tax payable | | 1,105 | 1,419 |
| Income in advance relating to contracts with specific performance obligations | | 413 | 441 |
| Capital charge due to the Crown | | 99 | 132 |
| | 20 | 10,313 | 9,634 |

## 18 Operating leases

**Leases as lessee**

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Lease payments made | 397 | 667 |
| | 397 | 667 |

The West Coast Distrcit Health Board leases motor vehicles, the premises of Greymouth Medical Centre, office space from the West Coast Primary Health Organisation and other short term accommodation.

Motor vehicle leases run for periods of up to 45 months, while the other leases are for one to three years with rights of renewal.

During the year ended 30 June 2011 $219,373.47 was recognised as an expense in the surplus or deficit respect of operating leases for motor vehicles (2010: $462,406). As vehicle leases expired during the year they were not renewed and vehicles were purchased at a cost of $773,591. $178,396 was recognised in respect of property leases (2010: $159,548) and $nil was recognised in respect of Telecom microwave link to Buller (2010: $45,290).

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 19 Non-current assets held for sale

The West Coast District Health Board has identified land which it intends to sell and presented this as assets held for sale. These assets are measured at current book value $136,650 (2010: $246,253).

## 20 Financial instruments

The West Coast District Health Board is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, trade accounts receivable and payable and loans.

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 Audit, Risk and Finance Subcommittee provides oversight for risk management.

*Credit Risk*

Credit risk is the risk that a third party will default on its obligation causing the Board to incur a loss. Financial instruments that potentially subject the West Coast Distrcit Health Board to risk consist of cash, term investments and trade receivables.

The Board places its cash and term investments with high quality financial institutions and limits the amount of credit exposure to any one financial institution. Term deposits and day to day banking and call facilities are with the Bank of New Zealand.

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry of Health, which comprises 51% (2010: 48%) of the debtors of the West Coast District Health Board. Together with other crown receivables (ACC, Pharmac, other District Health Board's) total reliance on Government debtors is 76% (2010: 65%). The Ministry of Health, as the government funder of health and disability support services for the West Coast region and other Crown entities are high credit quality entities and the Board considers the risk arising from this concentration of credit to be very low.

The status of trade receivables at the reporting date is as follows:

**Trade Receivables**

| | Note | Gross Receivable 2011 | Impair-ment 2011 | Net 2011 | Receiva ble 2010 | Impair-ment 2010 | Net 2010 |
|---|---|---|---|---|---|---|---|
| Due 0-30 days | | 331 | (6) | 325 | 263 | 0 | 263 |
| Past due 31-60 days | | 42 | (2) | 40 | 40 | (25) | 15 |
| Past due 61-365 days | | 194 | (21) | 173 | 94 | (40) | 54 |
| Past due more than one year | | 18 | (18) | 0 | 10 | (10) | 0 |
| Total Gross Receivables | 12 | 585 | (47) | 538 | 407 | (75) | 332 |

The total impairment recognised for doubtful debts is $65,357 (2010: $121,286). Of this $47,514 relates to trade receivables (2010; $75,234) and $17,842 relates to Ministry of Health receivables (2010: $46,052).

**Movements in the provision for impairment of receivables are as follows**

| | Note | 2011 Actual | 2010 Actual |
|---|---|---|---|
| Balance 1 July | | 121 | 31 |
| Trade receivables written off during the year | | 48 | (31) |
| Impairment reversed | | (48) | 31 |
| Additional provision made during the year | | (56) | 90 |
| Closing balance 30 June | 4c | 65 | 121 |

Trade receivables are due from patients and external parties to whom the West Coast District Health Board has provided health and ability services and other clinical supplies and services. Receivables due from the Ministry of Health, ACC, Pharmac, Crown entities and other District Health Board's are not included as trade receivables.

At the balance sheet date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of each financial asset in the statement of financial position.

*Interest Rate Risk*

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

The West Coast District Health Board has four short term deposits with the Bank of New Zealand invested on a fixed rate basis and secured term borrowings with the Crown Health Financing Agency on a fixed rate basis.

The West Coast District Health Board has a set-off arrangement with the Bank of New Zealand on its operating accounts. The debit rate of interest is 3.02% to $6,310,000, excess at 6.02% (2010: 3.165% to $6,310,000, excess at 5.94%). The credit rate is 2.25% (2010: 2.25%).

Surplus funds for daily operations are held on call until required, when they are transferred to operating accounts. The rate of interest for call funds at 30 June 2011 was 3.00% (2010: 3.15%).

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 20 Financial instruments (continued)

### Effective interest rates and repricing analysis

In respect of income-earning financial assets and interest-bearing financial liabilities, the following table indicates their effective interest rates at the balance sheet date and the periods in which they reprice.

| | | 2011 Actual | | | | | | | 2010 Actual | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Note | Effective interest rate | Total | 6 months or less | 6-12 months | 1-2 years | 2-5 years | More than 5 years | Effective interest rate | Total | 6 months or less | 6-12 months | 1-2 years | 2-5 years | More than 5 years |
| | | % | | | | | | | % | | | | | | |
| Cash and cash equivalents | 13 | 2.25 | 49 | 49 | 0 | 0 | 0 | 0 | 2.25 | 111 | 111 | 0 | 0 | 0 | 0 |
| Cash and cash equivalents | 13 | 3.00 | 1,873 | 1,873 | 0 | 0 | 0 | 0 | 3.15 | 3,065 | 3,065 | 0 | 0 | 0 | 0 |
| Other investments* | 11 | 3.75 | 1,000 | 1,000 | 0 | 0 | 0 | 0 | 7.79 | 1,587 | 1,587 | 0 | 0 | 0 | 0 |
| | | 3.50 | 1,000 | 1,000 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 4.00 | 1,000 | 1,000 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 4.50 | 1,500 | 1,500 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 |
| **Secured bank loans:** | | | | | | | | | | | | | | | |
| NZD fixed rate loan* | 15 | 7.28 | 1,500 | 0 | 1,500 | 0 | 0 | 0 | 6.58 | 3,500 | 0 | 0 | 0 | 3,500 | 0 |
| NZD fixed rate loan* | 15 | 6.58 | 3,500 | 0 | 0 | 0 | 3,500 | 0 | 6.11 | 7,695 | 7,695 | 0 | 0 | 0 | 0 |
| NZD fixed rate loan* | 15 | 4.75 | 3,000 | 0 | 0 | 0 | 3,000 | 0 | 7.58 | 0 | 0 | 0 | 0 | 0 | 0 |
| NZD fixed rate loan* | 15 | 5.22 | 4,695 | 0 | | 0 | 0 | 4,695 | 7.44 | 250 | 0 | 250 | 0 | 0 | 0 |
| NZD fixed rate loan* | 15 | 0 | | 0 | 0 | | 0 | 0 | 7.28 | 1,500 | 0 | 0 | 1,500 | 0 | 0 |
| **Bank overdrafts (total facility)** | | 3.02 | 6,310 | 6,310 | 0 | 0 | 0 | 0 | 3.165 | 6,310 | 6,310 | 0 | 0 | 0 | 0 |
| Bank overdrafts (drawn) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

* These assets/ liabilities bear interest at fixed rates.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 20 Financial instruments (continued)

*Liquidity Risk*

Liquidity risk represents the West Coast Distrcit Health Board's ability to meet its contractual obligations. The West Coast District Health Board evaluates its liquidity requirements on an ongoing basis. The Board received deficit support from the Ministry of Health during the year as it did not generate sufficient cash flows from its operating activities to meet its obligations from financial liabilities in the year ended 30 June 2011. The Board plans to make application for equity (deficit support) based on the approved District Annual Plan for 2011/12 and has credit lines in place to cover potential shortfalls on a short term basis.

The following table sets out the contractual cash flows for all financial liabilities that are settled on a gross cash flow basis.

| | Balance Sheet | Contractual cash flows | 6 months or less | 6-12 months | 1-2 years | 2-5 years | More than 5 years |
|---|---|---|---|---|---|---|---|
| **2011** | | | | | | | |
| Secured Crown Health Financing Agency loans | 12,695 | 16,525 | 312 | 1,918 | 618 | 8,123 | 5,554 |
| Unsecured bank overdraft facility | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Trade and other payables | 10,313 | 10,313 | 0 | 0 | 0 | 0 | 0 |
| Total | 23,008 | 26,838 | 312 | 1,918 | 618 | 8,123 | 5,554 |
| **2010** | | | | | | | |
| Secured Crown Health Financing Agency loans | 12,945 | 14,569 | 8,109 | 430 | 1,839 | 4,191 | 0 |
| Unsecured bank overdraft facility | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Trade and other payables | 9,634 | 9,634 | | 0 | 0 | 0 | 0 |
| Total | 22,579 | 24,203 | 8,109 | 430 | 1,839 | 4,191 | 0 |

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 20 Financial instruments (continued)

### Fair values

The fair values together with the carrying amounts shown in the statement of financial position are as follows:

| | Note | Carrying amount 2011 Actual | Fair value 2011 Actual | Carrying amount 2010 Actual | Fair value 2010 Actual |
|---|---|---|---|---|---|
| Equity securities available-for-sale | 11 | 2 | 2 | 2 | 2 |
| Financial instruments held to maturity | 11 | 4,500 | 4,500 | 1,587 | 1,587 |
| Debtors and other receivables | 12 | 4,182 | 4,182 | 3,478 | 3,478 |
| Cash and cash equivalents | 13 | 1,922 | 1,920 | 3,176 | 3,176 |
| | | 10,606 | 10,604 | 8,243 | 8,243 |
| Secured loans | 15 | 12,695 | 13,246 | 12,945 | 13,521 |
| Creditors and other payables | 17 | 10,313 | 10,313 | 9,634 | 9,634 |
| | | 23,008 | 23,559 | 22,579 | 23,155 |
| Unrecognised (losses)/gains | | | 551 | | 576 |

### Estimation of fair values analysis

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

#### Interest bearing loans and borrowings

Interest bearing loans are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest bearing loans are stated at amortised costs with any differences between cost and redemption value recognised in the statement of financial performance over the period of the loan on an effective interest basis. Financial instruments held to maturity are classified as current and non-current assets depending on their maturity date. Interest, calculated using the effective interest method is recognised in the surplus or deficit.

#### Receivables

Debtors and other receivables are initially recognised at fair value and subsequently stated at amortised cost less impairment losses. Bad debts are written off in the period in which they are identified

### Categories of financial assets and liabilities

| | 2011 Actual | 2010 Actual |
|---|---|---|
| **Loans and receivables** | | |
| Cash and cash equivalents | 1,922 | 3,176 |
| Debtors and other receivables | 4,182 | 3,478 |
| Investments-short term deposits | 4,500 | 1,587 |
| | 10,604 | 8,241 |
| **Financial assets at fair value through equity** | | |
| Investments-equity instruments | 2 | 2 |
| | 2 | 2 |
| **Financial liabilities** | | |
| Creditors and other payables | 10,313 | 9,634 |
| Borrowings-secured loans | 12,695 | 12,945 |
| | 23,008 | 22,579 |

## 21 Patient and restricted funds

The West Coast District Health Board 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.

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Opening balance patients deposits | 49 | 58 |
| Monies received | 2 | 2 |
| Interest earned | 1 | 1 |
| Payments made | (2) | (12) |
| Closing balance | 50 | 49 |

The West Coast Distrcit Health Board has trust funds donated for specific purposes which have not yet been met.

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Opening balance restricted funds | 6 | 6 |
| Monies received | 0 | 0 |
| Interest earned | 0 | 0 |
| Payments made | 0 | 0 |
| Closing balance | 6 | 6 |

## 22 Contingencies

**Contingent liabilities**

**Superannuation schemes**

The West Coast District Health Board is a participating employer in a multi-employer defined benefit superannuation scheme. If the other participating employers ceased to participate in the scheme the West Coast District Health Board could be responsible for the entire deficit of the scheme. Similarly, if a number of employers ceased to participate in the scheme the West Coast District Health Board could be responsible for an increased share of the deficit.

As at 31 March 2010 (last available valuation) , the scheme had a past service surplus of $43.601 million (18.2% of the liabilities). As at 31 March 2010 the scheme had a past service surplus of $15.321 million (5.7% of the liabilities).

This amount is exclusive of Specified Superannuation Contribution Withholding Tax (SSCWT). This surplus 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 NZ IAS 19.

The Actuary to the Scheme has recommended the employer contribution are suspended with effect from 1 April 2011. Previously the employer contribution rate was 1.0 inclusive of SSCWT.

The West Coast District Health Board has no other contingent liabilities .

**Contingent assets**

The West Coast District Health Board has no contingent assets (2010: nil)

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 23 Related parties

**Ownership**

The West Coast District Health Board is a Crown Entity in terms of the Crown Entities Act 2004 and is wholly owned by the Crown. The government significantly influences the role of the West Coast District Health Board in addition to being its major source of revenue.

**Transactions with other entities controlled by the Crown**

The West Coast District Health Board enters into transactions with government departments, state owned enterprises and other Crown Entities. These transactions that occur within a normal supplier or client relationship on terms and conditions no more or less favourable than those which it is reasonable to expect the West Coast District Health Board would have adopted if dealing with that entity at arm's length in the same circumstances, have not been disclosed as related party transactions.

**Identity of related parties**

The West Coast District Health Board has a related party relationship with its Board members and Executive Management Team. In addition to salaries the West Coast District Health Board contributes to a post-employment defined benefit scheme, to a defined contribution scheme and to Kiwi Saver for some executive officers. In accordance with the terms of the defined benefit scheme, on retirement the employees entitlement is based on the their average salary over the previous five years multiplied by a factor determined by the number of years they have contributed.

Key Management Personnel comprises the Executive Management Team and the Board. The aggregate value of transactions and outstanding balances relating to key management personnel other than the Board and entities over which they have control or significant influence were as follows:

**Key management personnel compensations**

| | 2011 Actual | 2010 Actual |
|---|---|---|
| Short-term employee benefits - executive management | 1,101 | 1,459 |
| Post-employment benefits | 24 | 37 |
| | 1,125 | 1,496 |

The executive management team consisted of 8 members (2010:11) employed by the West Coast District Health Board. A further 3 members, including the Chief Exective were employed by Canterbury District Health Board. For the year under review no key management personnel were Board members (2010: nil). Short-term employee benefits include all salary, leave payments and lump sum payments. Post-employment benefits are West Coast District Health Board contributions to superannuation and kiwi saver schemes.

Board member remuneration is shown in note 24. There were no outstanding balances owing to or from Board members at 30 June 2011 (2010: Nil).

**Sales to related parties**

| | | 2011 Actual | 2010 Actual |
|---|---|---|---|
| West Coast Primary Health Organisation | 2 | 4,170 | 3,994 |
| Christchurch Polytechnic Institute of Technology (CPIT) | | 20 | 21 |
| Canterbury District Health Board (excluding inter district flows) | | 116 | 154 |
| | | 4,306 | 4,169 |

Elinor Stratford (Board member and member of the CPHAC and DSAC advisory committees) is a member of the Clinical Governance Committee of the West Coast Primary Health Organisation. The West Coast District Health Board provides funding to and receives funding from the West Coast Primary Health Organisation for primary medical services, including capitation, very low cost access and rural incentives. Peter Ballantyne (Board member-deputy chair ) is a member of the Canterbury District Health Board and a member of the Audit, Risk and Finance Committee of the University of Canterbury. Susan Wallace (Board member) is a member of the Canterbury District Health Board. Rex Williams (member of the Audit, Risk and Finance committee) is the Chancellor of the University of Canterbury and council member of CPIT. The West Coast District Health Board provides public health services to Canterbury District Health Board and clinical training for CPIT students.

**Purchases from related parties**

| | 2011 Actual | 2010 Actual |
|---|---|---|
| West Coast Primary Health Organisation | 8,264 | 8,125 |
| Canterbury District Health Board (excluding inter district flows) | 3,879 | 1,902 |
| University of Canterbury | 1 | 1 |
| Christchurch Polytechnic Institute of Technology (CPIT) | 3 | 15 |
| South Island Shared Services Agency Limited | 195 | 220 |
| | 12,342 | 10,263 |

The West Coast District Health Board has a 4% (2010: 4%) equity interest in South Island Shared Services Agency Limited which provides governance services including audit, contract management and analysis. The West Coast District Health Board purchases a wide range of services from the Canterbury District Health Board, including specialist medical, diagnostic and support services. CEO, payroll and human resource services are provided by Canterbury District Health Board and some medical equipment was sourced through them. The West Coast District Health Board purchases training courses from CPIT and clinical supervision services from the University of Canterbury.

**Leases from related parties**

| | 2011 Actual | 2010 Actual |
|---|---|---|
| West Coast Primary Health Organisation | 28 | 31 |
| | 28 | 31 |

The West Coast District Health Board has entered fixed term agreements to lease premises and office space. The Board leases office space from the West Coast Primary Health Organisation. The lease terminated in August 2011 with two rights of renewal of two years each. The lease was not renewed and the West Coast District Health Board relocated its Carelink services in October 2011.

## Notes to the financial statements

*in thousands of New Zealand dollars*

### 23 Related parties (continued)

**Outstanding balances to related parties**

| | 2011 Actual | 2010 Actual |
|---|---|---|
| West Coast Primary Health Organisation | 412 | 312 |
| Canterbury District Health Board (excluding inter district flows) | 1,421 | 472 |
| Christchurch Polytechnic Institute of Technology | 0 | 5 |
| | 1,833 | 789 |

**Outstanding balances from related parties**

| | 2011 Actual | 2010 Actual |
|---|---|---|
| West Coast Primary Health Organisation | 301 | 219 |
| Canterbury District Health Board (excluding inter district flows) | 9 | 13 |
| | 310 | 232 |

### 24 Board member remuneration

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

| | 2011 Board | 2011 Advisory Committe | 2011 Total | 2010 Board | 2010 Advisory Committee | 2010 Total |
|---|---|---|---|---|---|---|
| **Board members** | | | | | | |
| Dr S P McCormack (Chair from Dec 2010) | 26,839 | 250 | 27,089 | 12,667 | 750 | 13,417 |
| P Ballantyne (Deputy Chair from Dec 2010) | 18,280 | 1,750 | 20,030 | 8,000 | 250 | 8,250 |
| K Brown | 16,000 | 750 | 16,750 | 16,000 | 1,500 | 17,500 |
| W Gilbertson | 16,000 | 1,250 | 17,250 | 16,000 | 1,875 | 17,875 |
| H Gillespie | 16,000 | 3,625 | 19,625 | 16,000 | 3,250 | 19,250 |
| M Molloy | 9,118 | 1,250 | 10,368 | 0 | 2,000 | 2,000 |
| S Pugh | 16,000 | 1,750 | 17,750 | 16,000 | 1,375 | 17,375 |
| M Shahadat | 6,882 | 0 | 6,882 | 16,000 | 750 | 16,750 |
| E Stratford | 16,000 | 1,938 | 17,938 | 16,000 | 2,250 | 18,250 |
| D Truman | 9,118 | 500 | 9,618 | 0 | 0 | 0 |
| S Wallace | 16,000 | 1,750 | 17,750 | 16,000 | 1,438 | 17,438 |
| W Vaile | 16,000 | 500 | 16,500 | 16,000 | 938 | 16,938 |
| R Williams (Board member and Chair to December 2010) | 13,763 | 1,000 | 14,763 | 32,000 | 2,250 | 34,250 |
| C Robertson (Deputy Chair to December 2009) | 0 | 0 | 0 | 10,000 | 2,750 | 12,750 |
| **Advisory committee members (not board)** | | | | | | |
| J Ayling (CPHAC/DSSAC) | | 500 | 500 | | 0 | 0 |
| B Greer (CPHAC) | | 0 | 0 | | 250 | 250 |
| B Holland (CPHAC/DSSAC, HAC) | | 3,000 | 3,000 | | 2,000 | 2,000 |
| S Ransom (CPHAC/DSSAC) | | 0 | 0 | | 1,250 | 1,250 |
| G Morgan (HAC) | | 0 | 0 | | 1,000 | 1,000 |
| R Wallace (HAC) | | 1,250 | 1,250 | | 1,250 | 1,250 |
| G Axford (DSAC) | | 0 | 0 | | 1,250 | 1,250 |
| L Beirne (CPHAC/DSSAC) | | 1,250 | 1,250 | | 1,750 | 1,750 |
| P Nolan (CPHAC/DSAC) | | 1,750 | 1,750 | | 1,750 | 1,750 |
| M Mahuika Forsyth (CPHAC/DSSAC) | | 1,500 | 1,500 | | 2,000 | 2,000 |
| | 196,000 | 25,563 | 221,563 | 190,667 | 33,876 | 224,543 |

The West Coast District Health Board pays mileage to Bard and Advisory Committee members to attend meetings. These payments are not included in the figures for remuneration in the table above. Total gross mileage paid was $17,099 (2010: $16,807). The West Coast Distrcit Health Board carries Directors and Officers Liability insurance and letters of indemnity have been arranged which cover the actions of Board members and employees of the West Coast District Health Board.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 25 Employee remuneration

**Remuneration of employees earnings more than $ 100,000 per annum.**

| | 2011 Actual | 2010 Actual |
|---|---|---|
| 100,001 - 109,999 | 15 | 10 |
| 110,000 - 119,999 | 4 | 4 |
| 120,000 - 129,999 | 4 | 7 |
| 130,000 - 139,999 | 2 | 2 |
| 140,000 - 149,999 | 3 | 1 |
| 150,000 - 159,999 | 3 | 2 |
| 160,000 - 169,999 | 1 | 2 |
| 170,000 - 170,999 | 2 | 0 |
| 180,000 - 189,999 | 1 | 0 |
| 190,000 - 199,999 | 3 | 3 |
| 200,000 - 209,999 | 1 | 2 |
| 210,000 - 219,999 | 2 | 4 |
| 220,000 - 229,999 | 2 | 1 |
| 230,001 - 239,999 | 3 | 2 |
| 240,000 - 249,999 | 1 | 1 |
| 250,000 - 259,999 | 3 | 4 |
| 260,000 - 269,999 | 2 | 1 |
| 270,000 - 279,999 | 0 | 3 |
| 280,000 - 289,999 | 0 | 1 |
| 290,000 - 299,999 | 3 | 0 |
| 300,000 - 309,999 | 0 | 1 |
| 310,000 - 319,999 | 1 | 0 |
| 320,000 - 329,999 | 1 | 0 |
| 330,000 - 339,999 | 0 | 2 |
| 340,000 - 349,999 | 0 | 1 |
| 350,000 - 359,999 | 0 | 1 |
| 360,000 - 369,000 | 1 | 0 |
| 370,000 - 379,999 | 1 | 0 |
| 390,000 - 399,999 | 1 | 0 |
| 400,000 - 409,999 | 0 | 1 |
| 410,000 - 419,999 | 1 | 0 |
| 440,000 - 449,999 | 0 | 1 |
| 480,000 - 489,999 | 1 | 0 |
| | | |
| Total employees | 62 | 57 |

Sixty two employees 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 kiwi saver schemes.

The figures stated above for 2011 excludes the Chief Executive's remuneration as this service is delivered by Canterbury District Health Board as an outsourced service. For the 2010 year the Chief Executive's remuneration for 2010 is shown in the $250,000-$259,999 band.

Of the sixty two employees shown, fifty eight are clinical employees and four are non clinical employees.

During the year ended 30 June 2011, 1 (2010: 1) employee received payments relating to the termination of their employment totalling $33,000 (2010 $17,003), excluding retiring gratuities paid out. No Board members received compensation or other benefits in relation to cessation (2010: 0).

## 26 Subsequent event

There are no significant events subsequent to balance date.

# Notes to the financial statements

*in thousands of New Zealand dollars*

## 27 Explanation of significant variances against budget

Explanations of significant variances from the figures in the Statement of Intent when compared to actual figures for the year ended 30 June 2011.

**Statement of comprehensive income.**

The West Coast Distrcit Health Board recorded an operating deficit before other comprehensive income of $6.843m compared to the budgeted deficit of $7.200m. The favourable variance of $0.357m was the net of revenue $2.253m favourable to budget and costs $1.896m unfavourable to budget.

Total comprehensive income ($9.421m) includes the revaluation of property as at 30 June 2011 which was not budgeted and resulted in a loss in fair value of $2.578m.

The increased revenue from the Crown related to targeted initiatives by the Ministry of Health and included amoungst others additional revenue for the elective services, Pharmaceutical Cancer Treatments and oral health services.

Other operating income was better than budget with patient co-payments being higher than budget and interest being a favourable variance to budget due to the higher than budgeted cash on hand.

Expenditure was an unfavourable variance of $1.896m overall with the following being the main contributors:

- Cost increases were primarily outsourced services related to maintaining acute services.
- Clinical supply costs were over budget due to a combination of higher than budgeted elective volumes and higher demand for pharmaceuticals than budgeted, some of which revenue was received to offset the cost.
- Capital charge was under budget as the West Coast District Health Board revalued land and property as at 30 June 2010, which resulted in a significant decrease in the value of the property revaluation reserve (equity), which is used as the basis for capital charge. The revaluation of the land and buildings was not budgeted.
- Payments to external health service providers were under budget due lower volumes in age related care and that certain services which were budgeted to be outsourced have been delivered by the West Coast District Health Board.

**Statement of financial position**

Property,plant and equipment is under budget, this is due to the revaluation which occurred on 30 June 2010 which is not included in the budget. This significantly decreased the value of property and plant at this date.

Cash and cash equivalents is lower than budget as cash surplus to the short term (less than three months) operating needs have been placed on term deposits to maximise the interest earnings potential. These investments are reflected under Other investments.

Interest-bearing loans and borrowings under non-current liabilities is less than budget as the portion repayable within 12 months has been transferred to current liabilities. Overall the budgeted interest-bearing loans equals the actual outstanding as at 30 June 2011.
Employee entitlements and benefits reflect greater provisions based on an actuarial valuations at 30 June 2011.

**Changes in equity**

The variance as at 30 June 2011 ($6.004m) mainly reflects the effects of the revaluation of property and plant (revaluation reserve) over the past two years.

**Statement of cash flows**

Cash and cash equivalents are lower than budgeted cash position by $2.187m.
The main reason for this is that $4.500m of cash was placed in an investment account and reflected under Other investments.

Cash generated from operations reflects both increased funding and operating costs. Increased funding relates to additional funding received for Ministry of Health initiatives and costs increases mainly driven by increased outsourced service costs. Capital charge is under budget due to the revaluation of property and plant.

Investing cash flow is greater than budget due to $4.500m being placed in an investment account.