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

Annual Report 2011-2012

Our aim

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"To provide a people-centred, single health system for the West Coast, that is integrated and viable"

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Statistical snapshot

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Did you know that in an average week on the West Coast…

6 babies are born

18 people have a diabetes annual review

24 youth aged under 22 are provided with free contraception and sexual health checks through primary care services

29 cardiovascular disease risk assessments are undertaken by GPs

34 people have elective surgery

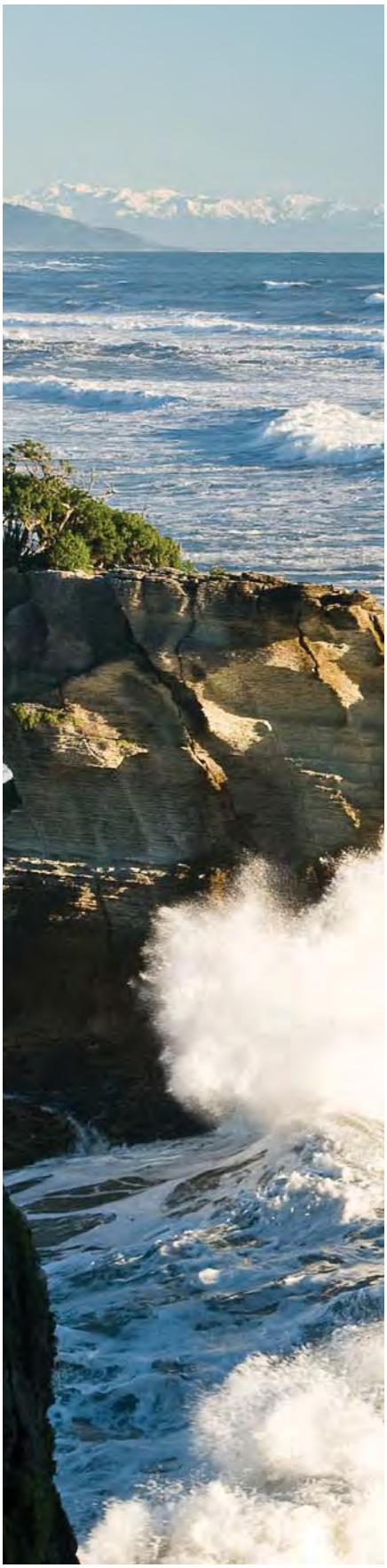
38 women have a cervical smear

41 primary care cardiovascular, diabetes, and chronic obstructive airways disease annual reviews are undertaken

101 children have a dental check

238 people attend the Grey Base Emergency Department

330 Coasters go to local specialist outpatient appointments



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714 Meals on Wheels are delivered

1,790 long term residential care bed nights are provided in rest homes and long stay hospitals

1,859 hours of home-based health and personal care are provided

2,169 people are in PHO's long-term conditions management programme

2,612 general practice appointments take place

$24,139 of laboratory tests are completed

$158,014 is spent on pharmaceuticals

Also...

In 2011–12 there were **605** people enrolled in smoking cessation programmes and **31,114** people enrolled with the West Coast PHO

1. Statutory information

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This Annual Report outlines the West Coast DHB's financial and non-financial performance for the year ended 30 June 2012. Through the use of performance measures and indicators, this report highlights the extent to which we have met our obligations under Section 22 of the New Zealand Public Health and Disability Act 2000 and how we have given effect to our functions specified in Section 23 (1) (a) to (e) of the same Act.

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

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

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

2. Report from the Board Chair and Chief Executive

Our goal in the 2011/12 financial year was to provide sustainable and effective health services for people living on the West Coast, and to do this within our allocated resources. Despite continuing challenges, we are heartened by the progress made in many key areas.

We are committed to working with our community to ensure the services we provide effectively meet real needs. During the year under review we held a series of community meetings up and down the Coast, following public consultation on the proposed Buller Integrated Family Health Centre, the proposed redevelopment of the Grey Base Hospital and the new Integrated Family Health Centre at Greymouth. At these meetings Coasters were asked for input into our plans for the future. We asked: "if you could change one thing about health services on the Coast, what would it be?" These meetings were an important way for the community to feed back on what they want from their health providers. The input we have received has been very valuable.

Being a health provider on the Coast means we face many unique challenges – a small population spread over a large geographical area; difficulty in recruiting and retaining staff (which had led to an over-reliance on locums); out-dated hospital facilities, and some of our services proving to be unsustainable. None of these challenges are new. One solution is to work more collaboratively with the Canterbury District Health Board to ensure essential services remain on the Coast. During the year increased collaboration with Canterbury saw the development of a Transalpine approach by clinicians on the West Coast and in Canterbury. This was in response to the challenges of providing health services better, sooner and more conveniently to the people of the Coast.

During the past year we came a long way towards providing viable healthcare services that will still be around for our grandchildren. In the year under review the West Coast DHB launched a world-class telehealth service. Telehealth equipment allows doctors, nurses and other health professionals in remote outposts to consult about a patient's condition with specialists in Christchurch, or anywhere in the country. Increased use of telehealth services will prevent unnecessary transfers from the West Coast and result in less disruption for patients. Other important steps taken include: improving clinical information systems; commencing the development of the Buller Integrated Family Health Centre (which we hope will be operational by late 2014); outlining plans for a $51 million rebuild of the Grey Base Hospital and recruiting much needed full-time senior clinicians.

The necessity of improving primary care on the Coast is an imperative. Practice reviews are taking place and progress is being made towards achieving this.

We were very pleased to partner with St John to provide a new ambulance station and medical centre at Franz Josef, the DHB portion of the facility is larger than other rural clinics, reflecting the growing population in Franz Josef.

We continue to perform well against the Government's health targets and are continuing to seek improvement in certain areas. For example, we lead the country on the requirement for shorter stays in emergency departments. Our continued excellent performance in this target is particularly pleasing as it requires the whole health system on the Coast to work together to provide as good a patient experience as possible.

During the year we were happy to report that the breastfeeding rates for babies at six months were above the national average. Ten years ago the West Coast DHB area had some of the lowest breastfeeding rates of all the district health boards in the country, so to turn these figures around so successfully is a credit to all staff involved.

In the year under review we established a West Coast Health System Clinical Board. This is a step towards providing stronger clinical leadership and clinical governance, with the aim of ensuring safe and sustainable health services on the Coast.

In May this year we received a detailed engineer's report that found the laundry and boiler house and boiler house chimney at Grey Base Hospital to be earthquake prone and high risk. We immediately closed these buildings. Since then we have received additional engineer's reports that show other buildings are also earthquake prone. We are moving quickly to identify options that will enable us to strengthen certain buildings where appropriate, or safely relocate those services currently operating out of the buildings identified. Ensuring the safety of our patients and staff is underpinning all of our decision making. This activity is being undertaken in conjunction with the planned rebuild of the Grey Base Hospital facilities.

People living on the Coast or contemplating moving here, must have trust and confidence in the West Coast healthcare system. Being able to deliver the right services, in a safe, sustainable and cost effective manner is the most important task we have ahead of us.

We would like to express our appreciation to all members of the staff of the West Coast District Health Board and all others involved with or working within the West Coast health system. Their efforts and dedication over the last twelve months have continued a service that the West Coast community should be proud of.

Peter Ballantyne
Acting Chair

David Meates
Chief Executive

3. Some key achievements

New health centre opens – A combined West Coast DHB and St John health centre / ambulance station in Franz Josef is opened by Director-General of Health, Kevin Woods and St John Chairman, South Island Region, Geoff Ridley.

Virtual paediatric clinics – More services are provided to children via a new mobile telehealth unit purchased with funding from Countdown Kids. This means fewer children and their families having to travel to Christchurch.

Seismic drilling commences – Drilling equipment moves onto the Grey Base Hospital site to begin seismic testing of the land to inform the redevelopment business case.

Community Updates – *Report to the Community* is produced to inform Coasters about developments in health service delivery across the Coast. It details some of the ways the West Coast health sector is working collaboratively to improve on health priority areas. *Report to the Community* is delivered via *The Messenger*.

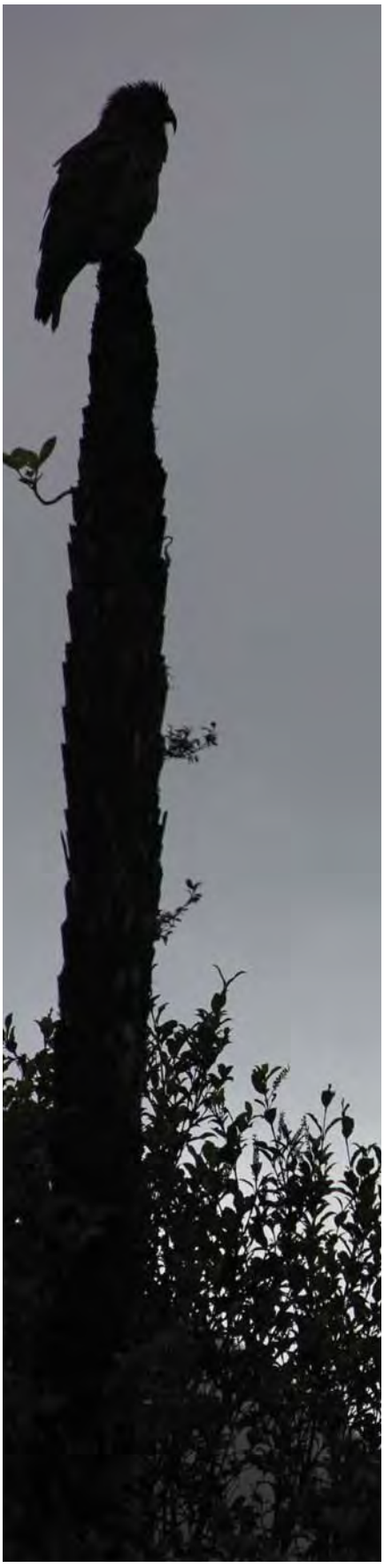
Community Consultation meetings – A series of community meetings are held up and down the Coast, following on from public consultation on the proposed Buller Integrated Health Centre and the redevelopment of Grey Base Hospital. At these meetings Coasters are asked if they could change one thing about the West Coast Health System, what would it be? Community feedback is welcomed and has been taken into consideration as plans are developed.

Free home insulation – 170 homes are insulated for free as part of a joint venture between the West Coast District Health Board, Autex GreenStuf, The Insulation Company, and the Energy Efficiency and Conservation Authority via the Government's insulation programme Warm Up New Zealand: Heat Smart. The DHB's role is to identify people in the community most at risk due to living in households with poor home insulation.

Breastfeeding figures rise – West Coast mothers lead the charge in their commitment to breastfeeding. Strong community support and a number of local health initiatives are behind the outstanding results, including a strong focus on face-to-face, baby-friendly, inclusive initiatives that have been introduced to support groups, workplaces and public spaces such as cafes.

Focus on rural learning – The Rural Learning Centre is set up on the Grey Base Hospital campus with two units. The first has a training room and a smaller study area which will accommodate three students. The other unit has a dedicated study area for Rural Medical Immersion Programme students, a student lounge and kitchen.

4. Strategic imperatives



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As outlined in our Annual Plan our strategic imperatives for 2011/12 were:

a. Achieving the Government's health targets

b. Managing our financial performance to achieve financial sustainability

c. Driving *Better, Sooner, More Convenient* health care

d. Collaboration with the Canterbury DHB

e. Facilities planning

f. Recruitment and Retention

RECRUITMENT AND RETENTION – A new careers website was recently launched to attract health professionals to roles in hospitals and the community on the West Coast.

a. ACHIEVING THE GOVERNMENT'S HEALTH TARGETS

	TARGET	PERFORMANCE IN 2011/12
	• >95% of patients are to be admitted, discharged or transferred from an ED within six hours.	99.7%
	• West Coast's volume of elective surgery is to be increased to 1,592 in 2011/2012.	1751
	• 100% of people needing cancer radiation oncology treatment receive it within four weeks of their first specialist assessment	100%
	• 95% of two year olds are to be fully immunised. (West Coast progress target – 88% by July 2012)	82%
	• 95% of hospitalised smokers are to receive help and advice to quit by July 2012. • 90% of enrolled patients who smoke and are seen in General Practice will be provided with advice and help to quit smoking by July 2012	84% 39%
	• 90% of the eligible adult population will have their CVD risk assessed once in every five years. • 70% of the expected population with diabetes will receive a free annual review. • 80% of those receiving a free annual diabetes review will have satisfactory or better diabetes management (HbA1c≤8%).	56.7% 77% 75.6%

b. MANAGING OUR FINANCIAL PERFORMANCE TO ACHIEVE FINANCIAL SUSTAINABILITY

Our drive to deliver health services on the West Coast within existing resources in 2011/12 focused on improving patient pathways and improving the efficiency and effectiveness of patient services and programmes. During the year we achieved a 27% reduction in the operating deficit from $6.83m in 2011 to $5.024m for the year ending 30 June 2012. The underlying principles of reducing variation, duplication and waste, doing the basics well, investing in clinical leadership and a whole of system approach to health service delivery were key to achieving this reduction in our operating deficit.

c. DRIVING *BETTER, SOONER, MORE CONVENIENT* HEALTH CARE

Considerable progress was made during 2011/12 on the implementation of *Better, Sooner, More Convenient* health care that will provide sustainable health services on the West Coast into the future. The key focus this year was on developing new models of care, 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. During 2011/12 an indicative business case has been completed for the Buller Integrated Family Health Centre, with comprehensive and integrated services that span primary care, secondary services, community services and older person's health. In addition, a comprehensive health needs analysis and model of care work for the development of the business case for the Grey Integrated Family Health Service was undertaken.

During the year a key enabler for *Better, Sooner, More Convenient* health care, telehealth, was further implemented. Telehealth allows the delivery of medical care and education by remote transmission of audio and video data in real or delayed time and during the year telehealth equipment has been progressively installed at Karamea, Hokitika, Hari Hari, Whataroa, Fox Glacier, Franz Josef and Haast medical centres. This is in addition to the facilities already available in Greymouth, Buller and Reefton.

d. COLLABORATION WITH CANTERBURY DHB

The planning and delivery of health services on the West Coast is inextricably intertwined with the Canterbury DHB, and 2011/12 has seen further integration of our workforces and development of a 'Transalpine approach' to health service delivery. This Transalpine approach focuses on clinical collaboration and cooperative arrangements between Canterbury and West Coast DHB clinical and support staff so that sustainable health services continue to be provided to the West Coast community.

The Transalpine approach and telehealth technology has enhanced paediatric medical services on the West Coast in 2011/12 through the provision of virtual ward rounds and consultations by the West Coast liaison consultant paediatrician who is based in Christchurch. In addition, the Transalpine approach has supported shared clinical appointments and clinical service delivery including a jointly appointed geriatrician, head of department for anaesthetic services, and the nursing director for older persons' health in Canterbury. They will all provide strategic input into the West Coast DHB service planning. An agreement for the joint provision of orthopaedic services is in place, and learning and development services have also been jointly established.

e. FACILITIES PLANNING

The imperative for changes to primary, community and hospital facilities on the West Coast is to secure a clinically sustainable future for the West Coast health system and meet the Government's objectives for *Better, Sooner, More Convenient* primary and community health care. A business case was developed for the Grey Integrated Family Health Service that details the proposed changes to primary and community models of care on the West Coast. The business case supports recommendation that a new facility for an integrated family health services is built and integrated on the Grey hospital site. It also supports the Grey Hospital Redevelopment Indicative Business Case that was produced concurrently and was put forward for consideration to the Capital Investment Committee. In August 2012 the business case for the Buller Integrated Family Health Centre was also completed.

f. RECRUITMENT AND RETENTION

The West Coast DHB is committed to being a good employer and 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.

As part of the Transalpine health service, the Canterbury DHB and West Coast DHB have adopted a combined approach to the recruitment and retention of staff. During the year this joint approach included the establishment of a joint learning and development process under the human resource team, a joint Nursing Entry to Practice programme that enables shared elements of training such as the rapid assessment course and the opportunity for West Coast and Canterbury DHB graduates to come together during their first year of practice.

Supporting the upskilling and ongoing education of West Coast DHB staff has been a key focus for 2011/12 with 28 nurses undertaking postgraduate studies during the year. A further ten nurses completed their professional supervision training and are providing oversight to nurses working in isolated and autonomous roles. A number of regular patient-focused clinical learning sessions are provided in conjunction with clinical teams in Canterbury. Newly appointed senior doctors have planned time working with Canterbury colleagues. It is pleasing to report that appointments were made to a number of long-standing senior hospital doctor vacancies in the year under review.

Leadership, Accountability and Culture

The West Coast DHB recognises that leadership, particularly clinical leadership, is a key component in the delivery of positive patient outcomes. During 2011/12 we established a West Coast Health System Clinical Board that is responsible for leading clinical governance in health care services on the West Coast and provides leadership on quality and safety.

The West Coast DHB operates a quality audit and monitoring function, and actively encourages an organisational culture that is supportive of continuous quality improvement and quality initiatives through a systems approach.

All controlled documents – policies, protocols, procedures and guidelines – are required to be prepared in a standardised format, reflecting best practice, are reviewed regularly and are appropriately consulted on.

Recruitment, Selection and Induction

The recruitment and retention of the right people, with the right skills was a key strategic imperative for the West Coast DHB in 2011/12. The West Coast DHB aims to be an employer of choice and to make our workplace more attractive by offering challenging work, more patient contact time, ongoing career and leadership development and opportunities to be part of decision-making.

We support the principles of equal employment opportunity as outlined in West Coast DHB's Equal Employment Opportunity procedure whereby staff are employed or promoted on the basis of merit. All staff are valued for their different skills and experiences.

Safe and Healthy Environment

The West Coast DHB is committed to providing a safe and healthy workplace with a dedicated health and safety position to provide advice and support to management and staff.

We operate a health monitoring programme including screening and immunisation, and employees are encouraged to access the Employee Assistance Programme if they are faced with personal problems that may impact their work situation.

An employee participation programme with safety training encourages all employees to be responsible for building and maintaining a healthy and safe environment at work.

The West Coast DHB continues to participate in the ACC Partnership Programme and is focused on developing and implementing injury prevention programmes that address high risk areas and in the rehabilitation of employees back to work following an injury or illness.

Remuneration and Recognition

The West Coast DHB endeavours to remunerate all staff fairly and consistently, linking this to the principles of performance, employee competency development and organisation affordability.

5. Improving outcomes for our population

Enrolled nurse Kay Bone

This section presents an overview of how, over the mid-to longer-term, we demonstrate whether we are making a positive change in health outcomes for our population and the population of the wider South Island. Our aim is to improve the availability (access and equity), quality and timeliness of services and to enable people to make healthier choices and enhance their quality of life.

5.1 OUTCOME: PEOPLE TAKING GREATER RESPONSIBILTY FOR THEIR OWN HEALTH

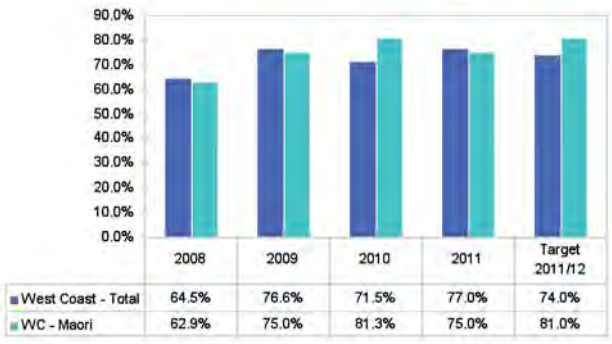
Population health and prevention programmes, through enhanced education and support, ensure people are better protected from harm, are more informed of the signs and symptoms of ill health and are supported to reduce risk behaviours and modify lifestyles in order to maintain good health. They create health-promoting physical and social environments which support people to take more responsibility for their own health and improve individual and community capability to make healthier choices.

LONG-TERM OUTCOME MEASURES

Outcome	Outcome Measure	Comment
People take responsibility for their own health	A reduction in smoking rates	This data is sourced from the NZ Health Survey and the latest results are not yet available from the Ministry of Health.
	A reduction in obesity rates	

IMPACT MEASURES OF PERFORMANCE – MEDIUM TERM

An increase in the proportion of babies fully and exclusively breastfed. Measured by the percentage of West Coast children fully/exclusively breastfed at 6 weeks.



	2008	2009	2010	2011	Target 2011/12
West Coast - Total	64.5%	76.6%	71.5%	77.0%	74.0%
WC - Maori	62.9%	75.0%	81.3%	75.0%	81.0%

Note: The result for 2011 includes data from all three providers (West Coast DHB, Plunket, and Rata Te Awhina). Previous years have only utilised Plunket breastfeeding data.

Progress Target – Māori: 81%

Progress Target – Total: 74%

During the 2011 calendar year the West Coast DHB breastfeeding target of 74% of all babies fully or exclusively breastfed at 6 weeks was achieved with a result of 77%.

The target for Māori Pepe of 81% was not achieved with a result of 75% of Māori Pepe fully or exclusively breastfed at 6 weeks in 2011. This result is in spite of follow-up and encouragement to women to breastfeed wherever possible being undertaken.

Initiatives to support West Coast mothers to breastfeed included breastfeeding education for health professionals and social service agency staff, breastfeeding ante-natal classes, the development of the West Coast Breastfeeding Handbook and the provision of community based lactation consultation services. 103 clients accessed the community-based lactation consultation service in 2011/12 (including 65 living in deciles 8-10 areas).

A reduction in the proportion of young people who take up tobacco smoking. Measured by the percentage of 'never smokers' among Year 10 West Coast students.

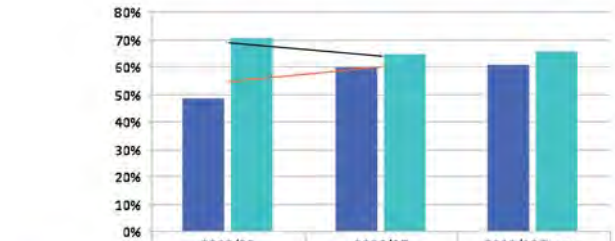
	2003	2004	2005	2006	2007	2008	2009	2010	2011
WCDHB	33%	39%	49%	50%	54%	58%	61%	41%	75%
National Average	42%	47%	49%	54%	57%	61%	64%	64%	70%
WCDHB 2011/12 Target	70%	70%	70%	70%	70%	70%	70%	70%	70%

Progress Target: 70%

The West Coast DHB has achieved the target for the percentage of 'never smokers' among Year 10 West Coast students at 75%, an increase of 34%.

The appointment of the Smokefree / Auahi Kore Youth Coordinator in Buller is promoting the benefits of living a smokefree lifestyle. Promoting smokefree lifestyles is also a priority for the Health Promoting Schools initiative, including the development of positive smokefree strategies within schools.

An increase in the proportion of adults who have healthier diets. Measured by the percentage of the West Coast population (15+) having the recommended servings of fruit and vegetables.



	2002/03	2006/07	2011/12 Target
Fruit	48.8%	59.8%	61.0%
Vegetables	70.8%	64.8%	66.0%
National - Fruit	54.6%	60.0%	
National - Veg	68.6%	64.1%	

Note: This data is sourced from the NZ Health Survey and the latest results are not yet available from the Ministry of Health.

Target – Fruit 2+ : 61%

Target – Veg 3+ : 66%

Eleven community nutrition programmes were delivered in 2011/12, including Appetite for Life and Cooking Skills to Life Skills. These programmes and community-wide promotion and education of healthy food messages, through media, themed health weeks and schools and early childhood centres, supported individuals and the community to make healthier choices.

Nutrition and physical activity grants were provided to West Coast schools and Early Childhood Centres in 2011/12 for projects that support improved nutrition. A number of these projects were built on existing nutrition fund projects and the Tucking In – A West Coast Grow Your Own initiative.

West Coast DHB Board meeting

5.2 OUTCOME: PEOPLE ARE SUPPORTED TO STAY WELL IN THEIR OWN HOMES AND COMMUNITIES

Population health and prevention programmes, through enhanced education and support, ensure people are better protected from harm, are more informed of the signs and symptoms of ill health and are supported to reduce risk behaviours and modify lifestyles in order to maintain good health. They create health-promoting physical and social environments which support people to take more responsibility for their own health and improve individual and community capability to make healthier choices.

<table>
<tr><th>Outcome</th><th>Outcome Measure</th><th>Comment</th></tr>
<tr><td rowspan="2">People are supported to stay well in their own home and communities.</td><td>A reduction in ‘avoidable’ presentations to hospital Emergency Departments</td><td>There was a slight increase in the ‘avoidable’ presentations to our Emergency Departments, up marginally from 20% in 2010/11 to 20.3% in 2011/12.</td></tr>
<tr><td>An increase in the proportion of the population supported to manage their long-term conditions</td><td>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:
<table>
<tr><th></th><th>2008/2009</th><th>2009/2010</th><th>2010/2011</th><th>2011/2012</th></tr>
<tr><td>Total LTC Enrolment</td><td>416</td><td>1881</td><td>1639</td><td>2169</td></tr>
<tr><td>Diabetes Annual Reviews</td><td>664*</td><td>767</td><td>831</td><td>923</td></tr>
<tr><td>CVD Annual Reviews</td><td>528</td><td>637</td><td>900</td><td>974</td></tr>
<tr><td>COPD Annual Reviews</td><td>61</td><td>148</td><td>212</td><td>232</td></tr>
</table>
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.</td></tr>
</table>

<table>
<tr><th>Outcome</th><th>Outcome Measure</th><th>Comment</th></tr>
<tr><td>People are supported to stay well in their own home and communities.</td><td>An increase in the proportion of the population aged over 65 supported to live well in their own homes</td><td>The proportion of the West Coast population aged over 65 years supported to live well and remain living in their own homes through the provision of home based support services has been maintained, and in turn there has been a continued decline of people in age residential care facilities (rest homes and long stay hospital care) in 2011/12.
<table>
<tr><th></th><th>2008/2009</th><th>2009/2010</th><th>2010/2011</th><th>2011/2012</th></tr>
<tr><td>West Coast DHB % in Age Residential Care</td><td>6.7%</td><td>6.7%</td><td>6.6%</td><td>6.5%</td></tr>
<tr><td>South Island % in Age Residential Care</td><td>7.3%</td><td>7.1%</td><td>7.0%</td><td>6.7%</td></tr>
<tr><td>West Coast DHB % receiving home based support services</td><td>14.5%</td><td>13.9%</td><td>13.1%</td><td>13.2%</td></tr>
<tr><td>South Island % receiving home based support services</td><td>12.8%</td><td>12.0%</td><td>10.1%</td><td>10.2%</td></tr>
</table></td></tr>
</table>

IMPACT MEASURES OF PERFORMANCE – MEDIUM TERM

An increase in the proportion of children with good oral health. Measured by percentage of West Coast children who are caries free (have no holes or fillings) at age 5.

	2008	2009	2010	2011	2011/12 Target
Maori	35.4%	48.4%	45.0%	47.0%	55.0%
Pacific	28.6%	28.6%	12.5%	40.0%	55.0%
Total	50.0%	49.3%	54.1%	61.0%	55.0%
National Average	57.5%	56.2%	57.2%		

Note: The result are for the 2011 Calendar year.

Progress Target – Māori: 55%

Progress Target – Pacific: 55%

Progress Target – Total: 55%

Overall, 61% of all West Coast 5 year olds were dental caries free in the 2011 school year which is 6% greater than the target set for 2011.

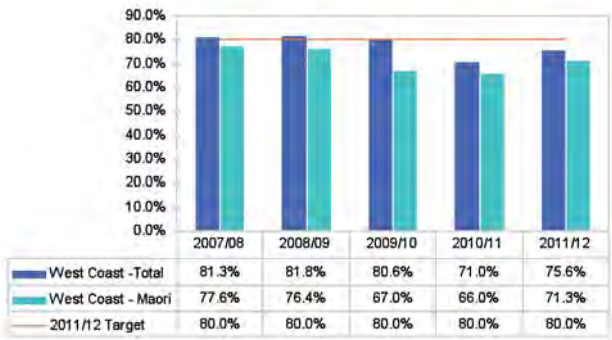
West Coast Māori 5 year olds caries free rate has also increased to 47% from 2010 school year, however, the target of 55% was not achieved.

The implementation of the preventive model of care which includes topical fluoride service for pre-schoolers at risk of tooth decay, and oral health education with parents about their child's oral health needs has helped in ensuring West Coast Children are caries free.

In addition, getting children enrolled with the School Dental Service ensures that they are captured and are followed up on. In 2011/12, enrolment packs and resource information were sent to twenty-six preschools and twenty-eight other agencies and providers such as Child, Youth and Family Services, Māori Health Provider, new coasters, and GP practices resulting in 68% of total enrolment for pre-schoolers.

An up-to-date electronic enrolment register for preschool and primary school children including a Māori enrolment register has been has been set up by the School Dental Service and this has been a major undertaking in 2011/12.

An increase in the proportion of people identified with diabetes having 'satisfactory' management of their diabetes. Measured by the percentage of people receiving diabetes annual reviews who have satisfactory or better diabetes management (HbA1c<8%).



	2007/08	2008/09	2009/10	2010/11	2011/12
West Coast -Total	81.3%	81.8%	80.6%	71.0%	75.6%
West Coast - Maori	77.6%	76.4%	67.0%	66.0%	71.3%
2011/12 Target	80.0%	80.0%	80.0%	80.0%	80.0%

Progress Target – Māori: 80%

Progress Target – Total: 80%

Diabetes detection rates exceeded the 70% target for our core monitored populations for 2011/12. As a result, more patients with high clinical needs were identified and have been provided with annual reviews, received close support and management for their care needs. This has resulted in a correspondingly lower than our 80% target result for diabetes management results (HbA1c levels at or below 8.0). Notwithstanding this, the overall management outcome results are an improvement from last financial year, with closer care now being provided to a greater number of people identified through diabetes checks.

A reduction in the proportion of the population admitted to hospital with conditions considered 'avoidable' or 'preventable'. Measured by the ratio of actual to expected avoidable hospital admissions for the West Coast population aged 0-74.  		Dec 2008	Sep 2010	Mar 2011	Mar-12	2011/12 Target
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Maori	88	93	95	67	95
Total	89	89	91	77	95
New Zealand	100	100	100	100	| *Note: This data is sourced from the NZ Health Survey and the latest results are not yet available from the Ministry of Health.*	**Progress Target – Māori: < 95** **Progress Target – Total: < 95** West Coast results for the year to 31 March 2012 (the latest available published data) were • Māori – 66.7 • Total – 78.5 West Coast DHB overall total discharge rates per 1000 for ambulatory sensitive 'avoidable' hospitalisations continues to be low. It does not vary significantly from the overall national rates at the 99% confidence interval for any of the three indicator age band category and ethnicity population cohorts; with the exception of the rates for the Other Ethnicity population in the group age 0 – 74, which was well below the national rate (down by 16.0% against the national average rate for the group, and 16.5% below our target).
An increase in the proportion of people aged over 75 who are supported to maintain functional independence. Measured by the percentage of the population in West Coast aged over 75, admitted to hospital as a result of a fall.	**Progress Target: Measure Discontinued** The intention was for this measure to be based on a new national DHB indicator (PP15). However, data for 2009/10 was not available from Ministry of Health at the time the Statement of Intent was published, inhibiting target-setting, and the Ministry of Health has since discontinued the PP15 indicator.

Grey Base Hospital

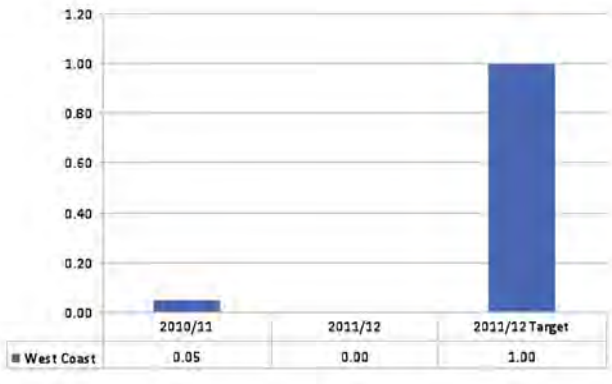
5.3 OUTCOME: PEOPLE RECEIVE TIMELY AND APPROPRIATE COMMUNITY AND COMPLEX CARE

Most people will receive effective acute care in the community so that only the most ill people will require hospital admission. Secondary-level hospital and specialist services meet peoples' complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, health outcomes and quality of life are improved and untimely deaths reduced.

Outcome	Outcome Measure	Comment
People receive timely and appropriate community and complex care	A reduction in unplanned acute readmission to hospital and specialist services	West Coast had the lowest standardised acute readmission rate of any DHB in New Zealand at 7.76 for the twelve month period to 30 June 2012. The national average was 10.12. Our target for the year was to remain below 8.21.
	A reduction in the rate of mortality within 30 days of discharge from hospital and specialist services	West Coast DHB had a 30-day mortality rate of 1.67 for the twelve month period to 31 March 2012 *(latest published data)* for this measure. This measure has since been disestablished by the Ministry. The national average was 1.5 for the same period. West Coast DHB was not significantly different from other DHBs at the 99% confidence interval for this measure. Our intention was to track hospital mortality rate using the national DHB performance measure OS9, 'the rate of mortality within 30 days of discharge from hospital. However, the Ministry of Health discontinued the use of this national measure in 2012/13.

IMPACT MEASURES OF PERFORMANCE – MEDIUM TERM

A reduction in serious incidents (adverse events) causing harm to patients in Hospital and Specialist Services.
Measured by the rate of Serious Assessment Code (SAC) 1 and 2 levels falls in Hospital and Specialist Services (people aged 65+)



Target – 1

The 2011/12 year saw no reported falls that met the Severity Assessment Code (SAC) 1 or 2 criteria. The SAC scoring uses a matrix of consequence by likelihood and would see SAC 1 and 2 events as:

- those where death results from health care and is unrelated to the expected outcome for the patient or
- a permanent disability or loss of function unrelated to the natural course of the patients illness and may recur within the next five years or
- a permanent reduction of function unrelated to the natural course of the illness and is likely to recur within the next two years.

Of note, the 2011/12 year has seen an improvement in the reporting and investigation process for all incidents occurring within hospital services, and as a result reporting overall is increasing. Streamlining and robustness of process around serious incidents (SAC 1 and 2) has also improved, and an increase in reporting of these incidents is evident. These events are now consistently reported nationally and investigated using root cause analysis methodology helping to create an expectation for open disclosure and a culture of learning from errors.

Improving outcomes for our population in the provision of elective services. Measured by:

- The percentage of people waiting longer than six months for their first specialist assessment (ESPI 2)
- The percentage of people given a commitment to treatment, but not treated within 6 months (ESPI 5)

	2007/08	2008/09	2009/10	2010/11	2011/12
ESPI 2	100%	100%	99.3%	99.7%	100%
ESPI 5	98.9%	97.8%	98.5%	98.1%	100%
Target 2011/12 for both ESPI 2 & 5	100%	100%	100%	100%	100%

Note: Graph shows percentage of people provided with a first specialist assessment within 6 months of referral (ESPI 2) and percentage of people given commitment for surgery and treated within 6 months of referral (ESPI 5). (ESPI = Elective Services Performance Indicator).

Target – ESPI 2: 0%

Target – ESPI 5: 0%

As at 30 June 2012, there were no patients waiting longer than six months for outpatient first specialist assessment, nor for elective surgery at the West Coast DHB's hospital and secondary services.

An increase in timely access to Urgent Care services. Measured by the percentage of patients presenting at ED who are admitted, discharged or transferred within six hours.

	2007/08	2008/09	2009/10	2010/11	2011/12
West Coast	98.89%	98.81%	99.39%	99.52%	99.7%
2011/12 Target	95%	95%	95%	95%	95%

Target: >95 %

99.7% of all patients presenting to ED services at West Coast DHB's Emergency Departments during 2011/12 were seen, and either admitted, discharged or transferred within six hours of arrival to the services.

Of those presenting, 96.2% were either admitted, discharged or transferred within four hours

6. Statement of responsibility

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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 the West Coast DHB 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 2012, 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 DHB.

Peter Ballantyne
Acting Chair
26 October 2012

Helen Gillespie
Board Member
26 October 2012

7. Independent auditor's report

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To the readers of

West Coast District Health Board's financial statements and statement of service performance for the year ended 30 June 2012

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 40 to 78, that comprise the statement of financial position as at 30 June 2012, 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 24 to 38.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 40 to 78:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board's:
    - financial position as at 30 June 2012; 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 24 to 38:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board's service performance for the year ended 30 June 2012, 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 26 October 2012. 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.

continued overleaf...

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.

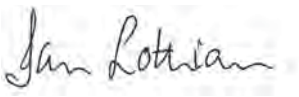
Responsibilities of the Auditor

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.

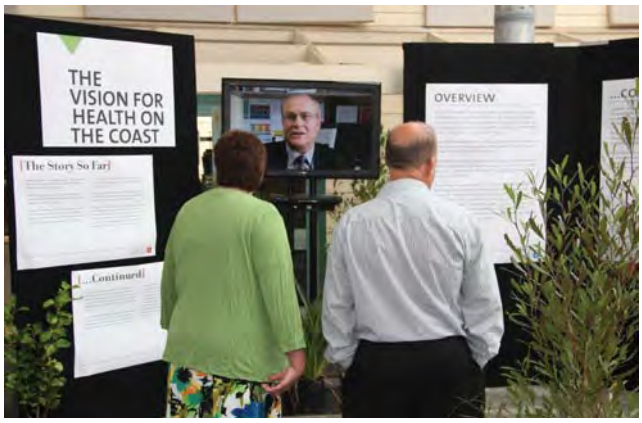
Other than the audit, we have no relationship with or interests in the Health Board.



Ian Lothian

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

8. Statement of service performance



Sharing the vision for health on the West Coast.

This section details the Board's performance to its service objectives and performance targets, as stated in the 2011/12 Statement of Intent, the formal accountability document that sets out the DHB's plans and performance targets at the start of the financial year.

NATURE AND SCOPE OF ACTIVITIES

The West Coast DHB is the principal funder and provider of health and disability services to the 32,875[1] 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 DHB faces challenges not faced by other DHBs.

Geography and rurality create significant diseconomies of scale in the delivery of services provided and funded by the West Coast DHB. Notwithstanding this the Board both funds and provides a broad range of health services to the West Coast population.

The West Coast DHB 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 DHB's District Strategic Plan, and are operationalised through their inclusion in the DHB's District Annual Plan and Statement of Intent that outlines our service objectives and performance targets over a three year period.

DHB GOVERNANCE AND MANAGEMENT

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

The governance role of the West Coast DHB is also focused on monitoring the delivery and performance of services by, its provider arm, other DHBs 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.

2011/12 saw a continuation of the formal involvement and collaboration between West Coast and Canterbury DHBs, including joint appointments in Specialist Paediatric and Specialist Gerontology and formalisation of combined orthopaedic services from late in the financial year.

OUTCOMES AND PRIORITIES

In order to present a representative picture of performance, our outputs have been aggregated into four 'output classes' that are applicable to all DHBs, and are a logical fit with the specific stages of the continuum of care. The four output classes are:

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

[1] *District Health Board Population Projection for 2011/12 – updated June 2011; provided by Statistics*

Scope of DHB Operations – Output Classes against the Continuum of Care

Prevention Services

Early Detection and Management Services

Intensive Assessment and Treatment Services

Rehabilitation and Support Services

For each output class there are agreed national performance measures and targets 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 activities of the West Coast DHB. These measures highlight our activity toward achieving our local and national strategies, priorities and targets.

OUTPUT CLASS 1: PREVENTION SERVICES

Prevention health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and population-based immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

These services are the domain of many organisations across the region including: the Ministry of Health; Community and Public Health (the public health unit of the Canterbury DHB, which also provides services for the West Coast and South Canterbury districts); West Coast PHO and general practice; as well as private and non-government organisations and local and regional government. Services are provided with a mix of public and private funding.

DHBs 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 DHBs using a weighted population-based funding formula. The district public health priorities are determined by the DHB 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 DHB. The West Coast DHB is working collaboratively with both the West Coast PHO 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 2011/12 this joint planning focused on nutrition and physical activity (including breastfeeding), tobacco control, immunisation, alcohol and home insulation. 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 and other health promotion areas. During 2011/12 Active West Coast jointly developed eight written submissions including the Grey District Council proposed Grey District's Miner's Memorial Centre, West Coast Regional

Land Transport Programme and Long Term Plan submissions for all three West Coast Territorial Local Authorities and West Coast Regional Council, as well as objections to two off-license applications. Membership of this network includes the West Coast DHB, West Coast PHO, Community and Public Health, Territorial Local Authorities, and a range of Non-Government Organisations including the Disability Resource Service.

In 2011/12, the West Coast DHB continues to coordinate and encourage population based screening services which are national funded programmes. These services help to identify people who are at risk of illness and pick up conditions earlier. The role undertaken by the DHB has yielded increase in the uptake of antenatal HIV screening and neonatal hearing testing by pregnant West Coast mothers and their newborns respectively. The percentage of eligible women on the West Coast who had breast screening has also increased in 2011/12; 5% more than the target set for breast screening in 2011/12.

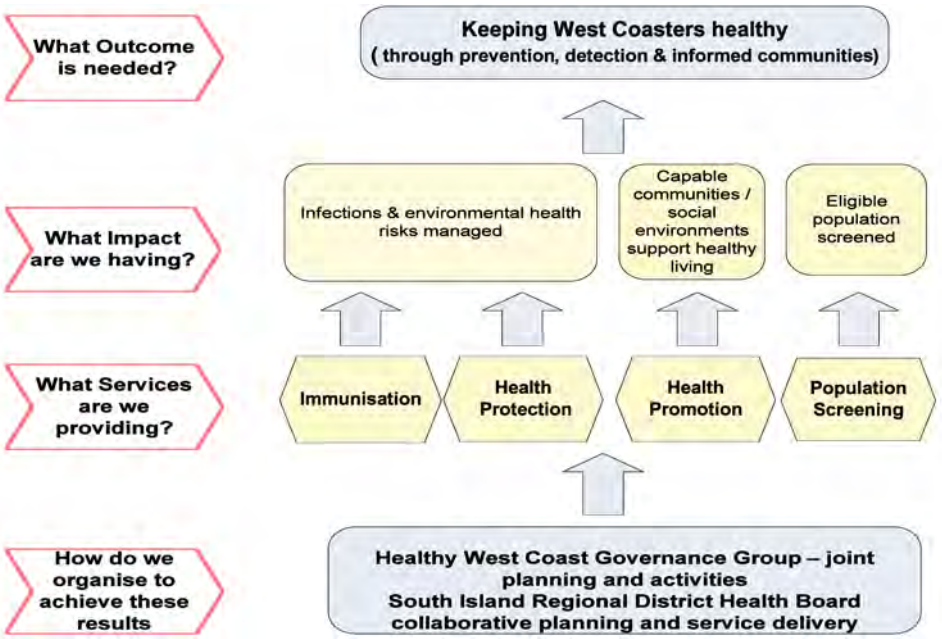
Improving immunisation coverage continued to be a focus for the West Coast DHB in 2011/12. The West Coast has historically had a higher than average 'opt-off' and 'decline' rate for 2 year old immunisation within its communities. This currently amounts to nearly 15.7% of the total eligible population, meaning that we routinely achieve 97% coverage for those willing to be immunised. Half of those opting off have strongly held ethical and religious views on this issue and are unlikely to change their view. However, the West Coast DHB continues to work collaboratively with all child health service providers to improve the immunisation coverage for all two year olds on the West Coast.

Implementation of the Child and Adolescent Oral Health Services and the preventative model of care continued to be a focus in 2011/12, which saw topical fluoride service being fully implemented in the school dental service programme for all preschool enrolled children. There was also an increase in the enrolment of adolescent in community dental services and importantly the increased utilisation of the DHB funded oral health services by adolescent from Year 9 including and up to 17 year olds. The utilisation rate is 81% in 2011, 1% more than the target set by the DHB.

A key focus of the West Coast Tobacco Free Coalition for 2011/12 continued to be the implementation of the Ask, Brief advice & Cessation (ABC) strategy across both primary and secondary care services and reaching the 'Better help for smokers to quit' health targets. Within secondary care, three areas regarding the implementation of the ABC initiative were targeted by the smokefree staff; leadership, training and visibility with the aim of ensuring successful implementation and sustainability of the ABC approach. The impact of these activities resulted in an improvement from 67% in the first quarter of 2011/12 to 90% in quarter 4.

Another success was the securing of funding to continue the delivery of high priority community physical activity and nutrition services to replace elements previously funded through the Healthy Eating Healthy Action programme. This includes the Tai Poutini Breastfeeding Initiative, Waka Ama Leadership Project and Community Nutrition Programmes.

Outcomes for Prevention Services



We have chosen to present a mix of measures focused on four key elements of performance: Quantity or 'Volume' (V, to demonstrate capacity), Quality (Q, to demonstrate effectiveness) and Timeliness and Coverage (T and C, to demonstrate reach and access). Wherever possible, we have included a past year's baseline data to support evaluation of our performance at the end of the year, and national averages to give context in terms of what we are trying to achieve.

Health Promotion and Education Services	Notes	2010/11 Result	2011/12 Result	Target 2011/12
The provision of Mum 4 Mum peer support training to volunteer mothers	V [2]	17	18	17
The proportion of women breastfeeding on discharge from hospital	Q [3]	96%	91%	96%
Lactation support and specialist advice consults provided in community settings	V	152	103	152
The proportion of Māori infants exclusively and fully breastfed at 6 weeks	Q [3]	75%	75%	81%
Help and smoking cessation advice provided to hospitalised smokers	C	55%	84%	Reach 95%
Help and smoking cessation advice provided to smokers identified in primary care	C	Not Available	39%	90%
Enrolments in the Aukati Kai Paipa smoking cessation programme	V	119	126	100
The percentage of year 10 students who have never smoked	Q	61%	75%	70%
Total West Coast population enrolments to all smoking cessation services	Q	1282	1498	1200
The provision of community-based Cooking Skills to Life Skills and Senior Chef courses	C	4	11	5
The number of people provided with Green Prescriptions	V	243	389	250
The percentage of women accessing hospital services 15+ screened for family violence	C	30%	20%	50%

Statutory and Regulatory Services	Notes	2010/11 Result	2011/12 Result	Target 2011/12
Compliant tobacco retailers identified from controlled purchase operations	Q	New Measure	92%	95%
Compliant alcohol retailers identified from controlled purchase operations	Q	56.5%	66%[4]	95%

Population Based Screening Services	Notes	2010/11 Result	2011/12 Result	Target 2011/12
Women screened for HIV as part of routine antenatal blood tests	C	67%	77%	75%
Infants screened for neonatal hearing loss	V	93%	94%	95%
Children provided with a B4 School Screening Health Check	C[5]	120%	99%[6]	85%
Young people in alternative education provided with a HEADSSS assessment	C[7]	New Measure	50%	75%
Eligible population (20-69) provided with cervical cancer screens	C[8]	76%	71%[9]	75%
Eligible population (45-69) provided with breast screen examinations	C[8]	76%	79%	75%

[2] Mum4Mum training supports social change by allowing the DHB to significantly increase its capacity to deliver key messages through informal contact facilitated by appropriately trained volunteer mothers. The measure is the number of Mothers trained.

[3] The proportion of women/children breastfeeding is seen as a measure of service quality – demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period.

[4] This figure is low due to the CPOs being carried out at targeted, high risk venues.

[5] More checks were completed on 4 year olds than were expected to be in the 4 year old population.

[6] Percentage of all eligible targets which is equivalent to 80% of the coverage for all eligible children. Funding target is 80% of all eligible children.

[7] A HEADSSS assessment covers Home environment, Education/employment; eating and exercise, Activities and peer relationships; Drugs, cigarettes and alcohol; Sexuality; Suicide, depression, mood screen; Safety; and Spirituality – provided to year nine students attending decile 1 or 2 secondary schools, students attending teen parent units; and students attending alternative education facilities.

[8] The breast and cervical screening standards are based on national targets set for DHBs. Canterbury aims to continue to successfully deliver at a level above these national targets and the national result.

[9] Data for the three years to 31 March 2012.

Immunisation Services	Notes	2010/11 Result	2011/12 Result	Target 2011/12
Children fully immunised at age two	C	85%	82%	88%
Eligible young women engaged in the HPV vaccination programme.	C[10]	New Measure	49.3%	70%
Flu vaccinations provided to people aged over 65.	V[11]	56%	54.3%	65%
The proportion of the population, deemed high need, under 65+ receiving a flu vaccination.	C	60%	56.3%[12]	65%
Reduction in the number of cases of (per 100,000) pertusis diseases in the community	Q	89	730.2	85

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

Early detection and management services cover a range of services provided across the continuum of care to maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated – particularly where people have multiple conditions requiring ongoing interventions or support.

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori health services, pharmacy services, community radiology and diagnostic services and child oral health and dental services.

The West Coast DHB provided a range of such 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 as close to areas of population in our district as possible. It also operated General Practitioner practices in Greymouth (also covered Moana), Reefton, Westport (which also covers Karamea and Mgakawau) and South Westland.

Non-Government Organisation providers form a critical core of the primary and prevention 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 PHO, 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.

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

- **Transparent national priorities** – DHBs, PHOs and the Ministry focused on national health priorities and working collaboratively to improve sector performance
- **Collective stewardship and governance** – Communities and PHOs 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 periodic issue of access to various general practices. During 2011/12 the general practitioner shortage was assisted by the continued recruitment of additional general practitioners to the region and the benefits of a number of recruitment and retention initiatives, including the GP training programme. The greater use of practice nurse triage and assessment at general practice is also continuing to

[10] The population engaged measures eligible young women who have been provided with Dose 1. The national average based on the 'major' six DHBs.

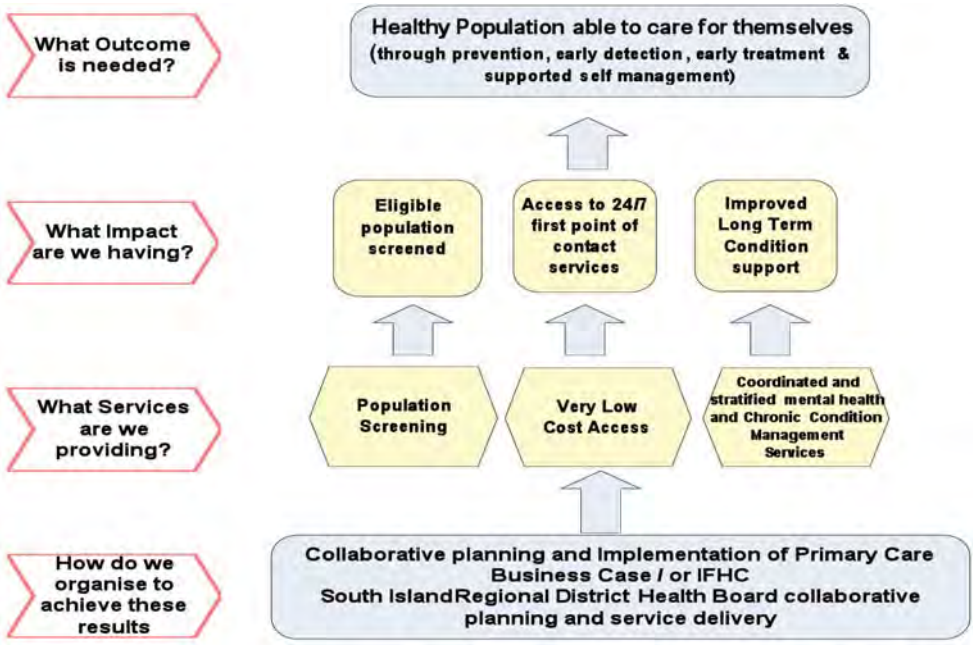
[11] This volume target is based on the number of vaccination required to achieve 75% coverage of the population and assumes an enrolled population of 68,000. The volume is important for this age group as the population growth means an increased volume must be delivered year on year to maintain the same percentage coverage for the over 65 population.

[12] The proportion of the population, deemed high need, over 65+ receiving a flu vaccination. The PHO Performance Program does not capture the under 65 population.

help improve access and reduce waiting times for patients seeking care compared to previous years, where General Practitioners had been unavailable. A nurse practitioner has been recruited to one of the general practice teams.

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 2011/12.

Outcomes for Early Detection and Management Services



Primary and Community Health Care Services	Notes	Actual 2010/11	Actual 2011/12	Target 2011/12
Population enrolled with the West Coast PHO	C [13]	97%	94.6%	>95%
Proportion of the Māori population enrolled with the West Coast PHO	C	80%	85.4%	>95%
Number of patients receiving extended primary care consultations for mental health conditions	V	237	754	300
Provision of brief intervention counselling provided in Primary Care				
– ages 0-19 years	V	59	60	80
– ages 20+ years		254	265	200
Number of District Nursing visit (personal care services)	V	20346	23036	23000
Reduction in rate of preventable (ambulatory sensitive) hospital admissions for Māori across all ages.	0-74 years	80	66.7	<95

[13] *The national target for PHO enrolments is 95%, and the aim is to continue to achieve above this level.*

Primary and Community Health Care Services	Notes	Actual 2010/11	Actual 2011/12	Target 2011/12
Oral Health Services				
Percentage of preschool children enrolled in DHB funded dental service	C	71%	91.4%[14]	75%
Children enrolled in dental services, examined according to planned recall	T	96%	93%	98%
Decayed, missing or filled permanent teeth rate at Year 8	V	1.32	1.39	1.12
Increase adolescent enrolments in the community dental services	V	29	49	250
The percentage of adolescents accessing oral health services	C[15]	76%	81%	80%
Long-term Conditions Programmes				
Eligible population (35-74) provided with CVD risk assessments	C[16]	New measure	56.7%	90%
Provision of diabetes annual reviews (in all population groups)	C[17]	49.2%	77.0%	70%
People with diagnosed diabetes (in all population groups) who have satisfactory or better diabetes management	C[18]	80.6%	75.6%	80%
Proportion of people (in all population groups) with diabetes accessing biennial retinal screening.	C[19]	72.6%	83.9%	90%
Pharmacy Services				
Dispensed pharmaceutical items per enrolled population	C	86%	96%	100%
Number of Pharmacist Medication reviews completed for older people with complex needs	V[20]	New measure	0	50
Community Referred Tests and Diagnostic Services				
Number of community referred Radiological tests to Grey Hospital	V	5232	5807	5000
Percentage of GP referred laboratory expenditure (actual against expected)	C[21]	101%	97%	100%
Percentage of referred pharmacy expenditure (actual against expected)	C	86%	96%	100%

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Intensive assessment and treatment services are services that are usually complex and provided by specialists and other health care professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services and emergency or urgent care services.

As owner of hospital and specialist services, the DHB provides an extensive range of intensive treatment and specialist services to its population. The DHB also funds some intensive assessment and treatment services for its population that are provided by other DHBs, private hospitals or private providers. A proportion of these services are driven by demand, such as acute and maternity services. However, others are planned services for which provision is determined by capacity and resource,

[14] 2011 calendar year pre-school enrolment.

[15] Half of 14 years olds and 18 year olds.

[16] Percentage of eligible people aged 35 – 74 years (in all populations groups) who have had their CVD risk assessed via lipid/fasting glucose test.

[17] Percentage of people with diagnosed diabetes (in all population groups) who have had their free annual checks [Note actual 2009/10 for Māori 47.1%; Other 49.7%].

[18] Percentage of people with diagnosed diabetes (in all population groups) who have satisfactory or better diabetes management (defined by having HbA1c level of equal to or less than 8% at their free annual diabetes check) [Note Actual for 2009/10 for Māori 67.0%; Other 82.0%].

[19] Percentages of all people who have had their free annual diabetes check have had retinal screening or an ophthalmologist examination within the last two years of the check. [Note Actual for 2009/10 Māori 66.7%; Other 73.2%].

[20] This measure refers to programmes, which began in hospital settings in 2009 and primary settings in 2010; no baseline data prior to 2009/10.

[21] These indicators respectively measure how actual pharmaceutical and laboratory expenditure for a DHB region relates to 'expected expenditure' as part of the PHO performance programme. This is based on historical utilisation and national tests. It is expected that these are matched.

clinical triage, national service coverage agreements and treatment thresholds determine access to these services.

Our hospital and specialist services provide a range of inpatient, outpatient and community-based services to the people of our region. The West Coast DHB has primary level care facilities at Westport and Reefton, and its base secondary care level hospital at Greymouth. All three sites have an Emergency Department service 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, and acute community mental health services. These are supported by preventative primary mental health services also provided through the West Coast PHO, in order to help manage the number of patients requiring acute assessment through early intervention. Tertiary level services are funded for our population via inter-district flows to other DHBs – principally Canterbury.

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

i) Acute Services

Emergency Department services are 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 99.7% of presentations being seen within this timeframe during the year.

The Emergency Department After-Hours Services Plan that was put in place in 2009/10 to help reduce demands on emergency services has failed to achieve the desired result of reducing the large number of triage level four and five attendances at Emergency Department to target levels. There has been a reduction in the overall number of triage level five attendances at Grey Base Hospital during 2011/12 compared to 2009/10 (down from 4993 to 4015; and being up slightly from 3938 in 2010/11) – but this is well below our target of a 35% reduction over three years.

ii) Elective Services

The priorities for our Secondary Health Services in 2011/12 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, with no patients waiting more than 6 months as at 30 June 2012. West Coast also delivered a record 1751 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 the South Island as a region. In doing so however, the West Coast delivered significantly higher volumes than planned or budgeted, which also reflected in delivering standardised intervention rates at significantly higher and disproportionate rates than other parts of the country.

In the 12 months to 31 March 2012 (the latest available comparative data), overall elective surgical discharges elective surgical intervention rates for West Coast residents were 40% higher than the national average, while cataract surgery intervention was 30% higher, and major hip and knee joint replacement was twice that of the national average (102%). It is not intended that this will be continued into the future, and it is planned to return to greater levels of equitable surgical delivery in the year ahead.

The West Coast DHB remained focused on its continuous quality improvement efforts in three key areas during 2011/12:

1. **Improving scheduling and appointments, including:**
    - maintaining a list of patients that could come in at short notice for surgery in the event of other case cancellations
    - the delivery of elective surgical interventions for all patients within six months of decision to operate
    - continuous capacity and production planning systems used to manage patient flow and ESPI compliance
    - the drive for improved theatre utilisation, and reducing turn around times. A project to focus on theatre start times and turn around times between each procedure was commenced; as well as a reduction in out of hour's surgery due to better utilization of the available theatres and nursing staff – resulting in the decreased cancellation of cases on the day of surgery due to late running lists

- the implementation of senior physiotherapist-led orthopaedic assessments to help reduce waiting times for patients accessing both outpatient and elective surgery in our operating theatres

2. **Theatre efficiency to improve utilisation, including:**
   - Employment of a Lead Anaesthetist from Canterbury DHB to ensure alignment with the specialty at Christchurch Public Hospital, and to offer expertise and consistency to the department
   - Efficient use of locum anaesthetists when they are on site and a drive to recruit permanent anaesthetists
   - Back-filling of short-notice patient cancellations and "no shows" with replacement cases
   - Streamlining the use of orthopaedic implants and prostheses thus reducing the costs through use of combining procurement arrangements with Canterbury DHB
   - Re-establishing the Theatre Committee Meeting, so that the specialties that use theatre meet regularly to discuss and resolve operational issues and set up clear strategic issues
   - Setting up of an Endoscopy Users Committee to align with a national initiative, thus ensuring all endoscopy teams are working consistently, and have the same criteria for treatment
3. **Improvement of patient flow within day and inpatients units at Grey Base Hospital, including:**

- More efficient start times have been achieved due to the surgical ward having a dedicated Day Of Surgery Admission nurse
- Review of Day of Surgery Admission practices commenced to help reduce number of patients being unnecessarily admitted the day before surgery is scheduled, where clinically appropriate
- Use of the Surgical Safety Checklist by all health professional across all specialties
- Multi-disciplinary health professional team involvement in production planning – both to help improve throughput and to improve patient follow-up and care coordination within the theatre, the wards, and in the community following discharge from hospital
- Quality Improvement project undertaken by senior physiotherapist of referrals for total hip and knee joint replacement patients to help appropriate triage of patients requiring surgical intervention.

The West Coast DHB also embarked on further developing formal ties for clinical support with Canterbury DHB, particularly in regard to orthopaedic services. Close ties between the secondary services of the two DHBs were further consolidated in the provision of direct support and joint appointments in the specialist orthopaedic, paediatric, geriatric, and mental health services; in shared professional development for clinical staff; and in aligning of clinical practice and policy procedures for both specialist and allied health services.

Throughout 2011/12 the West Coast DHB continued to participate in the South Island-wide regional planning process for the delivery of elective services and development of a wider regional strategy for surgical service delivery and future provision.

iii) Mental Health

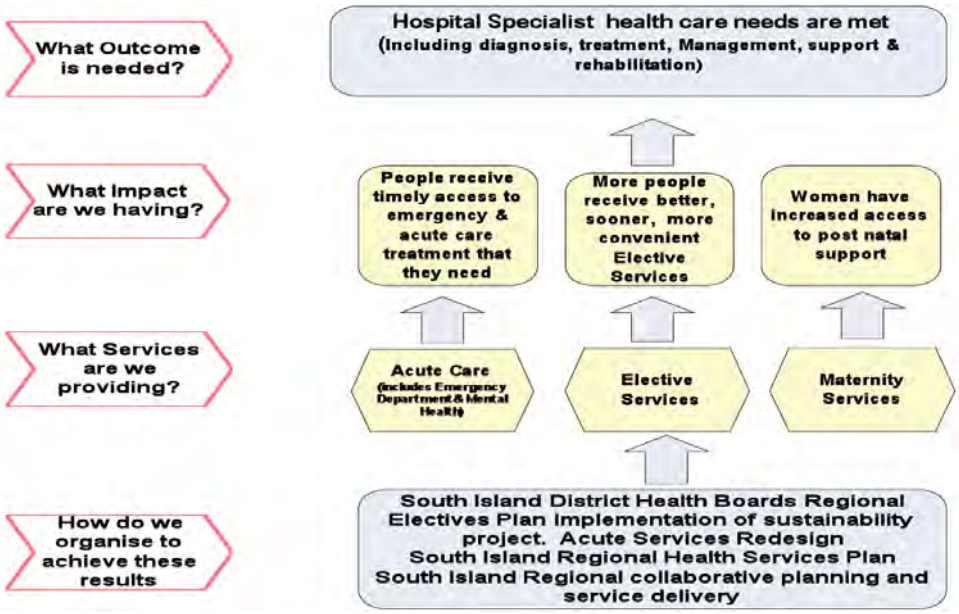
Our community mental health teams provide both acute assessment and community treatment for patients who experience mental ill health. For those with higher acuity, intensive assessment and treatment services are provided through Greymouth. The mental health urgent assessment service is based there and provides services across the district. There is also a nine bed acute inpatient unit that provides intensive treatment for those clients who cannot be safely managed in the community.

In 2011/12 the demand for acute inpatient admission has risen, with a higher than usual need for specialist intervention for people from within and outside the district. This has led to the inpatient unit being fully occupied, and on occasions, over planned bed numbers during the year. This has resulted in out-of-area transfers on a few occasions.

Recruitment and retention issues were an ongoing issue for acute inpatient mental health services for both medical and nursing.

High-risk times have been managed through the use of video conference and remote support from Canterbury DHB. There were no critical incidents related to this issue. In the year ahead we will see the full integration of community mental health into the proposed Integrated Family Health Centres and permanent staff appointments for the inpatients mental health unit.

Outcomes for Intensive Assessment and Treatment Services



Short Term Performance Measures	Notes	Actual 2010/11	Actual 2011/12	Target 2011/12
Specialist Services Mental Health Services				
Acute inpatient mental health services provided (bed days)	V[22]	1704	2806	1700
Mental health inpatient services for people aged over 65 (bed days)	mhis02	823	1159	800
Young people (0-19) accessing specialist mental health services	C	4.8%	4.9%	3.8%
Adults (20-64) accessing specialist mental health services	C	4.9%	4.9%	3.4%
Older adults (65+) accessing specialist mental health services	C[23]	2.56%	3.2%	2.5%
Long-term mental health clients (20-64) with current Relapse Prevention Plans	Q	97%	74%	98%
Average length of acute inpatient stay (KPI 8)	Q[24]	13 days	18 days	<15 days-
28-day acute inpatient readmission rate (KPI 12)	C[25]	8%	11%	<5
Pre-admission community care (KPI 18)	C[26]	74%	73%	75%
Post-discharge community care (KPI 19)	C[27]	84%	71.03%	90%

[22] *Purchase Unit Code MHC29.*

[23] *PP6 The average number of people domiciled in the DHB region seen per year aged 65+*

[24] *The total number of in-scope acute inpatient bed nights for referral closures in the reference period. Number of in-scope overnight referral closures from the mental health service organisations acute mental health and addiction service inpatient unit occurring during the reference period. Excludes transfers, deaths etc. Excludes leave days*

[25] *Total Number of in-scope overnight referral closures by the participants acute mental health and addiction services in patient unit during the reference period that are followed by a re-admission within 28 days to the organisations acute metal health and addiction services in patient units. Total of number in-scope overnight referral closures by the participants acute mental health and addiction services in patient unit during the reference period excludes transfers, deaths etc. Re admission from same day events excluded*

[26] *Number of in-scope acute inpatient referrals to the mental health and addiction service organisation's acute inpatient teams, occurring during the reference period for which a face to face community mental health contact was recorded in the seven days immediately preceding that admission by community care services managed by the organisation. Total number of in-scope acute inpatient referrals. The total number of in-scope acute inpatient bed nights for referral closures in the reference period. Number of in-scope overnight referral closures from the mental health service organisations acute mental health and addiction service inpatient unit occurring during the reference period. Service user participation in contact is required. Contact must occur in the seven days prior to admission but not on the day of admission Excludes transfers, deaths etc. Excludes leave days*

[27] *The number of overnight referral closures from Acute in-scope acute inpatient units referrals to the organisations community catchment the mental health and addiction service organisation's acute inpatient teams, occurring during the reference period for which a face to face community mental health contact with client participation was recorded in the seven days immediately following preceding that discharge admission by community care services managed by the organisation. Total number of overnight acute in patient referral closures to the organisations community catchment area in-scope acute inpatient referrals occurring during the reference period. Service user participation in the contact is required. Contact must occur in the seven days post discharge prior to admission but not on the same day of discharge admission.*

Short Term Performance Measures	Notes	Actual 2010/11	Actual 2011/12	Target 2011/12
Elective Services				
Elective surgical discharges (raw volume)	V[28]	1578	1,751	1,592
Other Elective surgical service discharges provided	V[29]	90	145	158
Surgical electives as a percentage of national case-weight delivery.	Q	1.14%	1.14%	1.1%
Standardised intervention rates per 10,000 for key indicator elective services are provided in line with national levels (* Targets are subject to annual review and update by the Ministry of Health)				
1. Overall intervention	C	378.57	441.02	308
2. Major Joints	C	28.84	30.02	21.0
3. Cataracts	C	38.1	43.47	27.0
4. Cardiac Procedures	C	2.72	9.25	6.5
Maintain compliance with Elective Service Patient Flow Indicators (ESPIs) 1 to 8 (national targets indicated below)				
ESPI 1 – >90%	V	100%	94%	92.0%
ESPI 2 – <1.5%	V	0.74%	0%	0%
ESPI 3 – <5%	V	0.01%	0%	4.0%
ESPI 4 – <5%	V	0%	0.%	0.0%
ESPI 5 – <4%	V	1.53%	0%	0%
ESPI 6 – <15%	V	0%	0.%	12.0%
ESPI 7 – <5%	V	1.73%	0%	4.0%
ESPI 8 – >90%	V	100%	100%	92%
Elective and arranged inpatient indirectly standardised length of stay (days) [OS3[	Q[30]	3.68	3.64	< 3.9
Theatre utilisation [OS5]	Q	83.9%	90.75%	85%
Elective and Arranged indirectly standardised day of surgery rate [OS6]	Q	60%	55.7%	64%
Elective and arranged day of surgery admission rates for case mix included discharges [OS7]	Q	68.8%	76.6%	75%
Specialist Medical and Surgical outpatient "Patient did not attend" Rates	Q	9.9%	8.7%	< 6%
First Specialist Assessments (FSA) provided on the West Coast	V	5357	5799	5663

[28] *The elective surgical discharge volumes exclude elective cardiology and dental and are based on the national health target.*

[29] *This represents elective surgical discharges [Cardiology and dental] that are not included as part of the heal target volumes.*

[30] *The definitions for the six measures identified OS3 - OS8 below are based on national indicators of performance set for all DHBs. The result for this measure, OS3, is data for the 12 months to 31 March 2012. This measure was subsequently merged with measure OS4 to include both elective, arranged and acute length of stay within the one measure. As a consequence, data beyond 31 March is no longer published for standardised elective and arranged length of stay alone.*

Short Term Performance Measures	Notes	Actual 2010/11	Actual 2011/12	Target 2011/12
Acute Services				
Acute inpatient indirectly standardised length of stay (days) [OS4]	Q[31]	3.67	3.6	< 3.9
Standardised acute readmission rate [OS8]	Q	7.64	7.76	< 8.21
Total presentations at Emergency Departments [Buller, Reefton and Grey]	V[32]	15,068	15,679	15,376
Proportion of people assessed, treated or discharged from ED in under six hours	T[33]	99.3%	99.7%	>95%
Proportion of people triaged in ED and seen within clinical guidelines	Q[34]	80.5%	88.4%	>85%
Reduction in inappropriate triage level five presentations at Emergency Department at Grey Base Hospital [over three years]	V[35]	3938	4015	2943
GP practices utilising telephone triage systems outside of business hours	C	New Measure	100%	100%
Percentage of patients waiting less than 4 weeks between FSA and start of radiation oncology treatment	T[36]	New Measure	100%	100%
Provision of chemotherapy treatment within 4 weeks of decision to treat	T	100%	100%	100%
Maternity Services				
Deliveries in West Coast DHB facilities	V	307	293	350
Proportion of total deliveries, made in Primary Birthing Units	Q	8.8%	5.5%	10%
Specialist obstetric consultations provided	V	492	534	560
Assessment, Treatment and Rehabilitation Services				
Provision of inpatient AT&R services [bed days]	V	2753	2412	2152
Provision of outpatient and domiciliary AT&R services	V	2009	1712	1900
Proportion of AT&R inpatients discharged home (as opposed to residential care or other inpatient services)	Q	61.7%	55.3%	>60%
Number of inpatient falls causing serious harm for people in AT&R service as a percentage of bed days	Q[37]	0.12%	0%	<0.5%
Number of inpatient falls (all falls) for people in AT&R service as a percentage of bed days	Q	0.81%	1.04%	<1.0%
Number of patient falls as a percentage of bed days for Dementia and Psychogeriatric AT&R service	Q	1.61%	0.68%	<1.5%

[31] This measure was subsequently merged with measure OS3 to include both elective, arranged and acute length of stay within the one measure. As a consequence, data beyond 31 March is no longer published for standardised acute length of stay alone.

[32] Baseline 2009/10: 14,390.

[33] This measure is based on the national health target of 95% and is based on a sub-set of the total population - young people 0-15 years of age. The aim is to maintain performance above the health target in Canterbury.

[34] This measures percentage of people presenting at emergency departments in triage categories 1-3 who are seen within Triage time-guidelines [Triage 1 - seen immediately on presentation; Triage 2 - seen within ten minutes; Triage 3 – seen within thirty minutes of presentation]

[35] Target for 2009/10 had been 3312

[36] Target for this measure was 6-weeks in 2009/10. The Actual result for the year was 93%. The new four week target commenced with effect from 1 December 2010; hence no comparative percentage is available for the 2009/10 year, nor for current national average.

[37] The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the consequence or outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood and this measure cover SAC 1&2.

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

Rehabilitation and support services provide people with the support and assistance they need to maintain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered following a 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) Services and include: domestic support, personal care, community nursing and community services provided in people's own homes and places of residence and also long and short-term residential care, respite and day services. Services are provided mostly for older people, mental health clients and for personal health clients with complex health conditions

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 DHB and Access Homehealth), and West Coast PHO Navigators.

The West Coast DHB 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 DHB 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 DHB funder arm funds a range of other providers to deliver long-term aged residential care rest home and hospital level services, as well as respite care, carer support and daycare at Westport, Reefton, Greymouth and Hokitika.

Pact (Patients and Community Trust) is funded to provide residential care services in the community for people with mental health issues. The West Coast DHB 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 DHB's hospital facilities, or through individual placements in other facilities where this is clinically appropriate. The 2011/12 year saw the further expansion of the palliative care support network with the Community Palliative Care Specialist from Nurse Maude, the completion of the first phase of the Liverpool Care Pathway for the Dying (LCP) implemented in Buller, the replacement of the LCP Coordinator in January 2012 (following the departure of the previous coordinator), as well as training opportunities for staff involved in the provision of palliative care – including commencement of LCP training for staff in hospital, community and rest home facilities in Greymouth involved in the care of people in the last stages of life, as Phase Two of the LCP programme roll-out.

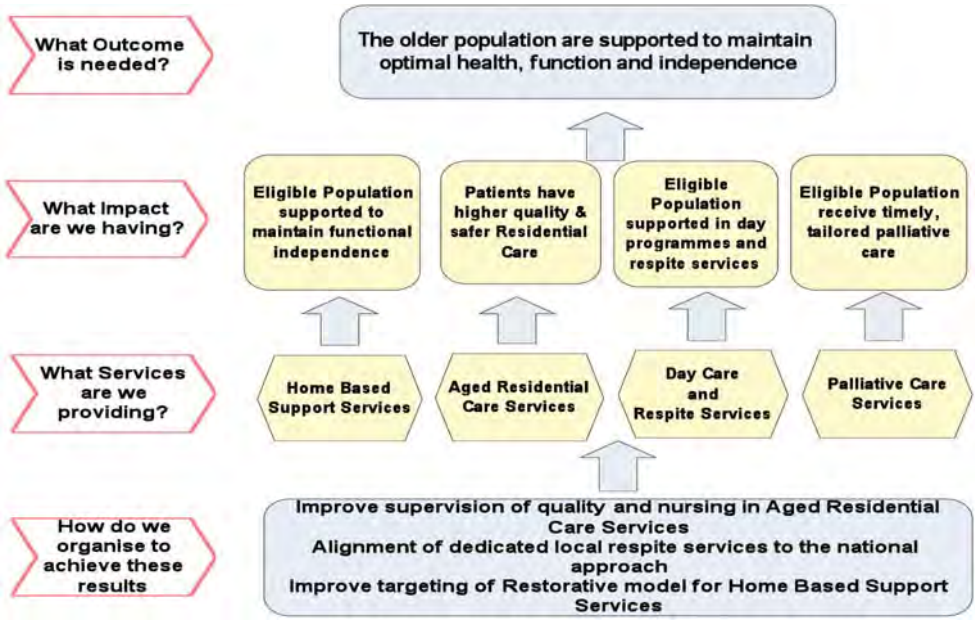
The work of voluntary sector organisations such as the Disability Resource Centre, Alzheimers Canterbury, Presbyterian Support, Age Concern, CARE, wheelchair van drivers and Crippled Children Society play a vital role in supporting the health needs of people in our community. This is a role that is greatly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

During 2011/12 the West Coast DHB continued expanding the range of services supporting people living at home and their carers through new contracts with Presbyterian Support Services and Alzheimers Canterbury for carer support groups for those caring for people with dementia, and community-based respite services.

West Coast DHB participated in the regional South Island work plan for older person's services to improve the quality of services and equity of access to support services throughout the South Island through the use of InterRAI, common access criteria and a regional service specification for home support.

Work progressed on a Transalpine collaboration with Canterbury DHB on the development of a Complex Clinical Care Network. This will basically align the NASC and Assessment, Treatment and Rehabilitation function with that of CDHB's community Older Persons Health Service, through strengthening the Single Point of Entry to both long-term care and community-based specialist assessment, treatment and rehabilitation for people with complex conditions. Active planning began on additional geriatrician and gerontology nurse specialist resources, and telehealth linkages to primary health centres.

Outcomes for Rehabilitation and Support Services

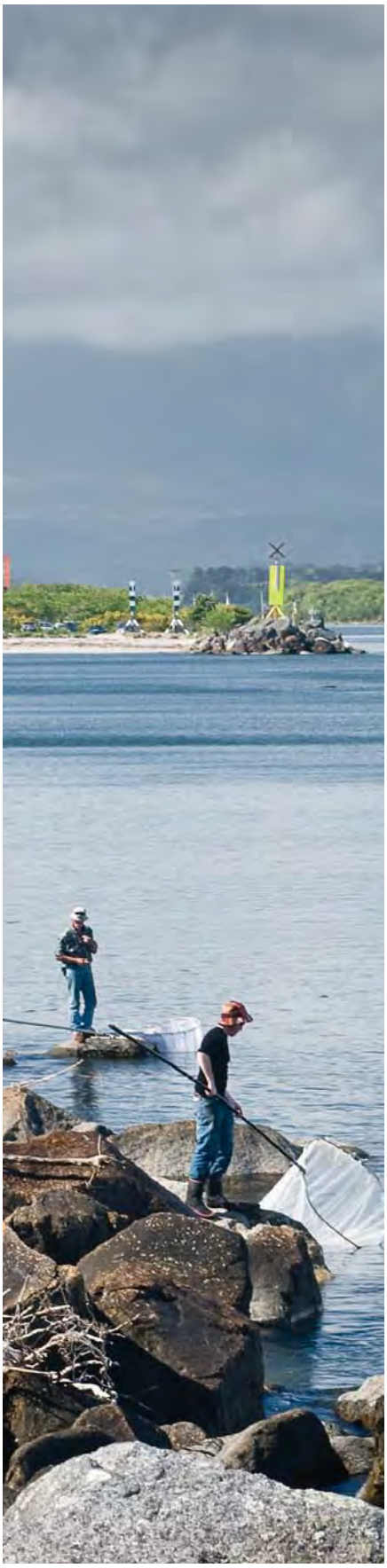


Short Term Performance Measures	Notes	Actual 2010/11	Actual 2011/12	Target 2011/12
Needs Assessment and Services Coordination Services				
Needs assessments provided to people with age related disability	V	313	633	500
Proportion of needs assessments completed using InterRAI assessment tool	Q	100%	60%	100%
Mental health needs assessments provided	V	102	387	150
Palliative Care Services				
Palliative packages of care in place provide appropriate care to meet individual clinical needs	C	100%	100%	100%
ARC facilities trained to provide the Liverpool Care Pathway option to residents	Q[38]	Started 2010/11	Phase 1 complete	Phase 1 complete
People in ARC services being supported by the Liverpool Care Pathway	V	New Services	18	No base to set target against at this stage

[38] The Liverpool Care Pathway is an international programme adopted nationally, and has been progressively implemented on the West Coast from February 2010. The programme begins with case evaluation and training and is planned to be implemented in all aged residential care facilities over time.

Short Term Performance Measures	Notes	Actual 2010/11	Actual 2011/12	Target 2011/12
Rehabilitation Services				
People having had an acute event referred to stroke rehabilitation services	C	Unknown	71.4%	At least 69%
People having had an acute event referred to cardiac rehabilitation services	C	Unknown	100%	At least 30%
Provision of integrated falls prevention services for older people in community	V	Unknown	0	50 available
Provision of Mental Health Activity and Living Skills and Education and Employment Support services	V	70	84	150
Clients accessing Education and Employment support services supported into full or part time employment	Q	57%	66.7%	65%
Home-Based Support Services				
Provision of home help services (hours) – long term only	V	64170	57288	65000
Provision of home-based personal care services (hours) – long term only	V	22950	26907	23000
Provision of community-based district nursing services (contacts) – long term only	V	4580	5189	4000
Meals on wheels services provided	V	43763	37148	40500
Provision of Mental Health Support Work Services (clients)	V	96	105	100
Residential Care Services				
Unplanned (issues-based) audits undertaken on ARC facilities	Q	0	0	0
Provision of (subsidised) long-term residential mental health services (bed days)	V	6935	4041	8030
Number of people residing in permanent rest home level care as a % of the 75+ population	Q	6.1%	5.8%	5.6% (regional average)
Respite and Day Services				
Provision of mental health respite beds for planned respite -(bed days)	V	280 bed days	384 bed days	365 bed days
Provision of aged care respite beds	V	1068 bed days	1557 bed days	1500 bed days
Provision of day services	V	410 days	523 days	500 days

9. Statement of revenue and expenditure by output class



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This table summarises the revenue and expenditure for the four output classes listed above for the year ending 30 June 2012. The basis of arriving at the net cost for each output class can be found under note 1 in the notes to the Financial Statements.

In thousands of New Zealand dollars

	2012 Actual	2012 Budget
Income		
Prevention	3,679	3,705
Early Detection and Management	43,799	44,387
Intensive Assessment and Treatment	64,268	63,231
Rehabilitation and Support	22,314	21,617
Total Income	**134,060**	132,941
Expenditure		
Prevention	2,141	2,192
Early Detection and Management	44,679	45,826
Intensive Assessment and Treatment	68,002	65,690
Rehabilitation and Support	24,262	23,732
Total Expenditure	**139,084**	137,441
Surplus/ (Deficit)		
Prevention	1,538	1,513
Early Detection and Management	(880)	(1,439)
Intensive Assessment and Treatment	(3,734)	(2,460)
Rehabilitation and Support	(1,948)	(2,114)
Total Surplus/ (Deficit)	**(5,024)**	(4,500)

10. Financials

West Coast District Health Board
Statement of comprehensive income
For the year ended 30 June 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2012 Budget	2011 Actual
Income				
Revenue	2	132,692	131,595	129,229
Other operating income	3	1,055	1,145	1,151
Interest income	6a	313	201	272
Total income		134,060	132,941	130,652
Expenditure				
Employee benefit costs	5a	52,769	52,289	51,634
Other personnel costs	5b	1,266	1,106	1,038
Depreciation and amortisation expense	8,9	4,757	4,801	4,578
Outsourced services	4a	13,097	11,174	14,546
Clinical supplies		7,488	7,292	7,708
Infrastructure and non-clinical expenses		10,496	9,852	9,684
Payments to other health service providers	4b	47,008	48,483	45,980
Other operating expenses	4c	858	629	861
Finance costs	6b	732	735	776
Capital charge	7	613	1,080	690
Total expenditure		139,084	137,441	137,495
Surplus/(deficit)	14	(5,024)	(4,500)	(6,843)
Other comprehensive income				
Gain/(losses) on revaluation of land and buildings	14	859	0	(2,578)
Other changes recognised directly in equity (impairment)	14	(2,600)	0	0
Total other comprehensive income/(expense)		(1,741)	0	(2,578)
Total comprehensive income		(6,765)	(4,500)	(9,421)

The accompanying notes form part of these financial statements

West Coast District Health Board
Statement of financial position
As at 30 June 2012

in thousands of New Zealand dollars

	Note	2012 Actual	2012 Budget	2011 Actual
Assets				
Non-current assets				
Property, plant and equipment	8	29,040	35,691	33,002
Intangible assets	9	943	1,130	940
Other investments	11	2	2	2
Total non-current assets		29,985	36,823	33,944
Current assets				
Inventories	10	1,040	746	791
Other investments	11	0	0	4,500
Debtors and other receivables	12	4,493	4,603	4,182
Cash and cash equivalents	13	7,398	3,358	1,922
Patient and restricted funds	21	58	55	56
Non-current assets held for sale	19	136	246	136
Total current assets		13,125	9,008	11,587
Total assets		43,110	45,831	45,531
Liabilities				
Non-current liabilities				
Borrowings	15	12,195	12,195	11,195
Employee entitlements and benefits	16	3,062	3,204	2,858
Total non-current liabilities		15,257	15,399	14,053
Current liabilities				
Borrowings	15	250	250	1,500
Creditors and other payables	17	10,076	7,520	10,313
Employee entitlements and benefits	16	7,273	7,949	7,092
Patient and restricted trust funds	21	58	55	56
Total current liabilities		17,657	15,774	18,961
Total liabilities		32,914	31,173	33,014
Equity				
Crown equity	14	66,197	66,173	61,753
Revaluations	14	19,569	23,888	21,310
Accumulated surpluses/(deficits)	14	(75,609)	(75,442)	(70,585)
Trust funds	14	39	39	39
Total equity		10,196	14,658	12,517
Total equity and liabilities		43,110	45,831	45,531

The accompanying notes form part of these financial statements

West Coast District Health Board
Statement of changes in equity
For the year ended 30 June 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2012 Budget	2011 Actual
Balance at 1 July		12,517	14,726	14,794
Comprehensive income/(expense)				
Surplus/(defict) for the year		(5,024)	(4,500)	(6,843)
Other comprehensive income/(expense)		(1,741)	0	(2,578)
Total comprehensive income/(expense)		(6,765)	(4,500)	(9,421)
Owner transactions				
Capital contributions from the Crown		4,512	4,500	7,212
Repayment of capital to the Crown		(68)	(68)	(68)
Balance at 30 June	14	10,196	14,658	12,517

The accompanying notes form part of these financial statements

West Coast District Health Board
Statement of cash flows
For the year ended 30 June 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2012 Budget	2011 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health, patients and other revenue		133,962	132,740	129,181
Cash paid to suppliers		(79,496)	(77,429)	(78,287)
Cash paid to employees		(53,657)	(53,395)	(52,322)
Interest received		318	200	820
Interest paid		(735)	(735)	(814)
Goods and services tax (net)		30	0	58
Capital charge paid		(712)	(1,080)	(723)
Net cash flow from operating activities	13	(290)	301	(2,087)
Cash flows from investing activities				
Receipts from sale or maturity of investments		4,500	0	1,587
Purchase/roll over of investments		0	0	(4,500)
Receipts from sale of property, plant and equipment		2	0	0
Purchase of property, plant and equipment		(2,665)	(4,110)	(3,053)
Purchase of intangible assets		(265)	(140)	(95)
Net cash flow from investing activities		1,572	(4,250)	(6,061)
Cash flows from financing activities				
Capital contributions from the Crown		4,512	4,500	7,212
Repayment of capital to the Crown		(68)	(68)	(68)
Proceeds from borrowings		0	0	0
Repayment of loans		(250)	(250)	(250)
Net cash flow from financing activities		4,194	4,182	6,894
Net increase /(decrease) in cash and cash equivalents		5,476	233	(1,254)
Cash and cash equivalents at the start of the year		1,922	3,125	3,176
Cash and cash equivalents at the end of year	13	7,398	3,358	1,922

The GST (net) component of cash flows from operating activities reflects the movement in opening and closing net GST paid to the Inland Revenue Department. The GST (net) component has been presented on a net basis as the gross amounts do not provide meaningful information for financial statement purposes.

The accompanying notes form part of these financial statements

West Coast District Health Board
Statement of commitments
As at 30 June 2012

in thousands of New Zealand dollars

	Note	2012 Actual	2011 Actual
Capital commitments		850	232

	2012 Actual	2011 Actual
Non-cancellable commitments - contracted services		
Not more than one year	4,343	3,229
One to two years	1,450	849
Two to three years	90	70
Three to four years	0	3
Four to five years	0	0
Over five years	0	0
	5,883	4,151

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.

	2012 Actual	2011 Actual
Non-cancellable commitments – operating lease commitments		
Not more than one year	107	182
One to two years	91	33
Two to three years	33	15
Three to four years	0	10
	231	240

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

Notes to the Financial Statements

For the year 30 June 2012

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 2012, and were approved by the Board on 26 October 2012.

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.

- NZ IAS 24 *Related Party Disclosures* (Revised 2009) replaces *NZ IAS 24 Related Party Disclosures* (Issued 2004) was applied for the first time in the West Coast District Health Board's 30 June 2012 financial statements. Changes to disclosure requirements include:
  More information is required to be disclosed about transactions between the West Coast District Health Board and entities controlled, jointly controlled, or significantly influenced by the Crown;
  Clarifies that related party transactions include commitments with related parties; Information is required to be disclosed about any related parties with Ministers of the Crown.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments). The adoption of this standard did not result in any additional disclosures being required.

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.

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.

As the External Report Board is to decide on a new accounting standards framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefit entities. This means that the financial reporting requirements for public benefit entities are expected to be effectively frozen in the short-term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

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 at 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 comprise 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 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 forecasted periods from year ending 2013 to 2015.

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.

in thousands of New Zealand dollars

2 Revenue

	Note	2012 Actual	2011 Actual
Ministry of Health Crown Funding Agreement		117,390	113,400
Ministry of Health (other)		3,335	4,704
Accident Compensation Corporation		2,074	1,992
Inter district patient inflows and other District Health Boards		1,993	1,750
Patients and consumers		3,096	2,829
Other government entities		563	384
West Coast Primary Health Organisation		4,241	4,170
		132,692	129,229

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

3 Other operating income

	Note	2012 Actual	2011 Actual
Donations received		36	89
Donated equipment		46	14
Rental income		206	188
Gain on disposal of property, plant and equipment		2	0
Other		765	860
		1,055	1,151

4a Outsourced services

	Note	2012 Actual	2011 Actual
Outsourced personnel			
Medical and nursing services		8,118	9,178
Allied health services		84	117
Other services		853	1,246
Outsourced services			
Clinical services		4,042	4,005
		13,097	14,546

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	2012 Actual	2011 Actual
Personal health and Maori health services		18,525	18,122
Mental health services		2,753	2,543
Public health services		390	457
Disability support services		7,830	7,298
Inter district patient outflows		17,510	17,560
		47,008	45,980

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 and screening programmes. Disability Support Services include payments for aged related care, in homes, rest homes and hospital level.

in thousands of New Zealand dollars

4c *Other operating expenses*

	Note	2012 Actual	2011 Actual
Impairment of debtors	20	96	65
Loss on disposal of property, plant and equipment		0	41
Audit fees (for the audit of the financial statements)		99	93
Audit related fees for assurance and related services		0	0
Fees paid to auditor for other services		0	0
Board and advisory members fees	24	217	222
Community consultation		28	10
Operating lease expenses	18	248	397
Restructuring expenses		170	33
		858	861

5a Employee benefit costs

	2012 Actual	2011 Actual
Wages and salaries	51,201	50,324
Contributions to defined contribution schemes	1,032	1,010
Increase in liability for employee entitlements	536	300
	52,769	51,634

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

5b Other personnel costs

	2012 Actual	2011 Actual
Other personnel costs	1,266	1,038

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

	2012 Actual	2011 Actual
Interest income	313	272

6b Finance costs

	2012 Actual	2011 Actual
Interest expense	732	776

7 Capital charge

	2012 Actual	2011 Actual
Capital charge	613	690

The West Coast District Health Board pays a monthly capital charge to the Crown. This charge is based on the greater of its actual or budgeted closing equity for the month. The capital charge rate for the period ended 30 June 2012 was 8% (2011: 8%).

The total capital charge expense for 2012 was $613,585 (2011: $689,582). This included a credit of $258,655 which related to the 10/11 year (2011: -$253,672 relating to the 09/10 year); without this credit actual cost would have been $872,240 (2011: $943,254).

in thousands of New Zealand dollars

8 Property, plant and equipment

	Freehold land (at valuation)	Freehold buildings + Fixtures and fittings (at valuation)	Plant, equipment and vehicles	Leased assets	Work in progress	Total
Cost						
Balance at 1 July 2010	6,005	21,856	19,525	273	410	48,069
Additions	0	487	2,362	47	510	3,406
Disposals	0	0	(552)	0	0	(552)
Revaluations	346	(5,116)	0	0	0	(4,770)
Transfer from non-current assets held for sale	44	128	0	0	0	172
Work in progress allocated	0	309	1	20	(330)	0
Balance at 30 June 2011	6,395	17,664	21,336	340	590	46,325
Balance at 1 July 2011	6,395	17,664	21,336	340	590	46,325
Additions	0	384	1,366	0	473	2,223
Disposals	0	0	(208)	0	0	(208)
Revaluations and impairments	(310)	(3,896)	0	0	0	(4,206)
Transfer from non-current assets held for sale	0	0	0	0	0	0
Work in progress allocated	0	566	4	0	(570)	0
Balance at 30 June 2012	6,085	14,718	22,498	340	493	44,134
Depreciation and impairment losses						
Balance at 1 July 2010	0	(75)	(11,361)	(254)	0	(11,690)
Depreciation charge for the year	0	(2,157)	(2,103)	(15)	0	(4,275)
Transfer to non-current assets held for sale	0	(62)	0	0	0	(62)
Disposals	0	0	511	0	0	511
Revaluations	0	2,193	0	0	0	2,193
Balance at 30 June 2011	0	(101)	(12,953)	(269)	0	(13,323)
Depreciation and impairment losses						
Balance at 1 July 2011	0	(101)	(12,953)	(269)	0	(13,323)
Depreciation charge for the year	0	(2,433)	(1,999)	(12)	0	(4,444)
Transfer to non-current assets held for sale	0	0	0	0	0	0
Disposals	0	0	208	0	0	208
Revaluations	0	2,465	0	0	0	2,465
Balance at 30 June 2012	0	(69)	(14,744)	(281)	0	(15,094)
Carrying amounts						
At 1 July 2010	6,005	21,781	8,164	19	410	36,379
At 30 June 2011	6,395	17,563	8,383	71	590	33,002
At 1 July 2011	6,395	17,563	8,383	71	590	33,002
At 30 June 2012	6,085	14,649	7,754	59	493	29,040

Valuation
Freehold property and plant was revalued 30 June 2012 by Coast Valuations (registered valuers). Greymouth, Westport and Reefton Hospitals as well as Fox Glacier Clinic and Ngakawau Clinic were valued on the basis of operational assets, Fair Value (Depreciated Replacement Cost). All other operational assets were valued at Fair Value (Market based). Residential houses and leasehold sections were valued at Net Current Value. The resulting movement in property and plant has been recognised in equity in a Property Revaluation Reserve (refer to note 14).

Impairment
Current engineering reviews of Grey Base buildings have identified structures which are earthquake prone. For these structures West Coast District Health Board has considered whether their carrying value exceeded their recoverable amount. As a result, the District Health Board has recognised a $2.6m asset impairment in other Comprehensive Income, with a corresponding decrease to the Property Revaluation Reserve and to Freehold Buildings and Fixtures and Fittings in the Statement of Financial Position. The total carrying amount of Freehold Building, Fixture and Fittings is $14.649m and would have been $17.249m had the District Health Board not impaired the assets. Where the recoverable amount is determined on a depreciated replacement cost basis, the West Coast District Health Board has based the impairment on the best available estimate of the likely costs to restore the assets to be building code compliant for earthquake prone buildings.

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.

in thousands of New Zealand dollars

9 Intangible assets

	Software	Total
Cost		
Balance at 1 July 2010	2,380	2,380
Additions	95	95
Balance at 30 June 2011	2,475	2,475
Balance at 1 July 2011	2,475	2,475
Additions	316	316
Disposals	(147)	(147)
Balance at 30 June 2012	2,644	2,644
Amortisation and impairment losses		
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)
Balance at 1 July 2011	(1,535)	(1,535)
Amortisation charge for the year	(313)	(313)
Disposals	147	147
Balance at 30 June 2012	(1,701)	(1,701)
Carrying amounts		
At 1 July 2010	1,148	1,148
At 30 June 2011	940	940
At 1 July 2011	940	940
At 30 June 2012	943	943

10 Inventories

	2012 Actual	2011 Actual
Pharmaceuticals	109	123
Surgical and medical supplies	851	569
Other supplies	80	99
	1,040	791

There were no write downs of inventories or reversal of prior years write downs during the year (2011: $0). The amount of inventories recognised as an expense during the year ended 30 June 2012 was $1,488,298: (2011: $1,457,568).

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

in thousands of New Zealand dollars

11 Other investments

	Note	2012 Actual	2011 Actual
Non-current			
Equity instrument		2	2
		2	2
Current			
Term deposit (maturing 22 September - 3.75%)		0	1,000
Term deposit (maturing 22 October 2011 - 3.5%)		0	1,000
Term deposit (maturing 22 November 2011 - 4.0%)		0	1,000
Term deposit (maturing 22 December 2011 - 4.5%)		0	1,500
		0	4,500
Total investments		2	4,502

The West Coast District Health Board has a 4% share in South Island Shared Services Agency Limited (2011: 4%). Subsequently to balance date 30 June 2012, the South Island Shared Services Agency Limited is no longer operating and is held as a shelf company. Functions of the South Island Share Service Agency Limited are being conducted by the South island Alliance Programme office under the umbrella of Canterbury District Health Board under an agency agreement with South Island District Health Boards. The West Coast District Health Board has no funds on deposit (2011: $4.5m ASB Bank Limited).

12 Debtors and other receivables

	Note	2012 Actual	2011 Actual
Trade receivables	20	329	538
Ministry of Health receivables		1,719	1,993
Other Crown receivables		1,445	961
Accrued revenue		657	423
Prepayments		343	267
	20	4,493	4,182

Trade receivables are shown net of provision for doubtful debts amounting to $88,160 (2011: $47,514) recognised in the current year and arising from patient debt and small balances uneconomic to pursue. Ministry of Health receivable are shown net of provision for doubtful debts amounting to $nil (2011: $17,842) and Other Crown receivables are showing net of provision for doubtful debts amounting to $8,340 (2011: $nil).

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

13 Cash and cash equivalents

	Note	2012 Actual	2011 Actual
Cash at Bank		333	1,036
less unpresented cheques		(451)	(995)
Bank overdraft		0	0
Petty cash and imprest		8	8
Call deposits		7,508	1,873
Cash and cash equivalents in the statement of cash flows	20	7,398	1,922

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

In December 2011 the West Coast District Health Board received a donation of $31,368 (2011: $57,000) from the Fresh Futures Trust 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 2012 was $30,020 (2011: $58,623), included in bank balances above. 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).

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	2012 Actual	2011 Actual
Deficit for the period		(5,024)	(6,843)
Add back non-cash items:			
Depreciation and amortisation expense		4,757	4,578
Remove non-cash revenue:			
Donated assets		(46)	(14)
Add back items classified as investing activity:			
Net loss/(gain) on disposal of property, plant and equipment		(2)	41
Movements in working capital:			
(Increase)/decrease in debtors and other receivables		(265)	(704)
(Increase)/decrease in inventories		(249)	(30)
Increase/(decrease) in creditors and other payables		154	339
Increase/(decrease) in employee benefits		385	546
Net movement in working capital		25	151
Net cash inflow/(outflow) from operating activities		(290)	(2,087)

14 Equity and reserves

Reconciliation of movement in equity and reserves

	Crown equity	Property revaluation reserve	Trust/ Special funds	Accumulated surpluses/ (deficits)	Total equity
Balance at 1 July 2010	54,609	23,888	39	(63,742)	14,794
Surplus/(deficit) for the year				(6,843)	(6,843)
Capital contributions from the Crown	7,212				7,212
Repayment of capital 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
Balance at 1 July 2011	61,753	21,310	39	(70,585)	12,517
Surplus/(deficit) for the year				(5,024)	(5,024)
Capital contributions from the Crown	4,512				4,512
Repayment of capital to the Crown	(68)				(68)
Movement in revaluation of land		(310)			(310)
Movement in revaluation of buildings, fixtures and fittings		1,169			1,169
Movement in revaluation of building, fixtures and fittings due to impairment		(2,600)			(2,600)
Balance at 30 June 2012	66,197	19,569	39	(75,609)	10,196

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 and general financial dealings to ensure that it effectively achieves its objectives and purposes, whilst remaining a going concern.

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 2012 by Coast Valuations (registered valuers).
Greymouth, Westport and Reefton Hospitals as well as Fox Glacier Clinic and Ngakawau Clinic were valued on the basis of Operational Assets, Fair Value (Depreciated Replacement Cost). All other operational assets were valued at Fair Value (Market Basis). Residential houses and leasehold sections were valued at Net Current Value.

Trust funds	2012 Actual	2011 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 Borrowings

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

	Note	2012 Actual	2011 Actual
Non-current			
Crown Health Financing Agency	20	12,195	11,195
		12,195	11,195
Current			
Crown Health Financing Agency	20	250	1,500
		250	1,500

The details of terms and conditions are as follows:

Interest rate summary	**Note**	**2012 Actual**	**2011 Actual**
		%	**%**
Crown Health Financing Agency	20	2.30-6.58	4.75-7.28

Repayable as follows:		**2012 Actual**	**2011 Actual**
Within one year		250	1,500
One to two years		250	0
Two to three years		3,750	0
Three to four years		3,250	3,500
Four to five years		250	3,000
Later than five years		4,695	4,695
	20	12,445	12,695

Total loan facility limits	**2012 Actual**	**2011 Actual**
Crown Health Financing Agency	12,445	12,695
Overdraft facility (BNZ)	6,310	6,310
	18,755	19,005

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 written consent:

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

	2012 Actual	2011 Actual
Non-current liabilities		
Liability for long-service leave	517	489
Liability for sabbatical leave	90	108
Liability for retirement gratuities	2,455	2,261
	3,062	2,858

	2012 Actual	2011 Actual
Current liabilities		
Liability for long-service leave	177	182
Liability for sabbatical leave	93	76
Liability for retirement gratuities	479	543
Liability for annual leave	3,921	3,766
Liability for other leave	1,009	872
Liability for sick leave	134	64
Liability for continuing medical education leave	213	190
Salary and wages accrued	1,247	1,399
	7,273	7,092

The present value of long service leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Key assumptions used in calculating this liability include the discount rate, the salary escalation rate and resignation rates. Any changes in these assumptions will affect the carrying amount of the liability. The discount rates used have been obtained from the NZ treasury published risk-free discount rates as at 30 June 2012.

Liability for defined benefit plan

The West Coast District Health Board makes contributions to the National Provident Fund Defined Benefit Plan Contributors Scheme ('the Scheme'). The Scheme provides pension benefits for employees on retirement. 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 deficit or surplus will affect future contributions by individual employers, as there is no prescribed basis for allocation.

As at 31 March 2012, the Scheme had a post service surplus of $19.833m (8.3% of the liabilities). This amount is exclusive of Employer Superannuation Contribution Tax. 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 recommended previously that the employer contributions were suspended with effect from 1 April 2011. In the latest report, the Actuary recommended employer contributions remain suspended.

in thousands of New Zealand dollars

17 Creditors and other payables

	Note	2012 Actual	2011 Actual
Trade payables		8,274	8,334
ACC levy payable		323	362
GST and PAYE tax payable		1,072	1,105
Income in advance		407	413
Capital charge due to the Crown		0	99
	20	10,076	10,313

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

18 Operating leases

Leases as lessee

	2012 Actual	2011 Actual
Lease payments made	248	397
	248	397

The West Coast District Health Board leases motor vehicles, the premises of Greymouth Medical Centre, office space 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 2012 $99,631 was recognised as an expense in the surplus or deficit in respect of operating leases for motor vehicles (2011: $219,373). As vehicle leases expired during the year they were not renewed and vehicles were purchased at a cost of $143,395 (2011: $773,591). $148,457 was recognised in respect of the property leased (2011: $178,396).

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 (2011: $136,650).

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 Quality, Finance, Audit and Risk Subcommittee provide 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 District 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, which comprises 41% (2011: 51%) of the debtors of the West Coast District Health Board. Together with other Crown receivables (ACC, Pharmac, other District Health Boards) total reliance on Government debtors is 76% (2011: 76%). The Ministry of Health, as the government funder of health and disability support services for the West Coast region and other Crown entities are high credit quality entities and the Board considers the risk arising from this concentration of credit to be very low.

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

Trade Receivables

	Note	Gross Receivable 2012	Impairment 2012	Net 2012	Gross Receivable 2011	Impairment 2011	Net 2011
Due 0-30 days		222		222	331	(6)	325
Past due 31-60 days		24		24	42	(2)	40
Past due 61-365 days		139	(80)	59	194	(21)	173
Past due more than one year		32	(8)	24	18	(18)	0
Total Gross Receivables	12	417	(88)	329	585	(47)	538

The provision for impairment has been calculated based on a review of debtor balances. The total impairment recognised for doubtful debts is $96,499 (2011: $65,357). Of this $88,159 relates to trade receivables (2011: $47,514), nil relates to Ministry of Health receivables (2011: $17,842) and $8,340 relates to ACC (2011: nil).

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

	Note	2012 Actual	2011 Actual
Balance 1 July		65	121
Receivables written off during the year		57	48
Impairment reversed		(57)	(48)
Additional provision made during the year		31	(56)
Closing balance 30 June	4c	96	65

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 Boards 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 case 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 2.9728% to $6,310,000, excess at 5.9728% (2011: 3.02% to $6,310,000, excess at 6.02%). The credit rate is 2.25% (2011: 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 2012 was 3.00% (2011: 3.00%).

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.

		2012 Actual							2011 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		2.25	(118)	(118)	0	0	0	0	2.25	49	49	0	0	0	0
Cash and cash equivalents		3.00	7,508	7,508	0	0	0	0	3.00	1,873	1,873	0	0	0	0
Other investments*	11	0			0	0	0	0	3.75	1,000	1,000	0	0	0	0
					0	0	0	0	3.50	1,000	1,000	0	0	0	0
					0	0	0	0	4.00	1,000	1,000	0	0	0	0
					0	0	0	0	4.50	1,500	1,500	0	0	0	0
Secured bank loans:															
NZD fixed rate loan*	15	2.37	250	0	250	0	0	0	7.28	1,500	0	1,500	0	0	0
NZD fixed rate loan*	15	2.31	250	0	0	250		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	4.75	3,000	0	0	0	3,000	0
NZD fixed rate loan*	15	4.75	3,000	0		0	3,000		5.22	4,695	0	0	0	0	4,695
NZD fixed rate loan*	15	2.50	250	0	0		250	0	0	0	0	0	0	0	0
NZD fixed rate loan*	15	2.30	250				250								
NZD fixed rate loan*	15	2.69	250					250							
NZD fixed rate loan*	15	5.22	4,695					4,695							
Bank overdrafts (total facility)		2.97	6,310	6,310	0	0	0	0	3.02	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 District Health Board's ability to meet its contractual obligations. The West Coast District Health Board evaluates it 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 2012. The Board plans to make application for equity (deficit support) based on the approved District Annual Plan for 2012/13 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
2012							
Secured Crown Health Financing Agency loans	12,445	15,639	326	572	892	8,540	5,309
Unsecured bank overdraft facility	0	0	0	0	0	0	0
Creditors and other payables	10,076	10,076	0	0	0	0	0
Total	22,521	25,715	326	572	892	8,540	5,309
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
Creditors and other payables	10,313	10,313	10,313	0	0	0	0
Total	23,008	26,838	10,625	1,918	618	8,123	5,554

in thousands of New Zealand dollars

20 Financial instruments (continued)

Fair values

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

	Note	Carrying amount 2012 Actual	Fair value 2012 Actual	Carrying amount 2011 Actual	Fair value 2011 Actual
Equity securities available-for-sale	11	2	2	2	2
Financial instruments held to maturity	11	0	0	4,500	4,500
Debtors and other receivables	12	4,493	4,493	4,182	4,182
Cash and cash equivalents	13	7,398	7,398	1,922	1,920
		11,893	11,893	10,606	10,604
Secured loans	15	12,445	13,619	12,695	13,246
Creditors and other payables	17	10,076	10,076	10,313	10,313
		22,521	23,695	23,008	23,559
Unrecognised (losses)/gains			1,174		551

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

	2012 Actual	2011 Actual
Loans and receivables		
Cash and cash equivalents	7,398	1,922
Debtors and other receivables	4,493	4,182
Investments-short term deposits	0	4,500
	11,891	10,604
Financial assets at fair value through equity		
Investments-equity instruments	2	2
	2	2
Financial liabilities		
Creditors and other payables	10,076	10,313
Borrowings-secured loans	12,445	12,695
	22,521	23,008

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.

	2012 Actual	2011 Actual
Opening balance patients deposits	50	49
Monies received	1	2
Interest earned	1	1
Payments made	0	(2)
Closing balance	52	50

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

	2012 Actual	2011 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 the Defined Benefit Plan Contributors Scheme ('the Scheme') which is a multi-employer defined scheme. If the other participating employers ceased to participate in the Scheme the West Coast District Health Board could be responsible for the entire deficit of the Scheme (see note 16).
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.

Contingent assets

The West Coast District Health Board has no contingent assets (2011: nil).

in thousands of New Zealand dollars

23 Related parties

West Coast District Health Board is a wholly owned entity of the Crown.

Significant transactions with government related entities
West Coast District Health Board has received funding from the Crown and ACC of $127.60m to provide health services in the West Coast area for the year ended 30 June 2012 (2011: $124.65m).

Revenue earned from other District Health Boards for the care of patients domiciled outside the West Coast District Health Board's district as well as services provided to other District Health Boards amounted to $1.99m for the year ended 30 June 2012 (2011: $1.75m). Expenditure to other District Health Boards for the care of patients from West Coast District Health Board's district and services provided from other District Health Boards amounted to $20.43m for the year ended 30 June 2012 (2011: $20.83m).

Collectively, but not individually, significant transactions with government-related entities
In conducting its activities, the West Coast District Health Board is required to pay various taxes and levies (such as GST, FBT, PAYE and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The West Coast District Health Board is exempt from paying income tax.

The West Coast District Health Board also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Significant purchases from these government-related entities for the year ended 30 June 2012 totalled $2.07m (2011: $1.89m). These purchases included the purchase of air services from Air New Zealand, blood products from the New Zealand Blood Service, coal from Solid Energy and services from educational institutions.

Compensations of key management personnel

	2012 Actual	2011 Actual
Short-term employee benefits-executive management	1,170	1,101
Post-employment benefits	19	24
	1,189	1,125

The executive management team consisted of 8 members (2011: 8) employed by the West Coast District Health Board. A further 4 members, including the Chief Executive were employed by Canterbury District Health Board (2011: 3). For the year under review no key management personnel were Board members (2011: 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.

Services in relation to Chief Executive, Human Resource, Procurement & Supply Chain are provided to West Coast District Health Board under contract by Canterbury District Health Board.

in thousands of New Zealand dollars

24 Board member remuneration

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

	2012 Board	2012 Advisory Committee	2012 Total	2011 Board	2011 Advisory Committee	2011 Total
Board members						
Dr S P McCormack (Unpaid Leave from March 2012)	21,333	250	21,583	26,839	250	27,089
P Ballantyne	20,000	1,813	21,813	18,280	1,750	20,030
K Brown	16,000	1,813	17,813	16,000	750	16,750
W Gilbertson	16,000	2,188	18,188	16,000	1,250	17,250
H Gillespie	16,000	1,813	17,813	16,000	3,625	19,625
M Molloy	16,000	1,250	17,250	9,118	1,250	10,368
S Pugh	16,000	1,750	17,750	16,000	1,750	17,750
M Shahadat	0	0	0	6,882	0	6,882
E Stratford	16,000	1,875	17,875	16,000	1,938	17,938
D Truman	16,000	1,750	17,750	9,118	500	9,618
S Wallace	16,000	750	16,750	16,000	1,750	17,750
W Vaile	16,000	1,000	17,000	16,000	500	16,500
Advisory committee members (not Board)						
R Williams (QFARC)		1,500	1,500	13,763	1,000	14,763
J Ayling (CPHAC/DSAC)		750	750		500	500
R Moore (CPHAC/DSAC)		1,500	1,500		0	0
L Beirne (CPHAC/DSAC)		1,250	1,250		1,250	1,250
P Nolan (CPHAC/DSAC)		1,500	1,500		1,750	1,750
M Mahuika-Forsyth (CPHAC/DSAC)		1,750	1,750		1,500	1,500
B Holland (CPHAC/DSAC, HAC)		2,500	2,500		3,000	3,000
G Howard (HAC)		1,250	1,250		0	0
R Wallace (HAC)		1,250	1,250		1,250	1,250
P Cutbush (HAC)		2,000	2,000		0	0
	185,333	31,502	216,835	196,000	25,563	221,563

The West Coast District Health Board pays mileage to Board 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 $14,008 (2011: $17,099). The West Coast District 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.

in thousands of New Zealand dollars

25 Employee remuneration

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

	2012 Actual	2011 Actual
100,001 - 109,999	18	15
110,000 - 119,999	9	4
120,000 - 129,999	5	4
130,000 - 139,999	6	2
140,000 - 149,999	6	3
150,000 - 159,999	2	3
160,000 - 169,999	2	1
170,000 - 170,999	6	2
180,000 - 189,999	2	1
190,000 - 199,999	0	3
200,000 - 209,999	1	1
210,000 - 219,999	2	2
220,000 - 229,999	0	2
230,001 - 239,999	1	3
240,000 - 249,999	3	1
250,000 - 259,999	0	3
260,000 - 269,999	2	2
270,000 - 279,999	2	0
280,000 - 289,999	3	0
290,000 - 299,999	1	3
300,000 - 309,999	0	0
310,000 - 319,999	0	1
320,000 - 329,999	1	1
330,000 - 339,999	0	0
340,000 - 349,999	1	0
350,000 - 359,999	0	0
360,000 - 369,000	0	1
370,000 - 379,999	0	1
380,000 - 389,999	1	0
390,000 - 399,999	0	1
400,000 - 409,999	1	0
410,000 - 419,999	1	1
460,000 - 469,999	1	0
480,000 - 489,999	0	1
Total employees	77	62

Seventy seven employees received total remuneration of greater than $100,000. The figure stated includes payment for additional duties, lump sump payments, including payment of back pay and employer contributions to superannuation and kiwi saver schemes.

The figures stated above exclude the Chief Executive's remuneration as this service is delivered by Canterbury District Health Board as an outsourced service.

Of the seventy seven employees shown, sixty nine are clinical employees and eight are non clinical employees.

During the year ended 30 June 2012, 9 (2011: 1) employees received payments relating to the termination of their employment totaling $169,500 (2011: $33,000), excluding retiring gratuities paid out. No Board members received compensation or other benefits in relation to cessation (2011: 0).

26 Events after balance date

On 5 September 2012 changes were announced regarding a review of the West Coast District Health Board leadership structure and a staff consultation paper was issued. This review proposed joint leadership roles between the West Coast District Health Board and Canterbury District Health Board for General Manager-Finance, General Manager Planning and Funding and a joint Corporate Services role. New positions for a General Manager – Buller Health Services and a General Manager-Greymouth and Westland Health Services were also proposed.

In September 2012 the West Coast District Health Board received updated information about the seismic risk of hospital facilities in Greymouth. Although engineering evaluations of buildings are not yet complete, enough information exists to show that there is a high level of risk associated with the present facilities. From this assessment building structures have been impaired as at 30 June 2012 (see note 8) and further impairment may be made as more evaluations are completed. Planning is now underway as to how hospital-based services in Greymouth will be provided given the earthquake status of key buildings.

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 2012.

Statement of comprehensive income

The West Coast District Health Board recorded an operating deficit before other comprehensive income of $5.024m compared to the budgeted deficit of $4.500m. The unfavourable variance of $0.524m was the net of revenue $1.119m favourable to budget and costs $1.643m unfavourable to budget.

Total comprehensive income ($6.765m) included the revaluation of property as at 30 June 2012 which was not budgeted and resulted in a gain in fair value of $0.859m and $2.6m impairment of property and plant as a result of engineering assessments of the Greymouth Site which identified structures that were classified as earthquake prone and need remedial work to bring them to a compliant level. Increased revenue from the Crown related to ACC, devolved funding for long term chronic conditions, dementia care, additional funding for Very Low Cost Access and Careplus and West Coast Primary Health Organisation.

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 $1.643m overall with the following being the main contributors:

- cost increases were primarily outsourced services, both for staff and service costs needed to maintain acute services and meet Clinical supply costs were over budget. Actual implants used for some procedures differed to those that were included in the budget and prices were higher than budget.
- Infrastructure costs were over budget, with price increases for utilities, fuel and insurance after the budget was set.
- Capital charge was under budget as the West Coast District Health Board revalued land and property as at 30 June 2011, which resulted in a significant decrease in the value of the property revaluation reserve (equity), which is used as a basis for capital charge. The revaluation of the land and buildings was not budgeted. A credit was also received in December 2011 relating to capital charge paid in the prior year ($258,655).
- Payments to external health service providers were under budget. Community pharmaceutical costs and National Travel Assistance costs were less than budget, Maori services were under review and discretionary costs in primary health were under spent.

Statement of financial position

Property, plant and equipment are under budget; this is due to the revaluation which occurred on 30 June 2011 which is not included in the budget. This significantly decreased the value of property and plant at this date. Expenditure on property, plant and equipment was also less than budget for the year.

Cash and cash equivalents are higher than budget with expenditure on property, plant and equipment less than budget and creditors higher than budget.

Inventories are higher than budget as items held in theatre which were previously treated as an expense when issues or purchased were counted and valued as stock on hand at year end.

Changes in equity

The variance as at 30 June 2012 ($4.462m) mainly reflects the effects of the revaluation of property and plant (revaluation reserve) over the past two years and impairment of building, fixtures and fittings at 30 June.

Statement of cash flows

Cash and cash equivalents are higher than budgeted cash position by $4.040m.

The capital expenditure was $1.320m less than budget, capital charge paid to the Ministry of Health was $0.368m less than budget and opening investments were higher than budget.

11. Our clinical leaders and leadership

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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 Officer
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
Garth Bateup	General Manager – Hospital Services (on secondment from Canterbury District Health Board from March 2011)
Colin Weeks	Chief Financial Manager
Gary Coghlan	General Manager – Māori Health
Allan McGilvray	General Manager – Human Resources (West Coast and Canterbury District Health Boards)

12. 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 2011/12

Dr Paul McCormack, Chair (Leave of absence from December 2011)

Peter Ballantyne, Deputy Chair (Acting Chair from December 2011)

Kevin Brown

Warren Gilbertson

Helen Gillespie

Mary Molloy

Sharon Pugh

Elinor Stratford

Doug Truman

John Vaile

Susan Wallace

Board Committees

The Board has three statutory committees:

- Community and Public Health Committee
- Hospital Advisory Committee
- Disability Support Advisory Committee

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.

In addition there is also an advisory committee:

- Quality, Finance, Audit and Risk Committee

As well as a committee of local Iwi representatives and Māori Community representatives with whom the Board has a Memorandum of Understanding

- Tatau Pounamu Manawhenua

Community and Public Health Advisory Committee and Disability Support Advisory Committee

(Combined Meetings held)

Elinor Stratford, Chair

Kevin Brown, Deputy Chair

John Ayling

Peter Ballantyne

Lynnette Beirne

Dr Cheryl Brunton

Barbara Holland

Marie Mahuika-Forsyth

Mary Molloy

Robyn Moore

Patricia Nolan

John Vaile

Hospital Advisory Committee

Warren Gilbertson, Chair

Sharon Pugh, Deputy Chair

Paula Cutbush

Gail Howard

Barbara Holland

Peter Ballantyne

Doug Truman

Richard Wallace

Quality, Finance, Audit and Risk Committee

Helen Gillespie, Chair

Peter Ballantyne, Deputy Chair

Dr Paul McCormack

Susan Wallace

Rex Williams

Tatau Pounamu Manawhenua

Richard Wallace, Chair (to February 2012)

Ben Hutana, Deputy Chair (to February 2012), and Chair from February 2012

Marie Mahuika-Forsyth

Sharryn Marsh

Wayne Secker

Elinor Stratford

Francois Tumahai

13. West Coast DHB Board and committee member attendance

2011/12 Financial Year (1 July 2011 to 30 June 2012)

	Board		QFARC		HAC		CPHAC & DSAC	
	Meetings Held	Attended	Meetings Held	Attended	Meetings Held	Attended	Meetings Held	Attended
Paul McCormack[1]	3[1]	3	4[1]	4	4[1]	2	4[1]	2
Peter Ballantyne	7	6	9	9	7	7	7	6
Kevin Brown	7	6					7	7
Warren Gilbertson	7	6			7	7		
Helen Gillespie	7	5	9	8				
Mary Molloy	7	7					7	6
Sharon Pugh	7	7			7	7		
Elinor Stratford	7	7			7		7	6
Doug Truman	7	7			7	7		
John Vaile	7	5					7	4
Susan Wallace	7	6	9	7				
John Ayling							7	4
Lynnette Beirne							7	5
Dr Cheryl Brunton							7	4
Marie Mahuika-Forsyth							7	7
Robyn Moore							7	6
Rex Williams			9	7				
Barbara Holland					7	5	7	5
Gail Howard					7	6		
Paula Cutbush					7	7		
Richard Wallace					7	5		
Patricia Nolan							7	6

[1] Leave of Absence from December 2011

QFARC = Quality, Finance, Audit and Risk Committee

HAC = Hospital Advisory Committee

CPHAC = Community and Public Health Committee

DSAC = Disability Support Advisory Committee

West Coast District Health Board
Grey Base Hospital, PO Box 387
Greymouth 7840

www.westcoastdhb.org.nz

We would like to thank Tourism West Coast for the use of some of the images used on the cover and throughout this publication.