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

Annual Report

For the year ended

30 June 2013

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DIRECTORY

Board Members during 2012/13
Dr Paul McCormack, Chair (Leave of absence until February 2013)
Peter Ballantyne, Deputy Chair (Acting Chair until February 2013)
Kevin Brown
Warren Gilbertson
Helen Gillespie
Mary Molloy
Sharon Pugh
Elinor Stratford
Doug Truman
John Vaile
Susan Wallace

Chief Executive
David Meates

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

Auditor
Audit New Zealand on behalf of the Auditor-General

Banker
Westpac Banking Corporation

REPORT FROM THE CHAIR AND CHIEF EXECUTIVE

The 2012/2013 financial year saw the ongoing transformation of the West Coast health system, as we continued to work toward the goal of providing sustainable and effective health services in which Coasters can have confidence. The year under review brought about a number of significant challenges, but it also sowed the seeds for the most significant investment in health facilities that the Coast has seen in over a generation.

Facilities do not, in and of themselves, provide care to our communities, but they are a critical enabler of health service delivery. Throughout the 2012/2013 year, the District Health Board commissioned and received Detailed Engineering Evaluations [DEEs] into all of its facilities on the Greymouth campus. These reviews pointed to significant seismic earthquake vulnerability with many buildings. In the wake of these reviews, we took decisions to close buildings most at risk, undertake urgent temporary repairs of other structures, and reconfigure some clinical services in order to maintain the delivery of health services in Greymouth. This work has presented challenges to staff and patients, who have shown both resilience and ingenuity in true West Coast style.

In this context, we welcomed the news on 25 September 2013 that we have the green light to proceed with plans for a new hospital and adjoining Integrated Family Health Centre [IFHC] on the current Grey Base Hospital site, and a new IFHC development for Westport. The Government's investment is a significant vote of confidence in our transition to a reliable health service on the Coast that is sustainable over the long term, as it is a vote of confidence in the future of services on the Coast. These announcements will be welcomed by our communities and we thank the many people who have worked hard over many years to get us this this point.

Alongside our facilities efforts, we have been working hard to transform the delivery of health services. Significant effort has been invested during the 2012/2013 year in improving primary health care on the Coast. We have entered into a partnership with Better Health Limited, an organisation with significant experience in the management of general practice. Together, we are working to stabilise the GP workforce to reduce locum reliance and improve access to care, lift the quality and consistency of systems and processes, and improve the financial performance of DHB-owned practices.

The West Coast health system is also working hard to better coordinate the delivery of care to Coasters with long-term complex conditions as part of our commitment to keeping people healthier, for longer, living in their own homes. We are delivering more services in people's homes than ever before through the development and delivery of patient-centred packages of care. These are enabled via partnerships between clinical teams from general practice, hospital-level services, and community-based clinicians.

Our collaboration with Canterbury is on-going and has gained further momentum during the last financial year. It is no secret that one of the most significant challenges facing West Coast Health services is recruitment and retention of the clinicians needed to maintain the availability of local health services and provide continuity of care for Coasters. Historically our services have been heavily reliant on locum doctors, and we are very clear that this needs to change. It is therefore very pleasing that the Coast – Canterbury partnership is successfully delivering numerous transalpine services from neonatal and paediatric care to older person's health, joint appointments continue to be made between the two District Health Boards to improve continuity of care, and we are improving access to services delivered locally on the Coast as a result. In addition, we have built transalpine teams in non-clinical areas such as Planning and Funding and Finance, significantly increasing the capacity and capability of these functions to support the delivery of health services to Coasters.

Improving the health of the community also saw a reorientation of health services with an emphasis on prevention and health promotion. A focus on Māori health resulted in a collaborative restructure of our principal Whānau Ora provider to improve service delivery and realign its goals with those of the community. As part of that process, Kaiarataki and Kaupapa Māori nurses are being appointed.

Technology is a big player in enhancing access to care. We've made significant progress with the West Coast, Canterbury and South Canterbury DHBs now all using the same clinical information system [called *Health Connect South*]. Using *Health Connect South* we can easily share information such as x-rays, lab test results and other clinical information via a secure network, which is particularly useful for our transalpine services. In addition, the West Coast is leading the nation in the development of telehealth, which has seen better access to specialist services for West Coasters. Telehealth allows health professionals in remote areas to consult about a patient's condition with specialists in Canterbury or anywhere in the country via a video link, which allows the specialist to see the patient. It has reduced unnecessary transfers to Christchurch Hospital as well as ensuring that those who can be treated locally have quick and easy access to specialist services.

Better, sooner, more convenient health care can also be measured by looking at the West Coast District Health Board's performance against Government health targets, which clearly show that the hard work, integration and collaboration are paying dividends. It is a particularly pleasing to have achieved two health targets that we have never met before: the immunisation target and the hospitalised smokers target, as well as maintaining exceptional performances in some key areas during the past year.

Engaging the West Coast community in the journey that we are on has been a significant priority in the year under review. Our programme of engaging with the community and reconnecting through 'grass roots' meetings to discuss the future direction of West Coast health services continues to be invaluable for creating a better health system. The voice of the community has proven essential to help us provide the right mix of services in the right places, while making sense to people of the changes that we are making as we bring to life sustainable health services on which Coasters can rely.

We are grateful for the efforts of the many dedicated people working within the West Coast health system who themselves have been living with extraordinary change and challenges. We are proud of them and the work they do.

Peter Ballantyne
Acting Chair
31 October 2013

David Meates
Chief Executive
31 October 2013

WHAT ARE WE TRYING TO ACHIEVE?

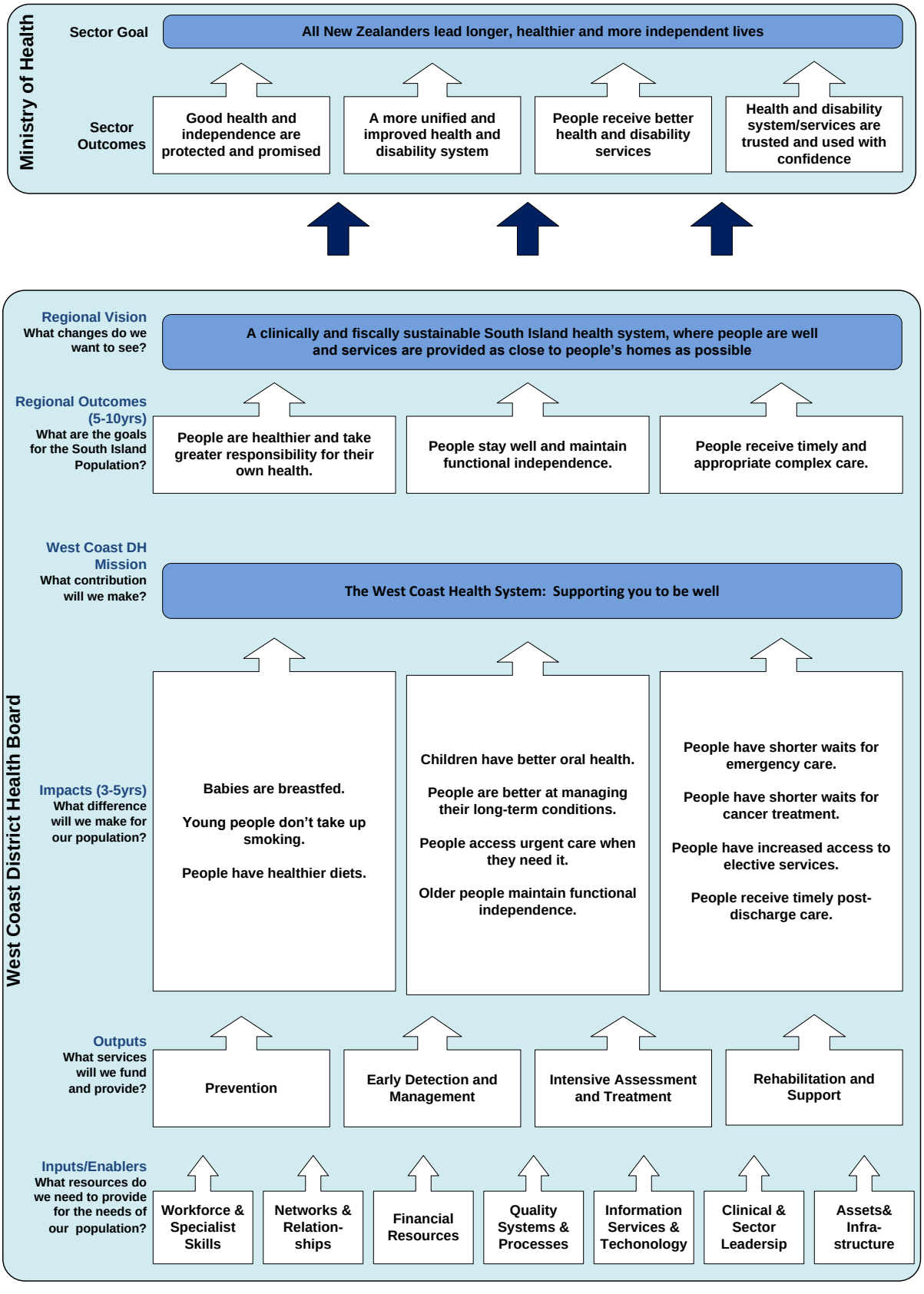
DHBs are responsible for supplying health and disability services to meet the needs of their populations. The decisions we make in terms of which services to fund and at what level have a significant impact on the health of our population. In achieving our mission, 'The West Coast Health System: Supporting you to be well', it is important that we understand the level of need within our population and the drivers of demand. In doing so, we take a long-term view, shifting resources to where they are most needed in order to improve the health of our population, while ensuring the sustainability of West Coast's health system.

This section provides an overview of the key elements of our outcomes framework, which has been agreed across all five South Island DHBs as a means of demonstrating whether we are making a positive change in the health of our collective population. The framework identifies three strategic goals or outcomes:

- PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH: The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing.
- PEOPLE STAY WELL AND MAINTAIN FUNCTIONAL INDEPENDENCE: The development of primary and community-based services that provide early diagnosis and treatment and support to better manage enduring health conditions, reduce the complications of disease and injury and maintain functional independence in their own homes and communities.
- PEOPLE RECOVER FROM COMPLEX ILLNESS AND/OR MAXIMISE THEIR QUALITY OF LIFE: The development of systems and models of care that free up secondary and specialist resources to provide timely and appropriate complex care and advice to reduce the progression of illness, better support people's functional capacity and improve people's quality of life.

These long-term outcomes will be achieved not just through our work alone, but through the combined effects of the whole of the West Coast health system, central and local government, other regional DHBs and wider health and social services.

The intervention logic diagram on the following page visually demonstrates how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired regional outcomes and the overarching sector goals of Government.


Ministry of Health
Sector Goal
All New Zealanders lead longer, healthier and more independent lives
Sector Outcomes
Good health and independence are protected and promised
A more unified and improved health and disability system
People receive better health and disability services
Health and disability system/services are trusted and used with confidence
West Coast District Health Board
Regional Vision
What changes do we want to see?
A clinically and fiscally sustainable South Island health system, where people are well and services are provided as close to people's homes as possible
Regional Outcomes (5-10yrs)
What are the goals for the South Island Population?
People are healthier and take greater responsibility for their own health.
People stay well and maintain functional independence.
People receive timely and appropriate complex care.
West Coast DH Mission
What contribution will we make?
The West Coast Health System: Supporting you to be well
Impacts (3-5yrs)
What difference will we make for our population?
Babies are breastfed.
Young people don't take up smoking.
People have healthier diets.
Children have better oral health.
People are better at managing their long-term conditions.
People access urgent care when they need it.
Older people maintain functional independence.
People have shorter waits for emergency care.
People have shorter waits for cancer treatment.
People have increased access to elective services.
People receive timely post-discharge care.
Outputs
What services will we fund and provide?
Prevention
Early Detection and Management
Intensive Assessment and Treatment
Rehabilitation and Support
Inputs/Enablers
What resources do we need to provide for the needs of our population?
Workforce & Specialist Skills
Networks & Relation-ships
Financial Resources
Quality Systems & Processes
Information Services & Techonology
Clinical & Sector Leadersip
Assets& Infra-structure

WHAT DIFFERENCE HAVE WE MADE FOR OUR POPULATION?

We have identified measures related to each of the three strategic outcomes outlined on page 5. Given the long-term nature of these 'outcome' measures (5-10 years in the life of the health system), our aim is to make a measurable change over time rather than achieve a fixed target.

We also have a set of medium-term (3-5 years) 'impact' measures, where individual DHB performance can have a measureable impact to the longer-term outcomes we are seeking. These reflect areas of activity where the DHB can influence change and help to demonstrate the difference we are making in the health of the West Coast population. Because change will be evident over a shorter period of time, these impact measures are our 'main measures' of performance; we have set local targets against them in order to evaluate the impact of service delivery over a three-year period.

This section provides an update on our progress against these measures. Results are also given for Māori wherever possible to assess our impact on Māori health and reducing inequalities.

These results show that the West Coast has exceptionally low rates of avoidable hospital admissions (just 69% of the national rate) and the lowest acute readmission rate in the country (just 6.9%, compared with the national rate of 10.3%). This suggests that health services across our health system are doing a good job of keeping Coasters healthy in their own communities and out of hospital. Coasters are also receiving timely hospital care when they need it. 100% of those referred for First Specialist Assessment or treatment got it within six months; 100% of patients ready for radiation or chemotherapy cancer treatment began it within four weeks; and 99.7% of those attending ED were admitted or discharged within six hours.

PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH.

LONG-TERM OUTCOME MEASURES

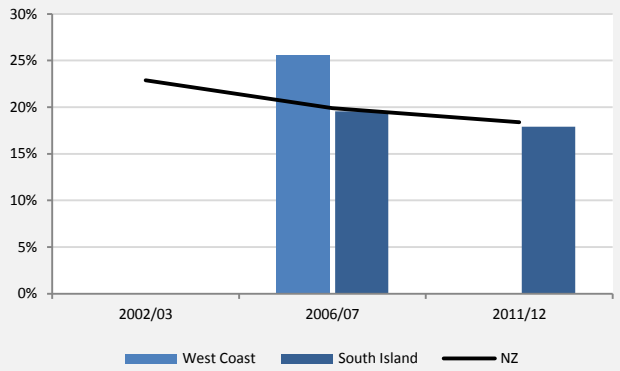
A reduction in smoking rates.

2011/12 survey results for the West Coast are not available; however, South Island and national results both show an encouraging downward trend in smoking rates.

The West Coast health system works to reduce smoking prevalence in two main ways. The first is encouraging young people to be smokefree and not take up smoking in the first place – see the impact measure below for more information. The second is encouraging current smokers to quit, which we do through our ABC quit initiatives in hospitals and general practices, as well as ensuring access to Aukati Kaipaipa and the variety of other smoking cessation programmes available on the Coast.

Data sourced from the New Zealand Health Survey.[1]

The percentage of the population (15+) who smoke



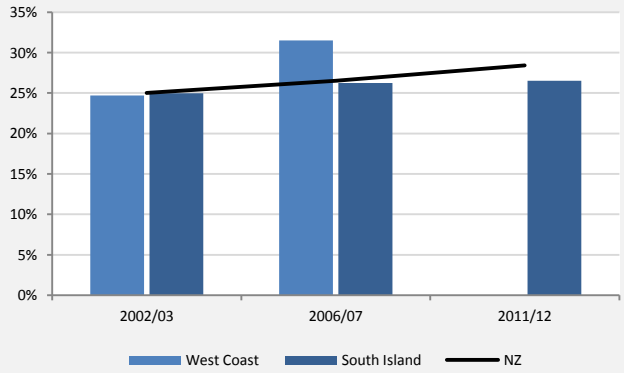
A reduction in obesity rates.

2011/12 survey results for the West Coast are not available, although South Island results show a lower rate of obesity than New Zealand overall.

The West Coast health system works to reduce obesity through a range of local initiatives that encourage healthier diets and more physical activity, such as community-based nutrition courses, Health Promoting Schools and Green Prescriptions.

Data sourced from the New Zealand Health Survey.[1]

The percentage of the population (15+) who are obese



MEDIUM-TERM IMPACT MEASURES

More babies are fully and exclusively breastfed.

West Coast's overall breastfeeding rate has dropped in 2012/13, with 61% of all six-week-olds fully or exclusively breastfed. However, it is encouraging that rates for Māori pepe have improved, reaching 70%.

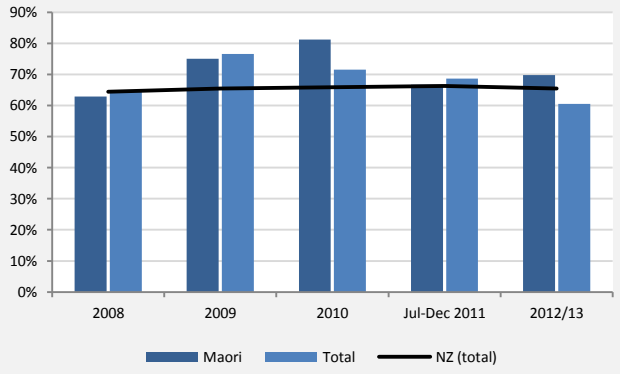
Initiatives to support West Coast mothers to breastfeed include breastfeeding ante-natal classes, Mum 4 Mum breastfeeding peer support, breastfeeding education for health professionals and social service agency staff, and community-based lactation consultation services for mothers. 149 clients accessed the community-based lactation consultation services in 2012/13.

It is important to note that the DHB is unfortunately unable to present a full picture of breastfeeding results this year. The data presented is from Plunket services only. Rata Te Awhina and the West Coast DHB also provide WellChild/Tamariki Ora services, but due to national data issues with Plunket data the three data sources cannot be accurately combined as they have been in previous years.

Data sourced from Plunket via the Ministry of Health.[2]

The percentage of West Coast babies fully/exclusively breastfed at 6 weeks

	Actual 12/13	Target 2012
Māori	70%	74%
Total	61%	74%



Fewer young people take up tobacco smoking.

The 2012 ASH Survey found that 69% of Year 10 (age 14) students on

The percentage of 'never smokers' among Year 10 West Coast students.

Actual 2012	Target 2012
69%	75%

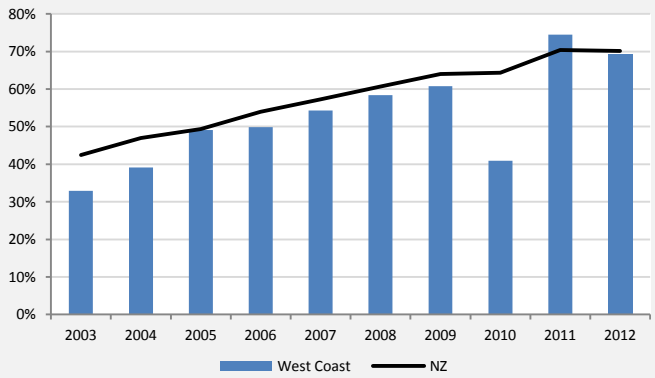
[1] *The NZ Health survey was conducted by the Ministry of Health in 2003/04, 2006/07 and 2011/12. Results by region and district are subject*

[2] *The Ministry of Health sources this data from Plunket for calendar years. There have been issues with data availability; therefore, the 2011 breastfeeding data presented is only for the final 6 months of 2011 (i.e. July to December), and the latest result is for the 2012/13 financial year, rather than the usual calendar year. Non-Plunket WellChild/Tamariki Ora providers' data cannot be included in the results, as the necessary raw data from Plunket is not available (i.e. only percentages, rather than numerator and denominator data, have been provided).*

the West Coast had never smoked. While this is lower than our exceptionally high 2011 result, it is much higher than the results seen in 2010 and earlier years, and the long-term trend is an increasing percentage of young people who have never smoked.

This reflects the impact of supportive legislation and social environments combined with local initiatives such as promotion of the benefits of a smokefree lifestyle, Health Promoting Schools, smokefree strategies within schools and training and advice provided to tobacco retailers to limit youth access to tobacco.

Data sourced from national Year 10 ASH Survey.[3]



More adults have healthier diets.

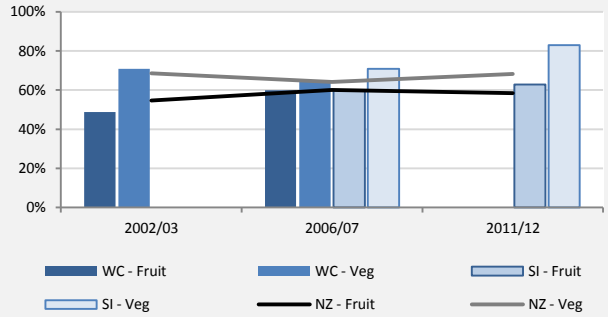
2011/12 New Zealand Health survey results for the percentage of West Coasters having the recommended servings of fruit and vegetables are not available; however, South Island results show an encouraging increase in people eating both fruit and vegetables.

Six community nutrition programmes were delivered in 2012/13, including Appetite for Life and Cooking Skills to Life Skills. These programmes supported individuals and the community to make healthier choices, alongside community-wide promotion of healthy food messages through media, themed health weeks, community group visits and schools and early childhood centres.

Data sourced from the New Zealand Health Survey. [1]

The percentage of the population (age 15+) having the recommended servings of fruit and vegetables.

	Actual 11/12	Target 12/13
Fruit 2+	NA	61%
Veg 3+	NA	66%



[3] *The ASH survey is run by Action on Smoking and Health. It provides a point prevalence data set and is reported on calendar years. www.ash.org.nz*

PEOPLE STAY WELL AND MAINTAIN FUNCTIONAL INDEPENDENCE.

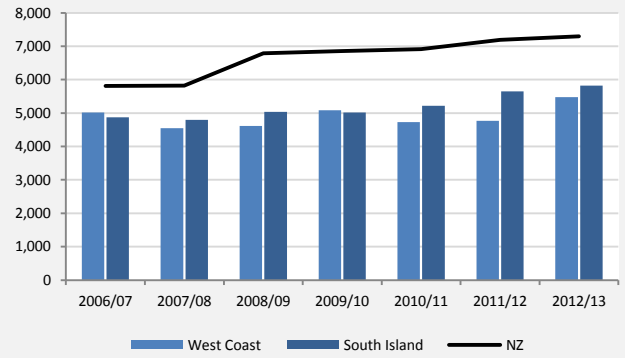
LONG-TERM OUTCOME MEASURES

A reduction in the proportion of the population being admitted to hospital for an acute medical illness.

At 5,474 per 100,000 people, the West Coast's standardised acute medical admission rate continues to be lower than both the South Island and national rates. In fact, it is just 75% of the national rate (7,296 per 100,000). This reflects the success of our health-system-wide focus on keeping people well in their own homes and communities.

Data sourced from National Minimum Data Set.

The rate of acute medical admissions to hospital (age-standardised, per 100,000)



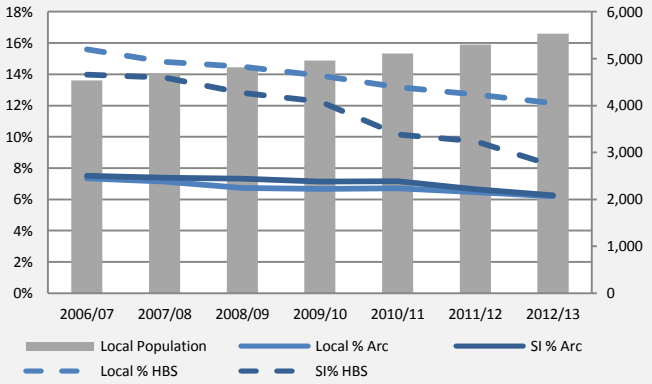
An increase in the proportion of the population 65+ supported to live well in their own homes.

Over the last several years, the percentage of the population in aged residential care has decreased from 7% down to 6%. This is in line with the trend for the wider South Island and is consistent with our strategic direction of supporting people to 'age in place'.

The percentage of those receiving home-based support has declined, but remains much higher than the South Island rate. However, these are early results, and it will take time to see whether the changes we are making towards a more restorative model will be reflected in these measures in the long term.

Data sourced from Client Claims Payments provided by SIAPO.

The percentage of the older population (65+) in ARC and those receiving home-based support services



MEDIUM-TERM IMPACT MEASURES

More children have good oral health.

Overall, 56% of all West Coast 5 year olds were caries-free in the 2012 school year. While this was lower than in 2011 (61%), it was higher than in 2010 (54%) and earlier years, suggesting that the overall trend is still increasing.

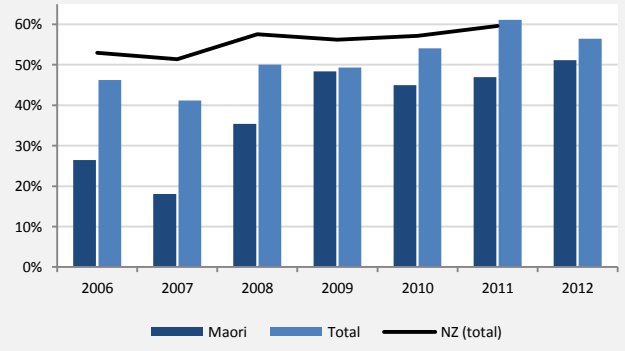
It is encouraging to see that Māori caries-free rates have continued to increase (up to 51% from 47% in 2011), continuing a positive trend in reducing inequalities.

In addition, getting children enrolled with the dental service ensures that they receive preventative care and follow-up early. 2012 has seen a substantial increase in preschool enrolment, with 85% of 0-to-4-year-olds enrolled, up from 68% in 2011/12.

Data sourced from Ministry of Health.[4]

The percentage of West Coast children caries-free (no holes or fillings) at age 5.

	Actual 2012	Target 2012
Māori	51%	61%
Total	56%	61%



[4] *Oral health data is reported annually for the school year (i.e. calendar year) and is based on the national DHB performance indicator PP11.*

More people better manage their long-term conditions.

While short of our 80% target, the percentage of Coasters identified with diabetes who have satisfactory or better diabetes management has increased from last year – both overall and for Māori.

The West Coast has a well established Long-Term Conditions Management Programme, which supports Coasters with diabetes to better manage their condition.

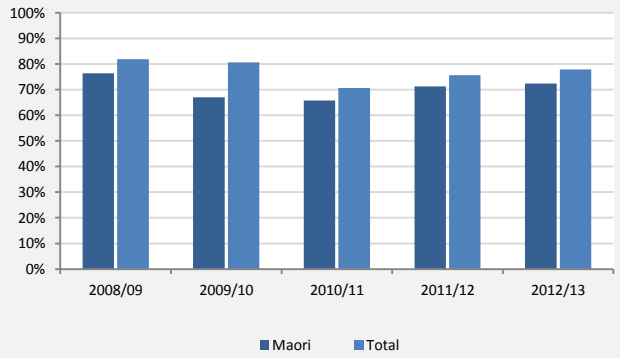
In addition, closer collaboration between general practice, the DHB's Diabetes Nurse Specialists and Rata Te Awhina Trust's newly appointed Kaupapa Māori nurses is helping to reach more people and provide them with more joined-up care.

Next year, a new model of education classes for people with diabetes will be rolled out, tailored around group-based discussion and support to self-manage diabetes facilitated by nurses.

Data sourced from the West Coast PHO.

The percentage of the West Coast population identified with diabetes with HbA1c≤64mmol/mol (indicating 'satisfactory' or better diabetes management).

	Actual 12/13	Target 12/13
Māori	72%	80%
Total	78%	80%



People access care appropriate to their needs.

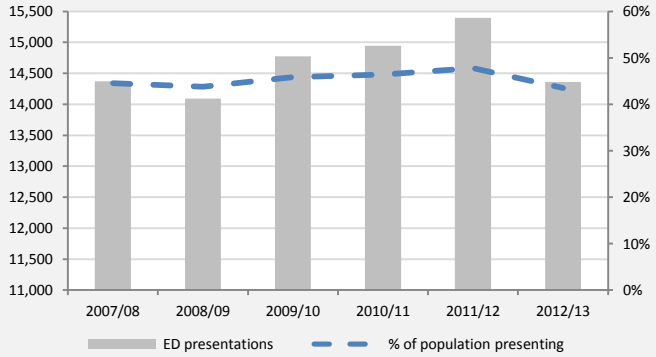
It is encouraging to see that presentations at our ED have decreased in 2012/13 for the first time since 2008/09.

This reflects the impact of local initiatives – such as the Long-Term Conditions Management Programme, wider use of practice nurses to provide care and support, extended general practice clinics and afterhours telephone triage in general practice – in successfully helping people to stay well in their own homes and communities.

Data sourced from individual DHBs.[5]

The percentage of the West Coast population presenting at ED

Actual 12/13	Target 12/13
43%	45%



Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

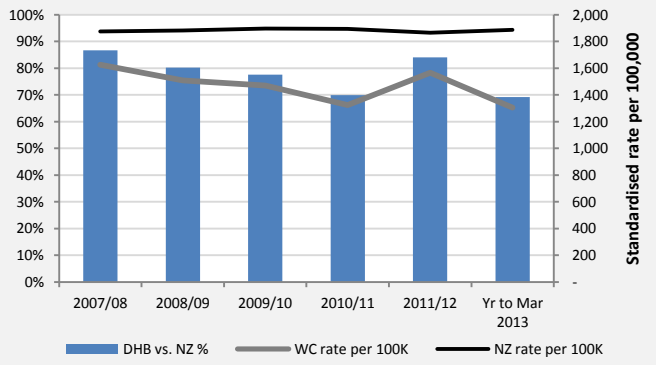
In the year to 31 March 2013, the West Coast's avoidable hospital admission rate was 1,306 per 100,000 – just 69% of the national rate (which was 1,888 per 100,000).

This is an exceptional result that shows the Coast's continued strong performance in preventing avoidable hospitalisations. A wide range of local initiatives contribute to preventing unnecessary admissions to hospital, including immunisation programmes, smoking cessation services, the DHB's school-based dental service and the Long-Term Conditions Management programme.

Data sourced from the Ministry of Health. [6]

The percentage of avoidable admissions for the West Coast population compared to the NZ population (aged <75).

	Actual Mar 13	Target 12/13
Total	69%	≤95%



[5] *'Presenting' and 'admitted' are defined as per the MoH national ED health target.*

[6] *This measure is based on the national DHB performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 for the West Coast divided by the standardised rate per 100,000 for NZ. A lower percentage is therefore better, as it indicates a lower rate of avoidable hospitalisation than the national rate. Data is subject to availability from the Ministry; results are for the 12 months up to and including March 2013. It should also be noted that there has been a definition change nationally and the presented results are based on the new national definition and are not directly comparable to results published previously.*

Older people maintain functional independence.

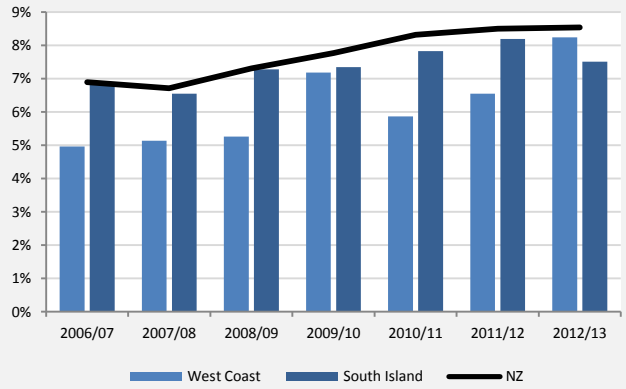
At 8.2%, the percentage of the West Coast population aged 75+ admitted to hospital as a result of a fall continues to be lower than the national rate (8.5%), although it is higher than the previous year.

The West Coast DHB has introduced a falls prevention coalition to help prevent falls among older people. The agencies involved in the coalition include the West Coast DHB, St John, ACC, aged care agencies, the Complex Clinical Care Network, physiotherapists, Community and Public Health, Rata Te Awhina and general practices. This group is taking a whole-of-system approach – aiming to prevent falls both in hospitals and in the community through a range of strategies, such as falls risk assessments and medication reviews for people whose medications increase their falls risk.

Data Sourced from National Minimum Data Set.

The percentage of the West Coast population (75+) admitted to hospital as a result of a fall.

Actual 12/13	Target 12/13
8.2%	5%



PEOPLE RECOVER FROM COMPLEX ILLNESS AND/OR MAXIMISE THEIR QUALITY OF LIFE.

LONG-TERM OUTCOME MEASURES

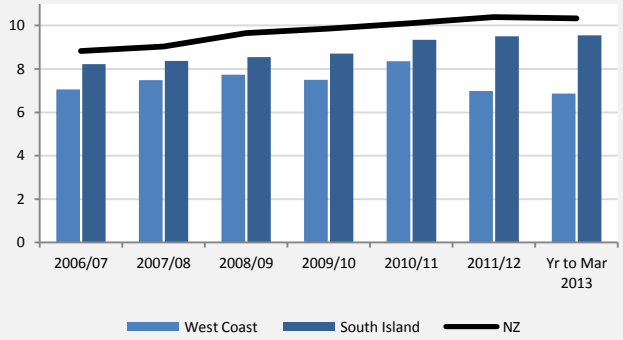
A reduction in the rate of acute (unplanned) readmissions to hospital.

At 6.9%, the West Coast had the lowest standardised acute readmission rate of any DHB in New Zealand for the twelve month period to 30 June 2013. The national rate was 10.3%. This suggests that people on the Coast are getting the right care at the right time to recover safely and avoid needing to return to hospital.

This reflects both the impact of quality treatment in our hospitals and also good post-discharge support in the community.

Data sourced from Ministry of Health[7]

The rate of acute (unplanned) readmissions to hospital within 28 days of discharge (un-standardised)



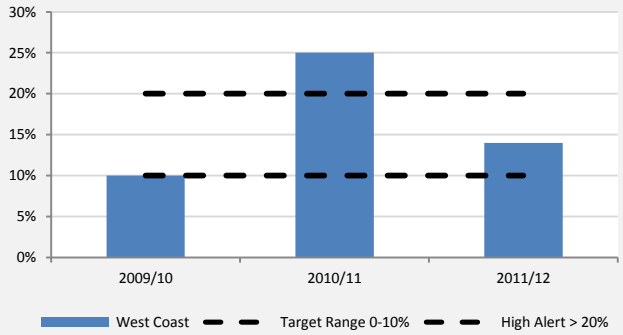
A reduction in the rate of acute (unplanned) readmissions to hospital – mental health.

In 2011/12, the West Coast reduced its mental health readmission rates to 14 – 6% below the high alert level.

Relapse prevention planning for long-term mental health clients, general practice brief intervention counselling and NGO mental health services all contribute to supporting Coasters to stay well in their own communities and out of hospital.

Data sourced from Mental Health and Addictions KPI project[8]

The rate of acute (unplanned) readmissions to mental health services within 28 days



MEDIUM-TERM IMPACT MEASURES

More people receive timely emergency care.

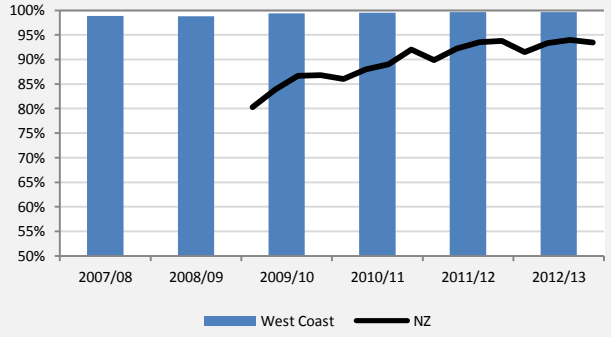
99.7% of all patients presenting to ED services at West Coast DHB's Emergency Departments during 2012/13 were seen and either admitted, discharged or transferred within six hours of arrival to the services.

The West Coast's strong performance shows the impact of the whole West Coast health system working together. Community-based services keep down the load on ED by helping people to stay well in their own homes and communities (see ED presentations above), while ED and wider hospital services ensure timely treatment and steady flow for those patients who do require urgent hospital care.

Data sourced from individual DHBs.[9]

The percentage of people presenting at West Coast EDs who are admitted, discharged or transferred within 6 hours.

Actual 12/13	Target 12/13
99.7%	100%



[7] *This measure is the national DHB performance measure OS8. The 2012/13 result is for the year up to and including March 2013, as this was the most recent result available form MoH at the time of publishing.*

[8] *This measure is based on the national Mental Health and Addictions KPI Framework measure; data is not yet available for 2012/13.*

[9] *This measure is based on the national health target 'Shorter stays in Emergency Departments', introduced in 2009/10.*

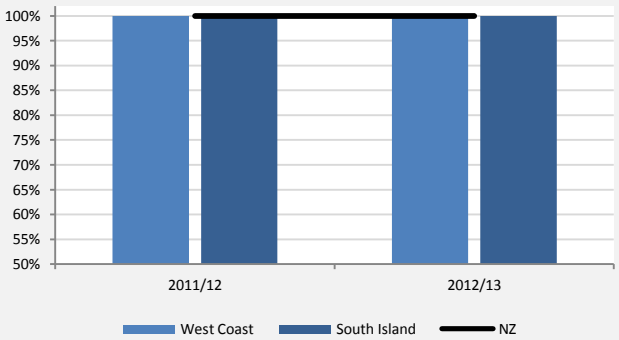
More people receive timely cancer services.

The West Coast has continued to achieve the national cancer treatment health target throughout 2012/13, with 100% of patients ready for radiation therapy treatment receiving it within four weeks of the decision to treat.

Data sourced from individual DHBs.[10]

The percentage of patients ready for treatment who receive radiation therapy within four weeks of decision to treat.

Actual 12/13	Target 12/13
100%	100%



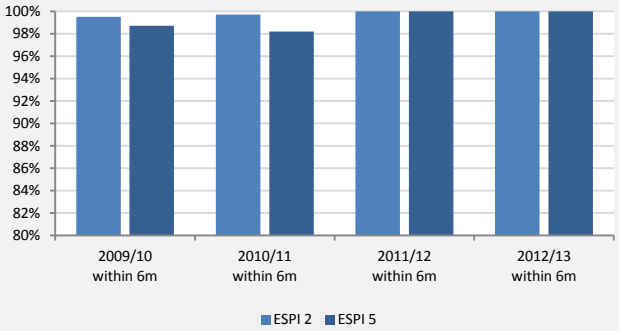
More people receive timely access to elective services.

As at 30 June 2013, 100% of Coasters needing a First Specialist Assessment (FSA) received on within six months of referral, and 100% of those given a commitment to treat began their treatment within six months. Over the coming year, we will look to further improve to five months.

Data sourced from Ministry of Health.[11]

The percentage of people waiting ≤6 months from:

	Actual Jun 13	Target 12/13
- referral to FSA (ESPI 2).	100%	100%
- commitment to treat until treatment (ESPI 5).	100%	100%



Fewer people experience adverse events that cause harm.

The 2012/13 year two reported patient falls met the Severity Assessment Code (SAC) 1 or 2 criteria. There were no falls in this category in the previous year.

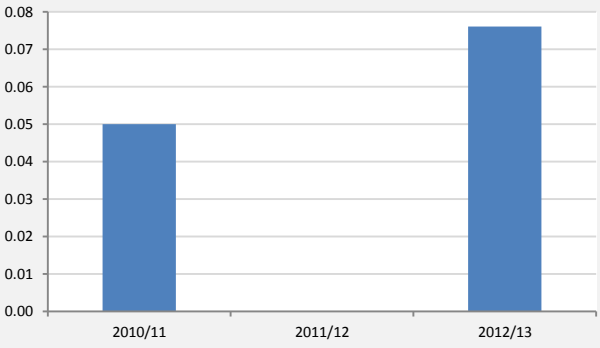
The 2012/13 year has seen the formalisation of reporting systems within all of our DHB hospitals, including Buller in early 2013 and Reefton by June 2013 (Grey Base Hospital having been completed in 2011/12), so that reporting of falls within our hospitals has become more accurate. These events are now 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.

As noted above, the West Coast DHB has introduced a falls prevention coalition to help prevent falls in both hospital and community environments.

Data sourced from Individual DHBs.[12]

The rate of SAC 1 and 2 level falls in West Coast hospitals for older people (65+)

Actual 12/13	Target 12/13
0.08	<1.0



[10] *This measure is the national health target 'Shorter waits for cancer treatment', introduced in September 2010.*

[11] *The Elective Services Patient Flow Indicators (ESPIs) are measures of system performance, for which DHBs receive summary reports from the Ministry of Health on a monthly basis. National performance data is not made available for these measures.*

[12] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days*

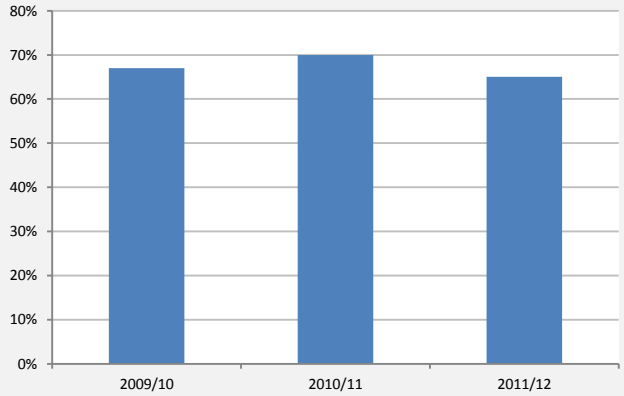
More people receive timely post-discharge care.

In 2011/12, 65% of people leaving Specialist Mental Health Services had contact with a community-based mental health service within seven days of discharge. This ensures continuity of care and support.

While the result is slightly down on the previous year, there is a drive for increased integration across all parts of the mental health and addiction system, with an expectation this will support improved continuity of care.

Data sourced from Mental Health and Addictions KPI project. [13]

The percentage of people having a post-discharge contact within seven days of discharge from Specialist Mental Health Services	Actual 11/12	Target 12/13
	65%	n/a



[13] *This measure is based on the national Mental Health and Addictions KPI Framework measure; data is not yet available for 2012/13. No target was set for this measure because at the time of target-setting, data was not yet established.*

STATEMENT OF SERVICE PERFORMANCE 2012/13

MEASURING OUR NON-FINANCIAL PERFORMANCE

As part of evaluating our performance, we provide an annual forecast of the services we plan to fund and provide (and to what standard) and report actual delivery against that forecast at the end of each year. The following section presents the West Coast's actual performance against the forecast 'outputs' presented in our Statement of Intent 2012-15.

In presenting our performance, it would be overwhelming to measure every output delivered. We therefore choose to measure those activities with the greatest potential to contribute to improving the health and wellbeing of our population, those which are markers of broader system changes and those where we expect to see a marked change in activity levels or settings.

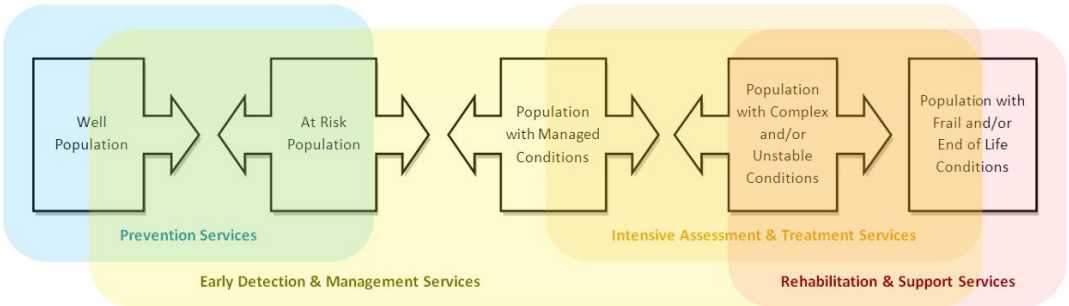
In doing so, we also cannot simply measure 'volumes'. The number of services delivered or the number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'. We therefore present a mix of measures focused on four elements of service performance: Volume (V), Quality (Q), Timeliness (T) and Coverage (C). Together, these short-term outputs have an impact that contributes to the longer-term health outcomes we seek to achieve for our population.

As well as comparing our 2012/13 results against the targets we set in our Statement of Intent, we have included (wherever possible) prior years' results to assess performance over time and a national result to give wider context in terms of what we are trying to achieve.

- Some data is collected on calendar, rather than financial, years and is indicated with the following symbol: **†**. In these cases, the '11/12' result is for the 2011 calendar year, and the '12/13' result is for 2012.
- Some service data is provided or held by third parties, outside the DHB, and can be affected by a lag in invoicing for the services provided. Rather than footnote every instance, a symbol is used to indicate where this is the case: **Δ** marks data that can be affected by a lag in invoicing and therefore may differ from previously published figures.
- Any other irregularities have been footnoted.

The outputs that we measure are grouped into four 'output classes' that are a logical fit with the continuum of care: Prevention Services, Early Detection and Management Services, Intensive Assessment and Treatment Services, and Rehabilitation and Support Services. This helps to provide a picture of overall performance by grouping services with similar aims or goals.

Output grouping set against the continuum of care for our population



PREVENTION SERVICES

Preventative health services promote and protect the health of our population by improving physical and social environments and supporting people to make healthier choices. These services include education programmes to raise awareness of risk behaviours, legislation and policy to protect people from environmental risks, and health protection services such as immunisation and lifestyle programmes that support people to modify their lifestyles and maintain good health.

Success is defined by positive changes in behaviours and high coverage levels, which signal engagement in programmes and the effectiveness of positive health messaging and the quality of the support and advice being provided.

OUTPUT MEASURES

HEALTH PROMOTION AND EDUCATION SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Volunteer mothers trained to provide Mum 4 Mum breastfeeding peer support	V [14]	18	15	17	-
Proportion of mothers having established breastfeeding on discharge from hospital	Q [15]	91%	92%	96%	-
Lactation support and specialist advice consults provided in community settings	V	103	149	150	-
Proportion of infants exclusively and fully breastfed at 6 wks	Q [16] †	69%	61%	74%	65%
Percentage of hospitalised smokers who receive smoking cessation advice and support - Full year results	C [17]	84%	91%	95%	-
- Quarter 4 results		90%	95%	95%	96%
Percentage of identified smokers attending general practice who receive smoking cessation advice and support	C [18]	39%	55%	90%	57%
Number of smokers participating in the Aukati Kaipaipa smoking cessation programme	V	126	124	100	-
Percentage of year 10 students who have never smoked	Q [19] †	74%	69%	75%	70%
Total West Coast enrolments to all smoking cessation services	Q	1,498	1,336	1,300	-
Number of community-based nutrition courses provided	C	11	6	5	-
Number of people provided with Green Prescriptions	V [20]	389	374	350	-
Percentage of women accessing hospital services 15+ screened for family violence	C	20%	29%	50%	-
STATUTORY AND REGULATORY SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Controlled purchase operations carried out on tobacco retailers	Q	New	3	3	-
Monitoring visits on alcohol retailers identified as high risk premises	Q	New	3	3	-

[14] 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.

[15] 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.

[16] The Ministry of Health sources this data from Plunket for calendar years. There have been issues with data availability; therefore, the 2011 breastfeeding data presented is only for the final 6 months of 2011 (i.e. July to December), and the latest result is for the 2012/13 financial year, rather than the usual calendar year. Non-Plunket WellChild/Tamariki Ora providers' data cannot be included in the results, as the necessary raw data from Plunket is not available (i.e. only percentages, rather than numerator and denominator data, have been provided).

[17] The ABC Strategy for Smoking Cessation was implemented in all West Coast DHB hospitals from 2009 and involves Asking a patient's smoking status, offering Brief quit advice and referring the patient to Cessation support.

[18] The ABC initiative is new to primary care, with data collection beginning in 2010/11 via the national PHO Performance Programme.

[19] The 2011 result was previously reported as 75%; however, this was the result of a rounding error. The correct result is 74.47%.

[20] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.

POPULATION-BASED SCREENING SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Women screened for HIV as part of routine antenatal blood tests	C [21]	76%	67%	75%	-
Infants screened for neonatal hearing loss	V	94%	94%	95%	-
Eligible children provided with a B4 School Check	C [22]	80%	81%	85%	80%
Youth in alternative education provided with a HEADSSS assessment	C [23] †	50%	55%	75%	-
Percentage of women aged 25-69 having a cervical cancer screen every three years	C [24]	75%	78%	75%	77%
Percentage of eligible women (45-69) having a breast screen examination every two years	C [24]	79%	81%	75%	72%
IMMUNISATION SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Percentage of children fully immunised at age eight months - Full year results	C	new	84%	85%	-
- Quarter 4 results	C	new	93%	85%	90%
Percentage of children fully immunised at age two years	C	82%	83%	95%	90%
Percentage of Year 8 girls completing HPV vaccinations	C [25] †	30%	44%	60%	52%
Percentage of older people (65+) receiving a free influenza ('flu') vaccination	C [26] †	58%	55%	65%	65%
Percentage of older people (65+), deemed 'high need', receiving a free influenza ('flu') vaccination	C [26] †	61%	56%	65%	64%

[21] *The 11/12 result differs slightly from previously published results due to the correction of an error.*

[22] *The B4 School Check is the final core WellChild/Tamariki Ora check, which children receive at age four. It is free and includes vision, hearing, oral health, height and weight. It allows health concerns to be identified and addressed early in a child's development, giving him/her the best start for school and later life.*

[23] *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. For 2012, 22 HEADSSS assessments were completed for youth in alternative education facilities. The denominator for this measure is difficult to determine, as the number of youth attending alternative education fluctuates throughout the year; the December figure of 40 enrolled has been used to calculate the result.*

[24] *National screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce associated mortality. Standards are based on national targets, and data is subject to availability from the national programmes. The national cervical screening programme has recently changed its targets and reporting to the 25-69 age group (previously it used the 20-69 age group); results therefore differ from previous years.*

[25] *The measure is the percentage of girls having all three doses and uses calendar years so as to align with the school year. For 2011, the cohort born in 1998 is used, and for 2012, the 1999 cohort is used.*

[26] *Flu vaccination results are for calendar years, and have been aligned so that the result in the '11/12' column is the 2011 result and 12/13 is 2012; they may therefore differ from past reports using different time periods.*

EARLY DETECTION AND MANAGEMENT SERVICES

Early detection and management services support people to better manage their long-term conditions and avoid complications, acute illness and crises. By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes.

Providing flexible and responsive services in the community is all the more important, as it allows early intervention and treatment to occur without the need for a hospital appointment. This helps more people stay well and reduces the rate of avoidable hospital admissions and unnecessary specialist referrals.

Success is defined by high coverage and utilisation of services, signalling engagement with and access to health services. Increases in access to diagnostics and agreed referral pathways and reductions in avoidable hospital admissions also reflect improvement.

OUTPUT MEASURES

PRIMARY HEALTH CARE (GP) SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Population enrolled with the West Coast Primary Health Organisation	C [27]	95%	94%	>95%	96%
Proportion of the Māori population enrolled with the West Coast Primary Health Organisation	C	85%	88%	>95%	-
Number of patients receiving extended primary care consultations for mental health conditions	V Δ	780	634	300	-
Provision of brief intervention counselling provided in Primary Care - ages 0-19 years	V [28] Δ	64	59	80	-
- ages 20+ years		286	298	250	-
Number of District Nursing visits (personal care services)	V Δ	23,036	24,092	23,000	-
Avoidable hospitalisation rate for West Coast Māori (aged 0-74) compared to the national rate - % of national rate	Q [29]	59%	55%	<95%	100%
- Rate per 100,000		1,746	1,654	-	2,994
ORAL HEALTH SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Percentage of preschool children enrolled in DHB dental services	C [30] †	68%	85%	77%	-
Percentage of enrolled children (0-12) examined according to planned recall	T [30] †	99%	72%	98%	-
Decayed, missing or filled teeth (DMFT) rate at Year 8	Q [30] †	1.39	1.48	1.12	1.24
Number of adolescent enrolments in the community dental services	V [30] †	49	29	50	-
Percentage of adolescents (13-17) accessing DHB-funded oral health services	C [30] †	81%	77%	85%	72%

[27] The national target for PHO enrolments is 95%, and the aim is to continue to achieve above this level. The population used to is the estimated resident population for the WCDHB as at June 2011 from Statistics New Zealand: Total population - 32,900 and Māori population - 3,320

[28] Brief intervention counselling provides people with mild to moderate mental health concerns up to 5 sessions of free 'early' psychological intervention from their general practice teams, with the possibility of onward referral to a related community agency if appropriate. The aim is to provide early intervention and help people to reduce the likelihood of developing enduring conditions.

[29] Some hospital admissions are seen as preventable through early intervention; they provide an indication of the access and effectiveness of primary care and the interface between primary and secondary services. The measure is defined as the standardised rate per 100,000 for the West Coast divided by the standardised rate per 100,000 for NZ. A lower percentage is better, indicating a lower rate of avoidable hospitalisation than the national rate (100%). Data is subject to availability from the Ministry; results are for the 12 months up to and including March 2013.

[30] Oral health results are for calendar years, and have been aligned so that the result in the '11/12' column is the 2011 result and 12/13 is 2012. Some enrolment results also differ from past reports due to correction of population estimates. The NZ results (where available) for the oral health measures are for the 2011 year, as the 2012 national results are not yet available.

LONG-TERM CONDITIONS PROGRAMMES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Percentage of the eligible population receiving CVD risk assessments every five years	C [31]	57%	58%	75%	67%
Percentage of people with diabetes having a diabetes annual review	C	77%	70%	70%	-
Percentage of those having a diabetes annual review who have satisfactory diabetes management (HbA1c ≤ 64mmol/mol)	C	76%	78%	80%	-
COMMUNITY REFERRED AND DELIVERED SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Number of community referred Radiological tests to Grey Hospital	V	5,807	5,721	5,000	-
Percentage of GP referred laboratory expenditure (actual against expected)	C [32]	27%	NA	100%	23%
Percentage of referred pharmacy expenditure (actual against expected)	C	59%	47%	100%	68%

[31] The SOI listed this measure as the percentage of the eligible population having had a fasting lipid/glucose test in the past five years; however, that was the old national health target, and data is no longer supplied by MoH. Instead, results against the new national health target are given, which is the percentage of the eligible population receiving a CVD risk assessment (as defined by the PHO Performance Programme) in the past five years.

[32] Measures of actual vs. expected expenditure for GP referred laboratory and pharmacy have been aligned to the national PHO Performance Programme measure and are not comparable with the results in last year's Annual Report. Due to data load issues, the dataset for the laboratory measure is currently incomplete for 2012/13.

INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Intensive assessment and treatment services are more complex services provided by specialist healthcare professionals. These services are typically provided in settings which enable the co-location of clinical expertise and specialist equipment – usually (but not always) hospitals.

A proportion of these services are driven by demand that we must meet, such as emergency (acute) and maternity services. However, others are planned (elective) services where access is determined by capacity, clinical need and treatment thresholds.

It is important to reduce avoidable demand in order to provide specialist services in a timely manner. By reducing the utilisation of our limited resources for avoidable acute or less complex demand, we are able to free up specialist services to undertake more complex and elective interventions. Success is therefore defined by a reduction in acute demand and increased access to less complex care in community settings rather than in hospitals.

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action. Success is therefore also defined by increased access to services and timely treatment.

We are committed to funding and providing high-quality health services for our community. As a provider of services, we closely monitor patient safety within our hospitals. Improved patient safety is reflected by improved patient health outcomes and a reduction in adverse events and delays in treatment, which as well as causing harm, drive unnecessary costs and redirect resources from other services.

OUTPUT MEASURES

SPECIALIST MENTAL HEALTH SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Acute inpatient mental health services bed-days provided (MHC29)	V[33]	2,806	NA	1,700	-
Mental health inpatient services for people aged over 65 bed-days provided (MHIS02)	V[33]	1,159	NA	800	-
Percentage of young people (0-19) accessing specialist mental health services	C [34]	5.5%	6.1%	3.8%	3.2%
Percentage of adults (20-64) accessing specialist mental health services	C [34]	4.7%	4.9%	3.4%	3.6%
Percentage of older adults (65+) accessing specialist mental health services	C [34]	1.8%	2.0%	2.5%	2.2%
Percentage of adult long-term mental health clients (20-64) with current relapse prevention plans	Q [35]	54%	100%	98%	92%
Average length of acute inpatient stay – in days (KPI 8)	Q [36]	18	NA	<15	19
28-day acute inpatient readmission rate (KPI 2)	Q [36]	14%	NA	<5%	14%
Pre-admission community care (KPI 18)	Q [36]	56%	NA	75%	56%
Post-discharge community care (KPI 19)	Q [36]	65%	NA	117%	62%

[33] *Due to the transition to a new mental health information system, data for this measure was unavailable at the time of printing.*

[34] *This measure is based on the PP6 national DHB performance measure. 2011/12 results have been aligned to true financial years (and may therefore differ from previously published results), while 2012/13 results are for the year to 31 March 2013, as these were the latest results available from MoH at the time of publishing.*

[35] *Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what actions to take. This measure is based on the PP7 national DHB performance measure. 2011/12 results have been aligned to true financial years (and may therefore differ from previously published results). The NZ result is as at 31 December 2012, as this was the most recent figure available from MoH.*

[36] *These measures are based on the national KPI project and have been aligned to reflect the final published numbers rather than preliminary internally sourced numbers, so results may differ from those previously published. 2012/13 KPI results are not yet available.*

ELECTIVE SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Number of elective surgical discharges (raw volume)	V [37]	1,751	1,686	1,592	-
Other Elective surgical service discharges provided	V [38]	145	135	137	-
Surgical electives as a percentage of national case-weight delivery.	Q	1.14%	1.06%	1.1%	-
Standardised intervention rates per 10,000 for: - Major joints	C [39]	30.02	23.11	21.0	21.52
- Cataracts		43.47	40.79	27.0	31.84
- Cardiac Procedures		9.25	8.06	6.2-6.5	6.50
- Percutaneous Revascularisation		17.61	13.29	11.9	12.51
- Coronary angiography		30.58	27.30	32.3	34.92
Maintain compliance with nationally monitored Elective Service Patient Flow Indicators (ESPIs) - national targets indicated below: - ESPI 1 – >90%	T	94%	94.4%	92.0%	99.5%
- ESPI 2 – <1.5%		0%	0%	0%	0%
- ESPI 3 – <5%		0%	0.1%	4.0%	0.2%
- ESPI 5 – <4%		0%	0%	0%	0%
- ESPI 6 – <15%		0%	0%	12.0%	7.9%
- ESPI 8 – >90%		100%	100%	100%	99.6%
Inpatient indirectly standardised length of stay (days) (OS3)	Q [40]	3.47	3.25	3.43	3.93
Theatre utilisation rate (OS5)	Q	91%	86%	89%	-
Elective and arranged day of surgery admission rates for case mix included discharges (OS7)	Q [40]	76.6%	89.5%	82%	86.3%
Specialist Medical and Surgical outpatient 'Patient did not attend' rates at Provider Arm services	Q	8.7%	8.2%	< 6%	-
Specialist Medical and Surgical First Specialist Assessments (FSA) provided to West Coast residents (all providers)	V [41]	7,302	6,724	7,328	-

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

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

[39] 2012/13 results are for the year to 31 March 2013, as these were the latest results available from MoH at the time of publishing. Prior results have been aligned to true financial years and may therefore differ from previously published results.

[40] OS3 and OS7 measures are national indicators of performance set for all DHBs, with data subject to MoH availability. The 2011/12 results have been aligned to the financial year to 30 June 2012, while12/13 results are for the year to 31 March 2013, as these are the most recent available.

[41] This number now includes 'virtual' FSAs and may therefore differ from previously published results.

ACUTE (URGENT) SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Standardised acute readmission rate (OS8)	Q [42]	7.8	7.6	<8.2	10.3
Total presentations at ED (Grey Base Hospital) and Accident & Medical Departments (Buller Health and Reefton)	V [43]	15,394	14,359	15,376	-
Proportion of people assessed, treated or discharged from ED in under six hours - Full year results	T	99.7%	99.7%	>95%	-
- Quarter 4 results	T	99.5%	99.6%	>95%	93%
Proportion of people triaged in ED and seen within clinical guidelines	Q [44]	88%	87%	>85%	-
GP practices utilising telephone triage systems outside of business hours	C	100%	100%	100%	-
Percentage of people ready for radiation treatment receiving treatment within four weeks (excludes Category D patients)	T	100%	100%	100%	n/a
Percentage of people ready for chemotherapy treatment receiving treatment within four weeks	T	100%	100%	100%	-
MATERNITY SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Number of deliveries in West Coast DHB facilities	V	293	325	350	-
Percentage of total deliveries made in primary birthing units	Q [45]	5.5%	5.5%	10%	-
Number of specialist obstetric consultations provided	V	534	496	560	-
ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Number of inpatient AT&R bed days	V	2,412	1,921	2152	-
Number of outpatient and domiciliary AT&R attendances	V	1,712	1,601	3,000	-
Number of referrals of complex clients to the new Chronic Conditions Clinical Network	V	new	116	50	-
Standardised acute readmission rates to hospital for: - people aged 65 +	Q [42]	12.5	11.9	12.22	14.0
- people aged 75 +		14.1	11.6	12.91	14.6

[42] These measures are based on the national indicator OS8. 2012/13 results are for the year to 31 March 2013, as this was the most recent data available from MoH at the time of publishing; prior results have been aligned to true financial years and may therefore differ to previously published numbers.

[43] This measure has been aligned to the ED national health target definition and therefore counts only those who stayed for treatment.

[44] This measures the percentage of people presenting at ED in triage categories 1-3 who are seen within triage time-guidelines: Triage 1 - seen immediately on presentation; Triage 2 - seen within 10 minutes; Triage 3 – seen within 30 minutes of presentation.

[45] The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women birth in secondary or tertiary facilities when it is not needed in order to make better use of resources and to ensure limited secondary services are more appropriately available for those women who need complex or specialist intervention.

REHABILITATION AND SUPPORT SERVICES

Rehabilitation and support services assist people to regain functional independence after an illness or disability. Even when returning to full health is not possible, timely access to responsive support services helps people to manage their needs and remain safe and well in their own homes. In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of the wider health system, reducing acute demand for services and the need for more complex intervention. By providing ongoing care for patients and improving recovery after an acute illness or hospital admission, these services also help to reduce hospital readmission rates.

Services that support people in their own homes typically provide a much higher quality of life, as a result of people staying active and positively connected to their communities. Success is therefore defined by increased access to community-based services, less dependence on hospital and aged residential care (ARC) and a reduction in illness or deterioration that leads to acute admission or readmission.

OUTPUT MEASURES

NEEDS ASSESSMENT AND SERVICE COORDINATION	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Number of needs assessments provided to people with age-related and other chronic conditions	V Δ	633	747	700	-
Percentage of needs assessments completed using the InterRAI assessment tool	Q [46] Δ	79%	79%	100%	-
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan (PP18)	Q [47] Δ	79%	97%	90%	-
Number of mental health needs assessments provided	V Δ	387	242	150	-
PALLIATIVE CARE SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Palliative packages of care in place provide appropriate care to meet individual clinical needs	C	100%	100%	100%	-
Number of ARC facilities trained to provide the Liverpool Care Pathway option to residents	Q [48]	2	3	Phase 1 complete	-
Number of people in ARC services being supported by the Liverpool Care Pathway	V	18	31	No base to set target	-
REHABILITATION SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Number of people on high/complex packages of care	V[49]	271	280	30	-
Number of people accessing Mental Health Activity and Living skills and Education and Employment Support services	V	84	69	150	-
Number of people accessing Education and Employment support services supported into full or part time employment	Q	67%	35%	65%	-

[46] *InterRAI is an evidence-based geriatric assessment tool. Using InterRAI ensures assessments are high quality and consistent so that people receive equitable access to support and care. InterRAI also supports improved integration by providing health professionals with a common language of assessment and an electronic means of transferring information. Results have been extracted from the official interRAI database to ensure that they are of highest possible quality. They may differ from previously published estimates captured through other systems.*

[47] *Comprehensive clinical assessment ensures that service decisions are based on a robust, internationally verified assessment tool (InterRAI) so that the level of support provided matches a person's level of need and people receive equitable access to support. The 2012/13 result is for the year ending 31 March 2013. Prior results are for true financial years.*

[48] *The Liverpool Care Pathway is an international programme adopted nationally, and reflects best-practice care. It is currently being 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.*

[49] *These are the clients who are deemed complex or have a large case. We are moving to a restorative model, and over the past 12 months interRAI assessments have been completed alongside a support allocation tool to determine their complexity.*

HOME-BASED SUPPORT SERVICES	Notes	11/12 Result	12/13 Result	Target 12/13	Latest NZ result
Number of hours of long-term home help delivered	V Δ	57,318	54,358	63,000	-
Number of hours of personal care delivered	V Δ	26,920	31,744	23,000	-
Number of Meals on Wheels provided	V	37,148	35,234	39,000	-
Number of clients receiving Mental Health Support Work Services	V	105	226	100	-
RESIDENTIAL CARE SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Number of unplanned (issues-based) audits undertaken on ARC facilities	Q[50]	1	0	0	-
Number of people residing in permanent rest home level care as a % of the 75+ population	Q[51] Δ	8.5%	7.1%	5.5% (regional average)	-
Number of people residing in permanent specialist dementia residential care as a % of the 75+ population.	Q Δ	1.1%	1.3%	1.97%	-
Number of bed-days provided for subsidised long-term residential mental health services	V Δ	6,455	6,534	8,030	-
RESPITE AND DAY SERVICES	**Notes**	**11/12 Result**	**12/13 Result**	**Target 12/13**	**Latest NZ result**
Number of bed-days provided for mental health respite beds for planned respite	V Δ	384	375	365 bed days	-
Number of aged care respite bed-days used	V Δ	1582	1,028	1500 bed days	-
Number of day-care days provided	V Δ	523	209	800 days	-

[50] *Previous publications mistakenly omitted one issues-based audit (occurring in July 2011). The 2011/12 result has been amended to include this.*

[51] *Results differ from those previously published due to the correction of an error in the calculation for this measure.*

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2013.

PRINCIPAL ACTIVITIES

West Coast DHB is a New Zealand based District Health Board, which provides health and disability support services principally to the people of the West Coast.

RESULTS

During the year, the West Coast DHB Group recorded a net deficit of $3.576M against the budgeted deficit of $3.600M (2011/12 result was a net deficit of $5.024M).

BOARD AND COMMITTEE MEMBER ATTENDANCE

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

*Leave of Absence until February 2013

QFARC = Quality, Finance, Audit and Risk Committee
CPH&DSAC = Community and Public Health & Disability Support Advisory Committee
HAC = Hospital Advisory Committee

BOARD FEES

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

	Year ended 30 June 2013			Year ended 30 June 2012		
	Board	Advisory Committee	Total	Board	Advisory Committee	Total
Board members						
Dr S P McCormack (Unpaid Leave until February 2013)	13,333	1,000	14,333	21,333	250	21,583
P Ballantyne	20,000	2,000	22,000	20,000	1,813	21,813
K Brown	16,000	1,500	17,500	16,000	1,813	17,813
W Gilbertson	16,000	2,250	18,250	16,000	2,188	18,188
H Gillespie	16,000	2,500	18,500	16,000	1,813	17,813
M Molloy	16,000	1,750	17,750	16,000	1,250	17,250
S Pugh	16,000	1,983	17,983	16,000	1,750	17,750
E Stratford	16,000	2,188	18,188	16,000	1,875	17,875
D Truman	16,000	1,750	17,750	16,000	1,750	17,750
S Wallace	16,000	1,750	17,750	16,000	750	16,750
W Vaile	16,000	1,250	17,250	16,000	1,000	17,000
Advisory committee members						
R Williams (QFARC)		500	500		1,500	1,500
J Ayling (CPHAC/DSAC)		1,750	1,750		750	750
R Moore (CPHAC/DSAC)		1,500	1,500		1,500	1,500
L Beirne (CPHAC/DSAC)		1,750	1,750		1,250	1,250
P Nolan (CPHAC/DSAC)		250	250		1,500	1,500
M Mahuika-Forsyth (CPHAC/DSAC)		1,750	1,750		1,750	1,750
B Holland (CPHAC/DSAC, HAC)		500	500		2,500	2,500
G Howard (HAC)		1,000	1,000		1,250	1,250
R Wallace (HAC)		1,250	1,250		1,250	1,250
P Cutbush (HAC)		1,750	1,750		2,000	2,000
K Hamilton (HAC)		250	250		-	-
J McGill (CPHAC/DSAC)		1,250	1,250		-	-
	177,333	**33,421**	**210,754**	**185,333**	**31,502**	**216,835**

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 $25,164 (2012: $14,008). 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.

BOARD AND COMMITTEE MEMBERS' INTEREST AS AT 30 JUNE 2013

The Board and Committee Members have declared their interest in the Interest Register:

Dr Paul McCormack Chair	• General Practitioner Member, Pegasus Health
Peter Ballantyne Deputy Chair	• Appointed Board Member, Canterbury District Health Board • Chair, Quality, Finance, Audit and Risk Committee, Canterbury DHB • Retired partner now in a consultancy role, Deloitte • Member of Council, University of Canterbury • Trust Board Member, Bishop Julius Hall of Residence • Spouse, Canterbury DHB employee (Ophthalmology Department) • Niece, Juliette Reese, Coordinator/Administrator Medical Training Programmes, West Coast District Health Board
Kevin Brown	• Councillor, Grey District Council • Trustee, West Coast Electric Power Trust • Wife is a Pharmacy Assistant at Grey Base Hospital • Member of CCS • Co Patron and Member of West Coast Diabetes • Trustee, West Coast Juvenile Diabetes Association
Warren Gilbertson	• Chief Operational Officer, Development West Coast • Member, Regional Transport Committee • Director, Development West Coast Subsidiary Companies • Trustee, West Coast Community Trust
Helen Gillespie	• Peer Support Counsellor, Mum 4 Mum • Employee, DOC
Sharon Pugh	• Shareholder, New River Bluegums Bed & Breakfast • Deputy Chair, Grey Business Promotions Association
Elinor Stratford	• Clinical Governance Committee, West Coast Primary Health Organisation • Committee member, Active West Coast • Chairperson, West Coast Sub-branch-Canterbury Neonatal Trust • Deputy Chair of Victim Support, Greymouth • Committee Member, Abbeyfield Greymouth Incorporated • Trustee, Canterbury Neonatal Trust • Committee Member of C.A.R.E. • Advisor MS/Parkinson West Coast • Member of sub committee for Stroke Conference • Contracted to wind up the Disability Resource Trust organisation

John Vaile	• Director, Vaile Hardware Ltd
Susan Wallace	• Tumuaki, Te Runanga o Makaawhio • Member, Te Runanga o Makaawhio • Member, Te Runanga o Ngati Wae Wae • Director, Kati Mahaki ki Makaawhio Ltd • Mother is an employee of West Coast District Health Board • Father member of Hospital Advisory Committee • Father member of Tatau Pounamu • Father employee of West Coast District Health Board • Director, Kōhatu Makaawhio Ltd • appointed member of Canterbury District Health Board • Chair, Rata Te Awhina Trust • Area Representative-Te Waipounamu Maori Womens' Welfare League
Mary Molloy	• Spokesperson for Farmers Against 1080 • Director, Molloy Farms South Westland Ltd • Trustee, L.B. & M.E. Molloy Family Trust • Executive Member, Wildlands Biodiversity Management Group Inc. • Deputy Chair of the West Coast Community Trust
Doug Truman	• Deputy Mayor, Grey District Council • Director Truman Ltd • Owner/Operator Paper Plus, Greymouth

DIRECTORS' AND BOARD MEMBERS' LOANS

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

DIRECTORS' AND BOARD MEMBERS' INSURANCE

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

USE OF BOARD OR SUBSIDIARIES' INFORMATION

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

PAYMENTS IN RESPECT OF TERMINATION OF EMPLOYMENT

During the year, the Board made the following payments to former employees in respect of the termination of their employment with the Board. These payments include amounts required to be paid pursuant to employment contracts in place, for example, amounts for redundancy (based on length of service), and payment in lieu of notice etc.

During the year ended 30 June 2013, 23 (2012: 9) employees received payments relating to the termination of their employment totalling $422,925 (2012: $169,500), excluding retiring gratuities paid out. No Board members received compensation or other benefits in relation to cessation (2012: $nil).

REMUNERATION OF EMPLOYEES

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

	2013 Actual	2012 Actual
100,001 - 109,999	16	18
110,000 - 119,999	10	9
120,000 - 129,999	6	5
130,000 - 139,999	9	6
140,000 - 149,999	1	6
150,000 - 159,999	2	2
160,000 - 169,999	3	2
170,000 - 170,999	1	6
180,000 - 189,999	2	2
190,000 - 199,999	2	-
200,000 - 209,999	1	1
210,000 - 219,999	1	2
220,000 - 229,999	3	-
230,001 - 239,999	1	1
240,000 - 249,999	1	3
250,000 - 259,999	3	-
260,000 - 269,999	3	2
270,000 - 279,999	3	2
280,000 - 289,999	2	3
290,000 - 299,999	-	1
300,000 - 309,999	1	-
310,000 - 319,999	1	-
320,000 - 329,999	2	1
330,000 - 339,999	2	-
340,000 - 349,999	-	1
350,000 - 359,999	-	-
360,000 - 369,000	-	-
370,000 - 379,999	1	-
380,000 - 389,999	-	1
390,000 - 399,999	1	-
400,000 - 409,999	-	1
410,000 - 419,999	-	1
430,000 - 439,999	1	-
460,000 - 469,999	-	1
Total employees	**79**	**77**

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

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

Of the 79 employees shown, 74 are clinical employees (2012: 69) and 5 are non clinical employees (2012: 8).

STATUTORY INFORMATION

This Annual Report outlines the West Coast DHB's financial and non-financial performance for the year ended 30 June 2013. 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

STATEMENT OF RESPONSIBILITY

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

a) The preparation of financial statements and statement of service performance of 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 2013, 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 the West Coast DHB.

Signed on behalf of the Board:

Peter Ballantyne
Acting Chair
31 October 2013

Helen Gillespie
Chair, Quality, Finance, Audit & Risk Committee
31 October 2013

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2013
in thousands of New Zealand dollars

	Note	2013 Actual	2013 Budget	2012 Actual
Income				
Revenue	2	133,744	134,555	132,692
Other operating income	3	798	1,155	1,055
Interest income	6a	291	334	313
Total income		134,833	136,044	134,060
Expenditure				
Employee benefit costs	5a	54,058	56,220	52,769
Other personnel costs	5b	1,630	279	1,266
Depreciation and amortisation expense	8,9	4,156	4,661	4,757
Outsourced services	4a	10,564	10,026	13,097
Clinical supplies		7,369	7,911	7,488
Infrastructure and non-clinical expenses		11,728	10,669	10,496
Payments to other health service providers	4b	46,519	47,037	47,008
Other operating expenses	4c	1,060	1,383	858
Finance costs	6b	650	735	732
Capital charge	7	675	723	613
Total expenditure		138,409	139,644	139,084
Surplus/(deficit)	14	**(3,576)**	**(3,600)**	**(5,024)**
Other comprehensive income				
Gain/(losses) on revaluation of land and buildings	14	-	-	859
Other changes recognised directly in equity (impairment)	14	-	-	(2,600)
Total other comprehensive income/(expense)		-	-	(1,741)
Total comprehensive income		**(3,576)**	**(3,600)**	**(6,765)**

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION

As at 30 June 2013

in thousands of New Zealand dollars

	Note	2013 Actual	2013 Budget	2012 Actual
Assets				
Non-current assets				
Property, plant and equipment	8	28,826	32,474	29,040
Intangible assets	9	1,812	839	943
Other investments	11	-	2	2
Total non-current assets		30,638	33,315	29,985
Current assets				
Inventories	10	1,124	831	1,040
Debtors and other receivables	12	3,968	4,452	4,493
Cash and cash equivalents	13	6,172	5,667	7,398
Patient and restricted funds	21	60	56	58
Non-current assets held for sale	19	136	136	136
Total current assets		11,460	11,142	13,125
Total assets		**42,098**	**44,457**	**43,110**
Liabilities				
Non-current liabilities				
Borrowings	15	12,195	11,945	12,195
Employee entitlements and benefits	16	2,927	3,248	3,062
Total non-current liabilities		15,122	15,193	15,257
Current liabilities				
Borrowings	15	250	250	250
Creditors and other payables	17	8,304	8,531	10,076
Employee entitlements and benefits	16	8,210	8,645	7,273
Patient and restricted trust funds	21	60	56	58
Total current liabilities		16,824	17,482	17,657
Total liabilities		**31,946**	**32,675**	**32,914**
Equity				
Crown equity	14	69,729	69,717	66,197
Revaluations	14	19,569	21,310	19,569
Accumulated surpluses/(deficits)	14	(79,185)	(79,284)	(75,609)
Trust funds	14	39	39	39
Total equity		10,152	11,782	10,196
Total equity and liabilities		**42,098**	**44,457**	**43,110**

For and on behalf of the Board

Peter Ballantyne
Acting Chair
31 October 2013

Helen Gillespie
Chair, Quality, Finance, Audit & Risk Committee
31 October 2013

The accompanying notes form part of these financial statements

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2013
in thousands of New Zealand dollars

	Note	2013 Actual	2013 Budget	2012 Actual
Balance at 1 July		10,196	11,850	12,517
Comprehensive income/(expense)				
Surplus/(deficit) for the year		(3,576)	(3,600)	(5,024)
Other comprehensive income/(expense)		-	-	(1,741)
Total comprehensive income/(expense)		(3,576)	(3,600)	(6,765)
Owner transactions				
Capital contributions from the Crown		3,600	3,600	4,512
Repayment of capital to the Crown		(68)	(68)	(68)
Balance at 30 June	14	**10,152**	**11,782**	**10,196**

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS

For the year ended 30 June 2013
in thousands of New Zealand dollars

	Note	2013 Actual	2013 Budget	2012 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health, patients and other revenue		135,452	135,734	133,962
Cash paid to suppliers		(78,700)	(77,086)	(79,496)
Cash paid to employees		(55,710)	(56,499)	(53,657)
Interest received		229	260	318
Interest paid		(648)	(735)	(735)
Goods and services tax (net)		50	-	30
Capital charge paid		(677)	(723)	(712)
Net cash flow from operating activities	13	(4)	951	(290)
Cash flows from investing activities				
Receipts from sale or maturity of investments		-	-	4,500
Receipts from sale of property, plant and equipment		-	-	2
Purchase of property, plant and equipment		(3,048)	(3,745)	(2,665)
Purchase of intangible assets		(1,706)	(1,405)	(265)
Net cash flow from investing activities		(4,754)	(5,150)	1,572
Cash flows from financing activities				
Capital contributions from the Crown		3,600	3,600	4,512
Repayment of capital to the Crown		(68)	(68)	(68)
Repayment of loans		-	(250)	(250)
Net cash flow from financing activities		3,532	3,282	4,194
Net increase /(decrease) in cash and cash equivalents		(1,226)	(917)	5,476
Cash and cash equivalents at the start of the year		7,398	6,584	1,922
Cash and cash equivalents at the end of year	13	**6,172**	**5,667**	**7,398**

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.

STATEMENT OF COMMITMENTS

As at 30 June 2013

in thousands of New Zealand dollars

	Note	2013 Actual	2012 Actual
Capital commitments		**1,477**	**850**

	2013 Actual	2012 Actual
Non-cancellable commitments – operating lease commitments		
Not more than one year	89	107
One to two years	-	91
Two to three years	-	33
	89	**231**

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

NOTES TO THE FINANCIAL STATEMENTS

For the year 30 June 2013

1 Statement of Accounting Policies

Reporting Entity

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 for the purposes of New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

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 and the Crown Entities Act 2004.

The financial statements for the West Coast District Health Board are for the year ended 30 June 2013, and were approved by the Board on 31 October 2013.

Statement of Compliance

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

Basis of Preparation

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

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

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

Changes in Accounting Policy

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

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

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

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurements. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets and has been completed and has been published in the new financial instrument standard NZ IFRS 9. 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 IFRS 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 is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. 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 surplus or deficit 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 public authority and consequently is exempt from the payment of income tax.

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 initially measured at fair value and subsequently measured by amortised cost using the effective interest rate method.
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 other comprehensive income, which are initially measured at cost.

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

On derecognition the cumulative gain or loss previously recognised in other comprehensive income is recognised in the surplus or deficit. For equity investments classified as fair value through other

comprehensive income, 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 other comprehensive income, 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 surplus or deficit are not reversed through the surplus or deficit.

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.

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

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 22.

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 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.

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 Canterbury DHB.

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

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

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 surplus or deficit, and carrying amount of the asset in the statement of financial position.

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.

2 Revenue

	2013 Actual	2012 Actual
Ministry of Health Crown Funding Agreement	119,148	117,390
Ministry of Health (other)	3,377	3,335
Accident Compensation Corporation	1,786	2,074
Inter district patient inflows and other District Health Boards	1,692	1,993
Patients and consumers	3,112	3,096
Other government entities	113	563
West Coast Primary Health Organisation	4,516	4,241
	133,744	**132,692**

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

	2013 Actual	2012 Actual
Donations received	11	36
Donated equipment	55	46
Rental income	187	206
Gain on disposal of property, plant and equipment	-	2
Other	545	765
	798	**1,055**

4a Outsourced services

	2013 Actual	2012 Actual
Outsourced personnel		
Medical and nursing services	6,187	8,118
Allied health services	10	84
Other services	153	853
Outsourced services		
Clinical services	4,214	4,042
	10,564	**13,097**

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

	2013 Actual	2012 Actual
Personal health and Maori health services	18,598	18,525
Mental health services	2,897	2,753
Public health services	426	390
Disability support services	7,923	7,830
Inter district patient outflows	16,675	17,510
	46,519	**47,008**

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.

4c Other operating expenses

	Note	2013 Actual	2012 Actual
Impairment of debtors	20	(15)	31
Loss on disposal of property, plant and equipment		132	-
Audit fees (for the audit of the financial statements)		105	99
Audit related fees for assurance and related services		82	-
Board and advisory members fees		211	217
Community consultation		-	28
Operating lease expenses	18	122	248
Other		-	65
Restructuring expenses		423	170
		1,060	**858**

5a Employee benefit costs

	2013 Actual	2012 Actual
Wages and salaries	52,086	51,201
Contributions to defined contribution schemes	1,170	1,032
Increase in liability for employee entitlements	802	536
	54,058	**52,769**

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

5b Other personnel costs

	2013 Actual	2012 Actual
Other personnel costs	**1,630**	**1,266**

These are costs incurred in relation to employees which are not paid directly to employees. These include costs of recruiting and training staff and costs of professional registration.

6a Interest income

	2013 Actual	2012 Actual
Interest income	**291**	**313**

6b Finance costs

	2013 Actual	2012 Actual
Interest expense	**650**	**732**

7 Capital charge

	2013 Actual	2012 Actual
Capital charge	**675**	**613**

The West Coast District Health Board pays a capital charge every six months to the Crown. This charge is based on actual closing equity as at the prior 30 June or 31 December. The capital charge rate for the period ended 30 June 2013 was 8% (2012: 8%).

The total capital charge expense for 2013 was $675,436 (2012: $613,585).

8 Property, Plant and Equipment

12/13 financial year	**Freehold land (at valuation) $'000**	**Freehold buildings + fitout (at valuation) $'000**	**Plant, equipment and vehicles $'000**	**Leased assets $'000**	**Work in progress $'000**	**Total $'000**
Cost or valuation						
Balance at 1 July 2012	6,085	14,718	22,498	340	493	44,134
Additions	-	805	1,404	-	2,231	4,440
Disposals/transfers	-	(64)	(1,264)	-	-	(1,328)
Revaluations and impairments	-	-	-	-	-	-
Transfer from non-current assets held for sale	-	-	-	-	-	-
Work in progress allocated	-	-	-	-	(492)	(492)
Balance at 30 June 2013	**6,085**	**15,459**	**22,638**	**340**	**2,232**	**46,754**
Depreciation & impairment losses						
Balance at 1 July 2012	-	(69)	(14,744)	(281)	-	(15,094)
Depreciation charge for the year	-	(1,720)	(2,111)	(5)	-	(3,836)
Transfer to non-current assets held for sale	-	-	-	-	-	-
Disposals	-	(128)	1,130	-	-	1,002
Revaluations	-	-	-	-	-	-
Balance at 30 June 2013	**-**	**(1,917)**	**(15,725)**	**(286)**	-	**(17,928)**

11/12 financial year	Freehold land (at valuation) $'000	Freehold buildings + fitout (at valuation) $'000	Plant, equipment and vehicles $'000	Leased assets $'000	Work in progress $'000	Total $'000
Cost or valuation						
Balance at 1 July 2011	6,395	17,664	21,336	340	590	46,325
Additions	-	384	1,366	-	473	2,223
Disposals/transfers	-	-	(208)	-	-	(208)
Revaluations and impairments	(310)	(3,896)	-	-	-	(4,206)
Transfer from non-current assets held for sale	-	-	-	-	-	-
Work in progress allocated	-	566	4	-	(570)	-
Balance at 30 June 2012	**6,085**	**14,718**	**22,498**	**340**	**493**	**44,134**
Depreciation & impairment losses						
Balance at 1 July 2011	-	(101)	(12,953)	(269)	-	(13,323)
Depreciation charge for the year	-	(2,433)	(1,999)	(12)	-	(4,444)
Transfer to non-current assets held for sale	-	-	-	-	-	-
Disposals	-	-	208	-	-	208
Revaluations	-	2,465	-	-	-	2,465
Balance at 30 June 2012	**-**	**(69)**	**(14,744)**	**(281)**	**-**	**(15,094)**

Carrying amount	Freehold land (at valuation) $'000	Freehold buildings + fitout (at valuation) $'000	Plant, equipment and vehicles $'000	Leased assets $'000	Work in progress $'000	Total $'000
At 1 July 2012	6,085	14,649	7,754	59	493	29,040
At 30 June 2013	**6,085**	**13,542**	**6,913**	**54**	**2,232**	**28,826**

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

Engineering reviews of Grey Base buildings last financial year identified structures which are earthquake prone. For these structures, the West Coast District Health Board has considered whether their carrying value exceeded their recoverable amount. As a result, the District Health Board recognised as at 30 June 2012 a $2.6m asset impairment. As at 30 June 2013, no further impairment was considered necessary.

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.

9 Intangible assets

	Software
Cost	
Balance at 1 July 2011	2,475
Additions	316
Disposals	(147)
Balance at 30 June 2012	**2,644**
Balance at 1 July 2012	2,644
Additions	1,189
Disposals	(72)
Balance at 30 June 2013	**3,761**
Amortisation and impairment losses	
Balance at 1 July 2011	(1,535)
Amortisation charge for the year	(313)
Disposals	147
Balance at 30 June 2012	**(1,701)**
Balance at 1 July 2012	(1,701)
Amortisation charge for the year	(320)
Disposals	72
Balance at 30 June 2013	**(1,949)**
Carrying amounts	
At 30 June 2012	943
At 30 June 2013	1,812

10 Inventories

	2013 Actual	2012 Actual
Pharmaceuticals	115	109
Surgical and medical supplies	927	851
Other supplies	82	80
	1,124	**1,040**

There were no write downs of inventories or reversal of prior years write downs during the year (2012: $0). The amount of inventories recognised as an expense during the year ended 30 June 2013 was $1,392,000: (2012: $1,488,298).

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.

11 Other investments

	2013 Actual	2012 Actual
Non-current		
Equity instrument	-	2
Total investments	**-**	**2**

The West Coast District Health Board has a 4% share in South Island Shared Services Agency Limited (2012: 4%). 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.

12 Debtors and other receivables

	Note	2013 Actual	2012 Actual
Trade receivables	20	935	329
Ministry of Health receivables		1,394	1,719
Other Crown receivables		792	1,445
Accrued revenue		340	657
Prepayments		507	343
	20	**3,968**	**4,493**

Trade receivables are shown net of provision for doubtful debts amounting to $70,959 (2012: $88,160) 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 (2012: $nil) and Other Crown receivables are showing net of provision for doubtful debts amounting to $9,738 (2012: $8,340).

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

13 Cash and cash equivalents

	Note	2013 Actual	2012 Actual
Cash at Bank		129	333
Less unpresented cheques		(832)	(451)
Petty cash and imprest		10	8
Call deposits		6,865	7,508
Cash and cash equivalents in the statement of cash flows	20	**6,172**	**7,398**

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

In December 2012 the West Coast District Health Board received a donation of $56,524 (2012: $31,368) 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 2013 was $29,574 (2012: $30,020), 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.)

Cash and cash equivalents (continued)

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

	2013 Actual	2012 Actual
Deficit for the period	(3,576)	(5,024)
Add back non-cash items:		
Depreciation and amortisation expense	4,156	4,757
Remove non-cash revenue:		
Donated assets	(55)	(46)
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	-	(2)
Movements in working capital:		
(Increase)/decrease in debtors and other receivables	525	(265)
(Increase)/decrease in inventories	(84)	(249)
Increase/(decrease) in creditors and other payables	(1,772)	154
Increase/(decrease) in employee benefits	802	385
Net movement in working capital	(529)	25
Net cash inflow/(outflow) from operating activities	**(4)**	**(290)**

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 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**
Balance at 1 July 2012	66,197	19,569	39	(75,609)	10,196
Surplus/(deficit) for the year	-	-	-	(3,576)	(3,576)
Capital contributions from the Crown	3,600	-	-	-	3,600
Repayment of capital to the Crown	(68)	-	-	-	(68)
Movement in revaluation of land	-	-	-	-	-
Movement in revaluation of buildings, fixtures and fittings	-	-	-	-	-
Movement in revaluation of building, fixtures and fittings due to impairment	-	-	-	-	-
Balance at 30 June 2013	**69,729**	**19,569**	**39**	**(79,185)**	**10,152**

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.

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.

	2013	2012
Trust funds	**Actual**	**Actual**
Balance at beginning of year	39	39
Transfer from retained earnings in respect of:		
Interest received	-	-
Donations and funds received	-	-
Transfer to retained earnings in respect of:		
Funds spent	-	-
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 comprehensive income. 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 loans
The West Coast District Health Board has secured loans with the Ministry of Health (previously Crown Health Financing Agency).

	Note	2013 Actual	2012 Actual
Non-current			
Ministry of Health (previously Crown Health Financing Agency)	20	12,195	12,195
		12,195	**12,195**
Current			
Ministry of Health (previously Crown Health Financing Agency)	20	250	250
		250	**250**

The details of terms and conditions are as follows:

Interest rate summary	Note	2013 Actual	2012 Actual
		%	%
Ministry of Health (previously Crown Health Financing Agency)	20	2.30-6.58	2.30-6.58
Repayable as follows:			
Within one year		250	250
One to two years		3,750	250
Two to three years		3,250	3,750
Three to four years		250	3,250
Four to five years		-	250
Later than five years		4,945	4,695
	20	**12,445**	**12,445**
Total loan facility limits			
Crown Health Financing Agency		12,445	12,445
Overdraft facility (BNZ)		-	6,310
		12,445	**18,755**

Security and terms

The Ministry of Health (previously 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 Ministry of Health'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

	2013 Actual	2012 Actual
Non-current liabilities		
Liability for long-service leave	596	517
Liability for sabbatical leave	76	90
Liability for retirement gratuities	2,255	2,455
	2,927	**3,062**
Current liabilities		
Liability for long-service leave	170	177
Liability for retirement gratuities	523	479
Liability for annual leave	4,008	3,921
Liability for other leave	1,283	1,009
Liability for sick leave	141	134
Liability for continuing medical education/ sabbatical leave	898	306
Salary and wages accrued	1,187	1,247
	8,210	**7,273**

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 31 May 2013.

17 Creditors and other payables

	Note	2013 Actual	2012 Actual
Trade payables		6,429	8,274
ACC levy payable		310	323
GST and PAYE tax payable		1,455	1,072
Income in advance		110	407
	20	**8,304**	**10,076**

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	2013 Actual	2012 Actual
Lease payments made	122	248
	122	**248**

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 2013 $33,497 was recognised as an expense in the surplus or deficit in respect of operating leases for motor vehicles (2012: $99,631). As vehicle leases expired during the year they were not renewed and vehicles were purchased at a cost of $141,000 (2012: $143,395). $89,000 was recognised in respect of the property leased (2012: $148,457).

19 Non-current assets held for sale

The West Coast District Health Board has identified land which it intends to sell and these are shown as assets held for sale. These assets are measured at current book value $136,650 (2012: $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 via a National DHB shared banking arrangement, facilitated by Health Benefits Limited (refer note 25).

Concentrations of credit risk with respect to accounts receivable are high due to the reliance on the Ministry, which comprises 35% (2012: 41%) 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 55% (2012: 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 2013	Impairment 2013	Net 2013	Gross Receivable 2012	Impairment 2012	Net 2012
Due 0-30 days		658	-	658	222		222
Past due 31-60 days		93	-	93	24		24
Past due 61-90 days		42	-	42	139	(80)	59
Past due more 90 days		213	(71)	142	32	(8)	24
Total Gross Receivables	12	**1,006**	**(71)**	**935**	**417**	**(88)**	**329**

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

	Note	2013 Actual	2012 Actual
Balance 1 July		96	65
Receivables written off during the year		155	57
Impairment reversed		(155)	(57)
Additional provision made during the year	4c	(15)	31
Closing balance 30 June		**81**	**96**

Trade receivables are due from patients and external parties to whom the West Coast District Health Board has provided health and disability services and other clinical supplies and services. Receivables due from the Ministry of Health, ACC, Pharmac, Crown entities and other 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 cashflows from a financial instrument will fluctuate, due to changes in market interest rates.

Surplus funds for daily operations are swept into a HBL facility where HBL invest funds until required. The rate of interest for call funds at 30 June 2013 was 2.5% (2012: 3.00%).

The Ministry of Health loans (previously Crown Health Financing Agency loans) are issued at fixed rates of interest. The carrying amounts of borrowings approximate their fair values.

The West Coast District Health Board has cancelled a set-off arrangement with the Bank of New Zealand on its operating accounts. The 2013 rate of interest was 2.97% to $6,310,000, excess at 5.97%. The 2012 credit rate was 2.25%.

Credit quality of financial assets

The table below provides the credit quality of West Coast DHB's financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit rating (if available) or to historical information about counterparty default rates.

Counterparties with credit rating	**2013 Actual**	**2012 Actual**
Cash		
AA-	(693)	7,390
Total Cash at bank	**(693)**	**7,390**

Counterparties without credit rating	**2013 Actual**	**2012 Actual**
Balance with Health Benefits Limited		
Existing counterparty with no defaults in the past	6,865	-
Total balance with Health Benefits Limited	**6,865**	**-**
Debtors and other receivables		
Existing counterparty with no defaults in the past	3,968	4,493
Total debtors and other receivables	**3,968**	**4,493**

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.

		2013 Actual							2012 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	(693)	(693)	-	-	-	-	2.25	(118)	(118)	-	-	-	-
Cash and cash equivalents		2.50	6,865	6,865	-	-	-	-	3.00	7,508	7,508	-	-	-	-
Other investments*	11	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Secured bank loans:															
NZD fixed rate loan*	15	2.31	250	-	250	-	-	-	2.37	250	-	250	-	-	-
NZD fixed rate loan*	15	2.30	250	-	-	250	-	-	2.31	250	-	-	250		-
NZD fixed rate loan*	15	6.58	3,500	-	-	3,500	-	-	6.58	3,500	-	-	-	3,500	-
NZD fixed rate loan*	15	4.75	3,000	-	-	-	3,000	-	4.75	3,000	-	-	-	3,000	
NZD fixed rate loan*	15	2.50	250	-	-	-	250	-	2.50	250	-	-	-	250	-
NZD fixed rate loan*	15	2.69	250	-	-	-	250	-	2.30	250	-	-	-	250	-
NZD fixed rate loan*	15	4.30	250	-	-	-	-	250	2.69	250	-	-	-	250	-
NZD fixed rate loan*	15	5.22	4,695	-	-	-	-	4,695	5.22	4,695	-	-	-	-	4,695
Bank overdrafts (total facility)			-	-	-	-	-	-	2.97	6,310	6,310	-	-	-	-
Bank overdrafts (drawn)		-	-	-	-	-	-	-	-	-	-	-	-	-	-

*These assets/liabilities bear interest at fixed rates.

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 2013. The Board plans to make application for equity (deficit support) based on the approved District Annual Plan for 2013/14 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
2013							
Secured Ministry of Health (previously Crown Health Financing Agency) loans	12,445	12,445	-	250	3,750	3,500	4,945
Creditors and other payables	8,304	8,304	8,304	-	-	-	-
Total	**20,749**	**20,749**	**8,304**	**250**	**3,750**	**3,500**	**4,945**
2012							
Secured Ministry of Health (previously Crown Health Financing Agency) loans	12,445	12,445	250	-	250	7,250	4,695
Creditors and other payables	10,076	10,076	10,076	-	-	-	-
Total	**22,251**	**22,251**	**10,326**	**-**	**250**	**7,250**	**4,695**

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 2013 Actual	Fair value 2013 Actual	Carrying amount 2012 Actual	Fair value 2012 Actual
Equity securities available-for-sale	11	-	-	2	2
Debtors and other receivables	12	3,968	3,968	4,493	4,493
Cash and cash equivalents	13	6,172	6,172	7,398	7,398
		10,140	**10,140**	**11,893**	**11,893**
Secured loans	15	12,445	13,226	12,445	13,619
Creditors and other payables	17	8,304	8,304	10,076	10,076
		20,749	**21,530**	**22,521**	**23,695**
Unrecognised (losses)/gains			**781**		**1,174**

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 surplus or deficit 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

	Note	2013 Actual	2012 Actual
Loans and receivables			
Cash and cash equivalents	13	6,172	7,398
Debtors and other receivables	12	3,968	4,493
		10,140	**11,891**
Financial assets at fair value through other comprehensive income			
Investments-equity instruments	11	-	2
		-	**2**
Financial liabilities			
Creditors and other payables	17	8,304	10,076
Borrowings-secured loans	15	12,445	12,445
		20,749	**22,521**

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.

	2013 Actual	2012 Actual
Opening balance patients deposits	52	50
Monies received	-	1
Interest earned	3	1
Payments made	(1)	-
Closing balance	**54**	**52**

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

	2013 Actual	2012 Actual
Opening balance restricted funds	6	6
Monies received	-	-
Interest earned	-	-
Payments made	-	-
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. 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 (2012: nil).

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, ACC and other government entities of $128.94m to provide health services in the West Coast area for the year ended 30 June 2013 (2012: $127.60m).

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 $1.69m for the year ended 30 June 2013 (2012: $1.99m). 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 $19.56m for the year ended 30 June 2013 (2012: $20.43m).

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 2013 totalled $2.46m (2012: $2.07m). 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

	2013 Actual	2012 Actual
Short-term employee benefits-executive management	945	1,170
Post-employment benefits	25	19
	970	**1,189**

The executive management team consisted of 5 members (2012: 8) employed by the West Coast District Health Board. A further 5 members, including the Chief Executive were employed by Canterbury District Health Board (2012: 4). For the year under review no key management personnel were Board members (2012: 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.

24 Events after balance date

During September 2013, the Government announced approval for a new hospital facility, as well as an Integrated Family Health Centre for the West Coast to be built on the current Grey Hospital site. Design recommendations are expected to be made to the Government early in 2014. The planned completion date is by the end of 2016.

The Government also approved for design work to be prepared for an Integrated Family Health Centre in Westport, which the West Coast DHB will seek private sector partners to develop.

There were no other events after 30 June 2013 which could have a material impact on the information in West Coast DHB's financial statements.

25 Bank Facility

West Coast DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of their provider arm's planned monthly Crown revenue, used in determining working capital limits, and is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For West Coast DHB that equates to $5.25M.

STATEMENT OF REVENUE AND EXPENDITURE BY OUTPUT CLASS

In thousands of New Zealand dollars

This table summarises the revenue and expenditure for the four output classes for the year ending 30 June 2013. 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.

	2013 Actual	2013 Budget
Income		
Prevention	4,388	3,954
Early Detection and Management	34,287	36,198
Intensive Assessment and Treatment	71,331	73,431
Rehabilitation and Support	24,827	22,168
Total Income	**134,833**	**135,751**
Expenditure		
Prevention	4,476	2,711
Early Detection and Management	35,235	37,809
Intensive Assessment and Treatment	73,275	75,071
Rehabilitation and Support	25,423	23,760
Total Expenditure	**138,409**	**139,351**
Surplus/ (Deficit)	**(3,576)**	**(3,600)**

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

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of West Coast District Health Board's financial statements and performance information for the year ended 30 June 2013

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 performance information of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 34 to 65, that comprise the statement of financial position as at 30 June 2013, 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 performance information of the Health Board that comprises the report on outcomes on pages 5 to 15 and the statement of service performance on pages 16 to 25.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 34 to 65:

- comply with generally accepted accounting practice in New Zealand; and

- fairly reflect the Health Board's:

    - financial position as at 30 June 2013; and

    - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information

Reason for our qualified opinion

Some significant performance measures of the Health Board, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 5 to 25:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2013, including for each class of outputs:
    - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2013. 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 performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, 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 performance information 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.

Our audit of the financial statements involved 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; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board's framework for reporting performance;
- the material performance measures, including the national health targets; and

- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

Responsibilities of the Board

The Board is responsible for preparing financial statements and performance information 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 and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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 performance information 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 External Reporting Board.

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