THE WEST COAST HEALTH SYSTEM
– supporting you to be well

WCDHB Annual Report

for the year ended 30 June 2014

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DIRECTORY

Board Members during 2013/14
Dr Paul McCormack, Chair (until 12 June 2014)
Peter Ballantyne, Deputy Chair (Chair from 20 June 2014)
Kevin Brown
Helen Gillespie
Michelle Lomax (from 10 December 2013)
Peter Neame (from 10 December 2013)
Sharon Pugh
Elinor Stratford
Joseph Thomas (from 10 December 2013)
John Vaile
Susan Wallace

Warren Gilbertson (until 9 December 2013)
Mary Molloy (until 9 December 2013)
Doug Truman (until 9 December 2013)

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 2013/14 financial year brought us closer to an integrated and person-centred health system for the West Coast community. In this past year it was pleasing to see tangible results from many of the programmes planned and put in place in the preceding year which are now making a real difference to people's health and wellbeing.

An increased focus on primary care has paid dividends
Over the past year there has been a significant reduction in the average wait times for routine GP appointments on the Coast and this has increased access to primary care for our community.

Average waiting times for a GP visit have dropped from 5.8 days last year to just one day. This has been achieved in the past six months, largely due to efforts to recruit and retain our primary care workforce. This has come about as the result of our efforts in partnership with Better Health, West Coast and Canterbury DHBs. Our focus remains on stabilising the important GP workforce. Better access means people are seen and treated sooner.

More care in the home & fewer people in Aged Residential Care
We've also recorded a significant number of Coasters who are now receiving customised packages of care in their own homes. This is happening throughout the West Coast. The Complex Clinical Care Network (CCCN) assessed 23% more new clients than last year. The CCCN provides needs assessment and service co-ordination for people who have an identified need for support services.

Admissions into aged residential care decreased 11% from last year as more people are being supported to remain well and independent in their own homes. Currently 94% of West Coasters aged 65 and over live in their own homes.

Timely access to acute care and surgical services
West Coast people needing surgery and outpatient services are now waiting one month less than they were last year. Throughout the year under review, there have only been four occasions when patients have waited more than 150 days for a first specialist assessment or surgery.

Health Targets
The West Coast Health System continued to improve its performance on all of the Health Targets.

We continue to lead the country in shorter stays in the emergency department, with more than 99% of patients consistently admitted, discharged or transferred from ED within six hours.

We exceeded our target of 1,592 planned surgical discharges by 103.

In addition, West Coast DHB consistently met the target for shorter waits for cancer treatment and we were pleased to meet the hospital smoking target in Q4.

We remain committed to doing all that we can to improve our performance against the immunisation, primary smoking cessation and heart and diabetes targets.

An integrated system centred on the needs of people
Our goal is to develop a health system that supports people to stay well and independent in their own homes for as long as possible, with timely access to specialist services and hospital care when that's the best option. Due to the geographical challenges on the Coast, transport and technology have been two key areas of focus to support access to care.

- Our use of Telehealth is continuing to improve access for West Coast people, with a 38% increase in the number of patients seen via Telehealth in the past 12 months.
- Three quarters of community pharmacies now work directly with general practice teams inside their practice.
- HealthPathways standardise how best practice care is provided to people on the Coast – regardless of where they enter the health system. There are now 434 localised and live clinical HealthPathways on the Coast leading to consistent management of common conditions.
- Our transalpine partnership with Canterbury DHB evolved over the past year. The range of services and specialists providing treatment and care to Coasters has increased and this is provided in a variety of ways to improve the quality and stability of a wide range of hospital-level services on the Coast.
- The West Coast Health System is working hard to better coordinate the delivery of care to Coasters with long-term complex conditions. This is part of our goal to support people to stay independent in their own homes where appropriate. We are providing more patient-centred packages of care. This reflects the integration across the system from primary services such as general practice and pharmacy, to hospital level services and home support services that make such a difference to people's health and wellbeing.

Progress with planning for our new facilities
Facilities are a critical enabler of health service delivery. With the government's commitment to a new Integrated Family Health Centre for the people of Buller, and the redevelopment of Greymouth Hospital with an adjoining Integrated Family Health Centre we embarked on an extensive staff engagement process.

The new 60 bed Grey Hospital and 40 room Integrated Family Health Centre is the biggest project of its type on the Coast for quite some time and the design is being led by our clinicians.

As we faced some significant seismic issues with our buildings, some buildings were closed with those most at risk decommissioned and in the case of the laundry, demolished. Temporary repairs were carried out to ensure we could continue to deliver services. Our existing facilities are safer for our staff and patients while we wait for new facilities to take shape. A comprehensive upgrade of the electrical systems at Greymouth Hospital, including back up power generation was completed in the past year.

We've continued to transform medical, nursing and allied health workforces on the Coast in preparation for the workforce needed to support different ways of working in Greymouth.

At the cutting edge of health technology innovation
Workforce transformation and technology investment continue to be critical enablers of the changes we are bringing to life. The West Coast DHB continued to invest in integrated clinical information systems that better enable clinicians to deliver coordinated care. A single transalpine clinical information system is up and running, and mental health services are now supported on this platform. Referrals to hospital services are now managed electronically, and a number of other initiatives have been started, including technology to link primary and hospital data systems.

Maori Health
We've continued to work towards equitable health outcomes for Maori. Of note - 97% of Maori estimated to have diabetes have had an annual check in the past year – a 19% increase on last year's performance – this is tangible evidence that we are addressing equity issues.

Best for Breast screening – 93% of eligible Maori women living on the Coast had a breast screen exam this year. This result makes us the best-performing DHB in the country and reflects a 7% increase on last year's figures.

A renewed emphasis on the West Coast Health System Alliance
Underpinning our work to better connect our health system is a significant effort made during the year to reincarnate the West Coast Alliance teams. Working across organisational boundaries, the Alliance delivers whole of system clinical leadership across eight key clinical areas. Alliance workstreams include:

- The Buller Integrated Family Health Service
- Greymouth and Westland Integrated Family Health Services
- Health of older people
- Pharmacy
- Mental health
- Child and youth health
- Public health and health promotion
- Rural health services

We've also established an alliance support group of non-clinical leaders to ensure that the resources of the system are aligned with the clinical-led decisions we're making to deliver agreed outcomes.

Balancing the books
West Coast District Health Board is closer to living within its means, having driven down the deficit from $9.4 million to $1.1 million over the past three years, delivering on our District Annual Plan commitment for the year in review.

Healthy families and environments
Good health starts at home, and we have put a real emphasis on promoting and supporting healthy lifestyles and environments. Reorienting health services with a focus on prevention has seen a 27% increase in the number of people referred to the green prescription programme for healthy lifestyle education during the past year – this exceeded our target by 31%.

The creation of health promoting environments is being achieved by working with the community to ensure health impacts are reflected in all policies. An example of this is working with the community on town development strategies.

Providing life skills classes is helping equip the next generation to live a healthy lifestyle. Smoking cessation services are having a positive impact too, the percentage of 'never smokers' amongst year 10 students more than doubling over the past 10 years.

Our nurses carried out B4 school checks on 90% of 4 year olds – that's a 9% increase on last year.

Engaging the community
Our grass roots strategy involves talking directly with and listening to the community, via presentations to community groups and organisations. This has been an excellent vehicle to give the community first-hand knowledge about projects and programmes, our successes, and to answer the public's questions about our health system. Senior management have been engaging with community leaders on a number of issues.

As the Coast's biggest employer, we have a workforce that has the potential to be great advocates for the excellent work going on at the DHB. We recognise the importance of keeping staff informed,

particularly about the new facilities which will impact the way we deliver care. As well as regular updates for all staff, regular staff forums have been held.

In summary

Much has been achieved to reorient our health system over the past year – we look forward to seeing further progress on facilities and importantly, the new ways of working that will help improve the health and independence of Coasters. Our relationship with Canterbury has strengthened and we are seeing tangible benefits for staff and our patients. We expect this relationship will continue to evolve and mature over the coming year as we develop services and ways of working that are sustainable long-term.

A heartfelt thank you to all our staff who continue to do the best for their community.

Peter Ballantyne
Chair
31 October 2014

Mary Gordon
Acting Chief Executive
31 October 2014

WHAT ARE WE TRYING TO ACHIEVE?

DHBs are responsible for delivering against the national health sector goal: "*All New Zealanders lead longer, healthier and more independent lives*" and for meeting Government commitments to deliver '*better, sooner, more convenient health services*".

However, there is no single measure alone that can demonstrate the impact of the work DHBs do in terms of delivery against the health sector goal. Instead we choose to use a mix of both population health and service access indicators to demonstrate improvements in the health of our population and determine whether we are succeeding in delivering on expectations of Government.

In agreement with the five South Island DHBs, we have identified four lower-level strategic outcome goals (and a set of associated outcome indicators) that will contribute to the delivery of the national goal. These are long-term population health outcomes, influenced by a number of different factors not just the performance of the DHB, as such we are aiming for positive trends and a measurable change over time, rather than achievement of fixed targets.

- OUTCOME 1: PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH.

  A reduction in smoking rates.

  A reduction in obesity rates.
- OUTCOME 2: PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES.

  A reduction in the rate of acute medical admission.

  A reduction in premature ischemic heart disease rates.
- OUTCOME 3: PEOPLE WITH COMPLEX ILLNESS HAVE IMPROVED HEALTH OUTCOMES.

  A reduction in the rate of acute readmissions.

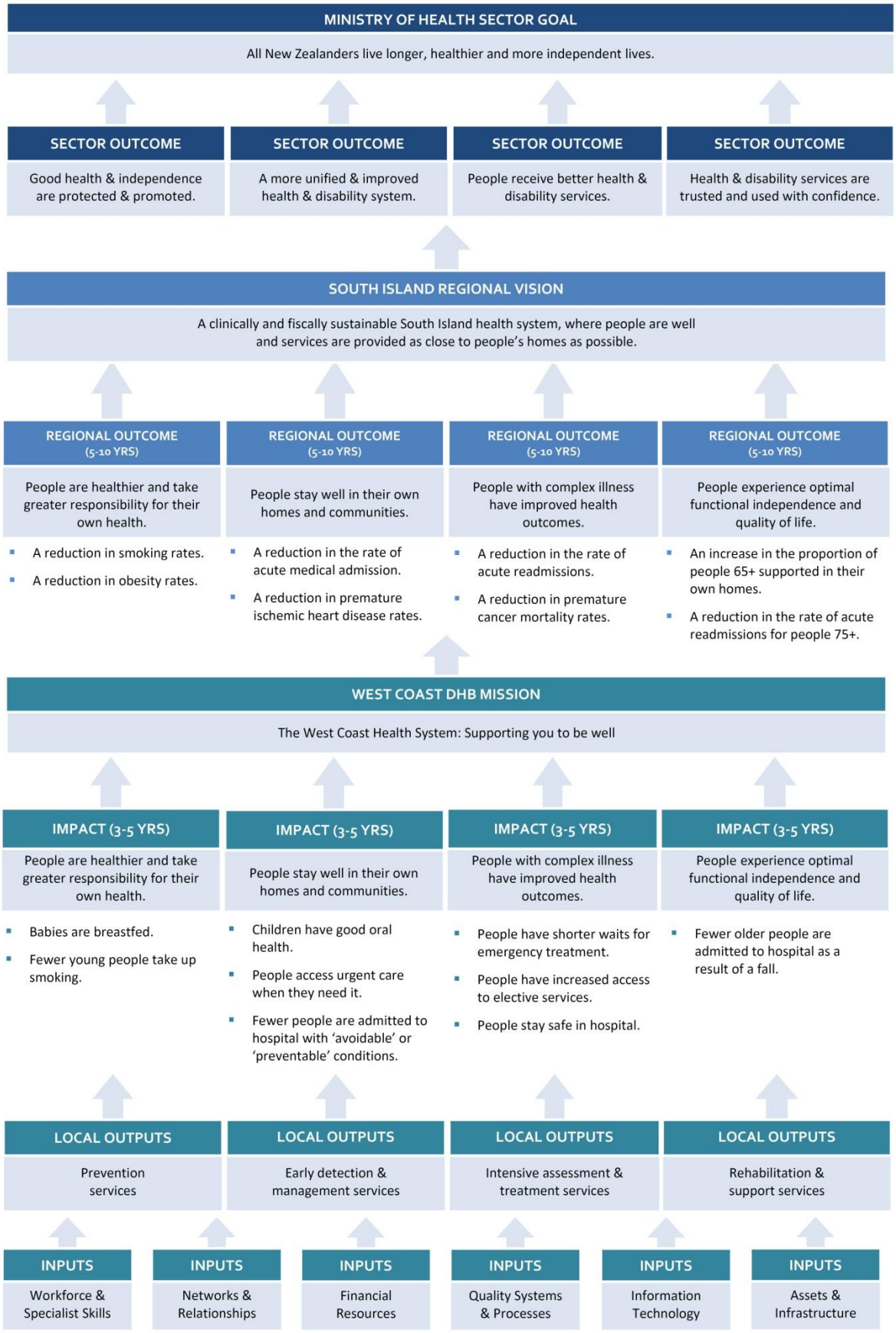
  A reduction in premature cancer mortality rates.
- OUTCOME 4: PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE.

  An increase in the proportion of people over 65 supported in their own homes.

  A reduction in the rate of acute readmissions for people over 75.

Sitting underneath the long-term outcome indicators, we have also identified a second set of measures where individual DHB performance will have a more direct impact on success. Because change will be evident over a shorter period of time these measures have been identified as the 'main measures' of performance and the West Coast DHB has set targets against which to evaluate performance over the next three years.

The following intervention logic diagram visually presents the value chain: or how the services that the DHB chooses to fund or provide will have an impact on the health of the population and result in the achievement of the desired long-term outcomes – improving the health of our population and meeting the expectations of Government.


MINISTRY OF HEALTH SECTOR GOAL
All New Zealanders live longer, healthier and more independent lives.
SECTOR OUTCOME
Good health & independence are protected & promoted.
SECTOR OUTCOME
A more unified & improved health & disability system.
SECTOR OUTCOME
People receive better health & disability services.
SECTOR OUTCOME
Health & disability services are trusted and used with confidence.
SOUTH ISLAND REGIONAL VISION
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 OUTCOME (5-10 YRS)
People are healthier and take greater responsibility for their own health.
A reduction in smoking rates.
A reduction in obesity rates.
REGIONAL OUTCOME (5-10 YRS)
People stay well in their own homes and communities.
A reduction in the rate of acute medical admission.
A reduction in premature ischemic heart disease rates.
REGIONAL OUTCOME (5-10 YRS)
People with complex illness have improved health outcomes.
A reduction in the rate of acute readmissions.
A reduction in premature cancer mortality rates.
REGIONAL OUTCOME (5-10 YRS)
People experience optimal functional independence and quality of life.
An increase in the proportion of people 65+ supported in their own homes.
A reduction in the rate of acute readmissions for people 75+.
WEST COAST DHB MISSION
The West Coast Health System: Supporting you to be well
IMPACT (3-5 YRS)
People are healthier and take greater responsibility for their own health.
Babies are breastfed.
Fewer young people take up smoking.
IMPACT (3-5 YRS)
People stay well in their own homes and communities.
Children have good oral health.
People access urgent care when they need it.
Fewer people are admitted to hospital with 'avoidable' or 'preventable' conditions.
IMPACT (3-5 YRS)
People with complex illness have improved health outcomes.
People have shorter waits for emergency treatment.
People have increased access to elective services.
People stay safe in hospital.
IMPACT (3-5 YRS)
People experience optimal functional independence and quality of life.
Fewer older people are admitted to hospital as a result of a fall.
LOCAL OUTPUTS
Prevention services
LOCAL OUTPUTS
Early detection & management services
LOCAL OUTPUTS
Intensive assessment & treatment services
LOCAL OUTPUTS
Rehabilitation & support services
INPUTS
Workforce & Specialist Skills
INPUTS
Networks & Relationships
INPUTS
Financial Resources
INPUTS
Quality Systems & Processes
INPUTS
Information Technology
INPUTS
Assets & Infrastructure

ARE WE MAKING A DIFFERENCE?

Overall the progress against these indicators suggest that the health status of the West Coast population remains positive with improvements in a number of areas and West Coast results stacking up well against national trends and targets.

These results show that the West Coast population is smoking less, has lower rates of acute admissions to hospital and lower rates of readmission within 28 days of discharge. The West Coast DHB has been consistently the best performing DHB in terms of waiting times in emergency departments (99.7% of people being seen within 6 hours). The DHB has also delivered an additional 103 surgeries above the elective surgery target set by the Ministry of Health – 106% of target.

Alongside these positive results there has been less movement than desired against key indicators for child health. Both breastfeeding and oral health results have dropped back against the previous year and are below national averages. Further focus will be placed on supporting our younger population in the coming year with a cross-sector Child & Youth Health Work Stream now established under the West Coast Alliance.

Outcome 1: People are healthier and take greater responsibility for their own health

Long-term Outcome Measures

A reduction in smoking rates

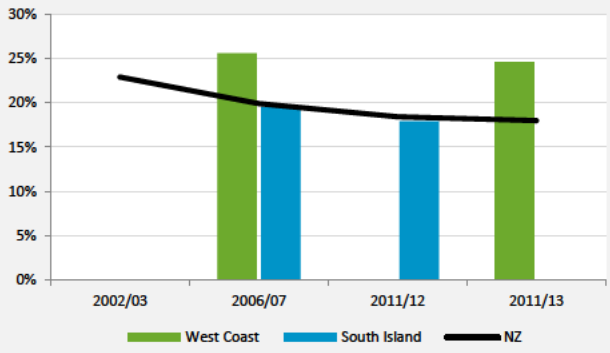
Combined 2011/12 and 2012/13 survey results[1] suggest an encouraging, slight downward trend in smoking rates.

The West Coast health system works to reduce smoking prevalence in two main areas. The first is encouraging young people to be smokefree and not take up smoking in the first place. The second is encouraging current smokers to quit, which we do through our ABC quit initiatives in hospitals and general practice.

Results against indicators in both of these impact areas are looking positive and enrolments in cessation programme are on the rise. We are optimistic about a continued downwards trend in smoking rates.

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

The percentage of the population (15+) who smoke



A reduction in obesity rates

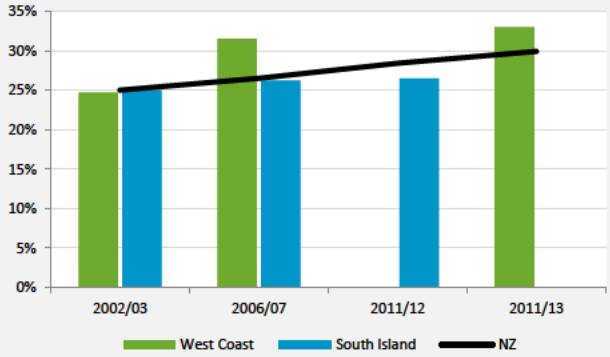
In line with national results, combined survey results for the West Coast in terms of obesity rates are not so encouraging.

However there are a number of programmes in place where uptake and engagement is positive and where we anticipate a continued focused will yield longer-term results.

The West Coast continues to deliver community-based nutrition courses and engage schools in the Health Promoting Schools Programme and the number of people provided with Green Prescriptions (encouraging increased physical activity) is higher than ever before.

Data sourced from the New Zealand Health Survey.[2]

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



[1]The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. However results by region and ethnicity are subject to availability. West Coast-specific results have not been provided for the 2011/12 and 2012/13 years as the sample size was considered too small to be statistically significant – instead results were combined for these two years hence the different time periods presented.

[2] 'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.

Medium-term Impact Measures

More babies are breastfed

West Coast's overall breastfeeding rate has dropped 1% over the past year and while this in itself is not a major change there is an evident downward trend in rates and results are below the national average.

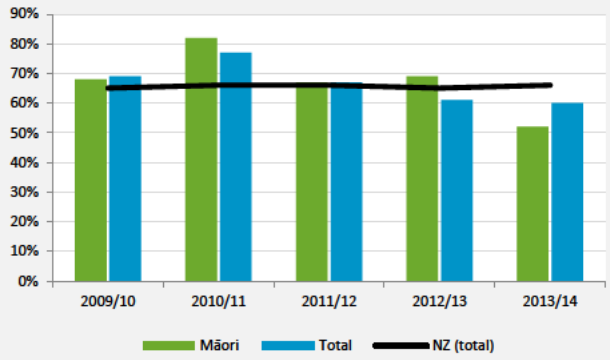
In terms of Māori rates it is important to note that the data presented is for Plunket only and does not include data from Poutini Waiora and DHB's own Well Child/Tamariki Ora service due to data combination issues. However, even allowing for the omitted data, overall trends are not as positive as we would like.[3]

Improving breastfeeding rates will continue to be a focus for the DHB with breastfeeding being a priority area for the cross-sector Healthy West Coast Alliance Work Stream. Initiatives to support and encourage West Coast mothers to breastfeed include breastfeeding ante-natal classes, Mum 4 Mum peer support, breastfeeding education for health professionals and social service agency staff and community-based lactation consultation services for mothers needing additional support.

Data sourced from Plunket.

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

	Actual 13/14	Target 13/14
Māori	52%	≥74%
Total	60%	≥74%



Fewer young people take up tobacco smoking

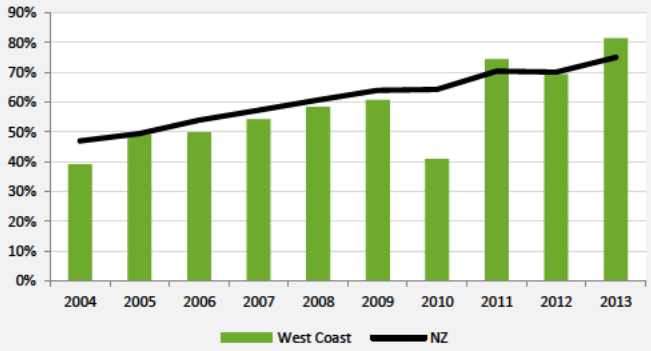
The 2013 ASH Survey found that 82% of Year 10 (age 14) students on the West Coast had never smoked, an encouraging 13% increase in a single year and continuation of a long-term positive trend.

This success reflects the impact of supportive legislation and healthier environments combined with local initiatives such as promotion of the benefits of a smokefree lifestyle, smokefree strategies within schools, training provided to tobacco retailers to limit youth access to tobacco and increased uptake of smoking cessation programmes by adults which helps influence the decisions made by their children.

Data sourced from national Year 10 ASH Survey.[4]

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

Actual 2013	Target 2013
82%	≥75%



[3] *This data differs slightly against previously published results which were available only by calendar year via the Ministry of Health. Data is now sourced directly from Plunket by financial year, to align with the DHB's other measures. The West Coast has two other Well Child providers who operate alongside Plunket encouraging breastfeeding (one who specifically targets Māori and Pacific mothers) however their data is not able to be included in the published results. At this stage Plunket data does not identify individuals and as people can be seen by more than one provider we risk double counting if the data is combined. While this may mean that results for Māori and Pacific babies may be slightly undercounted, Plunket is by far the largest provider and as such their data is used as the base result.*

[4] *The ASH survey is run nationally by Action on Smoking and Health and provides an annual point prevalence data set used by the South Island DHBs to track trends in youth smoking (the survey is reported by calendar year): www.ash.org.nz.*

Outcome 2: People stay well in their own homes and communities

Long-term Outcome Measures

A reduction in premature ischemic heart disease mortality

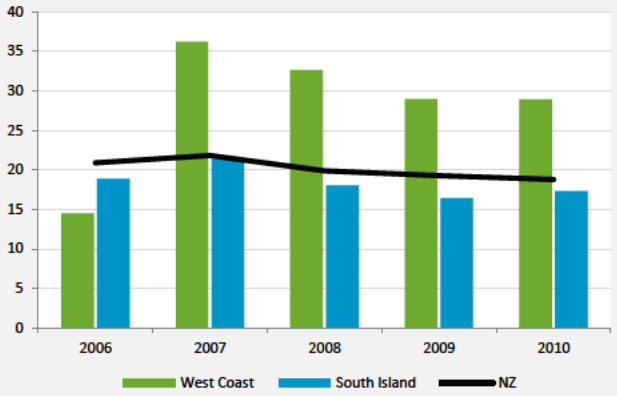
The rate of premature mortality from ischemic heart disease has remained static between 2009 and 2010 at 28.9 per 100,000.

West Coast DHB has a number of initiatives and programmes in place to reduce smoking rates and encourage more physical activity including smoking cessation programmes, Appetite for Life and community nutrition programmes and Green Prescriptions.

The West Coast has also increased the proportion of the eligible population having had cardiovascular risk assessments in the past five year, as part of delivery against the national More Heart and Diabetes Checks health target.

Data sourced from MoH national mortality collection.[5]
This is a new measure introduced in the 2013/14 year.

The rate of death due to ischemic heart disease in people aged under 65 (per 100,000 people)



A reduction in acute medical admissions

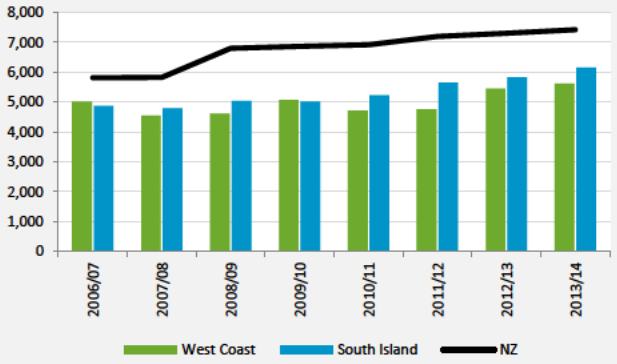
At 5,624 per 100,000 people, West Coast's standardised rate of acute medical admissions remains lower than the South Island rate and significantly lower than the national rate (at 7,426 per 100,000 people).

This positive result reflects the impact of the system-wide approach taken on the West Coast to keep people safe and well in their own homes. Initiatives such as the PHO-led Long-term Conditions Management Programme are embedding primary care as the key point of continuity and supporting people to better manage their own health.

It is also likely to be reflective of reduced waiting times and increased access to planned treatment and surgery which will have had some influence on results in this area.

Data sourced from the National Minimum Data Set.

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



Medium-term Impact Measures

Children have good oral health

Like national results the overall percentage of West Coast 5-year-olds caries-free (no holes or fillings) disappointingly continues to drop. While Māori rates should be interpreted with caution, due to the small numbers, trends here are also disappointing.

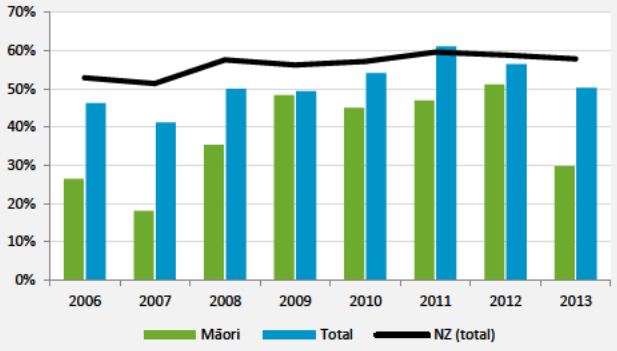
An oral health review has been completed on the West Coast in the past year and recommendations made as part of this review are expected to result in improvements in the oral health status of children on the West Coast over the longer-term.

The percentage of children enrolled with school and community dental services helps to ensure that they receive preventative care and follow-up and un-enrolled children are now being actively targeted.

Data sourced from Ministry of Health.[6]

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

	Actual 2013	Target 2013
Māori	29.8%	61%
Total	50.3%	61%



[5] *Mortality data sets are collected and managed by the Ministry of Health and published by calendar year three years in arrears.*

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

People access urgent care when they need it

The percentage of the population presenting at West Coast Emergency Departments has decreased to 42.3% of the population.

This positive result reflects the impact of local initiatives in helping people to stay well in their own homes by ensuring access to the right services at the right time.

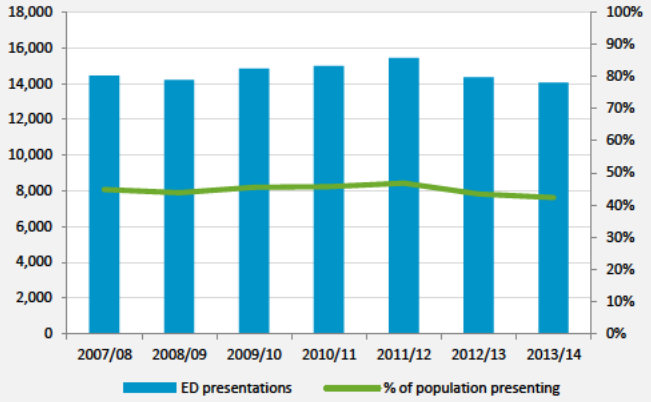
Initiatives such as extended general practice clinics, the availability of afterhours telephone triage and generally reduced waiting times for general practice appointments are all likely to be having influence on results in this area.

The DHB has also invested in the development of the Complex Clinical Care Network providing support for older people in their own homes with a focus on restorative models which will help to reduce acute presentations to our emergency departments.

Data sourced from the DHB and Ministry of Health.[7]

The percentage of the population presenting at ED

Actual 13/14	Target 13/14
42.3%	45%



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

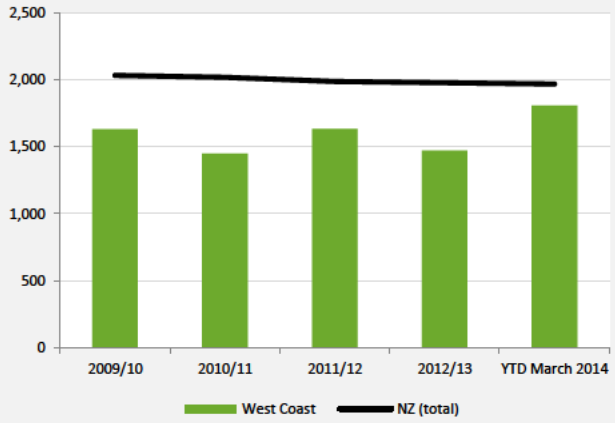
In the year to 31 March 2014, the rate of avoidable hospital admissions on the West Coast was 1,810 per 100,000 – which, while slightly higher than previous years, remains below the national rate of 1,971 per 100,000 people.

Leading causes of avoidable admission include gastroenteritis, dehydration, respiratory infections, pneumonia and angina (or chest pain). A wide range of local initiatives contribute to preventing these unnecessary admissions, including the Long-Term Conditions Management Programme and our restorative home-based support and community-based rehabilitation services.

Data sourced from the Ministry of Health. [8]
This is a new measure introduced in the 2013/14 year.

The rate of avoidable hospital admissions (per 100,000 people aged <75)

	Actual 13/14	Target 13/14
Total	1,810	<1,883



[7] *Presentation data is sourced from the DHB's patient management system (aligned to the national ED Health Target definition) and population figures from the Ministry of Health's national population based funding formula population estimate (December 2013).*

[8] *This measure is based on the national indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The results presented differ to those previous published due to revision of the national definition by the Ministry of Health. The measure is now defined as the standardised rate per 100,000 people and a lower rate of avoidable hospitalisation is better. The target is set to maintain performance at below 95% of the national rate.*

Outcome 3: People with complex illness have improved health outcomes

Long-term Outcome Measures

A reduction in premature cancer mortality

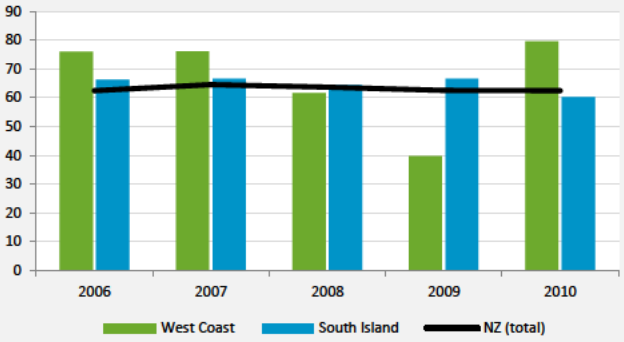
There has been an increase in the rate of premature mortality as a result of cancer between this year and last from 39.8 per 100,000 to 79.5.

While small population numbers mean the results can jump around year on year, the DHB is focused on ensuring cancer is identified and treated early. West Coast consistently meets the Shorter Waits for Cancer Treatment health target, ensuring that 100% of patients ready for radiotherapy or chemotherapy receive treatment within 4 weeks.

The West Coast is also currently implementing the national Faster Cancer Treatment Programme to further reduce the time patients with a high suspicion of cancer wait for assessment and treatment.

Data sourced from Ministry of Health national mortality collection.[9]
This is a new measure introduced in the 2013/14 year.

The rate of deaths due to cancer in people aged under 65 (per 100,000 people)



A reduction in acute readmissions to hospital

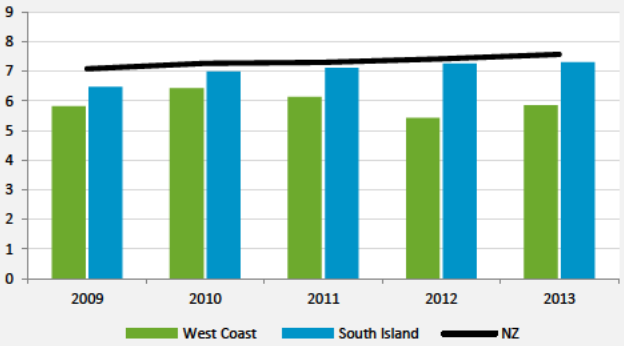
The national definition for this measure was revised in 2013/14. Under the revised definition, West Coast's acute readmission rate was 5.85 a very slight increase on the previous year – however still well below both the South Island and national results.

The West Coast has a number of local initiatives and programmes in place which contribute to this positive result including: supported discharge and rehabilitation services, restorative home based support services and a targeted Long-term Conditions Management Programme.

In the coming year the DHB will implement the national Enhanced Recovery After Surgery (ERAS) Programme designed to optimise surgical outcomes, support recovery and further reduced readmissions.

Data sourced from Ministry of Health.[10]

The rate of acute readmissions to hospital (unstandardised, within 28 days of discharge)



Medium-term Impact Measures

People have shorter waits for treatment

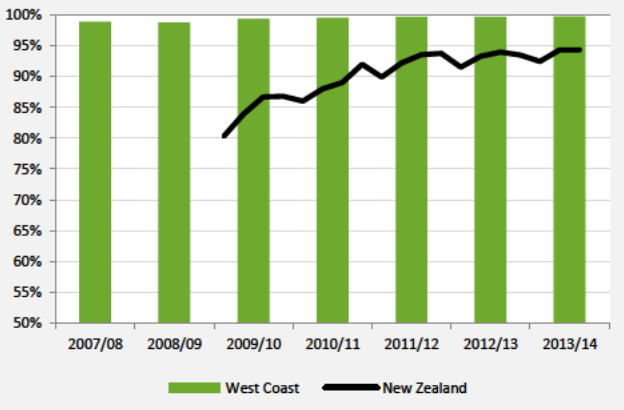
The West Coast has continued to maintain its outstanding performance against the Shorter Stays in Emergency Departments health target. The DHB leads the country with 99.7% of all people presenting to a West Coast DHB Emergency Department (ED) in the past year being either admitted or discharged within six hours.

The West Coast's strong performance reflects the impact of the whole health system working together. General practice and community-based services keep down the load on ED by helping people to stay well and out of hospital while the DHB's ED team works with wider hospital services to ensure timely treatment and admission for those patients who do require urgent hospital care.

Data sourced from the DHB's patient management system.[11]

The percentage of patients presenting in ED who are admitted, discharged or transferred within six hours

Actual 13/14	Target 13/14
99.7%	≥95%



[9] *Mortality data sets are collected and managed by the Ministry of Health and published by calendar year three years in arrears.*

[10] *The results under this measure differ to those previous published due to a revision of the national definition, previous year's results against the revised definition have been provided by the Ministry of Health. The DHB has chosen to present the unstandardised or 'raw' rates as these are easier to replicate and match against admissions internally and therefore enable closer analysis of performance.*

[11] *This measure is based on the national health target 'Shorter stays in Emergency Departments' introduced in 2009/10 and as such includes Grey ED and Buller A&E.*

People have increased access to elective services

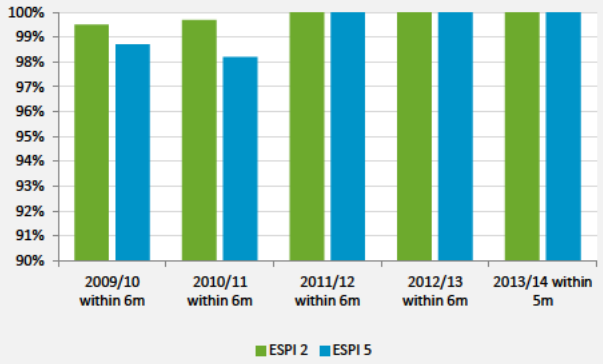
National waiting time targets have been further reduced over the past year with patients now expected to wait no more than five months for assessment or treatment, down from a maximum of six months.

The West Coast has met this challenge and as at the end of June 2014, 100% of West Coast patients waited no more than five months from referral to their first specialist assessment and no more than five months between the commitment to treat and receiving treatment.

Over the coming year further improvements are desired and the DHB will be working to reduce waiting times to a maximum of four months.

Data sourced from Ministry of Health.[12]

	Actual 13/14	Target 13/14
The time people wait from referral to First Specialist Assessment (ESPI 2)	100%	100% < 5m
The time people wait from commitment to treat until treatment (ESPI 5)	100%	100% < 5m



People stay safe in hospital

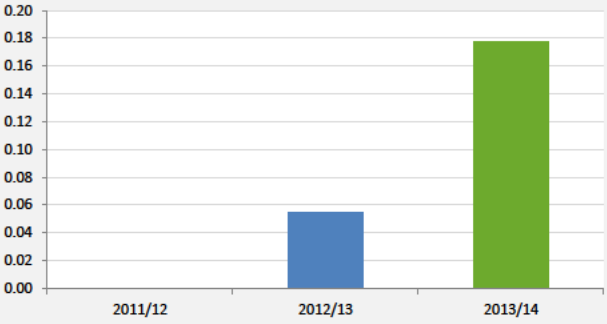
There has been an increase in the number of reported patient falls in the past year with six patient falls that met the Severity Assessment Code (SAC) 1 or 2 - there were two falls in this category in 2012/13.

Over the past two years the DHB has been working on the formalisation of reporting systems across Buller and Reefton hospitals (Grey having been completed in 2011/12). Serious events are now being consistently reported and investigated helping to create an expectation of open disclosure and a culture of learning from errors. The recent increase in falls reported is likely to stem from improved incident reporting rather than an increase in the actual number of falls.

The introduction of a new electronic incident management system in the coming year is expected to further improve reporting and assist in informing future project work to reduce serious events.

Data sourced from internal quality and incident reporting systems.[13]

	Actual 13/14	Target 13/14
The rate of SAC level 1 and 2 falls (per 1,000 inpatient bed days)	0.18	<0.05



[12] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available. Historical data is against a six month target - the target was reduced to five months from January 2014.*

[13] *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. These results differs from that previous published as the measure has been expanded to include SAC 1 & 2 falls for all inpatients, rather than just those aged over 65. The results presented are preliminary and are yet to be finalised - this may result in a change to the rates presented once complete event analysis has been completed.*

Outcome 4: People experience optimal functional independence and quality of life

Long-term Outcome Measures

An increase in the proportion of the population (65+) supported to stay well in their own home

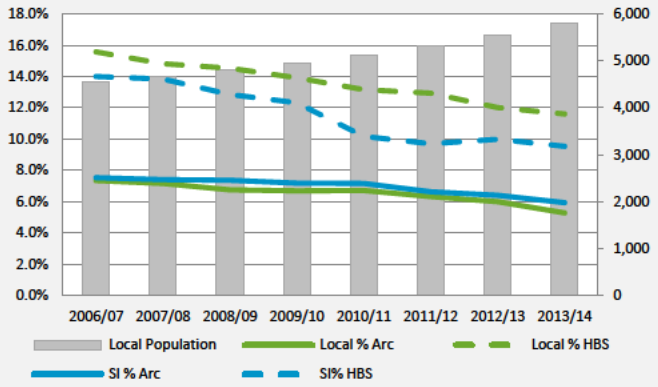
The percentage of the population living in aged residential care continues to drop from a high of 7.3% eight years ago to 5.3% in 2013/14.

This has brought the West Coast rate below that of the South Island and, alongside a higher level of home based support, is consistent with our strategic direction - supporting people to stay safe and well in their own homes.

The work of the Complex Clinical Care Network supports this direction including more restorative home-based rehabilitation and targeted support for people with long-term complex conditions, both of which enable people to live in their own homes for longer.

Data sourced from Client Claims Payments provided by SIAPO.[14]

The percentage of the older population (65+) living in aged residential care compared against those receiving home-based support services



A reduction in acute readmissions to hospital (people 75+)

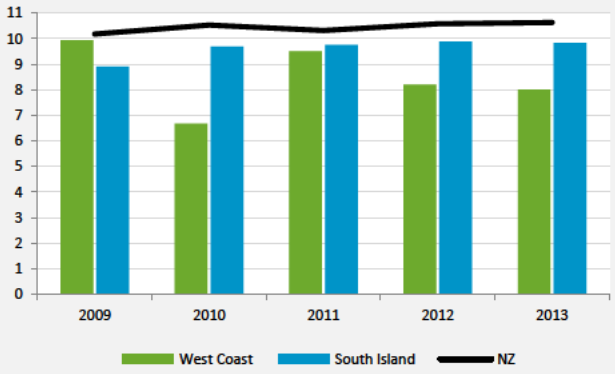
Under the new national definition, West Coast's acute readmission rate was 8.01 – lower than the South Island rate and the national average.

The West Coast is implementing a number of new local initiatives and programmes to reduce readmission rates for older people, largely driven through the Complex Clinical Care Network.

A key focus for the coming year is implementation of First Level Options for Community Care (FLOCC) - a community-based rapid response and supported discharge service. This initiative will facilitate earlier hospital discharge by linking people into appropriate home-based rehabilitation supported by district nursing and primary care. FLOCC aims to better support older people at home and promote recovery in a community setting. It is anticipated that readmission rates will remain low.

Data sourced from Ministry of Health.

The rate of acute readmissions to hospital for people aged 75+ (unstandardised, within 28 days of discharge)



Medium-term Impact Measures

Fewer older people are admitted to hospital as a result of a fall

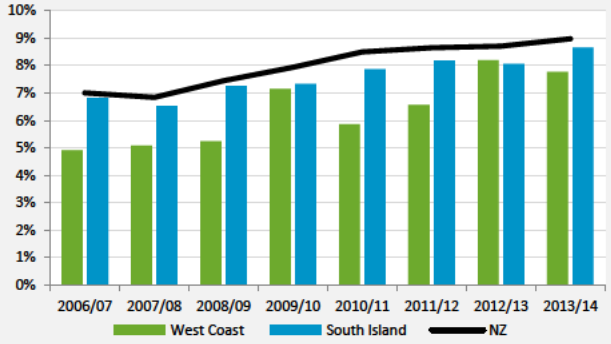
The percentage of the West Coast population (aged 75+) admitted to hospital as a result of a fall is lower than the previous year and remains below the South Island rate and the national average.

The West Coast Falls Prevention Coalition continues to provide leadership in terms of the implementation of strategies to reduce harm from falls. In the coming year a new community-based Falls Prevention Programme and Fracture Liaison Service will be established, based on successful models implemented by other DHBs. These initiatives will help to support people to better manage their own health and in doing so will improve long-term health outcomes for our older population.

Data sourced from the National Minimum Data Set.

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

Actual 13/14	Target 13/14
7.8%	6%



[14] *Results for 2012/13 differ slightly from those previously published due to the addition of late claims from ARC and home based support providers.*

STATEMENT OF SERVICE PERFORMANCE 2013/14

Measuring our Non-financial Performance

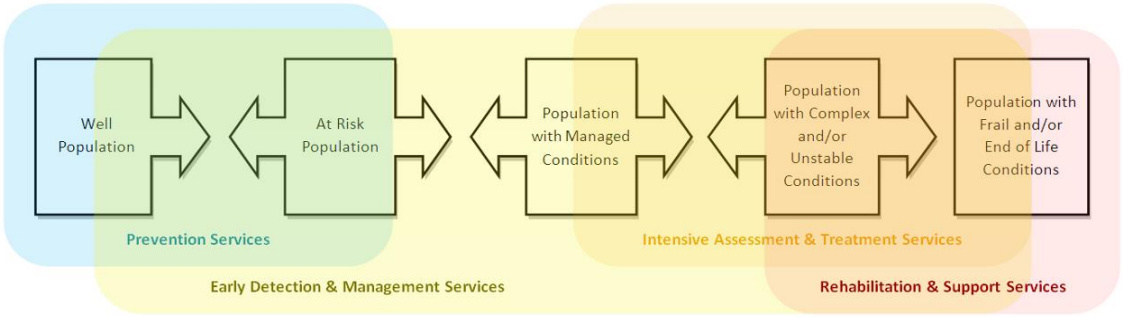
As part of evaluating our performance, we provide an annual forecast of the services we plan to fund and provide (and to what standard) and report actual delivery against that forecast at the end of each year. The following section presents the West Coast's actual performance against the forecast service performance expectations presented in our Statement of Intent for 2013-2016.

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 measure more than simply service outputs or 'volumes'. Often the number of services delivered or the number of people who receive a service is 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, Coverage, Timeliness and Quality. Together, these measures demonstrate how well we are contributing to the longer-term health outcomes we seek to achieve for our population.

The service outputs that we measure are grouped into four 'output classes' that are a logical fit with the continuum of care: Preventative 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



2013/14 Performance Overview

Our performance results for 2013/14 are beginning to indicate the impact of the new models of care being implemented across the West Coast health system. While we have not met every target, we have improved access and reduced waiting times in many areas. It is positive to see the continued uptake of programmes focused on supporting healthier environments and lifestyles and the growing focus on primary care as the point of continuity to support people closer to their own homes.

In terms of delivery against the national health targets, West Coast has achieved four of the seven targets, delivering on elective surgery, cancer and hospital smoking targets and once again leading the country in delivery of the ED waiting time target.

Results are also beginning to suggest a return on the development of the Complex Clinical Care Network (CCCN) with increasing numbers of older people being supported in their own homes and communities, fewer acute presentations to our hospitals and readmission rates remaining low. The close collaboration between home-based support, district nursing and general practice services, facilitated by the CCCN, is expected to demonstrated clear improvements in the health of our older population over the next few years.

The results we have achieved over the past year reflect the commitment of individuals and teams from right across the West Coast health system and the development of clinical networks and transalpine

pathways with the Canterbury DHB. We are grateful for the support and commitment of all of the people involved in the delivery of healthcare to our population.

Notes on the Data

This Annual Report incorporates a large number of measures to reflect the scope and volume of the services funded or delivered by the West Coast DHB. In interpreting the data the following should be noted:

- Access to a significant proportion of the public health services we deliver (such as emergency care, maternity services or palliative care) is unrestricted or 'demand-driven'. For such services, we cannot set targets. Instead estimated demand volumes are included to give the reader a more rounded picture of where and how funding and resource is being used across our health system. These are not service targets but simply a forecast of expected demand, indicated by the abbreviation '**est.**'
- 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.
- Some data is collected on calendar, rather than financial, years and again rather than footnote every instance: **†** indicates data where this is the case. The 2012-13 result relates to the 2012 calendar year and the 2013-14 result reflects the 2013 year.
- The DHB regularly reviews the mix of performance measures used in an attempt to ensure the measures accurately represent where resource and effort is being directed and provide a fair picture of the DHB's performance. For the 2013/14 year a significant number of new measures were introduced to better reflect the new models of care being implemented on the West Coast, and to align nationally with measures being used by other DHBs in order to allow some comparison and context. The ⅄ symbol indicated new measures introduced for the 2013/14 year.
- In a number of cases the small population numbers on the West Coast have a disproportionate effect on the results presented in this report, particularly for sub-sets of the population. Results by age-bands and ethnicity should be interpreted with caution.
- In terms of the national health targets both full year and final quarter results are presented. While the aim of the national targets is to achieve an expected standard by the end of the year, performance for some of the targets can differ significantly quarter on quarter (particularly due to small population numbers as indicated above). The result across the full year is provided to give greater context to the results.
- To assist in providing addition context to the performance results national averages are provided wherever possible. Unless otherwise stated the latest national results have been sourced from the Ministry of Health.
- Any other irregularities have been footnoted.

OUTPUT CLASS

Preventative Health Services

Preventative health services promote and protect the health of the whole population by improving physical and social environments and supporting people to make healthier choices - reducing some of the major risk factors that contribute to long-term conditions. These services include education programmes to raise awareness of risk behaviours, legislation and policy to protect people from environmental risks and health protection and prevention services such as immunisation and lifestyle programmes that support people to modify their lifestyles and maintain good health.

High-needs and at-risk population groups are more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Preventative health services are therefore our foremost opportunity to target improvements in the health of these populations and to reduce inequalities in health status and outcomes. Success is defined by positive changes in behaviours and high coverage levels, which signal engagement in programmes, the effectiveness of positive health messaging and the quality of the support and advice being provided.

Increased focus is being placed on creating healthier environments and encouraging healthier lifestyles as part of the West Coast's new model of care and it is pleasing to note increased uptake and access to a number of programmes in this area include a significant increase in the number of green prescriptions and 100% of priority schools continuing to engage in the Health Prompting School Programme. The DHB reached the Better Help for Smokers to Quit health target in its hospitals and while we are yet to achieve this in primary care, results have increased 23% in the past two years—a positive effort.

The West Coast has also made some key inroads into safeguarding the health of our more vulnerable population groups. The national target for the delivery of B4 Schools Checks was met with a 9% increase on last year's results. While the national immunisation target was not reached, more eight month olds were fully immunised that in the previous year, more young girls completed their HPV vaccinations and more older people received their flu vaccinations.

Output measures

Health Promotion and Education Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Volunteer mothers trained to provide Mum4Mum breastfeeding support	V [15]	18	15	13	≥17	-
Lactation support & specialist advice consults provided the community	V	103	149	117	≥100	-
% of mothers having established breastfeeding on hospital discharge	Q [16]	91%	92%	90%	≥85%	-
% of smokers identified in primary care receiving advice and help to quit	C	39%	55%	62%	90%	86%
% of smokers identified in hospital receiving advice and help to quit						
Quarter 4 results	C	90%	95%	95%	95%	96%
Full year results		84%	91%	92%		-
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	126	124	129	≥100	-
Nutrition courses provided in the community	V	11	6	7	≥5	-
People accessing Green Prescriptions for additional physical activity support	V [17]	389	374	474	≥360	-
% of priority schools supported by the Health Promoting School Framework	C↗ [18]	66%	100%	100%	66%	-

[15] *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 who provide peer support to other mothers.*

[16] *The percentage 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. This figure shows the percentage of babies being both exclusively and fully breastfed. Babies fully breastfed may have also consumed some medicine or water.*

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

[18] *The Health Promoting Schools Framework is used to address health issues with an approach based on activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated and/or have a high proportion of Māori and/or pacific children.*

Population-Based Screening Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of four-year-olds provided with a B4 School Check (B4SC)	C [19]	80%	81%	90%	≥90%	91%
% of referred children receiving a Gateway Assessment	C ⅄ [20]	new	56%	55%	100%	-
% of Year 9 students in decile 1-3 schools, alternative education facilities and teen parent units provided with a HEEADSSS assessment	C † [21]	50%	55%	56%	≥50%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [22]	75%	78%	79%	80%	77%
% of women 45-69 having a breast cancer screen in the last 2 years	C [22]	79%	81%	80%	≥70%	73%

Immunisation Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of children fully immunised at age eight months *Quarter 4 results*	C [23]	new	93%	81%	90%	92%
Full year results			84%	85%		-
% of eight-month-olds 'reached' by immunisation services	Q ⅄ [24]	new	97%	96%	90%	-
% of Year 8 girls completing HPV vaccinations (Dose 3)	C † [25]	30%	44%	54%	60%	53%
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	58%	55%	63%	75%	69%
% of older people (65+) deemed 'high needs' receiving a free flu vaccination	C † [26]	61%	56%	63%	75%	68%

[19] The B4 School Check is the final core Well Child/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.

[20] Gateway Assessments aim to ensure every child or young person entering Child, Youth & Family care receives an assessment that helps build a comprehensive picture of the child or young person's needs and ensures referral to services that address those needs. Whilst this result looks low, it relates to 13 children still waiting to be assessed. An additional nurse has now been employed to address the backlog of assessments.

[21] 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 - 3 secondary schools, students attending teen parent units; and students attending alternative education facilities.

[22] National screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce associated mortality. Targets are set nationally and data is provided by Breast Screening New Zealand and the National Screening Unit.

[23] West Coast has a unique population with a large number of children born into a community that chooses to opt off the national immunisation register and not vaccinate. This choice has a significant impact on the West Coast's performance results against the immunisation health target and makes achieving the target incredibly challenging. For example: in the final quarter of this year 81% of eight month old children were fully immunised, 3.1% of parents declined and 15.3% opted out only one child was actually missed and they have subsequently been immunised.

[24] 'Reached' is defined as those children fully immunised, as well as those who have declined immunisations or have opted off the NIR. Because the West Coast has a high number of opt-off and declines tracking children 'reached' provides a clearer indication of service quality.

[25] The Human Papillomavirus (HPV) Immunisation Programme aims to protect young women from HPV infection and the risk of developing cervical cancer later in life. Currently, around 150 women are diagnosed with cervical cancer and 50 women die from it each year in New Zealand. The baseline for the measure is the percentage of girls born in 1998 receiving Dose 3 by the end of 2011, and the 2013/14 result is the percentage of girls born in 2000 receiving Dose 3 by the end of 2013.

[26] The 'high needs' population is defined as PHO enrolees who are Maori, Pacific and/or NZDep decile 9 or 10.

OUTPUT CLASS

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 are able to support 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 particularly important, as it allows early intervention and treatment to occur without the need for a hospital appointment. This helps reduce long waits for assessment as well as reducing avoidable hospital admissions and unnecessary specialist referrals.

Success is evident in terms of continued access to the Long-Term Conditions Management Programme in primary care and increased access to brief intervention counselling. The DHB is also pleased to note the continued development of agreed referral pathways between primary and secondary care which are helping to streamline referrals and improve the quality of care.

Output measures

Primary Health Care (GP) Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of the DHB population enrolled with the a Primary Health Organisation	C	95%	94%	92%	≥95%	96%
HealthPathways in place for West Coast residents	V ⅄ [27]	new	308	434	400	-
People provided Brief Intervention Counselling (BIC) in primary care settings	V Δ [28]	346	360	393	≥300	-
Avoidable hospitalisation for children aged 0-4 (rate per 10,000)	Q [29]	4,432	3,704	5,135	<5,359	4,522

Oral Health Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of children aged under 5 enrolled in DHB-funded oral health services	C † [30]	91%	85%	75%	≥77%	73%
% of enrolled children (0-12) examined according to planned recall	T †	99%	72%	78%	≥90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C †	81%	77%	72%	≥75%	70%

Long-term Conditions Programmes	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of the eligible population having a CVD risk assessment in the last five years	C	57%	58%	77%	≥90%	84%
% of people with diagnosed diabetes who have had an annual check	C [31]	77%	70%	99%	≥70%	-
% of people who have satisfactory or better diabetes management (HbA1c ≤ 64mmol/mol) at their annual diabetes check	Q	76%	78%	78%	80%	-

[27] The HealthPathways website helps general practice better manage their patients by using clinically designed patient pathways that provide up-to-date information on referrals, conditions management, specialist advice, diagnostic tools and patient resources. Results are as at June 2014.

[28] Brief intervention counselling provides people with mild to moderate mental health concerns free 'early' psychological intervention from their general practice team, with the possibility of onward referral to a related community agency if appropriate. The aim is to provide help and intervention early and reduce the likelihood of people developing enduring conditions or needing acute care. Data is sourced directly from the PHO and 2011/12 and 2012/13 results differ slightly to those previously published (350 & 357) due to alignment of invoicing dates between the two years.

[29] Some hospital admissions are seen as preventable through early intervention and this measure is used as a proxy indicator of the availability and effectiveness of primary care and quality of the interface between primary and secondary services. The measure is based on the national DHB performance indicator SI1 and results differ from those previously published as the measure was revised nationally in 2013. Previous year's results were provided by the Ministry of Health – the rates is standardised and per 100,000 people.

[30] Oral health results relate to the school or calendar year and the 2011/12 result differs slightly from that previously published due to alignment between the 2011 and 2012 calendar year and correction of population estimates. The West Coast DHB has struggled to fill a long-term dental therapist vacancy in its school and community dental service which has had a significant impact on these results. A review of Oral Health Services has been completed and recommendations are expected to result in improved outcomes with clearing the backlog of examinations a key focus for the coming year.

[31] Diabetes results have been calculated using the PHO delivery numbers and the Ministry's 2013 Virtual Diabetes Register population estimates.

Pharmacy Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Pharmaceutical items dispensed in the community	V⅄Δ	588K	480k	445k	Est. <600k	-

Referred Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Laboratory tests completed for the West Coast population	V⅄Δ[32]	149k	NA	NA	Est. <150k	-
Number of community referred radiological tests to Grey Hospital	V	5,807	5,721	5,590	Est. >5k	
% of people receiving their CT Scan within 6 weeks	T⅄[33]	new	100%	100%	85%	80%

[32] *Laboratory test results are now completed by Canterbury Health Laboratories on behalf of the West Coast DHB. New reporting processes are under development and the number of test completed has not been tracked as anticipated and hence this data is not available*

[33] *Diagnostic tests are an important aid in clinical decision making and reducing the waiting time for diagnostics is a national expectation. A Computerised Tomography (CT) Scan is an x-ray procedure that combines many x-ray images with the aid of a computer to generate cross-sectional and three-dimensional images of the internal organs and structures of the body. This measure is based on the national diagnostics measure (DV2) and results are as at June 2014 in line with national reporting.*

OUTPUT CLASS

Intensive Assessment and Treatment Services

Intensive assessment and treatment services are more complex services provided by specialist healthcare professionals. These services are typically (but not always) provided in hospital settings which enable the co-location of clinical expertise and specialist equipment. A proportion of these services are demand driven, such as emergency (acute) and maternity services. However, others are planned (elective) services where access is determined by capacity, clinical need and treatment thresholds.

Timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or corrective action. Success can therefore be defined by increased access to planned services and shorter waits for treatment. As a provider of services, we also 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.

While not all targets have been met, access has been maintained or improved in almost all areas. Despite an increase in the number of people accessing services waiting times have dropped. Fewer people are presenting in our emergency departments and more people are getting access to first specialist assessments, elective surgery, mental health services and assessment, treatment and rehabilitation (AT&R) services.

The number of patient falls in our hospitals has increased, however this is seen as a positive indicator with serious events now being consistently reported and investigated which is helping to create an expectation of open disclosure and a culture of learning from errors. The increase is likely to be related to an increase in falls reported, rather than an increase in the actual number of events.

Output measures

Specialist Mental Health Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of young people (0-19) accessing specialist mental health services	C Δ [34]	5.5%	6.1%	6.1%	≥3.8%	3.4%
% of adults (20-64) accessing specialist mental health services	C Δ	4.7%	4.9%	5.4%	≥3.8%	3.8%
% of people referred for non-urgent MH and AOD services seen < 3 weeks	T ⅄ [35]	65%	72%	76%	80%	79%
% of people referred for non-urgent MH and AOD services seen < 8 weeks	T ⅄	84%	91%	93%	95%	93%
% of long-term clients aged 0-19 with current relapse prevention plans	Q ⅄ [36]	100%	100%	100%	≥95%	-
% of long-term clients aged 20-64 with current relapse prevention plans	Q	54%	100%	88%	95%	-

[34] *These access measures are based on the national DHB performance measure (PP6) and the national expectation is that around 3% of the total population will need to access specialist mental health services. Results are provided three months in arrears and are for the year to 31 March.*

[35] *These wait time measures are based on the national DHB performance measure (PP8). Results are three months in arrears and are for the year to 31 March. Results for 2011/12 differ slightly to those published reflecting alignment with national definitions and timeframes.*

[36] *These relapse plan measures are based on the national DHB performance measure (PP7). Relapse prevention planning helps to minimise the impact of mental illness, improving outcomes for clients by ensuring they have an up-to-date treatment plans identifying early warning signs and actions to take.*

Acute/Urgent Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of children under six with access to free primary care after hours	C⅄	new	100%	100%	100%	-
% of general practices using telephone triage outside business hours	C [37]	100%	100%	100%	100%	-
Attendances at West Coast Emergency Departments (EDs)	V [38]	15,394	14,359	14,051	≤14,875	
% of people presenting in ED (Triage 1-3) seen within clinical guidelines	Q [39]	88%	87%	87%	≥85%	
% of people ready for treatment waiting less than 4 weeks for radiotherapy or chemotherapy						
Quarter 4 results	T	100%	100%	100%	100%	100%
Full year results		100%	100%	100%		-
Standardised acute inpatient average length of hospital stay	Q⅄ [40]	new	3.27	3.06	≤4.02	3.94

Elective Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Medical & Surgical First Specialist Assessments (FSAs) provided (incl. virtual)	V	7,302	6,724	6,864	Est. >6,500	-
% of Medical and Surgical FSAs that are non-contact (virtual)	Q⅄ [41]	3.9%	5%	4.2%	≥3.9%	-
Elective surgical discharges (surgeries provided)	V [42]	1,751	1,686	1,695	1,592	-
% of elective/arranged surgeries provided as day cases	Q⅄ [43]	54%	56%	55%	≥54%	56%
% of people who receive their surgery on the day of admission	Q⅄ [43]	77%	88%	93%	≥77%	81%
Standardised elective surgical inpatient average length of hospital stay	Q⅄ [40]	new	3.30	3.14	≤3.16	3.27
Medical and Surgical outpatient 'Did Not Attend' rates	Q	8.7%	8.2%	7.7%	≤ 6%	-

Maternity Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Maternity deliveries in DHB facilities	V	293	325	279	Est. 300	-
Baby friendly hospital accreditation of DHB facilities	Q⅄ [44]	YES	YES	NA	YES	-
% of total deliveries made in Primary Birthing Units	V [45]	5.5%	5.5%	3%	7%	-

[37] All eight West Coast general practices use systems that direct patients to either a telephone triage or on-call nursing services after hours.

[38] This measure is based counts attendances at Grey and Buller Emergency Departments and at the Reefton Accident and Emergency Centre.

[39] Triage time clinical guidelines are: Triage 1 seen immediately on presentation; Triage 2 seen within 10 minutes; Triage 3 seen within 30 minutes.

[40] These measures are based on the national DHB performance measure (OS8). Results are provided three months in arrears for the year to 31 March. Length of stay measures are balanced against readmission rates to ensure services quality is appropriate.

[41] Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity, reducing wait times for patients and taking duplication and waste out of the system.

[42] This measure is based on the national elective services health target definition and therefore excludes elective cardiology and dental volumes.

[43] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own homes, and frees up hospital beds. Day case and day of surgery admission rates are balanced against readmission rates to ensure service quality is appropriate. These measures are based on DHB performance measures (OS6 & OS7) which are no longer produced nationally. Results are now being calculated internally based on the same definition, however results may differ slightly to those previous published.

[44] The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to deliver a high standard of care and implement best practice in relation to infant feeding for pregnant women and mothers and babies. An assessment and accreditation process recognises those that have achieved the required standard. This process was still in progress at time of publishing.

[45] The drop in the use of primary birthing units in the past year results from changes in primary birthing services in the Buller region following a clinically-led review of maternity services.

Assessment, Treatment and Rehabilitation Services (AT&R)	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Admissions into inpatient AT&R services	V⅄	151	125	131	Est. >150	-
Number of outpatient and domiciliary AT&R attendances	V	1,712	1,601	2,060	Est. >1,700	-
% of AT&R inpatients discharged to their own home rather than ARC	Q⅄Δ[46]	91%	90%	89%	≥55%	-

Quality and Patient Safety Measures	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Rate of all patient falls resulting in harm—per 1,000 inpatient bed days	Q⅄[47]	1.82	3.65	4.39	≤1.0	-
Rate of correctly performed hand hygiene 'moments'	Q⅄[48]	47%	69%	73%	70%	-

[46] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, when people receive adequate support remaining in their own homes provides a higher quality of life as a result of staying active and positively connected to their communities. Therefore, a discharge from AT&R to home (rather than into ARC) reflects the quality of AT&R and community support services in terms of assisting that person to regain their functional independence. This measure is meant to exclude those people who were ARC residents prior to AT&R admission—the 2011/12 baseline differs to that published in the 2012/13 Annual Plan where recent data runs found these people has been incorrectly included in counts.

[47] 'All patient falls resulting in harm' includes falls resulting in very minor harm, e.g. bruising. 2011/12 results differ from that previously reported due to an adjustment following an incident review.

[48] This measure is based on ward audits of the medical and surgical wards conducted according to Hand Hygiene NZ standards. Baseline 2011/12 data was collected from internal databases and subsequent years directly from Hand Hygiene NZ.

OUTPUT CLASS

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 and a reduction in illness that leads to acute admission or readmission.

While it is early in the implementation of the new model of care and Complex Clinical Care Network, the increased focus on community-based care appears to be having the desired effect, with an increase in the number of older people being supported to stay well in their own homes and fewer people requiring long-term support. Access to rehabilitation service is up on the previous year and the increased use of evidence-based and evidence-informed assessment tools such as InterRAI provide greater assurance that the right services are being provided to the right people.

Output measures

Needs Assessment and Service Coordination	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Older people (65+) provided with a clinical assessment of need using InterRAI	V ⅄ Δ [49]	473	409	314	Est. >470	-
% of older people (65+) receiving long-term home and community support who have had a comprehensive clinical assessment using InterRAI	Q Δ[50]	79%	83%	94%	95%	-
% of people entering ARC having had a clinical assessment of need using InterRAI	Q ⅄ Δ	91%	99%	97%	95%	-

Palliative Care Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
ARC facilities trained to provide the Liverpool Care Pathway option to residents	C [51]	2	3	5	4	-
People in ARC services being supported by the Liverpool Care Pathway	V	18	31	12	30	-

[49] These needs assessment measures have been refocused to reflect the use of the InterRAI Assessment Tool only, rather than a variety of assessment tools and methods. InterRAI is an evidence-based geriatric assessment tool and the use of this one tool across all services ensures assessments are both high quality and consistent and helps to ensure people receive equitable access to care and support. InterRAI also supports improved integration by providing health professionals with a common language of assessment and an electronic means of transferring information. The results against this measure reflect both new assessments and reviews for current clients. The higher number of assessments in 2011/12 and 2012/13 reflect the effort put in by the CCCN to review the care plans of all existing clients to ensure they align with the restorative model of care.

[50] This measure is now based on the national DHB performance measure (PP18) and 2012/13 results differ slightly to those previously published after revision to better align the definition with the national measure and to include late invoices from providers.

[51] The Liverpool Care Pathway is an international programme adopted nationally and reflects best-practice care. It begins with training of staff with the eventual aim of increasing the number of people supported by the pathway.

Rehabilitation Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of people referred to an organised stroke service after an acute event	C ⅄ [52]	40%	39%	55%	80%	-
% of people referred to cardiac rehabilitation services after an acute event	C ⅄ [53]	100%	100%	99%	≥80%	
People provided with Mental Health Activity and Living skills and Education and Employment Support services	V [54]	84	69	83	≥84	-
% of clients accessing Education and Employment support services supported into full or part time employment, or further education programmes	Q	67%	35%	57%	≥65%	-

Home-Based Support Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
People supported by long-term home and community support services	V ⅄ Δ	741	734	751	Est. >740	-
Number of long term community-based district nursing visits provided	V ⅄ Δ	5,189	4,913	4,364	Est. >5,000	-
Number of Meals on Wheels provided	V Δ	37,148	35,234	33,082	Est. >37k	-

Respite and Day Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
People accessing mental health planned and crisis respite	C ⅄ Δ [55]	37	50	45	>60	-
Occupancy rate of mental health planned and crisis respite beds	C ⅄ [56]	83%	71%	51%	85%	-
People supported by aged care respite services	V ⅄ Δ	72	58	64	Est. >70	-

Residential Care Services	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
Subsidised ARC rest home beds provided (days)	V ⅄ Δ	49,412	43,573	42,932	Est. <50,000	-
Subsidised ARC hospital beds provided (days)	V ⅄ Δ	36,542	40,821	39,118	Est. <40,000	-
Subsidised ARC dementia beds provided (days)	V ⅄ Δ [57]	2,414	2,805	3,434	Est. >2,000	-
Subsidised ARC psycho-geriatric beds provided (days)	V ⅄ Δ	4,041	3,729	2,296	Est. >4,000	-
% of ARC residents receiving vitamin D supplements	C ⅄	60%	57%	59%	75%	-

[52] This measure is now aligned with the national DHB performance measure (PP20); a change in the definition nationally has affected baseline data.

[53] This measure counts those who are referred to a community-based cardiac rehabilitation nurse specialist on discharge.

[54] These measures refer to people engaged in the Te Ara Mahi Vocational Service only.

[55] Results for the 2011/12 were incorrectly published; the result and the target have been corrected.

[56] Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilized and could be better directed to other areas.

[57] A review was undertaken in the past year with regards to dementia and psycho-geriatric allocations with a shift between categories occurring as people's needs were more closely and consistency assessed – the resulting increased and decrease bed-days under these to categories is largely as a results of the active review rather than increased/decreased in actual demand.

Māori Health Action Plan Priorities

Sitting alongside our Annual Plan the West Coast DHB has a standalone Māori Health Action Plan which outlines the key areas of focus in terms of improving outcomes for our Māori population. Achieving the goals in the Action Plan will require a collaborative effort from across the whole of our health system. While very few of the targets have been met this year progress has been made in the delivery of the primary care health targets for CVD risk assessment and smoking advice, screening rates for cancer and uptake of activity programmes.

Small population numbers mean the results need to be interpreted with caution, however increased focus is needed particularly around the delivery of services for children and young people. Breastfeeding is a key focus for the Healthy West Coast Alliance Work Stream for the coming year and recommendations from a recently completed review of Oral Health Services are also expected to improve results in this area.[58]

Māori Health Action Plan Indicators	Notes	2011/12	2012/13	2013/14 Result	2013/14 Target	Latest NZ result
% of PHO enrolees with ethnicity 'not stated' is maintained	Q	1%	1%	1%	<10%	-
% of Māori enrolled with the PHO	C	85%	93%	92%	>95%	-
% of tamariki exclusively and fully breastfed *Age 6 weeks*	Q[59]	67%	69%	52%	>74%	60%
Age 3 months		54%	52%	52%	>57%	44%
Age 6 months		20%	15%	19%	>40%	16%
% of the eligible population having a CVD Risk Assessment in the last 5 yrs	C	54%	59%	77%	90%	80%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C[60]	85%	86%	93%	>75%	73%
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C[60]	59%	69%	73%	80%	-
% of smokers identified in hospital receive advice and help to quit	C				95%	
Quarter 4 results		89%	98%	84%		96%
Full year results		86%	93%	87%		
% of smokers identified in primary care receiving advice and help to quit	C[61]	39%	55%	62%	90%	86%
% of tamariki fully immunised at eight months of age	C⅄				90%	
Quarter 4 results		86%	100%	94%		88%
Full year results		84%	95%	88%		-
% of the eligible population (65+) who have had an influenza vaccination	C	66%	69%	62%	>75%	-
% of pre-school children enrolled in DHB-funded oral health services	C † [62]	69%	70%	66%	77%	-
% of tamariki caries-free (no holes or fillings) at age 5	Q †	47%	51%	30%	61%	38%
Number of Māori participating in Te Whare Oranga Pai	V[63]	new	new	new	-	-
Number of Māori participating in the Green Prescription Programme	V	37	39	58	-	-
Number or Māori participating in Appetite for Life (nutrition courses)	V	2	8	12	-	-

[58] *Results for three of the national measures set in the 2013/14 Māori Health Action Plan (Acute Coronary Syndrome and Ambulatory Sensitive Hospital Admissions) have not been included in this report. Data collection for the Acute Coronary Syndrome measures is new and confirmed national results have not yet been made available by ethnicity. In regards to Ambulatory Sensitive Hospital Admissions, there has been a revision of the measure nationally and issues have been identified around the new denominator for Māori and Pacific populations which significantly distorts the results. The DHB is working with the Ministry of Health to resolve this issue.*

[59] *These results differ from previous years due to a change of reporting to financial rather than calendar year - data is now sourced from Plunket.*

[60] *These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment and reduce the rate of associated mortality. Standards are based on national targets and data is sourced from the National Screening Units. Previous year's results have been updated to reflect year's periods to June of each year and to reflect age band changes.*

[61] *Data for this measure is sourced from the PHO Performance Programme and results are now available by ethnicity, instead of the 'high-need' population grouping used in previous years. Data may therefore vary slightly.*

[62] *Oral health results relate to the school or calendar year and the 2011/12 result differs slightly from that previously published due to alignment between the 2011 and 2012 calendar year and correction of population estimates.*

[63] *The target for 2013/14 was to establish a baseline. The Te Whare Oranga Pai is still in implementation, and as such results are not yet available.*

BOARD'S REPORT & STATUTORY DISCLOSURE

to the stakeholders on the affairs of the Board for the year ended 30 June 2014.

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 $1.087M against the budgeted deficit of $1.100M (2012/13 result was a net deficit of $3.576M).

BOARD AND COMMITTEE MEMBER ATTENDANCE

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

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 2014			Year ended 30 June 2013		
	Board	Advisory Committee	Total	Board	Advisory Committee	Total
Board members						
Dr S P McCormack	31,997	1,000	32,997	13,333	1,000	14,333
P Ballantyne	20,775	2,000	22,775	20,000	2,000	22,000
K Brown	16,320	1,500	17,820	16,000	1,500	17,500
W Gilbertson	7,151	1,250	8,401	16,000	2,250	18,250
H Gillespie	16,320	2,188	18,508	16,000	2,500	18,500
M Lomax	9,169	750	9,919	-	-	-
M Molloy	7,151	750	7,901	16,000	1,750	17,750
P Neame	9,169	750	9,919	-	-	-
S Pugh	16,320	1,875	18,195	16,000	1,983	17,983
E Stratford	16,320	2,937	19,257	16,000	2,188	18,188
J Thomas	9,169	250	9,419	-	-	-
D Truman	7,151	1,000	8,151	16,000	1,750	17,750
S Wallace	16,320	1,500	17,820	16,000	1,750	17,750
J Vaile	16,320	1,750	18,070	16,000	1,250	17,250
Advisory committee members						
J Ayling (CPHAC/DSAC)	-	1,000	1,000		1,750	1,750
L Beirne (CPHAC/DSAC)	-	1,500	1,500		1,750	1,750
P Cutbush (HAC)	-	1,750	1,750		1,750	1,750
K Hamilton (HAC)	-	-	-		250	250
B Holland (CPHAC/DSAC, HAC)	-	-	-		500	500
G Howard (HAC)	-	1,250	1,250		1,000	1,000
M Mahuika-Forsyth (CPHAC/DSAC)	-	-	-		1,750	1,750
J McGill (CPHAC/DSAC)	-	1,500	1,500		1,250	1,250
R Moore (CPHAC/DSAC)	-	1,500	1,500		1,500	1,500
P Nolan (CPHAC/DSAC)	-	-	-		250	250
R Wallace (HAC)	-	1,250	1,250		1,250	1,250
R Williams (QFARC)	-	-	-		500	500
	199,652	**29,250**	**228,902**	**177,333**	**33,421**	**210,754**

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 $15,720 (2013: $25,164). 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 2014

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

Peter Ballantyne *Deputy Chair* *(to 19 June 2014)* *Chair* *(from 20 June 2014)*	• Member, Quality, Finance, Audit and Risk Committee, Canterbury DHB • Retired partner, 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 • Temporary Acting Chair, Brackenridge Estate Limited
Kevin Brown *Board Member*	• Councillor, Grey District Council • Trustee, West Coast Electric Power Trust • Wife works part time at CAMHS • Patron and Member, West Coast Diabetes • Trustee, West Coast Juvenile Diabetes Association
Helen Gillespie *Board Member*	• Peer Support Counsellor, Mum 4 Mum • Employee, DOC
Michelle Lomax *Board Member*	• Kawatiri Action Group – Past Member • Autism New Zealand – Member • West Coast Community Trust – Trustee • Buller High School Board of Trustees – Joint Chair • St John Youth Leader
Peter Neame *Board Member*	• President, Multiple Sclerosis Society, West Coast
Sharon Pugh *Board Member*	• Shareholder, New River Bluegums Bed & Breakfast • Chair, Greymouth Business & Promotions Association
Joseph Thomas Board Member	• Chief Executive, Development West Coast • Ngati Mutunga o Wharekauri Asset Holding Company Limited – Chair • Motuhara Fisheries Limited – Director • Management South Limited – Director • Ngati Mutunga o Wharekauri Iwi Trust – Trustee & Member • New Zealand Institute of Management Inc – Member (Associate Fellow) • New Zealand Institute of Chartered Accountants – C A, Member

Elinor Stratford *Board Member*	• 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, Grey/Westland district • Committee Member, Abbeyfield Greymouth Incorporated • Trustee, Canterbury Neonatal Trust • Advisor, MS/Parkinson West Coast • Trustee, Disability Resource Centre, Queenstown/West Coast • Elected Member, Arthritis New Zealand, Southern Regional Liaison Gp
John Vaile *Board Member*	• Director, Vaile Hardware Ltd
Susan Wallace *Board Member*	• 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 • Member of Tatau Pounamu • Father employee of West Coast District Health Board • Director, Kōhatu Makaawhio Ltd • Appointed member of Canterbury District Health Board • Chair, Poutini Waiora • Area Representative-Te Waipounamu Maori Womens' Welfare League
John Ayling *CPH&DSAC Committee*	• Chair of West Coast Primary Health Organisation • Chair of Access Home Health, a subsidiary of Rural Women New Zealand which has a contract with the West Coast District Health Board • Shareholder/Director in Split Ridge Associates Limited (which provides services to the disability sector). • Chair PHO Alliance
Lynette Beirne *CPH&DSAC Committee*	• Patron of the West Coast Stroke Group Incorporated • Member South Island Regional Stroke Foundation Advisory Committee • Partner in Chez Beirne (provider of catering and home stay services for the West Coast DHB and West Coast Primary Health Organisation) • Contract for the Café and Catering at Tai Poutini • Daughter employed as nurse for West Coast DHB • Member of West Coast DHB Consumer Council

Dr Cheryl Brunton *CPH&DSAC Committee*	• Medical Officer of Health for West Coast - employed by Community and Public Health, Canterbury District Health Board • Senior Lecturer in Public Health - Christchurch School of Medicine and Health Sciences (University of Otago) • Member - Public Health Association of New Zealand • Member - Association of Salaried Medical Specialists • Member - West Coast Primary Health Organisation Clinical Governance Committee • Member – National Influenza Specialist Group • Member, Alliance Leadership Team, West Coast Better Sooner More Convenient Implementation • Member – DISC Trust
Paula Cutbush *HAC Committee*	• Owner and stakeholder of Alfresco Eatery and Accommodation
Warren Gilbertson *QFARC Committee*	• Chief Operating Officer, Development West Coast • Member, Regional Transport Committee • Director, Development West Coast Subsidiary Companies • Trustee, West Coast Community Trust
Gail Howard *HAC Committee*	• Chair, Coal Town Trust • Trustee, Buller Electric Power Trust • Director, Energy Trust New Zealand
Jenny McGill *CPH&DSAC Committee*	• Employment with Lifelinks working with Ministry of Health contracted providers, including West Coast DHB. • Husband employed by West Coast DHB
Robyn Moore *CPH&DSAC Committee*	• Family member is the Clinical Nurse Manager of Accident and Emergency • Member of the West Coast Clinical Board • Consumer Representative on South Island Quality & Safety SLA

Richard Wallace *HAC Committee*	• Upoko, Te Runanga o Makawhio • Negotiator for Te Rau Kokiri • Trustee Kati Mahaki ki Makawhio Limited • Honorary Member of Maori Women's Welfare League • Wife is employed by West Coast District Health Board • Trustee West Coast Primary Health Organisation • Kaumatua Health Promotion Forum New Zealand • Kaumatua for West Coast DHB Mental Health Service (employed part-time) • Daughter is a Board Member of both the West Coast DHB and Canterbury DHB • Kaumatua o te Runanga o Aotearoa NZNO • Te Runanga o Aotearoa NZNO • Member of the National Asthma Foundation Maori Reference Group

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 2014, 6 (2013: 23) employees received payments relating to the termination of their employment totalling $265,772 (2013: $422,925), excluding retiring gratuities paid out. No Board members received compensation or other benefits in relation to cessation (2013: $nil).

REMUNERATION OF EMPLOYEES

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

	2014 Actual	2013 Actual
100,000 - 109,999	19	16
110,000 - 119,999	12	10
120,000 - 129,999	3	6
130,000 - 139,999	4	9
140,000 - 149,999	7	1
150,000 - 159,999	3	2
160,000 - 169,999	1	3
170,000 - 179,999	1	1
180,000 - 189,999	1	2
190,000 - 199,999	-	2
200,000 - 209,999	1	1
210,000 - 219,999	1	1
220,000 - 229,999	2	3
230,000 - 239,999	4	1
240,000 - 249,999	2	1
250,000 - 259,999	2	3
260,000 - 269,999	1	3
270,000 - 279,999	-	3
280,000 - 289,999	2	2
290,000 - 299,999	4	-
300,000 - 309,999	2	1
310,000 - 319,999	1	1
320,000 - 329,999	2	2
330,000 - 339,999	-	2
340,000 - 349,999	1	-
350,000 - 359,999	1	-
360,000 - 369,000	1	-
370,000 - 379,999	-	1
380,000 - 389,999	-	-
390,000 - 399,999	-	1
400,000 - 409,999	-	-
410,000 - 419,999	-	-
430,000 - 439,999	-	1
Total employees	78	79

78 employees (2013: 79) 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 78 employees shown, 74 are clinical employees (2013: 74) and are 4 non clinical employees (2013: 5).

STATUTORY INFORMATION

This Annual Report outlines the West Coast DHB's financial and non-financial performance for the year ended 30 June 2014. 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

GOOD EMPLOYER

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

Leadership, Accountability and Culture

It is often said that an organisation's strength is derived from its leaders and leadership behaviour, systems and processes, and storytelling – in other words its culture. This coupled with aligned strategies, structures, staffing, and skills; as well as integrated physical infrastructure, relationships and networks provides the best chance of achieving of our vision, as well as having the ability to meet the challenges of delivering quality health services to a physically remote and widely distributed population. To meet this considerable challenge we need an engaged, motivated, and highly skilled workforce that is committed to doing its best for their patients and for the wider health system.

Staff Mix by Average Age	Average age
Medical	48.9
Nursing	51
Allied Health	50
Support	57.5
Management & Administration	48.6

Staff Mix by Gender	Number	Percentage
Female	920	84
Male	170	16
Total	1,090	

Our leadership practices are concerned with ensuring that those who know best are the ones who are involved in developing and determining outcomes. This approach together with effective governance arrangements within West Coast DHB and across our health system work in a way so as to deliver positive patient outcomes.

Our expectations are that our leaders will tell a clear, consistent and compelling story about our direction of travel; will motivate and energise their teams to meet agreed organisational goals; and will be responsible and accountable for outcomes.

Staff Ethnicity	Number
Americas	2
Australian	9
British	30
Chinese	4
Indian	18
Maori	31
Middle Eastern	3
New Zealand European	299
New Zealander	2
Not Stated	671
Other	4
Other African	2
Other Asian	4
Other European	4
Pacific Peoples	4
South African	3

Integrated Talent Management

We utilise an integrated approach to attracting, selecting and engaging people across the West Coast Health System for today, tomorrow and the future. This approach has a range of elements including recruitment, candidate care, talent management and succession planning, and strategic sourcing. The purpose of this approach is to support an integrated West Coast Health System by providing proactive, targeted and agile initiatives at every level; maximising opportunities that result in faster recruitment turnaround and more engaged employees; and ultimately improving the patient journey throughout the West Coast Health system. As part of these approaches we fully embrace best practices of equity and diversity. We are also active participants in the development of consistent regional approaches to recruitment and associated support systems in this critical area.

Workplace Safety, Health and Wellness

We are committed to supporting and further developing a safe and healthy workplace. This focus is supported by a professional Health and Safety team through our partnership with Canterbury DHB, that includes experts in workplace safety, occupational health and rehabilitation, as well as employee Wellbeing. In addition to working with our employees this dedicated team also provides advice and support to management and staff. There is a health monitoring programme which includes screening and immunisation and employees are encouraged to access the Employee Assistance Programme if they are

faced with personal problems that may impact their work situation. Wellbeing programmes and activities to encourage and support employees in terms of healthier lifestyles are available throughout the organisation. An employee participation programme with safety training encourages all employees to be responsible for building and maintaining a healthy and safe environment at work. West Coast DHB continues to participate in the ACC Partnership Programme and is focussed on developing and implementing injury prevention programmes that address high risk areas and in the rehabilitation of employees back to work following an injury or illness. We do not tolerate any form of harassment or workplace bullying and ensure all staff is aware of harassment policies and procedures to deal with such a situation. This includes discussions with new employees at orientation, information and the training of managers to facilitate early intervention.

Remuneration and Recognition

Our policy is to ensure a fair, equitable, and transparent approach to remuneration management as well as a consistent approach to conditions of employment for both our IEA and MECA contracted workforces. Our IEA practice is to remunerate at an agreed market line which includes consideration of appropriate market data, as well as alignment to the principles of performance, employee competency development and organisation affordability. We also monitor feedback from employee engagement, exit, and attachment surveys to ensure our practices are relevant.

Employee Engagement

In June 2011, the West Coast DHB undertook a staff survey to measure the engagement of our workforce. Employee engagement illustrates the commitment and energy that employees bring to work and is a key indicator of their involvement and dedication to the organisation. International research suggests that highly engaged people put forth 57% more effort and are 87% less likely to leave an organisation. The survey was well represented by all demographics and professional groups. The results demonstrated that 80% of West Coast DHB's overall workforce is either engaged or highly engaged, with only 2% reported as disengaged. The areas that people reported to be most happy with were:

- **Empowerment** – they value the work they do and have a high level of confidence;
- **Commitment** – they are committed to their colleagues and prepared to go the extra mile;
- **Nature of the job** – the work people do is mentally stimulating and challenging; and
- **Patient Safety** – they would be comfortable being a patient here and feel confident raising any concerns.

West Coast DHB's focus on engaging and empowering our workforce will continue with a follow-up measurement during late 2014. Turnover rates remain slightly higher than national rates: the average time spent working in West Coast DHB services is 6.96 years, compared to an average of 8.3 years across all DHBs.

Employee Development

We continue to develop an integrated workforce approach across the West Coast Health System by engaging with primary and community providers on common HR systems, leadership development and workforce planning. This work is underpinned by a capability framework that has identified the management and leadership knowledge, skills, and behavioural attributes that will be required by all employees as we transform our system. To enable this work we have formed a tertiary alliance with the University of Otago, the University of Canterbury, and the TANZ network (10 SI and lower NI polytechnic institutes) to make available a common curriculum of development to all employees. These programmes are additional to the extensive skills development initiatives that come through the various professional groups for both clinical and non clinical employees. The rollout of an online performance appraisal process that ensures that all employees are focussed on the right things and expected behaviours at an individual level is continuing with rollout continuing in 2014/15. This process also identifies and provides input to the development needs of individuals.

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 2014, 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
Chair
31 October 2014

Helen Gillespie
Chair, Quality, Finance, Audit & Risk Committee
31 October 2014

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2014
in thousands of New Zealand dollars

	Note	2014 Actual	2014 Budget	2013 Actual
Income				
Revenue	2	135,794	136,185	133,744
Other operating income	3	629	519	798
Interest income	6a	608	240	291
Total income		137,031	136,944	134,833
Expenditure				
Employee benefit costs	5a	54,251	51,560	54,481
Other personnel costs	5b	1,226	1,750	1,630
Depreciation and amortisation expense	8,9	4,475	5,085	4,156
Outsourced services	4a	7,981	3,992	10,564
Clinical supplies		7,727	9,114	7,369
Infrastructure and non-clinical expenses		11,055	9,964	11,728
Payments to other health service providers	4b	48,868	54,174	46,519
Other operating expenses	4c	1,069	951	637
Finance costs	6b	713	642	650
Capital charge	7	753	812	675
Total expenditure		138,118	138,044	138,409
Surplus/(deficit)	14	**(1,087)**	**(1,100)**	**(3,576)**
Other comprehensive income				
Gain/(losses) on revaluation of land and buildings	14	-	-	-
Other changes recognised directly in equity (impairment)	14	-	-	-
Total other comprehensive income/(expense)		-	-	-
Total comprehensive income		**(1,087)**	**(1,100)**	**(3,576)**

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2014
in thousands of New Zealand dollars

	Note	2014 Actual	2014 Budget	2013 Actual
Balance at 1 July		10,152	12,128	10,196
Comprehensive income/(expense)				
Surplus/(deficit) for the year		(1,087)	(1,100)	(3,576)
Other comprehensive income/(expense)		-	-	-
Total comprehensive income/(expense)		(1,087)	(1,100)	(3,576)
Owner transactions				
Capital contributions from the Crown		1,100	1,100	3,600
Repayment of capital to the Crown		(68)	(68)	(68)
Balance at 30 June	14	**10,097**	**12,060**	**10,152**

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION

As at 30 June 2014

in thousands of New Zealand dollars

	Note	2014 Actual	2014 Budget	2013 Actual
Assets				
Current assets				
Cash and cash equivalents	13	7,483	7,809	6,172
Debtors and other receivables	12	8,786	4,614	3,968
Inventories	10	1,010	1,041	1,124
Patient and restricted funds	21	61	57	60
Assets held for sale	19	136	136	136
Total current assets		17,476	13,657	11,460
Non-current assets				
Property, plant and equipment	8	27,069	29,804	28,826
Intangible assets	9	1,681	1,002	1,812
Other investments	11	80	2	-
Total non-current assets		28,830	30,808	30,638
Total assets		**46,306**	**44,465**	**42,098**
Liabilities				
Current liabilities				
Borrowings	15	3,750	3,750	250
Creditors and other payables	17	10,587	8,072	8,304
Employee entitlements and benefits	16	8,468	8,427	8,210
Patient and restricted trust funds	21	61	57	60
Total current liabilities		22,866	20,306	16,824
Non-current liabilities				
Borrowings	15	10,695	8,695	12,195
Employee entitlements and benefits	16	2,648	3,404	2,927
Total non-current liabilities		13,343	12,099	15,122
Total liabilities		**36,209**	**32,405**	**31,946**
Equity				
Crown equity	14	70,761	72,761	69,729
Revaluations	14	19,569	19,569	19,569
Accumulated surpluses/(deficits)	14	(80,272)	(80,309)	(79,185)
Trust funds	14	39	39	39
Total equity		10,097	12,060	10,152
Total equity and liabilities		**46,306**	**44,465**	**42,098**

For and on behalf of the Board

Peter Ballantyne
Chair
31 October 2014

Helen Gillespie
Chair, Quality, Finance, Audit & Risk Committee
31 October 2014

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS

For the year ended 30 June 2014
in thousands of New Zealand dollars

	Note	2014 Actual	2014 Budget	2013 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health, patients and other revenue		132,678	136,704	135,452
Cash paid to suppliers		(67,286)	(75,509)	(78,700)
Cash paid to employees		(62,065)	(55,948)	(55,710)
Interest received		608	240	229
Interest paid		(781)	(642)	(648)
Goods and services tax (net)		(238)	-	50
Capital charge paid		(897)	(812)	(677)
Net cash flow from operating activities	13	2,019	4,033	(4)
Cash flows from investing activities				
Purchase of investments		(80)	-	-
Purchase of property, plant and equipment		(2,054)	(3,096)	(3,048)
Purchase of intangible assets		(506)	(204)	(1,706)
Net cash flow from investing activities		(2,640)	(3,300)	(4,754)
Cash flows from financing activities				
Capital contributions from the Crown		-	1,100	3,600
Repayment of capital to the Crown		(68)	(68)	(68)
Drawdown of loans		2,000		-
Repayment of loans		-		-
Net cash flow from financing activities		1,932	1,032	3,532
Net increase /(decrease) in cash and cash equivalents		1,311	1,765	(1,226)
Cash and cash equivalents at the start of the year		6,172	6,044	7,398
Cash and cash equivalents at the end of year	13	**7,483**	**7,809**	**6,172**

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 2014

in thousands of New Zealand dollars

	Note	2014 Actual	2013 Actual
Capital commitments		**1,716**	**1,477**

	2014 Actual	2013 Actual
Non-cancellable commitments – operating lease commitments		
Not more than one year	114	89
One to two years	49	-
Two to three years	55	-
	218	**89**

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

NOTES TO THE FINANCIAL STATEMENTS

For the year 30 June 2014

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 2014, and were approved by the Board on 31 October 2014.

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 de-recognition 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 West Coast DHB.

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

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

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. Due to the anticipated two year rebuild programme commencing in 2015, we expect some of the existing Grey Hospital buildings will be demolished in the 2017-18 year.

2 Revenue

	2014 Actual	2013 Actual
Ministry of Health Crown Funding Agreement	123,729	119,148
Ministry of Health (other)	1,041	3,377
Accident Compensation Corporation	1,806	1,786
Inter district patient inflows and other District Health Boards	1,635	1,692
Patients and consumers	2,880	3,112
Other government entities	130	113
West Coast Primary Health Organisation	4,573	4,516
	135,794	**133,744**

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

	2014 Actual	2013 Actual
Donations received	55	11
Donated assets	27	55
Rental income	176	187
Gain on disposal of property, plant and equipment	-	-
Other	371	545
	629	**798**

4 (a) Outsourced services

	2014 Actual	2013 Actual
Outsourced personnel		
Medical and nursing services	6,194	6,187
Allied health services	21	10
Other services	352	153
Outsourced services		
Clinical services	1,414	4,214
	7,981	**10,564**

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

(b) Payments to other health service providers

	2014 Actual	2013 Actual
Personal health and Maori health services	22,660	18,598
Mental health services	2,988	2,897
Public health services	417	426
Disability support services	8,317	7,923
Inter district patient outflows	14,486	16,675
	48,868	**46,519**

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.

(c) Other operating expenses

	Note	2014 Actual	2013 Actual
Impairment of debtors	20	-	(15)
Loss on disposal of property, plant and equipment		55	132
Audit fees (for the audit of the financial statements)		102	105
Audit related fees for assurance and related services		97	82
Board and advisory members fees		229	211
Community consultation		-	-
Operating lease expenses	18	154	122
Other		432	-
		1,069	**637**

5 (a) Employee benefit costs

	2014 Actual	2013 Actual
Wages and salaries	52,545	52,086
Contributions to defined contribution schemes	1,401	1,170
(Decrease)/increase in liability for employee entitlements	(21)	802
Restructuring expenses	326	423
	54,251	**54,481**

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

(b) Other personnel costs

	2014 Actual	2013 Actual
Other personnel costs	**1,226**	**1,630**

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.

6 (a) Interest income

	2014 Actual	2013 Actual
Interest income	**608**	**291**

(b) Finance costs

	2014 Actual	2013 Actual
Interest expense	**713**	**650**

7 Capital charge

	2014 Actual	2013 Actual
Capital charge	**753**	**675**

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 2014 was 8% (2013: 8%).

8 Property, plant and equipment

13/14 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 2013	6,085	15,459	22,638	340	2,232	46,754
Additions	-	511	1,466	-	-	1,977
Disposals/transfers	-	-	(528)	-	-	(528)
Revaluations and impairments	-	-	-	-	-	-
Transfer from non-current assets held for sale	-	-	-	-	-	-
Work in progress allocated	-	1,495	726	-	(2,158)	63
Balance at 30 June 2014	**6,085**	**17,465**	**24,302**	**340**	**74**	**48,266**
Depreciation						
Balance at 1 July 2013	-	(1,917)	(15,725)	(286)	-	(17,928)
Depreciation charge for the year	-	(1,980)	(1,850)	(8)	-	(3,838)
Transfer to non-current assets held for sale	-	-	-	-	-	-
Disposals	-	311	258	-	-	569
Revaluations	-	-	-	-	-	-
Balance at 30 June 2014	**-**	**(3,586)**	**(17,317)**	**(294)**	**-**	**(21,197)**

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						
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)**

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 2013	6,085	13,542	6,913	54	2,232	28,826
At 30 June 2014	**6,085**	**13,879**	**6,985**	**46**	**74**	**27,069**

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 at 30 June 2012 a $2.6m asset impairment. As at 30 June 2014, 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

	2014 Actual	2013 Actual
Software		
Cost		
Opening balance	3,761	2,644
Additions	447	1,189
Disposals	(56)	(72)
Closing balance	4,152	3,761
Amortisation		
Opening balance	(1,949)	(1,701)
Amortisation charge for the year	(637)	(320)
Disposals	(50)	72
Closing balance	(2,636)	(1,949)
Health Benefits Limited	165	-
Carrying amounts	1,681	1,812

There are no restrictions over the title of intangible assets and no intangible assets are pledged as security for liabilities. There is no impairment for the financial year ended 30 June 2014. There has been no change since last year.

West Coast DHB has contributed $165,000 (2013: Nil) to Health Benefits Limited (HBL) in relation to the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by HBL, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

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

- Class B Shares confer no voting rights
- Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services
- Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service
- Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company
- On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share

of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.

- On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

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

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

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

10 Inventories

	2014 Actual	2013 Actual
Pharmaceuticals	131	115
Surgical and medical supplies	865	927
Other supplies	14	82
	1,010	**1,124**

There were no write downs of inventories or reversal of prior year write-downs during the year (2013: $0). The amount of inventories recognised as an expense during the year ended 30 June 2014 was $1.77m (2013: $1.39m).

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

	2014 Actual	2013 Actual
Non-current		
Equity instrument	-	-
Other term deposits	80	-
Total investments	**80**	**-**

In December 2013 the West Coast District Health Board received a donation of $55,221 (2013: $56,524) 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 2014 was $78,969 (2013: $29,574) is included in the investment balances above, however in the prior year were reflected in cash and cash equivalents in note 13.

12 Debtors and other receivables

	Note	2014 Actual	2013 Actual
Trade receivables	20	1,380	935
Ministry of Health receivables		2,743	1,394
Other Crown receivables		3,857	792
Accrued revenue		433	340
Prepayments		373	507
	20	**8,786**	**3,968**

Trade and other receivables are non-interest bearing and receipt is normally on 30 day terms. Therefore the carrying amount of debtors and other receivables approximates their fair value.

13 Cash and cash equivalents

	Note	2014 Actual	2013 Actual
Cash at Bank		7,483	129
Less unpresented cheques		(90)	(832)
Petty cash and imprest		4	10
Call deposits		86	6,865
Cash and cash equivalents in the statement of cash flows	20	**7,483**	**6,172**

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

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

	2014 Actual	2013 Actual
Deficit for the period	(1,087)	(3,576)
Add back non-cash items:		
Depreciation and amortisation expense	4,475	4,156
Remove non-cash revenue:		
Donated assets	(27)	(55)
Add back other items:		
Equity receivable	1,100	-
Movements in working capital:		
(Increase)/decrease in debtors and other receivables	(4,818)	525
(Increase)/decrease in inventories	114	(84)
Increase/(decrease) in creditors and other payables	2,283	(1,772)
Increase/(decrease) in employee benefits	(21)	802
Net movement in working capital	(2,442)	(529)
Net cash inflow/(outflow) from operating activities	**2,019**	**(4)**

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 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**
Balance at 1 July 2013	69,729	19,569	39	(79,185)	10,152
Surplus/(deficit) for the year	-	-	-	(1,087)	(1,087)
Capital contributions from the Crown	1,100	-	-	-	1,100
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 2014	**70,761**	**19,569**	**39**	**(80,272)**	**10,097**

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.

Trust funds	2014 Actual	2013 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.

	Note	2014 Actual	2013 Actual
Non-current			
Ministry of Health	20	10,695	12,195
		10,695	**12,195**
Current			
Ministry of Health	20	3,750	250
		3,750	**250**

The details of terms and conditions are as follows:

Interest rate summary	Note	2014 Actual	2013 Actual
		%	%
Ministry of Health	20	2.30-6.58	2.30-6.58
Repayable as follows:			
Within one year		3,750	250
One to two years		3,250	3,750
Two to three years		250	3,250
Three to four years		-	250
Four to five years		-	-
Later than five years		7,195	4,945
	20	**14,445**	**12,445**
Total loan facility limits			
Ministry of Health		14,445	12,445
		14,445	**12,445**

Security and terms

The Ministry of Health 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

	2014 Actual	2013 Actual
Non-current liabilities		
Liability for long-service leave	622	596
Liability for sabbatical leave	73	76
Liability for retirement gratuities	1,953	2,255
	2,648	**2,927**
Current liabilities		
Liability for long-service leave	173	170
Liability for retirement gratuities	622	523
Liability for annual leave	3,901	4,008
Liability for other leave	1,234	1,283
Liability for sick leave	141	141
Liability for continuing medical education/ sabbatical leave	900	898
Salary and wages accrued	1,497	1,187
	8,468	**8,210**

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 2014.

17 Creditors and other payables

	Note	2014 Actual	2013 Actual
Trade payables		9,072	6,429
ACC levy payable		381	310
GST and PAYE tax payable		1,110	1,455
Income in advance		24	110
	20	**10,587**	**8,304**

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

	2014 Actual	2013 Actual
Not later than one year	49	89
Later than one year and no later than five years	105	33
	154	**122**

The West Coast District Health Board currently leases the premises of Greymouth Medical Centre, office space and other short term accommodation. During the previous year motor vehicles were leased.

The other leases are for one to three years with rights of renewal.

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 (2013: $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 31% (2013: 35%) 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 75% (2013: 55%). 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 2014	Impairment 2014	Net 2014	Gross Receivable 2013	Impairment 2013	Net 2013
Due 0-30 days		1,057	-	1,057	658	-	658
Past due 31-60 days		154	-	154	93	-	93
Past due 61-90 days		90	-	90	42	-	42
Past due more 90 days		109	(30)	79	213	(71)	142
Total Gross Receivables	12	**1,410**	**(30)**	**1,380**	**1,006**	**(71)**	**935**

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

	Note	2014 Actual	2013 Actual
Balance 1 July		81	96
Receivables written off during the year		(51)	155
Impairment reversed		-	(155)
Additional provision made during the year	4c	-	(15)
Closing balance 30 June		**30**	**81**

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 cash flows 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 2014 was 4.55% (2013: 2.5%).

The Ministry of Health loans are issued at fixed rates of interest. The carrying amounts of borrowings approximate their fair values.

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

	2014 Actual	2013 Actual
Cash		
AA-	(112)	(693)
Total Cash at bank	**(112)**	**(693)**

Counterparties without credit rating

Balance with Health Benefits Limited	2014 Actual	2013 Actual
Existing counterparty with no defaults in the past	7,595	6,865
Other investments	80	-
Total balance with Health Benefits Limited	**7,675**	**6,865**
Debtors and other receivables		
Existing counterparty with no defaults in the past	8,786	3,968
Total debtors and other receivables	**8,786**	**3,968**

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.

		2014 Actual							2013 Actual						
	Note	Effective interest rate	Total	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years	Effective interest rate	Total	6 months or less	6-12 months	1-2 years	2-5 years	More than 5 years
		%							%						
Cash and cash equivalents	13	4.26	(112)	(112)	-	-	-	-	2.25	(693)	(693)	-	-	-	-
Cash and cash equivalents	13	4.55	7,595	7,595	-	-	-	-	2.50	6,865	6,865	-	-	-	-
Other investments*	11	4.55	80	80	-	-	-	-	-	-	-	-	-	-	-
Secured bank loans:															
NZD fixed rate loan*	15	2.30	250	-	250	-	-	-	2.31	250	-	250	-	-	-
NZD fixed rate loan*	15	6.58	3,500	-	3,500	-	-	-	2.30	250	-	-	250	-	-
NZD fixed rate loan*	15	4.75	3,000	-	-	3,000	-	-	6.58	3,500	-	-	3,500	-	-
NZD fixed rate loan*	15	2.50	250	-	-	250	-	-	4.75	3,000	-	-	-	3,000	-
NZD fixed rate loan*	15	2.69	250	-	-	-	250	-	2.50	250	-	-	-	250	-
NZD fixed rate loan*	15	5.22	4,695	-	-	-	-	4,695	2.69	250	-	-	-	250	-
NZD fixed rate loan*	15	4.30	250	-	-	-	-	250	4.30	250	-	-	-	-	250
NZD fixed rate loan*	15	4.61	250	-	-	-	-	250	5.22	4,695	-	-	-	-	4,695
NZD fixed rate loan*	15	4.92	2,000	-	-	-	-	2,000		-	-	-	-	-	-
Bank overdrafts (total facility)										-	-	-	-	-	-
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 2014. 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
2014							
Secured Ministry of Health loans	14,445	14,445	-	3,750	3,250	250	7,195
Creditors and other payables	10,587	10,587	10,587	-	-	-	-
Total	**25,032**	**25,032**	**10,587**	**3,750**	**3,250**	**250**	**7,195**
2013							
Secured Ministry of Health 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**

Financial instruments (continued)

Fair values

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

	Note	Carrying amount 2014 Actual	Fair value 2014 Actual	Carrying amount 2013 Actual	Fair value 2013 Actual
Other investments	11	80	80	-	-
Debtors and other receivables	12	8,786	8,786	3,968	3,968
Cash and cash equivalents	13	7,483	7,483	6,172	6,172
		16,349	**16,349**	**10,140**	**10,140**
Secured loans	15	14,445	14,924	12,445	13,226
Creditors and other payables	17	10,587	10,587	8,304	8,304
		25,032	**25,511**	**20,749**	**21,530**
Unrecognised (losses)/gains		**-**	**479**	**-**	**781**

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	2014 Actual	2013 Actual
Loans and receivables			
Cash and cash equivalents	13	7,483	6,172
Other investments	11	80	-
Debtors and other receivables	12	8,786	3,968
		16,349	**10,140**
Financial assets at fair value through other comprehensive income			
Investments-equity instruments	11	-	-
		-	**-**
Financial liabilities			
Creditors and other payables	17	10,587	8,304
Borrowings-secured loans	15	14,445	12,445
		25,032	**20,749**

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.

	2014 Actual	2013 Actual
Opening balance patients deposits	54	52
Monies received	-	-
Interest earned	-	3
Payments made	-	(1)
Closing balance	**54**	**54**

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

	2014 Actual	2013 Actual
Opening balance restricted funds	6	6
Monies received	-	-
Interest earned	1	-
Payments made	-	-
Closing balance	**7**	**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 (2013: 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 $131.28m to provide health services in the West Coast area for the year ended 30 June 2014 (2013: $128.94m).

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 $1.64m for the year ended 30 June 2014 (2013: $1.69m). 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 $16.96m for the year ended 30 June 2014 (2013: $19.56m).

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 2014 totalled $2.86m (2013: $2.46m). These purchases included the purchase of blood products from the New Zealand Blood Service, coal from Solid Energy and services from educational institutions.

Compensations of key management personnel

	2014 Actual	2013 Actual
Short-term employee benefits-executive management	757	945
Post-employment benefits	20	25
	777	**970**

The executive management team consisted of 5 members (2013: 5) employed by the West Coast District Health Board. A further 6 members, including the Chief Executive were employed by Canterbury District Health Board (2013: 5). For the year under review no key management personnel were Board members (2013: 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, and Procurement & Supply Chain are provided to West Coast District Health Board under contract by Canterbury District Health Board.

24 Events after balance date

Work will continue on the facilities redevelopment plans for Greymouth and Buller under the nationally directed Partnership Group, with funding anticipated as a mix of debt and equity.

The Buller facility development was approved in April 2014, the DHB has not had the opportunity to fully explore procurement options and their financial impacts, with only an EOI process completed as at balance date. Development costs and any capital or lease expenditure associated with Buller have therefore not been included.

The detailed business case for the redevelopment of Greymouth Hospital and Integrated Family Health Centre (including the energy centre) was approved by Cabinet and the national Capital Investment Committee in April 2014. Construction is anticipated to begin at Grey Hospital in 2015; a secondary tranche of redevelopment has been identified for a later stage (yet to be determined), this includes demolition and furniture, fittings, and equipment. This project has commenced, with the securing of project resources post balance date.

There were no other events after 30 June 2014 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 $6.8M.

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 2014. The basis of arriving at the net cost for each output class can be found under the statement of accounting policy in the notes to the Financial Statements.

	2014 Actual	2014 Budget
Income		
Prevention	3,135	3,482
Early Detection and Management	33,557	35,177
Intensive Assessment and Treatment	76,843	78,015
Rehabilitation and Support	23,496	20,273
Total Income	137,031	136,947
Expenditure		
Prevention	2,577	2,424
Early Detection and Management	36,067	36,060
Intensive Assessment and Treatment	76,644	78,708
Rehabilitation and Support	22,830	20,855
Total Expenditure	138,118	138,047
Surplus/ (Deficit)	**(1,087)**	**(1,100)**

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 2014

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 39 to 72, that comprise the statement of financial position as at 30 June 2014, 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 about outcomes on pages 7 to 15, the statement of service performance on pages 16 to 27 and the summary of revenues and expenses by output class on page 73.

Unmodified opinion on the financial statements

In our opinion the financial statements of the Health Board on pages 39 to 72:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information because of limited control on information from third-party health providers

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.

Our audit opinion on the performance information of the Health Board for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

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 7 to 15, pages 16 to 27 and page 73:

- 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 2014, including for each class of outputs:
    - the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
    - the 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 2014. 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; 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 qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board. 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